The Royal Wolverhampton NHS Trust

Bundle Public Trust Board 12 December 2023

1 10:00 - Chair's Welcome and Note of Apologies
Lead: John Dunn, Deputy Chair/Non Executive Director
Action: To note
Apologies;
Sir David Nicholson, Gwen Nuttall, Chief Operating Officer, Tracy Palmer Director of Midwifery
Additional Attendees:
Kate Shaw attending on behalf of Gwen Nuttall
Kate Cheshire attending on behalf of Tracy Palmer
Debbie Corbett Clinical Scientist, as a member of the public
Laskshmi Nath, Representative for Neuronostics, as a member of the public
Yolanda Hill, Representative for Neuronostics, as a member of the public

2 10:01 - Staff Voice - Employee Voice Groups
Lead: Alan Duffell, Group Chief People Officer
Action: To note
Presenters: Carl Halford, Interim Chair RWT, LGBT+ Employee Voice Group
Kerry Flint,
Di Davies, Project Manager - Service Efficiency
Pam Kang

3 10:21 - Declarations of interest
Lead: John Dunn, Deputy Chair/Non Executive Director
Action: To note
Declarations December 23

4 10:22 - Minutes of the Previous Meeting of the Board of Directors held in Public on 10 October 2023
Lead: John Dunn, Deputy Chair/Non Executive Director
Action: To approve
Draft RWT Public Trust Board Minutes 10 October 2023 v4 OP SB SC TP GN

5 10:24 - Board Action Points and Matters Arising and from the Minutes of the Board of Director Meeting held in Public on 10 October 2023
Lead: John Dunn, Deputy Chair/Non Executive Director
Action: To review, update and for information
See also items
RWT Public Board Action Points v1 051223

5.1 10:28 - Reinforced Autoclaved Aerated Concrete (RAAC) Update
Presenter: Stew Watson, Group Director of Estates Development
Action: To inform, Assure and approve proposed plan
RWT RAAC Report and RA 07122023

5.2 Covid -19 National Inquiry Update
Lead: Kevin Bostock, Group Assurance Officer
Action: To Inform and Assure
RWT Public Trust Board - Covid-19 National Inquiry Update Report 121223

6 10:30 - Chair's Report – Verbal
Lead: John Dunn, Deputy Chair/Non Executive Director
Action: To inform and assure

7 10:35 - Group Chief Executive's Report
Lead: Prof. David Loughton, Group Chief Executive
Action: To inform and assure
Group Chief Executive's Report to comprise of:
CEO Report
Trust Management Committee Chair's Report (item 7.1 Reading Room)

RWT Trust Board - Chief Executive Report 12.12.23 - Pack A

7.1 Trust Management Committee - Chair's Report

Pack B - RWT Trust Board TMC report 24.11.23 - Pack B

Pack B - RWT Trust Board TMC report 27.10.23 Pack B

8 Effective Collaboration (SECTION HEADING)

8.1 10:40 - Group Chief Strategy Officer Report by Exception

Lead: Simon Evans, Group Chief Strategy Officer
Action: To inform, assure and endorse recommendations of Improvement Innovation and Research Group
Comprises
Black Country Provider Collaborative Update (8.1.1 Reading Room)
Update from Improvement, Innovation and Research Group (8.1.2 Reading Room)

CSO Report December 23 RWT v2 - Pack A

8.1.1 Black Country Provider Collaborative Update

Appendix 1 - BCPC Update Nov 2023 - Pack B

Appendix 2 - System Operating Model - Pack B

8.1.2 Update from Improvement, Innovation and Research Group

IIRG RWT report for TB12-12-23 Pack B

Appendix 1 - QI Board action plan and NHS Impact Pack B

Appendix 2 - Improvement & Research Group ToR updated 27-11-23 Pack B

9 Improve the Health of our Communities (Section Heading)

9.1 10:45 - Integration (Place) Committee Chair's Report

Lead: Lisa Cowley Non-Executive Director Chair/Integration Committee
Action: To inform assure and approve Terms of Reference
Comprises
Integration Committee Terms of Reference (Reading Room item 9.1.1)

RWT Chairs Report -Integration November 2023 - Pack A

RWT Chairs Report -Integration October 2023 - Pack A

9.1.1 Integration Committee Terms of Reference

Integration Committee Terms of Reference - FINAL - Pack B

9.2 10:48 - Group Director of Place Report - by Exception

Lead: Stephanie Cartwright, Group Director of Place
Action: To inform and assure

RWT Trust Board Group Director of Place report December 2023 v2 - Pack A

10 Excel in the Delivery of Care (Section Heading)

10.1 10:53 - Quality Committee (QC) - Chair's Report

Lead: Louise Toner, Non-Executive Director/Chair Quality Committee
Action: To inform and assure

November 2023 2023 QC Chairs Report. v1.1 - Pack A

October 2023 2023 QGAC Chairs Report. v1.1 Pack A

10.2 10:58 - Chief Nursing Officer Report by Exception

Lead: Debra Hickman, Chief Nursing Officer
Action: To inform and assure
Comprises
Patient Experience & Complaints Report (item 10.2.1 Reading Room)
Infection Prevention and Control Report (item 10.2.2 Reading Room)
Safeguarding Report (10.2.3 Reading Room)

November 2023 CNO report - Trust Board version v2 Pack A

10.2.1 Patient Experience & Complaints Report

TB -Patient Experience report - August September 2023 14112023 v2_ - Pack B

10.2.2 Infection Prevention and Control Report

IP report TB Dec 23 - Pack B

10.2.3 Safeguarding Report

Safeguarding Assurance Report Q2 Trust Board - Dec 2023 - Pack B

10.2.4 Health and Safety Annual Report 2022/23

Lead: Kevin Bostock, Group Chief Assurance Officer
Action: To inform and Assure

RWT TB 12th December 2023 HS Annual Report 2022 to 2023 FINAL v3 - Pack B

OP_04_Policy - Pack B

OP_04_Appendix1 - Pack B

10.3 11:03 - BREAK

10.4 11:13 - Midwifery Services Report by Exception
Presenter: Katherine Cheshire, Head of Maternity
Action: To inform and assure

Maternity Services Summary Report Public Trust Board December 2023 v2 - Pack

10.5 11:18 - Finance and Productivity Committee (FPC) - Chair's Report
Lead: John Dunn, Deputy Chair/Non Executive Director/Chair Finance Committee
Action: To inform and assure

Report to Board - Chairs Report F+P Nov - Pack A

Report to Board - Chairs Report F+P Oct - Pack A

10.6 11:23 - Group Chief Financial Officer Report
Lead: Kevin Stringer, Group Chief Financial Officer
Action: To inform and assure, Standing Financial Orders/Standing Financial Instructions and Scheme of Delegation for approval
Comprises
Monthly Finance Reports (item 10.6.1 Reading Room)
Annual Review of SFI/SO (item 10.6.2 for approval)

M07 Board Report Front Sheet v2 - Pack A

M06 Board Report Front Sheet v2 -Pack A

10.6.1 Monthly Finance Reports - Month 6 and 7

M07 Board Report reference - Pack B

M06 Board Report reference - Pack B

10.6.2 11:28 - Annual Review of Standing Financial Orders/Standing Financial Instructions and Scheme of Delegation G102 Financial Management Policy (B)
Lead: Kevin Stringer, Group Chief Financial Officer/James Green
Action: to approve

Standing Financial Orders, Standing Financial Instructions and Scheme of Delegation -GI02 Financial Management Policy Dec 23 Front Sheet

Standing Financial Orders, Standing Financial Instructions and Scheme of Delegation -GI02 Financial Management Policy Dec 23 Reference Pack

10.6.3 Audit Committee Chair's Report

Audit Committee Chair's Report 5 December 2023 vKW (002)

Lead: Martin Levermore, Non-Executive Director/Chair Charity Committee
Action: To inform and assure report, approve Charity Annual Report and Accounts
Comprises
Charity Annual Report and Accounts, Audit Findings Memorandum, Representation Letter (Reading Room Item 10.7.1)

RWT Chairs Report - Charity Committee-Board Nov 23 v2 - Pack A

10.7.1 Charity Annual Report and Accounts, Audit Findings Memorandum, Representation Letter

Charity Annual Report and Accounts Front Sheet Dec 23
Charity Annual Report and Accounts 22-23
Representation letter 2023 - signed
Royal Wolverhampton Audit Findings Memorandum 2023

10.8 11:38 - Chief Medical Officer Report by Exception
Lead: Dr Brian McKaig, Chief Medical Officer
Action: To inform and assure
Comprises
RWT NIHR Clinical Research Network Report(item 10.8.1 Reading Room)
Schwartz Rounds Annual Report (item 10.8.2 Reading Room)
Research and Development Report (item10.8.3 Reading Room)

Chief Medical Officer's Report - Trust Board - 12 December 2023 v2 - Pack A

10.8.1 RWT NIHR Clinical Research Network Report

Trust Board NIHR CRN WM Nov 2023 - Pack B
Partner Satisfaction Survey 2022 - Pack B

10.8.2 Schwartz Rounds Annual Report

Schwartz Round Annual Report TB December 2023. Front Sheet - Pack B
Schwartz Rounds Annual Report 2022-23 Pack B
Appendix 2 - Schwartz Rounds Evaluation 2022-2023 - Pack B

10.8.3 Research and Development Report

Trust Board Research Report Nov 23 - Pack B
Trust Board Research Report Nov 23 Ref pack Appendix 1 - Pack B
Trust Board Research Report Nov 23 Ref pack Appendix 2 - Pack B

10.9 11:43 - Chief Operating Officer Report by Exception
Lead: Gwen Nuttall, Chief Operating Officer
Action: To inform and assure
Comprises
EPRR (item 10.9.1 Reading Room)
Winter Plan update and OneWolverhampton Winter Plan update (item 10.9.2 Reading Room)

Chief Operating Officer Report - 12th December 2023 - Pack A

10.9.1 Emergency Preparedness, Response & Resilience (EPRR) Annual Assurance 2023 – 2024

EPRR Front Sheet Trust Board 12 December 2023 - Pack B
EPRR Reference pack TB 121223 - Pack B

10.9.2 11:48 - Winter Plan Update and OneWolverhampton Winter Plan Update

RWT Winter Plan update TB front sheet December 2023 Pack B
Reading Room - OneWolverhampton Winter Plan Update 24112023 v2 Pack B
RWT Winter Plan update to TB December 2023 Pack B

11 Support our Colleagues (SECTION HEADING)

11.1 11:58 - People Committee (PC) - Chair's Report
Lead: Allison Heseltine, Associate Non-Executive Director
Action: To inform and assure

RWT Chairs Report - People Committee December 23 vKW - Pack A

11.2 12:03 - Group Chief People Officers Report by Exception Workforce Report
Lead: Alan Duffell, Group Chief People Officer
Action: To inform and assure
To approve process set out in annex 3 of Reducing Staffing Agency Usage Report
Comprises
Executive Workforce Metrics (item11.2.1 Reading Room)
Reducing Staffing Agency Usage (item 11.2.2 Reading Room)

Chief People Officer Part (1) RWT TB (front cover) - 12 12 2023 - Pack A

11.2.1 Workforce Metrics

CPO Part (2) TB 12 12 2023 - M7 Oct 23 FINAL - Pack B

11.2.2 12:08 - Reducing Agency Staffing Usage

Reducing Agency Staffing Usage December Board Report 2023
Annex 2 - 20231031 - Agency Plan and Trajectory
Annex 3a - Admin & Estates Agency Request Process (V2)
Annex 3b - Draft Nursing Agency Request Process v2
Annex 3c - Draft Process Medics Agency Request
Annex 3d - Process AHP and HSS Clinical Agency Request v0.2

12 12:13 - Any Other Business

12.1 12:18 - Questions Received from the public

13 Integrated Quality and Performance Review (IQPR) - Executive Summary

Integrated Quality & Performance Report October 2023 FINAL - Pack B

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

15 Date and Time of Next Meeting
Tuesday 13 February 2024 at 10:00 am

16 Approved (and redacted if required) Minutes of Committee Meetings of the Board (for Information only)

16.1 People Committee Approved Minutes

(07) PODC Mins 22 Sept 2023
(08) PC Mins 27 Oct 2023

16.2 Quality Committee Approved Minutes

Enc 1 - Quality Committee Minutes - October
Enc 1 - Quality Committee Minutes - September

16.3 Finance and Productivity Committee Approved Minutes

3. Finance & Productivity Mins 20.09.23
3. Finance & Productivity Mins 25.10.23

16.4 Trust Management Committee Approved Minutes

RWT Approved TMC Minutes 22 September 2023 v 1.2 TP SE DH
Approved RWT Minutes of TMC meeting 27 October 2023 v1 cira 071123docx

16.5 Charity Committee Approved Minutes

Charitable Funds Committee Minutes 25.7.23 final version

16.6 Integration (Place) Committee Approved Minutes

2. Minutes Integration Committee - October 2023 V2 Amended

RWT DECLARATIONS OF INTEREST – DECEMBER 2023

Employee	Role	Interest Type	Provider	Interest Description (Abbreviated)
Adam Race	Director of HR & OD	Loyalty Interests	UHB	Wife works as Head of Medical Workforce and Temporary Staffing at UHB
Adam Race	Director of HR & OD	Loyalty Interests	CIPD	Chartered Member CIPD
Adam Race	Director of HR & OD	Loyalty Interests	West Midlands Social Partnership Forum	Management Side Co-chair

Adam Race	Director of HR & OD	Outside Employment	Dudley Integrated Health and Care NHS Trust	Employed as Interim Associate Director of People at DIHC from 4 April 2022
Alan Duffell	Group Chief People Officer	Loyalty Interests	UK and Ireland Healthcare Advisory Board for Allocate Software (Trust Supplier)	Member (unpaid)
Alan Duffell	Group Chief People Officer	Loyalty Interests	Chartered Management Institute	Member
Alan Duffell	Group Chief People Officer	Loyalty Interests	CIPD (Chartered Institute for Personnel and Develovement)	Member

Alan Duffell	Group Chief People Officer	Outside Employment	The Dudley Group NHS Foundation Trust	Interim Chief People Officer
Alan Duffell	Group Chief People Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief People Officer
Alan Duffell	Group Chief People Officer	Outside Employment	Black Country Provider Collaborative	Provider Collaborative HR & OD Lead
Alan Duffell	Group Chief People Officer	Outside Employment	NHS Employers Policy Board	Member

Allison Heseltine	Non Executive Director	Loyalty Interests	Jason Ryall - Employee of KPMG.	Associate Director - Asset Management Advisory Sector, Infrastructure Advisory Group, KPMG.
Allison Heseltine	Non Executive Director	Loyalty Interests	Jake Meyers,	Future son in law works for Hydrock South West as a Senior Electrical Engineer.
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

Angela Harding	Associate Non Executive Director	Outside Employment	Inspired Villages Group	Executive Operations Director, integrated retirement community sector Replaces employment with the GDC
Brian McKaig	Chief Medical Officer	Loyalty Interests	Rotha Abraham Trust	Trustee for the Rotha Abraham Trust which was set up to advance medical research and practice to benefit the population of Wolverhampton. Upaid role
David Loughton	Group Chief Executive	Outside Employment	West Midlands Cancer Alliance	Chair
David Loughton	Group Chief Executive	Loyalty Interests	National Institute for Health Research	Member of Advisory Board

David Loughton	Group Chief Executive	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Executive
David Loughton	Group Chief Executive	Loyalty Interests	Institute of Health and Social Care Management	Companion
David Nicholson	Group Chairman	Outside Employment	Sandwell and West Birmingham Hospitals NHS Trust	Chair
David Nicholson	Group Chairman	Outside Employment	Global Health Innovation, Imperial College	Visiting Professor

David Nicholson	Group Chairman	Outside Employment	The Dudley Group NHS Foundation Group	Chairman
Debra Hickman	Chief Nursing Officer	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	Associate Non Executive Director	Outside Employment	Tong Charities Committee	Unpaid member of the Committee
Gwen Nuttall	Chief Operating Officer	Hospitality	Abbott Diagnostics	Meal sponsored by Abbott Diagnostics for an award ceremony for clinical staff.
Gwen Nuttall	Chief Operating Officer	Loyalty Interests	Calabar Vision 2020 Link	Trustee
John Dunn	Non Executive Director/Deputy Chair	Nil Declaration		

Jonathan Odum	Group Chief Medical Officer	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Medical Officer
Jonathan Odum	Group Chief Medical Officer	Loyalty Interests	Royal College of Physicians of London	Fellow of the Royal College of Physicians
Jonathan Odum	Group Chief Medical Officer	Outside Employment	Black Country and West Birmingham ICS Clinical Leaders Group	Chair
Jonathan Odum	Group Chief Medical Officer	Outside Employment	Wolverhampton Nuffield Hospital	Private out-patient consulting and general medical/hypertension and nephrological conditions at Wolverhampton Nuffield

Jonathan Odum	Group Chief Medical Officer	Gifts	Overwritten for Data Protection	Cash received from a patient during the periods July 2023, May 2023 and November 2022 for a total combined sum of £50
Julie Jones	Non Executive Director	Outside Employment	Heart of England Academy	CFO
Julie Jones	Non Executive Director	Outside Employment	Academy Advisory	Associate Director
Julie Jones	Non Executive Director	Outside Employment	Walsall Housing Group	Member of Audit & Risk Committee

Julie Jones	Non Executive Director	Outside Employment	Solihull School Parents' Association	Trustee
Julie Jones	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/Group Deputy Chief Executive	Outside Employment	Healthcare Financial Management Association	Treasurer West Midlands Branch
Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Loyalty Interests	Midlands and Lancashire Commissioning Support Unit	Brother-in-law is the Managing Director

Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Loyalty Interests	CIMA (Chartered Institute of Management Accounts)	Member
Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Outside Employment	Walsall Healthcare NHS Trust	Group IT Director and SIRO
Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Outside Employment	Walsall Healthcare NHS Trust	Group Chief Financial Officer
Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Outside Employment	The Dudley Group NHS Foundation Trust	Chief Financial Officer for the Dudley Group NHS Foundation Trust from 21st June 2023.

Kevin Stringer	Group Chief Financial Officer/Group Deputy Chief Executive	Loyalty Interests	National Institute of Health Research	Daughter works part-time for this organisation.
Lisa Cowley	Non Executive Director	Outside Employment	Beacon Centre for the Blind	Healthy Communities Together Project Sponsor
Lisa Cowley	Non Executive Director	Outside Employment	Beacon Centre for the Blind	CEO
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 and Member of Board of Directors
Louise Toner	Non Executive Director	Loyalty Interests	Greater Birmingham Commonwealth Chamber of Commerce	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 Communicatons 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

Simon Evans	Group Chief Strategy Officer	Outside Employment	City of Wolverhampton College	Governor - unpaid
Stephanie Cartwright	Group Director of Place	Nil Declaration		
Tracy Palmer	Director of Midwifery	Nil Declaration		
Umar Daraz	Non Executive Director	Nil Declaration		

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	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
James Green	Operational Director of Finance	Shareholdings and other ownership interests	i3 Consulting Limited	Director of Company. The Company has never traded and will not trade whilst James is an employee at RWT

The Royal Wolverhampton NHS Trust (RWT)

Minutes of the meeting of the Board of Directors held on Tuesday 10 October 2023 at 10:00 am virtually via Microsoft Teams (MT)

PRESENT:

Sir David Nicholson	Chair
Prof. D Loughton (v) CBE	Group Chief Executive Officer,
Ms D Hickman (v)	Chief Nursing Officer
Mr J Dunn (v)	Deputy Chair/Non-Executive Director
Mr S Evans	Group Chief Strategy Officer,
Mr A Duffell	Group Chief People Officer,
Prof. L Toner (v)	Non-Executive Director,
Mr K Stringer (v)	Group Chief Financial Officer,
Ms G Nuttall (v)	Chief Operating Officer/Deputy Chief Executive,
Ms L Cowley (v)	Non-Executive Director,
Ms J Jones (v)	Non-Executive Director,
Mr K Bostock	Group Chief Assurance Officer,
Dr G Pickavance	Associate Non-Executive Director,
Ms A Harding	Associate Non-Executive Director,
Ms A Heseltine (v)	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 (v)	Chief Medical Officer
Dr U Daraz	Associate Non-Executive Director,
Mr M Levermore (v)	Non-Executive Director,
Dr J Odum	Group Chief Medical Officer,
Ms S Cartwright	Group Director of Place,
Mr A Race	Director of Operational Human Resources and Organisational Development,
Mr J Green	Operational Director of Finance,
Lord Carter	Strategic Advisor to the Board,

*(v) denotes voting Directors, **

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,
Ms N MacDuff	Nurse Consultant, RWT for Patient Story Item,
Ms K Thickett	Consultant Respiratory Physician, RWT for Patient Story Item
Ms K Creedon	Head Nurse, RWT and WHT, for the Staff Voice Item,
Ms K Saville	Quality Matron RWT, for Staff Voice Item,
Ms R Spedding	Senior Sister RWT, for Staff Voice Item,
Ms A Dowling	Head of Patient Experience, RWT.

APOLOGIES:

Ms P Boyle	Group Managing Director of Research and Development

Part 1 – Open to the public

TB. 9233: Chair's Welcome and Note of Apologies

Apologies were noted from Ms Boyle.

TB. 9234: Patient Voice – Excel in the Delivery of Care

Ms Murdoch said the story was of a patient who had been under the care of the Respiratory team managing Bronchiectasis. Ms Murdoch said the patient had been provided with a new device which enabled them to deliver Intravenous Antibiotics (IV) antibiotics at their home. Ms Murdoch introduced Ms Macduff and Ms Thickett

Sir David asked how the device would apply to other patients. Ms Macduff said a trial had taken place in Respiratory, 25 devices had been given to 25 patients. She said 260 bed days had been saved by the patients undertaking treatment at home instead of the treatment taking place at the hospital. She said it was positive for patients to receive the treatment within their own homes and assisted with patient flow.

Ms Macduff said the Trust administered approximately IV antibiotics to 140 patients per year and as outpatients. Ms Thickett said it was also being considered whether a wider patient group outside Respiratory, such as Osteomyelitis, Cellulitis or stable Endocarditis could benefit from the device.

Prof. Toner said it was a positive story and made a difference to the quality of life for the patient. Ms Toner asked whether community services were required to assist the patient at home in using the device or whether the patient could use the device independently.

Ms Macduff said this was dependant on the criteria of the patient i.e., if a patient had severe learning difficulties or dementia then they would require assistance. She said some dexterity was required to unscrew and fuse the saline fluid to attach the new saline bag, and it was identified that 50% of patients who undertook the trial required assistance from Community Services.

Sir David asked if the device was used in Walsall Healthcare NHS Trust (WHT). Ms MacDuff said she did not believe the device was being used by the Respiratory department at WHT. Ms Hickman mentioned dialogue was taking place within the community about the provision of IV Antibiotics within Walsall. She said WHT did not have the same level of resources as RWT, and WHT were looking to expand that. Ms Hickman mentioned cross-divisional directorate learning, as Respiratory, was shared at the research event but currently there was a resource issue which required addressing.

Sir David said the device was a positive benefit and asked how it could be spread across the whole of the Black Country. Ms Cartwright agreed and said this was something that should be shared and taken as good practice.

Ms Pickavance asked if the device need to be initiated in the hospital or if it could be initiated first line by the community. Ms MacDuff said any allergic reactions needed to be taken into consideration and the first dose would be administered on-site in the outpatient area.

Sir David said the opportunities with the device were positive for the benefit of patients, improving productivity, spreading good practice and how it could interface with primary care in a constructive way. He asked Ms Cartwright to ensure a plan was created to extend the use of the device across the whole of the Black Country. He thanked Mc MacDuff and Ms Thickett for all the innovative work undertaken.

Action: Ms Cartwright to ensure a plan was created across the Black Country to the extend the use of the device to allow patients to deliver IV antibiotics within their own home.

Resolved: that the Patient Story be received and noted.

TB.9235: Staff Voice –Quality Team

Mr Duffell introduced Ms Creedon, Ms Saville, Ms Spedding from the Quality Team.
Mr Duffell asked what the team enjoyed as part of their jobs and whether they faced any key challenges whilst working at the Trust. Ms Spedding said she enjoyed working with staff to grow the culture of safety and it was rewarding to assist staff groups to create trajectories for improvement. Ms Creedon said as the team worked across both RWT and WHT, both Trusts used different systems, processes together which was challenging.

Mr Duffell asked what key learning was being taken from one Trust to another. Ms Creedon said the team implemented a continuous journey of improvement. Ms Creedon stated that once something was implemented at one Trust it would be taken to the other, and feedback from staff would be requested to highlight any improvements.

Ms Jones asked whether the team was doing as much as possible to reduce the clinical paper being used and technology was being embraced. Ms Saville said digitalisation was a slow process due to the different systems. Ms Saville said a lot of the documentation was around risk assessment and the streamlining was to go through the documents being used to ensure that information was not being repeated. Ms Saville mentioned the concept of a paper picnic used at other Trusts where divisions brought all the paperwork they used, reviewed it to identify what was being repeated. She said this was something being looked at for RWT and WHT.

Prof. Toner asked how the roles of the teams interfaced with Tissue Viability Specialist team and how they worked with them to ensure nothing was missed. Ms Creedon said the team worked closely with the Quality and Tissue Viability teams, attending regular meetings to look through themes which may be causing issues to see whether any quality improvement methodology could be included to address any issues.

Sir David thanked the team and said it described the fundamentals of care of what was important for patients and the services provided.

Resolved: that the Staff Voice item of the Quality team be noted

TB. 9236: Declarations of interest

Sir David asked whether there were any new or changed declarations to be made. None were noted.

TB. 9237: Minutes of the meeting of the Board of Directors held on 1 August 2023

Sir David confirmed there were no amendments to the minutes of the meeting of the Board of Directors held on 1 August 2023.

Resolved: that the Minutes of the Board of Directors held on 1 August 2023 be approved as a true record

TB. 9238: Reinforced Aerated Autoclaved Concrete (RAAC) Letter

Ms Nuttall said the letter was for information. She provided assurance to the Board that the process was underway for assessing all the buildings as outlined in the letter. She said there were 4 buildings which remained to be fully assessed, due to complications accessing the roof. She said further updates would be provided to the Board.

Resolved: that the Reinforced Aerated Autoclaved Concrete (RAAC) Letter be noted

TB. 9239: Matters arising and Board Action Points from the minutes of the meeting of the Board of Directors held on 1 August 2023

1 August 2023/TB 9193
Urology Update
"Ms Nuttall to provide at a Board meeting a plan setting out the medium-term position in relation to Urology."
Action: it was agreed an update be provided to the December Board meeting.

1 August 2023/TB 9193
Staff Voice – IT Cyber Security Team
"*Dr Daraz to liaise with Mr Duffell and Mr Bruce to see if discussions with University of Wolverhampton could be progressed further in relation to the training centre at the University for Cyber Security"*
Dr Daraz confirmed he was in the process of arranging a meeting with colleagues at the Trust and University.
Action: it was agreed an update be provided to the December Board meeting.

TB. 9240: Chair's Report – Verbal Update
Sir David said there was no update this month.

Resolved: that there was no update to be noted

TB. 9241: Group Chief Executive's Report
Prof Loughton mentioned the Lucy Letby case. He assured the Board that RWT had good practices in place, and he attended monthly meetings with maternity leads at both Trusts. He also said he regularly meets with trade unions. He said he and the Executive Team had sight of all cases that went through to the Coroner. He finally mentioned the difficulties during industrial action strikes.

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

Support our Colleagues

TB.9242: People Organisational and Development Committee - Chair's Report
Ms Heseltine highlighted there had been improvement in performance for sickness. She said the sickness absence improvement and development plan was to be presented to the October Committee meeting. She said Occupational Health had been asked to attend meetings for any discussions relating to sickness. She mentioned the Board Assurance Framework (BAF) had been reviewed and remained the same. She said the Committee had received an in-depth report on retire and return which highlighted the lack of nurses returning after retirement. She said this would be reviewed at future meetings. She also mentioned there was a national issue with Band 2 clinical staff asking or requesting through their unions to be regarded at Band 3. She said the model hospital review had been reviewed and it was noted that medical and midwifery staffing had a higher turnover than other organisations.

Ms Heseltine said a deep dive took place on estates and facilities and noted the quality improvement work the team had been undertaking and ward huddles. She said the teams felt they were listened to and could promote work moving forward which was positive.
Ms Heseltine finally mentioned the staff survey had been launched, and there was an option to

submit in paper form or electronically.

Mr Dunn expressed his concern about sick leave, which was approximately 5%. He asked if this was an underlying long-term or short-term issue. He also asked whether there was enough publicity around the staff survey i.e. visual stands promoting it.

Mr Duffell said the biggest issue was short-term sickness absence, long-term sickness absence was managed well. He said managing sickness by ensuring staff infrastructure was available for staff through occupational health or other health and wellbeing initiatives. He also said this included working with Managers on how to manage sickness absence. He said nationally RWT performed reasonably well with sickness levels and there was continued focus by the Trust.

Mr Duffell said regarding publicity of the staff survey comms had been circulated to staff, but he could have a conversation with Ms Evans after the meeting to see whether anything further could be done for promoting the staff survey. Ms Evans said a series of posters had been printed. She said the communications and engagement team spoke to those groups of staff that did not predominantly receive messages via email to encourage them to complete the staff survey.

Ms Pickavance said a large amount of sickness was musculoskeletal (MSK) related. She asked if staff had easy access to Occupational Health and physiotherapy, also when working from home how easy it was it to assess workstations from home.

Mr Duffell said that there was fast-track access to physiotherapy. He said sickness was not only related to MSK but also to several cases of stress, anxiety, and personal issues. He said that the workstation assessment at home would need to be reviewed with how this would be undertaken. He highlighted that it was rare for staff to work permanently from home, more staff undertook hybrid working. Sir David asked for an update on how assessments were undertaken for staff working from home.

Action: Mr Duffell to provide an update on how workstation assessments were undertaken for staff who worked from home.
Resolved: that the People Organisational and Development Committee - Chair's Report be received and noted

TB. 9243: Group Chief People Officer – by exception Workforce Report

Mr Duffell introduced the report and mentioned weekly league tables were being undertaken for the staff survey to identify which areas were doing well in responding to the staff survey. He said conversations would then take place with managers for teams where the figures were low for completing the survey. Mr Duffell highlighted the vacancy rate was below 3% which was positive. He said work was being undertaken with Divisions to ensure appraisals progressed. He mentioned the ongoing long-term pressure on staff and the services provided by RWT together, with the impact on patients due to ongoing strikes.

Resolved: that the Group Chief People Officer - Workforce Report be received and noted

Excelling in the Delivery of Care

TB. 9244: **Winter Plan**

Ms Nuttall introduced the report and highlighted the RWT plan included the Acute Community and an element of Primary Care Service together with the OneWolverhampton Place Winter Plan. She said the plan was required during the winter period, due to changes in presentations

for patients and seasonality factors which could be experienced. She said this could include Flu, COVID and increases in norovirus that could impact adults and paediatrics. Ms Nuttall said that in 2022/2023, it was recognised nationally as one of the most severely challenged times for delivery, mainly for Acute Care and Urgent and emergency care across the whole system. She said there were numerous reports of the significant delays that ambulances faced in handovers when they arrived at organisations. She said there was national challenge for the time patients waited in the A&E department to be seen, assessed, triaged, discharged, or admitted to a bed, known as the four-hour target. She said the national target for 2023/24 was for 76% of all patients, who presented to an emergency portal would be seen within that metric. Ms Nuttall said the severity of the challenges last year were reflected with the West Midlands Ambulance Service escalated the risk being faced by patients in the community to the highest-level of risk on their BAF score at 25, as they were failing to respond to patients in the community that called 999. She said this year's plan for RWT included a mixture of plans that had been implemented last winter and that those schemes had been reviewed and assessed to their impact last year. She said they had also been reviewed against a national set of principles and priorities to improve urgent and emergency care flow known as the 10 high impact changes and were documented throughout the plan where it referred to the schemes that the Trust was continuing or proposing to introduce. She mentioned the plan incorporated acute and community. She said there were also complications with any impact of ongoing industrial strike action.

Ms Nuttall mentioned the success of last year was the opening of the Ambulance Receiving Centre (ARC) together with the continued development of the virtual wards and Community Response Team. The Trust had also developed an enhanced same day emergency care across Medicine, Surgery, ENT and Frailty She said this would all continue this year.

Ms Nuttall said the target was 76% of patients admitted, transferred or discharged needed to be seen within 4 hours by the end of March 2024. She said it was positive to note the Trust was currently achieving that metric. She mentioned there was a national incentive of sharing of capital funding if patients were seen within 80% in quarter 4. She said another national ambition was the response time for the ambulance service for category 2 incidents which included stroke and significant falls. The ambulance service should respond within 30 minutes to all calls that were classified as category 2. She said it was essential the Trust maintained its handover times and ensured that it received handovers of 90% of patients in less than 30 mins. She said funding had been received to support schemes which were mentioned in the Place Report. She said last year the Trust opened 10 additional beds and funding for that had continued throughout the year. She said the key element and focus was on bed modelling. She said there was a RWT approach and an external approach which had identified based on activity undertaken last and into this year a gap of 37 acute beds and a worst-case scenario of 53 beds. She said the winter plan looked to see how to mitigate that challenge. She said key elements were virtual wards, same day emergency care and flow. She said other elements crucial to deliver the plan were workforce and the management of infection prevention. She said the Trust continued to protect elective recovery and cancer patients with ring fenced elective ward.

Ms Nuttall said the Winter Plans for all the Black Country Places and Organisations had been assessed by the system urgent and emergency care group. She said the Trust's plan was rated at amber which was reliant on actions the Trust would undertake, focussing on improving timing of discharges, increasing the use of the virtual ward particularly for Staffordshire patients and focussing on no increase in patients who are discharged or MFFD (medically fit for discharge). She said the Trust had no capacity to open additional adult beds. She also mentioned one of the mitigation plans were the opening of additional paediatric beds between 8 and 10 from quarter 4. She said funding had been received for this. She said there was a mitigated bed plan, which was high risk. She mentioned last year during the winter challenges the Trust was an exporter of ambulances from the New Cross site due to the challenges it faced. She said because of the systems and schemes introduced predominantly, the

Ambulance Receiving Centre (ARC) the Trust was now a net receiver of ambulances into the system supporting other systems. She said other risks were social care, primary care and mental health.

Mr Dunn asked how the Board would be updated on monitoring and control of the plan. He also asked, if some risks materialised, was there a plan for what actions would be taken if certain issues arose i.e. need for beds. Finally, he also mentioned there were still no details of Primary Care or inclusion of mental health and asked when completeness of OneWolverhampton Mental Health and Primary Care response to the Winter would be available.

Ms Nuttall said all metrics were available now and were reported on. She said the mitigation plan needed to be monitored, which impacted on reducing the length of stay and the impact of the same-day discharge centre. She said that same-day emergency care was not reported in-depth, but the metrics could be incorporated into the IQPR and could go through the finance and productivity committee. Ms Nuttall said there was no space to open additional capacity for beds in terms of adult capacity and that all the space at RWT, Cannock Chase and West Park was currently utilised. She said there were no plans to open any additional adult beds. She said there was an escalation tool called “Opel Level” which was used on a daily basis. She mentioned if matters deteriorated the Trust would look for support within the Community Teams. She said Mental Health did have their own Winter Plan and was an action at an Integrated Care Board (ICB) meeting that that it be articulated into the Place Plan together with any actions taken across Primary Care.

Ms Pickavance said Primary Care had an acute respiratory hub for children currently out for people to volunteer. She asked if there was any money to ensure it linked in. She also asked if RWT was a net receiver of ambulances, there was mention of applying to the ICB for additional funds. She asked what the likelihood was of receiving those funds.

Ms Nuttall said that the expressions of interest for the acute respiratory hub were looking at the Phoenix Centre as the base. She said discussions of funding was currently with the ICB and her understanding was the schemes and requests would be supported.

Mr Stringer said, with regard to out of area ambulance activity, this was an ongoing discussion with the national team. He said the Trust had ICB support and were in active discussion with commissioners who were linked to our system.

Ms Cowley asked if funding was not received, was there a plan B, and if funding was received would the Trust be able to recruit and get posts in a timely manner. She asked what the relationship was with social workers in outside areas, and what links were the Trust doing with Community based Social Care teams to try and keep people at home and being supported by Social Care Teams

Ms Nuttall said she was expecting confirmation of the funding this week following the ICB discussion and Board. She said the main challenge would be a pharmacist, which was not readily available. She said that all other schemes which were mentioned the Trust would be able to support. She said that transport would be external support and discussions are underway with paediatrics around staff. She said it was recognised that staffing would be a challenge. Ms Nuttall said the Trust had a positive relationship with Wolverhampton Social Care and discussions took place daily. She said approximately 20% to 30% patients were treated from Staffordshire and regular meetings took place with the teams. She said there were positive routes for escalation.

Ms Harding said there was reliance on care homes. She asked if any thought had had been given into extra care housing because often older people were medically fit to come out of the

hospital but required more support with daily living.

Ms Nuttall said RWT provided nursing support to care homes to ensure that people were not conveyed to the organisation. She said there was the opportunity to spot-purchase additional care home support, which was expensive and short-term. She said that if a crisis was responding to a 999 call, it would be part of the escalation conversation.

Mr Levermore asked how the Trust was to best produce predictive work through 2024- 2025, being aware of the position as 2023-2024.

Ms Nuttall said it was an ongoing process undertaken each year. She said, there were complex algorithms that picked up all the nuances, which were based on evidence, for example review of flu activity from Australia, alongside monitoring things like length of stay.

Ms Cartwright said that BCH had commenced the One Wolverhampton Place partnership on the inclusion of mental health. She said there was a mental health scheme which was part of the adult social care discharge fund. She said more work was to be done to ensure the Winter Plan for mental health was incorporated. She said that primary care had had no additional funding specifically to support primary care from a winter perspective, which was continually under review. She said there was focus on prioritising work undertaken across the Black Country with the community services to look at the uptake of the virtual ward and promoting that as much as possible.

Sir David expressed the importance of the One Wolverhampton plan and the volume of work involved. He said it was important to build the confidence of local communities to ensure they were aware the Trust was there to support them. He said the Board was agreeable to approve the plan however expected the Executives to continuously review to ensure when getting to the next meeting in December that it was no longer high risk in putting in things that would deliver.

Resolved: that the Winter Plan be received, noted and approved subject to the plan being continuously reviewed.

BREAK 11:23 – 11:28

Effective Collaboration

TB.9245: Group Chief Strategy Officer Report

Mr Evans introduced the Strategy and said it had been reviewed by the subcommittees, Chairs and Lead Executives and all were confident with the detail data, and what was to be achieved with the metrics for the year. He said the reporting mechanism had also been agreed for each of the metrics back through to the Trust Board.

Mr Evans provided an update from the Black Country Provider Collaborative (BCPC) and the approach of continuous improvements. He said the BCPC event entailed and update on the clinical program, outpatient programme and detailed work around some of the work with GRIFT which required more work. He said the corporate improvement programme was underway, and a date was to be arranged when services were to be aligned for payroll and mandatory training. He said RWT would be the chosen provider. He also mentioned the approved annual plan was now available. He said a positive first joint board development session for the Black Country took place on 12 September which emphasised some of the benefits of collaborative working. He also mentioned the Trust's approach to continuous improvement and the national direction of travel. He said a quality management system was to be delivered nationally. He said every Trust rated as outstanding by the CQC already had this in place. He said as part of this each Trust in the Country now had to complete a maturity matrix self-assessment which needed to be

signed off as a Board. He finally mentioned all 4 Trusts across the Black Country were working on one consistent approach to try and get a Quality Improvement system adopted, the report was being prepared by Black Country Provider Executive and would come to the Board for sign off.

Resolved: that the Group Chief Strategy Officer Report be received and noted, the Quality Improvement Maturity Matrix be approved

Improve the Health of our Communities

TB. 9246: Group Director of Place Report - by Exception

Ms Cartwright introduced the report and said that positive progress had been made for the One Wolverhampton Place-based partnership and it was moving forward regarding delegation from the ICB. She said a previous risk in young people's oral health was raised and work had commenced to address that risk. She said the terms of reference for the new integration committee had been drafted and the first meeting was to take place in October. She said a piece of work had commenced by Mr Matthew Dodd looking at development work across Black Country Community Services. She said there was focus on winter, where community services could learn from each other, share best practices across the winter period, and looking at cross border and discharges and admissions. She mentioned a piece of ongoing work looking at the urgent community care response, the falls protocol, and the single points of success across the system from an ambulance perspective. She said a Black Country Operational Group had been created with all the leads of the community services. She said several pieces of work around cross border acceptance of patients particularly into community services and urgent care pathways and 24/7 access for care navigation, which were in place at Wolverhampton and Walsall were being reviewed to extend the use by each Trusts.

Ms Heseltine said it mentioned in the report that legal advice on delegation was awaited from NHS England. She asked for an update on the position.

Ms Cartwright said there had been no further advice regarding the delegation from NHS England. She said they were awaiting legal advice on what delegation may mean. She said the ICB are looking at what is possible within its existing governance mechanisms. She said there were a number of areas with its existing power and control that they could instigate with regards to delegation particularly for example responsibility for community services contracts down to Place Based Partnerships though a host organisation. She said advice was still awaiting from NHSE but progress was still being made at a system level. She said there would be governance available from April 2024, and there would be a number of systems put in place to allow delegation.

Sir David asked for conclusions about governance for the next board meeting.

Action: Ms Cartwright to provide information on governance for the next meeting.
Resolved: that the Group Director of Place Report be received and noted

TB. 9247: Finance and Productivity - Chair's Reports April and May

Mr Dunn highlighted the Committee focused on Finance, Productivity, investment of 2 very large value business cases, increase in waiting lists, cancer performance and finances. He said the 52-week waiting position pre Covid there were zero waiters over 52 weeks. He said at the end of the year there could be approximately 5500 which all related to capacity. He said the Trust had been escalated in Tier 2 for cancer performance and trajectories were on track but there were performance issues. He said the Trust was looking to clear very long waiters, key areas being urology and 2 other areas.

Mr Dunn said the Committee looked at results of finances against the deficit plan of £26.7 million the Trust was at £24.5 million. He said the Committee decided not to go for a reforecast but utilise the time now and between quarter 3 to put precise focus on the position with the finances. He said listed within the report were mitigation factors the Trust would possibly consider, which included the run rate challenge and Cost Improvement Programme(CIP). He said divisional meetings were taking place regarding run rates with focus on the usage of bank staff. He said sick leave was a key contributor and from a financial perspective was approximately £5 million contribution to the deficit. He said key focus was to improve performance and stabilise performance so that the Trust was aware how it would end the year. He said the Trust had commenced the first draft of medium term plan as the Trust needed to build a plan to take the Trust to a break even position.

Sir David said the Trust was in a serious position in terms of ability to deliver what it said it would around waiting lists and money. He asked from the Committee's perspective what assurance there was that the Executives were taking the action that was required to get the Trust back into those 2 places. Mr Dunn said the first action was reviewing the run rates as it was something that the Trust was able to do something about it and divisional meetings were taking place to review this. He said the Executive Directors should ensure there was absolute focus on this. He said actions were taking place, but time would be required to see any results. He said in relation to the waiting lists, he felt the Trust needed to look very closely i.e, if 10 procedures had been undertaken could 11 be done, could the Trust start to use the data that was available to ensure the Trust enhances productivity. He said more work was required area.

Sir David asked what the delay was in getting the run rate and activity correct. Ms Nuttall said she felt there was not a delay in terms of productivity the Trust was pushing hard to deliver over the expectations on the elective recovery fund. She said reports had been received on that particular element. She said there had been some changes nationally in terms of recommendations. She said urology was a challenge in achieving 78 weeks. She said the Trust was forecasting to achieve 65 weeks at the end of March for all other specialities which was the national expectation in terms of reducing that. She said there was focus to reduce the 52 weeks but the Trust was aiming to achieve what was expected nationally around 65 weeks at the end of March. She said discussions had taken place on risk one being any potential industrial action strikes. She mentioned a lot of the recovery plans focused on GIRFT and productivity. She said the throughput through theatres and the theatre metric utilisation were monitored weekly. She said this organisations day care rate was benchmarked in the top quartile. She said there was always more the Trust could do but she felt on the productivity element and ambitions to achieve additional Elective Recovery Fund (ERF) funding was already in train. She said there was more that could be done with CIP and that was a challenge to making that recurring as opposed to non-recurring. She said conversations were taking place with Ms Hickman, Dr McKaig and the finance team to the challenge on run rate and bank staff. She said a whole multi-disciplinary approach was required. Ms Hickman provided assurance that scrutiny was being explored together with the levels of involvement and work within their teams.

Dr McKaig said in relation to productivity a lot revolved around activity that medical staff undertook. He said there was considerable amount of positive engagement from the clinical teams i.e., around further faster outpatient activity work. He said the Trust had seen significant amounts of over and above work undertaken by staff at weekends to reduce some of the outpatient demands. He mentioned there was also ongoing industrial action which was taking place which was not assisting with morale and resilience of the workforce. He said the way that RWT and the teams had responded to some of those challenges were to the credit to the organisation and teams. He felt teams were putting in over and above the discretionary effort which was not necessarily seen across the Board.

Sir David asked what the percentage improvement was in this year's elective activity compared to last. Ms Nuttall said it currently stood at 4%, she said there were different elements of the financial opportunity's dependant on case mixes. She said she could provide a breakdown by treatment function. She said there were some challenges in some areas, and some were progressing ahead significantly. Ms Nuttall said in terms of the expectations of the original ERF value waited the Trust was below that originally. She said as that had now been reduced the Trust was just slightly below the 108.5 that was expected. She said industrial action was the key impact on that. She said at the end of the year assuming that industrial action could be manged the Trust would achieve the activity levels that it said it would. Sir David said the issue of run rate was important.

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

Excel in the Delivery of Care

TB. 9248: Report of the Chief Financial Officer Months 4 and 5

Mr Stringer highlighted at the end of August, there was £4.7 million adrift from the original profile submitted, and said £2.2 million of that related to strike costs. He said that RWT had not as yet been fully funded for inflation of approximately £1.3 million. He said several technical issues were to be resolved with the Elective Recovery Fund (ERF), funding of industrial action, release of winter monies at the centre, which was approximately £200 million and an ongoing in-year discussion about funding from the treasury. He said that could all have an impact of funding through the ICB and into the Trust.

Resolved: that the Report of the Chief Financial Officer Months 4 and 5 be received and noted

TB. 9249: Audit Committee - Chair's Report

Ms Jones introduced the report and highlighted an annual meeting took place with external, internal auditors and counter fraud, without an Executive present. She said it was an important meeting for the Committee to engage their views of the culture of the organisation, the willingness to audit the receptiveness, recommendations. She said the auditors were very complimentary that the organisation was willing and did point audit towards the areas that Executives believed Audit should review. She said this provided assurance that internal controls that were written were being followed.

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

TB. 9250: Chief Operating Officer Report by exception Verbal Report

Ms Nuttall said the report had been discussed at a Board development session and confirmed an assessment had to be submitted. She said there was an ask from the centre that anyone who breached the 65 weeks at the end of March 24 would have their outpatient appointment booked by the end of October. She said that there were some areas of concern and red risk where it was stated the Trust would not achieve that metric. She said the Trust had submitted that Cardiology patients, would be seen by November and Urology and Gynaecology, would be by the end December; and Community Paediatrics patients would be all seen by the end of March. She provided assurance to the Board the reason why end of March was noted for Community Paediatrics was once all those patients had seen their outpatient appointments the clock stopped and they would be deemed as treated. She said it was a low risk decision that had been made by the Trust. She said this would be monitored and reported back to the

Board.

Resolved: that the Chief Operating Officer Report by exception Verbal Report be received and noted

TB. 9251: Quality Committee (QGAC) - Chair's Reports

Prof. Toner highlighted RWT remained in tier two scrutiny for cancer performance. She said that Urology and Prostate cancer remained an issue, and mutual aid was in place for both areas. She said that diagnostics and histopathology continued to be a challenge; however, there were slight improvements in skin cancer performance. She said another area of concern was ophthalmology and follow-up with ophthalmology patients, which was currently at 7,800 patients in the system, with another 4,500 patients to come into the system within 30 days and no outpatient slots. She said an issue was discussed previously where the Trust had asked for support for these patients being treated within the community, which would take many patients out of the system. She said no funding had as yet had been received from the ICB.

Sir David said Histopathology was a constant issue highlighted every month and asked if there was a systemic issue.

Prof. Toner said it varied across different tumour sites as histopathologists were specialists in terms of what they looked at. She said that there were plans to train and educate histopathologists so that they have a wider skill set and were not just looking at skin or breasts.

Dr McKaig said the turnaround times for histopathology had several complicated factors, the main were capacity and demand. He said there was not capacity within the Black Country Pathology to deal with the demand from all four acute sites with histopathology. He said that data showed that 41 consultants are required, but RWT only had 27. He stated recruitment was ongoing to mitigate the recruitment; there was a detailed but short-term action plan around better utilisation of digital technology and how, in time, could potentially use AI to improve that. He said only basic histopathology could be outsources not more complex cancer work. He said there was a medium to long term plan in place. He said the commissioners within Staffordshire were to agree to a pathway for stable glaucoma patients within Staffordshire, which would take approximately 2700 stable patients into that system which was positive news.

Resolved: that the Quality Committee (QGAC) - Chair's Reports be received and noted

TB. 9252: Chief Nursing Officers Report by Exception

Ms Hickman highlighted the Trust remained in a positive vacancy position for nurse registered nursing and non-registered nursing. She said the majority of the recruitment had been international and newly qualified, which impacted the skill mix. She said several activities were underway, around newly qualified with a preceptorship programme that evaluated well. She mentioned the skill mix review and the organisation had completed phase two for adult inpatient areas, adult assessment areas and paediatric inpatient areas. She provided assurance that there were underpinning quality impact assessments that related to all areas where there were additional roles and were referenced Allied Health Professionals (AHP). She said particularly within rehab pathways and paramedics within the emergency department. She said that Deprivation of Liberty Safeguards (DOLS) reporting numbers were positive due to a strong presence for safeguarding. She mentioned work continued to progress and the audit would not be reviewed for Mental Capacity Act (MCA) until more assurance about the process was provided. She said for Tissue Viability the Trust had achieved both pressure ulcer and leg ulcer Commissioning for Quality and Innovation (CQUIN). She said expert review of audits had been undertaken by leads due to an increase in cases.

Ms Hickman said the Covid risk assessment had been reviewed in relation to the emerging variants of concern and Covid cases remained low in the hospital. She said conversations were taking place on how to present data for C-Difficule in Statistical Process Control (SPC) format. She also provided an update on the deep cleaning programme which was underway. She said the CQC surveys which had been published in July and September for Emergency Department (ED) Urgent Treatment Centre (UTC) and inpatient recognising that survey was undertaken in late 2022, there were a number of improvements in inpatient areas across a number of the domains. She said there was continued work for waits for beds and movement and were aware of interventions which took place last winter particularly around ARC and Push. She said there was deterioration in some of the areas of ED and UTC predominately around waiting times and communication.

Resolved: that the Chief Nursing Officer's Report be received and noted,

TB.9253: Midwifery Services by Exception Report

Ms Palmer introduced the report and highlighted the improvement in vacancies; however there were challenges with skill mix and getting staff prepared to move into areas as some were highly specialised areas. A plan is in place to support newly qualified staff. She said acuity and staff ratios were not meeting the recommended standards but should see improvement over the coming months as staff establish within the areas. This is being monitored closely. She mentioned the Trust was triangulating any adverse outcomes or harm with the data to see if any harm or incidents related to midwifery staff deficit. She said included within the papers was the Perinatal Mortality report 2021 for the Board's information. She felt following the Lucy Letby case there would be more scrutiny placed on neonatal and maternity services around mortality reviews. She said mortality was being monitored closely and EMBRACE had provided assurance that the Trust was reporting, reviewing and monitoring 100% of mortality cases. She mentioned there was a slight improvement with the extended mortality rates from the latest Perinatal Mortality report and work continued through the Maternity transformation plans and the Saving Babies Care Bundle to improve perinatal mortality rates within the Black Country.

Resolved: that the Midwifery Services by Exception Report be received and noted

TB. 9254: Any Other Business

There was no other business and no questions from members of the public.

TB. 9255: Questions from members of the public

Mr Wilshere confirmed no questions had been received.

TB. 9256: Integrated Quality and Performance (IQPR) Review Executive Summary

Resolved the IQPR report was received and noted.

TB. 9257: To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest

Resolved; that the resolution be approved.

TB. 9258: Date and time of the next meeting 12 December 2023 at 10:00 am

The meeting closed at 12:10 pm

The Royal Wolverhampton NHS Trust

5 December 2023 10:54

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 01/08/2023 9.1 Elective Recovery Update Report				
1425.	Urology update	Nuttall, Gwen	05/12/2023	Pending
	Explanation action item Ms Nuttall to provide at a Board meeting a plan setting out the medium-term position in relation to Urology. **UPDATE:** An update will be provided to the December Board meeting			
Public Trust Board 10/10/2023 12.1 Group Director of Place Report - by Exception				
1489.	Proposed Governance arrangements for OneWolverhampton	Cartwright, Stephanie	28/11/2023	Completed
	Explanation action item Ms Cartwright to provide information on governance for the next meeting.			
	UPDATE The proposed governance arrangements are still being developed by the ICB but are further explained in the latest iteration of the System Operating Model. The OneWolverhampton Place Based Partnership and RWT as a potential host will be fully consulted with in terms of any governance proposals that are developed. The recent establishment of the Integration Committee will support any proposed governance arrangements.			

Public Trust Board 10/10/2023 9.1 People Committee (PC) - Chair's Report				
1488.	Working From Home Workstation Assessments	Duffell, Alan	28/11/2023	Completed
	Explanation action item Mr Duffell to provide an update on how workstation assessments were undertaken for staff who worked from home.			
	UPDATE Having spoken with H&S, they have stated that where additional equipment is deemed necessary, for example as part of a reasonable adjustment, these will be discussed and arranged locally between the line manager and the employee and may require an assessment by Health and Safety or Occupational Health and Wellbeing. In addition to this, they are creating a series of videos to support the process of workstation set-up both at work and at home. Currently, there is also a video available for staff, from the HSE, which supports working from home and gives excellent insight into how best to set up a workstation at home but also good practice when setting up any workstation.			
Public Trust Board 10/10/2023 2 Patient Voice				
1487.	Use of IV Antibiotics at Home	Cartwright, Stephanie	28/11/2023	Completed
	Explanation action item Ms Cartwright to ensure a plan was created across the Black Country to the extend the use of the device to allow patients to deliver IV antibiotics within their own home.			
	UPDATE Following the Board meeting, Walsall community teams have confirmed that this has been in place for some time (approximately 4 years) in Walsall. The difference between the two models is that patients in Wolverhampton can administer themselves, and in Walsall it is undertaken by the community team. Matthew Dodd will incorporate as part of his Black Country work on community services/out of hospital care.			

Public Trust Board 01/08/2023 3 Staff Voice - IT Cyber Security Team				
1424.	Training Centre for Cyber Security at the University of Wolverhampton	Daraz, Umar	28/11/2023	Completed
	Explanation action item Dr Daraz to liaise with Mr Duffell and Mr Bruce to see if discussions with University of Wolverhampton could be progressed further in relation to the training centre at the University for Cyber Security. UPDATE: 02/10/23 Dr Daraz is in process of arranging a meeting with colleagues at the Trust and University **UPDATE:** 16/11/23. Dr Daraz mentioned a solution was not available via Wolverhampton University. A meeting was arranged with himself, Alan Duffell, Nick Bruce, Alvina Nisbett, Jayne Lawerence, Jo Watts with the Birmingham City University (BCU) Pro Vice Chancellor – Prof. Hanifa Shah. He said the core team at the BCU were now working up a Skills, Placements, projects action plan with short/medium and long-term outcomes. Workforce requirements; Digital , Cyber, Data Warehouse BCU and the Trust will also hold a workshop to showcase progress and agreed roadmap for the long term – February 2024			

Paper for submission to the Trust Board Meeting to be held on 12th December 2023		
Title of Report:	Update on Reinforced Autoclaved Aerated Concrete (RAAC) Inspections – Outpatients building, New Cross Hospital	Enc No: 5.1
Author(s):	Stew Watson, Group Director of Estates Development Lindsay-Ibbs George, Divisional Manager, Estates and Facilities	
Presenter/Exec Lead:	Stew Watson, Group Director of Estates Development Tel: 07785 421041 Email: stew.watson@nhs.net	

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

Recommendations:

The Board is asked to acknowledge and approve the actions required, as set out in this report, to reduce the risks associated with the Trust estate, where RAAC has now been identified, and to ensure the safety of our staff, patients and visitors.

The Board is requested to support a plan to address the risks to the Outpatients building and agree with the approach recommended by the technical teams to make temporary and potential permanent changes across the New Cross Hospital site. It is currently estimated that to temporarily relocate the services affected, it will take approximately 3 months to prepare alternative areas, in order to decant services, from the building, to permit free access to the facility to remove and replace the RAAC materials from the Outpatients building.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐		
Changes to BAF Risk(s) & TRR Risk(s)	This risk will need to be added to the TRR		
Resource Implications:	Funding Source: Capital: Trust capital allocation 2023/24 and 24/25, however we are expecting to receive capital funding from NHSE, subject to the submission of a successful application		
Report Data Caveats	Intrusive structural surveys will be required in order to fully ascertain the risks; further updates will be made available on the conclusion of the fuller inspections.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☒No☐	Details: Compliance with the requirement to report where RAAC has been identified on the RWT estate.
	Health & Safety	Yes☒No☐	Details: Implications to users of the New Cross site
	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	N/A		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Executive Oversite Group established
	Board Committee	Yes☒No☐	Previous updates in September of October 2023
	Board of Directors	Yes☐No☒	
	Other	Yes☒No☐	Capital Review Group

Summary of Key Issues using Assure, Advise and Alert
Assure To assure that the Trust estate remains safe to provide and operate services for staff, patients and visitors.
Advise To advise that the actions taking place to assess, understand, and manage risks associated with RAAC are shared with the Trust Board.
Alert To ensure that the Board are aware of the need to affect interim changes to manage such risks, together with plotting out a longer-term solution to address the concerns associated with RAAC, now identified in the Outpatients building on the New Cross Hospital site.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Safe and responsive urgent and emergency care • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Improve the Healthcare of our Communities	• 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 clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall

Update on RAAC Inspections – Outpatients building, New Cross Hospital
Report to Trust Board Meeting on 12th December 2023

1.0 EXECUTIVE SUMMARY

1.1 This paper updates the Board on the current position regarding inspections and surveys that are currently taking place to the Outpatients building at New Cross Hospital, following the requirement from NHSE to assess the condition of the Trust buildings regarding the potential presence of RAAC on our estate. This paper is a further update following the Board Development session of 5th September 2023 and the Trust Board of 10th October 2023.

1.2 Following previous reports, this paper updates the Board on the recent activity in relation to inspections carried out by NHSE's appointed Structural Engineers to the Outpatients building together with their advice and recommendations. The paper also provides an updated Risk Assessment and shares further information on the NHSE RAAC "on-boarding" programme.

1.3 Building owners have a responsibility to manage their buildings and ensure that they are compliant with legislation, including duties under health and safety legislation to maintain a safe workplace.

2.0 THE TRUST POSITION

2.1 As reported previously, further to receipt of the September 2023 letter from NHSE, to date, the Trust technical teams have carried out visual surveys on 25 buildings across the estate that fit into the timeframe, where RAAC was heavily used within the construction process, c1950 -1995. Of the 25 buildings inspected, in line with the guidance, only 1 building, the Outpatients department at New Cross Hospital, has been confirmed as to having been constructed with the use of RAAC materials in the roof structure. This space was surveyed by Trust specialist engineers that confirmed the existence of such materials. In their report, they also advised that further detailed intrusive surveys are required to fully ascertain the level of risk.

2.2 Following this discovery, the Trust teams worked up a solution to vacate the building, on a temporary basis, to permit the conducting of further intrusive tests and to fully determine and assess the level of risk. Until such time that full access can be gained to permit more intrusive investigations of the entire roof slab, the recommendation from the specialist engineers was to ensure that a "management strategy" be put in place in accordance with the Institute of Structural Engineers guidance. As part of the management strategy; monitoring plans were developed, and an inspection regime was set in place; appropriate risk assessments were established; areas for proposed remediation were considered; assumptions by engineers as to the condition and degradation of the RAAC panels were made, as well as plans to reduce the risks associated with RAAC panels. All these measures have now been set in place and will remain under review until we are able to conduct fuller intrusive surveys to fully determine the level of risk.

2.3 As a requirement of the recent letter received from NHSE, we had alerted NHSE of our discovery and shared the Trust Structural Engineers initial report. NHSE subsequently sent their "RAAC Team" to visit the Outpatients building on 18th October 2023 in order to assist the Trust in our continued assessment of the building. Following the inspection, the Trust received verbal assurance that the building was not in any imminent danger of collapse, and indeed it was very much towards the lesser end of risk when compared to other facilities that had been inspected under the programme and that we were to continue monitoring the building via regular inspections and risk assessments. A written report was promised for release within a week to 10 days.

2.4 In the meantime, an Operational Group was subsequently established, chaired by the Chief Operating Officer, to discuss the initial findings of the NHSE inspection, to also review and update the Risk Assessment and to discuss plans to oversee the potential temporary relocation of outpatient services currently operating from the building in question – as soon as was possible – to enable the intrusive surveys to take place.

2.5 The NHSE inspection report took much longer to be presented to the Trust than was originally anticipated.. The report was received on 17th November 2023. On review the report did confirm the condition of the RAAC panels, noting that they were generally in good condition, with few localised areas of damage. The NHSE Engineers also confirmed that no significant deflections of the RAAC panels were observed. The report also went on to make further recommendations to the Trust to continue to monitor the building whilst ensuring that the following steps took place to further investigate the Outpatients building.

(i) Undertake a LiDAR (Light Detection and Ranging) scan displacement survey; this survey is a remote sensing technology that uses laser lights to measure building components and create accurate 3D maps of the building. They are used for capturing precise data identifying potential hazards which are important to support Risk Assessments and are an industry standard towards contributing a more thorough risk evaluation.

(ii) Undertake intrusive investigation works; this is to fully determine as to whether the bearings of the panels are within certain tolerances and will ensure panel bearing widths and location of associated reinforcement bars.

(iii) Conduct a Cover-meter survey; this will allow the Trust to understand any variance in reinforcement locations within the RAAC panels. The report notes this recommendation is considered optional.

2.6 The NHSE Structural Engineers report also confirmed some additional control measures that have been addressed as part of the updated Risk Assessment. These measures included a communication strategy to articulate the awareness campaign to staff members and the associated challenges together with the reassurance of the measures that are in place and the steps taken so far in line with guidance. Additional controls and restrictions to accessing the roof and continuous visual inspections as well as not introducing any additional loading to the roof structures. A focus on maintaining services, roof gutters, downpipes and roof finishes are also in place.

2.7 Since receipt of the report, the Trust has obtained quotations for the recommendations and work is planned to take place across December and January to complete. The works are intended to take place over weekends to minimise any impact to provision of Outpatient services, with all making good works to be included also.

2.8 Staff consultation has also taken place to alert those using the building of the current status of the review and the measures that are in place to manage the building in line with the guidance made available by NHSE and the Engineering reports.

2.9 As part of the NHSE processes associated with the management of RAAC materials, once identified, the Trust were required to be “on-boarded” to the national RAAC Programme. Part of this requirement is to make available associated regular status reports, as well as applying for capital funding to undertake works to monitor, assess, and eventually remove and replace such materials from the Trust’s estate.

3.0 FUNDING POSITION

3.1 A part of the on-boarding process, the Trust has requested access to capital funding. NHSE are optimistic of supporting the Trust to allow the works to commence before the end of the 23/24 financial year. The approximate value of the works is in the order of c£6M. This figure includes the temporary relocation costs of Outpatient services across other parts of the Trust together with the removal of the whole of the roof structure and to replace it with a timber framed roof and new roof coverings.

3.2 Subject to concluding intrusive investigation works and associated surveys noted previously, there are several likely options available to the Trust to mitigate any associated risks associated with the RAAC roof panels:

Option 1 – If deemed a requirement, the Trust consider the installation of appropriate, additional interim support structures to ensure that the roof structure is braced accordingly and look towards a potential replacement of the roof structure in line with when appropriate capital funding is made available. Costs will be determined following the conclusion of intrusive surveys.

Option 2 – Consider full replacement of the roof to remove the RAAC materials and to bring the building back into use as soon as is possible. This remains the preferred solution and costs currently stand in the order of £6M.

Option 3 – Consider the demolition of the facility and look towards rebuilding a new Outpatients facility within the same footprint of the existing building. Access to capital funding to undertake this will be challenging and it will be a much longer timeframe required for the services to be provided from the alternative temporary locations. Costs are likely to be in the order of £20-25M.

