Public Trust Board Bundle

Date 01/08/2023
Time 10:00 - 12:02
Location MS Teams Virtual Meeting
Chair Sir David Nicholson

1 10:00
Chairman's Welcome and note of apologies for absence, Prof. David Loughton, Debra Hickman
Lead Chair Sir David Nicholson, Prof. Loughton
Steph Cartwright will be joining the meeting later
Additional Attendees
Paul Terry, member of the public
Andy Tibbs, Business Development Director, Acacium Group
Shiela Gill, member of the public

2 10:04
Patient Voice - Excel in the Delivery of Care
Lead Head of Communications Hannah Murdoch
Action to note
Attendees

- Maria Glover, Cardiac Rehabilitation Nurse Manager
- Karen Wooding, Interim Senior Matron for Cardiology, Cardiothoracic, Critical Care and Outreach Services

https://youtu.be/PwnsRomQhHE

3 10:14
Staff Voice - IT Cyber Security Team
Lead Alan Duffell, Group Chief People Officer
Attendees
Jo Watts Head of IT Cyber Security
Jon Lockley Senior IT Cyber Security Technician

4 10:24
Declarations of interest
Lead Chair Sir David Nicholson
Action to note

5 10:25
Minutes of the meeting of the Board of Directors held on 6 June 2023
Action To approve
Lead Chair Sir David Nicholson

6 10:27 **Matters arising and Board Action Points from the minutes of the meeting of the Board of Directors held on 6 June 2023**
Lead Chair Sir David Nicholson
Action to note

7 10:31 **Chairs Report - verbal update**

8 10:35 **Chief Executive's Report- Verbal Update**
Lead Group Chief Executive Officer Prof. Loughton/ Group Strategy Officer Simon Evans
Presenter Chief Operating Officer Gwen Nuttall

Comprises the CEO Report and approved TMC minutes. Together with updates from the Group Chief Strategy Officer regarding progression on

- Strategic Delivery Plan Update Action to approve (see item 12.2)

Please see the reading room (item 18) for relevant information 18.1.1 and 18.1.3

To receive for information and assurance

9 **Excelling in the Delivery of Care (Section Header)**

9.1 10:40 **Elective Recovery Update Report**
Lead Chief Operating Officer
Action to note for information and assurance

9.2 10:50 **Performance and Finance- Chair's Reports**
Lead John Dunn
Action to discuss for information and assurance
Action to approve ToR
Please see the reading room (item 18) for relevant information 18.4.9 ToR

9.2.1 11:00 **Report of the Chief Financial Officer Months 2 and Month 3**
Lead Group Chief Financial Officer and Group Deputy Chief Executive Kevin Stringer
Action to discuss and note

9.3 11:10 **Quality Governance Assurance Committee (QGAC) - Chair's Report June and July 2023**

Lead Prof. Louise Toner
Action to discuss

9.3.1 11:15 **Chief Nursing Officer Report**

Lead Martina Morris, Deputy Chief Nursing Officer for and on behalf of Chief Nursing Officer Debra Hickman
Presenter Martina Morris

Comprises CNO Report, Patient Experience and Complaints Report, (under sperate item Director of infection Prevention and Control Report (item 9.3.3) and Patient Experience Enabling Strategy 2022-2025 (18.4.4)

Martina may also cover item 9.3.3 the DIPC Report

Action to discuss and note
Please see the reading room (item 18) for relevant information 18.4.3, 18.4.4

9.3.2 11:20 **Midwifery Services Report**

Lead Director of Midwifery Tracy Palmer
Action to discuss and note
Please see the reading room (item 18) for relevant information 18.1.4

9.3.3 11:25 **Director of infection Prevention and Control Report**

Presenter Martina Morris, DCNO, for and on behalf of Deb Hickman, CNO
Lead Dr Jo Macve Consultant Microbiologist, for Debra Hickman
Action to note

Note: this item may have already been covered by Martina in her report under 9.3.1 CNO Report

9.3.4 11:30 **Chief Medical Officer's Report**

Lead Chief Medical Officer, Brian McKaig
Comprises Mental Health Report, Pharmacy and Medicines Optimisation Report, Medical Appraisal Quality Assurance Annual Submission and NIHR Clinical Research Network Report (item 12.1)

Action To approve the Medical Appraisal Quality Assurance Annual Submission **18.4.8**
Remainder - to discuss and note

Please see the reading room (item 18) for relevant information 18.4.6, 18.4.7 and **18.4.8**

10 **Improve the Health of Our Communities (Section Heading)**

10.1 **OneWolverhampton Progress update Report**
11:35
Lead Group Group Director of Strategy, Simon Evans
Action to note

Please see the reading room (item 18.1.2) for relevant information

11 **Support our Colleagues (Section Heading)**

11.1 **People Organisational and Development Committee- Chairs Report June**
11:45
Lead Alison Heseltine
Action to discuss

11.1.1 **Group Chief People Officer by exception Workforce Report**
11:50
Lead Group Chief People Officer Alan Duffell
Comprising Annual Equality Report
Action to discuss and note

Please see the reading room item 18.4.1 for relevant information

11.1.2 **Annual Equalities Report**
Lead Group Chief People Officer
Action to approve

Please see the reading room (item 18) for relevant information 18.3

12 **Effective Collaboration (Section Heading)**

12.1 **NIHR Clinical Research Network (CRN) West Midlands**
Lead Chief Medical Officer /Pauline Boyle Group Director of Research and Development
Action to note

Additional information relating to agenda item 9.3.4

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

Lead Group Chief Strategy Officer
Action to approve
Please see the reading room (item 18) for relevant information 18.1.3

13 **Any other Business**

11:55

14 **Integrated Quality and Performance Review Executive Summary**

12:00 Lead Chief Nursing Officer Debra Hickman/ Chief Operating Officer and Deputy Chief Executive Gwen Nuttall
Action to discuss and note.

Please see the reading room item 18.4.2 for relevant information

15 **Questions from members of the public**

16 **Date and time of the next meeting Tuesday 10 October 2023 at 10:00 am**

17 **Resolution To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudical to the public interest**

18 **Reading Room - Reference Pack enclosures for Information**

18.1.1 **Chief Executive's Report of the TMC held on 26 May and 29 June 2023**
Additional information relating to agenda item 8

18.1.2 **OneWolverhampton Progress update Report**
Lead Group Chief Strategy Officer
Action to note

Addition enclosure relating to agenda item 10.1

18.1.3 **Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy**
Lead Group Director of Place
Action to note

Addition enclosure relating to agenda item 12.2

18.1.4 **Midwifery Services Report**

Lead Director of Midwifery Tracy Palmer
Action to note

Additional information relating to agenda item 9.3.2

18.2 Approved Committee minutes to note

18.2.1 Performance and Finance Committee minutes 25 May 2023 and 21 June 2023

18.2.2 People Organisational Development Committee Minutes 26 May 2023

18.2.3 Quality Governance Assurance Committee minutes 24 May 2023

18.2.4 Trust Management Committee 26 May 2023 and 30 June 2023

18.3 Annual Reports - Annual equalities
Lead Group Chief People Officer
Action to approve

Addition enclosure relating to agenda item 11.1.2

18.4 Regular Reports

18.4.1 Executive Workforce Report
Lead Group Chief People Officer Alan Duffell
Action to note

Additional enclosure relating to agenda item 11.1.1

18.4.2 Integrated Quality and Performance Report
Lead Chief Nursing Officer Debra Hickman and Chief Operating Officer and Deputy Chief Executive Gwen Nuttall
Action to note

Additional enclosure relating to agenda item 14

18.4.3 Patient Experience & Complaints Report
Presenter Alison Dowling
Lead Chief Nursing Officer Debra Hickman
Action to note

Additional enclosure relating to agenda item 9.3.1

18.4.4 Patient Experience Enabling Strategy 2022-2025

Presenter Alison Dowling
Lead Chief Nursing Officer Debra Hickman
Action to approve

Additional enclosure relating to agenda item 9.3.1

18.4.5 Joint Infection Prevention Delivery Plan

Lead Chief Nursing Officer Debra Hickman
Action to note

Additional enclosure relating to agenda item 9.3.1

18.4.6 Mental Health Report

Lead Chief Medical Officer Brian McKaig
Action to note

Additional enclosure relating to agenda item 9.3.4

18.4.7 Pharmacy and Medicines Optimisation Report

Lead Chief Medical Officer, Brian McKaig
Action to note

Additional enclosure relating to agenda item 9.3.4

18.4.8 Medical Appraisal Quality Assurance Annual Submission

Lead Chief Medical Officer Brian McKaig
Action to note

Additional enclosure relating to agenda item 9.3.4

18.4.9 Finance and Performance Terms of Reference

Lead Group Chief Financial Officer and Group Deputy Chief Executive Kevin Stringer
Action to approve

Additional enclosure relating to agenda item 9.2

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

Employee	Role	Interest Type	Provider	Interest Description (Abbreviated)
Alan Duffell	Group Chief People Officer	Loyalty Interests	UK and Ireland Healthcare Advisory Board for Allocate Software (Trust Supplier)	Member (unpaid)
Alan Duffell	Group Chief People Officer	Loyalty Interests	Chartered Management Institute	Member
Alan Duffell	Group Chief People Officer	Loyalty Interests	CIPD (Chartered Institute for Personnel and 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.
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
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
Stephanie Cartwright	Group Director of Place	Nil Declaration		

The Royal Wolverhampton NHS Trust (RWT)

Minutes of the meeting of the Board of Directors held on Tuesday 6 June 2023 at 9:30 am virtually via Microsoft Teams (MT)

PRESENT:

Sir David Nicholson	Chair
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 K Bostock	Group Director of Assurance,
Dr G Pickavance	Associate Non-Executive Director,
Ms P Boyle	Group Managing Director of Research and Development,
Ms A Harding	Associate Non-Executive Director,
Ms A Heseltine	Associate Non-Executive Director,
Mr K Wilshere	Group Company Secretary,
Ms T Palmer	Director of Midwifery,
Ms S Evans	Group Director of Communications and Stakeholder Engagement
Dr B McKaig	Chief Medical Officer

*(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,
Ms H Murdock	Head of Communications, RWT for Patient Story item,
Mr M Reid	Infection Prevention, RWT for Infection Prevention item,
Ms A Dowling	Head of Patient Experience and Public Involvement, RWT for Patient Experience item,
Ms G Nightingale	Executive Assistant to Group Chief Executive, RWT,
Ms K Flint	Lead Freedom to Speak Up Guarding, RWT, for Freedom to Speak Up item,
Ms K Haywood	Matron, RWT, for Staff Voice item,
Mr J Fordham	Member of the Public,
Mr C Randles	Member of the Public,
Ms O Powell	Administrator for the Company Secretary, RWT,
Ms Michelle Poulton	Deputy Head Radiotherapy Physics RWT, for Staff Voice item,
Ms K Cheshire	Deputy Director of Midwifery, RWT, for Patient Story item.

APOLOGIES:

Lord Carter	Strategic Advisor to the Board,
Dr U Daraz	Associate Non-Executive Director,
Mr M Levermore (v)	Non-Executive Director,
Dr J Odum (v)*	Group Chief Medical Officer.

Part 1 – Open to the public

TB. 9142 Apologies for absence
Sir David noted apologies from Dr Odum, Mr Levermore, Dr Daraz, and Lord Carter

TB. 9143 To receive declarations of interest from Directors and Officers
Sir David asked whether there were any new or changed declarations to be made. None were noted.

TB. 9145 Minutes of the meeting of the Board of Directors held on 4 April 2023
Sir David confirmed there were no amendments to the minutes of the meeting of the Board of Directors held on 4 April 2023.

Resolved: that the Minutes of the Board of Directors held on 4 April 2023 be approved as a true record

TB. 9146 Matters arising and Board Action Points from the minutes of the meeting of the Board of Directors held on 4 April 2023

4 April 2023/TB
Patient Safety, Quality and Experience
"Ms Dowling to clarify content of maternity patient section on page 4 within the report and report back to the Board."
Ms Dowling said the case related to a premature baby needing care but the case was assigned to maternity services which was where he was an inpatient.
Action: it was agreed the action be closed.

4 April 2023/TB
Education and Training (including Clinical Fellowship Programme)
"Ms Nickell to forward details of whether interest had been shown from other organizations for Physician Associates, if so who the organization was and who was it aimed for.
Ms Nickell provided the update below
Currently RWT engaged with the following HEIs:
• University of Wolverhampton: Course was closed to new applicants however RWT was still progressing placements for students until all current students had completed their studies (16 total)
• University of Birmingham: On placement the Trust currently had 3 students for their first placement year of their studies, and 6 on year two placements, (9 total)
• University of Keele: 8 first year students and 3 second year students (11 total)
• Aston University: PA programme was due to start September 2023, and plans were for RWT to take on 20 students (subject to actual numbers recruited): 10 at RWT 10 at Walsall Healthcare NHS Trust (WHT)
Action: it was agreed the action be closed.

TB. 9147 Patient Story
Sir David highlighted the Patient Story was a great opportunity to discuss patient experience and management within the organisation, he introduced Ms Cheshire. Ms Cheshire said the story was of a new-born patient who went through a traumatic birth and was transferred from Worcester Royal Hospital to RWT for cooling therapy. Ms Cheshire said the story highlighted the positive support the mother of the patient received from staff at the postnatal ward. Ms

Cheshire introduced her colleagues Ms Haywood and Ms Sarah.

Sir David felt it was a positive story and opened the item for questions.

Ms Rawlings asked whether the process was easy for patients to access the Local Maternity and Neonatal System (LMNS). She also asked if any issues were identified, or lessons learnt during the process. Ms Cheshire said there were concerns in obtaining intensive care slots and staff to look after the babies as some babies were sent to level three units due to capacity through delivery suite, she said the Triage system would assist with the process.

Ms Cowley asked about the delay in transporting the patient's mother to the hospital following the patient's arrival. She asked how the transfer gap time was managed between the patient and mother of the patient. Ms Cheshire said she did not know the details of the mother's transport and priority would have been to ensure the baby was taken into the intensive care unit (ICU) as quick as possible. Ms Cheshire said a transport team was used to transfer the baby which was different from the main ambulance service.

Prof. Cannaby commended the neonatal service for all their hard work done throughout the year on recruitment, education and training.

Mr Duffell said he felt patient experience was driven by attitudes, behaviour and support of staff, which in some instances could mean more to the patient than the clinical intervention itself.

Prof. Toner felt it was a positive story and agreed with Prof. Cannaby's comments in relation to activity which had taken place within the unit. She mentioned in particular the work being undertaken with developing the triage system in Wolverhampton. Ms Hickman mentioned the importance of building relationships with external stakeholders, in particular the West Midlands Ambulance Service (WMAS) colleagues in transport who were critical to LMNS.

Ms Cheshire said this was the type of experience the team wished to achieve with women using the service. She said the video had been shared with staff and discussions had taken place on the importance of patient experience.

Sir David said the experience the patient received was a positive reflection on the commitment and hard work undertaken by staff within the unit and thanked the team.

Resolved: that the Patient Story be received and noted.

<u>TB.9148 Staff Voice - Radiotherapy physics team</u>

Mr Duffell introduced Ms Poulton. Ms Poulton provided an introduction. Mr Duffell asked how she felt working for the Trust and whether the team had faced any challenges. Ms Poulton said she worked with a brilliant team, and staffing was a significant challenge and a national issue. She also mentioned the lack of Physician training places available at Universities. She said this led to high level posts being vacant for long periods of time. Mr Duffell said conversations had taken place with The Marches College as to whether support could be provided with training programs.

Dr McKaig mentioned accreditation reports received from the radiotherapy department were always positive. He also mentioned a family member had praised staff on how friendly staff were and the speed he had received treatment during his attendance.

Mr Dunn asked how many plans were undertaken weekly by the team. Ms Poulton said the team undertook approximately 40 to 45 plans a week with 6 physicists.

Mr Dunn asked if equipment used to administer radiation was up to date, whether correct maintenance contracts were in place and whether different machinery was required.
Ms Poulton said machines had a ten-year replacement program, the oldest machine being approximately 7 years old. She said the computer contracts used to produce treatment plans were to end December 2026.

Dr Pickavance asked if mental health support was being received for cancer patients undergoing plans. Ms Poulton said she did not have patient contact, so could not answer the question.

Ms Nuttall mentioned part of the development plan for Wrekin House was linked in with the radio pharmacy department together with the new aseptics as part of the capital program.

Ms Hickman said in response to the question from Dr Pickavance around psychological support. She said that it was an area of expertise that had challenges nationally to recruit into. She said regular dialogue took place with the Integrated Care Service (ICS), to look at regional provision and support.

Prof. Toner asked about the staffing issues and the most senior post which had been vacant for a long period of time. She asked whether there was a possibility of doing work based jobs with the current staff and if something could be done on the job or work based. Ms Poulton said that the positions that had been vacant for a long period of time were 8A physicists which would be for someone with 6 or 7 years' experience. She mentioned a trainee physicist was to commence in September who had undertaken Master of Science (MSc) but not hospital training, which would be provided by the Trust.

Sir David thanked Ms Poulton and the team for all their work. He said what had been see was the workforce challenges and said the Trust had always been very creative on how it dealt with those challenges. He said computer systems were important and the sooner the Trust commenced corporately thinking about the platform and how it fit within plans was important. He said in relation to mental health a review may be required on what was occurring in practice between the Trust, the Black Country Trusts and the Integrated Care Service (ICS).

Resolved: that the Staff Voice item of the Radiotherapy physics team be noted

TB. 9149 Chief Executive's Report

Prof. Loughton introduced his report and highlighted 12 new Consultants had been made including a Consultant on Cellular Pathology. He also mentioned a Urology Consultant had been appointed who had completed a Fellowship in Robotics. He said that this would assist in creating a Fellowship Program in Robotic Urology at Wolverhampton. He highlighted a number of meetings had taken place with Compton Hospice who was helpful during Covid with creating capacity, he felt there were opportunities of a closer working relationship across RWT and WHT. He mentioned work was being undertaking on Research and Development on how to take forward clinical trial activity as this was halted during Covid. He said he was hopeful that the contract with National Health Institute for Health and Care Research (NIHR) would be extended until 2030. He said he attended a meeting with the Vice Chair of the University of Wolverhampton and was optimistic that support would be provided for the Clinical Fellows Program and the Nurse Fellows Program. He said Matthew Taylor, the Chief Executive of the NHS Confederation visited RWT and looked at hospital at home, in Wolverhampton and Walsall together and positive feedback had been received following his visit. Prof. Loughton introduced Mr Evans.

Mr Evans mentioned a paper on the agenda on the aims and objectives. He said there had been additional work because of the signed off joint strategic plan with WHT. He said the

paper would entail what was meant in terms of strategic delivery plans for the year and had been through all relevant subcommittees. He said the work of the Black Country Provider Collaborative was progressing and there was significant work being undertaken on clinical work streams and sustainable services. He said Dr Odum was the lead for the program. He mentioned other work being undertaken to align to the support service and how to get further integrated around procurement, payroll and some HR elements. He said the Black Country Provider Collaborative and the four organisations were to work more closely and integrated now that there was a shared Chair. He said initial proposals for the development of a joint provider committee would enable faster and more streamlined decision making. He said the drafted terms of reference in the collaboration agreement had been compiled and was currently being reviewed by the four organisations.

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

TB. 9150 Freedom to Speak Up Report

Ms Flint introduced the report and said she was the new Freedom to Speak up Lead for the Trust. She said a full-time lead and 2 deputy leads were in post. She mentioned walk arounds continued and there was an aim to undertake sessions to more remote areas such as GP surgeries and West Park hospital. She said there had been a national increase in reporting concerns for nursing which was believed to be due to dispute over pay. She said work was to be undertaken on improving culture of the Trust, civility and respect package. She mentioned the aim for the next 12 months was to continue working closely with stakeholders and the ICS.

Ms Rawlings asked whether data for nursing and midwifery could be broken down specifically to each section of nursing and midwifery and not highlighted as one as she felt with the publication of the Ockenden Report the data would be helpful. Ms Flint said it was a requirement of the National Guardians Office to report the data together. She said data was collected separately for departments and that information was available if required.

Mr Dunn asked if a walkabout visit with Ms Flint could be arranged. Ms Flint confirmed this could be arranged.

Resolved: that the Freedom to Speak Up Report be received and noted
Action: Ms Flint to arrange a walkabout with Mr Dunn

TB.9151 OneWolverhampton Progress update Report

Mr Evans introduced the report and provided an update on out of hospital care which was one of the six strategic working groups. He mentioned the biggest single improvement had been seen across the Black Country within OneWolverhampton in medical fit for discharge. He highlighted there were 3.500 appointments that should have come to the hospital which had been diverted elsewhere using different pathways which had been developed. He said the length of stay of patients within the virtual ward had reduced due to the time spent within the virtual Ward. He mentioned quality feedback received from service users was also contained within the report.

Mr Dunn said the work being done was positive and asked whether a dashboard could be produced showing progress, how effective it was on managing demand, reducing visits and whether it was being done cost effectively. He said this information could be shared with the sub-committees to review. Mr Evans said he agreed with Mr Dunn and work was being undertaken to produce a dashboard. He also mentioned there was an agreement with the Local Authority regarding sharing data. He said he agreed that there needed to be a routine report to a performance committee and sub-committees. He said some of the data was already contained within the IQPR report.

Prof. Toner asked about priority 5, patient referral and seeing patients within 2 hours of referral. She said the Trust was compliant in 7 out the 9 areas. She asked what the remaining 2 areas were. Mr Evans said he would obtain the information and liaise direct with Prof. Toner.

Ms Cowley asked about the challenges within digital and technology, she acknowledged funding around Technology and within the Integrated Care Board (ICB) and Wolverhampton that was not being utilised by communities. She asked whether this was all linked. She also asked whether it was linked in with domiciliary care provision of keeping people in their own homes, how linked in were those providers in terms of accessing it. She finally asked whether provision was accessible to non-Wolverhampton residents presenting at Emergency Department (ED) both through ambulance and walking ins.

Mr Evans said in relation to digital and technology work 2 items were being trialled. He said 1 had an academic article published on it and the second was in the process of an academic piece of work to be published. He said a lot of funding was attracted for this. He felt nothing was being missed out from a technology perspective. He said he was aware OneWolverhampton was heavily engaged with ICB on securing funding on digitally. He said a lot of the work was through what was invested via OneWolverhampton themselves, and corporate partners working together. He said domiciliary care was undertaken through the integration work with social care, which was not as developed as nursing homes, but within the work program and actions were in place. He said that OneWolverhampton had a contract to deliver work within South Staffordshire and there were 3 localities within South Staffordshire and those 3 localities contributed 90% of all Medically Fit For Discharge (MFFD). He said a contract was in place to try and work with community services in those areas with the virtual ward they had developed.

Prof. Loughton said British Telecom were working with him on next generation of technology in terms of sensors on toilet seats, toasters, kettles, and other things. He felt more work was needed with Shropshire and Staffordshire to achieve similar development. He also mentioned the Trust was working closely with WMAS to enable alternatives to be made at an early stage.

Sir David said it was an important piece of work to be involved in and lessons could be learnt from some neighbouring organisations, WHT in particular. He said the work being undertaken for Community Services at Wolverhampton was very positive and was national leading work. He said thought needed to be given on ensuring the services were reviewed appropriately. He said Mr Dunn mentioned a dashboard could be created to be reviewed by performance committees. He said this should be commenced with thought given on how this would created and circulated for review.

Resolved: that the OneWolverhampton Progress update Report be received and noted
Action: Mr Evans to provide information direct to Prof. Toner on what the remaining areas were where the Trust was non-compliant on priority 5, patient referral and seeing patients within 2 hours of referral.
Action: A dashboard be created showing progress being made, to be reviewed by sub-Committees

TB.9152 Quality Account (QA) approval

Mr Bostock introduced the report and said the QA was led by Communications and Stakeholder Engagement team and he had overseen the legislative alignment for content. He said the QA had been through all the relevant Committees for comment and approval was sought by Board for it commence to the final stages on production. He said following approval the QA would be stylised ready for publication. He said it reflected the quality pledges that were made to the public for 2021/2022 and the achievement of those together with setting out the pledges for

2023.

Ms Heseltine felt that the document was in draft form for it to be approved, she acknowledged times scales on publishing and asked if there would be an opportunity to see the QA again in a complete version. Mr Bostock said it would be normal practice to sign off in draft format and asked Sir David if it could be circulated separately once ready for publication. Sir David agreed for the QA to be prepared ready for publication then circulated to Board members for any comment.

Resolved: the QA be approved subject to circulation to the Board by email prior to publication.

TB.9153 Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy approval

Mr Evans introduced the report and said the year 1 plan included how the Joint Strategic Plan was to be delivered across RWT and WHT. He said it covered all the four C's and all national planning requirements were to be included within the delivery plan. He mentioned there were key metrics for each of the objectives which would be measured and monitored through the relevant subcommittee structure. He said this would provide assurance as a Board that each of the objectives were being monitored on a regular basis, being scrutinised and then reported through the relevant Committees. He said one of the key objectives was to deliver on the financial challenge for the year. Mr Evans said the plan also included work with the provider collaboration together with the Place Based Partnership.

Ms Cowley asked how the plan would be embedded, how it would be relevant to staff across the organisation and how it would be factored within work plans.

Mr Evans said most of the items within the document were already being done by staff. He said staff needed to identify things in the plan which were relevant to their role to enable them to contribute and deliver. He said a piece of work was being undertaken with a divisional performance review process. He said during this process divisions were asked how they were contributing their activities to the delivery of both the Trust Strategy and the objectives.

Ms Jones said it was positive to see the board level metrics within the plan to monitor achievement of objectives. She said some were more input based rather than outcome based, i.e. the increased number of pathways being offered, and felt it should be matched with preventing admission or reducing time in the hospital. She also mentioned one that referred to increasing the number of researchers, which she said did not necessarily translate into achieving the objective of improving the quality and care through knew knowledge. She asked that more work be undertaken on translating some of the board level metric into actual patient facing outcomes rather than inputs.

Mr Evans agreed and said next to each item was reference to the relevant subcommittee which had an identified NED. He said he would review with the relevant NED and Executive Director.

Ms Heseltine highlighted on page 4 of the report WOD was mentioned but it should state PODC. Mr Evans said this was noted and would be amended.

Sir David thanked Mr Evans and said he agreed with Ms Jones in that some of the numbers needed to be refined to more outcome focused. He said the plan being brought to Sub-Committees to review would be helpful and it should also be brought back to the Board for future discussion.

Resolved: that the Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy approval be Approved

Action: Mr Evans together with relevant NED and Executive Director review board level metrics within the Strategic Delivery Plan – monitoring achievements of objectives to identify if they were input based or outcome based
Action: Mr Evans to amend the wording on page 4 of the Strategic Delivery plan from WOD to PODC

TB.9154 People Organisational and Development Committee - Chair's Report May.
Ms Heseltine highlighted the last meeting was not quorate with Mr Hemans departure from the Trust, but the meeting took place. She mentioned some divisions were not meeting performance, turnover, sickness absence but there had been an improvement with staff turnover during the last four months. She said no amendments were proposed to the Board Assurance Framework (BAF). She mentioned industrial action and some dates had been set by junior doctor's strike. She also said an objective was being considered in relation to workforce productivity.

Resolved: that the People Organisational and Development Committee - Chair's Report May be received and noted

TB. 9155 Quality Governance Assurance Committee (QGAC) - Chair's Reports April and May
Prof. Toner highlighted concerns relating to the cancer improvement plan and the 62 day waits in chemotherapy. She said the 62-day waits included renal patients and mutual aid was now available in Leeds, London and Russells Hall Hospital. She said 11 patients were going to Dudley and 3 to Frimley Park in London for their treatment which was purely patient choice. She said in terms of the 62 day waits and chemotherapy, plans had been accepted and signed off by NHSE. She said there had been increase with referrals for cancer in gynaecology and mutual aid was being sought. She also mentioned histopathology remained a challenge in terms of turnaround times, despite outsourcing.

Prof. Toner said staff had received the required training Mental Health Capacity Assessments (MCAS) but did not translate to assessments undertaken in practice, and when assessments were undertaken in practice processes were not being following. She said staff were looking at different areas for learning and improvement. She mentioned the other area for concern was scanning capacity within maternity services which had been referred to in two serious untoward incidents. She said mutual aid was being discussed with WHT to free resources at RWT to enable scanning to take place where required.

Prof. Toner also mentioned there were also concerns due to the financial deficit and the impact on decisions that may be taken where the money was to be spent and what impact that could have on quality and safety.

Ms Cowley asked in relation to the mental capacity act assessments due to the low level of compliance of assessments undertaken, was any harm seen to patients or any decisions made which were incorrect. She also asked how progress was to be overseen by QGAC.

Prof. Toner said there had been no evidence that there any harm had taken place due to assessments not being undertaken or not been undertaken correctly. She said staff were to review other areas to determine how improvements could be made which would be reported back to QGAC.

Dr McKaig mentioned in terms of training, compliance with the medical capacity and training was above 95%. He said there had not been any serious clinical incidents as a result. He said processes were difficult, areas or Trust's that did well had automated electronic systems that

lead through the process. He said once moving to the Electronic Patient Records (EPR) this would need to be reviewed. He said oversight and support was required from safeguarding teams and the ward teams when completing MCAS, in that that they were completed within the correct times. He said information was being received but accuracy needed to be audited.

Sir David asked whether the current Cancer Plans would assist in achieving targets as previously targets had not been met.

Prof. Toner said Cancer performance had related to medical staffing and other types of staffing, histopathology times, diagnostics, together with delays with diagnostics. She said there had been improvement in some metrics whilst others had deteriorated. She said plans were in place to improve performance. Sir David asked whether the Committee were assured that the Cancer Plan would deliver on the items mentioned.

Prof. Toner said unless there was an improvement with diagnostics and histopathology turnaround times there would continue to be a challenge. She said these had an impact on Treatment plan for patients. She said there were concerns as to whether these would be achieved within a timely manner.

Ms Nuttall said there were different elements affecting different tumour sites. She said renal tumour patients and nephrectomy patients had been identified as key risk. She said a plan was recently developed and in place together with clinical and operational oversight. She said this included mutual aid from other organisations together with the development of the robotic training and support from Russells Hall hospital. She said the Trust was focussing on the major tumour site. She said there were different elements to other tumours.

Sir David asked if the plan currently in place would provide improvements that were required by patients. Mr Loughton said there was still a shortage of histopathologists.

Prof. Toner said histopathology staff could report on paper or electronically but if there was a system that did not allow the correct decision to be made. She felt changing in systems was one of the things required to assist in improving performance. Prof. Loughton said job plans were being reviewed within histopathology to identify what changes could be made and what could be improved to assist in improving the cancer position.

Sir David felt more thought was required on how improvements could be made and Prof. Toner and the committee needed a degree of assurance of whether the plan would deliver and if not, then another plan was required.

Ms Nuttall said key was to treat more patients in a timely manner. She said the 62-day target would not be achieved due to the increase of the numbers of patients that they were being treating. She said the patients that were being treated and the length of time it took to treat them needed to be monitored. Sir David asked for information to be provided to QGAC to provide assurance that the Trust would deliver what was mentioned in the plan.

Sir David said with regard to mental health it was noted that the training was not an issue the issues was operationalising, whether through a digital process or some other process to enable outcomes to be achieved with patients. He asked Executive Directors for proposals to achieve this.

Resolved: that the Quality Governance Assurance Committee (QGAC) - Chair's Reports April and May be received and noted
Action: Information be provided to QGAC to provide assurance as to whether the Trust would deliver what was mentioned within the Cancer delivery plan.
Action: Proposals be sought on how monitoring of the MACS in practice would take

place

TB. 9156 Performance and Finance - Chair's Reports April and May
Mr Dunn highlighted there had been improvement with performance of Emergency Department (ED). He said it was anticipated the Trust would achieve the target of 78 week and P2 high priority patients and the long waits. He said due to increase of referral to treatment and the number of patients attending this was having an impact on the long waiting times which required focus. He said following the first month of the year the financial performance was adverse to plan. He said this was contributed by the exit run rate, sickness levels together with the considerable target of the cost improvement program. He said a group had commenced to review the pre and post Covid position, exit run rates productivity and how to utilise the huddle tool. He said a productivity program had also been created.

Sir David asked whether there was assurance on whether the performance or financial targets would be achieved. Mr Dunn assured that the 78-week target would be achieved and work was in progress on the financial targets.

Sir David acknowledged the focus on removing long waiters off the list. But felt if focus was on this individual point change could not be delivered. He said e.g. the way outpatients were dealt delt with. He felt a model was required to show how it would work during the next six weeks. He asked whether for assurance that there was an outpatient improvement plan in place.

Ms Nuttall said there was a long-standing but being reviewed outpatient transformation group looking at follow ups which included Patient Initiated Follow Up (PIFU). She said that the Black Country overall was part of Prof. Tim Briggs scheme to accelerate outpatient performance which the Trust would be undertaking. She said the program would be supported by dedicated transformation managers and the lead doctor being Dr Dowson from the QI team and overseen by herself and Dr McKaig. She said the program had commenced with a challenge of aiming for 20% of PIFU. She said the program of work varied by speciality and would be produced by the end of July. She said work was being undertaken linked with national schemes, advice and guidance.

Resolved: that the Performance and Finance - Chair's Reports April and May be received and noted

TB. 9157 Audit Committee - Chair's Report
Ms Jones introduced the report and stated the focus on year-end matters by the Committee. She said feedback had been received KPMG, external auditors on the findings of their external audit for the year ended March 2023. She said discussion also took place on important accounting policies and the impact they had on the reported results. She recommended to the Board that the annual report and financial statements be approved.

Resolved: that the Audit Committee – Chair's Report be received and noted, the annual report and financial statements for year ending 31 March 2023 be approved

TB. 9158 Report of the Chief Financial Officer - Months 12 and 1
Mr Stringer introduced the report and said the accounts had been reviewed by the auditors, and the Trust had delivered all statutory financial targets and made £90 thousand on a £900 million turnover. He thanked all the budget managers and the executive team together with the Board for their support. He highlighted the budget was £26.75 million deficit budget for this year as part of the system. He mentioned a regulatory response was awaited to the system plan submitted on the 4 May. He said during month 1 against the £5.9 million budget deficit for month

1 the Trust was at £8.3 million which was £2.3 million above the budget. He said highlighted within the report were exceptional costs, strike related costs for the 4 days of strike action and the cost of some medics covering the junior doctors during the strike which was just above £1 million and the loss of elective recovery fund (ERF) and activity that was expected but the Trust did not achieve. He said guidance had been received for month 1 and 2 not to report underperformance against the ERF plan. He said focus was on pay budgets challenges with sickness and cover on the bank, together with Cost Improvement Plan (CIP).

Sir David acknowledged the positive work undertaken last year to deliver within the resources available.

Resolved: that the Reports of the Chief Financial Officer - Months 12 and 1 be received and noted

TB. 9159 Chief Nursing Officer Director Nursing Report

Ms Hickman highlighted the pastoral team who had received recognition from the national office of the Chief Nurse on supporting clinical fellows which was positive news. She mentioned communication had been received from the Nursing Midwifery Council (NMC) on an issue with the computer based theory test which was pre country entry test. She said organisations where asked not to undertake anything at the time. She said FAQ's had been received from the NMC and further correspondence was awaited. She said the main point was to support individuals who had been asked to come forward and let employers know if they had been identified.

She said positive feedback had been received in relation to workforce report and the oversight from NHSEI in terms of review of process. She said there were some points of recommendations which were part of the efficiency work that was already being undertaken. She mentioned the Infection Prevention Annual report. She also said that C-Difficile had finished over trajectory 72 against 58 and the new trajectory had been reduced to 53. She said work was being undertaken with the Quality Improvement Team (QI). She said there would be an extension to the QI programs with ED and innovation around the implementation of Ultraviolet. She said the Trust was below trajectory for E.coli, pseudomonas and Klebsiella.

Resolved: that the Chief Nursing Officer Director Nursing Report be received and noted

TB.9160 Midwifery Services Report

Ms Palmer introduced the report and mentioned midwifery workforce, together and combined with vacancy and maternity leave there was over 22% whole time prevalent midwives to recruit into. She said it may be a challenging summer period and a contingency plan was in place. She said 1-1 care rates in established labour was still being maintained which was a priority for the service. She mentioned a positive recruitment event took place hosted together with the LMNS and all the vacancies were recruited into, who were due to commence at the Trust in September. She said work was being undertaken with the director and the quad team in benchmarking with the recommendations of the single delivery plan.

Resolved: that the Midwifery Services Report be received and noted

TB. 9161 Group Chief People Officer - Workforce Report

Mr Duffell introduced the report and highlighted the Trust was still maintaining a low vacancy level of 3.4%. He mentioned in relation sickness absence it was reported absence 2 months in arrears. He said the figures in March included seasonal influence and a carryover of Covid. He said in April there had been a significant reduction in requests for bank usage in both medical and nursing. He said there was a comprehensive health and wellbeing approach which had

been through PODC and HR advisors were focusing on areas of short-term sickness to try and address the cause. He said largely the long-term sickness was very well maintained and organised. He mentioned a dedicated paper could be brought to PODC to focus on sickness absence for scrutiny and review. He said junior doctors and RCN were currently balloting their members again. He said that if the threshold was met from an England perspective, then regardless of whether induvial Trusts met or did not meet that threshold they could take industrial action, so they would either succeed or fail on a national level rather than based on individual Trusts.   Sir David asked for sickness absence be reviewed at PODC.

Mr Loughton asked if the Trust was prepared for industrial action that was to take place next week.   Ms Nuttall said that there were two elements, there was a WMAS Unite strike on Monday and was expected to have minimal impact within the Black Country. She said in relation to the doctors in training, plans were in place but the impact had not assessed on any activity the Trust was trying to minimise that in line with expectations.

Resolved: that the Group Chief People Officer - Workforce Report be received and noted
Action: Sickness absence to be reviewed at PODC

TB. 9162 Learning from Deaths Report

Dr McKaig introduced the report and highlighted it was anticipated there would be a reduction in the Summary Hospital-level Mortality Indicator (SHMI) of 9.0 which would take the Trust below the 2.5 % of the lowest in the country. He said it was anticipated there would be an increase in the SHIM once SDEK activity was removed which would apply to all organistions. He said in relation to the medical examiner system and the national requirement for that to the rolled out to all GP practices and community services by July 2023 year, the date had been amended to April 2024. He said it was not a legal requirement until that time however the Trust had all practices in place.   He also mentioned two alerting diagnosis which were consistent for RWT being pneumonia ad stroke. He said for pneumonia the SHMI had reduced from 129 to 114 but was consistent with QI activity on metrics and around pneumonia pathways. He said there had been improvement in Sentinel Stroke National Audit Program (SSNAP) audit data together with a reduction in SHMI but were still alerting a SHIM of 116 which again was following clear QI pathways.

Prof. Loughton congratulated the team for all their hard work during the last 7 years in reducing the SHMI.   Sir David said it was positive news for the organisation together with the learning from deaths and all the work staff undertook which provided all the useful information.

Resolved: that the Learning from Deaths Report be received and noted

TB. 9163 Any Other Business

Sir David mentioned it was Ms Rawlings last Board meeting and thanked her on behalf of the Board for her contribution to the Organisation.   He said she had been on the Board for 11 years.   He said she had been a key part of supporting Executives together with giving challenge to people, together with work done around the Charity.   Ms Rawlings said it had been a privilege working with everyone at the Trust.

Sir David also thanked Mr Hemans whose term also ended with the Trust having spent 8 years on the Board.   He mentioned Mr Hemans was the Senior Independent Director and Chair of PODC

TB. 9164 Integrated Quality and Performance (IQPR) Report

Resolved the IQPR report was received and noted

TB. 9165 Questions from members of the public
Mr Wilshere confirmed no questions had been received.

TB. 9166 Date and time of the next meeting 1 August 2023 at 10:00 am

TB. 9167 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

Resolved; that the resolution be approved.
The meeting closed at 12:05 pm

26 July 2023 10:42

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 06/06/2023 8.3 Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy approval				
1330.	Strategic Delivery Plan – Year 1 (2023/24)	Evans, Simon	28/07/2023	Completed
	Explanation action item Mr Evans together with relevant NED and Executive Director review board level metrics within the Strategic Delivery Plan – monitoring achievements of objectives to identify if they were input based or outcome based. UPDATE: 07.07.23 Updated report is on the agenda for August Board meeting			
Public Trust Board 06/06/2023 8.1 OneWolverhampton Progress update Report				
1328.	OneWolverhampton Progress update Report	Evans, Simon	28/07/2023	Completed
	Explanation action item A dashboard be created showing progress being made, to be reviewed by sub-Committees. UPDATE 7.7.23 the report has been added to the August Board meeting agenda			
Public Trust Board 06/06/2023 8.3 Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy approval				
1331.	Strategic Delivery Plan – Year 1	Evans, Simon	21/07/2023	Completed
	Explanation action item Mr Evans to amend the wording on page 4 of the Strategic Delivery plan from WOD to PODC. UPDATE 07.07.23 the wording has been amended to reflect above			

Public Trust Board 06/06/2023 10.4 Group Chief People Officer - Workforce Report				
1334.	Staff Sickness Absence	Duffell, Alan	21/07/2023	Completed
	Explanation action item Sickness absence to be reviewed at PODC			
	UPDATE: Alan Duffell This has now been added to the POD agenda for July			
Public Trust Board 06/06/2023 9.2 Quality Governance Assurance Committee (QGAC) - Chair's Reports April and May				
1332.	Cancer Delivery Plan	Nuttall, Gwen Toner, Louise	21/07/2023	Completed
	Explanation action item Information be provided to QGAC to provide assurance as to whether the Trust would deliver what was mentioned within the Cancer delivery plan UPDATE: 25/07/23 a brief recovery report has been added to the agenda for the August Board meeting			
1333.	Mental Health Capacity Assessments	McKaig, Brian Toner, Louise	21/07/2023	Completed
	Explanation action item Proposals be sought on how monitoring of the MACS in practice would take place			
	UPDATE: Brian McKaig A recent MCA audit (March 2023) found that MCA compliance remains around 51% across RWT. This is due to a number of factors including new staff, winter pressures and the safeguarding adult's team being less visible on the wards due to			

	reduced capacity within the team. To remedy this, team has recently appointed a Band 6 MCA DoLS nurse and a Band 3 Safeguarding Adults Healthcare to ensure the team are more visible on the wards. This has resulted in higher numbers of DoLS applications across the trust the past 5 months. We are aiming to develop the Safeguarding Champions programme and reinvigorate the MCA service improvement project to ensure sustainability in the work we are undertaking. In addition to this the team have met with the digital nursing team with the intention of adding the safeguarding team to the app to give MCA advice. This will expand the scope of staff the team will be able to contact and provide support to. The Safeguarding adult's team are also researching MCA policies from other trusts with the intention of developing a stand-alone MCA policy. This will provide RWT staff and stakeholders with a better understanding of the application of the legislation with the aim of embedding it better across RWT. Further audits are planned to monitor future compliance of MCA and our team are working collaboratively with other trusts within the Black Country ICB to develop stronger auditing processes are in place. Another recent audit on the quality of mental capacity assessments has demonstrated poor adherence to the record keeping policy. Further to this, the safeguarding team are reviewing the current MCA form and putting procedures in place to review the quality of MCA's completed for DoLS referrals. We've reviewed and amended the bespoke MCA / DoLS training package and have aligned it with WHT to ensure consistency for staff with the application of legislation across both sites. The team are undertaking some targeted MCA / DoLS training with the Divisional Leads for specific areas of RWT where compliance has identified further work is required.			
Public Trust Board 06/06/2023 8.1 OneWolverhampton Progress update Report				
1327.	OneWolverhampton Progress Update Report June 2023	● Evans, Simon	20/07/2023	■ Completed
	Explanation action item Mr Evans to provide information direct to Prof. Toner on what the remaining areas were where the Trust was non-compliant on priority 5, patient referral and seeing patients within 2 hours of referral.			

	UPDATE: 07.07.23 the relevant information has been provided to Prof. Toner			
Public Trust Board 06/06/2023 7.1 Freedom to Speak Up Report				
1326.	Freedom to Speak Up	● Wilshere, Keith	07/07/2023	Completed
	Explanation action item Ms Flint to arrange a walkabout with Mr Dunn UPDATE: 07/07/23 a walkabout had been arranged and to take place in July			
Public Trust Board 06/06/2023 8.2 Quality Account approval				
1329.	Quality Account (QA) approval	● Bostock, Kevin	07/07/2023	Completed
	Explanation action item The QA be approved subject to circulation to the Board by email prior to publication. UDPATE: the QA was circulated and approval obtained			

Trust Board Meeting – to be held in Public on 1 August 2023		
Title of Report:	Chief Executive's Report	Enc No: 8
Author:	Gayle Nightingale, Executive Assistant to the Group Chief Executive	
Presenter/Exec Lead:	Gwen Nuttall, Chief Operating Officer/ Deputy Chief Executive	

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

Recommendations:

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

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

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

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

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

Chief Executive's Report

Report to Trust Board Meeting to be held in Public on 1 August 2023

EXECUTIVE SUMMARY

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

BACKGROUND INFORMATION

As follows

RECOMMENDATIONS

To note the report.

1.0	**Consultants**
	There has been two Consultant Appointments since I last reported: **Chemical Pathology** Dr Tejaskumar Kalaria **Radiology** Dr Zubair Sarang
2.0	**Policies and Strategies**
	Policies for June 2023 • Policies, Procedures, Guidelines and Strategies Update for May 2023 Report • CP61 - Management of the Deteriorating Patient Policy • HR08 - Recruitment and Selection Policy • OP96 - Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult and Paediatric Patients in Hospital and Community Services Policy • SOP27 – Standard Operating Procedure for Work Schedule Reviews and Exception Reporting for Doctors and Dentists in Training • SOP28 – New Standard Operating Procedure for the Discharge Lounge **Policies for July 2023** • Policies, Procedures, Guidelines and Strategies Update for June 2023 Report • CP54 – Supervision Policy • IP10 – Infectious Disease Isolation Policy • GDL08 – Parkinson's Disease Guidelines • SOP06 – Corporate Records Management – Standard Operating Procedure (SOP)
3.0	**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 • 24 May 2023 – chaired the virtual West Midlands Cancer Alliance Board, chaired the virtual Joint Staff Briefing and participated in the Joint Negotiating Committee (JNC) • 25 May 2023 – participated in the Deputy Chair interviews • 26 May 2023 – presented the Exceeding Expectation Award to Jasveer Kaur – Volunteer and chaired the virtual Trust Management Committee (TMC) • 30 May 2023 - virtually met with Mark Axcell, Chief Executive – Integrated Care System (ICS) • 31 May virtually met with Kerry Flint, Freedom to Speak Up Guardian • 2 June 2023 - virtually met with Becky Wilkinson - Director of Adult Services, Wolverhampton City Council and joined the Princes Trust Celebration event and met with Mark Ondrak, Staff-side Lead • 5 June 2023 - participated in the virtual Black Country Collaborative Executive Group meeting • 6 June 2023 – participated in the Black Country Provider Chief Executives and ICS Chief Executive virtual meeting • 8 June 2023 – hosted a visit for colleagues from NHS England (NHS) on the GP Clinical Fellows Model • 9 June 2023 – participated in the virtual Local Negotiating Committee (LNC) • 13 June 2023 – attended the 'Getting it Right First Time (GIRFT) virtual webinar on meeting the demand for Rheumatology Outpatient services • 15 June 2023 – participated in a Wolverhampton Local Authority hosted visit with Professor Chris Witty, Chief Medical Director – NHS England and Chief Medical Adviser to the UK Government • 19 June 2023 – participated in the virtual Local Medical School Liaison Committee with Healthcare Education England (HEE) and Birmingham Medical School and undertook Institute of Safety and Occupational Health (ISOH) Executives and Directors virtual training • 20 June 2023 – undertook a virtual Non Executive Directors (NEDs) briefing and participated in a virtual Senior Medical Staff Committee meeting • 21 June 2023 – participated in a hosted visit by NHS England's Digital Team, participated in a virtual Regional Cancer Board meeting • 23 June 2023 – presented the Exceeding Expectation Award to Lydia Akhaine - Healthcare Assistant, virtually met with Mark Axcell, Chief Executive – Integrated Care System (ICS) and participated in a Black Country ICS and NHS England Financial Plan Delivery meeting • 26 June 2023 – participating in a virtual Black Country ICS Organisation Development (OD) discussion and attended the joint Sustainability staff webinar • 27 June 2023 – attended the University of Wolverhampton's Alumni 2023 Awards • 28 June 2023 – hosted The Institute of Digital Health, Inaugural meeting on A digital care pathway for care at the end of life: The Proactive Risk-Based and Data-Driven Assessment of Patients at the End of Life (PRADA) and participated in the Joint Negotiating Committee (JNC) and attended Professor James Cotton's Inaugural Lecture on Interventional Cardiology: Drugs, Devices and Developments at the University of Wolverhampton • 29 June 2023 – chaired a Staff Briefing, participated in a virtual Health Scrutiny Committee and attended along with Dr Jonathan Odum - Group Medical Director, a GP Collaboration Inaugural event with North Staffordshire Local Medical Committee (LMC) • 30 June 2023 - participated in a virtual Institute of Health and Social Care Management (IHSCM) Executive Advisory Committee meeting and attended a thank you event for the International Midwifery programme • 3 July 2023 - attended Amanda Pritchard's – Chief Executive, virtual briefing on the newly launched NHS Workforce Plan • 4 July 2023 – undertook a radio interview with BBC West Midlands on the newly launched NHS Workforce Plan • 5 July 2023 – participated in the Joint Trust Board Development session and presented awards to staff at the Joint Clinical Quality Improvement (CQI) ceremony and joined in various NHS75 Birthday Celebration events

	• 7 July 2023 - virtually met with Becky Wilkinson - Director of Adult Services, Wolverhampton City Council • 11 July 2023 – chaired the virtual West Midlands Cancer Board and chaired the virtual West Midlands Acute Provider meeting • 14 July 2023 - virtually met with Professor John Raftery, Vice Chancellor, University of Wolverhampton • 18 July 2023 - undertook a virtual Non Executive Directors (NEDs) briefing and participated in the Black Country Provider Chief Executives and ICS Chief Executive virtual meeting • 20 July 2023 – participated in a Black Country virtual finance meeting with Julian Kelly, Chief Financial Officer, NHS England, attended a virtual NHS Providers - Roundtable on Trust Board Engagement with Health Services Research and participated in a Black Country Quarterly System Review meeting (QSRM) • 21 July 2023 –chaired the virtual Trust Management Committee (TMC)
4.0	**Board Matters**
	Professor Ann-Marie Cannaby, Group Chief Nurse/ Deputy Chief Executive – Walsall, left the Trust on Friday 14 July 2023 to take up the post of Pro Vice Chancellor – Health and Life Sciences at Coventry University. On behalf of the Trust Board I would like to take this opportunity to thank her for all her support and hard work in improving services for staff and patients and appointed John Dunn, Non Executive Director (NED) as Deputy Chair.

Any Cross-References to Reading Room Information/Enclosures:

Paper for submission to the Trust Board Meeting – to be held in Public On 1 August 2023		
Title of Report:	Elective Care Recovery	Enc No: 9.1
Author:	Tim Shayes, Deputy Chief Strategy Officer Gwen Nuttall – Chief Operating Officer	
Presenter/Exec Lead:	Gwen Nuttall – Chief Operating Officer	

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

Recommendations:

The Board is asked to note the contents of the report and endorse the plans in progress.

The Board is asked to note the content of the letter received on 26th July, concerning escalation of the Trust into Tier 2 (regional support) for Delivery of Cancer 62 Days treatment standard.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Various risks identified, detailed on BAF SR16 On Risk Register: Yes☒No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	Risk Description Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable): BAF SR16.		
Resource Implications:	Revenue: The additional plans increase the revenue being received by the Trust Capital: None Workforce: Some of the schemes rely on recruitment of additional workforce Funding Source: Elective Recovery Fund		
Report Data Caveats	Not applicable		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☒No☐	Details: Constitutional standards and planning guidance. See attached letter.
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

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

Summary of Key Issues using Assure, Advise and Alert

Assure
Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee

The Trust is on trajectory to reduce the number of patients waiting over 62 days for treatment by the end of March 24

The Trust has achieved the Qtr. 1 trajectory for the achievement for 28 day faster diagnostic standard.

The Trust is part of the going further faster project to improve and streamline outpatient care for patients. Implementation of national tool kit for best practice is being rolled out – Orthopaedics and Ophthalmology first specialties.

Theatre utilisation and patient touch time in theatres are in the top quartile nationally.

Trust Day case rates for the British Association of Day Case Surgery (BADS) are over the national benchmark and in the top quartile overall. There are action plans in place for the specialties that are not (Paediatric Tonsillectomies)

The Trust has a plan to increase the amount of elective activity to ensure more patients can be treated and assist with financial recovery.

Advise
Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought

Current performance for 2-week cancer wait is affected as the Trust is providing mutual aid to Walsall Healthcare for suspected skin (dermatology appointments).

The Trust is currently treating sufficient patients overall to eliminate 65 week waits by the end of March 24. Urology, Gynaecology and General Surgery in particular may require mutual aid to achieve.

The Trust has agreed external support for endoscopy, metrics improving and on trajectory to achieve year end position; gynaecology – due to start in Aug 23; mutual aid from other NHSE hospital for Urology Cancer Patients – numbers of patients reducing monthly.

Alert
Positive assurances & highlights of note for the Board/Committee

Trust has not achieved the target to have zero patients waiting over 78 weeks by the end of July.

The Trust has not achieved the standard for the number of patients are treated within 62 days for cancer treatment and is unlikely to recover this metric in 2023/24 (due the fact we are treating the long waiters).

Black Country Pathology Service (BCPS) have a recovery plan to improve turnaround times, which is an 18month action. Currently performance for improvement is off trajectory and this can affect all Trusts in the Black Country.

On going strike action by Doctors in Training and Consultants will impact on the capacity available to treat patients on the waiting lists. This could have impact on reducing waiting list numbers and achievement of 65 weeks.

The Trust has been escalated into Tier 2 performance for cancer 62 day performance. The letter from NHSE is a separate attachment to this paper.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Prioritise the treatment of cancer patients • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Effective Collaboration	• Improve clinical service sustainability

Elective and Cancer Care Recovery

Report to Trust Board Meeting to be held in Public Tuesday 1st August.

BACKGROUND INFORMATION

Context

- The Trusts incomplete waiting list (i.e., the number of patients awaiting planned treatment) stood at 81,398 at the end of July 23. At the beginning of Covid (i.e., March 20), it stood at 39,142, i.e., a rise of 107%.
- The waiting list has risen consistently during this period up until the end of the last financial year when it began to plateau. The impact of the repeated instances of industrial action combined with the transfer of Urology patients from Walsall has caused it to rise again.
- The rise in the number of patients waiting is of equal challenge to the change in the profile of the waiting list which has been seen. A much greater proportion of patients are now waiting longer, as demonstrated in the chart below. This has given rise to challenges in meeting the national ambitions for long waiting patients, particularly the target to clear 78 week waits by the end of June 2023.

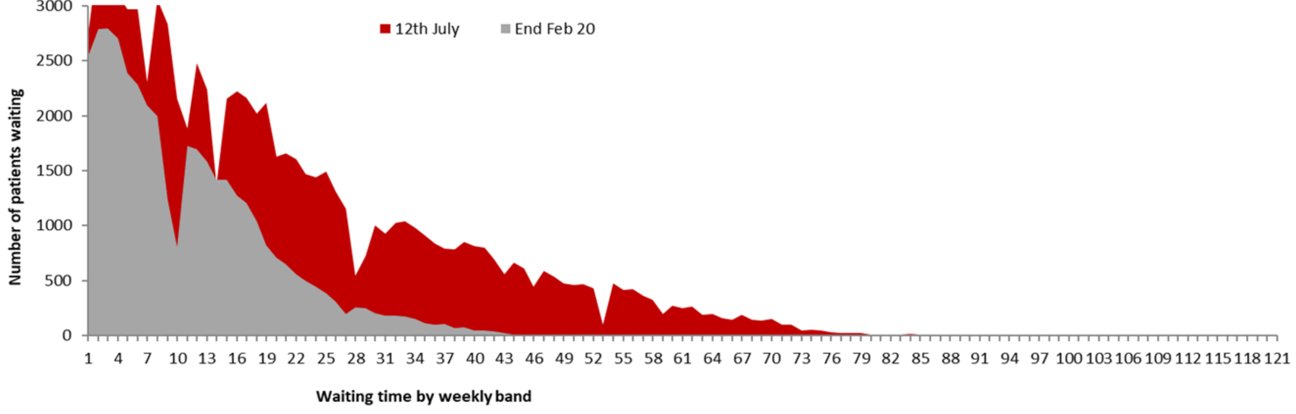

Figure 1: Waiting List Profile

- Whilst the Trusts Referral to Treatment (RTT) performance is similar to other similar sized Trusts across the Midlands region, the Trust is an outlier for its 78-week performance compared with other Trusts within the Black Country. This dates back to before Covid when the Trust had a greater proportion of longer waiting patients than its Black Country peers. There is a lack of any meaningful mutual aid on offer within and outside of the system.
- The challenges, both in terms of waiting list growth and waiting time position, are more significant in surgical specialties which were impacted by the pandemic more greatly than non-admitted specialties.
- The reasons are multifactorial, however there is limited appetite for clinicians to undertake waiting list initiative working.

Current Position

- As detailed above, the Trust's waiting list currently sits at 81,398 with 57% of patients waiting 18 weeks or less for treatment.
- Whilst the plans below are not exclusively focused on long waiting patients, this remains the focus of NHS England. 39 patients were waiting over 78 weeks at the end of June, with a similar number forecast for July and August (around 56 for July and 53 (worse case scenario) for August.

- The challenge with regards to 78 weeks are isolated to three specialties – General Surgery, Gynaecology and, of most concern, Urology. Clearance of 78-week waits is expected in General Surgery by the end of August. Clearance within Gynaecology and Urology is currently at risk to be achieved by the end of August. In the case of gynaecology, a plan has been developed (and detailed in the section below) but is likely to need a month to accommodate the patients that convert from the outpatient capacity being insourced. In the case of Urology, we do not have a plan that fully accommodates all the demand coming through. The Trust has repeatedly requested mutual aid from outside the Black Country, none has yet materialised.

- The Trust had initially forecast clearance by the end of June – two primary factors led to this changing:
    1. The impact of industrial action, and
    2. The volume of Urology patients transferred from Walsall.

  Since June, the Trust has been in regular discussion with the system over the extent of the challenge and the likely timeline for recovery which has not changed. In reports to the Performance and Finance Committee, the risk to achieving the 78 weeks has been clear, as it has in the same meetings with NHSE West Midlands. and the Black Country system. It is the system who submit the forecast for the Black Country to NHS England.

Future Plans

The plans below focus on maximising the activity we can deliver in the short, medium, and long term. Whilst they will have a positive impact on the longest waiting patients, they are primarily focused on reducing the overall waiting list to a more sustainable position. It is acknowledged that the 'tail gunning' approach to long waiters is not sustainable with a reduction in initial outpatient waiting times needed to give flexibility within patients' pathways.

Short to mid-term

- A number of schemes have been devised that will result in 10,940 additional attendances throughout the remainder of the financial year. The Performance and Finance Committee were presented with these in the form of an updated ERF (Elective Recovery Fund) plan in July. These include:
    - Additional locum support within Urology – commenced.
    - Additional activity in Urology resulting from the combined service with Walsall - commenced.
    - Increased theatre productivity in Orthopaedics – commenced.
    - Increase day case rates in specialties below the BADs expectation – commenced.
    - Additional weekend working where there is appetite for WLI – Restart in September
    - Insourcing within Gynaecology and Urology. Gynaecology to commence in Aug, Urology under procurement.
    - Insourcing within endoscopy – commenced.
    - Expansion of Community Diagnostic Centre activity - commenced
    - Substantive recruitment in ERF generating workforce, e.g., additional theatre staffing.
- It is worth emphasising that the constraints around workforce and mutual aid mean the requirement for insourcing is one of only practical options for delivering a material reduction in the waiting list.
- All of the above are focused on increasing the throughput of activity within the system already.
- Alongside this, the outpatient transformation programme is targeting a reduction in demand through the use of advice and guidance, PIFU (patient initiated follow up) and a reduction in follow ups. Participation in the go faster further outpatient programme – commenced, Orthopaedics and Ophthalmology. The P&F committee has asked for an in-depth report on the activities of the outpatient improvement group.

Longer term

- The schemes are likely to continue for the next one to two years. Outpatient transformation and the work already commenced is key to assisting with the longer-term achievability of NHS plan expectations. In conjunction, the longer-term solution is the additional theatre capacity that is secured at Cannock North Hub through the TIF process. Approval and subsequent completion of this scheme will enable the Black Country Provider Collaborative to continue with transformation of services across the system.

Cancer Performance

Timely Cancer treatment is vital to treat the disease early, which is associated with improved survival rates. The patient experience of waiting for a cancer diagnosis or treatment is an anxious and stressful time for any patient and often their relative, therefore clinicians aim to provide holistic care as soon as possible.

There are three main cancer metrics that are used as the performance markers for the timely treatment of patients with suspected, diagnosed and treatments. These are the 2 week wait (2WW) for suspected cancer referrals, achievement of ensuring patients receive their diagnosis within 28 days (28FDS) and the treatment of patients within 62 days of their referrals. There are other metrics, however the focus below is on the metrics mentioned above.

The Trust has recently been escalated into Tier 2 regional management and support for failure to achieve 62-day cancer metric. (Note - there are 3 tiers for escalation,1 national support, 2 regional support and 3 self-management). This letter was received on 26th July and is shared with the board for information. There is a lack of clarity on the criteria for exiting tiering at this stage.

Current Performance.

2 week wait. Trust achievement of this metric has wavered between months and is affected most often by a surge in referrals (since Covid and pretransfer of Walsall Urology service) there has been an overall increase in 2 week referrals of 15% The specialities with the most significant increase (%) are breast, colorectal, gynaecology, skin and haematology. The Trust provides mutual aid to other Black Country Trusts for 2 week waits, indeed the Black Country Trusts have developed a strong mutual system to support patients who are willing to travel to be seen at the site that has the shortest waiting time. At the moment RWT are supporting WHT with Skin referrals, this has a negative impact on the 2ww performance in this specialty and for the Trust as whole. If there are referral increases (often seen post be clear on cancer campaigns) restoration of the standard is achieved by additional waiting lists.

Actions in place or underway to ensure patients are referred via the correct pathway include:

- Triage of appointments by Clinical Nurse Specialists (e.g. breast and colorectal) development of other specialist clinics that are not on cancer pathways (eg breast pain or iron deficiency anaemia).
- The implementation of national initiatives such as Faecal Immunochemical Testing (FIT) and Teledermatology in Primary Care are to assist patients and enable clinicians to provide assurance that patients will be treated on the appropriate clinical pathway. The Trust / Wolverhampton are not yet are the nationally set standard for FIT, however all the Black Country are above national trajectory. Public engagement is key to this metric and improvement. There is evidence the implementation of FIT (blood in poo test) is reducing referrals to the colorectal / Lower GI tumour site. Teledermatology is still in roll out phase.
- Haematology are currently auditing referrals to their service to review if referrals can be streamlined in consultation with Primary Care

28 Day Faster Diagnosis. The trust is achieving this metric. This was for 67% of patients to receive their diagnosis in 28 days at the end of Qtr 1. The Trust achieved 67.5%. Forecast in July are currently above 70%. Risks to improvement to this metric are in turnaround of Histology waiting times, which could affect all the Black Country Trusts and the availability of diagnostics. The Trust has achieved the national standard for MRI and CT since April.

Action in place or underway to ensure patients are diagnosed in 28 days:-

- Implementation of the CDC to increase ultrasound capacity (Dec 23) and maintain MRI and CT scanning times.
- Use of insourcing to improve waiting times for Endoscopy, including bowel screening patients.
- Black Country Pathology action plan to improve turnaround times.

62 Day Treatment. There are two measurements used for assessment of performance with 62-day treatment. The first is a nationally / regionally mandated number for all Trusts to achieve in reducing the number of patients waiting over 62 days. The RWT number of patients waiting over 62 days had more than doubled post covid in May 21 to 278. The Black Country have agreed Trust targets to reduce the number of patients, for RWT the number to achieve is no more than 217 patients waiting over 62 days by the end of March 24. The Trust figure has been recalculated within the ICB and accepted by NHSE West Midlands following the transfer of the urology waiting list since June 23. This has not yet been reflected in national metrics. The Trust is currently on trajectory to achieve the reduction; however a series of actions are required to ensure that this will be achieved.

The other 62-day metric and the one used nationally is the percentage of patients who wait over 62 days for their treatment. This is that no less than 85% of patients (on the cancer PTL) will be treated within 62 days. The Trust, for multifactorial reasons, has not achieved this metric since 2018. The top three reasons for failure are; lack of capacity in certain specialities, late referrals into the Trust as a tertiary receiving centre, late reporting of histopathology and then subsequent delay for the MDT to make a treatment decision. The speciality that is most challenged is Urology for Prostate and Renal tumours. The Trust is not likely to achieve the 62% metric by the end of Mar 23 – this is due to the numbers of longer waiting patients we will treat during this time period.

Actions in place or underway number of patients waiting is reduced: -

- Additional weekend lists in Urology - commenced
- Transfer of renal tumours to the Dudley Group (DGFT) providing mutual aid and part of the longer term Black Country Urology Action plan, under the remit of the provider collaborative
- Use of nationally available mutual aid for Urology – Frimley Park and Nottingham Circle – commenced. Limitation is patient preference to be treated locally.
- As above – Black Country Pathology action plan to improve turnaround times.
- Medium term discussions around closer working with SWBH with regard to Gynae-Oncology
- Plan to increase number of clinical oncology consultant to support patients requiring Radiotherapy and Chemotherapy treatments – underway, but likely longer term.
- Cannock Chase Chemotherapy Centre re-opened - Apr 23.

DIAGNOSTICS PERFORMANCE

- Around 55% of patients currently have their diagnostic undertaken within six weeks of request.

- Performance varies significantly by modality with some (e.g., CT and MRI) achieving the constitutional standard of 99% but others well below this.
- Our greatest challenges lie within ultrasound, endoscopy, echocardiography, and cystoscopy.
- A deep dive of diagnostics performance is being presented to the Finance and Performance Committee in August but with the following plans already in trail:
    - Increased insourcing in endoscopy at Cannock as part of the CDC programme – commenced.
    - Additional lists in echo – completed
    - Additional insourcing in echo – due September
    - Additional rooms for ultrasound at Cannock as part of the CDC programme – build due December with locum working before then

RECOMMENDATIONS

Note the content of the report, the actions underway and the risk to delivery.

Any Cross-References to Reading Room Information/Enclosures:

Elective Recovery Paper – July 23

To: David Loughton, CEO
Gwen Nuttall, COO
The Royal Wolverhampton NHS Trust

cc. Diane Wake, ICD Lead for Cancer

NHS England
Cardinal Square – 4th Floor
10 Nottingham Road
Derby
DE1 3QT

26 July 2023

Dear David and Gwen

Tier 2 – Cancer - Royal Wolverhampton NHS Trust

Firstly, I would like to take this opportunity to thank you for all you have done for long waiting patients in your work to eliminate 78week waits and reduce the 62-day cancer backlog. The progress that has been made in the last twelve months, in an extremely challenging context, has been exceptional.

It is imperative we continue this excellent work, and support each other to ensure patients are seen, diagnosed, and treated in a timely fashion, whilst delivering the best health outcomes for them individually.

On next steps, the tiering approach will continue through 23/24 for both elective recovery and cancer.

From an elective recovery perspective, the challenge now moves to the elimination of 65 week waits by April 2024. For cancer, work will continue to reduce the 62-day backlog, but also the achievement of the Faster Diagnostic Standard (FDS).

This letter confirms Royal Wolverhampton NHS Trust has been placed into Tier 2 for Cancer. This will involve regular meetings to discuss progress and facilitated support from the relevant parts of NHS England where required.

Tier 2 Cancer meetings will review progress against specific elements of cancer recovery. This will include 2 key priorities areas as follows:

1. Cancer: Continue reducing the number of patients waiting over 62 days and take steps to ensure that the Cancer Faster Diagnosis Standard (FDS) is met by March 2024. In support of this, we ask that you continue to prioritise diagnostic capacity to reduce cancer backlogs as set out in the 1st February letter from Dame Cally Palmer, aiming for a maximum turnaround time of 10 days from referral to report where cancer is suspected

2. Cancer: In support of the over-arching objectives on performance, this year's Operational Planning Guidance incudes specific actions around priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (utilisation of teledermatology) and prostate cancer (implementation of best practice timed pathway, supported by carved out capacity for MRI where required).

It is these three tumour groups which continue to drive low performance in most providers.

There is of course a need to ensure Tier 2 meetings cover wider elements of provider recovery programmes. As for Cancer we would expect tumour level breakdowns to be included for both the >62-day backlog and Faster Diagnosis Standard to inform these discussions.

The progress of trusts in Tier 2 will be reviewed monthly, using Cancer Waiting Times, Cancer PTL, and WLMDS data. Trusts can be moved in or out of Tiers. Any changes to Tier status, and therefore oversight and support, will be agreed between regional and national teams.

Thank you for all your continued hard work in addressing what is one of two critical priorities for the NHS over the remainder of this year. Please share this letter with the Trust Board and relevant committees and do email yavenushca.lalloo-padley@nhs.net should you have any questions.

Yours sincerely,

Nick Hardwick
Regional Director of Performance -
Midlands

Paper for submission to the Trust Board Meeting to be held in Public on 1st August 2023

Title of Report	Exception Report from the Finance and Performance Committee Chair	Enc No: 9.2
Author:	J Dunn	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	19th July 2023 and 21st June 2023	

Action Required of Committee/Group			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes	Yes	Yes	Yes

Recommendations:

To note the Chairs Report and to review and authorise the following 2 business cases:

Fresh, Frozen & Chilled Food Contract Award (REAF 1122)
Linen & Laundry (REAF 1121)

To note and discuss the financial and acute recovery position.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	A Change of scoring to risk SR18 (Cyber) is being evaluated and will be presented to the next committee		
Compliance and/or Lead Requirements	CQC	Yes/No	Details:
	NHSE	Yes/No	Details:
	Health & Safety	Yes/No	Details:
	Legal	Yes/No	Details:
	NHS Constitution	Yes/No	Details:
	Other	Yes/No	Details:

Summary of Key Issues:
See attached report.

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 d) Implement technological solutions that improve patient experience e) Progress joint working across Wolverhampton and Walsall f) Facilitate research that improves the quality of care

Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)	Working/Executive Group	N	Date:
	Committee	N	Date:
	Board of Directors	N	Date
	Other	N	Date:

Trust Committee Chairs Assurance Report

Name of Committee/Group:	Performance & Finance Committee Meeting
Date(s) of Committee/Group Meetings since last Board meeting:	19th July 2023
Chair of Committee/Group:	John Dunn
Date of Report:	23rd July 2023

ADVISE Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	
	• Financial Performance – The Trust is reporting an in month adjusted deficit of £4.25m this is £0.77m adverse to plan, this leads to a year to date deficit of £15.8m which is £2.7m behind plan. The remainder of the year looks exceptionally challenging. • Integrated Quality and Performance Review – The Committee advises of the following: ◦ ED 4 Hour Performance – Performance dipped slightly in month, continuing to exceed the new national standard of 76%. We continue to benchmark well both locally and nationally. ◦ Patients who are Medically Fit for Discharge (MFFD): at the end of June 23 we had 51 patients in a hospital bed that were medically fit for discharge, this is an improvement when compared with the previous month and continues to show an overall improving trend. ◦ The contractual partnership with Arcturis will terminate on 31st July • Elective Recovery Programme – The Committee advises of the following: ◦ The Urology waiting list transferred from Walsall on 1st June ◦ Having plateaued towards the end of 2022/23, our waiting list has risen steadily since the turn of the year, primarily as a result of the continued instances of industrial action and the transfer of Urology patients from Walsall which created the jump in June. Only the latter was known when devising the trajectory and therefore incorporated. RTT is growing and patients will be waiting longer. Patients waiting over 52 weeks is forecast to be approximately 5000 at year end. ◦ The Trust delivered 112.7% of activity in June (compared to 2019/20) compared to a plan of 104%. On a value weighted activity basis however, this equates to 101% (compared with a plan of 103%) as the overperformance was higher in outpatients. ◦ Diagnostics: performance has shown some improvement and is continuing to show an overall upward trend. The largest waits continue to be in endoscopy, echocardiography and ultrasound. Remedial action plans are in place with an expectation that performance improves throughout 2023/24. ◦ Cancer: We continue to see high volumes of 2ww referrals particularly in Breast, Gynaecology, Lung and Skin. Referrals for June 23 were 16% higher than 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.

	• 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. • A revised ERF plan was presented to the Committee.
ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Financial Performance Report – Financial performance is deteriorating. A Q2 forecast and end of year forecast has been requested for next month's meeting. • CIP is showing a £27m shortfall, Divisional run rates are under pressure from higher than planned sick leave and costs associated with the industrial action. • The committee agreed the following action: • Increased monitoring and control of Divisional run rates • Review of the ERF plan to increase productivity beyond the planned target to increase capacity to combat the growing waiting list. • Review the implementation of all additional financial controls. • Continue the deep dive review into the Cost Improvement Programme. • Review comparative data. • Q2 and year end forecasts. • Financial Recovery Group – The Committee agreed the following: • A deep dive into the Cost Improvement Programme was requested as it falls short of target and further action is critical. • Comparisons will take place with colleagues and good practice will be shared. • Investigate recurrent costs and savings and those which were recurrent last year that flow into this year. • Investigate the use of Allocate to assist with Bank costs. • Look into demand management via OneWolverhampton to possibly identify savings that could flow into the Emergency Department against visits saved. • Grip and control measures will be presented to the AOP Oversight group for sign off. • Elective Recovery Programme – • The Trust has been alerted to the likelihood of it being escalated to the tiering system for its 62 day cancer performance – formal confirmation has still not been received. There is also ambiguity over whether performance will be managed at system or provider level and the criteria for exiting the tiering system. • 623 patients (570 outpatients and 52 admitted patients) either had their appointment cancelled or rearranged as a result of the Junior Doctor strike. This activity is being re-arranged but to the detriment of other patients who would have otherwise utilised this capacity. • The Trust had 39 x 78 week breaches at the end of June and the likelihood is that these will increase to around 56 in July. These breaches are isolated to three specialties with most significant challenges in Urology and Gynaecology. Additional plans have been developed to minimise the number of breaches for August. Performance is falling short in 78 weeks and ERF. There is a remedial plan in place. The Trust is not going to hit the zero target for 78-week patients at the end of July. The Trust is forecasting that performance will be between 50 – 60 patients that will require plans across 3 specialties. The Committee has requested a recovery plan for those patients impacted. • The Committee have requested a deep dive into cancer performance at next month's meeting.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The Committee reviewed the 3 BAFS risks (see BAF section). The Committee has requested a more detailed review of the cyber risk at next month's meeting.
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	Fresh, Frozen & Chilled Food Contract Award (REAF 1122) Linen & Laundry (REAF 1121)
Changes to BAF Risk(s) & TRR Risk(s) agreed	• BAF risks 15, 16 and 18 were discussed and agreed. • There were no new emerging/arising risks.
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**	• Revised Performance & Finance Committee Terms of Reference • Monthly Financial Report • Financial Recovery Group Report • Elective Care Recovery Programme • IQPR extract • Winter Plan • Extension of Alliance Medical CDC Contract Until December 2023 (REAF 1104) – Endorsed • Annual Work Plan 6 Month Review • Proposed Performance & Finance Committee Dates 2024
Matters presented for information or noting	• Capital Report • High Value Contract Report • Supplementary Finance Report • Temporary Staffing Dashboard Report • NHSI Monthly Return
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

Trust Committee Chairs Assurance Report

Name of Committee/Group:	Performance & Finance Committee Meeting
Date(s) of Committee/Group Meetings since last Board meeting:	21st June 2023
Chair of Committee/Group:	John Dunn
Date of Report:	21st June 2023

<table>
<tr>
<td>ADVISE
Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought</td>
<td>

Financial Performance – The Trust is reporting an in month adjusted deficit of £3.3m, this is £0.35m favourable to plan, this leads to a year to date deficit of £11.6m which is £1.9m behind plan.
Integrated Quality and Performance Review – The Committee advises of the following:

ED 4 Hour Performance – Performance remained static in month, continuing to exceed 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.
Medically Fit For Discharge – At the end of May 23 we had 60 patients in a hospital bed that were medically fit for discharge, this is a very small deterioration of 4 patients when compared with the previous month.

Finance Recovery Group – The Committee have asked for a deep dive into Outpatients Transformation and a separate meeting is being arranged.
Elective Recovery Programme – The Committee advises of the following:

The Urology waiting list transferred from Walsall on the 1st June.
Having plateaued towards the end of 2022/23, our waiting list has risen steadily since the turn of the year. This is primarily as a result of the industrial action in March and April. This trend is expected to continue as a result of the transfer of Urology patients from Walsall as well as the further industrial action in June.
The activity plan for this year was signed off at 106.9%, falling slightly short of the 108% Trust target. On a value weighed activity basis (i.e. the financial value of our activity plan), the value of this plan is 103%. The committee asked for the plan to be revisited with the objective of meeting or exceeding target.
The Trust delivered 101.6% of activity in May (compared to 2019/20) compared to a plan of 104%. On a value weighted activity basis however, this equates to 106% (compared with a plan of 103%)
Since the last meeting, additional plans have been developed that include additional weekend working to support the 78 week position and business cases to support an overall increase in activity. Our activity plan now stands at 104% as a result.

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<tr>
<td>ALERT
Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee</td>
<td>

Financial Performance Report – The Trust is unlikely to improve performance to meet Q1 target.
Financial Recovery Group – The Committee agreed the following:

A deep dive into the Cost Improvement Programme was requested as it falls short of target and further action is critical.

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	• Comparisons will take place with colleagues and good practice will be shared. • Investigate recurrent costs and savings and those which were recurrent last year that flow into this year. • Investigate the use of Allocate to assist with Bank costs. • Look into demand management via OneWolverhampton to possibly identify savings that could flow into the Emergency Department against visits saved. • Grip and control measures will be presented to the Committee for sign off. • A deep dive will take place to look into the unidentified £28m. • Elective Recovery Programme – • The Trust has been alerted to the likelihood of it being escalated to the tiering system for its 62 day cancer performance – formal confirmation has still not been received. There is also ambiguity over whether performance will be managed at system or provider level and the criteria for exiting the tiering system. • 623 patients (570 outpatients and 52 admitted patients) either had their appointment cancelled or rearranged as a result of the Junior Doctor. This activity is being re-arranged but to the detriment of other patients who would have otherwise utilised this capacity. • The Trust anticipates having 63 x 78 week breaches at the end of June. Whilst a plan had been developed to clear these patients, this was impacted by the industrial action, the transfer of Urology patients from Walsall and the limited number of surgeons (or alternative providers) to treat perform these operations.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Elective Recovery Report – The Trust has completed a self-assessment of its Elective Recovery Plans using the appended tool from NHS England. This demonstrates either existing compliance or a plan to achieve this in all areas with the exception of the reduction in our follow up waiting list. • IQPR – Highlights in performance, Board to compliment the team on ED performance as it continues to operate at a high level.
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 risks were discussed and agreed. • There were no new emerging/arising risks.
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**	• Revised Performance & Finance Committee Terms of Reference • Monthly Financial Report • Financial Recovery Group Report • Elective Care Recovery Programme • IQPR extract

Approved	• Winter Plan • Extension of Alliance Medical CDC Contract Until December 2023 (REAF 1104) – Endorsed • Annual Work Plan 6 Month Review • Proposed Performance & Finance Committee Dates 2024
Matters presented for information or noting	• Capital Report • High Value Contract Report • Supplementary Finance Report • Temporary Staffing Dashboard Report • NHSI Monthly Return
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

Paper for submission to the Trust Board Meeting – to be held in Public 1 August 2023		
Title of Report:	Report of the Chief Finance Officer – Month 3	Enc No: 9.2.1
Author:	James Green, Interim Director of Finance Mark Greene, Deputy Chief Financial Officer	
Presenter/Exec Lead:	Kevin Stringer, Group Chief Financial Officer	

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: See below BAF On Risk Register: Yes☒No☐ Risk Score (if applicable) :20		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None Risk Description SR15 23/24 is a significant challenge financial challenge, encompassing the following over a three-year period. • 23/24 operating a Deficit Plan (in this financial year). • 23-26 Recovery Plan operating across three years. • 23/24 Internal and External Financial constraints including workforce controls, expenditure controls, external interventions, oversight, and monitoring. Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable): 20		
Resource Implications:	(if none, state 'none') Revenue: Yes Capital: None Workforce: Funding Source:		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: Well-led – Delivery of statutory duty
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: TMC 21st July
	Board Committee	Yes☒No☐	Date: P&F 19th July
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure In month deficit of £3.48m, £0.77m adverse to plan, leading to a £13.09m YTD deficit, £2.71m adverse to plan.
Advise The pay position in month includes a further £0.43m of strike costs, taking the total YTD to £1.38m. However, following national guidance, we have seen no financial impact from this relating to ERF activity, valued at £0.78m YTD.
Alert It should be noted that £5m of planned balance sheet support has been released to the YTD, with a further £4.9m planned for the remainder of the year. The level of CIP required remains extremely challenging; £9.8m of cash releasing CIP has been identified against a target of £45m, with £2.9m delivered against a plan of £4.9m YTD, of which much is non-recurrent. The CIP target in budgets moving forwards has a large step change in each of the quarters.

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

Reference Pack

Report of the Chief Financial Officer

Finance Report
June 2023 - Month 3

Safe & Effective | Kind & Caring | Exceeding Expectation

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Capital and Cash		7
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Cost Improvement Programme and Reserves		9

Appendices		
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Appendix B	Statement of Financial Position	11
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Dashboard

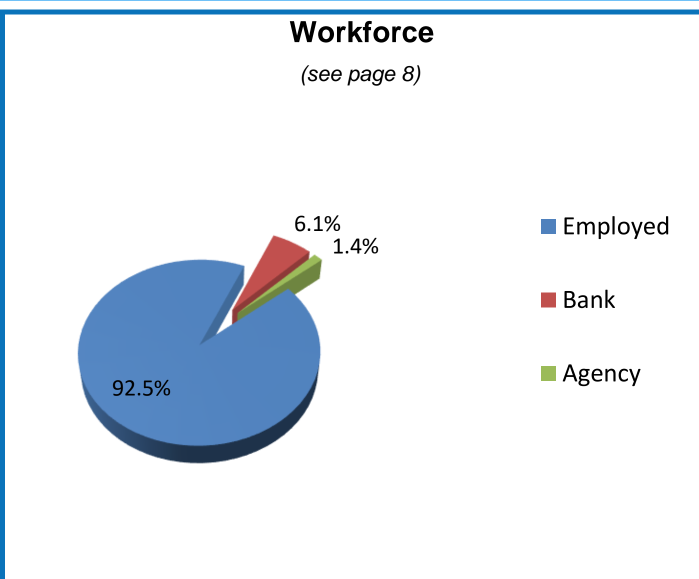
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Patient income	59.09	172.05
2. Other income	12.99	44.63
Total	**72.08**	**216.68**
Expenditure	**76.32**	**232.48**
Surplus/ (deficit)	**(4.25)**	**(15.80)**
Planned surplus/(deficit)	**(3.48)**	**(13.09)**
Variance to plan	**(0.77)**	**(2.71)**

Workforce

(see page 8)



Patient Income

Elective recovery fund activity to date is £0.8m behind the national expectation , mainly in elective and day case activity and as per NHSE guidelines no ERF clawback is yet included in the position. Other variable income relating to drug, devices and diagnostics is £0.3m behind plan. All other income is within the block.

Cost Improvement Programme (CIP)

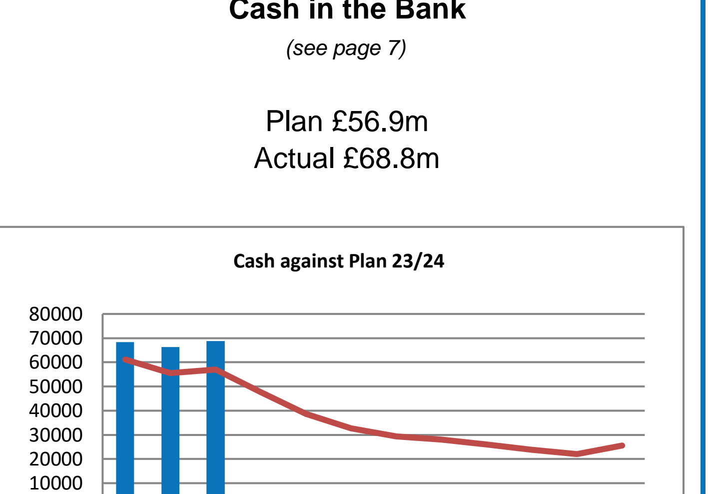
(see page 9)

The Trust has achieved its in month target of £1.7m CIP, however only 22% of this achievement is recurrent. The Trust is forecasting savings of £9.8m, of which £2m, (21%) is forecast to be achieved recurrently.

Cash in the Bank

(see page 7)

Plan £56.9m
Actual £68.8m



Covid-19 Expenditure

In month 3 there was expenditure of £111.8k on testing and £38.3k on Covid Medicines Delivery Unit. (Year to date £335k and 108k respectively).

Income is received for both of these services to offset the costs.

Reserves

(see page 9)

£5.2m of reserves are released into the position at month 3 of an annual value of £26.6m.

Actual Outturn

(see page 5)

£4.25m deficit in month
(£0.77m adverse to plan)

£15.8m deficit year to date
(£2.7m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted deficit of £4.25m, this is £0.77m adverse to plan, this leads to a year to date deficit of £15.8m which is £2.7m behind plan.

Income was £1.3m adverse in month and £1.7m adverse YTD against plan, primarily due to capital grant funding not running in line with plan in month under performance is £3.2m and YTD £3.3m, this will catch up as the capital project spend is incurred later in the year. This is off set by overperformance on patient income (£1.8m in month and £1.3m YTD) the main drivers being £0.6m release of prior year provisions, £0.5m investment from commissioners for current service developments and growth.

In month pay expenditure has over spent by £2.3m. This is due to a number of reasons including: £432k for cover for the junior doctors strike, £410k relating to temporary medical staffing covering gaps in the rota and other absences, £468k in nursing areas where there has been cover required for increased sickness, maternity and annual leave as well as some patient acuity requirements. In addition there are some unfunded cost pressures awaiting a decision to possibly fund from reserves that are being released into the position. Some one off costs have also been incurred in month due to some back pay in critical care and general surgery.
Non pay is also overspent in month by £1.3m, this includes £290k relating to hosted services which attracts additional income along with £425k relating to activity increases in Cardiology and Cardiothoracic. There have been some one off costs of £424k some of which will be a phasing issue. Utilities are also overspent by £489k largely as a result of the CHP being broken.
Drugs is also overspent by £252k, most notably in Gastro, Oncology and Rheumatology due to patient case mix.

Year to date the position is also overspent, Pay is £6.4m overspent including, £1.5m strike costs, £1.8m medical staffing cover, £1.9m nursing cover for sickness etc, £829k for cost pressures awaiting a decision.
Non pay is overspent by £1.1m of which £104k relates to hosted services then £1m for activity case mix. £500k on utilities due to the broken CHP is offset by an underspend on pathology services due to cytology activity being low.
Drugs is close to plan at £19.5k underspent.

System Updates

The ICB has a YTD deficit of £46.1m, £14.9m adverse to plan (2.2%) with 5 out of 8 organisations off plan.

Against plan there are £5m of demand pressures; including £3m within Mental Health, £6.6m of CIP underperformance (largely within 3 organisations), £2.5m relating to a plan phasing issue, an estimated £4.5m of direct costs from industrial action, and £2.5m of agency. These are partially supported by other underspends elsewhere.

It should be noted that the YTD position is supported by £8.7m of planned Balance Sheet support and that whilst the agency expenditure is higher than the internal plans across all organisations, collectively it is still within the ICB agency cap.

Capital Allocation: The ICB has a YTD underspend against its planned capital allocation spend of £13.4m (73.2%) but is forecasting to spend its total allocation of £88.4m.
CDEL is underspent by £43.2m YTD (67.3%) but is currently forecasting a small £1.2m (0.6%) over spend by year end.

Capital

The Trust has five types of capital programme with a combined plan of £72.3m for the year; these are CRL totalling £20.9m, and PDC £23.4m, both monitored as part of our statutory duty by NHSE, and additionally Grant funding from PSDS of £17.3m, IFRIC 12 related capital spend of £9.2m, and IFRS 16 new leases £1.5m.

YTD capital is underspent by £13.0m, with a capital spend of £10.8m YTD. Against ICS CRL, there is an underspend of £4.0m YTD against plan due to timing of orders compared to plan phasing, this is only a timing difference and the Trust are expecting to meet the ICS CRL of £20.9m by the end of the year.
PDC capital - there is an underspend of £4.2m due to formal finalisation of two business cases and its expected PDC funding. Until the business cases are formally agreed and PDC formally approved to the Trust there is no agreed PDC CRL. However the Trust anticipates that the business cases will be approved with the relevant PDC funding provided.
Grant funding has a YTD variance of £3.3m, due to timing of orders, with the Trust forecasting to spend all Grant approved capital funding projects.
£1.5m IFRS 16 YTD variance due to leases (predominantly BCPS) still being commercially agreed, however still forecasting for leases to commence during 23/24. IFRIC 12 YTD is £0.0m which is in line with Plan.

Income and Expenditure Run Rates

		22/23										23/24			Move-
	£m	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	ment
	Patient Income														
1	Plan	55.94	54.24	54.79	61.89	57.85	57.06	57.44	58.17	58.41	97.46	54.90	58.57	57.27	*0.53*
2	Actual	55.67	56.40	54.82	60.56	56.79	60.38	54.88	57.79	58.18	100.44	53.48	59.49	59.09	*2.60*
3	Variance	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	(1.42)	0.92	1.82	*2.07*
	Non Patient Income														
4	Plan	15.53	11.30	11.67	17.01	13.26	12.41	21.15	13.07	14.23	30.98	16.07	15.50	16.15	*0.36*
5	Actual	15.61	11.60	11.80	11.49	19.22	13.75	16.99	14.40	18.15	17.82	14.65	16.99	12.99	*(2.83)*
6	Variance	0.08	0.30	0.13	(5.52)	5.97	1.34	(4.16)	1.33	3.92	(13.16)	(1.43)	1.49	(3.16)	*(3.20)*
	Pay Expenditure														
7	Plan	42.73	41.29	41.49	46.92	42.71	42.54	43.20	40.89	43.28	82.72	44.11	47.15	45.61	*0.02*
8	Actual	41.42	42.23	42.75	48.28	43.60	42.16	40.52	42.64	42.71	82.05	46.78	48.56	47.93	*(0.26)*
9	Variance	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.38	2.69	(1.75)	0.57	0.67	(2.67)	(1.41)	(2.32)	*0.28*
	Non Pay Expenditure														
10	Plan	17.80	16.48	16.35	16.60	17.14	17.10	18.15	17.43	19.31	18.47	17.18	17.10	16.27	*0.87*
11	Actual	16.52	15.94	16.24	16.32	17.23	17.78	15.75	15.85	17.87	24.20	17.52	16.54	17.59	*(0.56)*
12	Variance	1.28	0.54	0.12	0.28	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	(0.34)	0.56	(1.32)	*1.43*
	Drugs Expenditure														
13	Plan	5.74	5.51	5.58	6.10	5.55	5.65	5.98	5.97	5.70	6.03	5.92	6.10	6.34	*(0.33)*
14	Actual	5.63	5.66	6.03	6.58	5.91	5.95	6.32	6.47	5.83	6.56	5.66	6.09	6.59	*(0.71)*
15	Variance	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	0.27	0.01	(0.25)	*0.39*
	CIP over/ (under) achievement														
16	Variance	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	(1.39)	(0.57)	(0.08)	*(0.91)*
	BCPS Savings over/ (under) achievement														
16	Variance	0.08	0.08	0.08	0.08	(0.01)	0.03	0.00	(0.14)	(0.10)	(0.07)	0.00	0.00	0.00	*(0.00)*
	Reserves supporting position														
17	Actual	(1.70)	(0.71)	0.68	1.58	1.47	1.59	(0.48)	2.50	0.95	(0.31)	2.85	1.09	1.30	*0.67*
	Other Non Operating Expenditure														
18	Plan	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	(3.79)	(3.81)	(3.85)	*(0.05)*
19	Actual	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	(3.77)	(3.78)	(3.75)	*0.02*
20	**Variance**	(0.53)	0.03	0.08	(0.26)	0.03	0.21	**0.24**	**0.26**	**0.32**	**1.79**	**0.02**	**0.03**	**0.09**	*(0.07)*
	Total														
	Plan	3.46	0.06	(0.58)	4.76	1.65	0.62	**9.81**	**1.54**	**1.10**	**17.18**	**(1.48)**	**(0.61)**	**0.13**	
	Actual	3.91	0.60	(1.93)	(2.66)	5.52	4.68	**5.74**	**3.69**	**6.41**	**3.42**	**(5.60)**	**1.50**	**(3.79)**	
	Variance	0.45	0.54	(1.35)	(7.42)	3.87	4.06	**(4.07)**	**2.16**	**5.31**	**(13.76)**	**(4.12)**	**2.11**	**(3.92)**	

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. For June, additional income has been included for the position for releasing prior year provisions (£0.6m), additional investment from commissioners for current cost pressures (£0.5m), a gain on hosted services (£0.3m) and other increases in income (£0.4m) including plan phasing differences.

Non-Patient Income - excluding grant funding for capital schemes in month 2 this increased by £238k compared to month 2. This was due to CRN (hosted service) £533k (due to planned cost increases), and increases in Trust R&D accounts of £37k. These increases were offset by reductions on directorate income in BCPS (hosted service) £232k and corporate £100k)largely due to lead recruiter activity), resulting in the overall £238k increase.

In terms of variance private patients under performed by £13k. Other Directorate income was over plan by £88k. In corporate areas there was an over achievement of £88k due to salary sacrifice schemes overperforming, lead recruiter activity and recharges off staff to other organisations, and Division 3 (£88k) due mainly to increased GP activity income.. There was underperformance in BCPS (£213k) due to lower than planned expenditure, Division 1 (£40k) due to an SLA issue in Orthopaedics.

Pay - Decreased in month (£0.63m) largely due to a release of accruals no longer required on both the pay award estimate £200k and April's strike £430k. There are also decreases in bank and agency costs but WLI's and substantive costs have increased.

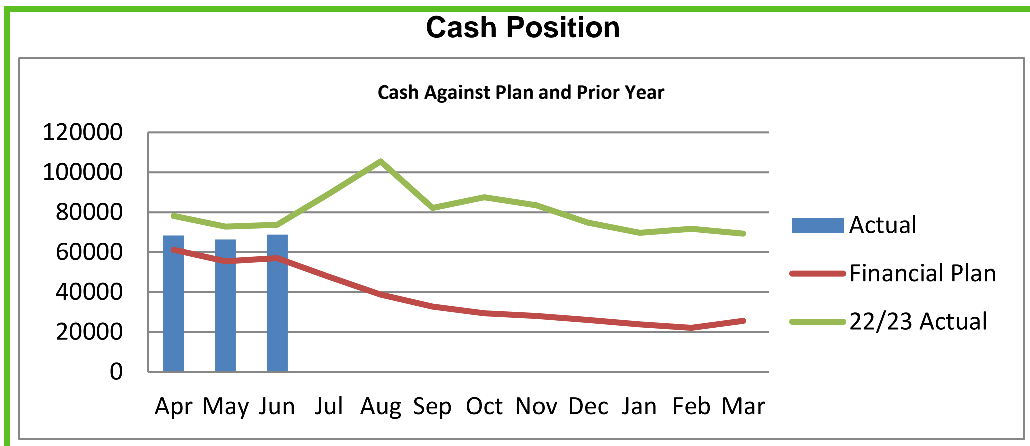
There was an overall overspend of £2.32m. Of this £480k relates to strike costs. Division 1 had the largest overspend (£988k) (£200k strike) there was also £300k in ward and theatre absence cover costs, £220k in backdated pay claims as well as £152k for posts in maternity which funding is awaited. Division 2 also had a large overspend being £859k (£264k Strike) of which £270k related to additional cover on wards for staff absences above plan (maternity and sick leave etc). There were then overspends in medical staff (£347k). Other overspending areas include HR £40k, Medical Director £70k both due to unfunded posts. There are also less significant under and overspends in other areas.

Non-Pay - An increase in the run rate in month of £1.05m. £545k relates to CRN and £227k BCPS which are offset by income. The balance is largely linked to activity and case mix £294k and increased utility costs as the CHP is out of operation (£244k) which is all offset by decreases in other areas.

In terms of variance there is an overspend of £1.32m. Estates and facilities are overspent by £369k due to the CHP being out of service (£350k). Division 1 had overspends related to activity case mix (£387k) offset by an underspend of £143k in pathology. Division 2 were £280k overspent, due to activity levels in Endoscopy, Respiratory (CPAP) & Insulin pumps. Division 3 were £205k overspent. In month they incurred costs for a number of one off items as well as increased radiology consumables (£58k) and paediatric insulin pumps (£24k).

Drugs - Expenditure was £500k higher in month 3 than month 2. Predominantly in areas where there are high cost drugs, Rheumatology and Oncology being the largest. In terms of spend against budget there was £250k overspend. This appeared in a number of specialties and was due to patient case mix. £208k of this was in Division 2 across many specialties including Gastro £80k and Acute Medicine £28k).

Cash Position



The cash balance as at 30th June 2023 is £68.8m, a £2.4m increase on the previous month and an increase of £11.8m on the financial plan. The increase on plan is due to: £18.7m cash settlement of 22/23 pay award income netted out by £16.8m additional pay cost; next month the associated HMRC and pension costs will be paid (in lie with usual practice). Additional movements are £5.1m Staffs 22/23 income received in 23/24, £5.1m ICB income due to timing differences between plan & cash received, £1.4m additional LDA funding for Q1 and £7.0m reduced capital spend (this is timing on projects and will be spent later in the year). This is netted out by £3.3m less cash for PDC due to business cases still being agreed (see Capital Section) & £5.3m additional non pay costs.

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:

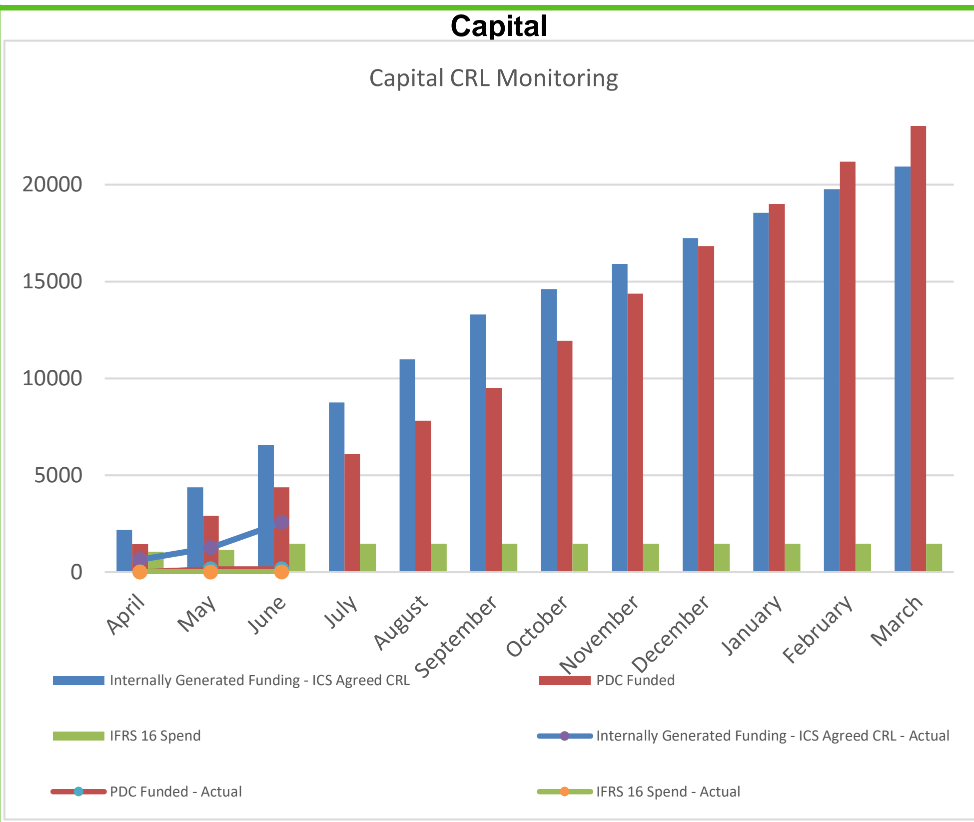
	M3 23/24	Cumulative	M2 23/24	Cumulative
Value	96%	95%	92%	94%
Volume	96%	94%	92%	93%

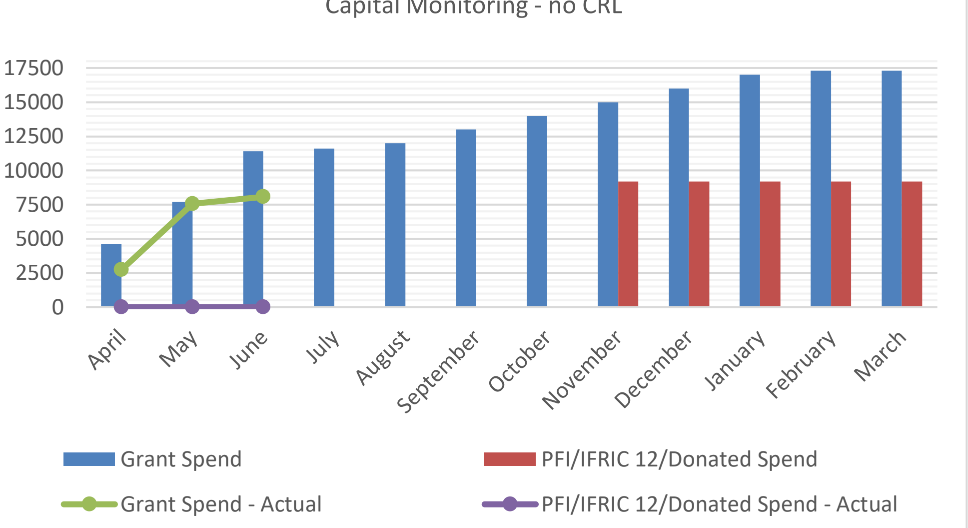
Debtor Days

Calculated Debtor Days for the year are:-

	M3 Actual	M2 Actual
Total	5.08	6.60
Being:-		
NHS	5.40	6.85
Non NHS	3.40	5.70

Capital



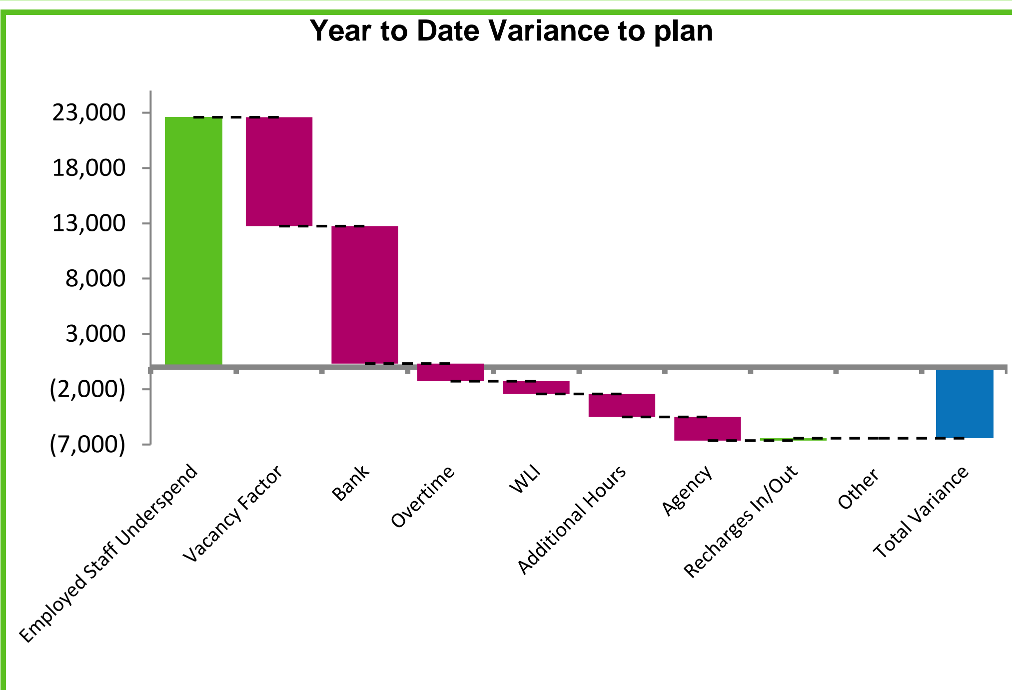


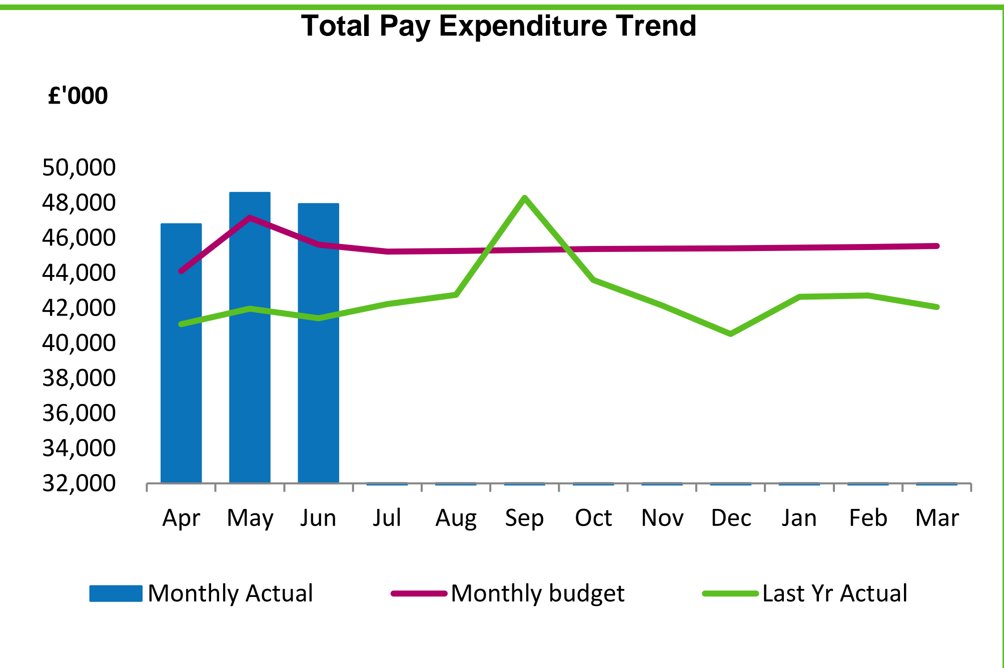
The Trust have spent £10.8m of capital YTD to 30th June 23, which is an underspend of £13.0m against planned YTD capital spend of £23.8m. Of this £10.8m YTD spend:

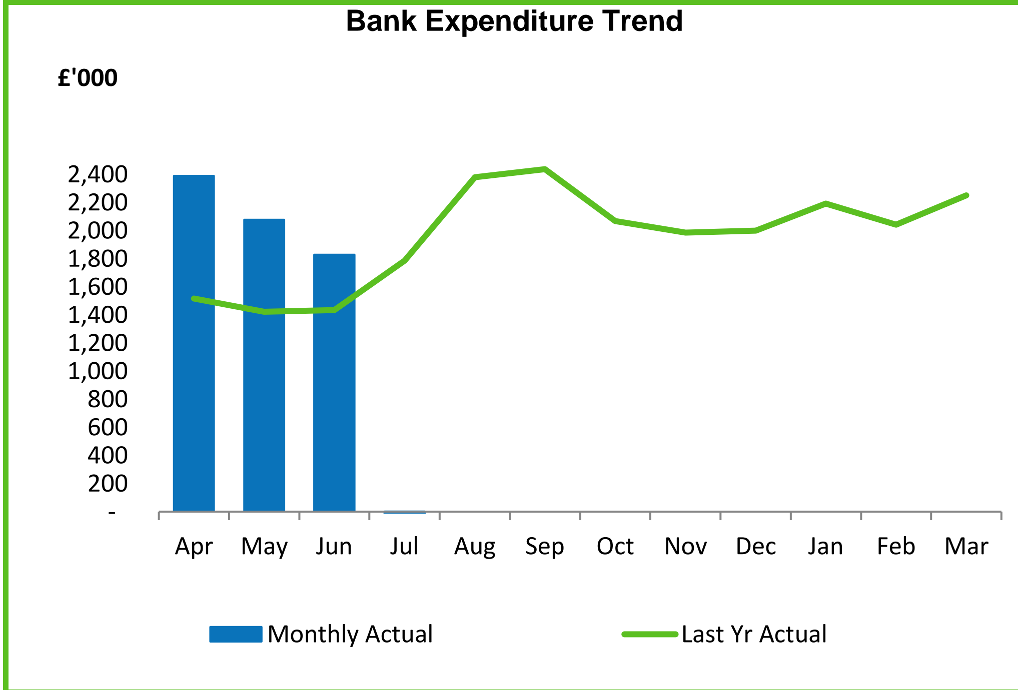
Capital CRL Monitoring - £2.6m relates to capital spend which the ICS is measured against, this is an underspend of £4.0m against Plan due to timing of orders. The Trust envisages meeting the ICS CRL of £20.9m. There has been £0.2m spend YTD on PDC due to the business cases still being agreed creating variance to Plan of £4.2m. There was £0.0m spend YTD on IFRS 16 due to leases (predominantly BCPS) still being commercially agreed, creating a variance to Plan of £1.4m.

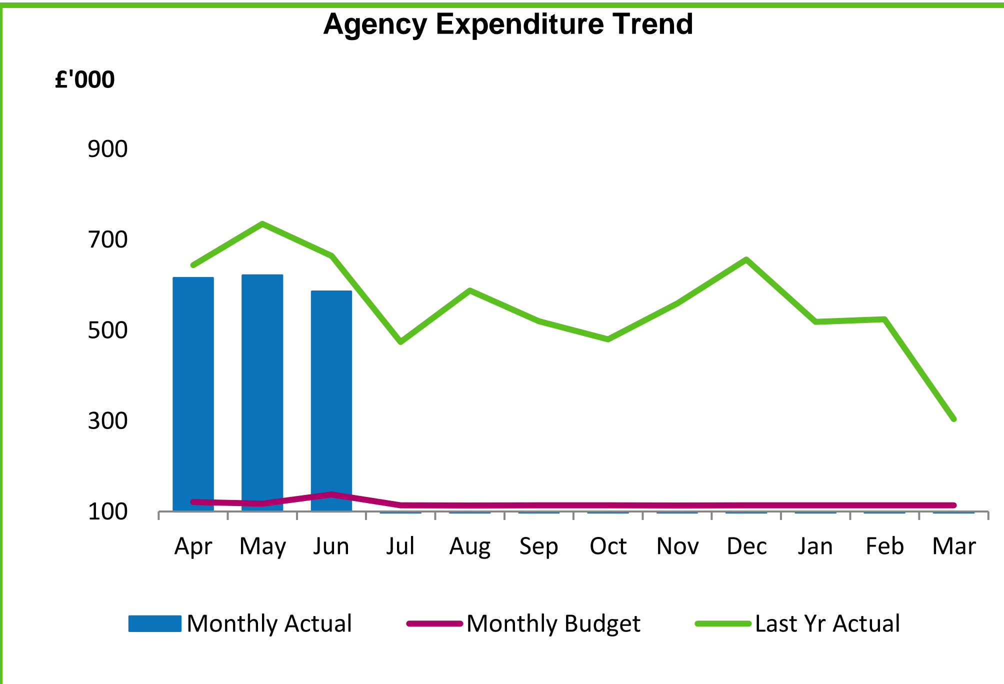
Capital Monitoring - non CRL - The balance of the capital YTD, £8.0m, relates to capital spend on grant funded items with £7.9m relating to PSDS Phase 3a and £0.2m relating to Phase 3b. This is variance of £3.3m against Planned Grant spend of £11.4m due to timing of orders.

The Trust are forecasting to meet the Plan capital expenditure spend for 23/24 of £72.3m.


Year to Date Variance to plan
23,000
18,000
13,000
8,000
3,000
(2,000)
(7,000)
Employed Staff Underspend
Vacancy Factor
Bank
Overtime
WLI
Additional Hours
Agency
Recharges In/Out
Other
Total Variance


Total Pay Expenditure Trend
£'000
50,000
48,000
46,000
44,000
42,000
40,000
38,000
36,000
34,000
32,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Monthly budget
Last Yr Actual

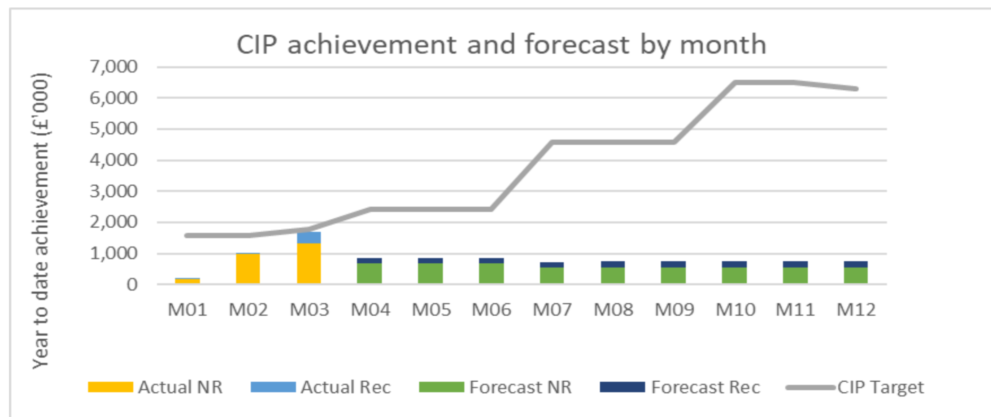

Bank Expenditure Trend
£'000
2,400
2,200
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Last Yr Actual


Agency Expenditure Trend
£'000
900
700
500
300
100
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Monthly Budget
Last Yr Actual

Cost Improvement

Division	YTD Plan	YTD Actual	Variance
Corporate	174	19	(154)
Division 1	878	943	65
Division 2	571	156	(415)
Division 3	382	318	(64)
Division 4	23	0	(22)
Estates And Facilities	193	11	(182)
Trustwide	2,709	1,440	(1,269)
Grand Total	**4,930**	**2,888**	**(2,041)**

Division	Total target	FOT total	Variance
Corporate	2,985	91	(2,894)
Division 1	15,080	3,012	(12,068)
Division 2	9,815	1,095	(8,720)
Division 3	6,560	1,429	(5,131)
Division 4	388	2	(386)
Estates And Facilities	3,322	100	(3,222)
Trustwide	7,003	4,115	(2,888)
Grand Total	**45,153**	**9,843**	**(35,309)**



The Trust has achieved its in month CIP target, however only 22% of the in-month achievement is recurrent. 13% of the year to date achievement of £2.89m is recurrent.
The Trust is currently forecast cash releasing savings of £9.8m against the £45m plan, with 21% of the total forecast achievement (£2.1m) expected to be achieved recurrently.
There are a number of schemes that continue to be developed, however more will be required if the Trust is going to achieve it's CIP target.

Reserves

Start point			29,703,056
Additional Income allocated to reserves			13,945,061
Full Year Effect of reserves 'drawn down' upto current month			(17,086,451)
Reserves phased into position			(5,235,828)
Reserves available for future months			**21,325,838**
Earmarked Reserves	Division 1	(4,170,338)	
	Division 2	(4,686,630)	
	Division 3	(3,508,271)	
	Division 4	(41,441)	
	Estates and Facilities	0	
	Corporate & Other	(1,214,181)	
	Less: Expected Slippage	44,891	
			(13,575,970)
	Available Balance		**7,749,868**
Balance made up of	Drugs	0	
	Inflation	5,336,125	
	Trustwide Education/LDA	480,844	
	Contingency	613,815	
	CDC - Trustwide	1,319,085	
Less:	Expected Balance Sheet Release	0	
			7,749,868

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				
161,390	57,266	59,087	1,820	Patient Activity Income	691,744	170,734	172,052	1,318
254	127	81	(46)	Other Patient Care Income	1,521	380	245	(135)
1,585	0	0	0	Top Up Income	0	0	0	0
11,910	5,066	5,060	(7)	Education, Training & Research Income	52,945	14,091	13,849	(242)
11,996	3,763	577	(3,186)	Non Patient Care Other Income	17,578	11,463	8,136	(3,327)
27	55	42	(13)	Private Patient Income	658	164	165	0
18,247	7,141	7,228	88	Income on Directorate Budgets	83,567	21,629	22,235	606
205,410	**73,418**	**72,075**	**(1,343)**	**Total Income**	**848,012**	**218,463**	**216,682**	**(1,781)**
				Expenditure				
124,457	45,611	47,932	(2,321)	Directorate Expenditure Budgets - Pay	545,262	136,868	143,270	(6,401)
49,318	16,271	17,589	(1,318)	Directorate Expenditure Budgets - Non Pay	205,249	50,556	51,657	(1,101)
16,998	6,337	6,589	(252)	Directorate Expenditure Budgets - Drugs	72,093	18,357	18,338	19
0	1,254	0	1,254	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	25,472	4,760	0	4,760
0	44	0	44	Contingency Reserves	1,090	476	0	476
0	(76)	0	(76)	Cost Improvement Savings	(38,352)	(2,041)	0	(2,041)
0	0	0	0	BCPS Savings	0	0	0	0
190,773	**69,442**	**72,110**	**(2,669)**	**Total Expenditure**	**810,814**	**208,977**	**213,265**	**(4,288)**
14,637	**3,976**	**(35)**	**(4,011)**	**EBITDA Surplus/(Deficit)**	**37,199**	**9,486**	**3,417**	**(6,069)**
7,065	2,595	2,615	(20)	Depreciation	33,017	7,757	7,843	(85)
467	93	(21)	114	(Interest Receivable) / Payable	1,606	213	(13)	226
3,155	1,158	1,158	0	Other Charges	13,900	3,475	3,474	1
10,687	**3,846**	**3,752**	**94**	**Other non operating items**	**48,524**	**11,445**	**11,304**	**142**
3,950	**130**	**(3,787)**	**(3,917)**	**Net Surplus/(Deficit) before Adjustments**	**(11,325)**	**(1,959)**	**(7,887)**	**(5,927)**
(11,864)	(3,608)	(459)	3,150	Adjustments as per NHSI reported position	(15,425)	(11,126)	(7,910)	3,217
(7,914)	**(3,478)**	**(4,246)**	**(768)**	**Adjusted Financial Performance as NHSI**	**(26,750)**	**(13,085)**	**(15,796)**	**(2,711)**

Note : Adverse Variances in Brackets

2023/24 Balance Sheet as at 30th June 2023

	June 2023 Plan	June 2023 Actual	May 2023 Actual	Movement in Month	March 2023 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	502,119	489,991	490,686	(696)	486,739
Intangible Assets	6,610	5,544	5,646	(102)	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	**514,790**	**501,596**	**502,394**	**(798)**	**498,660**
CURRENT ASSETS					
Inventories	8,347	8,480	8,386	95	8,347
Trade and Other Receivables	49,658	33,887	65,365	(31,477)	59,564
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	56,955	68,785	66,356	2,429	69,265
TOTAL CURRENT ASSETS	**114,960**	**111,152**	**140,106**	**(28,953)**	**137,176**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**629,750**	**612,748**	**642,499**	**(29,751)**	**635,836**
CURRENT LIABLILITES					
Trade & Other Payables	(108,219)	(98,519)	(120,218)	21,700	(114,207)
Liabilities arising from PFIs / Finance Leases	(6,199)	(6,048)	(6,048)	0	(13,462)
Provisions for Liabilities and Charges	(3,833)	(3,563)	(4,172)	609	(4,201)
Other Financial Liabilities	(10,098)	(13,065)	(16,180)	3,115	(10,424)
TOTAL CURRENT LIABILITIES	**(128,350)**	**(121,195)**	**(146,618)**	**25,424**	**(142,294)**
NET CURRENT ASSETS / (LIABILITIES)	**(13,389)**	**(10,042)**	**(6,512)**	**(3,530)**	**(5,118)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**501,401**	**491,554**	**495,881**	**(4,328)**	**493,542**
NON CURRENT LIABILITIES					
Trade & Other Payables	(287)	(271)	(279)	9	(287)
Other Liabilities	(11,925)	(11,314)	(11,845)	531	(5,470)
Provision for Liabilities and Charges	(1,780)	(1,780)	(1,780)	0	(1,780)
TOTAL NON CURRENT LIABILITIES	**(13,992)**	**(13,365)**	**(13,905)**	**540**	**(7,537)**
TOTAL ASSETS EMPLOYED	**487,408**	**478,189**	**481,976**	**(3,788)**	**486,005**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	308,971	305,676	305,676	0	305,676
Retained Earnings	70,471	64,545	68,332	(3,788)	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	187	190	190	0	190
TOTAL TAXPAYERS EQUITY	**487,408**	**478,189**	**481,976**	**(3,788)**	**486,005**

Appendix C Cash Flow Statement

2023/24 Cash Flow as at 30th June 2023

	Jun-23 Plan £'000	Jun-23 Actual £'000	Jun-23 Variance £'000	Jun-23 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**1,690**	**(4,426)**	(6,115)	(2,651)
Depreciation	7,699	7,843	144	2,615
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(11,399)	3	11,402	0
Interest Paid	(886)	(870)	16	(288)
Dividends Paid	0	0	0	0
Release of PFI /Deferred Credit	0	0	0	0
(Increase)/Decrease in Inventories	0	(134)	(134)	(95)
(Increase)/Decrease in Trade Receivables	9,945	25,714	15,769	31,477
Increase/(Decrease) in Trade Payables	1,628	(3,716)	(5,344)	(14,668)
Increase/(Decrease) in Trade Payables Ann Leave Acc	0	(2,037)	(2,037)	0
Increase/(Decrease) in Other liabilities	0	2,640	2,640	(3,115)
Increase/(Decrease) in Provisions	0	(546)	(546)	(609)
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**8,677**	**24,471**	**15,795**	**12,667**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	706	884	178	308
Payment for Property, Plant and Equipment	(33,214)	(24,218)	8,996	(9,997)
Payment for Intangible Assets	(1,101)	(47)	1,054	(18)
Receipt of cash donations to purchase capital assets	11,199	0	(11,199)	0
Proceeds from sales of Tangible Assets	0	0	0	0
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(22,410)**	**(23,382)**	**(972)**	**(9,707)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(13,733)**	**1,089**	**14,822**	**2,960**
FINANCING				
New Public Dividend Capital Received	3,295	0	(3,295)	0
Capital Element of Finance Lease and PFI	(1,872)	(1,569)	303	(531)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**1,423**	**(1,569)**	**(2,992)**	**(531)**
INCREASE/(DECREASE) IN CASH	**(12,310)**	**(480)**	**11,830**	**2,429**
CASH BALANCES				
Opening Balance at 1st April 2023	69,265	69,265	0	0
Opening Balance at 1st March 2023				
Closing Balance at 30th June 2023	56,955	68,785	11,830	2,429

Trust Board Report

Meeting Date:	No meeting
Title:	Report of the Chief Financial Officer - Month 2
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 2
Item/paragraph 1	This paper reports the in-month, year-to-date and the draft year end position for the Trust as at Month 2. The paper also reports on delivery against financial targets.