Option 4 – Consider providing Outpatient services from an alternative location for the medium term and mothball the building until appropriate funding can be sourced to address the removal of the roof. There is the opportunity, with the national GIRFT Going Further Faster Outpatient improvement programme to review and redesign the nature of some of our Outpatient services. This programme of work will not however negate the need to have an Outpatient facility available for use by the clinical

teams. If this option is to be explored, further costs will be prepared accordingly, once a suitable location has been identified.

Option 5 – Take this as an opportunity to relocate the Outpatients department and refurbish an alternative existing part of the estate to accommodate the service. We currently have redevelopment works taking place at Wrekin House, that we could investigate further to examine if this could be a feasible and cost-effective option. If this option is to be explored, further costs will be prepared accordingly, once a suitable location has been identified.

3.3 It is likely that Options 1 and 2 will be the preferred solution, subject to the intrusive survey results and the availability of capital funding to secure option 3, 4 or 5.

3.4 Each of the options noted above require access to finances to address the risks, with little flexibility across the Trust in-year capital programme, we would be faced with significant costs should we consider the cancellation of committed contracts already awarded and on-site to accommodate this – should NHSE be unable to support the Trust with access to capital funding. It is a similar picture across the Black Country ICS with funding committed to the delivery of capital programmes across our system partners. However, current notable slower spending across the ICS managed capital programme in the Black Country, may give the Trust potential access to some capital funding before the end of March 2024, to address our concerns, but this is not guaranteed, nor has it been requested at this stage. We are currently working up more detailed costs across the options noted above, as well as several hybrid options, should we secure appropriate funding.

3.5 Other public sector buildings that have been found to contain RAAC are still in use under managed and monitored solutions that assess the current condition of the building and monitoring any signs of wear and tear that could lead to implications within structural integrity. We are conducting the same approach.

3.6 As discussed above, access to funding will be a significant challenge, and with no further funding seemingly being confirmed, as of yet, by the Government, Hospital Trusts, educational establishments and indeed all public sector service providers are being asked to address such matters within their existing finances. We would assume this position will need to change as more and more surveys across the public sector estate discuss the presence of RAAC on their estates, as the impact to potential closures and reduced or non-delivery of services cannot be underestimated in its impact to providing services to the public.

4.0 THE WIDER TRUST ESTATE

4.1 It should be noted that inspections by the estates technical teams have taken place across other areas of the Trust estate including West Park Hospital and Cannock Chase Hospital, to which no risks have been identified, and we are now undertaking inspections across other Trust properties where we have an interest or indeed staff operating from buildings that could be affected by RAAC. On this basis we are also requesting assurance from respective building owners to ensure that such premises are inspected accordingly to provide further assurance to the Trust.

5.0 RECOMMENDATIONS

5.1 The Board is asked to understand, acknowledge, and approve the actions required as set out in this report to reduce the risks associated with the Trust estate where RAAC has been found, and to ensure the safety of our staff, patients and visitors.

5.2 The Board is requested to support the development of an appropriate plan to address the risks and agree with the approach recommended by the technical teams to make temporary and potential permanent changes across the New Cross Hospital site to ensure Outpatient services remain as unaffected as is possible.

5.3 The Board support the continued investigations to mitigation of the risks noted and for the Trust to continue to liaise with the NHSE regional teams for advice, potential funding support and direction, to ensure compliance with NHSE requirements.

5.4 The Board support the decision to conduct the further intrusive tests to be carried out over the next two months, together with continued monitoring of the roof for any changes (be it cracks, additional water leaks etc.). We continue to develop relocation plans for the service should that be needed, either due to structural changes or as a result of roof replacement.

5.5 The Board endorse the continued exploration of outpatient transformation schemes as part of the GIRFT programme of work and that we continue to work with NHSE to secure capital funding where possible.

5.6 We continue to provide staff, Trust Board, patients, and visitors updates concerning safety.

5.7 The Board is asked to note the contents of the report and the emerging challenges to ensure the Trust is complying with NHSE guidance, whilst also ensuring that we are able to comply with the requirement to manage our buildings and ensure they are compliant with legislation, including duties under Health and Safety legislation to maintain a safe workplace.

5.8 To receive further reports and updates following the conclusion of the recommended additional surveys to the Outpatients building and any further views of NHSE.

Reading Room Information/Enclosures:

Current Risk Assessment.

Datix No:
Risk Ref:

The Royal Wolverhampton NHS Trust

HS01 Appendix 4B

Occupied Buildings with RAAC Roofing Systems

Refer to the guidance before completing and use a separate form for each risk. Refer to the guidance before completing and use a separate form for each risk. After completing Sections A-C please give this form to your manager. Thank you.

SECTION A: Initial Assessment Details		
Date of Assessment:	11th Sept 2023 updated 4th December 2023	**Risk Assessor (s): L.Ibbs-George** **Estates Managers**
Directorate / Specialty:	Compliance	
Location:	New Cross Acute Hospital	

SECTION B: The Risk

Further to recent Government guidance, Institute of Structural Engineers (ISE) May 2023 and several non-intrusive surveys, a Reinforced Autoclaved Aerated Concreate (RAAC) roofing system has been identified in Building NX 019 OPD.
It is estimated that this system covers approximately 75 % of the total covered floor area (occupied) with the later extension to the building "rear" incorporates a distinctly separate pitched roofing system therefore not a comprising any RAAC material.

The main structure was completed circa 1978 with an anticipated (RAAC) life expectancy of 30 years, this roofing system is overcovered with a mastic asphalt sheeting this providing rainwater protection. This mastic asphalt (again original life expectancy of 25 years) has had a number of localised repairs following rainwater ingress particularly the link bridge entrance and the main reception area.

The hazard is severe injury or death to persons in the instance of catastrophic failure (collapse) when,

A) occupying the ground floor area beneath the RAAC roofing system.
B) actually, standing on the RAAC roofing system.
C) loss of facility & service in the event of failure while unoccupied.

Who is affected? Staff Patients Visitors to the building.

What is the potential outcome(s)? Servere injury or death, detrimental effect on Trust reputation and loss of service.

How was the risk identified, From visual survey`s undertaken by a Structural Engineer.

Associated information.	**Lead for Control**	**Date Started**	**Gaps in Controls**
As guidance provided by the Institute of Structural Engineers (ISE) the determination of Risk is elevated by prolonged rainwater ingress.	Estates	Completed	There are no areas of prolonged rainwater ingress. There are 4 four areas of the building that have experienced leaks. The only area that has a repeated leak is the area above reception where sky windows are situated, these leaks were due to window closures failing or the seal around the windows failing.
Repairs to rainwater protection membrane once each occasion rainwater had been witnessed at ceiling level.	Estates	Completed	Local repairs completed satisfactorily
Roof covering had been identified as part of the back log maintenance program, until now there have been more pressing priorities.	N/A	N/A	N/A
As defined in the ISE guidance section 2.3 the “end bearing and support configuration” is yet to be identified therefore Risk level must be assumed as elevated. Section 4.1.2 defines the panel condition as a function of cracking, deflection and water ingress.	Estates	1/10/23	Currently high Amber, will be fully defined following invasive investigation in line with the ISE guidance.

Where water ingress has been identified the risk level is Red or Amber dependent deflection ratio.			
Please note given the current understanding and knowledge the ISE categorization would result in an interim risk level of High Amber.	Estates	January 2024	Invasive investigation to be carried out in conjunction with the ISE guidance the Risk level could be reduced to Amber.
Estates management have prohibited access to the RAAC affected roof area for artisans & third-party contactors.	Estates	Complete.	
Initial Risk Evaluation with controls: (Please use the Trust Categorisation Matrix and circle below)			

Likelihood:	Consequence:	Severity:			
1 2 3 4 5	1 2 3 4 5	(1- 3) green	(4 – 6) yellow	(8 – 12) amber	(15+) red

SECTION C: Treatment Plan (Further measures required to reduce the risk)				
Action No	**Action Required** **To be defined**	**Responsible/Lead for implementation**	**Timescale for completion (MUST have date, NOT on-going)**	**Date Action Complete**
1.	Prohibit access to Roof	Estates	Immediate	25/09/23
2.	Complete regular (weekly) inspection and assessment of roof. This will include a visual inspection by Estates to monitor any changes in the appearance of the RAAC panels.	Estates	Weekly- Evidence in planet system.	
3.	Plan to relocate all services from the 75 % of building. The back area which has a pitched roof and no RAAC will remain occupied.	Estates Development/ Div 1 leads/ Estates	December 2023	
4.	Identify Estates works required for relocation of services	Estates/Estates Developments	December 2023	See Section E
5.	Complete intrusive surveys to determine actual risk.	Estates	February 2024	See Section E
6.	Review Surveys and explore options to either manage/ remedy the risk or remove.	Estates Development	February 2024	

7.	Review building immediately if report of any water ingress from local team.	Estates	Sept 2023- immediate	In place
8	Relocation group established, including communication to ensure safe transfer of services from current building to alternative location	COO	Sept 2023	Complete
9	Report incidence of RAAC to NHSE	Estates Development	October 2023	Complete
10	NHSE visit arranged	Estates Development	18th October 2023	Complete

SECTION D: To be completed by the areas Lead Manager for Risk / Head Nurse

Risk Re-Evaluation after Action(s) Implemented:

(Please use the Trust Categorisation Matrix and circle below) i.e. the target risk score once actions are in place

Likelihood:	**Consequence:**	**Severity:**			
1 2 3 4 5	1 2 3 4 5	(1 - 3) green	(4 – 6) yellow	(8 – 12) amber	(15+) red

Recommended actions in Section C are agreed and I have added as necessary			
Full Name:	L.Ibbs-George	**Designation:**	Div. Manager , E and F
Signature:		**Date:**	04/11/2023
		Date for Review: 4/12/2023- monthly	

SECTION E: RISK ASSESSMENT REVIEW SHEET

Treatment Plan (Further measures required to reduce the risk)

Date of Review	Actions required/brought forward from last review (state action numbers)	Changes to/or new controls	Grade	Responsible / Lead for Implementation of Action	Timescale for Completion	Date Action Complete	Managers Signature for RA & Actions	Comments (Barriers / Progress)
4/12/2023	NHSE inspection completed. Inspection report received by the Trust.	Vacation of the OPD1 on hold until intrusive surveys are completed.		Estates	January 2024			
4/12/2023	Intrusive surveys to be arranged asap.			Estates	February 2024			Availability of contractors.
4/12/2023	Local Fire Service alerted to the presence and whereabouts of RAAC on site			Estates	December 2023	December 2023		
4/12/2023	Regular communications to staff, patients and visitors			Comms Team	Started December 2023			

Next Review Date:4/1/24

Treatment Plan (Further measures required to reduce the risk)

Date of Review	Actions required/brought forward from last review (state action numbers)	Changes to/or new controls	Grade	Responsible / Lead for Implementation of Action	Timescale for Completion	Date Action Complete	Managers Signature for RA & Actions	Comments (Barriers / Progress)

Next Review Date:

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public On 12 December 2023		
Title of Report:	Covid – 19 National Inquiry	Enc No: 5.2
Author:	Steph Poulter	
Presenter/Exec Lead:	Kevin Bostock	

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 as an update.			

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☒ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None Risk Description Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') None Revenue: Capital: Workforce: Funding Source:		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☒No☐	Details: Covid-19 National Inquiry
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☐No☐	Details: Covid-19 National Inquiry
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration:		
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

- Members of the Trust Board are asked to note the progress to date in participation in the National Inquiry into Covid-19 specifically Module 3 – '*The impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland*'.

- **Advise**
  The National Inquiry was established on 28 June 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future.
- Module 3 relates to the specific impact on healthcare systems and commenced on 8 November 2022.
- The Inquiry's current focus is on Module 2 – This relates to core political and administrative governance and decision-making for the United Kingdom (UK).

Alert

- That the Trust has complied with the Inquiry's requirement to notify all staff of their legal duty in relation to record-keeping to support the Trust's preparation for the Inquiry. This is called a 'STOP Notice' and the requirement is for colleagues to ensure that all records are saved, whether they are/were working directly on Covid-19 recovery, or as part of business-as-usual activities.
- That the Preliminary Hearing was held on 28th February 2023
- That the dates for the next Module 3 Hearings are expected to take place over the course of ten weeks, starting with a second preliminary hearing in Spring 2024 and the public hearings thereafter from Autumn 2024.

The Royal Wolverhampton NHS Trust

Covid-19 National Inquiry Update

Report to Trust Board Meeting to be held in Public on 12 December 2023

EXECUTIVE SUMMARY

The purpose of this report is to inform the Trust Board and its associated committees that all appropriate and necessary steps have been taken in preparation for Walsall Healthcare NHS Trusts (WHT) involvement in the Covid-19 National Inquiry which opened in June 2022.

It is also to inform the Trust Board of relevant updates on next steps and likely expectations on the Trust regarding its input to the Inquiry.

BACKGROUND INFORMATION

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

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

The approach Baroness Hallet has taken is modular and in October 2022 a preliminary hearing was held on '*Module 1- Government Planning and Preparedness'*. The group is scheduled to meet again on 14 February 2023 with '*Module 2 – Political and Administrative Decision Making'* meeting on 1 March 2023 and continued in October 2023 and is ongoing at the time of this report with an expected conclusion date of 14 December 2023.
'*Module 3 - looking at the impact of the pandemic on healthcare'* on Tuesday 28 February 2023 and another preliminary hearing will be held in Spring 2024.
'*Module 4 - Consider and make recommendations on issues relating to the development of Covid-19 vaccines and the implementation of the vaccine rollout programme in England, Wales, Scotland and Northern Ireland'* this was launched on 13 September 2023 with public hearings to start in July 2024.
'*Modules 5 - which is to examine the response of the health and care sector across the UK in relation to the procurement and distribution of key equipment and supplies, including PPE and ventilators'* will be launched by the end of 2023.

RECOMMENDATIONS

Trust Board members are requested to note the content of the report as an update for the end of the 2023 calendar year.

Any Cross-References to Reading Room Information/Enclosures:

More information can be found at: **https://covid19.public-inquiry.uk/**

The Royal Wolverhampton NHS Trust

Trust Board Meeting – to be held in Public on 12 December 2023		
Title of Report:	Chief Executive's Report	Enc No: 7
Author:	Gayle Nightingale, Executive Assistant to the Group Chief Executive	
Presenter/Exec Lead:	Prof David Loughton CBE, Group Chief Executive	

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

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

The Royal Wolverhampton NHS Trust

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

Summary of Key Issues using Assure, Advise and Alert
Assure Assurance relating to the appropriate activity of the 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

The Royal Wolverhampton NHS Trust

Chief Executive's Report

Report to Trust Board Meeting to be held in Public on 12 December 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: **Obstetrics** Dr Laura Bevington **Neo-natal Medicine** Dr Sebastin Brown
2.0	**Policies and Strategies**
	Policies for October 2023 • Policies, Procedures, Guidelines and Strategies Update for October 2023 Report • CP03 – management of Ligature Risk Policy • CP10 – Withdrawing or Withholding Clinically Assisted Nutrition and Hydration in Adult Patients Who Lack Capacity to Consent for Treatment Policy • CP52 – Intrathecal Chemotherapy Policy • HR01 – Work Life Balance/ Family Friendly (Leave) Policy • HR02 – Agile Working Policy • HR10 – Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Needs for Care and Support Policy • HR49 – Leave for Official Duties Policy • OP31 – Legal Services Policy • OP41 – Induction and Mandatory Training Policy • OP108 – Domestic Abuse Policy • SOP22 – Safeguarding Team Process for Managing Section 42 Enquiries – Standing Operating Procedure **Policies for November 2023** • Policies, Procedures, Guidelines and Strategies Update for Quarter 7 Report • GDL09 – New – Peri-operative Management of Diabetes in Adults Guidelines • IP08 – Infection Prevention Policy • OP04 – New – Patient Safety Incident Reporting Policy and Update • OP09 – Corporate Governance of Partnership Agreements Framework and Policy • OP10 – Risk Management and Patient Safety Reporting Policy

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 • 26 September 2023 – attended a Joint RWT and WHT Speech and Language Therapy (SLT) Services - celebratory event • 27 September 2023 – chaired the virtual West Midlands Cancer Alliance Board, chaired the virtual joint RWT and WHT Staff Briefing and participated in the Joint Negotiating Committee (JNC) and as part of an introduction session met with Nick Wilson, Chief Executive – System C • 28 September 2023 – participated in the RWT and WHT Annual General Meetings (AGMs) and met virtually with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme • 6 October 2023 – met with Rukman Kaur, Catering Assistant – to celebrate her 80th birthday, virtually met with Becky Wilkinson - Director of Adult Services, Wolverhampton City Council, participated in a National Digital Innovation: Data Centric Digitised Care Pathways visit and participated in a virtual Black Country Integrated Care System (ICS) Financial meeting • 9 October 2023 - participated in the virtual Black Country Collaborative Executive Group meeting • 12 October 2023 - met virtually with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme and • 13 October 2023 - participated in the Black Country Joint Provider Committee • 17 October 2023 – undertook a joint RWT and WHT Non-Executive Directors (NEDs) briefing, and virtually met with Mark Axcel, Chief Executive (ICS) • 18 October 2023 – participated in a Senior Medical Staff Committee meeting and joined a New Senior Staff Welcome/Networking event • 20 October 2023 – hosted a site visit for Rachel Sylvester, Journalist - The Times in relation to the Vertical Integration Model and Hospital at Home System • 23 October 2023 – participated in the virtual Local Estates Forum (LEC) • 24 October 2023 – virtually met along with Sir David Nicholson KCB CBE, Dr Anthony Marsh MBA, Chief Executive and Professor Ian Cummings OBE, Chairman – West Midlands Ambulance Services (WMAS), met virtual with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme and participated in the PA Consulting/ System Chief Executives Productivity and Value Group • 25 October 2023 – participated in a Freedom to Speak Up: Breaking Barriers - Staff Questions and Answers session and participated in the Joint Negotiating Committee (JNC) • 26 October 2023 – chaired a virtual Staff Briefing • 1 November 2023 – undertook a site visit of the Midland Metropolitan University Hospital, participated in a Joint RWT and WHT Board Development session and virtually met with Stacey Lewis, Manager – Healthwatch Wolverhampton • 2 November 2023 - virtually met with Becky Wilkinson - Director of Adult Services, Wolverhampton City Council • 6 November 2023 - participated in the virtual Black Country Collaborative Executive Group meeting • 7 November 2023 - participated in the Black Country Joint Provider Committee and participated in a virtual NHS ICB and Trust Chief Executive and Chief Financial Officer webinar with Amanda Pritchard, Chief Executive and Julian Kelly, Chief Financial Officer – NHS England (NHSE) • 8 November 2023 – attended a national NHS Leadership event with Amanda Pritchard, Chief Executive (NHSE)

	• 13 November 2023 - met virtually with PA Consulting as part of the Black Country Integrated Care Board (ICB) Financial Improvement programme • 14 November 2023 - virtually met with the ICB – to review the provide a joint RWT and WHT Month 6 Financial Update • 15 November 2023 – participated in a Black Country ICS, Provider Chief Executives and Chief Financial Officers virtually met to review the Financial and Operational Delivery Plan • 16 November 2023 – attended a PA Consultancy half day workshop and participated in a Black Country ICS, Provider Chief Executives and Chief Financial Officers virtually met to review the Financial and Operational Delivery Plan • 17 November 2023 – attended a Princes Trust Celebration event and attended an International Nurses One Year Celebration event
4.0	**Board Matters**
	There are no Board Matters to report on this month.

Any Cross-References to Reading Room Information/Enclosures:

The Royal Wolverhampton NHS Trust

Trust Board Meeting – to be held in Public on 12 December 2023		
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 24 November 2023 – to note this was a virtual meeting	Enc No: 7.1
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:**		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 24 November 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
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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

The Royal Wolverhampton NHS Trust

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

Report to Trust Board Meeting to be held in Public on 12 December 2023

EXECUTIVE SUMMARY

Chair's report of the Trust Management Committee (TMC) held on 24 November 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 • Electronic Patient Record (EPR) Presentation on Project Initiation and Implementation timetable.
2	**Exception Reports** • Medicine Model of Care Report • Winter Plan Report
3	**Items to Note – all of the following reports were reviewed and noted in the meeting** • Integrated Quality and Performance Report • Division 1 Quality, Governance and Nursing Report • Division 2 Quality, Governance and Nursing Report • Division 3 Quality, Governance and Nursing Report • Executive Workforce Summary Report • Chief Nursing Officer (CNO) Report • Finance Position Report – Month 7 • Financial Recovery Board Update Report • Capital Programme Update Report • Operational Finance Group Minutes • Black Country Provider Collaboration and System Operating Model Update Report
4	• **Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting.** • Infection Prevention and Control Report • Patient Experience Report • Wolverhampton Place Report • Contracting and Business Development Update Report • Freedom to Speak Up Quarterly Report • Safeguarding Adults and Childrens Report • Emergency Preparedness, Resilience and Response (EPRR) Core Standards Report

	• Research and Development Report • National Institute for Health and Care Research (NIHR) Clinical Research Network (CRN) Report • Group Chief Strategy Officer Report • Midwifery Services Report
5	**Business Cases approved - Division 1** • Business Case for the funding of TA679 Dapagliflozin for the Treatment of Chronic Heart Failure. • Business Case for the funding of TA773 Empagliflozin for the Treatment of Chronic Heart Failure
6	**Business Cases approved - Division 2** • There were none this month.
7	**Business Cases approved - Division 3** • Business Case for the funding of TA882 Voclosporin with Mycophenolate Mofetil for the Treatment of Lupus Nephritis. • Business Case for the funding of TA916 Bimekizumab for the Treatment of Active Psoriatic Arthritis.
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 Quarter 7 Report • GDL09 – New – Peri-operative Management of Diabetes in Adults Guidelines • IP08 – Infection Prevention Policy • OP04 – New – Patient Safety Incident Reporting Policy and Update • OP09 – Corporate Governance of Partnership Agreements Framework and Policy • OP10 – Risk Management and Patient Safety Reporting Policy
11	**Other items discussed:** • There were none this month.

The Royal Wolverhampton NHS Trust

Trust Board Meeting – to be held in Public on 12 December 2023		
Title of Report:	Chair's report of the Trust Management Committee (TMC) held on 27 October 2023 – to note this was a virtual meeting	Enc No: 7.1
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:**		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 27 October 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
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Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

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

Report to Trust Board Meeting to be held in Public on 12 December 2023

EXECUTIVE SUMMARY

Chair's report of the Trust Management Committee (TMC) held on 27 October 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) Report • Finance Position Report – Month 6 • Financial Recovery Board Update Report • Capital Programme Update Report • Black Country Provider Collaboration Update Report
4	• **Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting.** • Schwartz Round Annual Update Report
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** • Business Case for the Expansion of Education Leads and Postgraduate Medical Education.
9	**Outline/proposals for change** • There were none this month.
10	**Policies approved** • Policies, Procedures, Guidelines and Strategies Update for October 2023 Report • CP03 – management of Ligature Risk Policy • CP10 – Withdrawing or Withholding Clinically Assisted Nutrition and Hydration in Adult Patients Who Lack Capacity to Consent for Treatment Policy • CP52 – Intrathecal Chemotherapy Policy • HR01 – Work Life Balance/ Family Friendly (Leave) Policy • HR02 – Agile Working Policy • HR10 – Managing Allegations of Behaviour Indicating Unsuitability to Work with Children and Adults with Needs for Care and Support Policy • HR49 – Leave for Official Duties Policy • OP31 – Legal Services Policy • OP41 – Induction and Mandatory Training Policy • OP108 – Domestic Abuse Policy • SOP22 – Safeguarding Team Process for Managing Section 42 Enquiries – Standing Operating Procedure
11	**Other items discussed:** • There were none this month.

The Royal Wolverhampton NHS Trust

Report to Public Trust Board– The Royal Wolverhampton NHS Trust On Tuesday 12 December		
Title of Report:	Group Chief Strategy Officer Report: - Black Country Provider Collaborative Update	Enc No: 8.1
Author:	Simon Evans - Group Chief Strategy Officer Report	
Presenter/Exec Lead:	Group Chief Strategy Officer Report	

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

Recommendations:

- **Note the good progress being made in the BCPC**

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ On Risk Register: Yes☐No☒		
Changes to BAF Risk(s) & TRR Risk(s)	None		
Resource Implications:	None		
Report Data Caveats	None		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led
	NHSE	Yes☒No☐	Details: Response to NHS Impact
	Health & Safety	Yes☒No☒	Details:
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

Equality and Diversity Impact	None as a result of this paper		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: BCPC Executive Group
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date: Improvement and Research Sub-Group

Summary of Key Issues using Assure, Advise and Alert
Assure • Good progress is being made with the BCPC work programme in both clinical and corporate work streams. • The Joint Provider Committee is now in place and will oversee progress of the BCPC on behalf of all four Trusts.
Advise • The BCPC has sought Expressions of Interest from Directors across all four trusts to take the lead role on a slimmed down executive committee.
Alert • Any future delegations to the Trust from the ICB will need to be approved by the Joint Provider Committee before it can be introduced.

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
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Key Messages on the Provider Collaborative – November 2023

The following are the key messages from the BC Provider Collaborative Executive meeting of the 6th November.

a) Clinical Improvement Programme

BCPC CMO outlined a diverse range of progress being made across the Clinical Network areas, of which the following particularly notable:

- **Vascular Services** – an update on progress was presented with some further work identified. Timelines and the signoff process between the two partner organisations were agreed with a view to presenting a final proposal in early 2024 for the repatriation of SWBH vascular activity back into the Black Country from UHB.
- **ENT** – Mr. John Murphy, the BCPC Clinical Lead for ENT presented the ENT strategic plan, focusing on the pursuit of a new model of care between WHT and SWBH which would mirror arrangements currently in place between DGFT and RWT, and provide much needed resilience to the system, with CE endorsing and supporting the identified direction of travel.
- Good progress has been made in some Clinical Networks (Critical Care / SKIN) who have completed most of their identified priorities enabling the BCPC CMO and MD to review and potentially redistribute capacity / support to other future priorities.
- **Clinical Summit** was very well attended and well received. Feedback on the 'Spotlight video's', and Annual Reports was very positive, and the format of the programme seemed to work well with positive engagement and interaction.

b) Mandatory Training

The Collaborative Executive received an update from Cat Lisseman and Dr. Brian McKaig detailing progress to date on the scoping exercise. All partner organisations are engaged in the work, with commitment key to ensuring a robust output. A PID and project GANNT chart were shared outlining key tasks and timelines to deliver the requested business case for review by the CE in Dec 23 / Jan 24.

c) Digital Workstream update

A proposal paper outlining the possibility for convergence on a system wide approach to PACs was presented to the Collaborative Executive with support and agreement to progress system wide work across the four partners in developing an options appraisal and proposed next steps paper to be submitted for review at the earliest possible time.

d) Establishing a robotic Renal Surgery Centre of Excellence at DGFT

Following the receipt of Surgical Robots at DGFT and SWBH earlier this year, the Urology Network is now progressing its plans to transform specialist elements of the Urology service and establish a robotic renal surgery (for nephrectomies and partial nephrectomies) at DGFT. BCPC MD to coordinate the way forward over the remainder of this financial year, engaging with all stakeholders and managing any 'service change' processes in conjunction with ICB colleagues.

Key Messages on the Provider Collaborative – November 2023

The following are the key messages from the BC Provider Collaborative Executive meeting of the 6th November.

1) **Clinical Improvement Programme**
   BCPC CMO outlined a diverse range of progress being made across the Clinical Network areas, of which the following particularly notable:
   - **Vascular Services** – an update on progress was presented with some further work identified. Timelines and the signoff process between the two partner organisations were agreed with a view to presenting a final proposal in early 2024 for the repatriation of SWBH vascular activity back into the Black Country from UHB.
   - **ENT** – Mr. John Murphy, the BCPC Clinical Lead for ENT presented the ENT strategic plan, focusing on the pursuit of a new model of care between WHT and SWBH which would mirror arrangements currently in place between DGFT and RWT, and provide much needed resilience to the system, with CE endorsing and supporting the identified direction of travel.
   - Good progress has been made in some Clinical Networks (Critical Care / SKIN) who have completed most of their identified priorities enabling the BCPC CMO and MD to review and potentially redistribute capacity / support to other future priorities.
   - **Clinical Summit** was very well attended and well received. Feedback on the 'Spotlight video's', and Annual Reports was very positive, and the format of the programme seemed to work well with positive engagement and interaction.

2) **Mandatory Training**
   The Collaborative Executive received an update from Cat Lisseman and Dr. Brian McKaig detailing progress to date on the scoping exercise. All partner organisations are engaged in the work, with commitment key to ensuring a robust output. A PID and project GANNT chart were shared outlining key tasks and timelines to deliver the requested business case for review by the CE in Dec 23 / Jan 24.

3) **Digital Workstream update**
   A proposal paper outlining the possibility for convergence on a system wide approach to PACs was presented to the Collaborative Executive with support and agreement to progress system wide work across the four partners in developing an options appraisal and proposed next steps paper to be submitted for review at the earliest possible time.

4) **Establishing a robotic Renal Surgery Centre of Excellence at DGFT**
   Following the receipt of Surgical Robots at DGFT and SWBH earlier this year, the Urology Network is now progressing its plans to transform specialist elements of the Urology service and establish a robotic renal surgery (for nephrectomies and partial nephrectomies) at DGFT. BCPC MD to coordinate the way forward over the remainder of this financial year, engaging with all stakeholders and managing any 'service change' processes in conjunction with ICB colleagues.

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Black Country Integrated Care System

NHS
Black Country
Integrated Care Board

The Black Country Integrated Care System

Operating Model Summary

1. Introduction

This document summarises the proposed operating model for the Black Country Integrated Care System setting out the governance and decision-making processes, relationships between the different elements of the model and the development areas required to move to the next stage of system decision making over the next 12 months.

The model, designed to respond to the changing landscape and taking into account the planned reduction in the running costs for the Integrated care Board (ICB), aims to achieve the following:

- maximise collaboration within the system.
- build upon the longstanding model of distributed leadership
- further devolve decision making as Collaboratives and Partnerships develop.

The model has been developed with partners from across the Integrated Care System to deliver the key strategic functions of:

- Integrated Commissioning
- Integrated Assurance
- Integrated Care

In this new model the ICB takes on an increased role in assurance and oversight with Place based partnerships and collaboratives taking an increased role in integrated commissioning. Integration of care at a cross provider and indeed with social care is also a key characteristic of the new model.

2. Our Strategic Priorities

Our NHS Black Country Joint Forward Plan takes into account national direction, the views of local people and our local health challenges to set out the following five priority areas:

- Priority 1- Improving access and quality of services
- Priority 2- Community where possible – hospital where necessary
- Priority 3- Preventing ill health and tackling health inequalities
- Priority 4- Giving people the best start in life
- Priority 5- Best place to work.

The operating model has been set out to reach mutual agreement on where responsibilities sit in delivering these strategic priorities for the people whom we collectively serve.

3. Principles for working

As the system transitions to a new way of working in line with our operating model the following principles will underpin our approach to delivery of our priorities.

4. Components of our operating model

Overall, The Black Country Integrated Care System aims to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

Each part of our system plays a role in this.

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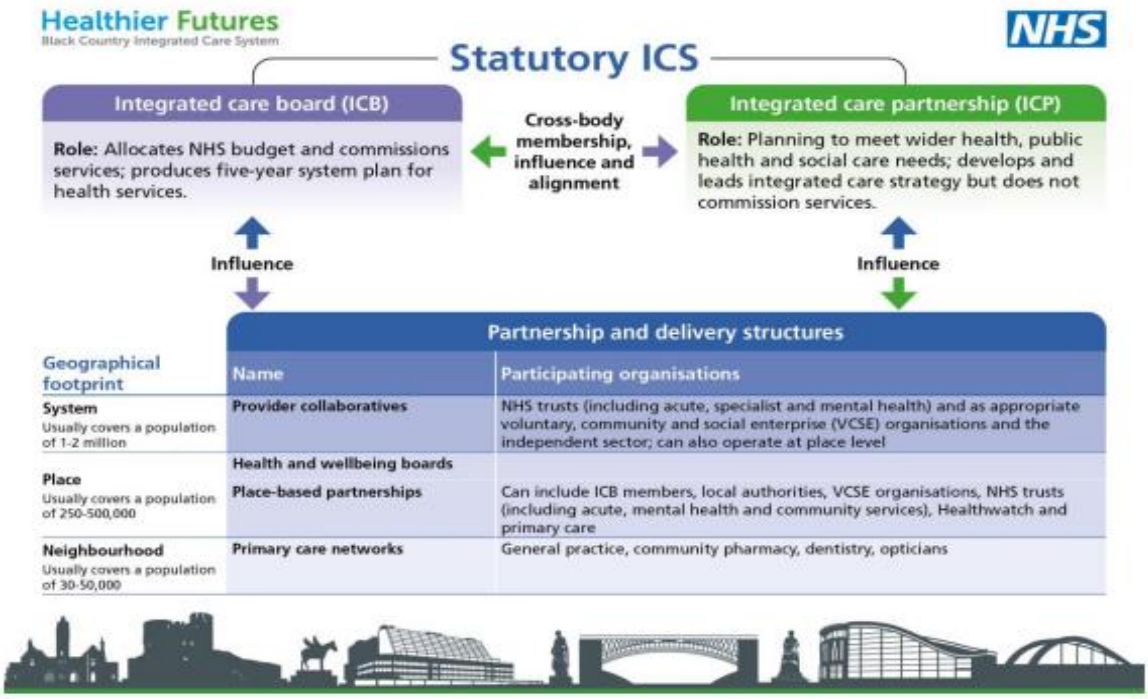
Black Country Integrated Care System



Integrated Care Partnership

The Black Country Integrated Care Partnership (ICP) is a statutory committee jointly formed between the NHS Integrated Care Board and the four councils in the Black Country. Together with other partners they form a broad alliance of partners concerned with improving the care, health, and wellbeing of the population. They aim to deliver on the Black Country Integrated Care Strategy.

Integrated Care Board

Supporting our Integrated Care System (ICS) vision for a healthier place, with healthier people and healthier futures. The ICB is responsible for leading system strategy, resource allocation and oversight and assurance of the NHS system. The ICB receives the local NHS budget and develops a plan to ensure services are there to meet the health needs of local people.

Provider Collaboratives

Partnerships that bring together our Provider Trusts to work together at scale to plan and deliver services. They are Black Country wide collaboratives that provide and/or coordinate services with the aim of improving quality, productivity, sustainability, and effectiveness of services.
There are three Provider Collaboratives in the Black Country

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Black Country Integrated Care System

Characteristics

- Operate at the level of system.
- All NHS Acute and MH Trusts are expected to be part of one or more provider collaboratives, with Acute Collaborative and MH Collaborative structures featuring in national policy guidance as key elements of system architecture.
- Important vehicles for NHS providers to collaboratively lead the transformation of services, restoration and shared ownership of objectives and plans across all parties.
- Will help facilitate the work of alliances and clinical networks enabling speciality levels plans and decisions to be made and implemented in a more co-ordinated and systematic way.
- Contracts will continue to be held with each NHS Trust as the statutory body, for the in scope acute element of acute element of their contracts, but with increased harmonisation of reporting.
- Where the Trusts also act as the host for community contracts, these will be managed at a Place level driven by the local Partnerships.
- The 4 NHS Trusts will continue to work together through Joint Committees to inform the service strategies developed by the relevant Programme Boards.

The Black Country Provider Collaborative

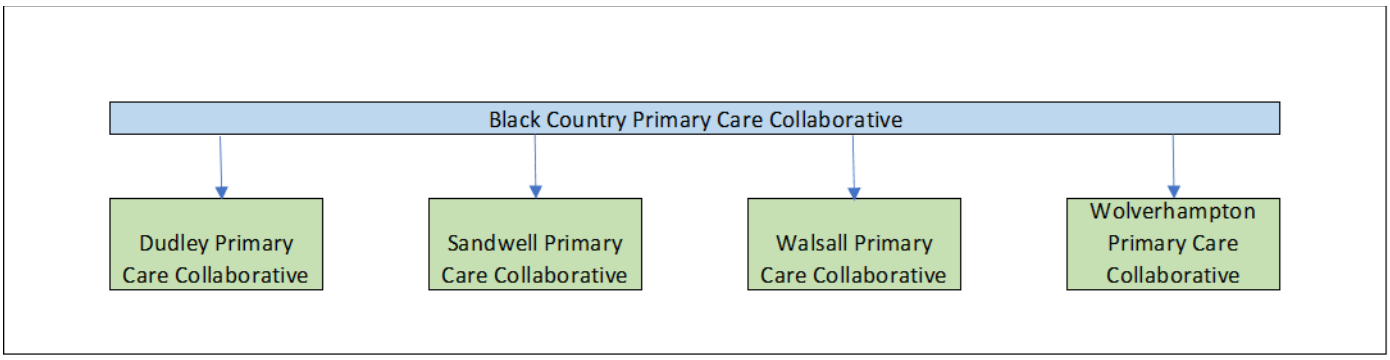
A partnership which was formed in late 2020 to promote better partnership working between Sandwell and West Birmingham Hospital NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

The Black Country Primary Care Collaborative

Established to promote the interests, wellbeing, and sustainability of Primary Care services and more importantly, to ensure that a single voice for Primary Care is properly heard in decision making at all levels.

Dudley Primary Care Collaborative

Dudley Primary Care Collaborative



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Lead provider for Mental Health, Learning Disabilities and Autism

In the Black Country we have a lead provider for mental health, learning disabilities and autism services. Black Country Healthcare NHS Foundation Trust (BCHFT). The Trust takes responsibility for the whole pathway of care, which means the Trust has the flexibility to decide the best services and support for local people.

Place Based Partnerships

Partnerships that bring together NHS, local government, public health and other local organisations to help ensure more effective use of combined resources within a local area (Place) and to tackle the wider determinants/factors that influence health and drive inequalities.

They both plan and deliver services defined as in-scope, predominantly out of hospital services, focussing on demand management, relationship management with Local Authorities and partners, and targeting local inequalities.

There are four local place-based partnerships in the Black Country covering populations which mirror the boundaries of local councils in Dudley, Sandwell, Walsall and Wolverhampton. Whilst working at a Black Country level can bring the benefits of working at scale to tackling some of the bigger challenges in health and care, smaller place-based partnerships are better able to understand the needs of local people and design/deliver changes in services to meet these needs.

In the Black Country, Place is the level at which most of the work to join up budgets, planning and pathways for health and social care services will happen. Each of our place-based partnerships involve the NHS, local government and other partners, such as voluntary, community and social enterprise (VCSE) sector organisations, education, housing and social care providers.

Primary Care

There are around 180 GP practices, 288 pharmacies, 121 optometrists and 159 general dental practices in the Black Country, each playing a key role in preventing and treating ill health. The ICB will continue to contract directly with primary care providers for services wholly funded from ringfenced primary care budgets.

NHS Trusts and Providers

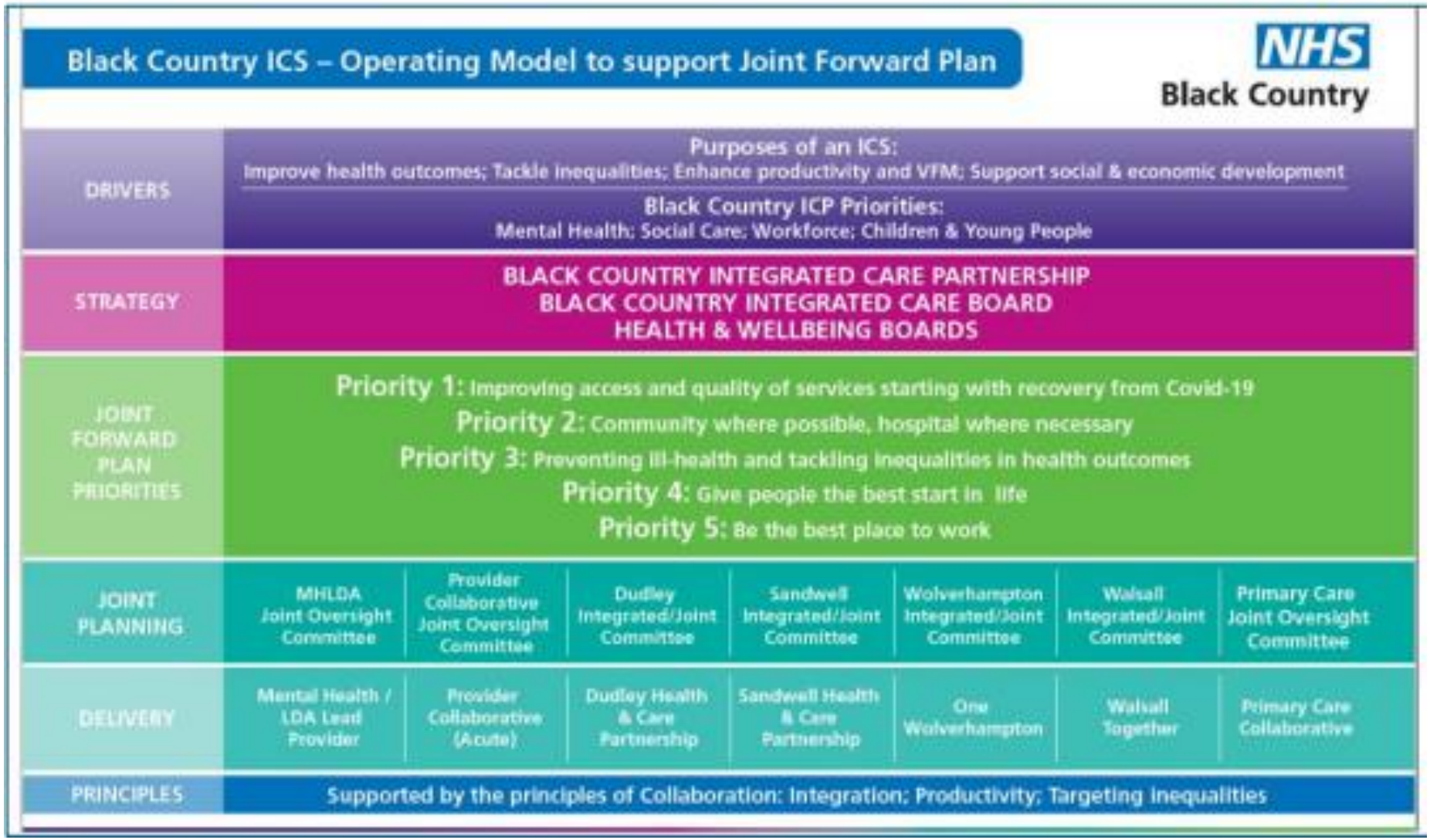
These Trusts will retain formal accountability for their statutory duties and responsibilities, continuing to be accountable for quality, safety, use of resources and compliance with standards for delivery of any services or functions commissioned from or delegated to them.

Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible.

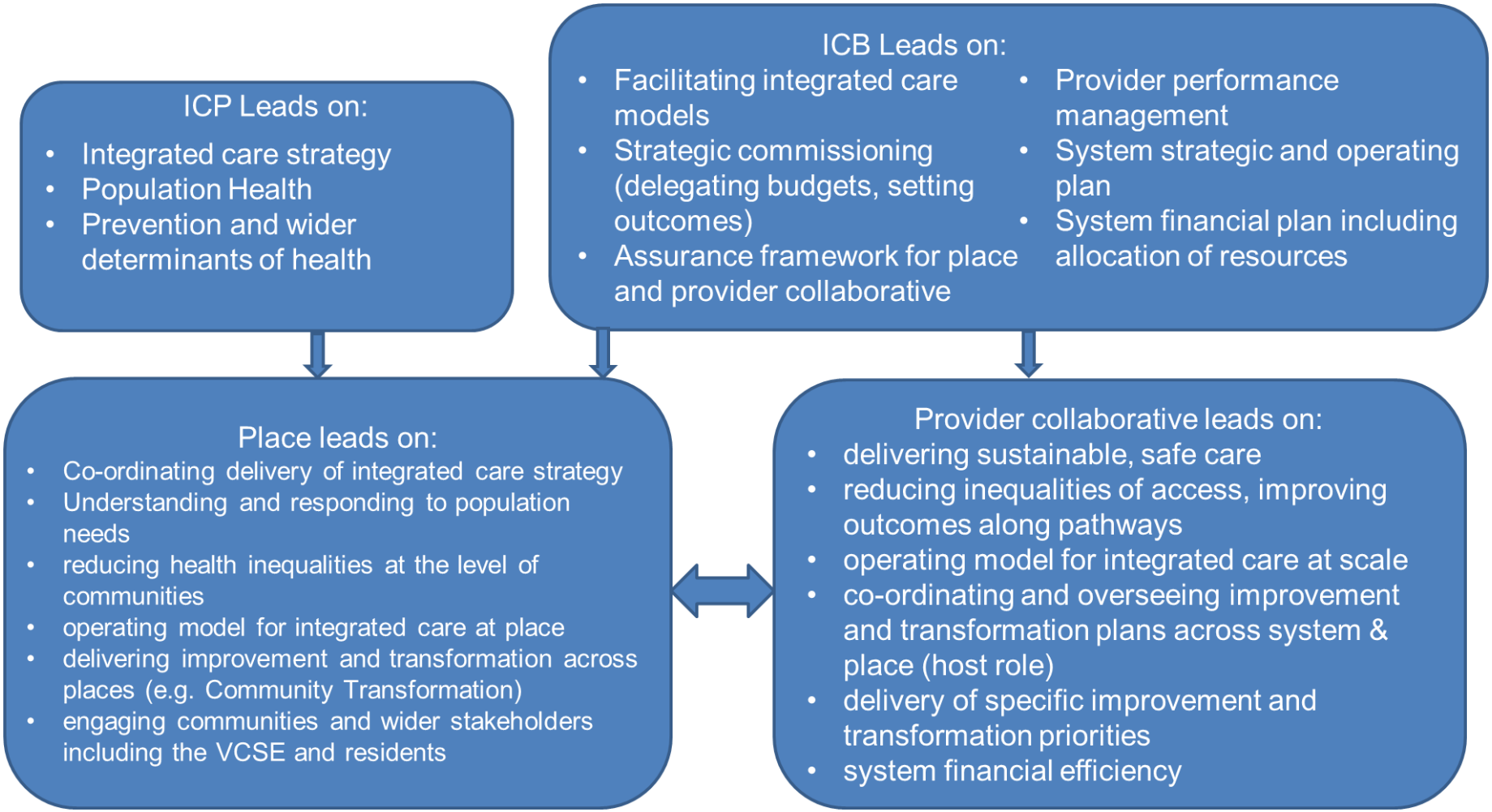
Characteristics

- Created to bring health and care services together to meet the needs of a designated population.
- Must have footprints that enable integration between the NHS and Local Authorities
- Lead the detailed design and delivery of integrated primary and community services
- Should include the VCS and have strong links to local communities.
- Allow decisions to be taken as close to local communities as possible.
- Each Place Based Partnership will be led by a host organisation. The role of the host will be to hold resources for finance and workforce on behalf of the partnership for services and running costs (where they are devolved by each commissioning organisation).
- Within 2 years, the Place Based partnerships will take over as the lead provider for all out of hospital NHS services.
- Some partnerships are likely to also be the lead provider for social care services.
- Will have the flexibility to redesign services within the contract value including greater use of non-NHS providers.
- Any service changes requiring additional resources will need to be recommended to the Out of Hospital Programme Board and if supported to the Strategic Commissioning Committee.
- Services will be developed to improve delivery against a common wellbeing outcome framework.
- Will be responsible for supporting the development of Primary Care Networks in each of the 4 Places, with GPs forming part of the governance model for each area.

5. Operating Model



6. System roles



7. The Governance

ICB Committees

The ICB committees ensure appropriate ICB oversight and assurance, including statutory duties offering a governance mechanism from Strategic/Enabling Programme Boards to the ICB Board.

They include a new Oversight and Assurance Committee will be established to replace the System Development Committee.

Strategic Programme Boards

Strategic Programme Boards bring commissioners and providers together into a joint dialogue around a portfolio area to:

- Define the high level strategy, outcomes and priorities for the portfolio area.
- Consider and recommend responses to national policy directives.
- Support planning processes and the development of annual plans and mandated returns.
- Identify areas for transformation, service change and service development and form business cases to define the opportunity.

Integrated/Joint Committees

Joint Committees will be established to undertake joint planning between the ICB, Local Authority and where appropriate NHSE and respective collaboratives/partnerships. Each committee will act as the vehicle to hold resource and decisions devolved or delegated by the ICB (and partners) and take joint responsibility for implementation of plans. They will be constituted by the ICB and members of a Collaborative or Partnership and will ensure conflicts of interest are appropriately managed. Escalation will be to respective ICB Committees.

Strategic Commissioning Committee

The Strategic Commissioning Committee (SCC) is the committee with delegation from the ICB Board to support decision-making for commissioning and strategy. It has a number of functions to fulfil:

Policy and Guidance Review- Within policy and guidance, the ICB hold the statutory responsibility for ICS level healthcare strategy, planning and commissioning.

Oversight and Assurance- Feedback from oversight and assurance meetings from Providers and identify any required changes to commissioning intentions.

Major service change- agreeing support for major service change, ensuring programme boards are overseeing the change appropriately and ensuring that statutory duties are met.

Programme and Enabling Boards

A key element of the new operating model will be that all services either commissioned or provided within the ICS are aligned to a System Programme Board which report into the SCC. In reaching decisions, the SCC is supported by a series of Programme Boards covering all of the major areas of service:

- Cancer
- Children and Young People
- Electives and Diagnostics
- Maternity (LMNS)
- Mental Health (including Learning Disabilities and Autism)
- Out of Hospital Care (including Health Inequalities, Prevention and Long term Conditions)
- Primary Care
- Urgent and Emergency Care

Characteristics

- Advisory and consultative by nature
- Led by a Senior Responsible Officer (SRO) drawn from the ICS Executive Tier
- Multi-agency and disciplinary, engaging commissioners, clinicians and Provider management leads in dialogue.
- Membership to include full range of stakeholders to include NHS providers, LA, IS and VCS as appropriate.
- Recommend the high-level strategy, outcomes and priorities for the portfolio area
- Consider and recommend responses to national policy directives.
- Support planning processes and the development of annual plans and mandated

Supporting the Programme Boards are a number of Enabling Boards offering specialist advice and programme management capability:

- Digital
- Engagement
- Greener NHS
- Innovation and Research
- Medicines management
- Personalised Care
- Vaccinations and Immunisations
- Workforce and People
- Health Inequalities and Population Management Groups, including ICP groups

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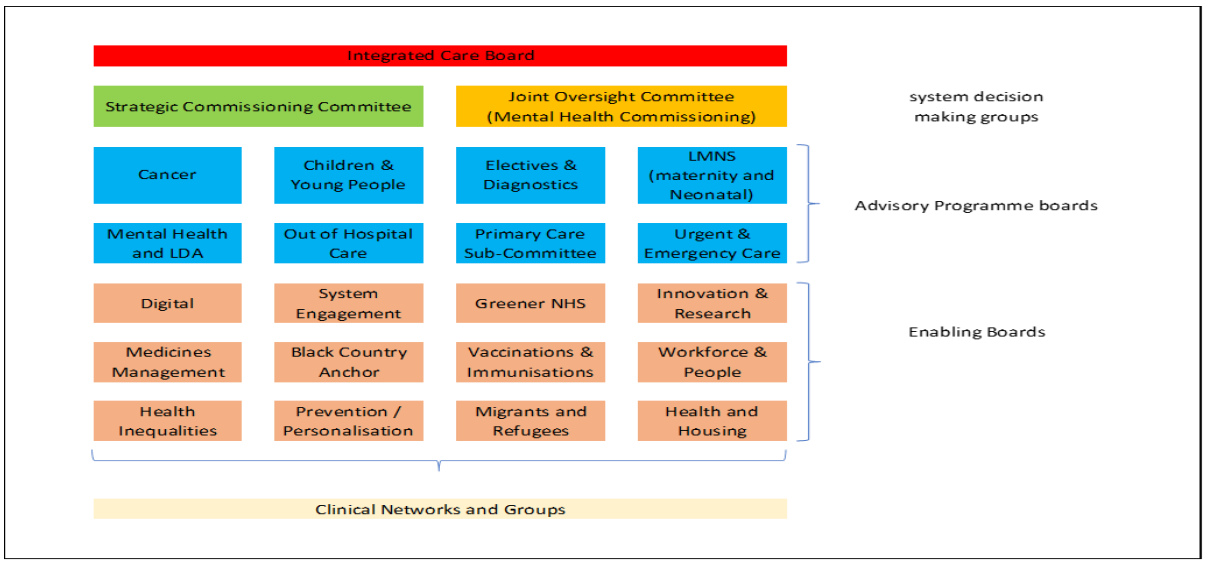

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Place Integrated Commissioning Committees (ICC)

To support the development of strategies and integration between health and care services the ICB and Councils have established 4 Integrated Commissioning Committees (ICC) to provide a space to support collaboration and joint commissioning activity.

In addition to overseeing Joint Commissioning activity managed by existing Section 75 Agreements, the Committees will act as fora for joint high-level strategic discussions for the development of commissioning activity that remains the formal responsibility of the individual partners to support collective approaches to tackling inequalities, and meeting needs across the borough.

The membership will include:

- ICB Managing Director
- ICB Clinical Commissioning Lead
- Head of Primary Care and Place Commissioning
- 3 Council representatives; Director of Adult Social Care, Director of Children's Services and Director of Public Health

The committees will report into the system Out of Hospital Board, through to the Strategic Commissioning Committee to discuss common themes and issues and there will be a common outcomes framework across the Black Country to allow meaningful comparison.

Characteristics

Plan and develop integrated commissioning intentions to work towards agreed integrated priorities which should include the Health and Wellbeing Board strategy.

Discuss and develop Place based strategic commissioning activity in relation to in scope service and budgets as per approved finance schedules.

Promote integration of both health services with other health services and/or health-related and social care services where the Committee considers that this would improve the quality of services or reduce inequalities.

Review and recommend arrangements for risk sharing and or risk pooling with other organisations for services commissioned in Place, including amendments to existing s.75 Agreements in place between the ICB and Council.

Oversee Place partnership development and delivery and provide oversight and management of actions to reduce health inequalities, including population health management.

Provide assurance through relevant agreed governance routes.

ICB Managing Directors

The ICB Place Managing Directors are the key link between the ICB and the Local Authorities. This link role operates at 3 levels:

- Day to day link with Local Authority Director team; Director of Adult Social Care, Director of Children's Services and Director of Public Health.
- ICB lead on the local Health and Wellbeing Board, to agree the health and wellbeing strategy based on the local joint needs assessment.
- Lead officer for the Place based scrutiny committees.

8. Service Change

The new model will allow Providers to redesign services within the agreed quantum, subject to ICB engagement to allow the ICB to fulfil its statutory obligations on major service change process.

It is therefore proposed that the following is implemented:

1. Where a service change affects one organisation or partnership and can be delivered within the current financial resource, the organisation or partnership can implement that change, subject to the agreed service change process.

- Acute changes should be notified to the Provider Collaborative in order to ensure that there are no unintended consequences to other Providers, and reported to the relevant Programme Board for awareness.
- Place Based Partnership changes should be agreed with the Place Managing Director and reported to the Out of Hospital Board.

2. Where a service change affects more than one organisation but can be delivered with the current financial resource of those organisations, the change can be agreed by the relevant Programme Board and reported to the Strategic Commissioning Committee, subject to the agreed service change process.

3. Where a service change cannot be delivered within the current financial resource the Programme can recommend the change for approval at Strategic Commissioning Committee and the System Investment Group, subject to the agreed service change process.

9. Further information

You can read the full operating model proposals in Appendix 1.

Appendix 1: Black Country Operating Model Implementation

1.0 Introduction

The ICB Board, and partner boards, received a paper in March 2023 outlining the proposed operating model for the Black Country Integrated Care System. This model was developed as part of the system design of the Joint Forward Plan and is designed to maximise collaboration within the system. The Black Country has a longstanding model of distributed leadership with an intention to further devolve decision making as Collaboratives and Partnerships develop. This paper builds on the model to consider the governance and decision-making processes, relationships between the different elements of the model and the development areas required to move to the next stage of system decision making over the next 12 months. Further work will take place with all system partners to agree the ambition for future delegation to enhance collaborative working over the next 2 years.

This report proposes changes to the current ICB, provider collaboratives and place based partnerships as they develop and is consistent with the changing governance model in the wider NHS with changes to NHS England (NHSE), the reduction in ICB management costs and the desire of the Black Country to operate a collaborative model with all Integrated Care System (ICS) partners being involved in the decision making processes prior to decisions being made by the ICB Board..

The report also provides an overview of the development work to be undertaken to build capacity and capability within Collaboratives and Place Based Partnerships to provide an infrastructure for the future delegation of duties.

2.0 Summary of Development Process

The recommendations within this report have been developed following the work undertaken by the System Development Group, which is a task group of the System Development Committee. The System Development Group is an inclusive group with representatives from:

- The Provider Collaborative
- The Primary Care Collaborative
- Black Country Healthcare as the approved MHLDA Lead Commissioner and Provider
- The 4 Place Based Partnerships

- The ICBs Place Managing Directors
- The ICBs CMO function
- The ICBs corporate finance, contracting, primary care and strategic commissioning functions, planning and governance teams.

The recommendations within this report have been discussed and developed by all parts of the ICS including Acute Directors of Strategy, Place leads both in the ICB and Providers, Mental Health Trust leads, Provider Collaborative leads, NHSE leads and the ICB executive team. In addition, system thinking on collaboratives and NHSE delegated functions have informed decision trees. The intention of the paper is to reinforce the role of the Programme Boards in developing and agreeing system strategy and simplify decision making within financial devolution.

3.0 Black Country Future Operating Model

A clear ambition was agreed as part the March 2023 operating model paper to move away from a fully centralised model of strategy and planning to more devolved model. It is recognised that there are multiple ways of developing collaborative working arrangements, and across the model a number of being employed.

Collaborative working arrangement	Description
Outcomes based contracting	Contract sets broad scope of what provider is expected to achieve, rather than the means of achievement.
Lead provider models	Single NHS trust or foundation trust takes on contractual responsibility for an agreed set of services, on behalf of a provider collaborative, and then subcontracts to other providers as required.
Conferral of discretions	Commissioning contract gives provider discretion in relation to the services provided under the contract; e.g. as to the allocation of resources between different services under the contract, and how those services are provided or subcontracted.
ICB committee or subcommittee including providers	An ICB board delegates exercise of certain ICB functions to one of its committees or subcommittees and appoints executives or nonexecutives from providers to membership of the committee or subcommittee exercising those functions. (Note – this must be in line with the ICB's constitution and other governance arrangements, including in respect of conflicts of interest.)
Joint committees between ICBs and providers or solely between providers	A joint committee of an ICB and NHS trust(s)/foundation trust(s) could exercise functions those bodies have agreed to exercise jointly through the committee, allowing binding shared decisions. A joint committee solely of trusts and foundation trusts could similarly exercise trust functions which the trusts have agreed to exercise jointly, which may for example form part of lead provider or other contracting models.

The intention over the next 2 years is to move to a model based on outcomes based contracting using both lead provider contracts (Place Based Commissioning) and Provider Collaborative arrangements (acute contracts). Initially, in the absence of a formal model of delegation (which NHSE are not currently advocating), it is intended to follow the conferral of discretions model which will allow Providers to redesign services within the agreed quantum, subject to ICB engagement to allow the ICB to fulfil its statutory obligations on major service change process.

It is therefore proposed that the following is implemented:

1. Where a service change affects one organisation or partnership and can be delivered within the current financial resource, the organisation or partnership can implement that change, subject to the agreed service change process.

    a. Acute changes should be notified to the Provider Collaborative in order to ensure that there are no unintended consequences to other Providers, and reported to the relevant Programme Board for awareness.

    b. Place Based Partnership changes should be agreed with the Place Managing Director and reported to the Out of Hospital Board.

2. Where a service change affects more than one organisation but can be delivered with the current financial resource of those organisations, the change can be agreed by the relevant Programme Board and reported to the Strategic Commissioning Committee, subject to the agreed service change process.

3. Where a service change cannot be delivered within the current financial resource the Programme can recommend the change for approval at Strategic Commissioning Committee and the System Investment Group, subject to the agreed service change process.

It is recognised that whilst this change to the ICS operating model reflects multiple changes in committee, board and organisational span of control it is equally important in terms of values, behaviours and ways of working and part of the system Organisational Development programme should be linked to supporting the change.

Recommendation 1: As part of the system OD work with Deloitte, time should be allocated to the implementation of the operating model

3.1 Commissioning and Strategy

3.1.1 Strategic Commissioning Committee

The Black Country ICS Operating Model is designed as a collaborative system. The ICB Board acts as the decision-making body for commissioning and strategy, supported by the Strategic Commissioning Committee (SCC). SCC is a decision making body within its Scheme of Delegation limits, recommending to the ICB Board above these limits.

As part of the contract with Black Country Healthcare NHS Foundation Trust, some of these duties for Mental Health are now being undertaken by the Trust. The governance arrangements for Mental Health service assessment based on the Joint Strategic Needs Assessment are considered through the Joint Oversight Committee (JOC), which reports to the ICB SCC and the membership of SCC needs to be changed to reflect this delegation. As system maturity develops there is potential to remove JOC from the operating model with delegation of the mental health commissioning function to the lead commissioner with a direct route to SCC.

Recommendation 2: The membership of the Strategic Commissiong Committee should be extended to include representatives of JOC to ensure mental health commissioning arrangements are represented. It is anticipated that the relationship between JOC and SCC will continue to evolve as governance arrangements further embed.

Recommendation 3: The MH/LDA Lead Provider should be invited to attend all Programme Boards to reduce the risk that the MH/LDA agenda is siloed. All programme boards have a responsibility to consider and take forward opportunities for the integration of physical and mental health.

Strategic Commissioning Committee has a number of functions that it must fulfil:

a) Policy and Guidance Review

Within policy and guidance, the ICB hold the statutory responsibility for ICS level healthcare strategy, planning and commissioning. Specifically, the ICB are required to:

- ✓ Assume the commissioning responsibilities of CCGs.Develop a plan to meet the health needs of the population, restore services, and deliver LTP commitments.

- ✓ Allocate resources agreed by the ICB Board, including financial recovery plan targets.
- ✓ Establish joint working relationships with partners to embed collaboration and drive delivery.
- ✓ Establish governance arrangements that support collective accountability.
- ✓ Arrange for the provision of healthcare through contracts and agreements.
- ✓ Convene and support providers to lead major transformation programmes and achieve agreed outcomes through enabling action.
- ✓ Retain the statutory duties of CCGs.
- ✓ Develop and implement an engagement plan to ensure that the citizen voice is heard.

In delivering these responsibilities ICBs must:

- ✓ Ensure the perspectives and expertise of all relevant partners to include all parts of the local health and care system across physical and mental health, primary care, community and acute services, patient and carer reps, social care and public health are taken into account.
- ✓ Must harness the expertise, energy, and ambition of the organisations directly responsible for delivering integrated care ensuring they play a central role in establishing the priorities for change and improvement to drive better outcomes.
- ✓ Demonstrate system leadership on issues that impact all within the ICS eg People and Digital technology
- ✓ Have open and transparent decision making based on consensus and collaboration.
- ✓ Develop and implement a model of engagement to secure the voices of patients, carers and citizens in planning and commissioning arrangements.

b) Oversight and Assurance

- ✓ Feedback from oversight and assurance meetings from Providers relevant to SCC agenda. Issues and risks will be escalated to the Oversight and Assurance Committee when developed.
- ✓ Identify any required changes to commissioning intentions.
- ✓ Develop exit criteria framework for providers that exhibit concerns or emerging issues.
- ✓ Work with Finance and Performance, and Quality Committees to coordinate responses.

c) Major Service Change

- ✓ Agree pipeline for major projects.
- ✓ Ensure that Programme Boards are overseeing delivery of service changes in their area.
- ✓ Ensure all statutory responsibilities are met in terms of the service change policy.
- ✓ Prioritise major service changes across Programme Boards.
- ✓ Advice ICB Board on system support for final sign off

Recommendation 4: The agenda of the Strategic Commissiong Committee should be restructured to reflect the 3 areas of responsibility, together with a feedback report from each of the programme and enabling boards.

Month	Programme Boards	Enabling Boards
1	Electives and Diagnostics Cancer	Digital Greener NHS Workforce & People
2	Urgent and Emergency Care Children & Young People LMNS	Innovation and Research Vaccinations & Immunisations
3	Out of Hospital Care Mental Health and LDA Primary Care Committee	System Comms and Involvement Medicines Management Health Inequalities Groups

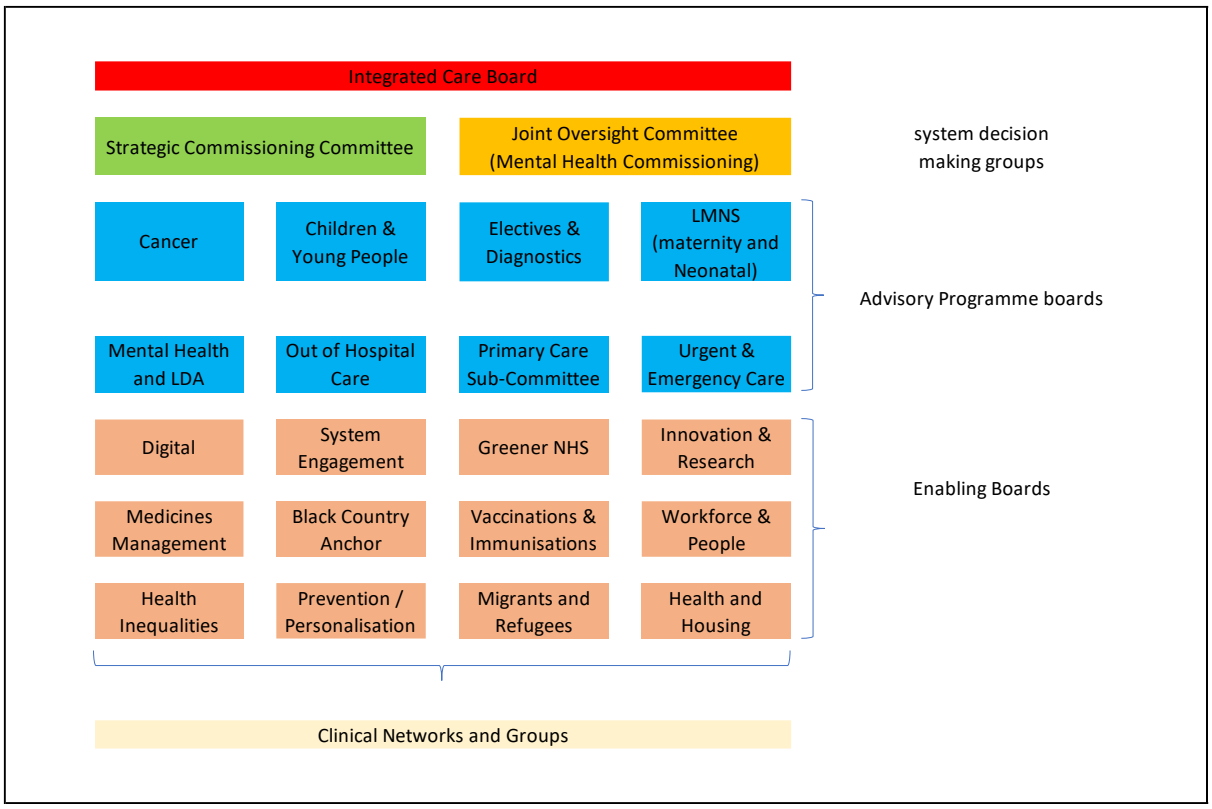
3.1.2 Programme and Enabling Boards

In reaching decisions, the SCC is supported by a series of Programme Boards covering all of the major areas of service:

- Cancer
- Children and Young People
- Electives and Diagnostics
- Maternity And Neonatal (LMNS)
- Mental Health (including Learning Disabilities and Autism)
- Out of Hospital Care (including Health Inequalities, Prevention and Long term Conditions)
- Primary Care
- Urgent and Emergency Care

Supporting the Programme Boards are a number of Enabling Boards offering specialist advice and programme management capability:

- Digital
- Engagement
- Greener NHS
- Innovation and Research
- Medicines management
- Personalised Care
- Vaccinations and Immunisations
- Workforce and People
- Health Inequalities and Population Management Groups, including ICP groups



The Programme Boards current remit is:

- ✓ Advisory and consultative by nature
- ✓ Led by a Senior Responsible Officer (SRO) drawn from the ICS Executive Tier
- ✓ Multi-agency and disciplinary, engaging commissioners, clinicians and Provider management leads in dialogue.
- ✓ Membership to include full range of stakeholders to include NHS providers, LA, IS and VCS as appropriate.
- ✓ Recommend the high-level strategy, outcomes and priorities for the portfolio area
- ✓ Consider and recommend responses to national policy directives.
- ✓ Support planning processes and the development of annual plans and mandated returns
- ✓ Undertake a demand and capacity exercise to ensure that in year and future services are appropriately commissioned.
- ✓ Maintain an oversight of delivery within portfolio area.

A priority of the operating model discussions will be to ensure that all services either commissioned or provided within the ICS is aligned to a System Programme Board. There is a current exercise being completed to realign provider contract values to the services being provided. Once this is complete all current contracts will be aligned to a lead Programme Board. It is recognised that some services will be relevant to more than one Programme Board and it will be the responsibility of the lead Board to ensure that any changes or recommendations are supported by all relevant Boards. In receiving update reports SCC will seek to identify the interdependencies and assign the lead Programme Board.

For indicative purposes, whilst the work is being completed, the current position for the main contracts is as follows:

	Walsall Healthcare		Wolverhampton		Sandwell		Dudley Group		DIHC		BCH		Total
	23/24 at 23/24 Prices		23/24 at 23/24 Prices		23/24 at 23/24 Prices		23/24 at 23/24 Prices		23/24 at 23/24 Prices		23/24 at 23/24 Prices		
	Activity	£000	Activity	£000	Activity	£000	Activity	£000	Activity	£000	Activity	£000	£000
SUS Data													
A&E	92,933	13,033	188,998	19,968	118,184	17,361	106,462	19,593					69,955
Daycase	21,196	14,869	24,605	21,975	17,757	14,608	34,097	24,431					75,883
Elective	3,859	15,444	2,887	14,164	3,369	10,809	4,295	14,617					55,034
Emergency	35,160	69,737	53,417	99,111	25,266	59,136	35,325	87,223					315,207
Non Elective	4,190	7,988	4,470	13,442	2,407	7,165	4,420	15,635					44,230
Outpatients	201,251	23,478	365,818	40,389	344,167	38,172	487,199	50,231					152,270
Mental Health/LD										3,459		282,690	286,149
ERF Funding		8,628		12,445		9,565		14,626					45,264
SLAM (including community)	1,346,616	84,005	612,203	38,829	46,233	16,202	2,934,098	77,619					216,655
OCL					3,176,707	34,288							34,288
Community			593,887	42,923	620,393	35,235				2,015			80,173
New Additions		11,366		19,448		5,525		22,490					58,829
Other		20		-3		-1,753		27		5,356			3,647
Total Value		248,568		322,692		246,314		326,492		10,831		282,690	1,437,587
Total Paid		286,202		379,622		303,852		394,564		14,676		294,865	1,673,781
Variance		37,634		56,930		57,539		68,072		3,846		12,175	236,196

Additionally, once the system financial recovery plan has been agreed these programmes need to be mapped wherever possible to the relevant programme board to ensure ownership and implementation. It is acknowledged that not all recovery areas can be mapped in this way, e.g. estates and back office

Recommendation 5: Align all current contract expenditure, and associated financial recovery targets wherever possible, to a lead Programme Board in order that they can understand the full quantum for monitoring and redesign.

Recommendation 6: Programme Board Chairs to review membership of the Board, supported by Lead Directors, in light of aligned services and contracts to ensure that stakeholders are engaged, including non-NHS providers, Local Authorities and voluntary sector. Membership needs to include finance, quality, contracting, clinical and strategy leads and links to the enabling boards.

Recommendation 7: Programme Board Chairs to review subgroups, supported by Lead Directors, in order to ensure Boards can focus on strategic direction whilst being assured of performance.

Recommendation 8: Change the terms of reference for Programme Boards in order that they can make changes to services to meet agreed strategy and targets set by the Strategic Commissioning Committee where this affects multiple organisations, subject to complying with service change obligations such as consultation.

Recommendation 9: SCC to oversee recurrent changes to services made by Programme Boards to ensure that all necessary service change processes and other governance processes are followed, and any recurrent budget adjustments between providers are made as a result of the Programme Board changes. There will be review after 12 months in order to ensure that the correct process has been followed in all service changes.

Recommendation 10: ICS to reconsider the use of the title SRO and replace with Programme Board Chair to reflect the limited delegation powers in the current model. There will also be a need to consider whether the term Board is appropriate for an advisory committee.

The work of the programme boards needs to be supported by the enabling boards. This may be to address a specific requirement a board has identified, or to support a cross-cutting theme identified by a number of Boards. The enabling boards should have an identified link to each of the Programme Boards and provide monthly feedback on projects being supported. This would not necessarily require each enabling board to have a nominated member of each Programme Board.

Recommendation 11: Programme Board chairs to agree a work programme with each of the enabling boards and a reporting timetable, including the production of an annual report.

In order to fulfil its revised remit, the system will need to consider the support capacity for the Chair of the Programme Board. There are currently differential resources attributed to each of the 8 boards and increased responsibilities for budget management and redesign will require additional capacity. This could be provided by a devolution of capacity/funding from the ICB as part of the requirement for a 30% running cost reduction, a shared resource created by all organisations in the ICS or a combination of the 2 options.

A linked issue, picked up later in the paper, will be the resource required if the ICB were to fully subcontract commissioning functions to collaboratives and partnerships. However, this is considered unlikely in the first stage of the development of the operating model (April 2024) as no discussions have taken place on risk management and accountability for this option.

Recommendation 12: System to agree the management support required to Programme Boards in order to deliver the revised remit in a more standardised way.

Recommendation 13: ICS to consider options to resource the functioning of the Programme Boards.

In the interim, the ICB will align a senior Director to each of the Programme Boards to provide support to the Chair. The ICB lead will be the conduit to SCC for reporting and will support the Programme Board Chair in ensuring that outcome targets are delivered.

Programme Board	Lead Director (s)
Cancer	Paul Tulley
Children & Young People	Michelle Carolan
Electives & Diagnostics	Pip Mayo
Maternity	Michelle Carolan
Out of Hospital Care	Neill Bucktin
Primary Care	Sarb Basi
Mental Health / LDA	Michelle Carolan
Urgent & Emergency Care	Steve Wheaton / Pip Mayo

Note: the Mental Health Programme Board functions on strategy and planning are provided via the Joint Oversight Committee (JOC).

Recommendation 14: Resource transferred to Black Country Healthcare as part of the lead commissioner arrangements to be considered as part of the recommendation above on Programme Board capacity.

3.1.3 Commissioning at Place Level

As part of the implementation of the operating model considerable work has been undertaken in developing the relationships at Place to reset the relationships with the 4 Local Authorities following the transition to the new ICB model and the disestablishment of the Local Commissioning Boards.

The ICB Place Managing Directors is the key link between the ICB and the Local Authorities. This link role operates at 3 levels:

- Day to day link with Local Authority Director team; Director of Adult Social Care, Director of Children's Services and Director of Public Health.
- ICB lead on the local Health and Wellbeing Board, to agree the health and wellbeing strategy based on the local joint needs assessment.
- Lead officer for the Place based scrutiny committees.

To support the development of strategies and integration between health and care services the ICB and Councils have established 4 Integrated Commissioning Committees (ICC) to provide a space to support collaboration and joint commissioning activity.

In addition to overseeing Joint Commissioning activity managed by existing Section 75 Agreements, the Committees will act as fora for joint high-level strategic discussions for the development of commissioning activity that remains the formal responsibility of the individual partners to support collective approaches to tackling inequalities, and meeting needs across the borough.

The 4 ICCs have standard terms of reference and membership and are designed to complement the emerging Place Provider structures. Over the next 2 years there is a desire to move the ICCs to more strategic committees, in parallel with the transition of ICBs.

The core functions of the committee are:

- ✓ Plan and develop integrated commissioning intentions to work towards agreed integrated priorities which should include the Health and Wellbeing Board strategy.
- ✓ Discuss and develop Place based strategic commissioning activity in relation to in scope service and budgets as per approved finance schedules.
- ✓ Promote integration of both health services with other health services and/or health-related and social care services where the Committee considers that this would improve the quality of services or reduce inequalities.
- ✓ Review and recommend arrangements for risk sharing and or risk pooling with other organisations for services commissioned in Place, including amendments to existing s.75 Agreements in place between the ICB and Council.
- ✓ Oversee Place partnership development and delivery and provide oversight and management of actions to reduce health inequalities, including population health management.
- ✓ Provide assurance through relevant agreed governance routes.

Each Committee will have a total of six members – 3 ICB representatives and 3 Council representatives.

- ICB Managing Director
- ICB Clinical Commissioning Lead
- Head of Primary Care and Place Commissioning
- 3 Council representatives; Director of Adult Social Care, Director of Children's Services and Director of Public Health

There has been considerable discussion on the scope of services within Place devolution, both in terms of the final range of service and also the pace of any devolution. It is recognised that the 4 Places start in different positions in terms of infrastructure and maturity and whilst there is considerable agreement on likely final destination, there is a likely to be a considerable range on the starting portfolio. It is expected that Places will develop at different paces and therefore there is likely to be a requirement for flexibility in the operating model to allow for evolution.

Based on the most recent discussions with Place, the desired final devolution model is based on the following assumptions:

Services to be led by Place Based Partnerships	Services to be influenced by Place Based Partnerships
Adult Social Care (where agreed with LA)	Acute Diagnostics
Better Care Fund services	Acute Inpatients
Community diagnostic hubs	Acute Outpatients
Community Outpatients	Children's Services
Community Services in current NHS Agreements	Emergency Departments
Continuing Healthcare (Dudley with others tbc)	Frail Elderly Services
Independent Sector AQP (single Place)	NHS funded Mental Health and LD
Medicines Management (Dudley with others tbc)	NHS111 and 999
Non-Emergency Patient Transport	Paediatric and Maternity
Out of Hours	Primary Care Enhanced Services
Palliative Care	Public Health Commissioned Services
Place Development Team incl PCN development	Same Day Emergency Care
Urgent Treatment Centres	Sexual Health Services

The committees will report into the system Out of Hospital Board, through to the Strategic Commissioning Committee to discuss common themes and issues and there will be a common outcomes framework across the Black Country to allow meaningful comparison.

Recommendation 15: Budgets devolved to the Out of Hospital Programme Board will be devolved to each of the 4 Places wherever possible for local decision making, with the Managing Director being the responsible commissioner.

Recommendation 16: Managing Directors will be the lead agreeing Better Care Fund plans.

Recommendation 17: The Place commissioning strategy will be co-ordinated with all other Place commissioners, e.g. Local Authorities.

Recommendation 18: The ICB Managing Director will be in attendance at the Place Partnership Board and the Place Provider lead will be in attendance at the Integrated Commissioning Committee in order to ensure that decisions are taken collaboratively.

Recommendation 19: The 4 Places will agree a common outcomes framework to allow comparison across the Black Country.

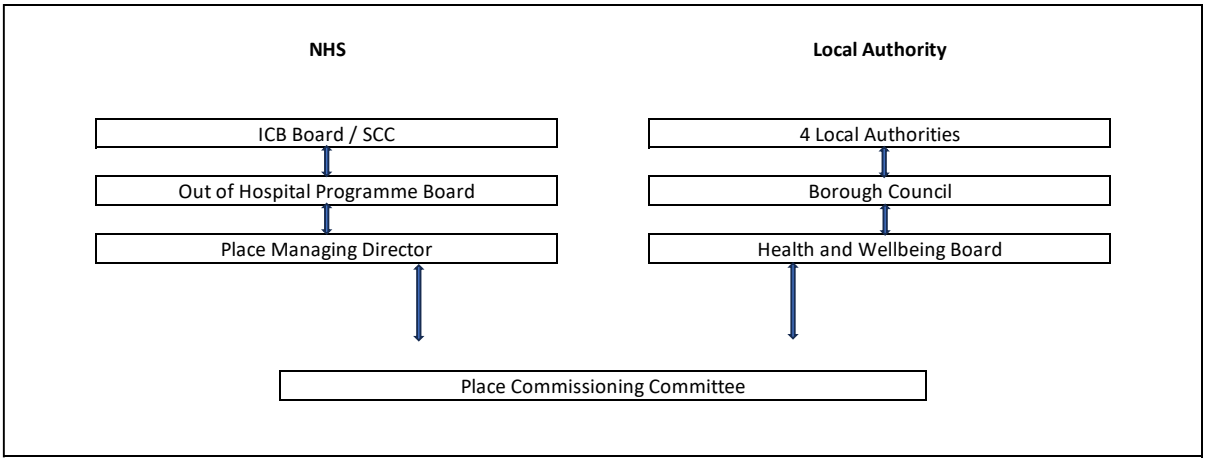
Further work is required on the relationship between Place commissioning and primary care commissioning. A primary care Transformation Strategy programme is being commissioned and

this will facilitate a discussion on the level of devolution to be recommended. The current matrix is set out in Appendix 2.

It is expected that discussions on GP commissioning are likely to be the focus of the early discussions in the primary care transformation programme, this will be in line with our statutory responsibilities outlined in the delegation agreement with NHSE. It is expected that primary care infrastructure programmes will continue to be commissioned at Black Country level, e.g. major IT & Digital projects, estate development and workforce planning.

Recommendation 20: GP services funded from ringfenced primary care budgets remain commissioned by the ICB corporate team in 2023/24 in line with our statutory and legal responsibilities outlined in the delegation agreement with NHSE. The ICB has set out a system / place responsibilities matrix which outlines the ICBs legal and statutory requirements around PC commissioning and contracting and this will act as the reference documents in relation to future working arrangements. Services commissioned as alternatives to secondary/community provider activity are included as part of the Place commissioning budget and managed through the Out of Hospital Board.

As Place Based Partnerships are established, the oversight and assurance function will be managed by the Integrated Commissioning Committee and led by the Managing Director. The Partnerships will have the freedom to innovate locally recognising local priorities and a differential inherited start point. Place Based Partnerships will determine areas where they will work together on joint priorities, which may be at Black Country level, or smaller combinations.



An opportunity has also been identified to create an improved alignment between the infrastructure for strategy and planning and the clinical leadership structures which are currently under review across the system. It is proposed that this piece of work be progressed in Q1 to

create a coherence of approach between service-based strategy and planning and condition focused clinical pathway work.

3.2 Provider Collaboratives and Place Based Partnership Arrangements

a. Policy and Guidance Review

Provider Collaboratives and Place Based Partnerships are identified as having key roles in relation to the architecture of Integrated Care Systems, sitting alongside Integrated Care Board structures to create an operating model which supports integration.

A summary of guidance in relation to these additional elements of system architecture is provided below:

Provider Collaboratives:

- ✓ Operate at the level of system.
- ✓ All NHS Acute and MH Trusts are expected to be part of one or more provider collaboratives, with Acute Collaborative and MH Collaborative structures featuring in national policy guidance as key elements of system architecture.
- ✓ Community Trusts and Ambulance Services should participate in provider collaboratives where it is beneficial for them to do so.
- ✓ Should engage the full range of providers to include the Independent Sector to ensure co-ordination of care.
- ✓ Important vehicles for NHS providers to collaboratively lead the transformation of services, restoration and shared ownership of objectives and plans across all parties.
- ✓ Will help facilitate the work of alliances and clinical networks enabling speciality levels plans and decisions to be made and implemented in a more co-ordinated and systematic way.

The Black Country Provider Collaborative, consisting of 4 Acute and community trusts, is operational with an executive committee and is focussing on areas of common capacity issues where mutual aid is required and starting to consider areas where joint developments will advance the system.

Contracts will continue to be held with each NHS Trust as the statutory body, for the in scope acute element of acute element of their contracts, but with increased harmonisation of reporting. Where the NHSD Trusts also act as the host for community contracts, these will be managed at a Place level driven by the local Partnerships. The 4 NHS Trusts will continue to work together through Joint Committees to inform the service strategies developed by the relevant Programme Boards.

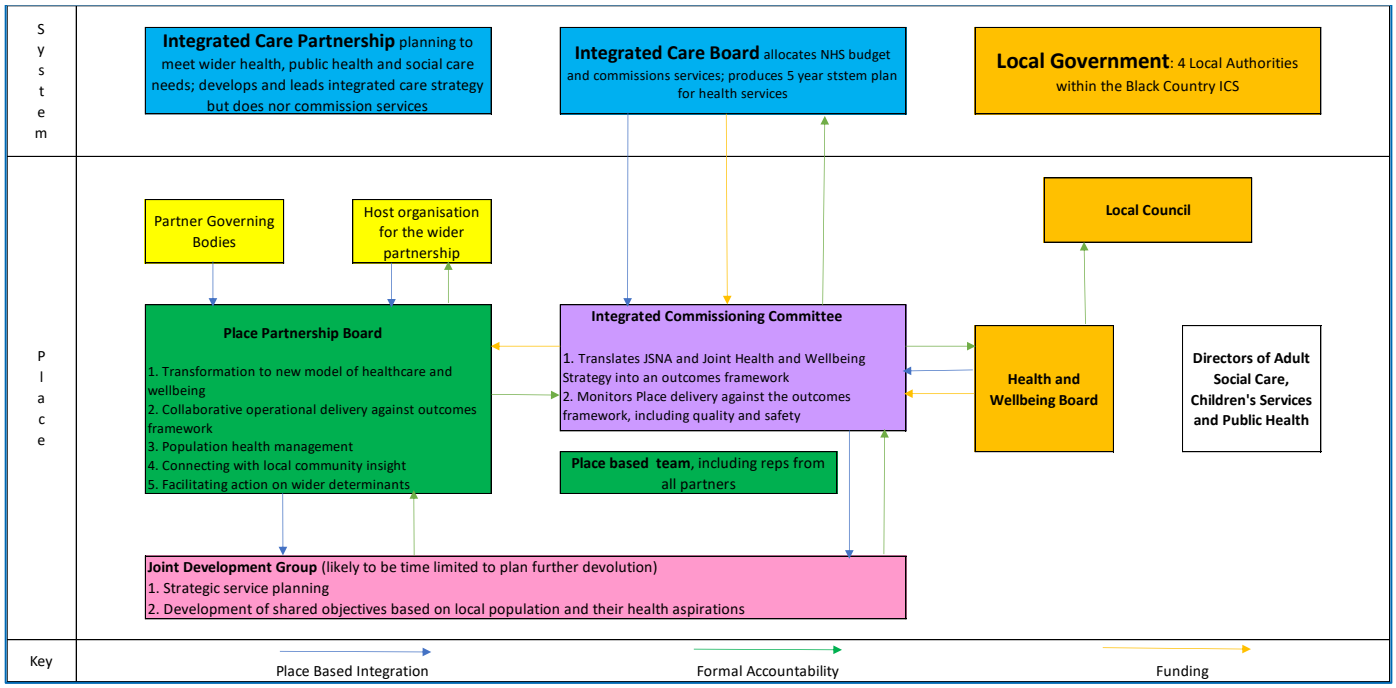
Work has started within the Collaborative to consider risk management arrangements for transfers of services between the 4 Providers and the contract mechanisms need to be flexible enough to reflect this joint working.

In order to consider further delegation from the ICB to the Provider Collaborative further work is required on system risk management with risk and gain shares across the system.

Place Based Partnerships

- ✓ Created to bring health and care services together to meet the needs of a designated population.
- ✓ Must have footprints that enable integration between the NHS and Local Authorities
- ✓ Must make sense to local people.
- ✓ Lead the detailed design and delivery of integrated primary and community services for a defined population.
- ✓ Should include the VCS and have strong links to local communities.
- ✓ Allow decisions to be taken as close to local communities as possible.

Place Based Partnerships have evolved over the last few years in each of the 4 Places. All are based on a strong relationship between community NHS Services and Local Authorities, coupled with engagement with wider community partners.



Each Place Based Partnership will be led by a host organisation, for at least a minimum core set of functions. In 3 of the Places the current host is the local NHS Trust, with arrangements for Dudley being finalised. The role of the host organisation is different to the traditional contracting relationships managed by the ICB. The role of the host will be to hold resources for finance and workforce on behalf of the partnership for services and running costs (where they are devolved by each commissioning organisation). The host may employ staff on behalf of the partners in order to fulfil the role of the host functionality. The resources of the PBP will need to be ringfenced from other contracts held by that host through a separate governance structure.

Within 2 years, the Place Based partnerships will take over as the lead provider for all out of hospital NHS services. Each Place will set out its ambition and timescale for taking on the lead Provider role by 31st December 2023. Some partnerships are likely to also be the lead provider for social care services. It is likely that some PBP will wish to take on the lead Provider role sooner and the model will need to be flexible enough to manage this variation.

The PBPs will have the flexibility to redesign services within the contract value including greater use of non-NHS providers. These changes will need to follow the service change process and agree with the local Place Managing Director. Any service changes requiring additional resources will need to be recommended to the Out of Hospital Programme Board and id supported to the Strategic Commissioning Committee.

Services will be developed to improve delivery against a common wellbeing outcome framework. Place Based Partnerships will be encouraged to integrate services with partner organisations to remove service boundaries.

Place based Partnerships will be responsible for supporting the development of Primary Care Networks in each of the 4 Places, with GPs forming part of the governance model for each area.

Recommendation 21: ICB Place development teams and DIHC staff are transferred to Place Based Partnerships from April 2024, other than those resources/staff who carry out a corporate ICB role i.e. primary care commissioning and contracting where further discussions are required to repatriate this resource within the ICB Primary Care corporate function.

The Partnerships have differential levels of infrastructure with funding coming from the multiple sources, including ICB, host organisations and councils. In order to develop PBPs there will be a requirement to develop a more consistent base funding level in all 4 Places to deliver the base level of devolution agreed. Some of the Places are likely to have more advanced local integration with additional capacity provided by the partners.

In April 2024 PBPs will start to assume responsibility for operational service redesign and transformation with capacity transferring from the ICB. By April 2025 PBPs will assume full responsibility for in scope service redesign and transformation in out of hospital services. This may require a local review of conflicts of interest and Partnership membership.

Recommendation 22: A minimum level of capacity is agreed to form PBPs.

Recommendation 23: The timeline for the creation of the Place Based Partnership capacity across the Black Country is harmonised with the changes in Dudley Place in order to ensure consistency. Consideration will need to be given for services devolved in Dudley which are not devolved in other Places, e.g. Medicines Management, CHC.

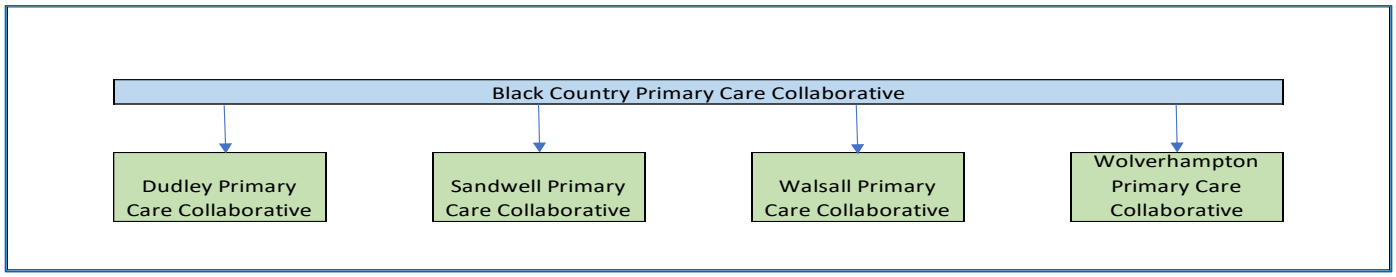
Recommendation 24: The staffing model for PBPs and collaboratives are developed in parallel with the ICB programme for reducing running cost allowance.

Primary Care

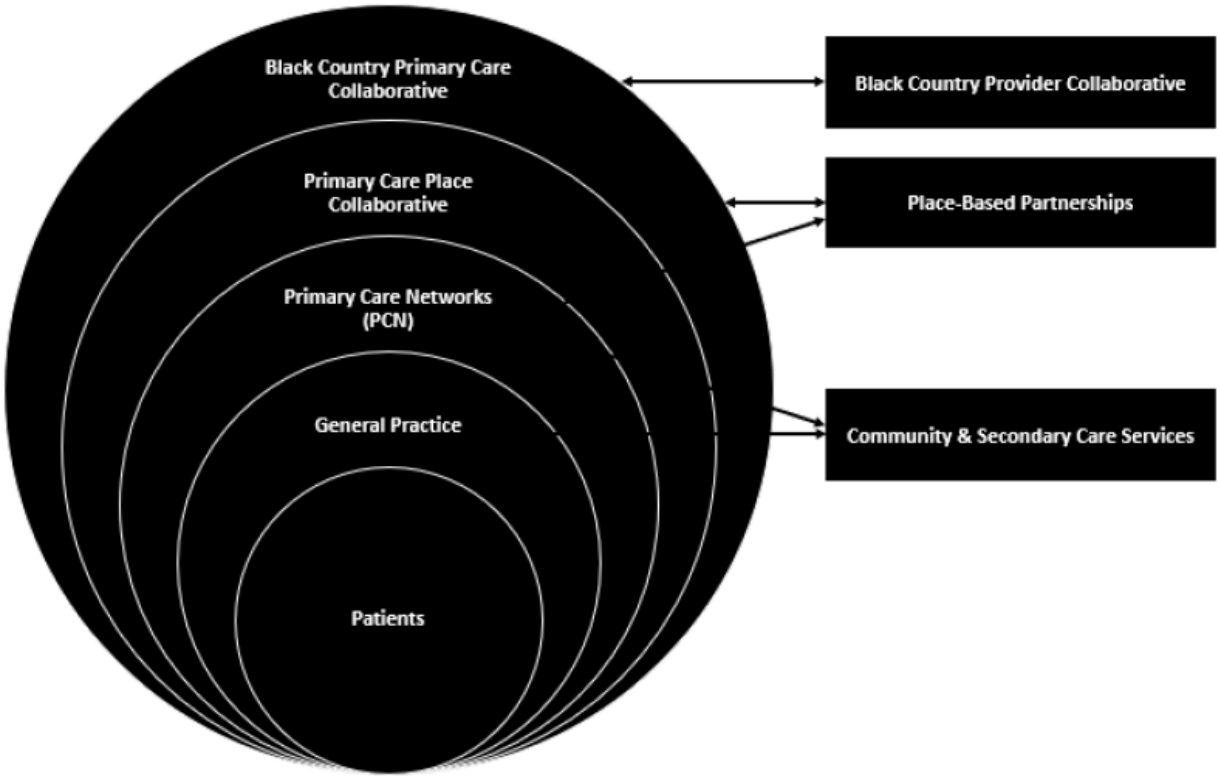
- ✓ Fuller Review points to need for at scale primary structures to support sector resilience in addition to primary care being partners in integrated delivery at place.

The Black Country Primary Care Collaborative (BCPCC) was established in early 2022 and is continuing to establish its role and purpose within the system. To ensure of the BCPCC can represent the views of all primary care providers and remain connected, four place-based (Dudley, Wolverhampton, Walsall and Sandwell) collaboratives have established.

The Local Primary Care Collaboratives (LPCCs) are the fundamental building blocks of BCPCC, each of them with 3 nominated representatives with a seat at the BCPCC. The LPCCs core membership is comprised of the PCN Clinical Directors. In this way there are two-way lines of communication, engagement, representation and accountability that flow between ***Individual Providers***, Neighbourhoods (PCN), ***Place*** (LPCC) and ***System*** (BCPCC).



As the Collaborative continues to develop, the LPCCs mirror and complement the work of BCPCC at
their local place whilst also addressing issues particular to that Place. LPCCs are not only vitally important building blocks in the Primary Care Collaborative construct and ensure connectivity with local communities, but they are also the visible clinical leadership structures for Primary Care at Place Level. The LPCC will provide the primary care input to the Place Based Partnerships and support Primary Care input to community service design.



The 5-year primary care transformation programme aims to determine the future operating model for primary care at pace, requiring primary care clinical leads for each of the several anticipated workstreams and to support delivery of an extensive communications and engagement exercise across primary care providers, our patients/public and wider system partners. The BCPCC has a lead role in driving the initial
design phase.

As part of the transformation programme options will be considered for delivering primary care at scale. These discussions are at an early phase and will require extensive consultation with primary care.

NHS Trusts and Providers

- ✓ Retain formal accountability for their statutory duties and responsibilities.
- ✓ Providers of NHS services will continue to be accountable:
  - for quality, safety, use of resources and compliance with standards
  - for delivery of any services or functions commissioned from or delegated to them,
- ✓ Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible.

The proposed model meets such policy expectations.

b. Confirming the Black Country Architecture

Seven provider structures have been created as additional elements within the Back Country architecture as set out below.

c. Developing the Operating Model through 23/24

Through the work of the System Development Group a clear ambition has been confirmed to develop the role of all Provider Collaboratives and Place Based Partnerships to receive delegations from the ICB and to increasingly act on behalf of constituent members.

Drawing on the learning from the formation of the Mental Health Lead Provider it is recognised this development journey needs to be well planned and supported.

To reinforce the role of Collaboratives and Partnerships from the 1 April 2024 and the ICBs commitment to their development it is proposed that MOU agreements be put in place which have as a minimum the following components:

The ICB ask of Provider Collaboratives and Place Based Partnerships:

- ✓ To provide a mechanism to connect with the full range of providers and stakeholders as appropriate to scope.

- ✓ To support demand and capacity modelling and inputting information about patient need and preferences.

- ✓ To lead on the development of credible delivery plans and models to implement the commissioning decisions developed by the programme boards.
- ✓ To deliver agreed outcomes and performance targets
- ✓ To share and promote innovation and good practice.
- ✓ To enable the effective co-ordination and integration of services.
- ✓ To promote the effective use of resource and support the delivery of balanced financial plans (budgets, estates, workforce).
- ✓ To develop plans to tackle inequity of access, experience, or outcomes.
- ✓ To comply with service change and business case processes.
  To support organisational resilience through the facilitation of mutual aid agreements.

A mandate for Provider Collaboratives and Place Based Partnerships to act:

To work with the Programme Boards to form and agree strategies and plans to meet patient group or population need which support delivery of the approved ICB Strategy and are in line with policy priorities:

- For System level collaboratives this relates to:
  - Increased harmonisation of outcomes
  - Improves sustainability rationalisation
  - Integration with more specialist services
  - Has the potential to realise efficiencies in both clinical and back office services
- For Place this relates to
  - Local integration of multi-disciplinary services
  - Greater continuity of care for those with long term conditions
  - Co-ordinated care for those with the most complex needs
  - Prevention or demand management potential – reducing utilisation of less appropriate higher cost services

- ✓ Develop and implement governance arrangements that reflect their current stage of development, function and form as defined in policy and via discussion with constituent members.

- ✓ Collectively restructure or rationalise central/back office functions to achieve efficiency targets or release funds for patient facing care.

- ✓ Propose and enact changes to service provision where the change proposed is supported by constituent members, does not require additional investment and will lead to improvements in outcomes, access or experience.

- ✓ Request changes to contracts for constituent organisations where these organisations agree to the proposed changes, there are perceived benefits and the contractual envelope remains unchanged.

The scope of responsibilities transferred to the Collaboratives and Partnerships will be determined by the implementation of the Delegation Assurance Framework. A detailed project plan has been agreed for the Place Based Partnerships to commence in April 2024 with delegated responsibilities.

The Provider Collaboratives and Place Based Partnerships ask of the ICB

- ✓ Engagement in strategy, planning and commissioning decisions.

- ✓ Transparency of decision making.

- ✓ Transparency in relation to financial and resource allocations.

- ✓ A commitment to support the development of PCs/PBPs via the allocation, alignment or transfer of resources.

- ✓ The maintenance of appropriate governance structures which support the principle of subsidiarity.

MOU agreements will be implemented and tailored to individual Collaboratives and Partnerships to the recognise the different levels of development and readiness to operate, with a quarterly review to ensure they reflect the changing roles and maturity on the road to delegation. For Place Based Partnerships this work will need to be undertaken in consultation with Local

Authorities to support local integration. It is also important to note that the MOUs will work alongside, and not replace, formal contracts with individual providers.

Recommendation 25: MOUs are signed by March 2024 outlining the annual delivery targets for the Provider organisations.

3.3 Clinical Leadership

Clinical leadership lies at the heart of the operating model. There are a number of major groups of clinical leaders:

- ✓ System portfolio leaders reporting to the ICB Chief Medical Officer and Chief Nurse
- ✓ Secondary care clinicians working as part of the Provider Collaborative
- ✓ Primary care clinicians who comprise the Black Country Primary Care Collaborative
- ✓ Primary Care Network Clinical Directors
- ✓ Place Based Clinical Commissioning Leads
- ✓ Clinical members of Place Based Partnerships
- ✓ Clinicians on the Joint Oversight Committee

A developing role of the Collaboratives and Partnerships is to design new pathways to improve patient care and deliver the strategies of the Programme Boards. There is a requirement for these redesigns to cover the whole patient journey rather than within one sector. It is therefore proposed that the system establish a Black Country Clinical Leadership Group to agree pathways or redesigns that has an implication beyond one collaborative or partnership, or which triggers the major service change protocol.

Recommendation 26: A Black Country Clinical Leadership Group is established involving clinical leaders from all parts of the system.

3.4 Finance, Contracting and Performance Arrangements

Based on the revised operating model described above, the contract and performance arrangements for 2024/25 would be based on the ICB leading an Assurance and Oversight process based on contracts with the statutory bodies in the system, but recognising the partnership arrangements that underpin the contracts.

- The MHLDA Lead Provider has the infrastructure in place to take on finance and contracting arrangements for Mental Health services. Given this, financial and contractual arrangements will continue to sit at this level for 2024/25.

- Acute NHS contracts will sit with the 4 NHS Trusts, but with a flexibility to redesign services within their combined contractual envelope, in conjunction with Partnership Boards. There is a longer term potential for the Provider Collaborative to hold a combined budget, including those of non-NHS Acute providers.

- Community service contracts will sit with the host organisations for the Place Based Partnerships, ringfenced from other contracts held by the host. This has the potential to include budgets for services delivered by other Providers as a Lead Provider where this is agreement by the Place partners.

- Functions and services delegated from the ICB to Place Partnerships will sit with the host organisation, including Place development.

- The ICB will contract directly with primary care providers for services wholly funded from ringfenced primary care budgets. Further discussion is required on the scope of primary care services devolved to Place and the timetable for so doing, in line with our statutory and legal responsibilities outlined in the delegation agreement with NHSE. The ICB has set out a system / place responsibilities matrix which outlines the ICBs legal and statutory requirements around PC commissioning and contracting and this will act as the reference documents in relation to future working arrangements.

- Work is underway to consider the mechanisms by which ICBs will contract across regional and sub-regional services. This work will be added to the operating model once agreed. Initially this will include specialist services, extended primary care services (opticians, dentists, pharmacists) and the 111/999 arrangements.

- Contracts will increasingly be migrated to outcomes based contracts.

- The financial recovery programme will be overseen by the relevant Programme Board and reported into the Productivity and Value Group (or its successor)

The main change in 2023/24 will be to the Oversight and Assurance regime with a transition of responsibility from NHSE to the ICB

The ICB's role in provider oversight is the following:

- Lead on the oversight and assurance of individual providers within the ICS, with support from NHSE, including the review of performance against the NHSOF framework and developing proposals for the segmentation of providers.
- Ensure there is a robust approach to managing risks and escalations arising from delivery and transformation through its Board Assurance Framework. This will routinely review system and individual provider risks through a clear governance framework.
- Develop exit criteria for individual providers that address any concerns or emerging issues. Agree these criteria with providers and NHSE, and sign-off through ICB and provider governance.
- Ensure that the ICB develops, monitors and oversees plans to meet the agreed 'exit criteria' for organisations receiving mandated support.
- Co-ordinate NHS support interventions, where appropriate, working in partnership with NHSE, including to jointly review the impact of interventions.
- In the ICB governance, updates on provider oversight arrangements, emerging risks or concerns and any changes to NHSOF segmentation will be overseen by the System Development Committee and updates will also be taken to other committees of the Board for feedback and triangulation.

NHSE's role in provider oversight is the following:

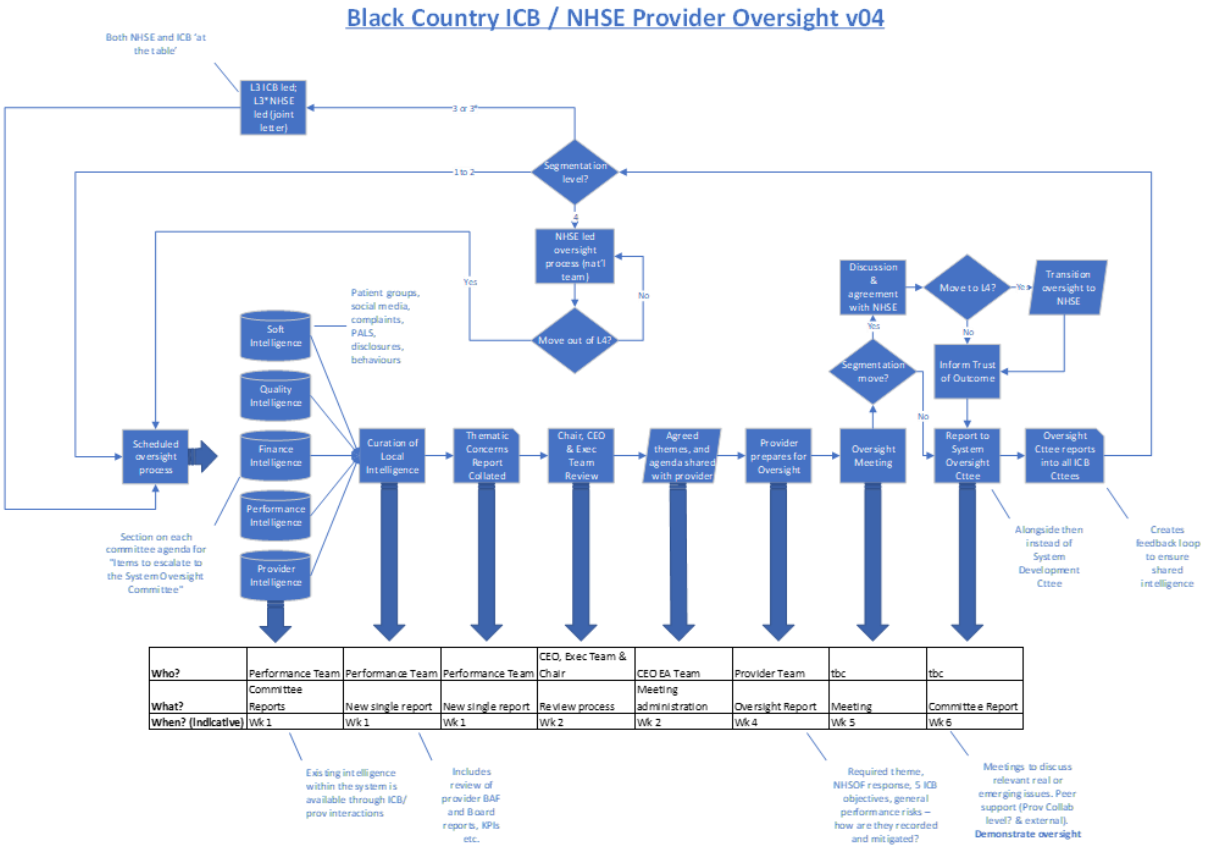
- NHSE has statutory accountability for oversight of both ICBs and NHS providers.
- The NHS Oversight Framework (NHSOF) outlines the segmentation approach and key metrics which will be considered by NHSE to assess performance of the system and providers against six key themes or domains.
- In general, NHSE will discharge its duties in collaboration with our ICB, asking NHSE to oversee and seek to resolve local issues before escalation.
- For individual providers, NHSE and the ICB will together discuss segmentation and any support required. However, NHSE will be responsible for making the final segmentation decision and taking any necessary formal enforcement action. Where there is a deterioration in segment, NHSE and the ICB will agree exit criteria which will need to be met to exit mandated support and move to a lower segment.

- NHSE will work with the system to identify quality, financial and operational improvement and transformation actions
- Where new concerns are identified, rapid risk and review (or escalation) meetings will be used as a consistent approach to understand issues, agree actions and outcomes required
- In some exceptional circumstances, such as where enforcement / regulatory action is required, NHSE will intervene directly with providers. Should such intervention be required this will happen with the full visibility of the ICB.
- Oversight of ICB and individual providers under the NHSOF is coordinated by the Strategy and Transformation team within the region, and formal reviews and decisions regarding segmentation are made by the Midlands Regional Support Group.

Leadership of the process will be determined by the segmentation of the provider

NHSOF segment	Frequency of meeting	Led by
1	Quarterly	ICB
2	Quarterly, or alternative agreed on basis of need of individual provider	ICB
3	Bi-monthly	ICB
3 enhanced*	Monthly	Joint with NHSE
4	Monthly with bespoke arrangements, determined by the scale and nature of the issues that caused escalation into NHSOF segment 4	NHSE

Capacity within the system will need to be considered to support this additional requirement on ICBs.



In order to reduce expanding the ICB Board committee structure the System Development Committee will be disbanded following approval of the operating model and replaced by a System Oversight Committee.

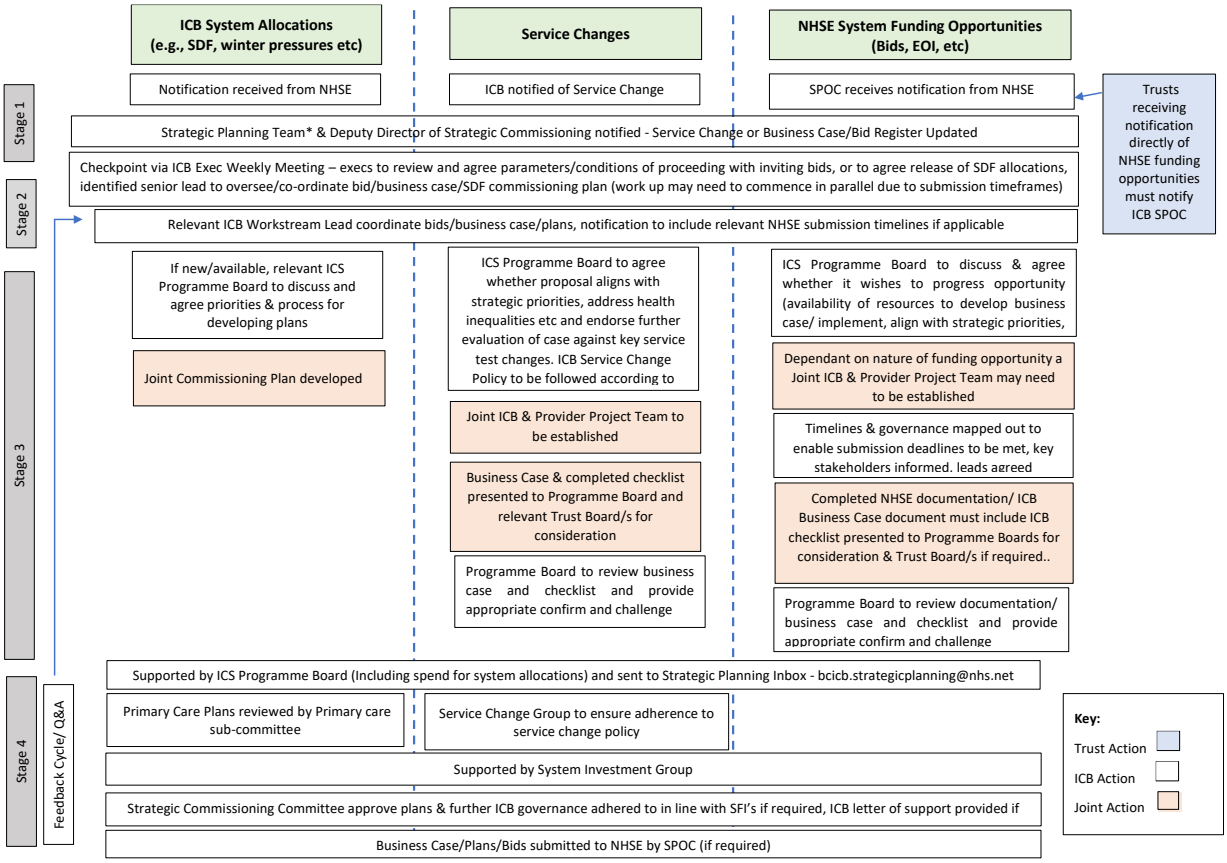
Recommendation 27: The System Development Committee is disbanded and replaced with a System Oversight Committee

Recommendation 28: Capacity to reviewed in all parts of the system to ensure that there is sufficient capacity to enable the separation of acute and community contracts, and for the ICB to deliver oversight arrangements previously led by NHSE. This includes a review of Mental Health capacity.

3.5 System Decision Making

Based on the implementation of the operating model, the decision making flowcharts for service change have been updated to reflect the different roles of the organisations in the system and to reinforce the strategic role that the system Programme Boards will undertake.

The process harmonises the process for new allocations, major service changes and bid opportunities offered to the system.



-Timelines may necessitate virtual sign off plans, where timeline s don't allow SCC sign off in advance f submission, it will delegated to Chief Operating Officer & Chief finance Officer
- This above process should be followed in conjunction with the Business Case Guidance, Service Change and Procurement Strategy if applicable
- Planning Oversight Group should have oversight and visibility of all the above to ensure system partners are aware of work programmes
- For cross cutting workstreams, all Boards need to review and support the development of work programmes & financial plans

Based on acceptance of the recommendations in the paper, each key decision area have been mapped out to clarify

- Who will take the decision.
- Who is accountable for the decision.
- Who will be consulted.
- Who will be informed.

Healthier Futures

Black Country Integrated Care System

Decision Area	Responsible (Who takes the Decision)	Accountable (Who is the decision on Behalf of)	Consulted (Who is actively asked for views)	Informed (Who is told that the decision has been taken)
Policy and Investment				
Agreeing Overall Strategy & Financial Allocations	ICB Board	ICB	Programme Boards Strategic Commissioning Committee Productivity and Value Group	Collaboratives Place Based Partnerships Organisations
Agreeing Outcomes at System	Strategic Commissioning Committee Mental Health JOC	ICB	Programme Boards	Collaboratives Place Based Partnerships Organisations
Agreeing Outcomes at Place	Place Managing Director	ICB	Place Integrated Commissioning Committee	Place Based Partnerships Strategic Commissiong Committee
Setting Principles and policies	Strategic Commissioning Committee Mental Health JOC	ICB	Programme Boards Collaboratives Place Based Partnerships	ICB Board Organisations
Agrreing proposals for service change affecting one organisation and within the current financial envelope	Acute - organisation with support of the Provider Collaborative Place Partnership - organisation with the support of the Place Managing Director	ICB	Provider Collaboraive Managing Directors	Partnership Boards Strategic Commissioning Committee
Agreeing proposals for service change affecting more than one organisation within financial envelope	Programme Boards Relevant ICB Lead Director (SCC to ensure service change requirements are met)	ICB	Place Integrated Commissioning Committee Place Based Partnership	Strategic Commissioning Committee Mental Health JOC
Agreeing proposals for service change outside financial envelope.	In line with SFI Delegated Limits:- • System Investment Committee • Strategic Commissioning Committee • ICB Board	ICB	Programme Boards Place Integrated Commissioning Committee Place Based Partnerships Collaboratives Mental Health JOC	Strategic Commissioning Committee ICB Board (based on limits)
Agreeing business cases for service investment	In line with SFI Delegated Limits:- • System Investment Committee • Strategic Commissioning Committee • ICB Board	ICB	Programme Boards Place Integrated Commissioning Committee Place Based Partnerships Collaboratives Mental Health JOC	Strategic Commissioning Committee ICB Board (based on limits)
Procurement/ Provider Selection	In line with SFI Delegated Limits:- •Mental Health JOC • Strategic Commissioning Committee • ICB Board	ICB	Programme Boards Place Integrated Commissioning Committee Place Based Partnerships Collaboratives Mental Health JOC	Strategic Commissioning Committee ICB Board (based on limits)
BETTER CARE FUND				
Sign-off of NHS Contribution to BCF	Place Managing Director ICB Chief Finance Officer	ICB	Place Integrated Commissioning Committee Place Based Partnership	Strategic Commissioning Committee
Sign-off of BCF Plan	Health and Wellbeing Board Place Managing Director	ICB/ Local Authority	Place Integrated Commissioning Committee Place Based Partnership	Strategic Commissioning Committee
Sign-off of BCF Governance arrangements	Place Managing Director (ICB) Cabinet/Exec Lead (LA)	ICB/ Local Authority	Place Integrated Commissioning Committee	Strategic Commissioning Committee
Management of BCF Pooled Fund	Place Integrated Commissioning Committee Place Managing Director	ICB/ Local Authority	Place Based Partnership	Strategic Commissioning Committee
SYSTEM DEVELOPMENT FUNDING				
Agree Proposals for SDF Funding	Strategic Commissioning Committee Mental Health JOC	ICB	Programme Boards Collaboratives Place Based Partnerships Mental Health Lead Provider Organisations	ICB Board

4.0 Summary

The proposals in this paper build on the agreed system operating model and is focussed on strengthening the role of the Programme Boards in developing system strategy and oversight of major change. The remainder of 2023/24 is focussed on establishing the Place Based Partnership coupled with continued evolution of the Provider Collaborative.

Key to the next phase of development will be realigned capacity to the new ways of working and the timelines for implementing the model have significant dependencies on other programmes, notably:

- Agreement of the organisational solution for Place Based Partnerships
- Output of the DIHC Programme Board
- Running Cost Allowance reduction programme for the ICB
- Development of the Memorandum of Understanding between the ICB and Providers
- Agreement of the outcomes framework for the system
- Agreement of the starting financial baselines for 2024/25, including the split of the acute quantum from the Place based quantum
- Delivery of the delegation assurance framework
- NHSE Assurance

Recommendation 29: A single programme plan is developed to understand the key decision points and inter-relations between the programmes.

Recommendation 30: Once the operating model has been agreed, the ICB will review the Scheme of Reservation and Delegation (SoRD) and make any amendments that are necessary to enact the changes.

5.0 Summary of Recommendations

Recommendation 1: As part of the system OD work with Deloitte, time should be allocated to the implementation of the operating model.

Recommendation 2: The membership of the Strategic Commissiong Committee should be extended to include representatives of JOC to ensure mental health commissioning arrangements are represented. It is anticipated that the relationship between JOC and SCC will continue to evolve as governance arrangements further embed.

Recommendation 3: The MH/LDA Lead Provider should be invited to attend all Programme Boards to reduce the risk that the MH/LDA agenda is siloed. All programme boards have a responsibility to consider and take forward opportunities for the integration of physical and mental health.

Recommendation 4: The agenda of the Strategic Commissiong Committee should be restructured to reflect the 3 areas of responsibility, together with a feedback report from each of the programme and enabling boards.

Recommendation 5: Align all current contract expenditure, and associated financial recovery targets wherever possible, to a lead Programme Board in order that they can understand the full quantum for monitoring and redesign.

Recommendation 6: Programme Board Chairs to review membership of the Board, supported by Lead Directors, in light of aligned services and contracts to ensure that stakeholders are engaged, including non-NHS providers, Local Authorities and voluntary sector. Membership needs to include finance, quality, contracting, clinical and strategy leads and links to the enabling boards.

Recommendation 7: Programme Board Chairs to review subgroups, supported by Lead Directors, in order to ensure Boards can focus on strategic direction whilst being assured of performance.

Recommendation 8: Change the terms of reference for Programme Boards in order that they can make changes to services to meet agreed strategy and targets set by the Strategic Commissioning Committee, subject to complying with service change obligations such as consultation.

Recommendation 9: Change the terms of reference for Programme Boards in order that they can make changes to services to meet agreed strategy and targets set by the Strategic Commissioning Committee where this affects multiple organisations, subject to complying with service change obligations such as consultation.

Recommendation 10: ICS to reconsider the use of the title SRO and replace with Programme Board Chair to reflect the limited delegation powers in the current model. There will also be a need to consider whether the term Board is appropriate for an advisory committee.

Recommendation 11: Programme Board chairs to agree a work programme with each of the enabling boards and a reporting timetable, including the production of an annual report.

Recommendation 12: System to agree the management support required to Programme Bords in order to deliver the revised remit in a more standardised way.

Recommendation 13: ICS to consider options to resource the functioning of the Programme Boards.

Recommendation 14: Resource transferred to Black Country Healthcare as part of the lead commissioner arrangements to be considered as part of the recommendation above on Programme Board capacity.

Recommendation 15: Budgets devolved to the Out of Hospital Programme Board will be devolved to each of the 4 Places wherever possible for local decision making, with the Managing Director being the responsible commissioner.

Recommendation 16: Managing Directors will be the lead agreeing Better Care Fund plans.

Recommendation 17: The Place commissioning strategy will be co-ordinated with all other Place commissioners, e.g. Local Authorities.

Recommendation 18: The ICB Managing Director will be in attendance at the Place Partnership Board and the Place Provider lead will be in attendance at the Integrated Commissioning Committee in order to ensure that decisions are taken collaboratively.

Recommendation 19: The 4 Places will agree a common outcomes framework to allow comparison across the Black Country.

Recommendation 20: GP services funded from ringfenced primary care budgets remain commissioned by the ICB corporate team in 2023/24. Services commissioned as alternatives to secondary/community provider activity are included as part of the Place commissioning budget and managed through the Out of Hospital Board

Recommendation 21: ICB Place development teams are transferred to Place Based Partnerships from April 2024.

Recommendation 22: A minimum level of capacity is agreed to form PBPs.

Recommendation 23: The timeline for the creation of the Place Based Partnership capacity across the Black Country is harmonised with the changes in Dudley Place in order to ensure consistency. Consideration will need to be given for services devolved in Dudley which are not devolved in other Places, e.g. Medicines Management, CHC.

Recommendation 24: The staffing model for PBPs and collaboratives are developed in parallel with the ICB programme for reducing running cost allowance.

Recommendation 25: MOUs are signed by March 2024 outlining the annual delivery targets for the Provider organisations.

Recommendation 26: A Black Country Clinical Leadership Group is established involved clinical leaders from all parts of the system.

Recommendation 27: The System Development Committee is disbanded and replaced with a System Oversight Committee

Recommendation 28: Capacity to reviewed in all parts of the system to ensure that there is sufficient capacity to enable the separation of acute and community contracts, and for the ICB to deliver oversight arrangements previously led by NHSE. This includes a review of Mental Health capacity.

Recommendation 29: A single programme plan is developed to understand the key decision points and inter-relations between the programmes.

Recommendation 30: Once the operating model has been agreed, the ICB will review the Scheme of Reservation and Delegation (SoRD) and make any amendments that are necessary to enact the changes.

Appendix 2: Current Primary Care Division of Responsibilities

Function	Areas of Responsibility	System	Place
Strategy and Transformation	• Strategy development and agreed design principles across system • Addressing health inequalities across primary care • Workforce Retention & Transformation • Overall programme management including Planning/Review/Evaluation/ monitoring • NHSE/I – guidance and Planning Cycle	• Delivery of PC strategy at system level • Define Population Health Need/ Shared Purpose • Development and principles of new PC operating (focusing on delivering at scale / reducing variation / addressing inequalities) • Partner engagement	• Share and inform local place-based approaches to ICP and PC development plans • Implementation of strategy at place • Implementation of transformation objectives including workforce, care redesign, workload and financial investment
Innovation and Development	• GPFV strategic development and deployment • Overall Programme/Project and governance • Monitoring and evaluation • Reporting to NHSE/I • Co-ordination of HEE training Hub • Overall Programme/Project and governance • Monitoring and evaluation • Reporting to NHSE/I	• GPFV development and deployment across system • Operational programme / project management • Reporting to ICB governance • Training Hub development and deployment across system • Operational programme / project management of HEE initiatives • Reporting to ICB governance/PCSC • Links to system wide Population Health Need projects	• GPFV deployment of resources and capacity to place based ICPs. • Training Hub deployment of resources and capacity to place based ICPs. • Monitoring and evaluation at place for GPFV/schemes designed for the place • Collate and assist with reporting to NHSE/I E.G: - care homes/PCNs etc. • Reporting to local place-based governance i.e. PCOG • Place based implementation of projects & transformation programme

Function	Areas of Responsibility	System	Place
Primary Care Commissioning	• Policy and guidance development • Commissioning framework development and standardisation across system • NHSE/I Statutory (Regional) and Internal assurance (ICB/ICS/PCSC) • Management of additional PC investment allocations • Management of delegated PC budget • Return on Investment/Impact Assessment	• Review frameworks incl. oversight commissioning of DESs • Technical PC commissioning expertise and support • Deployment of additional investment into PC • Strong engagement with stakeholders including LMCs • Management of PC estate in collaboration with estates team • Management of IT systems in collaboration with Digital team • Management of quality and safety in collaboration with quality team (i.e. CQC etc).	• Provide place-based guidance, advice and assurance through PCBMG • Support the development of place based LISs Agreement and monitoring of ICP PC in-scope contracts in line with national requirements. • Strong engagement with stakeholders including LMCs • PCN Development against maturity matrix/ DES/Population Health Need(s)

Primary care contracting	• Management of all Primary Care Medical Contracts in accordance with the delegation agreement • Make recommendations to the relevant committee regarding changes to contracts or where contractual action may be required regarding non-compliance • Provide assurance to NHSEI regarding the delivery of Primary Care Medical Services • Liaise with PCSE regarding all contractual changes in respect of performer status	• Provide technical contracting expertise and support with specialist knowledge of national and local policies relating to all routes of Primary Medical Services. • interpret these policies and provide advice on their application and impact • Develop a core contract monitoring framework and reporting mechanism working in collaboration with Quality & Safety • Deep dive of PCN DES • Performance management of commissioned frameworks/contracts • Maintenance of primary care contracts; contract variations, nationally agreed changes • Issue of breach/remedial notices where appropriate • Liaise with PCSE and GMAST colleagues • Authorise PCSE performer changes • Respond to NHSE returns • Annual eDec monitoring • Sub-contracting arrangements	• Provide place-based guidance, advice and assurance through PCBMG • Reporting of primary care performance issues relating to each place through PCBMG • Supports engagement of local procurements. • Post payment verification • Update PCBMG re any contractual matters relating to place • Support local practices with contractual matters to provide resilience e.g. prevention of list closure, changes in partnerships, changes in service • Assurance re delivery of PCN DES

The Royal Wolverhampton NHS Trust

Report to Trust Board To be held in Public on 12th December 2023		
Title of Report:	Update from Improvement, Innovation and Research Group	**Enc 8.1.2**
Author:	Kate Salmon, Deputy Chief Strategy Officer	
Presenter/Exec Lead:	Louise Toner, NED	

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

Recommendations:

Trust Board are asked to note the contents of the report and in particular the items referred to for discussion and approval.

The Group are asked to endorse the recommendations in the report as follows:

1. To review and discuss the high-level Board actions (Appendix 1) with a recommendation to continue the work, refining them further and to be presented to Trust Board in February 2024.

2. To note the decision of the IIRG that Digital Innovation ceases reporting formally to the IIRG and for the appropriate Digital Innovation representation to remain a core member of the Group.

3. To note the decision that the IIRG will formally be known as the Improvement and Research Group – IRG, (Appendix 2) for the amended Terms of Reference.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: The QI team is not an owner of any risks but their involvement in QI projects address various risks raised through Divisions and Corporate teams.		
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 KLOE 8
	NHSE	Yes☒No☐	Details: NHS Impact
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:

[1]B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf

The Royal Wolverhampton NHS Trust

	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led: KLOE 8		

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

The QI Teams continue to work across Divisions, developing and supporting the programmes of improvement work, alongside the delivery of QSIR training, including bespoke training to identified staff groups. Separate reports are submitted to TMC and Trust Board summarizing the QI work.

The Senior QI leadership team continues to collaborate with colleagues from the acute providers in the Black Country and have agreed a set of guiding principles to support our collaborative work as the 'Black Country Improvement System'.

Members of the senior leadership team attended an open day at Leeds Teaching Hospital NHS Trust – an exemplar Trust who took part in the Virginia Mason Institute programme, to share learning on embedding QI at all levels of the organization.

Advise

The NHS Impact 'stock-take' assessment and QI Maturity Matrix self-assessment assessing our state of readiness against the 5 domains for quality improvement, were submitted to the ICB. The QI Board action plan has been updated highlighting the actions needed and areas for Board consideration, if we are to progress through the stages of maturity and will be the focus of this report.

Alert

The report outlines the rationale for the removal of Digital Innovation as an agenda item requiring formal reporting requirements into the IIRG, a decision supported by the IIRG.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)

[1]B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf

Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Safe and responsive urgent and emergency care • Deliver the priorities within the National Elective Care Strategy
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
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

Report from the Improvement, Innovation and Research Group held in Private on 14th November 2023

EXECUTIVE SUMMARY

[1]B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf

This report summarises the meeting held on 14th November. The meeting was quorate.

The IIRG received reports from the Quality Improvement Team and Research and Development (R&D). It received a proposal from the Associate Director of Digital Innovation to not formally report into this group due to the reasons outlined below.

BACKGROUND INFORMATION

1. Delivering Continuous Improvement DCI Review – Maturity Matrix self-assessment

The Board previously approved the submission of the NHS IMPACT maturity matrix self-assessment results based on our maturity as an organisation into delivering the recommendations from the NHS Delivery and Continuous Improvement review (DCI review[1]) – average score of 2.4 (developing). These were submitted to the ICB.

The focus of the review identified 5 domains that need to be in place for an organisation to have truly embedded continuous improvement and for it to be part of "Business as Usual" (BAU) for everyone. Organisations that have the five foundations in place score highly on the matrix and have achieved CQC ratings of Outstanding.