Reference Pack

Report of the Chief Financial Officer

Finance Report
May 2023 - Month 2

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Dashboard

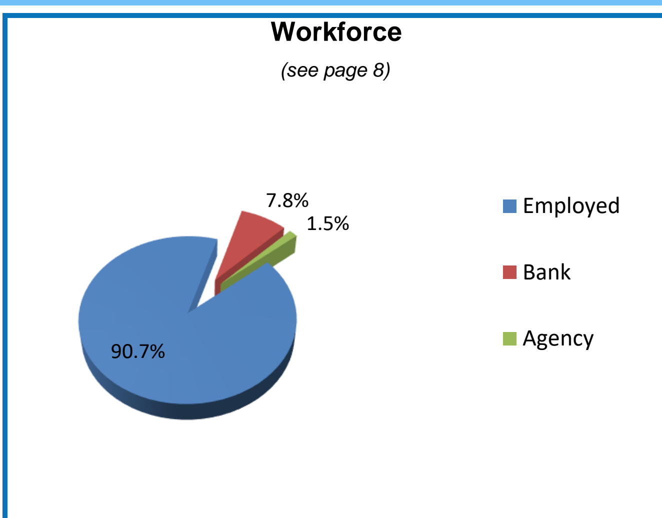
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Patient income	59.49	112.97
2. Other income	16.99	31.64
Total	**76.48**	**144.61**
Expenditure	**79.75**	**156.16**
Surplus/ (deficit)	**(3.26)**	**(11.55)**
Planned surplus/(deficit)	**(3.62)**	**(9.61)**
Variance to plan	**0.35**	**(1.94)**

Workforce

(see page 8)



Patient Income

Elective recovery fund activity in April and May is £0.8m behind plan, mainly in elective and daycase activity and as per NHSE guidelines no ERF clawback is yet included in the position. Other variable income relating to drug, devices and diagnostics is £0.5m behind plan. All other income is within the block.

Cost Improvement Programme (CIP)

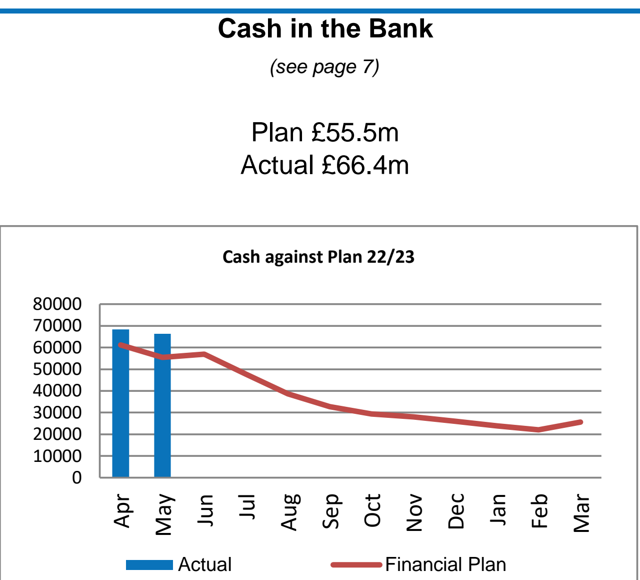
(see page 9)

Against an in month target of £1.57m, the Trust has achieved £1m. Of this, £8k is recurrent. The 23/24 target for the trust is £45m & the trust has identified savings with full year effect of £4.46m, of which only 2% are recurrent savings.

Cash in the Bank

(see page 7)

Plan £55.5m
Actual £66.4m



Covid-19 Expenditure

In month 2 there was a expenditure of £142.6K on testing and £35.5K on Covid Medicines Delivery Unit. Income is received for both of these services to offset the costs.

Reserves

(see page 9)

£3.9m of reserves are released into the position at month 2 of an annual value of £29.9m

Actual Outturn

(see page 5)

£3.3m deficit in month
(£0.35m favourable to plan)

£11.6m defecit year to date
(£1.9m adverse to plan)

Overview of Financial Performance

The Trust is reporting an in month adjusted deficit of £3.3m, this is £0.35m favourable to plan, this leads to a year to date deficit of £11.6m which is £1.9m behind plan.

Income was £2.4m favourable and £0.5m adverse YTD against plan, primarily due to guidance at the time to recognise full YTD ERF in M02 which is £0.9m more than delivery and timing of PSDS grant funding which was £1.7m more than plan in month bringing it broadly on plan YTD, with some small over an underperformances across the divisions.

Pay is £1.4m adverse to plan in month and £4.1m adverse YTD. YTD Pay pressures YTD include £1m of associated strike costs, continued ward pressures, high levels of sickness/absence and cover than budgeted and ED.

Non-Pay was £0.6m favourable in month and £0.2m favourable YTD, and drugs are broadly on plan. Notable items are; underspends on cytology and microbiology due to lower activity y than planned, and continued pressures on external oncology tests (outsourcing), endoscopy maintenance and renal. £0.4m of costs associated with CHP failure and a water leak were offset by other non-recurrent benefits.

CIP is £1.9m adverse YTD.

System Updates

The ICB is reporting a YTD deficit of £33m, £11m adverse to plan (2.4%), however accounting for a phasing issue in plans would adjust the variance to £6.9m. £3m of flexibilities has been released against a plan of £5.1m and there is under delivery of CIP by £6.6m, with £15.9m delivered against a planned £22.5m.

Capital

The Trust has three types of capital programme with a combined plan of £72.3m for the year; these are CRL totalling £20.9m, and PDC £23.4m, both monitored as part of our statutory duty by NHSE, and additionally Grant funding from PSDS of £17.3m, IFRIC 12 related capital spend of £9.2m, and IFRS 16 new leases £1.5m.

Against ICS CRL, there is an underspend of £3.1m against plan due to timing of orders compared to plan phasing, this is only a timing difference and we are expecting to meet the ICS CRL of £20.9m by the ned of the year.

PDC capital - there is a variance of £2.7m due to formal finalisation of the business case and its expected PDC funding.

Grant funding has a YTD variance of £0.1m, due to timing of orders, with the Trust forecasting to spend all Grant approved capital funding projects.

£1.1m IFRS 16 YTD variance due to leases (predominantly BCPS) still being commercially agreed, however still forecasting for leases to commence during 23/24. IFRIC 12 YTD is £0.0m which is in line with Plan.

	£m	22/23											23/24		Move-ment
		May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
	Patient Income														
1	Plan	53.09	55.94	54.24	54.79	61.89	57.85	57.06	57.44	58.17	58.41	97.46	54.90	58.57	*3.67*
2	Actual	53.12	55.67	56.40	54.82	60.56	56.79	60.38	54.88	57.79	58.18	100.44	53.48	59.49	*6.01*
3	Variance	0.02	(0.27)	2.17	0.03	(1.33)	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	(1.42)	0.92	*2.34*
	Non Patient Income														
4	Plan	17.19	15.53	11.30	11.67	17.01	13.26	12.41	21.15	13.07	14.23	30.98	16.11	15.50	*(0.60)*
5	Actual	17.70	15.61	11.60	11.80	11.49	19.22	13.75	16.99	14.40	18.15	17.82	14.65	16.99	*2.35*
6	Variance	0.51	0.08	0.30	0.13	(5.52)	5.97	1.34	(4.16)	1.33	3.92	(13.16)	(1.46)	1.49	*2.95*
	Pay Expenditure														
7	Plan	39.50	42.73	41.29	41.49	46.92	42.71	42.54	43.20	40.89	43.28	82.72	44.11	47.15	*(3.04)*
8	Actual	41.96	41.42	42.23	42.75	48.28	43.60	42.16	40.52	42.64	42.71	82.05	46.78	48.56	*(1.78)*
9	Variance	(2.46)	1.31	(0.94)	(1.27)	(1.37)	(0.89)	0.38	2.69	(1.75)	0.57	0.67	(2.67)	(1.41)	*(1.26)*
	Non Pay Expenditure														
10	Plan	16.02	17.80	16.48	16.35	16.60	17.14	17.10	18.15	17.43	19.31	18.47	17.22	17.10	*0.11*
11	Actual	16.25	16.52	15.94	16.24	16.32	17.23	17.78	15.75	15.85	17.87	24.20	17.52	16.54	*0.98*
12	Variance	(0.23)	1.28	0.54	0.12	0.28	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	(0.31)	0.56	*(0.87)*
	Drugs Expenditure														
13	Plan	5.31	5.74	5.51	5.58	6.10	5.55	5.65	5.98	5.97	5.70	6.03	5.92	6.10	*(0.18)*
14	Actual	5.59	5.63	5.66	6.03	6.58	5.91	5.95	6.32	6.47	5.83	6.56	5.66	6.09	*(0.44)*
15	Variance	(0.28)	0.11	(0.15)	(0.45)	(0.48)	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	0.27	0.01	*0.26*
	CIP over/ (under) achievement														
16	Variance	(0.13)	0.08	(0.79)	(0.76)	(0.41)	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	(1.39)	(0.57)	*(0.82)*
	BCPS Savings over/ (under) achievement														
16	Variance	0.08	0.08	0.08	0.08	0.08	(0.01)	0.03	0.00	(0.14)	(0.10)	(0.07)	0.00	0.00	*0.00*
	Reserves supporting position														
17	Actual	2.49	(1.70)	(0.71)	0.68	1.58	1.47	1.59	(0.48)	2.50	0.95	(0.31)	2.85	1.09	*1.77*
	Other Non Operating Expenditure														
18	Plan	(4.37)	(3.27)	(3.61)	(3.61)	(3.27)	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	(3.79)	(3.81)	*(0.03)*
19	Actual	(3.72)	(3.79)	(3.58)	(3.54)	(3.53)	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	(3.77)	(3.78)	*(0.02)*
20	**Variance**	0.65	(0.53)	0.03	0.08	(0.26)	0.03	0.21	**0.24**	**0.26**	**0.32**	**1.79**	**0.02**	**0.03**	*(0.01)*
	Total														
	Plan	2.64	3.46	0.06	(0.58)	4.76	1.65	0.62	**9.81**	**1.54**	**1.10**	**17.18**	**(1.48)**	**(0.61)**	
	Actual	3.30	3.91	0.60	(1.93)	(2.66)	5.52	4.68	**5.74**	**3.69**	**6.41**	**3.42**	**(5.60)**	**1.50**	
	Variance	0.65	0.45	0.54	(1.35)	(7.42)	3.87	4.06	**(4.07)**	**2.16**	**5.31**	**(13.76)**	**(4.12)**	**2.11**	

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. For May, following NHSE guidance no clawback for ERF has been factored into the position, therefore this has resulted in an increase in run rate actuals. Additionally, following the agenda for change pay award confirmed, the income relating to the pay award has been accounted for in the position to fund the pay costs, contributing to the material increase in run rate. There is a £0.5m adverse variance due to other variable income for drug, devices and diagnostics which is offset by expenditure.

Non Patient Income - excluding grant funding for capital schemes in month 2 this increased by £247k compared to month 1. This was due to CRN (hosted service) £160k (due to planned cost increases), along with increases in Lead recruiter activity £105k and medical examiner activity £23k. There were reductions in pharmacy sales £39k and GP income £63k partially offset by increased catering and car parking income £81k.
In terms of variance private patients over performed by £14k. Other Directorate income was under plan by £173k. In corporate areas there was an over achievement of £137k due to salary sacrifice schemes overperforming and recharges off staff to other organisations. There was underperformance in BCPS (£238k) due to lower than planned expenditure, Division 1 (£37k) due to an SLA issue in Orthopaedics and Division 3 (£88k) due mainly to reduced GP QOF activity income.

Pay - Increased in month (£1.8m) due to accounting for 2 months of the new pay award (as per NHSE guidance) £2m being offset by no strike costs in month, £1.1m and reclaimed pay from striking doctors £370k. Costs increased by £435k due to bank holiday enhancements paid and additional bank work £200k along with other substantive staff cost increases.

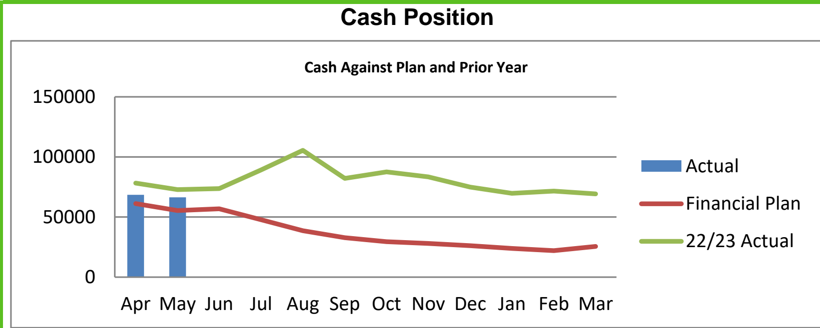
There was an overall overspend of £1.41m. Division 2 had the largest overspend being £859k of which £256k related to additional cover on wards for staff absences above plan (maternity and sick leave etc). There were then overspends in medical staff in many areas (£380k ED, £70k Stroke, £59k Older Adults, £24k Renal, £26k Gastro and £34k Haematology). In Division 1 agency medical staff caused a £46k overspend, in the Women's Directorate there was additional bank and some posts awaiting external funding £149k. In other Directorates there are overspends totalling £458k relating to temporary cover for staff absences. Other overspending areas include HR £90k, Medical Director £46k both due to unfunded posts. There are also less significant under and overspends on other areas.

Non Pay - A reduction in the run rate in month of £982k, this includes a planned release of GRNI's that are no longer required valued at £1.5m, reduced disability service spend of £120k and increased VAT reclaims of £132k. These have been partially offset by increased spend on utilities due to a CHP failure and a water leak £400k, as well as income matched over performance on high-cost TAVI devices £354k.

In terms of variance against budget BCPS are underspent due to cytology and microbiology activity (£280k). Division 1 are underspent by £224k due to lower activity in orthopaedics £100k and a pathology underspend to be transferred to CIP which is in the final stage of approval. Division 2 have an overspend of £290k due to increased renal home therapy of £35k, external oncology tests £84k, endoscopy maintenance of £94k and smaller issues across other directorates totalling £71k.

Drugs - An increase from last month of £435k of which £296k is high-cost pass through funded and £125k relates to ophthalmology injections. The overall cost is in line with budget with Divisions 1 and 2's overspends (£17k and £29k respectively) being offset by Division 3 underspending by £40k.

Cash Position



The cash balance as at 31st May 2023 is £66.4m, a £2.1m decrease on the previous month and an increase of £10.9m on financial plan. The increase on plan is due to: £6.0m on early receipt of LDA money (forecast end of Q1); £1.4m reduced capital spend (this is timing on projects); £7.1m reduced non-pay spend due to reduced payment runs in May due to bank holidays and timing on payment runs compared to forecast; offset by £2.5m additional pay spend.

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:

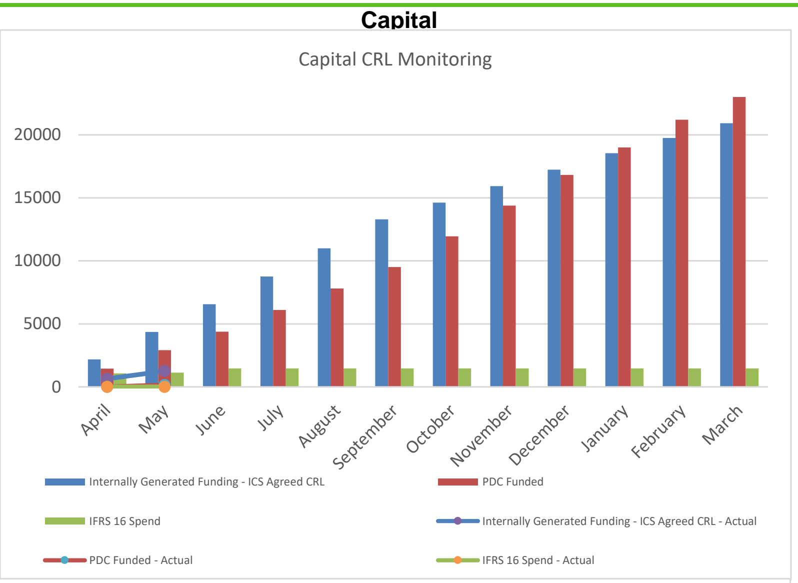
	M2 23/24	Cumulative	M1 23/24	Cumulative
Value	92%	94%	95%	95%
Volume	92%	93%	94%	94%

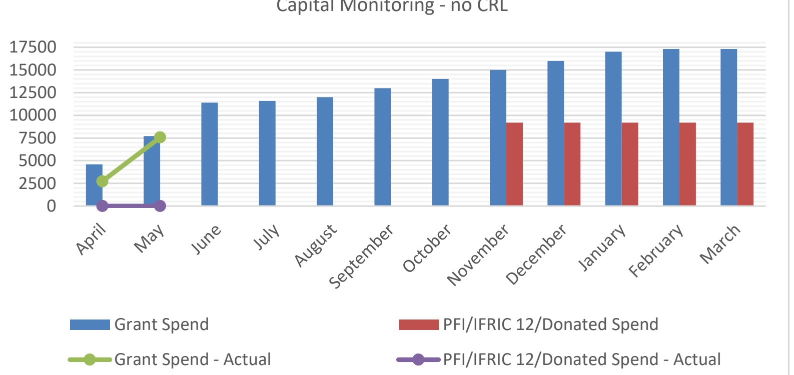
Debtor Days

Calculated Debtor Days for the year are:-

	M2 Actual	M1 Actual
Total	6.60	8.95
Being:-		
NHS	6.85	9.50
Non NHS	5.70	6.91

Capital

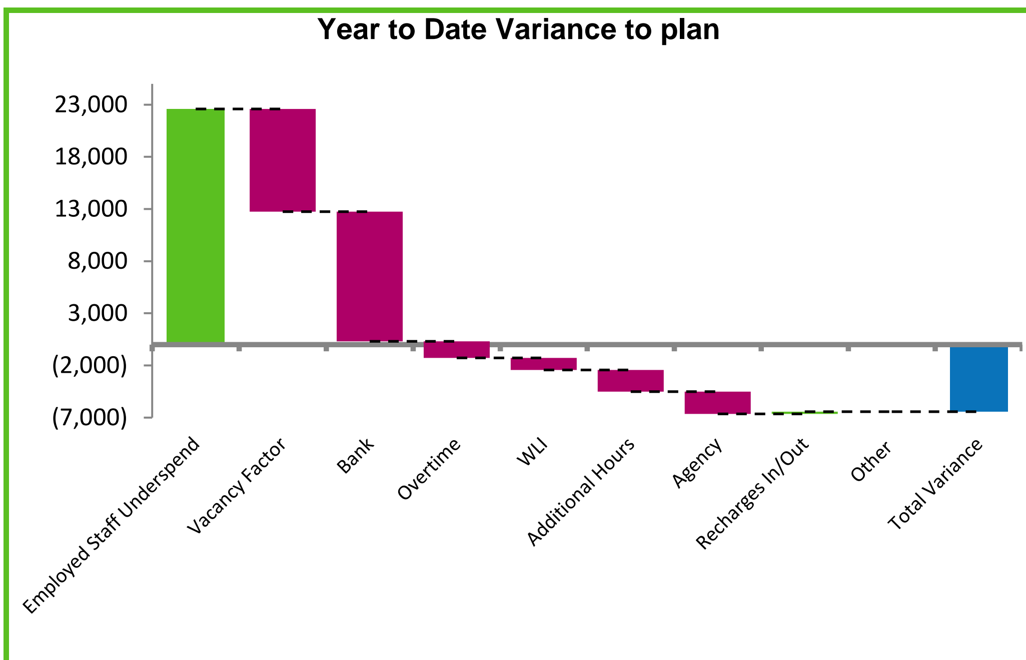


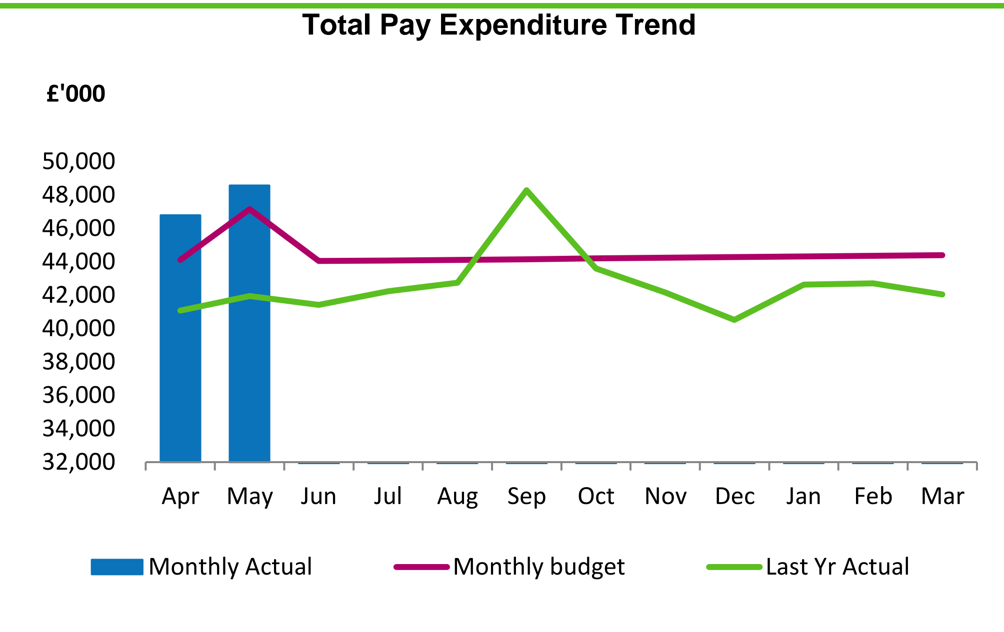


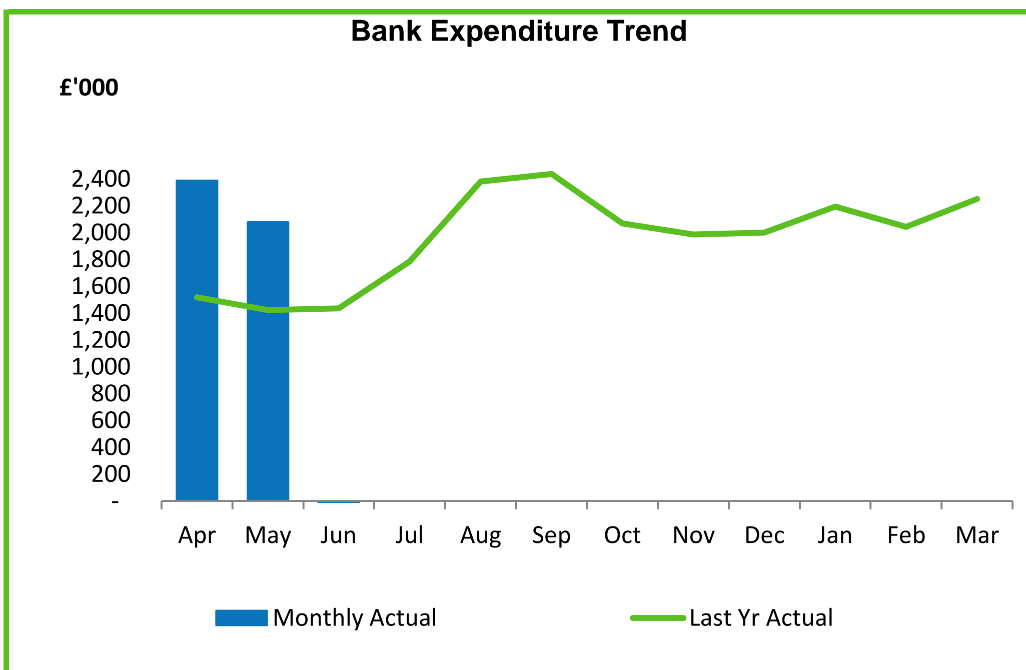
The Trust have spent £9.0m of capital YTD to 31st May 23, which is an underspend of £7.1m against planned YTD capital spend of £16.1m. Of this £9.0m YTD spend:

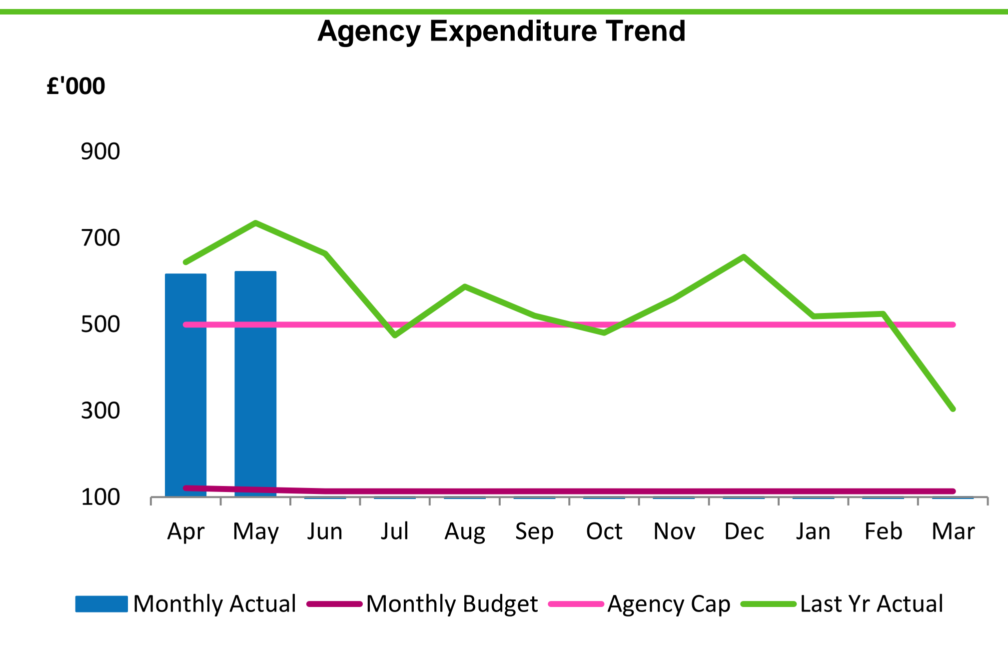
Capital CRL Monitoring - £1.3m relates to capital spend which the ICS is measured against, this is an underspend of £3.1m against Plan due to timing of orders. The Trust envisages meeting the ICS CRL of £20.9m. There has been £0.2m spend YTD on PDC due to the business cases still being agreed creating variance to Plan of £2.7m. 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, £7.6m, relates to capital spend on grant funded items with £7.4m relating to PSDS Phase 3a and £0.2m relating to Phase 3b. This is variance of £0.1m against Planned Grant spend of £7.7m due to timing of orders. The Trust are forecasting to meet the Plan capital expenditure spend for 23/24 of £72.3m.


Year to Date Variance to plan
23,000
18,000
13,000
8,000
3,000
(2,000)
(7,000)
Employed Staff Underspend
Vacancy Factor
Bank
Overtime
WLI
Additional Hours
Agency
Recharges In/Out
Other
Total Variance


Total Pay Expenditure Trend
£'000
50,000
48,000
46,000
44,000
42,000
40,000
38,000
36,000
34,000
32,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Monthly budget
Last Yr Actual


Bank Expenditure Trend
£'000
2,400
2,200
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Last Yr Actual


Agency Expenditure Trend
£'000
900
700
500
300
100
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Monthly Actual
Monthly Budget
Agency Cap
Last Yr Actual

Cost Improvement

YTD Value					
Division	Target	Non Recurrent	Recurrent	Total Achieved	Variance From Target
Corporate	-£105,059	£12,260	£453	£12,713	-£92,345
Division 1	-£530,831	£172,361	£13,241	£185,602	-£345,229
Division 2	-£345,497	£82,538	£802	£83,340	-£262,157
Division 3	-£230,911	£308,241	£1,688	£309,929	£79,018
Division 4	-£13,655	£317		£317	-£13,338
Estates And Facilities	-£116,928	£6,600	£521	£7,121	-£109,807
Trustwide	-£1,804,799	£583,144		£583,144	-£1,221,655
Grand Total	**-£3,147,679**	**£1,165,461**	**£16,705**	**£1,182,166**	**-£1,965,513**

2023/24 FYE					
Division	Target	Non Recurrent	Recurrent	Total Achieved	Variance From Target
Corporate	-£2,984,618	£87,835	£2,720	£90,555	-£2,894,063
Division 1	-£15,080,412	£326,073	£79,444	£405,517	-£14,674,895
Division 2	-£9,815,267	£167,514	£4,812	£172,325	-£9,642,942
Division 3	-£6,559,981	£364,407	£10,128	£374,536	-£6,185,445
Division 4	-£387,915	£1,903		£1,903	-£386,012
Estates And Facilities	-£3,321,807	£48,476	£3,125	£51,601	-£3,270,206
Trustwide	-£7,002,568	£3,361,162		£3,361,162	-£3,641,406
Grand Total	**-£45,152,568**	**£4,357,369**	**£100,229**	**£4,457,599**	**-£40,694,969**

Against an in month target of £1.57m, the Trust has achieved £1.0m. Of this, only £8k is recurrent. The in-month achievement takes the year to date achievement to £1.2m, however only 1% of the achievement is recurrent.

The 23/24 target for the trust is £45m & the trust has identified savings with full year effect of £4.46m, however these are mostly non-recurrent . There are additional CIP's forecast of £3.15m with £0.4m being recurrent.

There are approved PIDs of £1.41m, £1.35m recurrent and £60k non-recurrent with £2.52m of schemes in progress.

Reserves

Start point			29,703,056
Additional Income allocated to reserves			4,372,464
Full Year Effect of reserves 'drawn down' upto current month			(4,148,389)
Reserves phased into position			(3,936,905)
Reserves available for future months			**25,990,227**
Earmarked Reserves	Division 1	(4,584,511)	
	Division 2	(5,674,324)	
	Division 3	(4,526,149)	
	Division 4	(44,748)	
	Estates and Facilities	0	
	Corporate & Other	(754,940)	
Less:	Expected Slippage	91,800	
			(15,492,872)
	Available Balance		**10,497,355**
Balance made up of	Drugs	0	
	Inflation	7,599,608	
	Trustwide Education/LDA	773,817	
	Contingency	658,279	
	CDC - Trustwide	1,465,650	
Less:	Expected Balance Sheet Release	0	
			10,497,355

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				
105,719	58,569	59,490	921	Patient Activity Income	681,837	113,468	112,966	(503)
142	127	90	(37)	Other Patient Care Income	1,521	253	164	(90)
1,297	0	0	0	Top Up Income	0	0	0	0
7,973	4,517	4,484	(33)	Education, Training & Research Income	52,319	9,025	8,789	(236)
7,041	3,100	4,822	1,722	Non Patient Care Other Income	17,321	7,700	7,559	(141)
13	55	69	14	Private Patient Income	658	110	122	13
11,945	7,703	7,530	(173)	Income on Directorate Budgets	82,547	14,520	15,007	487
134,130	**74,070**	**76,485**	**2,414**	**Total Income**	**836,202**	**145,076**	**144,607**	**(469)**
				Expenditure				
83,033	47,150	48,560	(1,410)	Directorate Expenditure Budgets - Pay	533,443	91,257	95,337	(4,080)
32,796	17,101	16,543	558	Directorate Expenditure Budgets - Non Pay	204,653	34,316	34,068	248
11,366	6,098	6,092	6	Directorate Expenditure Budgets - Drugs	71,740	12,021	11,749	272
0	800	0	800	Activity Changes/Service Dev./Cost Pressures/Inflation Reserves	28,837	3,505	0	3,505
0	285	0	285	Contingency Reserves	1,090	432	0	432
0	(571)	0	(571)	Cost Improvement Savings	(40,695)	(1,966)	0	(1,966)
0	0	0	0	BCPS Savings	0	0	0	0
127,196	**70,864**	**71,196**	**(332)**	**Total Expenditure**	**799,068**	**139,566**	**141,154**	**(1,589)**
6,935	**3,207**	**5,289**	**2,082**	**EBITDA Surplus/(Deficit)**	**37,134**	**5,510**	**3,452**	**(2,058)**
4,469	2,581	2,614	(33)	Depreciation	32,978	5,162	5,228	(65)
323	74	12	62	(Interest Receivable) / Payable	1,581	120	8	112
2,101	1,158	1,158	0	Other Charges	13,900	2,317	2,316	1
6,894	**3,813**	**3,784**	**29**	**Other non operating items**	**48,459**	**7,599**	**7,551**	**48**
41	**(606)**	**1,505**	**2,111**	**Net Surplus/(Deficit) before Adjustments**	**(11,325)**	**(2,089)**	**(4,099)**	**(2,010)**
(6,956)	(3,009)	(4,768)	(1,759)	Adjustments as per NHSI reported position	(15,425)	(7,518)	(7,451)	67
(6,915)	**(3,615)**	**(3,263)**	**352**	**Adjusted Financial Performance as NHSI**	**(26,750)**	**(9,607)**	**(11,550)**	**(1,943)**
0	*0*	*85*	*85*	*Adjustments as per ICS reported position*	*0*	*0*	*(7)*	*(7)*
(6,915)	***(3,615)***	***(3,178)***	***437***	***Adjusted Financial Performance as ICS***	***(26,750)***	***(9,607)***	***(11,557)***	***(1,949)***

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2023/24 Balance Sheet as at 31st May 2023

	May 2023 Plan	May 2023 Actual	April 2023 Actual	Movement in Month	March 2023 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	497,239	490,686	487,630	3,056	486,739
Intangible Assets	6,354	5,646	5,738	(92)	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	**509,654**	**502,394**	**499,429**	**2,964**	**498,660**
CURRENT ASSETS					
Inventories	8,347	8,386	8,509	(124)	8,347
Trade and Other Receivables	49,658	65,365	62,099	3,265	59,564
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	55,490	66,356	68,399	(2,044)	69,265
TOTAL CURRENT ASSETS	**113,495**	**140,106**	**139,008**	**1,098**	**137,176**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**623,149**	**642,499**	**638,437**	**4,063**	**635,836**
CURRENT LIABLILITES					
Trade & Other Payables	(103,133)	(120,218)	(113,669)	(6,549)	(114,207)
Liabilities arising from PFIs / Finance Leases	(6,199)	(6,048)	(6,048)	0	(13,462)
Provisions for Liabilities and Charges	(3,925)	(4,172)	(4,181)	8	(4,201)
Other Financial Liabilities	(10,207)	(16,180)	(19,651)	3,471	(10,424)
TOTAL CURRENT LIABILITIES	**(123,464)**	**(146,618)**	**(143,549)**	**(3,070)**	**(142,294)**
NET CURRENT ASSETS / (LIABILITIES)	**(9,968)**	**(6,512)**	**(4,541)**	**(1,971)**	**(5,118)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**499,685**	**495,881**	**494,888**	**993**	**493,542**
NON CURRENT LIABILITIES					
Trade & Other Payables	(287)	(279)	(283)	4	(287)
Other Liabilities	(12,549)	(11,845)	(12,353)	508	(5,470)
Provision for Liabilities and Charges	(1,781)	(1,780)	(1,780)	0	(1,780)
TOTAL NON CURRENT LIABILITIES	**(14,617)**	**(13,905)**	**(14,416)**	**512**	**(7,537)**
TOTAL ASSETS EMPLOYED	**485,068**	**481,976**	**480,472**	**1,505**	**486,005**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	306,752	305,676	305,676	0	305,676
Retained Earnings	70,350	68,332	66,827	1,505	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	187	190	190	0	190
TOTAL TAXPAYERS EQUITY	**485,068**	**481,976**	**480,472**	**1,505**	**486,005**

2023/24 Cash Flow as at 31st May 2023

	May-23 Plan £'000	May-23 Actual £'000	May-23 Variance £'000	May-23 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit)	**54,205**	**(1,775)**	(55,980)	(40,071)
Depreciation	35,685	5,228	(30,457)	(21,734)
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(46,989)	3	46,992	28,725
Interest Paid	(3,368)	(583)	2,785	1,839
Dividends Paid	(18,974)	0	18,974	6,126
Release of PFI /Deferred Credit	0	0	0	0
(Increase)/Decrease in Inventories	0	(39)	(39)	124
(Increase)/Decrease in Trade Receivables	9,945	(5,763)	(15,708)	9,368
Increase/(Decrease) in Trade Payables	(20,959)	10,952	31,911	8,450
Increase/(Decrease) in Trade Payables Ann Leave Acc	0	(2,037)		3,831
Increase/(Decrease) in Other liabilities	0	5,755	5,755	2,200
Increase/(Decrease) in Provisions	0	64	64	4,113
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**9,545**	**11,804**	**2,259**	**2,972**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	518	575	57	(1,125)
Payment for Property, Plant and Equipment	(93,374)	(14,221)	79,153	38,693
Payment for Intangible Assets	(728)	(29)	699	(15)
Receipt of cash donations to purchase capital assets	47,320	0	(47,320)	(28,722)
Proceeds from sales of Tangible Assets	0	0	0	(119)
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(46,264)**	**(13,675)**	**32,589**	**8,712**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(36,719)**	**(1,871)**	**34,848**	**11,684**
FINANCING				
New Public Dividend Capital Received	31,138	0	(31,138)	(6,023)
Capital Element of Finance Lease and PFI	(8,194)	(1,038)	7,156	4,418
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**22,944**	**(1,038)**	**(23,982)**	**(1,606)**
INCREASE/(DECREASE) IN CASH	**(13,775)**	**(2,909)**	**10,866**	**10,078**
CASH BALANCES				
Opening Balance at 1st April 2023	69,265	69,265	0	
Opening Balance at 1st March 2023				68,399
Closing Balance at 31st May 2023	55,490	66,356	10,866	78,477

Paper for the Trust Board Meeting to be held in Public on 1 August 2023

Title of Report	Exception Report from the Quality Governance and Assurance Committee	Enc. 9.3
Author:	Louise Toner	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	21st June 2023 26th July 2023	

Action Required of Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Received/Noted/For Information**
Yes☐No☒	Yes☐No☒	Yes☒No☐	Yes☒No☐
Recommendations: The Board is asked to note the contents of the report and the Alerts section in particular. The Board is asked to endorse this report.			

ALERT

- The Trust has received the expected Tier 2 letter from NHSE related to our cancer performance in respect of 62 day waits and 31-day Radiotherapy/Chemotherapy metrics. Action plans are in place for both and weekly in house and monthly meetings with the ICB and NHSE continuing. The 31day metrics are beginning to show signs of improvement.
- Diagnostics and in particular Histopathology turnaround times remain particularly challenging with extremely poor performance in a number of areas (due to the specialties available within the cellular pathology team) – urology, skin, gynaecology are a particular issue despite outsourcing. Unfortunately, the recent ICE update did not include the required changes to facilitate more accurate time requirements for test results – this has been raised again with the organisation. Moving forward, no paper requests will be accepted for histopathology requests.
- In addition, BCPS is under pressure with the relocation of chemistry and immunology with new equipment and IT.
- An incident involving test results not being returned to the requester during the period September 2021 and March 2023 was discussed. All affected patients have been contacted and the appropriate actions are being undertaken based on individual circumstances.
- Urology and Prostate outsourcing continues with patients traveling to Nottingham and London for treatment.
- One Never Event was identified with an investigation taking place and actions being undertaken.

- Medicines storage and management continues to prove challenging, in the main, from a regulatory as opposed to a patient safety perspective. Actions are in place with estates and new systems will be put in place as part of ward upgrades e.g., temperature control for drug storage. Education and training is ongoing regarding staff behaviours in respect of storage at the bedside and ensure these are locked.

- Mental health activity is increasing with more patients attending ED and subsequently being admitted. Limited access to Tier 4 CAMHS beds continues both of which are increasing

stress for staff in both ED and inpatient areas. RWT has been asked to consider delivery of ECT on site, following the closure of provision elsewhere. This would be with support from the Black Country Partnership Trust if there is a decision to proceed. 421 mental health related incidents have taken place.

- Maternity staff will be over establishment for 3 months however, this will compensate for the known maternity leave and turnover. The acuity of women is high, and more work is being undertaken to analysis this further and determine the impact.
- The Neonatal ICU remains below the required level of activity for such a unit. However, the implementation of the 27-week pathway should resolve this situation.

- There are 6 NICE Guidelines open for over 12 months and 2 open for over 12 months as a result the Trust is required to identify associated risks through Risk Evaluation Forms completed by NICE leads. Of the 8 guidelines, 2 are related to risks on the Directorate Risk Register, 5 have not been added to the register and 1 will be updated by the end of July.
- Whilst the overall trust vacancy rate is low there are specific shortages in Podiatry, Dietetics, Occupational Therapists and health Visitors – the latter reflects the national picture.
- There has been a significant increase in Violence and Aggression incidents.

- Other alerting areas are VTE and Sepsis compliance in some areas. Pressure ulcers and falls, the latter particularly in the community and skill mix given the high numbers of overseas nurse in the workforce. All of these have action in place.

- Total numbers on the waiting list is 81,398 patients with numbers increasing over the past 3 months.

ADVISE

- In May there were 59 patients who have exceeded this target, however, none have experience physical or psychological harm.
- The Trust achieved the 28-day faster cancer diagnosis target last month and is on track to be achieved this month.
- C difficile is above set target. 12 v 14. Action plan in place and deep cleaning using the decant facility will commence in August.
- An audit of the paper-based Medicine Prescription Chart identified that improvements are required, despite this the Medicine Management Group were assured with the standards of prescribing.
- A number of NICE Guidelines are awaiting closure by Directorates/Divisions.
- The Trusts are currently reviewing the new Saving Babies Lives and CNST maternity incentive scheme for year 5.
- Red Flags in maternity services due to patient acuity did not result in any patient harm.
- Observations on time, whilst below target are slowly improving with additional support being provided in areas failing to reach the set target.
- The Trust will be part of a new low intensity, Lung Screening initiative commencing in January 2024.
- ED 4 hour wait on target despite an in-month dip in performance, Ambulance Handovers remain below target time. ARC remains operational.
- MFFD/Criteria to reside patients were at 51 at the end of June – specific challenges remain for the discharge of out of area patients.
- All integrated care services performing well with the exception of sexual health appointments and Rapid access to social care services.

ASSURE

- A positive second insights assessment visit took place recently with the LMNS and NHSE which confirmed that our Maternity services are fully compliant with the Ockendon 7 IEA's. The report of the visit is awaited.
- There have been no breaches in reporting and closing SI investigations with the numbers of overdue SI's actions reducing.
- The Trust is fully compliant with the ten criteria set out in the Code of Practice regarding Infection Prevention and Control (H&SC Act, 2008; Dept of Health & Social Care 2015)
- Pharmacy related assurance - medication incidents have been within the control limits for 6 months. Staffing is good with a 2.3 WTE vacancy rate, with Pharmacy Technicians over establishment. Successful bids submitted to expand homecare services, support Independent Prescribing Courses and training posts.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	**ID:6053** Lack of Consultant Cover within Cancer Services – this risk has been added to the register; however, it encompasses Risks ID: 6246 and ID: 5792 Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable): 16 4x4 = 16 Red Risk Two risks have been removed: **ID 5246**: Lack of Consultant Cover within Cancer Services **ID 6006:** Non – availability of Medical Equipment		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: All domains
	NHSE	Yes☒No☐	Details: Tier 2 monitoring
	Health & Safety	Yes☒No☒	Details:
	Legal	Yes☒No☐	Details: Delays in Results reported to patients
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:

Summary of Key Issues:

The key issues are:

- Cancer Improvement Plan and the receipt of a Tier 2 scrutiny letter from NHSE.
- Increase in Mental health patients presenting in A&E who are subsequently admitted, lack of Tier 4 capacity locally and nationally
- CAMH's beds and the changes in provision – ECT services impacting on inpatient service and receipt of the appropriate care as a result.
- Other areas identified above.

Links to Trust Strategic Aims & Objectives – Given that the committee is concerned with Quality and Safety all of the below are relevant	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

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

Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee P&F	Yes☒No☐	Date: TBC
	Board of Directors	Yes☒No☐	Date
	Other Discussions taking place with a view to aligning QPES and QGAC	Yes☒No☐	Date: Ongoing
Any Changes to Workplan to be noted	Yes☐No☒		Date:

EXCEPTION REPORT FROM: QUALITY GOVERNANCE ASSURANCE COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION
The Trust's receipt of the Tier 2 letter regarding our 62 and 31 day waits as identified in the ALERT section above. A report regarding the Cancer Recovery is currently in Preparation by the Chief Operating Officer.

ACTIVITY SUMMARY
Please see list below
Infection Prevention Delivery Plan was approved

Matters presented for information or noting

- Annual Equality Report
- Health and Safety Assurance Report
- External Reviews Registry Update Report
- Information Governance Annual Report
- Litigation and Inquest Summary Report
- Perinatal Mortality Quarterly Report
- Infection Prevention Delivery Plan
- Quality and Safety Advisory Group
- Chief Nursing Officer Report
- Integrated Quality and Performance Report
- Trust Risk Register
- Board Assurance Framework
- Cancer Improvement Plan

Chair's comments on the effectiveness of the meeting:
An effective meeting with relevant and useful discussion. However, as some reports were only received the day before the meeting it was not possible to consider these in the detail they deserved. However, the Health and Safety Report had been considered at QSAG and featured in the Chair's report and the Annual Equality Report had been considered at PODC and the Chair of PODC is a member of QGAC and attended the meeting. For some of the reports there were staff who were able to provide information and identify the key issues within the reports. One of the reports was for approval and this was considered and approved.

Trust Board/Committee/Group Chairs Assurance Report

Name of Committee/Group:	Quality Governance Assurance Report
Date(s) of Committee/Group Meetings since last Board meeting:	21st June 2023
Chair of Committee/Group:	Louise Toner
Date of Report:	10th July 2023

<table>
<tr>
<td>ALERT
Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee</td>
<td>Cancer Improvement Plan

It was reported that there had still been no written confirmation to the ICB of RWT of the Trust moving into Tier 2 scrutiny, however weekly meetings continue.

There was discussion regarding the plan as it is currently presented and it was acknowledged that it is more operational and, as a result, does not clearly identify where the metrics are improving or deteriorating. The intention is to produce a new report a draft copy of which will be forwarded to members prior to the next meeting.

It was reported that the expectations around the 28 days faster diagnosis standard is that this will be achieved for 75% of patients by March 2024. The Q1 expectation is set at 67% and the Trust is currently achieving this and expects to meet the 75% standard by March 2024.

It was confirmed that there are areas showing signs of improvement particularly the 31-day metric which is concerned with Radiotherapy and Chemotherapy and it is expected that by June the standard will be achieved. This was one of the areas of concern that led to the Tier 2 scrutiny with the action plan produced accepted by the ICB.

The 62 days wait continues to be a challenge with no real change in respect of Urology, despite mutual aid from Russell's Hall and Frimley Park. There is an operational group reviewing the Renal Pathway across the Black Country. As a result of the transfer of 2,600 patients from Walsall to RWT elective and cancer patients, discussions are taking place with NHSE to review RWT's targets.

As a result of the actions put in place and the areas of concern for NHSE showing signs of improvement, as identified above, it is anticipated that the current level of scrutiny will be reduced.

RTT 78+ week waits
Whilst additional lists have been implemented over weekends, the Trust will not deliver on the 78-week standard. Eighty-five patients are waiting currently.</td>
</tr>
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	Whilst there have been some improvements in diagnostics, histopathology turnaround times remain challenging despite outsourcing services and discussions have taken place with ICE the service provider regarding changes to the system to enable requesters to choose the appropriate level of urgency – a decision is awaited. Skin and Gynae are the principal areas of concern. A range of discussion took place regarding 2 week wait data, cancer trackers and chemotherapy services. Discussion took place regarding Mental Health Capacity Assessments and the low compliance rates 16%. It was confirmed that staff had visited other Trusts that are performing more effectively than RWT and changes are being made to the written documentation to improve compliance. The Safeguarding Team will continue to provide support and guidance. The Ethnic Minority Support Worker project has been completed but the report of the evaluation has been delayed. **Overseas Nurses** RWT has been contacted by the NMC who advised that eleven overseas nurses had been contacted regarding an issue that had been identified with a test centre in Nigeria. This relates to where they had undertaken the CBT test that has to be passed before coming to the UK. It was reported that now the staff are aware of who the eleven nurses are they can be supported appropriately. It is understood that they will be given the opportunity to take the CBT test again. All of those affected are known to their ward managers, have their NMC PIN Number and have passed the OSCE at an approved NMC centre. Concerns remain regarding the need for more cultural awareness for nurses from overseas and the increase numbers of Band 5 level nurses altering the skill mix.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	Ambulance waits and ED Breaches are showing an improving position overall with 4 hour waits at or exceeding the national 76% standard. C Difficile cases remain above trajectory six against and the target of 4. There is a decant plan in place over the summer. Observations on time showed a slight deterioration, however, quality improvement work is taking place re this and on the NEWS2 Scale2 usage. Criteria to reside patient numbers increased slightly to sixty patients. Daily meetings continue as do communications with the appropriate community-based services to facilitate discharge. 104-day harm review identified sixty-four patient who breached this in April. The Chief Medical and Nursing Officers will be meeting with the Cancer team – report to next QSAG. Vacancy, sickness, and retention rates are all showing slight improvements this month rates.

VTE Compliance remains a challenge with three areas failing to achieve the required 95% target.

The target to administer antibiotics within 1 hour for patients with Sepsis in ED is not being achieved.

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.

Improvements required to maintain Cardiotocography hourly fresh eyes compliance.

Approximately 2,600 patients (elective and cancer diagnosis) have been transferred to RWT from Walsall and this will impact on RWT metrics.

Smoking at the time of delivery remains above target with an action plan in place.

Awaiting further information regarding the reduction in referrals to the Rapid Intervention Team.

RWT End of Life Delivery plan is in development

Business case is being developed to increase the learning disabilities team in response to the Changing Our Lives review

Compliance with the completion of initial health assessment escalated to the Integrated Care Board and Local Authority.

Safeguarding supervision within Health Visiting has fallen due to staff shortages.

All outstanding actions for the Safeguarding Adult Review have been completed.

ASSURE

Positive assurances & highlights of note for the Board/Committee

The trust will be submitting full compliance with the Data

Protection and Security Toolkit 2022 – 2023 in respect of the Acute Trusts and the CP Practices.

One Wolverhampton End of Life Care Improvement Plan 2022 – 2024 approved at the Place Board.

The new Saving Babies Lives and CNST incentive Scheme has been received – currently under review to determine any new requirements to ensure plans in place to meet these.

No contractual breaches in reporting or closing SI investigations.

BCPS accreditation maintained

Midwifery safeguarding supervision compliance has increased from 25% to 95% in Q3.

DBS compliance now at 100% for new starters and 98.2% for existing staff

Daily monitoring of 16–18-year-olds on adult wards has had positive responses re care provided.

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 were no new risk to report 1 Risks was removed from the register **ED 5246 – Lack of Consultant cover in Cancer Service** Clarification was sought regarding this decision, and it was confirmed that the risk is being incorporated into ID 6053. Unfortunately, this risk could not be found on the Trust Risk Register. General discussion took place regarding a number of Risks and in particular where the issue is out with the ability of the Trust to do anything about it – e.g., 5536 – and whilst it has been escalated to the ICB was it possible to identify this within the Register. It was reported that in respect of **5388** staff had visited other NHS Trusts whose performance in respect of Mental Health Capacity Compliance is better that at RWT. This had identified that certain questions and tick boxes could be removed from the paperwork to streamline completion and whilst an electronic version of the form would help to improve the situation this is not possible at the present time. Discussion took place re other risk namely **5448** Medicines Management, **5182** Vascular Services, **5479** Cath Labs and **5316** RTT breaches.
ACTIONS Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)	Louise Toner and Alison Heseltine will be attending the meeting Trust Risk Register meeting in July to gain a greater understanding of the processes involved.
ACTIVITY SUMMARY Presentations/Reports of note received including those Approved	Cancer Improvement Plan Trust Risk Register Update Integrated Quality and Performance Report QSAG Chairs Report Safeguarding Assurance Report

ACTIVITY SUMMARY Major agenda items discussed including those Approved	Concerns remain regarding the financial situation and the impact of decisions that will have to be made regarding services currently in place having to be removed or reduced and the potential impact 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	A light agenda
Items for Reference Pack	There were none

Paper for submission to the Trust Board Meeting – to be held in Public On 1st August 2023		
Title of Report:	Chief Nursing Officer Report.	Enc No: 9.3.1
Author:	Martina Morris – Deputy Director of Nursing (interim)	
Presenter/Exec Lead:	Debra Hickman, Chief Nursing Officer	

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

Recommendations:

- The Board is asked to note the contents of the report and receive it for discussion and assurance.

Implications of the Paper:			
Risk Register Risk	Chief Nursing Officer (CNO) risks on the risk register: Yes ☒ No ☐ **Risk Description:** Mental Capacity and Deprivation of Liberty Safeguards (DoLs) Assessments. On Risk Register: Yes☒No☐ Risk Score (if applicable): 15 (High Risk) **Risk Description:** Non-compliance with Bacillus Calmette-Guerin vaccine (BCG) vaccine / Severe Combined Immunodeficient Syndrome (SCID) service provision. On Risk Register: Yes☒No☐ Risk Score (if applicable): 12 (Significant Risk)		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Contribution to the Trust's compliance with CQC fundamental standards.
	NHSE	Yes☒No☐	Details: Contribution to the Trust's compliance with NHS Oversight Framework requirements.
	Health & Safety	Yes☒No☐	Details: Contribution to the Trust's compliance with Health and Safety standards.
	Legal	Yes☒No☐	Details: Contribution to the Trust's compliance with legal framework such as complaints regulation.
	NHS Constitution	Yes☒No☐	Details: Contribution to the NHS Constitution principles.
	Other	Yes☐No☒	Details:N/A
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable		

	harm. **Effective:** care, treatment and support achieve good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it'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 adverse impact is anticipated as a result of the points articulated in this report.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Trust Management Committee – 21/07/2023
	Board Committee	Yes☒No☐	Date: Quality Governance Assurance Committee – 26/07/2023
	Board of Directors	Yes☐No☒	Date: N/A
	Other	Yes☐No☒	Date: N/A

Summary of Key Issues using Assure, Advise and Alert

Assure

- The established recruitment and retention initiatives continue. In terms of registered Nurses and Midwives, the vacancy position reduced to 1.25% and for non-registered staff it was -1.98, for clinical areas captured in the Nursing Quality dashboard. The Care Hours per Patient Day remained in a positive position of 8.4.
- There were 128.51 whole time equivalent (WTE) registered Nurses and Midwives in the recruitment pipeline and from this number, 30.76 WTE have start dates. In terms of non-registered Nursing and Midwifery staff, 21.35 WTE were in the recruitment pipeline and from this number, 9.58 WTE have start dates.
- As at the end of June, the Trust was below or at external targets for *Escherichia coli* and *Pseudomonas aeruginosa* bacteraemia. Carbapenemase producing Enterobacteriaceae (CPE) screening continues to identify patients and reduce the risk of transmission.
- The Trust's safeguarding governance and leadership arrangements remained in line with statutory requirements during 2022-23.

Advise

- Compliance with Infection Prevention and Control (IPC)-related mandatory training was below 95% at end June (94% for IPC mandatory training and 91% for Hand Hygiene).
- Challenges with some nursing and midwifery audit data availability via HealthAsssure remained and this has been re-escalated to the provider (My Assurance) for resolution.
- The falls and pressure ulcer (PU) rates increased in June. However, they remained below the mean level as a longer-term trend apart from community PUs and Moisture Associated Skin Damage (MASD). Focussed improvement work remains in place and consideration of seasonal variation.
- Positive progress remained with patient observations being completed on time with 85.7% compliance achieved in June.

- 60 complaints were received compared to 64 for the preceding reporting period (April-May 2023).
- The overall Trust wide Friends and Family Test (FFT) response rate for April was 14%, with 86% recommending the Trust and 9% not recommending the Trust. In May, the response rate was 19% with 86% recommending the Trust and 6% not recommending the Trust.

Alert

- The previously escalated issue, raised by the Nursing and Midwifery Council (NMC), regarding the Test of Competence process for International Nurses continues to be investigated with confirmation of Trust numbers received via the NMC.
- In June, the Trust was above the external target for Klebsiella bacteraemia. In addition, the Trust was above the external target for *C difficile* with 14 cases to date (target for end Q1 is 12). There was no evidence of transmission confirmed for any of the *C difficile* cases based on ribotyping.
- During 2022-2023, shortages of staff within the Health Visiting Service had impacted on the ability of staff to attend safeguarding supervision in a timely way. With support, this has now been achieved.
- During Q4 2022-23, the Trust wide audit to review compliance with completion of Mental Capacity Act assessments was repeated, and the compliance remained consistently at approximately 50%. As a result, the Mental Capacity Act and Deprivation of Liberty Safeguards action plans were updated to drive necessary improvements across the Trust.

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

Chief Nursing Officer Report.

Report to Trust Board Meeting to be held in Public on 1st August 2023.

EXECUTIVE SUMMARY

This report provides an overview of June's position with regards to key Nursing and Midwifery recruitment and retention activities and Nurse Sensitive Indicators (NSIs). In addition, it outlines brief summaries of detailed Patient Experience, Infection Prevention and Control (IPC) and Safeguarding Adult and Children reports, which feature on Part B of the Board meeting agenda.

The report demonstrates our ongoing commitment to growing and sustaining the Nursing and Midwifery workforce, with a positive vacancy position, and improvements in some of the NSIs as a result. There are improvement actions and/or overarching improvement plans in place to continue further improving our position with regards to, for example, key workforce indicators, pressure ulcers, falls, observations being completed on time, IPC indicators and learning from complaints and incidents.

BACKGROUND INFORMATION

NURSING QUALITY DATA

The Nursing Quality Dashboard (Appendix 1) provides an 'at a glance' view of ward/department/service performance with regards to workforce, quality and safety. Other nursing quality and safety data can be viewed on the Integrated Quality and Performance Report (IQPR).

Executive Level Nursing Quality Dashboard

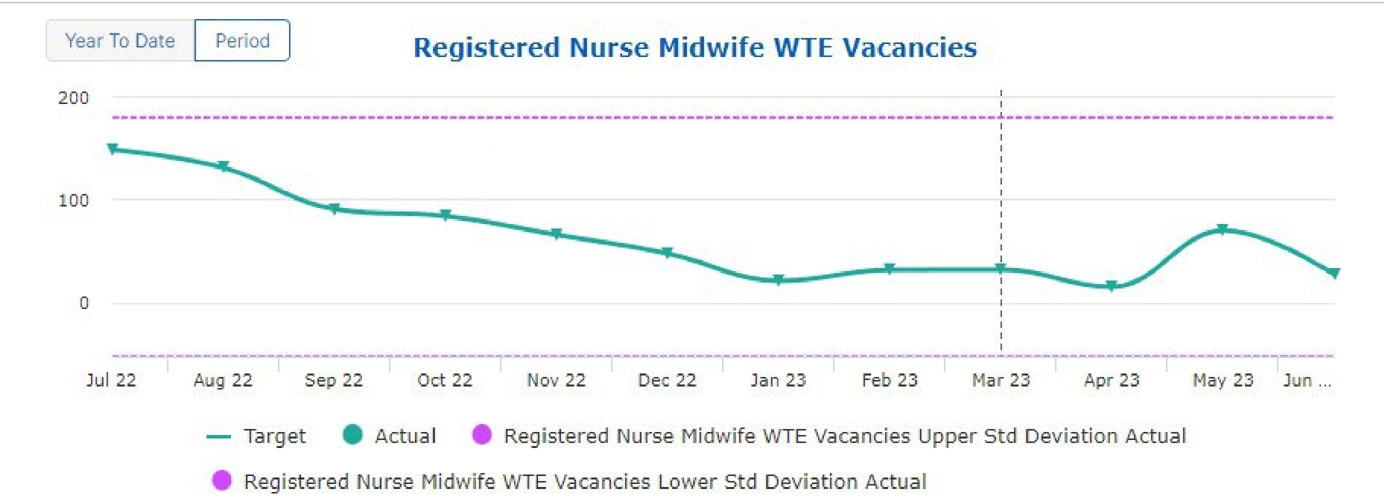
Based on data analysis in the latest Executive Nursing Dashboard, either issue specific actions are being taken or overarching action plans are in place for those areas noted as outliers. Key outlier indicators include sickness, complaints, falls, pressure ulcers, Moisture Associated Skin Damage, observations completed on time, *Clostridioides difficile* and medication errors.

A review of the dashboard, to incorporate trend data and triangulation with the Divisional reports will be undertaken in the coming months.

Workforce

Vacancies and Recruitment – June 2023 position	Registered Nursing and Midwifery staff	Unregistered Nursing and Midwifery staff
The latest number of vacancies	26.36 WTE (a decrease from 69.88 WTE)	-24.16 WTE an over-establishment is seen due to International Nurses who are awaiting Nursing and Midwifery Council (NMC) pin numbers being included in this figure
Latest vacancy %	1.25% (a decrease from 4.19%)	-1.98%
Recruitment pipeline	128.51 WTE and from this number, 30.76 WTE have start dates	21.35 WTE and from this number, 9.58 WTE have start dates
Maternity leave	3.51% (an increase from 2.40%)	Included within the overall workforce data set reported separately
Sickness absence	5.99% (a small increase from 5.77% last month)	Included within the overall workforce data set reported separately

Overall, Nursing and Midwifery vacancies and associated Care Hours Per Patient Day (CHPPD) remain in an improved position. Please see the graph below for a vacancy trend over time and IQPR for more information on CHPPD.



Other key headlines include:

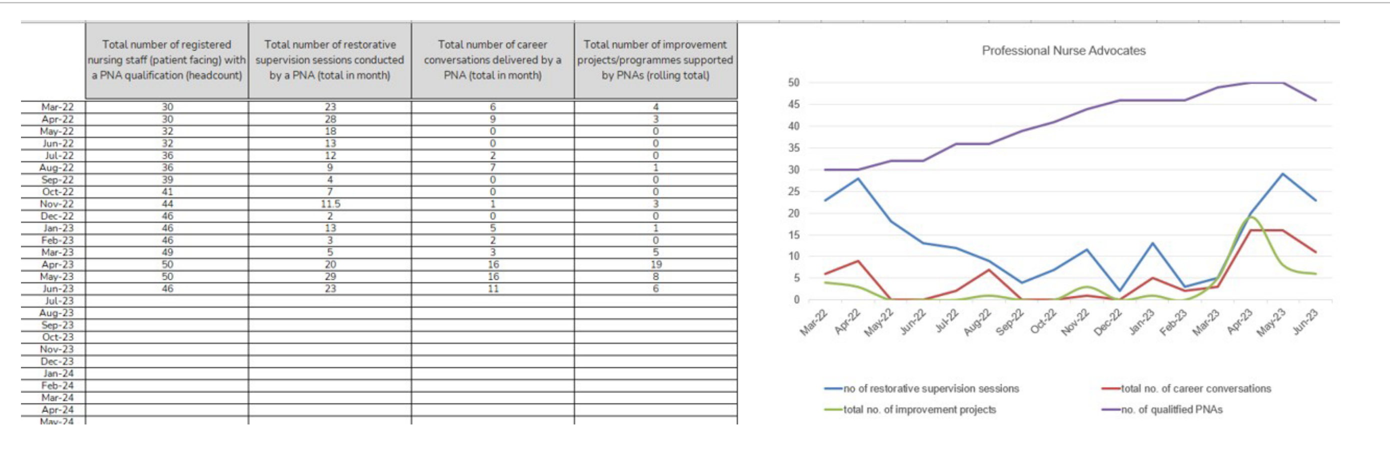
- Rostering efficiency improvements continue to be driven through confirm and challenge meetings with each clinical area across the year with oversight via the Nursing and Midwifery Recruitment and Retention meetings chaired by the Chief Nursing Officer.
- The Nursing and Midwifery Council (NMC) has 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 formally advised the Trust which candidates are affected and recommended a Trust led confidential offer of support whilst they continue to investigate one CBT centre abroad. We continue to await plans from the NMC with regards to next steps.

Oversight of the nursing and midwifery recruitment and retention matters is maintained by The Royal Wolverhampton NHS Trust (RWT) Nursing, Midwifery & AHP Workforce Oversight Group.

Education

Key updates for Nursing and Midwifery education and staff development include:

- The overall compliance for Standards for Student Supervision and Assessment (SSSA) is currently 87%. The associated training is being converted into e-learning and is planned to go live in August 2023. The student forum has been re-launched as a Shared Decision-Making Council to improve student engagement and provide a further platform for student voice.
- The Preceptorship programme is currently being reviewed and a new temporary lead has been appointed to deliver and launch a new plan to re-energise our approaches. The Trust continues to await the confirmation of the Quality Marker (IQMS) application.
- The Band 5 nursing and midwifery development days are currently being scoped with the Divisions, with a plan to launch them in early autumn. These are a succession from the Band 6 and 7 and Healthcare Support Worker sessions.
- A qualitative exploratory study conducted by our nursing research colleagues, and funded by NHS England, was completed in June 2023 and is due to be published on the national Professional Nurse Advocate (PNA) website. The table below outlines the latest update related to PNA activities.



	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	50	29	16	8
Jun-23	46	23	11	6
Jul-23				
Aug-23				
Sep-23				
Oct-23				
Nov-23				
Dec-23				
Jan-24				
Feb-24				
Mar-24				
Apr-24				
May-24				

Excellence in care

Quality

Key updates for Nursing and Midwifery quality include:

- In June 2023, 94 falls were reported (85 in May) and from this number, 78 were inpatient falls. The rate of falls per 1000 bed days was 2.80% (2.36% in May). Please see the latest IQPR for the graph with a trend over time and more information.
- In the same period, 33 pressure ulcers were reported (14 category 2; 6 category 3; 4 category 4 and 9 unstageable). The pressure ulcer rate for inpatients per 1000 occupied bed days was 0.61% (0.57% in May) and community occupied days was 0.53% (0.38% in May). Please see the latest IQPR for the graph with a trend over time and more information. In addition, there were 64 incidents of Moisture-Associated Skin Damage (MASD) reported (57 in May 23). The MASD rate per 1000 bed occupied days was 1.43% (1.43% in May) and community rate per 10,000 population was 0.91% (0.61% in May). Comprehensive improvement plans associated with falls and wound prevention and management remain in progress, with good progress being made.
- Further improvements have been made with patient observations being completed on time, with the overall score of 85.7% in June (84.8% in May). The focus on driving further improvements remains, especially for patients with National Early Warning Score (NEWS2) score of 5 and above.
- Focused improvement work is in progress with regards to nutrition and hydration and completion of Malnutrition Universal Scoring Tool (MUST) assessments, which is now available on Vitals.
- The Clinical Accreditation programme continues to be embedded in line with the implementation plan and the table below outlines the current position.

Number of clinical accreditation (CA) visits conducted at RWT and WHT since April 2023	**Diamond outcome** (Has sustained CA excellence and Sapphire status for one year)	**Sapphire outcome** (Meets the CA standards and is deemed excellent)	**Emerald outcome** (Meets the majority of the CA standards with a clear plan for improvement)	**Ruby outcome** (Meets the basic CA standards with a clear plan for improvement)	**Working towards accreditation outcome** (Working towards CA with a clear plan for improvement)	**Awaiting their accreditation outcome following the visit**
24 (13 at RWT and 11 at WHT)	0	0	6	4	4	10

- There remain challenges with some nursing and midwifery audit data availability via Health Assure and this has been escalated to the provider (My Assurance) for resolution. The last

escalation conversation with the provider was on Monday 10th July 2023, and the provider has agreed to resolve the current issues within a week. This will continue to be monitored.

- The Back to the Floor (BTTF) initiative, which involves clinical colleagues who usually work in non-frontline facing roles spending a weekly shift in a clinical area has been evaluated, with a positive overall outcome of colleagues stating that they enjoy their BTTF time. The table below outlines positive themes as well as areas for ongoing oversight and improvement. The concept will continue to be further embedded.

Positive themes	Improved communication; Improved staff and patient engagement; Increased visibility of senior leaders; Better appreciation of pressures and challenges; Support with problem solving and Regular patient and staff contact.
Areas for improvement	Collaborative working (ongoing work required); Consistent and effective communication; Fundamentals – medicines safety and management; patient observations; IPC compliance; documentation; patient repositioning; MUST completion; Visitor and ward information often out of date; Ensure that everyone who should be participating in the BTTF days is doing so and consistently; Inconsistencies with the Uniform policy/dress code compliance and Continue to maximise opportunities for staff development/retention/talent spotting. Actions are being taken to address findings from this survey.

Patient Experience

Key updates for Patient Experience include:

- 60 complaints were received compared to 64 for the preceding reporting period (April-May 2023). The greatest volumes were received for Emergency Department (14 cases), Renal (6 cases) and Adult Community, Gastroenterology and Trauma & Orthopaedics all received 4 cases each respectively. Please refer to IQPR for a trend over time with regards to complaint rates and responsiveness.
- In terms of the outcomes from closed complaints, 6 complaints were upheld in this reporting period.
- From 90 cases closed, 70% of cases were not upheld, 23% were partially upheld and 7% were upheld. There were no cases accepted for full investigation or closed following investigation by the Parliamentary Health Service Ombudsman (PHSO).
- The overall Trust wide Friends and Family Test (FFT) response rate for April was 14%, with 86% recommending the Trust and 9% not recommending the Trust. In May, the response rate was 19% with 86% recommending the Trust and 6% not recommending the Trust. Please refer to IQPR for a trend over time with regards to FFT.
- Volunteers achieved 1896 hours across the two months period.

Please see the detailed bi-monthly Patient Experience report for more information and IQPR for June's information on complaints and FFT.

Maternity

Latest updates for maternity services are contained in the Maternity Service report and Integrated Quality and Performance report (IQPR) presented to TMC and Trust Board separately.

Adult and Children Safeguarding

The latest headlines for Adult and Children Safeguarding include:

- Safeguarding training compliance varied in June and this remains a key focus for the Trust.
- There has been a reduction in Section 42s being processed in June. 2 were received in May compared to 6 in April.
- Deprivation of Liberty Safeguards (DoLS) reporting has significantly increased to 57 in May. This improvement has corresponded with additional support provided to clinical areas by the Adult Safeguarding team.

- The compliance for undertaking Initial Health Assessments within the appropriate timescale has increased to 77% (16 received and 13 returned to Wolverhampton Local Authority within the require timescale).

Key points for Adult and Children Safeguarding, based on the 2022-23 annual report, include:

- Safeguarding governance and leadership arrangements remained in line with statutory requirements.
- The monthly Black Country Safeguarding Assurance Framework was completed and shared across the organisation, demonstrating evidence that safeguarding responsibilities are being met by the organisation. In addition, the West Midlands Regional Self-Assessment for S11 (Children Act) and the Care Act was submitted. This self-assessment graded the Trust as outstanding.
- All mandatory safeguarding training except for Safeguarding Children level 3 e-learning was in line with Integrated Care System (ICB) training compliance requirements. Mental Capacity Act, DoLS, Prevent, Safeguarding Children and Safeguarding Adults level 1 and 2 training had demonstrated overall compliance of 95% or above throughout the period. Although Safeguarding Children level 3 e-learning compliance remained just below the required compliance rate of 85% in the early part of the year, an improvement was noted with compliance being 87% in March 2023. As of February 2023, both Learning Disability and Autism training compliance was 97% and in March 2023, these modules were replaced by the 'Oliver McGowan' training package.
- Maternity safeguarding supervision compliance varied considerably throughout 2022-23, due to staff absence within maternity services and capacity within the safeguarding service. As of March 2023, compliance improved to 95%. During 2022-23, shortages of staff within the Health Visiting Service (16.92 WTE vacancies) have impacted on the ability of staff to attend safeguarding supervision in a timely way. As a result, compliance reduced throughout the year and as of March 2023, it was 83% in comparison to 91% in Q1.
- Initial Health Assessments compliance remained the focus and priority over the year due to reduced compliance. Compliance had steadily increased from 10.3% in Q1 to 23.3% in Q4 (all assessments) and from 0% in Q1 to 31% in Q4, with a peak of 70.3% in Q3 for those assessments within provider control. There was a further improvement to 77% pertaining to all assessments and 100% pertaining to those within provider control in May 2023. Work is being undertaken to further improve this compliance. Review Health Assessment compliance remained stable throughout the year from 82.7% in Q1 and 78% in Q4.
- The number of Deprivation of Liberty Safeguards applications increased throughout 2022-23, with 453 applications completed in 2022-23 in comparison to 340 in 2021-22.
- During Q4, the Trust wide audit to review compliance with completion of Mental Capacity Act assessments was repeated, and the compliance remained consistently at approximately 50%. As a result, the Mental Capacity Act and Deprivation of Liberty Safeguards action plans were updated. Actions include the identification and training of Safeguarding champions within clinical areas, the delivery of bespoke training and the development of a stand-alone Mental Capacity Act Policy. The audit will be repeated in Q3 2023-2024.
- A total of 28 referrals were made against the Trust, which met the criteria for a section 42 enquiry. This demonstrates a significant increase in comparison to the previous year's data, when 11 section 42 enquiries were completed. This may be partially attributed to greater awareness of safeguarding adult processes across the Trust and an increased focus on incident reporting at the Trust Safeguarding Group. Common themes were categorised predominantly as neglect (unsafe discharge and pressure ulcer care) physical and sexual assault.

- Implementation of the Liberty Protection Safeguards (LPS) has been further delayed in 2022-23 due to the impact of the Covid-19 pandemic and the pressure on the health and social care sector during the pandemic.

Please see the detailed annual Adult and Children Safeguarding report for more details.

Infection Prevention and Control (IPC)

Key updates for IPC include:

- As at the end of June, the Trust was below or at external targets for *Escherichia coli* and *Pseudomonas aeruginosa* bacteraemia.
- Carbapenemase producing Enterobacteriaceae (CPE) screening continues to identify patients and reduce the risk of transmission. In total, 22 new patients were identified from April to June 2023.
- In the same period, the Trust was above the external target for Klebsiella bacteraemia. In addition, the Trust was above the external target for *C difficile* with 14 cases to date (target for end Q1 is 12). There was no evidence of transmission confirmed for any of the *C difficile* cases based on ribotyping.
- Compliance with IPC-related mandatory training was below 95% at end June (94% for IPC mandatory training and 91% for Hand Hygiene).

Please see the detailed Infection Prevention and Control report and Integrated Quality and Performance report (IQPR) for more details.

The Quality Framework

The Quality Framework, which enables the strategic vision for Nursing, Midwifery and Allied Health Professionals (AHPs) to be translated into an open and transparent plan that can be replicated over timeframes continues to be embedded, including the associated milestone plans for Maternity, Adult Acute, Paediatrics, Community and AHPs and we are currently collating progress updates for Quarter 1 milestones and will provide our position update in the next CNO report.

Research and innovation

- An article on our approach to implementing the Back to the Floor initiative has been accepted for future publication by the British Journal of Nursing.

Digital

Key updates for the Digital agenda include:

- Progress on the Electronic Patient Record (EPR) journey: The Trust has continued its ongoing journey to a Full EPR solution, implementing the further System C products. The transition is progressing, and we are seeing significant milestones in our move from legacy and fragmented systems to a cohesive, integrated EPR. The process is currently in the initialisation phase, working through plans for delivery and fine tuning the resource needs and the timelines for delivery.
- Feedback from the Regional Team on Digital Clinical Safety: The Regional Team recently reviewed our Digital Clinical Safety Strategy. They were specifically focussing on patient safety, clinical engagement, IT, informatics, and the utility of actionable data. The feedback was

overwhelmingly positive, and the team was particularly impressed by our proactive use of digital tools in ensuring clinical safety. The team praised our strategic use of technology to minimise risks associated with patient care. They highlighted our use of real-time data and analytics in driving informed decisions and improving outcomes, as well as our effective use of clinical engagement tools to foster better patient-provider communication. Given the success of the system, the Regional Team is currently exploring the possibility of using our strategy as a blueprint for other NHS trusts.

- Initiative to launch Careflow Connect in Medicine at Night Team: We continue to progress with our plans to initiate Careflow Connect in our Medicine at Night team. Careflow Connect's digital platform will facilitate effective and efficient communication among team members, ultimately enhancing the delivery of patient care during the night shift. The implementation of Careflow Connect is scheduled for after the next medical rotation.

RECOMMENDATIONS

- The Board is recommended to note the wide breath of activities in place to drive positive patient experience and quality of care and recruitment and retention of the Nursing and Midwifery staff.

Any Cross-References to Reading Room Information/Enclosures:

Please refer to the following detailed reports for more information:

1. Bi-monthly Patient Experience Report.
2. Annual Safeguarding Adults and Children Report.
3. Infection Prevention and Control Report.
4. Integrated Quality and Performance Report.

Appendix 1

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 13th July 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	12.27	2,506.51	8.4	5.99	93.3	3.51	26.36	1.25	-24.16	-1.98	31	83	64	33	94	85.7%	2	58
	Previous Period	14.35	2,560.92	8.4	5.77	92.4	2.40	69.88	4.25	-51.07	-7.02	36	86	67	25	83	84.8%	6	78

		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	12.06	1,229.95	11.0	6.02	92.5	3.55	-40.50	0.34	1.75	-6.26	14	87	10	6	22	86.6%	0	32
B14 Cardiology ward	This Period	13.45	69.62	7.3	5.79	94.4	2.81	-3.13	-5.97	4.11	23.83	1	91	1	0	4	92.9%	0	2
B15 Cath Labs and Day Ward	This Period	13.43	30.24	~	2.47	94.5	7.65	3.79	15.56	0.43	7.39	0	80	0	0	0		0	0
B8 Cardiothoracic ward	This Period	12.48	43.34	7.3	7.78	93.4	5.43	-0.91	-2.70	0.48	4.95	0	100	0	0	2	90.9%	0	3
ICCU	This Period	15.81	204.01	32.6	3.74	95.6	2.67	-0.78	-0.43	0.75	3.22	0	~	2	0	0	~	0	3
A12 General Surgery	This Period	11.80	35.23	6.8	8.40	91.7	5.56	-2.17	-10.19	1.84	13.25	0	88	0	0	3	88.4%	0	4
A14 General Surgery	This Period	12.55	35.23	7.0	3.41	92.0	1.57	-3.73	-16.73	1.91	14.79	0	80	0	1	2	75.9%	0	0
D7 ward	This Period	11.02	40.62	6.4	14.92	94.4	5.78	-1.06	-4.11	-2.64	-17.75	1		0	0	1	80.6%	0	0
SEU	This Period	13.87	80.50	9.4	5.07	94.2	4.78	1.10	2.17	1.94	6.49	0	67	1	2	2	88.0%	0	1
B7 Head and Neck	This Period	7.94	43.27	11.1	6.56	89.2	0.00	2.84	9.37	-0.25	-1.90	0	100	1	0	2	81.4%	0	1
Neonatal Unit	This Period	12.71	123.57	28.4	7.14	88.5	0.00	-6.89	6.43	-0.11	-160.50	0		1	1	0	~	0	10
Transitional Care	This Period	13.77	20.49	~	5.63	86.6	7.48	7.90	54.10	-0.24	-4.08	0	100	0	0	0	~	0	0
D10 Maternity Ward	This Period	11.90	44.15	9.4	5.75	87.4	5.34	-9.17	-31.29	-3.07	-20.66	1	87	0	0	0	~	0	2
Delivery Suite	This Period	14.84	89.59	~	5.16	91.2	5.43	-4.90	-6.85	-0.64	-3.53	0	85	0	0	0	~	0	1
Hilton main CCH	This Period	13.08	46.70	7.1	6.87	95.8	4.60	11.36	36.11	1.36	8.95	0	100	1	0	0	92.2%	0	0
A5 T & O ward	This Period	8.56	40.78	7.4	5.49	94.4	2.30	-0.10	-0.46	1.43	7.51	1	92	1	2	3	93.0%	0	1
A6 T & O ward	This Period	7.43	40.73	7.8	9.57	91.1	4.07	1.06	4.68	1.44	8.00	0	83	1	0	1	79.5%	0	0
Theatres	This Period	10.32	241.88	~	6.29	92.8	2.45	-35.72	-29.41	-7.01	-5.82	0	~	0	0	0	~	0	2

		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 %	Unregistere WTE Vacancies	Unregistere WTE Vacancies %	Number of Formal Complaints	Would Recommenc	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	11.06	727.19	6.6	5.95	92.3	3.92	-9.18	0.56	11.83	1.72	12	88	29	12	67	85.6%	2	11
AMU	This Period	10.53	89.29	7.7	3.98		5.46	2.99	5.39	3.30	9.76	0	78	1	0	5	84.2%	0	3
C15 Diabetes	This Period	11.94	32.10	5.9	5.59	90.7	10.63	-7.24	-37.71	2.21	17.11	0	75	7	1	1	87.8%	0	0
C16 Diabetes	This Period	11.11	37.20	5.9	2.14	91.1	0.00	-1.57	-7.22	2.53	16.45	0	77	1	0	4	73.1%	0	0
C17	This Period	9.96	23.20	7.0	8.71	93.6	0.00	-4.95		3.66		0	100	1	2	2	86.2%	0	0
ED	This Period	8.78	154.71	~	7.09	91.8	3.63	-3.02	-2.60	-0.18	-0.47	6	65	0	0	9	~	0	2
A7 Gastroenterology	This Period	8.76	40.28	6.2	0.39	92.0	1.49	5.21	20.99	1.68	10.88	0		0	0	1	0.0%	0	0
A8 Gastroenterology	This Period	10.02	40.28	5.7	9.41	97.6	0.57	6.24	25.12	2.44	15.80	0	82	0	0	2	82.6%	0	0
Clinical Haematology Unit	This Period	6.81	43.30	6.7	9.41	93.8	10.71	2.79	9.95	2.10	13.73	0	100	1	0	0	82.6%	0	1
C39 ward	This Period	13.46	0.00	6.4	28.78	60.0	0.00	-2.53		-2.00		0	75	2	2	2	86.3%	0	0
Fairoak	This Period	16.15	32.00	4.9	2.18	89.5	0.10	-0.93	-5.58	0.81	5.28	0	75	0	0	1	88.3%	0	0
Ward 2 West Park	This Period	13.17	31.20	5.9	5.34	94.6	0.00	0.69	4.92	0.38	2.22	0	86	0	0	2	90.6%	0	0
C18 Elderly Care	This Period	8.02	37.24	6.8	11.54		2.71	-0.13	-0.61	1.27	8.20	0	100	0	0	0	94.0%	0	0
C19 Elderly Care	This Period	4.74	37.20	7.3	8.42	90.3	3.55	-1.88	-8.62	-3.21	-20.82	2	100	1	1	4	94.5%	0	0
C35 Deansley Ward	This Period	14.90	29.00	7.4	2.34	92.1	3.19	2.13	11.11	-3.32	-33.88	0	90	3	0	2	78.6%	0	0
Durnall	This Period	12.41	20.81	~	5.60	97.3	3.84	-1.06	-6.29	-1.43	-35.67	0	98	0	0	1	92.7%	0	0
NRU West Park	This Period	9.87	21.80	9.2	12.05	97.5	0.00	1.74	15.13	-1.31	-12.75	0		1	0	1	97.0%	0	0
Ward 1 West Park	This Period	12.73	29.60	5.5	5.75	98.2	8.93	-1.08	-6.51	-1.41	-10.85	1	100	0	0	1	97.2%	0	0
C22 Renal	This Period	12.34	27.10	7.1	8.65	91.5	1.87	-2.16	-14.40	-1.50	-12.40	0	67	3	1	2	89.3%	0	0
C24 Renal Ward	This Period	12.18	34.54	5.9	3.11	86.3	2.24	-1.42	-6.83	2.66	19.36	0	100	3	1	5	91.5%	0	0
C25 Renal Ward	This Period	13.93	34.54	5.3	6.28	90.6	8.86	2.19	10.54	0.61	4.42	0	71	2	1	4	93.5%	0	0
C14 Respiratory	This Period	12.06	40.10	6.5	4.80	88.0	1.56	0.05	0.23	1.71	10.02	0	89	1	0	2	81.6%	0	0
C26 Respiratory	This Period	10.54	46.41	8.7	2.19	93.1	3.40	-6.84	-24.15	-0.81	-4.46	0	100	0	0	6	85.9%	0	1
C21 Acute Stroke Unit	This Period	9.93	61.69	6.9	8.36	91.2	0.00	1.59	4.14	1.63	7.01	0	100	2	2	6	75.3%	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 3 (CCSS)	This Period	14.68	549.37	7.8	5.99	96.5	1.80	30.41	2.84	-37.73	-26.71	4	94	24	15	1	77.9%	0	14
Community Children's Nursing Team - Generic Team	This Period		28.28	~	3.96	96.1	2.69	3.23	15.96	-5.67	-70.41			0	0	0	~	0	0
A21	This Period	12.75	59.28	8.9	6.26	94.2	8.08	1.20	2.41	-4.03	-42.12	0	77	0	0	1	77.5%	0	6
Clinical Nurse Specialist	This Period		7.98	~	0.38	94.7	0.00	-2.29	-28.66	0.00				0	0	0	~		0
PAU	This Period	14.51	17.81	6.8	9.19	94.7	13.76	-1.60	-12.74	-1.23	-23.50	0	79	0	0	0	76.0%	0	0
Planned Care	This Period	16.08	100.01	~	5.39	95.1	1.04	11.45	15.30	1.23	4.88	1		24	15	0	~	0	7
Urgent Care	This Period	17.49	88.49	~	9.31	96.4	3.40	6.14	11.16	-2.19	-6.55			0	0	0	~	0	0
Intermediate Care	This Period	15.13	0.00	~	6.41	92.6	0.00	0.00		-10.13				0	0	0	~		0
Dermatology	This Period	10.05	12.77	~	6.79	98.8	0.00	0.18	2.19	-0.05	-1.10	1	100	0	0	0	~	0	0
Physio & OT	This Period	~		~	~	~	~	~	~	~	~	0	~	0	0	0	~	~	0
Primary Care Services	This Period		30.72	~	8.96	92.2	1.89	-2.69	-10.65	-1.80	-33.09	2		0	0	0	~	~	0
Radiology	This Period	16.47	8.40	~	6.18	96.1	0.00	0.40	6.25	-1.91	-95.33	0	96	0	0	0	~	0	0
Rheumatology	This Period	10.98	14.38	~	4.36	99.3	0.00	0.83	10.47	-1.32	-20.52	0	96	0	0	0	~	0	0
Sexual Health	This Period	21.48	4.78	~	6.33	95.5	2.37	-9.05	0.00	-6.91	0.00	0		0	0	0	~	0	0
Ambulatory Care	This Period	10.80	23.39	~	3.34	98.7	2.30	0.75	3.75	-0.20	-5.88			0	0	0	~	~	0

Paper for submission to the Trust Board Meeting – to be held in Public On 1ST August 2023		
Title of Report:	Maternity Services Report	Enc No: 9.3.2
Author:	Tracy Palmer	
Presenter/Exec Lead:	Tracy Palmer Director of Midwifery and Neonatal Services	

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

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: **Midwifery Workforce** On Risk Register: Yes☒No☐ Risk Score (if applicable) : **15 (red)**		
Changes to BAF Risk(s) & TRR Risk(s) agreed	**None** Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	**Workforce:** Funding Source: **Business Case**		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details
	NHSE	Yes☒No☐	Details: **compliance with Ockenden 7 Immediate and Essential Actions (IEA's)**
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: Midwifery Workforce / Birth Rate Plus compliance business Case in progress.
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☒No☐	Date: July 21st, 2023, TMC
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure • The Royal Wolverhampton NHS Trust (RWT) demonstrated that all 10 safety standards set out in NHSR Maternity Incentive Scheme (MIS) were achieved for year 4. • The Maternity Service received their second Insights assessment conducted by the Local Maternity and Neonatal System (LMNS) and NHS England in June 2023. The inspection team confirmed full compliance with Ockenden 7 Immediate and Essential Actions (IEAs), with some positive high-level feedback at the end of the day. • One to one care rates in established labour continue to be maintained at 100% for Q1. • The Directorate continues to meet 100% compliance with NHSR: Clinical Negligence scheme for Trust (CNST) Maternity Incentive Scheme (MIS): Safety action 1: *using the National Perinatal Mortality Review Tool (PMRT) to review deaths to the required standard?*
Advise • Following a recent recruitment event, offers made would see the Maternity service reach required establishment September/ October 2023 based on current projections. The offers made are predominantly to Student Midwives due to qualify in the Autumn, this may incur a reported over established position in Q3. However, given the information we have around the workforce metrics and projections this is constantly being reviewed to ensure appropriate offsets are being made to achieve budgets are maintained. • NHSR Maternity Incentive Scheme: CNST Year 5 has been received by Trusts. The Directorate has commenced the programme of work required to meet the 10 safety standards for year 5. • The report provides an update on current SUI and HSIB open cases. • Birth-rate Plus business case is progressing and is being reviewed following the publication of the 3-year Delivery Plan for Maternity and Neonatal Service.
• Delivery suite minimum midwifery staffing levels matched the acuity, on only 45% of occasions according to data from the acuity tool. National target is to achieve minimal staffing on 85% of shift.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

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

Maternity Services Report

Report to Trust Board Meeting to be held in Public 1st August 2023.

EXECUTIVE SUMMARY

The Royal Wolverhampton Midwifery Workforce Update

The report outlines the present position for Midwifery and Maternity Support Worker (MSW) deficit related to vacancy and Maternity leave.

The workforce trajectory for filling vacancy and appointing into maternity leave has been forecasted and indicates a positive picture, with newly appointed Midwives joining the service in September and October 2023. Therefore, the predicted workforce position indicates that all Midwifery vacancies will be filled by October 2023.

Based on current workforce intelligence an over establishment is predicted in Q3 based on current budgeted establishments. However, predicted maternity leave and natural turnover should align budgets in Q4, with the outstanding business case to support Birth Rate plus indications in line with Ockenden recommendations and all students committing to offers made.

The report outlines Delivery staffing levels based on the acuity of patient the data is provided by the Birth Rate plus Acuity tool specific for Intrapartum areas. This is mitigated with staff redeployment / patient movement as per care needs.

NHSR Maternity Incentive Scheme CNST Year 5.

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The Directorate has commenced delivery of the plan to work towards achieving all 10 safety actions for year 5.

Further progress updates will be provided throughout the year.

Maternity Incentive Scheme Year 4
The Maternity Service achieved all 10 safety actions for MIS year 4; therefore, RWT are eligible to recover their element of contribution relating to the CNST maternity incentive funds.

NHSE: Insights Inspection for The Royal Wolverhampton NHS Trust Maternity Services.

The Royal Wolverhampton NHS Trust received their second insight inspection in June 2023. The purpose of the inspection was to assess progress against the 7 Immediate and Essential Actions (IEAs) recommended by Donna Ockenden following her independent review into the Maternity Services at Shrewsbury and Telford Hospitals 2020.

The inspection team were assured that all 7 IEAs had been achieved and that progress was being made to improve services further with several quality improvement projects. High level feedback at the end of the inspection was extremely positive for the Maternity Service.

The final report has yet to be received and will be presented to Trust Board in due co

Paper for submission to the Trust Board Meeting – to be held in Public On 1st August 2023		
Title of Report:	Infection Prevention and Control Report	Enc No: 9.3.3
Author:	Joanna Macve – Consultant Microbiologist	
Presenter/Exec Lead:	Debra Hickman – Chief Nursing Officer	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☐No☒	Yes☒No☐
Recommendations: The Board is asked to note the contents of the report and receive it for assurance.			

Implications of the Paper:			
Risk Register Risk	Infection Prevention Risks on the risk register: Yes ☒ No ☐ Risk Description: CPE Screening according to update guidance On Risk Register: Yes☒No☐ Risk Score (if applicable): 6 Risk Description: Limited number of side-rooms including those with en-suite facilities On Risk Register: Yes☒No☐ Risk Score (if applicable): 9		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Contribution to the Trust's compliance with CQC standards
	NHSE	Yes☒No☐	Details: Contribution to the Trust's compliance with NHSE framework
	Health & Safety	Yes☒No☐	Details: Contribution to the Trust's compliance with Health and Safety standards
	Legal	Yes☒No☐	Details: Compliance with the Health and Social Care act 2008: code of practice on the prevention and control of infection and related guidance
	NHS Constitution	Yes☒No☐	Details: Commitment to quality of

			care, right to be cared for in a clean environment
	Other	Yes☐No☐	Details:
CQC Domains	**Safe:** Protecting staff and patients from avoidable harm **Effective:** Care, treatment and support achieves good outcomes **Well-led:** The leadership, management and governance of the organisation make sure it's providing high-quality care.		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration: No adverse impact is anticipated as a result of the points articulated in this report.

Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Trust Management Committee – 21/7/23
	Board Committee	Yes☐No☒	Date: N/A
	Board of Directors	Yes☐No☒	Date: N/A
	Other	Yes☐No☒	Date: N/A

Summary of Key Issues using Assure, Advise and Alert
Assure Below or at external targets for *Escherichia coli* and *Pseudomonas aeruginosa* bacteraemia. Below internal target for device-related hospital-associate bacteraemias (DRHABs). Carbapenemase producing Enterobacteriaceae (CPE) screening continues to pick up patients and reduce the risk of spread – total of 22 new patients identified from April to June 2023.
Advise Above external target for Klebsiella bacteraemia. Above internal targets for MSSA bacteraemia and MRSA acquisition. Compliance with infection prevention-related mandatory training below 95% at end June 2023 (94% for IP mandatory training, 91% for Hand Hygiene).
Alert Above external *C difficile* target with 14 to date (target for end Q1 is 12).

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Safe and responsive urgent and emergency care
Support our Colleagues	• Improve overall staff engagement
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Infection Prevention and Control Report

Report to Trust Board Meeting to be held in Public on 1st August 2023

EXECUTIVE SUMMARY

This report provides an overview of the Trust's Infection Prevention performance in the first quarter of 2023-24. This includes performance against both external objectives and internal indicators.

BACKGROUND INFORMATION

1.0 ***Clostridium difficile*** **Infection**

The annual objective for *Clostridium difficile* toxin positive cases has been set at 53 cases for the year, based on case numbers in the 12 months to November 2022. In the period April to June 2023 there were 14 cases, breaching the external trajectory for that period (12 cases). PCR (non-toxin) cases are also monitored as patient outcomes can be just as harmful to patient safety. To the end of June 2023 there were 23 PCR positive cases against our internal trajectory of 27 (see Appendix 1).

MRSA Bacteraemia

The national objective for MRSA bacteraemia is zero for all NHS organisations. In the three months to end June 2023 there was no RWT-attributable MRSA bacteraemia.

Monthly totals and number externally attributable to RWT

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
22-23 (RWT)	0 (0)	1 (1)	0 (0)	0 (0)	1 (0)	0 (0)	1 (0)	0 (0)	1 (0)	1 (0)	1 (1)	0 (0)
23-24 (RWT)	0 (0)	0 (0)	0 (0)									

MSSA bacteraemia

MSSA is externally monitored by Public Health England (PHE) but targets are set internally. MSSA bacteraemia is a good proxy for MRSA bacteraemia and may be avoidable therefore a local target is applied and cases investigated. In the three months to end June 2023 there were 9 internally attributable cases, against a trajectory of 6 (see Appendix 1).

Monthly totals and number internally attributable to RWT

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
21-22 (RWT)	9 (4)	17 (7)	3 (2)	3 (1)	4 (1)	4 (1)	6 (3)	8 (0)	4 (0)	8 (1)	8 (4)	7 (4)
22-23 (RWT)	8 (2)	1 (1)	5 (2)	3 '(2)	6 (2)	9 (3)	10 (7)	8 (2)	8 (4)	10 (3)	5 (1)	9 (4)
23-24 (RWT)	4 (1)	4 (2)	11 (6)									

MRSA Acquisitions

There were 10 MRSA acquisitions in the 3 months to end June 2023, against our internal trajectory of 9 (see Appendix 1).

Device-related hospital-associated bacteraemias (DRHABs)
Bacteraemia (any organism) related to a medical device is surveyed and acted upon, within an internal target of 48 per year. To end June there were 9 DRHABs against a trajectory of 12 (see Appendix 1).

Gram negative bacteraemias
Gram negative bacteraemias include but are not limited to bacteraemias caused by *Escherichia coli*, Klebsiella species and *Pseudomonas aeruginosa*. Externally attributable bacteraemias include those that occur on day 2 or more of admission, or within 28 days of discharge. Annual trajectories for 2023-24 are 94 for *E. coli*, 29 for Klebsiella spp. and 15 for *P. aeruginosa*. To end June 2023 there were 18 *E. coli* bacteraemias against a trajectory of 22, 7 Klebsiella bacteraemias against a trajectory of 6, and 3 *P. aeruginosa* bacteraemias against a trajectory of 3.

Carbapenemase producing Enterobacteriaceae
These multi-antibiotic resistant organisms have caused large outbreaks in UK Trusts, putting patients at risk and causing organisational disruption. To end of June, 22 new patients were found to be carrying a CPE (see Appendix 1), with 21 of these were by rectal screening. Following a reduction in numbers related to a reduction in travel and screening for elective procedures due to the COVID-19 pandemic, we are now seeing rising numbers again.

While the community prevalence of CPE in the UK is unknown, in some health and social care organisations, CPE are now endemic. There is no doubt that we will continue to see rising numbers of patients with these multi-resistant organisms that are often resistant to all available antibiotics. In addition to increasing screening in line with current national guidelines, which has not been possible to progress due to the need for ICB agreement, reducing spread from positive patients requires en-suite side-rooms, meaning that more of these will be needed going forward.

Blood culture contaminants
The blood culture contamination rate April to end June 2023 had an average of 1.28%, which is below the nationally recommended maximum of 3%.

Outbreaks and Incidents – April – June 2023

C. difficile Periods of Increased Incidence (PIIs), SIs and Outbreaks

There were four *C. difficile* incidents in this period. There was an SI on C18 for two toxin positive cases in 28 days; typing demonstrated that there had been NO transmission between patients and this was downgraded to PII. There was also an SI for two toxin positive cases on Deanesly ward; again typing demonstrated that these were NOT linked and this was downgraded to PII. There was a PII on B11 for one toxin positive case and one PCR positive case in 28 days. On review it was thought unlikely these were linked.

COVID-19
There were 9 COVID- 19 outbreaks in the period April-June 2023-24. In the same period there were 74 probable or definite cases of hospital acquired COVID-19. Following a change in screening guidance in April we have seen reductions in the numbers of hospital-acquired cases. Almost all asymptomatic screening, apart from clinically vulnerable patients being admitted to inpatient units and for patients being discharged to care homes, has ceased in line with national guidance. There have also been outbreaks and cases in local care homes and RWT infection prevention are providing support and advice.

Influenza A
Unexpectedly one ward had a small outbreak in June with two cases. This was detected because there is some limited local influenza testing continuing over the summer months, whereas previously there was no influenza testing in summer months other than through the use of reference services.

MRSA PII
There was a PII for MRSA in July on the neonatal unit, where 3 patients were found to have acquired MRSA within 28 days of each other – typing demonstrated that these 3 cases were linked.

Norovirus
One ward was closed due to a Norovirus outbreak in April.

COVID-19 update
Universal mask wearing in the Trust has been stepped down, as has testing for the majority of staff, and asymptomatic testing of patients, other than for certain at-risk groups. In May 2023, the World Health Organisation advised that the pandemic itself not over, but the global emergency it has caused is over for now. The UK continues in the 'living with COVID-19 plan' as set out by the government in 2022.

Objectives for 2023/24

CDI – 53 cases

MRSA bacteraemia - 0

Flu vaccination – CQUIN with 75% requirement for minimum payment and 80% requirement for maximum payment.

E. coli bacteraemia – 94

Klebsiella bacteraemia – 29

Pseudomonas aeruginosa bacteraemia – 15

Appendix 1 – Illustrative Charts of Infection Data

C. difficile **Toxin Positives and External Target 2023 - 24**

Number

60
50
40
30
20
10
0

Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24

RWT
RWT Target

Cumulative *C. difficile* Positives All Methods RWT Internal Definition of Attribution from April 2016

140
120
100
80
60
40
20
0

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

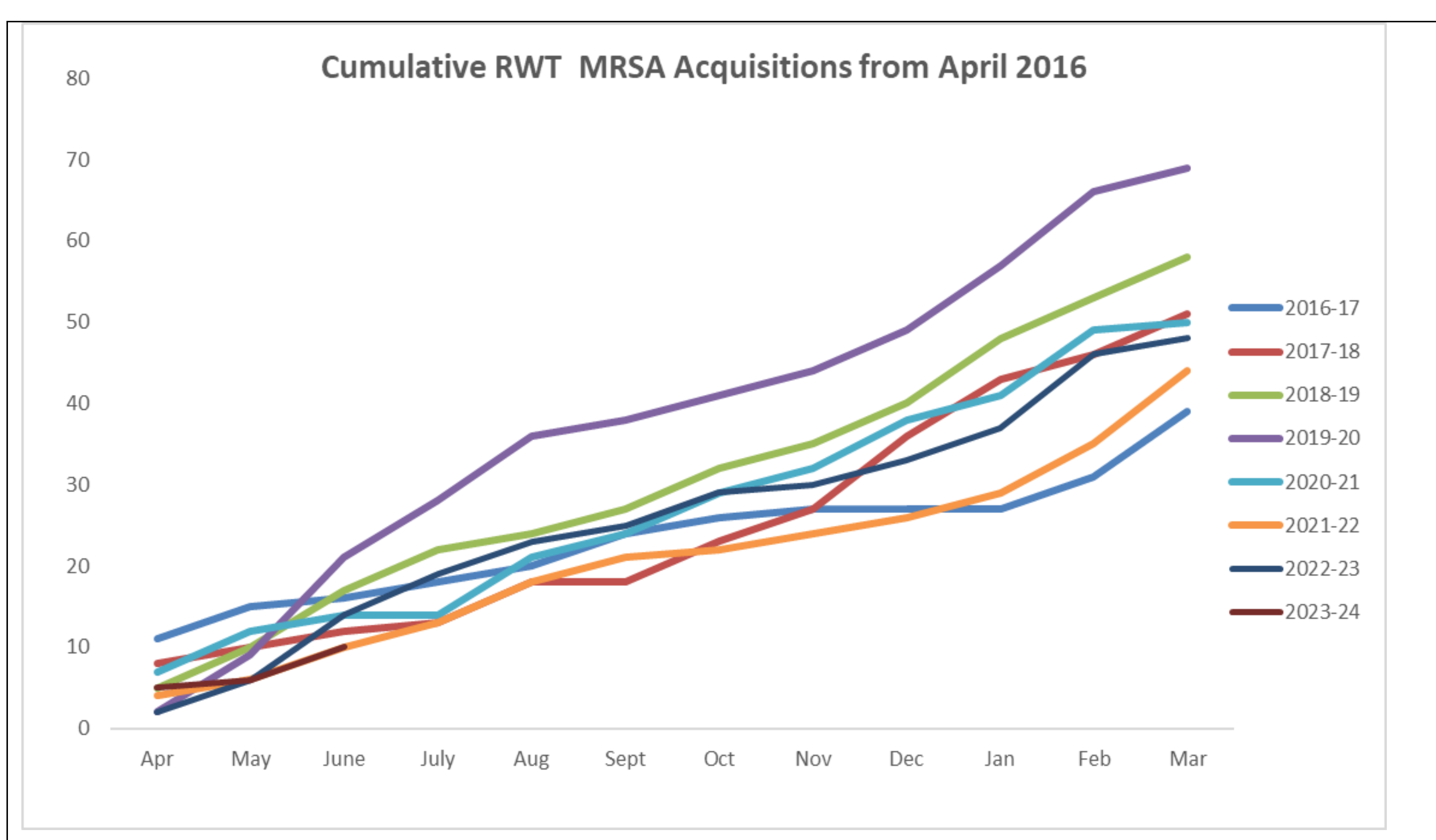
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
2023-24
Target

Cumulative RWT attributable MSSA bacteraemias from 2016

40
35
30
25
20
15
10
5
0

April May June July August September October November December January February March

2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
2023-24



Cumulative Device Related Hospital Acquired Bacteraemias (DRHABs) from April 2016

70
60
50
40
30
20
10
0

April
May
June
July
August
September
October
November
December
January
February
March

2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
2023-24

	NDM	OXA-48	KPC	Others	Total
2015-16	4	1	7	0	12
2016-17	6	2	9	1	18
2017-18	19	6	9	2	34
2018-19	15	3	2	0	20
2019-20	26	34	5	2	56
2020-21	6	11	4	0	18
2021-22	10	14	4	0	27
2022-23	22	32	7	0	53
2023-24	13	5	1	1	22

Healthcare associated COVID summary tables – April to June 2023

Table 1. Summary of Healthcare acquired cases of COVID 19 April 2023 to June 2023. Includes probable healthcare acquired (>8 days from admission) and definite healthcare acquired (>14 days)

Month	Number of HCAI COVID
April	49
May	18
June	7

Table 2. Summary of COVID outbreaks (externally reported) in April to June 2023

Date of Outbreak	Ward/Department
04/04/2023	C39
05/04/2023	C21
14/04/2023	B8
20/04/2023	A14
28/04/2023	C16
08/05/2023	WP2
07/06/2023	A8 (PII)
23/06/2023	C25 (PII)
28/06/2023	C24

RECOMMENDATIONS

To note the report.

Any Cross-References to Reading Room Information/Enclosures:

N/A

Paper for submission to the Trust Board Meeting – to be held in Public on Tuesday 1st August		
Title of Report:	Chief Medical Officer's Report	Enc No: 9.3.4
Author:	Dr Brian McKaig – Chief Medical Officer	
Presenter/Exec Lead:	Dr Brian McKaig – Chief Medical Officer	

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

Recommendations:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or approval. Detailed papers are listed below and can be accessed via the reading room.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 6017/6018/6019 – Mental health risks 5448: Safe and proper use of medicines On Risk Register: Yes☒No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None Risk Description		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Well led
	NHSE	Yes☒No☐	Details: Revalidation report
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

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

Summary of Key Issues using Assure, Advise and Alert
Assure As highlighted in summary below
Advise As highlighted in summary below
Alert As highlighted in summary below

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

Report of the Chief Medical Officer

Report to Trust Board Meeting to be held in Public on Tuesday 1st August

EXECUTIVE SUMMARY

The report covers the following functions:

- Mental Health services
- Pharmacy and Medicines Optimisation
- Medical Appraisal Quality Assurance

BACKGROUND INFORMATION

Mental Health

- Increased volume and acuity for patients attending The Royal Wolverhampton (RWT) with mental health concerns. These are predominantly working age adults. Extending waiting time in ED and AMU for MH assessments.
- 3 risks remain live on the corporate risk register, 2 in relation to internal and external risks for CYP who require Tier 4 provision and 1 in relation to adult mental health services.
- The trust is actively recruiting mental health clinical support workers to assist in the enhanced supervision of mental health patients.
- There have been 421 reported mental health related incidents
- Challenges with legal requirements of patients held on Section 2 & 3. Requires agreement of Memorandum of Understanding with Black Country Healthcare FT – common to all acute Trusts in the ICB and escalated accordingly

Pharmacy and Medicines Optimisation:

- Medication incidents have been within control limits since the last report (January 2023).
- Management Group were generally assured of prescribing standards on paper prescriptions.
- RWT Pharmacy Aseptic Services have reported quality indicators via the national compliance management system (interactive Quality Assurance of Aseptic Preparation Services); all indicators have been within control limits despite an aging facility that is on the TRR (Datix 5030).
- The Trust has 3% Pharmacist vacancies. Without further investment and growth in pharmacy establishment there will continue to be gaps in the pharmacy provision to wards/departments and no weekend clinical pharmacy service.
- 3.74% doses of critical medicines were omitted on EPMA wards. Omitted doses are reported monthly to ward level and in 21/22 a focused intervention resulted in a reduction in omitted doses. This reduction has been sustained but not further improved upon. AMU has the highest number of omitted doses and will be the focus of a CQI project.
- Pharmacy audits, Datix incidents and internal quality assurance visits continue to demonstrate that the safe and secure storage of medicines and management of controlled drugs remains below the standards required. The risks associated with this are patient harm from a medication error and regulatory non-compliance. Work is ongoing to improve the clinical environments within which medicines are stored and a medicines safety summit is planned for September.

Medical Appraisal Quality Assurance:

- The report provides assurance to the Board of the organisation's progress in implementing the statutory duty of the Trust in relation to the Responsible Officer Regulations.
- Medical Appraisal compliance as at 31st March 2023 was 99.75% (789/791 doctors)
- The Trust is fully compliant with the requirements of the "Designated Body Annual Board Report" (18.4.8) which requires CEO/Chair sign off prior to submitting to NHSE

RECOMMENDATIONS

The board are recommended to note the content of this high level report. Detailed reports are included within the reading room.

CEO/Chair to sign off the Designated Body Annual Board Report

Any Cross-References to Reading Room Information/Enclosures:

- Mental Health Report
- Pharmacy and Medicines Optimisation Report
- Medical Appraisal Quality Assurance Annual Submission

Paper for submission to the Trust Board Meeting – to be held in Public On 1 October 2023		
Title of Report:	OneWolverhampton Progress Update	Enc No: 10.1
Author:	Matt Wood – Head of the Programme and Transformation Office, OneWolverhampton	
Presenter/Exec Lead:	Stephanie Cartwright Group Director of Place	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☒	Yes☐No☒	Yes☒No☐	Yes☐No☒

Recommendations:

The Board is asked to note the contents of the report and receive assurance related to the progress made by OneWolverhampton with the development of our priorities and mechanisms for delivery assurance.

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

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date: 20 July 2023

Summary of Key Issues using Assure, Advise and Alert
Assure Since the last update, OneWolverhampton has revised its priorities and created a detailed delivery plan and dashboard to demonstrate delivery. Strengthening of relationships has continued with a joint OneWolverhampton and Children and Families Together Board workshop to discuss children's oral health.
Advise The dashboard has been developed alongside all partners from OneWolverhampton. Some metrics are therefore not directly within the remit of RWT.
Alert Further work on proposed delegation from Black Country ICB to OneWolverhampton are being discussed as part of the ICB Target Operating Model. All proposals will be presented to the Board once the details have been confirmed.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing
Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Facilitate research that improves the quality of care

OneWolverhampton Progress Update

Report to Trust Board Meeting to be held in Public on 1st of August, 2023

EXECUTIVE SUMMARY

Since the previous report, the delivery priorities for the six Strategic Working Groups (SWGs) of OneWolverhampton have been co-produced across the Partnership and approved by the OneWolverhampton Board. A summary of these priorities can be found below, and the full detail can be found in Appendix 1.

Adult Mental Health	Care Closer to Home	Children and Young People	Living Well	Primary Care Development	Urgent and Emergency Care
Prioritising the **prevention and promotion** offer Delivering the national Community **Mental Health Transformation** programme Improving the **physical health** of people with a mental health diagnosis Improving care for people with co-existing **substance misuse and mental health** problems Embedding **suicide prevention** approaches across the city	Enhancing our integrated **care coordination** function Expanding services in the community that provide **alternatives to urgent hospital care** Ensuring effective and appropriate **discharge from hospital (pull)** Delivering a high-quality **care home** offer Supporting people to **age well** Delivering a high-quality **palliative and end-of-life** service	Delivering the first **1,001 days** agenda Improving the uptake of **childhood immunisations** Improving early diagnosis and ongoing care for children with **asthma** Supporting children, their parents, and carers to maintain a **healthy weight** Improving the **oral health** of our children Improving the support for children's **mental health and emotional wellbeing**	Increasing **cancer screening** rates for breast, bowel and cervical Improving **health check uptake** to deliver a preventative approach Improving diagnosis and care for people with **dementia** Delivering **health and well-being hubs** across the city Developing our local offer for **healthy lifestyle service**	Developing **new primary care services** to deliver more care closer to home Enabling people to live well with their **long-term condition** Supporting patients with complex needs through a strong **MDT approach** Improving the **primary and secondary care interface** Enabling a resilient primary care **infrastructure**	Delivering an integrated approach to **demand and capacity planning** Helping people with urgent needs access the **right care, first time** Ensuring a **timely experience** when accessing urgent care Expanding new services in the community that provide **alternatives to bed-based care** Ensuring effective and appropriate **discharge from the hospital (push)**

A draft dashboard has also been developed to demonstrate the delivery of these priorities – found in Appendix 2.

BACKGROUND INFORMATION

<u>OneWolverhampton Priority Refresh:</u>

A robust approach has been taken to the creation of these priorities which has involved both a data and person-led approach. This has involved the use of metrics such as the Public Health Outcomes Framework (PHOF); Adult Social Care Outcomes Framework (ASCOF); General Practice PCF; Mortality data; and qualitative feedback from existing Partner engagement mechanisms and the People Panel public engagement events.

These priorities have also been peer-assessed by each of the SWGs and reviewed by the Place Management Committee (PMC) and the OneWolverhampton Board. This has led to the creation of a truly transformative set of priorities to support people accessing health and social care services across Wolverhampton.

There are allocated leads for each of these priorities, drawn from providers across the Partnership, and scopes of work are being completed to inform the delivery schedule which will be monitored by the OneWolverhampton Board.

Dashboard:

A dashboard has also been created (a draft version can be found at Appendix 2) which demonstrates the approach to monitoring and assurance which is being taken across the Partnership. This will involve three key metrics, drawn from the priorities, for each of the SWGs and a commentary completed by the SWG Chair. We are currently awaiting further data from partners to ensure the completeness of the Dashboard.

The alignment of these measures and priorities is as follows:

Strategic Working Group (SWG)	Measure	Priority
Adult Mental Health	Serious Mental Illness (SMI) Health Checks	Prioritising the prevention and promotion offer, Improving the physical health of people with a mental health diagnosis
	IAPT Waiting Times	Delivering the national Community Mental Health Transformation programme
	National metrics for the local suicide rate	Embedding suicide prevention approaches across the city
Care Closer to Home	2-hour Crisis Response Compliance	Expanding services in the community that provide alternatives to urgent hospital care
	Care Home Visits to ED – Proportion of Falls-Related Visits	Delivering a high-quality care home offer; Supporting people to age well
	Average Daily No Criteria to Reside (NCTR) patients	Ensuring effective and appropriate discharge from hospital
Children and Young People	Health Visiting Mandated Checks Compliance	Delivering the first 1,001 days agenda
	Asthma ED Attendances and Admissions	Improving early diagnosis and ongoing care for children with asthma
	Childhood Immunisations	Improving the update of childhood immunisations
Living Well	Completed NHS Health Checks	Improving health check uptake to deliver a preventative approach
	Cancer Screening Coverage for bowel, breast and cervical	Increasing cancer screening rates for breast, bowel and cervical cancer
	Dementia diagnoses	Improving diagnosis and care for people with dementia
Primary Care Development	GP Appointment Utilisation	Enabling a resilient primary care infrastructure
	GP appointments by mode (face-to-face or remote)	Enabling a resilient primary care infrastructure

	Ambulance Calls per 10,000 Head of Population	Developing new primary care services to deliver more care closer to home; enabling people to live well with their long-term condition; supporting patients with complex needs through a strong MDT approach
Urgent and Emergency Care	UEC Arrivals by Stream Pathway	Helping people with urgent needs access the right care, first time
	Ambulance Arrivals and Handover Times	Ensuring a timely experience when accessing urgent care
	Virtual Ward Occupancy and Utilisation	Expanding new services in the community that provide alternatives to bed-based care

As noted in previous updates, the strength of relationships across the Partnership has continued to grow, and this dashboard and delivery plan will provide assurance that these relationships are translating into measurably improved outcomes.

Children and Young People Strategic Working Group: A Focus on Family Hubs

OneWolverhampton Board received an update on Children and Young People's Strategic Working Group this month. This focused on a detailed presentation on the Family Hubs and Start for Life Programme (Appendix 3). Wolverhampton was chosen as one of 75 areas to take part in the programme which is jointly overseen by the Department of Health and Social Care and the Department for Education. The overall aims of the programme are to provide the best support to every family by ensuring:

- **Seamless support for families**: a coherent joined-up Start for Life offer available to all families
- **A welcoming hub for families:** family hubs as a place for families to access Start for Life services
- **The information families need when they need it**: designing digital, virtual and telephone offers around the needs of the family

The ambitions of the programme are closely aligned with the ambitions of OneWolverhampton – particularly the emphasis on reducing health inequalities and long-term health through a good start to life.

The programme is being delivered in partnership – chaired by Deputy Director of Children's Social Care and Vice Chaired by Group Manager for Adult and Community Paediatrics. This has served to enhance partnership working and ensure a joint approach between Local Authority, RWT and others has been taken throughout. The Board heard that this partnership model, with several of the workstreams being supported by the OneWolverhampton CYP SWG, had enabled the Wolverhampton model to go further in its ambitions than other trial areas. This has included an enhanced First 1,001 days offer which includes antenatal and postnatal care and support, new birth registrations, infant feeding, child development clinics and support, perinatal mental health and support and parenting programmes. It was acknowledged that the scope of this model would not have been possible without partnership working.

The programme has been able to develop at pace and has exceeded expectations in its delivery timeframes. All eight Family Hubs for the city will be operational by the end of July.

Further work is also ongoing, facilitated by OneWolverhampton, to discuss and review the Primary Care support available in both sharing the Family Hubs service and offer and also sign-posting families appropriately.

Beyond the Family Hubs and Start for Life work, we also held a joint workshop with the Local Authority's Children and Families Together Board (slides from the session can be found in Appendix 4). The focus was on improving children's oral health – one of OneWolverhampton's CYP priorities. We heard from the Youth

Representatives about a survey they had conducted which revealed a link between oral health and emotional health and well-being and self-esteem. Presentations were also given by Anna Lee Hunt – Consultant in Dental Public Health; Louise Sharrod – Principle Public Health Specialist; Dr Afy Ilyas – a local Dentist – and Caroline Bestwick and Laura Caesar-Kennedy from RWT's Specialist Dentistry service. Conversations included a discussion of the challenges in accessing high-street dental services and an acknowledgement of the lack of high-street dental provision in wards with the highest experience of dental decay within the city.

Several suggestions were made to improve children's oral health, including working more closely with schools to deliver a Make Every Contact Count (MECC) approach, with the creation of five key tips to support better oral health. An action plan is currently being developed following the workshop and this will be driven through the OneWolverhampton Children and Young People's Strategic Working Group.

Appendix 1 – OneWolverhampton Priorities for 23/24

Appendix 2 – OneWolverhampton Draft Dashboard

Any Cross-References to Reading Room Information/Enclosures:

Appendix 3 – Family Hubs and Start for Life Presentation

Appendix 4 – Children and Families Together Board Annual Development Session

Adult Mental Health	Care Closer to Home	Children and Young People	Living Well	Primary Care Development	Urgent and Emergency Care
Prioritising the **prevention and promotion** offer	Enhancing our integrated **care coordination** function	Delivering the first **1,001 days** agenda	Increasing **cancer screening** rates for breast, bowel and cervical	Developing **new primary care services** to deliver more care closer to home	Delivering an integrated approach to **demand and capacity planning**
Delivering the national Community **Mental Health Transformation** programme	Expanding services in the community that provide **alternatives to urgent hospital care**	Improving the uptake of **childhood immunisations**	Improving **health check uptake** to deliver a preventative approach	Enabling people to live well with their **long-term condition**	Helping people with urgent needs access the **right care, first time**
Improving the **physical health** of people with a mental health diagnosis	Ensuring effective and appropriate **discharge from hospital (pull)**	Improving early diagnosis and ongoing care for children with **asthma**	Improving diagnosis and care for people with **dementia**	Supporting patients with complex needs through a strong **MDT approach**	Ensuring a **timely experience** when accessing urgent care
Improving care for people with co-existing **substance misuse and mental health** problems	Delivering a high-quality **care home** offer	Supporting children, their parents, and carers to maintain a **healthy weight**	Delivering **health and well-being hubs** across the city	Improving the **primary and secondary care interface**	Expanding new services in the community that provide **alternatives to bed-based care**
Embedding **suicide prevention** approaches across the city	Supporting people to **age well**	Improving the **oral health** of our children	Developing our local offer for **healthy lifestyle service**	Enabling a resilient primary care **infrastructure**	Ensuring effective and appropriate **discharge from the hospital (push)**
	Delivering a high-quality **palliative and end-of-life** service	Improving the support for children's **mental health and emotional wellbeing**			

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Adult Mental Health	Prioritising the **prevention and promotion** offer	Deliver up-stream prevention and promotion interventions to keep people well Empower local communities to improve their mental health and wellbeing	• Undertaking a needs assessment of adult mental health and wellbeing for the city (JSNA) • Adopting the national prevention concordat for better mental health • Investing in community-based universal and targeted prevention and promotion interventions	• Sign-off of the JSNA by Health & Wellbeing Board • Sign-off of the concordat by relevant parties • Value and distribution of funding given to community-based universal and targeted prevention services. • Reduction in need for referral to secondary care • Improved patient experience/outcomes
	Delivering the national Community **Mental Health Transformation** programme	Support the citizens of Wolverhampton through provision of a transformed community mental health offering	• Implementing new models of service provision across all Primary Care Networks (PCNs) • Delivering 'age-less' primary and community mental health • Providing specialist services for complex emotional needs, eating disorders and rehabilitation	• Number of PCNs receiving transformed mental health offer • Reduced waiting times for adult mental health services • Meeting the four-week wait target
	Improving the **physical health** of people with a mental health diagnosis	Work with other services to improve access to physical health care services for people with Serious Mental Illness (SMI) Reduce premature mortality amongst people with SMI.	• Improving uptake from annual physical health checks for people with SMI • Removing barriers to access for lifestyle services for people with SMI • Implementing tobacco dependency pathways in mental health inpatient facilities •	• 70% of people with an SMI diagnosis receiving a physical health check • Effective outcome monitoring of the health check recommendations • Compliance with national tobacco dependency measures
	Improving care for people with co-existing **substance misuse and mental health** problems	Develop an understanding and subsequent strategy to best support those with a dual diagnosis	• Reviewing current service provision against best practice, identifying gaps, and making recommendations to improve the offer • Ensuring a no-wrong-door approach to those with dual diagnosis	• Complete delivery of Dual Diagnosis QIP scoping project • Implementation of scoping project recommendations
	Embedding **suicide prevention** approaches across the city	Make suicide prevention everyone's business	• Mapping and understanding suicide risks across the population of Wolverhampton. • Monitoring national metrics for local suicide rate (PHOF) • Implementing a range of evidence-based interventions with the aim to reduce suicide risk. • Enhancing support services for those at increased risk and those bereaved by suicide.	• Presenting suicide prevention JSNA for approval at Health and Wellbeing Board June 2023 • Others to be determined by JSNA findings
	Prioritising the **prevention and promotion** offer	Deliver up-stream prevention and promotion interventions to keep people well Empower local communities to improve their mental health and wellbeing	• Undertaking a needs assessment of adult mental health and wellbeing for the city (JSNA) • Adopting the national prevention concordat for better mental health • Investing in community-based universal and targeted prevention and promotion interventions	• Sign-off of the JSNA by Health & Wellbeing Board • Sign-off of the concordat by relevant parties • Value and distribution of funding given to community-based universal and targeted prevention services. • Reduction in need for referral to secondary care • Improved patient experience/outcomes

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Care Closer to Home	Enhancing our integrated **care co-ordination** function	Give professionals, partners, and patients a single contact to access services that enable people to stay at home when their care needs change and get them "home" if they have been in hospital	• Expanding the range of services available via integrated care coordination (ICC) • Enhancing our telephony system to ensure a timely and smooth experience for those using the ICC. • Working with primary care and the ambulance trust to provide alternatives to the Emergency Department (ED) • Supporting primary care Multi-Disciplinary Team (MDT) meetings to keep people at home • In reaching to hospital wards for proactive support back into community services	• Call volumes and response times • An increase in use of the ICC by the ambulance service and primary care • Increase in the use of urgent community response and Same Day Emergency Care. • Reduced ED attendances • Reduced hospital length of hospital stay • MDT outcomes
	Expanding services in the community that provide **alternatives to urgent hospital care**	Deliver the national Urgent Community Response (UCR)	• Undertaking a demand and capacity analysis to ensure the right resource is available for UCR • Expand the UCR inclusion criteria to include sepsis, diabetes, and point-of-care testing	• Consistently achieve the minimum of 70% response for 2hr UCR
	Ensure effective and appropriate **discharge from hospital** (pull)	Ensure people can return to the place they call home in a safe and timely manner once they are medically fit for discharge Ensure people have a positive outcome at home post discharge, reducing the risk of re-admission	• Developing an integrated health and care 'Home First' offer that enables people to return home for reablement before decisions about their ongoing care needs are made • Reduce in-hospital assessments to the minimum required to ensure someone is safe to go home • Ensuring the wider community offer seamlessly supports our home first principle	• Reduced number of days delayed for patients being discharged • Increased percentage of people entering pathway one • Decrease the number of people requiring long-term care • Reduced number of unplanned readmissions within 90 days
	Deliver a high-quality **care home** offer	Ensure our care home support offer is integrated across services Ensure our out-of-hours care home offer is consistent Ensure the care home MDT model is consistent across the city	• Developing an integrated care home development and quality service that proactively identifies homes needing help and supports them to improve • Providing clear guidance and training for MDTs, followed up with peer review • Ensuring ReSPECT documentation is completed • Supporting homes to monitor their residents through digital technology • Training homes to recognise deterioration and escalate to community services	• Increase in the number of homes rates CQC good • Increase the number/frequency of MDTs • Peer review MDT outcomes • Completion rate of ReSPECT • Number of homes using DoCoBO • Reduction in calls to Ambulance service • Reduction in conveyances from care homes
	Support people to **age well**	Expanding our falls prevention and response offer Rolling out a city-wide healthy ageing service Enabling people to have direct access to community services, with clear information on wait times	• Providing a range of falls prevention services, including self-help and strength and balance classes • Delivering a falls pick-up service which includes MDT input to reduce the need to convey and the risk of further falls • Offering a proactive, holistic assessment to every person over 65 living with mild to moderate frailty • Embed a Healthy Ageing Coordinator in every PCN • Increase the number of services accessible to direct patient referral. • Improve the data quality of community waits and produce a monthly report	• Reduction in the number of ambulance call-outs relating to falls • Reduction in conveyances to hospital for falls • Uptake rate and number of over 65 ageing well assessments delivered • Reported community wait times • Number of direct access referrals
	To deliver a high-quality **palliative and end-of-life** service	Deliver the 6 national PEoLC ambitions Deliver the 9 Integrated Care Board PEoLC commitments	• Improving our bereavement offer • Ensuring our PEoLC offer for children and young people is comprehensive • Ensuring our offer is accessible to those from Black, Asian, and Minority Ethnic communities • Improving the quality of our information and support for patients and families • Improving our data sharing for those receiving PEoLC • Improve our identification of individuals in their last 12 months of life	• Delivery against the Wolverhampton PEoLC improvement plan • Monitor the usage of PEoLC service by ethnicity and age

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Children and Young People	Delivering the **first 1,001 days** agenda	Ensure a partnership approach is taken to giving our children and young people the best start for life	• Develop an extensive campaign on the importance of the first 1001 days • Using the 'Five to Thrive' model to support healthy brain development • Developing a pregnancy offer, including weight management, smoking cessation, and perinatal mental health • Ensuring seamless and timely care from midwives and Health Visitors • Develop an infant feeding strategy and plan that normalises breastfeeding and expands peer support roles	• Successful rollout of the 'Five to Thrive' model across the early years workforce • 5 mandated contacts • The number of women and partners who cease smoking following support • The number of pregnant women supported through commissioned weight management service • Increased breastfeeding initiation and continuation at 6-8 weeks • Increased number of early years staff trained in Mental Health First Aid • Peer support roles in parental mental health in place
	Improving the uptake of **Childhood immunisations**	Work with communities to understand and remove barriers to childhood immunisations	• Completing insight work into the understanding and attitudes of parents on childhood immunisation • Developing a vaccination model to improve the uptake of childhood immunisations, starting with a focus on MMR and children in care • Piloting a roving vaccination model	• Creating an information campaign based on the views of parents • Increased uptake of MMR vaccinations • Increased number of vaccinations for children in care
	Improving early diagnosis and ongoing care for children with **asthma**	Co-produce a pro-active asthma care programme which supports people to stay well and reduces the need for secondary care escalation	• Co-producing an asthma care programme, building on the Young Health Champions model • Reviewing every child diagnosed with asthma on an annual basis • Identify opportunities to mitigate the impact of housing and environmental factors on asthma • Enhancing joint primary-secondary care working	• The number of asthma attacks resulting in hospital attendance • Reduced reliance on reliever medication • The number of annual asthma reviews being undertaken
	Supporting children, their parents, and carers to maintain a **healthy weight**	Take a whole-family approach to healthy weight management, incorporating nutrition, physical activity, and child development to support families	• Developing a multi-partner approach to improving healthy weight & activity • Enhancing the physical activity offer and participation in the DfE School food pilot • Participation in RCT of 'HENRY' (whole-family nutrition, healthy weight, and child development programme) • Collating measurement data at the 2-year developmental review to better understand weight status during the early years	• Participation in National Child Measurement Programme • The obesity levels at reception • Improvement in activity and healthy eating
	Improving the **oral health** of our children	Promote and encourage good oral health for our children	• Understanding dental care availability in Wolverhampton • Improving the oral health education offer • Ensuring access to oral health products for priority and vulnerable groups • Instilling good brushing behaviours in preschool children within targeted wards of the city	• Number of registrations from migrant communities • Number of education sessions delivered • Rates of tooth decay • Reduced tooth extractions, including fewer extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under
	Expanding the support for children's **mental health and emotional wellbeing**	Deliver the recommendations of the Strategic Needs Assessment to ensure we best meet the emotional and mental health needs of our children and young people	• Implementing a Charter Mark to drive a whole school approach to emotional health and wellbeing • Increasing awareness of local advice and support services amongst parents/carers and professionals	• Presenting the Needs Assessment at Children and Families Together Board (CFTB) • Improved access rates to children and young people's mental health services for 0-17-year-olds, for certain ethnic groups, age, gender, and deprivation • Improved transition up to age 25

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Living Well	Increasing **cancer screening** rates for breast, bowel and cervical	Identify cancers at an earlier stage resulting in better outcomes and improved survival rates	• Delivering an effective identification and invitation system • Target non-responders to previous cancer screening cycle invites • Regularly reviewing the demographics of screening uptake	• Number of invites made by practice • Screening uptake split by demographic group • Number of attendances from non-responders after targeted intervention
	Improving **health check uptake** to deliver a preventative approach	Improve universal uptake across the city and develop a digital offer to improve the uptake of health checks	• Working with low uptake communities to coproduce suitable delivery solutions • Increasing access options • Targeting invites to underrepresented groups • Enhancing public communications • Monitoring uptake by IMD, ethnicity and other factors	• Monthly & quarterly uptake data • Outcomes of completion • Patient experience
	Improving diagnosis and care for people with **dementia**	Increase dementia diagnosis in those over 65 Strengthen pathways from primary care and memory assessment into community-based support services Increase the number of care plans reviewed within the last 12 months Provide a robust and responsive carers support service	• Ensure clear alignment between Wolverhampton and wider black country dementia strategies • Work with primary care to increase dementia clinics, practice-based campaigns and case finding • Increase referrals from primary care to the dementia connect service • Deliver a range of community activities through the dementia action alliance including campaigns, training, and providing resources to community-based organisations for example supporting dementia cafés • Reduce wait times for diagnosis (MAS), offering community-based alternatives whilst waiting for a diagnosis	• Dementia diagnoses rates • Number of referrals to dementia clinics & dementia connect • Wait time for MAS
	Delivering **health and well-being hubs** across the city	Provide flexible, accessible, and integrated access in a range of settings across the city including Bilston, Oxley, and the city centre	• A robust partnership approach to delivering Oxley and Bilston • Developing a compelling partnership case to secure a city centre offer • Co-design our offer with residents	• Achieving mobilisation timelines for Oxley and Bilston • Approved business case for city centre offer
	Developing our local offer for **healthy lifestyle services**	Commission and deliver the local offer for weight management and smoking cessation	• Develop clear specifications for tier 2 weight management and smoking cessation including face-to-face and digital; NRT and vaping; behavioural support • Undertaking a comprehensive procurement exercise • Mobilising the chosen solution delivery service mechanisms	• Service reporting of relevant KPIs • Tier 2 DES uptake and outputs • Obesity and smoking prevalence • Patient/ service user feedback • Qualitative analysis to identify remaining gaps in the provision
	Increasing **cancer screening** rates for breast, bowel and cervical	Identify cancers at an earlier stage resulting in better outcomes and improved survival rates	• Delivering an effective identification and invitation system • Target non-responders to previous cancer screening cycle invites • Regularly reviewing the demographics of screening uptake	• Number of invites made by practice • Screening uptake split by demographic group • Number of attendances from non-responders after targeted intervention

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Primary Care Development	Developing **new primary care** services to deliver more care closer to home	Provide a greater range of services within primary care Maintain and improve access to primary care	• Delivering the Primary Care Framework (PCF) • Developing city-wide services • Delivering the Enhanced Health in Care Homes (EHCH) agenda (overseen by Care Closer to Home) • Undertaking horizon scanning to identify opportunities to move services into primary care and their funding mechanisms • Identifying current inequality in provision and solutions to close the gap • Ensure that health inequalities are not being exacerbated by access models	• Rate of appointments offered per 1,000 head of population • An increase in the number and range of funded services delivered by Primary Care • Published self-assessments against PCF delivery
	Improving the **primary and secondary care interface**	Work better together across organisational boundaries to support better patient and professional experience	• Reviewing the referral data to understand our greatest opportunities • Working with secondary care colleagues to identify [pathway issues and solutions, ensuring work is fairly distributed • Develop primary-secondary care protected learning time annual plan • Re-evaluate the WICKD programme	• The number of referrals to advice and guidance • A reduction in the number of inappropriate referrals • Qualitative feedback from clinicians and professionals about improved relationships and understanding
	Enable a resilient **primary care infrastructure**	Support resilient digital infrastructure Support the development of the primary care estate Improve business intelligence and reporting Deliver an effective ARRS model	• Increasing the uptake and utilisation of the NHS App • Moving all practices to cloud-based telephony • Improving the quality and consistency of practice websites • Ensuring the voice of primary care is represented in estates forums and has equal priority • Signing-off PCN estates strategies, ensuring they support service need • Reviewing the impact of the different ARRS roles and produce a strategy for the city to ensure the best use of the roles	• Sign-up and utilisation of the NHS App • Uptake of cloud-based telephony • Auditing of practice websites to ensure these are in-line with best practice • An increase in the available estates capacity for primary care
	Enabling people to live well with their **long-term condition**	Focus on the two ICB priorities of CVD and Diabetes Develop a clear plan for the remaining elements of the national Core 20 cohorts	• Supporting pro-active case finding • Empowering individuals with diagnoses to self-manage with appropriate support • Delivering a co-ordinated approach to CVD and diabetes based on best-practice	• An increase in the number of diagnoses of CVD and Diabetes • Reduced attendance at emergency portals for CVD and diabetes • The development of a robust plan to support care for national Core 20 cohort of patients
	Supporting patients with complex needs through a strong **MDT approach**	Ensure a consistent standard of MDT is delivered across the city Ensure the support staff and technology are in place to enable efficient and effective MDTs	• Reviewing existing MDTs and sharing bet practice • Setting a benchmark standard for what 'good' looks like, supported by regular peer review and outcomes reporting • Undertaking a gap analysis of the support available and identifying actions required to address inequalities	• MDT frequency and attendance against defined membership • Peer review feedback • Outcomes evaluation

	Our Priorities	This means we will	We will do this by	We will measure the impact by
Urgent and Emergency Care	Helping people with urgent needs access the **right care, first time**	Ensure a range of suitable services are available so only those who truly need an ED attend	• Working with primary care to support right-sizing the capacity for same-day and out-of-hours urgent care • Ensuring our local care coordination centre becomes the first option for WMAS, GPs and Care Homes to navigate individuals with a same-day urgent need to the most appropriate service • Delivering a range of community services that provide same-day urgent needs as an alternative to hospital	• Reduced ambulance handover delays and reduced time on average for ambulance handover
	Ensuring a **timely experience** when accessing ED	Ensure patients are optimally streamed at the front door	• Maximise the use of same-day emergency care (SDEC) and Urgent Treatment Centres (UTCs)	• The proportion of patients seen in SDEC and UTC settings
	Ensuring effective and appropriate **discharge from hospital (push)**	Ensure individuals can return to the place they call home in a timely fashion once they are medically fit for discharge	• Improving discharge processes by ensuring planning for discharge starts at admission • Working with community colleagues to ensure the 'Home First' offer has sufficient capacity and seamlessly links into discharge processes • Scaling up social care services with a particular focus on domiciliary care	• The number of individuals currently Medically Fit for Discharge • The number of individuals supported by an intermediate care service • The number of people being discharged home first (to their usual place of residence)
	Delivering an integrated approach to **demand and capacity planning**	Work collaboratively with all partners to pro-actively plan how we will manage changes in demand	• Starting as early as possible in the planning cycle to ensure we have time to implement changes • Learning from the approach taken to previous demand and capacity plans • Review the impact of previous initiatives ensuring effectiveness and value for money • Clearly identifying how we move successful short-term initiatives into business as usual	• The number of medically fit for discharge patients • The average ambulance handover time • ASCDF metrics
	Expanding new services in the community that provide **alternatives to bed-based care**	Deliver the national Virtual Ward requirements	• Undertake a demand and capacity analysis to ensure the right number of beds is available for Wolverhampton's needs • Expand the pathways to include a range of locally defined priorities	• The number of patients seen on a virtual ward • The number of virtual ward clinical pathways being delivered
	Helping people with urgent needs access the **right care, first time**	Ensure a range of suitable services are available so only those who truly need an ED attend	• Working with primary care to support right-sizing the capacity for same-day and out-of-hours urgent care • Ensuring our local care coordination centre becomes the first option for WMAS, GPs and Care Homes to navigate individuals with a same-day urgent need to the most appropriate service • Delivering a range of community services that provide same-day urgent needs as an alternative to hospital	• Reduced ambulance handover delays and reduced time on average for ambulance handover

Board Report Output Model

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	3.3	Asthma ED Attends & Admissions
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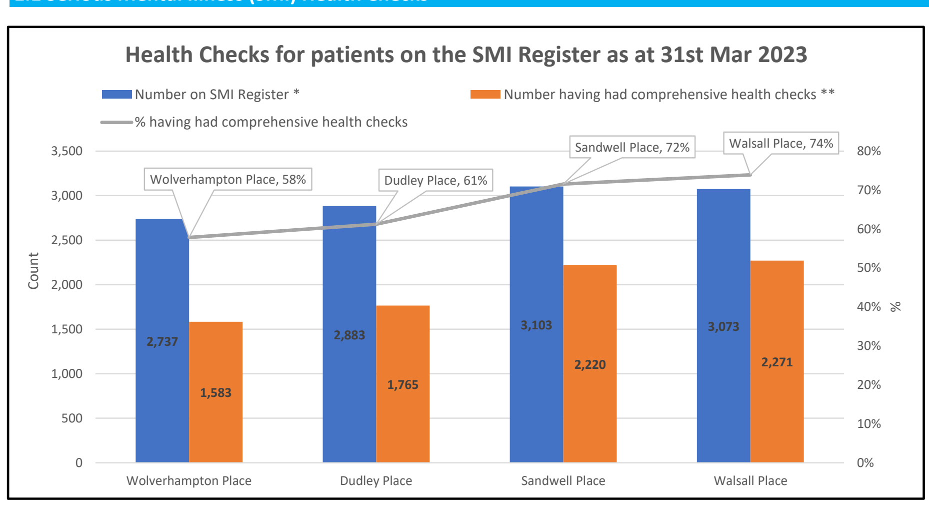
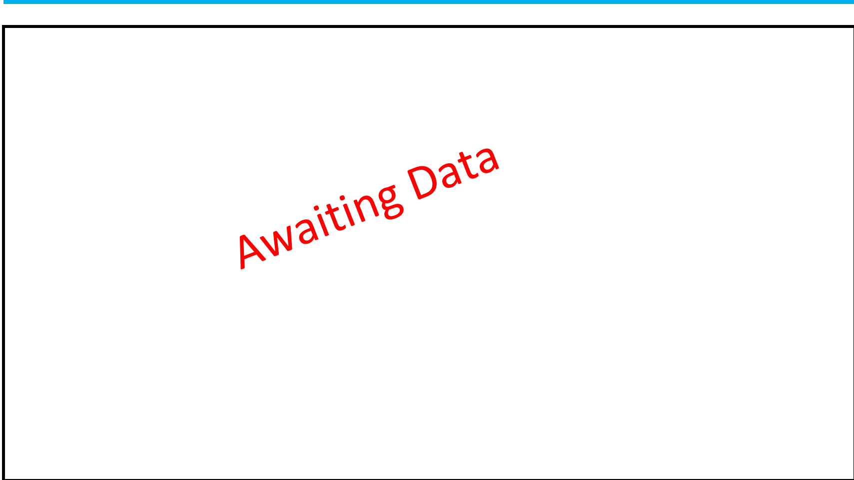
	6.3	Ambulance Arrivals & Handover Times
Appendix 1	7	Priorities
Appendix 2	8	Data Definitions

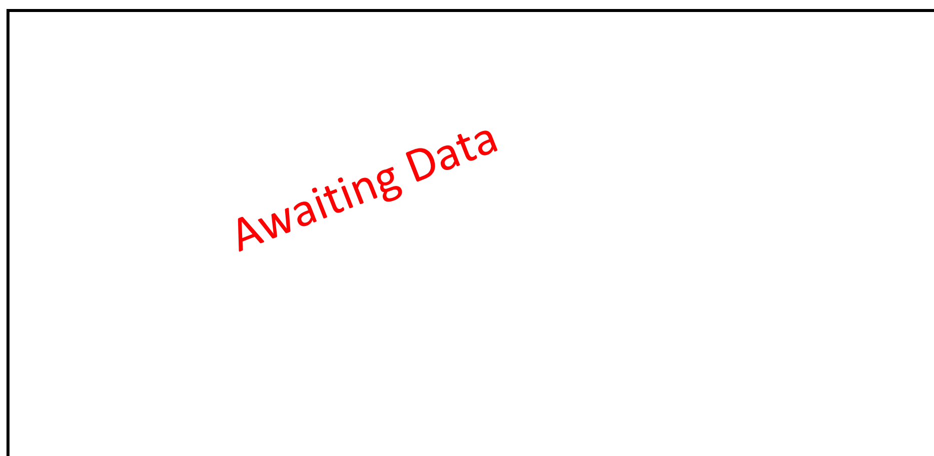
1.1 Serious Mental Illness (SMI) Health Checks



1.2 IAPT Wait Times

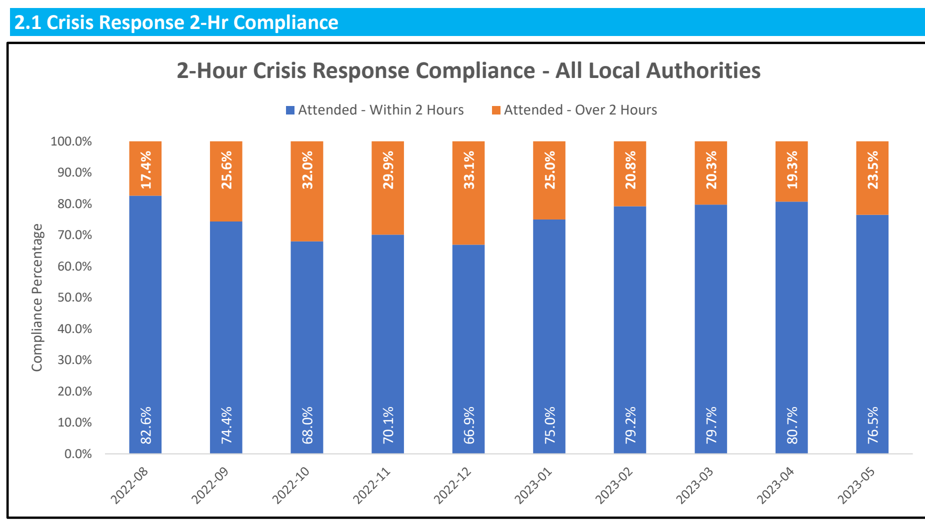


1.3 National Metrics for Local Suicide Rate

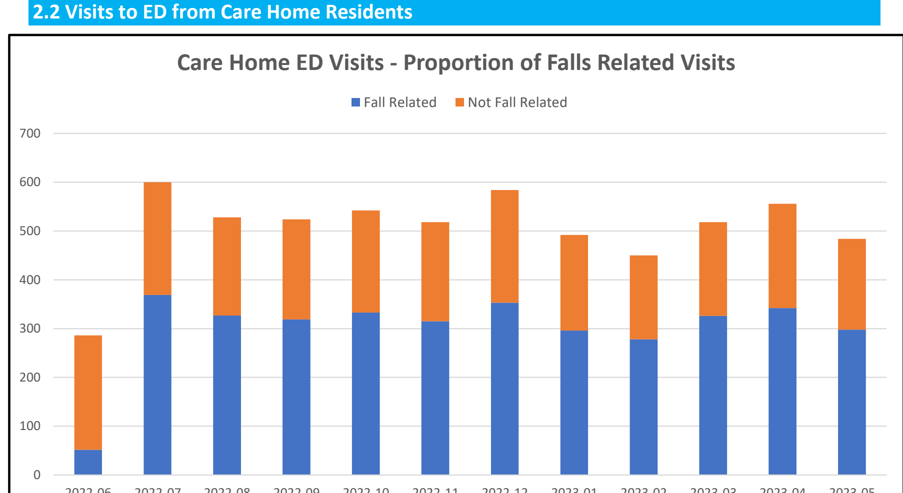


Commentary Section

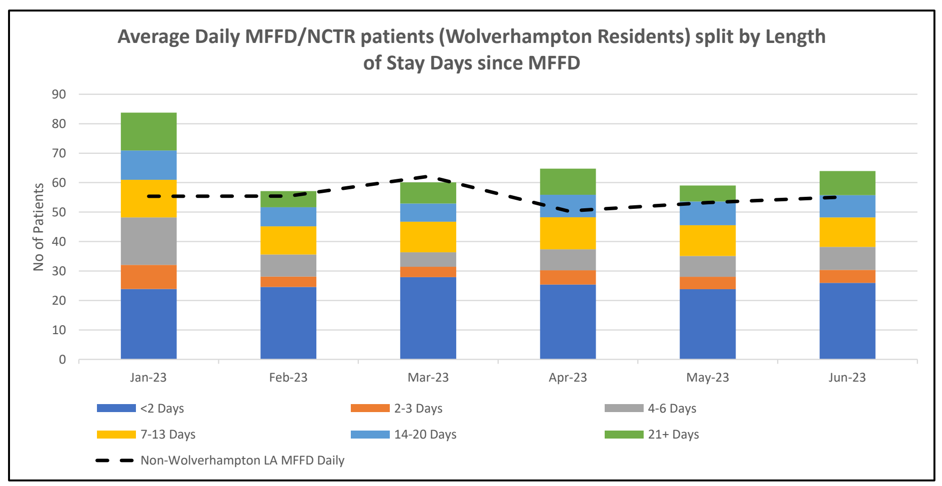
2.1 Crisis Response 2-Hr Compliance



2.2 Visits to ED from Care Home Residents



2.3 Medically Fit For Discharge/No Criteria to Reside



Commentary Section

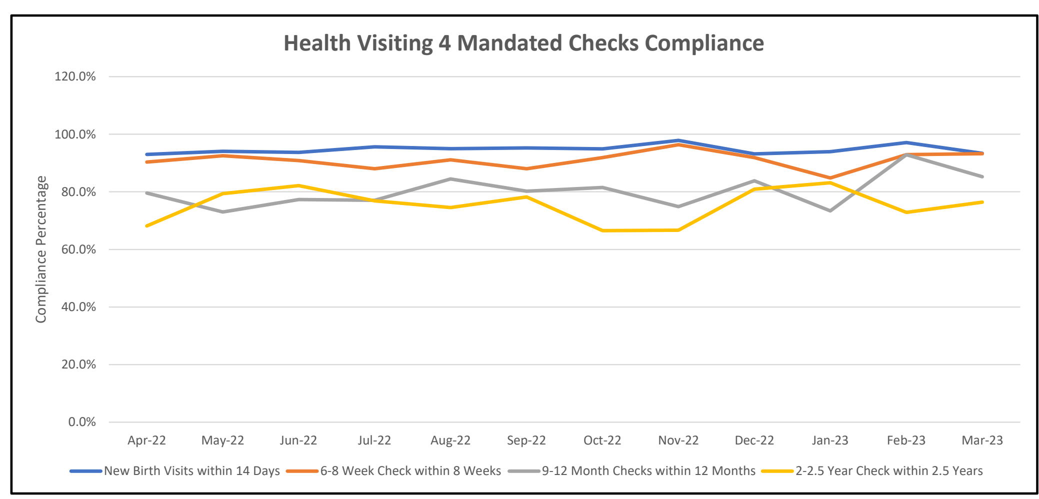
Crisis Response

The national target for crisis response services is that 70% of patients referred are seen within 2 hours by December 2023. We have already met and sustained this performance and in many months exceed it.

MFFD

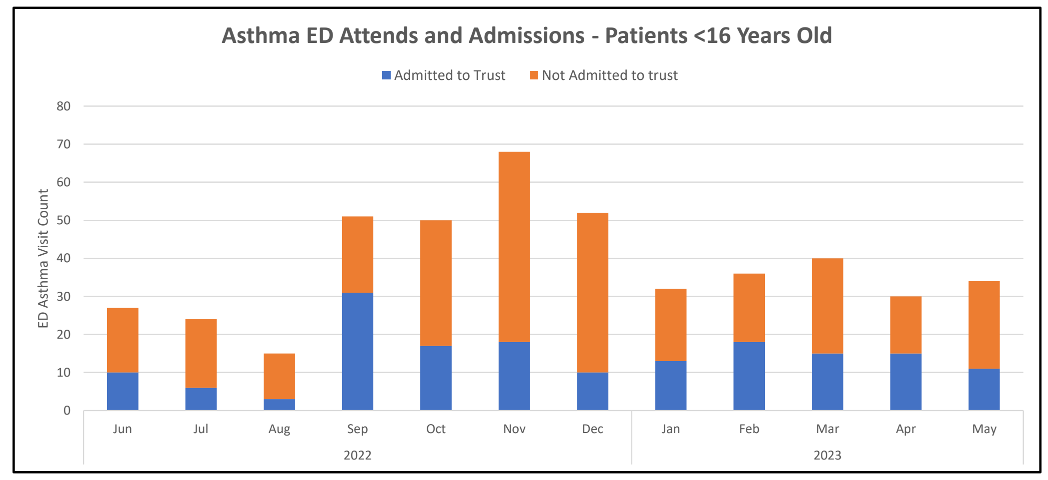
The average daily number of patients MFFD/NCTR has reduced since January, with an overall downward trajectory. The largest reduction is in the cohorts with the greatest length of stay.

3.1 Mandated Health Visiting Checks



3.2 Childhood Immunisations

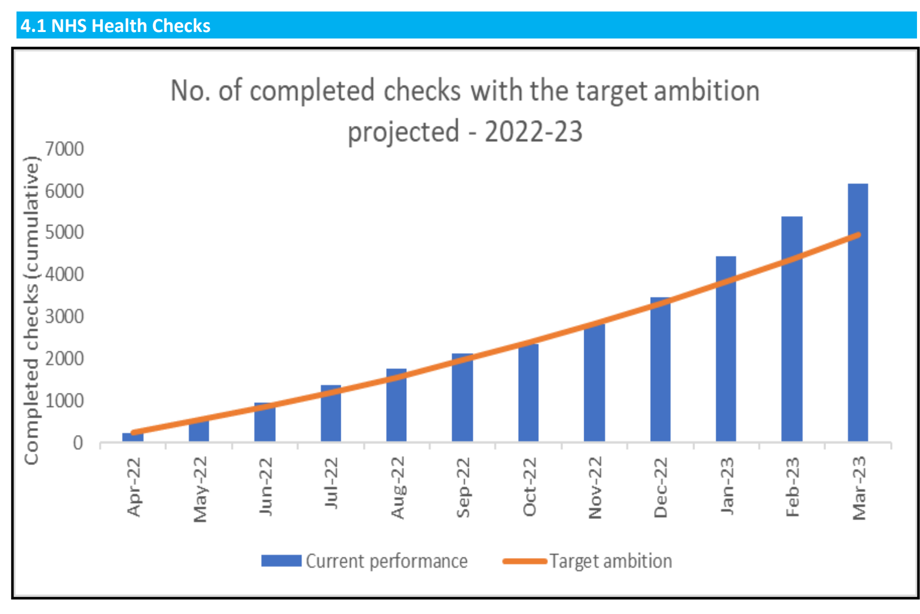
3.3 Asthma ED Attends & Admissions



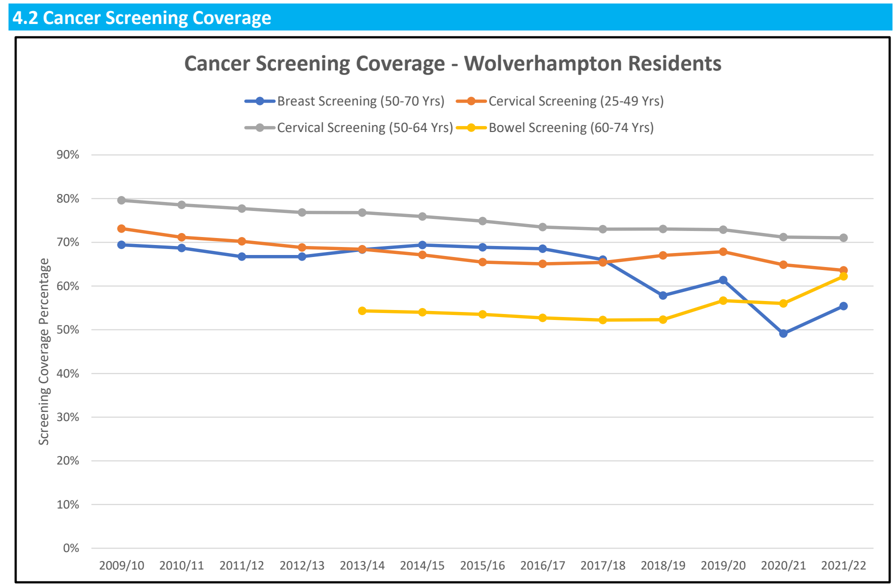
Commentary Section

Health Visiting
These are draft metrics, data validation is being undertaken on the KPIs. Commentary will be provided in the next report.

4.1 NHS Health Checks

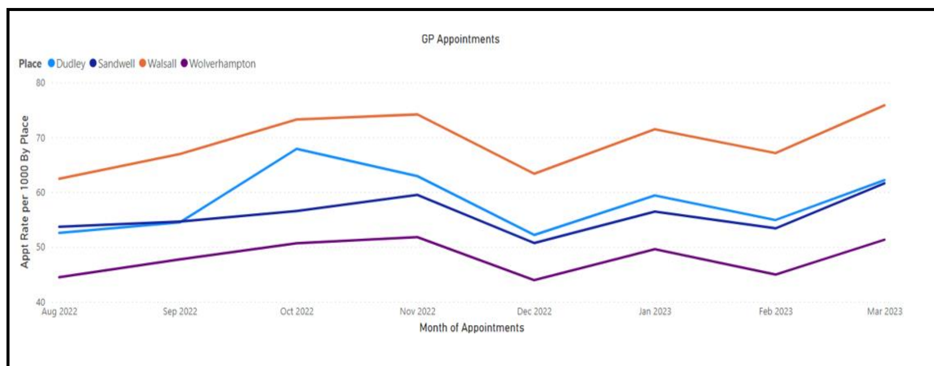


4.2 Cancer Screening Coverage

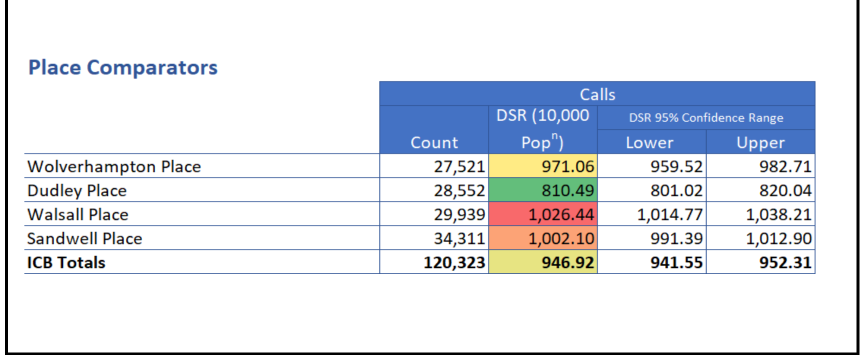


4.3 Dementia Diagnosis

5.1 GP Appointments Utilisation



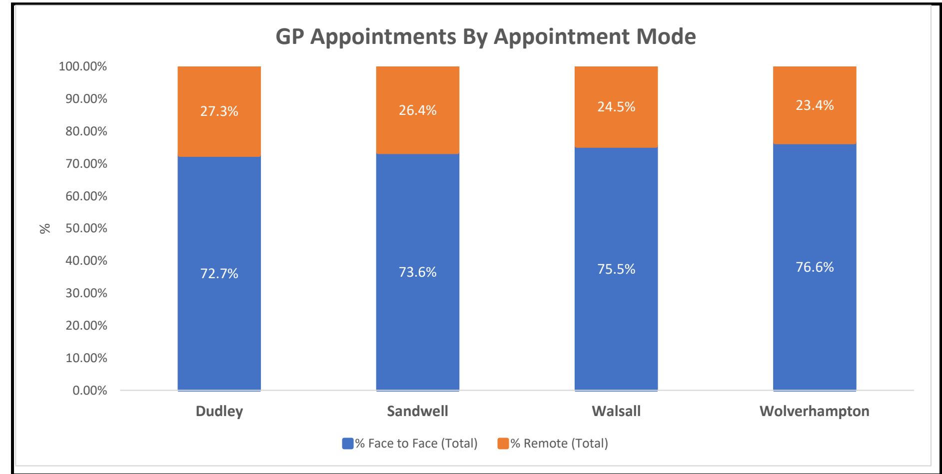
5.2 Ambulance Calls - Standardised Rate

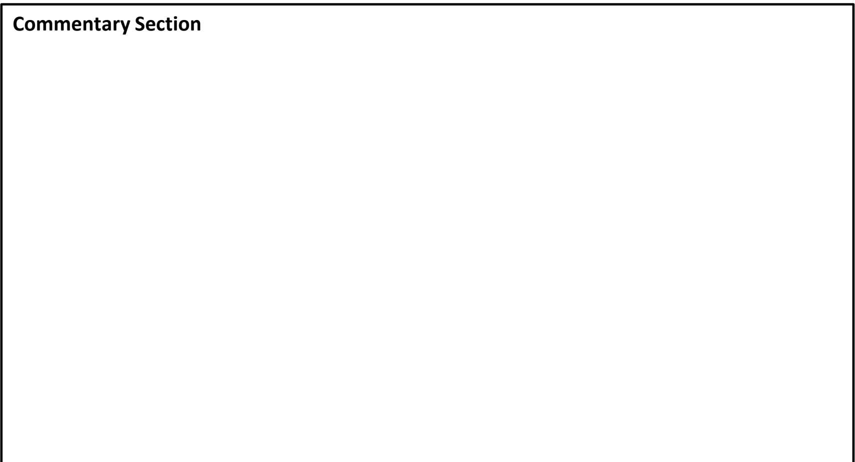


Place Comparators

	Calls			
		DSR (10,000	DSR 95% Confidence Range	
	Count	Pop^n)	Lower	Upper
Wolverhampton Place	27,521	971.06	959.52	982.71
Dudley Place	28,552	810.49	801.02	820.04
Walsall Place	29,939	1,026.44	1,014.77	1,038.21
Sandwell Place	34,311	1,002.10	991.39	1,012.90
ICB Totals	**120,323**	**946.92**	**941.55**	**952.31**

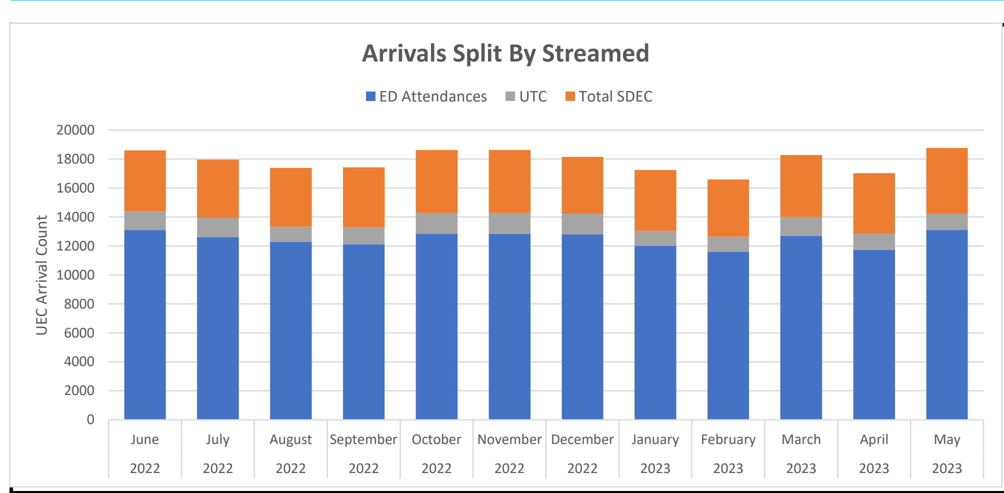
5.3 GP Appointments by Mode



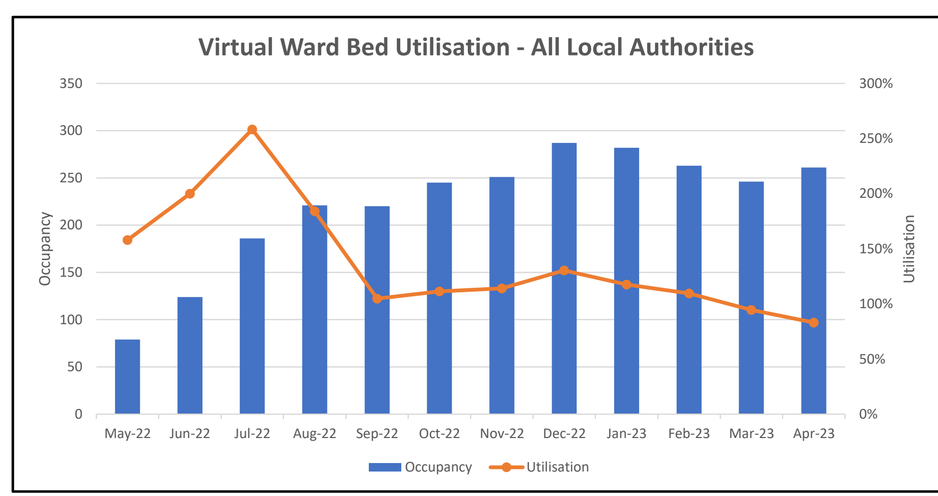


Commentary Section

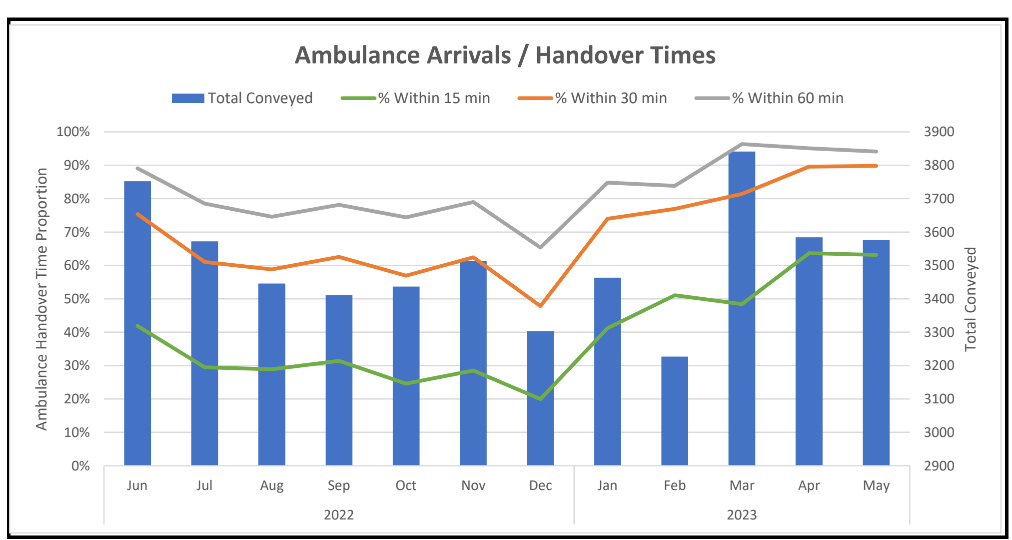
6.1 UEC Arrivals by Stream Pathway



6.2 Virtual Ward Occupancy and Utilisation



6.3 Ambulance Arrivals and Handover Times



Commentary Section

Ambulance Handover Performance

Criteria Led Handover continues in Divisions 1 & 2 to expedite timely transfers.
ARC is open and remains operational – AOA1 & 2 flexed as required to ensure timely offload of ambulances.
Push Pilot continues and is now extended where patients are pushed to every medical ward at 9:30 and 11:30 irrelevant of confirmed discharge.

Virtual Ward

The service remains above the national requirements for both bed base and occupancy. Additional pathways continue to be scoped and the service is growing it's step-up and pro-active monitoring pathways to reduce the need for admissions.

Paper for submission to the Trust Board Meeting to be held in Public on 1 August 2023

Title of Report	Exception Report from the People and Organisational Development Committee	Enc No: 11.1
Author:	Adam Race, Interim Director of Human Resources and Organisational Development	
Presenter:	Allison Heseltine, Non-Executive Director & Chair of People and Organisational Development Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	23 June 2023 28 July 2023 (July Meeting not included in this report due to proximity to Board)	

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

Recommendations:

The Board is asked to receive and approve the Equality, Diversity and Inclusion Annual Report.

The Board is asked to endorse the Committee's review of the Board Assurance Framework Strategic Risk (SR17).

The Board is asked to note the work of the Committee in relation, particularly, to the Grip and Control Checklist and sickness absence.

ALERT

- The Committee was not quorate due to new non-executive directors not being available. This has been remedied for future meetings of the Committee.
- 12 month rolling sickness absence is exceeding the target. The Committee will receive a deep dive on this item in July.

ADVISE

- The Equality, Diversity and Inclusion Annual Report was approved by the Committee and is recommended for approval by the Board. The report shows good progress in a number of areas, with further work to do. Performance has worsened in some areas and recovery plans are in place. Further updates will be presented to the Committee as outlined in the schedule of business.
- The Committee will receive the Grip and Control Checklist in September 2023.

ASSURE

- Key workforce indicators relating to retention, mandatory training and vacancies are meeting the standards.
- The hard to fill posts report was reviewed and assurance taken that action was in place to support recruitment to key/ hard to fill posts.
- The Committee approved the Terms of Reference for two subgroups; Operational Workforce

Group and the People and Organisational Development Group. - The Board Assurance Framework was reviewed – no changes are recommended.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	None Risk Description - Not Applicable Is Risk on Risk Register: Yes☐No☐ Not Applicable☒ Risk Score (if applicable): Not Applicable		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Effective, Caring, Responsive, Well-Led.
	NHSE	Yes☒No☐	Details: EDI High Impact Actions
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Annual EDI Report required under Equality Act.
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:

Summary of Key Issues:
Key issues discussed at the Committee were: - The Equality, Diversity and Inclusion annual report was reviewed and supported for approval by the Board. - The Committee noted the Financial Grip and Control checklist which it will receive and review in September. - The Committee noted the elevated levels of sickness absence and agreed to receive a deep dive and action plan at its July meeting. - The Board Assurance Framework was reviewed. No changes were proposed. - A report setting out details of posts considered hard to fill and actions in place to was address was received by the Committee.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Deliver improvements at PLACE in the health of our communities
Effective	• Improve population health outcomes through provider collaborative

Collaboration	• Improve clinical service sustainability • Implement technological solutions that improve patient experience

Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 23 June 2023
	Board of Directors	Yes☒No☐	Date: 1 August 2023
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

EXCEPTION REPORT FROM PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION

Meeting Quoracy

The meeting was not quorate, however, any decisions/ approval required was sought and gained as required with non-executive members virtually.

Equality, Diversity and Inclusion Annual Report

The Equality, Diversity and Inclusion Annual Report was reviewed with a particular focus on the workforce elements. The report was approved at the People and Organisational Development Committee for consideration for **approval** by the Board.

Grip and Control Checklist

The Committee noted that the Trust was under a level of financial focus and, there was a national 'Grip and Control' checklist which included a number of workforce elements. The Committee were advised that work to ensure the areas set out in the checklist was being undertaken through the Finance Recovery Group. This will be brought to the September meeting of the People and Organisational Development Committee to provide assurance on the actions.

Name of the Committee

The Committee discussed the desire to standardise and simplify board sub-committee names. It was concluded that the Committee recommends changing the name to the People Committee, this matter to be escalated to the Board and included in the Group Chief Strategy Officer's paper to the Board.

Deep Dive on Sickness Absence

The Committee has requested a deep dive into the elevated levels of sickness absence and this is to be reviewed at a future Committee.

Board Assurance Framework – SR17 (EDI)

The Committee reviewed the Board Assurance Framework and agreed to include the six-high impact actions within the controls. The Committee did not propose any change to the current risk rating.

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

Outstanding Actions for the Committee were reviewed:

- Flexible and agile working has been promoted across the Trust.
- The Committee Effectiveness Review was discussed where it was noted that not all Committee members were aware of the discussions that took place at Board and the implications for Committee business. It was agreed that feedback from the Board would be added to future agendas.

Hard to Fill Posts Report

The Committee received a report setting out the 'Hard to Fill' posts. The report identifies posts that

have been considered hard to fill through, for example, multiple unsuccessful recruitment campaigns, identification through the risk register or by being high in volume. The report is considered monthly by the Operational Workforce Group chaired by the Interim Director of HR and OD with membership including Deputy Chief Operating Officer colleagues. Reviewing the report, the Committee received detailed updates on activity to support recruitment of:

- ICU consultants
- Dietitians
- Sonographers
- Community Nurses and
- Health Visitors.

Following this discussion, the Committee were assured that posts that presented a risk to service delivery or that were difficult to recruit to were closely managed. Examples of actions to support recruitment in such areas included the use of head-hunters, targeted recruitment of international colleagues, revising job descriptions, improved opportunities for development and rotational posts. There is also a process of follow up where a candidate withdraws their application having been appointed to understand the reasons.

Equality, Diversity and Inclusion Annual Report 2022-23

The Committee received the annual equality report for the year 2023-23 for approval ahead of submission to Board. The report is required to ensure that the Trust complied with its obligations under the Equality Act 2010.

The report was produced between the Workforce EDI Team and the Patient Experience Team. The report identified the achievements over the last 12 months together with actions to address gaps. There was a detailed discussion on this report covering matters including:

- Unconscious bias in respect of which there was an e-learning module which could be accessed by all staff.
- The worsening performance in relation to the relative likelihood of black, Asian or minority ethnic staff entering a disciplinary process. This matter had been discussed in detail with rapid action agreed with particular engagement of cultural ambassadors and the nursing fellowship team.

The report will be submitted to Board for final approval.

Risk Review

The Committee reviewed the Board Assurance Framework. There were no changes proposed to the rating of this risk.

Standardisation of Committee Titles

The name of the Committee was discussed and it was agreed that the Committee would support proposals for it to be renamed the People Committee.

Matters presented for information or noting

Non-Executive Members of the Committee

Whilst it was noted that the Committee was not quorate, it was confirmed that Angela Harding and Umar Daraz had been nominated as Non-Executive members of the People and Organisational

Development Committee.

Key Updates

A number of key updates were received by from the Chief People Officer:

- The Trust had commemorated Armed Forces Week (19 – 24 June 2023) with a flag raising event attended by a number of Trust staff who were armed forces veterans/ reservists.
- The NHS Long Term Workforce Plan was due to be discussed at an NHS England roadshow being hosted by the Regional Director. A more detailed update would be brought to the committee when available.
- NHS England have produced a new document for all NHS Trusts setting out a number of high impact actions in respect of Equality, Diversity and Inclusion. It was agreed to bring an update back to a future meeting of the People and Organisational Development Committee.
- The pay award to staff had been confirmed and the Committee was advised that it would be paid from June, inclusive of back pay to 1 April 2023 and payments related to 2022/23. The Committee noted that there were some concerns being raised in relation to the award in that payments for 2022/23 were only payable to those in post at 31 March 2023 and that they were not payable to bank staff.
- The Committee received an update on the ballots for industrial action that were still to close at the date of the meeting.

Executive Workforce Report

The Committee received and reviewed the Executive Workforce Report. It was noted that three of the six indicators were achieving the standards required with vacancies at 2.26%, mandatory training at 95.40% and 12-month retention improving at 89.15%. There remained challenges with turnover, sickness and appraisals, with the first two indicators having improved over the month.

The Committee noted that a deep dive in relation to sickness absence would be presented to the next committee meeting. Sickness absence was also subject to review through the Performance and Finance Committee in relation to the financial impact of such absence.

There was a discussion regarding roster metrics, particularly, the sign off of rosters with more than six weeks' notice, which was only happening in 64% of cases. The Committee were advised that there was significant work on this area being undertaken by the Head of Nursing – Workforce to ensure compliance within the Divisions and it was agreed that an update would be brought to the September meeting of the People and Organisational Development Committee.

Operational Workforce Group – Update

The Operational Workforce Group has been previously established to ensure operational engagement and decision making across the workforce agenda. However, given the breadth of the agenda, this has now been split into two focused meetings. The Operational Workforce Group, dealing with matters such as resourcing, employee relations and rostering and the People and Organisational Development Group focused on culture, talent management, leadership and equality, diversity and inclusion. Terms of reference for these subgroups were received and supported. As the meeting was not quorate, these have been shared with Non-Executive members of the Committee for approval.

Grip and Control Checklist

The Committee were advised of the Grip and Control Checklist which is a national document designed for organisations to consider savings schemes and financial governance. It was noted that there are a number of workforce/ HR elements and this will be brough to the People and Organisational

Development Committee in September.
Chair’s comments on the effectiveness of the meeting: The meeting contained a full agenda supported by high quality papers and discussion around the agenda with significant contributions from all members. Due to the meeting not being quorate, there were a number of follow on actions. This has been remedied for future meetings.

Paper for submission to the Trust Board Meeting – to be held in Public On 1 August 2023		
Title of Report:	Executive Workforce Report	Enc No: 11.1.1
Author:	Adam Race, Interim Director of Human Resources and Organisational Development	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer	

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

Recommendations:

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

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

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 28 July 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure
The report provides assurance on key workforce metrics and items requiring escalation to the board, specifically:

- Vacancy rates
- Turnover and retention rates
- Sickness absence rates
- Training and appraisal compliance rates

Indicators relating to vacancies rates, retention, in month sickness, and training are meeting the targets/ standards.

Advise

Vacancy rates are below target at 3.12%

Retention is meeting the target at 89.57%

Mandatory training compliance is above target at 95.60%

Alert
The Board is alerted to:

- Sickness absence rates for the rolling 12 month period are elevated above the target. Actions are in place and the Trust benchmarks favourably.
- Appraisal compliance is not meeting the target, the paperwork has been streamlined and divisions are progressing plans to ensure delivery.
- Turnover remains elevated, actions are in place to further improve retention.
- Industrial action continues with the BMA calling upon Consultant colleagues to take industrial action. further ballot is being undertaken for Junior Doctors which closes at the end of August.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas

	that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Effective Collaboration	• Improve clinical service sustainability • Progress joint working across Wolverhampton and Walsall •

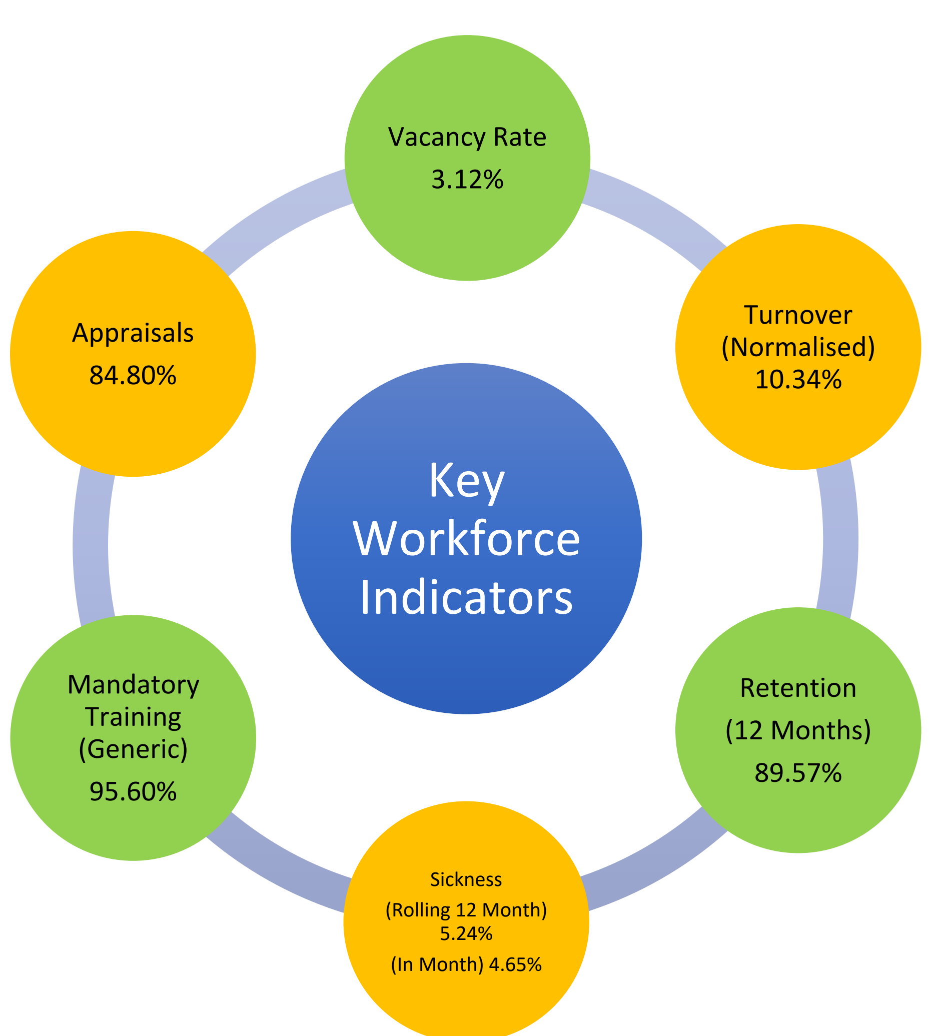
Executive Summary

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

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

- Normalised turnover is 10.34%, improving slightly in month and for the the sixth consecutive month. The retention rate is now reported as 12 month retention and is meeting the agreed standard showing improvement in month.
- The vacancy rate has worsened, however continues to meet the target at 3.12%. Over the last month the number of staff employed has increased by around 40WTE, driven by increases across the staff groups, with the largest increases in registered nursing staff of around 32WTE. Recruitment continues to outpace turnover. There were almost 124WTE newly qualified/ international nurses working towards their NMC Registration at the end of June.
- Attendance levels have remained broadly stable with a very slight improvement in May. The in month performance for this indicator is below the target at 4.65%. Levels of absence remained elevated, and will continue to impact performance in relation to the 12 month rolling absence rate for some time which currently sits at 5.24%.
- Performance in relation to generic Mandatory Training continues to meet the external target of 95.60%. Role specific mandatory training compliance is also slightly improved at 93.40% and above the target. In relation to appraisal, compliance rates have improved slightly over the last month to 84.80%. This indicator is again rated amber and below the target of 90%.
- The fill rate through the bank in June was 68% for registered nursing staff, worsening in month, and 87% for healthcare assistants, again, an improvement in month. The medical bank fill rate was 88%, showing improvement and continuing to exceed the new target of 87%.
- The report offers a brief overview of a number of key work streams:
  - Industrial Action
  - Rostering performance for non-medical staff

Key Workforce Metrics



Three of the six workforce indicators are meeting the agreed targets / thresholds; vacancy rate, retention rate and mandatory training compliance. Turnover, appraisals and sickness compliance are rated amber. Five of the six indicators improved over the month.

Turnover has improved slightly to 10.34%. Turnover performance is now meeting the standard for Medical and Dental, Admin and Clerical and Additional Professional, Scientific, and Technical staff groups with elevated levels particularly in AHP and Healthcare Scientist staff groups.

The vacancy level has worsened slightly in month, however, continues to meet the target. It is above target for AHP and medical staff only as the establishment has increased to a greater extent than the number of staff in post.
In month absence levels are now below target for the last two months. Rolling 12 month sickness is 5.24%, above the target and rated amber.

Mandatory training (generic) compliance rates have improved, and continues to exceed the 85% target.

Appraisal compliance has improved slightly but is not meeting the Trust target of 90%.

Paper for submission to the Trust Board Meeting – to be held in Public on 1 August 2023		
Title of Report:	Annual Equality Report	Enc No: 11.1.2
Author:	Balvinder Everett, Head of Equality, Diversity and Inclusion Alison Dowling, Head of Patient Experience	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer Debra Hickman, Director of Nursing	

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

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None Risk Description: 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. Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable):16		
Resource Implications:	Revenue: None Capital: None Workforce: None Funding Source: Not applicable		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well Led, Responsive
	NHSE	Yes☒No☐	Details: NHS EDI Improvement Plan, Midlands Race Equality Strategy
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Legal duties under Equality Act 2010.
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
Equality and Diversity	In being awarded the Race Code mark, the Trust agreed to increase its		

Impact	awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. The report references work in relation to the EDI Agenda.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: People and OD Committee 23 June 2023 Quality Governance and Assurance Committee 26 July 2023.
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure **The Annual Equality Report provides assurance to the Trust Board** of organisational compliance with the requirement set within the Equality Act and Public Sector Equality Duty to publish its annual equality information.
Advise
Alert

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy
Effective Collaboration	• Improve population health outcomes through provider collaborative • Progress joint working across Wolverhampton and Walsall

Paper for submission to the Trust Board Meeting – to be held in Public On 1 August 2023		
Title of Report:	NIHR Clinical Research Network (CRN) West Midlands	Enc No: To be completed by Board Administrator
Author:	Carly Craddock, Chief Operating Officer, Tel: 07342080507	
Presenter/Exec Lead:	Dr Brian McKaig	

Action Required of the Board/Committee/Group
For discussion
Recommendations: The Board is asked to note the content of the report Approve annual business report 2022/23 Approve annual financial report 2022/23 Approve annual financial plan 2023/24

Implications of the Paper:

Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☒No☐	Details: Research to improve health and care
	NIHR Performance and Operating Framework	Yes☒No☐	Details: Contractual agreement between DHSC and RWT as Host of CRN, WM
	Life Sciences Vision	Yes☒No☐	Details: Research to address the Country's health, wealth, and resilience
CQC Domains	Well-led		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: 28 June 2023
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	CRN, WM Partnership Group	Yes☒No☐	Date: 25 July 2023

Summary of Key Issues using Assure, Advise and Alert

Assure

RRDN contract awarded for a further six years
Excellent commercial activity

Advise

The report advises the Board that, as Host of the Clinical Research Network, West Midlands it has fulfilled its duties as part of the Performance and Operating Framework

Alert

Nothing to report

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

Clinical Research Network, West Midlands

Report to Trust Board Meeting to be held in Public on 01 August 2023

EXECUTIVE SUMMARY

RWT as Host of the National Institute for Health Research Clinical Research Network, West Midlands (CRN WM) is responsible for ensuring the effective delivery of research in across the health and care sector. This report seeks to provide an overview and assurance to the Trust Board on progress to date in the CRN WM against the Host responsibilities and objectives included within the contract between the DHSC and NIHR Coordinating Centre (NIHR CC).

The data below demonstrates that the CRN WM continues to perform well against the NIHR CRN High Level Objectives (HLO's).

Plans are in place for improvement against the Recruitment to Time and Target (RTT) High Level Objective, however, recruits into commercial trials are well above previous years activity and puts the CRN, WM in a positive position to deliver on the Lord O'Shaughnessy's recommendation of doubling recruitment into commercial clinical trials.

Our Annual Report here has been submitted to the NIHR CC as per instructions however the CRN WM is currently compiling a more comprehensive annual report to recognise and acknowledge all the additional work that has been undertaken.

Engagement with all the six Integrated Care System's (ICS's) across the region is good with a CRN, WM senior leader linked to each Integrated Care Board (ICB) for research.

The CRN WM is forecasting a breakeven year end position.

Through a competitive process RWT has been awarded the contract to Host the new Regional Research Delivery Network, West Midlands (RRDN, WM) from 2024 – 2030 with a budget of circa £30 million a year. Plans are well underway to transition from the current CRN, WM to RRDN, WM.

BACKGROUND INFORMATION

Performance 2022/23 (year end)

HLO Efficient Study Delivery (ESD)	AMBITION & OUTCOME
Studies Closed to Recruitment have achieved their recruitment target	80%
• Closed Commercial Contract Studies	MISS 65% (-19%)
• Closed Non-Commercial Studies	PASS 93% (+16%)
Studies Open to Recruitment are predicted to achieve their recruitment target	60%
• Open Commercial Studies	PASS 66% (+10%)
• Open Non-Commercial Studies	PASS 63% (+6%)

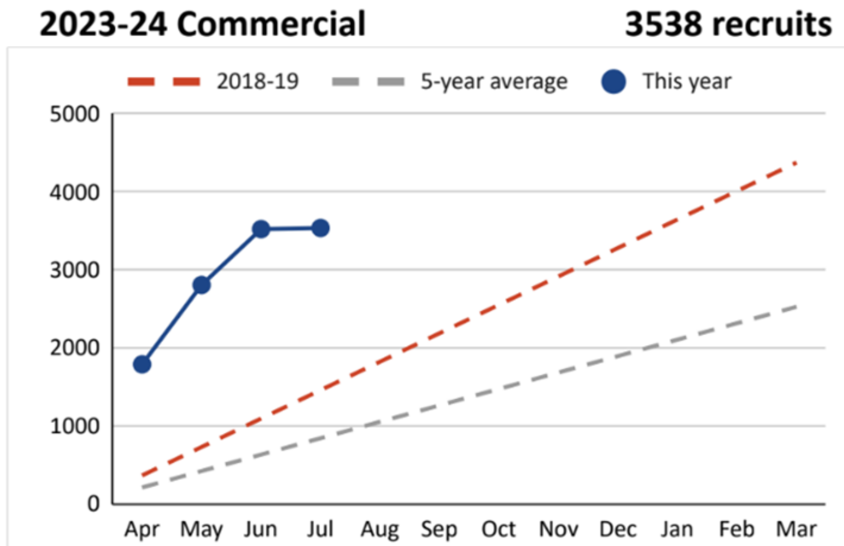
For Efficient Study Delivery (commercial trials) we have identified that where CRN WM are the performance review lead (PRL) we are more likely to achieve over 80% of efficient study delivery. Due to capacity, we have not been taking on this role for new studies, and the Coordinating Centre team have. We are now working on re-prioritising work to take on the PRL role for all WM commercial studies. This model involves engaging with the sponsor to ensure data is correct.

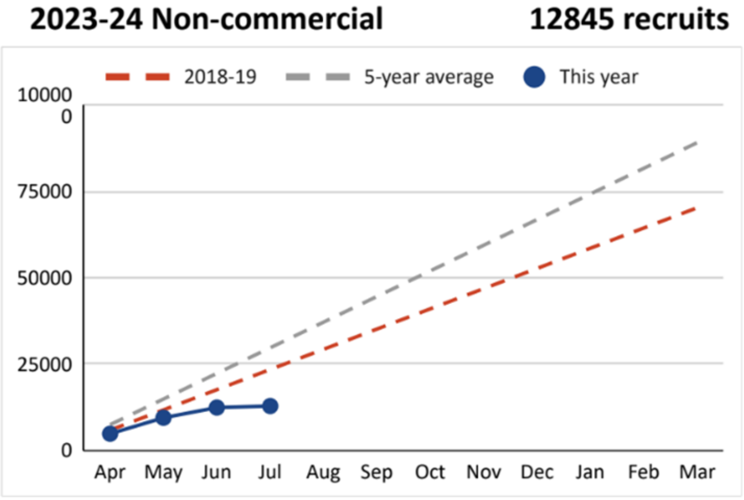
HLO Provider Participation	AMBITION	OUTCOME
Proportion of General Medical Practices recruiting into NIHR CRN Portfolio studies	45%	MISS 34% (-11%)
NHS Acute Trusts with recruitment in NIHR CRN Portfolio studies every quarter	99%	PASS 100% (+1%)
NHS Acute Trusts with recruitment in commercial contract NIHR CRN Portfolio studies every quarter	70%	PASS 80% (+10%)
NHS Ambulance, Care & Mental Health Trusts with recruitment in NIHR CRN Portfolio studies every quarter	95%	MISS 90% (-5%)
Participant Research Experience Survey (PRES) returns	1533	PASS (+7%)
• Proportion of LCRN Trusts (25) Participating in PRES	100%	84% (-14%)
• Proportion of LCRN Study Participants returning PRES	N/A	N/K

Performance 2023/24 to-date

HLO Efficient Study Delivery (ESD)				
Studies Closed to Recruitment have achieved their recruitment target	AMBITION	Unconfirmed PASS	Confirmed PASS	Study Excluded
• Closed Commercial Contract Studies (8)	80% PASS	25% (1/4)	100% (1)	4
• Closed Non-Commercial Studies (14)	80% PASS	83% (5/6)	100% (5)	3
Studies Open to Recruitment are predicted to achieve their recruitment target		INCLUDING Verified On Track	Sponsor Verified "On Track"	Study Excluded
• Open Commercial Studies (60)	80% PASS	75% (45)	43% (26)	3
• Open Non-Commercial Studies (232)	80% PASS	71% (164)	56.5% (101)	15

HLO PRES	AMBITION	Received	Needed
Participant Research Experience Survey (PRES) returns	1533 Returns	492	1041
• Proportion of LCRN Trusts (25) Participating in PRES	26 Trusts	19	07
• Proportion of LCRN Study Participants returning PRES	TBC		





Current Financial Position

The CRN, WM finished 2022/23 with a breakeven position. Please find year end position here and acknowledgement of approval from the NIHR Coordinating centre here.

Please find 2023/24 finance plan here along with the approval of the plan from the NIHR Coordinating Centre here. Income total: £30,378,643

Certain amounts are ringfenced for allocated spend as informed by DHSC. These include the following:
- National Specialty Leads who are employed within WM (£101,968)
- PRIDES Hub - this is a national primary care health informatics research service that is part-led by WM (£49,000)
- National Contract Value Review - this is passed through to our Partner Organisations who undertake a national costings review for commercial companies (£15,085)
- Excess Treatment Costs - these are passed through to Partners via CRN WM and so we are funded to provide this service and also to support the calculations of these for portfolio studies (£97,603)
- Public Health Prevention Research Funding - this is funding provided by DHSC to support the development of a research culture within Public Health in Local Authorities (£77,269)

At month 3 we predict a break-even position at year end.

We are currently awaiting confirmation from Black Country ICB to understand how the additional pay uplift will be funded as CRN staff are not included in RWT activity. However, we are retaining £500k of additional funding provided by DHSC until we have confirmation of the funding. We would require £232k to fulfil the additional 2.9% of salary uplift funding. The remainder/full £500k will then be allocated. We have plans in place to allocate the funding once we have this confirmation, hence a break-even position is being forecasted.

2% 23/24 funding ring fenced for underserved community engagement in research
Each LCRN is required to allocate 2% of its funding on engaging underserved communities in research. We have invested in several strategic projects and individual researchers whose focus is on this, via a competitive process including decision-making panels made up of stakeholder representatives. We report on outputs to the CRNCC and across the CRN.

CRN to RDN
In October 2024 the CRN will cease to exist. In its place will be the Research Delivery Network. Instead of 15 LCRNs there will be 12 Regional Research Delivery Networks. West Midlands partners and geographical boundaries will not change.

A part-time Transition Lead has been appointed by CRNCC to support the current leadership team and the Host to manage the transition to the new RRDNs and new ways of working. Pam Devall (also part-time Deputy Chief Operating Officer) started in the role early July.

An appointment of a Network Director will take place in the next few months. They will form part of the RDN leadership. The aim is to then to co-produce how we deliver our services as one RDN with consistency and meeting customer needs.

RECOMMENDATIONS

The Board is asked to note the content of the report

Approve annual business report 2022/23
Approve annual financial report 2022/23
Approve annual financial plan 2023/24

All the above have been agreed by the CRN, WM Partnership Group, and the Host Executive Group.

Any Cross-References to Reading Room Information/Enclosures:

NIHR EDI Strategy 2022-2027

Paper for submission to the Trust Board Meeting – to be held in Public On 1 August 2023		
Title of Report:	Strategic Delivery Plan – Year 1 (2023/24) of Joint Strategy	Enc No: 12.2
Author:	Tim Shayes - Deputy Chief Strategy Officer – Planning, Performance and Contracting Tel 01902 694366 Email timothy.shayes@nhs.net	
Presenter/Exec Lead:	Responsible Director – Simon Evans, Chief Strategy Officer Email: simon.evans8@nhs.net	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☒No☐	Yes☐No☐	Yes☐No☐

Recommendations:

The Board is asked to approve the Strategic Delivery Plan for 2023/24

Implications of the Paper:			
Risk Register Risk	This delivery plan supports a reduction in associated BAF risks.		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None from the plan specifically		
Report Data Caveats	Not applicable		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details:
	NHSE	Yes☒No☐	Details:
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details:
	NHS Constitution	Yes☒No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	Not applicable		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☒	Date: Various
	Board Committee	Yes☒No☐	Date: Various
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure Delivery metrics, and the relevant sub-committees that oversee them, 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 and objectives aligned both to sub-committees and non-executive director roles.
Alert Some metrics are outside of the control of WHT alone, e.g., PLACE based objectives.

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

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

Report to Trust Board Meeting to be held in Public/Private on -----------------------

EXECUTIVE SUMMARY

The attached, represents the Trusts Strategic Delivery Plan for 2023/24 (i.e., year one of Our Joint Strategy).

Since its presentation to June's board meeting, the objectives for 2023/24 have been aligned to our sub-committee structure and agreed with the respective non-executive chair and lead executive directors.

The sub-committees will oversee progress against the relevant objectives and report progress into Board on a bi-monthly basis (either through existing routine reporting or a bespoke report)

In addition, the objectives of the committees have been aligned to the objectives within this plan and the Deputy Chair is in the process of aligning the personal objectives of the sub-committee chairs to these as well.

RECOMMENDATIONS

The Board is asked to approve the Strategic Delivery Plan for 2023/24.

Paper for submission to the Trust Board Meeting – to be held in Public/Private on 1st August 2023		
Title of Report:	Integrated Quality and Performance Report – June 2023 (quarter 1 23/24)	Enc No: 14
Author:	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 Deputy Chief Strategy Officer - Planning, Performance & Contracting ext 85914 Email: timothy.shayes@nhs.net	
Presenter/Exec Lead:		

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

Recommendations:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or approval.

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

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

Summary of Key Issues using Assure, Advise and Alert
Assure **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.**

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

Executive Summary

Obs on time: increase in performance seen during June 23. A dashboard, which incorporates and triangulates various patient safety metrics is being developed with a prototype to be ready for the Deteriorating Patient Group in August 2023.
C.diff: 2 cases in month against a target of 4. 14 cases have been reported in Q1 with the new target being 53 cases for 2023/24.
MRSA: no cases during June 23.
CHPPD (total nursing): This remains stable and above target. Establishment reviews have been taking place during June 23.
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: the overall target has seen some slight deterioration in month but in line with the trajectory expected for a continued rise throughout 2023/24 as demand from the pandemic restores. From the beginning of June 23 the overall waiting list number now includes the transfer of the Walsall Urology patients. This has grown the waiting list by 2,684 patients.

RTT 78+ week wait: we saw a month end position of 39. This is a significant improvement from the previous month, however, did not achieve the month end target of zero. We continue to monitor these patients in a twice weekly patient level meeting and are utilising mutual aid where available and appropriate.

Diagnostics: performance has shown some improvement and is continuing to show an overall upward trend. The largest waits continue to be in endoscopy, echocardiography and ultrasound. Remedial action plans are in place with an expectation that performance improves throughout 2023/24.

ED 4 hour: performance dipped slightly in month, however, has remained above the new national standard of 76%. A new performance dashboard has been developed and is to be displayed within the Emergency Department to raise awareness. 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. 2ww waiting times continue to be monitored and discussed across the Black Country Trust's.
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: Referral numbers saw an increase during June 23 bringing them back to average expected numbers.
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.

Trust Board Meeting – to be held in Public on 1 August 2023		
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 21 July 2023 – to note this was a virtual meeting	Enc No: To be completed by Board Administrator
Author:	Gayle Nightingale, Executive Assistant to the Group Chief Executive	
Presenter/Exec Lead:	Gwen Nuttall, Chief Operating Officer/ Deputy Chief Executive	

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

Recommendations:

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

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

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 21 July 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure None in this report.
Advise Matters discussed and reviewed at the most recent Trust Management Committee (TMC).
Alert None in this report.

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

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

Report to Trust Board Meeting to be held in Public on 1 August 2023

EXECUTIVE SUMMARY

Chair's report of the Trust Management Committee (TMC) held on 21 July 2023 – to note this was a virtual meeting

BACKGROUND INFORMATION

As per the below.

RECOMMENDATIONS

To note the report.

<table>
<tr><td>1</td><td>Key Current Issues/Topic Areas/ Innovation Items:
• Digital Services – Deliottes
• Elective Care Recovery</td></tr>
<tr><td>2</td><td>Exception Reports
• None this month.</td></tr>
<tr><td>3</td><td>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 3
• Financial Recovery Board Update Report
• Capital Programme Update Report
• Operational Finance Group Minutes
• Black Country Provider Collaboration Update Report</td></tr>
<tr><td>4</td><td>• 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.
• Board Assurance Framework (BAF)/ Trust Risk Register (TRR) Heat Map
• Midwifery Services Report
• Pharmacy and Medicines Optimisation Pharmacy Quarterly Report
• Patient Experience Report
• Mental Health Report
• Revalidation Steering Group Report
• Infection Prevention Report
• Safeguarding Children, Adults and Young People in Care Annual 2022/ 2023 Summary Report</td></tr>
</table>

5	**Business Cases approved - Division 1** • Business Case to Replace the Cardiovascular Tilt Monitor Plus Table • Business Case for a Partnership with Health Harmonie to Improve Gynaecology Community Activity
6	**Business Cases approved - Division 2** • Business Case TA629 Obinutuzumab with Bendamustine for the treatment of Follicular Lymphoma after Retiux • Business Case TA641 Brentuximab Vedotin in Combination for the treatment of Untreated Systemic Anaplastic Large Cell Lymphoma • Business Case TA642 Gilteritinib for the treatment of Relapsed or Refractory Acute Myeloid Leukaemia • Business Case TA651 Naldemedine for the treatment of Opioid Induced Constipation • Business Case TA683 Pembrolizumab with Pemetrexed and Platinum Chemotherapy for the treatment of Untreated Metastatic Non-Squamous Non-Small Cell Lung Cancer • Business Case TA687 Ribociclib with Fulvestrant for the treatment of Hormone Receptor Positive HER2 Negative Advanced Breast Cancer after Endocrine Therapy • Business Case TA691 Avelumab for the treatment of Untreated Metastatic Merkel Cell Carcinoma • Business Case TA740 Apalutamide with Androgen Deprivation Therapy for the treatment of High Risk Hormone Relapsed Non-Metastatic Prostate Cancer • Business Case TA761 Osimertinib for the treatment of EGFPR Mutation Positive Non-Small Cell Lung Cancer after Complete Tumour Resection • Business Case TA763 Daratumumab in Combination for the treatment of Untreated Multiple Myeloma when a Stem Cell Transplant is Suitable • Business Case TA765 Venetoclax with Azacitidine for the treatment of Untreated Acute Myeloid Leukaemia when Intensive Chemotherapy is Unsuitable • Business Case TA766 Pembrolizumab for the treatment of Completely Resected Stage 3 Melanoma • Business Case TA772 Pembrolizumab for the treatment of Relapsed or Refractory Classical Hodgkin Lymphoma after Stem Cell Transplantation or at least Two Previous Therapies • Business Case TA779 Dostarlimab for the treatment of Previously Treated Advanced or Recurrent Endometrial Cancer with High Miro Instability or Mismatch Repair Deficiency • Business Case TA780 Nivolumab with Ipillmumab for the treatment of Untreated Advanced Renal Cell Carcinoma • Business Case TA781 Sotorasib for the treatment of KRAS G12C mutation positive Advanced Non-Small Cell Lung Cancer
7	**Business Cases approved - Division 3** • Business Case TA02997 (NICE TA791) Romosozumab for the treatment of Severe Osteoporosis
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 June 2023 Report • CP54 – Supervision Policy • IP10 – Infectious Disease Isolation Policy • GDL08 – Parkinson's Disease Guidelines • SOP06 – Corporate Records Management – Standard Operating Procedure (SOP)

11	**Other items discussed:** • There were none this month.

Trust Board Meeting – to be held in Public on 1 August 2023		
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 30 June 2023 – to note this was a virtual meeting	Enc No: To be completed by Board Administrator
Author:	Gayle Nightingale, Executive Assistant to the Group Chief Executive	
Presenter/Exec Lead:	Gwen Nuttall, Chief Operating Officer/ Deputy Chief Executive	

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

Recommendations:

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

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Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 30 June 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure None in this report.
Advise Matters discussed and reviewed at the most recent TMC.
Alert None in this report.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
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Chair's report of the Trust Management Committee (TMC)

Report to Trust Board Meeting to be held in Public on 1 August 2023

EXECUTIVE SUMMARY

Chair's report of the Trust Management Committee (TMC) held on 30 June 2023 – to note this was a virtual meeting

BACKGROUND INFORMATION

As per the below.

RECOMMENDATIONS

To note the report.

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 – Month 3 • Financial Recovery Board Update Report • Capital Programme Update Report • Operational Finance Group Minutes • Black Country Provider Collaboration Update Report • Research and Development Report • Infection Prevention and Control Delivery Plan 2022 - 25 (Draft) • National Institute of Health and Care Research (NIHR) Clinical Research Network (CRN) 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.** • Information Governance (IG) Data Protection and Security Toolkit (DPST) 2022-23 final submission • Freedom to Speak Up (FTSU) Annual Report 2022/23 • Equalities Annual Report • Integrated Care Services (ICS) Development - verbal update

5	**Business Cases approved - Division 1** • There were none this month.
6	**Business Cases approved - Division 2** • There were none this month.
7	**Business Cases approved - Division 3** • There were none this month.
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 May 2023 Report • CP61 - Management of the Deteriorating Patient Policy • HR08 - Recruitment and Selection Policy • OP96 - Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult and Paediatric Patients in Hospital and Community Services Policy • SOP27 – Standard Operating Procedure for Work Schedule Reviews and Exception Reporting for Doctors and Dentists in Training • SOP28 – New Standard Operating Procedure for the Discharge Lounge
11	**Other items discussed:** • There were none this month.

Family Hubs and Start for Life Programme

Background/ Context

- Wolverhampton one of 75 areas chosen to take part in Family Hubs & Start for Life Programme –jointly overseen by the DHSC & DfE

The overall aim for the programme is to provide the best support to every family by ensuring:

- **Seamless support for families**: a coherent joined-up Start for Life offer available to all families
- **A welcoming hub for families**: family hubs as a place for families to access Start for Life services
- **The information families need when they need it**: designing digital, virtual and telephone offers around the needs of the family

Background/ National Context

- The Best Start for Life: A Vision for the 1,001 Critical Days -2021
- Healthy Child Programme 0-19 public health services
- Levelling up - Government's manifesto commitment to champion family hubs
- Independent Review of Children's Social Care - 2022
- Ofsted's thematic inspection of early help services
- Early Intervention Foundation
- Best Start to Life – Big Lottery

Funded Areas

Investment and Funding

At the Autumn Budget, the Government committed £301.75m for 75 upper-tier local authorities to deliver start for life and family help services over the next three financial years.

The package contains funding for the following components:

£81.75m* to create a network of Family Hubs

£10m to publish Start for Life offer

£50m for parenting programmes

£100m for infant-parent mental health support

£50m for breastfeeding support

£10m for workforce pilots in small number of LAs

Additional **£24m**** for HLE recovery programmes

* This funding is in addition to previous £39.5m family hubs funding which includes the £12m transformation fund

** This forms part of the £153 million of new funding announced June 2021 to aid early years educational recovery

Finance

Government's investment in the Family Hubs and Start for Life to the City over the life of the programme amounts to 3.6 – 3.7million pounds (lower/ upper range)

Funding Strand	% of Total Funding	Year 1	Year 2		Year 3		Total (Y1-Y3)	
			Lower Range	Upper Range	Lower Range	Upper Range	Lower Range	Upper Range
Family Hubs Programme Spend	19.6%	£177,576	£287,532	£303,604	£240,688	£253,428	£705,796	£734,608
Family Hubs Capital Spend	4.9%	£43,941	£71,150	£75,127	£59,558	£62,711	£174,649	£181,778
Parenting Support	15.7%	£142,242	£230,319	£243,193	£192,796	£203,001	£565,357	£588,436
Home Learning Environment	9.1%	£81,993	£132,764	£140,185	£111,134	£117,017	£325,891	£339,194
Parent-Infant Relationships and Perinatal Mental Health	31.1%	£281,766	£456,237	£481,739	£381,908	£402,123	£1,119,911	£1,165,628
Infant Feeding Support	16.2%	£146,772	£237,654	£250,938	£198,936	£209,466	£583,362	£607,176
Publishing Start for Life Offers and Parent Carer Panels	3.5%	£31,710	£51,345	£54,215	£42,980	£45,255	£126,035	£131,180
Total		£906,000	£1,467,000	£1,549,000	£1,228,000	£1,293,000	£3,601,000	£3,748,000

Project Overview

The programme will:

- provide support to parents and carers so they can nurture their babies and children, improving health and education outcomes for all

- contribute to a reduction in inequalities in health and education outcomes by ensuring that support provided is communicated to all parents and carers, including those who are hardest to reach and/or most in need of it

- build the evidence base for what works when it comes to improving health and education outcomes for babies, children and families in different delivery contexts

Will achieve this by …

Transforming the way services are designed and delivered

- increasing the family hub model supporting children of all ages
- improving how local services share information and work together to provide holistic support for families (to address the fragmented services some families currently experience)
- ensuring that the Start for Life offer is clear, accessible and seamless, and voices of parents and carers are sought to influence the continuous improvement of the offer

Will achieve this by continued …

Universal Start for Life and family services

- enhancing and expanding services which seek to identify and address needs at an early stage before more specialist support is required

Tailored support for vulnerable communities

- ensuring additional targeted interventions which support vulnerable and under-served populations are included as part of the offer and delivered through the family hub model

Will achieve this by …

Workforce capacity and capability

- creating capacity through new workforce models that incorporate skill mix
- facilitating join-up of the multi-professional workforce to provide continuity of care to all families
- improving multi-agency training, addressing existing skill gaps, and ensuring empathy is at the heart of practice

Understanding what works and sharing best practice

Local Context

Contribute to improving key outcomes with a focus on first 1001 days ;

- Babies , Infants , Maternal, Parents and Carers (Dads / Grandparents)

Links to the Joint Local Health and Wellbeing Strategy
(Starting and Growing Well Theme):

First 1001 days, including support for parents, and maternal mental and physical health

Emotional health and wellbeing of children and young people

Good level of development and school readiness

Local Context

Council Plan objectives :

- Strong families where children grow up well and achieve their full potential
- Fulfilled lives for all with quality care for those that need it
- Healthy, inclusive communities
- Good homes in well-connected neighbourhoods
- More local people into good jobs and training

The project spans and is inclusive of several initiatives & transformation including:

- Financial Wellbeing
- Supporting Families
- Families front door
- SEND- Strategy & Local Offer
- Digital Wolverhampton
- Love your Community
- Early Years provision –terrific for two
- Public Health programmes eg healthy pregnancy

One Wolverhampton- CYP strategic group priorities

Our Priorities	This means we will	We will do this by
Delivering the first 1,001 days agenda	Ensure a partnership approach is taken to giving our children and young people the best start for life	• Develop an extensive campaign on the importance of the first 1001 days • Using the ‘Five to Thrive’ model to support healthy brain development in babies • Developing a pregnancy offer, including weight management, smoking cessation, and perinatal mental health • Ensuring seamless and timely care from midwives and Health Visitors • Develop an infant feeding strategy and plan that normalises breastfeeding and expands peer support roles
Improving the uptake of Childhood immunisations	Work with communities to understand and remove barriers to childhood immunisations	• Completing insight work into the understanding and attitudes of parents on childhood immunisation • Developing a vaccination model to improve the uptake of childhood immunisations, starting with a focus on MMR and children in care • Piloting a roving vaccination model
Improving early diagnosis and ongoing care for children with asthma	Co-produce a pro-active asthma care programme which supports people to stay well and reduces the need for secondary care escalation	• Co-producing an asthma care programme, building on the Young Health Champions model • Reviewing every child diagnosed with asthma on an annual basis • Identify opportunities to mitigate the impact of housing and environmental factors on asthma • Enhancing joint primary-secondary care working
Supporting children, their parents and carers to maintain a healthy weight	Take a whole-family approach to healthy weight management, incorporating nutrition, physical activity and child development to support families	• Developing a multi-partner approach to improving healthy weight & activity • Enhancing the physical activity offer and participation in the DfE School food pilot • Participation in RCT of ‘HENRY’ (whole-family nutrition, healthy weight and child development programme) • Collating measurement data at the 2-year developmental review to better understand weight status during the early years
Improving the oral health of our children	Promote and encourage good oral health for our children	• Understanding dental care availability in Wolverhampton • Improving the oral health education offer • Ensuring access to oral health products for priority and vulnerable groups • Instilling good brushing behaviours in preschool children within targeted wards of the city
Expanding the support for	Deliver the recommendations	• Implementing a Charter Mark to drive a whole school approach to emotional health and wellbeing

Key milestones/ Progress

CYP Needs Assessment (JSNA- starting well)

- Including maternal/ perinatal health and wellbeing
- Vulnerabilities and Protective factors in pregnancy and early parenthood
- Family Hub locality profiles
- Community Engagement

SELECT DOCUMENT RESTRICTION LEVEL Go to the 'Insert' menu option and click 'Header and Foote
one of the following options then click 'Apply to All' >> Not Protectively Marked >> PROTECT >>

Individual factors

Vulnerability factors

- Age<20 years
- Language difficulties
- Learning difficulties
- Learning disability
- Unintended pregnancy
- Own experience of being parented
- Black, Asian and Minority Ethnic
- Immigrants with no recourse to public funds
- Asylum seekers/recent migrants/refugees

Protective factors

- Secure attachment experience
- Educational attainment
- Individual's resilience
- Planned pregnancy
- Positive parenting/childhood experience
- Self-efficacy: belief in ability to succeed
- Good professional/therapeutic relationship
- The potential to be a role model to peers

Lifestyle factors

Vulnerability factors

- Substance use status
- Alcohol misuse
- Smoking
- Maternal obesity

Protective factors

- Self-care
- No non-medicinal drugs or unauthorised substances
- No alcohol
- No smoking and living in a smoke-free environment
- Participation in sport or leisure activities

Social factors

Vulnerability factors

- Low educational attainment
- Homeless/housing issues
- Low income/financial difficulties
- Food insecurity
- Mum, partner/father, baby or sibling known to social care as child or adult
- Abuse in adulthood – rape, sexual exploitation
- Not engaging with maternity care
- Looked after children (LAC)

Protective factors

- Perceived financial security
- Genuine engagement with services
- Clean and safe living environment
- Access to education and information

Health and Wellbeing

Vulnerability factors

- Perinatal mental health
- Physical disability/serious medical condition
- Child disability/serious medical condition
- Previous obstetric/medical history
- Low birth weight/extremely premature
- Multiple pregnancy
- Female Genital Mutilation (FGM)

Protective factors

- Access to services, local amenities and healthcare
- Stable mental health
- Breastfeeding
- Good health

Support network, family and relationships

Vulnerability factors

- Adverse Childhood experiences (ACE)
- Children affected by parental imprisonment
- Police involvement/criminal activity
- Unstable family relationships
- Bereavement of close family member
- Social isolation
- Domestic abuse partner/close family
- Single pregnant mother/single parent
- Traveller/Boating communities

Protective factors

- Stable family and friend relationships
- Wider family and support network
- Experiencing a positive, trusted relationship
- Strong family values
- Involvement in social interest groups and activities
- Helping with community projects

Key milestones/progress cont…

Start for Life Offer published on Wolverhampton Information Network -further work to develop digital offer pathways and join up across Start for Life services to ensure support is available and tailored when needed.

Parent Carer Panels – identified as good practice

Integrated Accessible Inclusive Family Hubs

- Wolves Online- All hubs designated trusted partners for digital inclusion; provision of free devices and data for community use
- Additional Clinical rooms established to provide antenatal, maternity and child development clinics.
- Child development clinics operating.
- Extended opening times to facilitate weekend child development clinics to enable working parents to access Health Visitor advice
- Embedding the Graduated Response to Special Educational Needs & Disabilities
- Independent Advice & Support Service presence within Hubs
- Financial Wellbeing Co-ordinators Citizens Advice Welfare rights providing training to universal practitioners in Hubs.
- Registration point for HAF with some activities running within Family Hubs sites.
- Birth Registration

Services provided from within the Family Hub, include:

Midwives & Health Visitors

Infant Feeding Support

Emotional Health & Wellbeing

Stay and Play Sessions

Parenting Support

Housing Support

Benefits & Welfare Rights Advice

Employment & Training

Special Educational Needs and/or Disabilities (SEND) Support

Out Of School Activities

Birth Registrations

Adult Education

Launch as Family Hubs Site **9 May 2023**:

7. Low Hill Strengthening Families Hub
   26-28 Fourth Avenue, Low Hill, Wolverhampton, WV10 9LZ
   Serving: Low Hill & The Scotlands
6. Dove Strengthening Families Hub
   Grangefield Close, Ryefield, Wolverhampton, WV8 1XF
   Serving: Bushbury, Oxley & Pendeford
   To be incorporated into Oxley Health and Wellbeing Hub by ***2025***

Launch as Family Hubs Site **22 May 2023**:

4. Bingley Strengthening Families Hub
   Norfolk Road, Pennfields, Wolverhampton, WV3 0JE
   Serving: Penn, Merry Hill & Penn Fields

Launch as Family Hubs Site by **June 2023:**

2. Rocket Pool Strengthening Families Hub
   25a Rocket Pool Drive, Bilston, Wolverhampton, WV14 8BH
   Serving: Bilston, Bradley & Ettingshall
   To be incorporated into Bilston Health and Wellbeing Hub by ***2026***

Launch as Family Hubs Site by **July 2023**:

1. Eastfield, Eastfield Strengthening Families Hub
   Colliery Road, Wolverhampton Postcode: WV1 2QY
   Serving: East Park, Eastfield & Portobello
3. Graiseley Strengthening Families Hub
   Pool Street, Blakenhall, Wolverhampton, WV2 4NE
   Serving: Blakenhall, Springvale & All Saints
5. Whitmore Reans Strengthening Families Hub
   Lansdowne Road, Whitmore Reans, Wolverhampton, WV1 4AL
   Serving: Tettenhall, Whitmore Reans & Dunstall
8. The Children's Village Strengthening Families Hub
   Graiseley Lane, Wednesfield, Wolverhampton, WV11 1PE
   Serving: Wednesfield, Heath Town & Ashmore

Family Hubs Delivery

Locality Partnership Boards have been established consisting of senior representatives from all local partners – both statutory and the voluntary and community sector (VCS) and will identify priorities for the communities underpinned by locality JSNA and intelligence, develop the local offer and evaluate the impact of early help services on outcomes for children and young people.

Integrated Leadership Teams (ILT) are being developed consisting of operational managers from all key local partner agencies working with families and will operate each of the hubs with the aim of streamlining and developing joint plans and evidence-based practice in response to their understanding of local need.

Forums for each family hub have been developed where parents and carers, young people and other community members provide feedback on design and development of services to help improve their lives and their community. Parents and carers will be an integral part of each ILT.

An Organisational Development Lead is working across the partnership to coordinate delivery of a multi-agency, graduated training offer that encompasses an I Thrive approach from signposting though to delivery of research-based programmes and ensures there is a consistent relational approach embedded across all sectors working with children and families.

Opportunities to link services offered to families through family hubs with supporting families programme and family help models of delivery

Key milestones cont…

Infant feeding/ breastfeeding

- Multidisciplinary infant feeding strategy produced
- Recruiting additional 3 Infant Feeding Support roles
- Expanded infant feeding peer support service including a Peer Support Co-ordination role and training, travel, phone and other expenses for volunteers.
- Creation of breastfeeding friendly environments in each of the Hubs and breastfeeding support groups at 4 hubs (to be extended to all 8).

Parenting Support – universal to targeted offer

- Parenting support team established in hubs and delivering evidence-based training programmes including Reducing Parental Conflict, Journey of Change and Circle of Security, as well as offering train the trainer to support to partner agencies.
- Solihull Approach being embedded across programmes of work
- Creation of universal service practitioner posts to provide targeted support for parents around nurture and the home learning environment.
- Five to Thrive training to frontline staff to encourage all to understand the basics of early brain development and the five building blocks/approaches

Key milestones cont…

Maternal / Perinatal Mental Health and Wellbeing

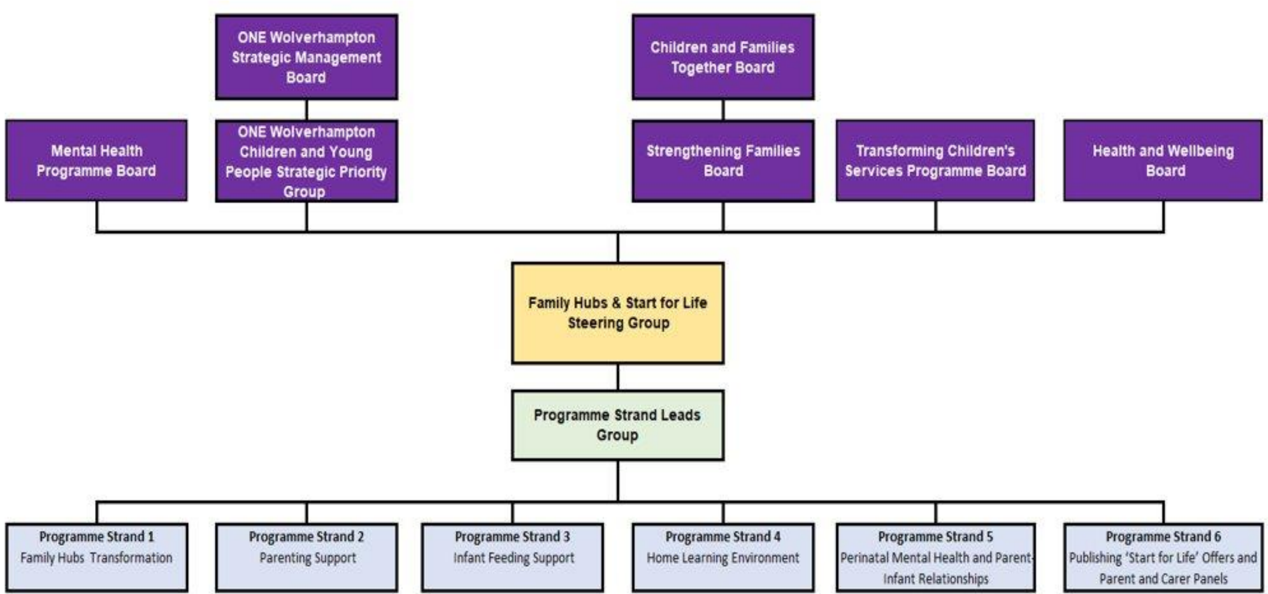
- All frontline staff to be provided with mental health first aid training.
- Use of 5 ways to wellbeing tool to be embedded in service delivery.
- Perinatal Mental Health lead roles in Healthy Child programme and recruitment to 3 perinatal mental health support posts ,recruitment through Local Authority
- Links to school emotional health & wellbeing services.
- Pathways into perinatal services and development of parent infant specialised team

Good level of development and school readiness (Home Learning Environment)

- Delivery of Early Talk Boost and the REAL project online and face to face to provide information and activities for families to improve school readiness.
- A range of pre-school, Stay & Play family engagement sessions, including communication, language, interactions and independence, both antenatal and postnatal delivered from Hubs
- All Family Hub staff trained to complete free childcare offer eligibility checks and signpost to provision
- Family Learning provided by Adult Education; ICT, numeracy, literacy, ESOL, vocational training
- Work with SLT Services to produce improved speech, language and communication
- Integrated 2 1/2 year development reviews

Governance

- Overarching Multi-agency Partnership Board in place reporting to Councils Transforming Children's Services Board, Children & Families Together Board and One Wolverhampton .



Performance Monitoring

There will be three elements of reporting:

- programme delivery returns
- financial returns
- management information

Taken together, these reporting expectations will provide us with the data we need to:

- monitor programme delivery
- develop the evidence base
- understand what good delivery looks like
- identify areas where additional support is required

Measuring Impact

	Benefit	How measure to show the benefit has been delivered?	How are you going to measure the benefit?
001	Increased accessibility for families to more of the services they need, through a single point of access	Family usage of Family Hubs and digital/virtual offer	Capture of attendance usage through systems which will be recorded in MI return
002	Increased awareness and uptake of family hub services, including by disadvantaged and vulnerable groups	Recording of EDI data on registration/ evaluation	Capture of attendance usage through systems which will be recorded in MI return
003	Improved experience for families of navigating services and reduced need for families to 'tell their story' more than once	Family surveys to demonstrate experience	Analysis of data collected through family surveys
004	Increased efficiency for professionals and services and more effective collaboration, leading to improved support for families	Outcomes Data	Analysis of data collected through referral, throughput & outcomes data. Dip samples & observation.
005	Increased consideration of a whole family's needs, leading to more appropriate and timely support	Family surveys to demonstrate experience	Analysis of outcomes data and qualitative feedback from family
006	Strengthened relationships within families and between them and professionals	Family & workforce surveys to demonstrate experience	Analysis of data collected through family surveys

Family Hubs & Start for Life – the foundations for a Healthy Start & Healthy Life Expectancy

Thankyou

Any Questions ?

Any Questions

SELECT DOCUMENT RESTRICTION LEVEL Go to the 'Insert' menu option and click 'Header and Footer...' Select from one of the following options then click 'Apply to All'   >> Not Protectively Marked >> PROTECT >> RESTRICTED <<

Annual Development Session

22 June 2023

OneWolverhampton and

Children and Young People Strategic Working Group Overview

Siân Thomas and Bal Kaur

An overview

Who are we

Board partners

Wolverhampton South East Collaborative PCN

Delivery partners

What are we trying to do?

General Practice – QOF/DES	Public Health Outcomes Framework	NHS Outcomes Framework	Adult Social Care Outcomes Framework
Neighbourhood inequalities	1. Improving the wider determinants of health		
Public Health – smoking, obesity, blood pressure, cervical screening	2. Health improvement		
	3. Health protection		
Early cancer diagnosis, LD, CVD diagnosis and prevention	4. Healthcare public health and preventing premature mortality	1. Preventing people from dying prematurely	
Clinical prevalence – detection and management of LTCs, medication reviews		2. Enhancing quality of life for people with long term conditions	1. Enhancing the quality of life for people with care and support needs
			2. Delaying and reducing the need for care and support
		3. Helping people to recover from episodes of ill health or following injury	
Enhanced Health Care Homes, anticipatory & personalised care		4. Ensuring that people have a positive experience of care	3. Ensuring that people have a positive experience of care and support
		5. Treating and caring for people in a safe environment and protecting them from avoidable harm	4. Safeguarding adults who are vulnerable and protecting them from avoidable harm

Indicator	Period	Wolves Recent Trend	Wolves Count	Wolves Value	Region Value	England Value	England Worst
E01 - Infant mortality rate	2018 - 20	–	62	6.3	5.6	3.9	6.8
E02 - Percentage of 5 year olds with experience of visually obvious dental decay	2018/19	–	-	24.9%	22.7%	23.4%	50.9%
E03 - Under 75 mortality rate from causes considered preventable (2019 definition) (1 year range)	2020	➡	406	193.7	156.5	140.5	272.5
E03 - Under 75 mortality rate from causes considered preventable (2019 definition) (3 year range)	2017 - 19	–	1,110	181.0	151.6	142.2	265.2
E04a - Under 75 mortality rate from all cardiovascular diseases (1 year range)	2020	➡	224	108.1	84.8	73.8	137.1
E04a - Under 75 mortality rate from all cardiovascular diseases (3 year range)	2017 - 19	–	654	108.2	77.0	70.4	121.6
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) (1 year range)	2020	➡	88	42.6	34.3	29.2	55.0
E04b - Under 75 mortality rate from cardiovascular diseases considered preventable (2019 definition) (3 year range)	2017 - 19	–	273	45.2	31.2	28.1	49.3
E05a - Under 75 mortality rate from cancer (1 year range)	2020	➡	289	140.5	133.2	125.1	187.1
E05a - Under 75 mortality rate from cancer (3 year range)	2017 - 19	–	892	147.4	135.0	129.2	182.4
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition) (1 year range)	2020	➡	129	63.2	55.4	51.5	98.2
E05b - Under 75 mortality rate from cancer considered preventable (2019 definition) (3 year range)	2017 - 19	–	371	61.9	56.1	54.1	92.4
E06a - Under 75 mortality rate from liver disease (1 year range)	2020	➡	76	35.3	24.0	20.6	44.9
E06a - Under 75 mortality rate from liver disease (3 year range)	2017 - 19	–	183	29.3	20.9	18.8	48.2
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition) (1 year range)	2020	➡	74	34.4	21.7	18.2	37.8
E06b - Under 75 mortality rate from liver disease considered preventable (2019 definition) (3 year range)	2017 - 19	–	164	26.3	18.8	16.7	43.4
E07a - Under 75 mortality rate from respiratory disease (1 year range)	2020	➡	68	33.8	31.8	29.4	77.2
E07a - Under 75 mortality rate from respiratory disease (3 year range)	2017 - 19	–	259	43.2	35.6	33.6	77.5
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition) (1 year range)	2020	➡	35	17.4	18.0	17.1	53.7
E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition) (3 year range)	2017 - 19	–	142	24.1	20.9	20.2	45.4
E08 - Mortality rate from a range of specified communicable diseases, including influenza (1 year range)	2020	➡	27	11.3	9.6	8.3	16.4
E08 - Mortality rate from a range of specified communicable diseases, including influenza (3 year range)	2017 - 19	–	114	16.1	10.3	9.4	17.0
E09a - Premature mortality in adults with severe mental illness (SMI)	2018 - 20	–	565	115.7*	110.7*	103.6	212.4
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	2018 - 20	–	-	308.5%	425.8%	451.0%	714.7%

NHS

REDUCING HEALTHCARE INEQUALITIES

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

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

Target population

20%

CORE20 PLUS 5

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

Key clinical areas of health inequalities

1. MATERNITY: ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups
2. SEVERE MENTAL ILLNESS (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
3. CHRONIC RESPIRATORY DISEASE: a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
4. EARLY CANCER DIAGNOSIS: 75% of cases diagnosed at stage 1 or 2 by 2028
5. HYPERTENSION CASE-FINDING: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

Single | Explore | Compare

Settings

Display: Cause | Risk

Measure: Deaths | YLDs | DALYs

Location: Wolverhampton

Year: 2019

Age: All | <5 | 5-14 | 15-49 | 50-69 | 70+

Sex: Male | Female | Both

Take tour ▶

IHME

Wolverhampton
Both sexes, All ages, 2019, Deaths

IHD, Stroke, Lung C, Colorect C, Stomach C, Endocrine, LRI, Breast C, Liver C, Esophag C, Leukemia, Brain C, Prostate C, Kidney C, Bladder C, Pancreas C, Myeloma, Lymphoma, Uterus C, Skin C, HTN HD, CMP, A Fib, Valvular, Oth Cardio, Aort An, PAD, Diabetes, CKD, Cirrhosis, Falls, COPD, ILD, Ileus, Gall Bile, Oth Digest, IBD, Vasc Intest, Bac Skin, Drugs, Alcohol, Alzheimer's, Parkinson's, MS, ALS, Self Harm

Annual % change 2014 to 2019 Deaths/100,000

-3%, -2%, -1%, 0%, 1%, 2%, 3%

Very low wellbeing	Below average wellbeing
Underweight	Used to smoke
Obese & average wellbeing	Overweight
Healthy weight poor lifestyle	Vigorously active
Drinkers & smokers	Healthy eaters

% in most deprived quintile: 40, 50, 60, 70, 80

% male: 40, 50, 60, 70

Our mission statement

Our Partnership commitments

- **We commit to** develop a shared understanding of the needs and preferences of our population.
- **We commit to** working as if the budgets, assets and capabilities of in-scope services were held in common, supported by jointly developed enabling strategies.
- **We commit to** collaboratively (re-)design the services that respond to population need so they better align to our shared outcomes.
- **We commit to** establish a sustainable model for the governance and management of OneWolverhampton that optimises the integration of partnership delivery and commissioning processes.
- **We commit to** continuous learning from the work we do together.
- **We commit to** developing an integrated workforce model for health and care.

How are we working together?

Our outcome domains

Domain 1 - Population Health & Wellbeing

Right care, right place, right time

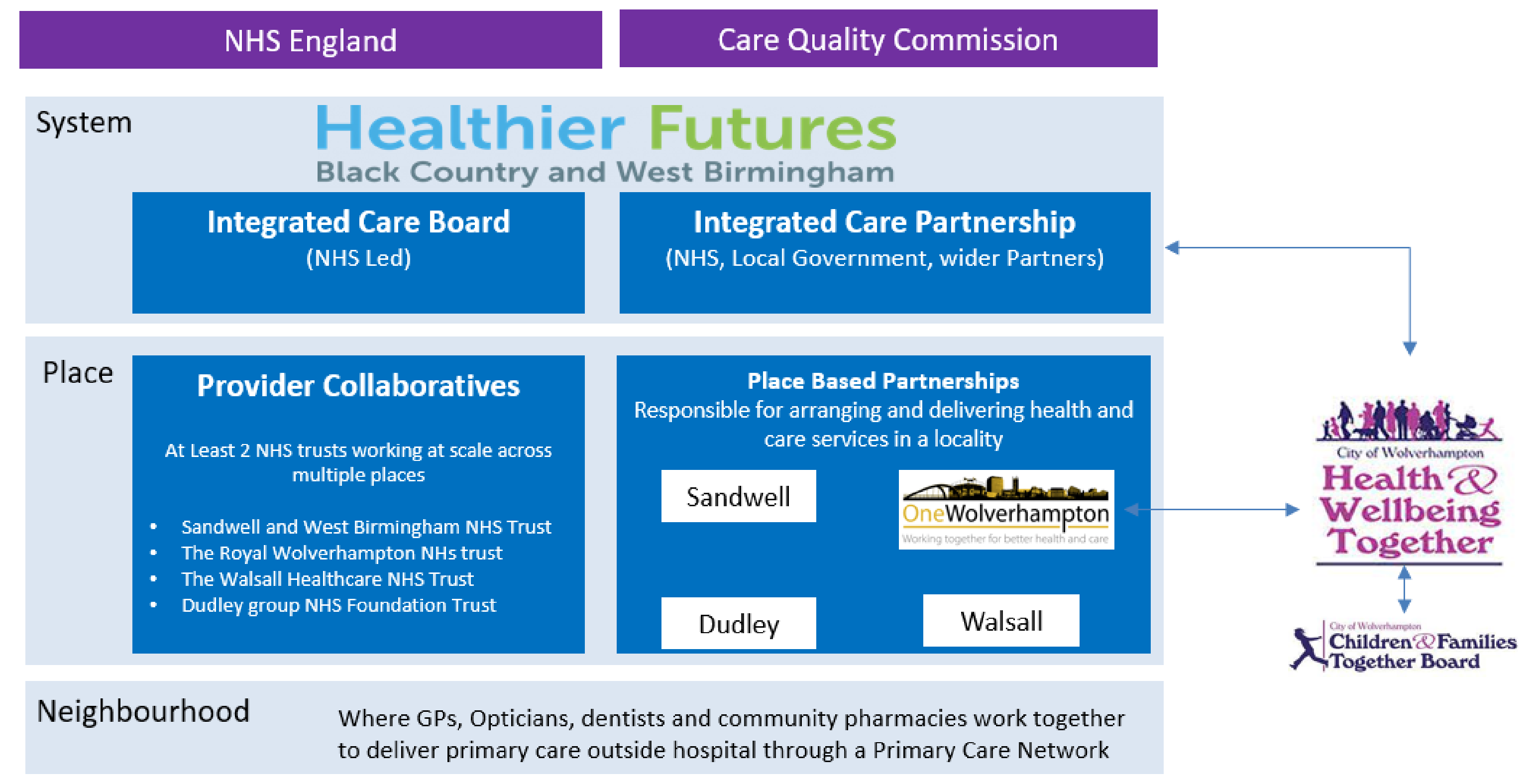
Domain 2 -Service User Experience

Put people at the heart of what we do

Domain 3 -System infrastructure

Work better together

External governance



Internal Governance

OneWolverhampton
Working together for better health and care

Place Board

Place Execs

Clinical & Professional Leadership Group

Research

HI

Education

$1^0 – 2^0$ interface

Place Management Committee

Strategic Working Groups

CYP

Primary care development

Adult MH

U&E Care

CCH

Living Well

Enablers

Estates

Digital

Workforce

Comms & engagement

CCH	UEC	AMH	PCD	CYP	LW
Home first is our approach	Urgent care when needed	Mental health is everyone's business	Investing in primary care	The best start to life	Prevention, prevention, prevention
Enhancing our integrated **care co-ordination** function.	Delivering an integrated approach to **demand and capacity planning**	Prioritising the **prevention and promotion** offer	Developing **new primary care** services to deliver more care closer to home	Raising the importance of the **first 1001 days**	Increasing **cancer screening** rates for breast, bowel and cervical
Expanding services in the community that provide **alternatives to urgent hospital care**	Helping people with urgent needs access the **right care first time**	Delivering the national Community **Mental Health Transformation** programme	Enabling people to live well with their **long-term condition**	Improving the uptake of **childhood immunisations**	Improving **health check uptake** to deliver a preventative approach
Ensuring effective and appropriate **discharge from hospital (pull)**	Ensuring a **timely experience** when accessing urgent care	Improving the **physical health** of people with a mental health diagnosis	Supporting patients with complex needs through a strong **MDT approach**	Improving early diagnosis and ongoing care for children with **asthma**	Improving diagnosis and care for people with **dementia**
Delivering a high quality **care home** offer	Expanding new services in the community that provide **alternatives to bed based care**	Improving care for people with co-existing **substance misuse and mental health** problems	Improving the primary and secondary care **interface**	Supporting children, their parents and carers to maintain a **healthy weight**	Delivering **health and wellbeing hubs** across the city
Supporting people to **age well**	Ensuring effective and appropriate **discharge from hospital (push)**	Embedding **suicide prevention** approaches across the city	Enabling a resilient primary care **infrastructure**	Improving the **oral health** of our children	Developing our local offer for **healthy lifestyle services**
Delivering a high-quality **palliative and end of life** service				Improving the support for children's **mental health and emotional wellbeing**	

Introduction to children's oral health in Wolverhampton

Youth reps survey

Anna Hunt [pre-recorded]: Black Country context

Louise Sharrod: Wolverhampton Context

Dr Afy Ilyas: Local Dental Committee Perspective

Caroline Bestwick and Laura Ceaser-Kennedy: Specialist Dentistry Perspective

Youth reps survey

- 28 responses
- Age range 13-18 (majority 17)
- 22 girls; 3 boys; 2 prefer not to say; 1 non-binary
- Live in a range of areas in the city
- Unrepresentative sample, self-selecting – snapshot of young people's thoughts and feelings

Findings

Do you visit the dentist on a regular basis - every 6-12 months?

- 20 yes; 8 no.

Can you easily access to a dentist?

- 27 yes; 1 no due to moving house

How can young people avoid oral health problems?

- Brushing your teeth regularly/ floss etc. 15
- Regularly attend dentist and listen to their advice 12
- Low sugar diet 8
- More education 3
- Stop vaping 3
- Self-care 1
- Don't smoke 1
- Don't drink alcohol 1

Do you think the cost of dental products is an issue for young people and their families?

- Maybe 16
- Yes 8
- No 4

Findings

Do you have a fear/phobia of visiting the dentist?

- No 20
- Yes 8

Which of the following do you use?

- Manual toothbrush 19
- Mouthwash 15
- Electric toothbrush 9
- Floss 5

How many times a day do you brush your teeth?

- Once 3
- Twice 20
- More 5

How often do you change your toothbrush?

- Majority 2-3 months; least often once a year.
- Other comments:
  - “When it wears out”
  - “When my mom decides”
  - “When I can afford it”

Findings

How is dental hygiene taught in schools?

- 8 could remember it being taught in primary school, but majority said it wasn't taught in their school.

What impactful key messages would you have around oral health?

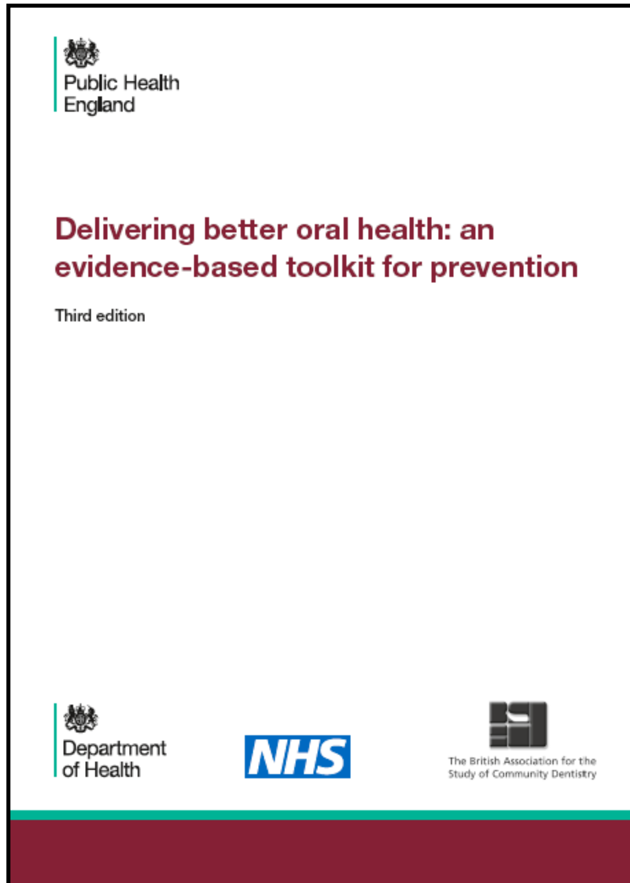
- "It's okay to not have the energy to take care of yourself, sometimes you might forget or just not want to get up and sort it because your already in bed. Set reminders and positive messages, it's very important for you to force yourself to get up even when you just want to let the world pass you by. Keep moving and give yourself a schedule."
- "It is so important for confidence"
- "Listen to your dentist!!"
- "Everyone should have equal access to quality and affordable dental care."
- "Vaping rots the back of your teeth, so just don't vape. Simple."

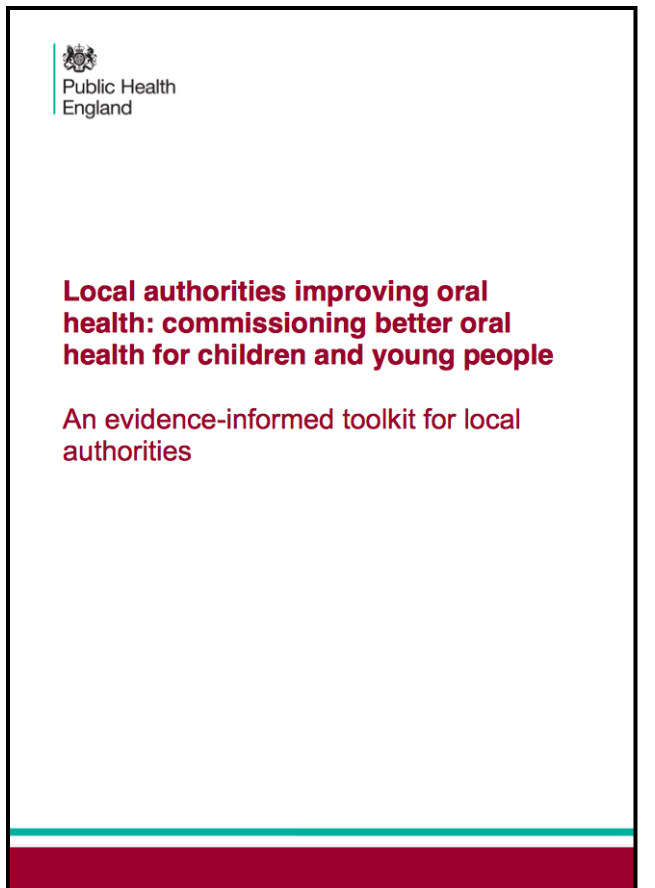
"Healthy mind, healthy teeth = happier life"

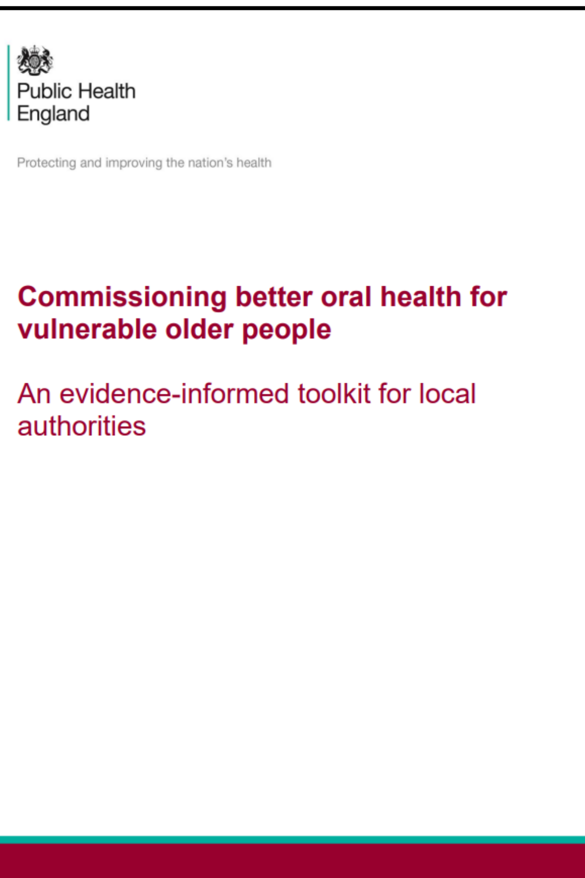
Oral Health Improvement in Wolverhampton

Anna Hunt, Consultant in Dental Public Health, NHS England

Evidence based/informed toolkits







Oral health improvement interventions - CYP

PHE reviewed a number of population level interventions for oral health improvement and graded them – recommended / emerging / limited value / discouraged.