Five foundations identified:

- Building a Shared purpose and Vision
- Investing in People and Culture
- Developing Leadership behaviours
- Building Improvement Capability and Capacity
- Embedding improvement into management systems and processes

The QI Board action plan has been updated and includes proposed actions (for consideration) that are designed to move the organisation towards levels 4 (spreading) and 5 (improving and sustaining) of the Maturity Matrix. Appendix 1 includes the high-level Board actions that were considered by the Group and needs further development with respective Executive and Non-Executive Director colleagues. Once finalised, the recommendations will be submitted to Trust Board for sign-off (February 2024).

2. Digital Innovation

Following the dissolution of the former Innovation and Research Committee it was agreed that two Groups would be established:

1. Information technology and Digital Platforms/Infrastructure
2. Innovation, Improvement and Research

At the point of establishment there was agreement that as the structure was newly formed and digital Innovation previously reported to IRAC it would be pertinent for this agenda to be reported into both working groups to ensure alignment.

The new structure has been in existence for almost 12 months, and it has become clear through the separate meetings and discussions held within those meetings that the Digital Innovation agenda should be reporting formally through the Information technology and Digital Platforms/Infrastructure Working Group, chaired by John Dunn.

[1]B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf

Whilst the proposal is to cease the formal Digital Innovation reporting requirements to IIRG it would be pertinent for the Associate Director of Digital Innovation (or their deputy) to remain a core member of the IIRG to ensure the collaborative agendas remain aligned.
The IIRG endorsed the proposal for Digital Innovation to cease reporting formally to the IIRG and for the appropriate Digital Innovation representation to remain a core member of the Group.

3. **Research and Development**

Highlights were presented by the Group Director for R&D. The approval times for studies being approved has improved from 298 days to just 35 days and therefore recruitment into commercial studies has increased substantially. The delivery into portfolio studies is on an upward projection.

Unfortunately, recruiting for the Professor of Midwifery post was unsuccessful, however, discussions are taking place re an alternative approach to allow the post to be progressed across both trusts and Birmingham City University Further, the University of Wolverhampton were unsuccessful in the appointment of a Professor of Nursing and discussions are taking place re the potential to readvertise or seek an Associate Professor role. Discussions are also taking place with WHT regarding an Associate Palliative Care post.
In addition, the team are collaborating with colleagues at SWBH and DGFT on how to bring research, innovation and improvement together across all 4 trusts.

RECOMMENDATIONS

1. To support the continued development of the QI Board Action plan working with the respective Executive and Non-Executive Directors to refine actions further.
2. To note the decision of the IIRG that Digital Innovation ceases reporting formally to the IIRG and for the appropriate Digital Innovation representation to remain a core member of the Group.
3. To note the decision that the IIRG will formally be known as the Improvement and Research Group – IRG, please refer to Appendix 2 for the amended Terms of Reference.

Enclosures:

Appendix 1 – QI Board Action plan and NHS Impact

Appendix 2 – Improvement & Research Group Terms of Reference (amended)

[1]B2137 - NHS delivery and continuous improvement review and recommendations - https://www.england.nhs.uk/wp-content/uploads/2023/04/B2137-nhs-delivery-and-continuous-improvement-review-recommendations-april-2023.pdf

Table Facilitator	Attendee Name	Designation	Trust (RWT / WHT)
Atul	Nicki Ballard	Div 3 Nurse Director	RWT
	Louise Nickell	Education Director	RWT
	Martin Levermore	NED	RWT
	Lisa Carroll	Nurse Director	WHT
Kate	Amy Boden	Head of Infection Prevention	WHT
	Maria Arthur	Deputy Director of Governance	WHT
	Amy Sykes	Head of OD and Workforce Transformation	RWT
	Caroline Yates	Matron - Surgery Division	RWT
Joyce	Fateh Ghazal	Divisional Director for Women's and Childrens' and	WHT
	Louise Toner	NED	RWT
	Martina Morris	Deputy Director of Nursing (Interim)	RWT
	Stacey Thacker	Deputy Head of Midwifery and Neonatal Services	RWT
	Simon Evans	Group Chief Strategy Officer	
Lee	Janet Mortimore	Head of Information	WHT
	Amanda Cater	Head of Performance	WHT
	Jayne Lawrence	Head of Information	RWT
	Chander Sharma	Group Manager - Cardiothoracics & Cardiology	RWT
	Simon Parton	Head of ICT Systems & Applications Services	RWT
Katy	John Murphy	Divisional Medical Director - Division 1	RWT
	Janet Mortimore	Head of Information	WHT
	Claire Flatt	Matron Post Registration Education	WHT
	Michelle Hickman-Smith	Matron for Education Quality	RWT

Q. Data: NHS Impact Self-assessment Levels across 22 Categories from National Survey

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Building a Shared purpose and Vision					**Average score**	**2.5**
7	Board and executives setting the vision and shared purpose	Starting: We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.	Developing: Our board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Progressing: Our board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (e.g. Operations, Quality, Financial and People / workforce).	Spreading: Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Improving & sustaining: Our vision and shared purpose is well embedded and often referred to by the board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.	3
8	Improvement work aligned to organisational priorities	Starting: Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	Developing: Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.	Progressing: Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Spreading: Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Improving & sustaining: Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.	3
9	Co-design and collaborate - celebrate and share successes	Starting: We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	Developing: The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Progressing: Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	Spreading: We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Improving & sustaining: Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.	3
10	Lived experience driving this work	Starting: There is an aspiration or stated commitment to engage patients, carers, staff and public in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.	Developing: Patients, carers, staff and public are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.	Progressing: Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Spreading: Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.	Improving & sustaining: Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at board level, including setting the strategic direction of the organisation and wider system.	1

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Investing in People and Culture					**Average score**	**2.25**
11	Pay attention to the culture of improvement	Starting: There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Developing: Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement.	Progressing: Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of patient care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Spreading: Leaders and managers at all levels understanding their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g., during 'go & see' visits).	Improving & sustaining: We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g., NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits patients and users. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.	2
12	What matters to staff, patients and carers	Starting: Our ways of understanding what matters most to staff, patients and carers tend to be reliant on formal mechanisms (e.g., surveys) and the link to improvement is not strong or systematic.	Developing: We understand well as an organisation what matters most to staff, patients and carers (e.g., through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Progressing: Most of our services and functions have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g., through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient sand carers into improvement priorities or goals.	Spreading: Most of our teams have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. Patients and service users have a role in the development, prioritisation and monitoring of delivery of improvement goals.	Improving & sustaining: Most of our staff can describe what matters most to them, patients and carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for patients, which is energising. Patients and service users often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.	2
13	Enabling staff through a coaching style of leadership	Starting: There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	Developing: There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g., through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.	Progressing: A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g., to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Spreading: Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	Improving & sustaining: A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.	2
14	Enabling staff to make improvements	Starting: Improvement activity is limited and may be centralised (e.g., led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make improvements in their own area of work.	Developing: Some staff and teams feel able to make improvements (e.g., if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.	Progressing: The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Spreading: The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems effectively.	Improving & sustaining: Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with other teams and organisations in improvement programmes.	3

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Developing Leadership behaviours					**Average score**	**2.2**
15	Leadership development strategy	Starting: Our board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.	Developing: Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role.	Progressing: Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Improving & sustaining: Our board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our board are visibly linked to future planning at a system level.	2
16	Leadership Values and behaviours	Starting: Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach.	Developing: Leadership values and behaviours are agreed across our organisation.	Progressing: Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation.	Spreading: Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.	Improving & sustaining: A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.	2
17	Leadership acting in partnership	Starting: Our Leadership works to competing and misaligned goals lacking in clarity.	Developing: Most of our leaders work in partnership with their fellow leaders and managers.	Progressing: Our leadership team have shared goals with commissioners and work effectively with systems partners.	Spreading: Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Improving & sustaining: Our board and system focus on constancy of purpose through multi-year journey with improvement at its core.	2
18	Board development to empower collective QI leadership	Starting: Our board discusses improvement at board meetings, but it is not a regular occurrence.	Developing: Our board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every board meeting.	Progressing: Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work.	Improving & sustaining: Our leaders and managers - CEO through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done.	3
19	Go and see visits	Starting: Some senior leaders spend time on the 'shop floor' from time to time to engage directly with staff and teams but it is not routine or widely practiced.	Developing: Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools.	Progressing: Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.	Spreading: All levels of leadership and management 'walk the floor'/'go & see' as a matter of routine and the insights they gain informs decision making and problem solving to support improvement.	Improving & sustaining: Leaders undertake 'walk the floor'/'go & see' visits for external bodies to visit their site and to observe different ways of working.	2

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Building Improvement Capability and Capacity					**Average score**	**2.25**
20	Improvement capacity and capability building strategy	Starting: We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School).	Developing: Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around quality improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.	Progressing: Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing QI capability.	Spreading: Sustainability is addressed via 'in-house' training and development approaches including train the trainer models. Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.	Improving & sustaining: There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally.	3
21	Clear improvement methodology training and support	Starting: No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	Developing: There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS Impact components, alongside a dosing formula and skills escalator to support capability building ambitions.	Progressing: Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.	Spreading: Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, patients, service users and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	Improving & sustaining: Learning from improvement activity is driving continuous improvement There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.	2
22	Improvements measured with data and feedback	Starting: Our organisational approach to reviewing and tracking progress against goals has yet to be defined, At present Improvement doesn't feature in whole organisational measures.	Developing: We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver.	Progressing: We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.	Spreading: Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.	Improving & sustaining: Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.	2
23	Co-production	Starting: We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors.	Developing: Learning is captured when doing improvements, but this is rarely shared across departments.	Progressing: Users and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, patients, service users and other stakeholders have access to improvement capability development.	Spreading: Stakeholders are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively.	Improving & sustaining: Stakeholders are both supported and challenged to ensure success. Users and wider stakeholders are embedded within teams and are an integral part of the capability building process.	2
24	Staff attend daily huddles	Starting: Any huddles are only traditional shift change clinical handovers.	Developing: There is a plan in place for team huddle to focus on continuous improvements in all clinical frontline areas with clinical and operational staff in attendance.	Progressing: All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all operational/support/corporate areas.	Spreading: All operational/support/corporate areas have continuous improvement team huddles established.	Improving & sustaining: There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.	2

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**WHT**
	Embedding improvement into management systems and processes					**Average score**	**2.25**
25	Aligned goals	Starting: Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at board and senior leadership level but executives' and functions goals are often not well aligned with each other.	Developing: Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Progressing: Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Spreading: Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Improving & sustaining: Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.	2
26	Using the management system for planning and understanding	Starting: Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Developing: Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.	Progressing: Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to our improvement priorities.	Spreading: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.	Improving & sustaining: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.	3
27	Using the management system to respond to local, system, and national priorities	Starting: We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting.	Developing: Across the organisation, we believe having a management method (e.g., Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Progressing: Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Spreading: Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.	Improving & sustaining: All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g., SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.	2
28	Using the management system to integrate QI into everything we do	Starting: Improvement/QI is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending conflicting signals within the organisation.	Developing: Improvement/QI is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some front-line clinical areas.	Progressing: Improvement/QI is starting generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.	Spreading: As part of our management system, all parts of the organisation are using improvement/QI methods, and learning occurs between areas (e.g., to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.	Improving & sustaining: The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.	2

Q. Data: NHS Impact Self-assessment Levels across 22 Categories from National Survey

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**RWT**
	Building a Shared purpose and Vision					**Average score**	**2.75**
7	Board and executives setting the vision and shared purpose	Starting: We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few and not lived by our executive team. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.	Developing: Our board, executive leaders and senior management team can describe a shared vision and purpose that is the start of the process to align these with our organisational goals.	Progressing: Our board, executive leaders and senior management team are active and visible in promoting the shared vision and translating it into a narrative that makes it meaningful and practical for staff. Measures have been agreed and defined with a small number of key metrics (e.g. Operations, Quality, Financial and People / workforce).	Spreading: Our vision and shared purpose inform our journey and plans, and operational and clinical leaders and teams across our organisation know how they are contributing to, and own, our organisational goals. All employees have been communicated to and understand our shared vision in a way that means something to them.	Improving & sustaining: Our vision and shared purpose is well embedded and often referred to by the board and other leaders, who are able to bring it to life and make the link between their team's priorities and improvement plans and the agreed organisational goals. Most of our staff can describe our vision and shared purpose in their own words and what they can do in their role to contribute.	3
8	Improvement work aligned to organisational priorities	Starting: Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all of our teams.	Developing: Our organisational purpose, vision, values and strategic priorities are understood by some within our organisation, but generally seen as organisational goals rather than something which is directly meaningful to them.	Progressing: Our organisational purpose, vision, values and strategic priorities have been translated into agreed organisational goals, and measurement systems have been established. The priorities are well understood by most leaders and managers, which is helping to create organisational alignment.	Spreading: Our organisational purpose, vision, values and strategic priorities are visible and understood by leaders, managers and most staff. Our organisational goals have been agreed and measurement systems have been established and are being used across most areas.	Improving & sustaining: Our organisational purpose, vision, values and strategic priorities are role modelled and actively reinforced and communicated by leaders and managers, widely understood by most staff across our organisation and translates into improvement activity at team level.	3
9	Co-design and collaborate - celebrate and share successes	Starting: We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.	Developing: The Board has set a small number of bold aims with measurable goals for improvement, and a communications and engagement plan ensures that staff have at least heard about these goals.	Progressing: Our improvement goals are developed and refined through a collaborative engagement process, which at least involves leaders and most managers and a two-way feedback process.	Spreading: We have an agreed plan for delivery at organisational level which is cascaded through line managers down to team level, based on an established engagement and co-development process and a common approach to improvement. Celebration and learning events are used to recognise and share improvements.	Improving & sustaining: Our leaders and managers model collaborative working as part of the organisation's continuous improvement approach. We have an agreed plan for delivery at organisational level that we can systematically track to team level. Celebrate and learning events are an established practice to recognise and share improvements widely.	3
10	Lived experience driving this work	Starting: There is an aspiration or stated commitment to engage patients, carers, staff and public in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.	Developing: Patients, carers, staff and public are involved in the design and communication of our shared purpose and vision, and may have a role in setting improvement priorities.	Progressing: Patients, carers, staff and public are actively engaged in co-designing organisational purpose, vision, values and setting strategic priorities for improvement.	Spreading: Patients, carers, staff and public are actively engaged in setting improvement priorities, including at service, pathway or team level, and in evaluating the impact of improvements from a user perspective.	Improving & sustaining: Patients, carers, staff and public have a voice which influences the strategic improvement agenda and decision making at board level, including setting the strategic direction of the organisation and wider system.	2

		1	2	3	4	5	
	Category	Starting	Developing	Progressing	Spreading	Improving & Sustaining	RWT
	Investing in People and Culture					Average score	2.25
11	Pay attention to the culture of improvement	Starting: There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and executive level.	Developing: Our Board is committed to establishing an improvement culture and has plans to put this into practice, including Board development. The organisation has ways of measuring culture change (e.g. using a cultural survey or the NHS staff survey) and readiness for improvement.	Progressing: Our improvement approach considers culture as an integral aspect, including for corporate functions, recognising the value they bring to enabling organisational improvement. The majority of improvement activity starts with ways to actively engage staff and teams from clinical, operational, and corporate services in support of improvement goals and effective delivery of patient care. Our organisation has ways of measuring culture change and readiness for improvement at departmental or team level.	Spreading: Leaders and managers at all levels understanding their part in establishing a culture consistent with improvement. We consider measures and markers of culture change alongside other ways of evaluating improvement, down to team level. We have established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are 'walking the floor' (e.g., during 'go & see' visits).	Improving & sustaining: We have a reputation for having established a culture consistent with improvement, and we can evidence that with data (e.g., NHS staff survey). Teams and departments work collaboratively across organisational boundaries to deliver improvement which benefits patients and users. We recognise leaders, managers and staff who are role models for the kind of behaviour and culture we want to create.	2
12	What matters to staff, patients and carers	Starting: Our ways of understanding what matters most to staff, patients and carers tend to be reliant on formal mechanisms (e.g., surveys) and the link to improvement is not strong or systematic.	Developing: We understand well as an organisation what matters most to staff, patients and carers (e.g., through two-way engagement) and this helps to shape our overall improvement priorities and our approach. Picking up on what matters most to our staff helps to bring us together around a common agenda and creates energy for improvement.	Progressing: Most of our services and functions have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Our staff have a voice at Board level to provide feedback on how it feels to work here (e.g., through staff stories, informal interactions, staff networks). Leaders and managers help to translate the needs of patient sand carers into improvement priorities or goals.	Spreading: Most of our teams have a good understanding of what matters most to staff, patients and carers (e.g., through two-way engagement) and this informs their local improvement priorities and activity. Most staff feel invested and excited about the opportunities they have to participate in improvement activity which matters to them. Patients and service users have a role in the development, prioritisation and monitoring of delivery of improvement goals.	Improving & sustaining: Most of our staff can describe what matters most to them, patients and carers and how this translates into their local improvement priorities and activity. There is a strong and direct connection between their improvement activity and making things better for patients, which is energising. Patients and service users often work in close partnership with our teams on improvement activity, helping to focus on what will make the greatest difference.	2
13	Enabling staff through a coaching style of leadership	Starting: There is some recognition of how a coaching style of leadership helps to encourage improvement, but it is not widely applied.	Developing: There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g., through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.	Progressing: A coaching style of leadership is well established with training available for leaders and managers who request it. Leaders and managers are widely engaged in improvement and regularly sponsor improvement activities (e.g., to help unblock issues). Senior leaders participate in improvement, celebration and learning events on a regular basis. Staff generally feel supported and empowered.	Spreading: Leaders and line managers are trained systematically in coaching and enabling teams to solve problems for themselves. Our executive leaders act as coaches and teachers of the improvement method for all levels, including role modelling a coaching style. Managers and clinicians participate in improvement, celebration and learning events on a regular basis. Staff talk about feeling more trusted and empowered.	Improving & sustaining: A coaching style of leadership is embedded as the default approach throughout the organisation, and it is applied to our greatest challenges. Staff and teams thrive in this environment and take greater ownership of improvement. Our leaders and managers are recognised as effective improvement coaches and are often sought after to lead and support improvements beyond our own organisation.	2
14	Enabling staff to make improvements	Starting: Improvement activity is limited and may be centralised (e.g., led by a discrete 'improvement team' with relevant skills operating independently). Staff do not generally feel able to make improvements in their own area of work.	Developing: Some staff and teams feel able to make improvements (e.g., if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.	Progressing: The majority of staff are actively involved in improvement activity and feel able to suggest ideas for improvement and to make changes in their own area.	Spreading: The majority of teams feel empowered and trusted to carry out improvement activity in their own areas, applying a consistent approach. Our staff understand the factors driving progress (whether positive or negative), and can solve problems effectively.	Improving & sustaining: Staff and teams are systematically engaged in improvement activity as part of their day to day work and are proactive in sharing the learning, and in looking for ways to collaborate with other teams and organisations in improvement programmes.	3

		1	2	3	4	5	
	Category	Starting	Developing	Progressing	Spreading	Improving & Sustaining	RWT
	Developing Leadership behaviours					Average score	2.2
15	Leadership development strategy	Starting: Our board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.	Developing: Our leadership team have started to develop their improvement knowledge and are gaining an understanding in how it can impact their role.	Progressing: Our leadership works with managers and teams across the organisation to develop improvement skills and enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work and all teams and staff have had training in improvement.	Improving & sustaining: Our board focus on constancy of purpose through multi-year journey and executive hiring and development, including succession planning. Our board are visibly linked to future planning at a system level.	2
16	Leadership Values and behaviours	Starting: Our leadership values and behaviours and our expectations of managers are not explicitly defined, or do not include reference to an improvement-based approach.	Developing: Leadership values and behaviours are agreed across our organisation.	Progressing: Leadership values and behaviours are agreed, and role modelled by leaders and managers across the organisation.	Spreading: Leadership values and behaviours are agreed, role modelled and supportively challenged when not lived up to.	Improving & sustaining: A clear framework and expectations for leadership and management values and behaviours which are consistent with an improvement-based approach are applied throughout the organisation.	2
17	Leadership acting in partnership	Starting: Our Leadership works to competing and misaligned goals lacking in clarity.	Developing: Most of our leaders work in partnership with their fellow leaders and managers.	Progressing: Our leadership team have shared goals with commissioners and work effectively with systems partners.	Spreading: Our leadership team has shared longer term goals with network partners or commissioners as well as collaborative involvement over wider health economy.	Improving & sustaining: Our board and system focus on constancy of purpose through multi-year journey with improvement at its core.	3
18	Board development to empower collective QI leadership	Starting: Our board discusses improvement at board meetings, but it is not a regular occurrence.	Developing: Our board has received some improvement training and visit to parts of the organisation at least monthly. Improvement is discussed at every board meeting.	Progressing: Our leadership works with managers and teams across the organisation to enable and co-ordinate improvement.	Spreading: Our leadership and management teams actively enable staff to own improvement as part of their everyday work.	Improving & sustaining: Our leaders and managers - CEO through to front line demonstrate their commitment to change by acting as champions of the improvement and management method, by removing barriers and by maintaining a visible presence in areas where direct care / operational work is done.	2
19	Go and see visits	Starting: Some senior leaders spend time on the 'shop floor' from time to time to engage directly with staff and teams but it is not routine or widely practiced.	Developing: Our leaders understand the importance of 'walking the floor' to 'go & see'; but we have variation in leader participation; some leaders and managers use our improvement tools.	Progressing: Our Executives regularly 'walk the floor'/'go & see'; they incorporate the tools and methods into their meetings, strategic planning and daily management.	Spreading: All levels of leadership and management 'walk the floor'/'go & see' as a matter of routine and the insights they gain informs decision making and problem solving to support improvement.	Improving & sustaining: Leaders undertake 'walk the floor'/'go & see' visits for external bodies to visit their site and to observe different ways of working.	2

		1	2	3	4	5	
	Category	Starting	Developing	Progressing	Spreading	Improving & Sustaining	RWT
	Building Improvement Capability and Capacity					Average score	2.25
20	Improvement capacity and capability building strategy	Starting: We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources (e.g. Academic Health Science Networks and Institute for Healthcare Improvement Open School).	Developing: Our improvement methodology has been agreed and the Board has undergone its own development to build literacy around quality improvement. Staff have access to induction on joining, improvement training and a small group of staff support capability building.	Progressing: Training is a balance of both technical skills, behavioural attributes and data analysis. Coaching support is available during and post training and time is given for staff to undertake training and development in the adopted improvement methodology. Some learning is shared across the organisation. A system exists to identify, engage and connect all those people that have existing QI capability.	Spreading: Sustainability is addressed via 'in-house' training and development approaches including train the trainer models. Improvement capability building for 'lived experience' service user partners is underway; they are seen as contributors to improvement teams. The programme is working towards being self-sustaining through developing its own improvement coaches.	Improving & sustaining: There is a systematic approach to improvement, and induction and training are provided to every member of staff as part of learning pathways and career progression, including induction and line manager training with >80% coverage. Capability building is self-sustaining, meeting the improvement needs of the organisation. The organisation consistently shares capability, building learning with other sites, regionally and nationally.	3
21	Clear improvement methodology training and support	Starting: No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.	Developing: There are pockets of capability built by motivated staff with an interest in improvement. We have a training needs analysis which is underway to understand staff development & training needs for NHS Impact components, alongside a dosing formula and skills escalator to support capability building ambitions.	Progressing: Clarity exists on which improvement methodology and approach is being consistently applied. A longer term commitment exists to a training and development system for building capability at scale. Service users and carers are recognised as key stakeholders.	Spreading: Training and development are undertaken by all leaders, managers and staff. Learning from all improvement activity is effectively shared across the organisation. Staff, patients, service users and wider teams are using their skills and knowledge to deliver improvement and cascade improvement techniques to their peers.	Improving & sustaining: Learning from improvement activity is driving continuous improvement There is a common improvement language across the organisation. Knowledge and learning from improvement is highly visible, harvested, collated and shared widely as part of a scaling up and spread strategy.	2
22	Improvements measured with data and feedback	Starting: Our organisational approach to reviewing and tracking progress against goals has yet to be defined, At present Improvement doesn't feature in whole organisational measures.	Developing: We are seeing minimal improvement in our organisational measures. We have developed some elements of our organisational approach to reviewing and tracking progress, however this is ad-hoc and stakeholders do not feel it supports them to deliver.	Progressing: We are tracking improvement over time for some of our organisational measures. We have a holistic approach to achieving our goals, evidenced by data, centred on problem solving, and management that stakeholders feel is supportive.	Spreading: Improvement is sustained for most organisational measures. Our goals are reviewed regularly at organisational level and our plans are adapted to ensure they meet the clearly defined goals if required.	Improving & sustaining: Sustained improvement over time for all system measures. We understand what is driving performance, (whether positive or negative), and problem solve effectively. Our goals around longer term sustainability are reviewed regularly at organisational level.	2
23	Co-production	Starting: We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors.	Developing: Learning is captured when doing improvements, but this is rarely shared across departments.	Progressing: Users and wider stakeholders are strongly involved in co-designing and co-producing the capability building approach. Staff, patients, service users and other stakeholders have access to improvement capability development.	Spreading: Stakeholders are both supported and challenged to ensure success. We understand the factors driving progress (whether positive or negative), and problem solve effectively.	Improving & sustaining: Stakeholders are both supported and challenged to ensure success. Users and wider stakeholders are embedded within teams and are an integral part of the capability building process.	2
24	Staff attend daily huddles	Starting: Any huddles are only traditional shift change clinical handovers.	Developing: There is a plan in place for team huddle to focus on continuous improvements in all clinical frontline areas with clinical and operational staff in attendance.	Progressing: All clinical frontline areas have continuous improvement team huddles established. There is a plan in place to establish continuous improvement team huddles in all operational/support/corporate areas.	Spreading: All operational/support/corporate areas have continuous improvement team huddles established.	Improving & sustaining: There is a cascade of huddles for all teams from Executive to frontline teams (clinical, operational, corporate) which hold regular continuous improvement huddles using a standardised format and process.	2

		1	2	3	4	5	
	Category	**Starting**	**Developing**	**Progressing**	**Spreading**	**Improving & Sustaining**	**RWT**
	Embedding improvement into management systems and processes					**Average score**	**2.5**
25	Aligned goals	Starting: Where improvement plans exist they are very locally determined and driven. Our business planning is an activity conducted at board and senior leadership level but executives' and functions goals are often not well aligned with each other.	Developing: Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.	Progressing: Our organisational goals are established to support our overall vision; our departmental goals align systematically with those of our organisation. Our business planning process is based on two-way engagement leading to greater local ownership of the goals.	Spreading: Our organisational and departmental goals are systematically aligned to our overall vision; and we are working to align goals across our system. Our organisational goals are developed using a consistent management system, based on two-way engagement leading to strong ownership of the goals and greater transparency between areas.	Improving & sustaining: Our organisational and departmental goals are systematically aligned to our overall vision and that of our system. Individual objectives are clearly linked to the strategic plan through the team, departmental and organisational goals and improvement plans.	2
26	Using the management system for planning and understanding	Starting: Our business planning and performance management processes do not make it easy for us to understand status or progress against our goals. We do not have visibility of what we are working on across the organisation.	Developing: Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.	Progressing: Our business planning and performance management processes give the Board and most line managers good visibility of status and progress against our goals. There is good visibility of what we are working on across the organisation. We have an agreed approach for selecting and prioritising improvement work. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to our improvement priorities.	Spreading: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams. We have an agreed and transparent approach for selecting and prioritising improvement work which generally works well. Our supporting resources are assigned to supporting delivery of improvement goals across the organisation in a way that is perceived to be fair and effective. Staff and assets from enabling services (e.g. HR, Finance, Comms, Informatics) are also aligned to improvement priorities and are shared across the system in an agile way.	Improving & sustaining: Our business planning and performance management processes give good visibility of status and progress against our goals across all departments and teams, and is considered the 'one version of the truth' across the organisation. We have an agreed and transparent approach for selecting and prioritising improvement work which works well and can flex to meet changing needs. There is complete and timely visibility of what teams are working on across our organisation. There is a co-ordinated approach to review, prioritise and co-ordinate allocation of resources to support pathway-level improvement.	3
27	Using the management system to respond to local, system, and national priorities	Starting: We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead it is perceived as reactive or firefighting.	Developing: Across the organisation, we believe having a management method (e.g., Lean) is important to our success. Some of our leaders are using management methods daily, which is recognised to be helping.	Progressing: Most leaders and managers in the organisation use our management methods to manage and run their departments, including responding to problems that may arise or to take account of changing priorities.	Spreading: Our management method is well embedded in how we work in all parts of the organisation, to team level. As an organisation we are using run charts and statistical process control (SPC) charts not just RAG or tables. Our technology, staff and facility decisions are aligned with our management system goals.	Improving & sustaining: All teams use the management method to understand, run and improve each aspect of our organisation; we use data effectively (e.g., SPC) to understand and improve performance. Whether our work is succeeding or is challenged, we strive for continuous improvement.	2
28	Using the management system to integrate QI into everything we do	Starting: Improvement/QI is seen as separate to the day to day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply, and may be sending conflicting signals within the organisation.	Developing: Improvement/QI is starting to be more integrated with day-to-day delivery and targeted towards particular performance priorities or risks. Improvement activity is contributing to performance in some front-line clinical areas.	Progressing: Improvement/QI is starting generally well integrated with day-to-day delivery across the organisation and is increasingly the basis of how we deliver against our performance goals. Improvement activity is contributing to performance in many front-line clinical areas and supporting clinical functions.	Spreading: As part of our management system, all parts of the organisation are using improvement/QI methods, and learning occurs between areas (e.g., to understand and reduce waste). We have multiple examples of sustained improvement over months and years, not just month-to-month variation.	Improving & sustaining: The way we understand, manage and improve performance across the organisation – including how we use and report data – is consistent with our approach to improvement and based on an improvement cycle. We have many examples of sustained improvement, including reference cases recognised beyond our organisation.	3

Q. Data: NHS Impact Self-assessment Levels across 22 Categories from National Survey

	Domains	Action	Action2	Action3	Action4	RWT	WHT
	Building a Shared purpose and Vision					**2.75**	**2.5**
7	Board and executives setting the vision and shared purpose	Define strategic priorities that link to the vision and engage with the Board. Discuss mechanism, potentially a series of board development sessions. Ensure alignment				3	3
8	Improvement work aligned to organisational priorities					3	3
9	Co-design and collaborate - celebrate and share successes	QI Quarterly Star - agree timing eg. monthly/quarterly to be presented to individual departments/wards (by NED/Executive) which is then shared in the Daily Dose/RWT Comms (ensure included with QI launch in New Year).	Sharing and learning events (Report outs). Design our equivalent where MDT's present their QI projects aligned with Trust priorities.			3	3
10	Lived experience driving this work	Agree a process that ensures patients/carers and staff and public have input (a voice) into our organisational priorities.				2	1

	Domains	Action	Action2	Action3	Action4	RWT	WHT
	Investing in People and Culture					**2.25**	**2.25**
11	Pay attention to the culture of improvement	To establish a method for assessing cultural readiness for teams doing improvement work, and link to an OD resource to support improving the cultural readiness. (Amend project brief to include - is the team culturally ready for this change).	Values - when these are revisited - to ensure QI contribute eg. Encouraging improvement ideas and supporting individuals, learning from others, this is how we do things here.	Include expectations about improvement being part of the appointment process inc job descriptions and asking about improvement at interview. (Standard questions similar to equality - part of BCIS work).		2	2
12	What matters to staff, patients and carers					2	2
13	Enabling staff through a coaching style of leadership	Board development session around a coaching style of leadership to seek agreement on developing as the default leadership style.				2	2
14	Enabling staff to make improvements	Encourages visiting and learning from others. Describe the support available for teams wishing to visit other services	Consider the Inclusion of QI within Appraisal documentation asking about involvement in Improvement projects, focus on personal development and objective setting (part of BCIS work)			3	3

	Domains	Action	Action2	Action3	Action4	RWT	WHT
	Developing Leadership behaviours					**2.2**	**2.2**
15	Leadership development strategy	Undertake board development session focussing on Developing leadership behaviours as part of the Maturity matrix.	It is proposed QI skills and knowledge form part of Essential or Desirable criteria for Personal Specifications. Part of BCIS work looking at JD's and individuals with line management responsbilities. From Band 4 upwards			2	2
16	Leadership Values and behaviours					2	2
17	Leadership acting in partnership					3	2
18	Board development to empower collective QI leadership	NED or Executive to sponsor QI programmes in priority areas	Consider the concept of a monthly QI Forum (quarterly initially) chaired by Chief Nurse and CMO to share successes and learning from QI projects. Similar to Schwarz rounds - a safe space to talk about successes, failures, barriers, networking and shared learning. On Teams, open to both Trusts, rotating chair between CNO and CMO - 'coach of the month'			2	3
19	Go and see visits	Schedule NED and Executive walkabouts on a rolling basis to specialties, ward areas, departments where they should take every opportunity to engage with staff about their QI ambitions, achievements, recognising and celebrating successes	Board to consider % of Exec time spent on the frontline, connecting with staff	Proposed all managers do walkabouts in their areas (similar to Gemba) and not just Execs and NEDs and incorporated into JD's and 'the way we do things around here'		2	2

	Domains	Action	Action2	Action3	Action4	RWT	WHT
	Building Improvement Capability and Capacity					**2.25**	**2.25**
20	Improvement capacity and capability building strategy	Proposed, as a minimum, Divisional triumvirates and Care Group/Directorate triumvirates attend one day QSIR fundamentals or bespoke training	Every area needs a defined leader for Improvement. (Agree what protected time would look like for this). For the individual and within the department.			3	3
21	Clear improvement methodology training and support	Identify the roles that have leadership and managerial responsibilities - and recommend Leadership for Improvement training.	QI presentation (video - 15 mins) at Trust induction - introducing the teams, huddle boards, this is what we do around here, how to register a project etc. All staff inductions including junior doctors.			2	2
22	Improvements measured with data and feedback					2	2
23	Co-production					2	2
24	Staff attend daily huddles					2	2

	Domains	Action	Action2	Action3	Action4	RWT	WHT
	Embedding improvement into management systems and processes					**2.5**	**2.25**
25	Aligned goals	Agree 2 way process for agreement of improvement priorities between execs and divisions and then divisions and directorates/departments				2	2
26	Using the management system for planning and understanding	To consider as part of the Board development session to how data is presented and reported eg. alignment to the CQC domains	Trust board and Divisional meetings should have QI on the agendas and discussed.	Agree process for reporting against improvement priorities at all levels	Set out how resources are aligned and prioritised to support improvement work (information, HR, Comms, finance)	3	3
27	Using the management system to respond to local, system, and national priorities					2	2
28	Using the management system to integrate QI into everything we do					3	2

Document Title
Improvement & Research Group

Document Description	
Document type	Terms of Reference
Version	1.2

Lead Author(s)	
Name	Kate Salmon
Job Title	Deputy Chief Strategy Officer – Improvement & Collaboration

Change History				
Version	Date	Comments	Review Date	Ratification Date
1.0	22-11-22	Draft for review at IIR Group 02-12-22	02-12-22	
1.1	28-11-22	Comments from KW prior to circulation	02-12-22	
1.2	28-11-23	Amendment to reporting arrangements for Digital Innovation. Name change of the Group. Addition – CD R&D to membership.	17-11-23	TBC

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TERMS OF REFERENCE: Improvement & Research Group

RATIFIED BY: Trust Board

NEXT REVIEW DUE: 17-11-24

1. CONSTITUTION

Both Trust Boards approved a new reporting structure through the Joint Committee ((JC) shared Executive and Non-Executive Directors) to keep them fully appraised on common and shared issues and to monitor the implementation of the trusts' joint 5-year Strategy. There are several JC working groups that will report into a JC Steering Group; the Improvement & Research Group (IRG) is one of these groups, chaired by a Non-Executive Director.

2. PURPOSE

The IRG will provide a formal platform for reporting progress against the trusts Strategic Aims and Objectives involving Improvement and Research activities. It informs and supports the JC in delivering the Strategic Objectives of the trusts.
IRG will consider and address cross Trust and cross Divisional issues and risks.
The IRG will review performance of the three separate activities against any agreed action plans and where necessary, agree remedial actions. The IRG can delegate responsibility for specific aspects related to Improvement and Research to other subgroups and working groups.

3. MEMBERSHIP

The Membership of IRG will be (But not limited to):

Non-Executive Director (Chair)
Non-Executive Director – Digital (Deputy)
Chief Strategy Officer
Deputy Chief Executive/Group Chief Nursing Officer
Associate Medical Director – QI Team
Managing Director, Research & Development
Clinical Director, Research & Development
Medical Director or Deputy Medical Director RWT & WHT
Deputy Chief Strategy Officer – Improvement & Collaboration
Associate Director of Digital Innovation

4. ATTENDEES

If necessary, deputies can be nominated to attend prior to the meeting and identify themselves as such. Deputies are expected to attend briefed, read-in and ready to contribute.
The IRG may request the presence of any senior manager/clinician/member of staff to present or comment (with notice).
For the purpose of leadership development occasional shadowing at this meeting will be allowed following prior discussion and agreement with the Chair.

5. QUORUM

The Committee will be quorate when a minimum of four members with two from:
Chair/Deputy Chair
Chief Strategy Officer/Deputy Chief Strategy Officer
Medical Director or Deputy

6. FREQUENCY OF MEETINGS

IRG will meet on an approximately bi-monthly basis. Meetings will be expected to last no more than 1.5 hours routinely. Cancellation of meetings will be at the discretion of the Chair and extraordinary meetings of IRG may be called by any member of IRG, with the consent of the Chair.
IRG will meet as a minimum six times per year.

7. ESTABLISHMENT OF SUBGROUPS

IRG may establish Task and Finish Groups made up wholly or partly or lead by members of the IRG to support its work. IRG may delegate work to such groups in accordance with an agreed terms of reference and timeframe. The Chair of each group will be expected to provide a report to the IRG on a frequency agreed with the Chair.

8. ADMINISTRATIVE ARRANGEMENTS

The IRG is chaired by a nominated Non-Executive Director. The Chair and/or Deputy Chair of the IRG will agree the agenda for each meeting with the Deputy Chief Strategy Officer – Improvement & Collaboration. IRG shall be supported administratively by the Quality Improvement Team Administrator. Agenda and papers will be published at least five working days prior to the meeting.

8 ANNUAL CYCLE OF BUSINESS

The IRG will develop an annual cycle of business for approval by the Chair and Executive at the start of each financial year. The IRG work plans informs the standing agenda items as described within the terms of reference.

9 REPORTING ARRANGEMENTS

The approved actions and, where deemed necessary, brief topic/issues notes of each meeting shall be provided to the JC Steering Group for information, supported by an executive summary. The Chairman of the IRG shall provide a report of each meeting drawing to the attention of the JC Steering Group the actions agreed and any issues that require disclosure to the JC or require executive action.
The IRG shall receive and review reports of its subgroups.

10 RESPONSIBILITIES

Seek opinions on potential improvement and research opportunities.
The IRG will advise on and be responsible to the JC Steering Group on all matters relating to Improvement and Research. This will include the following activities:

- Provide direction to and monitor progress of the implementation of key strategic aims and objectives within scope
- Recommend to the JC Steering Group schemes and projects for the trusts to consider.
- Receive updates from the Quality Improvement Team Action plan and Research Plans and collate efforts where appropriate.
- Advise on any issues relating to the Joint Committee governance, risk management and compliance.

Receive regular updates and advice from the leads for Quality Improvement and Research including but not limited to:

- Policy development
- Strategy development and implementation
- Other developments
- National & local strategies, policies, and developments
- Legal issues

Review reports to the IRG with a view to advise the JC on any potential prospective strategic risks to inform the Board Assurance Framework (BAF), Trust Risk registers & Divisional risk registers.
Ensure the IRG undertakes an effectiveness self-assessment at least every 2 years (as a minimum and if still in existence).

11 AUTHORITY AND ACCOUNTABILITY

The IRG is authorised by the JC to investigate any activity within the scope of its terms of reference at either Trust on behalf of the Joint Committee including information and co-operation in its endeavours.
The IRG shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01).

12 STANDARDS

As with any group within either organisation, it operates with due diligence and reference where appropriate to:

- Risk Assessment Framework
- Well-Led Framework
- CQC Essential Standards of Quality and Safety
- Risk Management Standards

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting to be held in Public on 12 December 2023

Title of Report	Exception Report from the Integration Committee Chair	Enc No: 9.1
Author:	Lisa Cowley, Chair of Committee	
Presenter:	Lisa Cowley, Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	28th November 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.

The Board is asked to review and approve the Terms of Reference for the Integration committee.

ALERT

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

No new alerts for the Board.

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

The Committee received further progress updates in relation to the System Operating Model, the committee were confident that there has been sufficient involvement and oversight from the Executive team. Further progress is anticipated in advance of the January committee meeting and the committee propose to bring a more detailed progress report and update to the February 2024 Trust Board.

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

The Committee received positive updates in relation to the progress at OneWolverhampton, especially in relation to broader Stakeholder engagement, with the Stakeholder Forum held on 28.11.2023.

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

The committee reviewed and agreed the Terms of Reference, which are enclosed for Board approval. As this is a newly formed committee and the integration landscape is evolving the committee agreed to regular reflect on the ToRs to ensure they remain appropriate and relevant.

A positive discussion was held in relation to the progress of OneWolverhampton and a broader discussion regarding integration agenda across the Black Country and within other systems that the Trust interacts. The committee were assured that the Trust has effective and positive relationships at all levels.

The report into the Joint Vision for Community Services gave the committee positive assurance that progress is being made both in relation to progressing provision in each Place and exploring opportunities for joint working and learning. There were updates on work plans for 2023/4 and plans for 2024/5. The committee were assured that the teams are working collaboratively with partners across Health & Social Care. There were some initial conversations regarding the Behavioural Science research and how this can be developed and utilised to increase engagement and confidence.

The Board metrics that the committee has oversight over were discussed and performance considered within the context of the broader system and the time of the year. There was nothing within the metrics that the committee consider requires Board attention. There was further discussion on how the committee ensures effective oversight of the impact of integration on other metrics and interrelationships with other committees.

The BAF was reviewed and the committee agreed there were no changes required.

The Place Performance Highlights focused on community services. It was noted that RWTs Virtual Wards are held up as an exemplar. There has been a dip in referrals from WMAS recently and the team are working collaboratively to increase engagement. There was positive assurance that UCR does result in admission avoidance. The team updated on the alteration to the care coordination model that has resulted in increased referrals. There were positive discussions regarding effective communication regarding the role of virtual ward in safe and timely discharge. The committee received updates on progress in relation to Place based support for patients outside of hospital including digital developments and investment in social care.

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

Report Journey/ follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 28th November
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

The Royal Wolverhampton NHS Trust

EXCEPTION REPORT FROM INTEGRATION COMMITTEE CHAIR

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

- Approval of the Integration Committee Terms of Reference
- System Operating Model is progressing and it is proposed that there will be further discussion at the January 2024 Integration Committee and an update provided for the February 2024 Trust Board.

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

The Committee received the following reports:

- Development and Progress of OneWolverhampton Place Based Partnership Presentation including an update on the System Operating Model
- Joint Vision for Community Services
- Board Metrics report
- Place Performance Highlights

Matters presented for information or noting

- Annexes to Joint Vision for Community Services, related to research into clinical engagement with Virtual Wards
- IQPR
- Board Assurance Framework

Chair's comments on the effectiveness of the meeting:

Prior to the meeting there had been beneficial reflection on the purpose of the committee and key areas for consideration and discussion. This supported the positive and constructive discussion during the meeting.

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting to be held in Public on 12 December 2023

Title of Report	Exception Report from the Integration Committee Chair	Enc No: 9.1
Author:	Lisa Cowley, Chair of Committee	
Presenter:	Lisa Cowley, Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	24th October 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.

ALERT

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

The Committee has noted an emerging risk in relation to the impact of delegation on the Trust. This is emergent and not a current risk. This is noted by the Committee and will be added to the risk register at the appropriate time.

ADVISE

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

The Committee noted the need for the Integration Committee to retain focus on the role of the Trust with regards to integration, it's role with regard to the developing delegation agenda and also it's role as a positive influencer to the Place Based Partnership**.**

The Committee noted the importance of being sighted on the performance of community services from an integration perspective, and recognised that the formal reporting of performance will be retained by the Finance Committee.

ASSURE

Positive assurances & highlights of note for the Board/Committee

The Committee accepted its responsibilities for oversight of three Board metrics:

Delivery of the 2 hour urgent community response standard (note this does not include the 76% A&E target)
Increase from March 23 in the number of patients being cared for in Virtual Wards by March 24
Reduction in number of medically fit for discharge patients (noted in the Integrated Quality Performance Report as no criteria to reside) from 22/23 at RWT

Board to note that these metrics have now transferred to the Integration Committee for oversight and assurance. It is noted that the delivery of these metrics is a collaborative approach.

The committee noted the need to also be sighted on other wider metrics whose performance will impact on the delivery of the three metrics that the Committee has responsibility for. They also discussed the need to consider other metrics where integration would be influential.

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

This was the first full meeting of the Trust Integration Committee. The draft Terms of Reference were considered and it was agreed that a revised version would be tabled at the November committee and then tabled for full Board approval in December.

The committee noted the development and performance of OneWolverhampton (the name of the place based partnership) and the Trust's fundamental role in its success to date and ongoing development. The committee reflected on the stakeholders involved in the place based partnership and recommended additional stakeholders for inclusion including education and care providers.

It was noted that the trust interacts with other Places and there was a consensus that the committee should consider the relationship with wider Place Based partnerships and the broader integration culture of the Trust. The committee acknowledged this is an evolving situation and would require regular review.

The Committee discussed and agreed with the recommendation from Finance Committee that the emerging risk in relation to delegation and potential impact on the Trust is transferred from the Finance Committee to the Integration Committee. It was noted by the Committee that this is not a current risk but emerging and will be kept under review.

The Committee agreed to take oversight and assurance responsibility for the three Board metrics referenced above in this committee report and to be sighted on the performance of other metrics which will be impact on the delivery of Committee metrics. There were positive discussions regarding virtual ward performance and the potential to increase capacity and performance.

The Committee reflected on the recent System Operating Model that has been shared by the ICB and noted the impending receipt of the updated model which will be discussed at the Committee meeting in November.

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

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

Report Journey/ follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to Work Plan)	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: 24th October
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

The Royal Wolverhampton NHS Trust

EXCEPTION REPORT FROM INTEGRATION COMMITTEE CHAIR

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

There is an emerging risk in relation to the impact of delegation on the Trust. This will be kept under review by the Committee.

The Committee agreed to take oversight and assurance of the following Board metrics:

Delivery of the 2 hour urgent community response standard (note this does not include the 76% A&E target)
Increase from March 23 in the number of patients being cared for in Virtual Wards by March 24
Reduction in number of medically fit for discharge patients (noted in the Integrated Quality Performance Report as no criteria to reside) from 22/23 at RWT

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

The Committee received the following reports:

- Development and Progress of OneWolverhampton Place Based Partnership Presentation
- OneWolverhampton Stakeholder Map
- Integrated Quality Performance Report
- Black Country System Operating Model
- Place Performance Pack (Community Services)

Matters presented for information or noting

Chair's comments on the effectiveness of the meeting:

This was the first full committee meeting and there was positive discussion on the purpose of the committee and its interaction with other committees and Place to prevent repetition and ensure effective oversight.

INTEGRATION COMMITTEE

TERMS OF REFERENCE

Trust Strategic Aims	Strategic Aim	Associated Strategic Objectives
	1. Excel in the delivery of Care *We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.*	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 communities and populations.
	2. Support our Colleagues *We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.*	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 Standard.
	3. Improve the health of our Communities *We will positively contribute to the health and wellbeing of the communities we serve.*	Develop a health inequalities strategy Reduction in the carbon footprint of clinical services by 1st April 2025. Deliver improvements at PLACE in the health of our communities.
	4. Effective Collaboration *We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.*	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.
BAF Risks	None at present.	

Meeting Purpose/Remit	To provide assurance to the Board that patient care is of the highest achievable standard and in accordance with all statutory and regulatory requirements. To provide assurance of proactive management and early detection of risks across the Trust. The purpose of the Committee is to provide the Board with assurance concerning the strategy and delivery plans for the Trust's Community Strategic Objective. The Committee will ensure that the performance and development of community-based services/primary care services for people of all ages. The Committee will provide oversight of the Trust's role in the development of the Place Based Partnership, meeting the objectives described within the Annual Operating Plan. The Committee will review evidence for assurance that the Trust services are well governed to the Trust Board. The Committee will ensure the Board is sighted on the progress of the Place Based Partnership and will act as a critical friend as required. The Committee will receive evidence for assurance on the Trust's role in supporting the Place Based Partnership in developing consensus based realistic and deliverable local strategy. The Committee will ensure it receives evidence for assurance oversight of the RWT services in scope of the Place Based Partnership. The Committee will ensure it has sight of evidence relating to wider community services development in the vision for community services and out of hospital model of care. The Committee will seek to contribute to the wider work in the Community regarding: • Socio Economic development • Sustainability and the Green Strategic plan • Widening participation • Regeneration plans with partners • Anchor institution
Responsibilities	The purpose of the Committee is to provide the Board with assurance from the review of evidence concerning the delivery of the Trusts `Improving the health of our communities' strategic aim and objectives. The Integration Committee will provide the connection between the OneWolverhampton Partnership and the Trust Board, ensuring that the Board is kept up to date on the progress, risks, issues and achievements of the Partnership Board in relation to: Supporting the development of the consensus-based local strategy Delivery of community services as part of realising the strategy. Provide oversight of the Trust services with the Partnership. Ensure oversight of the wider community services development.

The Committee will work with the other board committees to ensure that full oversight of the areas of responsibility are covered.

The key responsibilities of the committee can be categorised as follows:

- Provide oversight of any potential Board Assurance Framework risks relating to its area of function.
- Promote commitment to the OneWolverhampton Partnership.
- Ensure the delivery of the Trust and Place Strategies.
- Recognise areas beyond the scope, control and responsibility of the Trust that nevertheless impact on service delivery.
- Seek mitigations from other responsible organisations where this adversely impact on the performance of Trust services.
- Receive the transformation plans for the development of local Partnerships supporting both Place and Trust strategies.
- Seek evidence for assurance of robust delivery of plans within the scope of the Place Based Partnerships, anchor partnership work and the Trusts role within them.
- Seek assurance on the adequacy of the work with partners to integrate operational services with those that the Trust runs to improve quality, effectiveness, and sustainability.
- Ensure that plans realise the ambition of addressing the wider determinants of health and health inequalities.
- Seek evidence for assurance of adequate plans to develop the partnership working as a 'virtual organisation' removing barriers between organisations and developing towards a single operating framework.
- Seek evidence for assurance of adequate plans to develop each Place Based partnership in line with the Integrating Care White Paper.
- Seek evidence for assurance on any additional matters referred to the Committee from the Board.
- The Committee will use the key performance indicators dashboard to identify the impact on wider Trust services and will link with the Quality and Finance Committees accordingly.
- The Committee will seek evidence for assurance regarding data sharing agreements in place across the partnership to enable full view of the data impacting on the development of community based and integrated services.

Authority & Accountabilities	The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions. The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.
Reporting Arrangements	The Committee reports to the Board of Directors. The Committee Chair shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities. The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns.
Membership	The Committee shall comprise of two Non-Executive Directors (one of whom will be the Chair) and four Trust Executive Directors: • Chief Operating Officer • Group Director of Place • Chief Medical Officer • Chief Nursing Officer The Board of Directors will review membership of the Committee at least annually to ensure that it meets the evolving needs of the Trust. The members set out above shall be expected to attend all meetings and such attendance shall be reported in the Committee's Annual Report to the Trust Board. The partner representatives will be invited to attend the committee as and when the business of the Committee requires: • Place Managing Director for Black Country Integrated Care Board • Director of Adult Social Care – City of Wolverhampton Council • Director of Public Health – City of Wolverhampton Council • Director of Children's Services – City of Wolverhampton Council • Chief Strategy Officer, Black Country Healthcare NHS Foundation Trust • Representative of Wolverhampton Primary Care Collaborative This is an indicative and not exhaustive list. Nominated deputies may attend in the absence of a member and must be fully briefed (the deputy does not form part of the quorum group). In the absence of the designated Chair, the Chair will identify and brief another Non-executive Director to Chair the meeting.

Attendance	The following shall be required to attend regularly and receive papers. • Chief Strategy Officer • Deputy Chief Operating Officer/OneWolverhampton Partnership Director • Associate Group Chief Medical Officer for Community Services Other members of the Board are entitled to attend and have access to the papers. In addition, other directors/managers/staff are required to attend meetings as requested, appropriate to the issues under discussion. The Group Company Secretary will expect the administrative support of the Group Director of Place to provide an efficient secretariat service to the Group.
Chair	Non-Executive Chair
Quorum	A quorum will consist of at least two Directors, of which at least one must be a Non-Executive Director and one Executive Director.
Frequency of meetings	The Committee will meet at least 9 meetings a year, monthly except for December and August. It is expected that members will attend at least 50+% of the meetings. The agenda will be circulated with papers 7 days before the meeting. Late papers will only be accepted by agreement of the Chair of the Committee and Group Director of Place. Additional meetings may be held at the discretion of the Committee Chair following discussion with the Group Director of Place. Where members of the Committee are unable to attend a scheduled meeting, they must provide their apologies, in a timely manner, to the Secretariat of the Group and provide a deputy.
Administrative support	The meeting will be supported by the Executive Assistant to the Group Director of Place (Executive Lead for the committee).
Standards	• NHS Oversight Framework – June 2022 (NHSE) • H&SC Act Fundamental Standards of Care • CQC Provider guidance on meeting the Fundamental Standards • Annual Governance Statement • CQC Well Led Inspection Framework • Black Country Integrated Care System Operating Model • Black Country Integrated Care Strategy

Standard Agenda	• BAF and TRR • Board Metrics • Subgroup reports • Compliance/Performance (via Integrated Quality and Performance report, Compliance reports) • Development of OneWolverhampton • Themed review items • Committee action log
Subgroups	Under review.
Date Approved	November 2023
Date Review	April 2024

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public on 12th December 2023		
Title of Report:	Group Director of Place Update	Enc No: 9.2
Author:	Stephanie Cartwright – Group Director of Place; 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 the ongoing development work across Wolverhampton Place in the form of OneWolverhampton partnership.

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	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:

The Royal Wolverhampton NHS Trust

Board Committees	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure Good progress continues to be made in relation to the development of the OneWolverhampton Place Based Partnership with productive conversations about next steps for the partnership in relation to delegation from the ICB. Progress continues on the joint work across community services across the Wolverhampton and Walsall Group. A OneWolverhampton Stakeholder Forum took place on 28th November 2023 with excellent feedback and positive energy for more involvement. Trust colleagues are heavily involved in the production of the Black Country System Operating Model.
Advise The first two meetings of the Integration Committee have taken place (a separate Board report has been provided). The OneWolverhampton Partnership will be establishing an Acute Respiratory Infections (ARI) Hub at the beginning of December.
Alert The delegation of activity to place presents considerable opportunities for the development of OneWolverhampton through a hosted model. An options appraisal is currently underway for models of hosting and will be presented with recommendation to the Trust Board in February.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
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The Royal Wolverhampton NHS Trust

Group Director of Place Update

Report to Trust Board Meeting to be held in Public on 12th December 2023

EXECUTIVE SUMMARY

Board Development and Good Governance:

A Board away day was held in October which was very positively received. It has supported a strengthening of relationships within the OneWolverhampton Board, a greater understanding of how to navigate the partnership space, and also the creation of a Board development agenda. The away day included a Board effectiveness survey to support good governance. The results were overwhelmingly positive and suggestions have been made to strengthen the functioning of the Board. These recommendations will be taken to OneWolverhampton Board in December for support and sign-off.

To ensure good governance throughout the Partnership, the same effectiveness survey has been conducted for each of the Strategic Working Groups (SWGs). SWG members were asked whether the groups were truly demonstrating partnership working, undertaking work that could not be undertaken elsewhere in the system, and whether they were delivering impactful changes. Similar to the Board survey, the feedback has been overwhelmingly positive and with a high response rate. A few small changes are being made to increase the effectiveness of groups where suggestions have been made.

Stakeholder Engagement Event:

We hosted our first Stakeholder Engagement Event on the 28th of November 2023 to share the successes and developments made by OneWolverhampton since its inception in June 2022. We had over 50 attendees which encompassed a broad range of stakeholders – including education, West Midlands Fire and Rescue, West Midlands Police, and attendees from across the community and voluntary sector and primary care.

The workshop encompassed an understanding of the successes of OneWolverhampton and how we have capitalised on the legacy of successful partnership working within the city. This included a carousel event where each Strategic Working Group was able to discuss their achievements and plans, including:

- The creation of a city-wide winter plan
- The mobilisation of a city centre Health Hub
- Creation of a joint Falls Response Service
- Creatin of a dedicated Care Homes Support workstream to encompass the development of a standardised framework and a Care Homes Academy
- Piloting a revised approach to cervical cancer screening
- Developing a standard for Multi-Disciplinary Team working in Primary Care
- Ongoing implementation of the Asthma Friendly Schools programme

The feedback was overwhelmingly positive and there was a very high level of energy in the room. We will establish a Stakeholder Reference Group to ensure linkages with the wider partnership, and have committed to hosting further, similar events in the future to raise the profile of and engagement with OneWolverhampton.

Acute Respiratory Infection (ARI) hubs:

To support the delivery plan for recovering urgent and emergency care services, a new service is being mobilised in Wolverhampton to support patients with acute respiratory infections (ARIs). Due to funding constraints this has not been possible in all Black Country Places. However, as a result of the collaborative approach we have taken to funding decisions in Wolverhampton, we have been able to mobilise this service to support wider system pressures and flow.

The ARI Hub will support patients with urgent clinical needs by enhancing same-day access to assessment and specialist advice as needed. The ARI Hub will provide an additional 48 appointments a day and will operate from 1pm to 8pm, Monday to Friday, commencing on Monday the 4th of December.

The service is Primary-care-led and is being delivered by Unity East Primary Care Network (PCN). The mobilisation has been very much a partnership approach, with RWT providing clinical rooms for the service at the Phoenix Centre. The co-location of these services will ensure that, where appropriate, patients can be pulled from the Urgent Treatment Centre (UTC) waiting list to be seen by the ARI hub. This will the wider system by providing additional capacity for patients to ensure that they can be seen in the most appropriate service. This additional capacity will also support system-wide pressures by reducing ambulance call-outs, A&E attendances and hospital admissions for patients who could be managed in the community.

The Mander Centre Health Hub:

Following the update provided in the previous Board report, we have continued to develop the range of services being delivered from the Mander Centre. This has included the development of sexual health services and also phlebotomy services. The initial phlebotomy clinics have proven popular and were fully booked shortly after being opened. Following an initial trial period, plans are in place to increase the volume of phlebotomy clinics from the Mander Centre.

Supporting Mental Health support for the city – Right Care, Right Person Model:

Following implementation of the Right Care, Right Person model within policing, the response for Wolverhampton has been driven through OneWolverhampton. The model is aimed at making sure the right agency deals with health related calls, rather than the police being the default first response. This has ensured that we take a holistic, multi-professional approach and links to our ambition to make mental health everybody's business. This is due to be fully embedded by the Autumn of 2024, but the partnership is working on the agenda now to encourage any changes to embed more smoothly. The work is being led by Black Country Healthcare NHS Foundation Trust.

Delegation from the ICB to Place Based Partnerships

Work continues with the ICB and Black Country system colleagues on the progress towards delegation/devolution of some ICB responsibilities to place based partnerships from April 2024. The intention is that for the first year this would include community services and some areas of primary care development through a hosted model. The hosted model is currently being discussed within the partnership and the role of host could potentially be held by the Trust. Different places across the Black Country are likely to take a phased approach to delegation (based on ambition and track record of partnership working) and there is likely to be opportunity for a lead provider model (should that suit the partnership) from April 2025. An options appraisal for a hosted model is being prepared and will be presented to Board in February 2024.

The process for delegation and how it sits in the wider system is described in the System Operating Model that is currently being drafted by ICB colleagues. Trust colleagues are heavily involved in the development of the System Operating Model and provide regular feedback on various versions through the model development.

Integration Committee

The newly established Integration Committee has now met twice (at the end of October and November). The Committee is focused on the Trust's role with regards to integration both internally and across the place based partnership(s). The committee closely reviews the three Board metrics around urgent community response, virtual wards and patients who are medically fit for discharge, reviews the progress towards delegation/devolution to place based partnerships from the ICB and focusses on the Trust's role in regards to integration in the place, Black Country and wider system.

Joint Vision for Community Services

Work continues on the joint vision for community services across the Wolverhampton and Walsall Group. A working group has been established with 3 priorities:

1. Digital alignment & development
2. Joint working on out of hours (OOHs) support and care co-ordination model
3. Joint working on protocols and referral pathways

Progress to date has been as follows:

Sharing and alignment of protocols and pathways

- Protocols in development (stacking 2 hour urgent community response, falls, heads & lacerations, call to convey)
- Urgent Community Response and cross border agreement to referrals (GP registered versus LA boundary)
- Reviewed both out of hospital support and care co-ordination models & identified variance and best practice. A management plan for sharing calls out of hours has been agreed & is awaiting clinical sign off.
- A single Black Country telephone number (hosted by Sandwell) for West Midlands Ambulance Service for community response that will divert to the four care co-ordination centres

There is also a piece of working taking place across Black Country community providers to look at areas of best practice, particularly in relation to winter pressures.

RECOMMENDATIONS

The Board is asked to note the contents of the report and the continued development of OneWolverhampton place based partnership.

The Royal Wolverhampton NHS Trust

Title of Report	Exception Report from the Quality Committee	Enc No: 10.1
Author:	Louise Toner	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	22nd November 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 remains in Tier 2 scrutiny regarding its cancer metrics. However, the committee was assured that the Trust is meeting the 28-day faster diagnosis national performance standard, and it is anticipated that this will continue with the Trust meeting the 75% required target by the end of March 2024. It has to be recognised that achieving this will be dependent on histopathology turnaround times and other diagnostic measures.

In respect of the 62- day backlog numbers, there has been some improvement in the trust performance with the projected numbers by the end of March initially identified as 217 is now on target to be 205.

In respect of the 62-day constitutional standard, which is set at 70% by the end of March 2024, it was confirmed that the trust will not be in a position to meet this in the timeframe with gynaecology, lung and urology patients facing the most challenges.

Mutual aid continues to be accessed as required, in some instances subject to patient choice.

Diagnostics remain particularly challenging; however, some signs of improved performance are evident in respect of histopathology for some tumour sites. Ultrasound scanning capacity in obstetrics is a particular cause for concern, however, WHT is assisting, and it is hoped Shrewsbury and Telford will also come on board.

ADVISE

- C difficile cases remain above trajectory with 10 cases this month and E Coli infections are continuing to increase – 34 in month , however, there have been no specific themes identified and work continues under the direction of the IP team. A delivery plan in place which includes education and training, hand hygiene. The Deep Cleaning Facility has now ceased to operate give the winter plan and bed pressures however, the Permanent Patient Equipment Cleaning Centre is now operational. This is in addition to the cleaning undertaken within wards and departments. The Trust participated in antimicrobial week.

- The number of pressure ulcers has increased in month with oversight continued through the Tissue Viability Steering Group with a range of education and training being undertaken. It was noted that new guidance has been received for implementation by April 2024. A gap

analysis is being undertaken to ensure the Trust meets the new requirements within the necessary timeframe. Pressure ulcers are a key element of the Fundamentals of Care standards together with falls, nutrition and hydration with The Malnutrition Universal Screening Tool (MUST) scores showing signs of improvement.

- Observations on time compliance has improved to 89.9% and the focus on The National Early Warning Score (NEWS 2) Scale 2 continues with a number of activities in place and being reviewed by the Deteriorating Patient Group.

- The Clinical Accreditation programme continues with a programme evaluation planned early in the new year.

- MFFD/Criteria to reside patients were reduced to 47 patients a continuing, albeit slow improving picture over the last 3 months.

- Appraisal rates continue to be below target 84.90% against a target of 90%

- Ambulance handovers have shown some deterioration as has the increase in the acuity of patients who attend the Emergency Department (ED) and, in particular, the increasing numbers of patients with Mental Health issues and given the shortage of mental health beds this increases the strain on an already busy ED.

- Smoking at the time of delivery has deteriorate this month to 9.3% against a target of <7.

- Neonatal staffing in respect of those “Qualified in Specialty” does not currently meet BAPEM Standards. This is being addressed at national, regional and local levels.

- Stroke performance whilst still meeting the set target is showing some deterioration, the committee were advised that this was due to demand and capacity.

- The New Medical Model of Care is continuing whereby consultants see and stream patients in ED to improve patient flows and avoid admission where this is not required.

- VTE Compliance remains challenging in a number of areas with 50 hospital acquired cases in quarter 1.