Nine were ‘recommended’:

1. **Oral health training for the wider professional workforce**

   eg training HVs / teachers / pharmacists to deliver OH advice

2. **Integration of oral health into targeted home visits** by health/social care workers

   eg integrating oral health messages into family nurse partnership programme / troubled families programme

3. **Targeted community-based fluoride varnish programmes**

   eg fluoride varnish programmes in schools

4. **Targeted provision of toothbrushes and fluoride tooth paste** (i.e. postal or through health visitors)

   eg toothbrush & toothpaste handed out by HV at child development checks & by post

Oral health improvement interventions – CYP (cont'd)

5. Supervised tooth brushing with fluoride toothpaste in targeted childhood settings

eg toothbrushing programmes in schools

6. **Healthy food and drink policies** in childhood settings

eg nutritional standards in school canteens, school policies on celebration & reward foods, providing drinking water

7. **Fluoridation of the public water supplies**

ie to increase level of fluoride in water to optimum concentration for oral health

8**. Targeted peer (lay) support groups/peer oral health workers**

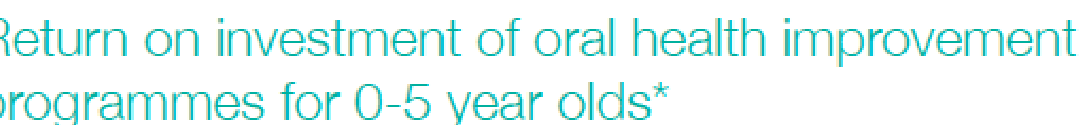
eg peer-led programmes within an ethnic minority community helping to improve OH knowledge & supporting behaviour change

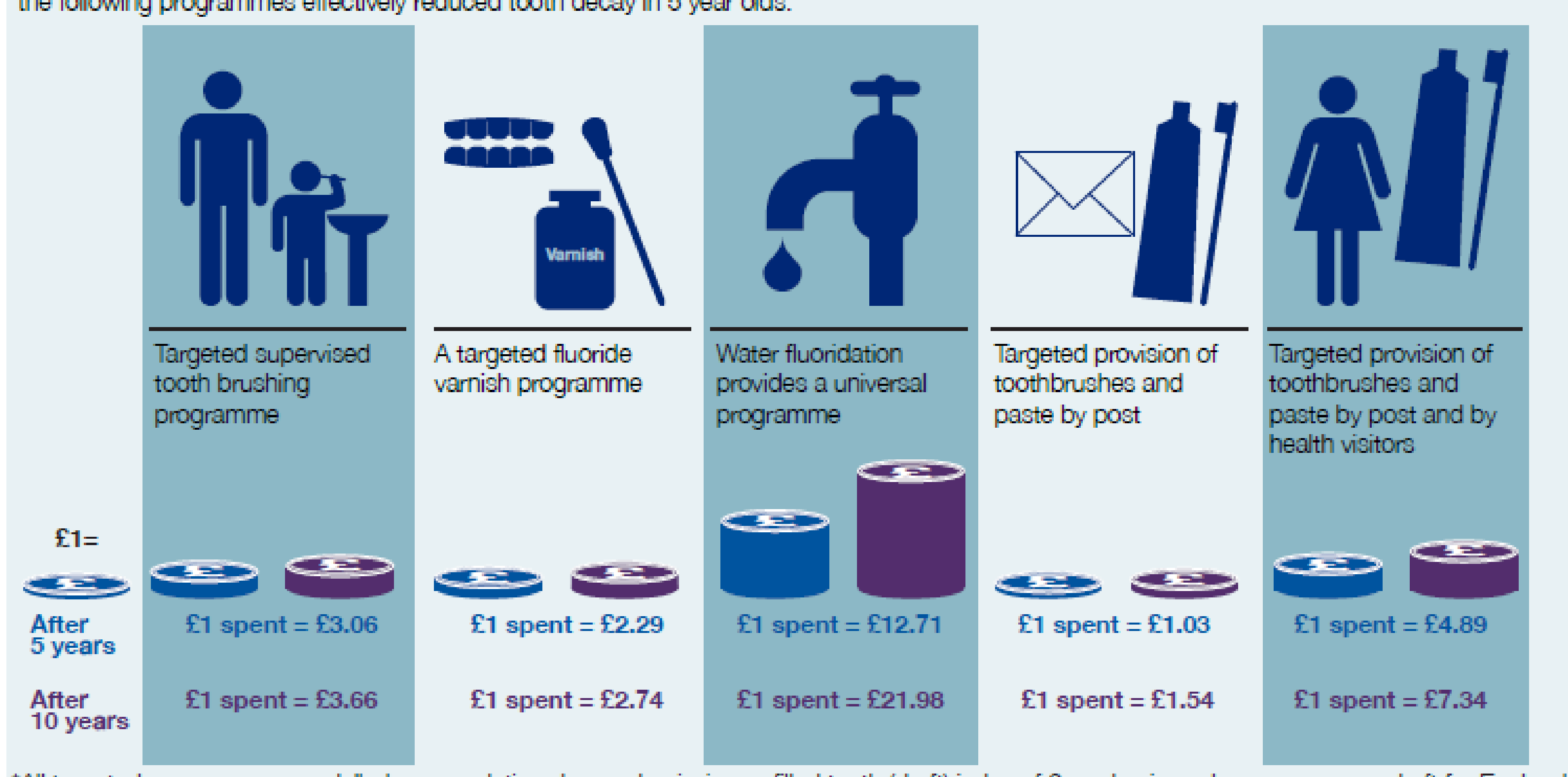
9. **Influencing local and national government policies**

eg PH input into planning decisions to restrict take away outlets near schools, tighter controls on labelling or sugary food & drink

Public Health
England

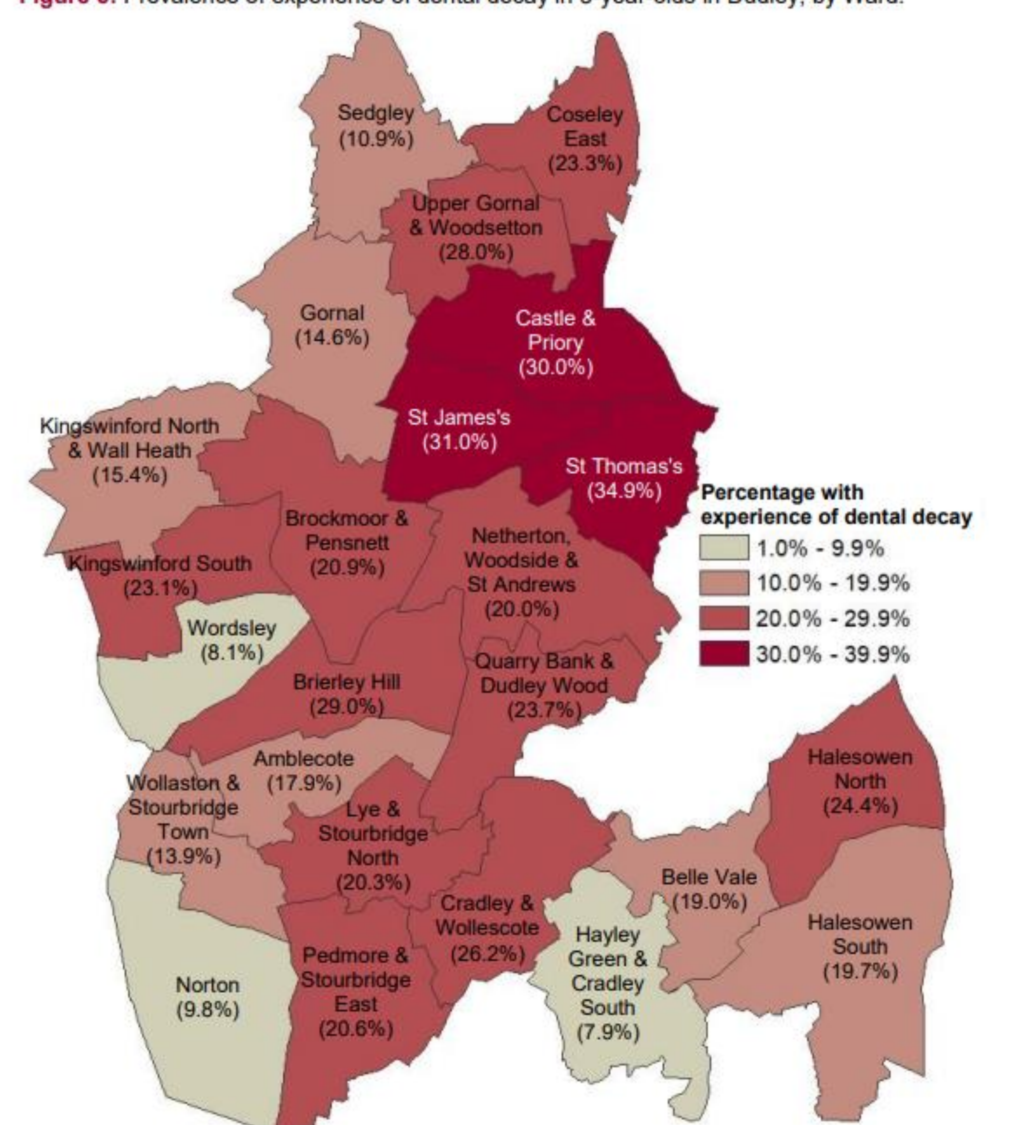
NHS
England

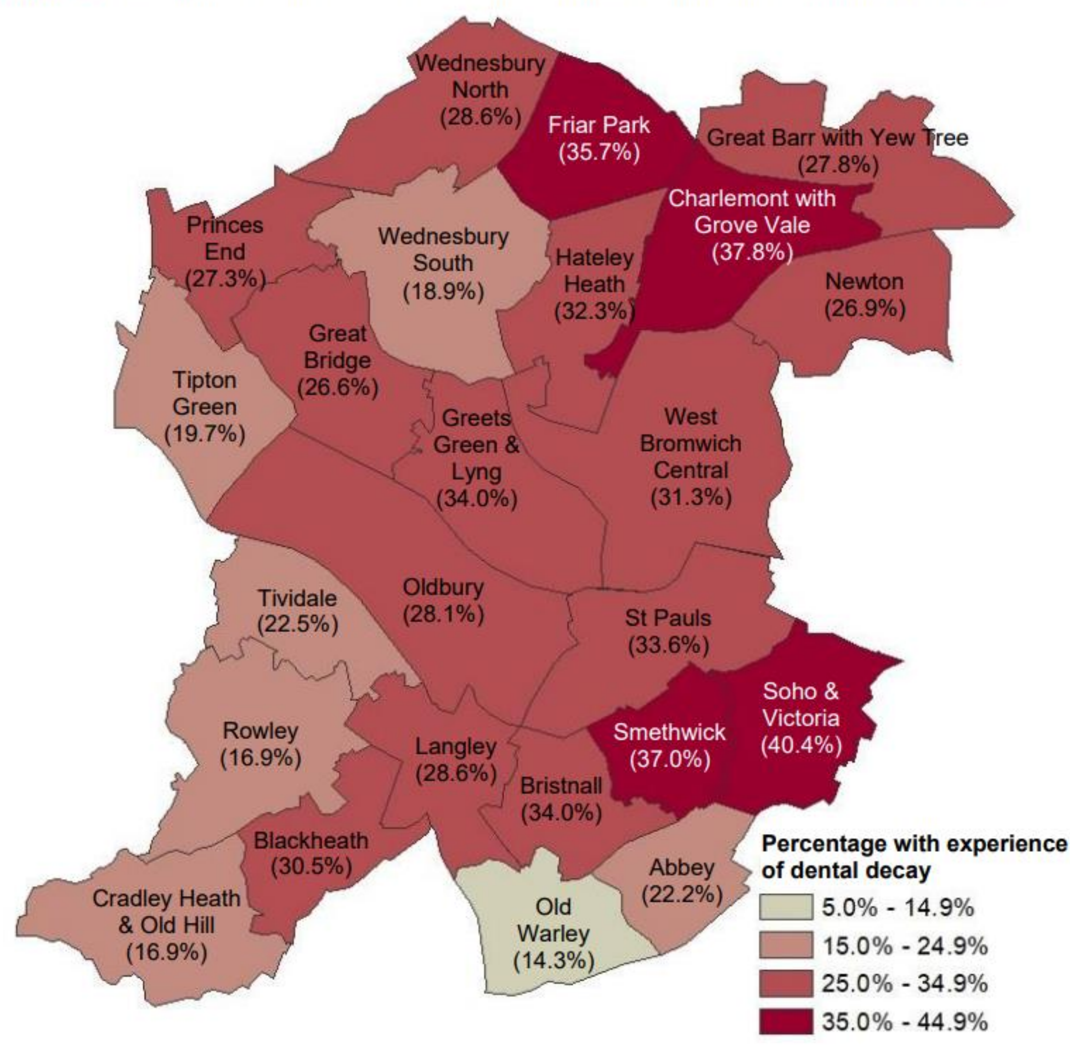

Return on investment of oral health improvement programmes for 0-5 year olds*


Reviews of clinical effectiveness by NICE (PH55) and PHE (Commissioning Better Oral Health for Children and Young People, 2014) have found that the following programmes effectively reduced tooth decay in 5 year olds:
Varnish
Targeted supervised tooth brushing programme
A targeted fluoride varnish programme
Water fluoridation provides a universal programme
Targeted provision of toothbrushes and paste by post
Targeted provision of toothbrushes and paste by post and by health visitors
£1=
After 5 years
£1 spent = £3.06
£1 spent = £2.29
£1 spent = £12.71
£1 spent = £1.03
£1 spent = £4.89
After 10 years
£1 spent = £3.66
£1 spent = £2.74
£1 spent = £21.98
£1 spent = £1.54
£1 spent = £7.34
*All targeted programmes modelled on population decayed, missing or filled teeth (dmft) index of 2, and universal programme on dmft for England of 0.8. The modelling has used the PHE Return on Investment Tool for oral health interventions (PHE, 2016). The best available evidence has been used in this tool and where assumptions are made these have been clearly stated
PHE Publications gateway number: 2016321
© Crown copyright 2016

5 year olds

Source: LA profiles 2019 5 yr 2019 - Public library - UKHSA national - Knowledge Hub (khub.net)





5 year olds

Source: LA profiles 2019 5 yr 2019 - Public library - UKHSA national - Knowledge Hub (khub.net)

Figure 6: Prevalence of experience of dental decay in 5-year-olds in Walsall, by Ward.

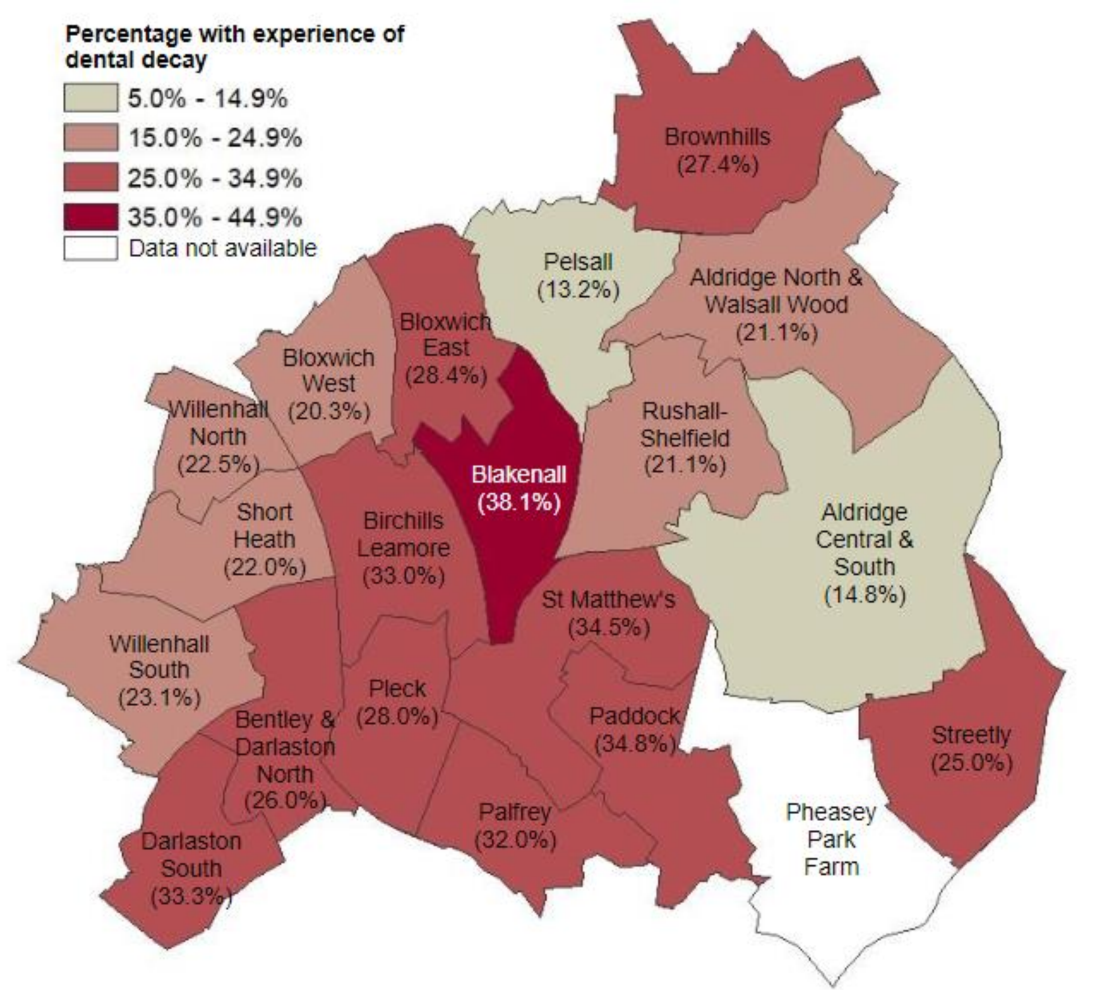
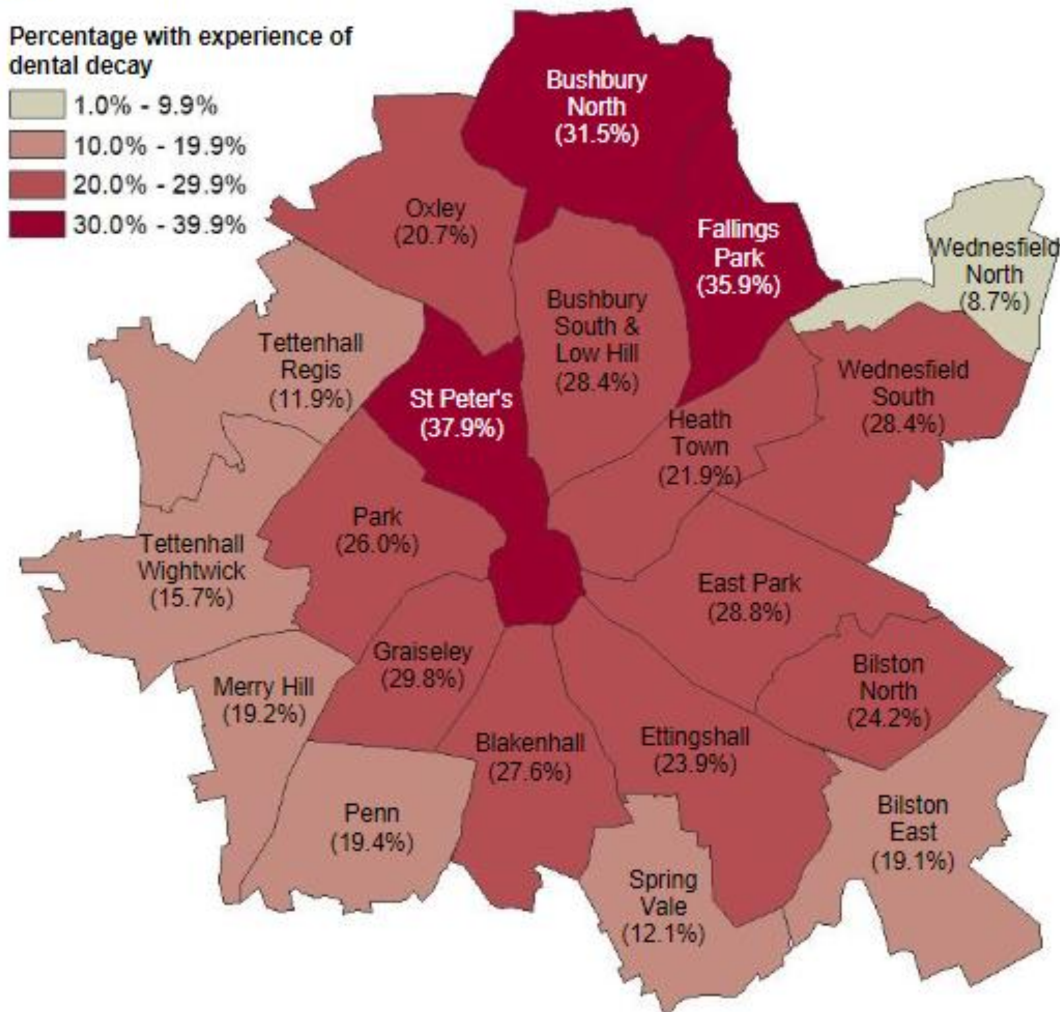


Figure 6: Prevalence of experience of dental decay in 5-year-olds in Wolverhampton, by Ward.



Current OHI services in Wolverhampton

- Wolverhampton Special Care Dental Service have an Oral Health Promoter who has worked in conjunction with LA colleagues over a number of years using non-recurrent LA funding to deliver targeted interventions including OHP in early years settings with parents and carers including provision of toothbrushing packs, training for other professionals who work with under 5's, OHP and toothbrushing packs at the 12 month health visitor check. (Funding from both CDS contract and direct from LA). Currently no adult programme.
- Recurrent funding in RWT Contract for Oral Health Improvement for Wolverhampton LA area. Activity in 2022 included:
    - RWT (New Cross, West Park, Cannock) – leading an oral health working group which developed mouth care risk assessments for all adult inpatient wards and being rolled out to paediatric wards, and mouth care assessments to be carried out within 24 hours of admission. (GREAT WORK!)
    - OHI and accessing dental services sessions for vulnerable groups – Cystic Fibrosis in Children's Outpatients, Diabetes in Children's Outpatients, Patients waiting in Heart and Lung Outpatients, patients having renal dialysis, sessions at the Gem Centre for LAC, Autism clinic, Solace Hostel, Recovery Near You Aquarius (mobile clinic), P3 services Bushbury Lane First Avenue Dickens Lodge, Good Shepherd, Changing Lives/Warm Welcome, Dementia Café's across Wolverhampton.
    - OHI training to staff working in special schools, plus attendance at events in school to promote OH and access to dental services (mobile clinic)
- No current specification can be identified for OHI service – general CDS specification exists. Annual reports shared with partners.

OHI across The Black Country

- Work commenced in 2022 to develop OHI services across each ICS footprint in the West Midlands. Money was invested by NHS England – Midlands into areas which had previously lacked services or needed an increased service provision to meet the oral health needs of the local population.
- New recurrent funding has been invested into Birmingham Community Healthcare NHS Foundation Trust to develop new services in Walsall and Dudley alongside the existing services they deliver for Sandwell LA residents. Wolverhampton OHI services will continue to be delivered by RWT using existing OHI funding within Community Dental Services contract.
- New draft specifications have been developed based on evidence-based interventions at a population level to direct future service permission – with a number of service descriptors developed:
    1. Oral Health Training for the wider professional workforce
    2. Supervised Toothbrushing in Early Years and School settings
    3. Targeted provision of toothbrushes and toothpaste by health and social care professionals and third sector organisations supporting those with high risk of poor oral health
    4. Mouthcare in care homes
    5. Mouthcare in Hospital settings
- A workplan will be developed which details how the BCHC service and RWT service will work alongside each other across the ICS geography to deliver each service descriptor for the population. Interventions will be targeted at those with poorer oral health and the most in need of support.

Oral Health Improvement - Prevention

Presenters:

Louise Sharrod **Principal Public Health Specialist, CWC**

Oral Health Disease - Impact

Children who have high levels of disease in primary teeth have an increased risk of disease in their permanent teeth

Tooth decay starts early in life - in half of children with decay it starts before 3 years old

Education

Impacts children's readiness for school

Missed school days due to pain and infection

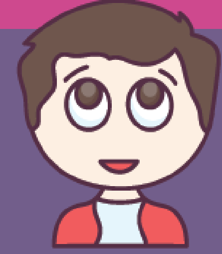
Affects ability to learn, thrive and develop

NHS

Increase demand for Emergency dental care

Tooth decay most common reason for hopistal admissions (5-9 years)

Significant pressure on NHS services



Wellbeing

Affects ability to eat, smile and socialise

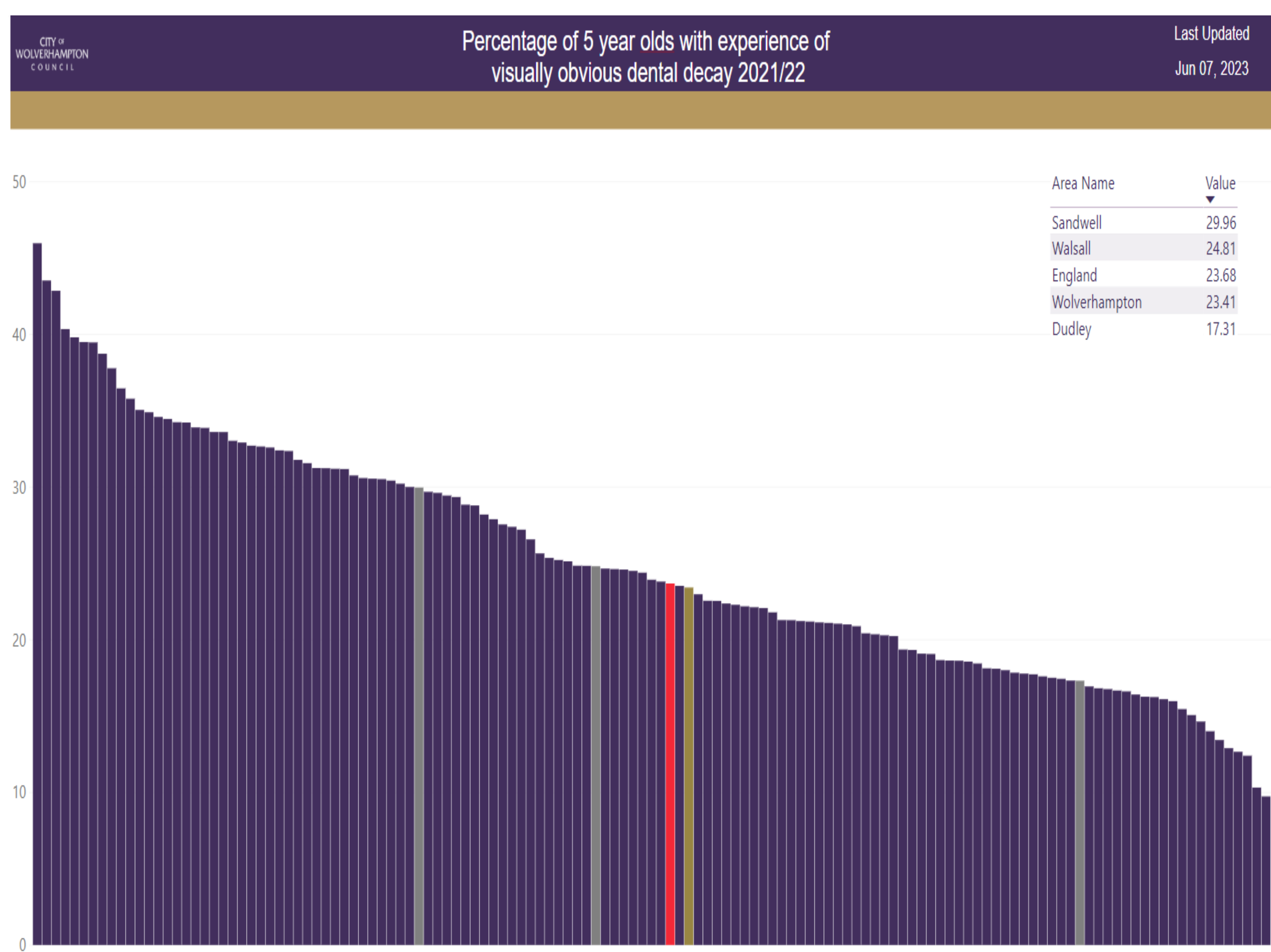
Affects confidence and wellbeing

Affects families (missed days of work)

Affects adult teeth

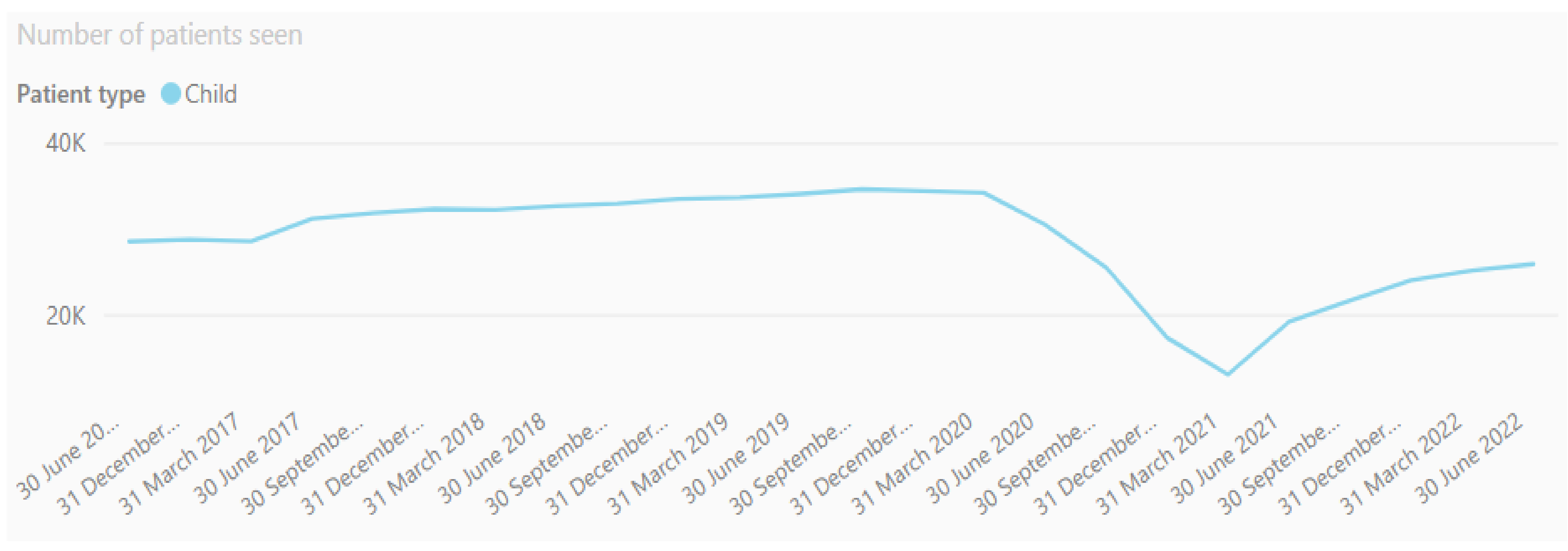
Oral Health Disease – Prevalence of Dental Decay in 5-year-olds

- In 2021-22 23.4% of children age 5 years-old had visually obvious signs of dental decay.
- This is similar to West Midlands and England averages of 23.8% and 23.7% respectively.
- However the rate of hospital admissions for 0-5 year-olds is markedly higher at 303 per 100,000 compared with 87 per 100,000 for West Midlands and 220.8 per 100,000 for England.
- Nationally children from minority ethnic groups such as South Asian (37%) are disproportionally affected by tooth decay compared to White British (20%).



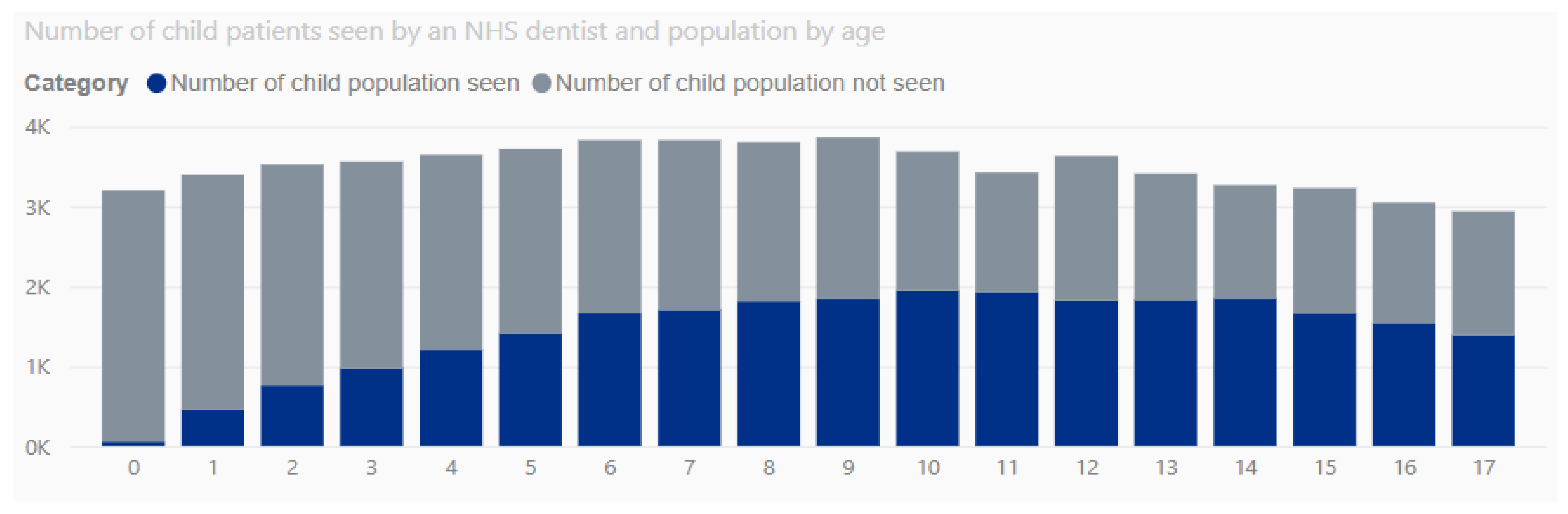
Access to NHS Dentists– Impact of Covid-19

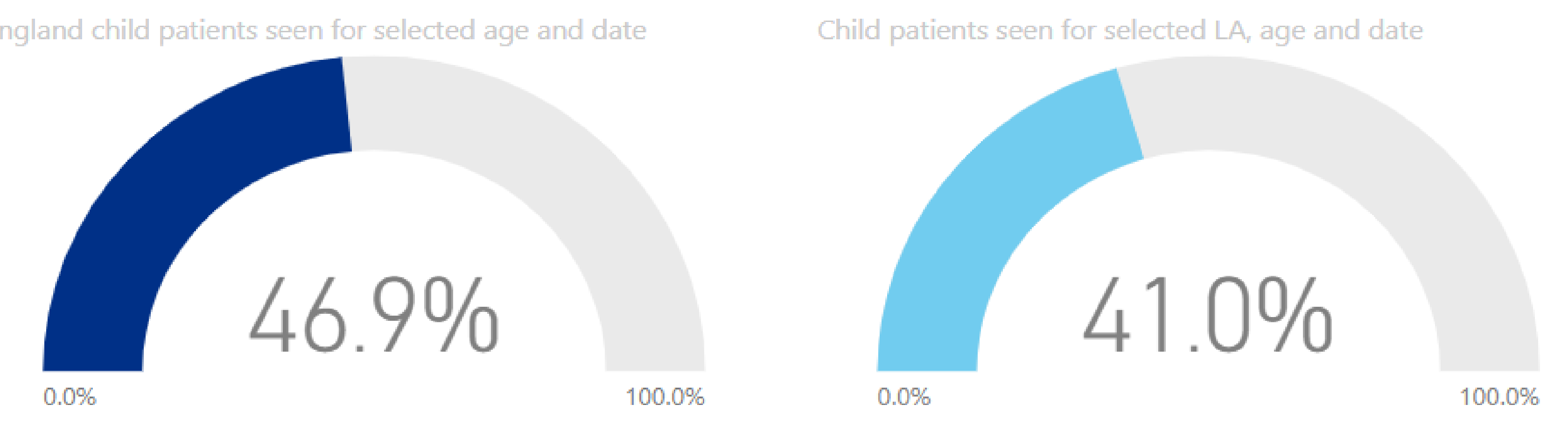
Numbers of children in Wolverhampton who received NHS dental care in the preceding 12 months:



Access to NHS Dentists – Age breakdown

Numbers of Wolverhampton children who have seen an NHS dentist by age:





Local Oral Health Improvement Governance Arrangements

Multi-agency Oral Health Improvement T&F group meets bi-monthly.

Aims:

- To deliver a coordinated universal and targeted approach to oral health improvement in Wolverhampton.

- To deliver the objectives of the non-recurrent funding obtained from NHS England for 2021-22 and 2022-23.

- To work towards implementation of the evidence base for oral health improvement locally as set out by NHS England.

Special Care Dental Service

Introducing Children & Families Together Board
to the Roles and Services provided within SCDS
RWT

Meet the Team

We are a unique service that provides dental care and treatment for special care patients including vulnerable and hard-to-reach groups in Wolverhampton

- 7 Dentists
- 1 Dental Therapist
- 10 Dental Nurses
- 1 Oral Health Specialist
- 6 Dental Administrators

What do we Offer in Our Service?

- Our service user groups include children and adults:

- With severe learning disabilities
- With severe autistic spectrum disorders
- With physical disabilities and wheelchair-users
- Who have severe Mental Health Problems
- With dental phobia
- Who are engaging in substance misuse
- From socially excluded groups (eg. asylum, homelessness)
- Elderly and frail adults residing in care homes
- Looked after children
- Children with high treatment needs who are difficult to manage

What is in a Smile?

Messages for the Wider Community

The value of good oral care and regular visits from an early age

Decay found negative impact on Quality of Life of children (function/social relationships in particular) (Abreu et al., 2021)

Putting mouth back in the body

Lifelong healthy habits

Collaborative approach for successful wider community engagement (schools, nurses, GPs, community centres etc)

Benefits of WSCDS

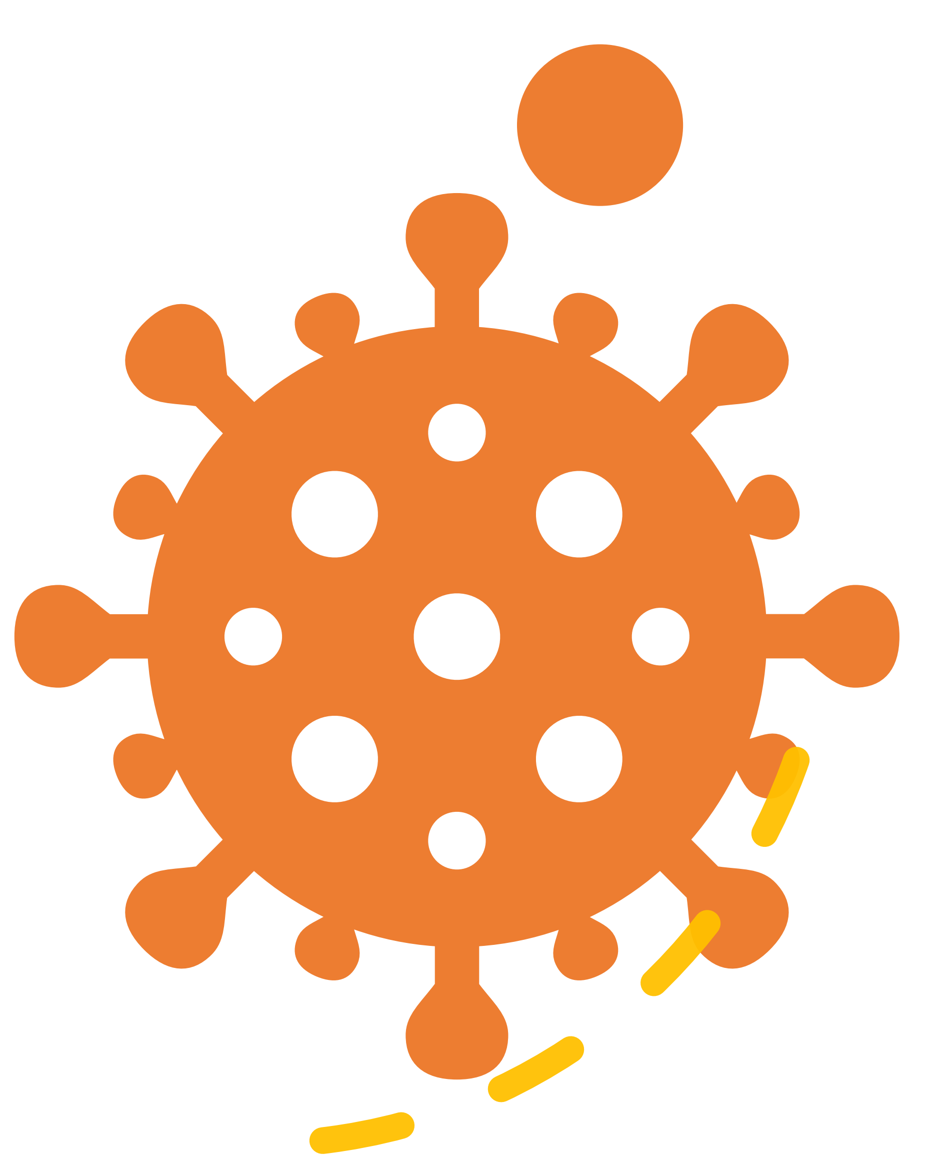
- The importance of prevention has been stimulated since the covid pandemic.
- The Community Dental workforce are emphasising importance of prevention
- Additionally skilled staff to help support the child.
- Sensory toys to help the patient feel more relaxed.
- Workforce adapt behavioural management techniques tailored towards the patient.
- Building confidence for patient to receive treatment under local anaesthetic.
- Communicating on a level which is relevant to the child's age and needs.
- Listening to parents and the patient.

Barriers to Dental Care – WSCDS and GDP

- Post Covid – Priority Care
- Saturated service
- Access to general anaesthesia is limited
- Shared care
- Patient Co-operation
- Expectation Management
- Access to NHS dentist is limited and often irregular attendance

Impacts of Covid-19

- Health-seeking behaviour impacted
- Drop of nearly 6% of children attending for routine check up
- Drop of around 10% of children attending for treatment
- Waiting lists increased
- Reduction in clinical time (fallow limitations, patient turnaround, increased emergencies)
- Clinical prioritisation (greater children with swellings/malaise etc) needing urgent treatment and less time available for routine/preventative treatment

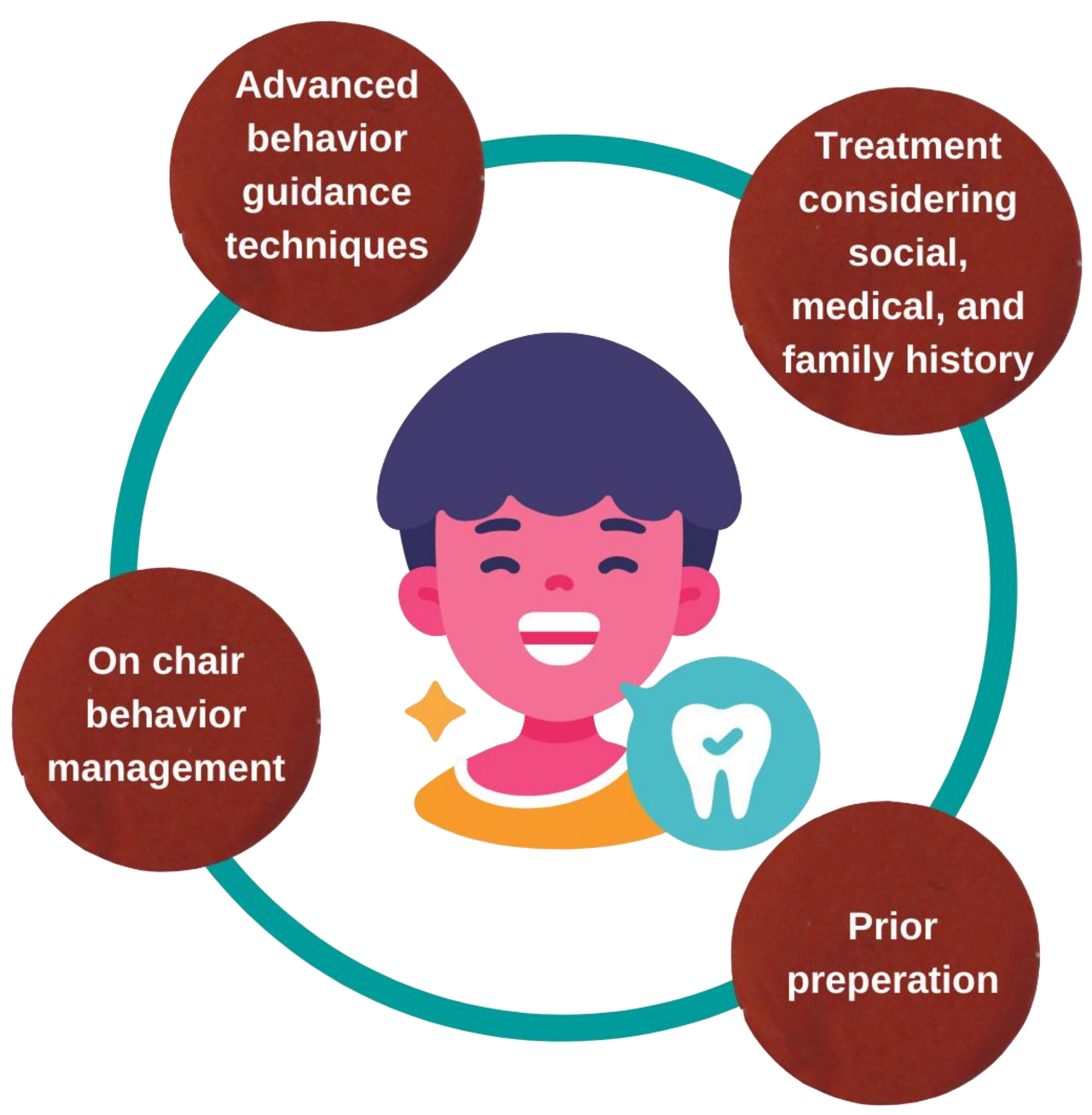


Modalities of Service – Behavioural Management

POSITIVE DENTAL ATTITUDE

The dentist aims to establish trust with the child to ensure compliance with prevention and allow for treatment. Examples of management techniques include:

1. Non-verbal communication
2. Preparatory information
3. Voice control
4. Positive reinforcement and behavioural shaping
5. Tell-show-do
6. Enhancing control



- This method can be provided by a General Dental Practitioner.
- It is important to inform the General Dental Practitioner how the child may feel more comfortable and what they may be anxious about.
- This is important so the dentist can make reasonable adjustments to help support the child’s needs.

Prevention and Management of Dental Caries in Children

Dental Clinical Guidance

Preventative based Approach

- Atraumatic restorative dentistry (ART)
- Treat what is in pain – monitor what is due to exfoliate
- Results – better engagement and reduced dental anxiety

Strategic Delivery Plan

2023/24

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.
- 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 assurance	Receiving Committee
Care	- We will embed a culture of learning and continuous improvement at all levels of the organisation	- 10% increase on previous year in the percentage of staff responding positively in the annual staff survey when asked if they are able to suggest and make improvements in their area.	Improvement Plan	Quality, Governance and Assurance Committee (QGAC)/Improvement, Innovation and Research Group (currently)
	- We will prioritise the treatment of cancer patients, focused on improving the outcome of those diagnosed with the disease	- Reduce the 62 day cancer backlog to 217 in RWT and 39 in Urology by the end of March 2024.	Cancer action plan	Quality, Governance and Assurance Committee (QGAC)/Quality, Patient Experience and Safety (QPES) Group & Performance and Finance Committee
	- We will deliver safe and responsive urgent and emergency care in the community and in hospital	- Delivery of the urgent 2 hour Urgent Community Response standard - Delivery of the 76% 4 hour A&E target	Emergency Care Action Plan	Quality, Governance and Assurance Committee (QGAC)/Quality, Patient Experience and Safety (QPES) Group & Performance and Finance Committee
	- 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)	Elective Recovery Plan	Quality, Governance and Assurance Committee (QGAC)/Quality, Patient Experience and Safety (QPES) Group & Performance and Finance Committee
	- 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 strategy	Finance and Performance Committee
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.	Enabling people strategy	People and Organisational Development Committee
	- 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.	Enabling people strategy	People and Organisational Development Committee
	- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged	- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged	Enabling people strategy	People and Organisational Development Committee
	- Deliver year on year improvement in Workforce Equality Standard performance	- Deliver an improvement on 2022/23 in Workforce Equality Standard performance by March 2024.	Enabling people strategy	People and Organisational Development Committee
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 collaborative project plan	Joint Provider Committee
	- Improve clinical service sustainability by implementing new models of care through the provider collaborative		Provider collaborative project plan	Joint Provider 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 patients being cared for in virtual wards by March 2024.	Digital Enabling Strategy	Improvement, Innovation and Research Group (currently)/ Digital innovation, infrastructure & IT platforms (DIP) group
	- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes	- Reduce the Urology waiting list across both Trusts by March 24, compared with the position at the end of March 23.	Integration Plan	Joint Provider 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	New research and development strategy	Improvement, Innovation and Research Group (currently)/ Digital innovation, infrastructure & IT platforms (DIP) group
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.	Health Inequalities Delivery Plan	Quality, Governance and Assurance Committee (QGAC)/Quality, Patient Experience and Safety (QPES) Group
	- 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 Plan	Finance and Performance Committee
	- Work together with PLACE based partners to deliver improvements to the health of our immediate communities	Reduction in the number of medically fit for discharge patients from 2022/23 at RWT and maintenance of the number in WHT.	Place Dashboard/Care at home report	Finance and Performance Committee

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.

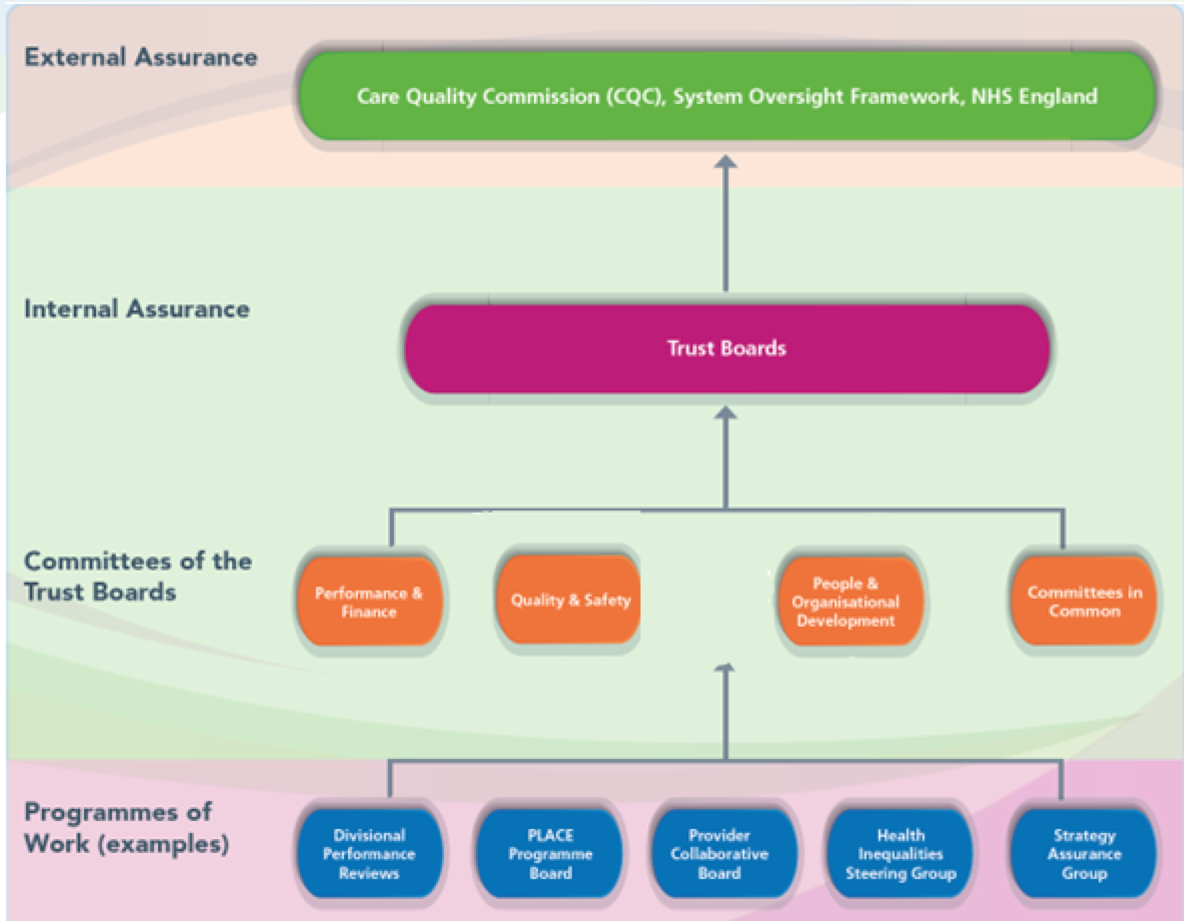
Reporting to Board

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
Walsall Healthcare NHS Trust

BACKGROUND INFORMATION

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 12.59 whole time equivalent (WTE) Midwifery posts and 0.73 WTE MSW posts within the Directorate. In May Maternity leave for Midwifery was 10.92 WTE and 2.03 MSW. Long term sickness within both workforces is minimum and is just over 4 WTE.

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

Table 1: Midwifery and Maternity Support Worker Workforce deficit.

Area	RM Vacancy	MSW Vacancy	RM Mat leave	MSW Mat Leave	RM LTS	MSW LTS
ANC/FAU	0	0.73	0.4	0.8	0	0
Delivery suite	0	0	6.44	0	0.96	0.64
Midwife Led Unit	2.63	0	0	0	0.96	0
Community	6.93	0	1.8	0	0	1
Maternity Wards D!0 D9	1.47	0	2.28	0.43	0	0
Sonography	1.56	0	0	0	0	0
Total	**12.59**	**0.73**	**10.92**	**2.03**	**1.92**	**1.64**

Forecasted turnover and maternity leave and recent position have been considered when appointing into Midwifery workforce vacancy. The Directorate may incur an over establishment in Q3. However, based on workforce intelligence, potential of not all students taking up posts in the Autumn, delays associated with receiving pin numbers etc. and an outstanding business case it is anticipated this may be offset.

The Directorate has developed a business case for Midwifery workforce based on the 2022 Birth Rate plus assessment. This is progressing through Trust process at the present time.

The Birth Rate plus assessment based on birth rates and acuity demonstrated that the deficit for Midwifery workforce was 6.98 WTE. This has been considered when recruitment into Midwifery posts have taken place.

One to One Care rates in Established Labour

The national ambition and recommendation in NHSR Clinical Negligence scheme for Trust (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	May 2023
1:1 Care rate in labour	99.5%	100%	100%	100%

One to One Care rates in established labour continue to be maintained at 100% for in Q1.

Data for % overall Midwifery Deficit per shift May 23 based on acuity of patient .

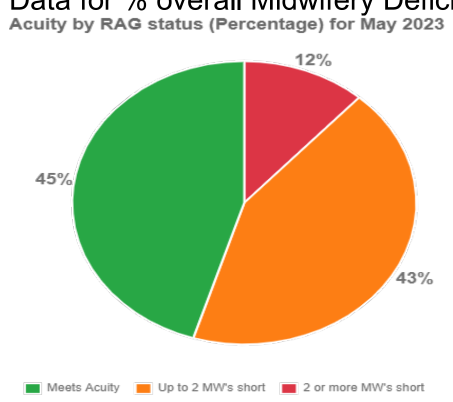
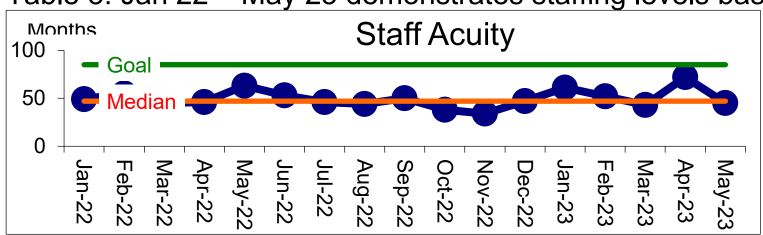


Table 3: Jan 22 – May 23 demonstrates staffing levels based on acuity of patient.



The graph indicates that staffing levels are not being met on Delivery Suite in line with best practice guidance from the Royal College of Midwives (RCM). This data demonstrates staffing levels determined by the acuity of the patients at that precise time the data is submitted into the tool. This does not take into account any redeployment of staff / movement of patients taken as a result.

Red Flags May 2023

Red flag events are delays in providing care to a woman that are 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.

Red Flags - % of Occasions Recorded

From 01/05/2023 to 31/05/2023

Showing the % of occasions when a Red Flag was recorded in the period selected - the contributing Red Flags recorded may be more than one, refer to chart to identify prevalence

During May 25% of shifts recorded a red flag attributed to midwifery staffing deficit. However, there were no adverse patient outcomes directly attributed to Red Flag events in May.

Number & % of Red Flags Recorded
From 01/05/2023 to 31/05/2023

RF1	Delayed or cancelled time critical activity	13	33%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2	5%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	5	13%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	18	45%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	1	3%
RF10	Delivery Suite Co-ordinator not supernumerary	1	3%
	Total	40	

Download

Quality Improvement work has commenced to improve delayed or cancelled time critical activity, and delay between admission and induction process. These red flags are specifically related to the Induction of Labour Process pathway. This QIP is work underway within the Directorate with the aim to reduce delays. Maternity providers are also working collaboratively to find a solution to this regional issue.

Maternity Triage Staffing Audit

Following the Care Quality Commission (CQC) inspection into Maternity Services at RWT in October 2022 an immediate recommendation was made to improve staffing levels on The Maternity Triage Unit (MTU). Audits are being completed to monitor staffing levels. The Audit data indicates a gradual improvement over a 3 month period.

Table 4: Audit data staffing levels on MTU

Standard: 2 Midwives per shift	March 2023	April 2023	May 2023
2 Midwives working on MTU	90.2%	97.5%	99%

NHSR Maternity Incentive Scheme CNST Year 5.

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care (Appendix 1).

The Directorate have commenced work with the relevant workstreams to work towards full compliance for each safety action for year 5.

<u>Maternity Incentive Scheme CNST Year 4</u>

The Maternity Service achieved all 10 safety actions for MIS year 4; therefore, RWT are eligible to recover their element of contribution relating to the CNST maternity incentive funds.

Within the Midlands region there are 21 Trusts providing Maternity Services; 8 out of 21 Trusts achieved full compliance with all 10 safety actions for year 4 Maternity Incentive Scheme. Therefore, in addition to the incentive RWT will also receive a share of the unallocated funds from Trusts that were not fully compliant with all 10 safety standards.

Local Maternity Dashboard / Minimum data measures for Trust Board

There is a recommendation that local maternity dashboards are presented to Trusts boards to monitor maternity and neonatal safety.

Maternity Services booking data indicated a rise through Q3 and into Q4. Booking rates are being monitored closely and forecasts indicate that overall, the birth rate trajectory is on plan for 5000 births.

Perinatal Mortality Report

The report gives an overview of the Perinatal Mortality Review Tool (PMRT) grade and the learning from each case during Q1 for year 4 (**Appendix 2**) and year 5 (**Appendix 3**).

All deaths continue to be reported, reviewed, and monitored in line with the National Perinatal Mortality Review Tool (PMRT) and CNST safety action 1. The data was validated by NHSR for year 4 of the Maternity Incentive Scheme to give an assurance that reporting and monitoring processes for RWT were compliant.

The Perinatal Mortality Report in line with NHSR Maternity CNST recommendation for safety action 1: *Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?*

The Royal Wolverhampton NHS Trust (RWT) continues to meet the recommendations and standards for Maternity CNST safety action 1: Standards a – d.

RWT are 100% fully compliant with standards a – d for all Perinatal Deaths in Q 1.

HSIB / SUI Report.

The Open incidents HSIB/SUI report has 6 open cases.

There are 3 active cases being investigated by HSIB.
1 RCA requiring Divisional approval.
2 Incidents reported as STEIS – progressing through Trust process.
A thematic review by HSIB has revealed no major themes for RWT.

Maternity Insights Inspection.

The Maternity service received their second Insights assessment conducted by the Local Maternity and Neonatal System (LMNS) and NHS England in June 2023. The inspection team confirmed full compliance with Ockenden 7 IEA's. Positive high-level feedback was given at the end of the day from the inspection team regarding The Maternity Services at RWT.

The Trust is awaiting the final report from NHSE/ LMNS inspection team.

RECOMMENDATIONS

That the Board accept and approve the Midwifery Services Report.

Any Cross-References to Reading Room Information/Enclosures:

Please refer to the following appendices.

Appendix 1: NHSR Maternity Incentive Scheme CNST Year 5 document.

MIS-year-5-FINAL-31-5-23.pdf (resolution.nhs.uk)

Appendix 2 / 3 Perinatal Mortality Report for CNST year 4 and 5.

The Royal Wolverhampton NHS Trust	
Trust Board Report	
Meeting Date:	Reporting quarter 1st April 2023 - 5th May 2023
Title:	Perinatal mortality report Clinical Negligence Scheme for Trusts CNST safety action 1
Executive Summary:	ai. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. aii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required. d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Action Requested:	To receive and note the report
Report of:	Tracy Palmer, Director of Nursing & Midwifery Women's, and Neonatal services

For the attention of the Board. • **Alert** • **Assure** • **Advise**	To Assure the Board that safety action 1 standards a – d have been met
Author: **Contact Details:**	Tracy Palmer Director of Nursing & Midwifery Women's and neonatal services. Tel: 01902 695162 Email: tracypalmer@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality. 2. Proactively seek opportunities to develop our services
Resource Implications:	Workforce.
Public or Private: **(with reasons if private)**	Public
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
Appendices/ **References/** **Background Reading**	1 – Perinatal reports – update position NHS Resolution; Maternity Incentive Scheme – year four (2021/2022)

Maternity incentive scheme – year four

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Required standard	a) i. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter. ii. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death. This includes deaths after home births where care was provided by your Trust. b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death. c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required. d) Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.
Minimum evidential requirement for Trust Board	Notifications must be made and surveillance forms completed using the MBRRACE-UK reporting website. The perinatal mortality review tool must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Board each quarter from 6 May 2022 onwards that includes details of the deaths reviewed and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard c) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Validation process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.

	NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	Reporting quarter 1st April 2023 - 5th May 2023
What is the deadline for reporting to NHS Resolution?	

CNST STANDARD 1 Trust Board Report

Update Position
Timeframe 1st April 2023 - 5th May 2023

Maternity Incentive Scheme Year 4-5 1st April 2023 - 5th May 2023	**Compliance**
Ai) All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within **seven working days** and the surveillance information where required must be **completed within one month of the death.** Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	100%
Aii) A review using the Perinatal Mortality Review Tool (PMRT) of **95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death**. This includes deaths after home births where care was provided by your Trust.	100%
B) **At least 50% of all deaths of babies** (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT **draft report has been generated by the tool within four months of each death and the report published within six months of each death.**	100%
C) For at least **95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place**, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.	100%
D) **Quarterly reports** will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	✓

<table>
<tr><td colspan="2">The Royal Wolverhampton NHS Trust</td><td> </td></tr>
<tr><td colspan="3">Trust Board Report</td></tr>
<tr><td>Meeting Date:</td><td colspan="2">Reporting quarter 6th May 2023 - 30th June 2023</td></tr>
<tr><td>Title:</td><td colspan="2">Perinatal mortality report

Clinical Negligence Scheme for Trusts CNST safety action 1</td></tr>
<tr><td>Executive Summary:</td><td colspan="2">ai. All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2023 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.

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b) At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2023 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.

c) For at least 95% of all deaths of babies who died in your Trust from 6 May 2023, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.

Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.

d) Quarterly reports will have been submitted to the Trust Board from 6 May 2023 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.</td></tr>
<tr><td>Action Requested:</td><td colspan="2">To receive and note the report</td></tr>
<tr><td>Report of:</td><td colspan="2">Tracy Palmer, Director of Nursing & Midwifery Women's, and Neonatal services</td></tr>
</table>

For the attention of the Board. • **Alert** • **Assure** • **Advise**	To Assure the Board that safety action 1 standards a – d have been met
Author: **Contact Details:**	Tracy Palmer Director of Nursing & Midwifery Women's and neonatal services. Tel: 01902 695162 Email: tracypalmer@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality. 2. Proactively seek opportunities to develop our services
Resource Implications:	Workforce.
Public or Private: **(with reasons if private)**	Public
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
Appendices/ **References/** **Background Reading**	1 – Perinatal reports – update position NHS Resolution; Maternity Incentive Scheme – year five (2023-2024)

Maternity incentive scheme – year five

Conditions of the scheme

Ten maternity safety actions with technical guidance

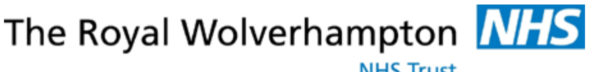
Questions and answers related to the scheme

June 2023

What is the deadline for reporting to NHS Resolution?	**12 noon** on **1 February 2024**
Required standard	a) All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from **30 May 2023,** MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from **30 May 2023** onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from **30 May 2023.** 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from **30 May 2023.**
Minimum evidential requirement for Trust Board	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website. The PMRT must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Executive Board each quarter from **30 May 2023** that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.
What is the relevant time period?	From **30 May 2023** until add **7 December 2023**

CNST STANDARD 1 Trust Board Report
Update Position
Timeframe 6th May 2023 - 30th June 2023

Maternity Incentive Scheme Year 5 6th May 2023 - 30th June 2023	Compliance
Ai) All perinatal deaths eligible to be notified to MBRRACE-UK from 6 May 2022 onwards must be notified to MBRRACE-UK within **seven working days** and the surveillance information where required must be **completed within one month of the death.** Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	100%
Aii) A review using the Perinatal Mortality Review Tool (PMRT) of **95% of all deaths of babies, suitable for review using the PMRT, from 6 May 2022 will have been started within two months of each death**. This includes deaths after home births where care was provided by your Trust.	100%
B) **At least 50% of all deaths of babies** (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 6 May 2022 will have been reviewed using the PMRT, by a multidisciplinary review team. Each of these reviews will have been completed to the point that at least a PMRT **draft report has been generated by the tool within four months of each death and the report published within six months of each death.**	cases to be discussed at August PMRT board
C) For at least **95% of all deaths of babies who died in your Trust from 6 May 2022, the parents will have been told that a review of their baby's death will take place**, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.	100%
D) **Quarterly reports** will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	✓



Minutes of the Performance & Finance Committee

Date	Wednesday 24th May 2023
Venue	via MSTeams
Time	08.30am

Present:	
John Dunn	Non-Executive Director (Chair)
Lisa Cowley	Non-Executive Director
Gwen Nuttall	Chief Operating Officer (Part Attendance)
Kevin Stringer	Group Chief Finance Officer & Deputy Chief Executive (Part Attendance)

In Attendance:	
Tim Shayes	Deputy Group Chief Strategy Officer
James Green	Interim Chief Finance Officer
Mark Greene	Deputy Chief Finance Officer
Adam Race	Director of Human Resources & Organisational Development
Stew Watson	Director of Estates Development (Part Attendance)
Dean Gritton	Group Manager, Oncology, Haematology, Radiotherapy and Palliative Care (Part Attendance)
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

043/2023	**Apologies for Absence** Apologies were received from M Levermore, S Evans, A Duffell and Lord Carter. Due to a minor delay the meeting was not quorate at commencement.	
044/2023	**Declarations of Interest** There were no declarations of interest.	
045/2023	**Minutes of Meeting Held on 26th April 2023** The minutes of the meeting from 26th April 2023 were agreed.	
046/2024	**Action Points from the Previous Meetings**	
046.01	1065 Financial Information (IQPR Format) – M Greene informed the Committee that the changes to the financial format will be implemented in Month 2. **Action closed.**	
046.02	1067 Financial Briefing Pre & Post Covid (EDs and NEDs) – M Greene confirmed that bridges have been shared with Executives and Divisions and that further planning meetings are taking place with Divisional Teams. **Action closed.**	
046.03	1199 Winter Plan Review (Circulation of 7 Schemes) – G Nuttall confirmed that the schemes would be included within the Winter Plan update. **Action closed.**	
046.04	1201 Identify Growth Linked Directly to Income – A Race closed the action stating that the information had been provided for the Board Development Session. L Cowley stated that the action was partially completed and that there was a further action to identify where there is an increase in staffing how this links to productivity and associated income. J Dunn stated that the AOP Committee is being created which will look into this into more detail. The action will be delegated to that Committee. **Action closed.**	

046.05	1202 Workforce Covid Costs – L Cowley queried which paper had the workforce covid costs listed. A Race confirmed that the costs were available in paper 6.2.2. **Action closed.**	
046.06	1203 Breakdown of Salary/Wage/Labour Cost – K Stringer said the action was closed as the information has been provided to Lord Carter as requested. **Action closed.**	
046.07	1204 Investigation into REAF 611 – This item has been added as an agenda item. **Action closed.**	
046.08	1205 High Value Contract Report – N Joy-Johnson had updated Ibabs to say that the letter has been issued to all Suppliers and the Monthly High Value Contract Report has been updated to include a 3 month view on high value contracts (£1m+) that are due to be presented to the Committee. **Action closed.**	
047/2023	**Performance**	
047.01	Winter Plan Review – Due to insufficient time this item was not discussed as part of the agenda. The item was deferred to June's meeting.	
047.02	Elective Recovery Programme – T Shayes provided an update on the paper and provided the following highlights: Advise: • The Trust's waiting list size is broadly in line with the trajectory predicted. • It is now expected by NHS England that 78 week waits will be cleared by the end of June (the target has been deferred from March as a result of junior doctor industrial action). The Trust has a cohort of 20 patients whom they are working to identify a plan for. Alert: • 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. • Activity in April was lower than planned. This was primarily as a result of the industrial action within April. 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 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. Assure: • Other than activity, 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. **Chair's Summary Alert to Board:** • 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. • Cancer referrals are continuing to increase, the back log has stabilised but is not reducing at the moment. The Trust is exploring further capacity through mutual aid.	

	Chair's Summary Advice to Board: • 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 over weekends, which is being funded via ERF. Action is underway to achieve this in hours. J Dunn asked T Shayes to provide a prediction of the cohorts of waits for 52, 65 and 78 week waits at the end of Q1 and Q2. K Stringer asked that the financial value be included within the update if they were to be done under ERF. L Cowley queried if the 65 week wait figures within the report were a realistic view or presenting best case scenario. T Shayes confirmed that the figures within the graph on slide 10 provides this information. L Cowley queried the expected dates to clear 65 week waits. T Shayes clarified that the local ambition was to clear new outpatient 65 weeks by October 2023. L Cowley asked for an update on outpatient transformation. D Gritton confirmed that 10 Directorates have been identified to progress with outpatient transformation and 6 clinical leads have been identified for each Directorate and that Lee Dowson is also leading with the QI Team. The Committee noted the report.	**T Shayes**
047.03	National & Contractual Standards (IQPR Extract) – The report was noted. L Cowley queried if the wait time with diagnostics was impacting on broader waiting times and acuity. T Shayes agreed that the modalities that were having greatest impact would be ultrasound, echocardiography and histopathology. T Shayes confirmed that a remedial action plan was in place to address this and that there were some challenges around staffing. L Cowley asked that this be examined by PODC. T Shayes and A Race agreed to discuss this outside of the meeting and to highlight the challenges via a deep dive to PODC. The Committee noted the report.	**A Race**
048/2023	**Financial Performance for Period**	
  048.01.01	G Nuttall joined the meeting making it quorate. Monthly Financial Report – K Stringer provided an overview of the financial performance. The Trust reported an in-month adjusted deficit of £8.29m, which is £2.3m adverse to plan. The in-month position was materially impacted by the strike action in April, with direct pay costs estimated to be £1.1m. Elective recovery performance was also behind plan by £0.8m, of which £0.4m is stretch (national) 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 appeared to have been a run rate increase of circa £0.5m (under review), £0.1m of which was related to Urology. Non-Pay was £0.3m overspent and is made up of a number of activity related under and overspends and Drugs was £0.3m underspent, also related to activity. CIP under performance was £1.4m against plan, and the position is partially off-set by £2.9m of reserves. A discussion took place regarding costs incurred from the Junior Doctor industrial action. M Greene clarified that the acting down payments have been picked up as an accrual and that the actual acting down cost will be clear in month 2. K Stringer clarified that cover costs were higher than actual costs as waiting list values are paid, which would result in a net increase.	

	J Dunn queried why sick costs were increasing if levels of substantive staffing were improving. A Race clarified that the Trust budgets for 3.2% sickness in budgets and that the Trust sickness rate is 5 – 5.5%. This is likely to present a cost pressure moving forwards. L Cowley suggested PODC examine this further. A Race to relay this back to PODC. A discussion took place regarding premium bank rates and super enhanced payments. L Cowley queried if the payments had been planned into budgets. M Greene clarified that that this had not been planned into budgets. G Nuttall clarified that all but one area have ceased enhanced rates by the end of March and that future enhancements would reduce over the next 2 months. L Cowley asked that the end dates for the payments be included within the report going forwards. L Cowley also queried how this would compare to neighbouring Trusts and if this presented a risk if other Trusts decided to continue with enhanced rates. G Nuttall clarified that work has been taking place to standardise rates across the Black Country unless a Trust was experiencing higher than average staffing challenges within specialist areas. G Nuttall clarified that the Trust is not paying the BMA rate card costs and that there had been a reduction with Consultants completing waiting list over weekends due to the decision but that people are starting to return to completing waiting lists over weekends.	**A Race**
048.01.02	Trust Income & Expenditure Position (within the report) –	

	In Month Actual	YTD
Income	£'m	£'m
Patient Income	53.48	53.48
Other Income	14.65	14.65
Total	**68.12**	**76.41**
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)**

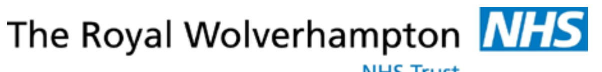
048.01.03	Covid 19 Expenditure – In month 1 there was a total of £124k expenditure relating to Covid-19, of this amount £80k is reimbursed for testing.	
048.01.04	Cash – The cash balance as at 30th April 2023 was £68.4m actual against £61.2 planned. **Chair's Summary Alert to Board:** • Month 1 position is very challenged, even with adjusted phasing there is a larger deficit than expected. • There are challenges on assumptions/actual levels of sickness. • There has been a net increase in cost due to the impact of the Junior Doctor Industrial Action and a loss of ERF income. • The Trust's CIP is not delivering to expectations. • There is good control over agency but Q1 targets are unlikely to be met. The Committee received and noted the report.	
049.02	Financial Planning – J Green presented the report to the Committee and outlined progress to date. The Trust Board met on 2nd May 2023 and approved the submission of the Trust Financial Plan to NHS England due on 4th May 2023. J Green reported a slight change to the overall position as the ICB submitted a plan which improved the System position by £5m from £73.9m to £68.9m. The overall position for the year is showing as £26.75m in deficit. Trust Board approved the Q1 budget which is £13.085m in deficit. The plan has not yet been formally accepted by NHS England.	

	J Dunn queried how close the Trust would be to achieving the Q1 budget. J Green stated that worst case scenario could be £18m deficit. G Nuttall informed the Committee that there may be an improvement to ERF from June, but that this is at risk due to further industrial action. J Dunn requested a forecast for Q1 to be included in the paper for Private Trust Board which will be lead by G Nuttall and K Stringer. J Dunn suggested a pre-meeting prior to Trust Board. J Dunn queried if there were any areas additional trained staff could help generate additional ERF. G Nuttall confirmed an additional 60 WTE had been invested in non-elective and community and that some of this could be utilised at Cannock Chase Hospital and Orthopaedics. The Committee noted the report.	**J Green/ K Stringer/ G Nuttall**
049.03	Financial Recovery Group Update – G Nuttall clarified that the Trust was not likely to achieve £45m CIP, however, a plan is being developed to make efficiency savings over the next 2 – 3 years. J Dunn stated that the additional Committee will assist with focus and scrutiny of CIP. D Gritton provided a summary of the report as follows: 2023/24 Summary – A Trust CIP target of £45,152,568 has been identified for 2023/24. Divisional allocations were confirmed by w/e 19th May 2023. Pipeline Summary – Reviews have taken place across the Divisions to identify opportunities to support the Productivity and Efficiency Programme. Reviews have also included assessment of opportunities identified from the Model Health System and these are included within the pipeline. Meetings to review opportunities identified in the Corporate Self-Assessment Toolkit have been progressing. Schemes identified from these reviews are also included in the pipeline. The final meeting with Legal Services team is planned for 8th June. A summary of schemes identified to date is included within the pack. Work is in progress with the individual services to support with the development of schemes. Triage of schemes to be undertaken to identify divisional priorities. A number of PIDs are already in development. A meeting with the Director of Nursing has been arranged for 9th June 2023 to support the QIA process ahead of the FRG meeting on 21st June 2023. A total of 159 schemes are included on the pipeline. Work is progressing to identify financial opportunity associated with each Scheme. Estimated numbers will need validation by the finance team as the schemes are further developed and PIDs are finalised. J Dunn asked that the cost avoidance schemes be split and reported separately going forwards. PIFU – There are currently 17 services which have introduced Patient Initiated Follow Up. The Trust is ranked 30/133 nationally. Additional services have also expressed their intention to implement PIFU (Cardiac services, Gastroenterology, Respiratory and Pain Management) **Chair's Summary Alert to Board:** • 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.	**D Gritton**

	Chair's Summary Advice to Board: • There is a need to develop radical change/service re-design via cost of poor quality, GIRFT, Model Hospital, Red Days from huddle and Outpatient Transformation throughout the Trust and to engage staff to assist with addressing the back log and increasing output. G Nuttall stated that a meeting is in place with D Hickman to complete the risk assessment process for all PIDs. L Cowley stressed the need to embrace service re-design to achieve the output required. G Nuttall agreed and informed the Committee that there has been a reduction in business cases being submitted to the Contracting and Investment Group Meeting which highlights a change in emphasis/focus throughout the organisation. J Green stressed the need to document the level of effort being put in to tackle the challenge ahead. The paper presented to Trust Board identified potentially £7m non-recurrent opportunities on top of the £4m CIP identified, which could assist with the significant challenge. L Cowley queried the progress of the "Grip and Control" document. J Dunn and G Nuttall confirmed that the detail will be examined at an alternative meeting which will feed into a Committee to look at the detail. J Dunn summarised that activity is increasing and all Divisions have been engaged via FRG. The Committee asked G Nuttall and K Stringer to review existing resources to ensure appropriate levels are in place to meet expectations. The Committee noted the report.	**G Nuttall/ K Stringer**
049.04	<u>Investigation into REAF 611</u> – D Gritton left the meeting for discussion regarding the paper due to a conflict of interest. J Green provided an update on the review of the circumstances surrounding the service commencement prior to governance approval. The investigation outlined the findings, lessons learnt, proposed actions and conclusions. J Dunn confirmed that there had been a Governance Breach which has been declared to Julie Jones, Chair of Audit Committee. J Green stressed that the staff involved had acted within the best interest of patients but confirmed that money had been committed without authority. J Green also informed the Committee that the Data Protection team were engaged ahead of the commencement of the Service and advice was given but a full review was not completed. The Data Protection Impact Assessment has been through the DPIA process but due to some queries it was not fully signed off prior to actions taking place. J Dunn stated that Audit Committee will make a decision on whether they're happy with the recommendations and course of action to be taken and will then report to Trust Board informing them of the actions being put into place. L Cowley expressed concerns that this has happened to more than one contract and felt that there was a need for training to address the cultural issues to ensure formal process is followed in future. J Dunn thanked J Green for completing the investigation and agreed next steps. J Dunn asked J Green to produce an action plan which displays a lead against each action and how its going to be monitored. J Dunn asked K Stringer to send a directive regarding the formal process which should be adhered to and that there is zero tolerance for not following process. If urgent approval is required business cases can be approved by the relevant authority within a 24 hour period. K Stringer provided some context to the Committee stating that the Trust processes 75,000 of purchase orders per year and that the vast majority follow process and adhere to the FSI's, but did agree that the breach was a serious matter and should be addressed.	**J Green** **K Stringer**

	Chair's Summary Alert to Board: An investigation has taken place into the circumstances surrounding a service commencement prior to governance approval. The investigation has been referred to Audit Committee. The Committee noted the report.	
050/2023	**Board/Pre-Board Approval Reports**	
050.01	Supply of Frozen, Chilled and Fresh Produce for Retail and Patient Feeding (REAF 885) – The report recommended noting the award of a contract for the supply of Frozen, Chilled and Fresh Food for Patient feeding and Retail units to Bidfood against the NHS Supply Chain (NHSSC) Framework: Multi Temperature Food Solutions (2021/S 000-003960) and Multi Temperature Distribution (2019/S 106-258299) for a 1-year period at an estimated value of £1,485,000, subject to a potential reduction following approval of product switches to alternative suppliers. J Green clarified that the delay in submitted the business case was part of a national process and the Trust contract ended at the end of the March, ongoing discussions were taking place with Suppliers due to increased food supply prices and organisations were instructed to wait until discussions had been completed due to an improvement in the costs, which resulted in a £280k saving. J Green informed the Committee that an update paper should have been presented to the Committee in March requesting a 1 – 2 month extension during the interim process. J Green informed the Committee that N Joy-Johnson will RAG rate and provide a forward look of large contracts which are due to be reviewed within the next 3 month period. The Committee expressed concerns regarding the breach and stressed the need for training to be rolled out as a matter of urgency. G Nuttall stated that the business case breached due to lack of forward planning by the Procurement Department. **The Committee noted the business case was made without authority. The business case will be submitted to Trust Board for further noting.**	
050.02	18 Week Ltd – Endoscopy Support (REAF 1100) – The paper requested approval for the insourcing of endoscopy services to support the delivery of the recovery programme within the service. Approval is being sought for the insourcing service to run from 1st July 2023 to 31st March 2026 at a cost of £6,199,904. The funding will be through the Community Diagnostic Centre (CDC) programme funding and Elective Recovery Fund. The Trust is looking to award a further 2 year contract from 2024 via a competitive process. J Dunn asked that the paper be split into 2 parts. The Committee would consider the 9 month extension at the meeting but asked that the request for the 2 year contract be re-submitted next month. J Dunn queried if finances were in place for the contract. T Shayes confirmed that finances were covered via ERF. L Cowley queried if the existing company had delivered a good service. T Shayes confirmed that this was the case and that the Trust had been utilising the service at New Cross Hospital and that the plan was to expand support to Cannock Chase Hospital. G Nuttall also confirmed that break clauses are also in place within the contract. **The Committed endorsed the business case to be submitted to Trust Board to raise a purchase order to accommodate the 9-month contract extension with 18 Week Support Limited.**	
050.03	FBC Update: Cannock Chase Hospital: Theatres Proposal (North Hub) – S Watson outlined the contents of the paper to the Committee.	

	The paper is an update to the project and an appendix to the Full Business Case. An expression of interest was submitted to Performance & Finance Committee prior to seeking TIF 2 funding. The Outline Business Case was brought to Performance & Finance Committee in August 2022. Professor Tim Briggs suggested revising the paper from 4 theatres to 3 theatres and 1 procedure room. NHSE Joint Investment Sub Committee conditionally approved the OBC subject to receiving the FBC in July 2023. G Nuttall and S Watson were invited to a meeting on 4th May via the Programme Lead from the Regional Finance Team who informed them that the bid was under consideration for potential rejection due to the programme being cut back. Following challenge the Trust was informed if we were able to submit a Full Business Case within the next 7 days, accepting it would be in draft and would not have gone through the Trust governance processes, they would reconsider their position. The Trust submitted the Full Business Case on 12th May with several caveats, including the Trust governance process. The paper submitted for consideration at Performance & Finance Committee today appends the cover of the version of the paper submitted. The developer requires an order in early June to meet the 2024 completion date, to start activity from January 2025. The Trust is working with the developer to try to squeeze time to place the order. The funding body have now started that they will take 14 weeks to consider the Full Business Case and will not provide confirmation until at least late September. NHSE are requesting ICB support for the level of risk for the capital and discussions are taking place regarding this. Trust Board sign off is also required against any derogations in the scheme. Discussions took place regarding the paper. L Cowley queried if there was a risk factor against not fully utilising theatres in place at neighbouring Trusts. G Nuttall confirmed that as part of the wider collaboration Walsall Healthcare NHS Trust and The Dudley Group NHS Foundation Trust were in agreement with the business case. M Green informed the Committee that the business case is based on a number of costed/financial income assumptions and that further work needs to take place. J Dunn asked K Stringer to arrange a dedicated meeting with the relevant parties prior to Trust Board to consider the paper in some depth.	**K Stringer**
052/2023	**Governance**	
052.01	BAF – The report was not discussed.	
053/2023	**Reports to Note**	
053.01	Annual Work Plan – The report was noted.	
053.02	Capital Report – The report was noted.	
053.03	High Value Contract Report – L Cowley requested clarity if the document was seeking approval for the 3 month rolling list. J Green to liaise with N Joy-Johnson to provide clarity regarding this section. The Committee noted the Teletracking System Business Case which is due to be approved by Performance & Finance Committee on 28th June, the contract is due to end on 1st July and the next Trust Board Meeting is 1st August. J Dunn advised that the business should be submitted for Performance & Finance Committee and Trust Board for authority outside of the cycle.	**N Joy-Johnson**
053.04	Contracting & Business Development Report – The report was noted.	
053.05	Sustainability Report – The report was noted.	
053.06	Monthly Supplementary Finance Report – The report was noted.	



053.07	Temporary Staffing Dashboard – The report was noted.	
054/2023	**Meeting Reflection**	
054.01	Meeting Reflection – Nothing to highlight this month.	
054.02	CEO Highlights – Nothing to highlight this month.	
055/2023	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on Wednesday 28th June at 8.30am via MSTeams. Please ensure that all reports are emailed to claire.richards12@nhs.net in pdf format by 12noon on Friday 23rd June.	

Minutes of the Performance & Finance Committee

Date	Wednesday 21st June 2023
Venue	via MSTeams
Time	11.00am

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

In Attendance:	
Tim Shayes	Deputy Group Chief Strategy Officer
Mark Greene	Deputy Chief Finance Officer
Adam Race	Director of Human Resources & Organisational Development
Keith Wilshere	Trust Secretary (Part Attendance)
Dean Gritton	Group Manager, Oncology, Haematology, Radiotherapy & Palliative Care (Part Attendance)
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

056/2023	**Apologies for Absence** Apologies were received from James Green, Stew Watson and Alan Duffell.	
057/2023	**Declarations of Interest** There were no declarations of interest.	
058/2023	**Minutes of Meeting Held on 24th May 2023** The minutes of the meeting from 24th May 2023 were agreed.	
059/2024	**Action Points from the Previous Meetings**	
059.01	Q1 & Q2 Update (Action 1225) – J Dunn had asked T Shayes to provide a prediction of the cohorts of waits for 52, 65 and 78 week waits at the end of Q1 and Q2. T Shayes confirmed that this information is now available within the report. **Action closed**	
059.02	Ultrasound, Echocardiography Histopathology Staffing Challenges PODC (Action 1226) – A Race confirmed that he would raise the challenges at PODC. **Action closed**	
059.03	Increased Sickness Costs (Action 1227) – A Race provided a verbal update against the action, confirming that a further deep dive would look into this action at the next PODC Meeting. A Race highlighted that the sickness absence target and budget target is not aligned. J Dunn expressed concerns as the lack of alignment will affect Q1 performance. G Nuttall agreed that there was a need to ensure that the Trust identify an average rate against the financial run rate. G Nuttall and A Race to meet and discuss with the Finance team.	**AR/GN**
059.04	Financial Planning Private Trust Board Report (Action 1228) – K Stringer confirmed that a pre-meeting had taken place and that there had been discussions at Private Trust Board.	**KS**

	K Stringer informed the Committee that an Escalation Meeting is due to take place on 23rd June which will result in actions to be taken and discussions regarding the Chair. K Stringer suggested that this information be collated into a report to the Performance & Finance Committee in July.	
059.05	FRG Cost Avoidance Schemes (Action 1229) – D Gritton confirmed that cost avoidance schemes information had been provided within the pack. **Action closed**	
059.06	FRG Resources (Action 1230) – G Nuttall confirmed that a discussion had taken place with K Stringer regarding resources in place to assist with CIP. G Nuttall informed the Committee that the Service Efficiency Team will be fully established from 1st July 2023. Discussions need to take place at Executive level to see if further resources are required to support this area. L Cowley queried if the culture was aligned to meet the requirement. S Evans clarified that the Quality Improvement Team are continually working to address longer term transformation. S Evans informed the Committee that a Transformational Event will be taking place in 3 weeks to work towards this and that the Trust is participating as a test site for the national roll out of the Delivering Continual Improvement approach. S Evans informed the Committee that a paper will be submitted to Trust Board informing the Board of the event.	**GN**
059.07	Investigation Action Plan (Action 1231) – The action plan was updated and circulated to the Committee for information. **Action closed**	
059.08	Formal Directive re REAF Governance Process (Action 1232) – J Dunn had asked K Stringer to send a directive regarding the formal process which should be adhered to and that there is zero tolerance for not following process. If urgent approval is required business cases can be approved by the relevant authority within a 24 hour period. K Stringer clarified that a briefing had been drawn up and will be revised if necessary after the Audit Committee had reviewed the investigation report.	**KS**
059.09	Meeting to discuss Cannock Chase Hospital: Theatres Proposal (North Hub) (Action 1233) – J Dunn had requested a dedicated meeting to consider the paper in some depth. K Stringer stated that the business case was submitted to NHSE on Monday 19th June, the cost overrun has been adjusted so now at £36m and the delivery date has been revised to February 2025. K Stringer stated that the FBC is cost neutral on an I&E basis, and it has been submitted to NHSE, ICB Finance Director and the Acute Collaboration. K Stringer confirmed that there is a need for the Committee to meet to have an exceptional discussion regarding the FBC. J Dunn asked that L Toner, J Jones and A Heseltine also be invited to the meeting, along with the Performance & Finance Committee NEDs. G Nuttall felt that there was also a need for oversight from Walsall and Dudley Trust Boards.	**KS**
059.10	Teletracking System Business Case (Action 1234) – The business case was not added as an agenda item following a decision to opt for a shorter contract extension while further negotiations are taking place regarding a wider scope within the application. The business case will be submitted via the appropriate financial approval process but will not require escalation to Performance & Finance Committee. **Action closed**	
059.11	3 Month Rolling List Clarification Action (1235) – L Cowley queried if the 3 month rolling list was seeking approval. N Joy-Johnson circulated a response to the query, clarifying that the contracts are not for approval but for information. The information is provided as the Committee had asked for transparency of when high value contracts would be being submitted to the meeting for consideration. **Action completed.**	

060/2023	**Review of the Performance & Finance Committee Terms of Reference**	
060.01	The Terms of Reference (ToR) were reviewed and updated to include: • Interim Executive Directors and nominated Deputies within the quoracy arrangement • The emerging Cyber Risk (SR18) is now a confirmed risk so this point was updated. The Contracting & Commissioning Group Meeting has been re-named to Contracting & Investment Group Meeting. C Richards sent a copy of the revised Terms of Reference to S Banga for formal Trust Board approval. **Action completed** S Evans informed the Committee that the new Chair has requested that all sub-committees align in principle, this will impact on the Terms of Reference of the committees. As the Terms of Reference are a live document a review will take place as and when required.	
061/203	**Financial Performance**	
061.01	Monthly Financial Report – K Stringer provided an overview of the financial performance. The Trust is reporting an in month adjusted deficit of £3.3m, this is £0.35m favourable to plan, this leads to a year to date deficit of £11.6m which is £1.9m behind plan. Income was £2.4m favourable and £0.5m adverse YTD against plan, primarily due to guidance at the time to recognise full YTD ERF in month 2 which is £0.9m more than delivery and timing of PSDS grant funding which was £1.7m more than plan in month bringing it broadly on plan YTD, with some small over an underperformances across the divisions. Pay is £1.4m adverse to plan in month and £4.1m adverse YTD. YTD Pay pressures YTD include £1m of associated strike costs, continued ward pressures, high levels of sickness/absence and cover than budgeted and ED. There are some phasing challenges surrounding CIP which will be addressed.	
061.02	Trust Income & Expenditure Position (within the report) –	

	In Month Actual	YTD
Income	£'m	£'m
Patient Income	59.49	112.97
Other Income	16.99	31.64
Total	**76.48**	**144.61**
Expenditure	**79.75**	**156.16**
Surplus/(Deficit)	(3.26)	(11.55)
Planned Surplus/(Deficit)	(3.62)	(9.61)
Variance to Plan	0.35	(1.94)

061.03	Covid 19 Expenditure – In month 2 there was a expenditure of £142.6k on testing and £35.5k on Covid Medicines Delivery Unit. Income is received for both of these services to offset the costs.	
061.04	Cash – The cash balance as at 31st May 2023 was £66.4m actual against £55.5m planned.	
061.05	System Update – The ICB is reporting a YTD deficit of £33m, £11m adverse to plan (2.4%), however accounting for a phasing issue in plans would adjust the variance to £6.9m. £3m of flexibilities has been released against a plan of £5.1m and there is under delivery of CIP by £6.6m, with £15.9m delivered against a planned £22.5m. A meeting is due to take place with NHSE on 23rd June.	

	M Green clarified that the current run rate includes the national assumption around counting all ERF income and that traditionally the pay award is not usually fully funded through the process. Lord Carter queried if the CIP programme was split between recurring and non-recurring within the budget. K Stringer clarified that the recurring CIP is built into the plan and the Trust accounts for non-recurring and recurring in all of the management reports. Lord Carter stated that the Trust was not meeting the recurring CIP target and queried what actions were being taken to address this. K Stringer confirmed that this was correct. J Dunn clarified that the detail would be available within the Financial Recovery Group Report update. **Chair's Summary Alert to Board:** • The Trusts position may remain as it is but Q1 performance could deteriorate. The Committee received and noted the report.	
061.02	Financial Recovery Group Report – G Nuttall provided an update as follows: 2023/24 CIP Summary – Against an in month target of £1,573,839, the Trust has achieved £1,002,802. Of this, only £8,352 is recurrent. The 2023/24 target for the trust is £45m and the Trust has identified savings with full year effect of £4.46m. G Nuttall clarified that following various mitigations the CIP ask has been reduced to £38.15m**.** There is currently a total of £28m unidentified CIP following the completion of PIDs and QIAs. G Nuttall confirmed that the Trust does not have a plan to remove 6.5% of the cost base. J Dunn requested a comparison of CIP proposals from the other 3 Trusts within the group and if there were any areas of good practice that could be shared to generate further savings. K Stringer confirmed that he could provide this information. Lord Carter queried if this was tied to staff savings and what GIRFT data shows against benchmarking. G Nuttall stated that this varies via speciality and outlined several areas where the Trust benchmarks in the top quartile nationally. J Dunn requested a separate deep dive CIP discussion at the next AOP Oversight Group Meeting w/c 26th June. A discussion took place, G Nuttall suggested a meeting to take place week commencing 3rd July instead. J Dunn queried if Allocate could be used to assist with bank expenditure. G Nuttall confirmed that this is underway and assured the Committee that Bank authorisation levels have been escalated to improve control and monitoring. G Nuttall suggested that the Committee formally sign off the revised Grip and Control Metric Spreadsheet. J Dunn asked that this be added as an agenda item. J Dunn queried if savings could be made from Place via the ED pathway if there were less visits. S Evans stated that a benchmark data would need to be set to enable attendance. S Evans stated that he would look into this and feedback. Pipeline Summary – A total of 161 schemes have been identified to date across all areas of the organisation. Current values identified against 47 of the schemes equates to £7,188,488 plus a further 22 schemes with estimated values of £2,825,342 but is subject to further scoping by the service and finance teams. **Chair's Summary Alert to Board:** • A CIP deep dive will take place in 2 weeks' time. • Comparisons will take place with colleagues and good practice will be shared. • Investigate recurrent costs and savings and those which were recurrent last year that flow into this year.	**KS** **KS/KG** **GN** **SE**

	• Investigate the use of Allocate to assist with Bank costs. • Look into demand management via OneWolverhampton to possibly identify savings that could flow into the Emergency Department against visits saved. • Grip and control measures will be presented to the Committee for sign off. • A deep dive will take place to look into the unidentified £28m.	
062/2023	**Performance**	
062.01	Elective Recovery Programme – T Shayes provided an update on the paper and provided the following highlights: Advise: • The Urology waiting list transferred from Walsall on the 1st June – the impact of this transfer is noted within the report. • Having plateaued towards the end of 2022/23, the waiting list has risen steadily since the turn of the year. This is primarily as a result of the industrial action in March and April. This trend is expected to continue as a result of the transfer of Urology patients from Walsall as well as the further industrial action in June. • The activity plan for this year was signed off at 106.9%, falling slightly short of the 108% Trust target. On a value weighed activity basis (i.e. the financial value of our activity plan), the value of this plan is 103%. • The Trust delivered 101.6% of activity in May (compared to 2019/20) compared to a plan of 104%. On a value weighted activity basis however, this equates to 106% (compared with a plan of 103%) • Since the last meeting, additional plans have been developed that include additional weekend working to support the 78 week position and business cases to support an overall increase in activity. Our activity plan now stands at 104% as a result. J Dunn queried why the activity plan was signed off at 106.9% rather than the 108% required and questioned if this could be exceeded. T Shayes stated that the primary reason for the lower sign off figure was due to staffing challenges but assured the Committee that efforts are being made to increase activity levels. G Nuttall clarified that the Financial Recovery Group are working on an ERF Plan to assist with this. J Dunn asked that the ERF Plan be submitted to the Committee for scrutiny at the July meeting. Alert: • The Trust has been alerted to the likelihood of it being escalated to the tiering system for its 62 day cancer performance – formal confirmation has still not been received. There is also ambiguity over whether performance will be managed at system or provider level and the criteria for exiting the tiering system. A discussion took place regarding the cancer trajectories. G Nuttall confirmed that the Trust was not meeting the trajectory in 2 – 3 specialities, the largest of which is Urological. G Nuttall clarified that further discussions would take place at QGAC but that the Trust was reliant on mutual aid. G Nuttall highlighted that due to the transfer of patients from WHT, RWT's cancer trajectories will change. M Levermore queried how much resource was being put into scenario planning to enable the Trust to engage in a Black Country solution. G Nuttall stated that this would vary via tumour site and via terms of national support in terms of programmes of activity. G Nuttall clarified that a piece of work is being undertaken to tackle the Urology waiting list now that a single PTL is in place. G Nuttall clarified that Cancer Alliance are providing some support with this. M Levermore queried if data analytics were in place. G Nuttall confirmed that good data analysis was in place but that there was a need to prioritise the workload. Lord Carter requested a reminder of the mutual aid financial process. G Nuttall clarified that if a patient transfers to an organisation, that organisation is paid for undertaking the work and there is no cost to the system other than the additional treatment and income that is earned. The Trust will pay to transport and transfer patients but that this will form	**GN**

	part of the PbR process. Lord Carter queried if the Trust received any mutual aid and if the Trust was receiving the correct funding for this. G Nuttall confirmed that this was the case. Alert: • 623 patients (570 outpatients and 52 admitted patients) either had their appointment cancelled or rearranged as a result of the Junior Doctor. This activity is being re-arranged but to the detriment of other patients who would have otherwise utilised this capacity. • The Trust anticipates having 63 x 78 week breaches at the end of June. Whilst a plan had been developed to clear these patients, this was impacted by the industrial action, the transfer of Urology patients from Walsall and the limited number of surgeons (or alternative providers) to treat perform these operations. Assure: • The Trust has completed a self-assessment of its Elective Recovery Plans using the appended tool from NHS England. This demonstrates either existing compliance or a plan to achieve this in all areas with the exception of the reduction in our follow up waiting list. L Cowley queried if weekend working was factored into budgets or whether it was a cost the Trust had not planned for. G Nuttall confirmed that it is additional activity over what was included within the plan and an element of this will make a contribution. L Cowley queried how 78 week breaches compared to other Trusts and whether the Trust would clear this by the end of July. T Shayes stated that the Black Country is the second best performing within the Midlands region for 78 weeks. T Shayes confirmed that the Trust has plans in place to achieve the target by the end of June. L Cowley queried if the new additions are lower than the trajectory and lower than 19/20 why the Trust was struggling to achieve this with higher levels of staff. T Shayes stated that Industrial Action and the Kings Coronation have impacted on waiting list clearance. G Nuttall informed the Committee that the bridging document will likely identify that the majority of additional staffing has been within the emergency portals which do not deliver against waiting list activity. L Cowley queried if the trajectories were achievable based on performance. T Shayes confirmed that they were, April performance fell short due to the impact of Industrial Action and May performance was overachieved despite the impact of Industrial Action and the Kings Coronation. L Cowley expressed concerns regarding the lack of progress with Outpatient Transformation. G Nuttall informed L Cowley that a plan is in place and that work is progressing. G Nuttall clarified that L Dowson is the QI Clinical Lead, B McKaig is the Medical Director Lead and 26 week Rapid Transformation Initiative Clinical Leads have been identified for specific specialities from within the Trust. G Nuttall clarified that the system has signed up to the Tim Briggs Improvement Project and suggested D Gritton arrange a separate briefing session at next month's meeting. J Dunn requested some modelling to look at capacity options to optimise the tail post 52 weeks and the throughput. The Committee noted the report.	 **DG** **TS**
062.02	National & Contractual Standards (IQPR Extract) – G Nuttall provided an update and informed the Committee that the Trust is achieving against the 4 hour metric, the expectation is for organisations to be over 76% which is being achieved. Ambulance handover is generally good but there are 1 – 2 days which posed significant challenges. G Nuttall informed the Committee that may be a potential area of additional funding for RWT and WHT around ambulance income which could form part of commissioning negotiations next financial year.	

	WHT and RWT are supporting each other with mutual aid with skin referrals. G Nuttall stated that the Trust is on target to achieve the target to treat 67% of patients within 28 days against the faster diagnosis standard. Histopathology continues to be a challenge. J Dunn requested an update on medically fit for discharge patients. G Nuttall informed the Committee that the target had reduced from an average of 100 to 75 as a whole system, however, the Trust still has the equivalent of 2 additional wards open. J Dunn clarified that this has been reduced by 25%. **Chair's Summary Assurance to Board:** • Highlights in performance, Board to compliment the team on ED performance as it continues to operate at a high level. L Cowley queried if the Trust was seeing high levels of non-ambulance presentations and if they continue to be broader than local residents. G Nuttall confirmed that there was a national pattern of an increase in non-ambulance presentations. G Nuttall clarified that the walk in presentations were predominantly local. L Cowley queried if there was any scope of modelling for teams to be moved around to assist in other areas of performance. G Nuttall confirmed that this was the case and that it was happening. The Committee noted the report.	
062.03	Winter Plan – The report was noted. L Cowley requested assurance that an effective discharge protocol is in place. G Nuttall confirmed that a clear discharge plan was in place to ensure patient discharges are safe no matter what the time of day. G Nuttall to ask D Hickman to liaise with L Cowley regarding the detail outside of the meeting. L Cowley queried how RWT initiatives that have been continued post the end of March are being funded. G Nuttall clarified that Service Development Funds have been reduced from £2.5m to £1.2m. The £1.2m covers the virtual ward schemes and a number of schemes are being continued at risk. Discussions are taking place around Better Care Fund Schemes at Place level around how BCF Schemes and the finances around them are allocated. G Nuttall stated that she was confident that the Trust would be able to mitigate any cost of schemes that are at risk. If the costs are not mitigated the Trust will make a decision on ceasing the schemes or stopping something else to fund the scheme. L Cowley queried when the information would be made available regarding the funding. G Nuttall stated that the BCF bid needs to be submitted by 26th June. M Levermore also asked for a list of services that this could impact. G Nuttall to update at the next meeting.	**GN** **GN**
063/2023	**Board/Pre-Board Approval Reports**	
063.01	Extension of Alliance Medical CDC Contract Until December 2023 (REAF 1104) – The report recommends the award of a 5-month extension of the contract for the provision of a mobile Magnetic Resonance Radiology (MRI) & Computerised Tomography (CT) scanning service at Cannock Chase Hospital to Alliance Medical Ltd at an estimated value of £1,351,584 (incl. VAT). EREAF no.1104. A total of £3,420,702.00 incl. VAT will have been spent with Alliance Medical to cover up to the 31st July 2023. This was approved by the Trust Board in October 2021. A discussion took place regarding the business case. K Stringer clarified that costs are covered for the 5 month extension on the current contract using a procurement framework that is compliant. J Dunn stated that the business case will also help the Trust to achieve elective recovery performance and is part of the strategy to augment CDC at Cannock.	

	The Committee endorsed the business case to be submitted to Chair of Trust Board for external approval process due to the time critical cut-off date.	
064/2023	**Governance**	
064.01	Annual Work Plan 6 Month Review – The Committee were asked to review the annual work plan and to submit any changes to C Richards.	
064.02 064.02.01 064.02.02 064.02.03 064.02.04	BAF Update – The Committee discussed the following BAF risks: SR15 – The risk target level has increased due to significant financial challenges throughout 2023/24 and the significant risks being placed on the Trust Risk Register over a 3 year period; 23/25 operating a Deficit Plan (this financial year), 23 – 26 Recovery Plan operating across 3 years and 23/24 Internal and External Financial constraints including workforce controls, expenditure controls, external interventions, oversight and monitoring. The recommendation is that the score remains at 20 Moderate. **The Committee agreed the level of risk.** SR16 – Due to the impact of extreme operational pressures during the winter and since March 2023 there has been a change to the risk rating. The rating is now 20 High. **The Committee agreed the level of risk.** SR18 – The target level is rated at 15 High. L Cowley queried if a separate Board Development Session was being arranged to discuss the cyber risk. K Wilshere confirmed that this was the case. **The Committee agreed the level of risk.** New and Emerging Risks – There were no new or emerging risks arising from the meeting.	
064.03	Proposed Performance & Finance Committee Dates 2024 – The Committee dates were discussed and agreed. C Richards to forward the Committee dates to S Banga for Trust Board approval. **Action closed**	
065/2023	**Reports to Note**	
065.01	Capital Report – The report was noted.	
065.02	High Value Contract Report – The following report highlighted that the following business cases are due to be submitted to the Committee next month: Fresh, Frozen & Chilled Food Contract Award (EREAF 1122), Procurement Lead: E Viola Renewal: 7/08/23 Linen and Laundry (EREAF 1121), Procurement Lead: E Viola Renewal: 12/8/23 Microsoft Office 365 (EREAF not allocated), Procurement Lead: S Price Renewal: 3/9/23 Car Parking and Security Services (EREAF not allocated), Procurement Lead: E Viola Renewal: 31/12/23 L Cowley highlighted that the Teletracking business case was listed within the report and that this information was no longer current. N Joy-Johnson to ensure that the report is updated to reflect any changes prior to the meeting in future.	**NJJ**
065.03	Monthly Supplementary Finance Report – The report was noted.	

065.04	Temporary Staffing Dashboard – The report was noted.	
065.05	NHSI Monthly Return – The return was noted.	
066/2023	**Meeting Reflection**	
066.01	Meeting Reflection – Nothing further to raise.	
066.02	CEO Highlights – Nothing further to raise.	
067/2023	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on Wednesday 19th July at 8.30am via MSTeams. Please ensure that all reports are emailed to claire.richards12@nhs.net in pdf format by 12noon on Friday 14th July.	

Minutes of the People and Organisational Development Committee

Date	**Friday, 26th May 2023**	
Venue	**Via MS Teams**	
Time	**10:30am**	
Present:	**Name**	**Role**
	Chrissla Davis	Deputy Director of Nursing
	Sally Evans	Group Director of Communications and Stakeholder Engagement
	Allison Heseltine (Chair)	Associate Non-Executive Director
	Catherine Lisseman	Head of Corporate Learning Services
	Mark Ondrak	Staffside Lead
	Adam Race	Interim Director of HR & OD
	Ananth Viswanath	Deputy Medical Director
	Cath Wilson	Deputy Director of Nursing
	Claire Young	Group Deputy Director of Education & Training
In Attendance:	Maria Dent	PA to Group Chief People Officer
	Elimina McKenzie	Research Midwife (Observing)
	Steve Phipps	Group Manager, Division 1
	Julie Shillingford	Head of HR Advisory
	Louise Sims	HR Manager, Division 1
	Seb Smith-Cox	Workforce Intelligence, Planning & Analytics Lead
Apologies:	Alan Duffell	Group Chief People officer
	Lewis Grant	Deputy COO, Division 1
	Lyndsey Ibbs-George	Divisional Manager, Estates & Facilities
	Gail Parry	Deputy Head of OD and Workforce Transformation
	Sue Rawlings	Associate Non-Executive Director
	Amy Sykes	Head of OD and Workforce Transformation

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1.	**STANDING ITEMS**	
1.1	**Apologies for Absence and Welcome to the Meeting** Apologies were noted and recorded as above. A Heseltine advised that the process for assigning new Non-Executive representatives to the Committee was ongoing but unfortunately the Committee was not quorate for this meeting.	
1.2	**Declarations of Interest** No new additional declarations recorded.	
1.3	**Confirmation of the Minutes from the Last Meeting, 24th March 2023** The minutes from the 24th March 2023 were agreed as a true record of the meeting.	
1.4	**Review of Action Log and Matters Arising:**	
1.4.1	**Staff Flexible Working Pledge (Action 2023/013)** J Shillingford advised that she had been asked to review a pledge that had gone to Walsall Trust Board around flexible working to ascertain whether there would be any merit in having something similar at RWT. She advised that flexible working provisions at RWT were set out within the Trust's work life balance policy and the Trust was committed to supporting its employee's work life balance. She noted that the same principles of the pledge were built into the RWT policy and recruitment practices and queried whether a formal pledge would add any further value. She stated that the real focus needed to be on implementation by managers supporting the requests and putting it into practice, which was an area that had been raised by Staffside at the recent JNC meeting. Following discussion the Committee agreed that a flexible working pledge was not required at RWT given that the policy was in place. It was noted that the commitment for managers to support should be encouraged, although recognising that service delivery was essential. A Race proposed that this was highlighted within the weekly David's Despatch, S Evans suggested that definition of flexible working and hybrid working was clearly defined to outline the difference between the two. C Davis commented that from a clinical perspective, the wording needed careful consideration, as flexibility between the organisation and staff was required to ensure that services were covered 24/7. J Shillingford advised that the Trust had the Flexible Working policy and also an Agile Working policy which covered hybrid working and there was a facility for staff to make less formal arrangements. She agreed to forward over the wording from the Trust's internet page for inclusion within the minutes (see below) and for consideration of the Trust notification. "***Flexible Working*** *- As a major employer in the Black Country and West Birmingham region we are committed to supporting all employees to achieve a healthy work life balance. We want the Black Country and West Birmingham region to be the best place to work and as such will consider all requests to work flexibly taking into account personal and individual circumstances alongside the needs of the service. We encourage all prospective applicants to discuss their individual circumstances with the Recruiting Manager as part of the on-boarding process.*"	**Action: 2022/021 A Race S Evans**

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	Action 2023/013 closed.	
	Workforce Targets and Thresholds (Action 2023/015) A Race confirmed that he had spoken with colleagues at Walsall and Dudley regarding the retention rate targets and the bank fill target rates. It had been agreed, for consistency, that all three Trusts would focus on the 12 month retention at a target rate of 88%. For bank fill rates however, he advised that all three Trusts were in different places as organisations with RWT having a well developed bank, therefore, all three Trusts would have the same measures but have slightly variable targets. Action closed.	
2.	**Key Updates and Workforce Performance s**	
2.1	**Key Updates**	
2.1.1	**Pay Award for Agenda for Change NHS Staff** A Race advised that the pay award for Agenda for Change staff in England which was a non consolidated payment for 2022-23 made up of a 2% plus the back log bonus and the 5% consolidated pay award moving into the current financial year which was due to be paid at the end of June. He advised that there had been some contention around the application of the lump sum award as it did not apply to bank staff. This concern was being escalated to NHS Employers and other national organisations. In response to a question by A Heseltine, A Race confirmed that enhanced rates had been made over the summer months ubiquitously, followed by more targeted rates for specific areas who were struggling to fill any bank shifts.	
2.1.2	**Industrial Action** A Race informed that whilst the trade unions had collectively accepted the pay deal, there were a number of unions that had not agreed and therefore, the Royal College of Nursing (RCN) and the Society of Radiographers (SOR) were re-balloting their members during the month of June on industrial action. He advised that the RCN would hold be a national ballot, not Trust specific as previously, therefore if mandate achieved this may result in industrial action taking place at RWT by nursing colleagues. A Race stated that the BMA, Medical Consultants and the BDA, Dental Association, would be balloting their membership during the month of June and he advised that the Junior Doctors had a mandate for industrial action until 19th August, so there was a possibility that both the junior doctors and senior doctors could call for action during mid-July to 19th August. He advised that the Junior Doctors had called for 72 hours industrial action between 14th-17th June and the operational teams were currently organising contingency plans but there would, of course, be some impact on elective activity.	
2.2	**Executive Workforce Report**	

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	A Race advised that the report provided performance against the revised targets as agreed by the Committee previously. Key points to note: • The new retention metric was meeting the standard, and this was the same standard across the Black Country. • The vacancy rate remained positive at 3.4%. • Turnover was improving but slightly above target. • Additional focus required on appraisals. • Short term and long term sickness absence continued to be affected by the legacy of increased levels of absence due to covid. • The report now included SPC charts. A Heseltine commented on the positive reception during an Executive walkabout visit she and Gwen Nuttall had made to the Radiology department where all staff were very welcoming and happy to provide an update on the work they doing to improve diagnostics and the working environment. She also stated that she and Sally Evans had visited the Portering department where again staff were very welcoming and were happy to share their views.	
2.3	**Key Updates from the Operational Workforce Group (OWG) and the People & Organisational Development Group (PODG)** No update received at this time.	
3.	**Formal Review / Sign Off**	
3.1	**Review of the Strategic Objectives** A Race provided an update on the indicators set out to measure delivery against the strategic objectives in 2022/23 against the four objectives which had evolved from the 2021 review of the strategy to provide assurance on the impact of the work in respect of the objectives: (i) To maintain the lowest vacancy levels in the Black Country The Trust had seen continued improvement in its vacancy figure over the past few months. (ii) To increase the percentage of staff who deem the organisation has taken positive action on their health and wellbeing There has been a number of positive improvements made on health and wellbeing facilities and support for staff. (iii) To improve overall employee engagement Overall staff engagement had been maintained with the Trust near the top quartile in the NHS but further work required to continue focussing in this area. (iv) To reduce the gap in engagement scores for BAME staff and improved WRES metrics	

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	Some improvement on previous years in some areas but still further work in specific areas and the Civility and Respect development initiative would support this area. In response to a question by A Heseltine, A Race advised that this was an annual update report which referred to the staff survey results and WRES data, although regular updates relating to particular areas were brought to PODC throughout the course of the year. He commented that the Committee may wish to consider the overall objectives and performance once the People Strategy had been completed and he would be happy to bring a summary report back to the Committee. This proposal was agreed.	**Action: 2023/22 A Race**
4.	**Strategic Focus Areas**	
4.1	**Deep Dive: Division 1** S Phipps, Group Manager for Womens & Neonates, and L Sims, HR Manager for Division 1 presented an update from the deep dive report for Division 1. Key points to note: • The report included a focus on Women's and Neonatal (W&N) services, especially on the OD work undertaken to date. • A reorganisation had taken place and Gynaecology had moved out of W&N Group into Surgical Services with a dedicated CD and operational team. • The Freedom to Speak Up (FTSU) team, Organisational Development Team and HR have continued to work together and a cultural heat map was collated for W&N using a number of data sources. The heat map put forward a list of recommendations many of which had already been implemented and work would continue. • The age profiles for the directorate W&N had the highest percentage of staff at 7.8% who were aged 61 and over. Further work would be required to understand if this would impact on any particular profession for future recruitment and succession planning. • A number of Maternity Sonographers had left the service which had left a gap with resources and this was recorded as a red risk on the risk register. • The Head of Maternity, the Group Manager and the two Clinical Directors for Obstetrics and Neonatology had been fully supported to join the NHSE Perinatal Cultural Leadership programme. This programme worked off site with a number of other Trusts, and as well as action learning sets with mixed Trust groups, the participants also had the opportunity to partake in 360 feedback. The next phase was cultural development work on site and this would involve staff being fully empowered to make change. • Across the wider Division, the main reason for staff leaving was work life balance at 22% and a review of the exit interviews was to be carried out to explore this further. • The Division continued to work with FTSU to develop positive working relationship and drop- in sessions were held in a number of areas. The Divisional Management team had also provided their own listening/drop in sessions in Ophthalmology and Theatres, improving visibility and open communication. • There would be a strong focus on recruitment, especially the recruitment of international nurses and to support cultural differences,	

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	the Division would be recruiting to the bespoke role of Senior Matron Lead for Workforce, Retention and Education, with the JD currently going through the AfC process. In response to a question from A Heseltine regarding the Sonographers, S Phipps confirmed that that there was an action plan in place which was reviewed fortnightly and focussed, not only on retention, but also on training and the group were collaborating with colleagues at Walsall, so plans were in place to support staff and improvements going forward. A Heseltine queried the leavers percentage rate of staff in Ophthalmology, L Sims stated that as previously reported, further analysis of the exit interviews would be carried out and she would follow up with L Grant, Deputy COO and the Ophthalmology department. A Heseltine reported that the Committee had previously discussed the provision of having an anonymous exit interview facility which may provide more detail and understanding; A Race stated that exit interviews were a challenging area, particularly in large organisations, however, further focus on workable solutions going forward would be included as part of the work around retention. A Heseltine asked what provisions were in place to allow staff to feel they were able to speak up without this being to their detriment; L Sims advised that the there was improved relationships within the department and the Freedom to Speak Up team were invited into the directorates and available for staff to approach as well as managers promoting open communication and assurances that any concerns would be followed up. S Phipps confirmed that with W&N directorate, the staff were encouraged to come forward with any concerns and the management teams were planning to undertake regular walkabouts in order to be able to go out and engage directly with colleagues. A Race queried whether there was any thoughts on how to measure the outcome metrics from the ongoing work around the perinatal services and culture; S Phipps advised that it was difficult to measure culture, but it was hoped that the outcomes from Freedom to Speak Up survey, Staff surveys, retention of staff etc, would reflect the changes within the department. A Heseltine thanked L Sims and S Phipps for the informative report.	
4.2	**Annual Age Profile Report** S Smith-Cox, Workforce Intelligence and Planning Lead for the Group, provided an update from the report provided; key points to note: • Key facts aligned to societal changes with the average age of the workforce at 43 years. • Age demographics of the workforce against local population was aligned apart from the under 25 workforce group, therefore some opportunity in terms of targeting that sector in recruitment campaigns. • Remuneration was as expected in an organisation of this size, the peak years of earnings were between 35-44. One outlier, linked to divisional analysis was the Bands 1-4 as seen within the Estates department where there was a significantly older workforce. • Review of age demographics and sickness absence, showed a strong correlation between an aging workforce and people incurring sickness absence, particularly long term periods.	

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	• Turnover rates for colleagues aged 65 or over was as expected due to retirement or other reasons, however, the turnover rate for 16-25 years was also high which again supported opportunities for the Trust to promote itself to this category of people as an employer of choice. • Over the next five years, there was a 10% attrition rate in terms of expected retirement, however, with retire and return this risk was mitigated in part, but local succession planning would be key. • The report had been circulated to Divisions and there were plans to link in with the EDI Lead to provide holistically data looking at age, demographics and other specific indicators to further support future decision making and planning. C Davis advised that there was a piece of work with the ICB which would be project managed by a company called NextGen Project. The project was around getting into schools, but this was still at an early stage. She advised that RWT linked in with the Princes' Trust and other areas, but the project would look at what was happening collectively across the System. She agreed to provide further update to the Committee when available. A Heseltine commented that in regards to reaching out to the younger generation, she queried whether the Trust linked with college and university students; C Davis confirmed that the Trust did approach these sectors as there were a number of subjects that the students undertook that were relevant to NHS careers. C Lisseman confirmed that the NHS Futures team, as well as the Apprenticeship team, were invited to the university and college's career days across the region, so there was good engagement with the local education providers. A Race, noted a couple of observations from the summary report, one was that the Trust was seeing the workforce becoming younger, so less of an issue with the workforce likely to retire sooner. The other was on a similar theme of retiring and returning, in that it would be helpful, if possible, to have some data around what the realistic expectation percentage would be of staff being able to take up this option; S Smith-Cox agreed that the was something that the team could look at in order to provide. A Viswanath thanked S Smith-Cox for the report which would be very helpful in supporting workforce planning. He also proposed that having trend analysis, in terms of how the Trust was moving, would be helpful. He also queried whether the information was accessible for divisional colleagues on a platform such as Power VI, so that colleagues can access and filter the data fields. S Smith-Cox confirmed that this was the part of the strategic ambitions for the service and HR division at large and options were being explored. A Viswanath commented that it would be important to have all the intelligence and data in one place for easy access and would be happy to discuss further. A Heseltine thanked S Smith-Cox for the informative report.	**Action: 2023/023 S Smith-Cox**
4.3	**Organisational Development (OD) Update (including Civility, Respect and Culture)** A Race provided a brief update on the report submitted on behalf of the Head of OD and Workforce Transformation. He reported that there had been an increased focus on OD to support the development of culture across the	

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	organisation with the development of the behavioural framework, the roll out of the civility and respect programme and an OD Toolkit. The team also supported: • the staff survey • the wider employee benefits and schemes • the Long Service Awards events • had set up a Big Talent Conversation workshop in October • had created a Great Employee Experience Delivery Group • provided coaching and mentoring support. A Heseltine thanked A Race for the update and commented that the report provided a useful update on the positive progress being made.	
4.4	**Staff Surveys and Engagement Update** A Race provided a brief update on the report submitted on behalf of the Head of OD and Workforce Transformation. He advised that the Trust had achieved a 34% response rate to the last NHS National Staff survey which had provided statistically important data but a higher return of staff feedback was preferable. He advised that the report provided assurance around the Divisional action plans devised in response to the issues identified and these were aligned to the People Promise. There was also a Trust wide organisational action which included developing a compassionate and inclusive culture which linked back to the previous discussions heard earlier in the meeting. He informed that the action plans were followed up by the Staff Survey Oversight Group, chaired by A Duffell, Group Chief People Officer. A Heseltine commented that it would be important to ensure that the action plans were embedded and to ensure that the principles were being driven through the Divisions with staff within the specified timeframes; A Race agreed to take this observation back to the Oversight Group.	**Action:2023/024** **A Race**
4.5	**People & OD Committee Effectiveness – Annual Self Assessment** A Heseltine thanked the committee members for completing the self-assessment survey. From the observations made regarding as to whether the Board challenged the updates received, she confirmed that a Chair's report was submitted and questioned. There was a good standard programme in place which included the deep dive reports and these were particularly useful and informative to provide a broader understanding. A Race commented that the majority of scoring returns were positive, and for those who do not attend Board, he suggested that it might be useful to include any feedback from Board to Committee members at future meetings.	**Action:2023/025** **A Duffell** **A Race**
5.	**KEY RISKS**	
5.1	**New Risks** No new risks were identified at this point of time.	

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5.2	**Board Assurance Framework (BAF)** A Race advised that the BAF risk SR-17 on equality, diversity and inclusion had been reviewed and revised slightly to take into account the outcomes from the staff survey, and he recommended that there was no change to the overall risk rating. This proposal was agreed.	
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 the wellbeing of the workforce together and actions being taken to address • To monitor Equality, Diversity & Inclusion areas of concern A Heseltine asked if there were any other objectives to consider; A Viswanath commented that as an organisation, the workforce output productivity was not measured and the tools to measure may not be available, but this was important given that resources were not going to increase and therefore there was a requirement to understand the current resourcing output. He put this forward to the Committee for consideration. A Heseltine queried whether this should come through the performance data rather than workforce and individuals. A Race commented that the productivity of services rather than individuals may be considered going forward as there might be some difficulty in defining and measuring. A Heseltine stated that the organisation was committed to appointing staff and retaining staff whilst also talking about saving finances through quality improvement programmes, which may also look at the productivity and Getting It Right First Time, whilst at the same time, ensuring patient safety and care. A Viswanath advised that at regional and national network meetings in terms of workforce and workforce planning, one of the issues raised was around levels of attainment and there were four levels around productivity including job planning and e-rostering, so he suggested that if additional focus from NHS England was set up, the Trust may wish to put something in place ahead of this. A Race agreed to take away an action to discuss the measuring of workforce productivity with T Shayes, Deputy Chief Strategy Officer – Planning, Performance & Contracting & Team, and A Viswanath for further consideration as to whether feasible and best place for this to be reviewed.	**Action:2023/026** **A Race**
7.	**Any Other Business**	
7.1	**Action from Performance & Finance Committee** A Race advised that at the recent Performance and Finance Committee there had been a conversation on the challenges on the diagnostic pathway which had identified workforce issues, and P&F had asked for the PODC to review this in further detail. Therefore, he proposed to bring a deep dive report on the diagnostic pathway workforce to the next meeting.	**Action:2023/020** **T King**

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7.2	**Acknowledgement and Thank You – Sue Rawlings, Non-Executive representative at PODC** A Heseltine advised that Sue Rawlings' tenure as a Trust Non-Executive was coming to an end at RWT and she wanted to formerly acknowledge Sue's commitment and support to this committee and indeed to the Trust as a whole.	
8.	**Evaluation of Today's meeting** A Race stated that the meeting had ran well, with good and engaging conversation and the reports submitted had been informative. The Chairman thanked the group for their contributions, challenges and participation in the meeting.	
9.	**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 : • The meeting was not quorate due to the unavailability of the Non-Executives • Deep Dive Divisional 1 update • Age Profile report update • The national pay award • Industrial action • BAF SR17 – no change • Review and agreement of the Strategic Objectives – previously agreed by J Hemans, former Chairman and S Rawlings, NED	
10.	**Date and time of Next Meeting** 9.30am-11.30am, 23rd June 2023 via MS Teams	

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 24 May 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
	T Palmer **(TP)**	Director of Midwifery
	Dr G Pickavance **(GP)**	Non-Executive Director

Apologies:	Dr J Odum	Chief Medical Officer
	Catherine Wilson	Deputy Director of Nursing

Attendees:	M Reid **(MR)**	Head of Nursing – Corporate Support Services

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1 1a	**Apologies for absence** Apologies were noted. **Declarations of Interest** None declared.	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 26 April 2023** The minutes dated April 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**
	
	GN informed the meeting of the key themes of the report:
	
	• No significant change in Pathology turnaround times but the recovery plan and out-sourcing continue
	
	• Challenges still remain on the 62-day standard. GN advised the meeting that to date the Trust had not received any formal notification regarding the national tier and escalation from NHSE. However, the Trust has weekly meetings with NHSE regarding cancer and 78-week position. NHSE have sight of more detailed improvement plan around Urology, i.e renal tumours, chemotherapy and 31-day standard recovery action plans. NHSE have signed these plans off and are happy with the actions taken and the progress that is underway.
	
	• Challenges within the 62-days – three tumour sites with the highest volume: -
	
	  • Renal – additional activity underway at RWT, the Consultant is undertaking additional sessions during the week and has increased capacity by two per week. Transferring 11 patients over to Russell's Hall, most are local to Russell's Hall. Three will be transferring to Frimley Park. Trajectory recovery timetable takes the Trust until the end of September / October. Some of this is due to the willingness of the patients to travel. Mutual aid is still available at either Frimley Park or Leeds. BM is having discussions with the clinical team as further conversations need to be had with some of the patients to support them travelling.
	
	  • Colorectal – additional sessions are underway. GN feels that the plan will come together and the activity will improve.	

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	• Gynaecology – discussions are being held with Sandwell and West Birmingham. Gynae cancers are on the increase nationally. GN mentioned that there is talk of a national Gynae recovery plan. GN advised the meeting that Gynae worries her more due to no plan, but the volume and potential risk / harm is more around renal tumours, however, the meeting was informed that the action plan has been updated we are starting to progress well. GP enquired about triaging the Histopathology and some of the scans as many were being marked urgent. GN replied that it is a piece of work which needs to be done and there are pilots underway in certain areas, where Histopathology are being triaged and it is also underway in some of the Radiology. Not necessary all cancers though. Meeting discussed this further with both GN and BM explaining difficulties with ICE and the requesting system. The meeting was informed that the Trust is due to get an ICE upgrade, however, it is unclear if this will resolve the issue.	
4.2	**Trust Risk Register – M Metcalfe** MMe advised the meeting that in the report last month for the total number of risks on-going was incorrect. The figure should have read **28** and not 18. MMe confirmed that the minutes were accurate and asked for the correction to be noted. MMe noted that there are: Two new risks – these were discussed last month but had not been approved: • **5957** – Clinisys no longer supporting the CSAS system – amber risk and is a national issue. The new middle phase system is being tested and should have end to end validation by the end of May. • **6006 –** Non-availability of Medical Equipment – is linked to equipment that is required for neo-natal transfer and the controls in place are in regard to the Repatriation Team providing the equipment if it is needed to move a sick baby. This is classed as a red risk. LT asked if the Trust has the ability to transfer, MMe confirmed that it does. BM advised that the Trust could use the Transport Services equipment but what is preferred and recommended is that the Trust has its own kit. Currently the Trust is waiting for the relevant company to come on site and do the relevant safety checks. MMe confirmed it was only a certain number of pieces of kit. LT sought clarification that the risks identified at the last meeting had not at that point been added to the register. MMe confirmed that this was correct and explained that the sub-group is currently working through the renaming of the risks for example these two risks would be classed as emerging risks. There were two removed risks:	

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	• **5610** – Increase in Haemodialysis (HD) numbers • **4913** - Emergency Gynaecology Service in D18 and lack of Gynae Ward MMe has received assurance and the evidence inputted onto Datix regarding the rationale for the two risks to be removed and have been through due process. Report indicated eight red risks: • **5849** – Reduced scan capacity in Fetal Medicine Department • **5802** – Division 2 MFFD patient numbers • **5246** – Lack of Consultant cover within Cancer Services • **1984** – Backlog of Ophthalmology Review Patients • **4900** – Histology cases breaching turnaround time target • **5667** – Cancer backlog • **5388** – Mental Capacity Assessment • **6006** – Non-availability of Medical Equipment The meeting was advised that risk **1984** was amber and has now been increased in scoring and this is due to external contract in place to clear the backlog is now coming to an end and work is building up. A plan is in place to get this risk back under control. MMe advised the meeting that this was especially for glaucoma patients, which is why the risk has been increased to red. The following three risks are overdue a review: • **5536 –** Provision of Mental Health beds • **5748 –** CAMHS Patients on A21 • **5802 –** Division 2 MFFD patient numbers MMe reported that the Healthcare Governance Managers are supporting Divisions to update risks and do the reviews. DH noted on the front sheet risk **5388** is red, however, in the report is amber with updates around assurances. Also noted on the front report the risk is with the COO when it should be with the CNO. MMe to amend. BM commented that the Mental Health risks have been re-written which will remove the red elements and noted that there seems to be issues with the updates being transcribed onto the TRR. MMe mentioned that she has a meeting the following week with the relevant person and will update the risks accordingly. LT asked about risk **5849** and BM advised that there were four or five updates in regard to scanning capacity. TP confirmed that the issues are in regard to the workforce and the ability to be able to fill the scan slots. Mutual aid from Walsall has been requested. The pathway is currently being worked through at the moment, therefore not actually happening yet. TP advised that the long-term plan is to have a midwifery run ultrasound scan service, this is being worked through with the Universities in terms of the training. TP reported that she is currently waiting for the Saving Babies Life Care bundle v3 and until this is received it is	

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	unknown if this will have changed or not. Other Trusts nationally are struggling to achieve this standard. The meeting discussed this further noting that it was a serious situation hence why it is a red risk. AH asked if a Mum is refused a scan is this escalated further. TP confirmed that if a call comes through to the Fetal Maternal Medicine or to the clinic and the scan is refused this should have a multi-disciplinary discussion in terms of looking at the care for the Mum, whether appropriate or not. DH mentioned the gaps around the missed screens reported to PHE and the 19 that have had the quad test. TP replied that all are reported and as the women have their babies, the team will know the outcome. If there was an issue, for example a Mum missed a downs screen and went onto have a downs baby this would be escalated as a SUI. All of the missed screens are reported to PHE. DH and TP to meet outside of the meeting to discuss reporting internally. LT enquired about risk **5388** noting that the Trust is brilliant with compliance with training but then staff do not tend to use. DH replied that the Trust has an individual and a Safeguarding team, but this is organisational wide and it is about practise. DH feels that the current daily processes around documentation etc do not integrate themselves well with MCA practises. In order to streamline the team have been reviewing other organisations where it is either embedded in a patient electronic record, DH mentioned that this is a while off yet. Therefore, the Trust needs to review how to embed in our current process. GP asked if it was an IT issue, is the form a template, paper format which is not being completed correctly etc. DH advised that it is a separate piece of paper to what is already in current documentation and therefore needs streamlining and adding in. The IT system would be the best as you are unable to move on without fully completing the page but currently the Trust do not have that option for a couple of years.	
4.3	**Trust Risk Register Heat Maps – M Metcalfe** This item was not discussed.	
4.4	**Board Assurance Framework – K Wilshere** In the absence of KW, MMe agreed to take any feedback from this paper to KW. LT commented that the report came so late no-one has had a chance to look at it.	
4.5	**Integrated Quality & Performance Report April 2023 – D Hickman & G Nuttall** DH presented the quality section of the report and advised that there is an improvement in a number of the metrics in month, for example complaint response and equated to four individual complaints from one service. DH assured the meeting that the Complaints team are working close to understand systems and processes. Obs on time – continue to see improvement. There are still some system issues that need to be rectified in the system.	

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	Care Hours Per Patient Day (CHPPD) – both generic and registered are moving in the correct direction. Recruitment is going well and the Trust is in a good position. DH informed the meeting that mixing skill set of staff seems to be working and there is more positivity around the Trust. GN presented the Performance section of the report and advised the meeting that at the Performance & Finance meeting in the morning there was not much chance to discuss the report. The meeting noted that the total time spent in ED (four hours combined) for April was 79.23%, the national expectation by the end of March 2024, all Trusts will be at the average of 76%. GN reported that the ambulance handover was less than one hour in April was 0.14%. This has been maintained through to May. GN advised that this is an improving position, good for patients and good for WMAS. This has come out has significant financial investment that has not been funded. The two-week cancer referral has deteriorated in April is a result of the Trust providing mutual aid within Dermatology for Walsall. RWT has taken on patients waiting over 14 days. In regard to Integrated Care, the number of referrals for the Rapid Intervention Team (RIT) between February, March and April have reduced quite a bit. This is due to the Local Authority winter schemes. GN explained that sometimes the Trust use the RIT to help discharge patients, however, the packages of care for Wolverhampton as a result of their winter planning schemes and their funding, often meant the Trust did not have to make those referrals to RIT's. A lot of the schemes that the Local Authority put in place have now ceased. JJ commented that the Trust has a very challenging Cost Improvement Plan (CIP) to achieve this year, with staff having to spend the time achieving CIP and make the changes to try and achieve the CIP, there is a concern that it may have an impact, adversely, on some of the metrics. JJ asked how this will be presented going forward, how are the Committee members going to see this information so everyone can receive the reassurance of the difference between a true service position and the impact on the amount of work to be done on CIP. GN replied that this was discussed at the Executive meeting this morning and previously. Work needs to be completed and then discuss at a future Trust Board around some of the investments made. For example, the ambulance receiving centre, there is clear evidence that the opening of additional handover space has had a positive impact in terms of the patient experience and outcomes, however, this has come at a cost (invest in staffing). GN feels the Executives need to discuss and make difficult decisions. GN reminded the meeting when any CIP scheme is implemented there is always a quality impact assessment to ensure clinical signoff. The meeting discussed further noting that some of the investments have generated huge engagement in changes in practise that have improved the areas. DH stressed the importance of not losing this. LT noted the referral to treatment (68 week plus) noting that the report states that the target of zero must be achieved by June 2023 and asked if this would be achieved. GN replied that in terms of the 78 weeks planned by the end of June, there are 20 patients that GN does not currently have a plan for. These patients belong to Urology. The Trust is working through the action plan as quickly as possible to ensure this is minimal. GN is looking for mutual aid	

Item No		Action
	or extra lists at RWT to reach the target. GN mentioned that she will hopefully get the final list by the end of the week. However, GN reminded the meeting that the Junior Doctors have announced a three-day strike and the issues this will cause.	
4.6	**Annual Governance Statement – K Wilshere** This report was not received by the meeting and AH asked when it was going to Trust Board or this committee. MMo advised that this report was in progress and is being led by the Communication team.	
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – May 2023 – Chair's Report – Dr B McKaig** BMc presented the Chair's report from May's QSAG meeting and noted the key items from the meeting: **104 Day Harm** • 46 patients waited >104 days for treatment. Of those reviewed, no physical or psychological harm identified. • New Cancer team have reviewed the process and are meeting with BM and DH to discuss new robust report. **Equality & Diversity** • Developing their five objectives. Three are related to staff and two are related to patient service. • Expectation is some progress around the objectives within six to eight months. **Patient Experience (2022 – 2023)** • Reduced number of formal complaints. • Greatest number of complaints is in ED, Obstetrics & Gynaecology. • Five top themes for complaints – general care of patient, delays, attitude, communication and administration. • FFT position - when benchmarked across the ICS the Trust is ranked above all of the four acute Trusts in ever domain except Community Services domain. It was felt that fatigue in some of the Community Services. **Safeguarding** • Audit of the mental capacity assessments. • Encouraging to see the increased number of referrals, suggesting that there is more awareness and more appropriate utilisation of the mental capacity act.	

Item No		Action

	External Visits Report
	
	• All of the reviews in the report were ones that the Executives are cited on.
	• All reviews were approved and closed.
	• Six external reviews, three were red rag rated (listed below):
	  ◦ Foundation year Doctors in Surgery and educational experience. An internal review commences at the beginning of June.
	  ◦ Critical care medical workforce – triangulates with the development of the ACCPs.
	  ◦ Peer review regarding Paediatric diabetes.
	
	Improving the Blood Culture Pathway
	
	• The BCPS covers all four acute Trusts, BM reported that he has a timely robust action plan and has received strong assurance that the majority of required actions were in place and the Trusts would perform well.
	• National recommendations suggest that each patient should have two sets of blood cultures to increase the pickup rate of infections. However, this has huge logistic implications. The Trust would have to increase the physical size of the laboratory which deals with this, along with increasing the workforce and the non-pay resources. At a minimum this would cost £1.5million plus the building works. Discussion are on-going with the Clinical Leaders Group and the BCPS regarding what is the clinical risk. It is felt that the clinical risk is very small, the increase in positivity is reaching around 5%, this is something that the Trust is unlikely to comply with. In the country, Nottingham is the only centre compliant currently.
	
	BM advised the meeting that two NCEPOD's were deferred, which was frustrating has there were questions to ask.
	
	TP advised that there is some good on-going work on Triage.
	
	The meeting was informed that has part of the Safety Champion, LT visited the service to see how it was progressing. The training for the Obstetric Triage System is working really well but there is still some work to be done. The majority of staff have been trained and the triage card is in use and patients are being triaged over the telephone and assessed on admission. The data can now be collected and TP advised that the data is being audited in terms of when the patient arrives to when they get assessed. TP will provide the information at the next Trust Board in August.
	
	Additional information which can now be gathered is the core waiting times on triage. Prior, it was known that lots of calls were being missed but the data could not be collected due to no system in place, this is now in place. TP will provide the information of how many women the Trust is missing. From a snapshot, it is showing that not many women are being missed now where before a significant number of calls were being missed.
	
	TP commented that the main work around triage and the work that is on-going is the change in the attitude and the passion for moving things forward.
	
	LT confirmed it was a good visit and noted that the staff were quite passionate, particularly the staff member who was the lead and was very clear on how far the department has come,	

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	also advising LT what else needs to be undertaken to make it even better. LT commented that she has seen the improvement following different stage visits but now is really good and also noting that they are properly staffed as opposed to being acquired from wherever they can be acquired from. TP updated the meeting on staffing and advised that it can now be evidenced that the department is now at 97% staffed with two midwives at all times. Pre-CQC it was approximately 40%. **Divisional Reports** • BM mentioned the task of getting the Divisional reports into similar format as the IQPR so that there is a consistence. The meeting was advised that it was a significant improvement, but it is still being worked on. This was discussed further and agreed that it was a good progress and beneficial to all Divisions and help them to see improvement or decline.	
6	**Assurance Reporting / Themed Reviews / Business**	
6.1	**Infection Prevention & Control – M Reid** MR advised the meeting that this report is a quarterly report and MR has included the 2022 / 2023-year end data in the metrics, as well as April's data. The meeting was advised that the Trust breached with 72 cases of toxin positive C. difficile to end of March 2023 against the Trust target of 58. The NHSE objective for 2023 / 2024 is a target of 53, also included in the objectives are the Gram-Negative bacteraemia (E coli, Klebsiella, Pseudomonas aeruginosa). The Trust did come under the objectives for 2022 / 2023, this will be monitored in the new financial year. The meeting was assured that there are actions in place regards C. difficile which can be seen in the report. MR did report that decant facility has not been available although it is anticipated that ward C41 will become available over the next few weeks following refurbishment work on A7 and A8. Collaborative work with Walsall regarding support in Emergency Department, where the RWT IP team will undertake a trial period to identify and facilitate timely stool sampling. This trial will happen twice daily. MR reported that the Infection Prevention Board Assurance Framework has had significant revision. The draft was circulated to the Committee and MR mentioned that he is currently awaiting some responses from RWT colleagues. MR advised that when Infection Prevention BAF commenced there was over 100 Key Lines of Enquiries (KLOE's), dropped to 97 and this new draft has 54 KLOE's. There are eight areas which are showing as partial compliance presently, further information in regard to self-assessment and evidence to be inputted into the BAF from colleagues.	

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	AH asked if Infection Prevention was being supported with the additional work. AH also enquired about the decontamination of side rooms of current C. difficile patients is not achieved only when vacated, asking if the rooms are being cleaned as every other patient in a side room, without C. difficile, are they getting that done. MR replied that it is not national guidance but the Trust endeavour to move a C. difficile positive patient into another single room at seven days to deep clean their room, unfortunately this is not being possible numerous times due to capacity issues. For assurance MR confirmed that deep cleaning does take place between patients. AH asked about daily cleaning. MR confirmed that rooms are being cleaned daily. AH noted on the BAF, Infection Prevention was all green but there were ambers on other departments, again AH asked if Infection Prevention was receiving all of the necessary support from the Executives to ensure the departments are responding when you need them to. MR replied that at Infection Prevention and Control Group (IPCG) appropriate colleagues attend for there to be accountability in terms of response. MR commented that support from colleagues across the organisation is always appreciated. At the IPCG meetings, Divisions and Directorates are in attendance to update on their IP metrics and give accountability to each area. DH mentioned that regionally and nationally dialogue is on-going around the stretched targets that have been released and for assurance noted that this work does not stop the work on-going internally. DH commented that the Trust has a transient nature with C. difficile if you can plot the overall increase. CQI are aware of the situation and discussions are being held with Dr Lee Dowson around how he can analysis of the data and how the CQI methodology can be applied. DH continued that one of the topic items that MR is working on with colleagues at WHT, is regarding Infection Prevention awareness and promotion. The meeting was informed that the Trust is working on a decant plan to commence in the summer. DH mentioned that the Trust has been in operational mode of well above 90% it has had a significant impact on the ability to decant. DH confirmed that there has been dialogue with the Executives, any area of the BAF which falls directly into other Executives portfolios, the acknowledgement that timely feedback is required. GP asked about moving of the beds and equipment to a separate site in the building to get them cleaned, enquiring how much turnaround time is there and also is a room being taken out of action for a while. DH replied that there is a throughput of beds to do this. The issue is when the decant programme is moved into the summer the Trust loses the patient equipment cleaning centre. A plan is being developed to see where the centre can be re-located to.	
6.2	**Quality Account – M Metcalfe** LT commented that the report was received very late that it has been impossible for the Committee members to review.	

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	MMe asked for thanks to be noted to Sue Hickman (SH), Compliance Manager, for the tremendous amount of work that she has done collating the report. MMe advised that the document is compliant with the requirements and asked if feedback could be sent to SH as soon as possible. The report must be published by Friday 30 June 2023 has this is the national requirement. AH enquired if the Quality Account was for RWT only or RWT and WHT combined. AH mentioned that she has found a couple of places she has found a comment "both Trusts". MMe replied that this is the RWT Quality Accounts and they have to be published separately. AH asked if the Committee will see the Quality Accounts before it goes to Trust Board. MMe commented probably not. AH mentioned some data anomalies throughout the report and noted some of the detail in the Improvement Priorities did not make sense. MMe thanked AH for the comments and advised that she would feed the comments back to SH. MMo wondered if WHT was mentioned because the priorities are based on the Quality, Safety & Enabling Strategy which is for both organisations. MMo suggested that it would be best to check as there are some joint actions. MMo asked MMe if there would be an easy read format as this was done in previous years. MMe advised she would ask SH and feedback. MMo suggested that SH speaks to the Head of Patient Experience for a previous example of the Quality Accounts easy read format. The meeting was advised that the way the Quality Accounts are produced will be changed next year.	
6.3	**Trust Clinical Audit Annual Report** Report deferred – new date to be agreed for submission.	
6.4	**Trust Clinical Audit Plan** Report deferred – new date to be agreed for submission.	
6.5	**Midwifery Services Governance Report – T Palmer** TP advised the Committee of the following key points: • On plan for the birth trajectory – no concerns that the Trust will go over 5,000 births • Vacancies within Midwifery staffing remain at 7%, however the department had a successful recruitment day, recruiting into all of the vacancies and offered all of the Trust students positions as well as nine extra external students. TP is confident that Midwifery will be fully staffed by autumn.	

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	• There is a plan in place to support the newly qualified Midwives into their areas of work over a two-month period. • Still above trajectory but there is more staff helping to support the Smoking Cessation. • TP reported the department has eight SUI's that remain open, five have been referred to HSIB, one is a screening incident where there was a delay in getting the woman a scan. These are currently being reviewed. All screening incidents are reported to PHE but also through internal Governance. • All of the mortality reviews are taking place in line with the national requirements, CNST standard one. All of the mortality reviews have been performed using the PRMT tool. • EMBRACE report demonstrates that there is improvement in the extended perinatal mortality rates. • TP reported that she is aware that under Health & Safety regulations, the department is not compliant with the air changes on Delivery Suite. However, the action plan is in operation and staff have been tested. To date 29 staff have been tested, 28 came back within normal limits, one staff member was slightly over the normal limit. TP confirmed that the department is working very closely with Estates and looking at alternative ways to provide extra ventilation into the rooms. The Entonox gases are quite heavy hence the need to improve the ventilation in the rooms. • Training package is now available for all staff on how to use Entonox gases correctly. Work is also being undertaken with the women. • Tests on staff will be conducted again in six months' time. Following these and the results, tests will then be conducted every 12 months. AH commented regarding the launch of a SOP for Entonox gases, noting that it was currently amber due this month. AH asked TP if the SOP was already in place, TP replied that it had gone through the Governance meeting earlier in the day and would be launched within the week. TP assured the meeting that staff have already started to unplug the Entonox from the outlet, due to possible leakages. AH asked if the two deaths mentioned in the CNST report were the same death or two different deaths. TP to confirm and reply back to AH outside of the meeting.	**TP**
7	**Themed Review Items**	
7.1	**Mortality Quality Improvement Plan – Dr B McKaig** BM presented the above report to the meeting, noting that the Trust SHMI for the period December 2021 to November 2022 is 0.9249. BM asked the meeting to note one of the RWT Diagnostic Groups with a higher-than-expected SHMI – Pneumonia. Actions have been put in place and are showing signs of improvement. The Medical Examiner position is still healthy at over 95%. The roll-out of the Medical Examiner Service into the community and has been successfully implemented to all Wolverhampton GP Practices and Compton Hospice. There are four	

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	Primary Care Networks to come on board from the South Staffs area and it is planned for September 2023. LT asked about chronic ulcer of skin and asked if this was pressure ulcers. BM confirmed that it was and continued to explain about SHMI's and the action plans in place.	
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** No other business to discuss.	
10	**Evaluation of Meeting** LT commented that due to the lateness of the papers it had been near impossible to read them properly and do them justice. The meeting discussed further.	
11	**Date and time of Next Meeting:** **Wednesday 21 June 2023 at 1.00pm to 3.00pm, Via MS Teams**	

Minutes of the Trust Management Committee

Date 30/06/2023
Time 13:30 - 15:30
Location MS Teams Virtual Meeting
Chair Simon Evans
Attendees: Suneta Banga, Dr Odum, Adam Race, Matthew Reid, Andrew Morgan, Damian Murphy, Sara Eacopo, Raz Edwards Prof. Loughton, Radhika McCathie, Dr.Higgins, Sally Evans, Debra Hickman, Angela Davis, Magdalena Zajac, Tracy Palmer, Stew Watson, Doreen Black, Pauline Boyle, Simon Evans, Alan Duffell, Louise Nickell, Lewis Grant, Kevin Bostock, Carly Craddock Dr Ananth Viswanath, Timothy Shayes, James Green, Martina Morris,

1	**Apologies for the absence: Beverly Morgan, Lee Dowson, Brian McKaig, Kate Cheshire, Sian Thomas, Leslie Rosalind, Kevin Stringer, Gwen Nuttall, Baldev Singh, Kate Shaw, Lindsay Ibbs-George, John Murphy, David Loughton, Nick Bruce, Kerry Flint, Nicki Ballard.**
2	**Declarations of interest** Mr Evans 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 26th May 2023.** **Resolved: that the minutes were approved unchanged.**
4	**Matters arising from the minutes.** Mr Evans confirmed there were no matters arising from the minutes.
5	**Action Points list** 1. **Overspend on staff sickness.** *Action item: Mr. Greene to provide information on the overspend for staff sickness to Ms. Hickman.* Mr Duffell said the action was to try and understand the level of the cost of sickness absence for the Trust per se and reconciling that with the amount of sickness that was included within the head room **Update: the item be added to the July TMC agenda.** 2. **Create a Press Release** *Action item: Comms to create a press release for the Trust achieving 10/10 for the Clinical Negligence Scheme for Trusts' (CNST) safety*

Ms Sally confirmed the action was complete.
Resolved: the action be closed.

3. **Recommendations of the East Kent Maternity Report**

Action item: Ms Palmer to go through the recommendations of the East Kent Maternity report with her counterpart at Walsall Healthcare NHS Trust.
Ms Palmer confirmed the action was complete and work was being undertaken on a Single Delivery Plan which incorporated the East Kent themes.
Resolved: the action be closed.

4. **Outpatient tariffs**

Action item: Mr. Shayes to provide details to Prof. Singh on outpatient tariffs.
Mr. Shayes said a meeting had arranged with Dr. Raghavan
Resolved: the action be closed.

6 Key Current Issues/Topic Areas - none this month

7 Elective Care Recovery

Mr Shayes highlighted there continued to be a rise in waiting lists. He said no patients should be waiting over 63 weeks by the end of June 2023. He said the cancer trajectory was to be revised to account for patients who had transferred from Walsall Healthcare NHS Trust (WHT) and to reflect actions within urology.

Resolved: the Report was received and noted

8 By Exception Papers- none this month

9 Monthly Reports

9.1 Integrated Quality and Performance Report

Mr Shayes said Emergency Department (ED) ambulance handover performance remained the best in West Midlands across the 4-hour target. Ms Hickman highlighted stability was being seen on quality metrics. She said focus was still required on observations on time.

Resolved: the Report was received and noted

9.2 Division 1 Quality, Governance and Nursing Report

Ms Black highlighted there had been continued improvements on observations on time from 83.3% to 88.6%. She said Sepsis screening for inpatients remained over the threshold for the past 7 months and there had been positive compliance with sepsis antibiotics administration

within the hour. She said there had been an improvement with the overall vacancy rate within the Division. She said current vacancies rate were at 3.47 whole time equivalent vacancies which did not include all staff who were in post. She said due to this a joint risk had been added to the Trust's Risk Register for skills mix with Division 2. She mentioned the workforce risk had been downgraded. Ms Black highlighted areas outside compliance were cardiology, urology and general surgery.

Mr Evans asked whether plans were in place for those 3 areas. Ms Black confirmed plans were in place. She also mentioned the report was split into 3 reports including maternity and BCPS. Mr Grant said he would ensure there was representation for the BCPS report at the next TMC meeting.

Ms Palmer highlighted there was a high level of bookings but this should not affect birth rates, the Trust had the necessary capacity. She said the year 5 Clinical Negligence Scheme for Trusts (CNST) technical guidance had been received and work was in progress. She mentioned the Trust was 1 of 8 Trust to achieve Year 4 CNST which was positive news. She highlighted an insights visit took place which initially looked at the Trusts compliance on Ockenden together with quality improvement work. She said positive feedback was received and assurance was provided that the Trust had met all the recommendations for Ockenden, a follow up report was awaited.

Action: Mr Grant to ensure there was representation for the BCPS report at the next TMC meeting.

Resolved: the Report was received and noted

9.3 Division 2 Quality, Governance and Nursing Report

Mr Morgan highlighted the divisional risk on staffing. He said there were 2 areas of poor compliance Venous thromboembolism (VTE) and sepsis compliance in Emergency Department. He said there had been improved compliance with screening but there were issues in administering antibiotics within the hour and work was ongoing.

Resolved: the Report was received and noted

9.4 Division 3 Quality, Governance and Nursing Report

Ms Higgins highlighted the poor compliance of VTE within the children's ward. She said two patients had been missed and ongoing discussions were taking place to discuss further. She said observation on time on the children's ward where at 70% and matrons were to travel to Walsall Healthcare NHS Trust (WHT) for learning on improvements for observations on time.

Resolved: the Report was received and noted

9.5 Executive Workforce Summary Report

Mr Duffell said the 6 key indicators were positive and the vacancy level had reduced to 2.26%. He said there had been an improvement in retention of staff. He mentioned the Royal College of Nursing (RCN) did not meet the threshold to take further industrial action. He said the Junior Doctors had been preparing for another mandate and Consultants voted to take industrial action, and discussions had been taking place as to any agreements. He also mentioned the new workforce plan which was to be published today. Ms Evans mentioned the Trust hosted Sky News for the launch of the plan which was positive. Ms Hickman said the plan had been published and was shared at the Chief Nursing Officers meeting.

Resolved: the Report was received and noted

9.6 Chief Nursing Officer and Director of Nursing Report

Ms Hickman highlighted there were issues in obtaining data for the dashboard from the platform inphase and ongoing discussions were taking place. She said there had been successful recruitment within the maternity department. She said there was commitment to the deep clean program and C41 should be available from the Summer period. She mentioned the issue with Computer Based Training (CBT), numbers had been received identified from the Nursing and Midwifery Council (NMC). She said NHSE had a different number compared with NMC and discussions were taking place. She said communication had been circulated on potential rise of measles for adults and in children during August and September. She also mentioned the Australian flu season was being monitored.

Resolved: the Report was received and noted

9.7 Finance Position Report

Mr Greene highlighted the Trust was in month £350 thousand ahead of plan delivering a £3.26 million deficit in month. He said the year to date deficit was £11.55 million £1.9 million adverse position to plan. He said pay pressures continued, together with pressures on obtaining drugs. Mr Greene said budget details had been circulated within divisions and review meetings had taken place. He said control mechanisms expected from NHSE were in progress in particular the vacancy panels. He mentioned the system through the Integrated Care Board (ICB) were in the final stages of appointing a delivery partner to work with the Trust.

Resolved: the Report was received and noted

9.8 Capital Programme Update

Mr Watson said the capital position remained challenging due to over demand against underfunding. He said bids were being undertaken within the NHS and outside the NHS for additional capital where possible to try and obtain funding. He provided an update on some development projects. He mentioned car parking continued to be a significant challenge across New Cros Hospital due to 3 major contractors being on site. He said conversations were taking place with other sites including Sainsburys, the Leisure Centre and owners of the former Manhattan Pub site to see if they could assist with releasing car parking spaces over the next 18 months.

Resolved: the Report was received and noted

9.9 Operational Finance Group Minutes

Mr Green said the minutes were to note

Resolved: the minutes were received and noted.

9.10 Financial Recovery Group Update

Mr Evans said there was a very challenging target to achieve in delivering efficiencies. He said thought needed to be given by all as to how they could be resourceful, creative and innovative within their teams in terms of what contributions could be made

Resolved: the Report was received and noted

9.11 Acute Care Collaboration- verbal update together with ICS Development - verbal update

Mr Evans said work was being undertaken with the financial plan for the Integrated Care Service (ICS). He said further delegation was sought from the Integrated Care Board (ICB) to support work being undertaken through the Black Country Provider Collaborative (BCPC). Mr Evans for the title of Acute Care Collaboration on the agenda be amended to BCPC for future meetings. He said BCPC were working on a clinical program led by Dr Odum. He said the program focused on efficiency and sustainability to support with the cancer program and other matters. He said by having one chair the BCPC had been able to develop a collaboration agreement across all four organizations. He mentioned the development of the Joint Provider Committee and said terms of reference had been drafted and were going through the review process. He said the Committee would report to the four Boards on the work program of the BCPC, some delegated strategic responsibilities from each Trust Board and programs of work. Mr Evans said members of the Joint Provider Committee would include Chief Executives of all four Trusts, Deputy Chairs together with the Chairman.

Resolved: the verbal updates were noted

9.12 Research & Development Report

Ms Boyle said there had been a reduction of 44% in commercial clinical trials in the UK. She said it was anticipated that the number of participants recruited into commercial clinical trials in the next two years would be doubled. She mentioned within the report of Lord O'Shaughnessy there was reference to annual Research and Development targets needing to be introduced at every level of the NHS. She said the report also mentioned the need for greater transparency as to where the money was spent to enable people to see where the benefits and rewards of the trials were being seen. She said the deadline was today for NHS England's consultation on how much services costs within the NHS. She said a standard one price was expected for every NHS organisation for commercial studies and feedback was awaited. She said the Trust was in the top 5 in the West Midlands for overall recruitment and in the bottom 3 commercial recruitment.

Mr Evans said it was important for the organisation to promote and encourage research work and actively participate in studies.

Ms Craddock provided an update on delivering the host contract. She said work was being undertaken for NIHR to become the performance review lead for commercial studies. She said provider participation and monitoring of how many organisations across the West Midlands were recruiting to studies was no longer a national metric. She said following the annual review meeting with the coordinating centre positive feedback was received on innovation and collaborative work. She said a £7 thousand underspend was predicted and would close the financial year with a zero balance. She highlighted the Clinical Research Network as a national organisation would cease to exist as of the end of September 2024 and there would be a new contract as a National Research Delivery Network organisation. She said it was positive to note that RWT had been confirmed as the host of the new Regional Research Delivery Network of West Midlands.

Resolved: the Report was received and noted.

9.14 Infection Prevention and Control Delivery Plan 2022 - 25 (Draft)

Mr Reid said the plan fed into the joint Quality and Safety Enabling Strategy and would provide direction both Trusts on infection prevention control and annual work programs.

Resolved: the Report was received and noted

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

10.1 Information Governance (IG) Data Protection and Security Toolkit (DPST) 2022-23 final submission

Ms Edwards highlighted 9 GP practices and RWT had achieved the final standard submission. She mentioned an improvement program would be launched next year to maintain those standards. She also said new additional standards would be contained within the Cyber Essentials Framework. She went through the 3 top data security risks. She said cyber security remained an ongoing challenge nationally. She said the Trust was investing in technology to maintain good cyber security standard but the biggest risk still remaining was staff awareness and understanding policies. She said improving training within the area was essential. She said Freedom of Information (FOI) requests had increased by 85% in March. She said analysis had taken place with colleagues across the region and it was concluded there was a campaign of individuals that were targeting NHS Trusts for basic information. Ms Edwards mentioned she had worked together with Integrated Care Organisation (ICO) on the requests to identify any concerns. She said requests were being refused if they were associated with the campaign. She said 150 requests had been refused to date.

Mr Evans asked if FOIs received by colleagues at the Trust, was there an assumption that the IG team had vetted the FOI as to whether they were genuine requests. Ms Edwards confirmed only genuine requests were sent out to staff at the Trust.

Ms Hickman said the FOI process should be reviewed. Ms Edwards said a work plan was being produced and the process for FOIs was being reviewed including templates, sign off leads and exemptions.

Mr Shayes asked if the Black Country ICB's FOI team were sighted on the issue. Ms Edwards confirmed they had been sighted.

Dr Odum mentioned Dr McKaig was to take over the role of Caldicott Guardian at the Trust as of 1 July.

Resolved: the report was received and noted

10.2 Freedom to Speak Up (FTSU) Annual Report 2022/23

Mr Duffell said the report was to note

Resolved: the Report was received and noted

10.3 Annual Equalities Report

Mr Duffell said the report was to note.

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- 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 Patient Experience Enabling Strategy 2022-2025
Resolved: Patient Experience Enabling Strategy 2022-2025 was Approved.

13.1.2 New, SOP28, Discharge Lounge SOP
Resolved: New, SOP28, Discharge Lounge SOP was Approved

13.1.3 HR08, Recruitment & Selection Policy
Resolved: HR08, Recruitment & Selection Policy was Approved.

13.1.4 SOP27, Procedure for Work Schedule Reviews and Exception Reporting for Doctors and Dentists in Training
Resolved: SOP27, Procedure for Work Schedule Reviews and Exception Reporting for Doctors and Dentists in Training was Approved.

13.1.5 CP61, Management of the Deteriorating Patient
Resolved: CP61, Management of the Deteriorating Patient was Approved.

13.1.6 OP96, Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult & Paediatric Patients in Hospital and Community Services
Resolved: OP96, Pressure Ulcer and Moisture Associated Skin Damage Prevention and Management for Adult & Paediatric Patients in Hospital and Community Services was Approved.

14 Any new Risks or changed risks as a result of the meeting.
None were identified

15 AOB

1. Mr Bostock mentioned the Annual Report accounts and Quality Account had been published today.
2. Mr Evans said two badges had been issued to staff, 75th Birthday of NHS badge and the compassion dedication badge. He said the Trust was disappointed to note the compassion dedication badge had a spelling mistake due to an error of the manufacturers and a second badge would be issued in the future. He asked all to reassure staff of the error.

16 Date and time of the next meeting 21 July 2023 at 1:30 pm.

Minutes of the Trust Management Committee

Date 26/05/2023
Time 13:30 - 15:30
Location MS Teams Virtual Meeting
Chair Prof. Loughton
Attendees: Catherine Wilson, Suneta Banga, Mark Greene, Alison Dowling Andrew Morgan, Gwen Nuttall, Nicky Ballard, Matthew Reid, Prof. Loughton, Radhika McCathie, Beverly Morgan, Dr.Higgins, Sally Evans, Debra Hickman, Adam Race, Nicky Ballard, Dr Odum, Kate Shaw, Angela Davis, Shyam Menon, Baldev Singh, Tracy Palmer, Magdalena Zajac, Janet Smith, Kevin Stringer, Leslie Rosalind, Stew Watson, Doreen Black, Pauline Boyle, Michelle Metcalfe, Dr Ananth Viswanath, Timothy Shayes, Maria Arthur, Sian Thomas, Angela Davis, Elaine Wharton, Nick Bruce, Kate Salmon, Shyam Menon

1 **Apologies for the absence: Simon Evans, John Murphy, Louise Nickell, Lewis Grant, Lindsay Ibbs-George, Ann-Marie Cannaby, Catherine Wilson, Lee Dowson, Brian McKaig, John Murphy, Alan Duffell.**

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 28th April 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. **International Overseas Nurses Survey.**

Action item: Ms. Hickman to create a survey for international overseas nurses to complete, to include the input from Prof. Singh in relation to Clinical Fellows
Ms Hickman said a National survey had been developed pursued and shared with Prof Singh. She confirmed progress was being made.
Resolved: the action be closed.

2. **Reminder to staff of hybrid working.**

Action item: Comms to be circulated reminding staff of hybrid working to reduce car parking issues.

Ms Sally confirmed the message had been circulated to staff

Resolved: 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 June 2023. She said a plan was in place for all patients with the exception of 20 neurology patients and work was underway. She said this would be on the potential impact the Junior Doctors Strike which was planned to take place. She said it was anticipated there would be no more than 195 cancer patients on the cancer waiting list waiting over 62 days at the end of March. She said currently there were 240 cancer patients on the waiting list with the largest number of those patients being neurology patients. She said plans were in place to use mutual aid via Russell's Hall Hospital, Frimley Park and with additional internal sessions at RWT. She said there had been significant improvement in Gynaecology but a deterioration in skin due to an increase in the number of referrals together with delays in pathways.

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 Nuttall said the average for medical fit for discharge patients was at 84% which was positive news. She mentioned time spent in Emergency Department (ED) for April was at 79% and the expectation was for the Trust to be at 76% for the 4 hour target by the end of March 2024. She highlighted the ambulance handover time was below 60 minutes. She said there was a low percentage of cancer patients waiting over 62 days for their first cancer treatment and active work was in place to reduce the backlog.

She said in relation to Integrated Care there had been a reduction in referrals during the winter period and there had been an improvement in the number of packages of care that were offered by Wolverhampton Council.

Ms Hickman highlighted there was a significant increase in staffing. She said there had also been an increase with observations on time and

some areas required improvement. She said there had been a reduction in C-Difficule and the Trust was above trajectory at year end. She mentioned revised trajectories had been received for this year and the target had reduced from 58 to 53. She said work was being undertaken with quality improvement on approach of the improvement of C-Difficule. She also mentioned C41 had been occupied until summer due to works being undertaken.

Prof. Loughton said the performance of the ambulance handover was positive news and thanked staff.

Resolved: the Report was received and noted

9.2 Division 1 Quality, Governance and Nursing Report

Ms Black highlighted there had been a reduction in the red risk for nurse vacancies and a new risk was in progress for nursing skills mix. She said nursing vacancies were at 40 whole time equivalent vacancies and there were 27 nurses in the pipeline waiting start dates together with 30 who had been given conditional offers.

Prof Loughton asked what waiting start dates meant. Ms Black said that was where an offer had been made but occupational health checks or references were awaited. Mr Race said employment checks for the recruitment process was 16 days with a target of 20 days which was a quick process.

Resolved: the Report was received and noted

9.3 Division 2 Quality, Governance and Nursing Report

Ms Morgan highlighted the risks mentioned within the Division 1 report also applied to Division 2. She said two specific training elements had been drafted into the supportive programme for induction of international Nurses and was awaiting finalisation.

Resolved: the Report was received and noted

9.4 Division 3 Quality, Governance and Nursing Report

Ms Ballard highlighted the poor compliance of observations on time and Venous thromboembolism (VTE). She said there was an improvement with vacancies.

Resolved: the Report was received and noted

9.5 Executive Workforce Summary Report

Mr Race said there was a reduction in the vacancy level and turnover. He said sickness levels remained high due and there was a reduction in

appraisals. He also mentioned the Consultants vote for the British Medical Association (BMA) and British Dental Association were to ballot their membership with a view to take industrial action over the summer period. He said the first date they could take action was dependant upon whether they received a mandate would be 11 July. He said the Royal College of Nursing (RCN) were also to ballot their membership nationally for further industrial action with the ballot to close in the middle of June.

Mr Race lastly mentioned the Society of Radiographers had rejected their pay deal and would also be balloting their membership.

Resolved: the Report was received and noted

9.6 Chief Nursing Officer and Director of Nursing Report

Ms Hickman said the team supporting international nurses had received a Pastoral Care Quality Award which was positive news. She mentioned the Nursing and Midwifery Council (NMC) had identified some anomalies with the computer-based test which had effected one site. She said individuals concerned had been contacted direct by the NMC. She said queries had been identified with the English language test certificate and had been raised with the NMC.

Resolved: the Report was received and noted

9.7 Finance Position Report

Mr Greene highlighted the Trust was at £8.29 million deficit in month and £2.3 million adverse position to plan. He said the Trust had £1.1 million worth of costs associated with the strike action and £0.8 million performance against submitted stretched plan half being the divisional target. He said there was approximately £1.4 million additional pay over spends due to sickness cover, increase in pay spend and the Ambulance Receiving Centre.

Prof. Loughton asked why sickness was not managed well. Ms Hickman asked for evidence on the sickness issue as this needed to be quantified.

Action: Mr Greene to provide information on the over spend for staff sickness to Ms Hickman
Resolved: the Report was received and noted

9.8 Capital Programme Update

Mr Watson said there was £40 million this year in the plan and there were outstanding capital bids. He mentioned there were £5 million worth of capital pressures on that program. He said more information had been added to the major projects at the request of Executive Directors.

Resolved: the Report was received and noted

9.9 Operational Finance Group Minutes
Resolved: the Report was noted.

9.10 Financial Recovery Group Update

Ms Nuttall said the report would be focussing on the importance of tracking progress. She said Cost Improvement Programme (CIP) target was £45 million which was a significant challenge. She said there had been positive engagement with teams at the Trust for efficiency and effectiveness. She said comms would be circulated focussing on quality to deliver some of the savings that would be required. She said various schemes had been proposed which required details of timescales She mentioned there needed to be clarity of what the aim was to assist with monitoring and reporting.

Mr Stringer said there had been a significant challenge to achieve the deficit budget across the Integrated Care Board (ICB), where a figure of £70 million was submitted with most of the deficits within the four acute Trusts. He said work was being undertaken on methodology of the balance sheet which should be circulated next week.

Prof Loughton highlighted that staff should be aware this was partly due to the Covid monies having been discontinued and focus should be on continuous quality improvement reducing patient harm and infection prevention. He said there would also be focus on research and development.

Dr Singh asked about changes in the outpatient tariffs.
Ms Nuttall said the change was in place with an expectation that follow-ups reduced by 25% and if this was not undertaken payment would not be given for the work done. She mentioned this could be managed through patient initiated follow up. Mr Shayes to liaise with Prof. Singh with more details.

Action: Mr Shayes to provide details to Prof. Singh on outpatient tariffs.
Resolved: the Report was received and noted

9.11 Black Country Provider Collaboration Update

Mr Shayes said draft terms of reference had been created for the joint committee that oversaw all four Trusts. He also mentioned the Executive teams at all Trusts had been asked for feedback on the work programme for the Provider Collaborative.

Resolved: the Report was received and noted

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

10.1 Safeguarding Adults and Children

Ms Wharton highlighted there had been issues with Safeguarding supervision with a significant improvement in midwifery supervision. She also mentioned there was an issue with compliance of the initial health assessments, and work was being undertaken. She highlighted the alert of the Trust audit of the Mental Capacity in accordance with the Record Keeping Act, there was poor compliance rate and an action plan was in place. She said the team were attending ward huddles and where possible having more physical presence on wards together with offering staff bespoke training.
Ms Hickman said there were keys issues on process and documentation. She said once the electronic patient record was in place this should assist, but during that period, work was being undertaking and asked for support from colleagues into how that could currently be embedded.

Resolved: the Report was received and noted

10.2 Nursing Skill Mix Report

Ms Hickman introduced the report which included the Emergency Department (ED) Skills Mix report which was undertaken for the first time. She mentioned there had been no change with the inpatient report together with minimal movement around establishment to support areas where there were some deficits. She said there were two key components, ARC the associated offload utilization together with Paediatrics. She said positive external oversight on the process had been received from NHSI. She said one of the elements noted was the strengthening of policies.

She highlighted previously 2 variances had been identified in ED, Covid and the introduction of the ARC. She mentioned to support had been provided for the opening of the ARC which led to a junior workforce. She said the skills mix did not align directly to the Safer Nursing Care Tool (SNCT).

Resolved: the Report was received and noted

10.3 Quality Account (QA)

Ms Arthur highlighted that the Integrated Care Board (ICB) now had responsibility for the scrutiny of the policy accounts and also provide the stakeholder comments before the report was finalised. She said 2023/2024 priorities had been taken from the joint quality, safety and patient experience enabling strategies. She mentioned two areas had

been ommited from the QA due to the unavailabity of data. She said a seven days audit was being undertaken. She finally mentioned the harms data for hip and knee replacement surgery was not available nationaly and had been acknowledged by NHS digital website.

Resolved: the Report was received and noted

10.4 Learning from deaths

Dr Viswanath highlighted the Summary Hospital-Level Mortality Indicator (SHMI) for the period December 2021 to November 2022 was 0.90. He said this was a great achievement for the Trust. He also mentioned there had been an improvement with the SHMI within the alerting diagnosis groups pneumonia and vascular disease group. He said the roll out of the national Medical Examiner Programme into the Community in Wolverhampton had been delayed until April 2024

Prof. Loughton thanked all staff for their contributions towards work with the SHMI and said it was a great achievement.

Resolved: the Report was received and noted

10.5 Property Management Updates

Mr Watson said the report included details of activity taking place across the region. He mentioned as the estate was being changed and developed across the development strategy this was leading to loss of parties who provided income.

Resolved: the Report was received and noted

10.6 TRR/BAF Heat Map

Ms Arthur said the report was for noting.

Resolved: the Report was received and noted

10.7 Midwifery Services report

Ms Palmer said a successful recruitment event took place in May and appointments had been made to all vacancies in the midwifery workforce. She said the single delivery plan had been released and work was being undertaking on the recommendations and benchmarking. She highlighted the Trust had achieved 10/10 for the Clinical Negligence Scheme for Trusts' (CNST) safety actions which were positive news.

Action: Comms to create a press release for the Trust achieving 10/10 for the Clinical Negligence Scheme for Trusts' (CNST) safety actions

Action: Ms Palmer to go through recommendations of the East Kent Maternity report with her counterpart at Walsall Healthcare NHS Trust

Resolved: the Report was received and noted

10.8 Patient Experience Report

Ms Dowling said from October a new initiative had been undertaken to promote local resolution of complaints. She said this had led to a considerable reduction of complaints. She said previously the highest volume of complaints had been seen in ED and Observations on Gynaecology which had now reduced from 14 to 5 complaints a month. She felt this was due to recruitment and training of volunteers. She said the pilot scheme for the Ombudsman Standards Framework had ceased. She said there had been 3 ombudsman cases throughout the year which were considered to be partly upheld against the Trust. She said 174 new clinical volunteers had been recruited throughout the year. She also mentioned work continued in supporting St. John's Ambulance and the NHS Cadets program through qualifications.

Resolved: the Report was received and noted

10.9 Contracting & Business Development Update

Mr Shayes said the report was for noting.

Resolved: the Report was received and noted

10.10 Sustainability Report

Ms Smith said the Trust was successfully completing the national and regional deliverables. She said it was expected the Trust would achieve the baseline interim target of 15%. She highlighted in catering services removed 469000 single plastics for last year.

Resolved: the Report was received and noted

10.11 Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2022/23 1:02

Resolved: the Report was received and noted

10.12 Annual Fire Safety Report

Ms Nuttall said there 3 areas deemed amber which were being reviewed. She highlighted the team provided support to Shrewsbury and Telford Hospital as they had received fire warning notices due to issues with their building. She mentioned the accountable officer was the Chief Executive of Shrewsbury and Telford Hospital.

Resolved: the Report was received and noted

10.13 Quality Improvement (QI) Update

Ms Salmon highlighted a National Improvement Board was to be established. She said there was an expectation for each Trust to use the QI methodology. She said a maturity matrix self assessment was to be completed which would be presented at the following meeting. She also mentioned the first Joint QI Awards was place on Wednesday the 5 of July at GTG Training Centre. She said 111 posters had been submitted.

Resolved: the Report was received and noted

10.14 Winter Plan 2022/23 – The Royal Wolverhampton and Wolverhampton Place

Ms Shaw highlighted improvements on ambulance offload, length of stay in ED and discharge times. She said elective and cancer activity had been maintained. She said the Trust had maintained an excellent community urgent care response performance and had consistently exceeded the target. Ms Shaw thanked clinical and non-clinical teams for their support throughout the challenging winter period.

Resolved: the Report was received and noted

10.15 Infection Prevention and Control Annual Report 2022/23

Mr Reid introduced the report and said the Annual Report was to note. He highlighted good performance around Gram negative bacteraemias. He said the team would be looking at the use QI within the team.
Ms Hickman thanked staff for their contribution during the challenging period after COVID 19, Strep A and monkeypox.
Resolved: the Report was received and noted

11 Business Cases

11.1 Division 1

11.1.1 Replacement and Upgrade of Morcellator
Resolved: Replacement and Upgrade of Morcellator report was Approved.

11.1.2 Staffing Elective and Emergency Maternity Theatres
Resolved: Staffing Elective and Emergency Maternity Theatres report was Approved.

11.1.3 Band 8A Advanced Practitioner Physiotherapist
Resolved: Band 8A Advanced Practitioner Physiotherapist report was Approved.

11.2 Division 2 - none this month

11.3 Division 3

11.3.1 NICE TA735 Tofacitinib for treating juvenile idiopathic arthritis.
Resolved: NICE TA735 Tofacitinib for treating juvenile idiopathic arthritis report was Approved.

11.3.2 NICE TA861 Upadacitinib for treating active non-radiographic axial spondyloarthritis.

Resolved: NICE TA861 Upadacitinib for treating active non-radiographic axial spondyloarthritis 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 HS06, Laser, UV and Optical Radiation Protection Policy

Resolved: HS06, Laser, UV and Optical Radiation Protection Policy was Approved.

13.1.2 OP62, Breaking Bad News Policy

Resolved: OP62, Breaking Bad News Policy was Approved

13.1.3 HR17, Implementation of Working Time Regulations

Resolved: HR17, Implementation of Working Time Regulations was Approved.

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

15 AOB

1. Prof Loughton said a positive visit took place by Matthew Taylor, the Chief Executive the NHS Confederation who attended the Trust to look at Hospital at Home and the Science Park.
2. Mr Stringer said verbal approval had been received from the decision group NHS England the full business case for the electronic patient record and the Patient administration system (PAS) replacement. He also mentioned the Senior Responsible Officer would be Ms Nuttall
3. Prof. Singh mentioned the Digital Group supported the implementation of the huddle and built a completely new system for the Care Coordination Centre together with creating the case load management for the virtual wards and support was welcomed by teams.

16 Date and time of the next meeting 30 June 2023 at 1:30 pm.

Annual Equality, Diversity & Inclusion Report

April 2022 – March 2023

Author (s)

Alison Dowling, Head of Patient Experience and Public Involvement, Mohan Sandhar, Patient Experience Equality Officer and

Balvinder Everitt, Head of Equality Diversity Inclusion (Workforce)

Russian

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ਜੇ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ ਦੀ ਜਾਂ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ।

Romanian

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Traditional Chinese

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Appendix 1 – Equality Objectives 2023 – 2027

Appendix 2 – Equality Delivery System Assessment Scoring Template

Appendix 3 – Protected Characteristics under the Equality Act 2010

*Please note that for statistical purposes, percentages have been rounded up to the nearest 0.5 figures unless indicated

Executive Summary

Producing this Equality Information Report is fundamental to The Royal Wolverhampton NHS Trust (RWT) as it allows us to understand the impact of our policies and practices on the people who use our services and on our staff. As a high performing NHS provider organisation, we seek to ensure that equality, diversity and inclusion (EDI) is firmly embedded in everything that we do.

We want our service users, the local population and our workforce to be confident about our commitment to eliminating discrimination, bullying, harassment, victimisation and promoting equality.

With this in mind, we strive to deliver safe, accessible and fair services to the diverse populations that we serve and ensure that they are treated with dignity and respect.

It is critical that we create working environments in which everyone can reach their full potential, thrive and deliver equitable services. There is also a link between the level of staff engagement and positive patient outcomes.

We recognize that some people may face unintended barriers presented by our working practices and whilst accessing our services. People have the right to be treated fairly by having their needs met as fully as possible and where appropriate. Some people may need support to ensure that they receive the same level of service, access, treatment and outcomes.

The two sections of this report aim to bring together the equality information available for the workforce and non- workforce areas of the Trust. In doing so, the Trust seeks to meet its legal and contractual obligations regarding these matters. Action plans will have been created for both sections to address imbalances in diversity in the workforce and to improve accessibility for our local communities.

The Trust recognises that there are some challenges ahead but is committed to making a difference to the people we serve and to our workforce, not only to adhere to the law but because it’s the social, moral and right thing to do.

Introduction

The purpose of this report is to use the best available data (disaggregated by personal protected characteristics as defined under the Equality Act 2010) to gain a clearer picture of possible gaps and identify possible patterns of inequality in relation to access to services and workforce activities.

There are many reasons for this, including:

The Equality Act 2010 replaced previous anti-discrimination laws with a single act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways to help tackle discrimination and inequality.

The Public Sector Equality Duty (PSED) 2011 is made up of a general overarching equality duty supported by specific duties intended to help the performance of the general equality duty. The Trust must capture a range of equality-related information and report on it. By analysing this information, the Trust can identify possible issues of inequality and seek to address them, specifically for people who have personal protected characteristics as defined by the Equality Act 2010.

The General Equality Duty:

In summary, in the exercise of functions, the Trust must have due regard to the need to:

- Eliminate unlawful discrimination, harassment, victimisation.
- Foster good relations
- Advance equality of opportunity. Particularly, having due regard to:

1. Remove or minimise disadvantages for people due to their protected characteristics.
2. Take steps to meet individual needs.
3. Encourage participation in public life or in other activities where people with protected characteristics are disproportionately low.

This includes taking into account the needs of people with disabilities and treating some people more favourably.

Having due regard means we must **think consciously** about the **aims of the General Equality Duty** in our day-to- day business and as part of our decision-making processes.

Personal Protected Characteristics (PPC) covered under the Equality Act 2010 are shown in the appendices. There are different levels of protection and areas of coverage for each PPC.

The Specific Duties require public bodies to gather and analyse equality information, accessibly publish relevant, proportionate equality information, and set specific, measurable equality objectives.

In addition to our legal requirements, there are local and national drives that influence our strategic direction, decisions, and the manner in which we carry out our daily business. These include:

- The NHS Constitution sets out what patients, the public and staff can expect from the NHS.
- The Care Quality Commission's (CQC) compliance with its fundamental standards, including person- centered care, dignity and respect, safety and safeguarding.
- EDI and human rights run throughout the CQC outcome requirements.
- NHS England's Equality Delivery System (EDS2) was originally launched in 2011 and has been refreshed. Its main purpose is to help NHS organisations review and improve their performance for people with protected characteristics.
- NHS England's NHS Workforce Race Equality Standard (WRES) aims to ensure that employees from Black, Asian and Minority Ethnic (BAME) backgrounds are treated fairly at work and have access to career opportunities.
- Progress is demonstrated against a number of workforce race equality indicators.
- NHS England's Accessible Information Standard (AIS) aims to ensure that disabled patients (including carers and parents, where applicable) receive accessible information and have appropriate support to help them communicate.

Further to this, EDI principles are threaded throughout our Trust Vision and Values. Our workforce is responsible for leading and driving forward change in the Trust, as well as improving standards in health.

This annual report contains information relating to the 12-month period from **1 April 2022 – to 31 March 2023**

(Unless indicated otherwise).

The report consists of two sections and aims to bring together the equality information available for **non-workforce, i.e., Patient Experience and Service Provision** (section 1) and **workforce** (section 2) areas of the Trust.

Analysis of this information will be used to:

- Improve access to services and employment opportunities.
- Identify areas where there could be possible discrimination, victimisation, bullying and harassment.
- Influence decision making processes.
- Undertake relevant initiatives both in service provision and workforce planning.
- Action planning

The Local Context and Demographics

Black Country and West Birmingham Integrated Care System (data links to this former title, however this is now known as The Black Country Integrated Care System)

The Black Country and West Birmingham, Integrated Care System, has a population of around 1.5 million people across five places: Dudley, Sandwell, Walsall, West Birmingham, and Wolverhampton.

There are 31 neighbourhoods and Primary Care Networks (PCNs) covering 216 GP practices.

There are 15 Statutory Partners (four hospitals, two mental health trusts, five local authorities, one clinical commissioning group, one community trust, one ambulance service, plus two associates in Birmingham Community and Birmingham and Solihull Mental Health NHS Foundation Trust.

Wolverhampton

We are a major acute, community and primary care Trust providing a comprehensive range of services for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire. We are the largest teaching hospital in the Black Country, providing teaching and training to more than 130 medical students on rotation from the University of Birmingham Medical School. We also provide training for nurses, midwives and allied health professionals through well- established links with the University of Wolverhampton.

As one of the largest acute and community providers in the West Midlands, we provide 839 beds at our New Cross site (including intensive care beds and neonatal cots). There are a further 51 rehabilitation beds at West Park Hospital and 54 beds at Cannock Chase Hospital.

We are the largest employer in Wolverhampton, with more than 11,000 staff.

We recognise that working together is crucial in delivering patient-centered care in a joined-up way. Reporting equality information every year is important to the Trust. It allows us to measure the effectiveness of our policies and practices on both our service users and on our workforce; it provides an additional platform for demonstrating primary areas of progress and identifying areas where further work is required. EDI is key to the culture of the Trust, and our ambition is to make sure that is a key part of everything we do.

These are some of the things that we know about the diverse groups of people in Wolverhampton and Cannock. This information helps us to identify some of the equality issues that could affect the people who use our services.

- Statistics population in the United Kingdom: June 2016, indicate that Wolverhampton has a population of about 263,257 people, whilst Cannock has a population of around 100,762 people (Source: Office for National Statistics, Mid-Year Estimates 2019)
- Wolverhampton has 64 per cent population as White British, 18 per cent Asian, seven per cent Black, six per cent All Other White, three per cent Mixed and two per cent Other (Source: Office for National Statistics, June 2016)
- Cannock has an overall BAME profile of around three per cent, compared to Wolverhampton which is 39 per cent (Census 2021)
- The life expectancy at birth is 77.2 years for males and 81.4 years for females in Wolverhampton and 79.0 and 82.4 respectively for Cannock (Source: Office for National Statistics, Life expectancy at birth 2016 to 2018)
- Age demographics between Wolverhampton and Cannock are almost identical with the exception of Cannock having a higher percentage than the UK average of people aged 50 plus years.
- Wolverhampton's gender pay gap (15.4 per cent) and Cannock's gender pay gap (10.7 per cent), as recorded in 2019, are both lower than the United Kingdom's average of 17.3 per cent.

Governance and reporting for EDI

The Trust has governance and regulatory frameworks and mechanisms in place to ensure that transparent assurances are provided in relation to the discharging of equality duties.

The Trust has an EDI steering group (EDISG), which has been running since May 2016. The EDISG is attended by senior managers across the Trust and hopes to build a culture that celebrates EDI. Regular EDI reports are presented to the Quality and Safety Assurance Group, various internal workforce groups and external clinical quality review meetings.

Section 1 – Non-Workforce Information

The Trust recognises the importance of embedding equality, EDI principles and practices throughout the organisation. We want to ensure that the people who use our services are confident about our commitment to eliminating discrimination, bullying, harassment, and victimisation and promoting equality by providing safe, accessible and fair services to the diverse communities whom we serve.

The Trust not only has legal and contractual requirements to adhere to, but we also recognise that embedding equality, diversity and inclusion is the social, moral and right thing to do.

Capturing and analysing equalities information can help to identify if there are possible barriers to accessing Trust services. This is a crucial step, not only in identifying possible barriers, but the data will also support initiatives and action planning to improve equality performance by tackling inequalities for people with protected characteristics as defined by the Equality Act 2010.

The Trust recognises that we do not hold comprehensive data for all the PPCs; therefore, we will need to look at IT systems and internal processes to help close this gap and provide more robust data in the future.

1.0 Patient Access to Services

The Trust saw a total of 436,249 patients in the year (an increase of 15898 or 3.7 per cent from the previous year's figure of 420,351).

The summary data below summarises available information desegregated by protected characteristics (where available) as far as possible:

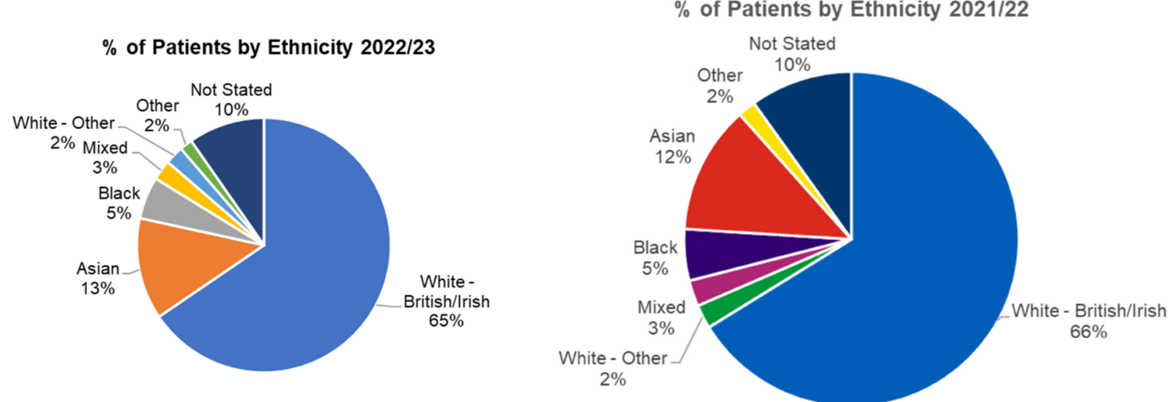
Gender: There is a fairly even representation, with 54 per cent being female and 46 per cent being male. This data is identical to last year's information.

This is not mirrored by the demographics of Wolverhampton and Cannock, where there is a two per cent difference between females (51 per cent and 49 per cent Male) as recorded for both Wolverhampton and Cannock areas in the 2011 Census. There was 25 indeterminate (unable to be classified as either male or female), as defined by the NHS data dictionary. In addition, 38 patients did not declare their gender.

Marital Status: 166,102 people, or 38 per cent of the overall total of patients, did not have their marital status recorded. This is a two per cent increase in volume compared to the previous year. Departmental recording of information is crucial to improving these.

The service area where there is the highest 'not knowns' category recorded is the Accident & Emergency Department, and the next highest is Outpatients. The lowest continues to be Maternity Services. 30 per cent of patients were married, and 27 per cent of patients were single.

Ethnicity: The group with the lowest representation who accessed services during this reporting period were people who identified as having a Bangladeshi origin (0.1 per cent). The largest group is White – British at 65 per cent, with the second-largest group being Asian at 13 per cent.



Age: The largest age groups of patients accessing services are the 51-60 and 71-80-year-olds, each group representing 14 per cent of the total service users.

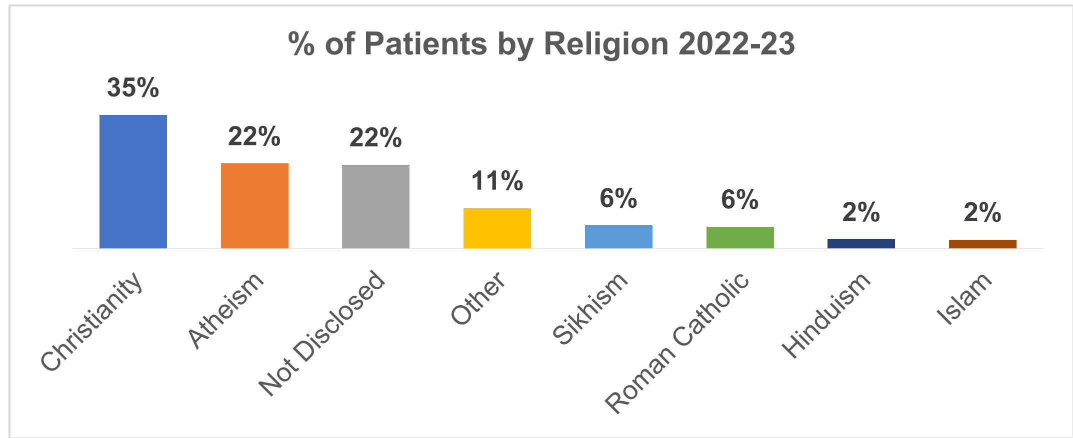
The smallest proportion of patients is the age group of 91 plus and represents two per cent of the overall total. Closely followed by the age group 11-20 at seven per cent. Trends show that older age groups tend to use Community, Inpatient and Outpatient services more than younger age groups which tend to be represented in A&E & Obstetrics.

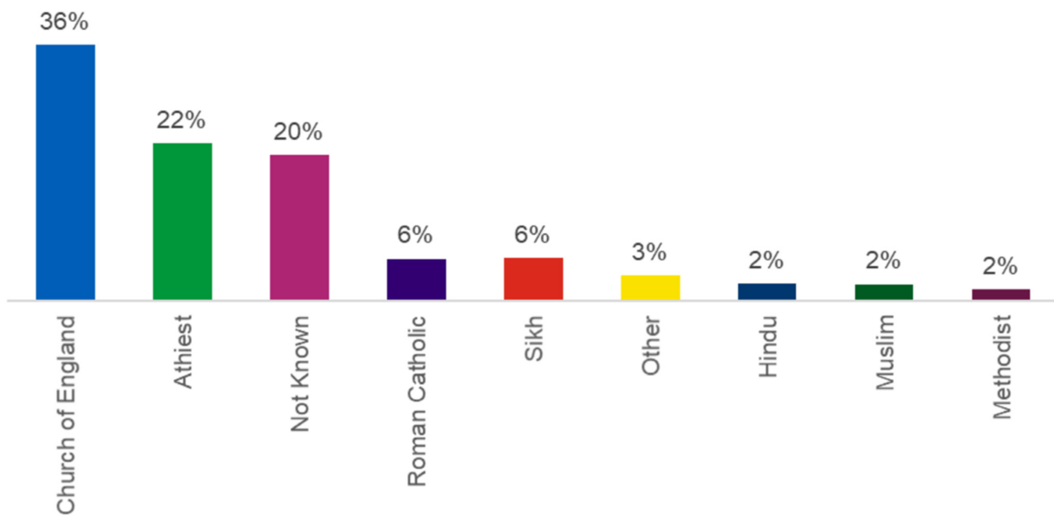
Religion or Belief: There are 32 different religions represented by patients of the Trust. The largest represented religion, of the patients who accessed services is Christianity, which represents 35 per cent of all patients. The smallest represented groups are Hinduism and Islam at 2 per cent each. A number of other religions are combined as the other category which is 11 per cent. There is still a high percentage of 'Not Disclosed' at 22 per cent, which is a slight increase of two per cent from the previous year.

It is recognised, however, that there is a high group (22 per cent) of patients who accessed services who state their religious status as ‘Atheist’.

This will help shape our chaplaincy services and ensure that we continue to offer support that is non-religion specific and holistic for those with no specific religious faith.

However, there is a range of other religions that access our services, demonstrating the diversity of the people who use our services.





2.0 Performance information relating to health outcomes and inequalities.

Due to the limited information available and the large proportion of ‘unknown’ categories, it is difficult, at this stage, to identify health outcomes for specific different groups. For example, in some service areas it is clear that there is an under-representation of data from members of the BAME community and people with disabilities.

It is intended that future action will be targeted in areas of low recording of equalities data to enable better analysis of service take up. Work is already underway to address this issue in the complaints service and Friends and Family Test (FFT).

However, in recognition of the wider health inequalities agenda the Trust has set up a Health Inequalities working group with senior representation. The group has been looking at the following areas:

(a) Governance and Education

- 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 process (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.

(b) RWT Initial Action Plan

- 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
- Mitigating against digital exclusion
- Considering data protection concerns, equipment and data availability, digital skills in access to information and services, monitoring uptake
- Ensuring datasets are complete and timely.
- Meeting ethnicity completion target of 95%, flags for Learning Disability in place
- 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
- Strengthening leadership and accountability
- Board level buy-in, working towards distributed leadership through education and changing business-as-usual processes.

Assessing Equity

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.

3.0 Patient Experience Metrics Data

With a variety of different ways in which patient feedback is obtained, the Trust, where possible, collects equalities data which is gathered and analysed. These methods include formal complaints, the FFT, Patient Advice and Liaison Service (PALS) concerns and information and feedback directly from patients. The data collected is used to check our progress, strengthen our accountability and find new ways of doing things better.

We keep information on our use of interpretation and translation services and provide a breakdown of languages used to show how we are meeting the needs of our diverse communities.

3.1 Formal Complaints Monitoring

The development and Trust-wide dissemination of a patient feedback leaflet, which includes an equalities monitoring form, has aided the capturing of equalities data in relation to PALS concerns and formal complaints.

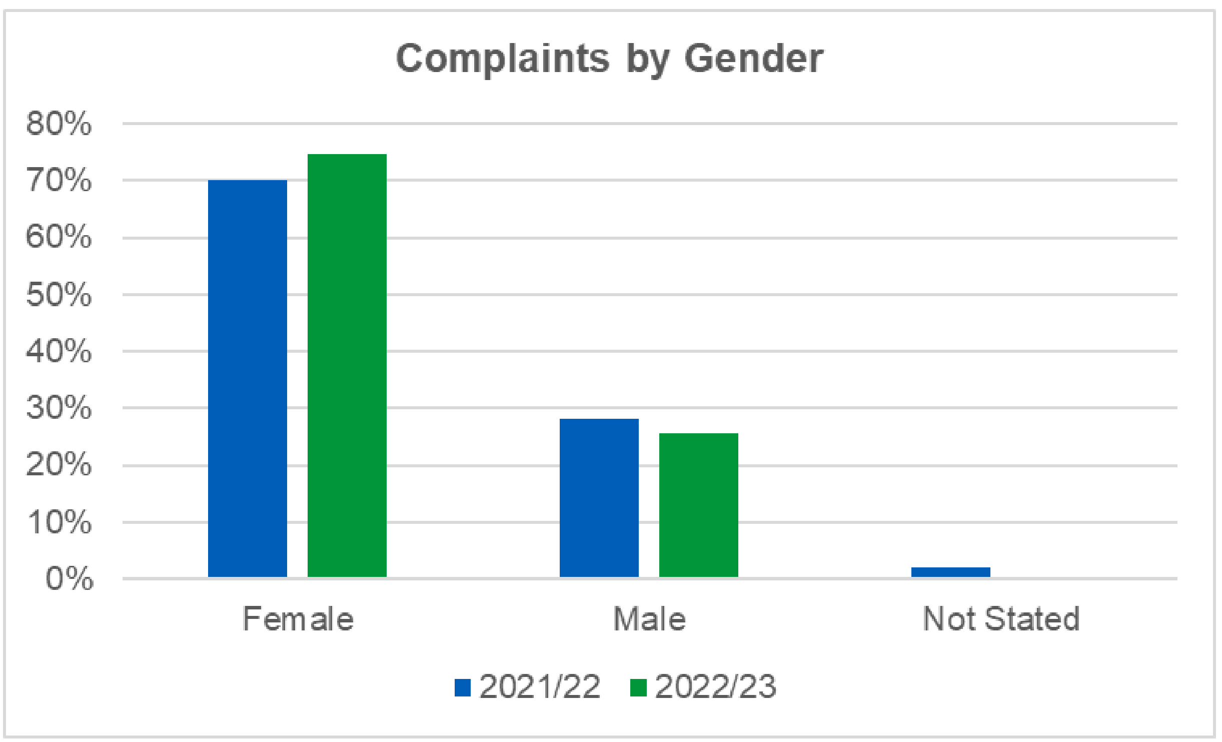
The implementation of a departmental telephony system which advises service users of the need and rationale for gathering such sensitive information has also assisted in conjunction with a review of the subjects noted in the Trust's Datix complaints module. The complaint data recorded relates to the actual patient rather than the complainant, which accounts for any volume of 'unknowns, not stated, undisclosed, or not available' where we have not been able to identify the protected characteristics required.

549 formal complaints were received from April 2022 to March 2023.

A summary of some of the PPCs recorded from complaints is as follows:

Gender

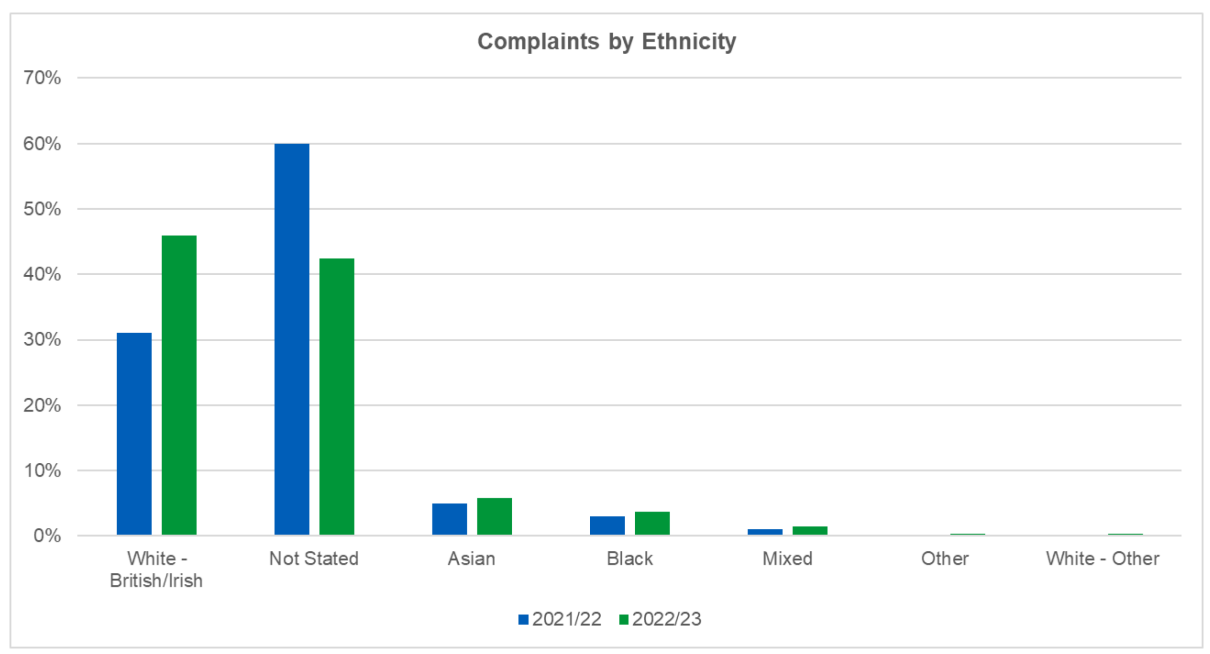
Of the 549 complaints in this period, 75 per cent relate to females and 25 per cent from males. In comparison to the previous year, 2021/22, complaints made by females have increased by 5 per cent.



Ethnicity

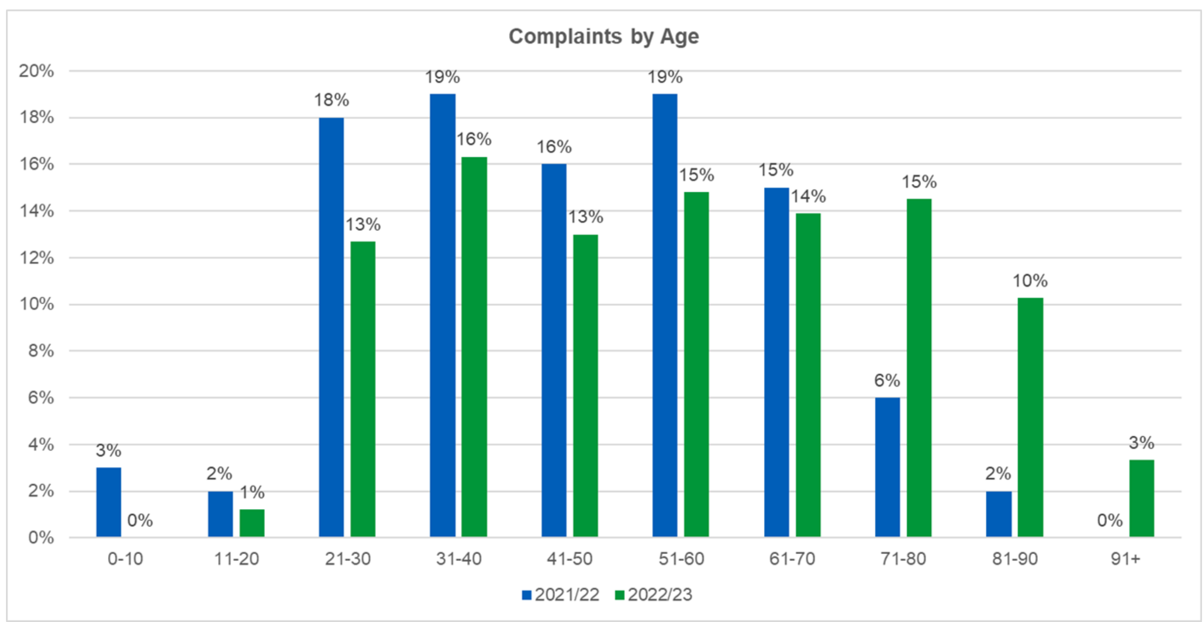
Wherever possible, the Trust collects personal data relating to ethnicity (race) for each complainant. Of the 549 formal complaints raised in this period, 42 per cent of the complainants' ethnicities have not been stated. This represents a decrease of 18 per cent in the non-declared category. 46 per cent of complaints are from the White – British/Irish category which is an increase of 15 per cent.

There has been an increase from 8 per cent to 10 per cent from members of the BAME community who complained during this reporting period.



Age

For those complaints where age had been identified, complainants from the age groups 31-40 made the most complaints at 16 per cent, followed by 51-60 and 71-80 at 15 per cent each. The lowest age group represented in complaints were 11-20 at 1 per cent.



3.2 The CQC National Inpatient Survey 2021

The 2021 Inpatient Survey was part of a National Survey Programme run by the 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 the patient experience.

The 2021 National Inpatient Survey used the "mixed mode" methodology for the second time.

- Mailing one – a letter with a link to an online survey, followed by an SMS reminder.

- Mailing two – a letter with a link to an online survey, followed by an SMS reminder.
- Mailing three – a letter with a paper questionnaire

The paper questionnaire covers eight pages and includes 49 questions about care, 10 background questions and three free-text questions.

The online version was available in English and 19 other languages. A British Sign Language version was also provided.

The Adult Inpatient 2021 benchmark reports (due in October 2022) will include an overview of the number of questions in which the Trust's performance has significantly improved, significantly declined, or not significantly changed compared with the result from the previous year. There will be details of the demographics of patients who responded, and these will be analysed. Once the results are known, the Trust will compile a comprehensive action plan to make service changes to improve inclusivity and the patient experience where possible.

3.3 Friends and Family (FFT) Test

The FFT provides patients with the opportunity to submit feedback to the Trust by using a simple question that asks how likely, on a scale ranging from extremely unlikely to extremely likely, they would recommend the service to their friends and family if they needed similar care or treatment.

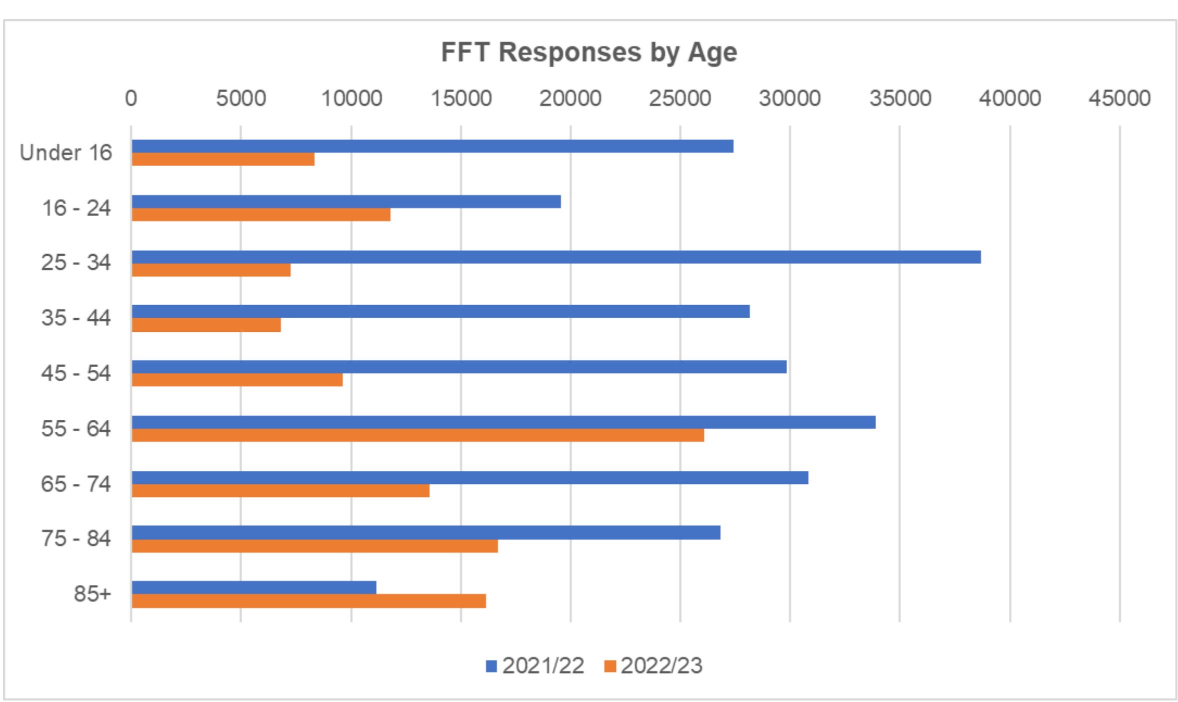
Throughout the year, the Trust has considered where there were gaps in surveying patients and has worked with the FFT provider to improve the feedback for those areas.

Improvements and actions included:

- The Patient Experience Team to implement and monitor the use of the ENVOY system to ensure that clinical staff can use the real-time data to effect timely change.
- Negotiation has taken place with CQC's agencies to translate 'disclaimer' posters in surveys into two of RWT's five most prevalent languages (Kurdish, Sorani and Romanian). Speakers of those languages will now be aware of their right to withdraw from the survey sample.
- The Patient Experience team continues to support the provision of QR codes for staff in key areas to localise feedback.

FFT responses by age

From the data collected electronically, the largest group of responses were in the age range of 55 - 64, this is a change from last year's highest group which was under 16 years old. The lowest age group of responses has changed from 85 plus to 35 – 44.



FFT responses by Ethnicity

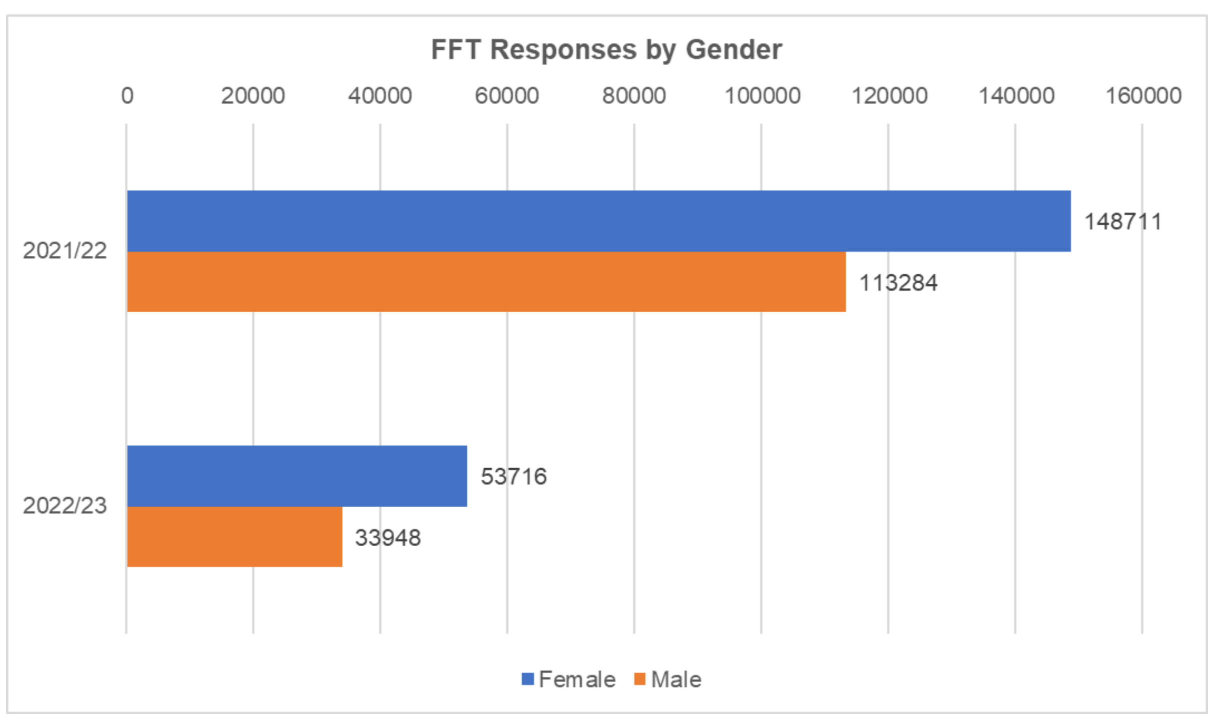
From the data collected, the largest group of responses was in the 'White British' ethnic category, followed by 'Asian', similarly to last year. It is noted that when compared to the previous years ethnicity data and trends that there has been a considerable decline in FFT feedback gained from the 'White British' ethnic category. This data does not reflect the access to services data for 2022/23. A deep dive into the data provided will be undertaken in order to understand this shift in data collection.

It is worth noting that there have been notable increases in the number of responses from all other ethnic categories which could be due to broader engagement and inclusivity.

Year	2021/22		2022/23	
Ethnic Group	**Overall Total**	**Percentage**	**Overall Total**	**Percentage**
Asian	44357	14%	63744	20%
Black	17897	6%	46543	14%
Mixed	4207	1%	59753	18%
Not Stated	5842	2%	16954	5%
Other	5844	2%	30060	9%
White - British/Irish	227361	72%	78284	24%
White - Other	9557	3%	30168	9%

FFT Responses by Gender

In terms of responses to FFT surveys, it is noted that the lowest number of responses continues to be from males, (39 per cent) which represents a seven per cent decrease from last year. Females represent 61 per cent of responses which is a seven per cent increase since last year.



4.0 Key activities for awareness and engagement and a focus on inclusivity

In partnership with Walsall Healthcare, The Trust has published a Patient Experience Enabling Strategy 2022 - 2023, which sets out how the Trust will achieve its objective to strengthen patient and public involvement across the organisation and to help compliance towards statutory equality requirements.

We endeavor to communicate with the wider community to ensure that marginalised or under-represented groups can become involved in shaping future services and decision-making processes. To achieve this aim, we have been involved in the following activities:

- Regular meetings take place with external providers as and when required, with the Engagement Leads for the Clinical Commissioning Group and Healthwatch.
- The Trust also attends regular meetings with representatives (both patients and staff) from the Patient Participation Groups for the Primary Care GP practices (Primary Care)
- Proactive engagement with the community continues to be monitored by the Patient Experience team. The team has been looking at ways in which engagement of young people in care can be improved.
- In collaboration with The University of Wolverhampton, the Royal Wolverhampton Trust has spent time working together with service users to consider the best way of engaging and learning from one another to provide solutions to improve services for patients. The project had three streams of improvement with services users that had experienced our services in Stroke, Pediatrics and Learning Disability areas. The work streams have resulted in the development of a logo to be used at the bed space for patients with Learning Disabilities who require additional support. For Stroke Services a lived experience app has been created and for Paediatric Services the outcome was the design of a service information and pathway product.

An additional co-production exercise took place in March 2023 when PET staff attended St. Anthony's Primary Academy School in Wolverhampton. The 2-hour exercise examined what information year 3 and 4 pupils need to make them feel safe and secure when in hospital. This

information is now being accommodated in a complete re-design of the Paediatric Wards' notice boards.

- Feedback Friends**:** Patient Experience Team is implementing Feedback Friends – 'a mystery shopper' style feedback route for patients who can simply feedback their comments from QR codes on posters designed by the team.
- Deaf Awareness/Initial British Sign Language training. - A series of cohorts was delivered designed to enable staff to learn how to communicate better with Deaf people and to make the Deaf community feel less excluded and fearful when in the hospital.
- The Trust has used NHS England Funding to devise and deliver a training package focused on reducing aggression in ED environments. The package identifies conflict situations and five common responses to conflict and the implications of these responses. Staff are equipped with 12 de-escalation strategies, and their interpersonal skills are honed to engage and to defuse conflict situations. Seven training sessions have been delivered. The desired outcome is that ED environments become safer spaces and staff are empowered to create a better and safer environment for patients and staff.
- The Patient Experience Team was approached by the International Nurses' Training Team. Help was requested to inform and empower nurses arriving from countries where LGBT+ legislation is not inclusive and where LGBT+ status carries a social stigma. A training package was devised that introduces Nurses to the LGBT+ lifestyle and culture in the UK. The legal standards which they are required to observe are introduced together with RWT's Dignity and Respect at Work Policy (HR06) plus supportive resources. The desired outcome is that incoming nurses are fully supported to ensure that LGBT+ patients and colleagues receive equal treatment and are free from harm.
- RWT's Guidance and Statement of Intent for Transgender Inclusion – this has now been launched. This document has been produced to provide guidance and information to staff within the organisation to support the needs of Transgender patients and staff. It will support staff who work with transitioning or transgender colleagues or patients to understand, support, and promote their colleagues' or their patients' inclusion in the care environment.
- Hematology. A short-life working group has met on a regular basis to address issues for patients with sickle cell and thalassemia conditions. The group, which includes patient and community representation, is looking at existing services, identify gaps, and consider the findings of the recently published report following a national inquiry into avoidable deaths and failures of care for sickle cell patients.

The initial focus of the working group has been to raise awareness of the sickle cell and thalassemia conditions, promote understanding of Trust complaints procedures and revisit how patients are treated when they attend ED. Work is currently underway to produce an awareness video involving group members.

Patient Involvement Partners (PIP). During the reporting period the Council of Members has been rebranded into a new group known as the Patient Involvement Partners. The rebranding exercise has resulted in adopting new terms of reference, new logo, and posters. Several new members have been recruited from our local community, who are current and former patients, and they all bring with them a wealth of different experiences to offer the Trust. Recent examples of their contribution include review of ward notice boards, feedback friends' initiative (mystery shopping) and participation in the NHS 15 Step Challenge exercise.

Further initiatives to promote equality, diversity and inclusion are also included in Section 2 of the report under Workforce Information.

5.0 Accessible Information Standard (AIS)

The Trust AIS working group keeps an overview of the main actions to be progressed. In November 2022 an audit was conducted by the Patient Experience Team on the state of key areas of the RWT action plan. The primary areas of focus continue to be as follows:

- Patient Administration Portal - Investigating the facility to record different communication requirements with the IT supplier. The patient administration portal is live, and the operational service is now canvassing patients for registration/use. The portal will then be used in preference to patient paper letters via post.

Currently, all patients are asked if they have specific information or communication requirements as part of their registration. This information is flagged, and the flagging system can identify people with hearing or sight impairments and learning disabilities or dementia. It has been developed by Learning Disability Services. This information is shared with other relevant organisations, e.g., at the point of referral to care homes, patient discharge etc. The flag remains on the patients' records, enabling them to be identified when they use the Trust's services again.

- Review of patient appointment letters - Officers continue to work with Synatec (hybrid mail provider) on letter content requirements. An Easy Read template for appointment letters for those patients identified with learning disabilities has been developed.
- AIS model for patient leaflets – Some work has been carried out on scoping exercises led by the LD Service.
- Compliance with the AIS through the Badgernet App in maternity services- The App meets accessibility standards with all users' needs to be recorded from when someone downloads the app.

The AIS has been the subject of a national review and a revised version is likely to be published later this year. Initial feedback from the review team points to the following key findings:

- Mixed staff awareness of the AIS
- Concerns around the accessibility of complaints processes resulting in under reporting of issues.
- Ability of systems to record reasonable adjustments.

6.0 Interpreting and Translation Provision

The Trust provides interpreting and translation services to enable people to access services fairly and get the best care and information. These services are provided via external service providers. A summary of interpreting and translation services is below:

Community language services provided:

- Face-to-face language interpreters: Available 24 hours per day all year round
- Telephone language interpreters: Available 24 hours per day all year round. (Instant telephone access – no booking required)
- Video Interpreting: This service allows staff to connect to an interpreter through a video connection, either on a desktop computer or through a mobile device such as a tablet or mobile phone

- Translation of written information into alternative formats:
  a) English to other languages or vice versa
  b) Larger print
  c) Braille
  d) Easy Read
  e) Audio (languages to English / English to languages)

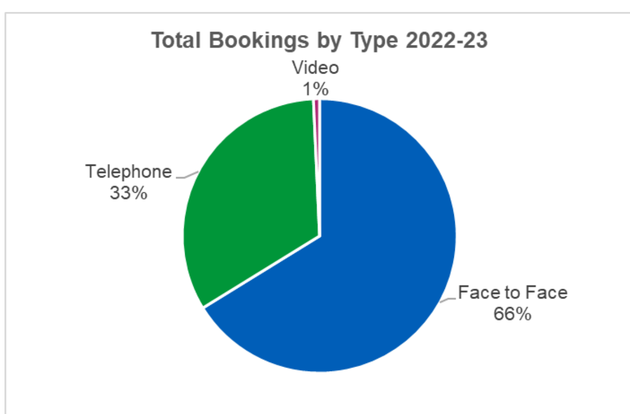
People who are d/Deaf or hard of hearing:

Face-to-face interpreters: available 24 hours per day all year round covering:

a) British Sign Language (BSL)
b) Sign Supported English (SSE). Relay interpreter
c) International interpreter for d/Deaf people
d) Note taker (manual)
e) Note taker (electronic)
f) Lip speaker for d/Deaf people
g) Deaf blind hands-on interpreter
h) FaceTime for basic non-clinical information only

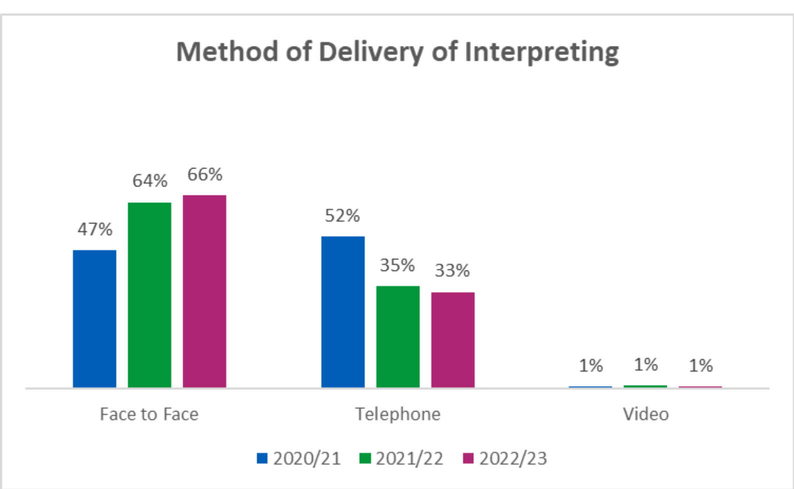
Interpreting summary

The costs for providing an interpreting and translation provision have risen year by year. This is currently being evaluated to determine how costs can be controlled through the use of less costly options such as telephone and video interpreting.



The Trust continues to undertake analysis of interpreting data. The most noteworthy trends from the latest analysis have been the increase in overall demand with face-to-face bookings being used as the most preferred option resulting in increased expenditure. Overall, the Trust made 21175 bookings for community languages which represents an increase of 16 per cent over the previous year (18221). Breakdown by booking type was as follows:

- Face-to-face language interpreters: The Trust made a total of 14008 face-to- face bookings compared to 11628 in the previous year. 14008 face-to-face bookings represents 66 per cent of the total bookings compared to 64 per cent for the previous financial year.
- Telephone Language Interpreting: The Trust used telephone interpreting a total of 7003 times, (representing 33 per cent of the total bookings). This represents a small decrease of 2% of using this method of interpreting for 2023/23 compared to 2021/22)
- Video Interpreting: The Trust used video interpreting on 154 occasions compared to 221 in the previous year. This is an unwelcome shift as the Trust has been promoting the use of video interpreting as an alternative to face-to-face sessions.



During the reporting period, the top five languages featuring in bookings were:

- Punjabi
- Romanian
- Polish
- Kurdish- Sorani
- Arabic

As with the previous year, Punjabi continues to be the most requested language. In terms of other languages, the pattern is repeated apart from Arabic replacing Lithuanian.

The Trust used BSL interpreters a total of 291 times during this reporting period which is consistent with the figure of 292 for the previous year.

Throughout the year, staff have received regular communications on making the most effective use of the interpreting and translation service. In addition, RWT's intranet was updated with the latest guidance from the service provider.

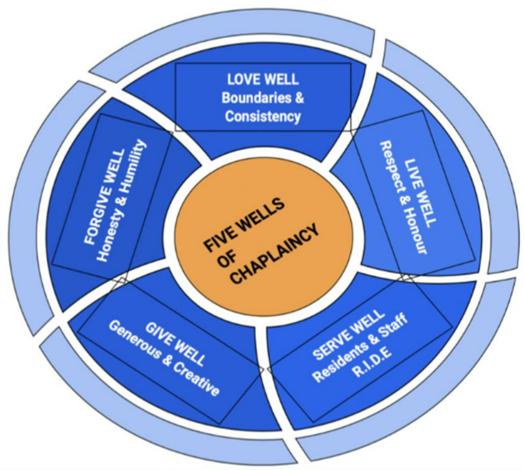
7.0 Meeting Religious and Cultural Needs of Service Users

The Multi-Faith Chaplaincy and Spiritual Care team exist to meet the needs of those of faith and none, irrespective of age, gender, ability, race, religion, belief or sexual orientation. The service is accessible to all patients, their families and friends, staff and volunteers throughout the Trust and, is available throughout the twenty-four-hour period across our hospital sites.

The team has been through significant change throughout 2022 with successful recruitment completed to five vacant positions. Currently it consists of representatives from the Christian, Hindu, Muslim and Sikh faith traditions and, representatives from other faiths may be available upon request. The new team has established itself across the Trust and has a strong and growing relationship with the Bereavement Services team, the Palliative care team, the NNU Clinical team and the Bereavement Midwives.

The Chaplains regularly visit each of the three hospital sites and, patients who require and/or request support, are visited by the bedside. Prayer resources and devices are available on all wards or may be obtained by contacting the team directly. There are four multi-faith prayer spaces and reflection rooms within the Trust, located within New Cross and Cannock Chase Hospitals. These spaces are open and available for private prayer and reflection. Compassionate support is provided to those who are affected by illness, injury, trauma and distress. It goes beyond patients – it's also taken up by visitors, relatives and increasingly and significantly staff across the Trust.

The service continues to work from the foundation of the newly implemented ***"Five Wells"*** values.



The team remains proactive and responsive in its approach to everyday requests for support and to specific events that affect the life and work of the Trust. As such, the team continues to mark important dates and deliver annual services on behalf of the Trust.

New Initiatives

- Visiting rotas - Chaplaincy everywhere, every week
- The team has introduced a web-based method of recording pastoral encounters at RWT (SPARC) which was previously used at WHT. This enables the Trust to have a greater depth of insight into the scope and impact of provision.
- Compton Care. Following several months of discussion and planning the team we have entered a new partnership with the Chaplaincy team at Compton Care. Support will be provided out of hours, at weekends, bank holidays and for annual leave cover. It is envisaged that this will bring a richness to chaplaincy provision in terms of experience and knowledge as well as bring some much-needed collegiality and support to the Compton team.

In 8 months of collecting data (August 2022 – March 2023) 3004 significant pastoral encounters were made. 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.

8.0 Learning Disabilities and Autism

The Trust's Learning Disabilities and Autism Team continues to provide advice and support to all staff across our services to meet the additional needs our patients. The team has recently expanded to support the needs of autistic patients who do not have an intellectual disability who access our service. This is a new and developing service that will not only be able to support the needs of our patients but will work closely with the Trust's Health and Wellbeing service and Human Resources department to support the needs of our neurodiverse staff. An electronic flagging system has the addition of the autism flag, which currently identifies approximately 1000 autistic people.

The service operates during office hours, where a member of the team is available on call to answer and manage concerns. The open referral system allows for patients, carers, and staff to contact the team directly via a mobile phone. Outside of office hours, the team have an internet site which provides staff with useful information to support the additional needs a person may have as a result of an LD or A

The team continues to use the electronic flagging system to be able to identify children, young people, and adults with a learning disability. This system currently recognises approximately 3000 people. Using this flagging system, the team have been able to recognize areas where improvements can be made. The team have recently led on the development of a reasonable adjustments tab on the individual electronic patients records. This tab is available for all staff to add and gain information which will help support the patient.

The team works closely with the paediatric consultants to support young people in transition from children's services to adult health services. The team supports Trust GPs to meet the requirements of the Directed Enhanced Service (DES) and ensure that young people, 14–17-year-olds are registered, and supported to have their annual health check.

9.0 Maternity Services

- To address inequalities experienced by women from BAME backgrounds the Trust has appointed an EDI midwife lead. This has resulted in a whole range of initiatives as follows:
- Sahara Maternity Support Group. This group was set up in partnership with Positive Participation who are a specialist Mental Health Service in Wolverhampton for Black, Asian, and Minority Ethnic groups. It helps Black, Asian, and Minority Ethnic women who need to access additional maternity support, parent education and mental health services in Wolverhampton. This includes accessing the same antenatal classes that are available in English (but in their specified language) with additional education on the antenatal journey and early parenthood.
- RWT now has a referral pathway to Sahara Maternity Support Group. The community midwives have been made aware to refer any women who require additional support including digital exclusion. Once referred, the women are contacted by the EDI lead by telephone in their spoken language and they are made aware of the support available at the group. For some women, the EDI lead has visited them to inform them of the support available and upcoming appointments if they do not have a telephone. They are encouraged to attend to achieve the maximum benefit to them from the support group.
- The EDI lead participates in a monthly TV recording on the Health Talk Show on the Asian TV channel called Kanchi TV Sky channel 772. This is popular amongst the local Punjabi communities in the vicinity of Wolverhampton, West Bromwich, Birmingham, Dudley and Walsall. Punjabi is one of the top 5 non-English-speaking languages at RWT. A wide variety of relevant topics have been covered such as Covid, diet, nutrition, and BMI in pregnancy, and sickle cell and thalassemia.
- RWT midwives have been provided with an up-to-date directory of local food and baby banks list, available to help meet the needs of low-income families. In addition, the EDI lead also runs an independent baby bank (Sharing is Caring) that is frequently utilised by RWT midwives to further support the needs of the families that we care for at short notice. Urgent baby items can be sourced immediately thus encouraging safe sleeping and reducing the chances of SIDS/infant mortality. This also meets the needs of the of teenage mothers, Refugee and Asylum Seekers, and low socio-economic groups in Wolverhampton.

- SAFE SPACE sessions are held for staff. Staff are encouraged to attend the sessions to address gaps in their knowledge regarding the diversity of the women that we care for. Staff have so far shared that they would like to know more about different practices, communities and particular customs.
- Women who face digital exclusion are identified by the EDI lead and midwives, their appointments are sent out by post and all communications are via an interpreter rather than by the app (badgernotes). This ensures that the women do not miss valid appointments and care. This migration from digital exclusion is proving to be helpful for the women who attend, and they also feel less social isolation.
- The EDI lead engages with mother and toddler groups to build relationships with the women in preparation for the **LMNS surveys** as this is the target group of women, some of whom are also pregnant.
- The EDI lead engages with the **Refugee and Migrant Centre**. Refugee and Asylum seeker women receive one-to-one parent education and birth preparation classes that are individualised specific to their needs. Language support is made available when required.

Section 2 - Workforce Equality Diversity and Inclusion Information 2022 /2023

The Trust workforce equality and diversity information is for the reporting period 1 April 2022 to 31 March 2023. It provides data and information on the Trust's performance on Equality Diversity and Inclusion along with analysis of gaps or possible unacceptable variations in the employee experience by protected characteristic.

The Trust employs 11,371 staff as at the end of 31 March 2023, increasing from 10,609 in 2022. The workforce profile information has been presented by protected characteristic and analysed to identify any gaps or possible barriers for staff.

10.0 Workforce EDI Context and Strategic Drivers

The Trust works to a number of strategic EDI drivers and priorities which are determined through legislation, NHSEI mandates and local directives, these include:

- New Trust Equality Objectives 2023-2027 (Appendix 1)
  NHS People Plan and Model Employer
- The People Promise
- The RACE Code
- NHSEI Workforce Race Equality Standard
- NHSEI Midlands Race and Inclusion Strategy: 6 High Impact Actions
- NHSEI Workforce Disability Equality Standard
- Equality Delivery System 2
- Reducing Workforce Health Inequalities
- Black Country Integrated Care System Equality Diversity and Inclusion Strategy 2023.

10.1) The NHS People Plan

One of the founding pillars of the NHS People Plan is **'Belonging in the NHS'**, reflected in an organisational culture that is open and inclusive, where staff have a voice, and where leaders are compassionate and inclusive at all levels.

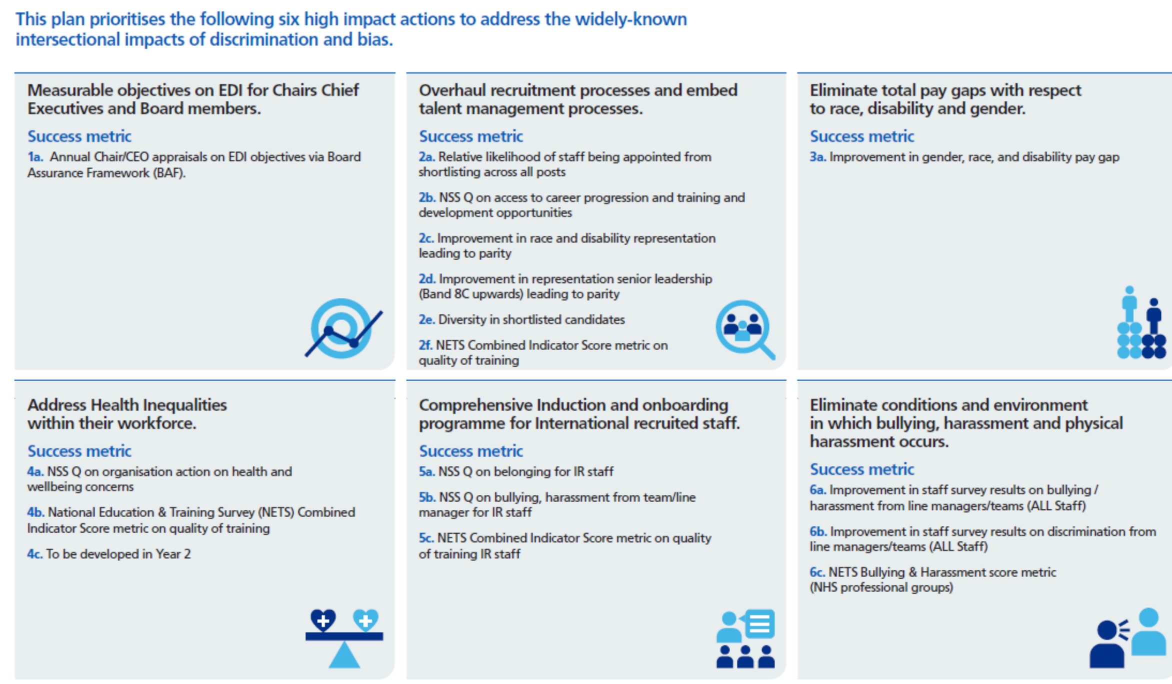
Our regional strategic priorities include:

1. Leading with compassion and inclusion
2. Removing barriers to help staff to speak up
3. Tackling racism and other types of discrimination (including bullying and harassment)
4. Eliminating racism and bias in disciplinaries
5. Reward and celebration when good practice is identified.

The NHS Equality Diversity Inclusion Improvement Plan 2023 has been introduced and sets out six high impact actions for NHS organisations, addressing inequalities across the nine protected characteristics as prescribed in the Equality Act 2010.

The plan focuses on addressing all forms of discrimination and inequalities to enable our workforce to use their full range of skills and experience to deliver the best possible care. The plan supports the objectives of the forthcoming Long Term Workforce Plan by setting out actions to improve the culture of our workplaces and the experiences of our workforce, benefiting retention and the attraction of new talent to the NHS.

By promoting equality of opportunity for progression and growth within the NHS we can have a positive impact on health inequalities and social mobility, enhancing the NHS's role as an anchor institution within the communities we serve and attracting diverse talent to our workforce.



The full plan can be found **NHS workforce equality, diversity and inclusion (EDI) improvement plan**

10.2) Black Country Integrated Care System (ICS) Leadership and Culture

The Black Country ICS has published its first Workforce Equality, Diversity and Inclusion (EDI) Strategy for 2023-27. The strategy has been developed in consultation and collaboration with system partners to address the on-going inequalities that persist in our society and across our NHS and Social Care organisations. The Black Country has a rich diversity of people (see population health profiles) who are our staff, patients and service users and we are committed to addressing the workforce inequalities experienced by staff with protected characteristics in the workplace (EDI data). The strategy focuses on the support available to the health and social care workforce, as well as the priorities and actions that will be taken to improve their work experience.

The EDI e-brochure for the Healthier Futures Black Country ICS was developed to showcase the breadth of EDI good practice that is taking place across health and care in the Black Country, contributing to making it the best place to work for everyone. The recent work undertaken by system partners is highlighted in this e-brochure and demonstrates how each partner organisation is working towards fulfilling our core purpose: to reduce the gap in different experiences and outcomes for all of our colleagues, service users and patients living in our local communities.

Black Country ICS Equality Objectives and System Pledges:

1. **Data collection and analysis:** We will publish an annual ethnicity pay gap report, adopting a standardised system approach.
2. **Leadership accountability and visibility:** We will ensure an EDI representative or Cultural Ambassador sits on every Board (Executive and Non-Executive) appointment panel, and will submit an annual report of Board recruitment and development activity (approach to advertisement, mentoring or coaching beneficiaries, aspiring leader training participants, recruitment panellists) and outcomes (application, shortlisting, and appointment) by gender, ethnicity, and disability to the ICB
3. **Inclusive people practices:** We will ensure every staff member has an equality, diversity and inclusion objective identified as part of their role or annual appraisal.
4. **Improve staff health and wellbeing:** We will ensure all staff have access to a Disability Health Inequalities Passport to support reasonable adjustments and improve health and wellbeing of our staff
5. **Improve systemwide learning and development:** We will commit to becoming an anti-racist organisation and ensure an anti-racism training offer is available to all staff.
6. **Improve communications and engagement of staff:** We will support our staff networks to engage at a system level (through a system staff network forum) to shape and influence system decision-making.

10.3) NEW Equality Delivery System

The EDS was introduced in 2011 to support NHS organisations to assess and improve their performance on equality, diversity and inclusion. A refreshed version, EDS2, was issued in 2013, and now a third revision (called EDS) was introduced in 2022/23.

The Trust has completed its assessment against Domain 1 and Domain 2. The Assessment and Scoring can be found in Appendix **2.**

Further details about the new EDS can be found in section 17.2.

10.4) RWT Equality Diversity Inclusion Delivery Plan 2023 – 24

The Trust sets out its plans for implementing its strategic equality priorities within its EDI Delivery Plan 2023/24. The Plan was refreshed in 2023 to reflect emerging priorities identified through the Staff Survey Results, WRES and WDES indicators and Equality Delivery System Assessment. The plan is regularly monitored, and progress is reported to the Equality, Diversity, and Inclusion Steering Group, Chaired by the Chief People Officer and People and OD Committee. The plan is a live document to ensure a responsive approach to the EDI challenges and opportunities. The plan is available upon request.

10.5) RWT Equal Opportunities Policy

The Equal Opportunities Policy HR05 ensures the Trust complies with the statutory and legal requirements to ensure compliance with the Equality Act 2010. A review of the policy was undertaken during the year. The Policy is available on the Trust web pages.

11.0 Highlights and Achievements 2022 /23

This section reports on the key activities and achievements that took place to enhance equality, diversity, and inclusion for the Trust.

11.1) Employee Voice Groups

Supporting our workforce and understanding the diverse needs of staff has been crucial during COVID-19 and will continue to be a priority for the Trust. Employee Voice Groups (EVGs) are an important part of building a workforce culture that is included and engaged, where staff concerns can be raised safely, and staff have opportunities to connect with their peers. The Trust Employee Voice Groups (EVG) are available to all staff who identify with a particular protected characteristic or support a particular protected characteristic as an ally.

EVG's act as a safe space for staff to come together, network, raise issues or concerns, and be heard. The EVG's are represented on the Trust Equality Diversity and Inclusion Steering Group as a means of actively participating in decision-making, including planning Trust EDI events, and shaping EDI priorities and responding to issues.

The Trust has in place four established EVG's and two new EVG's introduced in 2023. The Trust is committed to growing its EVGs. The following table illustrates the growing membership levels of the EVG's from 2021 to 2023.

Employee Voice Group (EVG)	Executive Sponsor	Membership April 2023	Membership April 2022	Membership April 2021
Black Asian and Minority Ethnic (BAME) EVG	Dr Brian McKaig	149	110	105
Lesbian Gay Bi-sexual Trans (LGBT+) EVG	Simon Evans	279	220 members and allies	62 members and allies
Disability and Long Term Conditions (D<C) EVG	Debra Hickman	78	55	42
Carers EVG	Gwen Nuttall	32	25	12
NEW Armed Forces Staff Network	Alan Duffel	12	-	-
NEW Health and Wellbeing Employee Voice Group	TBC	10	-	-

- All Employee Voice Groups are nominated a **named EVG Executive Sponsor** to provide support, senior leadership commitment, and a point for escalation.
- The Employee Voice Groups work jointly and came together as part of Staff Networks Day 2023 to promote the importance of employee voice and speak to staff about their respective groups.
- The Trust supported the development of two new Employee Voice Groups in 2023. The Armed Forces Staff Network has come together to provide a network of support for Armed Forces personnel, reservists, and veterans. The Trust is working with the network to support inclusion for this group and preventing any unfair disadvantage in employment. The group is working closely with the Trust to support the Veteran Aware accreditation.
- The new Health and Wellbeing Employee Voice Group brings together staff who are impacted by health and wellbeing issues or have an interest in supporting health and wellbeing within the Trust. The group is in its early stages of development.

The following table sets out the EVG activity in 20223 /23 and future plans.

Employee Voice Group	Achievements and Highlights	Top 3 Priorities for Each EVG Going Forward
Black Asian & Minority Ethnic (BAME)	- Won Staff Network of the Year Award - Race Code Charter Mark - Zero Tolerance to Racism Campaign - Black History Month art installation, Mayoral Visit and Race Equality Showcase Event - Race Equality Week – race infographic - Exploring use of terminology 'BAME' - Surveying members - Working jointly with Walsall BAME Staff Network - Listening events	**1) Re-launch the group with a face-to-face event, branding and logo, animation, and new webpage** **2) Develop accessible and inclusive approaches to engage junior members of the workforce, those without IT access, and front-line staff.** **3) Improve the BAME employee experience and access to development and support**
Disability and Long-Term Conditions (D<C)	- Launch of the Health Adjustments Passport and promotional animation - Raising the profile of Disability through a Disability Infographic - Supporting improvements and escalation of disabled parking issues impacting members - Supporting a wheelchair access walk around the Trust - Supporting the Access and Planning Group to ensure Disability access considerations for new projects E.g. Disabled Signage and Changing Places - Listening events and supporting staff shielding during the pandemic	**1) More lunch and learn sessions to promote awareness of disabilities, long-term conditions, and reasonable adjustments at work** **2) Research – increase disability declaration rates** **3) Improving staff experience of reasonable adjustments**
Lesbian, Gay, Bi-sexual Trans+ (LGBT)	- Promoted the Rainbow Badges Scheme so around 225 staff and allies have completed a short LGBT+ awareness e-learning and received the badge.	**1) To support awareness raising of the emerging Transgender Guidance for Staff and Patients** **2) To support member issues and escalate**

	- Supported Pride 2022 with 50 members and plus 1's marching and over 100 expressing an interest - Rainbow Crossing - Rainbow window installation due - Supported the scoping of LGBT+ training needs - Developed lived experience stories for staff as part of LGBT+ History Month	3) **To promote information on how to be an effective LGBT+ Ally**
Carers EVG	- Carers Week - Raising awareness of support services available to Carers - Lunch and Learn Session with Wolverhampton Carers Support Service - Promoted awareness of the experience of working and caring with a Carer Podcast with Executive Sponsor - Launched the Carer Passport - Awareness raising of how to record carer status on ESR	1) **Promote awareness of wellbeing support available to Carers through Carers Week** 2) **Further promote the Carers Passport so staff are aware of support available** 3) **Promote awareness of Carer Support Services available locally and in surrounding areas**
Armed Forces Staff Network	- Early stages of development with members meeting for the second time.	1) **To develop the terms of reference, web page, and promote awareness of the network to support serving Armed Forces personnel and veterans** 2) **To promote Armistice Day and Armed Forces Day** 3) **To support the Trust re-accreditation of Veterans Covenant Healthcare Alliance**

11.2) Inclusive Recruitment

The Trust has reviewed its Recruitment and Selection Policy and Procedures and is working to improve representation of diversity across all levels of the organisation. A number of inclusion initiatives are underway including:

Disability Confident

Disability Confident is a national scheme designed to enable employers to recruit and retain disabled staff and people with long term conditions. There are three levels to the Disability Confident scheme. The Trust has achieved level 2 ensuring that disabled applicants have access to a guaranteed interview as long as they meet the essential criteria, provide reasonable adjustments, ensure access to the recruitment and selection process, and monitor the recruitment outcomes for disabled applicants.

The Trust is committed to progressing to level three of the standard which will include taking steps towards:

- Improving disability information on its workforce
- Improving staff and manager awareness of disabilities and making reasonable adjustments
- Introducing Disabled Workers Passport

Recruitment and Selection Training

In line with the requirements of the NHS People Plan and Model Employer goals the Trust has undertaken an end-to-end review of recruitment and selection processes to ensure that equality and inclusion are firmly embedded throughout. The Trust will work towards a long-term target of being representative of its communities and demographic population, across

the employee pipeline by 2028 and employ the legislative tools available including sections 158 and 159 positive action provisions of the Equality Act 2010.

The Trust has reviewed its Recruitment and Selection Policy as part of its approach to overhaul its recruitment and selection processes and has developed its Inclusive Recruitment Guidance and Toolkit for Managers.

All recruiting managers will be issued with role-specific recruitment and selection e-learning encompassing learning on inclusive recruitment practice. This is due to be rolled out in 2023.

Positive Action in Recruitment

The Trust is committed to fairness in its recruitment practices and is working towards a workforce profile that is reflective of it local population at all levels of the organisation. The Trust launched a programme of Positive Action on targeted vacancies where there are known areas of under-representation in the workforce.

For 2023 all Nursing and Midwifery vacancies at Band 7+ will be eligible to apply for a positive action.

The Trust has launched its **Inclusive Recruitment Toolkit for managers** and guidance which sets out the following actions and activities:

- How to apply a positive action in recruitment for under-represented BAME and Disabled applicants at band 7 and above vacancies / roles
- How to widen vacancy reach into 'seldom heard' and protected characteristic communities through wider advertising through our local diverse employers and communities
- How to encourage our BAME and disabled staff to progress and apply for senior leadership roles –
    - Vacancy sponsorship from Senior leaders from BAME, disabled, female backgrounds
    - Providing access to interview skills coaching for internal candidates
    - Signpost all external candidates to free tools and tips for interview skills
- Introduce a new diversity statement for candidates on Trust webpages, job advertisements, and correspondence
- Develop inclusive selection processes guidance for recruiting managers
- Introduce Cultural Ambassadors to sit on recruitment panels
- Train recruiting managers in inclusive recruitment and selection methods.

11.3) RACE

11.3.1) The Race Code

The Trust become the first trust in the Black Country to adopt the Race Code, a framework to tackle race inequality and discrimination in the boardroom and workforce.

The Race Code principles are:

- Reporting
- Action
- Composition
- Education

The Trust successfully launched its Zero Tolerance to Racism campaign as part of **Race Equality Week 2021** with a guide and poster for staff to display.

The Trust takes a committed anti-racist approach across everything that we do.

Race Fluency Sessions

As part of its approach to become an anti-racist organisation and create inclusive working cultures, the Trust has worked jointly with Walsall Health Care to deliver 6 Race Fluency Sessions for over 300 staff. The sessions enabled staff and managers to constructively challenge racism in the workplace, acquire skills and knowledge to tackle these challenges and understand micro aggressions and their implications and to equip learners to understand the mechanisms and support structures in place to raise concerns regarding racism and racist practices.

Anti-racism Statement

The race fluency sessions were accompanied by an engagement exercise with staff across all levels of the organisation to feed their views on what was most important to becoming an anti-racist organisation.

The Trust's Anti-Racism Statement was launched during Race Equality Week 2023 where a number of race events were held including race fluency training, fireside chat on allyship, and a staff engagement event.

The Trust is proud of its anti-racism statement and seeks to further enable and deliver against the commitments made into 2023 and beyond.

NHS

Our commitment to antiracism

Creating a community of dignity, respect and unity

Here at The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, we are proactively working to eliminate racism within policies and day-to-day practices.

Every person should be treated with empathy and feel respected, regardless of race or ethnicity.

Scan the QR code to read our 'antiracism statement' in full.

Anti-racism Statement Commitments

Our senior leaders will act as role models – showing positive and assertive behaviours at all times, while striving to create inclusive, anti-racist environments.

Every person should be treated with empathy and feel respected, regardless of race or ethnicity. Where this is present, positive patient outcomes should follow.

The full statement can be found on the Trust web pages.

11.3.2) Civility and Respect

Civility and respect are core elements in the Trusts approach to ensuring its values are lived and behaved. Civility and respect are closely aligned with improving a culture of inclusion for all.

The civility and respect bite-sized programme was launched in August 2022. Since then, it has been advertised using a range of RWT Trust wide communication channels. A dedicated intranet page has been created to increase awareness and raise the profile of this important work.

This programme is currently being delivered by the OD and FTSU team with the aim to spread and scale across as many staff as possible.

The Trust has run 28 Civility and Respect sessions with 256 staff members across a range of teams and departments. The sessions have been designed specifically to inform and influence and are interactive to allow time for participants to consider and share impacts of behaviour, discuss personal values aligned with Trust Values. **100% of those attending and providing feedback found the sessions useful.**

11.3.3) Cultural Ambassador Programme

The Cultural Ambassador programme was developed by the Royal College of Nursing (RCN) to support employee relations processes within NHS organisations, with a view to enhance fairness and remove the potential of cultural bias occurring. The need for the programme arose out of the national Workforce Race Equality Standard (WRES) data which highlighted Black and Minority Ethnic (BAME) staff as over-represented in employee relations cases and experienced poorer outcomes, compared to their white counterparts. The Cultural Ambassador (CA) Programme was relaunched in 2021 with **27 Cultural Ambassadors** recruited and trained. Our number of Cultural Ambassadors has fallen to 21 active CA's, due to staff changing roles and CA's stepping into other commitments.

There continues to be a strong leadership commitment to the CA programme and a recognition of continuous learning. The Trust has invested in the on-going development and support for CA's including action learning sets and regular meetings with the HR Advisory Team.
The Trust is proud of the work it has undertaken over the past few years to ensure fairness is achieved within its Disciplinary and recognises that more needs to be done to ensure staff from Black Asian and Minority Ethnic backgrounds experience fair outcomes in disciplinary activity.

The Trust has supported a just culture approach along with establishing CA's within the Case Assessment and Disciplinary Approach.

The Trust is committed to revitalising its Cultural Ambassador programme in 2023 with a refreshed recruitment campaign and approach.

11.4 CARERS

11.4.1) Working Carers Passport

The Trust introduced its Working Carer Passport as part of Carers Week 2021 and has continued to promote use and access to the Carer Passport. There are currently an estimated 250,000 carers working in the NHS, many of whom are aged between 45-64 and so are likely to be among our most experienced and skilled staff. The care they give is unpaid and often helps to keep some of our most vulnerable members of society out of hospital or social care and improve their quality of life.

Supporting our staff with caring responsibilities has an overall benefit to our employees, patients, and wider community. Keeping our working carers in work can help to reduce health inequalities, improve employee experience, and benefit the trust in retaining its staff. Ensuring our staff who have caring responsibilities and our managers are aware of this is really important.

The Working Carer Passport is a tool for managers and staff that care for or look after someone to have a safe conversation about their caring role and how it impacts on their work. It can be taken with the member of staff so there is less need to repeat caring and working needs with different managers. It also enables the identification of any adjustments or flexible working needs that can be met.

The Trust has further and integrated the Working Carer Passport within the HR Managers Toolkit and Induction and on-boarding processes. It has been further promoted it during **Carers Week in 2023**.

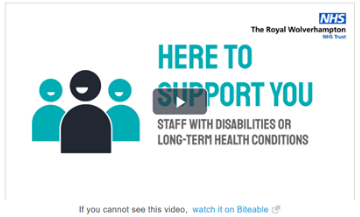
The Trust is also promoting the recording of Carer status on its Employee Support Service (ESR) to ensure accurate data on the number of people who are caring or looking after somebody in the organisation.