- Sepsis screening performance in ED is particularly good, however, the administration of antibiotics within 1 hour has been challenging, given the acuity of “waiting room” patients and the time taken for triage. As a result, an Immediate Care Clinician is now working with colleagues in triage to enable antibiotics to be commenced at that point. It was noted that new guidance is being issue that will impact the 1-hour antibiotic administration requirement.

- Clinical Fellows, currently in the pipeline are being reviewed in respect of their English Language competence in line with the requirements of the relevant regulatory body.

- RTT Incomplete Pathway is at 55.90% against a target of 92% and the RTT 78+ weeks has 61 patients waiting against a target of 70 – these are mainly urology patients, and it is anticipated this will be 0 by the end of November 2023. However, there remains an extremely high number of individuals on the waiting list.

- The Virtual Ward and the Rapid Intervention Team referrals are increasing; however, the committee were assured that there is sufficient staffing in place.

- Changes have been made with regard to the Clinical Hematology Unit and Durnal following a quality review visit. The changes have been made to ensure patients receive the best possible care within the right environment by appropriately training staff.

- It was reported that Patient Safety Incident Response Framework (PSIRF) has now been launched and that there will be changes in the reporting and that the SI report will no longer come to Quality Committee but be replaced with a PSIRF report.

- The Trust Clinical Audit plan was discussed and our compliance with national and other audits. It was identified that whilst there is room for improvement in compliance there has been no patient harm. There is a review across both Trust with a view to establishing a cross trust audit team.

- It was reported that there had been 2 anonymous concerns sent to the CQC that resulted in a robust response and an invite for the ICB to visit. The visit had a positive outcome, and a report is expected shortly. An ICS Visit is also due where any concerns can also be discussed.

- Maternity staffing is now at 0.7% vacancy with a mix of newly qualified staff and clinical fellows now in place.

- There has been an increase in the number of bookings for births at RWT which we will around 5000 by the end of the year. However, there is the resource to manage these numbers, however, this will be kept under review.

- There has been an increase in the number of still births across the Black Country with RWT conducted its own internal review. This is in addition to the Black Country Review that is taking place involving the LMNS and the ICB with a report expected at the end of January.

- Some challenges with the urology pathway across RWT and WHT was discussed, and it was agreed that the Chief Operating Officer, Clinical Director and Executive Chief Nurse compile a paper for consideration at the January meeting of the Quality Committee.

ASSURE

Positive assurances & highlights of note for the Board/Committee

- The Trust vacancy rates, retention rates and maternity leave continues to be above target, with Dieticians, Health Visitors and Speech and Language Therapist being the exception.

- The Trusts is 100% compliant with the reporting, review and monitoring of perinatal deaths in line with the national best practice standards.

- The maternity services team are confident that the Trust will be compliant with year 5 of the Clinical Negligence Scheme for Trusts (CNST) due for submission in February. It is intended to seek Trust Board approval that the Quality Committee" sign off" the CNST submission at its December meeting following a check and challenge meeting prior to this. It would then be reported at the February Trust Board.

- Maternity services are currently working through the 3-year Single Delivery Plan with assistance provided by the Trusts internal auditors.

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed.	**Board Assurance Framework (BAF)** It was agreed that there were no changes required for the 4 current BAF risks and, after consideration, it was agreed to keep 9B on the BAF ""watch" list given the continuing level of scrutiny being faced by maternity services. It was noted that the Trust is in Segment 2 of the NHSE Standard Oversight Framework and is subject to quarterly review. **Trust Risk Register (TRR)** There was one new risk this month: 5677 – Speech and Language Therapy (SLT) Staffing levels and the inability to deliver an effective service. This new risk gave rise to discussion in respect of the Sentinel Stroke National Audit Programme and the National Confidential Enquiry into Patient Outcomes and Deaths in respect of swallowing assessments. One risk was removed: 5536 – Clinisys no longer supporting the CSAS system 6 red risks remain. It was reported that a new Risk Management Framework is being developed across RWT and WHT and discussion took place regarding the escalations of risks with RWT doing this at 12 points and WHT at 15. Both are acceptable and in line with other trusts with the majority using 15. An agreement will be required to inform the new framework.		
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:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:

Summary of Key Issues:
The key issues are: • Cancer Improvement Plan and the continuation of Tier 2 scrutiny.

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 inequality 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 both Quality Committees	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 remains in Tier 2 scrutiny regarding our cancer metrics as identified in the ALERT section above.

Trust Board approval is being sought to allow the Quality Committee to "sign off" the CNST submission at its December meeting following a check and challenge meeting prior to this. It would then be reported at the February Trust Board.

It was noted that the Trusts has received a request for data in respect of neonatal services as part of the Thirwall Public Enquiry established as a result of the Lucy Letby case. The Chief Medical Officer is leading the Trusts response.

ACTIVITY SUMMARY

In addition to the lists below there was some discussion re the new Integrated Care Committee that has now started to meet. The Committee will be considering the community-related data; however, this data will still come to the Quality Committee to ensure oversight across the whole Trust and in particular to identify where there may be specific challenges across hospital and community services.

Matters presented for information or noting.

- Board Assurance Framework and Trust Risk Register
- Chief Nursing Officer Report
- Integrated Quality and Performance Report
- Cancer Overview
- QSAG Chair's Report
- Infection Prevention and Control Report
- Litigation and Inquest Report
- Maternity Services Governance Report and Single Delivery Plan
- Trust Clinical Audit Plan

Chair's comments on the effectiveness of the meeting:

The meeting ran to time with some good discussion on the papers presented.

The Royal Wolverhampton NHS Trust

Title of Report	Quality Committee Chair's Report	Enc No: 10.1
Author:	Louise Toner	
Presenter:	Chair of Committee	
Date(s) of Committee/Group Meetings since last Board meeting:	25th October 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 confirmation that it remains in Tier 2 scrutiny at the present time. There has been a change in the cancer targets since the 1st of October 2923 with the 28-day faster diagnosis standard, 31 day combined target and the 62-day combined target used for reporting. Our performance with the 28-day faster diagnosis standard is meeting the 70% target and we are on schedule to achieve the 75% target by the end of March 2024. In respect of the 62-day backlog, there were 226 patients in this category with 100 related to urology. The target agreed with the ICB and NHSE is for 217 by the end of March 2024 and the Trust expects to reach this target. However, this impacts on achieving the 70% target of patient being treated within 62 days we are currently well below this target with the three most challenging tumour sites being Urology, Gynaecology and Lung with mutual aid continuing where possible for Urology in London (Kidney) and Northampton(Prostate). Work is being undertaken for each tumour site re when the target will be met. Our performance with this metric could result in the Trust being placed in Tier 1 scrutiny but it is hoped that the collaborative work being undertaken with the ICB and NHSE will keep us in Tier 2. As a result of being in Tier 2 we are receiving some additional funding in support of improving the Trusts performance.

- Diagnostics remain particularly challenging. However, endoscopy performance is improving with some outsourcing as is histopathology with additional session being undertaken, outsourcing and more clarity by clinicians when an urgent report is required as the patient is on a cancer pathway. and additional consultants and outsourcing are resulting in a small improvement however, the skin cancer performance has shown a very slight improvement. Further, Moh's surgery has just commenced at the Trust with the first 2 patients receiving treatment. Discussion took place regarding the Community Diagnostics Centre's 7 day working and it was reported that the plan would be to offer a 6-day service with Waiting List Initiatives taking place on a Sunday but with a view to 7 days working.

- The implementation of Teledermatology with GP's has not been as successful as had been anticipated. This is under review by the ICB with a view to making the required changes to improve the uptake.

ADVISE

- C difficile cases remain above trajectory with 10 cases this month; with E Coli infections also increasing; ongoing actions are in place led by the IP team. Deep cleaning has now commenced using the using the decant facility, however this will cease as the facility will be used for the provision of more beds as part of the winter plan. There will be a Permanent Patient Equipment Cleaning Centre available from November 2023.
- The number of pressure ulcers had decreased but the numbers are beginning to show an upturn again.100 new hybrid mattresses have been ordered and the themed analysis is underway. Further consideration is being given to a rolling programme for mattress replacement. There are Rapid Improvement Facilitators in place, however, it appears when they are no longer in an area, care reverts to how it is “usually.” This links with the Fundamentals of Care Standards education and training.
- Observations on time compliance has improved to 87.32. Focus on NEWS” Scale 2 continues.
- Sepsis screening whilst 100% in ED with 87.50% in inpatients. However, antibiotic administration
- MFFD/Criteria to reside patients were reduced 60 in August to 51 in September.
- Appraisal rates continue to be below target despite this being widely promoted.
- Ambulance handovers demonstrate an improving picture, however, there has been an increase in the acuity of patients who attend ED and are in the waiting room to be reviewed. The Executive Significant Event Review Group has requested a thematic analysis following such activity undertaken earlier in the year which ED found vert useful.
- Smoking at the time of delivery has improved to 8.8% against a target of <7.
- Stroke performance is still meeting the set target; however, some deterioration was identified largely due to demand and capacity.
- A New Medical Model of Care initiative is underway where consultants have reviewed the ways in which they work to see and stream patients in Ed to improve patient flows and avoid admission where this is not required.
- Fundamentals of Care package being delivered to Band 5 staff to improve overall performance in respect of these aspects of care.
- VTE Compliance remains challenging in a number of areas.
- The Clinical Fellows identified as completing their CBT assessment at a test centre that is now under review will have three attempts at passing the test. If they fail on the 3rd attempt, they will be offered the opportunity of taking up a Health Care Support Worker role.
- Diagnostics remains challenging with ultrasound capacity from a general more than a cancer care perspective and obstetrics in particular.
- RTT Incomplete Pathway is at 54.75% against a target of 92% and the RTT 78+ weeks has shown a deterioration in month of 50 patients – mainly urology patients.
- National Patient safety Alert received re Beds and Bed rails – task and finish group have been set up and assurance has been provided re beds so looking specifically at trolleys given the service contracts involved.

ASSURE

Positive assurances & highlights of note for the Board/Committee

- The Trust vacancy rate is 2.31%. Challenges with the recruitment of Dieticians and Health Visitors
- Mandatory Training, retention and turnover remain at or slightly above target.
- Integrated care services are performing well.
- CQI report was presented for information with some excellent improvements taking place and good to see the CQI Initiatives across the various clinical and non-clinical groups. NHS IMPACT in operation to facilitate an NHSE wide approach to improvement.
- The SHMI is 0.9063
- 104-day Harm – nothing to report

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed.	Other than in respect of matters arising there was no discussion this month re the BAF or TRR.		
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:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:

Summary of Key Issues:
The key issues are: • Cancer Improvement Plan and the continuation of Tier 2 scrutiny.

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
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Report Journey/Destination Significant follow up action commissioned (including discussions with other Board Committees, Working Groups, changes to	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	Yes☒No☐	Date: Ongoing

Work Plan)	aligning QPES and QGAC		
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 remains in Tier 2 letter scrutiny regarding our 62 and 31 day waits as identified in the ALERT section above.
ACTIVITY SUMMARY Please see list below
Matters presented for information or noting. • Chief Nursing Officer Report • Integrated Quality and Performance Report • Cancer Overview • QSAG Chair's Report • Patient Experience Bimonthly Report • CQI report
Chair's comments on the effectiveness of the meeting: A somewhat light meeting in respect of the papers presented. The CQI and Patient Experience Reports had already been presented at Board – this was as a result of the cancelled QSAG meeting. However, some particularly useful discussion regarding the Cancer metrics and fundamentals of care.

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public On 12th December 2023		
Title of Report:	Chief Nursing Officer Report.	Enc No: 10.2
Author:	Martina Morris and Catherine Wilson, Deputy Chief Nursing Officers	
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): 12 (Medium 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	The risk score for the Mental Capacity and Deprivation of Liberty Safeguards (DoLS) Assessments risk has been reduced to 12 (amber) from 15 (red) as a result of the positive impact made through the mitigations put in place.		
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	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 (TMC) – 24/11/2023
	Board Committee	Yes☒No☐	Date: Quality Committee (QC) – 22/11/2023
	Board of Directors	Yes☐No☒	Date: N/A
	Other	Yes☐No☒	Date: N/A

Summary of Key Issues using Assure, Advise and Alert

Assure

- A stable vacancy position for Registered Nurses and Midwives remains.
- The Clinical Accreditation programme continues to progress in line with the plan.
- Falls per 1000 occupied bed days continues to show special cause improvement.
- The number of Deprivation of Liberty Safeguards applications have continued to rise during Q2 2023/24.
- Safeguarding supervision compliance for both, Health Visitors and School Nurses, has demonstrated sustained improvement.

Advise

- Sickness absence has decreased this month.
- The Trust has received a request for evidence in line with the Thirwall Inquiry into Neonatal services and the Chief Medical Officer is leading on providing the Trust's response.
- A notification of the system wide review of perinatal mortality has been received via the Integrated Care System.
- Support to the Emergency Department (ED) and Diabetes specialties continues from the Patient Experience Team with regards to complaints. Specific to ED, a deep dive will be undertaken to determine whether the theme of attitude relates to a specific staff group. In addition, a refresh of the managing aggression and violence training will be undertaken.
- The Trust has won the collaborative bid with Birmingham City University to deliver the ACCEND Leadership in Cancer programme in-house and work to develop it will commence in November 2023.
- Several Q2 Quality Framework objectives have been completed, with the partially achieved and not achieved objectives continuing to be progressed.

Alert

- Midwifery safeguarding supervision compliance has been impacted upon due to due to staff absence, in particular the safeguarding supervisors. Bespoke training has been commissioned for

Q3 and Q4 to train additional supervisors.

- *Clostridioides difficile, Klebsiella* and *E. coli* bacteraemias were above the set monthly external objectives. In addition, the Trust reported one Methicillin-resistant Staphylococcus aureus bacteraemia in October 2023. Improvement actions are being progressed in line with the Infection Prevention Delivery Plan.

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
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Effective Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience • Progress joint working across Wolverhampton and Walsall • Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

Chief Nursing Officer Report.

Report to the Trust Board meeting – to be held in Public on 12th December 2023.

EXECUTIVE SUMMARY

This report provides an overview of October's position with regards to key Nursing and Midwifery recruitment and retention activities and Nurse Sensitive Indicators (NSIs). In addition, it provides updates pertaining to wider quality initiatives.

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 actions and overarching improvement plans in place to continue further improving our position with regards to, for example, key workforce indicators, pressure ulcers and moisture associated skin damage, falls, observations being completed on time, infection prevention and control indicators, complaints and medication errors.

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

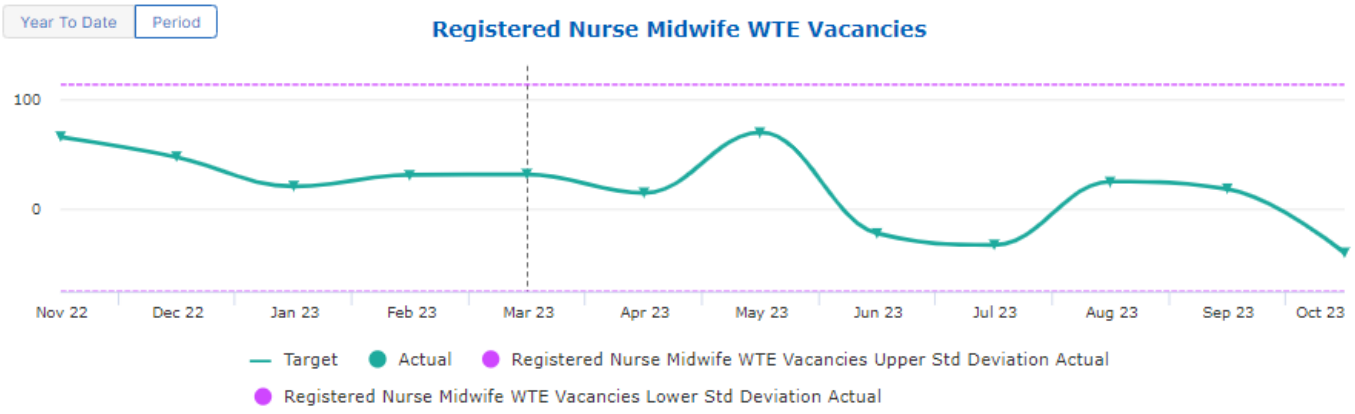
Based on data analysis in the latest Executive Nursing Dashboard, either issue specific actions are being taken or overarching action plans are in place for those areas noted as outliers. Key outlier indicators include combined sickness rate, pressure ulcers and moisture associated skin damage, observations being completed on time, infection prevention and control indicators, complaints and medication errors.

Please note a review of the dashboard has commenced, to ensure it remains current and provides information on longer term trends.

Workforce

Vacancies and Recruitment – September 2023 position	Registered Nursing and Midwifery staff	Unregistered Nursing and Midwifery staff
The latest number of vacancies	-39.38 WTE This position is in part due to a temporary hiatus of newly qualified Nurses and Clinical Nurse Fellows requiring placement allocation at the same time.	6.37 WTE. The International Nurses that were awaiting their NMC PIN were coded as unregistered staff last month and have now become registered.
Latest vacancy %	-2.44%	0.57%
Recruitment pipeline	96.0 WTE and from this number, 36.0 WTE have start dates.	20.0 WTE and from this number, 12.0 WTE have start dates.
Maternity leave	4.16 % and this equates to 161.4 WTE.	Included within the overall workforce data set reported separately.
Sickness absence	4.36 % and this equates to 169.2 WTE. This represents a decrease from 6.41% (247.7 WTE) 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 a stable position. Please see the graph below for a vacancy trend over time and IQPR for more information on CHPPD.



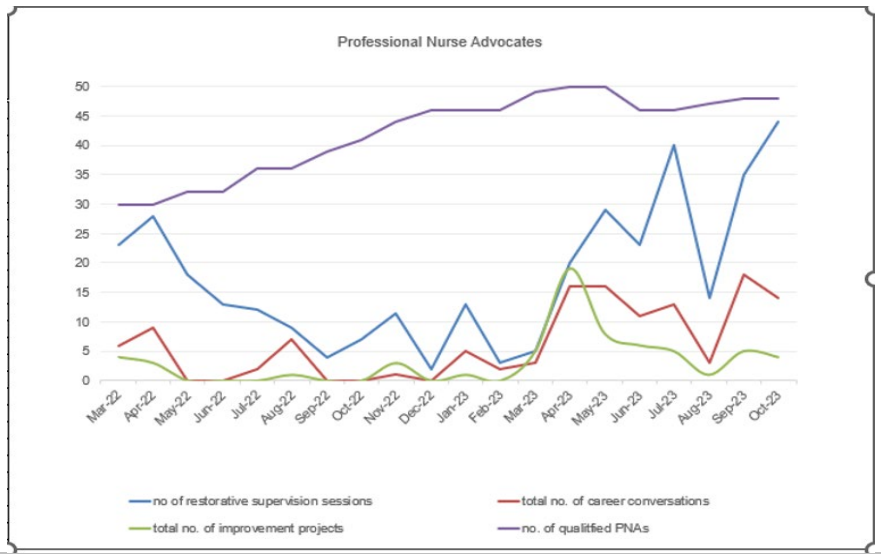
Scrutiny of Roster metrics continues with wards/departmental leads at regular Confirm and Challenge meetings and oversight of the data is maintained at the Nursing, Midwifery & Allied Health Professional Workforce Oversight Group chaired by the Director of Operational Human Resources and Organisational Development and the Chief Nursing Officer.

We have scoped all International Nurses awaiting a PIN to determine if the NMC has made contact with them regarding the Computer Based Test (CBT) data for the Yunnik Technologies Test Centre in Ibadan, Nigeria, to ensure we have oversight of those affected and to offer a supportive and standardised approach.

Education

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

- The Care Certificate compliance has improved to 89% for substantive staff, 100% for bank staff and 91% for staff requesting professional development.
- The NEWS2 training compliance is 96.7%.
- The latest data position confirms that 48 Professional Nurse Advocates (PNAs) remain active. There are currently 5 individuals on the programme to become PNAs. The Matron role to lead the PNA workstream across both Trusts has commenced in post.



Excellence in care

Falls
Please see information contained within the latest IQPR demonstrating a decrease when compared with the previous month's position. Oversight of the falls data and improvement activities is maintained via the joint Falls Steering Group and in line with the overarching improvement plan, which is updated monthly.

Pressure ulcers (PUs) and moisture associated skin damage (MASD)
Please see information contained within the latest IQPR, which demonstrates an increase when compared with the previous month's position. The Quality Committee, which met in November 2023, received more information regarding the data and actions in progress to drive continuous improvements.

A new national pressure ulcer recommendations and pathway document was published in October 2023. This document includes recommendation regarding the identification of risks and immediate treatment; screening, risk assessment and diagnosis; ongoing care and review and care post healing.

In terms of PU classification, categories 1-4 will remain, and the key changes will be as follows:

- Pressure ulcers where the skin is broken but the wound bed is not visible due to slough or necrosis (formally referred to as 'unstageable') should initially be recorded as Category 3 pressure ulcers but immediately re-categorised and re-recorded in the patient's records if debridement reveals category 4 pressure ulceration.
- Deep tissue injuries (DTIs) should not be reported as pressure ulcers unless they result in broken skin or they fail to resolve and it is evident on palpation that there is deep tissue damage present, at which point, they should immediately be categorised and reported.

A gap analysis is in progress and a plan will be developed to implement these changes, which will become operational from April 2024.

Patient Observations
Please see information contained within the latest IQPR, which demonstrates an improvement on the previous month, with the overall compliance being 89.9%. Clinical areas with challenged performance continue to be supported with their improvement actions.

Malnutrition Universal Screening Tool (MUST) completion
The overall MUST assessment completion and re-assessment performance continues to improve and was at 68% in October 2023 when compared with 66.1% reported in September 2023. The Nursing Quality team continue to support focussed improvement work on MUST assessments, meal service and catering.

Wider quality activities

- **Eat, Drink, Dress, Move to Improve (EDDMI)** launch is planned for 23rd of November. The EDDMI pledge board competition winners were C26, with AMU being highly commended.
- **The National Early Warning Score (NEWS 2) Scale 2** – quality improvement work continues with wards, focussing on the appropriate use of NEWS2 Scale 2. A re-audit was completed in late August, presented to the Deteriorating Patient Group in October 2023, in line with actions agreed as part of the overarching improvement plan. Daily reports have been developed for ward managers to have oversight of which patients are on NEWS2 Scale 2 and review as to whether this is appropriate. The use of a NEWS2 Scale 2 clinical notes sticker is under approval. A deteriorating patient dashboard for incorporating and triangulating different metrics is in development with a prototype presented to the Deteriorating Patient Group.

- **The Clinical Accreditation programme** continues, with 55 clinical areas visited across The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). Please see table below for more details pertaining to RWT. A formal evaluation of the programme is being shaped and will be undertaken during quarter 4 2023/24.

Clinical Accreditation RWT		
Date	**Ward/Dept/ Unit**	**Accreditation Level Awarded**
5/4/2023	A7	Working Towards Accreditation
14/4/2023	A8	Ruby
21/4/2023	C14	Emerald
28/4/2023	C26	Emerald
3/5/2023	C18	Emerald
19/5/2023	Fairoak	Emerald
31/5/2023	C39	Ruby
2/6/2023	Amu	Emerald
2/6/2023	AMU	Emerald
7/6/2023	Deansley (C35)	Working Towards Accreditation
16/6/2023	D7	Ruby
23/06/2023	C19	Ruby
30/06/2023	CHU	Working Towards Accreditation
5/7/2023	C22	Working Towards Accreditation
14/7/2023	C24	Working Towards Accreditation
21/7/2023	A7	Ruby
2/8/2023	A8	Working Towards Accreditation
18/8/2023	Ward 2 WP	Awaiting outcome
30/8/2023	Deansley (C35)	Awaiting outcome
6/9/2023	NRU	Awaiting outcome
8/9/2023	C15	Awaiting outcome
15/9/2023	C16	Awaiting outcome
22/9/2023	C21	Awaiting outcome
4/10/2023	C25	Awaiting outcome
13/10/2023	C17	Awaiting outcome
20/10/2023	C39	Awaiting outcome

Themes for improvement from Clinical Accreditation visits include:

- Secure storage of medical notes when not in use and quality of storage container locks often not working.
  Action – Discussed with manager/fed back in report.
- Patient repositioning to relieve pressure points and adherence to the recommendations contained within the intervention charts.
  Action – highlighted in clinical accreditation reports for individual wards/department and the Tissue Viability team are incorporating this into their training.

Patient Experience

Latest updates for patient experience are contained in the Patient Experience report and IQPR made available to Trust Board separately.

Maternity

Latest updates for maternity services are contained in the Maternity Service report and IQPR presented to Trust Board separately.

A notification of the system wide review of perinatal mortality has been received via the Integrated Care System.

Adult and Children Safeguarding

Latest updates for Safeguarding services are contained in the Adult and Child Safeguarding Service report made available to Trust Board separately.

Infection Prevention and Control (IPC)

Latest updates for Infection Prevention and Control services are contained in the Infection Prevention and Control Service report made available to Trust Board separately.

The Quality Framework (QF)

Stakeholder feedback was received from all five professional, speciality staff groups against the focussed objectives within the QF six pillars. The established groups include Acute Adult, Allied Health Professional, Community, Midwifery and Paediatric groups. Quarter 2 feedback focuses on achievements, whether full, partial, or not achieved in a specific timeframe (quarter). Examples of achievements in Q2 include, implementation of phase 1 of the Clinical Accreditation programme; Care to Share has been published with focus on quality and safety; the Back to the Floor initiative has been evaluated and outcome shared across both organisations; progress has been made against the 50% target for the Delivery and Triage staff to complete the Triage competencies across both Trusts; staff across both Trusts have participated in the Annual Multidisciplinary Research Conference; new Professional Nurse Advocates have been recruited at both Trusts; documentation revision has commenced and medication audits and competencies have been reviewed and re-launched at WHT, with this action being partially completed at RWT. A detailed update for Q3 will be provided to the Quality Committee in February 2024.

Research and innovation

For the period 01 April to 30 September 2023, data obtained via The Royal Wolverhampton NHS Trust (RWT) staff publications repository totalled 6 peer-reviewed journal publications where a nurse was either a lead or co-author, and 4 conference presentations, two of which were national, one international and one regional. Further information about the publications can be accessed by visiting RWT repository at: https://rwt.dspace-express.com/.

Further to the successful, nurse-led, home-grown NHS England funded Professional Nurse Advocate (PNA) study, the Trust has been invited by NHS England to submit a research proposal application for further funding and enquiry into the personal and professional impacts of the PNA role.

Digital

The Trust is taking significant strides in developing the Electronic Patient Records (EPR) project across its services. A pivotal step in this journey is the introduction of further Digital Nurse role specifically for the Emergency Department. Additionally, we are developing two new critical positions: the Digital Matron and the Chief Nursing Information Officer. These roles, currently undergoing Banding and Vacancy Control Panel evaluations, represent a landmark in our efforts to merge nursing expertise with digital innovation. These initiatives are not only crucial for streamlining our clinical processes but also pivotal in ensuring that our nursing staff are at the forefront of digital healthcare transformation.

RECOMMENDATIONS

Trust 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.

- Note that a review of the CNO dashboard has commenced, to ensure it remains current and provides information on longer term trends. The Quality Committee has been invited to provide feedback on what indicators would be helpful to include in the next iteration and those no longer required.

Please refer to the following detailed reports for more information:

1. Maternity Services Report
2. Infection Prevention and Control Report
3. Patient Experience Report
4. Safeguarding Adults and Children Report
5. Integrated Quality and Performance Report

The Royal Wolverhampton NHS Trust

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 14th November 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	11.99	3,880.08	8.1	4.36	94.3	4.16	-39.38	-2.44	6.37	0.57	39	86	58	44	79	89.9%	10	73
	Previous Period	12.74	3,864.82	8.3	6.41	93.9	3.92	18.38	0.67	-72.19	-6.39	50	85	53	33	105	87.3%	10	74

		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	11.61	1,248.14	10.3	4.92	93.2	4.38	-63.76	-4.58	8.70	-4.97	15	94	24	10	20	89.4%	4	36
B14 Cardiology ward	This Period	15.26	69.62	7.6	5.52	95.9	2.76	0.63	1.20	0.13	0.75	0	96	1	0	2	95.6%	0	0
B15 Cath Labs and Day Ward	This Period	9.22	30.24	~	0.10	93.4	9.60	-1.67	-6.86	0.67	11.49	0	96	0	0	0		0	0
B8 Cardiothoracic ward	This Period	13.49	43.21	7.5	1.33	95.6	9.62	-6.12	-17.23	-0.27	-3.46	0	100	3	0	1	95.2%	0	3
ICCU	This Period	13.82	204.01	29.2	4.73	96.7	2.38	-4.56	-2.52	1.83	7.87	1	~	9	6	0	~	0	10
A12 General Surgery	This Period	10.97	35.11	6.4	6.06	94.1	9.04	-0.72	-3.24	3.50	27.08	1	85	1	0	2	88.9%	1	4
A14 General Surgery	This Period	10.31	35.23	6.6	0.60	94.7	5.13	-2.73	-12.25	1.50	11.59	0	87	2	0	3	87.8%	0	1
D7 ward	This Period	8.10	40.62	7.3	15.02	96.8	3.97	-3.86	-14.43	0.08	0.55	0		1	0	1	89.1%	1	1
SEU	This Period	9.44	80.50	9.0	8.99	94.8	5.05	-2.51	-4.97	2.18	7.29	1	86	1	1	2	87.0%	0	2
B7 Head and Neck	This Period	10.93	43.27	10.9	6.06	93.4	1.63	-2.02	-6.66	0.83	6.42	0	86	0	0	1	85.5%	0	0
Neonatal Unit	This Period	12.47	123.94	25.4	5.77	87.5	0.00	-7.97	1.97	2.80	-115.36	0	100	1	0	0	~	0	8
Transitional Care	This Period	12.07	20.49	~	4.28	88.1	6.13	5.14	35.20	-0.32	-5.44	0	100	0	0	0	~	0	0
D10 Maternity Ward	This Period	12.15	44.15	8.9	1.79	84.7	5.64	-5.73	-19.55	-5.27	-35.49	1	73	0	0	0	~	0	0
Delivery Suite	This Period	9.68	89.59	~	3.05	93.5	7.35	-7.90	-11.04	0.24	1.35	0	96	0	0	0	~	0	0
Hilton main CCH	This Period	14.21	46.70	7.4	3.81	93.4	5.79	1.83	5.82	0.44	2.91	0	98	1	0	0	90.3%	0	1
A5 T & O ward	This Period	13.33	40.77	7.0	0.10	94.1	2.23	-1.87	-8.21	2.16	12.00	1	86	2	2	3	88.0%	1	1
A6 T & O ward	This Period	12.37	40.73	7.2	6.16	91.5	3.80	1.06	4.68	-1.64	-9.11	0	85	1	1	2	82.6%	1	1
Theatres	This Period	9.53	259.96	~	5.32	93.5	3.29	-24.76	-17.75	-0.17	-0.14	0	~	0	0	0	~	0	1

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		Nursing Workforce										Patient Voice		Pressure Ulcer		Falls	Deteriorating Patient	Infection Prevention	Medication
		Annual Leave 11-17%	Budget WTE	CHPPD (Care Hours Per Patient Day)	Combined sickness %	Mandatory Training % - trend from last month	Maternity leave %	Registered Nurse Midwife WTE Vacancies	Registered Nurse Midwife WTE Vacancies %	Unregistered WTE Vacancies	Unregistered WTE Vacancies %	Number of Formal Complaints	Would Recommend	Number of Moisture Associated Skin Damage (approved by line manager)	Number of Pressure Ulcers (Datix reported)	Number of patient falls	% of observations achieved	Number of C-Diff	Number of Medication Errors (reported) Exc. OPD.
Division 2 (EMS)	This Period	12.54	639.23	6.4	4.25	94.2	4.26	-1.94	0.56	6.61	0.27	17	77	16	15	51	90.6%	6	23
AMU	This Period	16.19	89.29	7.6	5.24		4.53	2.03	3.66	2.76	8.18	2	92	1	0	4	82.2%	0	3
C15 Diabetes	This Period	10.42	32.10	6.4	3.14	96.5	4.20	-3.11	-16.18	4.01	31.06	1	80	1	1	4	93.0%	0	2
C16 Diabetes	This Period	8.91	37.20	5.7	0.17	91.9	0.00	-3.49	-16.02	3.23	20.95	0	65	0	2	5	90.7%	0	2
C17	This Period	14.69	23.20	6.5	0.00	99.0	8.17	-4.95		3.66		0	74	0	1	0	96.2%	0	0
ED	This Period	13.83	154.71	~	3.18	92.8	4.53	-1.97	-1.70	-4.98	-12.89	5	69	0	0	8	~	0	4
A7 Gastroenterology	This Period	12.03	40.28	7.3	3.42	94.8	0.00	3.79	15.24	2.76	17.88	0	100	0	1	1	91.3%	0	0
A8 Gastroenterology	This Period	10.38	40.28	5.6	0.00	98.4	8.92	-1.77	-7.14	2.44	15.80	1	83	0	1	0	92.9%	0	0
Clinical Haematology Unit	This Period	9.37	43.30	7.5	8.06	93.4	10.75	-1.77	-6.11	1.70	11.89	0	100	0	0	3	83.5%	1	2
C39 ward	This Period	9.28	0.00	5.1	7.90		0.00	0.00		0.00		0	100	1	0	2	0.0%	0	0
C18 Elderly Care	This Period	17.30	37.24	7.5	7.41		2.43	1.87	8.56	0.80	5.18	1	100	0	1	1	93.2%	0	1
C19 Elderly Care	This Period	11.62	37.20	6.9	2.71	93.9	3.83	-1.27	-5.81	-1.21	-7.84	0	100	1	2	1	92.3%	0	0
C35 Deansley Ward	This Period	11.82	29.00	6.4	0.00	93.0	3.48	2.25	11.74	-0.71	-7.21	2	82	0	1	0	91.7%	2	0
Durnall	This Period	11.95	21.81	~	5.89	96.0	3.85	1.60	8.97	-1.43	-35.67	0	93	0	0	0	97.7%	0	0
Fairoak	This Period	13.53	32.00	4.7	6.30	91.6	0.00	-0.31	-1.89	2.00	12.99	0	100	1	1	1	92.6%	0	0
C22 Renal	This Period	8.80	27.10	5.5	9.11	93.2	7.98	-2.16	-13.50	-1.50	-13.51	1	90	0	1	3	92.6%	0	1
C24 Renal Ward	This Period	16.58	34.54	4.8	2.99	94.5	3.80	0.27	1.17	1.35	11.53	1	82	3	0	4	87.9%	0	2
C25 Renal Ward	This Period	12.41	34.54	5.0	5.39	90.9	12.38	3.27	14.36	0.87	7.44	0	91	0	1	4	89.9%	0	1
C14 Respiratory	This Period	14.88	34.70	6.4	5.23	90.5	1.70	3.01	13.07	-3.61	-30.83	0	100	2	0	3	90.5%	1	2
C26 Respiratory	This Period	13.10	45.45	7.9	4.48	94.0	3.19	-2.88	-8.52	-4.62	-39.49	0	100	4	0	1	92.7%	0	1
C21 Acute Stroke Unit	This Period	9.65	61.69	7.0	7.15	93.4	0.00	3.67	9.56	-0.93	-3.98	1	100	2	2	4	93.2%	0	1

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Division 3 (CCSS)	This Period	11.51	627.48	7.3	3.27	96.8	2.60	-0.16	-6.69	-9.23	-24.79	6	88	18	18	5	82.1%	0	12
Community Children's Nursing Team - Generic Team	This Period		30.01	~	5.52	97.3	2.52	0.02	0.13	-1.76	-14.85			0	0	0	~	0	0
NRU West Park	This Period	18.19	21.80	9.3	2.89	99.5	0.00	1.74	15.13	-0.15	-1.49	0	88	0	0	1	98.2%	0	0
Ward 1 West Park	This Period	10.80	29.60	5.9	0.00	97.5	7.02	3.61	21.77	-0.41	-3.15	0	80	2	0	1	97.7%	0	0
Ward 2 West Park	This Period	12.60	31.20	5.9	7.34	98.0	3.03	1.00	7.09	0.42	2.46	0	80	0	0	2	97.2%	0	0
A21	This Period	13.29	52.61	7.7	2.71	94.9	10.38	-15.55	-47.97	9.75	48.25	0	90	0	0	0	82.1%	0	5
Clinical Nurse Specialist	This Period		11.48	~	0.00	96.5	0.00	0.41	3.60	0.00				0	0	0	~		0
PAU	This Period	9.57	29.33	7.0	0.00	96.6	16.21	6.44	33.86	-0.07	-0.65	1	89	0	0	0	78.2%	0	0
Planned Care	This Period	9.58	99.41	~	4.45	93.0	2.97	3.73	5.02	0.83	3.29	1		16	18	1	~	0	5
Urgent Care	This Period	15.98	78.15	~	1.23	97.9	2.46	8.32	14.93	-7.86	-35.06			0	0	0	~	0	0
Intermediate Care	This Period	12.22	0.00	~	0.00	95.0	0.00	0.00		0.00				0	0	0	~		0
Dermatology	This Period	8.38	14.30	~	5.08	95.9	0.00	-2.16	-23.38	0.46	9.09	0	100	0	0	0	~	0	0
Physio & OT	This Period	~		~	~	~	~	~	~	~	~	0	~	0	0	0	~	~	0
Primary Care Services	This Period		29.72	~	5.93	95.1	4.20	-3.12	-12.85	-1.75	-32.11	0		0	0	0	~	~	1
Radiology	This Period	9.33	8.38	~	0.00	96.6	0.00	-1.60	-25.00	-1.93	-97.31	3	95	0	0	0	~	0	1
Rheumatology	This Period	13.16	3.61	~	0.00	98.2	0.00	-6.25		-3.67	-101.66	0	98	0	0	0	~	0	0
Sexual Health	This Period	11.70	4.78	~	6.85	98.2	3.45	-9.05	0.00	-6.69	0.00	0		0	0	0	~	0	0
Ambulatory Care	This Period	9.92	23.79	~	4.98	97.4	4.33	-1.37	-6.79	0.00	0.00			0	0	0	~	~	0

Paper for submission for Trust Board Meeting 12th December 2023		
Title of Report:	Patient Experience Bi-Monthly Report – August/September 2023	Enc No: 10.2.1
Author:	Alison Dowling	
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	Yes ☐ No ☒ Risk Description:		
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.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Trust Management Committee – 24/11/2023
	Board Committee	Yes☐No☒	QSAG 17/11/2023
	Board of Directors	Yes☒No☐	Date: Trust Board 05/12/2023
	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. • Compliance with the monthly submissions which are 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 • 84 complaints received compared to 74 for the preceding two months. • The specialties with greatest increase in volumes received are ED (17 cases) and Diabetes (6 cases). ED experienced a significant increase having received 17 cases compared to 9 in the previous two monthly reporting period. The volume of ED complaints received compared to the number of attendances for this reporting period equates to 0.06% in comparison to 0.03% in the previous 2 months. • In terms of outcomes from closed complaints there were 7 complaints upheld in this reporting period in comparison to 6 in the previous two months. This represents 10% of all cases closed (70 cases) in this period. • Two complaints accepted for formal investigation during August and September. There were no outcomes for complaint investigations completed. • The overall Trust wide response rate for August is 16% with 87% recommending the Trust and 8% not recommending the Trust. For September the response rate was 15% with 85% recommending the Trust and 7% not recommending the Trust.
Alert - Positive assurances & highlights of note for the Board/Committee • 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.

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	• 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

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.

Current Position

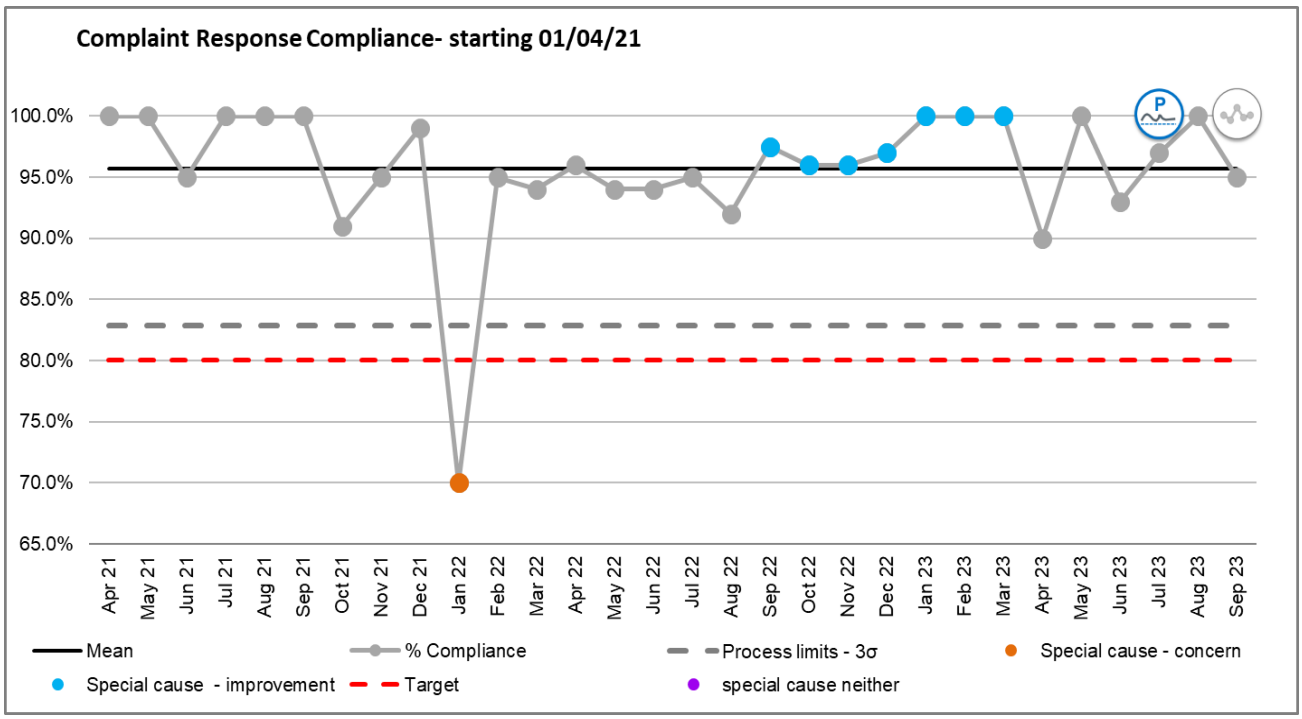
The Trust received a total of **53,551** feedback contacts between August and September 2023. This includes all Patient Relations related contacts, along with Friends and Family Test and Feedback Friend responses.

Complaints (including MP letters)	84
PALS Concerns	102
Local Resolution	139
Compliments	282
Friends and Family Test	53551
Feedback Friend (QR code)	15
Feedback Friday	8

Formal Complaints, PALS Concerns and Compliments

- Volume - For formal complaints in respect of the period August and September 2023, there were a total of 84 complaints received for this period compared to 74 for preceding two months.
- There have been notable increases in volume for Emergency Department (increased from 9 to 17 cases) and Diabetes (1 case to 6).
- Themes for the Emergency Department cases related to general care of patient with general lack of care (5 cases) and Diagnosis (3 cases). Complaints relating to Diagnosis have not been received since March 2023. These specifically relate to misdiagnosis and lack of exploratory X-Ray. One of the complaints relating to general lack of care also featured a delay in receiving diagnostic investigations.
- Head and Neck previously received an increased volume of 4 cases; however, this has reduced to 2 in this reporting period. A positive reduction in volume has also been received for General Surgery (10 down to 2).
- PALS Concerns - Assessed and allocated to operational teams to respond totalled 52 in August and 50 in September. The proactive approach to early intervention approach in working with complainants to achieve local resolution on concerns continues. These cases are resolved negating the need to escalate to operational teams, whether this be for PALS concerns or formal complaints. For this reporting period 139 cases were assessed and resolved. The theme of these cases relates to communication and delay.
- Themes - The top 3 themes for formal complaints closed are Patient Discharge (13), General Care of Patient (11) and Communication (10), and for PALS Concerns, General Care of Patient (60) and Attitude (10). Themes are generally consistent with previous reports other than concerns although there has been a notable decrease of PALS concerns relating to Attitude.

- Responding to complaints and complaint outcomes – from closed complaints there was one case upheld in August (T & O) and 6 in September (ED x 2, Cardiac x1, Respiratory x 1 and T & O x 1). Three of these were relating to patient discharge. A further 9 cases were partially upheld in August and 18 for September.
- Parliamentary and Health Service Ombudsman (PHSO) - Two complaints accepted for formal investigation during August and September. There were no outcomes for complaint investigations completed.
- The overall Trust response rate for cases closed in August was 100%, and September was 97% (1 case breached – Children's Services) which is consistent with performance in July. Further analysis has established that the fluctuation in performance relates to the monitoring of complaints management process at directorate and divisional level. More information can be found in the Action section under Complaint Breaches on page 7.



Friends and Family Test (FFT)

- The overall Trust wide response rate for August is 16% with 87% recommending the Trust and 8% not recommending the Trust.
- There is an increase of 2% not recommending the Trust when compared to July. Positive increase in the recommendation rates and positive decrease in the non recommendation rates for Divisions 1 and 3 are contributory factors.
- For September the response rate reduced to 15% and there was a 2% decrease of those recommending the Trust (85%) with a 1% reduction of those not recommending the Trust.
- Division 1's score for recommendation remained consistent however both Division 2 and 3 experienced a reduction in score. There was an increase of patient's opting out of taking the survey (7%) and this could be reflected in the reduction of response rates
- All data in relation to FFT national reporting can be accessed NHS England » Friends and Family Test data

Spiritual, Pastoral and Religious Care (SPaRC)

- There were 999 separate pastoral encounters undertaken in August and September 2023.
- At least 25% of chaplaincy encounters are to provide staff support.
- Top 3 main factors for encounters remain consistent: Staff, and Visiting generally
- Support continues to be widespread across Pastoral or Spiritual and Pastoral. 82% of care provided had a Pastoral element, 80% a Spiritual element, and Religious (Faith Specific) care has been present in 65% of encounters.
- The team visited 65 out of our 80 listed hospital areas as part of the implementation of their initiative 'Everywhere, Every Week'.
- The team have been providing staff wellbeing support to those whose colleagues have passed away. The quality, compassion, helpfulness, and accessibility of the past support provided by the Chaplaincy team has been cited as the reason why senior staff are recommending Chaplaincy to other senior colleagues as they managed these tragic events.

Engagement, Involvement and Experience

- **Equalities Objectives** - The Patient Experience team have refreshed its Equality Objectives for 2023-2027 which are to review and improve service accessibility for those whose first language is not English. As part of our work to meet these objectives during this reporting period, we have engaged further with veteran's groups, having an article published in the SSAFA (Soldiers', Sailors' and Air Force Association) newsletter.
- **The Sickle Cell and Thalassemia Working Group** met in August to look issues experienced by sickle cell patients across the Trust. The area of focus will be Paediatrics particularly in transition to adults.
- **Equality Delivery System** - The Trust completed the assessment of the first of its three services, Patient Experience, by holding an engagement and assessment session with volunteers, PIP members and some staff members on 1st August 2023. For the second service the evidence gathering exercise was drafted towards the end of September. The evidence highlighted a great deal engagement activity, particularly around the Sahara Maternity Support Group and the Pride in Pregnancy Support Group for women of BAME backgrounds.
- **Accessibility for those who have LD Needs** - The team have met with the LD team regarding making gathering patient feedback for patients with LD more accessible and have set up a working group. Early objectives achieved include making a video for LD patients informing them about FFT.
- **Co-production –** The co-production of Ward Welcome Boards for both adults and children was finalised with both sets of boards being fine tuned and submitted for management review prior to production.
- **Maternity Services Maternity Voices Partnership** Chair has shared the action plan following 15 Steps visit undertaken in February 2023, and the action plan is progressing well.
- **Patient Involvement Partners (PIP's)** - The work of the PIP's is expanding and they have been involved in the following projects: Supported the PLACE (Patient Led Assessment of the Care Environment) facilitated by the Trust Estates team. Worked with QI team, on patient improvement projects – supported Fracture Clinic around patient feedback in the waiting area - this was using a designed MS Forms style survey. Linked with a local

Academic who is conducting a piece of research around Health Inequalities. Supported the Research and Development Directorate by becoming Research Ambassadors.

- **Patient Experience Enabling Strategy** – This is a joint strategy with Walsall Hospital and updates are being reported through the Trusts newly formed Patient Experience Group (PEG).

Voluntary Services

- Volunteers achieved 1647 hours across the two months of August and September with 1508 hours at New Cross, 426 hours at Cannock Chase Hospital, and 170 at West Park Rehabilitation Hospital.
- A new volunteer role commenced with the Service Efficiency team which involves volunteers calling patients on elective waiting lists for Gynaecology and Ophthalmology with an agreed script to ask the patient if they are still aware of the scheduled appointment and if they still require it. This role will be reviewed in November 2023 for impact.
- The Arts in Health programme has been continuing at West Park Neuro Rehab ward once a month and is very successful.

Holistic Opportunities Preventing Exclusion (H.O.P.E)

During this reporting period, we saw our first cohort of volunteers commence their roles working with the Social Prescribing team in the community. Early indications show that this is a much needed and appreciated role. Our volunteer recruitment continued as well as a communications campaign including hosting promotional stands in our Emergency Department entrance at New Cross Hospital.

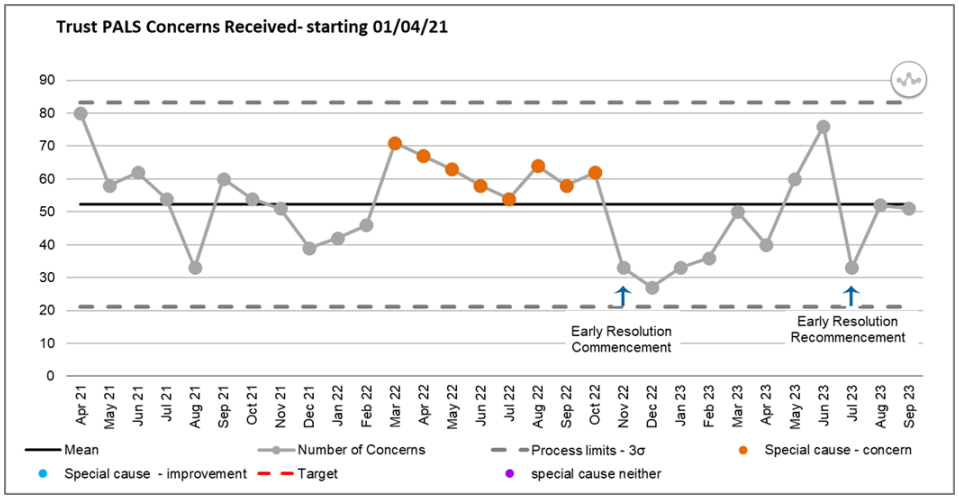
Actions

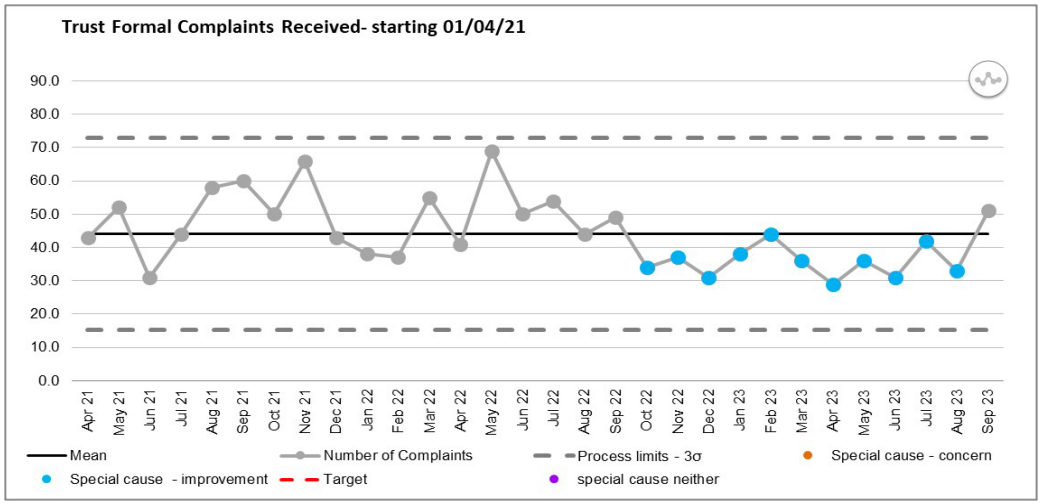
Actions in place or underway to address areas of concern or where improvements can be made are:

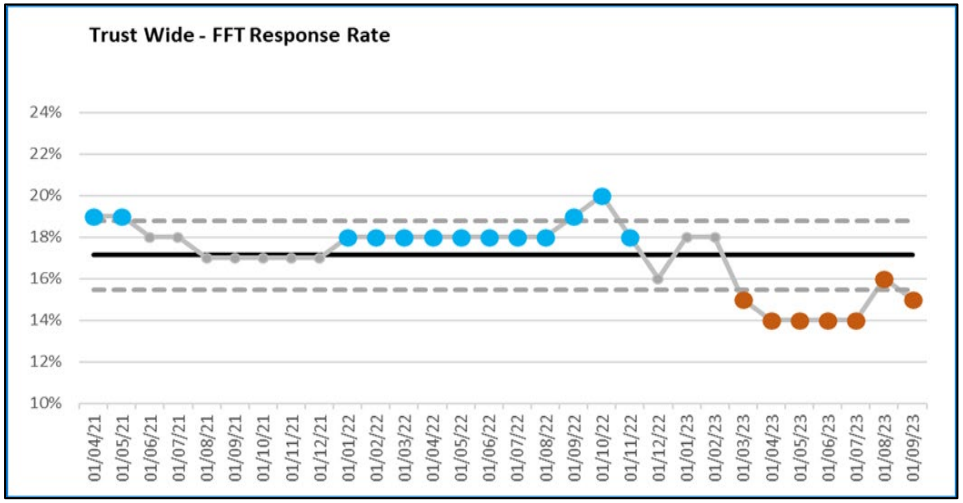
- Friends and Family Test - A series of outreach activities to support inpatient areas to improve the Trust's overall response and recommendation rate, in particular where notable month on month decline in performance for inpatient areas. This will help progress Trust's ambition to achieve and maintain a recommendation rate of 92%.
- Lessons Learned/Actions Taken – A monthly review of noted actions for cases with an outcome of partly/fully upheld to be undertaken to ensure actions are measurable.
- Increased volume of complaints - The triangulation of other feedback metrics indicative of trend to be undertaken at directorate/divisional level.
- Complaint breaches – Positive improvement in August however decreased performance in September. Ambition to return and maintain 100% compliancy. Review of supportive measures to be undertaken to aid directorate compliance. Monitoring of actions/process implemented at directorate level to be undertaken.
- DNA Support project – To establish a working group in conjunction with the Service Efficiency Team evaluate measurable data of the direct impact of volunteer support.

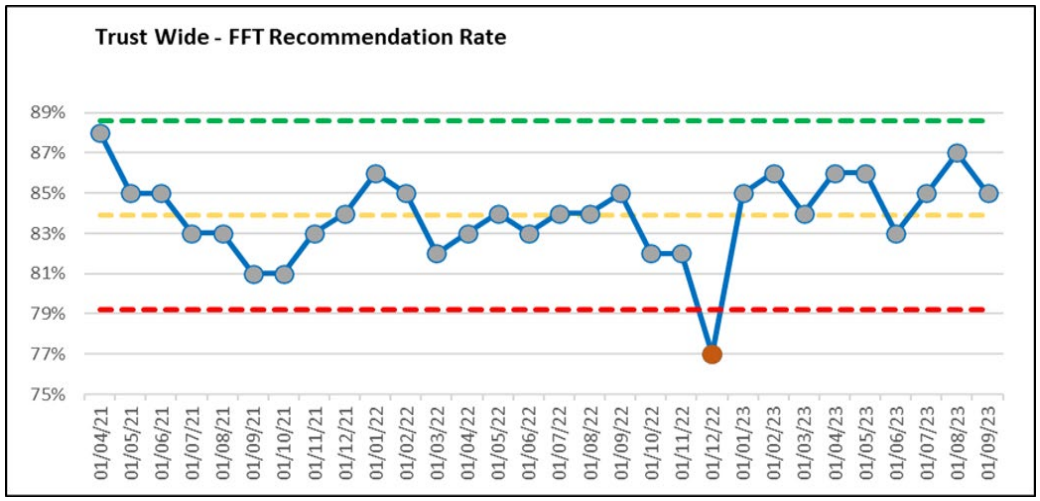
Appendices	
Appendix 1	**Patient Experience Metrics for Complaints and Friends and Family Test**

Appendix 1 – Patient Experience Metrics for Complaints and Friends and Family Test









The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public On 12th December 2023		
Title of Report:	Infection Prevention and Control Report	Enc No: 10.2.2
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.		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	None		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: Trust Management Committee – 24/11/23
	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 external target for *Pseudomonas aeruginosa* bacteraemia.
Below internal target for MRSA acquisition.
Below internal target for device-related hospital-associated bacteraemias (DRHABs).
Carbapenemase producing Enterobacteriaceae (CPE) screening continues to pick up patients and reduce the risk of spread – total of 17 new patients identified across September and October 2023.

Advise

Above internal target for *Clostridioides difficile* (*C difficile)*
Above external targets for *Escherichia coli* and Klebsiella bacteraemia.
Above internal target for MSSA bacteraemia.
Compliance with infection prevention-related mandatory training below 95% at end October 2023 (93% for IP mandatory training, 90% for Hand Hygiene).

Alert

Above external *C difficile* target with 48 to date (target for end October 2023 is 28, annual target 53).

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

The Royal Wolverhampton NHS Trust

Infection Prevention and Control Report

Report to Trust Board Meeting to be held in Public on 12th December 2023

EXECUTIVE SUMMARY

This report provides an overview of the Trust's Infection Prevention performance from April to end October 2023. This includes performance against both external objectives and internal indicators.

BACKGROUND INFORMATION

See body of report

RECOMMENDATIONS

To note the report.

Any Cross-References to Reading Room Information/Enclosures:

N/A

Clostridioides difficile Infection

The annual objective for *Clostridioides 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 September to October 2023 there were 20 cases, breaching the external trajectory for that period (8 cases), and taking the total to date to 48 cases against a trajectory for that period of 28. PCR (non-toxin) cases are also monitored as patient outcomes can be just as harmful to patient safety. To the end of August 2023 there have been 85 PCR positive cases against our internal trajectory of 63 (see Appendix 1). The Royal Wolverhampton NHS Trust is not unique within the West Midlands in seeing case numbers above the external trajectory, with the majority having cases numbers to end August 2023 above the cumulative objective for that period. Three nearby Trusts had already breached their annual objectives at the end of August 2023. It is important to remember that the target is based on the number of cases in previous years and not the rate (eg per 100,000 bed days), and so is not adjusted to take into account any increase in activity. In addition, a change to the laboratory testing method for *C. difficile* in October 2022 may be contributing to increased numbers. Finally, it is well recognised that running a high bed occupancy rate is associated with higher numbers of healthcare associated infections.

Actions for control of *C.difficile* include:

- RWT are contributing to the NHSEI *C. difficile* regional collaborative groups, including work to trial an updated RCA document.
- A collaborative Quality Improvement project with ED is currently being undertaken by the Infection Prevention Team (IPT), this will support timely sampling of symptomatic patients on admission.
- Task and finish group now concluded
- *C. difficile* action plan will continue to be reviewed monthly based on new learning or outcomes identified.
- Environmental audits completed monthly, results are incorporated into exemption reports that are reviewed at incident meetings
- Weekly *C. difficile* ward rounds with Microbiologist
- Weekly antimicrobial ward rounds with Microbiologist and Antimicrobial Pharmacist
- Targeted education continues across all in patient areas
- Trust *C. difficile* week was held 6th – 10th November 2023
- Wards are getting additional support from Housekeeping to assist them with the routine cleaning of communal areas and equipment where possible.
- Deep clean programme recommenced on 25th September 2023, prioritising higher risk wards
- Refurbishment of a permanent area for the Patient Equipment Cleaning centre is currently being undertaken; completion of this expected to be mid/late November 2023

MRSA Bacteraemia

The national objective for MRSA bacteraemia is zero for all NHS organisations. In October 2023 there were two MRSA bacteraemias, one of which was externally-attributable to RWT. The other case had been under the care of community teams prior to admission. Both cases were reviewed locally. On review of the RWT-attributable case, ANTT compliance was found to be low, and an admission screen had not been completed.

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)	0 (0)	0 (0)	0 (0)	2 (1)					

MSSA bacteraemia

MSSA is externally monitored by 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. September and October 2023 there were 2 internally attributable cases, against a trajectory of 4 (see Appendix 1). This takes the total since April 2023 to date to 18, against an internal trajectory of 14. Common sources of this infection since April have included indwelling lines (peripheral or central/dialysis), with a few cases additionally related to infected pressure sores.

Monthly totals and number internally attributable to RWT

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

Actions for control or *Staphylococcus aureus* bacteraemias include:
Emergency portals supported to sustain improved compliance with MRSA admission screening.
MSSA screening and decolonisation of high risk patients
Wards encouraged to ensure all devices are on Vitalpac

MRSA Acquisitions

There were 4 MRSA acquisitions across September and October 2023, against an internal trajectory of 6 (see Appendix 1). This takes the total for 2023-24 to date to 18, below the internal trajectory of 21.

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. In September and October there were 6 DRHABs against a trajectory of 8 (see Appendix 1), taking the total for 2023-24 to date to 27, against an internal trajectory of 28. Themes identified have incomplete documentation and low compliance with ANTT.

Actions include:

- Dedicated Intravenous Resource team
- All DRHABs are reviewed at IP Incident review meeting (formally Scrutiny meeting)
- Urinary catheter and PVC dashboards are now live

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 October 2023 there have been 64 *E. coli* bacteraemias against a trajectory of 54, 22 Klebsiella bacteraemias against a trajectory of 14, and 6 *P. aeruginosa* bacteraemias against a trajectory of 7. Nationally there is evidence of a seasonality in the trend of all 3 Gram negative bacteraemias, with the highest rates normally observed in July to September each

year. It is noted in the national report that although the number of *E. coli* cases has increased, the overall rate is lower because the bed-days denominator is higher. Similar to *C. difficile*, the Trust targets for Gram negative bacteraemias are a number based on previous performance, and do not take into account any increase in activity.

Actions include:

- Involved in Gram Negative collaborative work with NHSE, such as improving hydration and 'Eat, drink, dress and move to improve'.
- Trust Catheter Working Group meet monthly
- Catheter packs introduced with a program of education in the Acute Trust in August 2023
- Launch of catheter passport to commence 27th November 2023

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 October 2023, 56 new patients were found to be carrying a CPE (see Appendix 1). There was a reduction in numbers related to a reduction in travel and screening for elective procedures due to the COVID-19 pandemic, however we are now seeing rising numbers again, such that, compared with all previous years, we have the highest number of new patients at this point in the year. Of these 56 patients, 53 have been identified on rectal screening, with 3 being positive in urine specimens sent for culture.

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, and so every plan for a new or refurbished ward must include a plan to increase the number of side-rooms.

Blood culture contaminants

The blood culture contamination rate April to end October 2023 had an average of 1.67%, which is below the nationally recommended maximum of 3%.

Outbreaks and Incidents – October and September 2023

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

There were 5 *C. difficile* incidents in this period. There were PIIs on A12, A8, A14, C16 and Deanesly. Typing demonstrated that there was no transmission between patients, and so none of these were raised to SI, including those that included two toxin positive cases. It is encouraging that there has not been demonstrated spread between patients, so it possible that the cases have either been colonised prior to admission or acquired the strain since admission, perhaps from an environmental source. Increased bed occupancy, alongside reduced opportunity for targeted cleaning (such as 7 days hydrogen peroxide decontamination of side-rooms) and the new and increased pressure on side-rooms from other infections including COVID-19 and the increasing numbers of CPE positive patients, perhaps form part of the explanation for this.

CPE Outbreak

In September CPE was identified in a clinical sample from an inpatient in orthopaedics. Screening of bay contacts detected 2 further positive cases. Although typing of the organisms did not demonstrate that they were related, this does not mean there was not transmission, because the resistance genes are on a transmissible element that can move easily between different strains.

COVID-19

September 2023
Total of COVID PII = 7
Total patients in September identified with COVID-19 HCAIs = 23
19 HCAIs linked to outbreaks
4 not linked to an outbreaks

October 2023
Total of COVID PII = 4
Total patients in October identified with COVID-19 HCAIs = 29
HCAIs linked to outbreaks = 17
not linked to an outbreaks = 12

All the incidents and outbreaks are reviewed at Outbreak meetings.
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.