11.5 DISABILITIES AND LONG-TERM CONDITIONS

11.5.1) Health Adjustments Passport

The Trust launched its Health Adjustments Passport in 2022 to make it easier for staff and managers to identify, discuss and put in place reasonable adjustments. The Health Adjustments Passport is designed to store any information about a disability, long-term health condition, mental health issue or learning disability/difficulty. The aim is to minimise the need to re-negotiate workplace adjustments every time an employee moves post, moves between departments or is assigned a new line manager.

The Trust worked collaboratively with the Disability and Long-term Health Conditions employee voice group to co-produce the passport along with creating an animation about how it works. Click the link to view the animation:



The Trust launched the passport during Disability History Month and ran a launch event with guest speakers from the national NHS Workforce Disability Equality Standard and NHS Employers. The event was attended by 100 Trust staff and managers.

Deaf Awareness Week 2023

The Trust marked Deaf Awareness Week with a lunch and learn session with staff to raise awareness of what it's like to live with hearing loss, deaf, or hearing impaired. The Trust is exploring how it will continue to support the 'We are deaf aware campaign' across the Trust.

11.5.2) Disability Access and Planning Group

The Trust's Access and Planning Group is established and works with members of the Disability and Long-Term Conditions Employee Voice Group, the Staff Council, and relevant teams across the organisation to review all building projects and designs and advise on disability access to support and influence disability access from the point of project design and refurbishment. The group is undertaking work to progress the following:

'Not All Disabilities are Visual' campaign

The Trust is committed to improving its disability signage and promote awareness of the "Not All Disabilities are Visual" campaign recognises that not all disabilities are visible and some disabled people can experience challenge and even hostility when using disabled toilets. A promotional campaign will take place to raise awareness on invisible disabilities.

Changing Places

Three potential sites have been identified for a Changing Places facility. The group met with the project team to provide feedback on the programme of work. The Capital Project Team is exploring funding options.

Disabled Car Parking

The Trust is committed to ensuring adequate disabled car parking facilities for staff and patients and ensuring that disabled parking needs are planned as part of all rebuilds and planning.

Site Accessibility

A small subgroup participated in a tour of the site, to review and assess the accessibility provision for disabled staff. The tour provided useful insight and information on the priority areas to improve accessibility within the Trust. The review identified disabled signage as an area for improvement and has since engaged the Trust Signage programme lead onto the group.

11.6 LESBIAN, GAY, BI-SEXUAL, TRANS INCLUSION

11.6.1) Rainbow Badge scheme

The Trust has rolled out the Rainbow Badge. Wearing the Rainbow Badge symbolizes a pledge to play an active part in showing openly that our Trust offers non-judgmental and inclusive support and care for all, regardless of how people identify themselves. It's hoped that the LGBT+ Community will be comfortable and confident in our care as a result. LGBT+ patients who see the badge and identify with it will feel assured, knowing we are supportive. If necessary, badge wearers will be able to offer contact details for a range of external support agencies.

The NHS Rainbow Badge was created by Guy's and St Thomas' NHS Foundation Trust in London, in partnership with Evelina London Children's Hospital. Badges are handed to NHS staff who have pledged to reduce inequalities and provide support and signposting to LGBT+ people. The scheme is supported by NHS England, Stonewall, and GLADD (The Gay and Lesbian Association of Doctors and Dentists).

The Trust has promoted the Rainbow Badges scheme during a range of LGBT awareness campaigns and events and has developed a Rainbow Badge Poster for display in patient and staff areas.

279 staff members of staff have completed the Rainbow Badges awareness raising and received their Rainbow Badge, increasing from 220 in 2022. Further information on the Rainbow Badges can be found on the Trust's web pages.

11.6.2) LGBT History Month – Celebrating our Past Present and Future

LGBT History Month is celebrated annually in February and is an opportunity to raise awareness to staff of LGBT history and the impacts of stereotyping, discrimination and exclusion on the LGBT community.

The month involved sharing staff stories and celebrating the work of the LGBT+ EVG and the achievements made to promote and enhance LGBT inclusion.

11.6.3) Pride 2022

The Trust is proud to continue its support for Pride. Over the following years, it has become one of the most important LGBT+ festivals in the UK, attracting in excess of 40,000 people over the course of the weekend. This year, as a result of the COVID-19 pandemic, the Birmingham Pride festival was held over the weekend of September 25th.

The aim of Birmingham Pride is to build a community where all people are free to live without fear or prejudice – committed to challenging injustices, inequality and discrimination for all in the LGBT+ community. The theme was '25 years of pride and protest' demonstrating a commitment to stand in unity with all members of the LGBT+ community; fighting against any form of transphobia, biphobia, homophobia and hate.

RWT, along with a number of other NHS Trusts in Birmingham and the Black Country came together to support LGBT+ staff to participate in the Pride parade.

11.6.4) Trans Guidance and Training for Staff and Managers

The Trust launched its Staff and Patient Transgender Awareness Guidance which has been co-produced with members of the LGBT+ EVG and a number of departments across the Trust. The guidance has been developed to raise awareness of LGBT+ equality and particularly Trans equality and is being supported with the delivery of 10 LGBT+ Training Workshops for up to 250 staff.

Staff attending the training have learned:

- Awareness of where our own beliefs and experiences impact on the care that we deliver
- Consider the journey that a transgender person travels during transition
- Awareness of the Equality Act 2010
- Avoiding unintentional discrimination
- Tackling trans/bi/homophobic language

11.7 EQUALITY AND FAITH CELEBRATIONS

The Trust is committed to recognising and valuing the rich diversity of its workforce and actively promotes opportunities to raise awareness and engage with its diverse staff groups through events and awareness days.

During 2022 /23 the Trust has supported a range of key equality events and faith celebrations and works in collaboration with its Employee Voice Group, Chaplaincy Service, Health and Wellbeing, and other departments. Events and days celebrated included:

- Race Equality Week
- Black History Month
- LGBT History Month
- International Women's Day
- Disability History Month and International Day for Disabled Persons
- National Staff Networks Day
- International Day Against Homophobia and Transphobia
- Deaf Awareness Week
- Mental Health Awareness Day
- Carers Week
- South Asian Heritage Month

- Pride Month
- Anti-bullying Week
- Menopause
- Faith days including Christmas, Easter, Ramadan, EID, Diwali, and Vasakhi.

Key themes explored during events included:

- Sharing understanding of the diversity of lived experience
- Allies – enabling staff to support each other to tackle exclusion and discrimination
- Recognising and challenging bias
- Promoting wellbeing
- Celebrating difference
- Promoting inclusion through education

Further information can be found on the Trust webpages. There is a plan in place to broaden and build on the events and celebration days for next year, and an events calendar has been developed.

12.0 Workforce Equality Data and Information

The Royal Wolverhampton NHS Trust is committed to investing in and developing its diverse workforce and employs a total of 11, 371 people as at 31 March 2023, who are responsible for delivering nationally recognised excellence in healthcare. It recognises the impact that high levels of workforce engagement can have upon patient satisfaction, experience and outcomes and proactively works to maximise this relationship and demonstrate positive effect on patient experience.

The workforce data contained within the report is for the period 1 April 2022 to 31 March 2023. Where possible the data has been benchmarked to the new Wolverhampton Population Census 2021 data.

All data is rounded up or down to down to the nearest 0.5%

12.1) Board Composition

The make-up of the Trust Board including our Executives, Non-Executives and Very Senior Manager (VSM) as of 31 March 2023 is as follows:

- The ethnic representation is **White 86% and BAME 14%,** indicating no change in representation since 2022.
- The gender breakdown of the Board is 43% female and 57% male. The representation of females on the Board has fallen by 4% since 2022. (In 2022 the gender profile of the Board was 47% female and 53% male).

The Trust's workforce statistics covering key protected characteristics are presented in the following sections.

12.2) Age

The majority of our workforce is within the 25 to 54 age range; 8% are under the age of 25. The following table illustrates the breakdown of our age profile by age group. In Wolverhampton, there are more children (20.4%) and fewer older people (16.8%) compared to England (19% and 17.7%, respectively).

Age	% Workforce 2023	% Workforce 2022
Under 25	8%	8%
26 - 35	26%	25%
36 - 45	23%	22%
46 - 55	24%	24%
56 - 65	17%	17%
66 +	2%	2%
Total	**100%**	**100%**

- There is a lower proportion of young people aged under 25 years in the workforce.
- There has been a slight percentage increase in the middle-aged groups, with 26% in the 26 – 35 years age group and 23% in the 36 – 45 years age group.
- There are fewest staff in the 56 – 65 years group at 17%, and fewest staff represented in the 66+ years group, at 2%.

12.3) Disability

The proportion of staff that have declared a disability stands 4% increasing from 2% in 2022. According to the Census 2021 19.5% of residents in Wolverhampton are disabled or have a long-term condition that limits their day-to-day activities to some degree. This has fallen by 1% since the 2011 Census (20.5%).

The following table illustrates the percentage of disabled people within our workforce.

Disability Status	% Workforce 2023	% Workforce 2022
No	75.5%	73%
Not Declared	20%	24%
Prefer Not To Answer	0.5%	1%
Yes	4%	2%
Total		**100%**

- **4% of the workforce have declared a disability. The proportion of staff declaring a disability has doubled since 2022.**
- The proportion of staff who have not declared their disability status has fallen by 4% from 24% in 2022 to 20% in 2023. The Trust is working to improve its disability declaration rates and raising awareness of disability within the Trust.
- The Trust Disability and Long-Term Conditions Employee Voice Group is available to staff who identify as disabled or want to support disability equality within the Trust. A range of initiatives have been delivered during the year to raise awareness of disability and promote reasonable adjustments in the workplace.
- The Trust launched its first Health Adjustments Passport and has run a lunch and learn session on reasonable adjustments in the workplace. The passport is embedded into Trust induction and onboarding processes, ensuring accessible support for disabled staff and new starters.
- See section 15.0 on the Workforce Disability Equality Standard.

12.4) Ethnicity

The Trust's Black Asian and Minority Ethnic (BAME) profile for the organisation has increased by 4% since last year, **rising from 32% in 2022 to 36% in 2023**. The overall BAME profile of the Trust is not in line with the local BAME population of Wolverhampton which is 39%, according to the new Census 2021 information. Analysis by band in the following tables indicates the Trust has seen a 2% increase in BAME staff in senior roles (Band 7+).

The following tables illustrates the overall ethnicity workforce profile across the organisation.

Ethnicity Status	% Workforce 2023	% Workforce 2022	Wolverhampton Census 2021
BAME	36%	32%	39%
Not Stated/Not Given	1%	2%	-
White	63%	66%	61%
Total	**100%**	**100%**	**100%**

12.5) Ethnicity by Workforce Group

The following tables illustrates the breakdown by ethnicity staff by Trust Workforce Group 2023. Students have been removed from the count due to the small numbers.

	Headcount			Total Headcount %
Staff Group	**BAME**	**White**	**Unknown**	
Add Prof Scientific and Technic	1%	2%	0.04%	**3%**
Additional Clinical Services	7%	12%	0%	**19%**
Administrative and Clerical	5%	17%	0%	**22%**
Allied Health Professionals	2%	4%	0%	**6%**
Estates and Ancillary	1%	6%	0%	**7%**
Healthcare Scientists	2%	3%	0%	**5%**
Medical and Dental	7%	3%	1%	**10%**
Nursing and Midwifery Registered	12%	16%	0%	**28%**
Grand Total	**35.65%**	**62.64%**	**1.71%**	**100.00%**

Medical and Dental (All Bands)

Ethnicity Grouped	(M&D) Headcount	(M&D) Headcount %	% Total Workforce
Asian	558	49%	20%
Black	91	8%	11%
Mixed	32	3%	3%
Other	86	8%	2%
Unknown	83	7%	1%
White	294	26%	63%
Grand Total	**1144**	**100%**	**100%**

A significant proportion of BAME staff occupy roles within medical and dental roles.

The following table illustrates the breakdown of staff by ethnicity at band 7 and above 2023. (Students have been removed from the count due to the small numbers).

-	Headcount %			Total Headcount %
Staff Group	**BAME**	**White**	**Unknown**	
Add Prof Scientific and Technic	4%	3%	0%	**7%**
Additional Clinical Services	0%	0%	0%	**0%**
Administrative and Clerical	5%	18%	0%	**23%**
Allied Health Professionals	2%	13%	0%	**15%**
Estates and Ancillary	0%	0%	0%	**0%**
Healthcare Scientists	3%	11%	0%	**14%**
Medical and Dental	0%	0%	0%	**0%**
Nursing and Midwifery Registered	7%	33%	0%	**40%**
Total	**21%**	**78%**	**1%**	**100%**

The following table illustrates the break-down of staff by ethnicity at bands 3 – 6 in 2023. (Students have been removed from the count due to the small numbers).

Staff Group	Headcount %			Total Headcount %
	BAME	White	Unknown	
Add Prof Scientific and Technic	1%	2%	0%	**3%**
Additional Clinical Services	9%	16%	0%	**25%**
Administrative and Clerical	5%	19%	0%	**24%**
Allied Health Professionals	2%	3%	0%	**5%**
Estates and Ancillary	1%	8%	0%	**9%**
Healthcare Scientists	2%	2%	0%	**4%**
Nursing and Midwifery Registered	14%	15%	0%	**29%**
Grand Total	**34%**	**65%**	**1%**	**100.00%**

Analysis of BAME representation by Workforce Group

- The Trusts overall **B.A.M.E, profile has increased annually and has seen a significant rise since last year increasing by 4%. Comparison with the City demographic data indicates the Trust is not representative of the local population of 39%.**
- The proportion of B.A.M.E. staff at Band 7+ has also seen an increase rising from **19% in 2022 to 21% in 2023.** The Trust is committed to increasing the representation of BAME staff in senior leadership roles through overhauling its recruitment processes and developing its talent management framework.

Nursing and Midwifery	Nursing and Midwifery has the highest proportion of staff accounting for 40% of the workforce. The highest number of BAME staff across the Trust are within Nursing and Midwifery roles. There is a high proportion of BAME staff and Band 5 and 6 representing 14% of the workforce. The proportion of BAME staff at Band 7 and above has increased from 6% in 2022 to 7% in 2023.
Additional Clinical Services	Additional Clinical Services are the second largest workforce group. The proportion of BAME staff in the group represent 9% of the workforce with the largest number in Band 2.
Administrative and Clerical Roles	BAME staff are evenly represented across the bands (5% BAME at Band 7+, and 5% BAME at Bands 3-6). 5% of the total BAME workforce are within Administrative and Clerical role
Allied Health Care Professional	BAME staff evenly represented in Allied Health Care Professional Roles.
Estates and Ancillary	BAME staff are significantly under-represented in Estates and Ancillary Roles. 1% of estates and ancillary roles are occupied by BAME staff compared to 8% white.

12.6) Workforce Ethnicity Profile Compared to Local Population

According to the recently published Census 2021 Wolverhampton has a population of around

263,727. The City is ethnically diverse with 39% of the population coming from a BAME heritage. Furthermore 14% of the population have a non-UK identity.

The following table illustrates the ethnicity profile of the Trust by ethnic category, compared to the overall local demographic profile data for Wolverhampton, as of the Census 2021, compared to the Census 2011.

	RWT Workforce 2023%	Wolverhampton Population % (Census 2011)	Wolverhampton Population % (Census 2021)
White	63%	68%	61%
Black	11%	7%	9%
Asian	20%	18%	21%
Mixed	3%	5%	5%
Other	1%	2%	4%
Undefined	2%	-	-
Total	100%	100%	100%

- The ethnic population of Wolverhampton has grown by 7% since the 2011 Census with growth seen in the Asian, Black and Other ethnic categories.
- The Trust's overall ethnic profile has also seen year on year growth and currently sits at 36% BAME, which is 3% below the BAME profile of the local population.
- The Trust has in place commitments and actions to ensure it is representative of the local population across all levels of the organisation. The Workforce Race Equality Standard metrics offers a more complete picture of the Trusts performance on race equality. See section 13.0.

12.7) Gender

The following table illustrates the gender breakdown of the Trust workforce, compared with the local demographic gender profile, along with the proportion of staff working full-time and part-time.

Gender	Headcount	Headcount %
Female	9009	79%
Male	2362	21%
Grand Total	**11371**	**100%**

-	Headcount %		Total Headcount %
Full / Part Time	Female	Male	
Full Time	43.41%	18.06%	**61.47%**
Part Time	35.82%	2.71%	**38.53%**
Grand Total	**79.23%**	**20.77%**	**100.00%**

- The trust employs a significantly higher proportion of women, with an 79% female workforce.

- Overall, significantly more men work full-time hours compared to females.
- Of all the staff that work part-time hours, 93% are female and around 7% are male.

This following table illustrates the gender breakdown of the workforce by band.

	Headcount %		
Banding Grouped	**Female**	**Male**	**% Staff Group**
M&D	4%	6%	10%
AfC Bands 1-6, Apprentices, & Kickstarters	64%	12%	76%
AfC Bands 7+ and VSM/Execs	11%	3%	14%
Grand Total	**79%**	**21%**	**100%**

- Male representation is most significant in the middle bands.
- There is a significant proportion of female staff occupying Bands 1-6, Apprentice, and Kickstarter roles.

12.8) Maternity and Adoption Leave

A total of 267 staff went on maternity or adoption leave in the period, an increase of 23 since 2022. The most significant increase in numbers of maternity and adoption leave taken can be seem can be seen in Nursing and Midwifery. The following table illustrates the breakdown of staff going on maternity or adoption leave by group.

Staff Group	Count of Employee Number
Add Prof Scientific and Technic	5
Additional Clinical Services	51
Administrative and Clerical	38
Allied Health Professionals	27
Estates and Ancillary	9
Healthcare Scientists	11
Medical and Dental	15
Nursing and Midwifery Registered	111
Grand Total	**267**

12.9) Religion or Belief

The following table illustrates the workforce profile by religion or belief, compared to the Wolverhampton City religion or belief population profile, as at the Census 2021.

Religion or Belief	Workforce 2023	Workforce % 2022	Wolverhampton Population Census 2011%	Wolverhampton Population Census 2021%
Atheism	9%	8%	20%	28%
Buddhism	-	0%	0.4%	0.3%
Christianity	40%	40%	55%	44%
Hinduism	3%	3%	4%	4%
I do not wish to disclose my religion/belief	34%	36%	6.4%	-
Islam	3%	3%	4%	6%
Jainism		0%	-	-
Other	6%	6%	1.2%	1%
Sikhism	4%	4%	9%	12%
Judaism	-	0%	0%	-
Unspecified	-	0%	-	6%
Total		**100%**		

- The most significant change to the religion and belief population census has been the rise in the proportion of the population that identifies as Atheist. This is a national trend. This correlates with a fall in the percentage of people who are Christian which has fallen from 55% in 2011 to 44% in 2021. There has been a rise in people who follow Islam rising from 4% to 6% in the City.
- There are some significant differences to the religion or belief profile of the Trust compared to the local Wolverhampton population. There are fewer people who identify as Christian within the Trust at 40% compared to overall profile of Christianity within the City of 44%.
- The % of staff who follow Islam has remained unchanged.
- There are significantly higher proportions of staff within the Trust who do not wish to disclose their religion or belief, at 34%, compared to the City profile of 6.4%.
- The Trust has a diverse and multi-cultural and faith workforce, drawing from the local population as well as international community. The Trust provides a multi-faith chaplaincy service which is open and available to all Trust staff and patients. The Trust offers support and services to enable staff to observe their faith and celebrate key religious and cultural events through the calendar year.

12.10) Sexual Orientation

The following table illustrates the sexual orientation profile of the Trust. The sexual orientation data for the City is not currently available to compare this with. There are traditionally lower levels of disclosure of sexual orientation. According to the Office for National Statistics over the last five years, the proportion of the UK population identifying as lesbian, gay or bisexual (LGB) has increased from 1.5% in 2012 to 2.0% in 2017, although the latest figure is unchanged from 2016.

Sexual Orientation	Workforce Headcount %	% Population

		Census 2021
Not stated (person asked but declined to provide a response)	31%	8%
Heterosexual or Straight	67%	89%
Bisexual	1%	1%
Gay or Lesbian	1%	1%
Undecided	0%	-
Other sexual orientation not listed	0%	-
Grand Total	**100%**	

- The proportion of staff across the workforce that identify as LGB in 2023 is 2%, compared to a Wolverhampton population profile of 2%.
- The proportion of staff across the workforce that identify as heterosexual is 65%.
- There is a significant proportion of the workforce that prefer not to state their sexual orientation, at almost 33%, although this has fallen slightly since 2021

12.11) Trans

Gender Reassignment status is as yet not recordable in the ESR system and therefore not included in the workforce standard. Furthermore, information relating to Gender Reassignment cannot be held securely and in confidence on personal records on ESR, therefore the Trust has not collected this information and is currently unable to report on this.

The Wolverhampton Census 2021 reports that 0.7% of residents declared a gender different from the sex registered at birth, and 7.2% did not answer this question.

12.12) Marriage and Civil Partnership

The following table illustrates the marriage and civil partnership status of the workforce compared with the local City demographic population.

Marital Status	Workforce 2023	% Wolverhampton Population 2021 Census

Divorced	5%	8%
Legally Separated	1%	2%
Married or Civil Partnership	51%	42%
Single	36%	42%
Unknown	7%	-
Widowed	1%	7%
Grand Total	**100%**	

- The Trust has higher numbers of staff who are married, compared to the local population.

12.13) Disciplinary Data

The Trust monitors its disciplinary data. There was a total of 68 disciplinaries entered in the period.

Disciplinary cases - all staff (excl. medical & bank)	BAME	White	Undisclosed	Total
1. Number of disciplinary investigations commenced (BAME / White)	31	37	1	69

- 46% of all Disciplinaries entered into were for BAME staff. This is disproportionately higher than the BAME workforce profile of 36%.
- All Disciplinary and Case Assessment Panels for BAME and Disabled staff have in place a Cultural Ambassador. The Cultural Ambassador process is embedded into the Disciplinary process and helps to ensure a diversity of perspective and lived experience to a panel, ensuring any issues of cultural bias are identified and considered.
- The Trust also applies a Just Culture approach to reduce the numbers of formal disciplinaries being entered into.
- Please see section 13.0 on the Workforce Race Equality Standard for further data on the WRES Metric 4 relating to disciplinary.

12.14) Bullying and Harassment Data

The Trust monitors all formal reports of Bullying and Harassment. There were a total of 15 formal bullying and harassment reports recorded during the period. The Trust has commitments and actions to tackle formal and informal complaints and issues of bullying and harassment through Freedom to Speak up and its Bullying and Harassment Policy.

Bullying and Harassment	BAME	White	Undisclosed	Total
Number of Bullying and Harassment	9	6	0	15

%	75%	25%	%	100%

- The number of formal Bullying and Harassment complaints made by BAME staff represented 75% of all complaints, compared to a BAME staff profile of 36%. Whilst there is an over representation for BAME staff this is reflective of small numbers overall.
- The WRES section 13.0 provides more detailed information on Bullying and Harassment based on the national staff survey indicators.
- The Trust has a range of commitments in place to tackle bullying and harassment in the workplace including the introduction of Civility and Respect and the Race Code and Trust Anti-Racism Statement.

13.0 Recruitment and Selection Data

The following tables illustrate the Trusts recruitment and selection data for the period 1 April 2022 to 31 March 2023. The Trust has seen a substantial increase in recruitment activity with a significant rise in the number of vacancies and applicants. There was an overall total **of 52,705 applicants during the period**, compared to a total of 39,759 applications in the same period last year. There were a total of **2033 appointments** compared to 2597 appointments in the same period last year.

The data has been broken down by ethnicity and disability. The data is also broken down to illustrate the recruitment outcomes for vacancies as they apply to Bank roles.

Please note there are some variations in the data between ethnicity and disability as 'prefer not to say' and 'other' has not been included in the count.

13.1) Recruitment and Selection Ethnicity Data:

Total Applicants, Shortlisted, and Appointments By Ethnicity (not including bank roles)

Ethnicity	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
White	12939	6075	1165	24.55%	51.77%	57.30%
BAME	38883	5229	711	73.77%	44.56%	34.97%
Unknown	883	431	157	1.68%	3.67%	7.72%
Total	52705	11735	2033	100	100	100

Total Applicants, Shortlisted and Appointments By Ethnicity (Bank roles)

Ethnicity	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
White	446	278	85	20.87%	28.25%	22.61%

BAME	1351	390	126	63.22%	39.63%	33.51%
Unknown	340	316	165	15.91%	32.11%	43.88%
Total	2137	984	376	100	100	100

Analysis:

- White staff are more likely to be appointed compared to BAME candidates.
- More BAME candidates apply for roles compared to white candidates.
- White candidates are more successful in shortlisting and appointment stages.
- More BAME candidates apply, are shortlisted, and appointed to Bank roles compared to white candidates.
- See section 13.0 on the Workforce Race Equality Standard for further analysis.

13.2) Recruitment and Selection Disability Data:

The trust monitors all applicants by disability status. The trust is a Disability Confident Employer, so ensures a guaranteed interview for all disabled candidates that meet the essential criteria of a vacancy.

There were 2033 appointments during the period. A total of 88 disabled applicants were appointed during the period (compared to 87 disabled people recruited in the same period last year). The following tables illustrate the relative success rates of disabled and non-disabled applicants throughout each stage of the recruitment process.

Total Applicants, Shortlisted and Appointed by Disability (excluding Bank roles)

Disability	Applied	Shortlisted	Appointed	Applied %	Shortlisted %	Appointed %
No	50458	10723	1784	95.74%	91.38%	87.75%
Yes	1645	639	88	3.12%	5.45%	4.33%
Unknown	602	373	161	1.14%	3.18%	7.92%
Total	52705	11735	2033	100.00%	100.00%	100.00%

- The overall representation of disabled people in the workforce has increased during the period to 4%.
- The proportion of disabled people appointed is proportionate to the numbers applied.
- See section 14.0 on the Workforce Disability Equality Standard for further details of the disabled staff experience.

14.0 Workforce Race Equality Standard (WRES)

The WRES data for 2022/23 has been analysed together with annual WRES metric data that has been gathered annually since 2017/18. The following table illustrates the Trust WRES performance against the nine metrics.

WRES Metric	2022/23	2021/22	2020/21	2019 /20	2018 /19	2017 /18
Proportion of workforce from a BAME background	36%	32%	31%	29.4%	28.8%	26.1%

Relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants	1.4	1.5	1.44	1.41	1.38	1.41
Relative likelihood of BAME staff entering a disciplinary process*	2.0	1.1	1.0	1.33	1.59	1.97
Relative likelihood of white staff accessing non-mandatory training**	1.0	0.95	1.3	1.18	1.33	1.34

**This calculation is based on year end disciplinary data*

***This calculation is based on staff who access non-mandatory study leave and leadership training*

14.1) Analysis:

- The Trust Black Asian and Minority Ethnic (BAME) profile of the organisation has increased by 4% since last year, **rising from 32% in 2022 to 36% in 2023**. Whilst the overall BAME profile of the Trust has steadily risen, it is not in line with the local BAME population of Wolverhampton which is 39%, according to the new Census 2021 information.
- The **likelihood rate of white applicants being appointed is 1.4 times more likely to be appointed compared to BAME candidates**. This has remained static over the years. The Trust has introduced Cultural Ambassadors onto recruitment panels where a positive action has been applied to senior Nursing and Midwifery roles. A further recruitment drive to the CA programme will be undertaken to ensure there are a sufficient number of CA's to sit on recruitment panels
- The likelihood rate of **BAME staff entering a disciplinary process has increased significantly with 2.0 times likelihood rate** for BAME staff being entered into a disciplinary compared to their white colleagues. Further analysis of the data indicates that:

    - **Asian staff are 0.6 times as likely** to enter into a Disciplinary compared to their white colleagues (a figure below 0 indicated less likelihood)
    - **Black staff are 2.19 times as likely** to enter into a Disciplinary compared to their white colleagues. The Trust has a significant proportion of overseas staff and there has been a significant increase in the proportion of Black staff into the workforce increasing from 8% in 2022 to 11% in 2023. The Trust is working on a cultural adaption programme to support its international recruits. The Trust is also exploring inclusive leadership and cultural competence training for its senior leaders. It is also recommended that the Trust explore how it can make the informal stages of Disciplinaries more equitable
    - **Mixed staff are 2.3 times as likely** to enter into a formal disciplinary hearing (this represents less than 5 people)
    - **Analysis of Disciplinary Outcomes indicates** there was a slightly higher percentage of 'no case to answer' for white staff at 24%, compared to BAME staff at 19%. A higher percentage of white staff experienced a sanction or dismissal at 51%, compared to BAME staff at 35%.

- **White staff and BAME staff are equally as likely to access non-mandatory training** with a 1.0 likelihood rate for white staff.

14.2) Staff Survey Metrics

WRES Staff Survey Metric	2022		2021		2020		2019		2018		2017	
	BAME	White	BAME	White	BAME	White	BAME	White	BAME	White	BAME	White
Percentage of staff experiencing harassment, bullying or abuse from a) Patients, relatives or the public	24%	23%	26%	22%	23%	23%	25%	22%	24%	25%	28%	22%
b) Staff	29%	23%	26%	22%	24%	20%	28%	22%	21%	17%	28%	22%
Percentage of staff who believe the Trust provides equal opportunities for progression or promotion	46%	64%	46%	63%	48%	64%	48%	66%	46%	63%	52%	63%
Percentage of staff who have personally experienced discrimination at work from managers	15%	7%	14%	5%	13%	5%	12%	5%	14%	6%	13%	7%

14.3 Analysis of Bullying, Harassment, and Discrimination

In sum, the WRES staff survey metrics indicate variation between BAME and white colleagues across all four staff survey metrics. The largest variation in employee experience by ethnicity is on the metric **"percentage of staff who believe the Trust provides equal opportunities",** where there is an 18% point difference between BAME and white colleagues. There has also been an increase in BAME staff experiencing bullying and harassment from colleagues by 3% since 2021, and 2% reduction in BAME staff experiencing bullying and harassment from patients.

- The bullying and harassment indicators have remained fairly static over the years. However, there has been an increase in the percentage of BAME staff reporting harassment and bullying from staff members rising to its highest level this year to 29%.
- There has been a 2% increase in the percentage of BAME and white staff reporting experiencing discrimination at work from managers.

14.4) Bank WRES

The Trust has a total of 1339 active Bank Workers who hold a zero hours contract.

	White No	White %	BAME No	BAME %	Not Stated no	Not Stated %
1. Active Bank Workers (who hold a zero hours contract)	677	51%	619	46%	43	3%
2. Number of Bank workers entering a formal Disciplinary in last 12 months	1	-	1	-	-	-
3. Number of Bank worker dismissals in last 12 months	12	-	8	-	-	-

The following table illustrates the results of the Bank Survey 2022

3642 survey responses were received from staff.

	Bank Staff 2022	Substantive Staff 2022
4a Percentage of bank workers experiencing harassment, bullying or abuse from patients/service users, their relatives, or other members of the public in last 12 months.	**24%**	**30%**
4b: Percentage of bank workers experiencing harassment, bullying or abuse from: other colleagues in the last 12 months.	**20%**	**21%**
4c: Percentage of bank workers experiencing harassment, bullying or abuse from: Managers in the last 12 months.	**12%**	**12%**
4d: Percentage of bank workers who experienced harassment, bullying or abuse at work who then proceeded to report it?	**48%**	**49%**
5a: Percentage of bank workers that have personally experienced physical violence from patients / service users, their relatives, or other members of the public in the last 12 months.	**9%**	**15%**
5b**:** Percentage of workers who experienced physical violence at work who then proceeded to report it?	**33%**	**32%**
6a: Percentage workers who would, in the next 12 months consider moving to work in a form of permanent employment in the NHS.	**31% at Trust** **6% at another NHS organisation**	**NA**
6b: Percentage of bank workers that feel there are opportunities to develop their career in the organisation.	**57%**	**55%**
6c: Percentage of workers whose main paid source of work is on the bank	**72%**	**Not recorded**
6d: How long have bank only workers solely worked on the bank	Less than a year 9% 1-2 years 13% 3-5 years 18% 6-10 years 18% 11-15 years 12% More than 15 years 30%	**Not recorded**
7a: Percentage of bank workers that have in the last 12 months personally experienced discrimination at work from managers / team leader or other colleagues.	**9%**	**10%**
7b: Percentage of bank workers that have in the last 12 months personally experienced discrimination at work from: Patients, relatives, or members of the public. 8a: Percentage of bank workers who feel that the organisation values their work contribution.	**7%** **45%**	**9%** **41%**
8b: Percentage of bank workers that feel safe to speak up about anything that concerns them in their organisation.	**62%**	**60%**
8c: Percentage of bank workers that think the organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc.)	**70%**	**68%**
8d: Percentage of bank workers that feel they receive the respect they deserve from colleagues at work.	**69%**	**71%**

9: Percentage of bank workers who were originally recruited to the NHS from outside of the UK and now work in a bank only position	**5%**	**8%**

- A higher proportion of BAME staff are active on the Bank (representing 46% of all Bank staff) compared to the BAME profile of the organisation, which sits at 36%.
- The number of Bank staff undergoing disciplinary and dismissal is very low.
- A higher percentage of substantive staff (30%) report experiencing bullying and harassment from patients compared to Bank staff (24%).
- There is no significant variation between the experiences reported by bank staff compared to that of substantive staff across the Bank survey indicators.

14.5) WRES Actions 2023/24

The Trust is implementing a range of measures to improve its performance against the WRES metrics, which are detailed in the Equality Diversity and Inclusion Delivery Plan and will undertake the following additional actions to improve its WRES metrics:

- The Trust is continuing to build on its work programme to crease inclusive and civil cultures through a raft of initiatives and programmes including:
  - Civility and Respect
  - Race Code and Anti-racism statement
  - Joint Trust Behavioural Framework
  - Inclusive Talent Management plans
  - Inclusive Recruitment Toolkit and positive action initiative
- Further work for 2023 will include:
  - Development of quarterly dashboard reporting for WRES metric 1,2, and 3
  - Bystander training
  - Managing diverse teams / inclusive leadership training for managers to be commissioned
  - Recruitment drive for Cultural Ambassador Programme
  - Continuation of the Civility and Respect programme
  - Anti-racism and zero tolerance campaigns
  - Explore informal approaches with the HR Advisory Team and International Team to Disciplinary activity, to minimize inequitable outcomes for BAME groups

15.0 Workforce Disability Equality Standard (WDES)

15.1) The Workforce Disability Equality Standard (WDES) was introduced in 2018 with 2019 being the first reporting year. The WDES national report compares year on year progress into the career and workplace experiences of disabled staff in the NHS.

RWT Workforce WDES Metric Outcomes 2022/23						
WDES Metric	**National 2022 /23**	**RWT 2022/23**	**RWT 2021/22**	**RWT 2020/21**	**RWT 2019 /20**	**RWT 2018 /19**

Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.1	1.2	0.94*	0.22	1.63	1.48
Relative likelihood of disabled staff entering a formal capability process compared with non-disabled staff (note this is a two-year rolling metric)	1.94	0*	3.25 (based on a count of below 5)	2.4	2.86	4.26
Percentage of disabled staff saying the employer has made adequate adjustments	76.6%	74%	71.8%	77.9%	75.7%	73.4%

**This represents no disabled staff were dismissed on the grounds of capability*

15.2) Analysis of Disabled Staff Representation

- Non-disabled applicants were 1.2 times more likely to be appointed compared to non-disabled applicants. The Trust is a Disability Confident Employer and provides reasonable adjustments and positive action for disabled candidates during the recruitment process.
- The number of disabled staff being entered into formal capability process over a two-year rolling average is 0.
- There has been a 2% improvement in the disabled staff reporting that the Trust has made adequate reasonable adjustments (increasing from from 71.8% in 2021 to 74% in 2022). The Trust launched its new Health Adjustments Passport with a lunch and learn session as part of Disability History Month to raise awareness and promote access to reasonable adjustments. The Trust works closely with its Disability and Long-term Conditions EVG and is seeking to survey members on their experience of reasonable adjustments to gauge more information on disabled people's experiences.
- The Trust has established an Access and Planning Group to look at a range of physical access issues including

    - Accessible toilet provision
    - Not all disabilities are visible
    - Accessible car parking bays
    - Changing places provision
    - Engagement with disabled staff on Trust capital building projects
    - Undertake site tours to understand physical access issues on the site

15.3) WDES Metrics: Staff Experience (Based on Staff Survey Results)

The bullying and harassment reporting metrics have been broken down further this year. We therefore cannot provide the comparative analysis from previous years reports for the bullying and harassment metrics, due to the change.

WDES Staff Survey Metric	**National 2022/2023**		**RWT 2022/2023**		**RWT 2021/2022**		**RWT 2020/2021**		**RWT 2019 /20**	
	Disabled	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**	**Disabled**	**Non-Disabled**

Staff engagement score	6.4	7.0	6.5	7	6.6	7.1	6.7	7.2	6.9	7.3
Percentage of staff experiencing harassment, bullying or abuse from patients, in the last 12 months	33%	26%	28%	22%						
Percentage of staff experiencing harassment, bullying or abuse from managers, in the last 12 months	17%	10%	17%	10%						
Percentage of staff experiencing harassment, bullying or abuse from colleagues, in the last 12 months	27%	18%	24%	19%						
Percentage of staff experiencing harassment, bullying or abuse in the last 12 months and reported it	48%	47%	49%	47%						
% staff who believe the Trust provides equal opportunities for progression / promotion	51%	57%	55%	60%	52.9%	59.6%	80.9%	88.5%	83.2%	88.1%
% Staff who have reported feeling pressure from their line manager to attend work despite feeling unwell	30%	21%	30%	25%	34.1%	25.6%	32.6%	22.8%	33.4%	22.5%
% staff saying the organisation values their work	33%	44%	39%	47%	35.1%	47.7%	46%	56.9%	45.2%	56%

15.4) Analysis of Disabled Staff Experience in the Workplace

- A significantly higher percentage of disabled staff report experiencing bullying and harassment from patients, colleagues, and managers, compared to non-disabled staff.
- There is a significant 7% difference between disabled and non-disabled staff reporting bullying and harassment from their manager.
- Bullying and harassment experienced by disabled and non-disabled staff from patients and from colleagues is highest at 28%, but remains lower than the national average scores.
- There has been a 2% improvement in the proportion of disabled staff who believe the Trust provides equal opportunities, and is higher than the national average.
- There has been a 6% improvement in the proportion of disabled staff reporting attending work due to manager pressure when unwell.
- There has been an improvement of 4% in the proportion of disabled staff saying their organisation values their work, higher than the national average.

15.5) WDES Actions

The Trust has identified a range of measures to improve its WDES metrics as part of the RWT Workforce Equality, Diversity and Inclusion Delivery Plan 2023-24, including:

- Improve disability declaration rates on ESR.
- Actions to develop and improve support to the Disability and Long-Term Conditions Employee Voice Group. Survey members of the group to establish issues and improve disability declaration rates
- Actions to deliver the Civility and Respect toolkit and address bullying and harassment in the workplace.
- Implementation of the NHS Accessible Information Standard.
- Access and Planning Group to focus on:
  - Not all Disabilities are Visible Campaign
  - Changing Places facilities
  - Disabled Parking spaces
  - Improving site access identifying hot spot areas
- Raising awareness of disability and long-term conditions lived experiences of staff, through events such as Disability Awareness Month and a Deaf Awareness lunch and learn session for staff.
- Supporting reasonable adjustments for staff through further promotion of the Health Adjustments Passport
- Training for managers on making reasonable adjustments in the workplace

16.0 Gender Pay Gap 2023

16.1 Gender Pay Gap Reporting

Gender pay reporting legislation requires employers with 250 or more employees from April 2017 to publish statutory calculations every year showing how large the pay gap is between their male and female employees.

This report presents the following gender pay gap indicators which have been calculated for:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay

The data analysis snapshot for this report is as at **31st March 2023** and is taken from the Electronic Staff Record System (ESR). The total number of employees was 13,855, of which 77.47% were female, and 22.53% male, and includes all employees holding an employment contract with the Trust. For the purposes of this report staff who work bank shifts have been included.

Agenda for Change (AFC) was introduced to the NHS in 2004 to ensure fair pay is delivered. The Trust uses this national job evaluation framework to determine appropriate pay bandings providing a clear process of paying employees equally for the same or equivalent work.
These results can also be accessed on the UK Government website: https://gender-pay-gap.service.gov.uk/.

16.2 Overall GPG Trust Results

	2022		2023	
GPG	£	%	£	%
Overall Mean Gender Ordinary Pay Gap	£6.21	29.19%	£5.72	24.81%
Overall Median Gender Ordinary Pay Gap	£3.40	21.09%%	£2.96	16.25%

- **The Trust has seen a 5% improvement in it GPG since 2022 and is reducing the hourly pay differential between men and women.**
- This data shows that on average there is a mean average difference in favour of male employees of 24.81% with men earning on average £5.72 more an hour.
- There is a median gender pay gap of 16.25% in favour of male employers with men earning £2.96 more an hour.
- The Office for National Statistics reported a UK Gender Pay Gap in 2022 of 8.4% for full time employees. This means that on average, nationally women earn just over 15% less than men.
- The NHS overall has had a higher % female workforce due to the range of caring roles in the workforce, which tend to be in the lower bandings, and a predominantly male workforce in the higher banded Medical & Dental professions.

16.3 Average Bonus Gender Pay Gap

The Trust operates an annual Local Clinical Excellence Award (CEA) round for eligible consultants. This recognises and rewards individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS.

The Trust employs 516 substantive consultants of which 35.47% are female. Of the total number of eligible consultants, 156 are in receipt of a local Clinical Excellence Award, of which 25% are awarded to female consultants. Of eligible female consultants, 21.31% are in receipt of CEAs compared to 35.14% of eligible male consultants. The following table illustrates the average bonus gender pay gap.

	Mean	Median
Gender Bonus Gap (%)	5.77%	0.00%

The table above shows there is a mean average difference in favour of male employees of 5.77% with men receiving on average £611.28 more per year than female award receipts. The median average difference in favour of male employees is 0.00% with men receiving on average £0.00 more per year than female award receipts.

16.4 Analysis by Pay Grade

As part of the analysis, RWT are required to show the proportions of male and female across four quartile pay bands: the Lower, Lower Middle, Upper Middle, and Upper Quartiles of earnings as shown below. The following table illustrates the proportion of gender in each quartile pay band.

Quartile	Male	Female	Male %	Female %
Lower	453.00	2337.00	16.24%	83.76%
Lower Middle	483.00	2311.00	17.29%	82.71%
Upper Middle	474.00	2251.00	17.39%	82.61%
Upper	957.00	1904.00	33.45%	66.55%

When ranking the pay relevant employees as of 31 March 2023 according to their average hourly earnings it is clear that females are less well represented in the Upper Quartile.

17.0 Moving Forward

The trust has identified the following themes for further enhancing and developing our Workforce EDI agenda:
• Improving diverse representation across all levels of the organisation
• Improving data – accuracy and presentation
• Improving culture – addressing incivility and bullying and harassment
• Improving access to support for staff
• Improving awareness and understanding of diversity and exclusion
• Grow our Employee Voice Groups
WRES Actions
1. Initiate a recruitment drive for Cultural Ambassadors to meet the demands of Recruitment Panels
2. Evaluate and develop the positive action initiative on recruitment and selection programme
3. Roll out of e-learning on Recruitment and Selection and Inclusive Recruitment
4. Continue the roll out of Civility and Respect Toolkit.
5. Commission and deliver Bystander Training workshops
6. Commission and roll out Managing Diverse Teams and Inclusive Leadership training for all managers at Band 7+
7. Continued support and development of the Trust BAME Employee Voice Groups
8. Continue to develop the Race Code and Anti-racism approach across the organisation 9. Explore informal approaches with the HR Advisory Team and International Team to Disciplinary activity, to minimize inequitable outcomes for BAME groups 10. Develop and improve support to the BAME EVG
WDES and Carers Actions:
1. Continue to improve disability declaration rates.
2. Develop and improve support to the Disability and Long-Term Conditions Employee Voice Group including surveying staff on their experiences.
3. Commission and deliver training workshops for managers to promote awareness and understanding of reasonable adjustments in the workplace and HR policy and process
4. Promote awareness to address disability related Bullying and harassment campaign in collaboration with Communications Team and D<C EVG

5. Access and Planning Group to focus on:
   - 5.1 Not all Disabilities are Visible Campaign
   - 5.2 Changing Places facilities
   - 5.3 Disabled Parking spaces
   - 5.4 Improving site access identifying hot spot areas

6. Raising awareness of disability and long-term conditions lived experiences of staff, through events such as Disability History Month

7. Supporting reasonable adjustments for staff through the Health Adjustments Passport and Working Carers Passport.
8. Explore the Forward Carers Accreditation
9. Review the Trust performance on Disability Confident and progress the Trust to level 3 accreditation

LGBT+ Actions

1. Support the LGBT+ EVG to grow its membership
2. Roll out the Trust Staff and Patient Trans Guidance
3. Roll out LGBT awareness workshops with a focus on Trans awareness
4. Support LGBT+ events and campaigns including Pride 2022
5. Continue to grow the Rainbow Badges Scheme

Carers Actions

1. Promote the Carers Passport and Carers EVG to support working carers
2. Build links with local Care Support services to signpost staff
3. Promote the recording of Carer Status on the Employee Self Service
4. Raise awareness of the role and impact of caring on working

Equality Delivery System Actions: Domain 2

Set up a new Equality Delivery System Working Group to oversee improvements and activity to improve EDS outcomes:

1. Outcome 2a: Promote consistent approach from managers through development of guidance and training to considering and making reasonable adjustments and flexible working requests and support
2. Outcome 2a: Explore access to the provision of counselling and psychological support services for BAME and LGBT+ staff to improve uptake.

3. Outcome 2b: Review the formal B&H reporting process to improve psychological safety of staff wishing to report formally
4. Outcome 2b: Promote awareness and understanding of B&H through lived experience
5. Outcome 2b: Look at datix reporting for B&H of staff and patients
6. Outcome 2b: Improve triangulation of data across the reporting sources

7. Outcome 2c: Managers across the organisation receive and use B&H data reports to identify hot spot areas and address issues locally
8. Outcome 2c: Identify mechanisms to support staff to attend EVG meetings through protected time and also engaging manager in EVG to understand the benefits to the employee and organisation

9. Outcome 2d: Review exit interview process to make it more accessible for people to participate in a psychologically safe way
10. Outcome 2d: Gather themes and intelligence from Exit interviews
11. Outcome 2c: Improve staff retention for Black and International Staff and younger staff Y gen– culturally appropriate stay conversations / cultural adaption training for managers to manage diversity in the international workforce

The Trust EDI Delivery Plan 2023/24 will be reviewed to integrate the EDI themes and priorities highlighted within this report.

18.0 Equalities Duty Compliance

The Royal Wolverhampton NHS Trust strives to always be fully compliant with all duties under the Equality Act.

- Our Workforce Race Equality Standard (WRES) was published in line with requirements and will be refreshed as required
- Our Equality Delivery System (EDS2) self-assessment has been refreshed and the Trust are now preparing to work towards the revised version and will publish when assessments have been completed.
- Our Gender Pay report is published in line with the requirements
- We have submitted our initial data for the new Workforce Disability Equality Standard (WDES).
- The Trust has all appropriate policies and procedures to support equality and inclusion.

18.1 Equality Objectives

The Trust's objectives reflect key priorities in the Quality Account for both Patient Experience and Workforce. Our objectives will be supported by local action plans and embedded within existing monitoring and reporting processes.

A copy of our current Equality Objectives and progress updates can be found in Appendix 1.

18.2 Equality Delivery System

The EDS was introduced in 2011 to support NHS organisations to assess and improve their performance on equality, diversity and inclusion. A refreshed version, EDS2, was issued in 2013, and now a third revision (called EDS) was introduced in 2022/23.

The Trust has completed its assessment against Domain 1 and Domain 2. The Assessment and Scoring can be found in Appendix 2.

The EDS is a simplified and easier-to-use version of *EDS2*. It has been designed to take account of the various changes within the health service including local and regional NHS re-organisation; formation of single regional-based Clinical Commissioning Groups (CCGs); local or place-based partnerships of NHS and local authority commissioners, providers and others and eventually Integrated Care Systems. It has also considered the impact of COVID-19 on BAME community groups and those with underlying and long-term conditions such as diabetes. As such it requires organisations to make a better connection between the outcomes from EDS and other frameworks such as the WRES and WDES. There is a particular emphasis on the health and wellbeing of staff members.

NHS England issued several draft documents for consultation and the final framework will be implement from April 2023. These include:

- Rating and scorecard guidance
- Reporting templates
- Supporting Information
- Technical guidance

Key Features

The EDS now comprises eleven outcomes spread across three domains:

1. Commissioned or provided services
2. Workforce health and wellbeing
3. Inclusive leadership.

EDS Assessment and Review Cycle

The new EDS is due to be implemented from **April 2023.** EDS reviews are to be carried out **annually,** and results need to be published on organisation websites by **28th February**. It is recommended that the yearly cycle is completed as follows:

- **Reviews on Domain 1** (Commissioned or provided services) should occur during the summer months (quarter 2 of the financial year).
- **Reviews of Domain 2** (Workforce health and wellbeing) should occur during the spring and/or summer months (quarters 1 and 2 of the financial year).
- **Reviews of Domain 3** (Inclusive leadership) should occur during the Autumn months (quarter 3 of the financial year).

It is expected that that NHS organisations who are carrying out work with the existing framework should continue to do so until April 2023

Scoring and Rating system

Each outcome is to be scored based on the evidence provided. Once each outcome has a score, they are added together to gain domain ratings. Domain scores are then added together to give the overall score or the EDS Organisation Rating. The scoring system will be as follows:

Undeveloped activity – organisations score 0 for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – organisations score 1 for each outcome	Those who score between 8 and 21, adding all outcome scores in all domains, are rated Developing
Achieving activity – organisations score 2 for each outcome	Those who score between 22 and 32, adding all outcome scores in all domains, are rated Achieving
Excelling activity – organisations score 3 for each outcome	Those who score 33, adding all outcome scores in all domains, are rated Excelling

Equality Analysis (EA)

The Trust must demonstrate how it has paid due regard to the general equality duty in decision and policymaking, and publish information accordingly, we do this by using Equality Analysis to help demonstrate compliance.

All new and revised policies must adhere to our 'Development and Control of Trust policy and procedural documents as part of the approval and review framework.

The Trust's 'Undertaking an Equality Analysis' policy, which helps staff to determine the extent to which policies, procedures, practices and services impact upon people with protected characteristics, is embedded within this approval and review framework. Engagement is an integral part of EA as it can help with developing an evidence base, decision making and transparency rather than making assumptions.

Policy authors continue to receive timely feedback and advice from the Equality, Diversity and Inclusion Officer on EAs before the Trust Policy Group meetings. This process represents a proactive and rigorous approach to checking EAs. The Trust Policy Group has noted an improved engagement with the process.

During this reporting period, over 80 significant policies were reviewed with completed EAs.

The Trust is also compliant with its requirement to publish an annual register of completed EAs.

The Trust has undertaken a review of its EA tool to enable assessment and mitigation against health inequalities. The Public Health Equity Assessment Toolkit (HEAT) has been utilised. This aims to:

- Systematically address health inequalities and equity related to a programme of work or service
- Identify what action can be taken to reduce health inequalities and promote equality and inclusion

Appendix 1 – Equality Objectives 2023 - 2027

Patient Experience Objective 1

Review and improve service accessibility for those whose first language is not English. This is to understand patient demographics and interpreting requirements.

- We will continue to review and improve accessibility to services for those whose first language is not English – to understand the changes in demographics for our patient population and the subsequent provision of interpreting:
  (a) People who have left the UK due to Brexit. It is believed that this largely affects people from Eastern European countries. This is evidenced in the shortage of interpreters available as reported by the Trust Interpreting and translation provider. Any gap of provision identified will need to be addressed.
  (b) The likely increase in people from BAME communities in the local population because of (a) new arrivals, mainly as refuges and asylum seekers from countries such as Afghanistan and Ukraine (b) growth in the longstanding BAME communities in Wolverhampton
- We will engage with patient groups to understand barriers for effective communication

Patient Experience Objective 2

Ensure patients are able to have, and report having, positive experiences while using our services. We will ensure compliance against the Parliamentary Health Service Ombudsman complaint handling framework

- We will deliver inclusive engagement opportunities across the diversity of our patient groups including acute and community settings.
- We will deliver a program of outreach across all hospital sites to better understand the feedback from patients and their loved ones.

Workforce Equality Objective 3

Ensure all practices/ processes are inclusive and promote belonging, and are supported by actions that address inequitable outcomes for protected groups.

- We will deliver year on year improvements against our Workforce Race Equality Standard and Workforce Disability Equality Standard Metrics.

- We will support staff experiencing incivility, bullying or harassment, and provide access to advice, support and opportunities for reporting.
- We will deliver inclusive engagement opportunities across the diversity of our workforce.
- We will improve our equality data and reporting.
- We will grow and develop the Cultural Ambassador Programme.

Workforce Equality Objective 4

Our executives and senior managers lead with compassion and routinely demonstrate their understanding of, and commitment to equality and diversity.

- We will create a workforce that reflects the communities we serve across all levels of the organisation.
- We will provide inclusive leadership development opportunities for our leaders and managers including Reverse Mentoring
- We will grow our talent pool of under-represented groups through opportunities such as career conversations, coaching, and sponsorship.
- We will progress the Trusts performance through the Race Code Charter Mark and will identify other relevant charter marks where improvement needs are identified.

Workforce Equality Objective 5

Support staff health and wellbeing through the promotion of initiatives and healthy lifestyle services.

- We continue to build on our mental health first aiders programme and health and wellbeing champions.
- We will continue to deliver Respond training to all staff to encourage a caring and compassionate workplace.
- We will promote the Employee Assistance Programme to staff.
- We will monitor participation in health and wellbeing services by protected characteristic and promote ease of access to services.
- We will raise awareness of mental health and tackle stigma.

Appendix 2: EDS Assessment Scoring

NHS Equality Delivery System (EDS)

EDS Lead	Head of Patient Experience – Domain 1 Head of EDI – Domain 2 & 3		At what level has this been completed? Senior Level	
				*List organisations
EDS engagement date(s)	5 June		Individual organisation	The Royal Wolverhampton NHS Trust
			Partnership* (two or more organisations)	TBC
			Integrated Care System-wide*	Black Country ICB

Date completed		Month and year published	
Date authorised		Revision date	

Completed actions from previous year	
Action/activity	**Related equality objectives**
First year of New EDS	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly. Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance with scores are below	
Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service			
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service			
Domain 1: Commissioned or provided services overall rating				

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	12 Months participation data in H&WB support services by PC. Sickness Monitoring Policy, Attendance Policy, Sick Absence Data by PC H&WB Support Offer and promotion activity / activity to support the needs of PC groups H&WB Signposting services information WDES Metrics Employee Voice Group support to members Pastoral Leads for Clinical Fellows and International Staff Chaplaincy Pastoral Support for staff Professional Nurse Advocates Fresh Fruit and Veg Store outside ED	2-Achieving	EDS Working Group
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Zero Tolerance Guide and Campaign / Race Code / Rainbow Badges B&H Formal Reports by PC in last 12 months (Disputes and Just Culture) FTSU Data by PC – behaviours and bullying WRES Metrics: B&H Indicators EVG feedback and reports from members Civility and Respect Programme participation data and Joint Behavioural Framework Race Fluency Sessions NHS England Training – 10 session delivered to ED staff on De-escalation. Will be rolled out to Maternity and Primary Care	1 - Developing	EDS Working Group

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Union arrangements and Support Offer. Union reports of B&H by PC. FTSU structure and support offer to staff. FTSU reports by PC Employee Voice Group structure and support offer to staff. T of R and membership numbers. Bullying and Harassment Policy and Just Culture Framework – within Disputes Policy HR Advisory Toolkit FTSU Data by PC Civility and Respect Programme Bullying and Harassment Case Studies Pastoral Leads for Clinical Fellows and International Staff Chaplaincy Pastoral Support for staff Professional Nurse Advocates	2 - Achieving	EDS Working Group
	2D: Staff recommend the organisation as a place to work and receive treatment	Staff Survey results – Q23C / Q23D Analysis by ethnicity, Sexual orientation and Disability Sickness Monitoring by PC Staff Recruitment Policy Leavers Data by PC Exit Interviews Data by PC and Exit Interview Procedure (HR Toolkit) via ESR Evidence of Partnership Working – One Wolverhampton and BC ICS BC ICS EDI Leads Group BC ICS EDI Strategy and Engagement Findings Report Talent Plan	1 - Developing	EDS Working Group
Domain 2: Workforce health and well-being overall rating			6	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Board and Committee Cover Sheet and reports evidencing EDI discussions Annual Equality Report to Board EVG Executive Sponsors – EVG report EDI Events Schedule – events sponsored by Board members EDI SG minutes Communications Messages on EDI: David's Despatch / Web pages / Blogs / Health Inequalities Steering Group minutes		
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Policy Sub-Group Minutes Annual Equality Report to Board Sample EIAs Staff Risk Assessment process EDI BAF Risk Board and POD and OWG Meeting Action Logs RWT Strategy		
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	EDI Governance and Reporting Structure – Annual Equality Report section Menopause Policy Annual Equality Report to Board – actions WRES metrics WDES metrics GPG results EDI Delivery Plan Rag Rating Accessible Information Standard Minutes of Meetings and Action Plan BC ICS WREI Assessment Board Report and Minutes		
Domain 3: Inclusive leadership overall rating				

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): Mark Ondrak - UNISON	**Independent Evaluator(s)/Peer Reviewer(s):**

EDS Organisation Rating (overall rating):
Organisation name(s):
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
EDS Sponsor	**Authorisation date**

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service			
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service			

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions			
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source			
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source			
	2D: Staff recommend the organisation as a place to work and receive treatment			

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities			
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed			
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients			

Appendix 3 - Protected Characteristics as defined by the Equality Act 2010

Age - Refers to a person having a particular age (for example, 32 year olds) or being within an age group (for example, 18-30 year olds). This includes all ages, including children and young people.

Disability - Includes significant and lengthy conditions that are physical as well as not seen, such as those relating to sight, hearing, speech, learning and mental health. Also includes HIV and cancer and other types of diseases.

Gender reassignment* - This is the process of transitioning from one gender to another, whether proposing to undergo, undergoing or having already undergone a process (or part of a process) to reassign biological sex.

Marriage and civil partnership- Marriage being a union between a man and a woman and civil partnership being legal recognition of a same-sex couple's relationship. Civil partners must be treated the same as married couples.

Pregnancy and maternity - Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth and this includes treating a woman unfavourably because she is breastfeeding.

Race- Refers to a group of people defined by their colour, nationality (including citizenship), ethnic or national origins. Includes Asian, Black, Chinese, Mixed and Any Other Ethnic Group, as well as White British, Irish, Scottish and Welsh, Romany Gypsies and Irish Travellers.

Religion or belief Religion means any religion, including a reference to a lack of religion. Belief includes religious and philosophical beliefs including lack of belief (for example, Atheism).

Sex - Someone being a male or a female. Assigned at birth.

Sexual orientation - This is whether a person's sexual attraction is towards their own or opposite sex or to both. Includes people that are gay (men who are attracted to men), lesbian (women who are attracted to women) and bisexual (people attracted to both sexes).

Appendix 3 - Terms and Definitions

Age: Refers to a person having a particular age (e.g., 30 year olds) or within an age group (e.g., 20-25 year olds), this includes all ages, including children and young people.

d/Deaf. Conventionally the use of the word deaf (with a lower case 'd') refers to any person with a significant

hearing loss, whereas Deaf (with a capital D) refers to a person who's preferred language is British Sign Language. (Association of Sign Language Interpreters). But do not assume all Deaf people use BSL.

Disability: A person has a disability if they have a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities. Disability could include sensory impairments, a learning disability or difficulty. Some conditions are automatically classed as a disability e.g., HIV infection, multiple sclerosis, cancer.

Diversity: Recognising and accepting that people are individuals with different needs and requirements.

Engagement: The range of ways that public authorities interact with employees, service users and other stakeholders. This is over and above service provision or within a formal employment relationship.

Equality: Treating people **fairly**, with reasonableness, consistency and without prejudice.

Equality Analysis (EA): Public authorities are required to have due regard to the aims of the general equality duty when making decisions and when developing policies. EA can help identify potential negative impacts or unlawful discrimination, as well as any positive opportunities to advance equality.

Equality information: Information held or will be collected about people with PPCs, and the impact of organisational decisions and policies on them.

Equality objectives: A duty for relevant public authorities to prepare and publish one or more objectives to meet the aims of the general equality duty.

Gender re-assignment: The process of transitioning from one sex to another. See also trans, transsexual, transgender.

Harassment: This is unwanted conduct related to a PPC that has the purpose or effect of violating a person's dignity or creates an intimidating, degrading, hostile, humiliating or offensive environment.

Human Rights: The right to be treated fairly, respectfully, dignified and courteously. Core values of the Human Rights Act:- fairness, respect, equality, dignity and autonomy (FREDA).

Inclusion: Miller and Katz (2002) defined inclusion as: "…a sense of belonging: feeling respected, valued for who you are; feeling a level of supportive energy and commitment from others so that you can do your best."

LGBT: Lesbian Gay Bisexual Transgender.

Marriage and civil partnership: In England and Wales; **marriage** is no longer restricted to a union between a man and woman, and includes a marriage between two people of the same sex. Same sex couples can also have their relationships legally recognised as **civil partnerships**. Civil partners must not be treated less favourable than married couples (except where permitted under the Equality Act 2010).

Maternity: The period after giving birth. Employment: linked to maternity leave. Non-work context: protection against maternity discrimination is for 26 weeks after giving birth, including discrimination as a result of breastfeeding.

Pregnancy: Condition of being pregnant.

Race: Refers to a group of people defined by their colour, nationality (including citizenship), ethnic or national origins.

Religion or belief: Religion - any religion, including a reference to a lack of religion. **Belief** - includes religious and philosophical beliefs including lack of belief (e.g., Atheism).

Sex: A man or a woman.

Sexual orientation: A person's sexual attraction towards their own sex, the opposite sex or to both sexes.

Trans: The terms 'transgender people' and 'trans people' are both often used as umbrella terms for people whose gender identity and/or gender expression differs from their sex at birth; including transsexual people, transvestite/cross-dressing people, androgyne/polygender people, and others who define as gender variant.

Transgender: An umbrella term for people whose gender identity and/or gender expression differs from their sex at birth. They may/may not seek to undergo gender reassignment hormonal treatment/surgery. Often used interchangeably with trans.

Transsexual: Is a person who intends to undergo, is undergoing or has undergone gender reassignment (which may or may not involve hormone therapy or surgery). This could include part of the process. Transsexual people have the protected characteristic of gender reassignment under the Equality Act 2010. Once a transsexual person has a gender recognition certificate, it is probably the case they should be treated entirely as their acquired gender.

Some definitions have been taken/summarised from Equality and Human Rights Commission. (July 2014),

'The essential guide to the public sector equality duty'

Executive Summary Workforce Report

Trust Board
1 August 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 are sickness are rated amber.

- Normalised turnover is 10.34%, improving slightly in month and for the the sixth consecutive month. The retention rate is now reported as 12 month retention and is meeting the agreed standard showing improvement in month.
- The vacancy rate has worsened, however continues to meet the target at 3.12%. Over the last month the number of staff employed has increased by around 40WTE, driven by increases across the staff groups, with the largest increases in registered nursing staff of around 32WTE. Recruitment continues to outpace turnover. There were almost 124WTE newly qualified/ international nurses working towards their NMC Registration at the end of June.
- Attendance levels have remained broadly stable with a very slight improvement in May. The in month performance for this indicator is below the target at 4.65%. Levels of absence remained elevated, and will continue to impact performance in relation to the 12 month rolling absence rate for some time which currently sits at 5.24%.
- Performance in relation to generic Mandatory Training continues to meet the external target of 95.60%. Role specific mandatory training compliance is also slightly improved at 93.40% and above the target. In relation to appraisal, compliance rates have improved slightly over the last month to 84.80%. This indicator is again rated amber and below the target of 90%.
- The fill rate through the bank in June was 68% for registered nursing staff, worsening in month, and 87% for healthcare assistants, again, an improvement in month. The medical bank fill rate was 88%, showing improvement and continuing to exceed the new target of 87%.
- The report offers a brief overview of a number of key work streams:
    - Industrial Action
    - Rostering performance for non-medical staff

Key Workforce Metrics

Key Workforce Indicators

Indicator	Value	Trend
Vacancy Rate	3.12%	↑ (red)
Turnover (Normalised)	10.34%	↓ (green)
Retention (12 Months)	89.57%	↑ (green)
Sickness (Rolling 12 Month)	5.24%	
Sickness (In Month)	4.65%	↓ (green)
Mandatory Training (Generic)	95.60%	↑ (green)
Appraisals	84.80%	↑ (green)

Three of the six workforce indicators are meeting the agreed targets / thresholds; vacancy rate, retention rate and mandatory training compliance. Turnover, appraisals and sickness compliance are rated amber. Five of the six indicators improved over the month.

Turnover has improved slightly to 10.34%. Turnover performance is now meeting the standard for Medical and Dental, Admin and Clerical and Additional Professional, Scientific, and Technical staff groups with elevated levels particularly in AHP and Healthcare Scientist staff groups.

The vacancy level has worsened slightly in month, however, continues to meet the target. It is above target for AHP and medical staff only as the establishment has increased to a greater extent than the number of staff in post.

In month absence levels are now below target for the last two months. Rolling 12 month sickness is 5.24%, above the target and rated amber.

Mandatory training (generic) compliance rates have improved, and continues to exceed the 85% target.

Appraisal compliance has improved slightly but is not meeting the Trust target of 90%.

Performance Exceptions

Workforce Planning & Productivity
Effective use of Technology
Workforce Analytics & Intelligence
HR Metrics & Performance

Metric	What's driving the performance?	Actions

Turnover (10.34% v target of 10%)	Increased number of leavers particularly for AHPs, Healthcare Scientists and (albeit to a lesser extent) Nursing Staff.
	
	Most common reasons for leaving are:
	- Work-Life Balance
	- Retirement and
	- Promotion
	
	Data suggests excess leavers due to promotion is linked to increased number of retirements, creating increased number of promotion opportunities.
	
	Note – data includes leavers from 12 months prior due to nature of turnover measure.
		- Flexible working delivery plan including requesting and recording flexible working requests in ESR to enable review of flexible working by directorate/ department.
		- Retention conversations toolkit launched:
		  - 30, 60, 90 day conversations introduced for new starters
		  - Stay conversations introduced for staff in post beyond initial 90 days
		- Fellowship programme and Development in place for staff.
		- Anticipated improvement in this indicator with these actions and as post COVID turnover settles.

Appraisals (84.80% v 90% target)	Below target level compliance across all Divisions save Estates and facilities driven by: - Competing demands on managers cited as key reason for standard not being met. - In BCPS there remains a legacy of conducting appraisals in Q1 – this causes a high number of appraisals to fall due at the same time, impacting performance.	- Appraisal paperwork has been reviewed and simplified. - E-Appraisal under review using My Academy. - Divisional action plans in place and improvements continue to be made.

Sickness	Elevated levels of sickness in the NHS and in population generally. Whilst attendance is elevated, the Trust benchmarks well (Model Hospital data) for key staff groups where data is available (Nursing Staff, Medical Staff and AHPs). Elevated levels of sickness absence driven by:
	
	- Absence attributable to mental health
	- Increase levels of absence arising out of cough, cold etc and
	- Longer absences with chronic health conditions.
		- Comprehensive Health and Wellbeing offer in place for Trust staff
		- Detailed action plan for management of sickness absence summarised as part of deep dive report to PODC actions include:
		  - Increased focus on areas where sickness absence is elevated
		  - Training and support for line managers
		  - Strengthened governance and escalation of absence management.

Summary Update

Pay, Reward and Industrial Action

Board members will be be aware of the current industrial relations situation in the NHS and the wider public sector. As part of ballots across the country:

- The Royal College of Nursing (RCN) and Society of Radiographers (SoR) balloted their membership on further industrial action.
    - The RCN ballot, which was aggregated at national level, did not achieve a mandate for industrial action.
    - The SoR ballot, which was a disaggregated ballot, achieved a mandate in 43 organisations, not at RWT.
- The British Medical Association (BMA) ballot of their Consultant membership resulted in a mandate for industrial action and Consultants were called to take strike action on 20 and 21 July.
- The BMA and Hospital Consultants and Specialists Association (HCSA) are re-balloting their Junior Doctor Membership in ballots which are open until the end of August.

At the present time the BMA and HCSA have mandates for junior doctors to take industrial action which run until around 19 August 2023 with strike days anticipated between now and then. This follows a number of strikes that have taken place the most recent between 13 and 19 July.

In relation to all action, the Trust's business continuity plans have been put in place to ensure the safe running of services.

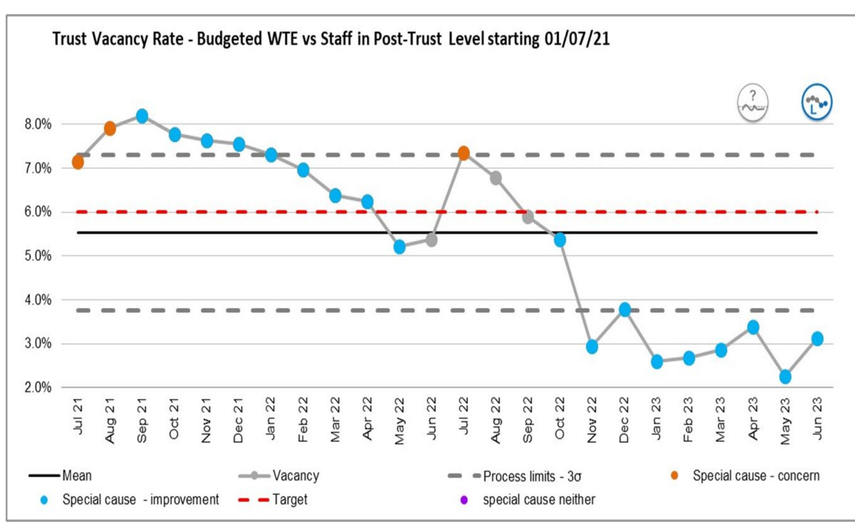
The pay award was implemented for NHS Terms and Conditions of Service (formally Agenda for Change) for NHS Staff in June comprising:

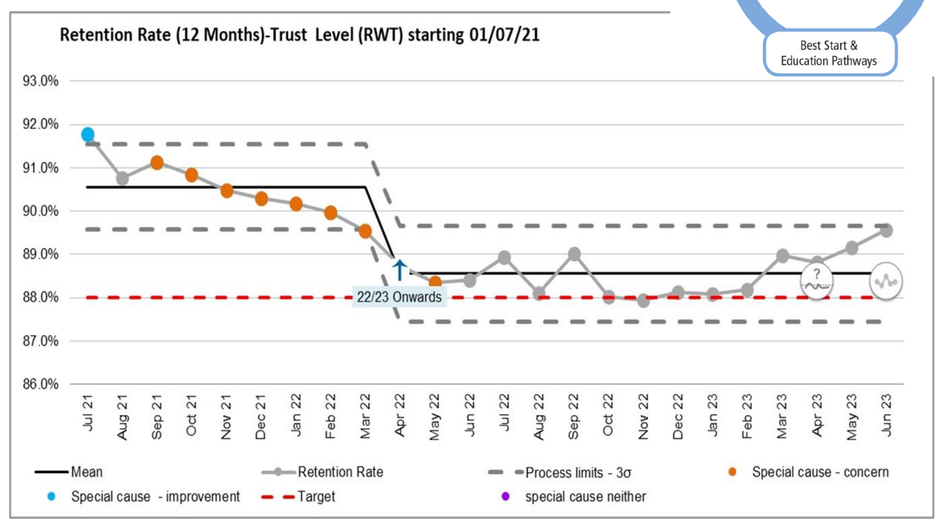
- A non-consolidated (non-pensionable and does not feed into the calculation of additional earnings) award for 2022/23 of:
    - 2% non-consolidated payment
    - A tiered cash payment (with an average value of 4%)
- A consolidated pay award of 5% for 2023/24
- Further investment in 2023/24 to increase entry level pay in the NHS to £11.45.

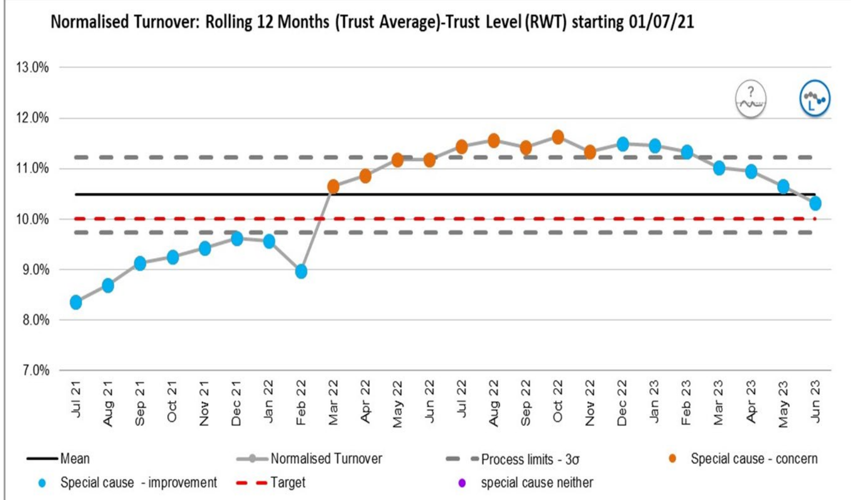
Offers have been made to the medical and dental trade unions which have been rejected.

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

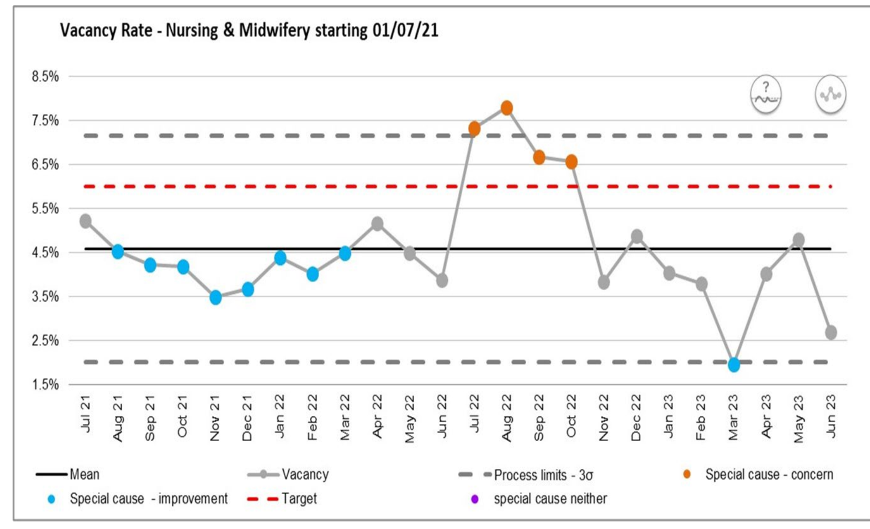
- Turnover exceeds the target at 10.65%.
- The vacancy rate remains elevated for medical staff and AHPs following an increase in the number of established posts for this staff group.
- Whilst the vacancy levels are performing well overall, there continues to be hotspots and there is a lead time, particularly 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.

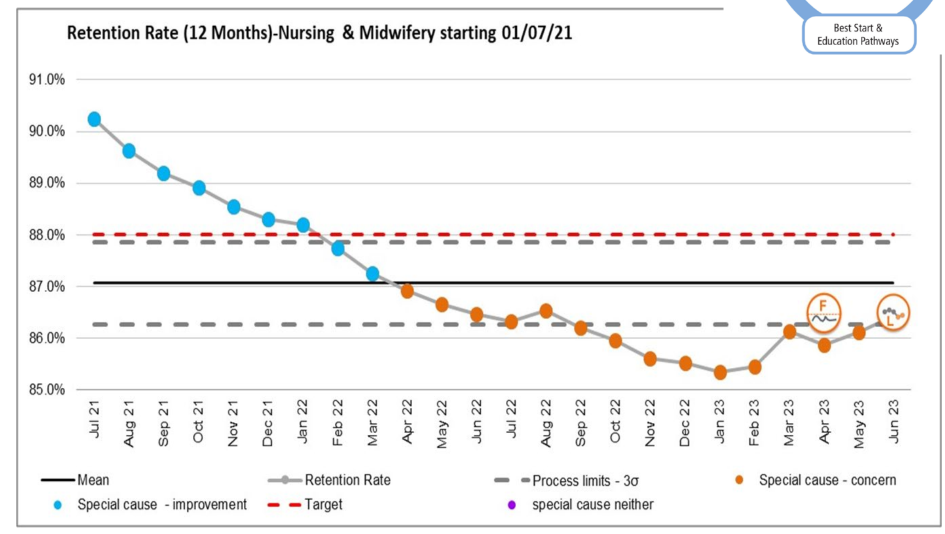
Key Actions & Progress

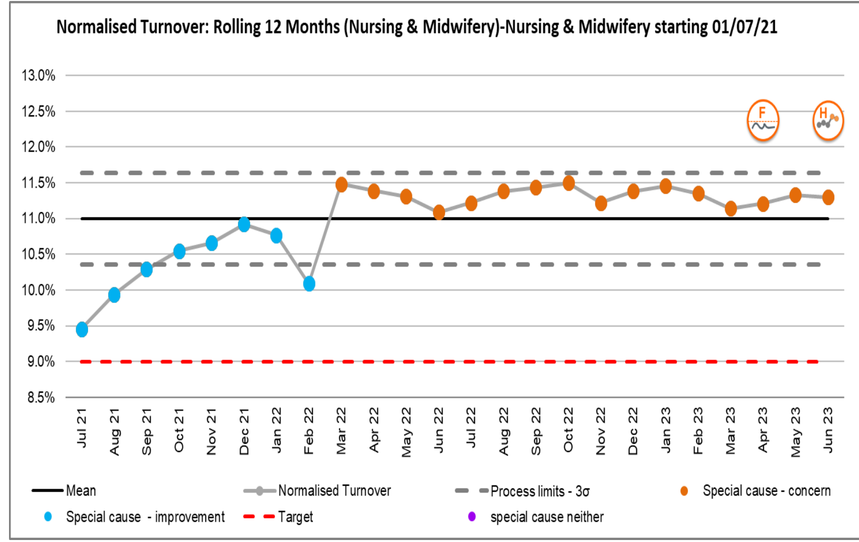
- The vacancy rate is now meeting the target consistently as is retention at 12 months which at 89.18% is now meeting the 88% target. Turnover has improved.
- Active work continues to identify hard to fill posts to ensure targeted actions are in place for these posts.
- Starters continue to outpace leavers 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

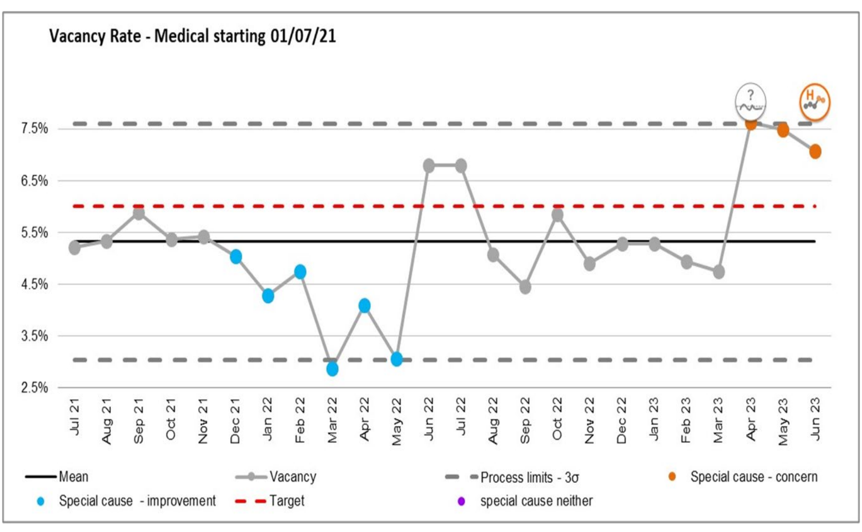
- Nursing turnover is above target at 11.30%, reducing slightly from the prior month. Work life balance is a key driver of turnover. Increased turnover is also driven by staff who deferred retirement/ may otherwise have left in prior years now leaving the service/ Trust in an increased number. Wider 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.

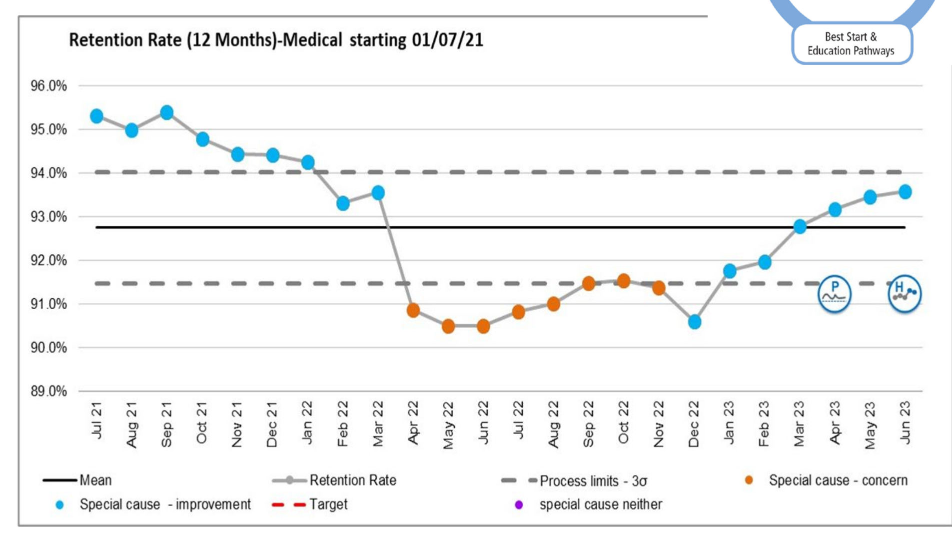
Key Actions & Progress

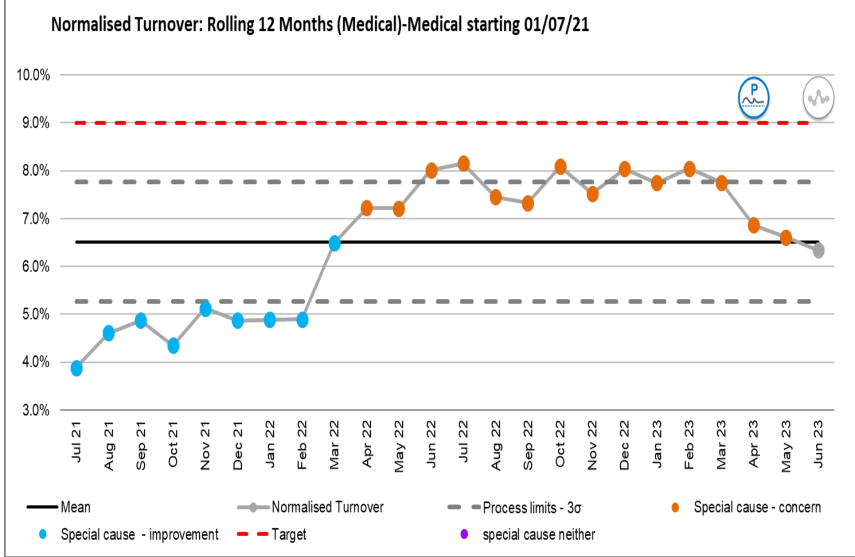
- Recruitment continues for this staff group with a net increase of just under 32 WTE in month and a further 124WTE staff working towards their NMC registration.

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

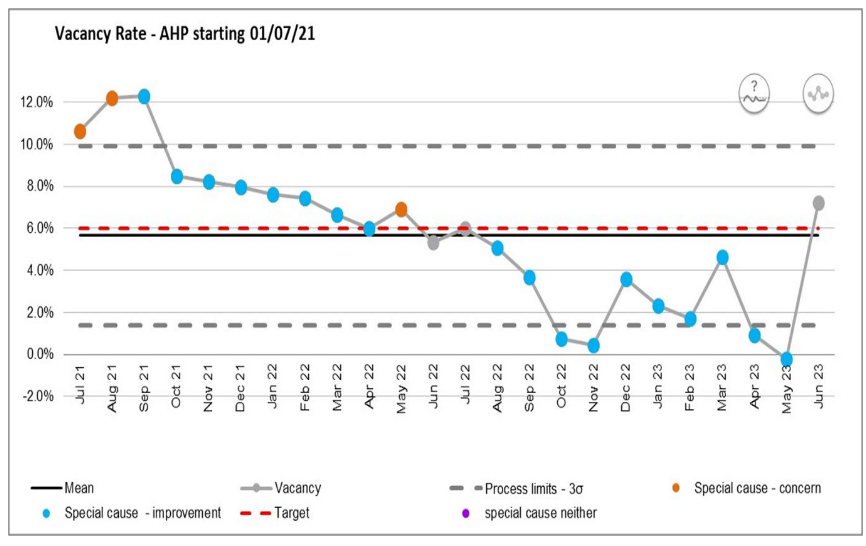
- The vacancy rate has initially risen as the number of established posts has been increased in April, as recruitment progresses the vacancy rate is reducing.
- Whilst the overall position is hugely positive, there are some hotspots in key services where vacancy levels give cause for concern, such as in clinical oncology, emergency medicine and microbiology.

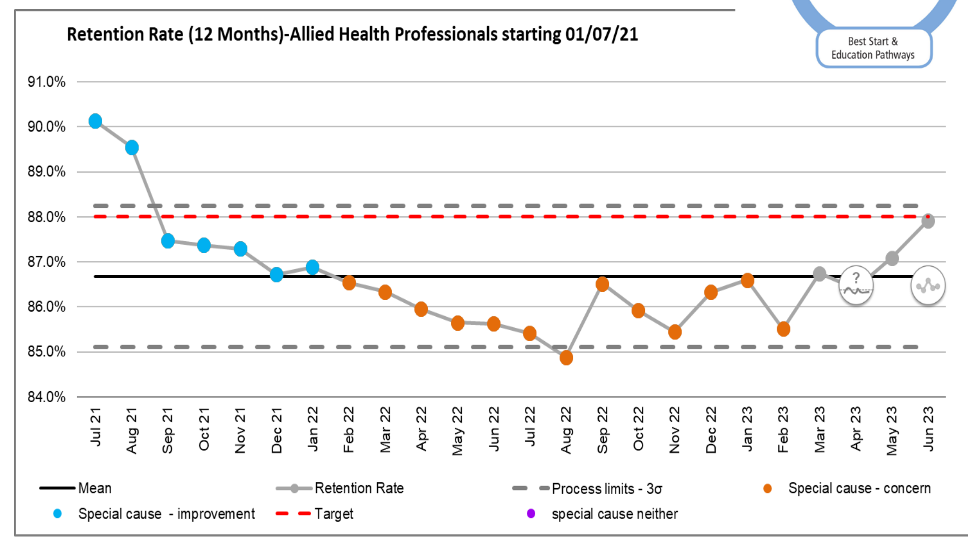
Key Actions & Progress

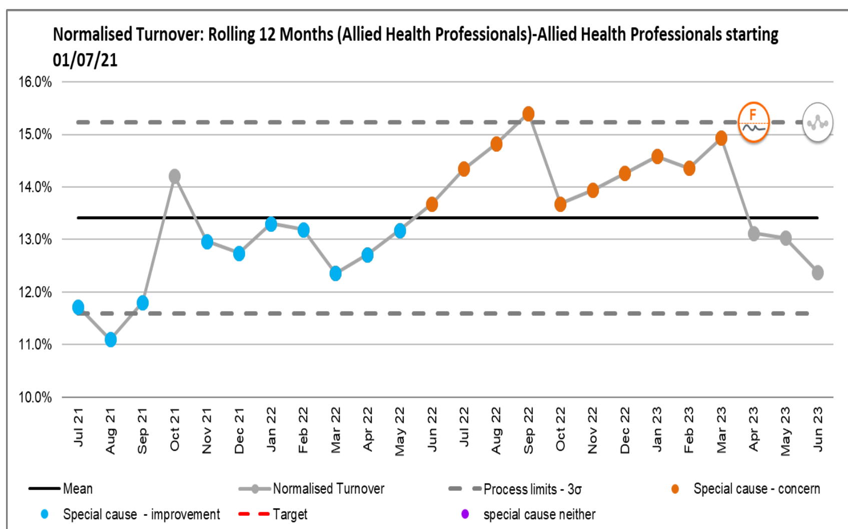
- Turnover and retention retention metrics for medical staff are being met.
- There is significant activity in place to recruit to hard to fill vacancies, particularly where vacancies lead to high cost agency/ bank spend.
- A detailed report of such posts together with actions is reviewed by the Operational Workforce Group to ensure targeted actions are in place. This report has been received by People and Organisational Development Committee in June.

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

Attract, Recruit & Retain





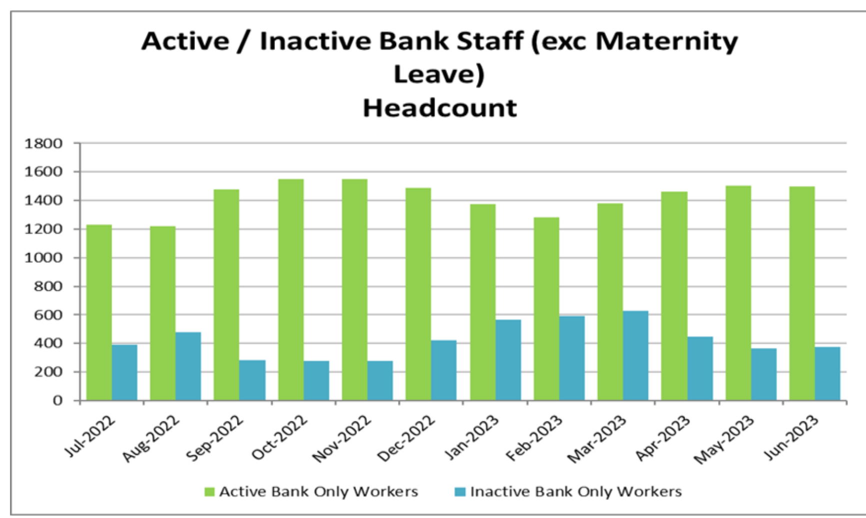


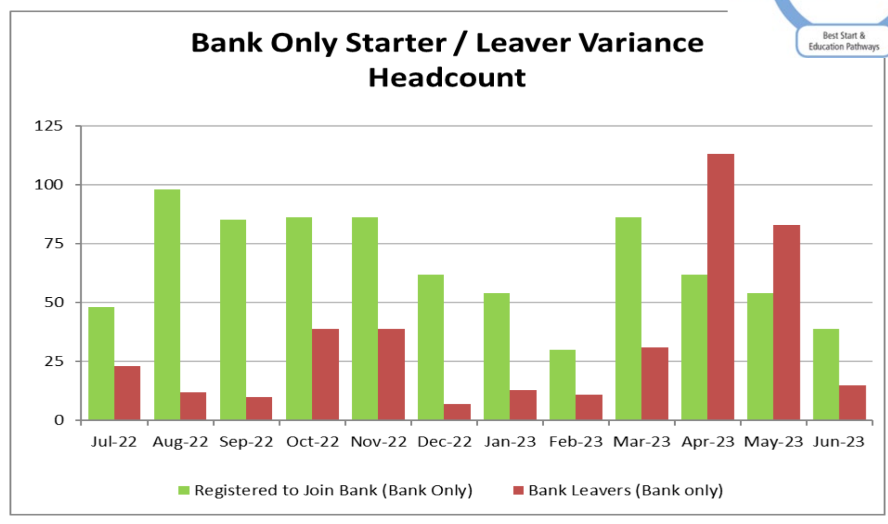
Key Issues & Challenges

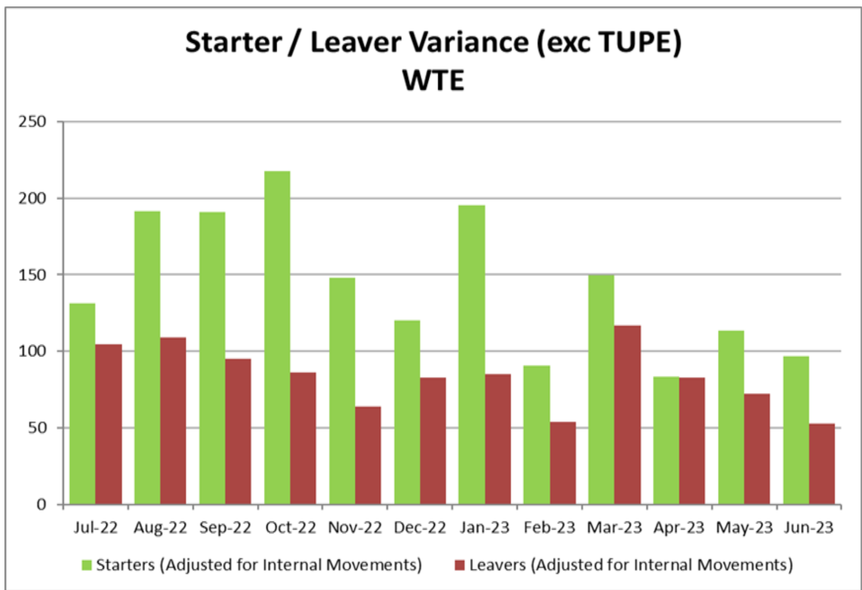
- Metrics for AHPs cover Podiatry, Dietetics, Occupational Therapy, Physiotherapy, Orthoptics, Radiography (diagnostic and therapeutic), Orthotics, Speech and Language Therapy (SaLT), and Operating Department Practitioners (ODPs).
- There are hotspots in particular staff groups, specifically, Chiropody/ Podiatry (3.2WTE, 24.51%), Dietetics (7.51WTE, 27.66%), Occupational Therapy (15.08WTE, 17.51%) and Operating Department Practitioners (38.38WTE, 24.51%).
- Increases in vacancy rates for Dietetics, Occupational Therapy, and ODPs are driven at least in part by increases in the establishment.
- The Trust took part in an NHS England initiative to recruit overseas podiatrist, unfortunately the candidates withdrew and this has not been successful.
- Turnover for AHPs is elevated although has seen recent improvements.

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.
- Temporary staffing arrangements are in place for vacancies where necessary to ensure services are appropriately staffed.







Key Issues & Challenges

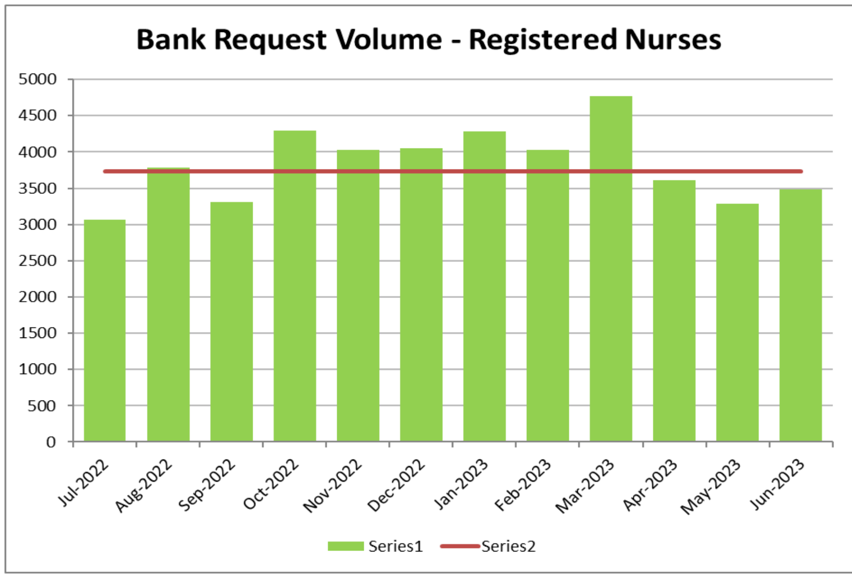
- 472 shifts were classified as 'late requests' (within and over 24 hours of the start time of the shift), 301 of these shifts have been identified that prior notice could have been given. 118 shift requests were requested more than 24 hours after the start time of the shift which is having a negative impact on fill rates. This represents a slight improvement from May.
- There has been a decrease in the fill rate for ED as the £5 Enhanced Rate has ceased – 75% fill rate in May, 58% fill rate in June.

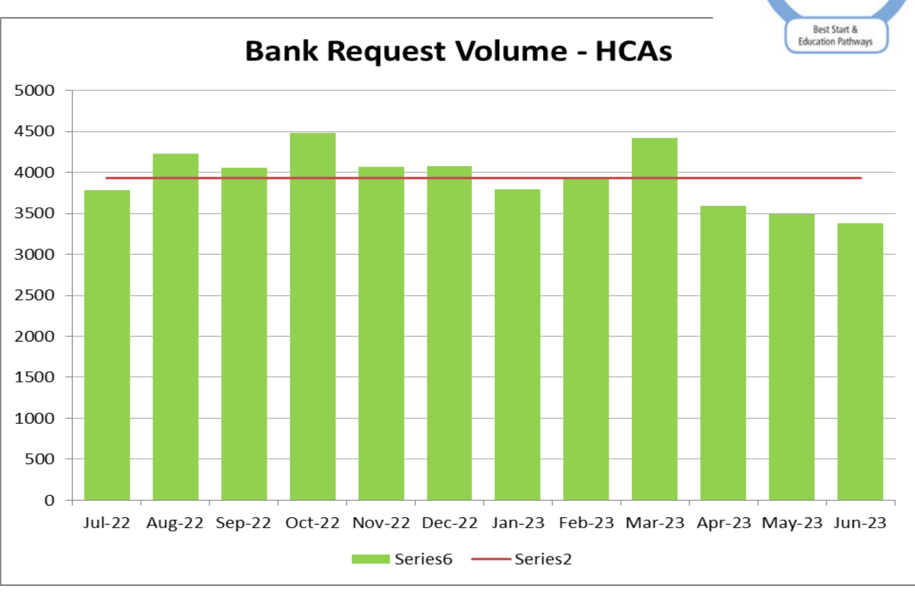
Key Actions & Progress

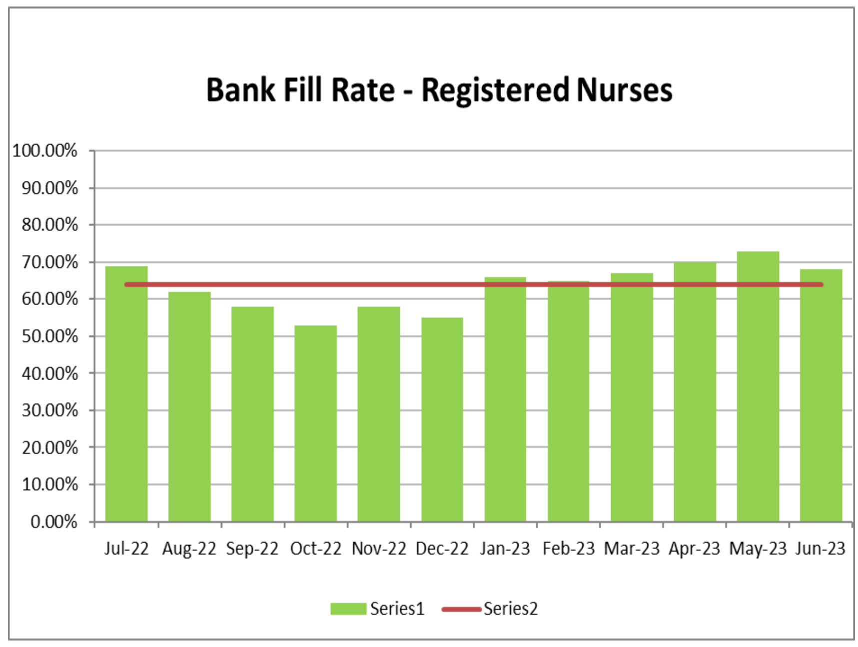
- In June the Enhanced Rate (additional) is applied to chemotherapy trained Registered staff on CHU and £45 per hour Enhanced Rate for Sonographers in Maternity.
- Bank Admin interviews taken place – 6 Successful Applicants.
- Students on placement with the Trust – 13 Conditional Offers made, 15 completed pre-employment checks and ready to start work.
- Step Into Work candidates successfully completed placement and sent to Bank – 3 HCA and 1 Admin.

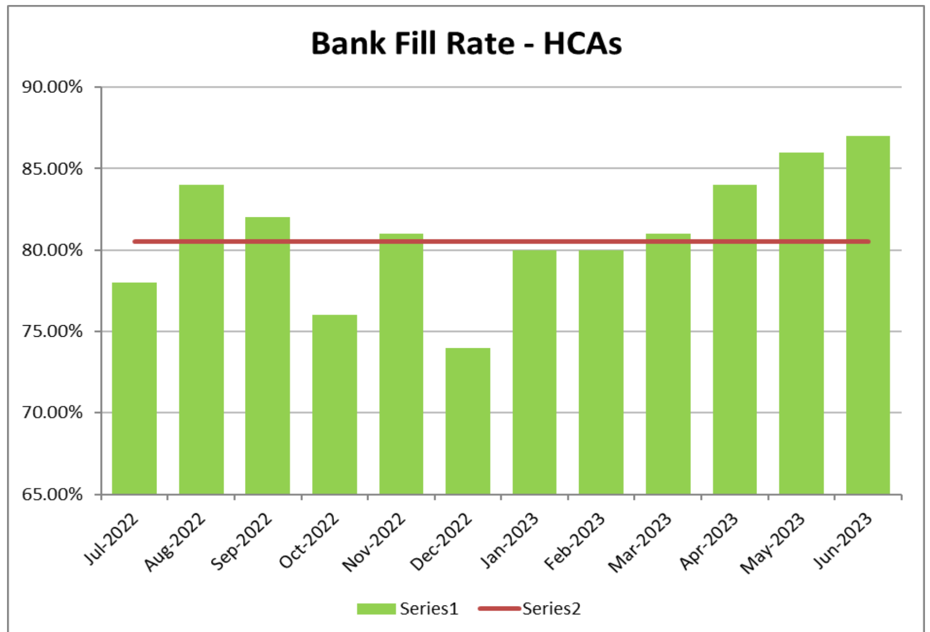
Attract, Recruit & Retain

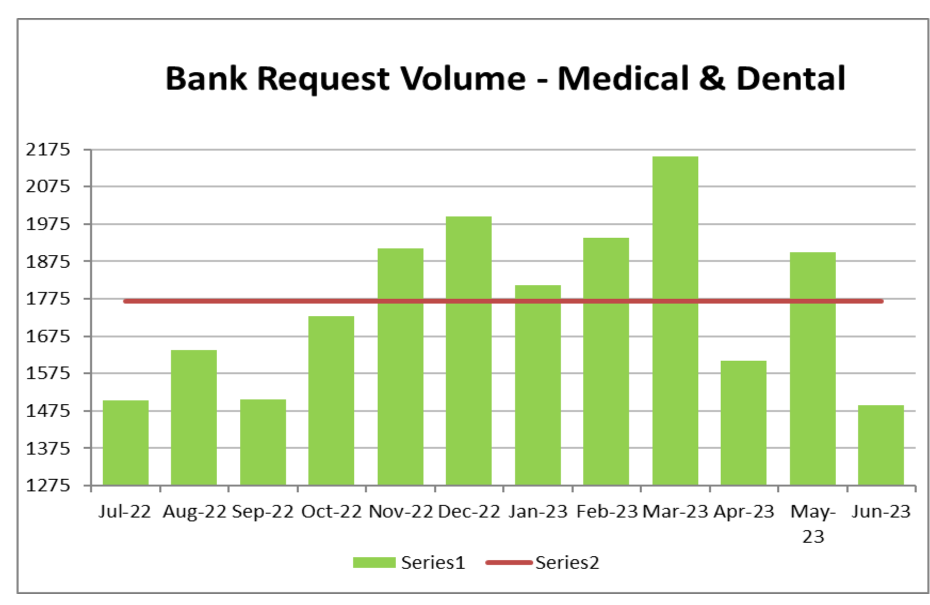
Employer Branding, Attraction, Recruitment & Retention
Apprentices & Graduates
Career Pathways & Succession Planning
Best Start & Education Pathways

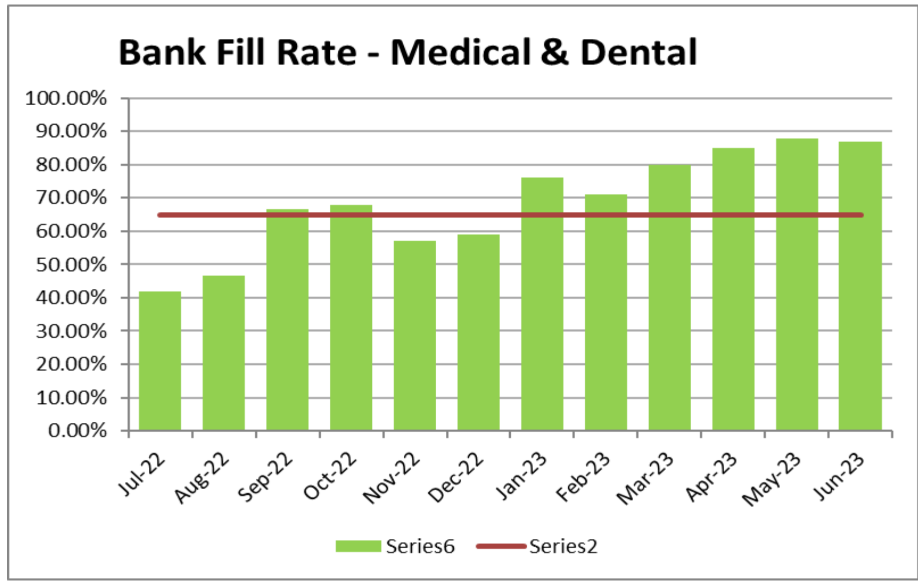












Key Issues & Challenges

- Bank fill rate below target for registered nurses at 68%. This is driven in part by the previously mentioned reduction in the fill rate in ED following the cessation of the enhanced bank rate in that area.
- Clinical system accesses for medical collaborative bank workers is working but could still be improved. Further work to be done, review with IT required to make accessing systems much simpler for collaborative bank workers.

Key Actions & Progress

- Bank demand is lower than the average for all staff groups.
- Medical bank fill rate has sustained its increase from circa 40% to 87%. This improvement is due to medical staff joining the medical locum bank internally and externally and the introduction of the collaborative bank system.
- Collaborative bank shifts continue to be booked at a steady rate throughout a number of the specialties across the Trust; ENT, ED, General Medicine and General Surgery.
- Robot Utilisation – Successful use for ED as large amount of vacant shifts.
- Health Roster Accreditation training has been scheduled for 2 further members of the team. Following training, exam will be taken to be accredited. Other team members will complete this training when further dates are scheduled.

Education / Organisational Development	BCPS	Corporate	Division 1	Division 2	Division 3	Division 4	Estates	Grand Total
Mandatory Training - Statutory Topics	92.00%	95.80%	95.70%	95.30%	96.40%	95.10%	97.40%	95.60%
Mandatory Training - Policy Required	92.30%	95.20%	92.50%	92.00%	95.00%	96.60%	97.60%	93.40%
Appraisal	86.60%	81.70%	82.80%	83.90%	85.80%	84.60%	93.00%	84.80%

Mandatory Training - Statutory Topics	Apr-23	May-23	Jun-23
225 Black Country Pathology Service	90.90%	91.10%	92.00%
225 Corporate Division	96.30%	97.10%	95.80%
225 Division 1	94.90%	93.40%	95.70%
225 Division 2	94.20%	92.90%	95.30%
225 Division 3	96.10%	96.40%	96.40%
225 Division 4	94.20%	97.30%	95.10%
225 Estates & Facilities Division	97.50%	98.40%	97.40%
Grand Total	95.10%	94.50%	95.60%

Mandatory Training - Policy Required	Apr-23	May-23	Jun-23
225 Black Country Pathology Service	95.10%	95.20%	92.30%
225 Corporate Division	97.70%	97.10%	95.20%
225 Division 1	93.10%	93.40%	92.50%
225 Division 2	92.50%	92.90%	92.00%
225 Division 3	96.10%	96.40%	95.00%
225 Division 4	97.00%	97.30%	96.60%
225 Estates & Facilities Division	98.00%	98.40%	97.60%
Grand Total	94.30%	94.50%	93.40%

Appraisals	Apr-23	May-23	Jun-23
225 Black Country Pathology Service	89.20%	88.40%	86.60%
225 Corporate Division	80.80%	79.90%	81.70%
225 Division 1	80.90%	82.00%	82.80%
225 Division 2	81.20%	80.40%	83.90%
225 Division 3	86.00%	85.20%	85.80%
225 Division 4	86.30%	85.90%	84.60%
225 Estates & Facilities Division	90.90%	92.20%	93.00%
Grand Total	83.70%	83.60%	84.80%

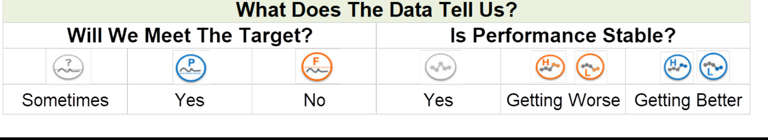
Key Issues & Challenges

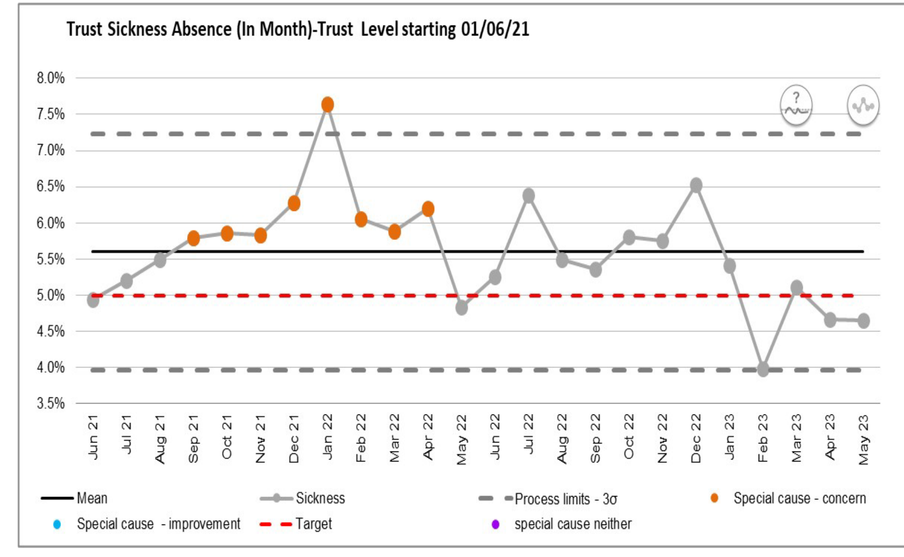
- Appraisal compliance is not meeting the target, other than in estates and facilities, and the last time this target was met was in December 2019.
- Particular focus is needed in corporate and Divisions 1 and 2 where performance is most challenged.
- Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals

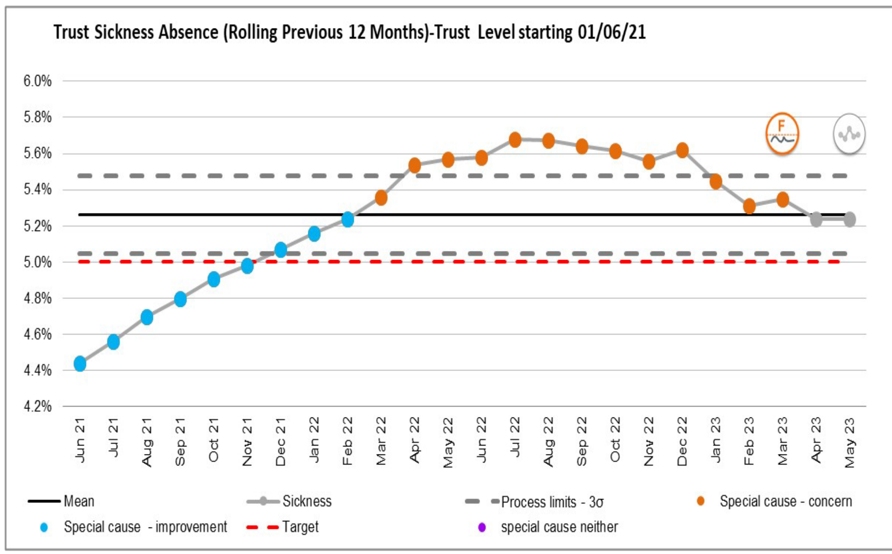
Key Actions & Progress

- 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







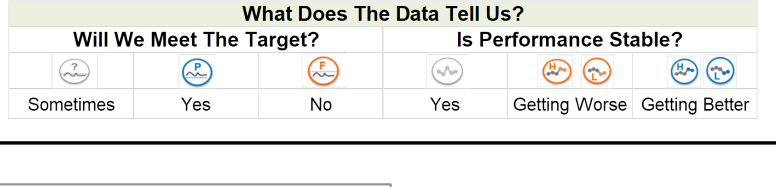
Key Issues & Challenges

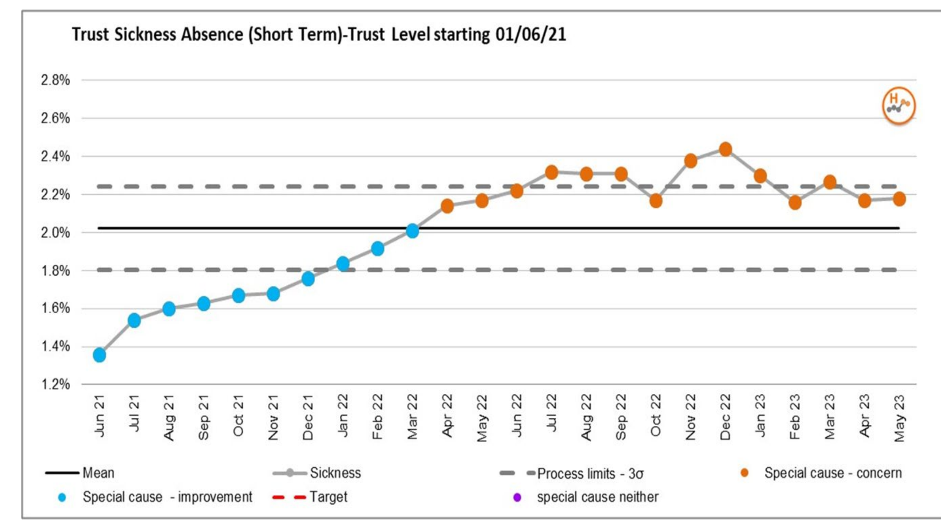
- The rolling 12 month absence rate remains above the Trust target at 5.24% despite an improvement in month.
- Occupational Health referrals at 236 remained elevated in June. The average number of referrals per month for the year to date is 214 referrals per month, which is comparable with the 2022/23 level.

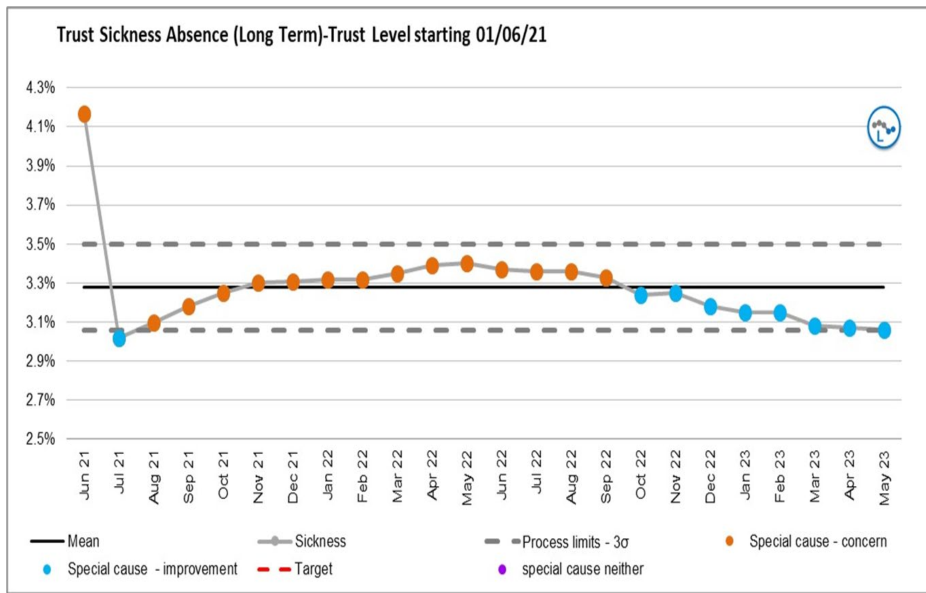
Key Actions & Progress

- In month sickness absence has reduced to 4.65%, meeting the target, in May 2023.
- 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 82% of cases despite the increase in activity as have 88% of referrals requiring a doctor were seen on the required timeline in June.
- A deep dive of sickness absence and summary action plan will be presented to the People and Organisational Development Committee in July 2023.

Health & Wellbeing







Key Issues & Challenges

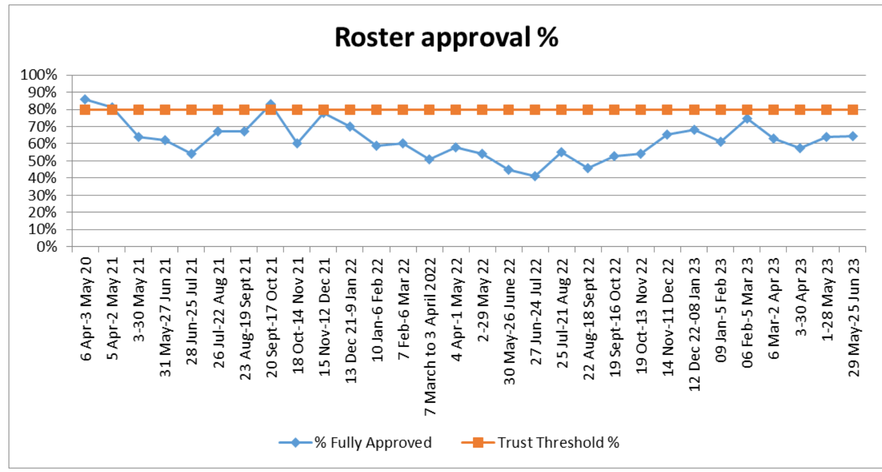
- Of the 5.00% target for sickness absence, it is typical for around 60% of the threshold (3.00%) to be attributable to long-term sickness absence and the remaining 40% (2.00%) to short term absence.
- Both absence types continues to be above this indicative 'targets' in May 2023. A detailed review has been undertaken by the Head of HR Advisory, which found the majority of cases were being appropriately managed in accordance with the policy.

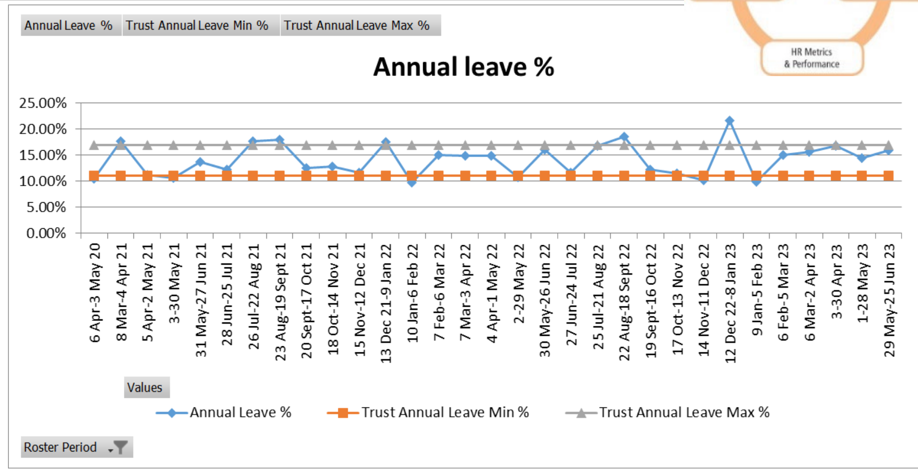
Key Actions & Progress

- 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.

Productivity – e-Rostering Metrics

Workforce Planning & Productivity
Effective use of Technology
Workforce Analytics & Intelligence
HR Metrics & Performance





Definition: Rosters fully approved 6-weeks in advance of roster start date
Trust threshold: 80% of rosters fully approved

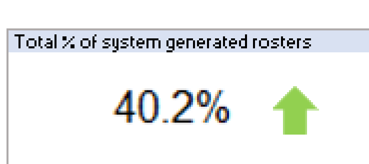
Definition: Absence from core service delivery due to annual leave
Trust threshold: Ideal is 15% but within 11-17%

Key Issues & Challenges

- The number of rosters fully approved six weeks in advance of the roster start date remains below the agreed threshold (80%). This month was again stable at 64%. The team continue to chase and challenge poor adherence to approval.
- Reasons cited for late approval were commonly service and staffing pressures, turnover of staff and lack of cover for managers or approvers.
- Annual leave met thresholds (11-17%) this month at 15.85%. This is higher than last month, but lower than the same time last year. A rise in this metric is anticipated in the coming months due to the approaching summer school holidays.

Key Actions & Progress

- Non-adherence continues to be escalated.
- Ongoing promotion of good rostering practice and training.
- Nursing Workforce continues to address compliance for nursing areas at the confirm, challenge and support meetings.
- Work continues in supporting and making adjustments to annual leave entitlement in collaboration with the ESR team.
- Auto-roster and service plan use continues to be encouraged and implemented on both activity-based rosters and shift-based rosters.
- This month reached a new record high of just over 40% of the rosters using auto-roster. BCPS, Division 3 and corporate maintain consistency within in the 60-80% range. Division 1 and 2 have a low uptake of auto-roster, however the figures are stable with no sign of dropping.