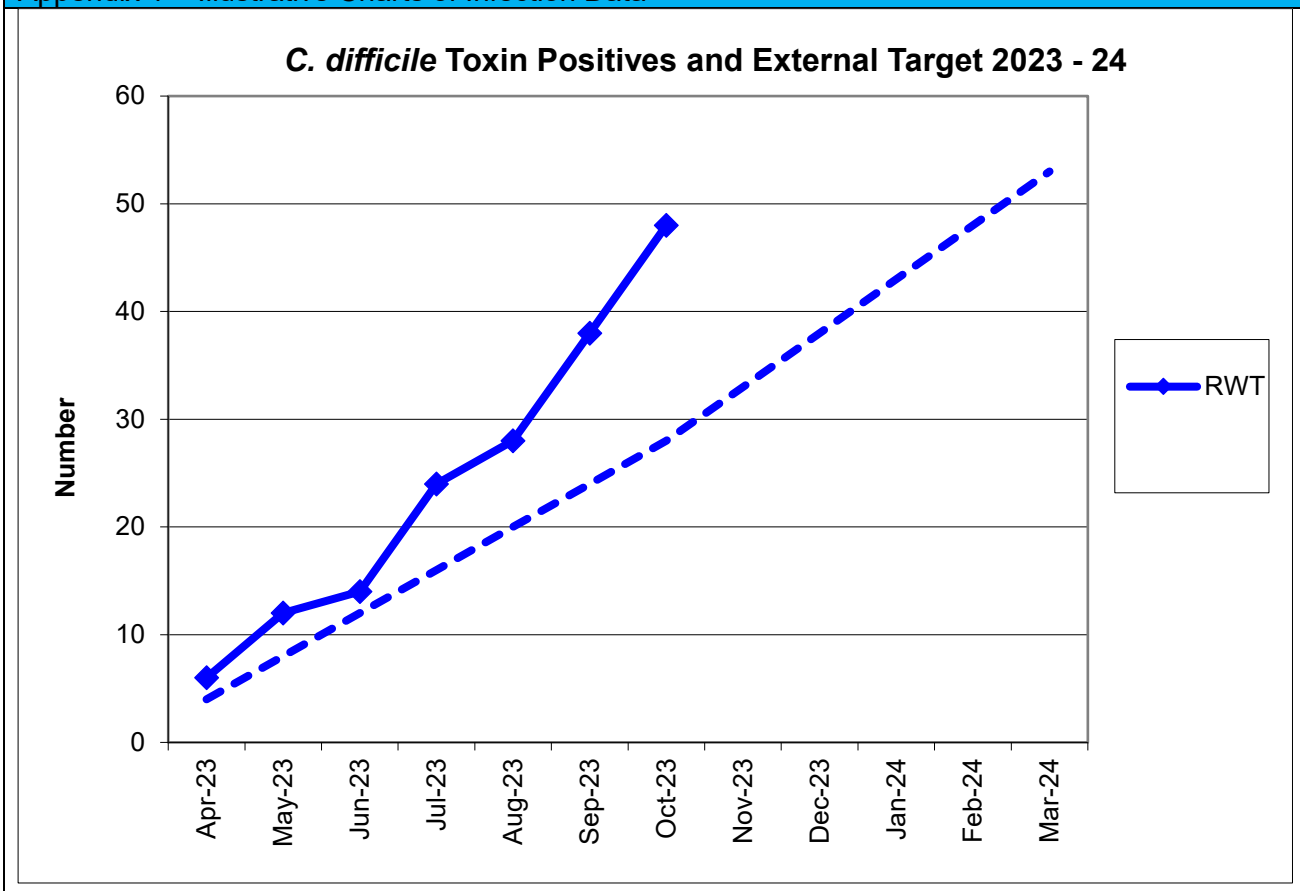
COVID-19 update
Universal mask wearing in the Trust remains stepped down, as does testing for the majority of staff, and asymptomatic testing of patients, other than for certain at-risk groups. Mask wearing currently remains based on risk assessment, although in September Haematology-Oncology services returned to mask wearing for all patient care.

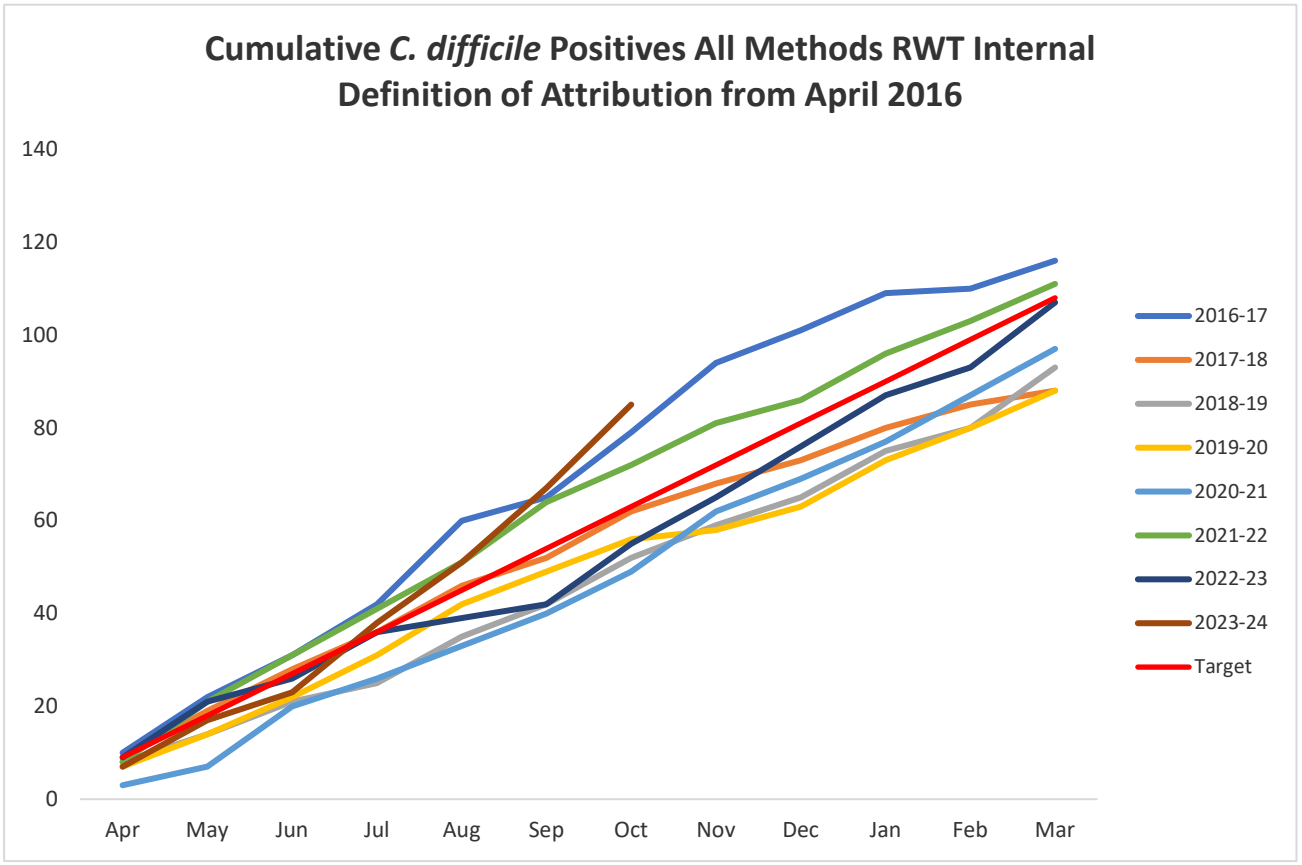
Influenza update
National and local indicators for influenza remain low. Rapid combined testing for influenza and COVID-19 is available in the laboratory. Point of care influenza testing will be introduced in the Emergency Department when it is recognised that influenza is circulating. The staff winter influenza and COVID-19 vaccination programme is in progress.

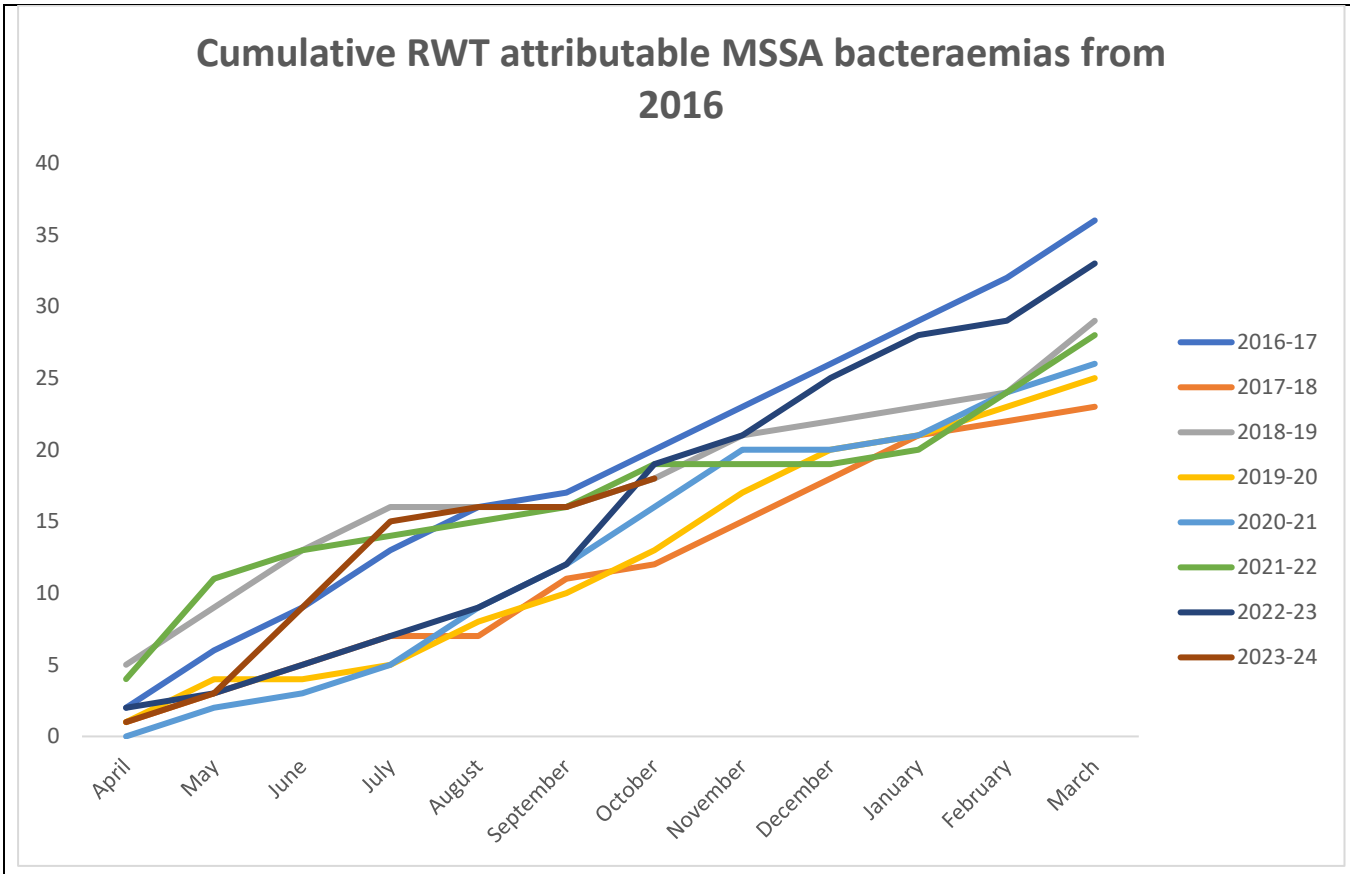
Respiratory syncytial virus (RSV)
RSV season is under way with increasing numbers seen in paediatric admissions. Point of care testing is available in admission areas, complimented by rapid laboratory testing if required.

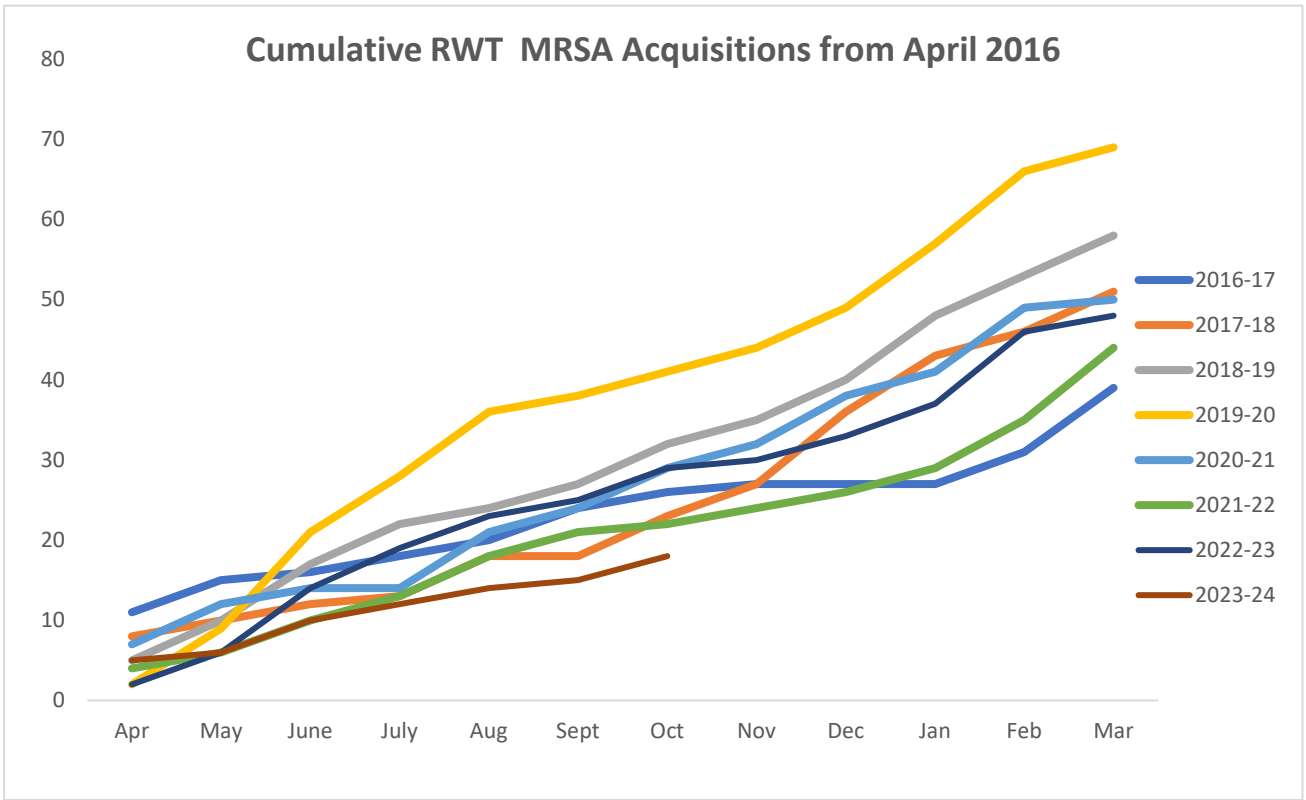
Objectives for 2023/24
CDI – 53 cases
MRSA bacteraemia - 0
Flu vaccination – CQUIN with 75% requirement for minimum payment and 80% requirement for maximum payment.
E. coli bacteraemia – 94
Klebsiella bacteraemia – 29
Pseudomonas aeruginosa bacteraemia – 15

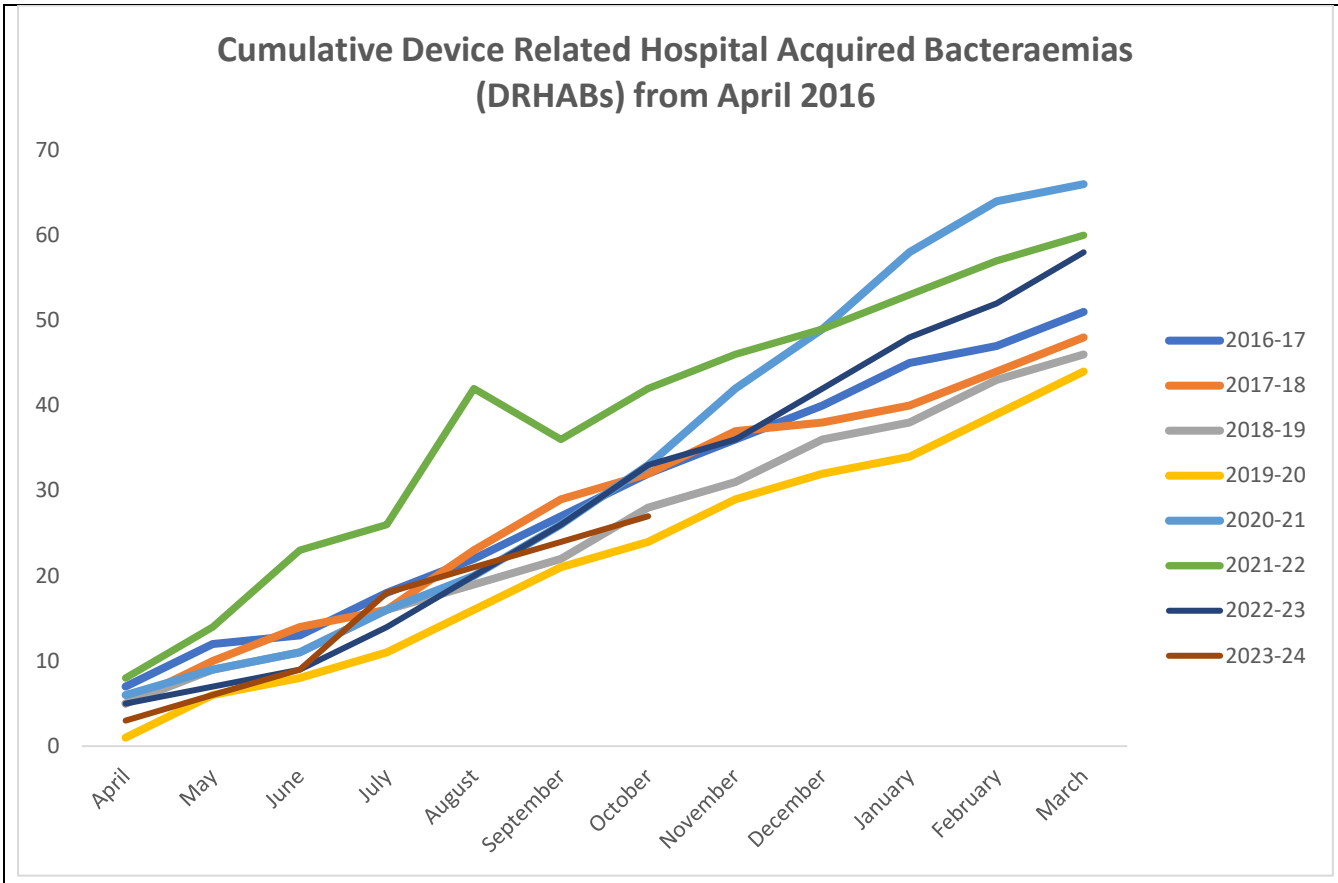
Appendix 1 – Illustrative Charts of Infection Data






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 RWT MRSA Acquisitions from April 2016
80
70
60
50
40
30
20
10
0
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
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	25	30	6	1	56

The Royal Wolverhampton NHS Trust

Healthcare associated COVID summary tables – September to October 2023

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

Month	Number of HCAI COVID
September	23
October	29

Table 2. Summary of COVID outbreaks (externally reported) in September and October 2023

Date of Outbreak	Ward/Department
01/09/23	A6
02/09/23	C39
05/09/23	C18
08/09/23	WP2
08/09/23	C21
18/09/23	C25
20/09/23	C19
02/10/2023	A12
29/10/2023	A14
29/10/2023	A7
31/10/2023	C39

The Royal Wolverhampton NHS Trust

Report to the Trust Board On 12th December 2023		
Title of Report:	Safeguarding Assurance Report, Quarter 2.	Enc No: 10.2.3
Author:	Clare Hope	
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 discussion and assurance.			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Risk Description: Mental Capacity and Deprivation of Liberty Safeguards Risk Score: 12 On Risk Register: Yes☒No☐ Risk Description: Deliver a safe and high-quality service (Children and Young People in Care) Risk Score: 6		
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: N/A
	Legal	Yes☒No☐	Details: Contribution to the Trust's compliance with legal framework such as The Mental Capacity Act, Care Act and Children Act.
	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. 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. 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 Safeguarding Group 01/11/2023 Trust Management Committee 24/11/2023
	Board Committee	Yes☐No☐	Date:
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- The monthly Black Country Safeguarding Assurance Framework has been completed and shared across the organisation, demonstrating evidence that safeguarding responsibilities are being met by the organisation.
- The number of Deprivation of Liberty Safeguards applications has continued to rise in Q2. In total 216 applications were submitted; this is a 33% increase in comparison to Q1 (Q1 163 applications).
- Safeguarding supervision compliance for both Health Visitors and School Nurses has demonstrated sustained improvement, with only two members of staff not receiving supervision within the required timescales (Q2 Health Visitor compliance 95%, School Nurse 92%).

Advise

- All mandatory training is in line with the Integrated Care Board (ICB) compliance requirements, with the exception of Level 4 Safeguarding Children training (Q2 91% - target 100%) and Safeguarding Board update (Q2 89% - target 100%). Training at both levels is planned for Q3.
- During Q2, the Safeguarding Team has been involved in attending workstream meetings for the Families First for Children Pathfinder Programme. Wolverhampton is one of three pilot areas identified by the Department of Education who will have a new multi-agency approach, which sees Early Help and Child in Need becoming 'Family Help'. These workstreams will continue into Q3 with a proposed launch in January 2024. Monthly updates will be provided to the Trust Safeguarding Group.

Alert

- Midwifery safeguarding supervision compliance has fallen from 93% in Q1 to 80% in Q2, due to staff absence. During this period support has been provided by the Safeguarding Childrens

Team. In addition, a new safeguarding supervisor is being trained and potential support from the Integrated Care Board discussed. All staff that missed supervision in Q2, have now received supervision or have an appointment in Q3 to do so. This will be closely monitored, and progress will be reported to the Trust Safeguarding Group.

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

The Royal Wolverhampton NHS Trust

Safeguarding Assurance Report, Quarter 2.

Report to Trust Board on 12th December 2023

EXECUTIVE SUMMARY

The aim of this quarterly report is to summarise safeguarding work undertaken across the Trust and demonstrate how the Royal Wolverhampton NHS Trust (RWT) discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004 and the Care Act 2014. The report outlines safeguarding activity across the Trust and highlights the achievements, challenges, and priorities during the year, set against the objectives detailed within the Black Country Integrated Care Board Safeguarding Assurance Framework.

BACKGROUND INFORMATION

Training:

All mandatory training is in line with the Integrated Care Board (ICB) compliance requirements, with the exception of Level 4 Safeguarding Children training (Q2 91% - target 100%) and Safeguarding Board update (Q2 89% - target 100%). Training at both levels is planned for Q3.

During Q2, Mental Capacity Assessment, Deprivation of Liberty Safeguards, Prevent, Safeguarding Children and Safeguarding Adults level 1 and level 2 training has demonstrated an overall compliance of 96% or above.

Safeguarding Children level 3 training compliance remains consistent, but below the Royal Wolverhampton NHS Trust compliance requirements of 95%, but within ICB requirements (target 85%).

The Safeguarding Adult Team has delivered bespoke Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) training sessions as part of the induction of new District Nurses, the Practice Education Facilitators team and Division 1 nurses.

During Q2, a bespoke Prevent awareness session was delivered by a specialist Counter Terrorism Police Team at New Cross Hospital. This was attended by both RWT and Local Authority staff. Very positive feedback has been received with another session planned for October 2023.

The Oliver McGowan mandatory Learning Disability and Autism training currently stands at 90.6% compliance, which is a small increase since Q1. This remains 20.9% above the exception reports trajectory.

Safeguarding Supervision:

Safeguarding supervision compliance for both Health Visitors and School Nurses has demonstrated sustained improvement, with only two members of staff not receiving supervision within the required timescales (Q2 Health Visitor compliance 95%, School Nurse 92%). This will continue to be monitored during Q3, to ensure that this progress is maintained. Any reduction in compliance with be escalated to the 0-19 service and the Trust Safeguarding Group.

The Safeguarding Children Team have acknowledged the number of complex safeguarding cases within paediatric in-patient services, which may require additional staff support. Therefore, supervision has been offered as part of in-service study days. This has not yet been actioned, but continuous ad hoc supervision is offered as and when required.

Midwifery safeguarding supervision compliance has been impacted upon by staff absence. In particular, the absence of three safeguarding supervisors. Compliance has fallen from 93% in Q1 to 80% in Q2. During this period support has been provided by the Safeguarding Childrens Team and will continue during Q3. In addition, a new safeguarding supervisor is currently in training and further supervisory support is being discussed with the ICB. All staff that missed supervision in Q2 have now received supervision or have an appointment in Q3 to do so. This will be closely monitored during Q3, and progress will be reported to the Trust Safeguarding Group.

No requests for ad hoc safeguarding adult supervision have been made during Q2.

As of September 2023, safeguarding supervision compliance for the safeguarding team was 100%.

Participation in Enquiries and Reviews:

RWT has attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Learning Disability Reviews and Domestic Homicide Reviews.

RWT is fully engaged with the LeDeR (Learning Disability Reviews) programme allowing timely access to the relevant patient records and Structured Judgement Reviews with Trust representation at the local LeDeR panels and the regional steering group.

During Q2, the Safeguarding Team has commenced a review of the scoping process for collating information for reviews. However due to reduced capacity within the team the development of Standard Operating Procedure and rollout of specialist training package has been postponed until Q4.

No Domestic Homicide Reviews, Child Practice Reviews or Safeguarding Adult Reviews have been published in Q2.

A Learning the Lessons Briefing was published in July 2023 following a review of exploitation services within Wolverhampton. It identified that there has been a drive to develop a detailed and comprehensive problem profile of exploitation, which provides practitioners with a more complete picture of the exploitation landscape in Wolverhampton. Learning to be shared across RWT via the communication team and specialist training.

The Safeguarding Children Team has participated in two Rapid Review meetings convened by Wolverhampton Safeguarding Together. One involved a 17-year-old who was involved in a non-fatal knife crime incident and the other was to discuss concerns raised regarding a one-year-old child that had ingested a class A drug. No learning identified in either case for The Royal Wolverhampton NHS Trust.

RWT are not currently leading on any statutory reviews but are participating in a number of reviews.

Safeguarding Assessment Processes:

The number of Mult-Agency Safeguarding Hub (MASH) checks for Children has seen a dip of 20% during Q2. This reduction is not unexpected, as activity during Q1 was the highest on record in recent years (16% higher than Q4 2022-2023). In addition, the reduction may be in part related to the school holidays, resulting in less referrals completed by the education sector.

It is positive to note that there has been a significant increase in the number of MASH enquires completed by RWT within the required timescales (Q1 78%, Q2 97%).

During Q2, the Safeguarding Team has been involved in attending workstream meetings for the Families First for Children Pathfinder Programme. Wolverhampton is one of the three pilot areas who will have a new multi-agency approach, which sees Early Help and Child in Need becoming 'Family Help'. These workstreams will continue into Q3 with a proposed launch in January 2024. Monthly updates will be provided to the Trust Safeguarding Group.

Initial Health Assessment (IHA) compliance has continued to be presented to the Trust Safeguarding Group. During Q2, compliance has remained steady for the majority of Key Performance Indicators (KPi's) with an average of 56% overall compliance in comparison to 61% in Q1. Reasons for this reduction in compliance was due to factors outside of provider control, including children not being brought to their appointments and carer cancellations regardless of appointments being offered within timeframes.

During Q2, reporting has continued to include the amended compliance indicators which reflects the number of days from the child being placed into care to the child being seen. Compliance has remained steady from 67% to 63% during Q2. Furthermore, to align data with the Local Authority, compliance is continued to be reported from the month the child was placed into care rather than the month the IHA was returned to the Local Authority. This will result in a delay in reporting due to the time lag. This demonstrates a compliance of 60% for July and 63% in August. The overall average compliance for Q1 was 62%.

The number of Deprivation of Liberty Safeguards applications has continued to rise in Q2. In total 216 applications were submitted; this is a 33% increase in comparison to Q1 (Q1 163 applications). This increase may be attributed to sustained greater visibility of the team in clinical areas.

There has a been a 48% decrease in MASH cases in Q2 compared to Q1. This is attributed to the new EMARF and Eclipse IT platforms, in which inappropriate referrals are now filtered out. The Safeguarding Team and the Local Authority are working collaboratively to audit and quality assure this work.

There was a marginal increase in the number of Multi-Agency Risk Assessment conference (MARAC) referrals completed in Q2 (5% increase). This is likely to be sustained during Q3 as the number of MARAC meeting has increased to weekly from bi-weekly as of September 2023. This increase is due to a back log of cases within the MARAC team and reduced capacity within their team. The issue is likely to be resolved in the new year and the safeguarding team continue to monitor the situation.

There were no Prevent referrals in Q2, this remains on parity with Q1.

Audit:

The Learning Disability Team has continued to roll out the service improvement project (SIP) in Q2 to reduce the number of adult patients with a Learning Disability who do not attend their outpatients' appointments. However, Q2 saw a slight increase in the average number of did not attends (DNA). An audit will be undertaken in Q3, with the purpose to identify where improvements can be made in the project.

The finding and recommendations from the NHS Improvements Standard and the Learning from Lives and Deaths of People with a Learning Disability and Autism Annual Report have been included in the Learning Disability Team development plan. This plan is monitored via the Trust Safeguarding Group.

The Trust has registered for the NHS Learning Disability Improvements Programme for 2023/24.

National Reports and Inquiries:

The Trust is committed to working in collaboration with all partners seeking to protect adults and children at risk from harm caused by abuse or neglect, regardless of their circumstances. As part of these arrangements the Trust is represented at all safeguarding and partnership meetings with Wolverhampton Local Authority (LA) and ICB. This includes MARAC, Interpersonal Violence Board, LeDeR Steering Group, One Panel and Wolverhampton's Autism Partnership Board.

RWT has submitted the completed monthly ICB dashboard. RWT actively participated in the mock Joint Targeted Area Inspection with the theme of Early Help. Named Nurses and Specialist Nurses networking days within the ICB have continued as a forum to share good practice and service improvement across the region.

RECOMMENDATIONS

The Group is recommended to note that safeguarding activity across the Trust demonstrates that patients, staff, and the public are protected from abuse and avoidable harm.

The Royal Wolverhampton NHS Trust

Report to the Public Trust Board Meeting to be held on 12th December 2023		
Title of Report:	Health and Safety Annual Report 2022/23	Enc No: 10.2.4
Author:	John Frazer – Health and Safety Manager	
Exec Lead/ Presenter:	Kevin Bostock Group Chief Assurance Officer Maria Arthur Group Deputy Director of Assurance	

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

Recommendations:

The Committee/Board members are asked to:

- Note the 22/23 assurance and compliance position for Health and Safety, work in progress and areas for targeted action/improvement;
- Confirm that the scope of content provides a level of assurance and captures an accurate and recognizable reflection of H&S adherence for 2022/23;
- Advise of any concerns or additional areas of focus for H&S for 23/24.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: Risk 5699 – If the Trust is unable to provide the required first aid training, this may result in non-compliance with First Aid Legislative requirements. On Risk Register: Yes☒No☐ Risk Score (if applicable) : 3 x 2 = yellow		
Changes to BAF Risk(s) & TRR Risk(s) agreed	No BAF or TRR risks		
Resource Implications:	Resource requirements for First Aid training is to be assessed. 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: CQC Fundamental Standards of Care
	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. There are no identified adverse impacts on persons with one or more protected characteristics.		
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: Quality Committee (formerly QPES) July 23
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure

- First Aid training and compliance – The Trust is exploring support and partnership working with WHT colleagues to improve training and ensure costs are kept minimal to RWT as we look to use shared resource.
- Stress – Work continues to support the identification of 'work' related stressors and support Occupational Health (OH) health and well-being programmes.
- The tracking and review of team risk assessments and the recovery of statutory compliance is in control across all divisions with improvements seen. The SharePoint system is use for monitoring and oversight.
- Health & Safety mandatory training compliance - 98.3% (Section 4.4)
- The restoration and relaunch of a coordinated H&S audit process to improve Trust assurance is implemented.

Advise

- Hybrid working remains a potential concern as injuries connected to Display Screen Equipment (DSE) namely, back pain and Musculoskeletal Disorders (MSD), eye strain and fatigue.
- The HSE are embarking on a UK wider inspection of Musculoskeletal injuries which cause MSD's and VAAG incident and though there is no indicator of a visit to RWT a gap analysis to ascertain current status is being triaged.
- Lack of compliance to managers job specific H&S e-learning packages (required to be at 95%) (Section 4.4 for compliance)
- RIDDOR incidents for 22/23 totalled 26 the main 'type' being slips, trips and falls with a total of 11

Alert

- Limited assurance due to a lack of quantifiable KPI data from Estates and Facilities/EPAG meeting process. The PAM process offers some assurance but reporting lacks consistency or a KPI framework and is generally 'report by exception' which only offers a limited picture of compliance.
- Violence and Aggression (VAAG) is becoming more prominent, severity and frequency have increased (Page 20).

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

Health & Safety
Annual Report 2022 / 2023

2.0 Executive Summary

The purpose of this report is to inform the Trust Board of the principal activities associated with the promotion and management of Health and Safety at the Trust for the period 1st April 2022 to 31st March 2023. The impacts of COVID-19 have continued to affect all areas within the Trust throughout 2022-23 and though the universal tracking of risk assessment and outbreaks meetings have now stopped in line with National guidance, operationally at least, the impacts are expected to continue as the recovery from COVID-19 continues to impact all areas across the Trust especially in clinical areas.

During the current reporting period, the Health and Safety team has continued to support clinical and non-clinical areas with managing Health and Safety considering the substantial operational issues they have faced with the recovery from the pandemic. The Health and Safety team have created new processes to increase competency and improve understanding and generate transparency on all H&S subjects, through monitoring and adherence to statutory compliance and compliance to the Health & Safety Policy (HS01), with the ultimate aim to improve the safety culture with a 'ward to board' approach.

The report provides information relating to key Health and Safety compliance activities undertaken including Health and safety Management and oversight, Operational Estates Health and Safety management, Occupational Health and Wellbeing, Infection Prevention Waste Management, Black Country Pathology Service, Manual Handling, Legal, Security and Fire Safety

A summary below provides the highlights of the report:

Emerging risks (all in Appendix 3)

- First Aid training and compliance – The Trust is exploring support and partnership working with WHT colleagues to improve training and ensure costs are kept minimal to RWT as we look to use shared resource.
- Limited assurance due to a lack of quantifiable KPI data from Estates and Facilities/EPAG meeting process. The PAM process offers some assurance but reporting lacks consistency or a KPI framework and is generally 'report by exception' which only offers a limited picture of compliance.
- Violence and Aggression (VAAG) is becoming more prominent, severity and frequency have increased (Page 20).
- Stress – Work continues to support the identification of 'work' related stressors and support Occupational Health (OH) health and well-being programmes.
- Hybrid working remains a potential concern as injuries connected to Display Screen Equipment (DSE) namely, back pain and Musculoskeletal Disorders (MSD), eye strain and fatigue
- The HSE are embarking on a UK wider inspection of Musculoskeletal injuries which cause MSD's and VAAG incident and though there is no indicator of a visit to RWT a gap analysis to ascertain current status is being triaged
- Lack of compliance to managers job specific H&S e-learning packages (required to be at 95%) (Section 4.4 for compliance)

Check & Act (all within Sections 5-6)

- Incident reporting (including RIDDOR reporting) though the total number of RIDDORs compared to total number of incidents recorded remained the same as 21/22 at 3.8% of total figure.
- The restoration and relaunch of a coordinated H&S audit process to improve Trust assurance is implemented.
- The number of personal injury claims increased to 28 in 22/23 (from 27 in 21/22) (Section 5.7)
- The tracking and review of team risk assessments and the recovery of statutory compliance is in control across all divisions with improvements seen. The SharePoint system is use for monitoring and oversight.
- The top three categories of incidents for 2022/23 are (Section 5.2)
  1. Sharps
  2. Slips, Trips and Falls
  3. Manual Handling
- Health & Safety mandatory training compliance - 98.3% (Section 4.4)
- Risk Assessment compliance (37 Red / 37 Amber / 218 Green / (all areas now have a set of risk assessments, are RAG rated, and are being tracked for compliance) as of 31st March 2023 (Section 5.3)

Accidents, Ill Health and Dangerous Occurrences (Section 5.6.1)

- RIDDOR incidents for 22/23 totalled 26 the main 'type' being slips, trips and falls with a total of 11.

Learning from other organisations (Section 6.1)

- The team are working to become accredited to the Institute of Safety and Health (IOSH) the chartered body for H&S which would enable them to deliver IOSH Managing Safely training. This is an externally recognised course which would improve competency at the Trust and offer opportunities to income generate.
- The H&S team regularly attends and contributes to the Midland NHS forum and Institute of Safety and Health (IOSH)
- Supporting clinical colleagues with ward accreditation/Podium audit process

Appendices (Section 9)

Risk profile for the Trust via the Estates PAM systems remains stable (Appendix 1) with the following risk profiles being identified as 'Amber' rated: pressure systems, slips trips and falls and decontamination with details found within Appendix 2. Appendix 3 is an emerging risk table with themes introduced within the report and a subsequent action plan in Appendix 4.

2.1 Introduction

All organisations have a legal duty to put in place suitable arrangements to manage Health and Safety. Ideally, this should be recognised as a part of the everyday process of conducting business and / or providing a service, and an integral part of workplace culture, behaviours, and attitudes. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing Health and Safety legislation. The HSE also fulfils a major role in providing advice on Health and Safety issues and practical guidance on the interpretation and application of the provisions of the legislative framework.

The HSE has an agreement called a Memorandum of Understanding (MoU, 2017) with the CQC to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public. It allows sharing of information and a collaborative working approach between the two enforcement bodies.

Regardless of the size, industry or nature of an organisation, the keys to effectively managing for Health and Safety are:

- leadership and management (including appropriate and effective processes)
- a trained / skilled workforce
- an environment in which people are trusted and involved.

This is an important definition of how RWT understands its H&S responsibilities. The Trust has a collective responsibility and the level of leadership required at divisional, directorate and department levels, is supported by a management system that incorporates the support of the central team at each level.

The HSE provides guidance to support organisations of all sizes to effectively manage Health and Safety based on the principles of 'Plan, Do, Check, Act' (PDCA). This is described in detail within the HSE's 'Managing for Health and Safety Guidance' (HSG65). The key components of the PDCA framework being applied within The Royal Wolverhampton NHS Trust are summarised, as follows:

- Plan determine policy, plan for implementation.
- Do profile Health and Safety risks; organise for Health and Safety management; implement the plan.
- Check measure performance; investigate accidents and incidents.
- Act review performance; apply learning.

The remaining sections of this report detail the Health and Safety management arrangements and performance contributions from various stakeholders to inform the Trust Health and Safety compliance. The PDCA cycle approach is applied to report the Trust's Health and Safety activity.

2.2 Health and Safety Stakeholder Summaries

The Trust Health and Safety Central Oversight

The Health and Safety Team work closely with Management Teams across the Trust, providing a Trust wide risk profile, ensuring safe premises, plant, and equipment, collaborating in the development of policy and procedures, audits and risk assessments, the delivery of training and promotion of the Health and Safety agenda.

The Trust continues to receive first line assurance from the specialty leads through business as usual / quality assurance audits and has expanded this year to include a new audit process which has been titled 'Podium Audit'. The Health and Safety Risk Profile is updated throughout the year by Specialist Leads who are responsible for the management of risk and reporting into the Health and Safety Steering Group (HSSG). The HSSG oversees compliance and continual improvement as well as monitoring the nature and level of risk within the Trust. This year we have added Moving and Handling and Black Country Pathology Services to the Report as they are now included in the HSSG/HSOG process. state HSOG in full at first mention

Health & Safety Team Resource and Competence

The central Health and Safety Team comprises of one Band 8a and four Band 5 posts (two full time H&S Officers, one seconded role, one 0.6 role (3 days per week) to cover all RWT sites / premises. At the end of the 2022 / 2023 period, the Health and Safety Team held 0 vacant Band 5 posts. The Health & Safety Manager is a Chartered Member of Institute of Occupational Safety & Health (CMIOSH), and each H&S Officer has a minimum standard of a National Examination Board in Occupational Safety & Health (NEBOSH General Certificate) with one member having a NEBOSH Diploma. We will pursue further CPD and training opportunities in individual appraisals in line with the H&S strategic delivery plan for continual improvement.

The progress on prioritised work over the past year has been enhanced through the collective efforts of the Health and Safety Team and colleagues across the Trust. It has been a busy and demanding year, and we thank them all for their continued efforts.

Estates Management

Estates Management have fully adopted the Operational Procedure (OP 33)

Within this procedure all technical responsibilities, quality standards, operational activities and the various reporting mechanisms are defined within and identified by 21 subheadings titled Safety Headings (SH`s) for example; SH3 ‘Estates & Facilities Document Management’, SH5 ‘Medical Gases’ and SH13 ‘Pressure Systems’.

Compliance to the appropriate standards both statutory and operational (functional), is reported within the monthly Estates Management Premises Assurance Group (EPAG), with Divisional and Trust oversight also provided by the Divisional Governance Meetings and the Health & Safety Steering Group (HSSG).

The application of enhanced reporting structures continues to improve overall quality standards throughout all of Estates responsibilities and activities. Additionally, the development of PAM system, continues to improve and enhance our Health and Safety management and performance – shown below and in appendix 1.

The Health and Safety Team work closely with Estates Management Team promoting specific issues such as slips, trips, and falls and the safe management of hazardous substances. The Teams collaborate in ensuring compliance with Safety Alerts and co-operate when undertaking incident investigations and developing control measures to reduce the risk of re-occurrence.

Premises Assurance Model (PAM) & Risk Profile

Premises Assurance Model (PAM) provides Estates & Facilities with oversight of H&S operational issues via the standard question Q3 (Risk Assessments) referenced in all SH`s. Overall progress is reported within EPAG H&S Steering Group. This systemic approach provides a real time view of assurance on differing aspects and features of the day to day running of Estates & Facilities including operational compliance with Health and Safety Regulations.

Appendix 1 provides a Trust Risk profile position as of 31st March 2023 with comparison to the previous three years. Action plans are monitored through specialist groups and HSSG with progress being reflected in the RAG status of the risk profile (more detailed information is available where on rating rationale).

Appendix 2 provides some detail and explanations for the decision on the grading of the risk where position is amber. There were three in total attaining this status.

Appendix 3 provides detail of the emerging risks in 2022/23 and an action plan defining their status.

Waste Management

The Waste and Recycling Compliance Lead has carried out waste audits across all clinical areas throughout the year and continues to support the Wards/Departments. With the support of the Waste and Recycling Compliance Lead, 97% of the Wards/Departments are now waste compliant.

The Waste Manager has reviewed the waste policy and all amendments to the policy and the training modules have been approved and the policy and training is now available on the intranet.

By 2025 Trust waste segregation needs to be legally made up of 60% offensive, 20% infectious and 20% medically contaminated waste, this will have cost implications for the Trust as new sack holders will have to be purchased. The Waste Manager and the Compliance Lead have identified all the areas that can meet the requirements and have implemented offensive waste streams in some areas. The intention is to ensure that all new builds, areas that are being refurbished and any areas that fail a waste audit and require new sack holders will be considered for offensive waste segregation.

All RWT sites now have zero waste to landfill. West Park and the Communities are recycling over 60% of their domestic waste, CCH are recycling 22% and NX are recycling 25% (this will improve when recycling is implemented in more areas), all other domestic waste from all sites is going to an Energy from Waste plant for electric recovery for the grid.

Black Country Pathology Service (BCPS)

The purpose of this report is to inform the Trust Board of the principal activities associated with the promotion and management of Health and Safety within BCPS for the period 1st April 2022 to 31st March 2023.

During the current reporting period BCPS has strengthened engagement with the Health and Safety Operational Group. Simon Brown, ESL Laboratory Lead for BCPS, has been identified as the representative to attend Health and Safety Steering Group on behalf of BCPS and to provide the requisite quarterly reports.

The first quarterly report for BCPS was provided in March 2023 and was complimented by the Chair. The format for this report will continue to be worked up and improved over the coming year to ensure that there is transparency over all key aspects of the management of Health and Safety within BCPS, including security, COSHH assessments, incidents and risks, and that assurance of this is regularly provided to the Trust Board. This engagement has also been valuable as a communication channel for Health and Safety management issues and discussions to be disseminated back to BCPS.

The only significant Health and Safety issue reported by BCPS during this reporting period has been a HSE inspection in March 2022 following which an issue was raised with the recording of the planned preventative maintenance programme for CL3 facilities in the Microbiology department. The inspection found that whilst maintenance was being

planned and performed as necessary, the maintenance visits had not been recorded on the Q-Pulse Quality Management System as required. As remedial actions, a system of recorded spot checks, a quarterly assessment and a spillage drill were introduced immediately. These actions satisfied the findings of the HSE, and there have been no further issues in this regard.

By March 2024 BCPS will be in a stronger position to provide a detailed annual report of Health and Safety management, as the current reporting mechanisms to capture this information from across BCPS are currently being developed.

Fire

This report provides the Trust Board of Directors accountable for the activities of the organisation with relevant information concerning the management and delivery of fire safety, from 1st April 2022 to 31st March 2023, in accordance with the recommendations of the Healthcare Technical Manual 05-01: Managing Healthcare Fire Safety.

As detailed in last year's report, we continue to experience issues with recruitment and retention, intensified by one of our most experienced Fire Safety Advisors retiring this year, we continue to explore all avenues to recruit staff.

The Fire Safety Advisor Apprentice we employed last June is doing extremely well and the department have learnt a lot from the process; talent management and succession planning now drives our recruitment and we are making investments to 'grow our own' for the future.

We introduced a programme of professional development to maintain and develop competencies within the team, and since this time, there has been a marked improvement in the 'job satisfaction' and 'your learning' elements in staff appraisals.

The latest development has been a piece of software for carrying out fire risk assessments and inspections – this will be further explained in Section 5.

The Royal Wolverhampton fire team are responsible for the delivery of fire safety services to The Royal Wolverhampton NHS Trust, Walsall Health care NHS Trust and Shrewsbury and Telford NHS Trust (SaTH).

2. Summary

The following summary profile gives brief details of this Trust's development towards compliance with the mandatory requirements for the NHS in England (considered as best practice for NHS Foundation Trusts).

Summary Profile				
Clearly defined fire policy	Fire Safety policy is in place and available via the Trust intranet			**G**
Board Level Director accountable to the Chief Executive for fire safety	Chief Operating Officer appointed as Board Level Director for Fire Safety			**G**
Fire Safety Manager to take the lead on all fire safety activities	Fire Safety Manager appointed			**G**
Have an effective fire safety management strategy which enables:				
Preparation and upkeep of the organisation's fire safety policy	The Fire Safety Group is responsible for the implementation, ongoing monitoring and review of the Fire Safety Policy and protocols.			**G**
Adequate means for quickly detecting and raising the alarm in case of fire	The fire alarm system remains inadequate across some inpatient areas, requiring significant investment for improvement.		**A**	
Means for ensuring emergency evacuation procedures are suitable and sufficient for all areas, without reliance on external services	Annual programme for fire drills and 'desktop exercises' for clinical areas is in place. The uptake of which continues to be heavily impacted by the COVID-19 pandemic and the effect this has had on staffing levels across all areas.		**A**	
Staff to receive fire safety training appropriate to the level of risk and duties they may be required to perform	Fire safety training for clinical staff is ineffective to equip staff with the knowledge and skills they would need to manage or be present at a fire incident. 'Online' Fire Warden training has been provided during the COVID-19 as a 'temporary' means for staff training. Face to face fire warden training recommenced April 2023; figures are not included in this report.		**A**	
Reporting of fires and unwanted fire signals	Most fire incidents continue to be reported via Datix, but not all. A comprehensive database of incidents is maintained by the Fire Safety Team and monitored by the Fire Safety Group.			**G**
Partnership initiatives with other bodies and agencies involved in the provision of fire safety.	Following the impact of COVID-19, we have begun to reconnect with the Fire and Rescue Services which cover our Organisation to ensure information sharing is relevant effective.			**G**

3. Statutory Enforcement Authority

West Midlands Fire and Rescue Service (WMFS) is the Enforcing Authority for fire safety across the West Midlands. RWT continues to build good relations with WMFS via regular liaison with by Operational Crews and Fire Safety Enforcement Officers.

Periodically, WMFS will undertake Fire Safety Audits, in line with the National Fire Chief Council's guidance. RWT have not received any external audit/inspections since before the COVID-19 pandemic and have not been served any notices under the Regulatory Reform (Fire Safety) Order 2005.

It should be noted that in November 2022, Shrewsbury and Telford Hospital NHS Trust were served with two Enforcement Notices under Article 30 of the Fire Safety Order, for failing to take steps to achieve the minimum fire safety standards required under the Order, and a Prohibition Notice under Article 31 of the Order, as the premises involved a serious risk to relevant persons. RWT have worked vigorously to support SaTH to improve safety standards and to satisfy the requirements of the notices. The Prohibition Notice was lifted in January 2023, whilst the two Enforcement Notices remain in place. Such notices are recorded on a public register and can attract media attention; to date, there has been no contact made by media sources, however given the nature of RWT relationship with SaTH, the Committee/Board should be aware of this issue.

4. Trust Fire Risk

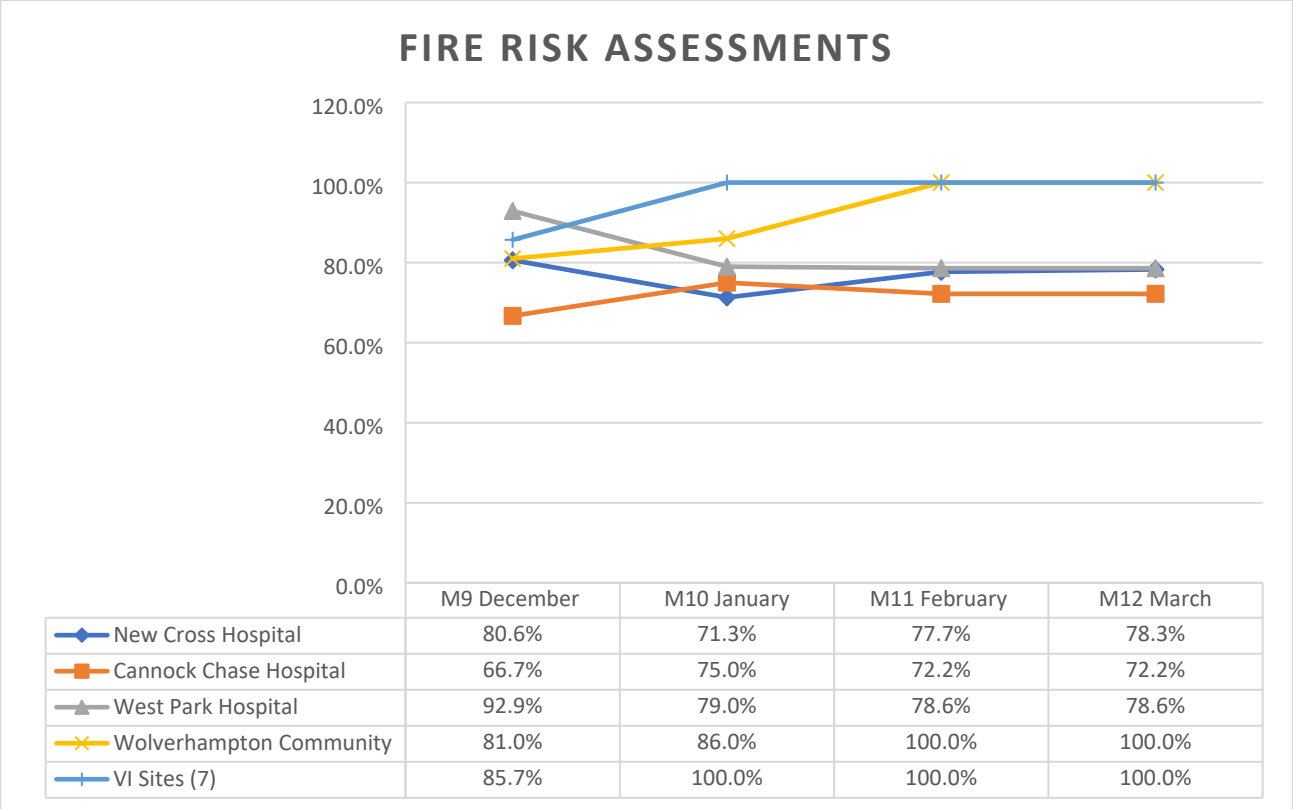
Since last year's report, the risks of the risk register have been scrutinised. The historic risks did not provide sufficient detail on what the risks were or how they affected the Trust, the building or the people working or being cared for in them.

The overhauled risk register now features 1 'parent risk' for fire safety and all the activity that contributes towards the fire safety management regime.

As specific risks are identified, they are introduced to the risk register as a 'child risk', sat under, and related back to the main risk. This approach ensures we do not consider fire risks in isolation and allows for a holistic and strategic response to reducing a risk.

5. Fire Risk Assessments

Access to ward areas during and since covid-19 has limited our ability to complete Fire Risk Assessments (FRAs); access for the Fire Safety Team onto wards has been reduced considerably with ward staff often turning us away due to staff shortages or outbreaks. However, the team continue to work with the areas to get them completed



	M9 December	M10 January	M11 February	M12 March
New Cross Hospital	80.6%	71.3%	77.7%	78.3%
Cannock Chase Hospital	66.7%	75.0%	72.2%	72.2%
West Park Hospital	92.9%	79.0%	78.6%	78.6%
Wolverhampton Community	81.0%	86.0%	100.0%	100.0%
VI Sites (7)	85.7%	100.0%	100.0%	100.0%

in a timely manner.

The Regulatory Reform (Fire Safety) Order 2005 (FSO) was introduced to provide a minimum safety standard for all non-domestic buildings. The FSO places a duty on the responsible person to take general fire precautions; general fire precautions include measures to reduce the risk of fire and fire spread, safe means of escape, measures for detecting a fire and giving warning, provision and training of media for fighting fires, and providing all relevant persons with information, instruction, training and supervision.

The FSO puts a duty on the Responsible Person (RP) to make an assessment of the risk with regards to fire and to identify the general fire precautions you have or will take. To comply with this requirement, the Trust undertake FRAs. Generally, these are undertaken on an annual basis, however timescale can differ depending on the level of risk.

In October 2023, there will be a change in legislation. Currently the requirement is to record the significant findings of the fire risk assessment, however the changes will require the RP to record all the findings of the FRA.

The new software for carrying out FRAs is a bespoke programme. The department has a huge amount of experience in fire risk assessment both within healthcare and

commercially and have created a tool which will allows for critical self-assessment against legislation, standards and best practice. The software also allows us to plan for Capital investment and aligns fire risk assessment outcomes with our risk register, which enables us to plan, manage and ensure we have safe environments from a fire perspective. We have designed the app with the legislative changes in mind to 'future proof' the software.

This software, once embedded, can be rolled out to other NHS Trusts with the potential for income generation, but most importantly, to raise the standards of Healthcare fire safety.

6. Fire Incidents

The total number of Fire Incidents reported for the year 2022/23 was 151; cooking was the main cause, however a large figure of unwanted fire signals were categorised as 'unknown'. To prevent incidents being uncategorised in the future, and losing the opportunity to learn from these events, 'unknown' has been removed as a cause option.

6.1 Unwanted Fire Signals

	New Cross	West Park	Cannock Chase	**Trust Total**
Unwanted Fire Alarms	127	4	9	**151**
False - Good Intent	1	0	0	
False - Malicious	10	0	0	
Total	**138**	**4**	**9**	

We experienced 138 unwanted fire signals at New Cross Hospital, West Park Hospital had 4 and Cannock Chase Hospital experienced 9. A breakdown of incidents per division is discussed quarterly at the Trust Fire Safety Group.

There has been an increase of 45 incident on last year's figures; there does not appear to be any trend for the increase and last year's figure of 106 was unusually low.

Financial Year	2018-19	2019-20	2020-21	2021-22	2022-23
Number of UwFS	146	129	141	106	151

6.2 Fire Incidents

The Trust experience 3 actual fire incidents, 2 of which were at New Cross Hospital.

In August 2022, a leased dishwasher started to produce smoke. Catering staff followed the fire procedures and were able to isolate the electrical supply to the appliance. Fire and Rescue Service attended as per procedures; however, the fire was out on their arrival.

In February 2023, a member of staff placed a wheat bag in a microwave within the Heart and Lung Centre. The member of staff was not informed that there is a dedicated microwave for the wheat bags so mistakenly heated it in a food microwave; the wheat bag caught fire and produced smoke. The Ward have implemented some changes for induction of Bank staff.

The was also an incident at Phoenix Health Centre were a toaster caught fire. The investigation could not determine if this toast was purchased by RWT however due to Trust staff being present at the incident, we have recorded this fire.

Notes

Unwanted Fire Alarm Signals (UFAS): relates to an avoidable actuation of the Fire Warning and Detection System.

Fire: relates to an incident that involved actual fire and smoke and had the potential to cause damage to property, affect Business Continuity and potentially cause harm.

Malicious: relates to a false operation of the Fire Warning and Detection System when it was known there was no fire or suspected fire.

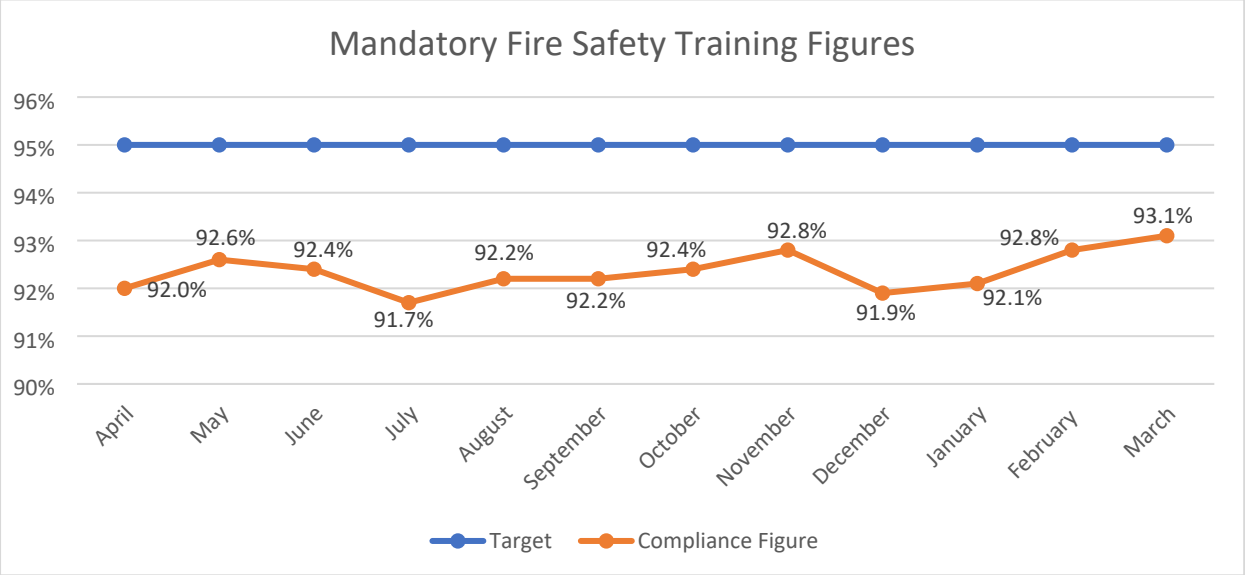
Good Intent: relates to a false operation of the Fire Warning and Detection System when there was a genuine belief that a fire had occurred.

7. Fire Safety Training

7.1 Mandatory Training: General Fire Safety Awareness

93.1% of staff participated in General Fire Safety Awareness Training during this reporting. Period, which although is just under the Trust target, this figure is very encouraging.

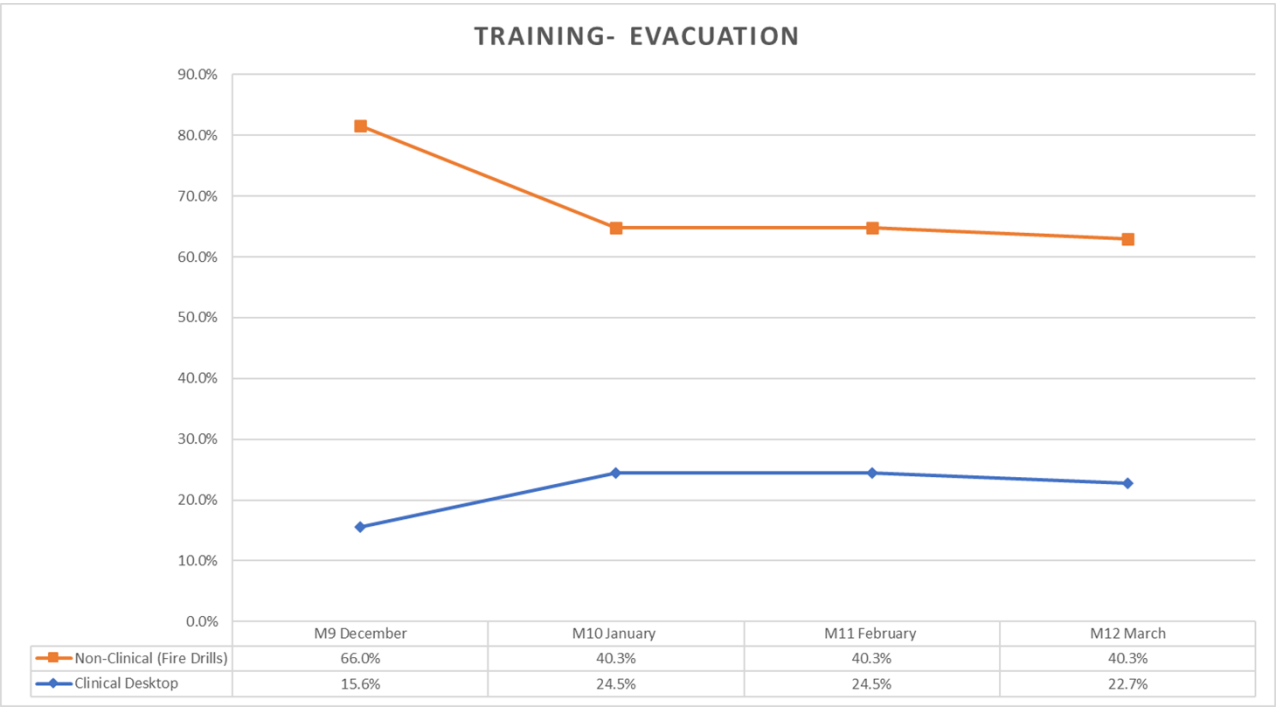
The table below provides an overview of the number of staff who undertook fire safety training during reporting period 2022/23 and the percentage level of staff compliance with policy requirements.



We have acted upon feedback received however we recognise there is still room for improvement to make training as accessible and effective as it can be. The aim was to harmonise the training packages for RWT and WHT however this has been postponed whilst we aligned our Fire Safety Management Policies. It is planned to implement all these changes in the first quarter of 2023/24.

7.2 Clinical Tabletop Evacuation Exercises and Fire Drills

The Fire Safety Team has continued to carry out fire drills at all required premises across the organisation, and clinical desktop exercises where it has been safe to do so respecting the restrictions imposed by the COVID-19 pandemic.



	M9 December	M10 January	M11 February	M12 March
Non-Clinical (Fire Drills)	66.0%	40.3%	40.3%	40.3%
Clinical Desktop	15.6%	24.5%	24.5%	22.7%

Attendance at clinical desktop exercises have been low due to the clinical pressures on the trust.