E-Rostering level of attainment	
Nursing & Midwifery	1
Healthcare Scientists	0
Pharmacy	0
Allied Health Professionals	0
Additional Clinical Services	0

Workforce Metrics - Trust Board
M3: Data Effective 30th June 2023
Full Trust

B01	Workforce Profile	31st Mar 2023 Out-turn	Target	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	10043.43	10086.45										87.12	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.2	Substantive Staff WTE (Exc Rotational Doctors)	9682.42		9687.54	9722.82	9768.75										86.33	Inc Permanent, Fixed Term, & Locums; Exc Rotational Drs
B01.3	Substantive Staff Headcount	11,371		11,379	11,428	11478.00										107	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.4	Bank Staff Only Headcount	2,017		1,918	1,881	1883.00										-134	
B01.5	Agency LMS Headcount	156		157	156	156										0	
B01.6	% Staff from a BME background	35.66%		36.41%	37.08%	0.36										0.48%	
B01.7	TUPE In WTE	0.00		0.00	0.00	0.00										0.00	
B01.8	TUPE Out WTE	19.11		10.08	1.00	2.33										13.41	

Data Owner: Workforce Planning & Business Intelligence

B02	Changes to Workforce Profile	31st Mar 2023 Out-turn	Target	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	-6.23	21.65										21.65	Leavers current month target calculated as 1/12th of 10.5% of in-month Staff in Post
B02.2	Starters WTE (Exc Rotational Doctors)			114.67	119.62	75.30										309.59	
B02.3	Leavers WTE (Exc Rotational Doctors)			82.70	72.09	52.93										207.73	

Data Owner: Workforce Planning & Business Intelligence

B03	Workforce Profile by Staff Group	31st Mar 2023 Out-turn	Target	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	279.64	279.36										2.53	
B03.2	Additional Clinical Services WTE	1,907.91		1,895.79	1,910.29	1,906.21										-1.70	
B03.3	*Add Clin Serv: Newly Qualified / Overseas Nurses Awaiting PIN*	114.52		*111.60*	*146.23*	*123.69*										9.17	
B03.4	Administrative and Clerical WTE	2,162.10		2,170.84	2,172.89	2,175.61										13.51	
B03.5	Allied Health Professionals WTE	568.46		566.16	564.26	565.01										-3.45	
B03.6	Estates and Ancillary WTE	596.55		600.58	602.90	610.40										13.85	
B03.7	Healthcare Scientists WTE	499.42		499.13	501.73	504.20										4.78	
B03.8	Medical and Dental WTE (Exc Rotational Doctors)	788.59		794.69	798.53	804.85										16.26	
B03.9	Medical and Dental WTE (Rotational Doctors)	316.91		314.59	320.61	317.70										0.79	
B03.10	Nursing and Midwifery Registered WTE	2,863.55		2,865.87	2,873.58	2,905.12										41.57	
B03.11	Students WTE	19.00		19.00	19.00	18.00										-1.00	

Data Owner: Workforce Planning & Business Intelligence

B04	Vacancy Rate by NHSI Staff Group	31st Mar 2023 Out-turn	Target	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%	2.26%	3.12%										2.92%	Staff in Post WTE vs Budgeted WTE in ESR
B04.2	Allied Health Professionals	4.66%	6.00%	0.93%	-0.20%	7.23%										2.65%	Refined calculation 2019/20: removal of recharges and reserves from
B04.3	Healthcare Scientists	15.00%	6.00%	1.29%	-1.78%	5.57%										1.69%	Budgeted WTE therefore not directly comparable to previous figures
B04.4	Medical & Dental	4.75%	6.00%	7.63%	7.48%	7.08%										7.40%	Staff Group definitions determined by NHS Improvement
B04.5	NHS Infrastructure Support	5.98%	6.00%	3.65%	4.91%	4.57%										4.38%	Staff in Post ajusted for St Helen's employed Rotational Doctors and
B04.6	Other ST&T	-10.47%	6.00%	-0.26%	-1.07%	-2.79%										-1.37%	removal of Chair / NEDs
B04.7	Registered Nursing, Midwifery and Health Visiting Staff	1.96%	6.00%	4.03%	4.80%	2.69%										3.84%	RAG ratings updated effective May 21
B04.8	Support to Clinical Staff	-0.04%	6.00%	2.18%	1.68%	0.71%										1.52%	

Data Owners: Finance & Workforce Planning & Business Intelligence

B05	Vacancies by NHSI Staff Group	31st Mar 2023 Out-turn	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B05.1	Total	296.27		352.02	352.11	325.05										343.06	Staff in Post WTE vs Budgeted WTE in ESR
B05.2	Allied Health Professionals	27.98		5.36	-1.13	44.73										16.32	Refined calculation 2019/20: removal of recharges and reserves from Budgeted WTE
B05.3	Healthcare Scientists	91.08		6.70	-8.86	30.12										9.32	Staff Group definitions determined by NHS Improvement
B05.4	Medical & Dental	56.40		93.90	92.55	87.48										91.31	Staff in Post ajusted for St Helen's employed Rotational Doctors and removal of Chair / NEDs
B05.5	NHS Infrastructure Support	86.86		52.08	68.66	63.98										61.57	
B05.6	Other ST&T	-22.04		-0.60	-2.53	-6.26										-3.13	
B05.7	Registered Nursing, Midwifery and Health Visiting Staff	57.44		120.91	145.65	80.70										115.76	
B05.8	Support to Clinical Staff	-1.45		73.67	57.77	24.30										51.91	

Data Owners: Finance & Workforce Planning & Business Intelligence

B06	Turnover	31st Mar 2023 Out-turn	Target	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%	12.18%	11.83%										12.17%	Exc Rotational Drs (reflects NHS Digital Benchmarked data)
B06.2	% Normalised Workforce Turnover (Rolling previous 12 months)	11.03%	10.00%	10.95%	10.66%	10.34%										10.65%	
B06.3	% Normalised: Additional Professional, Scientific, and Technical	12.36%	10.00%	10.72%	9.61%	9.04%										9.79%	
B06.4	% Normalised: Additional Clinical Services	10.95%	10.00%	10.91%	10.16%	10.17%										10.42%	
B06.5	% Normalised: Administrative and Clerical	10.37%	10.00%	10.55%	10.36%	9.42%										10.11%	Exc Rotational Drs, Students, TUPE Transfers, End of Fixed Term
B06.6	% Normalised: Allied Health Professionals	13.12%	10.00%	13.29%	13.03%	12.38%										12.90%	
B06.7	% Normalised: Estates and Ancillary	11.39%	10.00%	10.88%	10.10%	10.00%										10.33%	RAG ratings updated effective May 21
B06.8	% Normalised: Healthcare Scientists	13.68%	10.00%	13.40%	13.03%	12.61%										13.01%	
B06.9	% Normalised: Medical and Dental (Exc Rotation Drs & Clinical Fellows)	7.75%	10.00%	6.86%	6.61%	6.35%										6.61%	
B06.10	% Normalised: Nursing and Midwifery Registered	11.14%	10.00%	11.21%	11.33%	11.30%										11.28%	

Data Owner: Workforce Planning & Business Intelligence

B07	Retention Rate	31st Mar 2023 Out-turn	Target	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%	89.15%	89.57%										89.18%	No. Employees with 1 or more years service now / No. Employees employed one year ago x 100. Exc Rotational Drs, Students, TUPE Transfers, Clinical Fellows, & Fixed Term
B07.2	Retention Rate (18 months)	84.27%		84.01%	94.04%	84.49%										87.51%	
B07.3	Retention Rate (24 months)	80.41%	0.00%	80.08%	80.05%	80.37%										80.17%	

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)	5.00%	5.00%	4.67%	4.65%	Avail Aug											
B08.2	% Sickness Absence (Rolling previous 12 months)	5.00%	5.00%	5.24%	5.24%	Avail Aug											
B08.3	WTE Days lost to Sickness	11,084.90		13,643.37	14,431.76	Avail Aug											
B08.4	% Short Term Sickness	2.16%		2.17%	2.18%	Avail Aug											
B08.5	% Long Term Sickness	3.15%		3.07%	3.06%	Avail Aug											
B08.6	Estimated Cost of Sickness (£)	£1,091,089		£1,278,411	£1,434,332	Avail Aug											

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	19	17										23	
B10.2	Open Capability Cases	2		2	3	1										2	
B1103	Open Disciplinary Cases	36		36	35	34										35	

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. Discussi
B11.2	Number of Concerns Raised through FTSU Guardian In Month	14		9	15	15										39	

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	2	4										41	
B12.2	Number of Existing Staff Converted to Apprentices in Month	2		5	4											9	

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%	90.10%	90.10%										86.08%	
B13.2	Local Induction	94.30%	0.00%	94.50%	94.90%	95.10%										81.91%	
B13.3	Mandatory Training - Tier 1 - Statutory Topics (Formerly "Generic")	85.00%	85.00%	95.10%	95.40%	95.60%										95.13%	
B13.4	Mandatory Training - Tier 2 - Policy Required (Formerly "Specific")	94.30%	85.00%	94.30%	94.50%	93.40%										92.91%	
B13.5	Appraisal	90.00%	90.00%	83.70%	83.60%	84.80%										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	£716,067	£675,764										£2,113,644	
B14.2	Agency Spend - Nursing & Midwifery	£0														£0	
B14.3	Agency Spend - Medical Staff	£6,298,177		£607,200	£618,914	£494,966										£1,721,080	
B14.4	Agency Spend - Other	£1,296,219		£65,325	£97,153	£180,798										£343,276	

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	£3,766,081	£2,900,147										£10,260,638	
B15.2	Bank Spend - Nursing & Midwifery	£7,607,648		£751,216	£670,679	£526,752										£1,948,646	
B15.3	Bank Spend - Medical Staff	£13,584,214		£1,193,826	£1,672,126	£1,059,523										£3,925,474	
B15.4	Bank Spend - Other	£15,991,923		£1,649,368	£1,423,277	£1,313,873										£4,386,517	

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%	73.00%	68.00%										70.33%	Previously reported as number of shifts, now reporting fill rate
B16.2	Unregistered Nursing Shifts Filled	81.00%	90.00%	84.00%	86.00%	87.00%										85.67%	
B16.3	Medical Staff Shifts Filled	80.00%	60.00%	85.00%	88.00%	87.00%										86.67%	

Data Owner: Resourcing and LMS

B17	e-Rostering	6th Mar 2023 Out-turn	Target	2023-2024 6 Apr 23 - 5 May 23	6 May 23 - 5 Jun 23	6 Jun 23 - 5 Jul 23	6 Jul 23 - 5 Aug 23	27 Jun 2022 - 24 Jul 2022	6 Sep 23 - 5 Oct 23	6 Oct 23 - 5 Nov 23	6 Nov 23 - 5 Dec 23	6 Dec 23 - 5 Jan 24	6 Jan 24 - 5 Feb 24	6 Feb 24 - 5 Mar 24	6 Mar 24 - 5 Apr 24	2023-24 Average	Comments
B17.1	% Rotas Set 6 Weeks in Advance (42 Days)	63.00%	80.00%	57.00%	64.00%	45.00%										33.20%	Reporting periods 4 weeks (28 days)
B17.2	Unused Hours	130152.80	Roster WTE * 6h	143,274	151,847	93,941	0	0	0	0	0	0	0	0	0	77,812	RAG ratings updated effective Jan 21
B17.3	% Staff on Annual Leave	15.60%	14.00%	16.78%	16.78%	16.02%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	9.92%	Jump in Net Hours explained in relevant PPT slide

Data Owner: e-Rostering

New Cross Hospital
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Integrated Quality and Performance Report
June 2023

A Teaching Trust of the University of Birmingham
Safe & Effective | Kind & Caring | Exceeding Expectation

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Key to KPI Variation and Assurance Icons

Variation					Assurance		
H	L	H	L		P	?	F
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: increase in performance seen during June 23. A dashboard, which incorporates and triangulates various patient safety metrics is being developed with a prototype to be ready for the Deteriorating Patient Group in August 2023.
C.diff: 2 cases in month against a target of 4. 14 cases have been reported in Q1 with the new target being 53 cases for 2023/24.
MRSA: no cases during June 23.
CHPPD (total nursing): This remains stable and above target. Establishment reviews have been taking place during June 23.
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: the overall target has seen some slight deterioration in month but in line with the trajectory expected for a continued rise throughout 2023/24 as demand from the pandemic restores. From the beginning of June 23 the overall waiting list number now includes the transfer of the Walsall Urology patients. This has grown the waiting list by 2,684 patients.

RTT 78+ week wait: we saw a month end position of 39. This is a significant improvement from the previous month, however, did not achieve the month end target of zero. We continue to monitor these patients in a twice weekly patient level meeting and are utilising mutual aid where available and appropriate.

Diagnostics: performance has shown some improvement and is continuing to show an overall upward trend. The largest waits continue to be in endoscopy, echocardiography and ultrasound. Remedial action plans are in place with an expectation that performance improves throughout 2023/24.

ED 4 hour: performance dipped slightly in month, however, has remained above the new national standard of 76%. A new performance dashboard has been developed and is to be displayed within the Emergency Department to raise awareness. 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. 2ww waiting times continue to be monitored and discussed across the Black Country Trust's.
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: Referral numbers saw an increase during June 23 bringing them back to average expected numbers.
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: showing overall improving trend, this indicator remains above target.
Turnover (normalised): this target continues to show overall improvement, however, this remains slightly above target.
Retention (12 months): continuing on an upward, this indicator is currently achieving the target.
Appraisals: this is seeing an overall improving trajectory, although 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): static position when compared with the previous month, remains slightly above target. Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

Corporate Scorecard Summary

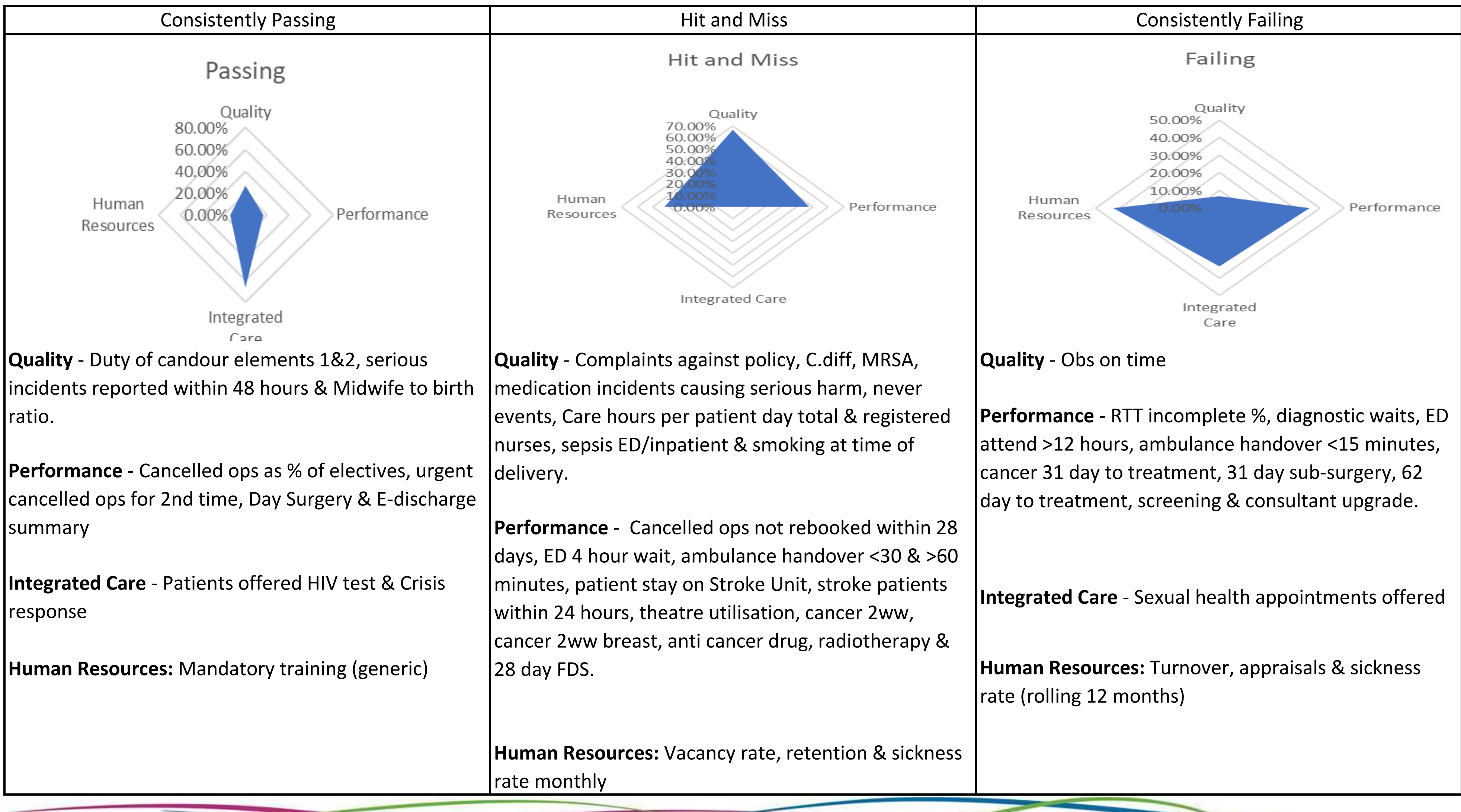
Quality				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Observations on time	>90%	85.75%		
Clostridioides difficile	4	2		
MRSA Bacteraemia	0	0		
CHPPD (total)	>/= 7.6	8.4		
Smoking at delivery	<7%			

Performance				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RTT - Incomplete Pathway	92%	57.16%		
RTT - 78+ Weeks	0	39		
Diagnostic 6 week wait	>99%	56.14%		
ED - 4 hour wait	76%	76.12%		
Cancer 2 week wait	93%	78.93%		
Cancer 62 day traditional	85%	29.85%		

Integrated Care				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RIT referrals received		1,051		
Patients accepted and seen		1,030		
Virtual Ward		143		
Care Coordination referrals accepted		2,368		

Human Resources				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Trust Vacancy Rate	6%	3.12%		
Turnover (normalised)	10%	10.34%		
Retention (12 months)	88%	89.57%		
Appraisals	90%	84.80%		
Sickness (monthly)	5%	4.65%		

Indicator Summary

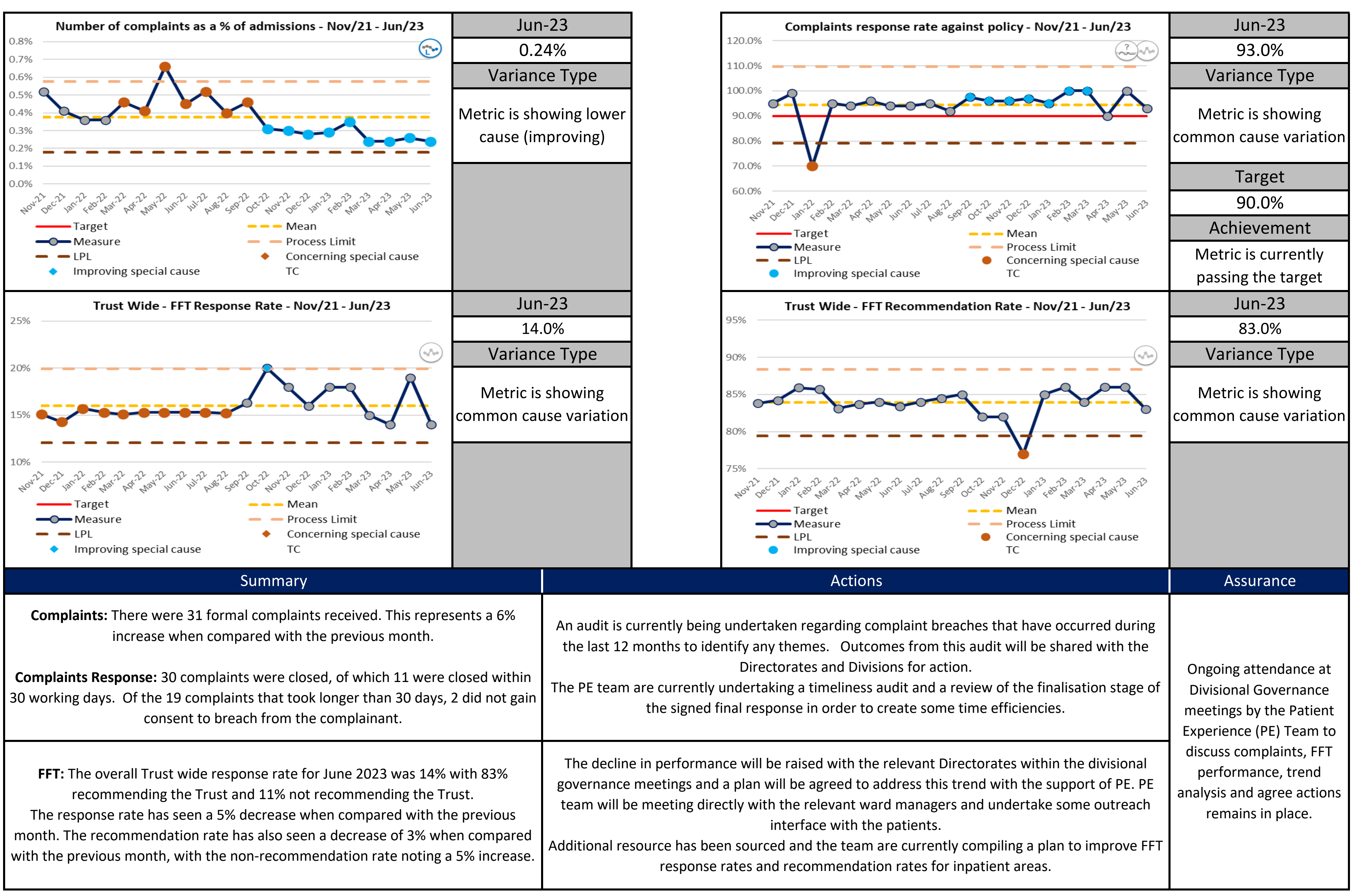


Consistently Passing	Hit and Miss	Consistently Failing
Quality - Duty of candour elements 1&2, serious incidents reported within 48 hours & Midwife to birth ratio. **Performance** - Cancelled ops as % of electives, urgent cancelled ops for 2nd time, Day Surgery & E-discharge summary **Integrated Care** - Patients offered HIV test & Crisis response **Human Resources:** Mandatory training (generic)	**Quality** - Complaints against policy, C.diff, MRSA, medication incidents causing serious 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, ED 4 hour wait, ambulance handover <30 & >60 minutes, patient stay on Stroke Unit, stroke patients within 24 hours, theatre utilisation, cancer 2ww, cancer 2ww breast, anti cancer drug, radiotherapy & 28 day FDS. **Human Resources:** Vacancy rate, retention & sickness rate monthly	**Quality** - Obs on time **Performance** - RTT incomplete %, diagnostic waits, ED attend >12 hours, ambulance handover <15 minutes, cancer 31 day to treatment, 31 day sub-surgery, 62 day to treatment, screening & consultant upgrade. **Integrated Care** - Sexual health appointments offered **Human Resources:** Turnover, appraisals & sickness rate (rolling 12 months)

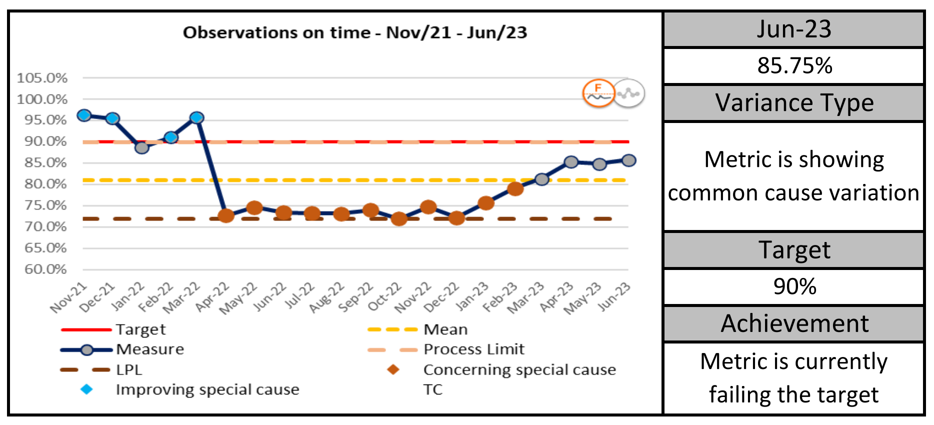
Quality

Metric - Patient Experience	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Number of complaints as a % of admissions	Surveillance			0.29%	0.35%	0.24%	0.24%	0.26%	0.24%
Complaints response rate against policy	90%			95.0%	100.0%	100.0%	90.0%	100.0%	93.0%
FFT response rates - Trust wide	Surveillance			18.0%	18.0%	15.0%	14.0%	19.0%	14.0%
FFT recommendation rates - Trust wide				85.0%	86.0%	84.0%	86.0%	86.0%	83.0%
Observations on time (Trust wide)	>90%			75.60%	79.10%	81.30%	85.30%	84.80%	85.75%
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**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Pressure ulcers - STEIS reportable cases	Surveillance			0	1	0	0	0	0
Pressure ulcers per 1,000 occupied bed days				2.17	1.25	1.41	1.34	0.95	1.14
Falls rate with harm per 1,000 occupied bed days				0.11	0.00	0.04	0.00	0.04	0.04
Patient falls - rate per 1,000 occupied bed days				3.80	3.64	3.69	2.61	2.36	2.80
Crude mortality rate				2.16%	2.07%	1.84%	1.97%	1.29%	1.65%
RWT SHMI				0.9	0.896				

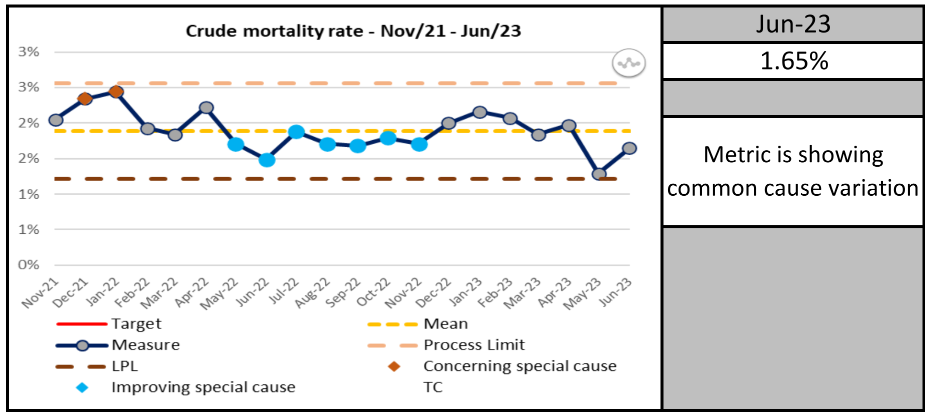
Metric - Patient Safety	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Clostridioides difficile	4			9	5	11	6	6	2
MRSA Bacteraemia	0			0	1	0	0	0	0
E.Coli	Surveillance			19	17	18	14	14	15
Medication error - incidents causing serious harm	0			0	0	0	0	0	0
Serious incident reporting - report incidences within 48 hours	0			0	0	0	0	0	0
Never events	0			0	0	0	0	0	0
Metric - Patient Safety (continued)	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Care hours per patient - total nursing & midwifery staff actual	>/= 7.6			7.9	7.6	8.1	8.6	8.4	8.4
Care hours per patient - registered nursing & midwifery staff actual	>/= 4.5			4.7	4.8	4.8	5.1	5.1	5.2
Midwife to birth ratio	</=30			29.0	29.0	28.0	29.0	29.0	29.0
Sepsis screening - ED	>/= 90%			86.0%	84.0%	88.0%	100.0%	100.0%	N/A
Sepsis screening - Inpatients (reported quarterly)	>/= 90%				93.33%			92.00%	
Thrombus - Hospital acquired (VTE numbers) per 1,000 occupied bed days (reported quarterly 1 month in arrears)	Surveillance				0.64				
Metric - Maternity	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Smoking at delivery	<7%			9.5%	10.8%	11.7%	10.8%	10.3%	10.0%
Babies being cooled (born here)	Surveillance			0	2	1	1	1	0



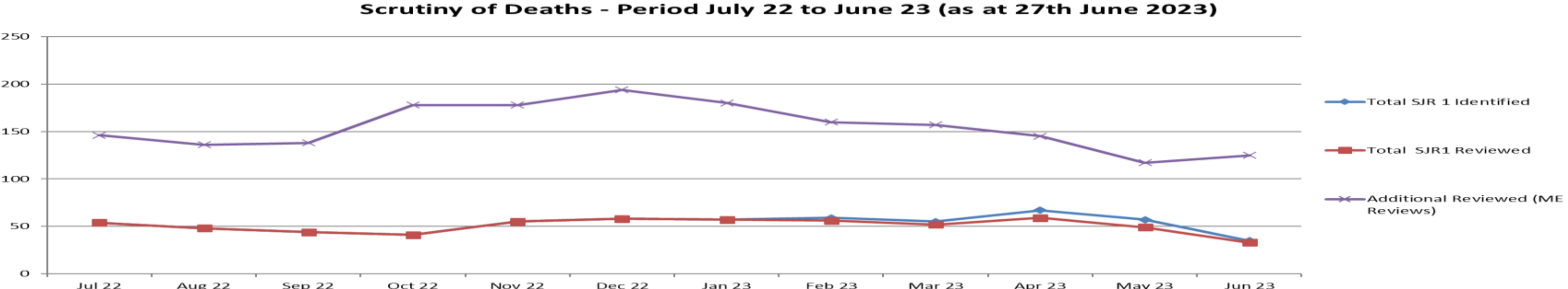
Summary	Actions	Assurance
Complaints: There were 31 formal complaints received. This represents a 6% increase when compared with the previous month. **Complaints Response:** 30 complaints were closed, of which 11 were closed within 30 working days. Of the 19 complaints that took longer than 30 days, 2 did not gain consent to breach from the complainant.	An audit is currently being undertaken regarding complaint breaches that have occurred during the last 12 months to identify any themes. Outcomes from this audit will be shared with the Directorates and Divisions for action. The PE team are currently undertaking a timeliness audit and a review of the finalisation stage of the signed final response in order to create some time efficiencies.	Ongoing attendance at Divisional Governance meetings by the Patient Experience (PE) Team to discuss complaints, FFT performance, trend analysis and agree actions remains in place.
FFT: The overall Trust wide response rate for June 2023 was 14% with 83% recommending the Trust and 11% not recommending the Trust. The response rate has seen a 5% decrease when compared with the previous month. The recommendation rate has also seen a decrease of 3% when compared with the previous month, with the non-recommendation rate noting a 5% increase.	The decline in performance will be raised with the relevant Directorates within the divisional governance meetings and a plan will be agreed to address this trend with the support of PE. PE team will be meeting directly with the relevant ward managers and undertake some outreach interface with the patients. Additional resource has been sourced and the team are currently compiling a plan to improve FFT response rates and recommendation rates for inpatient areas.	



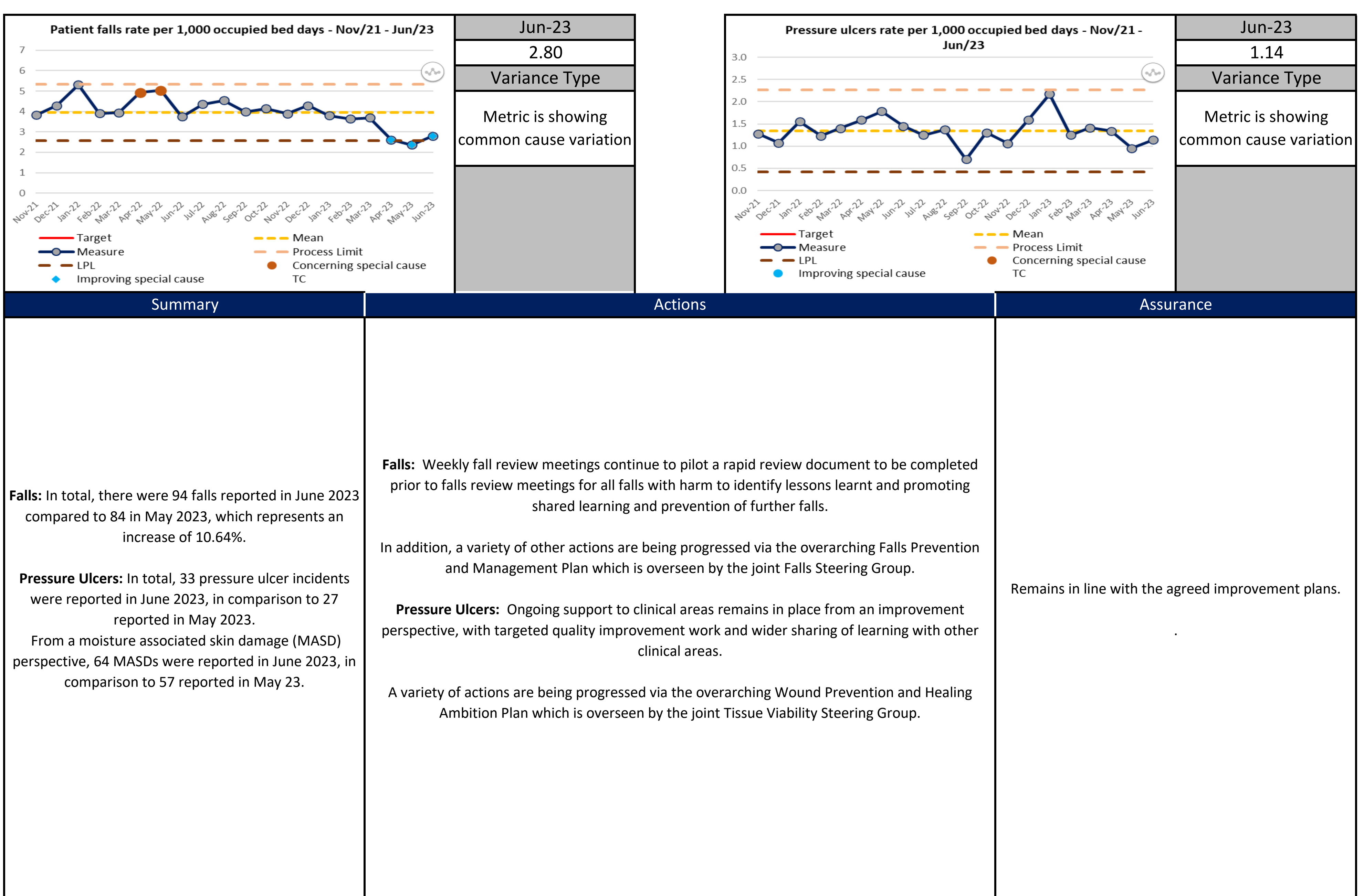
Jun-23
85.75%
Variance Type
Metric is showing common cause variation
Target
90%
Achievement
Metric is currently failing the target



Jun-23
1.65%
Metric is showing common cause variation



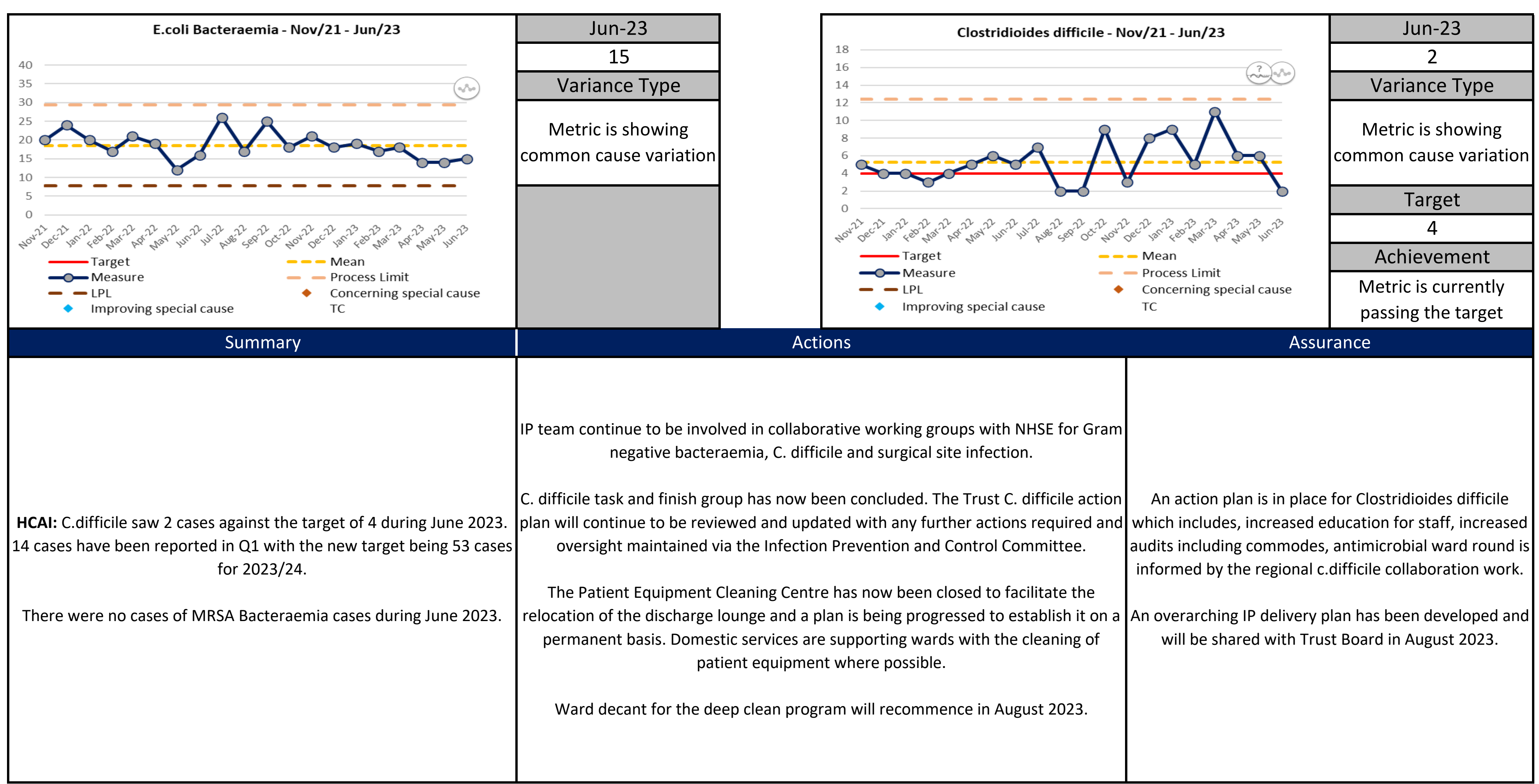
Summary	Actions	Assurance
Observations on time: Performance was 85.75% in June 2023 and this represents an increase of 0.95% when compared with the previous month.	Our quality improvement work continues with wards and this includes focus on the use of NEWS2 Scale 2 and observations being completed timely for patients with a NEWS2 score of 5 an above. A dashboard, which incorporates and triangulates various patient safety metrics is being developed with a prototype to be ready for the Deteriorating Patient Group in August 2023.	Monitoring and progress continue to be discussed at the Deteriorating Patient Group and other relevant forums.
Mortality: The SHMI was 0.896 and remained within the expected range. At last reported position to MRG Chair as at 27th June 23, there were 49 outstanding SJRs awaiting review.	Of the SJRs completed during quarter 1 reported to MRG Chair on 6th July 2023, 5 cases were assessed where an element of poor care has been identified at the overall phase of care.	SHMI remains within the expected range and oversight of the learning from SJRs and the wider mortality agenda continues via the Mortality Review Group.



Jun-23
2.80
Variance Type
Metric is showing common cause variation

Jun-23
1.14
Variance Type
Metric is showing common cause variation

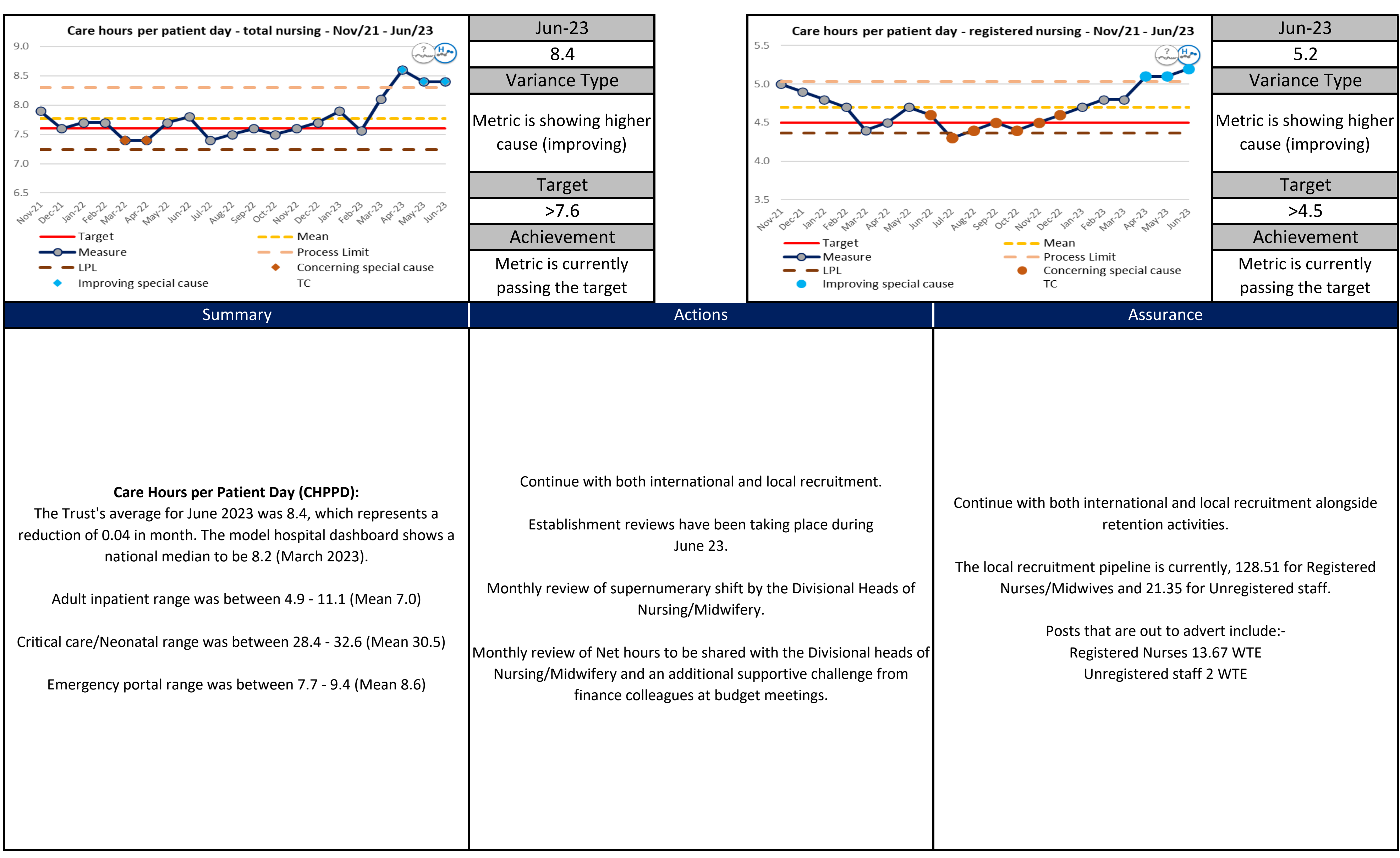
Summary	Actions	Assurance
Falls: In total, there were 94 falls reported in June 2023 compared to 84 in May 2023, which represents an increase of 10.64%. **Pressure Ulcers:** In total, 33 pressure ulcer incidents were reported in June 2023, in comparison to 27 reported in May 2023. From a moisture associated skin damage (MASD) perspective, 64 MASDs were reported in June 2023, in comparison to 57 reported in May 23.	**Falls:** Weekly fall review meetings continue to pilot a rapid review document to be completed prior to falls review meetings for all falls with harm to identify lessons learnt and promoting shared learning and prevention of further falls. In addition, a variety of other actions are being progressed via the overarching Falls Prevention and Management Plan which is overseen by the joint Falls Steering Group. **Pressure Ulcers:** Ongoing support to clinical areas remains in place from an improvement perspective, with targeted quality improvement work and wider sharing of learning with other clinical areas. 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.	Remains in line with the agreed improvement plans. .



Jun-23
15
Variance Type
Metric is showing common cause variation

Jun-23
2
Variance Type
Metric is showing common cause variation
Target
4
Achievement
Metric is currently passing the target

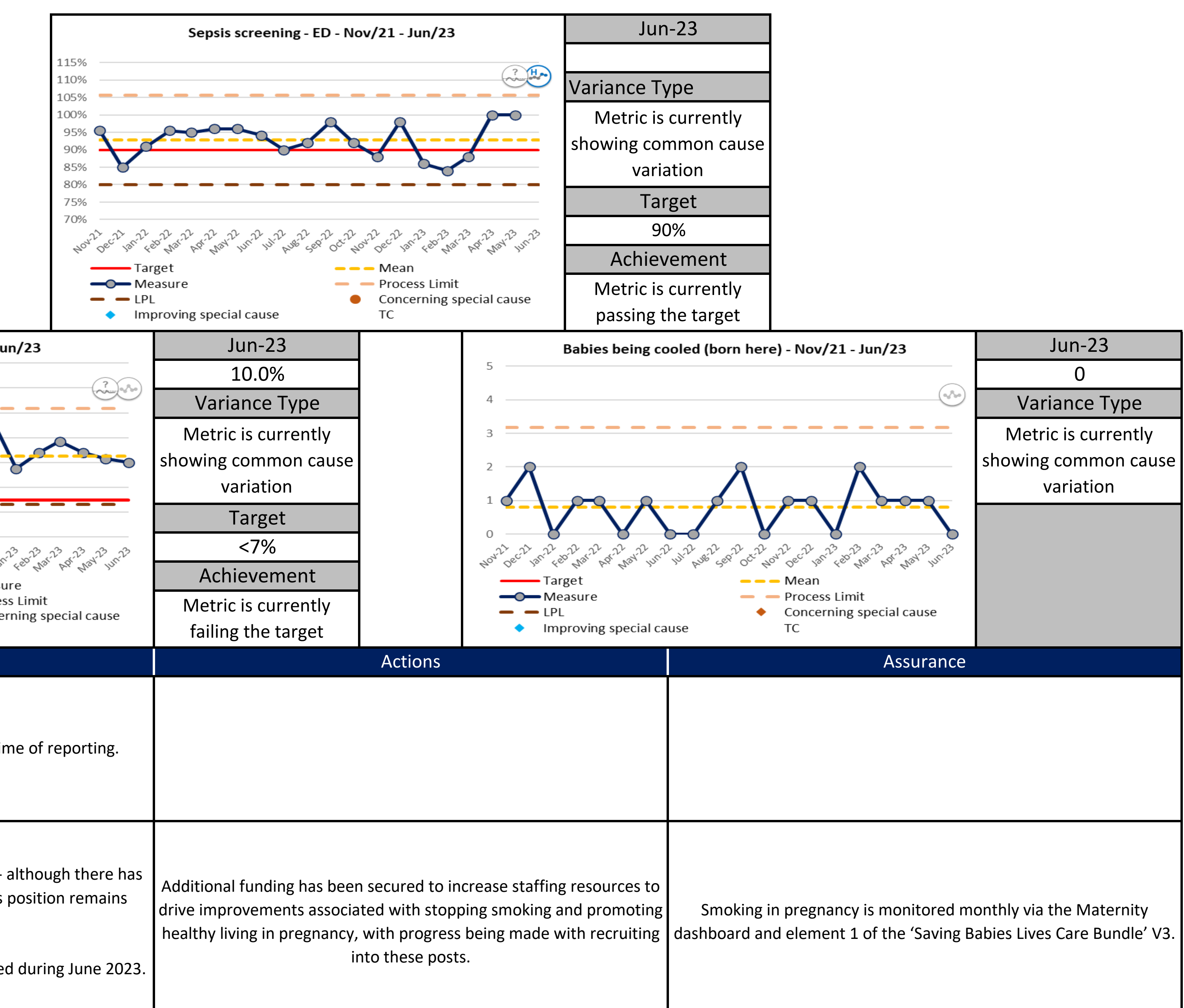
Summary	Actions	Assurance
HCAI: C.difficile saw 2 cases against the target of 4 during June 2023. 14 cases have been reported in Q1 with the new target being 53 cases for 2023/24. There were no cases of MRSA Bacteraemia cases during June 2023.	IP team continue to be involved in collaborative working groups with NHSE for Gram negative bacteraemia, C. difficile and surgical site infection. C. difficile task and finish group has now been concluded. The Trust C. difficile action plan will continue to be reviewed and updated with any further actions required and oversight maintained via the Infection Prevention and Control Committee. The Patient Equipment Cleaning Centre has now been closed to facilitate the relocation of the discharge lounge and a plan is being progressed to establish it on a permanent basis. Domestic services are supporting wards with the cleaning of patient equipment where possible. Ward decant for the deep clean program will recommence in August 2023.	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. An overarching IP delivery plan has been developed and will be shared with Trust Board in August 2023.



Jun-23
8.4
Variance Type
Metric is showing higher cause (improving)
Target
>7.6
Achievement
Metric is currently passing the target

Jun-23
5.2
Variance Type
Metric is showing higher cause (improving)
Target
>4.5
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Care Hours per Patient Day (CHPPD): The Trust's average for June 2023 was 8.4, which represents a reduction of 0.04 in month. The model hospital dashboard shows a national median to be 8.2 (March 2023). Adult inpatient range was between 4.9 - 11.1 (Mean 7.0) Critical care/Neonatal range was between 28.4 - 32.6 (Mean 30.5) Emergency portal range was between 7.7 - 9.4 (Mean 8.6)	Continue with both international and local recruitment. Establishment reviews have been taking place during June 23. Monthly review of supernumerary shift by the Divisional Heads of Nursing/Midwifery. Monthly review of Net hours to be shared with the Divisional heads of Nursing/Midwifery and an additional supportive challenge from finance colleagues at budget meetings.	Continue with both international and local recruitment alongside retention activities. The local recruitment pipeline is currently, 128.51 for Registered Nurses/Midwives and 21.35 for Unregistered staff. Posts that are out to advert include:- Registered Nurses 13.67 WTE Unregistered staff 2 WTE

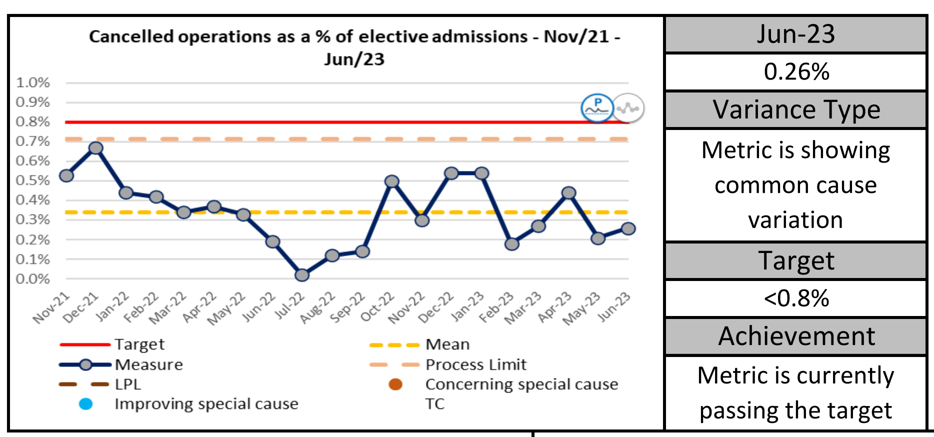


Summary	Actions	Assurance
Sepsis screening in ED: Not available at the time of reporting.		
Maternity: Smoking times at delivery (SATOD) - although there has been some improvement in month, the Trust's position remains above the target. **Babies being cooled** - there were no babies cooled during June 2023.	Additional funding has been secured to increase staffing resources to drive improvements associated with stopping smoking and promoting healthy living in pregnancy, with progress being made with recruiting into these posts.	Smoking in pregnancy is monitored monthly via the Maternity dashboard and element 1 of the 'Saving Babies Lives Care Bundle' V3.

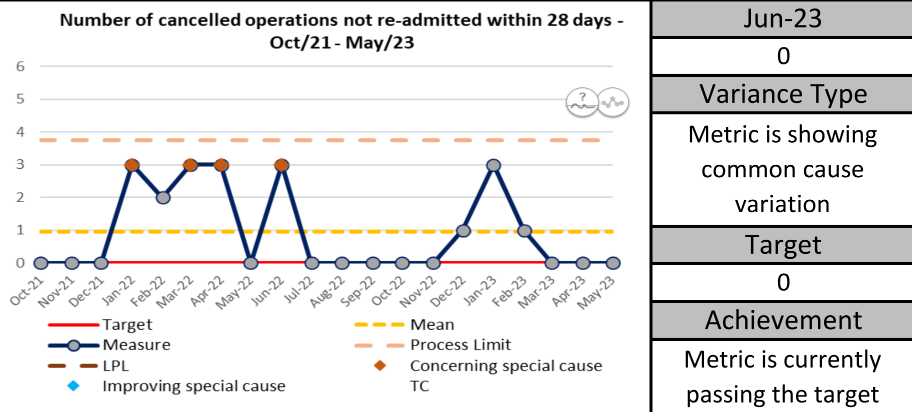
Performance

Metric - Patient Experience	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Number of cancelled operations on the day of surgery for non-medical reasons				28	9	14	19	12	15
Cancelled operations as a % of elective admissions	<0.8%		P	0.54%	0.18%	0.27%	0.44%	0.21%	0.26%
Number of cancelled operations not re-admitted within 28 days	0		?	3	1	0	0	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				61	65	76	54	60	51
Metric - Waiting Times	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
RTT - % of patients on an incomplete pathway	92%	L	F	57.05%	56.65%	56.98%	56.92%	58.43%	57.16%
RTT - number of patients waiting 78+ weeks		L		258	164	85	83	85	39
Total Incomplete Number		H		73,135	73,213	75,958	76,722	77,180	81,398
Diagnostic Test - % of patients waiting 6 weeks or more	>99%	H	F	51.57%	47.12%	47.94%	51.71%	52.73%	56.14%
Metric - Urgent Care	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Total time spent in ED (4 hours) - New Cross Hospital	76% (from Apr 23)		?	66.96%	66.63%	63.68%	69.86%	69.05%	66.89%
Total time spent in ED (4 hours) - Combined				75.79%	75.92%	75.18%	79.23%	79.08%	76.12%
% of ED attendances >12 hours	0		F	7.23%	7.24%	9.83%	4.35%	7.02%	6.20%
Ambulance handover within 15 minutes	65%		F	46.88%	61.25%	49.61%	68.04%	66.37%	57.33%
Ambulance handover within 30 minutes	95%		?	83.39%	91.51%	82.37%	95.72%	95.48%	88.71%
Ambulance handover >60 minutes	0%		?	6.71%	2.07%	4.95%	0.14%	0.89%	3.45%
% of emergency admissions via Emergency Department				42.39%	42.09%	41.11%	42.63%	41.80%	40.46%

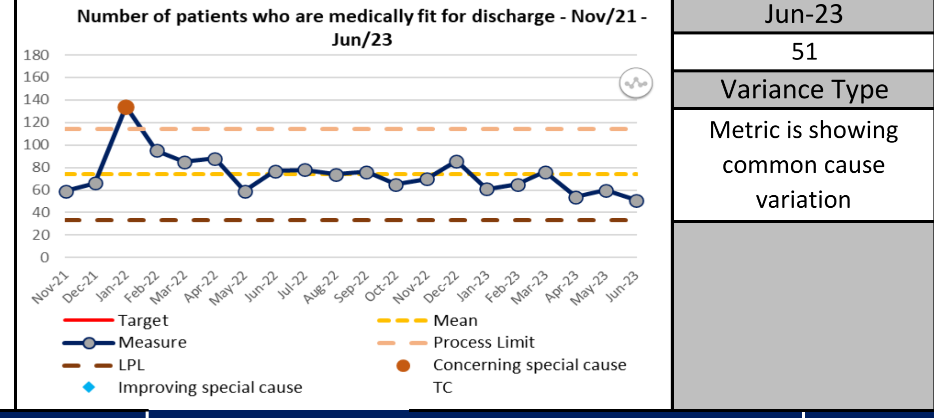
Metric - Stroke	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated stroke unit	80%		?	95.12%	100.00%	100.00%	100.00%	100.00%	100.00%
Stroke patients will be assessed and treated within 24 hours	60%		?	75.74%	74.23%	72.58%	61.73%	83.00%	80.12%
Metric - Organisational Efficiency	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
Theatre Utilisation (Trust Wide)	>/= 90%		?	87.71%	88.14%	90.92%	90.87%	90.45%	90.71%
British Association of Day Surgery	>/= 75%		P	96.26%	95.52%	96.68%	94.70%	95.44%	96.33%
Electronic discharge summary within 24 hours of patient discharge	>/= 90%		P	95.60%	94.29%	94.97%	94.13%	96.01%	95.34%
Metric - Cancer Waiting Times	**Target**	**Variation**	**Assurance**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**	**May-23**	**Jun-23**
2 Week Wait - Cancer Referrals	93%		?	83.87%	86.85%	86.70%	79.33%	87.69%	78.93%
2 Week Wait - Breast Symptomatic Referrals	93%	H	?	96.34%	97.65%	90.16%	98.86%	97.06%	96.19%
31 Day to First Treatment	96%		F	76.37%	80.10%	78.60%	79.11%	72.03%	74.89%
31 Day Sub Treatment - Anti Cancer Drug	98%		?	75.78%	82.29%	88.46%	90.22%	89.53%	90.54%
31 Day Sub Treatment - Surgery	94%		F	47.27%	58.54%	43.90%	48.72%	50.00%	53.49%
31 Day Sub Treatment - Radiotherapy	94%		?	88.89%	87.68%	83.33%	93.28%	88.97%	91.56%
62 Day Wait for First Treatment	85%		F	27.92%	40.23%	39.32%	36.51%	38.10%	29.85%
62 Day Wait - Screening	90%		F	45.16%	37.84%	47.46%	36.84%	30.61%	41.67%
62 Day Wait - Consultant Upgrade (local target)	88%	L	F	50.93%	54.76%	51.80%	36.19%	48.47%	44.70%
28 Day Faster Diagnosis Standard	75%		?	65.92%	72.16%	72.43%	67.26%	68.60%	76.69%



Jun-23
0.26%
Variance Type
Metric is showing common cause variation
Target
<0.8%
Achievement
Metric is currently passing the target

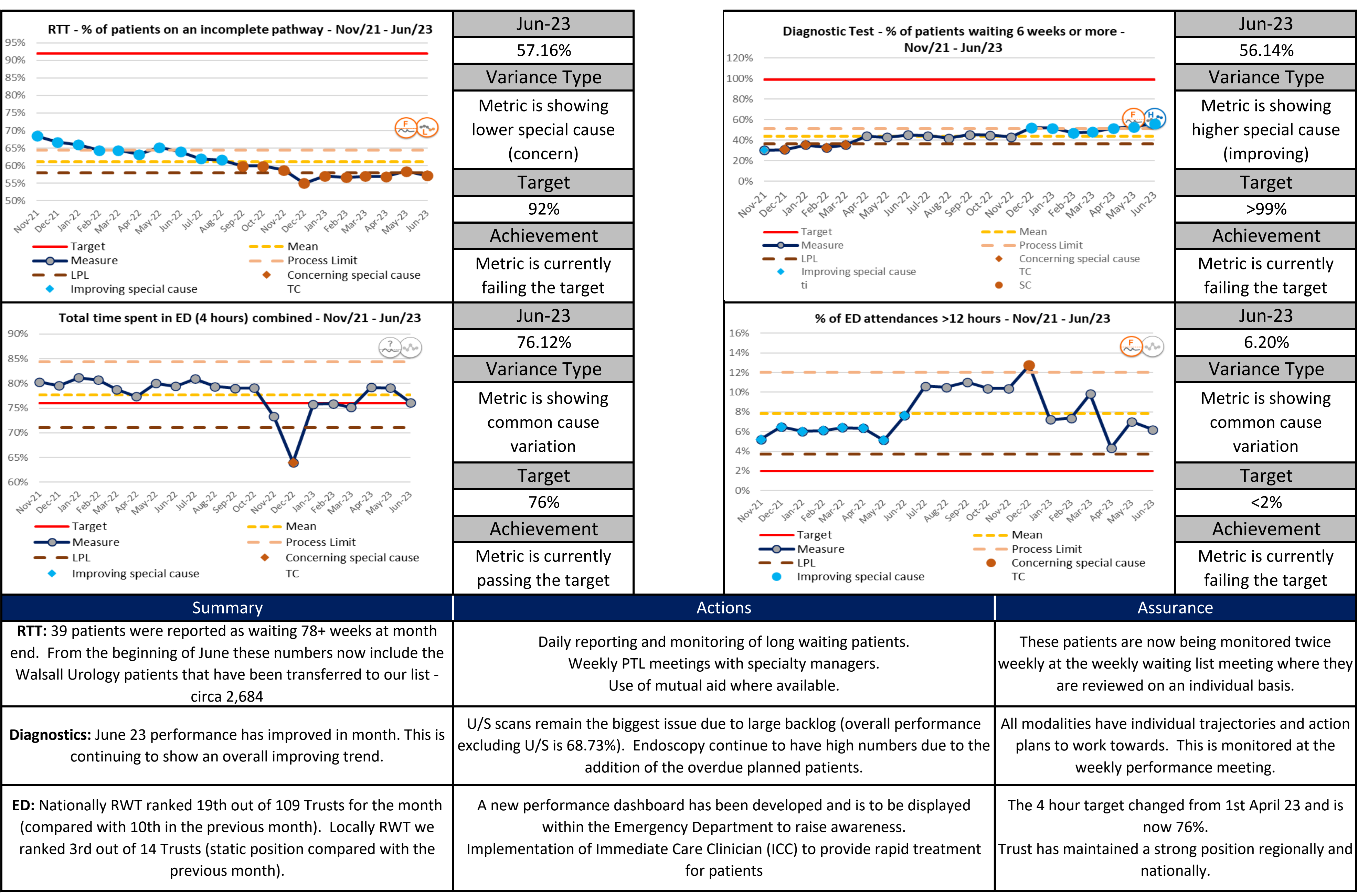


Jun-23
0
Variance Type
Metric is showing common cause variation
Target
0
Achievement
Metric is currently passing the target

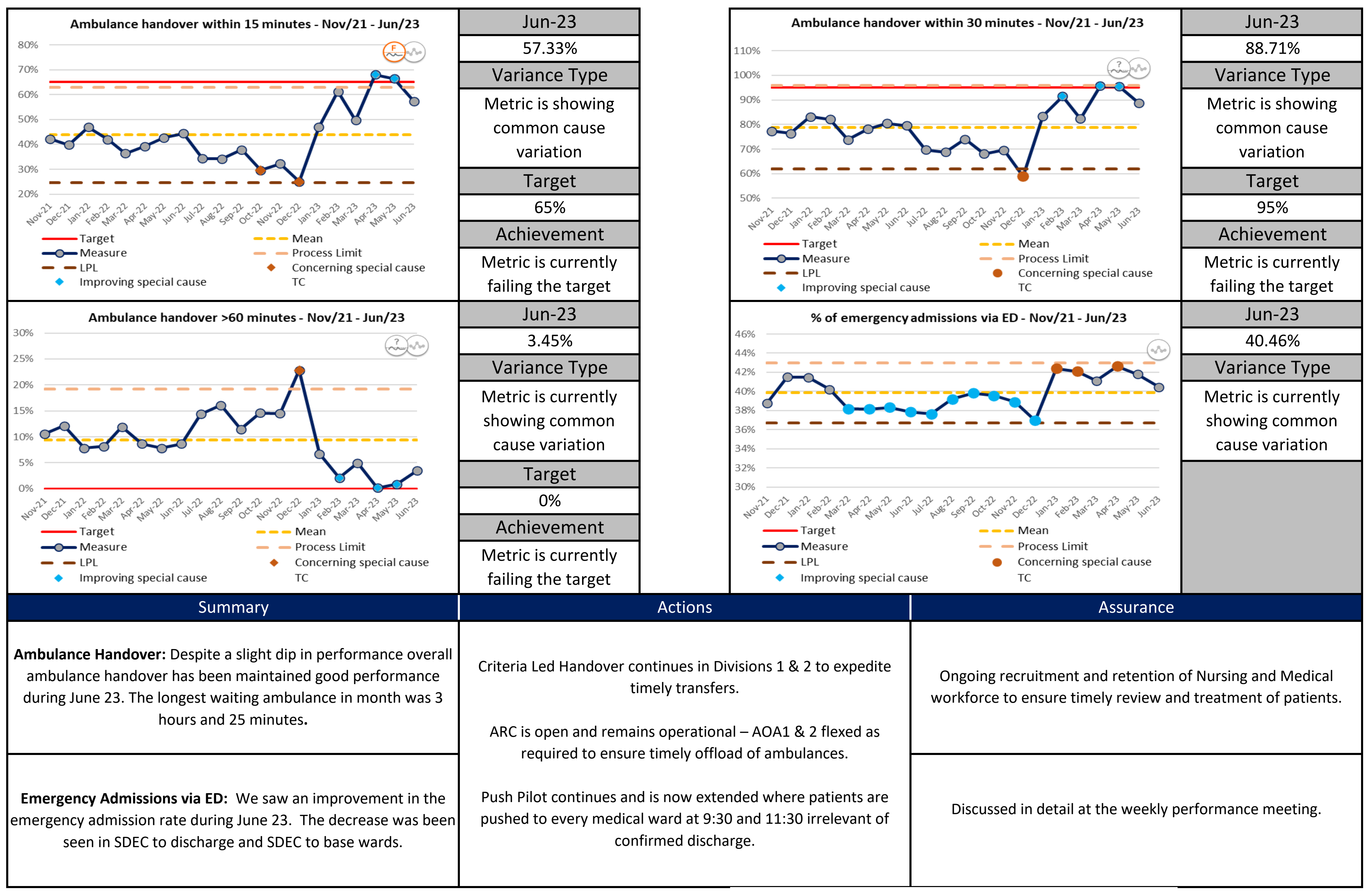


Jun-23
51
Variance Type
Metric is showing common cause variation

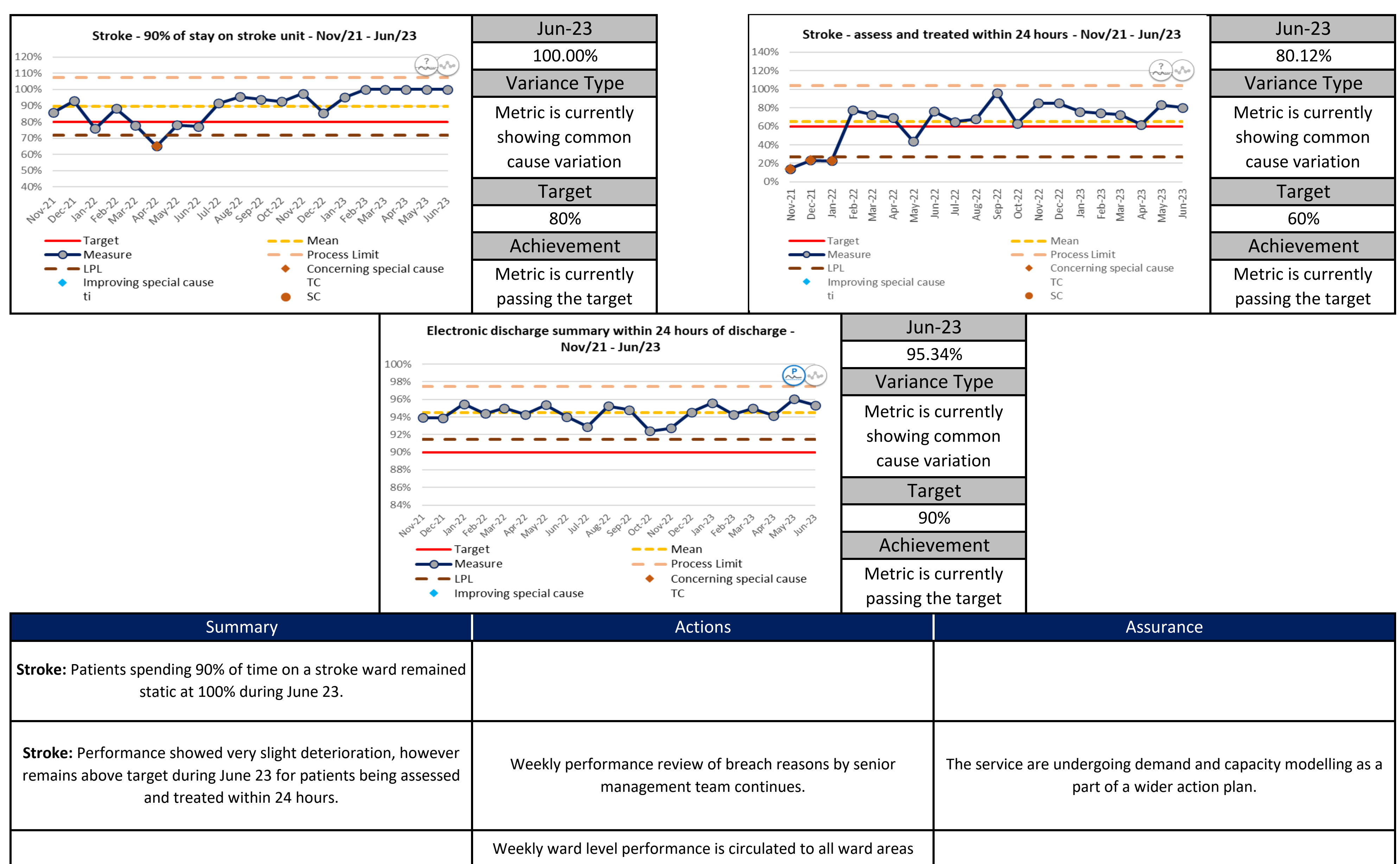
Summary	Actions	Assurance
Cancelled Operations: We remain below target. There were no patients who had been cancelled on the day that were not rebooked within 28 days.	All cancelled operations on the day of surgery are reported daily and root cause analysis (RCA) is completed	RCA's are circulated to 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 June 23 we had 51 patients in a hospital bed that were medically fit for discharge, this is an improvement when compared with the previous month and continues to show an overall improving trend.	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.



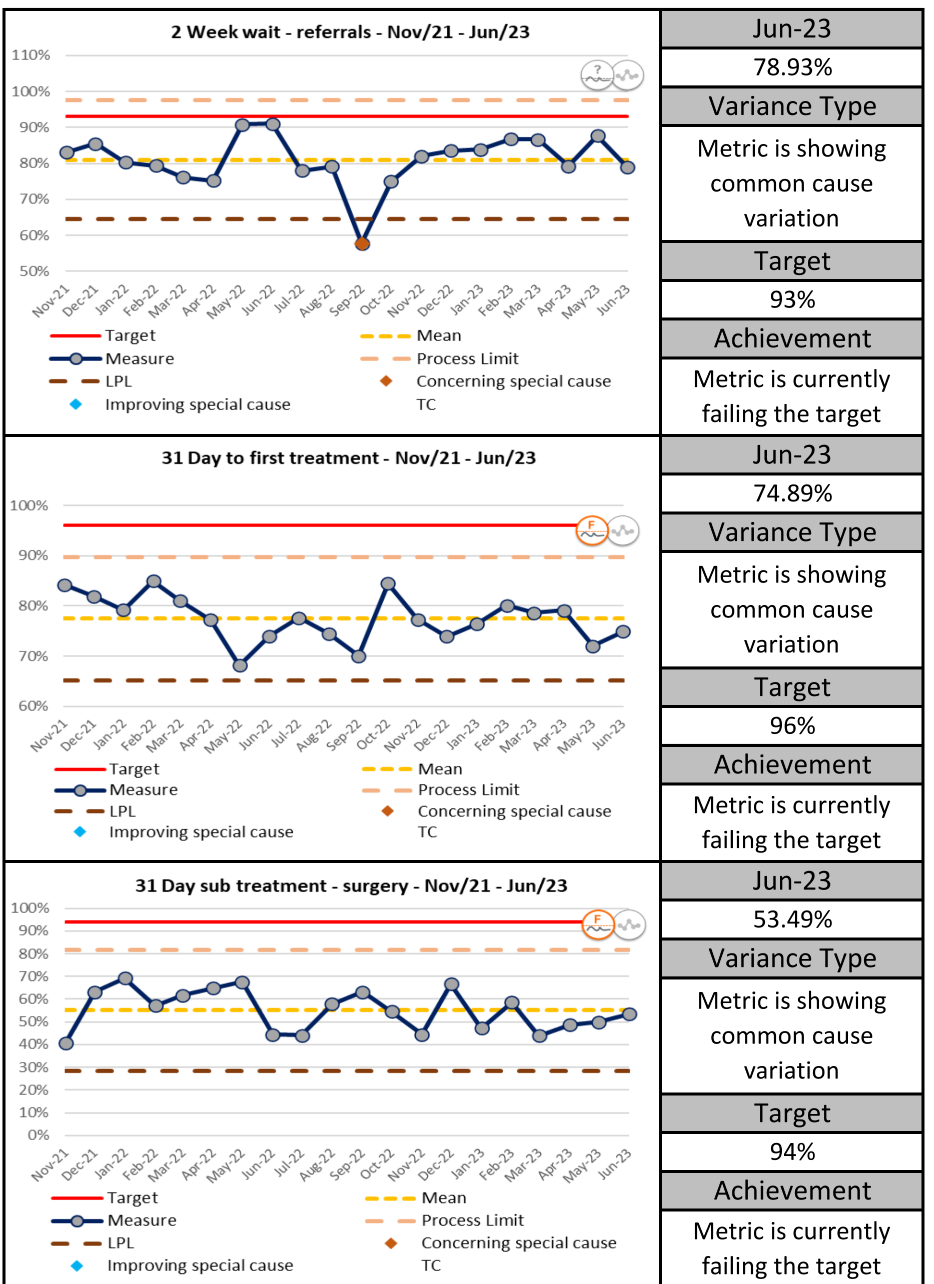
Summary	Actions	Assurance
RTT: 39 patients were reported as waiting 78+ weeks at month end. From the beginning of June these numbers now include the Walsall Urology patients that have been transferred to our list - circa 2,684	Daily reporting and monitoring of long waiting patients. Weekly PTL meetings with specialty managers. Use of mutual aid where available.	These patients are now being monitored twice weekly at the weekly waiting list meeting where they are reviewed on an individual basis.
Diagnostics: June 23 performance has improved in month. This is continuing to show an overall improving trend.	U/S scans remain the biggest issue due to large backlog (overall performance excluding U/S is 68.73%). 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 19th out of 109 Trusts for the month (compared with 10th in the previous month). Locally RWT we ranked 3rd out of 14 Trusts (static position compared with the previous month).	A new performance dashboard has been developed and is to be displayed within the Emergency Department to raise awareness. Implementation of Immediate Care Clinician (ICC) to provide rapid treatment for patients	The 4 hour target changed from 1st April 23 and is now 76%. Trust has maintained a strong position regionally and nationally.



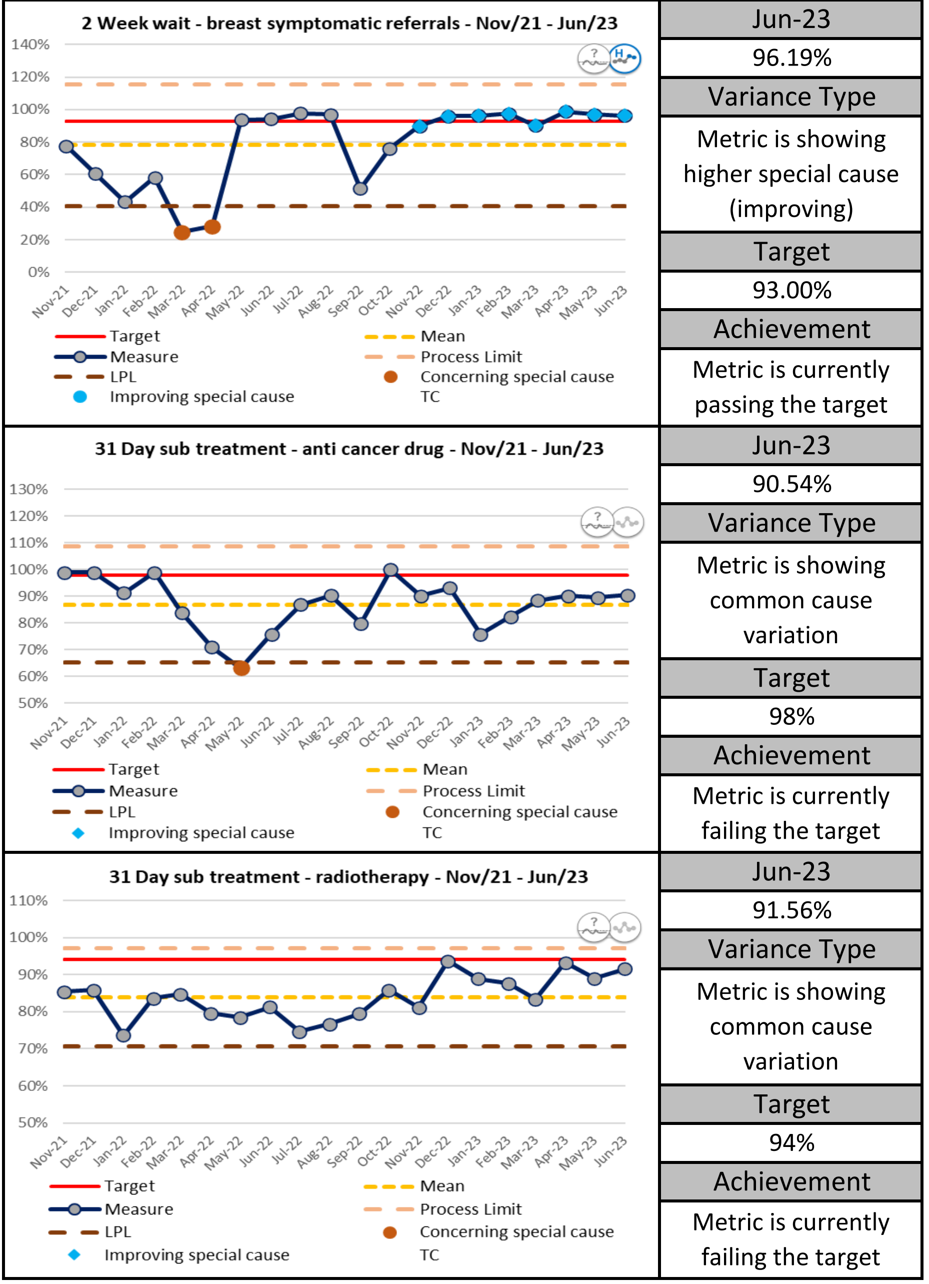
Summary	Actions	Assurance
Ambulance Handover: Despite a slight dip in performance overall ambulance handover has been maintained good performance during June 23. The longest waiting ambulance in month was 3 hours and 25 minutes.	Criteria Led Handover continues in Divisions 1 & 2 to expedite timely transfers. ARC is open and remains operational – AOA1 & 2 flexed as required to ensure timely offload of ambulances. Push Pilot continues and is now extended where patients are pushed to every medical ward at 9:30 and 11:30 irrelevant of confirmed discharge.	Ongoing recruitment and retention of Nursing and Medical workforce to ensure timely review and treatment of patients.
Emergency Admissions via ED: We saw an improvement in the emergency admission rate during June 23. The decrease was been seen in SDEC to discharge and SDEC to base wards.		Discussed in detail at the weekly performance meeting.



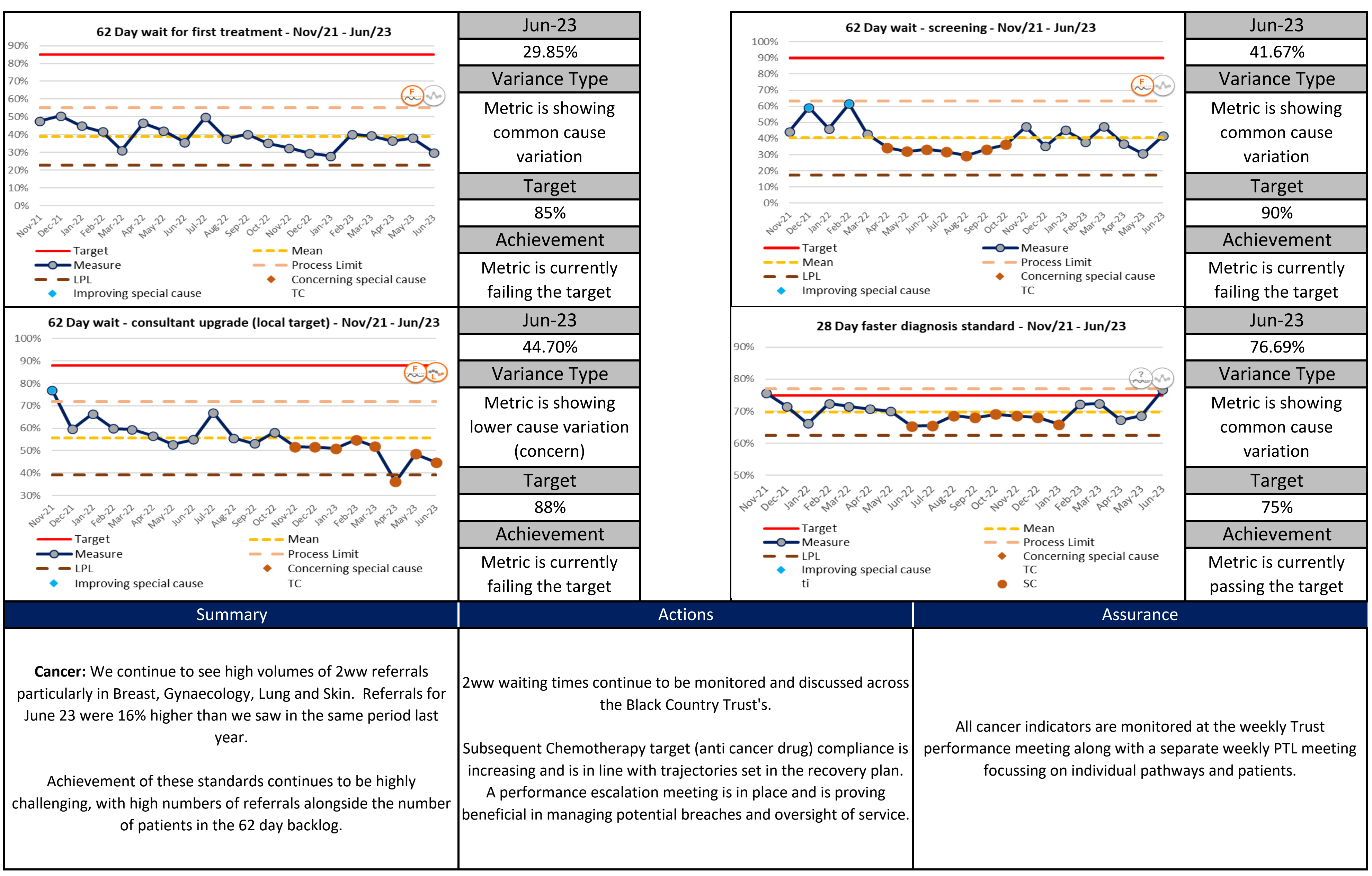
Summary	Actions	Assurance
Stroke: Patients spending 90% of time on a stroke ward remained static at 100% during June 23.		
Stroke: Performance showed very slight deterioration, however remains above target during June 23 for patients being assessed and treated within 24 hours.	Weekly performance review 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.



2 Week wait - referrals - Nov/21 - Jun/23
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC
Jun-23
78.93%
Variance Type
Metric is showing common cause variation
Target
93%
Achievement
Metric is currently failing the target
31 Day to first treatment - Nov/21 - Jun/23
Jun-23
74.89%
Variance Type
Metric is showing common cause variation
Target
96%
Achievement
Metric is currently failing the target
31 Day sub treatment - surgery - Nov/21 - Jun/23
Jun-23
53.49%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target



2 Week wait - breast symptomatic referrals - Nov/21 - Jun/23
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC
Jun-23
96.19%
Variance Type
Metric is showing higher special cause (improving)
Target
93.00%
Achievement
Metric is currently passing the target
31 Day sub treatment - anti cancer drug - Nov/21 - Jun/23
Jun-23
90.54%
Variance Type
Metric is showing common cause variation
Target
98%
Achievement
Metric is currently failing the target
31 Day sub treatment - radiotherapy - Nov/21 - Jun/23
Jun-23
91.56%
Variance Type
Metric is showing common cause variation
Target
94%
Achievement
Metric is currently failing the target


62 Day wait for first treatment - Nov/21 - Jun/23
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC
Jun-23
29.85%
Variance Type
Metric is showing common cause variation
Target
85%
Achievement
Metric is currently failing the target
62 Day wait - screening - Nov/21 - Jun/23
Jun-23
41.67%
Variance Type
Metric is showing common cause variation
Target
90%
Achievement
Metric is currently failing the target
62 Day wait - consultant upgrade (local target) - Nov/21 - Jun/23
Jun-23
44.70%
Variance Type
Metric is showing lower cause variation (concern)
Target
88%
Achievement
Metric is currently failing the target
28 Day faster diagnosis standard - Nov/21 - Jun/23
ti
SC
Jun-23
76.69%
Variance Type
Metric is showing common cause variation
Target
75%
Achievement
Metric is currently passing the target
Summary
Actions
Assurance
Cancer: We continue to see high volumes of 2ww referrals particularly in Breast, Gynaecology, Lung and Skin. Referrals for June 23 were 16% higher than 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.
Subsequent Chemotherapy target (anti cancer drug) compliance is increasing and is in line with trajectories set in the recovery plan. A performance escalation meeting is in place and is proving beneficial in managing potential breaches and oversight of service.
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

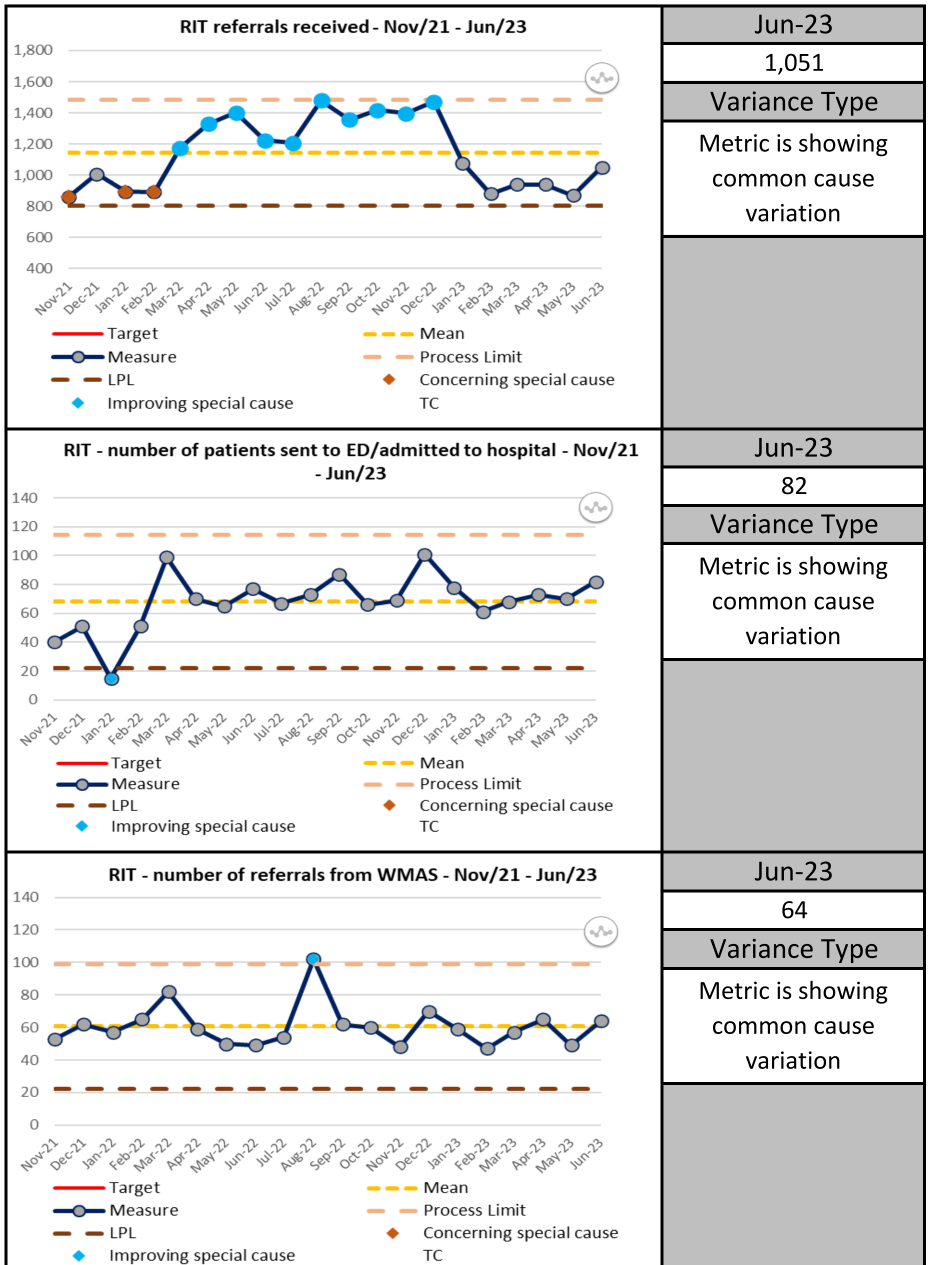
Metric - Sexual Health (a month in arrears)	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total number of appointments against block contract	>/=4,500	H	F	3,455					
% appropriate patients offered HIV test	>/=95%	H	P	99.1%					

Metric - Community Nursing (Rapid Intervention Team)	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Referrals received				1,079	882	941	941	871	1,051
Patients accepted and seen (actuals)				1,057	864	932	932	858	1,030
Number of patients sent to ED/admitted to hospital by RIT's				78	61	68	73	70	82
% of referred patients who are sent to ED/admitted		H		7.37%	7.06%	7.29%	7.83%	8.15%	7.96%
Number of referrals from West Midlands Ambulance Service				59	47	57	65	49	64
Night visiting service (initial)				236	217	201	206	229	245
Rapid response (initial)				854	703	768	748	741	886
Crisis response (within 2 hours)	>/=35%	H	P	75.6%	79.2%	79.7%	80.6%	76.5%	79.4%

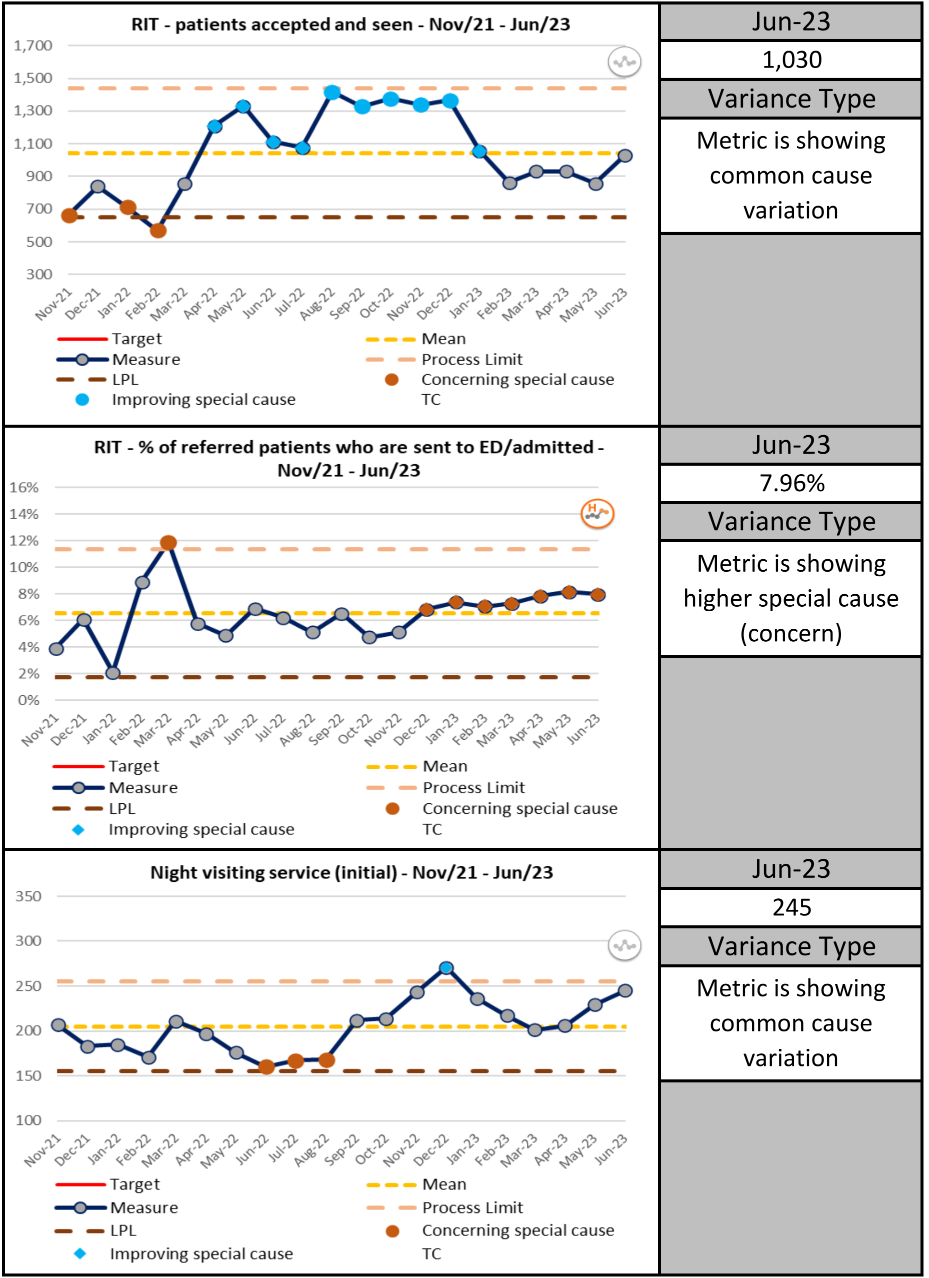
Metric - Virtual Ward	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Virtual ward (initial)				119	94	120	119	118	143

Metric - Rapid Access Care	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Rapid access social care (initial)		H		49	43	54	55	63	76

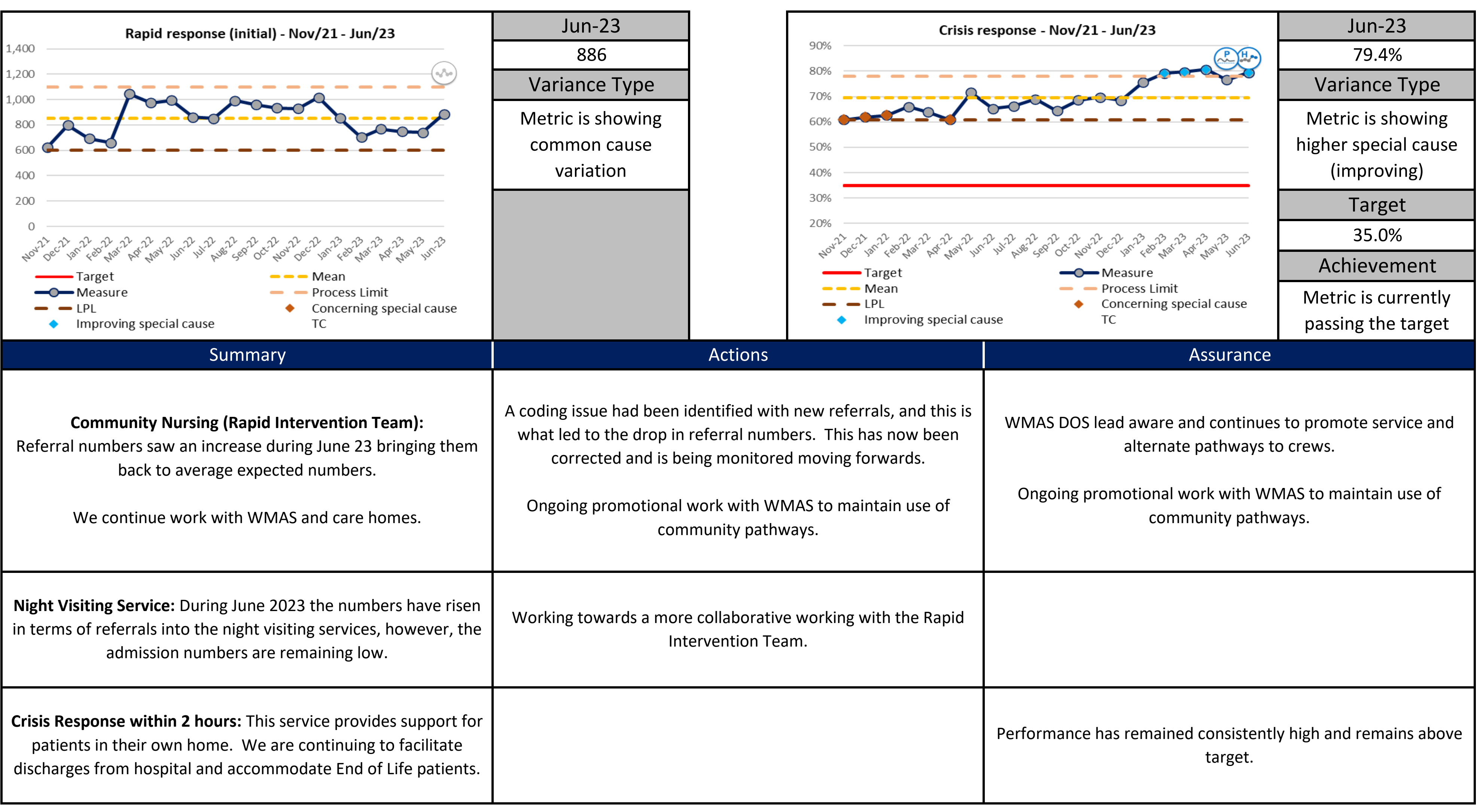
Metric - Care Co-ordination	Target	Variation	Assurance	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total number of referrals accepted		H		3,088	2,531	2,690	2,547	2,786	2,368
Number of referrals closed		L		724	668	564	867	892	955
Number signposted to ED				86	72	88	49	53	43
Number referred onto SDEC				84	58	64	47	38	21
Number referred on to community		H		2,171	1,728	1,952	1,557	1,788	1,336
Number of referrals sustained (admission avoidance)				15	3	11	13	12	4
Number of referrals admitted to hospital				8	2	11	14	3	9



RIT referrals received - Nov/21 - Jun/23
Jun-23
1,051
Variance Type
Metric is showing common cause variation
RIT - number of patients sent to ED/admitted to hospital - Nov/21 - Jun/23
Jun-23
82
Variance Type
Metric is showing common cause variation
RIT - number of referrals from WMAS - Nov/21 - Jun/23
Jun-23
64
Variance Type
Metric is showing common cause variation
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC



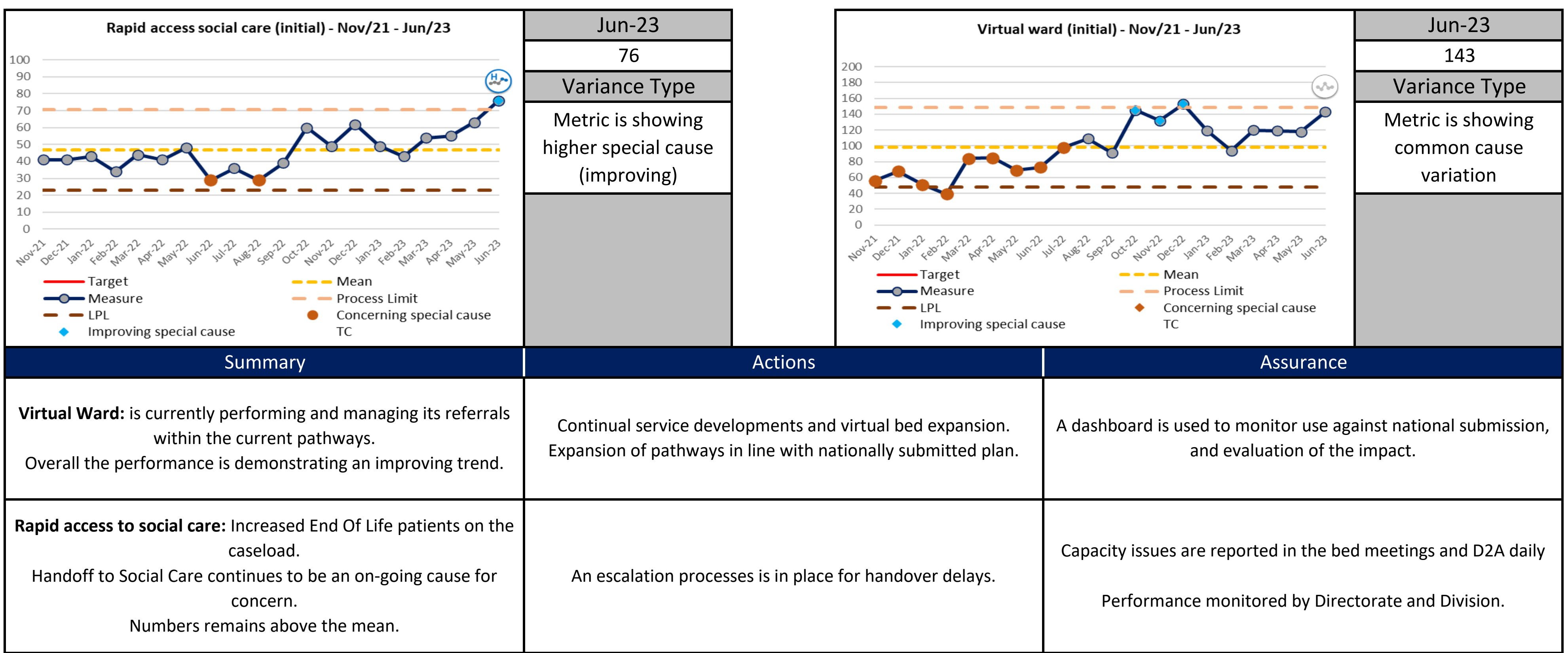
RIT - patients accepted and seen - Nov/21 - Jun/23
Jun-23
1,030
Variance Type
Metric is showing common cause variation
RIT - % of referred patients who are sent to ED/admitted - Nov/21 - Jun/23
Jun-23
7.96%
Variance Type
Metric is showing higher special cause (concern)
Night visiting service (initial) - Nov/21 - Jun/23
Jun-23
245
Variance Type
Metric is showing common cause variation
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC



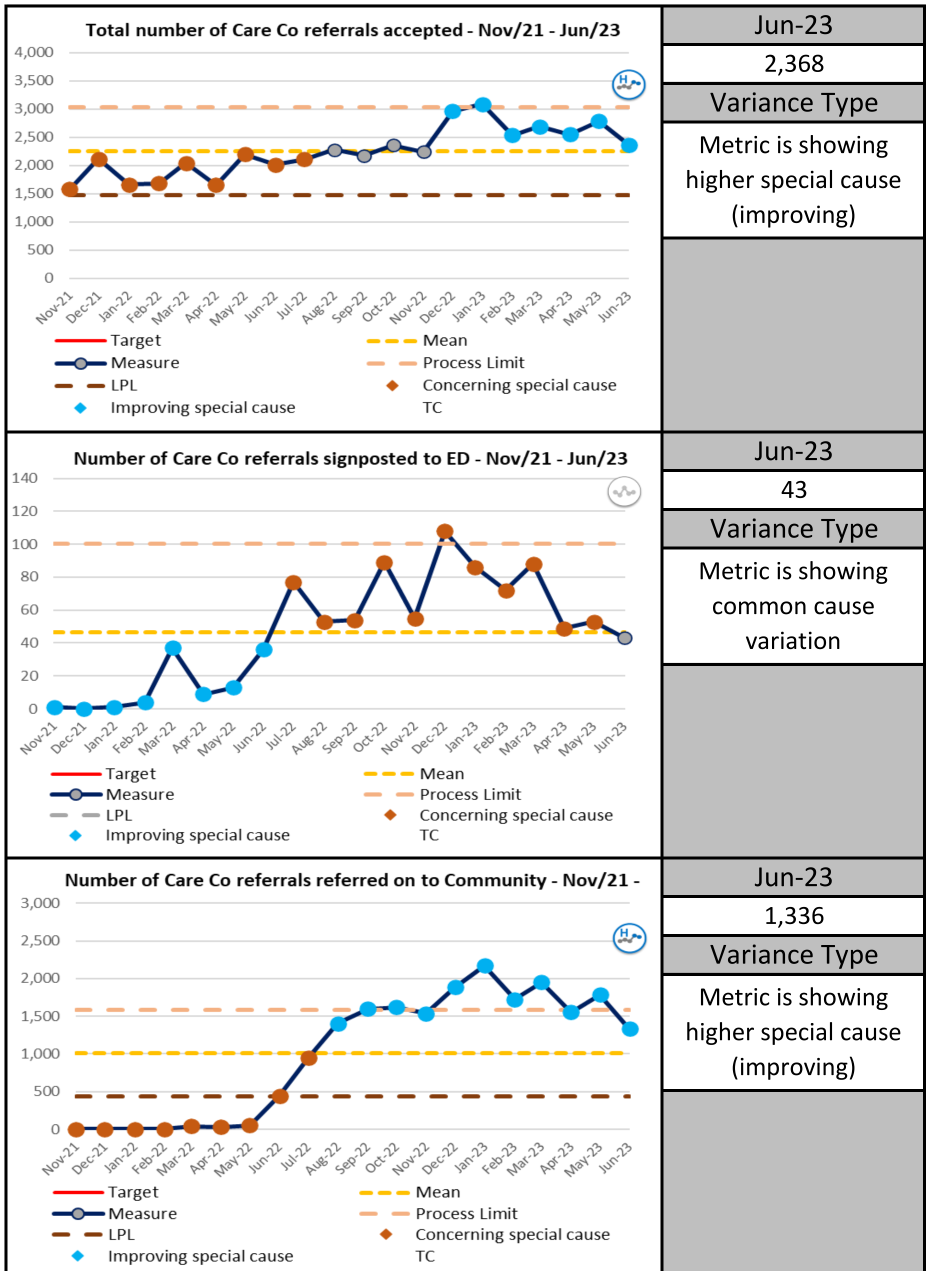
Jun-23
886
Variance Type
Metric is showing common cause variation

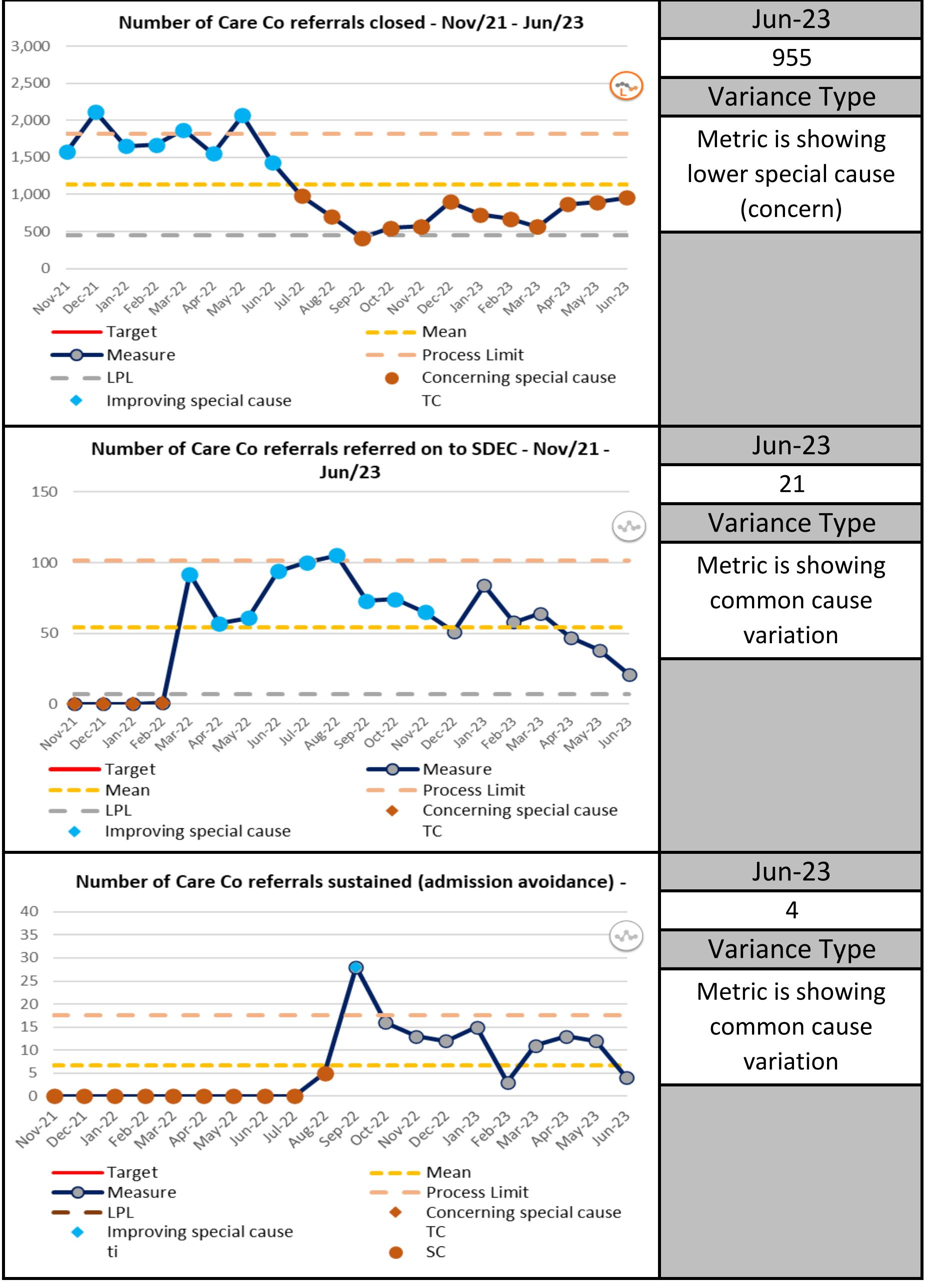
Jun-23
79.4%
Variance Type
Metric is showing higher special cause (improving)
Target
35.0%
Achievement
Metric is currently passing the target

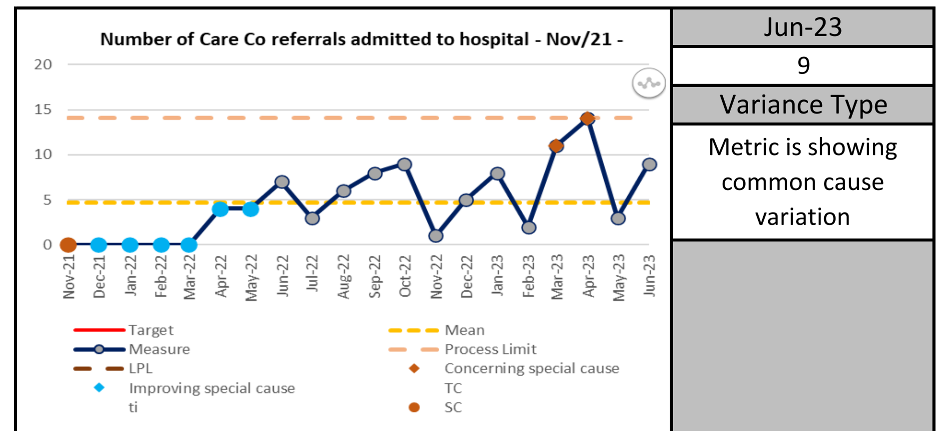
Summary	Actions	Assurance
Community Nursing (Rapid Intervention Team): Referral numbers saw an increase during June 23 bringing them back to average expected numbers. We continue work with WMAS and care homes.	A coding issue had been identified with new referrals, and this is what led to the drop in referral numbers. This has now been corrected and is being monitored moving forwards. Ongoing promotional work with WMAS to maintain use of community pathways.	WMAS DOS lead aware and continues to promote service and alternate pathways to crews. Ongoing promotional work with WMAS to maintain use of community pathways.
Night Visiting Service: During June 2023 the numbers have risen 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.



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.


Total number of Care Co referrals accepted - Nov/21 - Jun/23
Jun-23
2,368
Variance Type
Metric is showing higher special cause (improving)
Number of Care Co referrals signposted to ED - Nov/21 - Jun/23
Jun-23
43
Variance Type
Metric is showing common cause variation
Number of Care Co referrals referred on to Community - Nov/21 -
Jun-23
1,336
Variance Type
Metric is showing higher special cause (improving)
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC

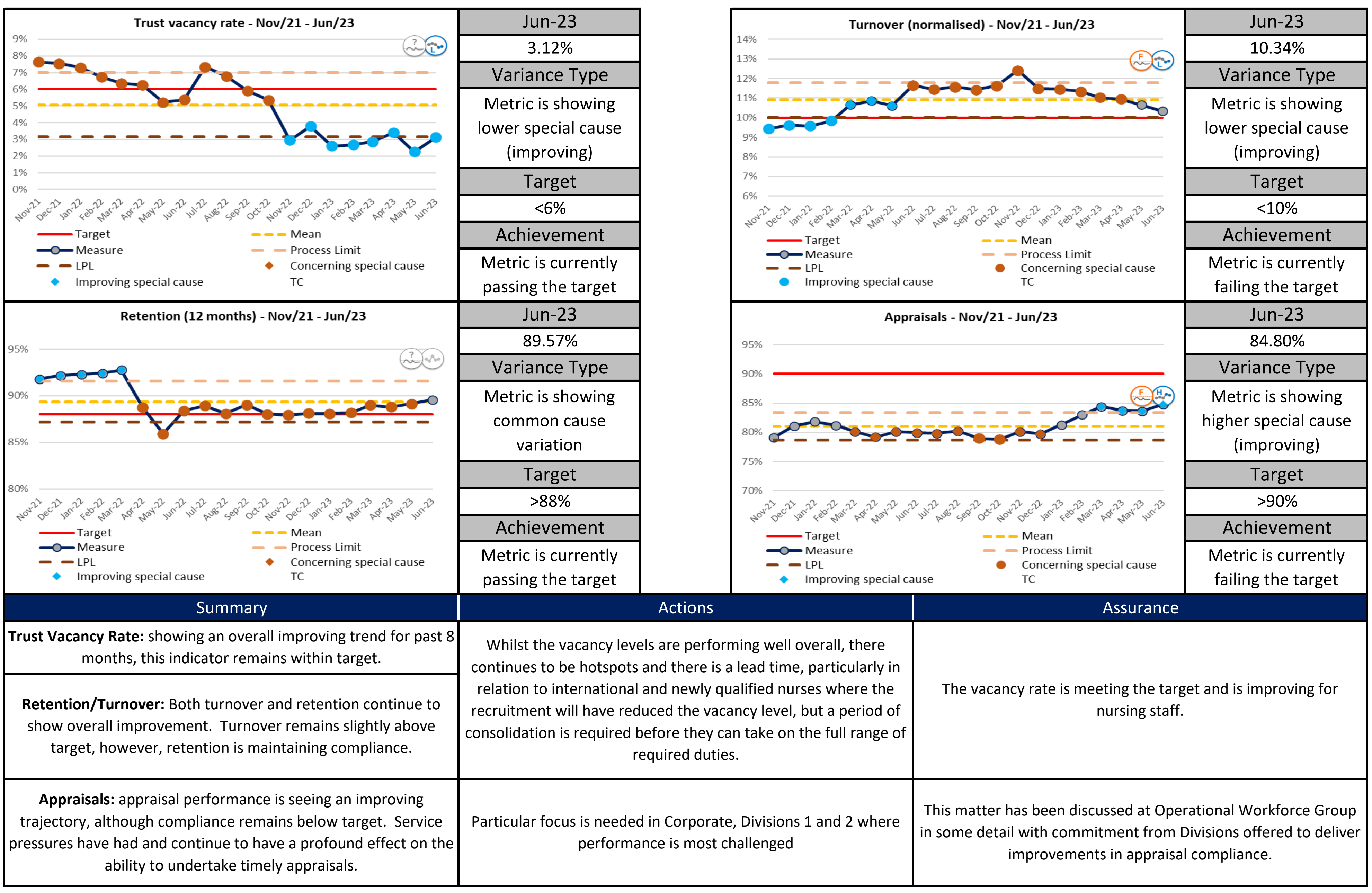

Number of Care Co referrals closed - Nov/21 - Jun/23
Jun-23
955
Variance Type
Metric is showing lower special cause (concern)
Number of Care Co referrals referred on to SDEC - Nov/21 - Jun/23
Jun-23
21
Variance Type
Metric is showing common cause variation
Number of Care Co referrals sustained (admission avoidance) -
Jun-23
4
Variance Type
Metric is showing common cause variation
Target
Measure
LPL
Improving special cause
Mean
Process Limit
Concerning special cause
TC
SC



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	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Trust Vacancy Rate	6%			2.61%	2.68%	2.87%	3.40%	2.26%	3.12%
Turnover (normalised)	10%			11.46%	11.34%	11.03%	10.95%	10.66%	10.34%
Retention (12 months)	88%			88.08%	88.19%	88.98%	88.81%	89.15%	89.57%
Appraisals	90%			81.30%	83.00%	84.40%	83.70%	83.60%	84.80%
Mandatory Training (generic)	85%			94.70%	94.90%	95.10%	95.10%	95.40%	95.60%
Sickness (in month)	5%			5.41%	3.99%	5.11%	4.67%	4.65%	
Sickness (rolling 12 months)	5%			5.45%	5.31%	5.35%	5.24%	5.24%	



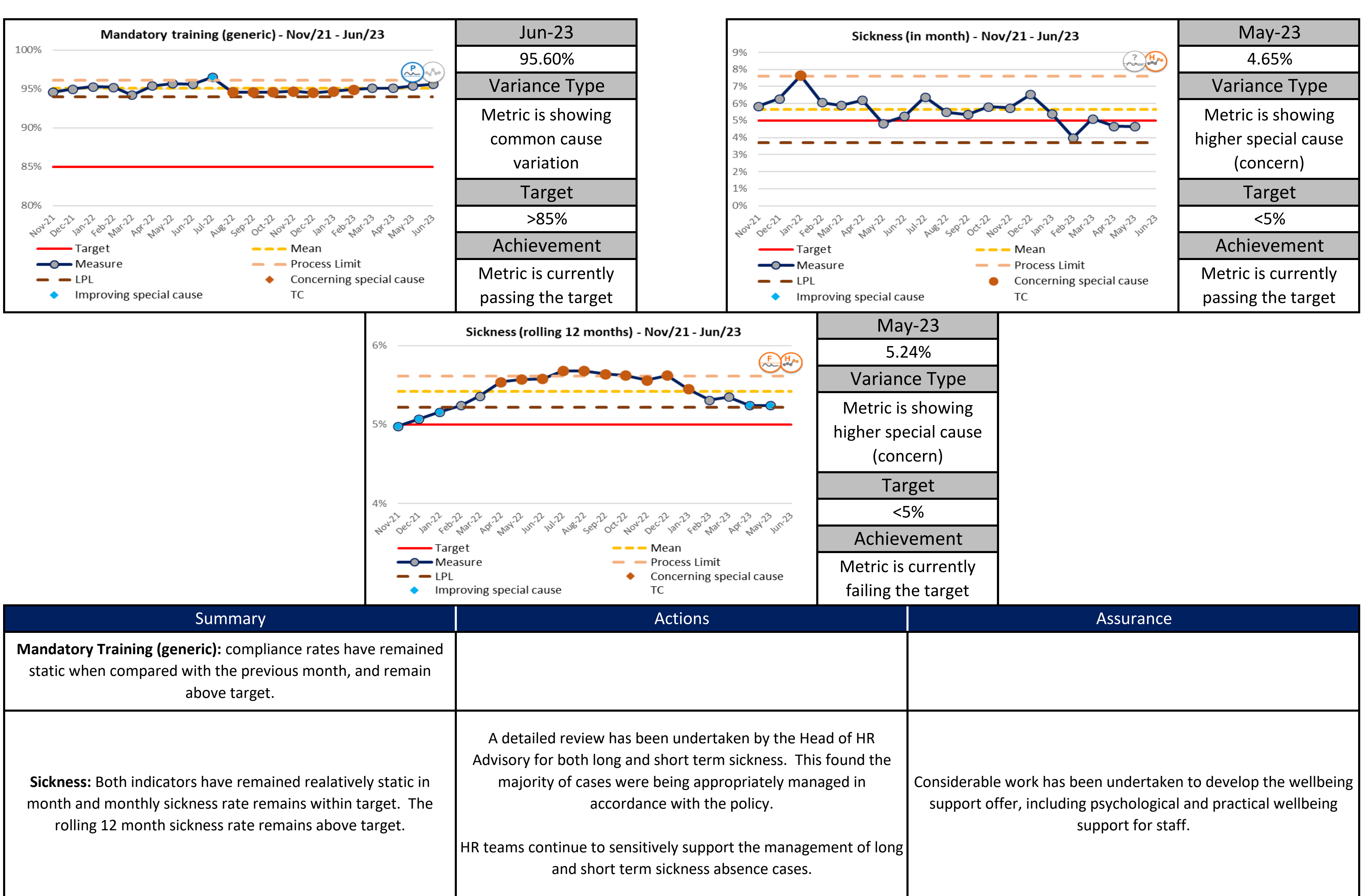
Trust vacancy rate	
Jun-23	3.12%
Variance Type	Metric is showing lower special cause (improving)
Target	<6%
Achievement	Metric is currently passing the target

Turnover (normalised)	
Jun-23	10.34%
Variance Type	Metric is showing lower special cause (improving)
Target	<10%
Achievement	Metric is currently failing the target

Retention (12 months)	
Jun-23	89.57%
Variance Type	Metric is showing common cause variation
Target	>88%
Achievement	Metric is currently passing the target

Appraisals	
Jun-23	84.80%
Variance Type	Metric is showing higher special cause (improving)
Target	>90%
Achievement	Metric is currently failing the target

Summary	Actions	Assurance
Trust Vacancy Rate: showing an overall improving trend for past 8 months, this indicator remains within target. **Retention/Turnover:** Both turnover and retention continue to show overall improvement. Turnover remains slightly above target, however, retention is maintaining compliance.	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.	The vacancy rate is meeting the target and is improving for nursing staff.
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.	Particular focus is needed in Corporate, Divisions 1 and 2 where performance is most challenged	This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.



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 remained realatively static in month and monthly sickness rate remains within target. The rolling 12 month sickness rate remains above target.	A detailed review has been undertaken by the Head of HR Advisory for both long and short term sickness. This found the majority of cases were being appropriately managed in accordance with the policy. HR teams continue to sensitively support the management of long and short term sickness absence cases.	Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

Paper for submission to the Trust Board Meeting – to be held in Public/Private On 1st August 2023		
Title of Report:	Patient Experience Bi-Monthly Report – April/May 2023/24	Enc No: To be completed by Board Administrator
Author:	Alison Dowling	
Presenter/Exec Lead:	Debra Hickman	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Board is asked to note the contents of the report and receive it for discussion and assurance.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒		
Changes to BAF Risk(s) & TRR Risk(s) agreed	**NONE**		
Resource Implications:	**NONE**		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Contribution to the Trust's compliance with the CQC fundamental standards.
	NHSE	Yes☒No☐	Details: Contribution to the Trust's with NHS Oversight Framework requirements
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Contribution to the Trust's compliance with legal framework such as complaints regulation: The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 (legislation.gov.uk)
	NHS Constitution	Yes☒No☐	Details: Contribution to the NHS Consultation Principles
	Other	Yes☐No☒	Details: N/A
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm **Effective:** care, treatment and support achieve good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect		

	Responsive: services are organised so that they meet people's needs **Well-led:** the leadership, management and governance of the organisation make sure it'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	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. No adverse impact is anticipated as a result of the points articulated in this report.

Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Trust Management Committee – 21/7/2023
	Board Committee	Yes☒No☐	Date: Quality Safety Assurance Group 20/7/2023
	Board of Directors	Yes☐No☒	Date: N/A
	Other	Yes☐No☒	Date: N/A

Summary of Key Issues using Assure, Advise and Alert

Assure - Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee

- The Trust's approach with statutory complaint handling is in line with the framework issued by the Parliamentary Health Service Ombudsman.
- Monthly submissions made to NHS Digital in relation to all national touch points for the Friends and Family Test (FFT).

Advise - Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.

- 60 complaints received compared to 64 for the preceding two months. There has been a decline in the early part of 2023 which correlates with early intervention work undertaken by the PALS team.
- In terms of outcomes from closed complaints there were 6 complaints upheld in this reporting period. This represents 7% of all cases closed (73 cases) in this period.
- From 90 cases closed, 70% of cases were not upheld, 23% were partially upheld and 7% were upheld.
- There were no cases accepted for full investigation or closed following investigation by the Parliamentary Health Service Ombudsman (PHSO).
- The overall Friends and Family Test (FFT) Trust wide response rate for April 2023 was 14% with 86% recommending the Trust and 9% not recommending the Trust. For May the response rate was 19% with 86% recommending the Trust and 6% not recommending the Trust.

Alert - Positive assurances & highlights of note for the Board/Committee

1) 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.
2) Ensure the patient voice is used to drive continuous improvement.

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

Patient Experience Bi-Monthly Report – April/May 2023/24

Report to Trust Board Meeting to be held in Public/Private on 1st August 2023

EXECUTIVE SUMMARY

- 60 complaints received compared to 64 for the preceding two months. There has been a decline in the early part of 2023 which correlates with early intervention work undertaken by the PALS team.
- The greatest volumes received are ED (14 cases) and Renal (6 cases) Adult Community, Gastroenterology and Trauma & Orthopaedics (T & O) all received 4 cases each respectively.
- In terms of outcomes from closed complaints there were 6 complaints upheld in this reporting period. This represents 7% of all cases closed (73 cases) in this period.
- From 90 cases closed, 70% of cases were not upheld, 23% were partially upheld and 7% were upheld.
- There were no cases accepted for full investigation or closed following investigation by the Parliamentary Health Service Ombudsman (PHSO).
- The overall Friends and Family Test (FFT) Trust wide response rate for April 2023 was 14% with 86% recommending the Trust and 9% not recommending the Trust. For May the response rate was 19% with 86% recommending the Trust and 6% not recommending the Trust.
- Volunteers achieved 1896 hours across the two months, 201 hours at Cannock Chase Hospital, 1539 hours at New Cross Hospital, and 111 hours at West Park. The remaining 45 hours were support with Patient Involvement Partner activities and Bereavement Hub service.
- The previously run Arts in Health Programme has been re-introduced. Funded by the RWT Charity, volunteers lead arts and crafts activities at West Park for patients recovering from neurological trauma as a form of cognitive and sensory stimulation as well as engagement and enjoyment.
- The Trust have also been successful in ensuring that the needs of volunteers are considered when identifying appropriate roles that enable volunteers to actively engage in the volunteer programme and develop personal and professional skills.
- A number of initiatives have commenced Trust wide to fulfil elements of the Patient Engagement Enabling Strategy. Many of these are held locally at Divisional level.