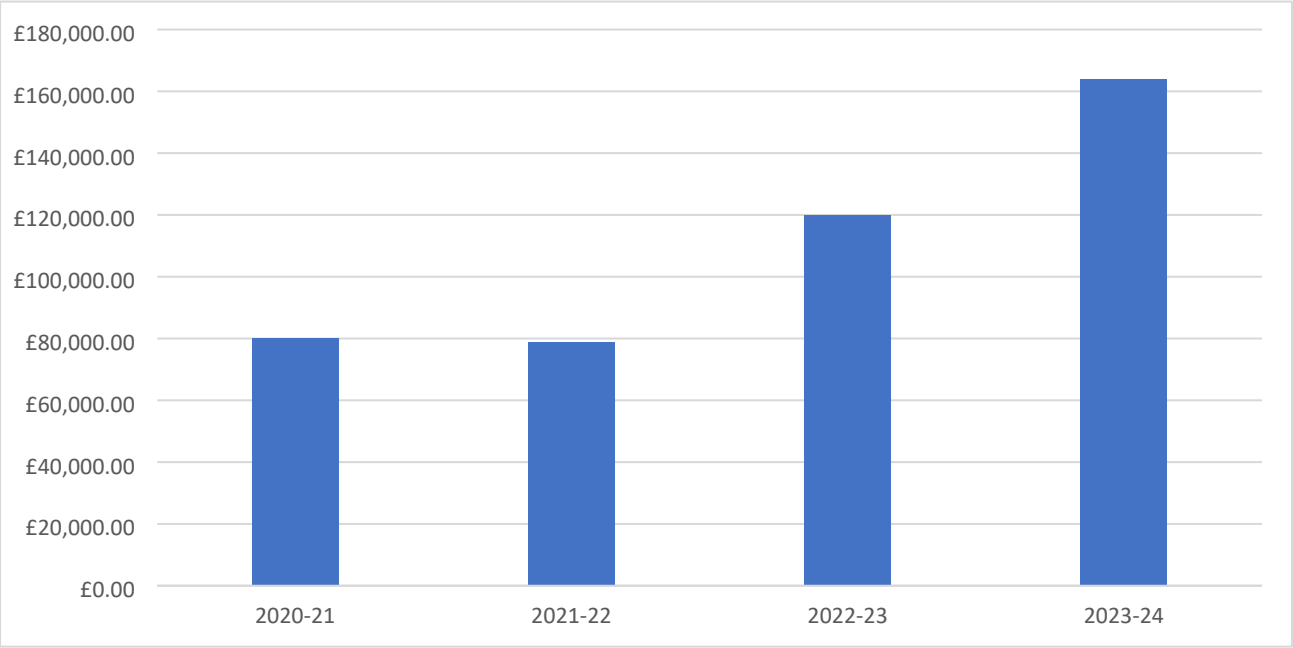
The aim for 2023/24 is to explore new ways to deliver clinical desktop exercises, and we have recently commissioned a piece of work with Shrewsbury and Telford Hospital NHS Trust which will be rolled out across all three (RWT, WHT, SaTH) once finalised.

8. Capital Development Investment

Scheme Number	Scheme	22/23 Commitments
42326	Fire safety improvements – compartmentation works"	**£69,438**
42303	Fire Safety Improvements - NX (Fire alarm upgrades & dry risers)	**£70,000**
41C52	Replacement of fire alarm devices CCH Hospital	**£380,000**

The Trust continue to investment in fire safety. With last year's planned commitments, several risks have been closed on the risk register. A major project of fire safety improvement works is being undertaken at Cannock Chase Hospital, with further plans to undertaken fire damper replacements throughout the site.

9. Income Generation



The team continue to offer professional fire safety services to Ergeam, formally known as Medipass Healthcare Ltd in the Radiology building on the New Cross Hospital site.

As of April 2022 the Fire Safety team have been supporting Shrewsbury and Telford Hospitals NHS Trust by way of professional Fire Safety services.

Recommendations for 2023-24

SaTH have expressed a keen interest to expand the services we offer into a long-term 'partnership' arrangement, and a consultation is underway with regard to this request.

Occupational Health and Wellbeing

The Occupational Health and Wellbeing Service continues to support COVID-19 as necessary as guidance changes. As the approach has now moved to a living with COVID model, the COVID-19 helpline closed as of December 2022 and management of positive staff is now dealt with at a local level. Vaccinations will continue to be available to include both Flu and COVID as necessary, in line with national guidance.

The staff sharps/splash injury group monitors sharps injuries and encourage the procurement and use of safety devices where possible.

Sharps / Splash incidents

- 184 incidents in 2022/23
- 171 incidents in 2021/22
- 121 incidents in 2020/21

Top three causes of sharps incidents are highlighted in the tables below and give a 3-year comparison:

Top 3 comparison			
	2020/21	**2021/22**	**2022/23**
Suture needle	7	25	9
Cannula	6	18	16
Splash	8	18	31
Sub cut safety needles	18	18	12
Blades	8	13	9

There appears to have been a significant reduction regarding incidents involving IM safety needles as evidenced below:

	2020/21	2021/22	2022/23
IM Safety needles	13	10	6

Stress referrals

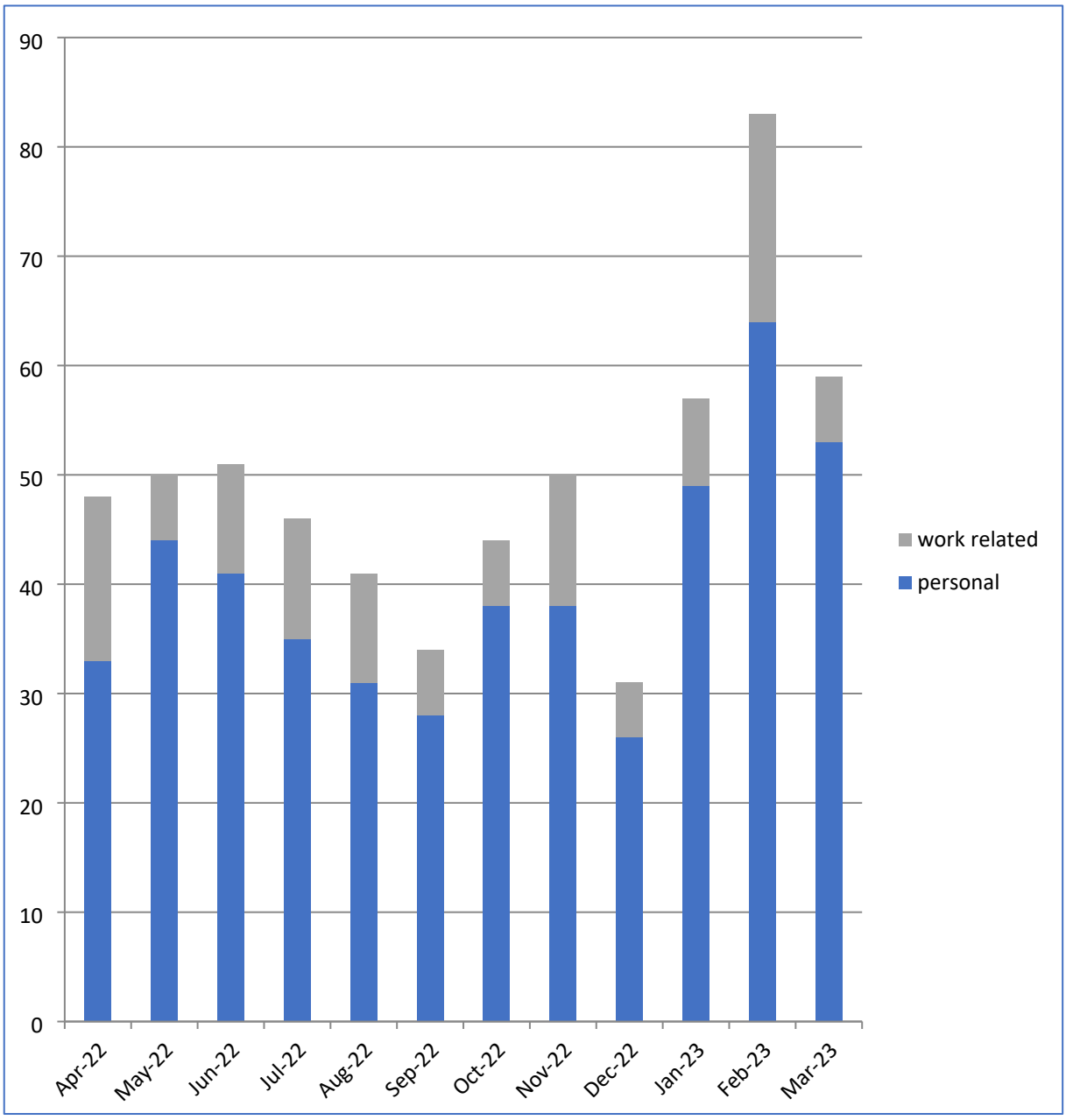
Stress Management remains a key issue for the Trust and is monitored for trends. The chart below shows the monthly new cases related to stress referred to the Occupational Health and Wellbeing service. All cases are categorised using OH standard categories on the basis that the key stressor determines the category.

The categories have changed slightly and there are now only 7 categories to show the overarching stress causes i.e., personal (category 1), work (categories 2-7). The category 'personal / work' was separated so we can challenge and clearly identify if employees were off sick from work due to 'personal' or 'work' stressors. The outcomes of referral cases are reported to managers as appropriate to undertake individual stress risk assessments and / or review their team risk assessments to reflect findings. Some cases, where appropriate, will be monitored and supported by Occupational Health offering various wellbeing services.

Non-personal identifiable data evidencing stress categories by division is presented to the health and safety steering group to enable them to offer reviews of team stress risk assessments/stress spreadsheets, to ensure controls are sufficient to support individuals as far as is reasonably practicable.

	Reporting criteria	Description	2021/22 referrals	2022/23	+/-
1	**Personal**	Not related to work no absence from work	319	508	+189
2	**Work DEMANDS**	Including issues like workload, work patterns and the work environment	121	83	- 38
3	**Work CONTROL**	Involving how much say the person has in the way they do their work	16	2	-14
4	**Work SUPPORT**	Including encouragement, sponsorship and resources provided by the organisation, line management and colleagues	2	4	+2
5	**Work RELATIONSHIPS**	Including promoting positive working to avoid conflict and	30	26	-4

		dealing with unacceptable behaviour			
6	**Work ROLE**	Including an understanding of one's role within the organisation and whether the organisation ensures that the person does not have conflicting roles	5	2	-3
7	**Work CHANGE**	About how organisational change is managed and communicated	2	0	0



The chart above shows the month-on-month new cases relating to stress and which had been referred to the Occupational Health and Wellbeing service.

The Trust Health and Wellbeing strategy continues to further develop. Several health and wellbeing initiatives have taken place including:

- Menopause policy & guidance documents developed and launched across Trust
- Menopause sessions developed and delivered by colleagues in HR & HWB
- HWB events and campaigns delivered upon over a 12-month period
- Face to Face HWB conference 'Career Wellbeing' took place on 28th March
- Staff Wellbeing Hub & food bank set up
- Nutritional needs assessment conducted
- OHWB added to online induction
- Reduced cost hot meals introduced at Trust catering outlets

Health surveillance was undertaken as below by the Occupational Health and Wellbeing Service during 2022/23 as follows, with outcomes reported to the Health and Safety Steering Group:

Surveillance	Department involved	Screening Required	Due Date	Comments
Skin Surveillance	All HCWs who use skin sensitisers	Questionnaire	Jun-22	N/A
Formaldehyde	Histopathology	Questionnaire and Spirometry	May-22	Questionnaire only, Spirometry not currently undertaken aligning with other OH services in the region due to the fact that this activity is considered an aerosol generating procedure and COVID-19 risk therefore attributable.
Bone cement	Theatres	Questionnaire and Spirometry	Jun-22	Questionnaire only, Spirometry not currently undertaken aligning with other OH services in the region since this activity is considered an aerosol generating procedure and COVID-19 risk therefore attributable.

Surveillance	Department involved	Screening Required	Due Date	Comments
Nail Dust	Foot Health	Questionnaire and Spirometry	Jul-22	Questionnaire only, Spirometry not currently undertaken aligning with other OH services in the region since this activity is considered an aerosol generating procedure and COVID-19 risk therefore attributable.
Noise	Estates	Questionnaire and Audiometry	Nov-22	N/A
TB	Respiratory wards, AMU, ED, ICCU, GUM and Respiratory Physiotherapists	Symptom reminder letter	May-22	N/A

Security

Security Management

The Security Management Team continues to provide support, guidance and training to Royal Wolverhampton Trust staff located at New Cross, Cannock Chase and community sites. The team meet with various managers to provide advice and guidance with regards to risk assessments relating to security, violence, and aggression as well as lone working.

During the reported-on year, the Security Management Team has appointed an extra position of “CCTV Operator” based within the Security Control Room at New Cross Hospital. This role has been developed to aid in a fast-paced environment working alongside our Contract Security Provider.

Within the reported-on year, Liam McEnhill (Assistant Security & Car Parking Manager) and Thomas Bishop (Control Room Operations Manager) have completed their Certified Security Management Professional (CSMP®) Level 6 qualifications.

CCTV / Intruder Alarm / Access Control

Over the year there has continued to be various refurbishments and upgrades with regards to CCTV, Intruder Alarms and Access Control. Key highlights are as follows:

- Additional CCTV cameras implemented at the following areas to alleviate blind spots and provide surveillance of new areas:

  - East Multi-Storey Car Park
  - South site exit and adjacent roadways

- Ambulance Receiving Centre (ARC)
- Ward A9
- AMU
- C14
- C21
- C26
- Outpatients
- WMI

- All cameras have been installed at key building entranceways which allows security to utilise a “person search” through the CCTV software. This allows for security to input a description of a person’s clothing and the system can narrow down potential matches who have passed though within a pre-set time frame. This has allowed for more efficient searching of absconded patients and allows security to be better informed allowing for more prompt responses. Areas that benefit from these AI cameras are as follows:

  - East Entrance
  - West Entrance
  - Maternity Reception
  - South Entrance
  - C41 Entrance
  - Heart & Lung Atrium

- A project is currently underway to migrate from the existing access control system to a new system which will provide advanced capabilities and futureproofing. This project has been completed in several phases with the 1st phase currently running according to schedule. The following phases will be conducted over the next financial year.

Security Related Incidents (Carlisle Support Services)

Carlisle Support Services continue to provide the onsite security service at New Cross hospital including manning the on-site control room and providing a dedicated presence to the Urgent Emergency Care Centre (UECC).

The security team’s day-to-day duties are varied and includes conducting patrols of the building and grounds which is logged using an audited smart patrolling application, maintaining building security including lock ups, assessing alarm activations, and providing a response service as well as being a source of guidance and advice to staff, patients, and visitors.

The security team continues to respond to calls for assistance from various wards / departments, receiving an average of 8 calls a day.

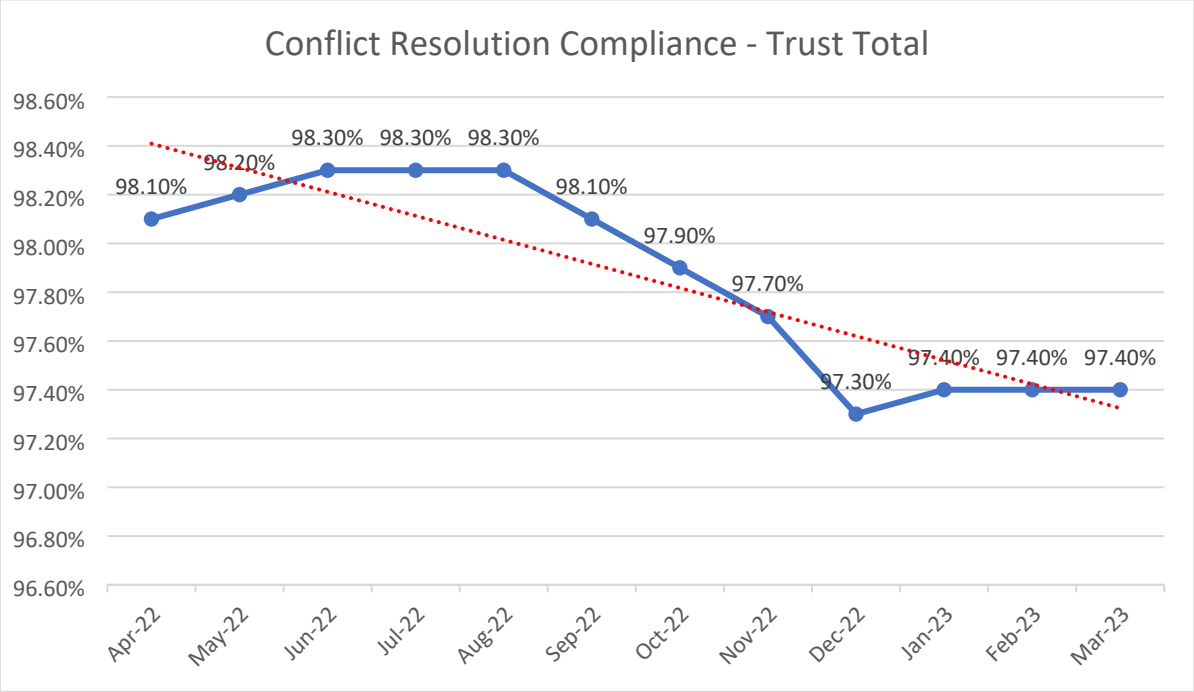
(Source – Carlisle Support Services Daily Occurrence Log)

Breakdown of Incident Type for Year (April 2022 – March 2023)	Total
Calls for assistance attended (Calls include but are not limited to responding to acts of violence and aggression and disruptive behaviour)	2,971
Calls for assistance unable to attend at the time of call	7
Calls for non-Urgent assistance (Calls that did not require an emergency response, but security was still required to be present)	408
Calls for advice and guidance	215
Calls for presence on ward / department	197
Alarm Activations (These include panic, intruder, and fire)	766
Baby Tagging Alarm Activations	6
Emergency Services related (Assisting with police and air ambulance landings)	10
General Patrols / Security Tag Routes	52,628
Car Park / Traffic Management Duties	14,983
Assisting with absconded patients	230
Miscellaneous Security duties (Examples include opening/locking of areas and escorting deliveries)	14,878

Conflict Resolution

Face-to-face conflict resolution training was moved to an online package at the start of the COVID-19 pandemic. Following the cessation of COVID-19 restrictions, the decision was made to continue offering conflict resolution training in this format. Additional face-to-face sessions are offered by the security management team where additional assistance is required.

Throughout the reported-on year, there was a slight decrease over the year in the amount of staff members who were up to date on their conflict resolution training, however it continued to remain above the target compliance score of 95%.



Target compliance – 95% (Source – RWT Mandatory Training Database)

Violence and Aggression Incidents for period 01/04/22 – 31/03/23

The following is a breakdown of incidents related to violence and aggression collected through DATIX incident reporting and collated by the security management team to give an overview to the categories of incidents recorded in relation to the calls for assistance received.

Not all the data relating to violence and aggression are reported through DATIX. The security management team will continue to encourage Datix reporting, as well as advise and guide staff to report incidents of violence and aggression accordingly so trends can be monitored, analysed, and allow for suitable mitigation moving forward.

V&A Incidents for period 01/04/22 to 31/03/23 *(Source - Datix Incident Reporting)*

Type	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
V&A Intentional (Actual Physical Assault)	7	10	12	8	11	14	18	4	11	7	17	15
V&A Unintentional (Actual Physical Assault)	2	6	3	2	2	2	2	2	2	3	2	3
Aggressive, Intimidating or Threatening Behaviour	14	19	12	20	16	12	13	11	12	14	13	18
Inappropriate Behaviour – Behavioural – Destruction / Damage to Property	5	6	5	5	8	5	9	3	5	7	6	8
Discriminatory Behaviour	0	0	0	0	0	0	0	0	0	0	1	1
Racial Abuse	0	4	1	0	1	0	0	1	2	0	0	3
Verbal Abuse	14	16	15	17	20	22	14	27	17	13	15	12
At staff	14	16	15	16	20	22	14	27	17	13	15	11
Sexual Abuse / Assault	1	0	0	0	0	0	1	0	1	0	1	1
No. of calls for assistance from staff responded to by Contract Security Provider	266	273	192	228	208	195	227	219	325	275	236	407
No. of calls unable to attend at time of call by Contract Security Provider	0	1	0	1	1	0	0	1	2	1	1	0

Management of Violence and Aggression (MOVA) – Red and Yellow cards

To support the security policy OP26 the management of violence and aggression (MOVA) procedure is used for the management of patients and visitor who are violent or abusive in their behaviour towards staff, other patients, or members of the public.

The table below outlines red and yellow cards issued over the financial year 2022-2023:

(Source – Datix Incident Reporting)

Type	April	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Red card	0	0	0	0	0	0	0	1	0	0	0	0
Yellow card	0	0	0	0	0	0	0	0	0	0	0	0

The security management team continue to advice and guide staff regarding decisions and implementing stages of the MOVA procedure to provide support through the process and ensure that the procedure is conducted correctly and fairly.

Infection Prevention

2022/23 has been another challenging year for Infection Prevention with the ongoing COVID-19 Pandemic. The Infection Prevention team (IPT) continued with the reactive work whilst managing to undertake some proactive work however, not all the key objectives set in March 2022 were met.

The IPT continued to work effectively with UKHSA, ICB, NHSEI and Wolverhampton City Council to ensure that COVID-19 guidance was implemented across the city. This included education and policy setting, establishing assurance processes and, most importantly, ensuring patient safety in the prevention of spread of COVID-19.

- (CPE) colonisation cases increased to 53 cases as international travel has resumed
- Clostridioides difficile (*C. diff*) is over trajectory this year with 72 cases, 14 over trajectory
- 2 MRSA bacteraemia's, 1 attributed to RWT, 1 joint attribution with Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)
- Surgical Site Infection (SSI) Surveillance data is shared with Consultant Surgeons via a monthly Dashboard and reported to IPCG
- Device related bacteraemia (DRHAB) was above the internal trajectory, with 58 being identified against a trajectory of 48
- Environmental controls have continued to be a top priority in our approach to tackle HCAI; this has remained a focus this year due to the ongoing Pandemic. The deep clean program was suspended due to the lack of a decant facility, wards received partial deep cleans throughout the year with support from the housekeeping team. The Patient Equipment Cleaning Centre (PECC) has a temporary location, the team have supported wards with the cleaning of patient equipment such as beds, hoists, tables and lockers

- The Intravenous Resource Team continues to deliver a high standard of line care with increasing numbers of patients discharged on Outpatient Parenteral Antibiotic Therapy
- COVID-19 outbreak management within care homes has continued throughout 2022/23. Other high-risk settings also received outbreak management. This continued to be a challenge with many COVID outbreaks and with a seasonal increase of Influenza and norovirus outbreaks
- Outbreak management for COVID-19 included dedicated wards/bays to cohort patients and prevent ward closures – 87 outbreaks were declared throughout 2022/23. From the end of December 2022, the ICB COVID-19 Outbreak Serious Incident (SI) reporting process for the Black Country System v1.1 was introduced for local outbreak management, so outbreaks were reported as a Period of increased incidence (PII) not as a serious incident (SI).

The team has showed great resilience throughout the year in managing the large number of COVID-19 outbreaks, the emergence of Monkeypox in the UK and a National alert regarding the increase in cases of Diphtheria and *Group A Streptococcus*. The team have delivered targeted service situated training including proactive *C. diff* awareness weeks in patient areas and presented structured education sessions e.g., Bitesize sessions, AMU teaching sessions and Student nurse education whilst facilitating an IP link worker group.

Policy review status:

Policy review status include dates, reason for review and whether approved or not:

IP03 Prevention and Control of MRSA, VRE and other antibiotic resistant organisms

IP06 Prevention and Control of *Clostridioides difficile*

IP08 IP Operational policy

IP10 Isolation policy for infectious diseases

IP12 Standard Precautions

IP18 Norovirus policy

IP21 Control and Management of Transmissible Spongiform *Encephalopathies* including *Creutzfeldt* Jacob Disease. (CJD)

IP06 and IP08, had amendments to attachments, these policies were not due for review. The additional policies listed were due the 3 yearly updates and have been approved and uploaded to the Intranet.

Risk Profile

5599 - GREEN

If due to an increase COVID-19 cases the Trust is unable to achieve policy for the reporting and investigation of healthcare acquired COVID-19 infections, there will be the following impacts: **Risk closed March 2023**

5648 – **YELLOW**

If CPE screening is not undertaken according to the updated guidance, RWT will not identify positive patients and will increase the risk of nosocomial transmission and outbreaks:

Patients are risk assessed on admission, but this only includes if travel abroad or has been an inpatient in another health care setting not including RWT.

A business case is required by the Black Country Pathology Service (BCPS) to enable RWT to be fully compliant with the updated guidance.

5682 – AMBER

The Trust is at risk of increased incidence of Healthcare Acquired Infections (HCAI) as there are a limited number of side rooms with ensuite facilities –

Patients are risk assessed on admission.

IP10 Isolation Policy and IP10 Appendix 1 Risk Categorisation table (RAG rated) available to support.

Explore converting bays into additional side rooms with ensuite facilities.

5777 – AMBER

Risk of outbreaks with potential to cause patient harm, disrupt activity and give rise to media attention.

COVID-19 inpatient dashboard in place

Infection Prevention Team (IPT) 7 day working.

Compliance with Mandatory Training for IP Level 1 and Level 2 is below expectations.

Infection Prevention – Moving forward - Our Plans for 2023/24

The Trust will continue to work effectively with colleagues in primary, secondary and social care to develop work streams and individual projects that will deliver the values of the Trust and our ICB. The IP team will continue to work collaboratively with the IP team at Walsall Healthcare Trust when reviewing policies and to maintain the joint COVID-19 risk assessment. Unfortunately, not all aspects of the Annual Work Programme commenced or were completed so have been carried over to 2023/24

The Annual Work Programme includes:

1. Back to Basics continued from 2022/23
2. Maintaining environment scores above 95%. With the IP education this will support
    - Reduction in MRSA Acquisition

- Reduction in *Clostridioides difficile*
- Reduction in DRHABs

3. A strategy for reducing the use of urinary catheters across the city, explore alternative products, develop a protocol for identifying catheter associated urinary tract infections (CAUTI) and develop a root cause analysis (RCA) tool
4. Sustain best practice and broaden knowledge of infections through collection and analysis of good quality surveillance data
5. Sustain the Trusts' excellent reputation for Infection Prevention through team members' participation in regional and national collaboration groups and projects
6. COVID-19 will continue to be identified; therefore, the IP will maintain and update protocols accordingly to changes in National and regional guidance
7. Identifying Trust baseline data on the number of Hospital Acquired Pneumonia (HAP) and Ventilator Associated Pneumonia (VAP) and develop a strategy to reduce these numbers

Moving and Handling Report

Moving and handling representation inputs into strategic steering groups across the Trust which support patient care health and safety and key Trust drivers including tissue viability, falls prevention, clinical procurement, Quality Assurance, Bariatric pathway.

Due to the amalgamation of Cannock Hospital, the additional wards /services at New Cross (due to Covid-19) along with a review of roles against existing training, there has been an increase of staff mapped to mandatory moving and handling training. Currently standing at Circa 6000 staff across the Organisation

The Trust compliance rates are required to be performing at above 95% but as of February 2023 they are - 83.4% and have remained in the 80% range for the last 6 months.

Month/year	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Average
Compliance	86.2 %	86.9%	87.9%	85.1 %	83.9%	84.8%	85.8%

An audit of the service identified the inability with the current capacity of the team to meet increased demands for several reasons. The service is currently on the Risk Register– see details of the risk and how we mitigate currently, and why this isn't working.

Current mitigation

To enable us to meet the increase in the Diversity of patient groups and care settings has resulted in more bespoke packages and versatility of delivery. Use of Governance days. Tailored delivery. Training is offered daily with bookable slots available on My Academy with reduced delivery time.

Limitations

Capacity of the team and training locations - only 3 members of staff and only one training room results in the inability to meet the demands of the staffing groups. The risk from reduced training is an increase of inappropriate use of equipment through lack of knowledge or poor cascade by existing staff.

Staffing levels for ward areas have been low and this has led to operational pressures this has resulted in significant DNA's which have an impact on the compliance in a 12-month period see Did not attend figures in the table below.

Time Period: January 2022 to January 2023

Course	No. DNA's	No. of hours
Initial	351	1229
Refresher	215	430
Community	20	40
Cascade (TTT)	16	32
Additional skills	6	12
Totals	608	1742

Current statistics report that there are 3,549 staff who require refresher training within the next 12 months along with any new starters, these figures include staff expiring from 2 years ago as the service attempts to recover from change in delivery to online any out-of-date training originating from COVID-19 provision.

Additional pressures on the team have increased with the demand for specialist advice and guidance to ward areas and therapy teams with increased request for supporting with equipment selection and complexed patient/bariatric handling assessments. The response from the team due to capacity can be delayed due to training demands.

Current Risk

Not having a team intervention into the initial admission of Bariatric/plus size patients – have such intervention would enable the timely identification of equipment and pathway reducing current bed blocking and preventable cost pressures to the Trust. There is a Governance and Audit Gap around equipment supporting this pathway.

Link (Cascade) Trainers (Commenced Sept 2022)

The Patient Moving and Handling service is supported by cascade /assessors across the organisation as a pressure reliving resource whereby identified staff can monitor / assess staff within their areas to identify capabilities and escalate any areas of concern back to the team. The model is a 2-day training programme that allows assessments to take place on wards / departments by the cascade trainer / assessor. The importance of this service is to identify areas of concern across the organisation, to ensure the team can provide

additional training to staff where required, thus reducing the risk of harm to patients and indeed staff if moving techniques are not being carried out following safe practice.

Mitigating risk

Utilizing this support for the PMH service relies also on the services ability to quality assure both the system and the assessors. Each cascade trainer/assessor has access to a mentor, and they are supported by the team. The implementation and support of the QA for the programme is key as lack of support/contact was found to be one of the key issues the original programme failed.

Limitations

The programme has been supported by a trainer who provided 82 hours of support from January to March 2023 this equates to a day a week and will be difficult to sustain but a necessary measure to endure the success of the new delivery model moving forward. This will obviously increase if the programme is taken forward. But supporting with existing staff will be problematic.

The service is Currently unable to check/perform.

- Competency assessment after training to ensure learning embedded.
- Regular Audit of areas
- Overview of hotspots and improvement planning

Statistical information

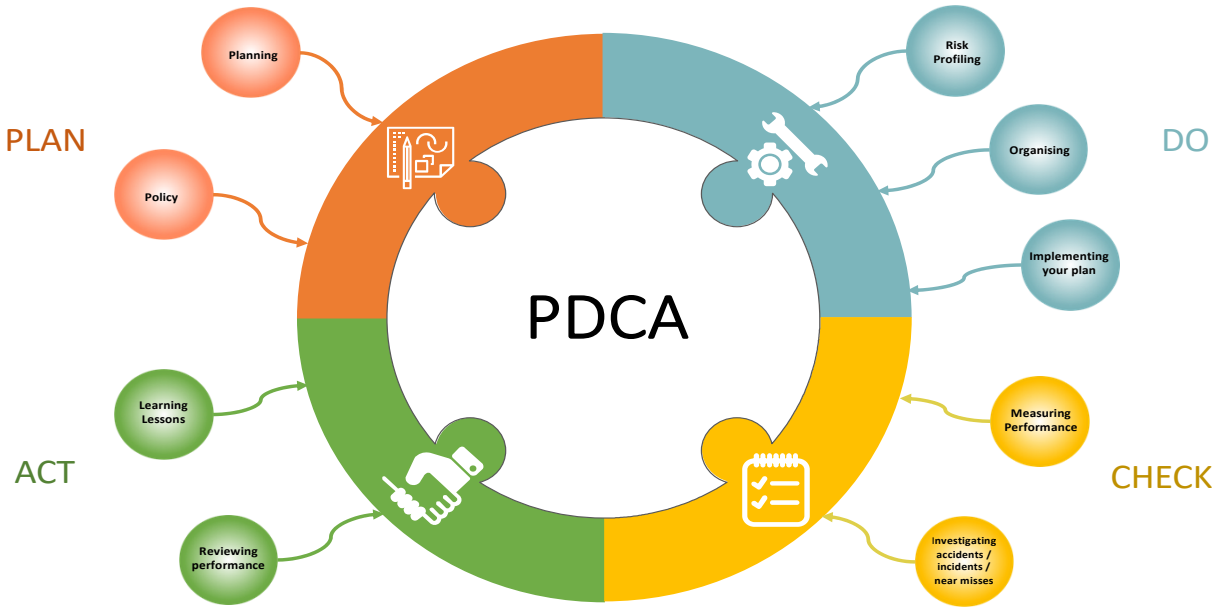
Staff Sickness

609 members of staff were absent in the Financial Year 2021/22 due to MSK related reasons.

(NB: it is not possible to determine if these episodes of sickness were because of work-related injuries as this data is not collected).

HSG65: RWT H&S Management Model (PDCA)

The Trust continues with the HSE model (HSG65) for managing Health and Safety to provide an analysis of Health and Safety performance across the Trust during Apr 21 to Mar 22 using the four elements of: Plan, Do, Check, Act.



3.0 PLAN – Strategy progress

HS01 – Management of Health and Safety is reviewed and updated regularly and is the main document detailing the arrangements, roles and responsibilities for Health and Safety Management within the Trust. Compliance with this policy will lead to compliance with legislation. This is monitored through the Health and Safety Steering Group (HSSG).

There is also a Health and Safety Strategic delivery plan. This document is split into two distinct parts, operational and a continual improvement element. Updates for both elements are covered in the progress statement in section 3.1 below.

The Trust has a range of Health and Safety related policies in place which are reviewed at regular intervals to ensure current arrangements are detailed.

The following policies were reviewed during 2022/2023:

Policy No	**Policy Title**	**Reason for update** (in year changes only)	**Current status**	**Expiry Date**
HS06	Laser, UV and Optional Radiation Protection Policy	Due for review	Approved Mar 23	Mar 2026
HS26	Fire Policy	Due for review	Approved May 23	May 2026

Policy No	Policy Title	Reason for update (in year changes only)	Current status	Expiry Date
HS32	None Smoking Policy	Due for review	Approved Aug 22	Aug 2025
HS33	Driving for Work Policy	Due for review/Incident	Approved May 23	May 2026

3.1 Progress statement - Strategy Implementation 31st March 2022/April 2023

Operational objective Indicator 1 - Maintenance of compliance with H&S Policy HS01			
Milestone	**Who:**	**When:**	**March 2023 status:**
Compliance with RA's as per HS01 Creation of Toolbox to support requirements within HS01 Podium Audit process to highlight adherence and support the application of HS01 in all 297 dept's	Health and Safety Manager	Throughout 23/24	17 mandatory RA's have been highlighted from policy to ensure support for each area to enable adherence to statutory compliance A project has started to formalise the H&S 'file' with the plan to convert to electronic from physical files in line the with Trust ethos of 'paper lite' Podium audit have begun and is scheduled to run throughout 2023/24 – one element of the Sefl assessment is adherence to policy
Operational objective Indicator 2 - Risk assessments are maintained, fit for purpose and of a quality standard as per H&S Policy HS01			
Milestone	**Who:**	**When:**	**March 2023 status:**
Fully updated SharePoint with all Departments	Health and Safety Manager	Throughout 2022/23	Only the H&S team now have access to SharePoint allowing protected oversight and quality control of department RAs. Each area is tracked weekly/monthly by

RA's known and RAG rated			the team and contacted to address any gaps. This system informs the KPI for each area which is reported at every divisional meeting and at the HSSG. 17 mandated risk assessments for all departments are recorded and loaded onto SharePoint (297 departments across all four divisions). Each H&S officer manages the RA's for a division and each area is RAG rated for compliance to policy. The policy rating categories are - Red - one or more assessment out of date Amber - one assessment dated between 11-12 months since review Green - assessments were reviewed within the last 0-11 months. These are 'live' KPI and tracked manually by the team. A Quality Assurance process in place throughout 2022/23 and is a fundamental part of the podium audit process.
Operational objective Indicator 3 - Improve the interaction and scrutiny of all health and safety incidents reported at the Trust to promote an effective safety culture revised 2022)			
Milestone	**Who:**	**When:**	**March 2023 status:**
Datix Project RIDDOR (serious incident/near miss) investigation Improved SMART KPI's with a meeting framework	Health and Safety Manager H&S Team	Throughout 2023/24	All H&S Datix reports are now reviewed, reported and responded to. Over 700+ were viewed by the H&S team in 22/23. This process is used as a 'safety net' to ensure incidents are being investigated and that no RIDDOR incidents are being missed. There is a H&S central email address with all the team having access – all H&S Datix reports are automatically sent thought for review – the H&S team operate on a

Monthly Team Meeting – Scrutiny of legal & RIDDOR incidents			rota to respond to both the Datix and the team email inbox SMART KPI included in the H&S KPI Report – some of which are based on H&S incidents and their outcomes – the KPI report is disseminated to the board/divisions via the meeting reporting structure. The team has a monthly meeting where legal elements are discussed – this includes legal changes, legal cases reported externally and also our RIDDOR report updates – these meetings act as a peer review and offer us the opportunity for consensus and learning.
Operational objective Indicator 4 - Improve lessons learnt from RIDDOR reportable incidents (revised 2022)			
Milestone	**Who:**	**When:**	**March 2023 status:**
RIDDOR investigation process Comms pathways / and Communication strategy	Health and Safety Manager H&S Team	Throughout 2023/24	Every RIDDOR incident is submitted to the HSE by H&S Team who also undertake a H&S RIDDOR investigation on each one. This offers a chance to produce recommendations and to learn lessons. These reports are always attached to the original DATIX report. These lessons can then be disseminated via our communication routes. These may be via the Governance Officers communication tool (called lessons learnt), via Risky Business, via the report, the meeting routes via the Safety Rep Forums, via the comms team as well as directly with the departments. The H&S team also work closely with our Legal department to ensure they have site of our reports.
Operational objective Indicator 5 - Maintain staff competencies, awareness and training			
Milestone	**Who:**	**When:**	**March 2023 status:**

Training for Risk Assessment (commonly known as 'Day 1') Training for Safety Reps / Duty of Care (for managers of others – more commonly known as 'Day 2') Planning a ½ day investigation course to support H&S investigation at RWT	Health and Safety Manager H&S Team	Throughout 2023/24 3rd Qtr 2023/24 (1/2 day course)	The courses are well embedded, generally well attended and the feedback is positive. Staff training for health and safety reps is in place over 2 days. We currently have 178 acknowledged safety reps at RWT and are working to embed this process.
Operational objective Indicator 6 - Maintain compliance with Safety Alerts			
Milestone	**Who:**	**When:**	**March 2023 status:**
Compliance is retained on a trust wide scale	Governance	Throughout 2023/24	There have been ZERO breached deadlines for safety alert responses since October 2021.
Operational objective Indicator 7 - Maintain compliance with other H&S Policies			
Milestone	**Who:**	**When:**	**March 2023 status:**
Continuation of a Weekly Intel Report completed by the H&S Officers and Team Meeting	Health and Safety Team	Throughout 2023	This is the forum where each divisional lead checks on each DATIX report received to highlight and discuss trends, benchmarking, and issues at the Trust – This includes all incidents i.e., Sharps, V&A etc.,

Implementation of a Safety Management Systems (SMS) audit	Health and Safety Manager	4th Quarter 2023/24	Yet to start

Operational objective Indicator 8 - Trust risk profile – monitoring and assurance			
Milestone	**Who:**	**When:**	**March 2023 status:**
Support Estates with PAM and EPAG meeting reporting pathway Completion of the Tenanted Building Task and finish group Creation of a ongoing monitoring register Creation of a Risk assessment template which supports recognition of Health Surveillance risks	Health and Safety Manager & Deputy Governance Manager Estates / Health and Safety Manager Estates / H&S Team Occ. Health / Health and Safety Team	4th Qtr 23/24	Pathway and flow chart to record the pathway is now created. EPAG meeting began. PAM to form a standard part of both the HSSG and HSOG meetings. Creation of the BUG group. Support PAM recognition and Estates requirement for trust wide monitoring. Creation of a trust wide schedule and assurance from OH.

Continual Improvement Indicator 1 Review & renew the specific KPI's to support the processes and understanding of H&S incidents			
Milestone	**Who:**	**When:**	**March 2023 status:**

Completion of Health and Safety self-assessment audits	Department / Ward Managers	Annually	This is being tracked within SharePoint and expanded to non clinical areas throughout 2023/24. It is monitored in the HSSG and then via the meeting hierarchy to the Trust board, as well as being discussed at the H&S weekly meeting. This process has been reviewed, revamped, and will be relaunched in 2022 3rd Quarter. Areas are now supported and followed up by the H&S team and is a new KPI for 2023/24 (the self-assessment tool is available on Myassure) The new Podium Audit program has begun in line with the ward accreditation program The Podium audit quality assures the departmental risk assessments, policy adherence, statutory compliance and safety culture within all 304 departments. This is part of the KPI's introduced in 2023/24 having been piloted in 2022/23.
All departments have a dedicated H&S lead and support	Health and Safety Officers	As often as required	All of the 304 Depts we monitored for H&S compliance have their portfolio of 17x mandatory risk assessments loaded onto SharePoint and this is monitored as a KPI by the H&S team. H&S Officers attend and present the KPI report to each of their division's on a quarterly basis In addition to routine audits targeted visits occur including incident investigations and follow up visits following a RIDDOR reportable incidents where required/feasible.
Full KPI report which is complied and reported	H&S Manager	Dependent on frequency of reporting	The H&S KPI report is embedded and has been utilised throughout 2022/23 via the meeting structure at divisional meetings, the HSSG and HSOG meetings. QSAG, QGAC, TMC and Trust boards as well as

			being reported via the Departmental safety rep quarterly forum. The KPI content within the report is now being reviewed as the H&S work has evolved throughout 2022/23 (new in inclusions will be Project work and VAAG incidents)

Continual Improvement Indicator 2 Creation of a best practise electronic Trust Health and Safety Management System to encompass all aspects of Assurance			
Milestone	**Who:**	**When:**	**March 2023 status**
Continuation of intranet project to improve and support the current H&S strategy Regular forum with RWT departmental safety reps which is electronic to extend reach and improve communication	Health and Safety Manager Health and Safety Manager	Continuous/ Quarterly	Intranet site has been updated and includes 15 key areas. The first step by step guide on our intranet site which we dubbed 'Golden Threads' was adapted in 2022 to support the DSE at RWT and has been a huge success. H&S intranet site to improve access to H&S information and training for staff. Quarterly safety reps forum are recorded, and recordings are placed on the intranet page. Four were held quarterly in 2022/23 and attendees ranged between 20-40 delegates on each forum with a recording to support non-attendees. We now track the list safety reps and currently have 178 reps across the 304 department's. We have a two-day training program for all safety reps (and managers of others) which is run monthly

Continual Improvement Indicator 3 Create an electronic H&S strategy to digitalise H&S processes			
Milestone	**Who:**	**When:**	**March 2023 status**

Creation of a Communication strategy New Project: Creation of a 'H&S Toolbox' Digitisation of Risk Assessments	Health and Safety Manager / H&S Officers	Commenced 1st Qtr 2023/24 3rd Qtr (Nov 2023) 4th Qtr 2023	Process has begun but further support is required to ensure there is communication strategy and subsequent pathways for any H&S 'lessons learnt'. The new project was initiated with a H&S comms strategy document. Strategy started; completion expected 2nd Qtr 2023/24. To create a new electronic risk assessment pathway and repository for all departments at the Trust and move away from a paper-based management system in line with the Trust policy of paper-lite.

Continual Improvement Indicator 4 To promote our people to achieve 'self-actualisation'			
Milestone	**Who:**	**When:**	**March 2023 status**

The opportunity to support staff to achieve qualifications The opportunity to support staff to achieve learning opportunities within the Trust To make the work interesting and includes project work and exposure to areas other than their specific job function	Health and Safety Team	Sept 2023 / Throughout 23/24	One member is due to start a MSc course with support from the RWT 'apprentice' scheme. Staff are supported to gain experience in all areas of the Trust (including outside of the Dept) to gain experience. All staff are expected to lead a project as this exposes them to new experiences and ensures there is interesting new work for staff to become involved with

Continual Improvement Indicator 5 - Evolve the H&S training programme 'from day one to competency'			
Milestone	**Who:**	**When:**	**March 2022 status**

First Aid Training (3 Day and 1 Day Emergency FA delivered Review of both e-learning packages (mandatory and Managers of others (Job specific) Completion of a new training package for incident investigation Create and deliver new H&S Governance induction package	Health Manager & Health Safety Officers	Aug 2024 4th Qtr 23/24	First Aid proposal paper now completed Booking for first aid courses from WHT to be in 2nd Qtr 2023/24 First aid compliance status monitored in HSSG Mandatory training status monitored in HSSG First Aid paper being written and planned for delivery 2023/24 Review the current first aid training package delivered monthly since its inception

Continual Improvement Indicator 6 Promotion of 'Golden Threads' (GT) in our Operational Assurance			
Milestone	**Who:**	**When:**	**March 2022 status**
Completion and start of golden threads 'DSE at RWT' on the H&S intranet site Start of Procedure Manual to create a record of all H&S SOP's	Health Manager & Health Safety Officers	August 2023 4th Qtr 2023/24	GT number 2 to be completed ('how to place an incident on Datix') and placed onto the intranet site Status continually monitored in HSSG

DO – [work completed against plan]

4.1 Audit Process

A new and ambitious audit program started in 2022/23 and will continue throughout 23/24. The new audit program called the 'Podium Audit', gives each audited area an accredited rating of gold, silver or bronze award based on the current state of their health and safety compliance – hence the term 'Podium Audit'.

Our approach when doing the audit is one of positive expectation so our auditors will ensure a good balance of seeking out compliance with identifying non-compliance. Our ethos is to reward engagement with our team and encourage areas that require improvement, and to offer real support to both our clinical and non-clinical teams.

The audit itself is made up of four distinct parts which have weighted questions which are combined to give an overall rating. Components are the quality assurance on all risk assessments and a self-assessment in three further elements that are anchored around Statutory Compliance, Policy Adherence and Safety Culture.

The audit schedule has been designed to be completed a month in advance of the ward accreditation process, so before they begin their ward accreditation, they understand how the area/ward is performing from a H&S assurance perspective enabling the accreditation to take a more rounded approach.

Table 2 - Podium Audits Complete in 22/23

Ward / Area	Date Scheduled	Current Status (Green = Fully Complete with report sent)	Overall Podium Score	ON Time?
Audiometry GEM (Div 1)	Mar-23	Feb-23	Silver	YES
Audiometry WP (Div 1)	Mar-23	Feb-23	Silver	YES
A7 RWT (Div 2)	Apr-23	Apr-23	Bronze	YES
A8 RWT (Div 2)	Apr-23	Apr-23	Silver	YES
C14 RWT (Div 2)	Apr-23	Mar-23	Bronze	YES
C26 RWT (Div 2)	Apr-23	Mar-23	Silver	YES

Table 3 - Podium Audits Scheduled (in-line with Ward Accreditation) for 2023

Ward / Area	Date Scheduled	Current Status (Green = Fully Complete with report sent)	Overall Podium Score
C18 RWT	May-23	TBC	TBC
C19 RWT	May-23	TBC	TBC
Fairoak RWT - CCH (Div 2)	May-23	TBC	TBC
C39 RWT	May-23	TBC	TBC
AMU RWT	Jun-23	TBC	TBC
Deansley RWT (C35)	Jun-23	TBC	TBC
D7	Jun-23	TBC	TBC
CHU	Jun-23	TBC	TBC
C22 RWT	Jul-23	TBC	TBC
Delivery Suite	Jul-23	TBC	TBC
Surgical SDEC	Jul-23	TBC	TBC
C24 RWT	Jul-23	TBC	TBC
Ward 1 WP	Aug-23	TBC	TBC
Ward 2 WP	Aug-23	TBC	TBC
NRU WP	Aug-23	TBC	TBC
C15 RWT	Sep-23	TBC	TBC
C16 RWT	Sep-23	TBC	TBC
C21 RWT	Sep-23	TBC	TBC
C25 RWT	Oct-23	TBC	TBC
C17 RWT	Oct-23	TBC	TBC
A9/SEU RWT	Oct-23	TBC	TBC
Hollybank RWT	Oct-23	TBC	TBC
A5 RWT	Nov-23	TBC	TBC
A6 RWT	Nov-23	TBC	TBC
B14 RWT	Dec-23	TBC	TBC
B8 RWT	Dec-23	TBC	TBC

4.1.2 Health and Safety Inspection Process

Quarterly Inspections are completed in all 304 department/areas (see Section 5.3 for details of which areas). We have designed a new inspection proforma to support this process. The document is now more stipulative and is aimed to support staff in understanding what to look for in local environments thereby improving safety and reducing operational incidents. A KPI target of 25% with 50% in the second Quarter of 2023 and further increases have been set throughout 23/24.

No. of Quarterly Inspections Completed: Jan to Mar 2023 (Target 25%)						
Division 1 complete	**Division 2 complete**	**Division 3 complete**	**Division 4 complete**	**Corporate complete**	**Estates & Facilities**	**Total complete**
53	17	3	0	4	2	**79**
of Division 1 total	of Division 2 total	of Division 3 total	of Division 4 total	of Corporate total	of Estates & Facilities` total	of Trust total

85	57	92	11	32	20	**297**
% achieved	**% achieved**	**% achieved**	**% achieved**	**% achieved**	**% achieved**	**% achieved**
62.00%	**29.82%**	**3.26%**	**0.00%**	**12.50%**	**10.00%**	**26.60%**

4.2 Organising for Health and Safety

The management system is based around the four key principles of HSG65 which are: worker involvement, risk profiling, competence and legal compliance.

There is a new and more ambitious Health and Safety Strategy which builds on the previous good work. Its key focus on operational and continual improvement and includes six KPI milestones that are monitored, and progression is reported in the 3.1.

The H&S Management policy is up to date, a statement of intent, it also guides its staff in how the Trust complies with its H&S arrangements with the final section being the roles and responsibilities to ensure these arrangements are carried out (refer section 4.5).

Both the strategy and policy provide a strategic and operational framework of arrangements to manage compliance and continuous improvement in Trust achievement of Health and Safety requirements.

4.3 Co-operation and Communication

The Health and Safety officers work closely with the Departmental Health and Safety Representatives and Department Managers to support the risk assessment process and providing advice and support. The Trust has various routes for communication that the Health and Safety Team utilise including the Governance Risky Business newsletter, all user bulletins, the Safety Representative Forum, subject specific communications, face to face meetings, informal meetings / catch up, additional training and general emails. We will use the most appropriate / relevant route to communicate messages throughout the Trust.

The Health and Safety Representative Forum is held at quarterly intervals and this year went online has been well received with good feedback allowing us to shape future forums. The representatives continue to provide an invaluable link between the Health and Safety Team and colleagues and Managers throughout the Trust. The content of the meetings is relayed via minutes and presentations to all Safety Representatives. (Refer to Section 3.1).

Messages shared 2022/23

Message shared	**Reason for communication**
Quarterly Safety Rep Forum	Risk Assessment / Datix project / H&S Brand and electronic strategy / Podium Audit / Intranet
Quarterly Safety Rep Forum	Slip, tip & Fall Project / KPI and Reporting Strategy / Training / Podium audit and quality assurance / Reporting Structure

Quarterly Safety Rep Forum	First Aid / DSE Catalogue / Site Inspection / Audit Project / IOSH Training / RIDDOR / HS33 & Tug
Quarterly Safety Rep Forum	Traffic Project / Audit Project / H&S Strategy / HS01 update
DSE	Datix incidents and Project to improve DSE and workstation assessment via Risky Business
Security Issues	Community Teams and Reps
HSE onsite inspection	Completion
First Aid Training courses	To obtain staff to partake
Departmental Safety Rep courses	To obtain staff to partake
Risk Assessment Training Courses	To obtain staff to partake
Specific incidents (STF's)	Governance informed approach

4.4 Competence

Mandatory Training Compliance Reports – As at March 31st 2023

3-Yearly Mandatory Health & Safety Training – all staff	Total Staff in post	No. Completed	%
Division 1	2968	2917	98.3%
Division 2	2154	2101	97.5%
Division 3	2076	2053	98.9%
Division 4	218	217	99.5%
Estates & Facilities	913	910	99.7%
Corporate Services	1082	1070	98.9%
Black Country Pathology	746	720	96.5%
Trust Total	10157	9988	98.3%

Health and Safety Awareness - Manager e-Learning	Amber	Green	Red	Grand Totals	Completed	% Compliance (Goal - 95%)
Division 1	0	5	6	289	272	94.1%
Division 2	0	9	7	267	238	89.1%
Division 3	0	12	2	404	383	94.8%
Division 4	0	2	0	6	6	100.0%
Estates & Facilities	0	4	0	63	63	100.0%
Corporate Division	0	8	2	305	295	96.7%
Black Country Pathology Service	**0**	**2**	**3**	136	130	95.6%
Grand Totals	**0**	**42**	**20**	1470	1387	94.4%

4.5 Implementing

In compliance with Health and Safety Legislation, the Trust has a Health and Safety Policy: HS01 Management of Health and Safety

The policy applies to all employees of the Trust and is displayed prominently on the Trust Intranet system. The Policy has the following key elements:

Structure: identifying the key accountable persons within the organisation and their roles and responsibilities within the Health and Safety management system.

The Arrangements: including risk assessment process for all areas, audit, compliance assessment and inspection processes, training and instruction. Risk assessments are taken through the local governance process to ensure they are approved by management then shared for implementation to all relevant staff. All divisions work to build a risk profile for their specific services to support the management of Health and Safety. Health and Safety profile details such as risk assessments folders, are held in all work areas and can be accessed by all staff. These are checked during audits / inspection visits by the Health and Safety officers.

Roles and Responsibilities: The key functions and structure at RWT and what they are responsible for.

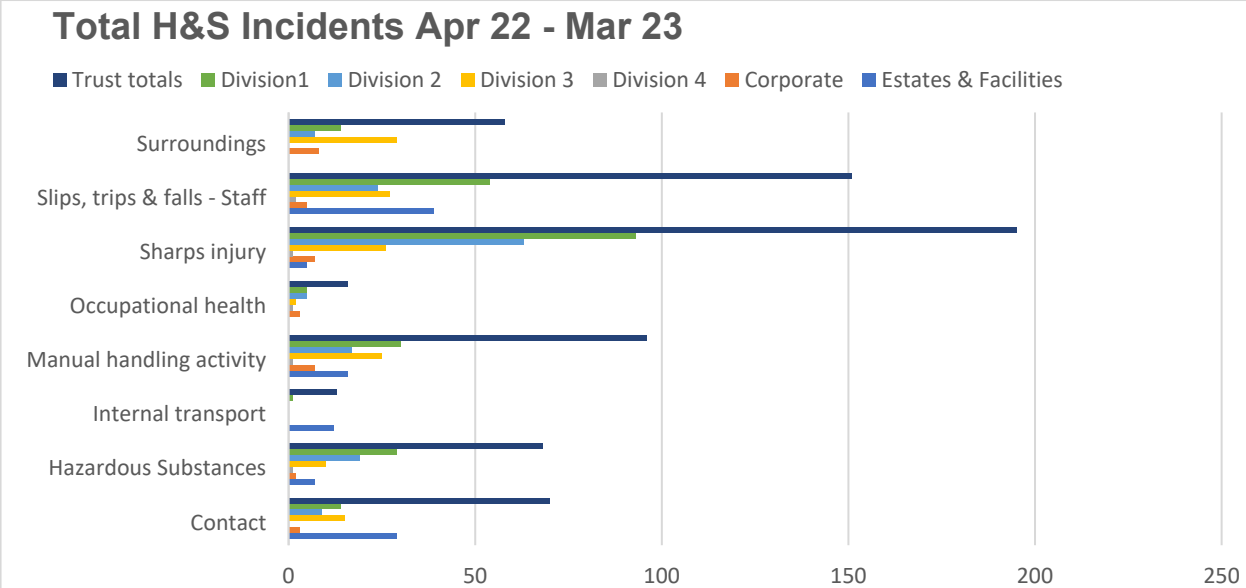
5.0 CHECK & ACT – [measuring performance, investigating incidents / near misses, training and acting on results]

5.1 Measuring performance – Active/Reactive Monitoring

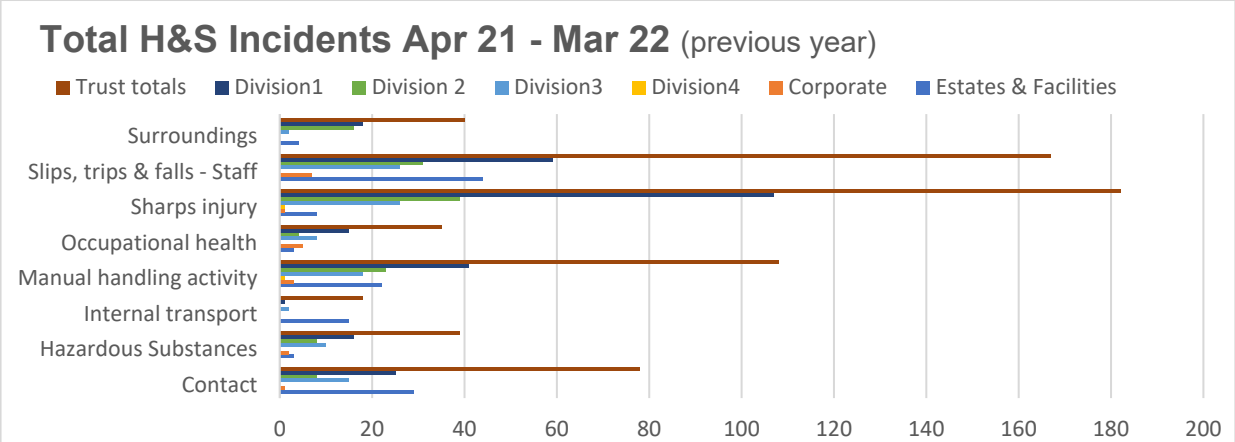
All (297 departments – this has fluctuated throughout the year from 304 to 286) departments throughout the Trust have been visited or contacted and supported by Health and Safety Officers for the following reasons:

- Support audit (based on criteria being triggered)
- One to one meeting with Managers and / or Safety Representatives
- Drop ins to support risk assessment adherence
- Specific visits regarding compliance with safety alerts or other specific material
- RIDDOR investigation/ Incident investigation
- Specific Health and Safety training
- Self-assessment follow-up
- Reviewing risk assessments (e.g., ligature/COVID-19 RAs)
- Complex DSE assessments
- Maximum Occupancy Reviews

5.2 Health & Safety Incident monitoring



	Contact	Hazardous Substances	Internal transport	Manual handling activity	Occupational health	Sharps injury	Slips, trips & falls - Staff	Surroundings
Estates & Facilities	29	7	12	16	0	5	39	0
Corporate	3	2	0	7	3	7	5	8
Division 4	0	1	0	1	1	1	2	0
Division 3	15	10	0	25	2	26	27	29
Division 2	9	19	0	17	5	63	24	7
Division1	14	29	1	30	5	93	54	14



	Contact	Hazardous Substances	Internal transport	Manual handling activity	Occupational health	Sharps injury	Slips, trips & falls - Staff	Surroundings
Estates & Facilities	29	3	15	22	3	8	44	4
Corporate	1	2	0	3	5	1	7	0
Division 4								
Division4	0	0	0	1	0	1	0	0
Division3	15	10	2	18	8	26	26	2
Division 2	8	8	0	23	4	39	31	16
Division1	25	16	1	41	15	107	59	18

Health & Safety Total Incidents in Datix
(last year comparison)

Period	Division 1	Division 2	Division 3	Division 4	Corporate	Estates & Facilities	Total
Apr 22 Mar 23	240	149	136	6	35	108	674
Apr 21 Mar 22	282	129	107	2	19	128	667

Near Misses
(last year comparison)

Period	Division 1	Division 2	Division 3	Division 4	Corporate	Estates & Facilities	Total
Apr 21 Mar 22	31	19	31	0	9	25	115
Apr 21 Mar 22	29	15	26	0	3	32	105

Datix incidents responded to by H&S Team
(April 2022 to March 2023)

810: Total number of incidents responded to (some would not be Categorised as H&S)

April 22 - March 23 (Financial year) TOP 4 MOST FREQUENTLY OCCURRING INCIDENTS				
	1	2	3	4
Trust Total	**Sharps (189)**	**Slips, trips & falls – Staff (151)**	**Manual handling activity (96)**	**Hazardous substances (49)**
Division 1	Sharps (93)	Slips, trips & falls – Staff (54)	Manual handling activity (30)	Hazardous substances (29)
Division 2	Sharps (63)	Slips, trips & falls – Staff (24)	Hazardous substances (19)	Manual handling activity (17)
Division 3	Surroundings (29)	Slips, trips & falls – Staff (27)	Sharps (26)	Manual handling activity (25)
Division 4	Slips, trips & falls – Staff (2)	Sharps (1)	Hazardous substances (1)	Manual handling activity (1)
Corporate	Surroundings (8)	Manual handling activity (7)	Sharps (7)	Slips, trips & falls – Staff (5)
Estates & Facilities	Slips, trips & falls – Staff (39)	Contact (29)	Manual handling activity (16)	Internal transport (12)

5.3 Risk Assessment monitoring and audit

Key	**Red**	A Department is classified 'Red' if at least one of its mandatory risk assessments exceeds the statutory required 12-month review date
	Amber	A Department is classified 'Amber' when no risk assessments are out of date however, at least one is 11-12 months since it's last review
	Green	A Department is classified 'Green' when no risk assessments exceed 11 months since it's last review

Risk Assessment Compliance status 1st April 2023:

Status	Division 1	Division 2	Division 3	Division 4	Corporate	Estates & Facilities	Trust (304 Dept's in total)
Red	**4**	**11**	**15**	**0**	**6**	**1**	**37**
Amber	22	8	5	0	2	0	**37**
Green	62	37	65	12	22	20	**218**

RA Status:	Red	Amber
Division 1	Heart Failure Team Pendeford Dental (Provider) Pennfields dental (provider) Phoenix Dental (Provider)	A33 Eye Hospital OPD Audiology Cannock Audiology New Cross Audiology West Park B14 Cardiology ward B15 Cath Labs and Day Ward CCH Eye theatres Children's hearing services GEM Clinical Chemistry Cytology D1 Antenatal OPD D10 Maternity Ward Haematology (Team) Histopathology Microbiology OPD - A25 ENT OPD - A31 Urology NX OPD - B3 Heart and Lung Outpatients OPD - Cannock Eye Level 2 Optometry Pre-op Ophthalmology A34 Eye ED
Division 2	C16 Diabetes C17 Diabetes C39 ward CDU/SDEC Clinical Haematology Unit Endoscopy CCH Endoscopy NX Frailty Haematology CNS Team Phoenix - Urgent Treatment Centre Radiotherapy (Deansley)	Bowel Cancer Screening C21 Acute Stroke Unit C25 Renal Ward Cannock Renal Unit Fairoak NXH - Urgent Treatment Centre Respiratory Centre Respiratory Centre CCH FastTrack/Holly bush House (A18)
Division 3	A21/PAU Breast Imaging CaSH Community Sexual Health CT / MRI D4 Maternity Ultrasound Fowler Centre For Sexual Health Green Park Special School Intervention Lea Road Medical Practice Main Radiology Nuclear Imaging Penn Hall Special School Radiology Orthopaedic UECC Radiology Ultrasound	Health Visitors - 0-19 Service Oxley Practice Penn Manor Thornley Street Surgery Warstones GP Surgery

Division 4	Information Centre	
Corporate	HR Infection Prevention (Team) Midland Research Network Procurement (Team) Safeguarding (Team) Tissue Viability	Chaplaincy Medical Illustration
Estates & Facilities	Commercial (Team) Fire	Housekeeping Housekeeping CCH Transport Garages

5.4 Health & Safety Training

The Health and Safety Training programme encompasses a new concept of 'Day One to Competency' in the H&S Strategy which is designed to improve competence from the staff member's first day on the job until they are competence and understand their duty of care from a H&S perspective. Partnering this with a return to face-to-face training and e-learning packages, the Trust has maintained its support mechanism to achieve compliance. Face to Face training was reinstated in August 2021 and has continued monthly with two full day courses, namely a risk assessment training program and a holistic course designed for Departmental Safety Reps and Managers of others.

Plans to train and income generate by becoming an external accredited course provider for the Managing IOSH (Chartered Institute of Safety and Health) training program will be a cornerstone of the 'from day one to competency' program in 23/24. The team is looking for new innovative and holistic ways to improve competency and understanding around H&S and the return to Face-to-Face training is key to the program's success throughout 2022/23 and moving forward into 23/24.

Health and Safety have throughout 2022/23 been part of the Governance Induction program which inducts/orientates staff members to the governance portfolio at the Trust, governance processes and their role in it. The team is also looking to review the H&S component at Trust induction and review the content of its e-learning packages in 23/24.

The pandemic should also not continually shape how the department but has continued to challenge the team, certainly it has continued to impact the team in 2022/23 as Breakout meetings took place throughout 2022/23. MSK training is still in backlog as well as First Aid as the challenges of catching up the position the Trust was in pre-pandemic, especially in areas such as First Aid and DSE.