BACKGROUND INFORMATION

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.

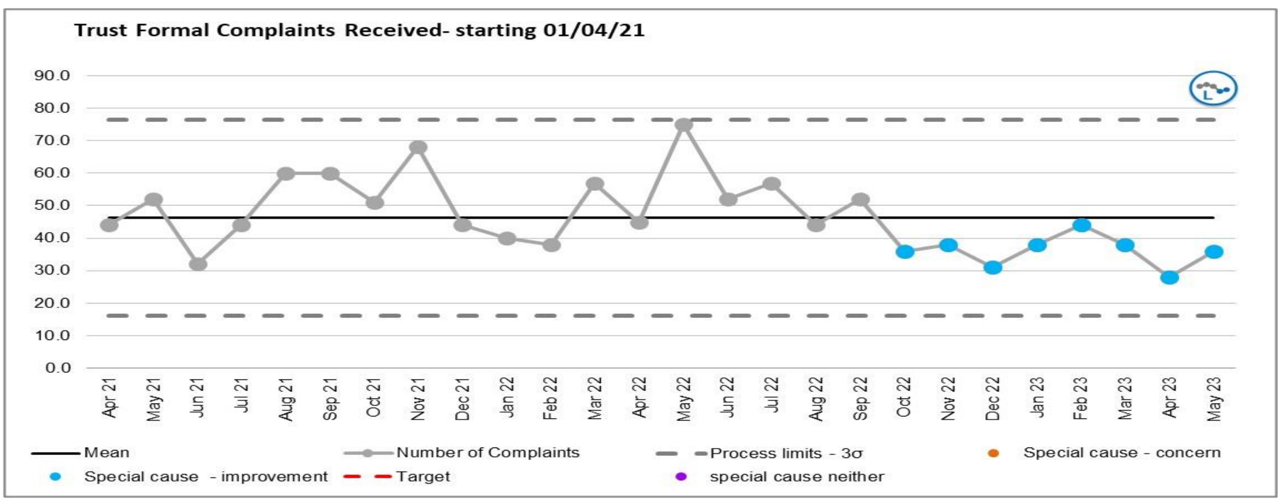
Feedback Data

The Trust received a total of **55,158** feedback contacts between April 2023 and May 2023. This includes all Patient Relations related contacts, along with Friends and Family Test and Feedback Friend responses.

Complaints (including MP letters)	64
PALS Concerns	102
Local Resolution (October to March)	12
Compliments	442
Friends and Family Test	54535
Feedback Friend (QR code)	3

Formal Complaints, PALS Concerns and Compliments

For formal complaints in respect of the period April and May 2023, there were a total of 60 complaints received for this period compared to 64 for preceding two months. Pleasingly there have been a number of months where the volume of complaints received is below the mean value as shown below.



Divisional comparison for complaints received are shown in **Appendix 1**.

The greatest volumes received are ED (14 cases) and Renal (6 cases) Adult Community, Gastroenterology and Trauma & Orthopaedics (T & O) all received 4 cases each respectively.

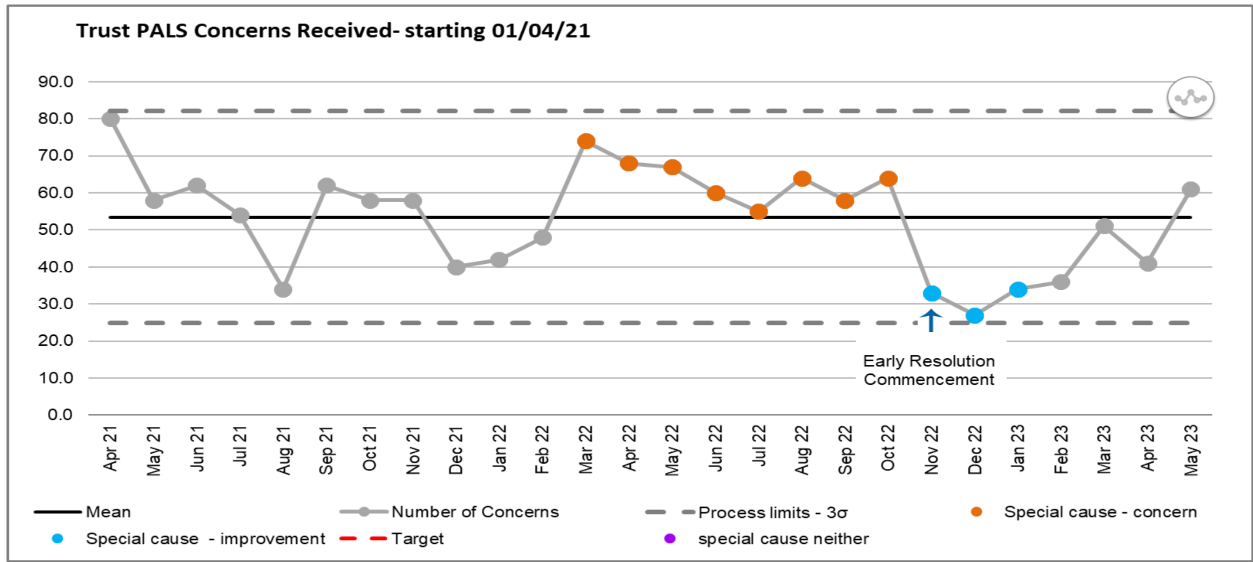
Actions taken and Assurance provided: Regular supportive meetings have taken place with Senior Managers for Division 2, in particular for ED, and attendance at divisional governance meetings have taken place to discuss key themes and actions for other specialties.

Upon analysis of the sub-categories for all cases received, General Lack of Care (General Care of Patient) was seen to be the highest area of dissatisfaction with 10 cases aligned to it. ED and Diabetes were the most featured Directorates. In relation to ED, the 10 cases represent 0.04% of A & E attendances (12,408) for the same reporting period.

Some examples of cases are shown in **Appendix 2.**

Actions taken and Assurance provided: The Patient Experience Team continues to work closely with the Quality team and have produced a series of themed reports. This was following a declining performance in a particular quality and safety metrics, resulting in the need to undertake a deeper analysis and triangulate against other metrics. These have been shared with senior management for improvements to be considered.

The total number of PALS concerns which needed to be assessed and allocated to operational teams to respond totalled 41 in April and 61 in May. A further 12 cases achieved local resolution subject to the early intervention approach adopted by the Patient Experience Team. The theme of these cases relate to communication with relatives and patients and appointments.



There has been an increase of PALS concerns for May and this is attributable to a reduced volume being suitable for early resolution due to increased complexity.

Actions taken and Assurance provided: The PALS and Complaints team will continue to monitor and where appropriate de-escalate cases for early resolution with the consent of the complainant, thus reducing impact on operational teams.

Themes of Formal Complaints and PALS Concerns

The top 3 themes for formal complaints received are :

General Care of Patient (19), Communication (16) and Clinical Treatment (21) and for PALS Concerns, General Care of Patient (58), Attitude (24) and Delay (18). This shows a slight variation when compared to the previous 2 months (Delay replacing Communication).

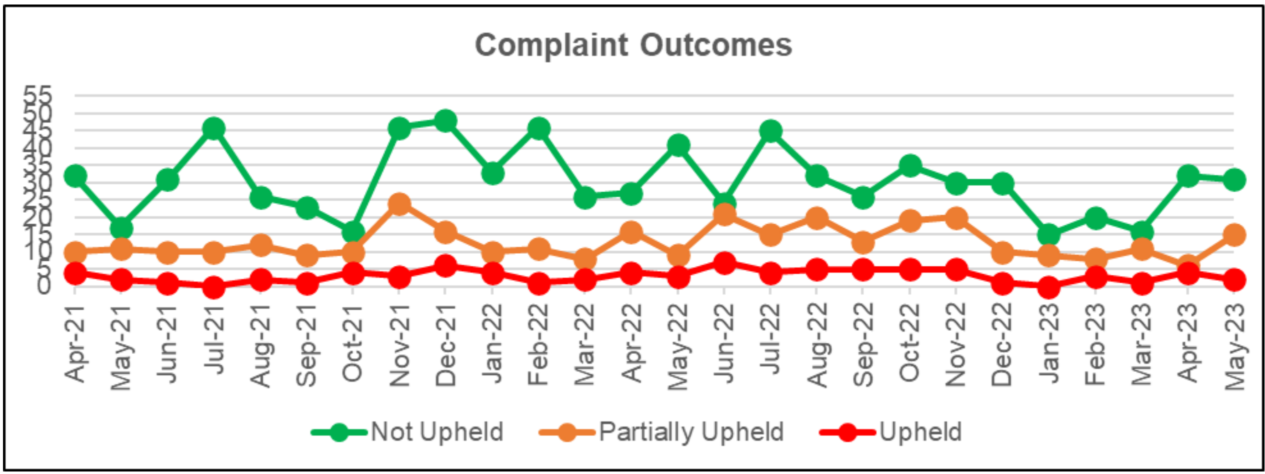
Actions taken and Assurance provided: A deep dive of the sub categories of these cases for formal complaints has highlighted that all three categories have experienced an increase in cases, more notably for clinical treatment (appropriateness of treatment). Communication with patient's appears to have improved however with relatives has increased. This downward trend will be reviewed in more detail at the next Patient Experience Feedback Group (PFOG) for Directorate Managers to consider and direct appropriate intervention strategies.

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 and 31st March for each financial year.

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.



In terms of outcomes from closed complaints there were four complaints upheld in April (ED x1; Ward C19 x1: West Park Ward 1 x1; Stroke x1) and two in May (Adult Community x1; Onc/Haem x1).

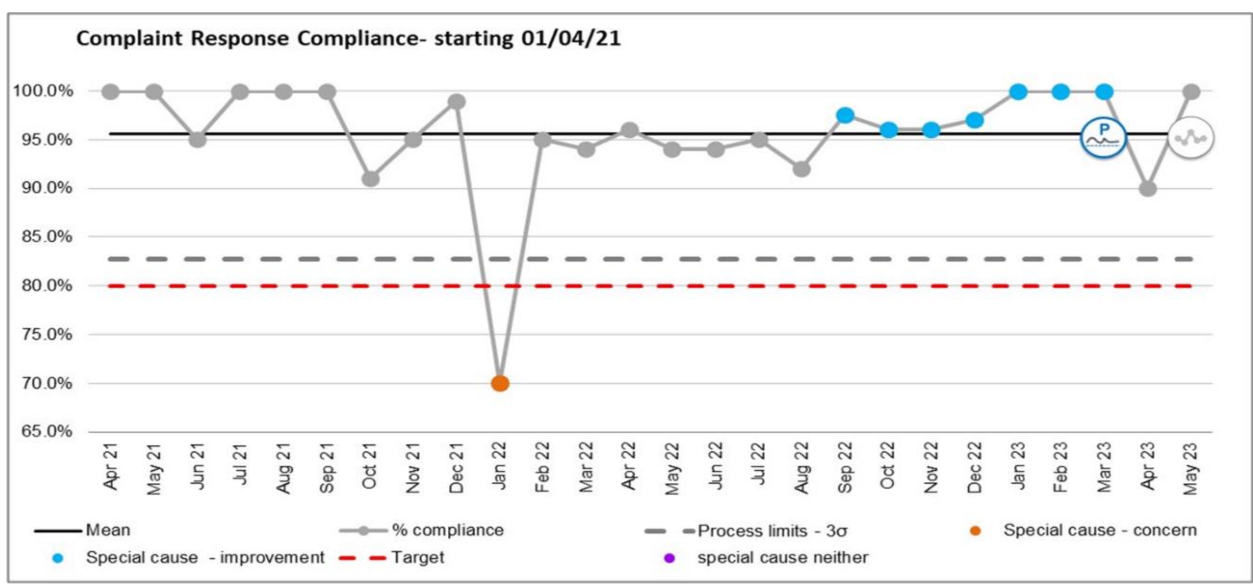
Actions taken and Assurance provided: It has been noted that Directorates make the determination themselves on the outcome of the complaint investigation, and to ensure accuracy – a two-step action is to be implemented.

(1) The complaint toolkit will also be amended to ensure that it is detailed clearly what elements of the complaint have been partially or fully upheld. This determination will also need to be confirmed by Head of Nursing /Deputy COO when undertaking final checking stage of response.
(2) A further sample audit will be undertaken by PE each month on the outcome factors, and, where appropriate, a challenge will be given to the Directorates to reconsider.

A summary of some key Learning for cases upheld is shown at **Appendix 3.**

Complaint compliance is measured on the adherence to policy (30 working days) and gaining consent for an extension for completion. The Trusts compliance for April and May is shown below.

The overall Trust response rate for cases closed in April is 90% and May is 100% which compares with 100% in March 2023. The policy states that the investigating officer is able to request and agree 1 extension directly with the complainant, subsequent extensions are at the approval of the Deputy Head of Head of Patient Experience who review case by case justification. No more than 2 extensions in total are agreed. This is audited and will be reviewed at the next Patient Feedback Operational Group (PFOG) meeting for consideration and action.



Actions taken and Assurance provided: The drop in compliance performance in April specifically related 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 exec approval. This has been addressed with the relevant Directorates and monitored for future for improvement. (These were three cases for Sexual Health and one case for T & O). Results have shown for May an improvement in working practice for complaint handling.

Parliamentary and Health Service Ombudsman (PHSO)

- No complaints accepted for formal investigation during April and May.
- No cases previously accepted for full investigation were concluded during this period.

Friends and Family Test

The overall Trust wide response rate for April 2023 was 14% with 86% recommending the Trust and 9% not recommending the Trust. For May the response rate was 19% with 86% recommending the Trust and 6% not recommending the Trust.

There has been positive improvement in the response rate from April to May, consistency in the recommendation rate and a pleasing decrease in the non-recommendation rate.

The Trust have seen higher scores for May 2023 when compared to March for Trust wide with an increase of 4% for response rates and an increase of 2% for recommendation rates resulting in 19% and 86% respectively.

Inpatient/Day Case and Community have both seen a reduction in response rate but have had increases in recommendation rates.

Actions taken and Assurance provided – Non-compliance with strategy ambitions to meet recommendation rate of 92% for Trust wide score. The need to improve rates has been discussed at the Patient Experience Group (PEG) and Directorates will be sourcing additional support regarding use of IT and volunteers which will be supplemented by PE where possible.

Full details of the main nationally reported touchpoints are shown in **Appendix 4.**

Trust Wide - FFT Response Rate - Oct/21 - May/23

Trust Wide - FFT Recommendation Rate - Oct/21 - May/23

Spiritual, Pastoral and Religious Care (SPaRC)

The Chaplaincy – Spiritual, Pastoral and Religious Care (SPARC) has a vision of engaging, inspiring, and empowering patients, and staff. Work continues on the joint RWT/WHT strategy through analysis of SPaRC tool data and the verbal/written feedback received. Analysis of the data captured by our SPARC tool, indicates that there have been at least 4,520 separate pastoral encounters between the staff and volunteer team.

The breakdown of support received and provided is as follows:

- 85% had a Pastoral element.
- 82% a Spiritual element, and Religious (Faith Specific) care has been present in 70% of our encounters.
- 56 out of 73 listed hospital areas have been visited and support provided.
- 40 hospital arranged adult and baby funerals.
- Support provided for 14 mortuary viewings.

The collaborative work continues with the Swan Champions and the palliative care teams across both Trusts.

The feedback received continues to highlight the benefit of maintaining good visibility and accessibility, recognises the delivery of compassionate and personable care, and the willingness of team members to go the extra mile to support staff.

Engagement, Involvement and Experience

Engagement and Experience and have been guided and informed by the patient voice and feature heavily in both initiatives to ensure inclusivity and meet our Strategy ambitions. Some of these initiatives include:

- **15 Steps Initiative** – The Patient Involvement Partners (PIP's) continue to support this NHS England and Improvement and collaborative initiative
- **Ward Accreditation** – PE team have undertaken visits on Wards C26, A8, C14, Fairoak, C39 and C18 in order to gain feedback from the Patient Voice perspective.
- **Feedback Friend**– Further roll out of this initiative which now includes Paediatrics, Maternity, and Neo natal areas and West Park Hospital and CCH wards.
- **Feedback Friday** The Patient Experience Team have implemented the 'Feedback Friday' initiative to highlight examples of excellent care and boost staff morale.
- **Co Production** – Working closely with a Trust wide Quality Improvement Development Session across both RWT and WHT - with the aim of engaging clinical leads to consider how to involve patient voice right from the very start of designing QI projects.
- **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, 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).
    - Division 1 (Surgery) outlined aims to improve self-care management programmes, promotion of Outreach and Information Services, Enhanced recovery and Same day emergency care facilities, and to collect feedback from workshops, patient groups, and training to inform future development of these interventions.
    - Division 2 (Medicine) outlined their vision to liaise with families and carers by inviting them to attend clinical areas to discuss plans of care and treatment options, pilot Criteria led Discharge, promotion of Virtual Ward pathways daily at Divisional update and bed meetings, and Outreach and Information Services promotion.
    - Division 3 (Paediatrics) outlined how they wish to extend their engagement to include representation on Child and Young People in care Board, Dad's groups, and linking into Asylum Seeker families.

Voluntary Services

The Trust continues to work closely with HR and Occupational Health to ensure that all new volunteers that are recruited have satisfied all legislative and organisational requirements, this includes Right to Work and DBS checks and being medically cleared by occupational health to be placed in key inpatient areas.

The Trust have also commenced initiatives or recruitment to specifically ensure equity and accessibility to volunteering. By the provision of bespoke roles for those with learning disabilities and projects regarding arts and crafts activities for patients recovering from neurological trauma as a form of cognitive and sensory stimulation as well as engagement and enjoyment.

Volunteers achieved 1896 hours across the two months, 201 hours at Cannock Chase Hospital, 1539 hours at New Cross Hospital, and 111 hours at West Park. The remaining 45 hours were support with Patient Involvement Partner activities and Bereavement Hub service. The main areas supported at New Cross Hospital were Discharge Lounge (167 hours), Acute Medical Unit (147 hours), Staff Wellbeing Hub (120 hours), and Ward C18 Elderly Care (117 hours).

Holistic Opportunities Preventing Exclusion (H.O.P.E)

Funding was awarded through NHS Charities Together to RWT and Wolverhampton Voluntary and Community Action (WVCA) to run a joint 2 year project around social isolation and positive mental wellbeing for our communities.

The first Steering Group meeting has taken place in April. To date, 19 volunteers have been recruited to support the project in the community, subsequent meetings with the WVCA have also commenced in order to place volunteers with Social Prescribers.

Appendices	
Appendix 1	**Formal Complaints Received - Divisional Breakdown**
Appendix 2	**Formal Complaints - Highest category of dissatisfaction General Lack of Care (General Care of Patient)**
Appendix 3	**Formal Complaints – Key learning examples**
Appendix 4	**FFT Recommendation Rate Breakdown by National Touchpoints**

Appendix 1 – Formal Complaints Received - Divisional Breakdown

Division 1 Formal Complaints Received- starting 01/04/21

Mean | Number of Complaints | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Division 2 Formal Complaints Received- starting 01/04/21

Mean | Number of Complaints | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Division 3 Formal Complaints Received- starting 01/04/21

Mean | Number of Complaints | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Division 4, Estates & Corporate Formal Complaints Received- starting 01/04/21

Mean | Number of Complaints | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target | special cause neither

Appendix 2 – Formal Complaints - Highest category of dissatisfaction General Lack of Care (General Care of Patient)

Case	Directorate	Description	Outcome code
1	**ED**	The complaint relates to a general lack of care and insensitive attitude of nurses in SDEC. Patient admitted via blue light following a fall at home. The patient had mobility issues which highlighted the need for wheelchair assistance. This was not considered throughout the ED pathway and patient had to walk with assistance which impacted on the patient who has a progressive neurological condition - Multiple Systems Atrophy (MSA). There was no care, empathy, understanding or dignity shown to the patient.	Partially upheld
2	**Diabetes**	Concerns raised by the patient's partner in regard to the treatment received whilst an inpatient. Patient admitted with various symptoms including paralysis from the waist down which led to double incontinence, weakness of the arms and inability to sit up. Family observed lack of care regarding support at mealtimes when patient was unable to feed herself. Other concerns related to frequency of change of incontinence wear, pain control and a delay in receiving an MRI scan. The family were advised that the patient would receive palliative care but not what this would entail also miscommunication about when the patient would be discharged to the care home, where she sadly passed away.	Still under investigation

Appendix 3 – Formal Complaints – Key learning examples

The common theme for learning appears to be around education/training and communication between specialities.

- Concerns regarding patient receiving regular medication whilst in ED. ED to devise plan to ensure long stay patients have access to regular medication and feed plan into long stay working group.
- Safeguarding complaint raised regarding inappropriate discharge/lack of appropriate arrangements for discharge. The Dieticians to reiterate information provided during mandatory training regarding food fortification.
- Concerns raised in relation to timely completion of MCA/DOLS with no risk assessment. Delay in ordering prescribed medication. No discussion regarding other forms of de-escalation documented or discussion regarding possible covert medication policy to be utilised if

no capacity and DOLS insitu. Additional training to be undertaken in regard to the appropriate use of DoLs and completion of risk assessments that need to be completed. Compliance to be monitored via audits.

- Safeguarding concern raised regarding patient's discharge with a grade 3 pressure injury and lack of information regarding a tear to the patient's skin. Complaint presented and discussed at the Trusts Rapid Review Pressure Ulcer Meeting and shared with the stroke nursing team via daily safety brief. The need for timely escalation to the Tissue Viability Team identified and process to be reviewed.
- Complaint relating to lack of appropriate arrangements prior to patient's discharge from District Nurses and lack of verbal information given to the patient's family and care home regarding arrangements. Improve quality of assessment of needs visits. RIT to review process for call outs and potentially include skin assessments.
- Concerns raised around clinical competence of staff inserting IV line and staff attitude. Concerns discussed with staff member around IP policy and review and observation of IV insertion undertaken by IV team.

Appendix 4 – FFT Recommendation Rate Breakdown by National Touchpoints

ED - FFT Recommendation Rate - Apr/21 - May/23

85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
55.0%
50.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Target
Mean
Measure
Process Limit

Inpatient/Daycase - FFT Recommendation Rate - Apr/21 - May/23

100.0%
95.0%
90.0%
85.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Target
Mean
Measure
Process Limit

Outpatient - FFT Recommendation Rate - Apr/21 - May/23

100.0%
95.0%
90.0%
85.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Target
Mean
Measure
Process Limit
LPL
Concerning special cause
Improving special cause
TC

Community - FFT Recommendation Rate - Apr/21 - May/23

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23

Target
Measure
Mean
Process Limit
LPL
Concerning special cause
Improving special cause
TC

Appendix 4 – FFT Recommendation Rate Breakdown by National Touchpoints

Paper for submission to the Trust Board Meeting – to be held in Public/Private On 1st August 2023		
Title of Report:	Patient Experience Enabling Strategy 2022-2025	Enc No: To be completed by Board Administrator
Author:	Alison Dowling	
Presenter/Exec Lead:	Debra Hickman	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☐No☐	Yes☒No☐	Yes☐No☐
Recommendations: The Board is asked to note the contents of the report and receive it for discussion and assurance.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	(if none, state 'none') Revenue: Capital: Workforce: Funding Source:		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Contribution to the Trust's compliance with the CQC fundamental standards.
	NHSE	Yes☒No☐	Details: Contribution to the Trust's with NHS Oversight Framework requirements
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: Contribution to the Trust's compliance with legal framework
	NHS Constitution	Yes☒No☐	Details: Contribution to the NHS Constitution Principles The NHS Constitution for England - GOV.UK (www.gov.uk)
	Other	Yes☐No☒	Details:
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm **Effective:** care, treatment and support achieve good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect **Responsive:** services are organised so that they meet people's needs **Well-led:** the leadership, management and governance of the organisation		

	make sure it'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	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. No adverse impact is anticipated as a result of the points articulated in this report

Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☐	Date:
	Board Committee	Yes☒No☐	QGAC 24/11/22 TMC 30/6/2023
	Board of Directors	Yes☐No☒	Date: 1/8/2023
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure: That the strategy will ensure compliance with all of the principles of the NHS Constitution to ensure patients will be at the heart of everything the NHS does.
Advise Progress towards milestones will be reported through usual internal committees for patient experience.
Alert This enabling strategy will set out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

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

Patient Experience Enabling Strategy 2022-2025

Report to Trust Board Meeting to be held in Public/Private on 1st August 2023

1. EXECUTIVE SUMMARY

The purpose of this report is to introduce the Patient Experience Enabling Strategy which sets out our priorities for improving patient experience in the next 3 years. This is a joint strategy that has been developed in partnership with Walsall Heath Care Trust.

2. BACKGROUND INFORMATION

The strategy sets out how both Trusts will strengthen its approach to patient experience, engagement, public involvement, and co-production. The strategy also 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.

This enabling strategy will set out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

These pillars have been guided and informed by the patient voice – using feedback and insight gained from our patients, families, and carers who either completed a national or local survey, took part in the Friends and Family Test, or raised a concern or complaint. We have set ourselves several priorities which will underpin each of the three pillars of improvement.

The strategy also outlines how the patient voice will inform the work of both Trusts, describes why it is important to engage with patients and the public, and defines the accountability structure and proposed measurements of success.

3. RECOMMENDATIONS

The enclosed strategy outlines our forward view of how we will respond to the feedback we have heard using a thematic approach to the information we have received in addition to stakeholder involvement from our patient involvement partners, patients, families, carers, staff and various external organisations through the completion of online surveys.

Committee members are asked to approve the Patient Experience Enabling Strategy 2022-2025

Any Cross-References to Reading Room Information/Enclosures

Full strategy is attached for reference.

Patient Experience Enabling Strategy 2022-2025

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

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Foreword

We are delighted to introduce the Patient Experience Enabling Strategy (2022 - 2025), which will support and empower all staff within our respective Trusts to put patient experience at the heart of everything we do.

The heart of our success as an organisation is the involvement of our patients, their relatives, carers and the community to give them the best experience of care possible for we are the patient experience.

We aim to be Providers of Healthcare that continually strive to improve patient experiences and outcomes, aligned with an outstanding patient experience that meets expectations.

The NHS Confederation (2011) states that whilst good clinical outcomes and processes are important elements of patient experience, it is far more than this. It states that experience is also determined by the physical environment patients are in and how they feel about the care they receive, including the way staff interact with them. Improving the experiences for all patients starts by treating each of them individually to ensure they receive the right care at the right time, in the right way for them.

We know that a positive experience during each interaction of care leads to positive clinical outcomes. If a patient feels listened to, involved in their care, respected and looked after, they will respond better to healthcare interventions and also be more able to manage their own journey through care.

Therefore, we pledge to actively seek, listen and act on feedback received from our patients, staff, and other key stakeholder groups. This Patient Experience Enabling Strategy has been co-produced with our patients, our staff and our partners and it reflects the needs of our local populations.

The strategy builds on our journey and cultural shift from 'doing to' patients, to 'working with' patients and carers. We aim to ensure that all patients and carers have a central role in all aspects of care, service design and improvement across the organisation.

The Trust is truly committed to the delivery of high-quality care. In order to achieve this, we must listen to our patient and carers feedback, ensuring that we learn and respond to continuously improve our services.

This joint strategy shows both Trust's commitment to improve outcomes for patients and efficiency of process through closer collaboration between the two Trusts.

Lisa Carroll,
Director of Nursing
Walsall Healthcare NHS Trust (WHT)

Debra Hickman,
Director of Nursing
The Royal Wolverhampton NHS Trust (RWT)

1.0 Introduction

This strategy sets out how both Trusts will strengthen its approach to patient experience, engagement, public involvement and co-production.

The strategy also encompasses the Trusts overall objectives and ambition to become an Integrated Care System with the aim to work in partnership with local authorities and others, to take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population served.

This strategy will set out our priorities for improving patient experience in the next 3 years. Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

These pillars have been guided and informed by the patient voice – using feedback and insight gained from our patients, families, and carers who either completed a national or local survey, took part in the Friends and Family Test, provided positive feedback or raised a concern or complaint. We have set ourselves several priorities which will underpin each of the three pillars of improvement. The strategy also outlines how the patient voice will inform the work of both Trusts, describes why it is important to engage with patients and the public, and defines the accountability structure and proposed measurements of success.

1.1 Developing this strategy

This strategy outlines our forward view of how we will respond to the feedback we have heard using a thematic approach to the information we have received in addition to stakeholder involvement from our patient involvement partners, patients, families, carers, staff and various external organisations through the completion of online surveys.

We asked the following questions:

1. What makes a good experience for you as a patient or carer?
2. What could we do better to improve the patient and carer experience?
3. Do you agree with the areas that have been identified for improvement?
4. Have we missed anything that you consider needs improving?
5. Do you think that the Patient Experience Enabling Strategy shows commitment to work with patients to listen to them and to learn and develop the services that they want to receive?
6. Is what matters to you most reflected in the current strategy?
7. As a result of the strategy, do you feel that the Trust has reached out to you, listened, learned and made changes to services as a result?
8. Which of the current work areas do you think that the Patient Experience Enabling Strategy should focus on?

1.2 Patient Participation and Involvement

We met with our Patient Representative Groups and shared the patient voice feedback, the improvement pillars and how these were decided upon. Our partners provided valuable feedback in support of the pillars and how they will involve themselves in seeking assurance on the improvement actions and measuring outcomes.

For Walsall Healthcare NHS Trust (WHT) - When we asked question 1, we received some really engaging feedback from our Patient Involvement Partners. Key points were made around civility, ensuring patients are listened to and ensuring staff are communicating well and giving relevant information to our patients.

Our Patient Involvement Partners explained, regarding question 2, they believe care in the hospital should be patient centred as everyone requires different levels of care and treatment. Whilst also making sure preference is a key factor.

All Patient Involvement Partners agreed with question 3 and that all the areas have been identified for improvement are correct.

Our members touched on time management as an area they consider needs improving in question 4. They trust that using time management more effectively will enable patients to have an opportunity to ask any questions relating to their treatment and to understand the next steps of their care if they are unsure.

For The Royal Wolverhampton NHS Trust(RWT) – 65% of the patients who responded were familiar with the current strategy and felt that it shows commitment to work with patients to listen to them and to learn and develop the services that they want to receive.

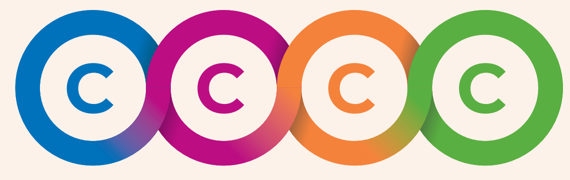
We asked our patients what matters to them the most when they receive NHS services. They responded that the service needed to be right to suit the needs of the patient and they wanted to be treated quickly.

We also asked them what areas could be specifically focus on and an over arching 76% wanted us to develop and produce services from start to finish by engaging meaningfully with patients and other stakeholders. They wanted us to learn from complaints and encourage better attitudes and practice from employees.

It was felt that patients related to the areas on which the strategy focuses. That they are relevant and assist to the development of the Trust to provide services which are truly patient-centred.

The Patient Experience Enabling Strategy links to both Trusts strategic vision working in partnership with each other: “To deliver exceptional care together to improve the health and wellbeing of our communities”.

Care	Excel in the delivery of **Care**
Colleagues	Support our **Colleagues**
Collaboration	Effective **Collaboration**
Communities	Improve the health and wellbeing of our **Communities**



Because of the thematic review, both Trust's have set several priorities which will underpin each of the three pillars of improvement, Involvement, Engagement and Experience. Each pillar is headed by a 'We statement' this statement of intent sets out a clear objective of improvement underpinned by a series of improvement actions and measurements.

1.3 Survey Feedback

An online survey was carried out during July and August for each Trust with variances to questions based on specific demographics of patient groups and data already gathered. Responses were received from a variety of Patients, Family members, carers staff members and members of the public or other.

Appendix 1 and 2 shows the responses received for each Trust.

For WHT

- 57% of respondents agreed with the areas identified for improvement
- 40% of respondents agreed to some extent with the areas identified for improvement
- 67% of respondents offered commentary on the identified areas for improvement
- 75% of respondents provided additional comments in relation to further improvements

For RWT

- 55% of those surveyed at RWT were either patient or family member/carer. The remainder responses were from staff
- Those surveyed were given a list of options to let us know what they believed were the highest priority for improvement. Those key areas chosen are featured in our priorities for the next three years
- 64% were familiar with the current strategy
- 70% of those who responded believe the strategy demonstrates commitment to work with patients to listen, learn and develop desired services
- 61% said that what matters to them is reflected in the strategy

Our Patient Experience Enabling Strategy – 2022-2025

Quality, Clinical Effectiveness and Safety

Involvement

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

Engagement

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

Experience

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

Patient Voice

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

1.4 What is Patient Experience?

Patient experience' is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing clinical excellence and safer care (NHS Institute for Innovation and Improvement 2013).

The Department of Health and Social Care defines a positive patient experience as: "Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal and being treated with honesty, respect and dignity" (Department of Health (2005) 'Now I feel tall – what a patient-centred NHS looks like').

1.5 What is patient and public engagement?

It is the active participation of patients, carers, community representatives, community groups and the public in how services are planned, delivered, and evaluated. It is broader and deeper than traditional consultation. It involves the ongoing process of developing and sustaining constructive relationships, building strong, active partnerships, and holding a meaningful dialogue with stakeholders. 1) Engaging with patients and the public can happen at two levels: individual level – 'my say' in decisions about my own care and treatment. 2) Collective level – 'my' or 'our say' in decisions about commissioning and delivery of services.

Effective patient engagement means involving patient cohorts (patients with common conditions) in helping to get the service right for them. It is also about engaging the public in decisions about the commissioning, planning, design and reconfiguration of health services, either pro-actively as design partners, or reactively, through consultation.

1.6 Why is this important?

Effective engagement leads to improvements in health services and is part of everyone's role in the NHS. Improving patient experience is about working with the people who use services to make these services better. It is about designing services that meet their needs and it requires a commitment to doing this on an ongoing basis, day-by-day and year-by-year.

2.0 The Patient Voice

We have undertaken thematic reviews using feedback received over a 12-month period from patients/public who either completed a national or local survey, took part in the Friends and Family Test, or raised a concern or complaint. Each theme highlights areas where change and improvement are required. The following themes are consistent for 86% of all feedback where improvements could be made (negative feedback) highlighting key areas to focus on.

Highlighted themes from patient feedback

1. Treatment and care
2. Communication and information
3. Appointments and admission
4. Environment and hospital access
5. Systems and processes
6. Customer service

2.1 Patient Voice Thematic Review

Appointments & Admission

Clear appointment letters and communications.

Reduce delayed or cancelled appointments.

Manage clinic cancellations before booking appointments.

Ensure appointments are required and appropriate for the needs of the patient.

Treatment & Care

Treat patients as individuals.

Support patients getting attention when they need help.

Listen to patients worries and fears.

Ensure patients feel safe.

Treat in a way that instils confidence in healthcare professionals.

Deliver safe staffing levels.

Involve patients in all treatment decisions.

Getting the right service to treat the patients needs

Systems & Processes

Discharged at the right time.

A discharge process from the point of admission.

Reduce waiting times and communicate what they are.

Communicate discharge at the right time.

A safe discharge where patients feel prepared.

Discharge plans that involve family and carers.

Having everything ready at the time of discharge.

Customer Service

Treat patients with respect and dignity.

Ensure patients do not feel a burden.

Act in a friendly, professional manner.

Respect patient views and beliefs.

Deliver compassionate care.

Communication & Information

A clear treatment plan patients can understand.

Patients involved in decisions around their treatment and care.

Involvement and clear communication with patients & family/carer.

Understand a patient's medical history to avoid repeating.

Give clear explanation of any changes or cancellations.

Clear and easy to understand after care information.

Avoid conflicting information that confuses patients.

Clear information around what to do at home.

Informed of discharge plan and information.

Clear communication around discharge.

Communicating waiting times.

Good communication verbal and non-verbal

Environment and Hospital Access

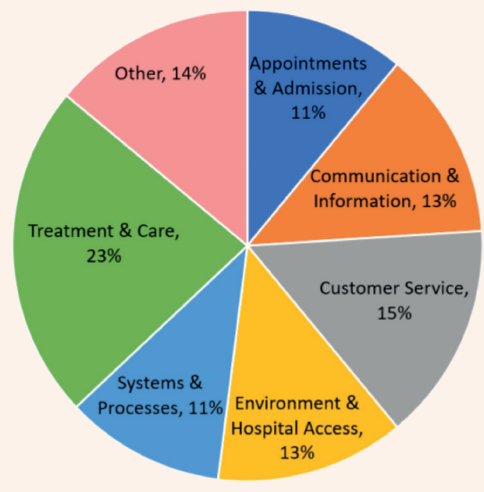
Ensure the environment feels safe.

Deliver a clean environment.

Maintain a hospital environment that is comfortable.

Safe access for disabled and immobile patients and visitors.

Reduce and manage noise and disturbances.



From our engagement sessions and thematic review, we have highlighted the following Strengths, weaknesses, Opportunities and Threats to the patient experience at our Trusts.

Strengths

- Excellent Leadership
- Compassionate and kind staff
- Greater confidence in patient care
- Improved patient care
- Reliable, consistent, health care provided, safe environment, great building and equipment, well trained staff
- Carers priorities in line with the NHS Long term plan

Weaknesses

- Inconsistent approach, decrease of communication, increase of risk
- Poor communication with our patients
- Efficient discharge of medically fit patients
- Patients not involved in their care plans

Opportunities

- Further build on patient involvement and co production;
- Collaboratively working with neighbouring Trusts
- Enhancing care using digital innovation
- Pro actively seek feedback
- Understand the demographics of our patients and improve health inequalities
- Opportunities to create friendships/ social interaction using volunteers aiming to reduce re admittance

Threats

- Impact of COVID-19 on staff, patients, families
- External factors outside of our jurisdiction e.g. packages of care
- Losing a patient's trust
- High costs (new technologies)
- Financial constraints
- Risk management
- Staffing ratio

3.0 Improvement Pillars

Three pillars of improvement have been identified. These are Involvement, Engagement and Experience.

3.1 Pillar one – Involvement

Pillar one – Involvement

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

Our Commitment to you:

- Involvement and clear communication with patients & family/carer.
- Clear and easy to understand after care information.
- Listen to patients worries and fears.
- Clear information around what to do at home.
- Informed of discharge plan and information.
- Clear communication around discharge.
- Systems & Processes Discharged at the right time.
- A discharge process from the point of admission.
- Communicate discharge at the right time
- A safe discharge where patients feel prepared.
- Discharge plans that involve family and carers.
- Having everything ready at the time of discharge.

How we will deliver this:

- By providing patient information in an accessible format and in a way, it can be understood.
- By empowering patients to ask questions to their health professional in any setting
- By valuing patients time, treating them with dignity, respect, and compassion
- By ensuring we learn from and improve our patients discharge experiences by actively asking for and using feedback
- By encouraging our patients to share their needs and preferences with us and to ensure they are the centre of the decision making for their care and treatment
- Ensuring that people from minorities (ethnic minorities, disabilities, religious groups, LGBT+ groups) have services that do not discriminate and equally meet their needs alongside others

Measuring success

✓ To be in the top 20% of all Trusts overall for 'patients feeling they were treated with dignity and respect' (National Inpatient Survey)

✓ To be in the top 20% of all Trusts for 'did hospital staff take your family or home situation into account when planning for you to leave hospital? (National Inpatient Survey)

✓ All our essential patient information leaflets to be available in easy read, large print and translated by the end of 2023

✓ To be in the top 20% of Trusts for 'Did you feel able to talk to members of hospital staff about your worries or fears?'

3.2 Pillar two – Engagement

Pillar two – Engagement

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

Our Commitment to you:

- Clear appointment letters and communications
- Reduce delayed or cancelled appointments
- Manage clinic cancellations before booking appointments
- Ensure appointments are required and appropriate for the needs of the patient
- Communicating waiting times.
- Avoid conflicting information that confuses patients
- Deliver a clean environment
- Maintain a hospital environment that is comfortable
- Safe access for disabled and immobile patients and visitors.
- Reduce waiting times and communicate what they are

How we will deliver this:

- By actively increasing the number and diversity of volunteers that support our services including those who will support asking for and recording patient feedback
- Recruiting, training, implementing and developing volunteers more widely with a program aiming to get young volunteers into paid employment
- By maximising the ways in which we engage with people which may be face to face, digitally, online surveys and seeking new partnerships with community groups
- By encouraging more patients to attend our Patient and Partner Experience Group and to emulate this across other Trust committees and meetings with allocated patient membership
- By involving our community partners on projects and initiatives that improve patient experience using co-design principles
- By ensuring Patient participation groups (primary care) Staff focus groups (all services) Long term condition - expert patient groups
- Developing and producing services from start to finish by engaging meaningfully with patients and other stakeholders

Measuring success

✓ A Patient Involvement and Engagement Hub that provides patients with an interactive involvement experience to improve Trust services by January 2023

✓ A systematic approach towards co-design, with a focus to embed this approach in all directorates.

✓ Improved positive communication to our patients - we will gather and evaluate feedback.

3.3 Pillar three – Experience

Pillar three – Experience

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

Our Commitment to you:

- Treat patients as individuals
- A clear treatment plan patients can understand
- Understand a patient's medical history to avoid repeating
- Support patients getting attention when they need help
- Ensure patients feel safe
- Treat in a way that instils confidence in healthcare professionals
- Deliver safe staffing levels
- Treat patients with respect and dignity
- Ensure patients do not feel a burden
- Act in a friendly, professional manner
- Respect patient views and beliefs
- Deliver compassionate care
- Ensure the environment feels safe

How we will deliver this:

- By using our Patient and Partner Experience Group meeting to gain assurance, monitor and manage patient experience workstreams and initiatives
- By supporting staff to place the patient voice at the centre of all we do. We will use feedback and insight to 'make every moment' count ensuring our hospital values are maintained and included in all interactions with patients, carers, and families
- By developing, building, and learning from National and regional best practice – benchmarking ourselves against other organisations
- By extending our 15 steps programme sharing the learning experienced by our patients and those who use our services
- Working with staff to develop communication and interpersonal skills
- Reduce the number of complaints relating to staff attitude and behaviour

Measuring success

✓ Have a system in place to monitor and record the actions taken as a result of feedback from national patient surveys

✓ 100% of in-patient wards to mandatory display information of improvements made from patient feedback

✓ 95% of patients would recommend us in the Friends and Family Test

✓ Reducing complaints, learning from them and encouraging better attitudes and practice from employees

✓ We are in the top 20% of Trusts for patients having confidence and Trust in the people caring for them (Doctors and Nurses)

4.0 Governance and Leadership

Both Trust's Patient Experience Groups have been strengthened by the Patient Involvement Partners Forum, and the Patient Feedback Oversight Group and acts as the catalyst for the Patient Voice at a strategic level, embedding quality and patient experience initiatives across the Trusts.

- Divisional Directors and Senior Managers are responsible for performance monitoring of patient experience taking place in their divisions which is measured through FFT, national and local surveys and complaints monitoring. Patient Experience should be an agenda item at all divisional quality boards.

- The Patient Experience Teams will support the patient experience agenda by: implementing and meeting Key Performance Indicators including those set nationally and locally by the commissioners; collection, analysis and dissemination of the findings across the Trusts; encouraging staff engagement to lead to better patient outcomes and better use of resources; identifying learning and improvement outcomes; developing systems for supporting action plans to close the feedback loop; offering good quality reporting that is themed with other key patient experience indicators.

- The Directors of Nursing are the Trust Board leads for Patient Experience and have specific responsibility for advising the Boards on all aspects of this strategy.

- The Trusts Non-Executive Directors who are the Trust Patient Experience Champion ensures that both the Boards and the Trusts act in the best interests of patients and the public; that patients and service users are treated with dignity and respect at all times, and that the patient voice is central to Trust decision making.

- Divisional Teams are responsible for ensuring that the views of patients, relatives, carers and the public are considered in all service development plans in a timely and effective manner and reports provided to the Patient Experience Teams.

- Patient Experience Groups receive regular progress reports from divisions and thematic work streams.

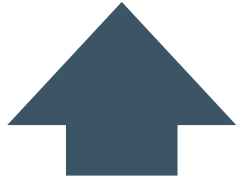
- WHC's Quality Patient Experience and Safety Committee (QPES) and RWT's Quality Governance Audit Committee (QGAC) receive monthly updates via bi-monthly reports of triangulated feedback and progress against plan.

- Both Trust Boards receive a summary from Quality Patient Experience and Safety. Each Trust Board is responsible for ensuring it receives and acts appropriately on information about the areas of public concern and assuring itself that engagement with patients, relatives, carers and the public has taken place.

- Both Trusts will provide a patient experience annual report detailing progress of this strategy, all other patient experience metrics and initiatives.

Whilst the above have the responsibilities described, all Trust staff at every level has a responsibility to promote positive patient experience and the principles of this strategy.

Walsall Healthcare NHS Trust and
The Royal Wolverhampton NHS Trust Boards



Quality Patient Experience and Safety Committee (QPES)

Quality Governance Audit Committee (QGAC)

Patient and Partner Experience Group

Patient Feedback Oversight Group

Patient Involvement Partner Forums

5.0 Equality Impact Assessment

This Patient Experience Enabling Strategy will be equality impact assessed to ensure that the guidance provided does not place at a disadvantage any service, population or workforce over another.

6.0 Risks and Mitigations

Risks	Mitigations
Lack of staff to engagement in or prioritisation of good patient experience.	Staff receive the necessary training and are supported to understand/undertake patient experience activities.
Failing to meet the recommended measure based on average national target for FFT.	Promotion of the FFT ensuring that patients have an opportunity to take part and are encouraged to provide honest feedback. Publication of the results and outcomes including service improvement.
Trust failure to demonstrate improvement in patient experience against national standards.	The creation of an environment in which staff are encouraged to report learning and improvements from engaging with patients.
Failure to monitor patient experience and making changes as a consequence of feedback received.	Focusing on patient experience, measuring it and acting on the results of that measurement and identifying any associated cost. Identification of the factors that influence patient experience including those that may need new investment or those where better use of existing resources may be appropriate.

7.0 Conclusion

Both Trusts aim to actively improve the patient experience by implementing the aims outlined in this Patient Experience Enabling Strategy.

Key focused themes from all the data at our disposal have been identified which should impact upon and improve patient experience and fulfil the priorities that we have set for ourselves.

8.0 Reviewing this Strategy

This is a 3-year strategy underpinned by an Implementation Plan. The Plan will be reviewed on an annual basis.

For this strategy to me meaningful for our patients, the implementation will be measured on it's delivery. A detailed delivery plan has been developed by each Trust which sets out the key activities, success measures and timescales to achieve our aims. The Plans will be reviewed annually, responding to any new and emerging priorities.

Designed and produced by The Department of Clinical Illustration, New Cross Hospital, Wolverhampton - Tel: 01902 695377 MI_10688014_11.11.22_V_2

Paper for submission to the Trust Board Meeting – to be held in Public On 1st August 2023		
Title of Report:	Infection Prevention and Control Delivery Plan 2023 - 26 (Draft)	Enc No: To be completed by Board Administrator
Author:	Matthew Reid (Head of Nursing – Corporate Support Services)	
Presenter/Exec Lead:	Debra Hickman (Chief Nursing Officer)	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☒No☐	Yes☐No☐	Yes☐No☐
Recommendations: The Board is asked to endorse the Infection Prevention and Control Delivery Plan 2023 – 26.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	None		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Contribution to the Trust's compliance with CQC standards
	NHSE	Yes☒No☐	Details: Contribution to the Trust's compliance with NHSE framework
	Health & Safety	Yes☒No☐	Details: Contribution to the Trust's compliance with Health and Safety standards
	Legal	Yes☒No☐	Details: Compliance with the Health and Social Care act 2008: code of practice on the prevention and control of infection and related guidance
	NHS Constitution	Yes☒No☐	Details: Details: Commitment to quality of care, right to be cared for in a clean environment
	Other	Yes☐No☒	Details:
CQC Domains	**Safe:** Protecting staff and patients from avoidable harm **Effective:** Care, treatment and support achieves good outcomes **Well-led:** The leadership, management and governance of the organisation make sure it's providing high-quality care.		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration: No adverse impact is anticipated as a result of the points articulated in this delivery plan.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Infection Prevention and Control Group (IPCG) 30/6/23
	Board Committee	Yes☒No☐	Date: Trust Management Committee – 30/6/23
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee.**
Advise **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought.**
Alert **Positive assurances & highlights of note for the Board/Committee.**

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Safe and responsive urgent and emergency care
Support our Colleagues	• Improve overall staff engagement
Improve the Healthcare of our Communities	• Reduction in the carbon footprint of clinical services by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Infection Prevention and Control Delivery Plan 2023 - 26 (Draft)

Report to Trust Board Meeting to be held in Public on 1st August 2023

EXECUTIVE SUMMARY

Joint three-year Infection Prevention and Control (IPC) Delivery Plan between The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT).

BACKGROUND INFORMATION

This three-year IPC Delivery Plan is the first joint IPC plan for RWT and WHT. The Plan sets the direction for IPC for our organisations and incorporates the four Cs of the joint strategy – Care, Colleagues, Collaboration and Communities, and is aligned to the Quality and Safety enabling strategy and joint organisational Quality Framework. The plan will be bolstered by the IP annual work programme generated by each of IP teams, and the plan will provide direction for the development of the annual work programmes.

The objectives of the draft delivery plan focus on:

- Fundamentals in IPC (back to basics)
- continuing to reduce healthcare associated infections (HCAI)
- to embed infection prevention in everyday practice
- sustain improvements to keep patients, staff, and visitors safe.

In doing so the Trusts will develop existing work and projects and initiate the development of leading-edge work, aspiring to be national leaders for the reduction of HCAI's. The Trusts will continue to monitor compliance and in doing so will ensure the enhancement of existing surveillance systems and introduce new systems where required ensuring learning from action and incidents takes place. This will be supported by a comprehensive communication/engagement plan to ensure awareness and support with delivery.

RECOMMENDATIONS

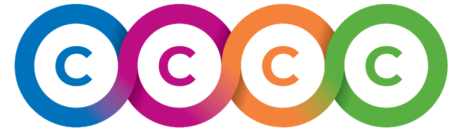
The Board is asked to endorse the Infection Prevention and Control Delivery Plan 2023 - 26

Any Cross-References to Reading Room Information/Enclosures: N/A

Infection Prevention and Control (IPC)
Delivery Plan 2023-26

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust



Care Colleagues
Communities Collaboration

This three-year Infection Prevention and Control (IPC) Delivery Plan is the first joint IPC plan for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT).

The Plan sets the direction for IPC for our organisations and incorporates the four C's of of the joint strategy – Care, Colleagues, Collaboration and Communities, and supports and is aligned to the Quality and Safety enabling strategy and joint organisational Quality Framework.

As an organisation registered the with Care Quality Commission (CQC) RWT and WHT are required to deliver services as set out in The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, more commonly known as The Hygiene Code. The Trusts are required to declare compliance with a specific standard relating to infection prevention and control and this relates directly to the Hygiene Code. The CQC monitors the Trusts compliance against the Code of Practice through formal visits and the implementation of enforcement actions where necessary. In addition to the standards set out in the Hygiene Code there are additional annual improvement expectations set by NHS England relating to some infections.

Preventing the spread of infection remains one of the top quality and safety priorities of both Trust's. To be truly effective, infection prevention and control must be an everyday process and consideration within the Trusts supported by all employees as an integral part of workplace culture.

Recognising the challenges posed by the COVID-19 pandemic and the learning realised, our aim will be to fully deliver on all key priorities as outlined within this joint Delivery Plan. This delivery plan is an integrated element of the Quality and Safety enabling Strategy.

Where are we now?

RWT and WHT have well established IPC services and inform a robust governance structure and process through mandatory reporting requirements and informing a number of key Trust Groups.

RWT and WHT are committed to ensuring the safety of patients, staff and visitors. Patient safety is high on the Trust agendas and is a priority for the Trusts. The provision of a robust Infection Prevention delivery plan is an essential element in achieving these safety objectives and in ensuring compliance to the Code of Practice and to national and local objectives. The IPC services have collaborated on a number of initiatives since the partnership working between the two Trusts commenced.

Where do we want to get to?

Our collective vision, as defined in our joint Trust Strategy, is 'To deliver exceptional care together to improve the health and well-being of our communities.'

Both RWT and WHT are continuously striving for excellence, we will deliver this by placing the patient in the centre of everything we do, embedding a culture of learning and continuous improvement. We want to encourage and facilitate evidence based practice, research and innovation. We will support the IPC teams to be educated in quality improvement methodolgies so that these can then be incorporated in everyday thinking and when approaching IPC issues. We will support and influence the drive for environmental sustainability through pragmatic and evidence based IPC decisions and approaches.

Use of invavsive devices such as urinary catheters, peripheral vascular devices and other intravenous devices are used frequently in healthcare and are often a necessity as part of the care being delivered to our patients. We want to ensure that such devices are used optimally, where required they are used only when clinically indicated for the shortest duration that is safe for the patient and also consider alternatives that will reduce the risk of infection.

As we emerge from the shadow of the COVID-19 pandemic, the key lessons learned through an era defined by unprecedented global health challenges should not be forgotten but rather leveraged for future preparedness. Notably, for IPC teams this is an opportune moment to review, reassess, and reinvigorate our approach to patient safety. RWT and WHT are in a position to pave the way for a new approach to IPC that capitalises on technology, innovation, and inter-Trust collaboration.

Fundamental to this endeavor is a re-emphasis on the basic or key elements of IPC. Maintaining rigorous hand hygiene, appropriate and adequate personal protective equipment, environmental cleanliness, and robust surveillance of healthcare-associated infections (HCAI) are the bedrock of any effective IPC program. But beyond that, we need to build a more resilient, adaptable, and comprehensive plan, capable of minimising harm to patients now and in the face of any future health threats.

How will we get there and what will we do?

Our key priority areas have been formed through external drivers such as the Health and Social Care Act Code of Practice. Activities and outputs will supported through trustwide action plans (for example C diff, outbreak, urinary catheters), self assessment against the national Infection Prevention and Control Board Assurance Framework, and alignment with the National IPC manual.

Objectives

The objectives focus on continuing to reduce healthcare associated infections (HCAI), to embed infection prevention in everyday practice and sustain improvements in order to keep patients, staff and visitors safe. In doing so the Trusts will develop existing work and projects and initiate the development of leading edge work, aspiring to be national leaders for the reduction of HCAI's. The Trusts will continue to monitor compliance and in doing so will ensure the enhancement of existing surveillance systems and introduce new systems where required ensuring learning from action and incidents takes place.

Priority Area	How will we achieve our aims?	Key actions we will take	How will we know we have succeeded and when?
Fundamentals of Infection Prevention and Control (IPC)	We will enable and empower our staff to be able to practice the fundamental elements of IPC on a consistent basis. This will be achieved through education, educational resources and information, employing innovative methods where appropriate, utilising quality improvement methodologies, aligned policies and IPC visibility. We will facilitate and influence the endeavour to meet or positively exceed nationally set objectives for C. diff and Gram negative bacteraemia.	• Utilise NHS Englands 'Take your gloves off' campaign to support both rationalisation of glove use by our staff and sustainability objectives • Support the 'Eat, Drink, Dress, Move to Improve' initiatives across both organisations • IPC staff will undertake Quality Improvement (QI) training • Work with areas utilising Quality Improvement methodology to support them to be able to do the right thing at the right time. The IP teams will explore the application of behavioural science and human factors in interventions made • Explore interventions, working with industry partners to support improvement in hand hygiene compliance assurance, for example triangulate audit data with alcohol hand gel and soap consumption data to establish expected metrics for clinical areas • Facilitate ownership of IPC across all areas • IPC policies will be aligned where possible between the two organisations and will incorporate the National IPC Manual • Audit programmes - Alignment of templates/frequency/ responsibilities for undertaking • Support and participate in initiatives to improve patient mouthcare • Explore and develop innovative methods of education delivery to ensure meaningful and interactive learning that will encourage and engage our workforce • We will activley support Clinical Nurse Fellow (CNF) support network to ensure our colleagues are inducted with regard to IPC and provided with education and guidance	Success will be measured - through audit and reductions in glove use - outputs of the 'Eat, Drink, Dress, Move to Improve' initiatives - through involvement of the CQI team and QI briefs - IPC staff completed QI practitioner training - established repeatable/ sustainable process to provide further assurance in hand hygiene compliance - alligned IPC policies which incorporate the National IPC Manual - IPC surveillance data

Priority Area	How will we achieve our aims?	Key actions we will take	How will we know we have succeeded and when?
Reducing procedure and device related infections	We will build upon existing surveillance processes to include catheter associated urinary tract infection (CAUTI), hospital acquired pneumonia (HAP) and ventilator associated pneumonia (VAP) and explore innovative methods of surveillance We will establish surgical site infection surveillance at WHT to mirror the established team and processes at RWT	• We will be involved with and contribute to all NHS England collaboratives groups and events (C diff, Gram negative bacteraemia) and establish surveillance processes for CAUTI, HAP and VAP • Establish surgical site infection surveillance team and processes at WHT • Utilise QI methodologies to improve device surveillance • We will explore innovative methods to support surveillance of devices • Continue with multidisciplinary urinary catheter group and further expand links between the two organisations • Facilitate use of the national One Together audit framework for Theatres	Success will be measured - CAUTI, HAP and VAP surveillance processes to be in use for 2024/25 - Surgical site infection surveillance team in operation at WHT with data being shared with clinicians by end of 2024/25 and local benchmarking of data (RWT and WHT) - Intravenous line surveillance app developed and in use in RWT and WHT in 2024/25 - Urinary catheter passport is fully operational in 2024/25 - Use of the standardised catherisation pack is embedded in the Acute Trust (except in paediatrics) by 2024/25 - Audit and surveillance data will be shared
Learning from IP related incidents	The Trusts will develop a Patient Safety Incident Response Policy and Plan in line with the Patient Safety Incident Response Framework (PSIRF), a fundamental shift in how the Trust responds to patient safety incidents for learning and improvement. The IP teams will ensure that processes are alligned to policy and plan.	• As part of the trusts moving to the Patient Safety Incident Reporting Framework (PSIRF), we will develop HCAI review processes aligned with PSIRF • Infection Prevention incident review meetings will continue where learning can be identified and then shared	HCAI incident process is fully alligned to PSIRF

Priority Area	How will we achieve our aims?	Key actions we will take	How will we know we have succeeded and when?
Research and innovation	Evidence-based practice forms the backbone of effective patient care, and the same should be true for our infection prevention and control strategies. Therefore, we will promote and participate in research activities aimed at improving IPC.	• We will work in partnership as teams and explore and undertake research activity with external academic and industry bodies • We will scope and apply for research grants to support activity and studies where appropriate • We will publish work undertaken and present work at professional conferences/events • We will develop an IP app to support staff with up-to-date information and guidance • Explore the development of critical appraisal topic (CAT) group for IPC to support the strive for evidence based practice	IPC peer reviewed publications, conference presentations and conference abstracts submitted successfully. CAT group developed and operating IP app is operational and available for use Research grant applications submitted where appropriate Research activity undertaken
Engagement	We will develop joint IPC communications to inform and educate our staff. We will keep our staff informed through improved sharing of data to support the drive for quality improvement.	• Develop an IPC data dashboard to allow timely sharing of data for trust staff • Explore the incorporation of IPC elements in of Huddle boards across both organisations and regularly connect with QI teams to maintain momentum • Develop invasive devices (urinary catheters, peripheral venous cannulae) data dashboards to allow timely sharing of data and drive quality improvements • Continue to support staff seasonal influenza and booster vaccination programme • We will have involvement in the Trusts work towards an electonic patient record to ensure that all relevant and meaningful IPC data is captured and used correctly • We will explore methods of bringing the patients voice to IPC	Data dashboards developed and shared with and accessed by staff

Priority Area	How will we achieve our aims?	Key actions we will take	How will we know we have succeeded and when?
IPC team development	It is fundamental to good IPC practice that our IPC workforce is educated and skilled and can build personal and professional capacity.	• We will continue to develop and grow the joint educational 'Thinking Thursday' sessions • We will utilise the Infection Prevention Society's (IPS) Credentialing Framework to recognise Infection Prevention and Control specialist expertise, it provides a self-regulated standard of higher professional training required for the leadership and delivery of high-quality infection prevention and control services, education programmes and research programmes	Infection Prevention Society's (IPS) Credentialing Framework intergal to team development and competency tools
Infection Prevention and Contol and the environment	It is imperative that the healthcare environment is clean and designed to support safe care and good IPC practice. It is vital the IPC is considered in new and refurbishment building projects at the earliest point. We will support the development and use of patient equipment cleaning centre (PECC) at RWT and support assessment of feasibility at WHT.	• We will explore innovations to support healthcare environment cleanliness to enable a reduced risk of HCAI • We will facilitate installation of UV light decontamination equipment in RWT ED and AMU single rooms and explore evaluation processes with NHS England New Hospital programme • We will consider established environment guidance but also engage with new and evolving IPC evidence and how that can be incorporated in practice. • We will be active members of our Water Safety Groups and Ventilation Safety Groups to encourage and faciliate safe and effective improvements in our healthcare environment	Evaluation of UV light decontamination undertaken following installation at RWT PECC in use at RWT

Priority Area	How will we achieve our aims?	Key actions we will take	How will we know we have succeeded and when?
Antimicrobial Stewardship	The IPC teams will support the vitally important stewardship of antimicrobials use	• We will be active members of the Trusts Antimicrobial Stewardships (AMS) Groups • We will support the AMS education of our workforce • We will participate in national point prevalence activity	Participation in the national HCAI/AMS 2023 point prevalence survey
Support environmental sustainability	The IPC teams will support the ongoing work that both organisations are undertaking to support and encourage environmental sustainability.	• We will be active members of the respective Trust Sustainability Groups • We will support the exploration and development of a combined Clinical Procurement Group (to enable product decisions to include IP, sustainability, cost-benefit analysis and contemporary evidence base) • We will support the drive to environmental sustainability through pragmatic and evidence based IPC decisions and approaches	Measurement against metrics developed through the respective trust Sustainability Groups

Paper for submission to the Trust Board Meeting – to be held in Public/Private on Tuesday 1st August 2023		
Title of Report:	Mental Health Overview Report	Enc No: To be completed by Board Administrator
Author:	Jodie Kirby-Owens, Head of Nursing, Mental Health	
Presenter/Exec Lead:	Dr Brian McKaig, Chief Medical Officer	

Action Required of the Board/Committee/Group (Please remove action as appropriate)			
Decision	**Approval**	**Discussion**	**Other**
Yes☐No☐	Yes☒No☐	Yes☐No☐	Yes☐No☐

Recommendations:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or approval.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 6017 - Children and Young People Mental Health quality of care. 6018 - Adult Mental Health Quality of Care 6019 - Children and Young People (CYP) Mental Health delays in access to Tier - 4 bed. On Risk Register: Yes☒No☐ Risk Score : 6017 – Score 20 6018 – Score 16 6019 – Score 20		
Changes to BAF Risk(s) & TRR Risk(s) agreed	None		
Resource Implications:	Workforce: • Agency/ bank costs to support and manage patients who require mental health 1:1 (support) trust wide. • Specialist resources are used via agency and external organisations trust wide to support complex mental health patients.		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Mental Health Provider status
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	NA		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: TMC July 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- During January 2023 - June 2023 there was 104 Mental Health Act Assessments. 22 of those were detained to RWT with the remainder to Mental Health Trust Beds or discharged home.
- There have been no deaths of patients held under the Mental Health Act in the Trust.

Advise

- Increased acuity for patients attending The Royal Wolverhampton (RWT) with mental health concerns. These are predominantly working age adults.
- The Mental Health team continue to work in collaboration with Black Country Foundation Healthcare Trust, Mental Health Liaison Service.
- 3 risks remain live on the corporate risk register, 2 in relation to internal and external risks for CYP who require Tier 4 provision and 1 in relation to adult mental health services.
- The trust is actively recruiting mental health clinical support workers to assist in the enhanced supervision of mental health patients.

Alert

- There have been 421 reported mental health related incidents.
- Challenges continue with capacity within the Mental Health Liaison Service resulting in delays to care & treatment.
- Challenges with access to Tier 4 system contributing to extended length of stay in the Emergency Department and Acute wards.
- Incident Themes include: Delays in access to appropriate mental health assessment, Insufficient documentation entries made by external services, Suboptimal quality of care that does not fall into recommended national standards for Psychiatric liaison service delivery.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

Mental Health Overview Report

Report to Trust Board Meeting to be held in Public/Private on -1st August 2023

EXECUTIVE SUMMARY

The purpose of the reports is to highlight the current mental health risks, progress and actions. Identifying internal and external factors

BACKGROUND INFORMATION

In 2021 The Royal Wolverhampton (RWT) registered as a provider of mental health with the CQC - allowing patients to be detained under the Mental Health Act (MHA) to the organisation. Being a detaining authority places a responsibility onto the hospital managers (Trust Board) to ensure any MHA detention is completed in a lawful way upholding patients human rights.

As an organisation it must be evidenced that there is compliance with:

- The Mental Health Act 1983
- The Code of Practice 2015

In the MHA the Trust Board are referred to as Hospital Managers and within the 'Code of Practice' the Hospital managers have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. They must ensure that patients detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

The trust board can accept or decline a detention to their organisation. The board are also required to support any tribunal or appeals that take place as they hold overall responsibilities of the Act within the organisation.

The MHA (1983) is the main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. People detained under the MHA need urgent treatment for a mental health disorder and are at risk of harm to themselves or others. The MHA enables a person to be detained or treated without their agreement. There are many sections of the MHA. Common sections of the MHA used at RWT are:

- Section 136 - Police Detention to access a mental health assessment and a patient can be held for up to 24 hours.
- Section 2 - detention for assessment for up to 28 days
- Section 3 - detention for treatment for up to 6 months (can be extended further)
- Section 5(2) – short term detention for assessment for up to 72 hours, usually resulting in further MHA assessment.
- Section 17 leave - for those patients detained to other organisations, however may be transferred to RWT for treatment. Section 17 leave is a requirement for anyone who is detained under the mental health act and requires "leave" from the place where they are detained to.

Overall, the organisation has supported all the detentions above. Since the employment of mental health act administrators and a wider mental health team the organisation can evidence that they comply with the MHA.

However, within current months due to lack of MOU/SLA for mental health services this has highlighted a gap within the adherence to the MHA.

Currently there is no formal process or agreement in place that supports the 'Responsible Clinician' (RC) under the MHA. This is a direct requirement for any patient detained, predominantly under section 3 MHA for 'treatment'. Without a RC the organisation would not be complying with the regulations of the MHA and code of practice.

Current national picture:
Newcastle upon Tyne Hospitals NHS foundation Trust were assessed by the CQC in February 2023.

<u>CQC response:</u>
"In response to our findings, we served the trust with a Warning Notice under Section 29A of the Health and Social Care Act 2008. The Warning Notice told the trust that they needed to make significant improvements in the quality and safety of healthcare provided in relation to patients with a mental health need, a learning disability or autism."
The CQC completed a very detailed report detailing all of the areas of improvements required and this report highlighted the responsibilities of the acute trust for all patients that are admitted and the required need for process and clear service delivery expectations, to support patients suffering mental health symptoms.

- There is learning from this report that the mental health team within RWT are reviewing to identify gaps and actions.

However, RWT can evidence the work that has been done against this report and this is a success for the organisation. RWT has invested in mental health act administrators and mental health staff who have implemented new processes that support parity of esteem and improvements in practice. There is ongoing work to continue to support mental health patients and deliver parity of esteem.

1.0 Risks

This report contains a summary of risks that are located on the corporate risk register in relation to mental health, providing an outlining updates, escalations, and de-escalations.

<u>6019– Children and Young People (CYP) Mental Health delays in access to Tier - 4 bed.</u>

External risk - risk score is 20.
This is a current risk and there has been a recent incident relating to a 17-year-old who was detained under section 2 MHA for 28 days on AMU and subsequently discharged after fulfilling the full 28 days of detention to RWT.

- This patient had a tribunal whilst an inpatient of RWT, this was supported by the RWT mental health act administration team.

The patient then returned to the emergency department less than a week after discharged and was assessed to require section 3 MHA. This patient was awaiting a section 3 Mental Health bed for several days whilst in ED. This patient was transferred to a Tier 4 bed from ED with recommended section 3 detention for treatment (for up to 6 months).

Overall, the trust is unable to fully support and manage CYP awaiting a tier 4 bed admission and manage patient safety through the patient journey. Identified issues:

- Developing CAMHS services.
- CAMHS service is daytime only.
- Lack of training for CYP staff that are supporting Mental Health patients in crisis.Actions:
- Paediatric team meet regularly with all services to support patient pathways.
- To have an agreed MOU and clarity for services.
- Staff to attend mental health training and suicide prevention training.
- Rapid tranquilisation policy is currently going through ratification processes.

- To add the Royal College of Emergency medicine (RCEM) CYP risk assessment tool to practice supporting an understanding of CYP in crisis risks.

6017 - Children and Young People Mental Health quality of care.

Internal risk - risk score of 20.
This is due to recent admissions to the organisation for CAMHS patients that have been admitted for several days/ weeks at a time.

- There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains within RWT; the lack of adequate service provision externally means the trust carries a high-level risk internally as a result of holding CYP who are in crisis.
- Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 08.00 – 18:00 and telephone access from 18:00-20:00.
- The current services delivered for CAMHS does not support the out of hours presentations.
- No locally commissioned beds and this contributes to challenges to access the national available CAMHS beds.
- Children who attend late in the day or out of hours have to wait several hours to access an appropriate mental health assessment, at times this can be 10-13 hours. Whilst they are awaiting the assessment the emergency department and wards are responsible for supporting and managing the risks. This has contributed to incidents due to a lack of understating of the patients and potential risk history.

6018 – Adult Mental Health Quality of Care

Risk score 16 - risk of sub optimal care and harm to adults who present in a mental health crisis, due to external services not able to deliver the required services due to the absence of an MOU. This in turn may contribute to a breach in part of the MHA, resulting in non-adherence to the MHA legislation and CQC requirements.

There is evidence of suboptimal quality of care delivery for mental health patients due to extended waiting times to access and receive assessment and support. As there is no formal agreement for services delivered to adults who require mental health assessment the current service at times is varied in service delivery and has inconsistent quality of care.

There has been challenges to adhere to the standards of contemporaneous record keeping due to the external services inconsistently documenting within the acute trust notes and at times not sharing relevant risk history and presentation. This contributes directly to incidents due to the acute trust staff not knowing the risks relating to the individual patient.

- There continues to be regular monthly incident reports relating to: patients waiting longer than the expected 1-hour response time for CORE24 mental health liaison services, often patients wait between 2-6 hours for this assessment whilst in ED.
- Other incidents are related to delays in access to psychiatrist, suboptimal documentation and information sharing, absconding patients and CORE 24 mental health liaison services not being met.

Actions:

- The Royal College of Emergency Medicine (RCEM) risk assessment tool has been put into practice to support the acute staff to understand the patient risks whilst awaiting the external services to complete an assessment.
- Additional training has been provided to key areas from the RWT mental health team to support the management of mental health patients who are in the acute trust.

2.0 Mental Health Activity

Patient acuity has increased significantly for patients attending the trust with mental health concerns, feedback from the Black Country Mental Health Trust suggest that attendances to the new Emergency Department since opening have increased by approximately 25% with significant increases in out of area patients presenting with mental health issues (Chart 1).

Nationally there has been an increase in attendance to the ED for mental health and this is also shared with the national lead nurse for mental health group that the head of nursing for mental health attends.

There has been through all current evidence-based practice an anticipated 'tsunami' of mental health across the country post COVID-19. There is evidence of this due to the attendance figures consistently being high and the lack of reduction in attendances that would usually be anticipated through the warmer months. Usually, mental health crisis and attendances follow a dynamic pattern throughout the year, however there is a consistent rate with a higher acuity. This has contributed to the increase in admissions to psychiatric hospitals, increase in MHA assessments, directly linked to extended ED DTA breaches, and wait times.

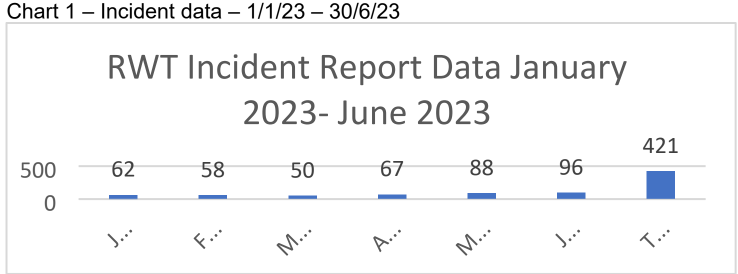
Nationally there as significant pressures to access mental health beds and this is evident in patients awaiting mental health admission and remaining in the acute trusts for days/weeks at a time awaiting access to appropriate psychiatric beds. This is a change across the system in the demand for services to support mental health patients.

3.0 Governance

There were 421 mental health related incidents reported between January 2023 – June 2023 (Chart 1) with the top 3 cause groups of:

- Non-adherence to local policy (External partners/ CORE24 response time breach)
- Patient absconded.
- Decision To Admit (DTA) breach.

Chart 1 – Incident data – 1/1/23 – 30/6/23



The list below highlights the common themes each month that are raised to the MH team within RWT (the MH team respond swiftly and offer support/ guidance for the trust):

- Absconding patients (all areas).
- Absconding patients ED.
- Patient delays in accessing mental health assessment by external provider.
- Breach in CORE24 service delivery standards.

- Lack of a streamlined service for external services for MHA process.
- Challenges with completing section 5(2) MHA 1983 documentation and assessment.
- Police 136 process, access to mental health suite, and management of patients under section 136.
- Increase in section 136 attendances to the ED.
- Supporting children under section 136 suite as CAMHS currently do not offer any support to ED.
- Challenges to access the local 136 suite for CAMHS.
- Supporting patients and plans of care for Tier 4 admissions.
- Supporting WCCSS division with the gaps in CAMHS provision.
- Supporting RWT with gaps in CORE24 provision.
- Supporting and escalating through appropriate routes.
- Overuse of restraint/inappropriate restraint by security staff/ward staff.
- Frequent admissions/HISU (High Intensity Service User).

The mental health team at RWT and RWT conducted an audit to further understand the issues and the findings are being worked through with partners in the mental health trust.

Action:
RWT have now developed a meeting to share incident reports with the external mental health provider on a regular basis. To improve collaborative working and supporting the quality of care for patients who are in acute trust.

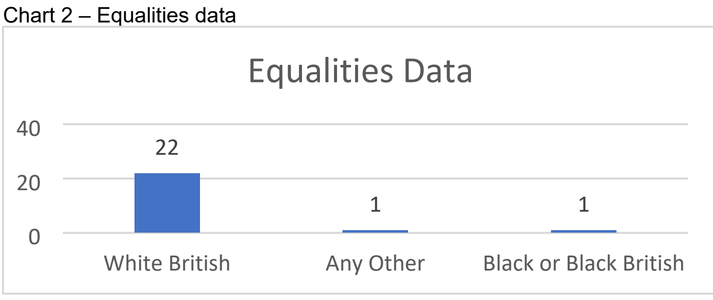
4.0 Mental Health Act

4.1 Equalities data

The equalities data for those that were detained is as follows:

- Age: The average age was 30 years (12 - 80years).
- Ethnicity: is detailed in the graph below for those detained to RWT.

Chart 2 – Equalities data



As an organisation all equality data is collated and compared with the other regional teams and acute trusts.

4.2 Mental Health Act (MHA) Assessments

Chart 3: There have been 105 MHA assessments within RWT between January 2023 – June 2023.

Chart 3 – MHA assessments

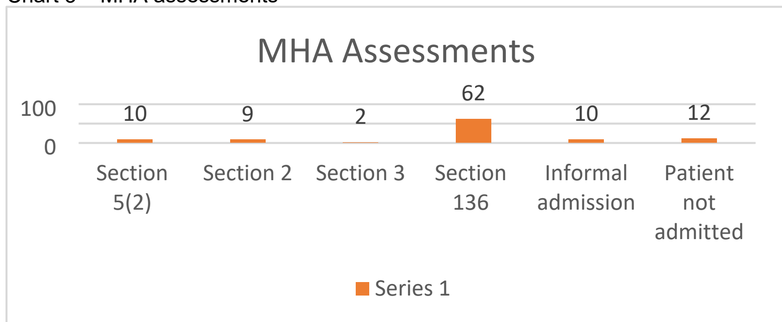
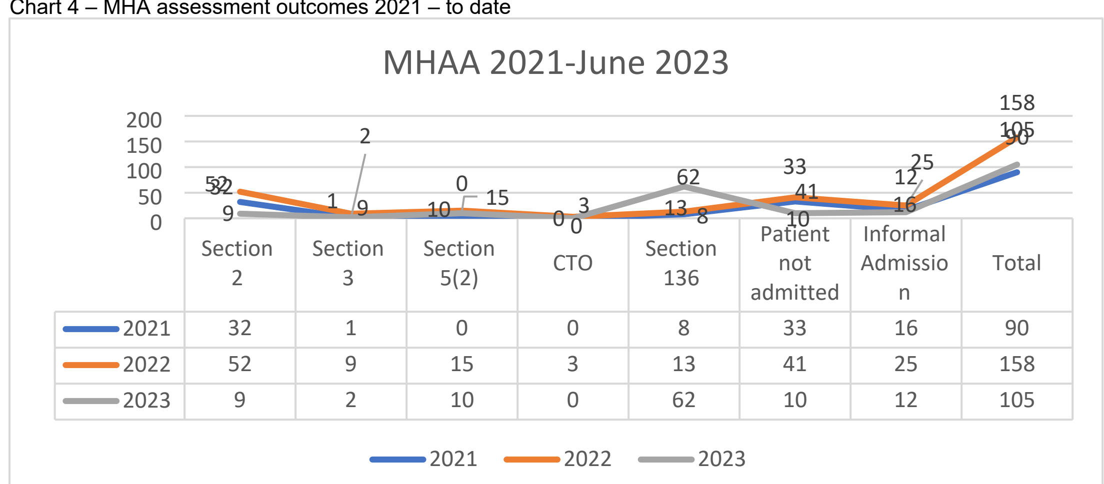


Chart 4 demonstrates the mental health act activity over the past 3 years, highlighting the overall increase in demand within the organisation in 2022 – 2023.

Chart 4 – MHA assessment outcomes 2021 – to date



	Section 2	Section 3	Section 5(2)	CTO	Section 136	Patient not admitted	Informal Admission	Total
2021	32	1	0	0	8	33	16	90
2022	52	9	15	3	13	41	25	158
2023	9	2	10	0	62	10	12	105

5.0 Mental Health Training

5.1 Mental Health Act training

- Mental Health Act Awareness Is available to all members of staff via the Trust intranet.

5.2 Ligature cutter training

- Training video is available via MyAcademy.

6.0 Project Work

6.1 Development of Clinical Support Worker (CSW) Band 3 Bank resource

The RWT mental health team have been working with the resourcing team to employ BANK CSW band 3 staff that are mental health trained and have experience of working within mental health services. This is to support the quality of care for all mental health patients within the organisation, ensuring safe high-quality care. Especially for those who require enhanced care and support.
RWT mental health team are providing an additional bespoke induction that includes de-escalation and breakaway training, incident reporting, documentation and escalation.

6.2 Training

The head of nursing for mental health has worked closely with the education team to develop a training plan for mental health training for the acute trust. This will provide bespoke relevant training to all staff. This project will be complete November 2023, as all training packages are being developed. The training is to support the staff to develop relevant skills and knowledge to support mental health patients who attend the acute trust. The training will also include up to date risk and suicide prevention data.

RECOMMENDATIONS

To note the contents of the report.

Any Cross-References to Reading Room Information/Enclosures: None

End of report.

Paper for submission to the Trust Board Meeting – to be held in Public On 1st August 2023		
Title of Report:	Pharmacy and Medicines Optimisation Report	Enc No: To be completed by Board Administrator
Author:	Angela Davis, Clinical Director of Pharmacy and Medicines Optimisation, Controlled Drugs Accountable Officer	
Presenter/Exec Lead:	Dr Brian McKaig, Chief Medical Officer	

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

Recommendations:
The Board is asked to note the contents of the report and in particular the key issues described under 'Alert' pertaining to medicines management. The Board members may wish to discuss whether they are satisfied with the assurance provided and improvement actions described, or whether further information is required.

Implications of the Paper:			
Risk Register Risk	Yes ☒ Risk Description: Datix 5448: Safe medicines management Datix 5030: Pharmacy Aseptic Suite -Facility On Risk Register: Yes☒No☐ Risk Score (if applicable) : Both risks are on the TRR and have a risk score of 12		
Changes to BAF Risk(s) & TRR Risk(s) agreed	No changes to TRR Risks		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Fundamental Standards: Safe
	NHSE	Yes☒No☐	Assurance of Aseptic Preparation of Medicines
	Health & Safety	Yes☐No☒	
	Legal	Yes☒No☐	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 Medicines Act 1968 The Human Medicines Regulations 2012 The Misuse of Drugs Act 1971 Controlled Drugs (supervision of Management and Use) Regulations 2013
	NHS Constitution	Yes☒No☐	Quality of Care
	Other	Yes☐No☒	
CQC Domains	**Safe: Well-led:**		

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration: There is nothing within this report that might disadvantage anyone with reserved characteristics.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: QSAG July 23
	Board Committee	Yes☒No☐	Date: TMC & QGAC July 23
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☐	Date: MMG July 23

Summary of Key Issues using Assure, Advise and Alert

Assure

- Medication incidents have been within control limits since the last report in January 2023.
- A Trust wide inpatient paper prescription chart audit showed some improvements required, but the Trust Medicines Management Group were generally assured of prescribing standards on paper prescriptions.
- From April 2023 RWT Pharmacy Aseptic Services have reported quality indicators via the national compliance management system iQAPPS (interactive Quality Assurance of Aseptic Preparation Services); all indicators have been within control limits despite an aging facility that is on the TRR (Datix 5030).

Advise

- The Trust has 2.3wte (3%) Pharmacist vacancies and is over established for Pharmacy Technicians. However, without investment and growth in pharmacy establishment there will continue to be gaps in the pharmacy provision to wards/departments and no weekend clinical pharmacy service. This limits improvement in pharmacy oversight of medicines use, and the ability to reduce medicines risks including reduction of omitted doses and improvement in medicines reconciliation within 24 hours of admission.
- The EPMA upgrade planned for July 2023 has been postponed to September 2023 due to 3 critical issues that are unresolved by the supplier. The upgrade is required to improve system stability and to address safety risks within the current system.

Alert

- In May 2023, 4854 (3.74%) doses of critical medicines were omitted on EPMA wards; omitted doses may result in patient harm and prolonged hospital stays. Omitted doses are reported monthly to ward level and in 21/22 a focused intervention resulted in a reduction in omitted doses. This reduction has been sustained but not further improved upon. AMU has the highest number of omitted doses and will be the focus of a CQI project.
- Pharmacy audits, Datix incidents and internal quality assurance visits continue to demonstrate that the safe and secure storage of medicines and management of controlled drugs remains below the standards required. The risks associated with this are patient harm from a medication error and regulatory non-compliance. The medicines risk on the Trust risk register (Datix 5448) has been reworded to be more specific to the safe and secure storage of medicines, including the disposal of unrequired and expired medicines. Work is ongoing to improve the clinical environments within which medicines are stored and a medicines safety summit is planned for September.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of cancer patients • Safe and responsive urgent and emergency care
Support our Colleagues	• Be in the top quartile for vacancy levels
Improve the Healthcare of our Communities	
Effective Collaboration	• Improve population health outcomes through provider collaborative • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall

Paper for submission to the Trust Board Meeting – to be held in Public On 1st August 2023

Title of Report: Pharmacy and Medicines Optimisation Report

1.0 Introduction

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 states that medicines must be supplied in sufficient quantities, managed safely, and administered appropriately to make sure people are safe. The Trust Medicines Management Group (MMG) provides oversight of medicines management within the organisation and reports to the Quality and Safety Advisory Group (QSAG). The purpose of this report is to advise the Trust Board of medicines management risks and activities since the last report presented in January 2023. This report covers Q4 2022/23 and Q1 2023/24. Data and charts are provided in the supporting reference pack.

2.0 Medication Incidents

Medication incidents have been within control limits for the last 6 months with low numbers of patient harm reported. Work is being undertaken to benchmark with the other Trusts in the ICS but only data from DGFT has been shared so far; DGFT data shows lower reported medication incidents and similar numbers of patient harm incidents to RWT. The reports are not adjusted for activity and higher numbers of medication incidents at RWT should not be viewed as a negative as it is likely to be due to higher activity and reporting culture within the Trust.

No new incident trends have been identified and the most frequently reported medication incident type continues to be ‘administration’, with omitted and delayed doses making up the largest proportion of these incidents. In May 4854 (3.74%) doses of critical medicines were omitted on EPMA wards for nonvalid reasons. Omitted doses can result in patient harm and prolonged hospital stays. The Trust Medicines Safety Group (MSG) have noted a small number of harm incidents where patients have not received antiepileptics, either because they have not been prescribed on admission or they have not been administered when prescribed. Most omitted doses occur in the admissions portals (AMU, SEU, Stroke), and in almost all cases the medicine is available on the ward or elsewhere within the Trust. The Board should note that missed doses of inhalers were identified by the CQC in the recent inspection of WHT. Actions taken to improve omitted doses:

- Publication of a critical medicines list
- Posters, pocket guides and educational videos
- Highlighting critical medicines on EPMA and a stock locator
- Omitted doses reported monthly to ward level on InPhase

Initiatives to drive further improvement include:

	• A Medicines Safety Summit in September • Shared Decision-Making Councils • A CQI project focusing on AMU • Inclusions of medicines management standards in ward accreditation
3.0	**Medicines Policy Compliance** In Q4 the Trust wide inpatient paper prescription chart audit was reported and whilst there is some improvement required the MMG were generally assured of prescribing standards. Pharmacy audits, Datix incidents and pharmacy / nursing quality assurance visits continue to demonstrate that the safe and secure storage of medicines and management of controlled drugs remains below the standard required. Findings include some that would be seen as 'home goals' if CQC were to visit. The risks are patient harm from a medication incident / error and regulatory non-compliance.
4.0	**Medicines Storage** The medicines risk on the Trust risk register (Datix 5448 Safe and proper use of medicines (12 Amber)) has been reworded to be more specific to the safe and secure storage of medicines, including the disposal of unrequired and expired medicines. The following improvement actions have been taken: • Inclusion of medicines standards in the ward accreditation scheme. • Recruitment to a Medicines Safety Nurse. • The introduction of Medicines Management Assistants into the ward-based teams utilising pharmacy vacancies. • Development of a medicine's storage specification for wards and departments. • Refurbishment of Ward A7 in line with the medicine's storage specification has been completed and will be used as a 'model' for future ward refurbishments. A8 is now being refurbished using the same template. • MP10 Medicines Cold Chain Policy has been rewritten to include ambient temperature monitoring and a new risk-based approach to ambient temperature excursions. • The Medicines Safety Team have developed a suite of key medicines management messages. • Pharmacy staff have had refresher training on the Safe and Secure Handling of Medicines. • A focus on medicines management as part of 'Back to Floor' across nursing and pharmacy. Of concern is high ambient temperatures of clean utilities and fluid stores across the Trust, this was reported by CQC in the last inspection of maternity services. The quality and safety of medicines is reduced with temperature storage deviations. Clinical areas across the organisation frequently record ambient room temperature deviations and medicines are stored in treatment rooms, often in confined spaces with no air cooling, and with unreliable temperature monitoring. Estates teams have engaged via the Well-led Group and have been asked to formulate a plan to address the issues, furthermore the business case from DGFT used to address similar issues has been obtained. The Trusts Energy Manager is scoping the feasibility of installing electronic temperature monitoring linked to the Trusts Building Management System, initially starting with C block at the New Cross site. Estates have informed that there is no straightforward fix to the cooling of medicines storage areas and work is likely to be complex, expensive and the solution individualised to each area. Any learning from the refurbishment of A7 and A8 will be applied to future refurbishments. Until a solution can be found areas with ambient temperatures between 25c and 30c will be required to write a risk assessment, including mitigating

actions. Temperature deviations >30c require the expiry dates of all medicines stored within the area to be reduced, this increases pharmaceutical waste and is resource intensive to complete.

5.0 **Electronic Prescribing and Administration (EPMA)**

An upgrade of the EPMA system is required to improve system stability following downtime in August 2022 and to address some of the know patient safety risks within the current version. The upgrade originally planned for July 2023 has been postponed to September 2023 due to 3 critical issues within the test system that remain unresolved by the supplier. Poor performance of the system is having a negative impact on productivity of the pharmacy team, with the system supplier required to restart the system on a regular basis and delays for screens to upload within the pharmacy desktop. Pharmacy have changed the way that they use EPMA and have removed information from the pharmacy desktop to improve system performance, however the impact of these changes has been minimal. A time and motion study is to be undertaken to quantify the impact of the performance issues. Areas including ED, Rheumatology out-patients, paediatrics and neonatal have expressed desires to adopt EPMA but the current system is not suitable for these areas.

6.0 **Collaborative Working**

The Black Country Pharmacy Leadership Team contributed to the medicines management section in the NHS Black Country Five Year Forward Plan which details the collaborative work in areas including antimicrobial resistance, medicines safety, better value medicines, reduction in prescribing variation and pharmacy workforce. RWT continues to host and lead on the Black Country Pharmacy Faculty and from July have hosted the Black Country Covid Medicines Delivery Unit. 3 chapters of the Black Country Joint Prescribing Formulary are now live.

At the Black Country Provider Collaborative Summit in March the Pharmacy Network provided an update on the 3 key workstreams of Aseptic Services, Ophthalmology Medicines, and Acute Pharmacy Workforce. The Ophthalmology Medicines workstream has since been expanded to include all best value biosimilars.

7.0 **Pharmacy Workforce**

At month 2 the Pharmacy Directorate had 2.3wte (3%) Pharmacist vacancies and was over established by 4.7wte (6%) Pharmacy Technicians. Despite a national workforce shortage, the Directorate continues to successfully recruit pharmacy professionals into most specialities. However, whether the Pharmacy Directorate has the right establishment to provide a safe service and sufficient oversight of medicines use is in question (see 8.0 below), and is complicated by a lack of national staffing recommendations and benchmarking data. Innovations to support recruitment and retention include a Pharmacist Step-up Programme, cross sector clinical posts, investment in education and training, and there is a strong focus on staff well-being within the Directorate.

From September 2023 Pharmacy worked with Wolverhampton University, Birmingham University and Aston University to provide clinical placements for pharmacy undergraduate students with positive feedback received from students and universities.

Pharmacy submitted successful bids for:

- £85,000 for Pharmacy Homecare services for NHSE commissioned medicines.

	• 13 funded Independent Prescribing Courses • £54,000 for Post Graduate Training • 5 Trainee Pharmacist posts and 6 Trainee Pharmacy Technician posts, both an increase in posts funded compared to previous years.
8.0	**Clinical Pharmacy Services** Although vacancies within pharmacy are low, without investment and growth in the pharmacy establishment there will continue to be gaps in the clinical pharmacy provision to wards/departments and no weekend clinical pharmacy service. This limits improvement in pharmacy oversight of medicines use, and the ability to reduce medicines safety risks including reduction of omitted doses and improvement in medicines reconciliation within 24 hours of admission. A business case to address gaps in the weekday clinical pharmacy service provision, and to introduce a 7-day clinical pharmacy service to ED and the admissions portals has been supported by the Executive Team, but no funding source has been identified to progress this. A Pharmacist Enablement Procedure has been implemented to provide non-prescribing pharmacists with a governance framework to amend prescriptions without input from a prescriber. This will support patient safety and reduce omitted doses through timely correction of prescribing errors and omissions. It will also potentially free-up medical prescriber time.
9.0	**Aseptic Services** The aseptic facility is on the Trust risk register with the risk escalated due to issues with the roof (now resolved) and plastic on the walls and ceiling; the new facility is anticipated to be commissioned in December 2024. In March 23 NHSE published new guidance NHS England » Assurance of aseptic preparation of medicines which sets out the governance and regulatory arrangements for aseptic preparation of medicines for NHS patients in England.[4] Key points to note: • NHS organisations are responsible for meeting quality standards, responding to audits and inspections, and reporting quality indicators when performing aseptic activities. • The NHS England Specialist Pharmacy Service Quality Assurance Service provides regulatory oversight and inspection of aseptic activities, and auditing services against quality standards. • NHS England is responsible for commissioning the overarching governance and assurance process, providing oversight, and ensuring the delivery of enforcement where necessary. • The ability of organisations to meet the necessary standards is monitored via implementation of a digital Good Manufacturing Practice (GMP) based audit and compliance management system iQAPPS (interactive Quality Assurance of Aseptic Preparation Services). From April RWT aseptic services have reported quality indicators via iQAPPs and all indicators have been within control limits despite the aging facility and ongoing maintenance requirements.
10.0	**Recommendations** The Board is asked to note the contents of the report and in particular the key issues described under 'Alert' pertaining to medicines management. The Board members may wish to discuss whether they are satisfied with the assurance provided and improvement actions described, or whether further information is required.

NHS
The Royal Wolverhampton
NHS Trust

Trust Board	
Meeting Date:	1st August 2023
Title of Report:	Pharmacy and Medicines Optimisation Report
	Supporting Reference Pack

Medication Incidents

Chart 1: Medication Incidents

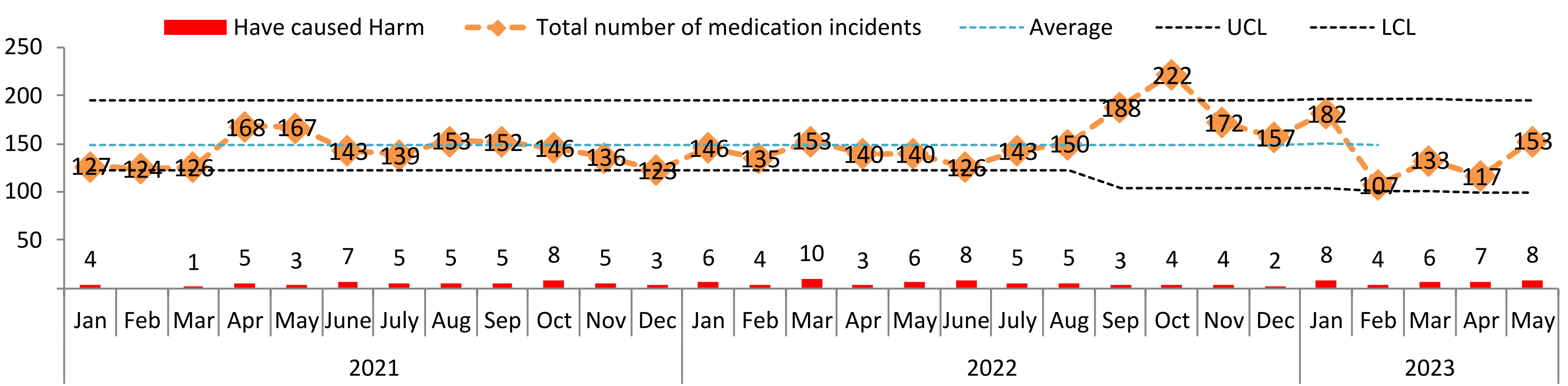
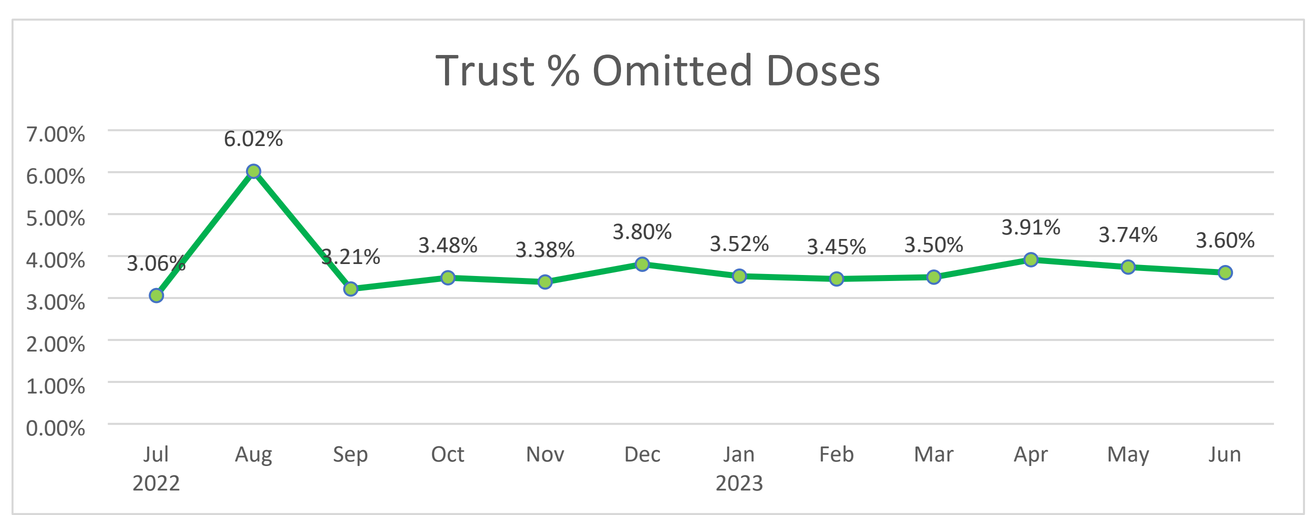


Chart 2: Omitted Doses EPMA Wards
NB. The spike in August 2022 was due to implementing EPMA business continuity and should be disregarded.



Medicines Policy Compliance

Medication Storage

143/159 (90%) areas scored >80% on their last audit. Area's scoring < than 80%: FMD, Renal Unit, A5, A6, A14, A21, PAU, SEU, D10, D7, NNU, C16, C17, C21, C24, FairOak. 22 audits overdue. Target is for all areas to achieve >80% and then to increase target to 90%. No improvement in the number of areas scoring >80% has been seen.

Controlled Drugs

60/69 (87%) areas scored >80% in Q1 audits. Areas scoring < 80%: A7, A8, C15, C25, C21, Th 1, Th 4, Th 5, WP1. 37 audits not completed in Q1.

Target is for all areas to achieve >80% and then to increase target to 90%. An improvement in the number of areas scoring >80% has been seen.

Omitted Doses (EPMA wards)

June 23: 4854 doses of critical medicines omitted (3.6%) Target is 0%. No improvement seen.

Patient Group Directions

150/152 PGD's are in date, 2 have expired and to be de ratified. There has been a significant improvement in PGD position and greater engagement from Directorates now that PGD's are included in local guidelines reports from the governance team. Work is being progressed to publish PGD's on the Trust intranet and Directorates are encouraged to use national PGD templates where these exist. Directorates have been asked to include a PGD's in their audit plans and an audit proforma is currently being piloted by Sexual Health with the aim to roll this out to all Directorates in Q3.

Prescription Chart Audit

124 inpatient prescription charts (79 supplementary prescription charts, 45 30-day prescription charts) were audited over a 2-day period in December. Good compliance was found with recording a patient demographics and use of supplementary prescription charts. Improvements are required for: • Prescribing in block capitals • Recording of allergy on supplementary charts as well as in EPMA • Correct cancelling of prescriptions • Endorsement by pharmacy within 24 hours of prescription being written

Medicines Storage

In January 2023 Pharmacy visited 32 treatment and fluid rooms across C block at New Cross Hospital, 28 had no evidence of cooling/air conditioning and 10 had reported temperatures in the preceding month of more than 25c.

National Patient Safety Alerts and Medication Supply Notifications

National Patient Safety Alerts for medicines received since the last report:

Potential risk of underdosing with calcium gluconate in sever hyperkalaemia (NatPSA/2023/007/MHRA) Issued 27 June 2023. Due to August MMG.

Shortage of pyridostigmine 60mg tablets (NatPSA/2023/006/DHSC) Issued 24 May 2023. Actions completed.

Class 1 Medicines Recall Notification: Recall of Emerade 500 micrograms and Emerade 300 micrograms autoinjectors due to potential device failure (NatPSA/2023/2023/004/MHRA) Issued 9 May 2023. Actions completed.

Supply of Licensed and Unlicensed Epidural Infusion bags (NatPSA/2023/002/CMU) Issued 23 January 2023. Actions completed.

An audit of the implementation of the National Patient Safety Alert - Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults issued August 2020 demonstrated areas for improvement, an action plan has been developed and a re-audit planned:

- 29% of steroid-dependant patients had been issued with an emergency steroid card prior to admission.
- 79% of steroid-dependant inpatients were flagged on clinical web portal.
- 77% of steroid-dependant patients did not miss doses of steroids as an inpatient.
- 66% of steroid-dependant patients were appropriately managed whilst acutely unwell.

Pharmacy Workforce

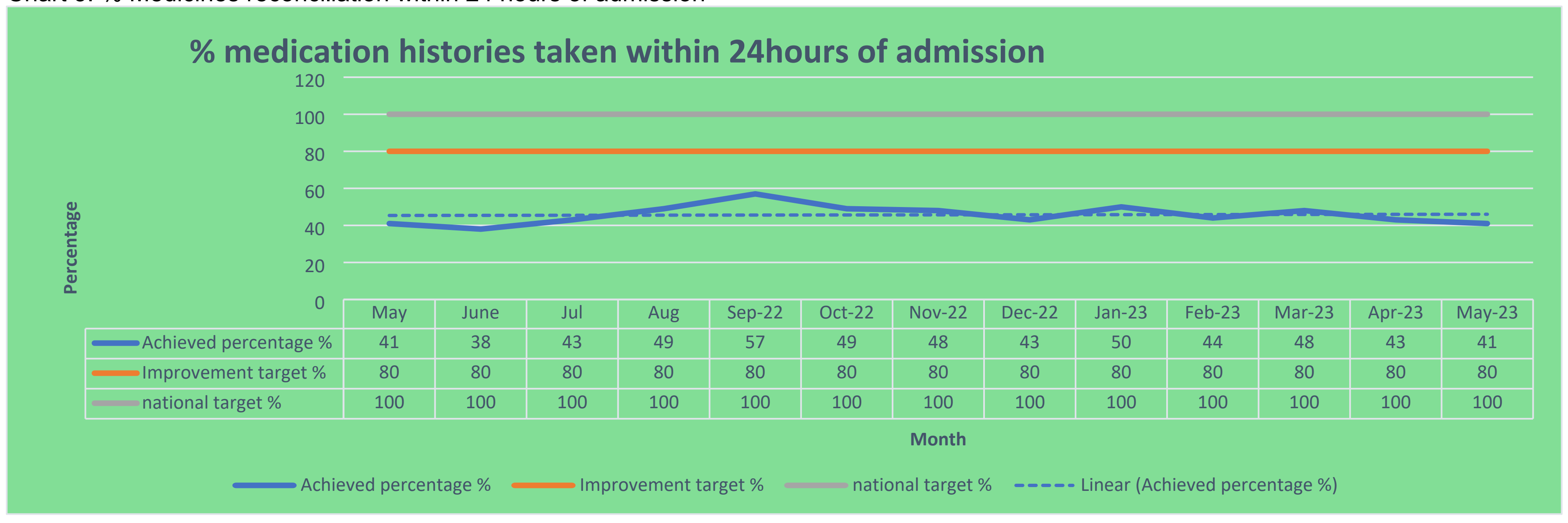
At month 2 the Pharmacy Directorate staffing position according to budget was:

	Budget WTE	Contracted WTE	Variance WTE	Variance %
Pharmacy Technicians	73.14	77.84	+ 4.7	+ 6%
Pharmacists	72.33	70.03*	- 2.3	- 3%

*Includes 3 WTE unfunded clinical pharmacist posts (Gastroenterology, Oncology, HIV)

Clinical Pharmacy Services

Chart 3: % Medicines reconciliation within 24 hours of admission



	May	June	Jul	Aug	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Achieved percentage %	41	38	43	49	57	49	48	43	50	44	48	43	41
Improvement target %	80	80	80	80	80	80	80	80	80	80	80	80	80
national target %	100	100	100	100	100	100	100	100	100	100	100	100	100

End

Paper for submission to the Trust Board Meeting – to be held in Public/Private On 1st August 2023		
Title of Report:	Revalidation of Medical Staff – Annual Report	Enc No:
Author:	Andrew Roberts – Business Development Manager	
Presenter/Exec Lead:	Dr Brian McKaig – Chief Medical Officer	

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

Recommendations:

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

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

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date: People and Organisational Development Committee - 28 July 2023

Summary of Key Issues using Assure, Advise and Alert
Assure The Annual Revalidation Report provides assurance to the Trust Board in the management of medical appraisal and revalidation during 2022/23.
Advise None
Alert None

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement
Support our Colleagues	• Improve overall staff engagement
Improve the Healthcare of our Communities	
Effective Collaboration	• Improve clinical service sustainability

Revalidation of Medical Staff – Annual Report

Report to Trust Board Meeting to be held in Public/Private on 01 August 2023

EXECUTIVE SUMMARY

This report describes the progress of the Trust in the management of medical appraisal and revalidation during 2022/23 and seeks to provide assurance to the committee of the organisations progress in implementing the Responsible Office Regulations.

- The Trusts Medical Appraisal compliance as at 31st March 2023 was 99.75%
- During 2022/23 there were 22 incomplete or missed appraisals,
    - 10 for Maternity Leave
    - 2 Sabbatical
    - 5 Long Term Sick
    - 3 Agreed Postponements
    - 2 Missed Appraisal
- During 2022/23 there were 67 positive revalidation recommendations were made to the GMC of which there was:
    - 1 Agreed deferral
    - 2 not required due to ongoing investigations.

BACKGROUND INFORMATION

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that executive teams will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations.
- checking there are effective systems in place for monitoring the conduct and performance of their doctors.
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- appropriate pre-employment background checks (including pre-engagement for Locums) are undertaken to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3. Governance Arrangements

The Trust's organisational structure for medical appraisal and revalidation is shown in Figure 1.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

Figure 1:

The Royal Wolverhampton NHS Trust Medical Appraisal/Revalidation Organisational Structure

Dr Brian McKaig
Revalidation Lead & Chief Medical Officer

↓

Dr Chipo Ndlovu
Medical Appraisal Lead

↓

Louise Nickell
Director of Education & Training

↓

Claire Young
Deputy Director of Education & Training

↓

Ravi Kainth
Group Head of Medical Education

↓

Lesley Flynn
Louise Bagnall
Revalidation Support Office

Governance reporting structure

The Trust's governance reporting structure for medical appraisal and revalidation is shown in Figure 2.

Figure 2: Medical Appraisal/Revalidation Reporting Structure

NHS England

- Quarterly - Medical appraisal compliance
- Annually – Annual Organisational Audit findings (AOA) (Section 2)
- Annually – Annual Trust Board Report

Trust Board

- Annually – Medical Appraisal/Revalidation update – assurance
- Annually – Annual Organisational Audit findings (AOA)

Trust Management Committee

- Annually – Annual Organisational Audit findings (AOA) (Appendix 1)
- Annually – Annual Trust Board Report – for information
- As required – Policy change approval – approval

People and Organisational Development Committee

- Annual – Medical Appraisal/Revalidation update – for information

Medical Appraisal/Appraisal Meeting

- Weekly – compliance, quality and recommendation monitoring

Local Decision Making Group

- As required – management of apparent non-engagement with medical appraisal/revalidation
- During 2022/23 the Trust did not have cause to hold any Local Decision Making Groups.

GMC Connect

Connect is the General Medical Councils (GMC) database used by designated bodies to view and manage the list of doctors who have a prescribed connection to their organisation.

The database is maintained by the Trusts Revalidation Support Office on behalf of the Trust's Responsible Officer. The Trusts Electronic Staff Record management system (ESR) is used as its main information source in relation to starters and leavers and is updated in 'real time'.

GMC Connect also allows doctors to directly add themselves onto the system, where this happens, contact is made with the doctor through the Revalidation Office, to check the validity of the prescribed connection, which is done by using the NHSE/I prescribed connection algorithm.

Policy and Guidance

The Medical Appraisal to Support Revalidation Policy (HR46) was reviewed and approved in February 2022 and will be due for further review in 2025.

4. Medical Appraisal

a. Appraisal and Revalidation Performance Data

Medical Appraisal Data as at 31 March 2022		
	Number of staff in post	**Number of completed appraisals**
Consultants	491	489
Staff Grade, Associate Specialist, Specialty Doctors	47	47
Temporary or short term contract holders	253	253
TOTAL	791	789

b. Compliance monitoring:

Medical appraisal compliance is monitored at various levels within the Trust, from Board Level (annually) to individual compliance reminders (monthly). In addition, appraisal is a divisional KPI and is contained within the Trust's integrated performance repository which is monitored through divisional performance meetings.

Compliance is also monitored externally, to NHSE quarterly and annually.

Non-compliance with Medical Appraisal is managed through the Trust's Local Decision Making Group as per HR46, the Trust's Medical Appraisal Policy.

c. Appraisers

The Trust has 139 approved medical appraisers. Each medical appraiser has undertaken NHSE approved training.

The Trust has 2 higher level medical appraiser, Dr Chipo Ndlovu and Dr Shyam Menom, trained to deliver medical appraiser training to newly appointed appraisers.

An appraiser forum chaired by Dr Chipo Ndlovu continues to meet regularly. The purpose of the forum is as follows:

- Leadership and advice on all aspects of the medical appraisal process
- Training and professional development activities to improve appraiser skills
- Sharing best practice between appraisers
- Keeping appraisers up to date on local and national developments
- Discuss handling the difficult areas of appraisal in an anonymised and confidential environment

The forums have been well attended by appraisers from across all specialties.

d. Quality Assurance

Outline of quality assurance processes:

The quality assurance of medical appraisal is two-fold. An initial screening of the appraisal documentation for completeness is carried out by the Trust's Revalidation Support Office (RSO), where incomplete documentation is received, this is followed up by the team. 50% of appraisals are quality assured through this process.

Further quality assurance of the medical appraisal paperwork is carried out by the Trust's Medical Appraisal Lead, Dr Chipo Ndlovu. The QA sample size is a minimum of 20% per annum.

For the appraisal portfolio:

- A review of appraisal folders to provide assurance that the appraisal inputs: the pre-appraisal declarations and supporting information provided is available and appropriate is carried out by the Revalidation Support Office.
- A review of appraisal folders to provide assurance that the appraisal outputs: PDP, summary and sign offs are complete and to an appropriate standard is carried out by the Medical Appraisal Lead.
- A review of appraisal outputs to provide assurance that any key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs is carried out by the Medical Appraisal Lead.

For the individual appraiser

- The Trust has set a minimum CPD requirement for each appraiser to attend one internal appraiser forum.
- 360° feedback from doctors for each individual appraiser is collated centrally and reviewed by the Revalidation Support Team and distributed to each appraiser for inclusion in their annual appraisal.

For the organisation

- Feedback from the doctor and appraiser is requested annually on how the organisation has supported their appraisal.

e. Access, security and confidentiality

All medical appraisal documentation is stored electronically in a restricted area of the Trust's server and is only accessible by the Revalidation team as shown in Figure 1.

The Trust outsources the management of colleague and patient feedback to Equiniti 360 Clinical. The Equiniti system is an online, web based system accessible through any internet enabled device. It is secured to IL3 level and is ISO27001 & ISO9001 accredited. The system has two factor authentication and is externally tested annually.

During 2022/23 there were **0** information breaches in relation to medical appraisal/revalidation.

f. Clinical Governance

Doctors are required to collate and reflect against 6 supporting information types set by the GMC.

All significant event, and complaints information is recorded centrally onto the Trust's governance reporting system, DATIX. A report is sent to each doctor prior to their appraisal.

5. Revalidation Recommendations

During 2022/23 the Responsible Officer made 67 revalidation recommendations to the GMC

Recommendation Type	Total
Positive	67
Late recommendation	1
Non-engagement	2
TOTAL	**70**

6. Recruitment and engagement background checks

The Trust operates a centralised recruitment model for medical staff. All pre-employments checks are conducted by the medical recruitment team before an unconditional offer is made to any new doctor. As part of the pre-employment checks, a template is sent to the Responsible Officer at the doctor's current organisation to highlight any concerns to the receiving organisation.

For agency/locum doctors, the Trust uses the HealthTrust Europe framework which sets out the responsibilities of agencies in terms of pre-employment checks and continuing checks on the doctors they supply. HealthTrust Europe are responsible for auditing the agencies against this requirement.

RECOMMENDATIONS

The Committee is asked to accept the contents of the report. This year's report will be shared with the higher level responsible officer at NHSE. (Appendix 2)

Any Cross-References to Reading Room Information/Enclosures:

Appendix 1

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2023 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 12-14 for assistance completing this table**		**1**	**1a**	**2**	**3**	
		Number of Prescribed Connections	**Completed Appraisal (1)**	**(Optional) Completed Appraisal (1a)**	**Approved incomplete or missed appraisal (2)**	**Unapproved incomplete or missed appraisal (3)**	**Total**
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	491	474	0	15	2	491
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other	47	46	0	1	0	47
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	253	249	0	4	0	253

2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	791	769	0	20	2	791

2.1.1 Approved incomplete or missed appraisal (17)
6 Maternity Leave
2 Sabbatical
4 Long Term Sick
3 Agreed Postponement
2 Missed Appraisals

2.1.2 Approved incomplete or missed appraisal (1)
1 Long Term Sick

2.1.5 Approved Incomplete or missed appraisal (4}
4 Maternity Leave

Classification: Official

Publication reference: PR1844

Appendix 2

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Section 6 – Summary of comments, and overall conclusion 10
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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of The Royal Wolverhampton NHS Trust can confirm that:

An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Compliant

The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: None Comments: Compliant Action for next year: No changes planned

An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Comments: Compliant

All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Comments: Compliant policy reviewed and agreed March 2022 (further review planned for 2025)

A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Planned to utilise links with Walsall Healthcare NHS Trust to undertake local peer review. Comments: Compliant. Action for next year: Ongoing work to increase collaborating with Walsall Healthcare NHS.

A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Comments: Compliant, support in place for locum and short-term placement doctors to gather information required for appraisal (incidents and complaints) as well as support for CPD depending on length of placement.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[2] Action from last year: To work with local private providers to provide annual statement with regard to complaints or issues on regular basis Comments: Compliant Action for next year: No further changes planned.

Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments: Compliant

[2] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments: Compliant

The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Plan to recruit and train more appraisers to accommodate expansion of medical staff Comments: Compliant Action for next year: Continue to recruit appraisers in line with medical workforce expansion

Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[3] or equivalent).

Comments: Comments: Compliant, Regular Appraiser Forums and Appraiser CPD events successfully arranged for 2022 and 2023 Action for next year: Continue with Appraiser CPD afternoon and Appraiser forum events

[3] http://www.england.nhs.uk/revalidation/ro/app-syst/

The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: Compliant

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	791
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	789
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	2
Total number of agreed exceptions	22

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Comments: Compliant, regular communication between RO, and GMC ELA when events occur.

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Comments: Compliant

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Comments: Compliant

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Comments: Compliant

There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Developing RO Advisory Group, trust policy to be re-written for advisory group

Comments: Compliant

Action for next year: Continue with work to develop the RO Advisory Group.

The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome

of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[4]

Comments: Compliant

There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[5]

Comments: Compliant

Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Comments: Compliant

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments: Compliant, HR process in place for pre-employment checks

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[4] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[5] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

The Trust's Medical Appraisal compliance remains high and there are no current issues. Appraisal compliance as of 31 March it was 99.75%. There is a Medical Revalidation Policy which due for review again in 2025, there are no significant planned changes in the current appraisal process.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

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Publication reference: PR1844

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: None

   Comments: Compliant

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   Action from last year: None

   Comments: Compliant

   Action for next year: No changes planned

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Comments: Compliant

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Comments: Compliant policy reviewed and agreed March 2022 (further review planned for 2025)

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Planned to utilise links with Walsall Healthcare NHS Trust to undertake local peer review. Comments: Compliant. Action for next year: Ongoing work to increase collaborating with Walsall Healthcare NHS.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Comments: Compliant, support in place for locum and short-term placement doctors to gather information required for appraisal (incidents and complaints) as well as support for CPD depending on length of placement.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] Action from last year: To work with local private providers to provide annual statement with regard to complaints or issues on regular basis Comments: Compliant Action for next year: No further changes planned.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Comments: Compliant

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Comments: Compliant

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Plan to recruit and train more appraisers to accommodate expansion of medical staff Comments: Compliant Action for next year: Continue to recruit appraisers in line with medical workforce expansion

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Comments: Comments: Compliant, Regular Appraiser Forums and Appraiser CPD events successfully arranged for 2022 and 2023 Action for next year: Continue with Appraiser CPD afternoon and Appraiser forum events

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Comments: Compliant

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	791
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	789
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	2
Total number of agreed exceptions	22

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Comments: Compliant, regular communication between RO, and GMC ELA when events occur.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Comments: Compliant

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

   Comments: Compliant

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

   Comments: Compliant

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

   Action from last year: Developing RO Advisory Group, trust policy to be re-written for advisory group

   Comments: Compliant

   Action for next year: Continue with work to develop the RO Advisory Group.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Comments: Compliant

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Comments: Compliant

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Comments: Compliant

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Comments: Compliant, HR process in place for pre-employment checks

Section 6 – Summary of comments, and overall conclusion

The Trust's Medical Appraisal compliance remains high and there are no current issues. Appraisal compliance as of 31 March it was 99.75%. There is a Medical Revalidation Policy which due for review again in 2025, there are no significant planned changes in the current appraisal process.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

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PERFORMANCE & FINANCE COMMITTEE TERMS OF REFERENCE	
BAF & Trust Risks	The committee will regularly review in detail any Board Assurance Framework risks allocated to it by the Board and agreed by the Committee. SR15 Impact of future funding flows resulting in potential deficit position and financial challenge SR16 Restoration of services (including Cancer Services) post pandemic. SR18: ~~Emerging Risk:~~ Impact of a potential risk of a successful cyber-attack, which could compromise Trust IT systems, personal data and records access
Meeting Purpose/Remit	To provide assurance to the Board on the effective financial and external performance targets of the organisation. It will also support the development, implementation and delivery of the Medium Term Financial Plan (MTFP) and the efficient use of financial resources.in order to review the Trusts Financial strategy, performance and business development.
Responsibilities	1. Utilise the assurance reporting processes (BAF/TRR) to inform the Trust Board of finance, performance, investment or related risk and redress actions. 2. Review annual plan modelling assumptions and in particular capital and revenue allocations as well as activity and investment assumptions. 3. Review and endorsement of annual performance to meet constitutional standards. 4. Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval. 5. Approve the development of financial and contractual reporting in line with best practice as appropriate. 6. Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur. 7. To receive and review the trust wide and divisional reports on finance and contractual performance and CIP before they are presented to the Board. The focus will be on forecast outturn, risks to delivering the plan and the mitigation plans. 8. Review expenditure against the agreed capital plan. 9. Review any matters which impact adversely on the financial performance or reputation of the Trust. 10. Oversee the development of Service Line Reporting. 11. Approve financial returns prior to submission to any external accountable authority, e.g. reference costs, ERIC, etc. (other than NHSE/I monthly returns due to timeliness) 12. Monitor the appropriate training and support is in place for budget holders/managers. 13. To make arrangements as necessary to ensure that all members of the Board and senior officers of the trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust. 14. Periodically review financial policies and procedures including scheme of delegation etc. to ensure that they are still relevant and appropriate. 15. Review financial and contractual performance against the main healthcare contracts inc budgets, performance and plans (short/medium long). 16. Receive reports regarding contract negotiations and progress in agreeing contracts with the Commissioning bodies.

	17. In line with the NHSE/I guidance, assess if any proposed investments should be reported to NHSE/I in the annual planning process or in year prior to financial closure. 18. To receive and undertake investment appraisals of submitted developments and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and external requirements to ensure that capital investments and transactions comply with the latest NHSE/I guidance. Ensure risks of any investments are properly evaluated and risk management arrangements put in place, including:- a. Obtaining independent professional advice where appropriate. b. Evaluate, scrutinise and monitor investments. c. Ensure Investments are supported by relevant stakeholders. d. To examine any relevant matters referred to it by the Board of Directors. 19. To examine any relevant matters referred to it by the Board of Directors. 20. To receive reports regarding new business and tender opportunities and the progress of tenders. 21. To receive and discuss updates regarding ICB developments and requirements of ICB strategy, performance and funding. 22. Monitoring of recovery and restoration plan delivery and variation 23. To receive reports on progress of implementation of green plan and progress and opportunities for funding and collaborative work as it arises. 24. Horizon scanning potential issues and risks. Chair to liaise with other Committees re cross-liaison and escalation. 25. Deep dive reviews conducted where appropriate. 26. Balance of performance – throughput/access, with quality/safety (with QGAC/QPES Chair) and workforce/recruitment (with PODC) and/or via Chairs Reports to Trust Board 27. Performance Management against constitutional standards – Plans, Performance (internal & External reporting) 28. Partnership(s) – Strategy, Funding, Performance role 29. Review Estates ('Group') – Strategy, Capital, Performance 30. Review business cases and contract awards 31. To receive a SIRO report on a 6 monthly basis.
Authority & Accountabilities	The Performance and Finance Committee is established pursuant to the Standing Orders. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01).
Reporting Arrangements	The Chair shall report to Trust Board with highlights any matters of concern or significant risks identified from the meeting. The approved minutes will be submitted to Trust Board.
Membership	Chair of Committee Two Non-Executive Directors Chief Operating Officer Chief Financial Officer Chief People Officer Group Chief Strategy Officer

Attendance	Chairman of the Trust – as required Chief Executive – as required Deputy Chief Operating Officer – Division 1 as required Deputy Chief Operating Officer – Division 2 as required Deputy Chief Operating Officer – Division 3 as required Deputy Chief Operating Officer – Division 4 as required Divisional Manager – Estates and Facilities as required Deputy Chief Financial Officer Deputy Chief Strategy Officer – Planning, Performance & Contracting
Chair	Non-Executive Director appointed by the Trust Board, and if he/she is absent another NED from those present at the meeting
Quorum	4 members must be present and must include the Chief Financial Officer or the Deputy Chief Financial Officer; another Interim Executive Director/Executive Director/Nominated Deputy and one Non-Executive Director.
Frequency of meetings	Monthly
Administrative support	The Planning and Performance Department will provide administrative support. Agenda and papers will be circulated two days prior to the meeting.
Standards	Standing Orders
Self-Assessment Review	To be completed every 2 years.
Standard agenda	Yes
Subgroups	• Capital Review Group • Financial Recovery Group • Contracting and ~~Commissioning~~ Investment Group • Operational Performance Review Group
Date Approved	~~24th November 2022~~ 22 June 2023
Date Review	20th December 2023

Strategic Aim	Associated Strategic Objectives
Excel in the delivery of Care *We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.*	• We will embed a culture of learning and continuous improvement at all levels of the organisation • We will prioritise the treatment of cancer patients, focused on improving the outcomes of those diagnosed with the disease • We will deliver safe and responsive urgent and emergency care in the community and in hospital • We will deliver the priorities within the National Elective Care Strategy • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations

Support our Colleagues *We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.*	• Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff • Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing • Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged • Deliver year on year improvement in Workforce Equality Standard performance
Improve the health of our Communities *We will positively contribute to the health and wellbeing of the communities we serve.*	• Develop a strategy to understand and deliver action on health inequalities • Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025 • Work together with PLACE based partners to deliver improvements to the health of our immediate communities
Effective Collaboration *We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.*	• Work as part of the provider collaborative to improve population health outcomes • Improve clinical service sustainability by implementing new models of care through the provider collaborative • Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital • Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes • Facilitate research that establishes new knowledge and improves the quality of care of patients