Training Completed 2022/23

Training Course	Provider	Venue	Month / Year	Date course held	Delegates booked	Attended	DNA
Emergency First Aid at Work (EFAW: 1 day)	A1 Training	Saturn Centre	Apr-22	14.4.2022	12	9	**3**
	A1 Training	Saturn Centre	Apr-22	22.4.2022	12	11	**1**
	A1 Training	Saturn Centre	Apr-22	28.4.2022	12	7	**5**
	A1 Training	Saturn Centre	Apr-22	29.4.2022	12	6	**6**
	A1 Training	Saturn Centre	May-22	23.05.2022	12	11	**1**
	A1 Training	Saturn Centre	May-22	24.05.2022	12	12	**0**
				Total	**72**	**56**	**16**
First Aid at Work (FAW: 3 day)	A1 Training	Saturn Centre	Apr-22	11-13/04/22	12	10	**2**
	A1 Training	Saturn Centre	Apr-22	19-21/04/22	12	12	**0**
	A1 Training	Saturn Centre	Apr-22	25-27/04/22	9	6	**3**
				Total	**33**	**28**	**5**
Risk Assessment Training (DSR Day 1)							
	RWT H&S	B12 boardroom	Apr-22	5.4.2022	6	4	**2**
	RWT H&S	B12 boardroom	Apr-22	27.4.2022	8	8	**0**
	RWT H&S	B12 boardroom	May-22	16.5.2022	7	8	**1**
	RWT H&S	B12 boardroom	Jun-22	21.6.2022	8	7	**1**
	RWT H&S	B12 boardroom	Jul-22	26.7.2022	7	6	**1**
	RWT H&S	B12 boardroom	Aug-22	17.8.2022	4	4	**1**
	RWT H&S	B12 boardroom	Sep-22	13.9.2022	8	7	**1**
	RWT H&S	B12 boardroom	Oct-22	20.10.2022	8	4	**4**
	RWT H&S	ESTATES	Oct-22	05/10/2022	5	N/A	**0**

	RWT H&S	ESTATES	Oct-22	06/10/2022	6	4	2
	RWT H&S	Rheumatology	Nov-22	08/11/2022	3	4	0
	RWT H&S	B12 boardroom	Nov-22	16.11.2022	7	4	3
	RWT H&S	B12 boardroom	Dec-22	08.12.2022	7	4	3
	RWT H&S	B12 boardroom	Jan-23	17.01.2023	9	6	3
	RWT H&S	B12 boardroom	Feb-23	14.02.2023	8	4	4
	RWT H&S	B12 boardroom	Mar-23	22/03/2023	6	5	1
				Total	**107**	**79**	**25**
Departmental Safety Rep Training (Day 2)	RWT H&S	B12 boardroom	Apr-22	28.4.2022	7	7	0
	RWT H&S	B12 boardroom	May-22	18.5.2022	8	7	1
	RWT H&S	B12 boardroom	Jun-22	22.6.2022	7	8	0
	RWT H&S	B12 boardroom	Jul-22	25.7.2022	7	6	1
	RWT H&S	B12 boardroom	Aug-22	22.8.2022	7	8	0
	RWT H&S	B12 boardroom	Sep-22	22.9.2022	2	0	0
	RWT H&S	B12 boardroom	Oct-22	26.10.2022	7	3	4
	RWT H&S	B12 boardroom	Nov-22	22.11.2022	10	9	1
	RWT H&S	training room 2 cch	Dec-22	12.11.2022	9	6	3
	RWT H&S	B12 boardroom	Dec-22	13.12.2022	6	7	0

	RWT H&S	B12 boardroom	Jan-23	26.1.2023	5	6	0
	RWT H&S	B12 boardroom	Feb-23	14.02.2023	6	5	1
	RWT H & S	B12 boardroom	Mar-23	22.03.2023	8	7	1
				Total	**89**	**79**	**11**

Training Planned 2022 with Confirmed bookings (as of April 1st 2023)

Training Course	Provider	Venue	Month / Year	Date of course	Delegates booked
Bespoke	RWT H&S	WMI Library Computer Suite	Apr-23	25/04/2023	5
	RWT H&S	WMI Library Computer Suite	Jul-23	19/07/2023	4
				Total	**9**
Risk Assessment Training (DSR Day 1)	RWT H&S	B12 boardroom	April	27/04/3023	4
	RWT H&S	B12 boardroom	May	25/05/2023	8
	RWT H&S	B12 boardroom	june	j20/06/2023	1
	RWT H&S	B12 boardroom	july	18.07/2023	3
	RWT H&S	B12 boardroom	Aug	15/08/2023	2
	RWT H&S	B12 boardroom	April	27/04/3023	4
				Total	**22**
Departmental Safety Rep Training (Day 2)	RWT H& S B12 boardroom	B12 boardroom	Apr-23	20.4.2023	3
	RWT H & S	B12 boardroom	May-23	31/05/2023	6
	RWT H&S	B12 boardroom	Jun-23	20/06/2023	6
	RWT H&S	B12 boardroom	Jul-23	25/07/2023	6
	RWT H&s	B12 boardroom	Aug-23	22/08/2023	2
				Total	**23**

5.5 Site Inspections

New external environmental audits are now completed by the H&S Team at New Cross, CCH and at West Park. The findings processed and are recorded against a schedule and tracked by the H&S Team (see detail below). This is part of the KPI process and will continue throughout 23/24.

This is in support of the Trust premises which are continually monitored and maintained by the Estates Buildings and Grounds Maintenance Teams. Health and Safety Officers continue to maintain a very visible presence on site and work closely with the Estates Teams, Department Managers, IPC teams, Waste audits and Health and Safety Representatives to support any regular inspections throughout the year and ensure the environment is as safe as practicable.

CCH
(Zone CCH Area #9) External
Car Parks

West Park
(Zone WP Area #10) External
Car Parks

NX
Zone Aa (Area #1)
A28, A29, A30, A31, A33
A34, A36, A37, A38, **P6,**

NX
Zone Ab (Area #2)
A2, A5, A6, A7, A8, A9, A10, A11
A12, A14, A16, A19-A25
A26, A27, **P1. N1**

NX
(Area #3) Bld 1-6 North Staff Car Park

NX
(Area #4) P3,N3 Bld 8-12

NX
Zone B (Area #5)
N2, P2
B5-15 B17-24

NX
Zone Ca (Area #6)
N3, P3 - C14, C26, C21, C24-27, C29
C1-2 C4,C6,C8, C12, C15-C19,

NX
Zone Cb (Area #7)
C35,C37,C39, C40, C41
P4, N4

NX
Zone D (Area #8)
P5, Bld 14, **N5**
D1-17, D18

NX
Communical Corridors #11)
Route A: Zone A & Zone B
Tugway

Area #	Schd. Month	Date Completed	Team	# of Observations
Area #1	Jan	May-23	JM & PD	11
Area #2	Feb	Feb-23	AB & KF	8
Area #3	Mar	Mar-23	JM & PD	9

Area #	Schd. Month	Date Completed	Team	# of Observations
Area #7	Jan	Jan-23	JM & PD	8
Area #8	Feb	Feb-23	PD & KF	8
Area #9	Mar	TBC: April 23		

5.5.1 Datix/RIDDOR Monitoring Project

In August 2021 a project with a commitment to scrutinise the DATIX system was implemented and now Health & Safety Officers' comment on each Health and Safety incident reported in Datix to quality check and ensure staff are receiving feedback. This acts as a safety net for any RIDDOR incidents which may have been missed and has allowed for improved scrutiny of any incidents for investigation.

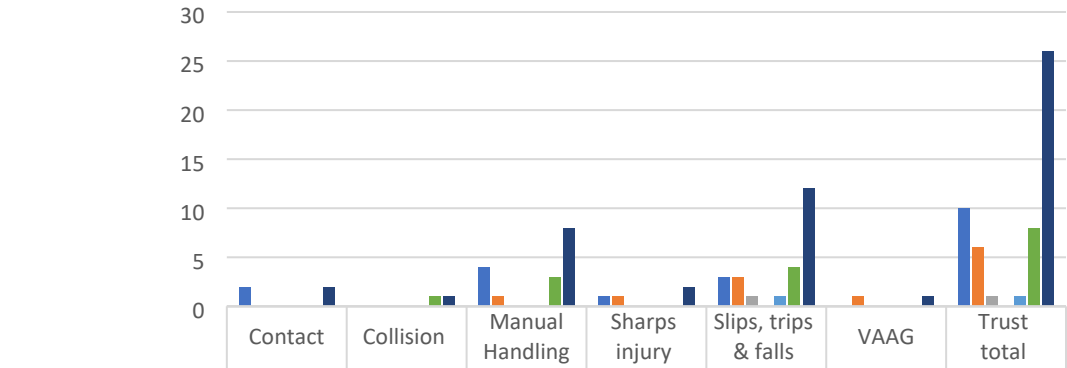
This will often lead to further communications with the Teams involved and may trigger review of risk assessments, provision of advice and support regarding implementation of additional risk control measures and other documentation review such as safe working procedures.

This is now an embedded part of the H&S Teams KPI process.

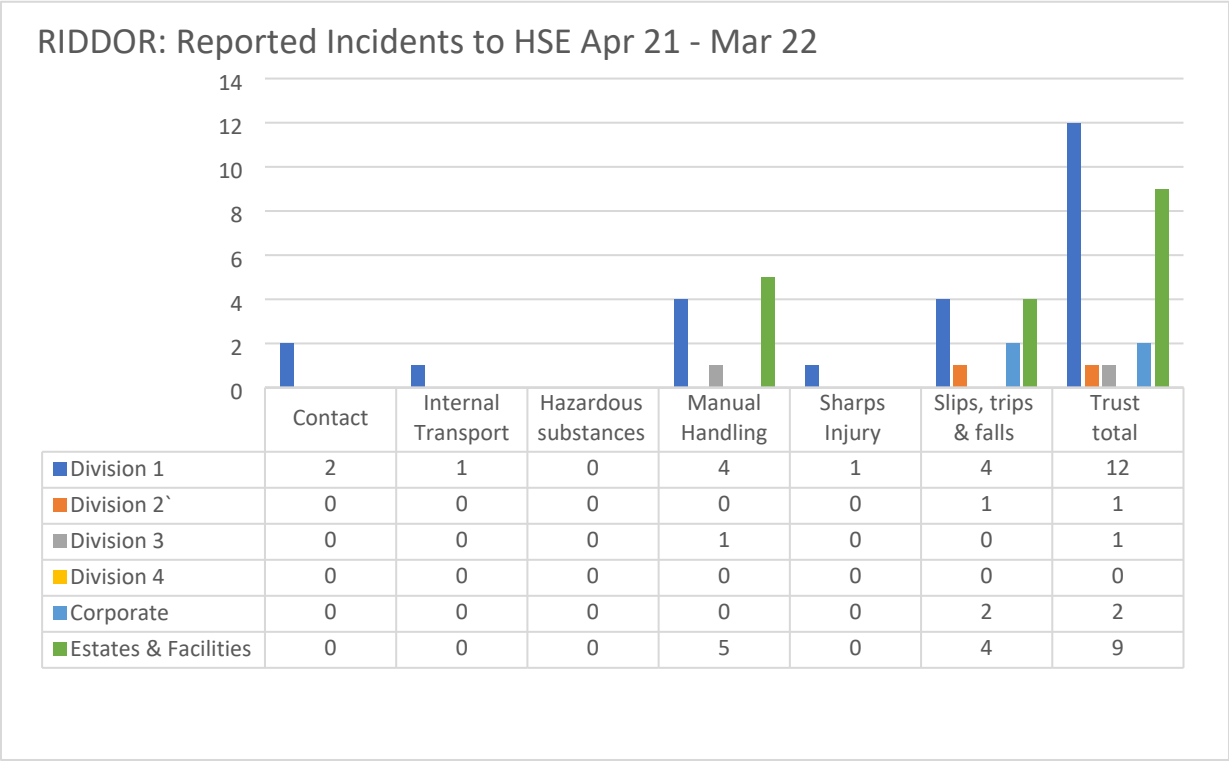
5.5.2 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR):

In accordance with the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), certain incidents must be reported to the Health and Safety Executive (HSE) within appropriate timescales. The details of any incidents can then be shared as set out in the MoU between the HSE and the CQC.

A breakdown of RIDDOR reportable incidents for April to March 2021/22 is shown below by subject and Division. Though the figure is one incident more than the previous year, the percentage of the incidents overall has not changed. By far the highest incident was slip, trip and falls (STF). Throughout 2022/23 as stated in Section 3.1, the H&S team have implemented a Datix project which has meant they have tracked and commented on every single Datix report created which has been categorised as H&S. This has given the Trust its first ever 'safety net' for any RIDDOR reportable incidents which has also meant a more accurate picture for RIDDOR incidents the Trust reports.



	Contact	Collision	Manual Handling	Sharps injury	Slips, trips & falls	VAAG	Trust total
Division 1	2	0	4	1	3	0	10
Division 2`	0	0	1	1	3	1	6
Division 3	0	0	0	0	1	0	1
Division 4	0	0	0	0	0	0	0
Corporate	0	0	0	0	1	0	1
Estates & Facilities	0	1	3	0	4	0	8
Trust Total	2	1	8	2	12	1	26



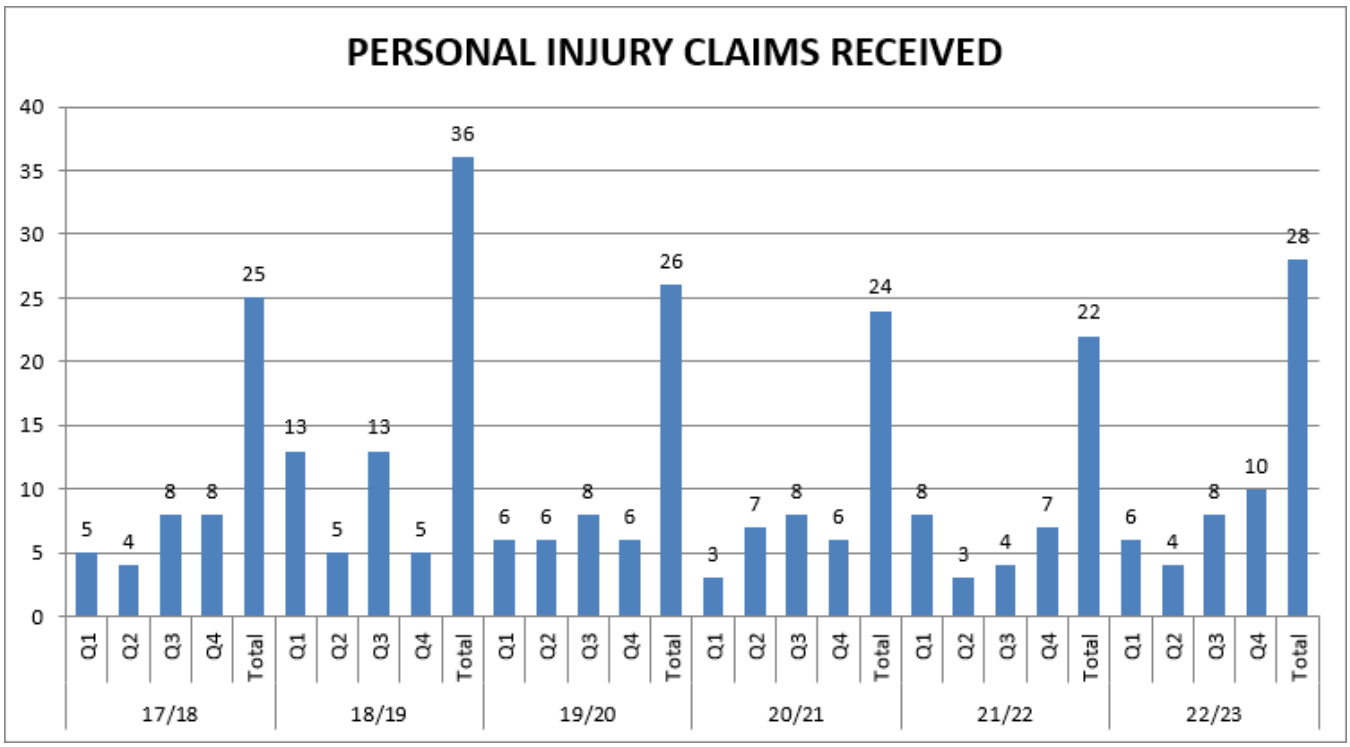
Incidents reported to HSE	**26**
+/- previous year	**0% (remains at 3.8%)**
RIDDOR investigations completed	**26**
RIDDOR investigations in progress	**3**
Direct enquiries from HSE	**0**

Total number of RIDDORs reported: 5-year comparison

Year	No. of RIDDOR Reported	Direction of change	RIDDOR incidents % total incidents
2022 / 2023	26 (674 total H&S incidents reported)	↑	3.8%
2021 / 2022	25	↑	3.8%
2020 / 2021	19	↔	2.8%
2019 / 2020	19	↑	1.63%
2018 / 2019	16	↓	1.32%

5.6 Personal injury claims 2022/23

The Trust uses a robust set of investigation procedures to assist with mitigation, defence, and trial preparation using a system that better captures the incident detail at the time (from April 2017).



5.6.1 New Claims received.

- A general increase in the number of claims received.
- Violence and aggression incidents within ED continue to be a feature.
- Use of patient needles left unattended cause a needle stick injury.
- Tug incidents where tugs have been subject to an accident resulting in injury appears to become a trend.
- Claims submitted by Porters show 2 claims received.
- Claims within theatres show a steady increase.

6.0 ACT – reviewing performance and learning lessons.

In the context of HSG65, the Trust is required to review performance and acting on any gaps highlighted and on lessons learned. The Health and Safety Risk Profile supports this with the reporting into Health and Safety Steering Group by subject specialists. It also forms part of the duties of the Health and Safety Team, with regular reviews to identify high risk areas using incident data and audit outcomes.

The Health and Safety Team have completed a review and a subsequent relaunch of the KPI's monitored by the H&S department. All H&S divisional reports are now standardised against all indicators identified in the Health and Safety Strategy. These reports are provided for the H&S meeting structure which incorporates Divisional

meetings, Health and Safety Steering Group and Quality and Safety Advisory and Assurance Groups (QSAG & QGAC), TMC and Trust board, to provide information on compliance with Health and Safety Legislation from ward to the board.

6.1 Learning from other organisations

The Health and Safety Executive is a regulatory / advisory organisation which:

- Provides advice and guidance to individual businesses or groups
- Undertakes proactive interventions including inspection
- Reactive interventions e.g. to investigate accidents or complaints.

Enforcement Notices are published by the Health and Safety Executive throughout the year and, where applicable, these will instigate preventative / review actions to assess and reduce the risk of those incidents occurring in our Trust. There were no unplanned visits which resulted in any regulatory action and no sanctions form the one planned visit in Microbiology.

The Health and Safety Team participates in the Midland Regional NHS Health and Safety Group. This groups is made up of H&S teams across sister Trusts and meets on a minimum of quarterly basis (in 2022/23 this was done virtually). Any messages received here are shared with the Health and Safety Steering Group and relevant Departments as appropriate.

Two of the team are members of the Institute of Safety and Health (IOSH) which is the chartered body which offers professional status and offers advice and support on all matters concerning health and safety including CPD opportunities.

6.2 Learning from External audit / inspection reports

The HSE were on site in March 2022 for a scheduled inspection of Microbiology. This was a two-part inspection firstly of our Microbiology processes and secondly of our adherence to COVID-19. COVID-19 was deemed by the inspector to be of an acceptable standard, and it was this element which if found unsuitable, would attract enforcement action (FFI, improvement or prohibition notices). The inspector wrote to the Trust in June 2022 and gave five recommendations for the Microbiology element of the inspection and a target date for completion of these targets. These were met in line with the target date with no enforcement action taken**.** (See BCPS report for details)

6.3 Safety Alerts

CAS Alerts published for action Apr 22 - Mar 23	**10**
CAS Alerts with completion dates due Apr 22 - Mar 23	**0**
CAS Alerts with breached deadline Apr 22 - Mar 23	**0**
CAS Alerts Open & Ongoing Apr 22 - Mar 23 (see below)	**0**

Action Ongoing on CAS website				
Deadline	**Reference**	**Alert Title**	**Nominated Lead**	**Issue Date**
There are none to report				

There have been no breached deadlines since October 2021.

7.0 Horizon Scanning / Moving Forward 2023/24

With the changes to the health and safety compliance approach and priorities now embedded in a routine monitoring via risk assessment, KPI, Training and investigation' there will be a more ambitious targets applied to the strategy when reviewed in 2024. There will be an emphasis to really empower and support staff to adopt systemic approaches using key themes to improve the safety culture. Integration of systems, processes and policies and partnership working with WHT will form a key part of our continuous improvement agenda in 23/24.

H&S improvements

We will look at new ways of working to support and improve local ownership and accountability and moving Health and Safety into "Business as Usual" for departments through innovative and training such as the new training program 'from day one to competency'. We will expand our training portfolio in 23/24 and aim to incorporate accreditation for delivering IOSH qualified courses.

In 2023 / 2024, the drive for an electronic management system e.g. Myassure will become an integral and important component of the Health and Safety Management system.

We want to build on our ward to the board compliance approach to ensure that all areas understand the H&S ask required of them within law and to ensure staff remain safe whilst at work.

Review of Strategy and fresh approach for 2023/24

The current system of audit will be expanded to embrace a priority system, ensuring that Departments requiring the most support/highest risk are provided with advice and support to improve compliance. We will continue to promote competency within H&S by providing both bespoke and targeted range of training opportunities for Trust personnel, but this will evolve, where practicable, back to a face-to-face holistic approach. Safety Representatives are seen as key stakeholders and continued focus is essential to both the local and Trust wide safety culture.

The Team will strengthen its assurance and evidence from the current strategy and ensure that updates are given regularly via the HSSG meeting to ensure transparency which is central to the team's values.

Health and Safety Steering Group (HSSG) and the Health and Safety operational Group (HSOG)

The Health and Safety Steering Group content will continue to be reviewed and will continue to challenge the strength of assurance being provided. It will recommend further action where gaps are identified and continue to use incident data and audit outcomes to identify problem areas, review documentation and escalate risks when identified. It will provide support and guidance to help improve the quality and suitability of control measures and improve reporting.

The Health and Safety Steering Group will remain a quarterly meeting in 23/24 but added to the H&S meeting hierarchy will be an additional forum called the Health and Safety Operational Group (HSOG) which will meet (face to face) monthly and will ensure better scrutiny to operational compliance, and to discuss and disseminate Health and Safety information throughout the Trust.

H&S Team values

The management system framework will be a focus with robust systems supported through innovation, KPI's and positive challenging via the HSSG are now in place and have started to become embedded, these are essential to continually build the profile of H&S at the Trust.

Health and Safety Team will continue to provide a clear picture of what the Trust is doing well within the Health and Safety Management system (based on the principles set within HSG65) and will continue to identify shortfalls and develop realistic action plans and timescales to maintain and improve compliance.

The Health and Safety Team will additionally provide support for other Departments such as Occupational Health, Infection Prevention as part of Awareness activities and training to spread the Health and Safety message throughout the Trust.

Above all, the Team are looking forward to working with our valued colleagues throughout the coming year to ensure a safe and healthy workplace. 2022/23 has provided the Health and Safety Team with another varied, exciting, and challenging year regarding the management of Health and Safety throughout the Trust.

We will review the H&S Strategy in 2023/24 to ensure we are aligned with Trust strategic objectives and continue delivering the Trust and our vision core values; ensuring continued statutory compliance whilst remaining pragmatic, sensible and clear on H&S requirements.

8.0 Acknowledgments

- Head of Estates
- Occupational Health
- Non-Exec Directors
- Head of Medical Physics and Clinical Engineering
- Governance Leads (Assurance)
- Portering Services Manager
- Head of Hotel Services
- Estates Compliance and Helpline Manager
- Fire Safety Team
- Medical Physics
- Waste Manager
- Security Team
- Pharmacy
- Infection Prevention
- Decontamination Lead
- Radiation
- Sharps Group

- Water Safety Group
- Ventilation Group
- IM&T Team

9.0 APPENDICES:

Appendix 1

The Estate Risk Profile at close of March 2023 detailing the subject, relevant legislation, Speciality Lead and level of compliance by year.

RED	Non-compliant with regulations: Many gaps / areas of concern **MAJOR** level of risk due to non-compliance for Trust (no actions identified or plan in place to manage) and / or unsafe for patients / staff - Enforcement action almost certain
AMBER	Non-compliant with regulations: some gaps / areas of concern **MODERATE** level of risk due to non-compliance for Trust (actions identified, plan in place and on target to complete) and / or unsafe for patients / staff - Enforcement action likely / possible
YELLOW	Non-compliant with regulations minimum gaps / areas of concern MINOR **/ INSIGNIFICANT** level of risk due to non-compliance for Trust (actions identified and plan in place and on target to complete) NO risk to patients / staff externally audited / assured - Enforcement action unlikely
GREEN	Fully compliant with regulations (i.e., Legislations, HTM's, Guidance and no areas of concern. (actions complete and monitored for maintenance of compliance) No risk to patients / staff: (Externally audited) -No enforcement action expected.

COSHH PAM SH 4					
Control of Substances Hazardous to Health Regs 2013					
Lead: Estaes Opertaional Team					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	N	Y
Commentry			All operational aspects of COSHH digitally managed within CAFM system,		

Asbestos Management PAM SH 5					
(Control of Asbestos Regulations 2012)					
Lead : B&G Manager					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	not required
Commentary			The removal of ACM in Energy Centre roof has been compited. Ongoing management surveys to block and buildings to refresh quality of data.		

Medical Gases System PAM SH 6					
EU Pharmacopeia Regulations; HTM 02-01					
Leads: Engineering Manager					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	Y
Commentary			Major improvements to the infrastructure undertaken		

Medical Air Quality Compliance PAM SH 6					
HTM 02-01 A & B					
Leads: Deputy Head of Estates					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	N/A
Commentary			Further Development work expected		

Water Safety (Trust Premises) PAM SH 8					
Control of Legionella 2012 (L8.)					
Lead: Head of Estates					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	N/A
Commentary			Primary management reporting via Trust Water Safety Group		

Low Voltage Systems (Electrical) PAM SH 9					
HTM 06-03					
Lead: Electrical Manager					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	N/A
Commentary			All in Place		

HV Systems Authorisation Process PAM SH 9						Air Conditioning Plant PAM SH 11						Ventilation / LEV Testing PAM SH 11					
HTM 06-03						Legionella 2012 L8						Reference to Control of Substances Hazardous to Health Regs 2013(COSHH) – EH40/2005					
Lead: Electrical Manager						Lead: Electrical Manager						Lead: EE Manager					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	N/A				Y	Y	N/A				Y	Y	Y
Commentary			All in place			Commentary			Specialist support contactor changed. F Gas register under review			Commentary			AP`s and CP`s have assumed managerial & operational roles with Estates team supported by the Ventilation Authorised Engineer. Review of all LEV locations and the allied scheduled ppm's continues.		

Pressure Systems PAM SH 13						Fire Safety PAM SH 14						Contractors PAM SH 18					
Pressure Systems Safety Regulations 2000						Regulatory Reform (Fire Safety) Order 2005 HS026 (functional provisions):						Referance`s Construction Design Management Regulations 2015					
Leads: E E Manager						Lead: B&G Manager						Lead: Estaes HelpLine Compliance Manager					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	Y				Y	N	Y				Y	N	Y
Commentary			Management attention required regarding systems and equipment integration into insurance inspection processes and PPM`s currently being reviewed			Commentary			The managemnt for operational fire safety systems has been delegated to the B&G Manager. Asset collection ongoing and remapping of the fire alarm system in various locations underway. This ties in with the ongoing upgrade of floor plans, room numbering and structures within CAFM system			Commentary			Web based Trust Induction and automatic Contactor & Visitor reception systems in place. Compliance team currently auditing operational processes. Installing remote Ambinet terminal at West Park hospital		

Falls from windows SH 20						Slips, trips and falls SH 20						Quality, Safety & Environmental Management					
Falls from windows or balconies in health and social care; MHRA Safety Alert; EFA/2012/001						HSE Guidance INDG225						Implementation of Premises Assurance Model (PAM)					
Lead: Buildings & Grounds Manager						Lead: Buildings & Grounds Manager						Lead : Helpline & Compliance Mgr					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	N	Y				Y	N	Y				Y	N	Y
Commentary			All windows above ground floor level have restriction in place. Targetted replacement to comply with the regulations based on the risk profile of the patient group ongoing. Substantial investment on window replacement schemes has upgraded a significant portion of the site to comply with the latest regulations. Maintenance inspections ongoing.			Commentary			Roads and pathways continue to be monitored on a planned and ad hoc basis to identify significant hazards and ongoing maintenance as well as significant backlog maintenance funds are targetted to improve the retained estate. Little progress has been achiveved to provide accurate locations for ST & F on site – this is a work in progress. The risk rating reflects the accumulative trust wide incidents not any single ST&F.			Commentary			Management focus currently by the individual SH reviews in EPAG meetings as defined in OP33 and SH 1		

Driving for Work (Community Drivers)						Lifting Equipment and handling including hoists (not lifts)						Workplace					
HSE Guidance						Lifting Operations and lifting Equipment Regs 1998 (LOLER)						HSE Regs					
Lead: Shared H&S and Community Directorate Manager						Lead: Head of Medical Physics						Lead: Estates Management					
Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan	Year	19/20	20/21	21/22 Internal Assurance	22/23 External Assurance	Gap Action Plan
			Y	Y	Y				Y	Y	N/A				Y	Y	N/A
Commentary			Estates vehicles maintained via outsourced mechanic on a regular basis. All Operatives undertake vehicle checks prior use. All Operatives carry mobile devices and are in direct communication with Estates Management			Commentary			Jointly controlled by Med Physics and Estates Management – fully compliant supported by insurance (LOLER) inspections.			Commentary			Estates workshops/workplaces are distributed across Trust premises and have all undergone a specific risk assement to identify significant hazards. Mitigation implemeted to address risks and areas secured so that only competant staff can use use the work space.		

Decontamination					
HTM Guidance					
Leads: Estates; Medical Physics; Theatres					
Year	19/20	20/21	21/22	22/23	
			Internal Assurance	External Assurance	Gap Action Plan
			Y	Y	Y
Commentary - Controlled by the clinical teams			Risk register established and monitored at Trust Decom Group, reviewed every 2 months, along with non-conformities, which are also shared at IPCG on a ¼ basis.	Jag accreditation decontamination audit	Continutation of key performance standards in line with HTM guidance in process. Development of a centralised service for Sterile Services & Endoscopy under review.

Appendix 2

Appendix 2 provides examples of rationale for the decision of the RED/AMBER graded subjects against the risk profile (provided by specialist leads)

No	AREA	EVIDENCE and FAILURE	RECOMMENDATION	COMPLETION DATE
1	Pressure Systems	PAM submission	Management attention required regarding systems and equipment integration and PPM`s currently being implemented	3rd Qtr 2023/4
2	Slips, Trips and Falls	Remains the largest H&S incident type reported via Datix at RWT	Completion of a Thematic review which results in a report and recommendations – New Traffic Project and naming convention and Datix category review in progress	4th Qtr 2023/4
3	Decontamination	Risk register established and monitored at Trust Decom Group, reviewed every 2 months, along with non-conformities, which are also shared at IPCG on a ¼ basis.	Continual monitoring at IPCG	Throughout 2023/2024
4	Stress	This is expected to be more of an issue due to the nature of work practises and recovery from the Pandemic	Overview to be seen by OH as well as HSSG meeting Support with Health and wellbeing and strengthened with OH Strengthening visibility of Stress RA and support from H&S Team	Throughout 2023/2024
5	Violence and Aggression	Support Security to ensure VAAG RIDDORS are kept to minimum. Create a KPI for the HSSG	Continual monitoring via Datix project to view all Datix reports and HSSG	Throughout 2023/2024
6	MSK Injuries	MSK injuries increase(d) which due to the backlog from the Pandemic recovery process	Continual monitoring at IPCG and work with M&H Teams – review in HSSG	Throughout 2023/2024

Appendix 3

Health and Safety Audit Emerging Risks	Emerging Risks identified within this report:	Potential impact (including regulation)	Actions	Timeframe	2022 / 2023 update
2023 / 2024	Concerns with Ventilation (Entonox)	Potential health implications to staff and patients	Support Estates, risk assessments, create SOP and health monitoring.	Regular but at least an annual Review	Risk assessment, audit process, monitoring process and health surveillance now in place
2023 / 2024	Violence and Aggression incidents at RWT	Increase in both racist and violent incidents leading to poor staff morale, increased litigation against the Trust, reduced retention of staff. Increased anxiety from increased workloads and patient aggression leading to potential increase sickness / absence in staff Increase in Stress cases across the Trust due to challenges and changes in work practises and changes to the support networks for staff	Ensure risk assessments are in place Support security colleagues by highlighting the issues via Datix Challenge security to support the reduction of VAAG on staff Ensure that incidents are checked so that VAAG RIDDOR incidents are reported in line with legislative requirements	Track at weekly team meetings. Monthly team meetings and at the HSSG/HSOG's	Weekly emails sent to Security Weekly discussion on VAAG incidents Weekly inspection of Datix to see if any incidents meet the RIDDOR criteria

2022/23 (& 2024)	Increase in MSK injuries at the Trust coupled with a lack of MSK training due to a backlog of training (due mainly to COVID-19 recovery)	A lack of transparency of what the issues are in relation to MSK injuries	Improve competence of staff Improve quality of risk assessments – due to the amount of M&H completed in each role at the Trust	Reviewed in the HSSG&HSOG	Manual Handling Dept now directly reporting to the HSSG to increase support and transparency. New training course to incorporate M&H inanimate objects Improve the amount of DSE checklists completed at the Trust
2023 / 2024	Increase in requirement for Home Working. National and Trust Guidance. This was a legal requirement instigated by government not the Trust during the pandemic – currently legislation remains as it was before the pandemic Increases in Stress and potential duplication of work equipment for those working hybrid	Increased numbers of personnel may be required to undertake work at home which could result in an increase in prevalence of ill health due to ergonomic issues. Potential for change in legislation (at time of writing HSE legislative requirement has not changed – this could change once contracts are given out stating WFH or hybrid working).	Agile Policy and documentation Provision of information and safety awareness instructions to home workers. Newly updated DSE support at the Trust via intranet site and Golden Threads Increase in Health and Welfare	Track at weekly team meetings. Monthly team meetings and at the HSSG/HSOG's	All support now on H&S intranet page for 24 hour access Standardisation of equipment ordering with Procurement and Occupational Health in place with catalogue to support

2022/23/24	Stress (Work Related Section 5) - Including promoting positive working to avoid conflict and dealing with unacceptable behaviour	There has been an expansion in reporting from OH which has highlighted this as a prominent issue	Support OH to identify issues to ensure they are able to perform the best health and wellbeing program feasible Analysis of data for themes and high reporting areas in HSSG	Reviewed in the HSSG	Better scrutiny of OH referrals has identified a specific issue around Work Related Stress. Stress continues to be an issue which is supported by H&S through adherence of statutory legislation via risk assessment and support from the H&S Toolbox and quality assurance process
2023/24	An overtly manual safety management system (SMS)	Without more technological advances staff are forced to complete manual checks where more mistakes are inevitable More laborious work resulting in reduced staff retention.	Need an electronic SMS system to support the staff. Need an electronic Risk Assessment process. Need an electronic audit system.	Throughout 2023/24	Opportunity with the amalgamation of Walsall and Wolverhampton Trust's to standardise electronic systems
2022/23/24	Lack of Assurance from Estates – All areas	Lack of qualitative data from the Estates team meaning only limited assurance can be offered at Trust board level Lack of assurance against statutory compliance	EPAG meeting has begun (an Estates meeting encompassing all areas covered by Estates) There is limited assurance from Ventilation group, Estates, Fire Estates project team, Electrical team	Throughout 2023/24	EPAG has begun as a forum in which challenge can be given but there is currently no-one invited from Assurance/Governance

Appendix 4

2023 / 2024 Action plan

Action	Health & Safety Strategic Aim / Indicator	Lead	Time Frame	Activity required
Formalise the thematic audit and review process	All Indicators	Health and Safety Mgr	Review in HSSG	Look at ensuring that there is a formal process to reduce the severity and frequency of H&S incidents
To monitor and support the EPAG Estates program	Create KPI's to support	Assurance/Governance	2023/24	Look at improving assurance to the Trust due to the breadth of assurance required from this area
Embed the new Podium audit process	Create KPI's to support	Health and Safety Manager	Review in HSSG	Portfolio review for Health and Safety Officers – Ensure it is a KPI
Support can challenge the Estate portfolio to improve their assurance across the Trust's portfolio	Legal Requirement	Assurance/Governance	2023/24	Support and challenge at EPAG group
Develop a communication strategy for H&S which includes all pathways available to build the H&S profile and complement the Trust H&S management system	All Indicators	H&S Mgr / Health and Safety Team	HSSG Review	Develop and implement the communication document and start implementation in 2023/24
Monitor introduction of hybrid or Working from Home legislation and review of current DSE practises at the Trust	Legal requirement	Health and Safety Team	HSSG Review	Liaise with Teams to develop suitable and sufficient risk assessments, DSE catalogues and synergy work with procurement and OH.
Continue to work with Infection Prevention and Occupational Health Teams to monitor and address issues with clinical sharps equipment.	Legal requirement	Occupational Health, Infection Prevention and Health and Safety Team	HSSG / Sharps Group review	Work with lead teams to promote safer working practice with clinical sharps, monitor / report on / investigate sharps incidents across the Trust. Create method to record and QA Risk Assessment

Action	Health & Safety Strategic Aim / Indicator	Lead	Time Frame	Activity required
Continue to work with Occupational Health Team to promote Health and Well Being in the Trust as a workplace. Use media and Forums to promote Health and Wellbeing and the stress and MSK/MSD incidents	Legal & Trust Requirements	Occupational Health, and Health and Safety Team	Via HSSG regular review	Work with lead teams to promote awareness of mental health and wellbeing. Maintain awareness at Safety Rep Forums and other media. Reduction in MSK injuries severity and frequency
Review the training provided by the H&S Team and achieve the accreditation for RWT as Managing IOSH Trust	Legal & Trust Requirements	Health and Safety Mgr	Via HSSG regular review	Achieve IOSH accreditation for RWT Look for two new 'local' courses M&H/COSHH combined and an incident investigation course
Align RIDDOR's with claims for last 3 years and analyse data	All indicators	Health and Safety Team	2023/24	Via the KPI process once it is expanded to incorporate more proactive data. Continue the work with creating RIDDOR incident investigations and work on claims data and improving knowledge on incidents and reduction in severity to the injured parties and the financial impact to the Trust.

Glossary:

HSG65	HSE Managing for Health and Safety Guidance. A framework to oversee an organisation's Health and Safety arrangements.
Health Technical Memoranda	Give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.
Risk Profiling	Overarching status assessed by Specialist Lead based on the strength of compliance with identified regulations

Definitions:

CAS	Central Alerting System
CDM	Construction Design Management Regulations 2015
CERL	Clinical Equipment Resource Library
CHAS	Contractor Health and Safety Accreditation Scheme
COSHH	Control of Substances Hazardous to Health Regulations 2013
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
DSE	Display Screen Equipment
EFA	Estates Facilities Alerts
FSN	Field Safety Notice
HSE	Health and Safety Executive
HSSG	Health and Safety Steering Group
HSOG	Health and Safety Operational Group
HTM	Health Technical Memoranda (HTMs)
IRMER	Ionising Radiation (Medical Exposure) Regulations 2000
LEV	Local Exhaust Ventilation
LOLER	Lifting Operations and Lifting Equipment Regulations 1998
MDA	Medical Device Alerts
MHRA	Medicines and Healthcare products Regulatory Agency
PAM	Premises Assurance Model (Estates).
PUWER	Provision and Use of Work Equipment Regulations 1998
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013
SDA	Supply Disruption Alert
SOP	Standard Operating Procedures
WTE	Whole Time Equivalent

TO BE READ BEFORE FOLLOWING THIS POLICY

OP04 Patient Safety Incident Response Policy

From 1 November 2023 this policy commences a phase out period, the guidance and principles of the NHS England Serious Incident Framework (2015) were used to write the OP04, Patient Safety Incident Response Policy.

The National Patient Safety Strategy is introducing new ways of working in relation to patient safety incidents and investigations under the new Patient Safety Incident Response Framework (PSIRF).

The OP10, Risk Management and Patient Safety Reporting Policy will be replaced once these changes are fully implemented by the Trust.

The change from the Serious Incident Framework 2015 to PSIRF *does not* apply to incidents outside the scope of PSIRF (i.e., incidents not involving a patient), including incidents that relate to:

- Professional standards
- Information governance;
- Health and Safety incidents (that do not highlight a significant patient safety concern);
- Digital and IT;
- Financial investigations;
- Estates and facilities;

These will continue to be managed the way they are now.

The transition from the OP10, Risk Management and Patient Safety Reporting Policy to OP04 Patient Safety Incident Response Policy will commence on 1 November 2023 and is expected to take 3 - 6 months.

Serious incidents occurring before 1 November 2023 will be investigated and closed under the Serious Incident framework (2015), this will then conclude the period of policy overlap.

In summary

Serious Incidents reported prior to 1 November 2023 will continue to be managed under the serious incident framework (2015).

Patient safety incidents reported on or after 1 November 2023 will be managed using the PSIRF Policy.

Reference to both policies for processing should be made accordingly.

The Royal Wolverhampton NHS Trust

Patient safety incident response policy

Effective date: 1 November 2023

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author(s)	**Dee Johnson**	**Group Patient Safety Specialist**		
Reviewer				
Authoriser	**Kevin Bostock**	**Group Chief Assurance Officer**		**October 2023**

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Wolverhampton NHS Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approaches to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents and safety issues
- Supportive oversight focused on strengthening response system functioning and improvement.

This policy is to be read together with the current patient safety incident response plan, which sets out how this policy will be implemented, in conjunction with the Trust's Incident Reporting and Monitoring Procedure 1 (OP10), which sets out how incidents outside of this policy are managed and the Duty of Candour Policy (OP60), which sets out the requirements where harm has been caused as a result of a patient safety incident.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across The Royal Wolverhampton NHS Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

A patient safety response is conducted for the purpose of learning and improvement and there is no remit to apportion blame or determine liability, accountability, causality, preventability or cause of death in a response under this policy. Where the principle aim of a response differs from this, they are beyond the scope of this policy. This includes, but is not limited to, the following processes:

- Claims handling;
- Human resources investigations into employment concerns;
- Professional standards investigations;
- Information governance concerns;
- Health and Safety incidents (that do not highlight a significant patient safety concern)
- Digital and IT concerns;
- Financial investigations and audits;
- Estates and facilities concerns;
- Safeguarding concerns;
- Coronial inquests and criminal investigations; and,
- Complaints (that do not highlight a significant patient safety concern)

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

The Royal Wolverhampton NHS Trust promotes a just culture approach (in line with the NHS Just Culture Guide) as part of its approach to learning from patient safety incidents.

There are clear mechanisms in place to enable reporting of patient safety related issues via multiple avenues, including a single incident reporting and management system, Freedom to Speak Up Guardians and processes for staff to raise concerns, and Complaint and PALs services for patients and the public.

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the Trust's Incident Reporting and Monitoring Procedure 1 (OP10) for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

In support the development of a just culture, policies and procedures are being updated to ensure Just Culture principles and language are incorporated and to provide a clear distinction between patient safety incident responses and other processes that may involve investigation processes. Our policies do not promote multiple errors as a basis to trigger corrective or punitive processes following involvement in incidents and staff receive appropriate training regarding this.

We will use the findings from safety related staff survey results to evaluate progress with improving our safety culture. This will be supported by implementing new culture related measures to oversee the monitoring of outputs and processes.

Patient safety partners

The Patient Safety Partner (PSP) is an evolving role developed by NHS England and Improvement to help improve patient safety across the NHS in the UK and is involved in the designing of safer healthcare at all levels in the organisation.

PSPs enable the Trust to value, listen and provide meaningful involvement opportunities for patients, their carers and families in the ongoing patient safety work of the organisation, supporting a culture that is 'patient centred'. They bring an independent non-Trust perspective and are involved, as an equal partner, in a wide range of activities and programmes such as the design of safer healthcare at all levels in the organisation. The Patient Safety Partner role ensures that the patient voice is heard within the Trust, with the core purpose of ensuring we prioritise the safety requirements of patients to improve care.

PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care. PSPs play a vital role by joining relevant safety groups and committees, where they will reflect the voice and needs of people who use hospital and community-based health services and will enhance the committee membership by providing appropriate challenge to ensure learning and change. Working alongside staff, volunteers and patients, PSPs will be involved in projects to co-design developments of patient safety initiatives including having a key role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

PSPs will be supported in their role by the Patient Safety Specialist and the Deputy Head of Patient Experience for the Trust who provide expectations and guidance for the role, along with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled. PSPs will have regular scheduled reviews and regular one-to-one sessions. PSP placements are on a voluntary basis and will be reviewed after one year to ensure the role stays aligned to the patient safety agenda as it evolves.

Addressing health inequalities

As a public authority, the Trust is committed to delivering on its statutory obligations under the Equality Act (2010) and endorses a zero acceptance of racism, discrimination, and unacceptable behaviours from and toward our workforce and our patients/service users, carers and families. The Trust recognises there is a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

Through our implementation of PSIRF, we will seek to utilise data and learning from investigations to intelligently consider health inequalities to patients and advise our Trust Board and partner agencies on how to tackle these. We will directly address if there are any features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics.

We will ensure that we use all available tools to meet the needs of those concerned, for example, easy read, translation and interpretation services, to make involvement as accessible as possible following a patient safety incident response.

When constructing our safety actions in response to any incident and/or improvement work, we will consider inequalities, and this will be inbuilt into our documentation and governance processes. This holistic, integrated approach to patient safety under PSIRF will require increased collaboration with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

In establishing our plan and policy we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy. We consider this as an integral part of the future development process.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident, maintaining effective communication with them, sharing the findings of any further review or investigation into the incident and signposting them to support as required.

Involving patients and families

Getting patients and families involved in how we respond to incidents is crucial, particularly to support improving the way we provide our services. Patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents and may have different questions or needs to that of the organisation.

Our key principle is being open and honest whenever there is a concern about care not being as planned or expected, or when an error has been made, regardless of the level of harm caused. The Trust recognises the importance of involving patients and families following patient safety incidents and is committed to engaging them in the investigation process as well as fulfilling the duty of candour requirements.

This policy therefore reinforces existing guidance relating to the duty of candour and ‘being open’ and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving staff, colleagues and partners

The involvement of staff and colleagues is vitally important when responding to a patient safety incident to ensure a holistic and inclusive approach from the start. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, concentrating on moving toward reviewing incidents, or groups of incidents that provide the greatest opportunities for learning and improvement.

This new way of working will be a culture shift for the organisation, providing support and guidance through the principles of good change management, so staff feel ‘a part of’ rather than ‘being done to’ during an investigation. This policy acknowledges the equal need for staff and colleagues to be involved in the same way as patients and families, as soon as possible, at all stages of an investigation or improvement planning.

Staff and colleagues will need to feel consistently supported to speak up and openly report incidents and concerns without fear of recrimination or blame. The Trust also recognises the importance of ensuring the Just Culture principles are applied and is committed to treating staff equitably during an incident response.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

This approach allows the Trust to focus its resources on responding to patient safety incidents that offer the greatest opportunities for learning and improving the safety of the healthcare we deliver. To fulfil this, we will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources, including direct feedback from staff and patients, to explore what we know about our safety position and culture. This will enable us to develop an evidence-based rationale for each identified patient safety incident type in our plan, which can also be updated in response to emerging intelligence and improvement efforts.

Our associated patient safety incident response plan (PSIRP) will reflect this approach, providing more detail on how the Trust will meet the national and local focus and will be published alongside this overarching policy.

Resources and training to support patient safety incident response

The Trust has committed to ensuring that we embed and meet the requirements of PSIRF and will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

The Trust will also have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation. The selection of appropriate learning response leads will be monitored to ensure the rigour of approach to the review and will maintain records to ensure an equitable allocation. The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will

work within our just and restorative culture principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety. There will be a pool engagement and involvement lead roles to independently support those affected by patient safety incidents.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), advice and proofreading.

PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan.

All systems-based Patient Safety Incident Investigations will initially be overseen by the Patient Safety Team; they will have undertaken specific training in systems-based investigation methodology. Currently the Patient Safety Team has the following working time equivalent posts to support and facilitate the PSIRF framework:

- 1 x Patient Safety Specialist
- 2 x Patient Safety Leaders

Other learning responses will be coordinated by the Divisional Teams or specialist subject teams (Quality), supported by the Assurance Team, and should be undertaken by staff who have received specific training in these techniques.

Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

There will be a pool of trained staff who can undertake learning responses, though the majority have a substantive clinical role, so therefore must be allocated time within job plans to complete investigations.

All staff in the trust are required to complete Level 1 National Patient Safety Syllabus training and for those staff who have a responsibility for managing and investigating

patient safety incidents at a local level, must complete Level 2 National Patient Safety Syllabus training.

All staff are also required to complete mandatory patient safety training which covers the basic requirements of reporting, investigating and learning from incidents as well as the PSIRF awareness training that will be developed.

Specific roles and competencies are required for PSIRF which are outlined below:

Learning response lead role

- Led by those with at least two days' formal training and skills development in learning from patient safety incidents and experience of patient safety incident response.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
  - Summarise and present complex information in a clear and logical manner and in report form.
  - Manage conflicting information from different internal and external sources.
  - Communicate highly complex matters and in difficult situations.

Engagement and involvement lead role

- Led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.
- Have completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.
- Competencies:
  - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
  - Listen and hear the distress of others in a measured and supportive way.
  - Maintain clear records of information gathered and contact with those affected.
  - Identify key risks and issues that may affect the involvement of patients, families, and staff.
  - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight lead role

- Led/conducted by those with at least two days' formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.
- Have completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.
- Competencies:
  - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
  - Apply human factors and systems thinking principles.
  - Obtain (e.g., through conversations) and assess both qualitative and quantitative information from a wide range of sources.
  - Constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
  - Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
  - Summarise and present complex information in a clear and logical manner and in report form.

All specified roles in relation to PSIRF are required to undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Initial training support for learning responses will be as below:

- Patient safety team, assurance team leaders, governance managers and Corporate Nursing Quality team and quality leads from support services – 3 days training on systems investigations, compassionate engagement and oversight.
- Directorate leadership teams - 3 days training on systems investigations and compassionate engagement
- Divisional Leadership Teams – two half days training on compassionate engagement and oversight. level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Executive Director quality and safety leads (Group Chief Assurance Officer, Chief Nursing Officer, and Chief Medical Officer) - two half days training on

compassionate engagement and oversight and in line with PSIRF guidance level 1 for Boards National Patient Safety Syllabus training.

- Deputy executive leads (Deputy Chief Medical Officer, Deputy Directors of Nursing and Director of Midwifery) - two half days training on compassionate engagement and oversight and in line with PSIRF guidance level 1 for Senior Leadership and Boards National Patient Safety Syllabus training.
- Non-Executive Director members of Quality Committee – half day oversight training and in line with PSIRF guidance and Level 1 for Boards National Patient Safety Syllabus training.

Specific training in PSIRF tools will be made available and will be accessible via the Patient Safety Team. Training and coaching in other learning responses can be accessed via the Patient Safety Team or in the Patient Safety section of The Beat.

Our patient safety incident response plan

Our patient safety incident response plan sets out how The Royal Wolverhampton NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The plan is based on an analysis of themes and trends from all incidents from financial years 2020 to 2023 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from serious incident investigations, mortality reviews, legal claims and inquests, risk registers, complaints and feedback from staff and patients.

A copy of our current plan can be found at:
http://intranet.xrwh.nhs.uk/pdf/policies/OP_04_Appendix1.pdf

Reviewing our patient safety incident response policy and plan

Our patient safety incident response policy will be reviewed in line with Governance of Trust-wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01). As the Trust works toward meeting the patient safety incident response standards, any changes to the policy will be shared and discussed with stakeholders. Once agreed, these changes will be presented to Board for approval.

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

PSIRF does not change any arrangements to report patient safety incidents. Patient safety incident reporting will remain in line with the Trust's Incident Reporting and Monitoring Procedure 1 (OP10). All patient safety incidents will continue to be recorded and monitored through the Trust's incident reporting system (Datix).

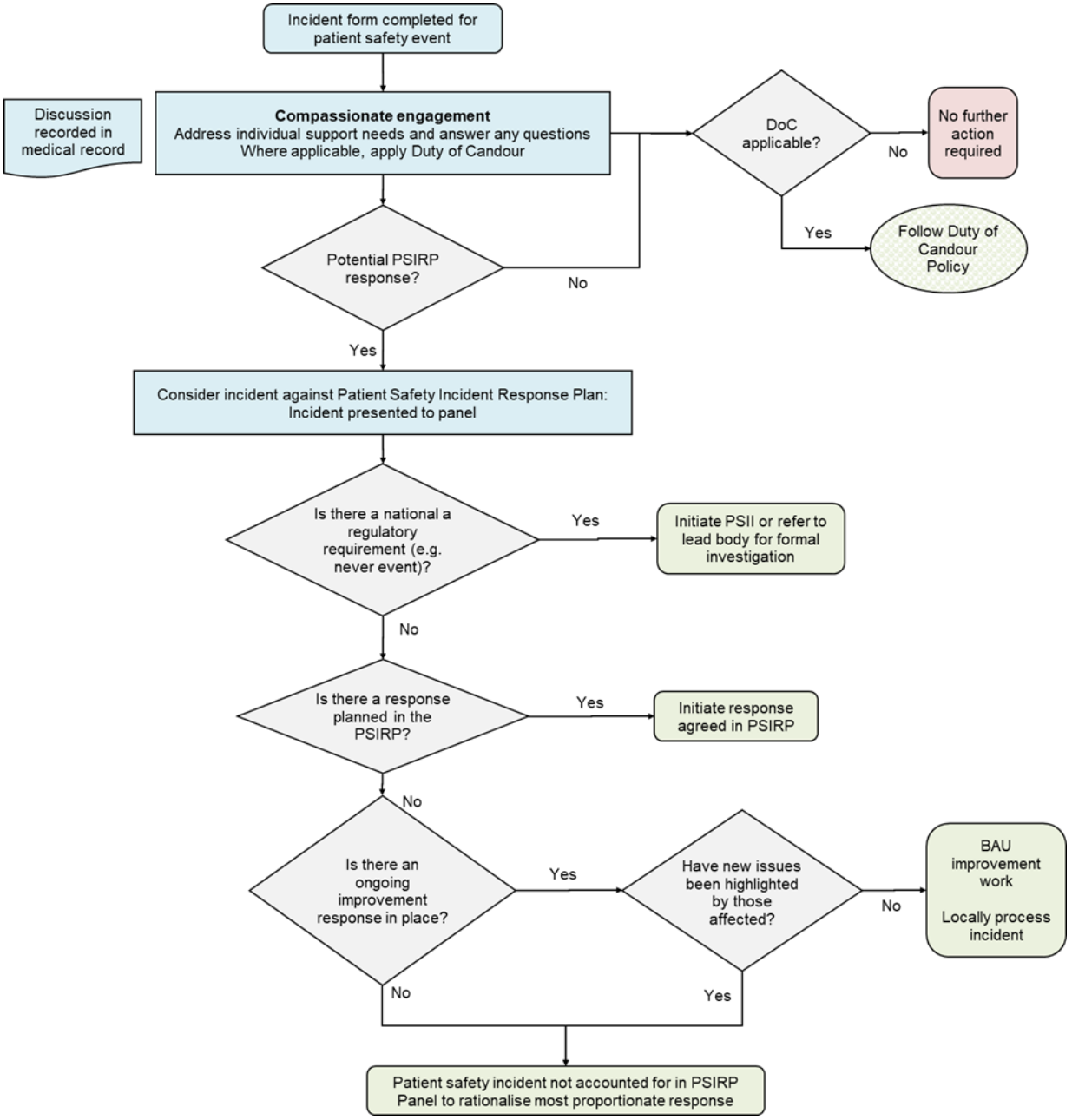
Divisions will have daily review mechanisms in place to ensure that patient safety incidents can be responded to proportionately and in a timely fashion. This should include consideration and prompting to service teams where Duty of Candour applies (see OP60) Monitoring of patient safety incidents locally, through the Directorate's governance meetings will remain the same, supported by their respective Assurance team members.

Most incidents will only require local review to ensure an incident has been appropriately dealt with and any mitigating actions have been initiated and shared where needed to prevent recurrence. However, for some, where it is felt that the opportunity for learning and improvement is significant, or it appears to meet the criteria for a learning response, these should be escalated within the Division. Divisions and corporate service leads will highlight these to the Assurance team, initiating the decision-making process.

Certain incidents require external reporting to national bodies such as HSIB, HSE and MHRA. The Patient Safety Team will work closely with relevant Trust departments to ensure we report incidents to external national bodies. Please refer to the Trust's Incident Reporting and Monitoring Procedure 1 (OP10) for full details and guidance.

Patient safety incident response decision-making

The Trust PSII decision making panel will have delegated responsibility for the consideration of incidents for PSII and validation of response approach adopted on a weekly basis for incidents reported in-week. The meetings will be led by the executive lead for patient safety in the Trust. Figure 1 sets out the essential decision-making steps under PSIRF:



The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified.

Where it is clear a PSII is required (for example, for a Never Event) the Division should notify the Assurance team as soon as practicable so that the incident can be shared to the decision-making panel.

Decision making for escalation to the Trust decision-making panel can be aided by a rapid review. The purpose will be to recommend the most appropriate learning response

method based on the Trust PSIRF plan and the assessed learning potential of each incident being reviewed.

Incidents with positive or unclear potential for PSII will be escalated to the decision-making panel by the division. Cases will be presented by the senior leadership team for the area in which the incident occurred. The Trust PSII decision making panel will meet at the earliest opportunity to discuss the nature of any escalated incident, immediate learning (which should be shared via an appropriate platform), and any mitigation identified or that is still required to prevent recurrence.

The PSIRP supports proactive allocation of patient safety incident response resources, but it is recognised there will always need to be a reactive element in responding to incidents. To ensure that there are sufficient resources to allocate to support responses to emergent issues that are not included in the initial PSIRF plan, one Trust priority will be left unallocated. Collectively the attendees of the panel will agree a proportionate learning response agreed and allocate a learning response lead. This will allow the Trust greater flexibility to react more promptly to emerging system issues to ensure learning and improvement is completed more promptly.

It is also recognised that some incidents may still require a case based comprehensive investigation, like a Serious Incident investigation under the old framework during the transition from that framework to PSIRF. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP.

The Quality and Safety Advisory Group will have overall oversight of the operation and decision-making of the Patient Safety Incident Investigation Panel, providing challenge to the decision making and the incident responses the panel has delegated responsibility to commission. This will support the approval process for all PSIIs. Through this mechanism the Board will be assured that it meets expected oversight standards, the intent of PSIRF is being implemented within our organisation, we are meeting the national patient safety incident response standards and also understanding the ongoing and dynamic patient safety and improvement profile within the organisation.

Responding to cross-system incidents/issues

The Trust will ensure any incidents that require cross system or partnership engagement are identified and shared through existing channels and networks. Where we identify the involvement of multiple agencies, we will invite our partner organisations to work with us

to understand the system issues, providing the opportunity for partnership colleagues to be fully engaged in investigations and learning as required.

Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

We will seek to involve our Integrated Care Board in the event that it is unclear which organisation should lead on a learning response or where commissioning is identified as an issue.

Where appropriate, we will review our patient safety intelligence alongside our system partners to collectively tackle common issues and promote the opportunity for consistent collaboration across specific themes (e.g., falls, health inequalities, mental health).

Timeframes for learning responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

A key factor in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The purpose of learning responses is to understand the context of the incident and develop a thorough understanding of the work processes. PSIRF places resistance against the temptation to quickly identify what needs to change, instead, learning responses include the requirement to understand the work as done and what system factors affect this.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident.

PSII learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and timeframes for completion should be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision. PSIIs should not take longer than six months.

A balance must be struck between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that actions to improve safety may be delayed until completion. This may impact on the need to make further checks to ensure the findings remain relevant.

In the extraordinary circumstance where there are issues with accessing information or where information cannot be provided, the Trust can opt to progress the PSII with the available information, with the caveat this can be revisited should the added information indicate the need for further investigative activity once this is received. This would require a decision by the Trust Patient Safety Incident Investigation Panel.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

Other forms of learning response

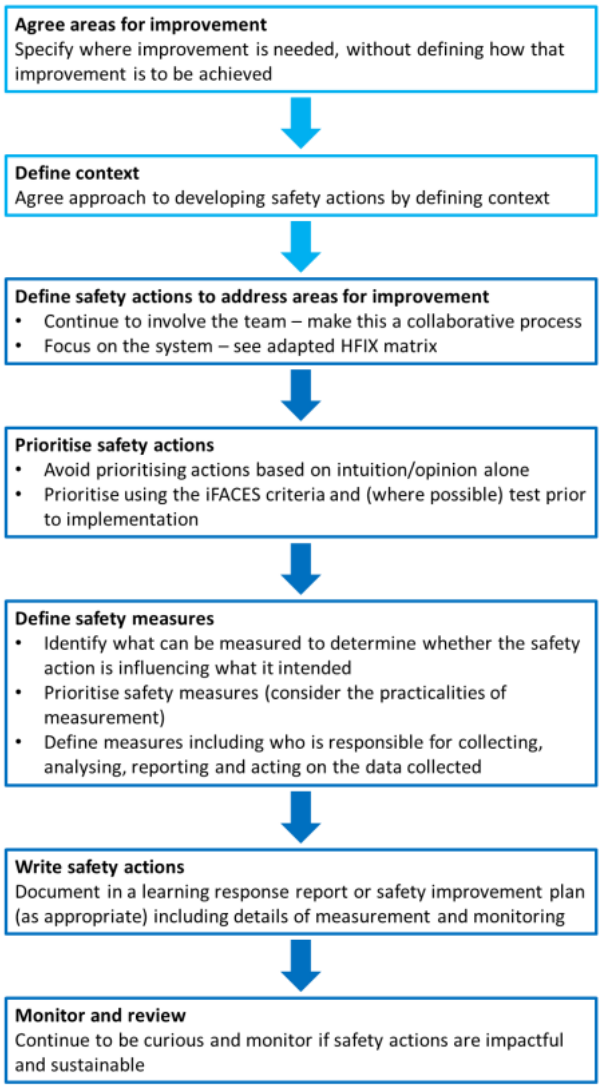
Other forms of learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

Safety action development

PSIRF promotes the term ‘areas for improvement’ instead of ‘recommendations’ with the aim of reducing the possibility of ‘solutionising’ at an early stage of the safety action development process. Following learning from incident responses, areas for improvement will be defined. Safety actions are created in response to each defined area for improvement and can depend on issues and boundaries that sit outside the scope of a learning response. PSIRF advocates a move toward implementing the lessons with an “integrated process for designing, implementing, and monitoring safety actions” to reduce risk and potential for harm.

Safety actions will be developed alongside the clinical and operational teams responsible for implementation to ensure ownership of the actions and outcomes. The Trust will use the process for developing safety actions outlined by NHS England in the Safety Action Development Guide (2022):



A quality improvement approach is essential to learning and improvement following a patient safety investigation. to ensure safety actions are: clearly defined, describe responsibilities and timescales, are aligned to reportable outcome measures and assurance processes. Close links with the Quality Improvement Team will be developed and maintained so their QI expertise and guidance can be utilised when developing safety actions. The quality improvement approach is recognised within the Trust and there is extensive, ongoing work to educate colleagues in the principles of QI methodology. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety teams to work more closely together.

Monitoring improvement

Monitoring of completion and efficacy of safety actions will be through the divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Reporting on the progress with safety actions, including the outcomes of any measurements will be made to the Quality and Safety Advisory Group.

The Patient Safety Team will align its work with the Quality Improvement Team to maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

For safety actions with a wider significance, this may require oversight by a Safety Improvement Panel, reporting to the Quality and Safety Advisory Group.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which will be adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes.

The Patient Safety Incident Response Plan (PSIRP) clarifies what our improvement priorities are and takes into consideration the fundamental priority areas outlined in the Quality and Safety Enabling Strategy.

The themes detailed in the PSIRP that are selected for an improvement pathway will have an improvement plan utilising QI methodology, where appropriate, to determine what the key drivers are to patient safety risks, how improvements can be made and how these can be monitored for completion and effectiveness.

These improvement plans will be a key focus of the regular thematic reviews within the patient safety groups related to that theme and explore the impact of improvement plans on subsequent incidents. There will be a clear alignment between some safety actions arising from patient safety responses and the overarching safety improvement plans.

The Trust will use the outcomes from existing patient safety incident reviews where present and any relevant learning response conducted under PSIRF to create related safety improvement plans to help to focus our improvement work.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed.

Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a directorate or specialty level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach.

The Trust is reviewing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through divisional and corporate governance structures and processes. Directorate level improvements will be managed locally with assurance and reporting to Division, then, corporate oversight and assurance committees will provide ‘ward to board’ assurance.

Safety improvement plans will often lead to the outcome measurement and assurance processes that underpin safety actions and will be considered by the Safety Improvement Group both to receive progress and assurance regarding existing plans but also to recommend the need for future improvement plans following review of responses and individual safety actions.

Completed safety improvement plans should be examined to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared, adapted and adopted with other areas of the organisation and peer organisations via the Patient Safety Specialist to the ICB Patient Safety Incident Surveillance Group and/or Shared Learning Events.

Oversight roles and responsibilities

Responsibility for effective patient safety incident management sits with the Trust Board. This includes supporting and participating in cross system/multi-agency responses and/or independent patient safety incident investigations (PSIIs) where required. The Executive Lead is the Group Chief Assurance Officer who holds responsibility for effective monitoring and oversight of PSIRF.

The Trust, through the Executive lead, has a responsibility to:

1. Ensure the Trust meets the national patient safety response standards
2. Ensure PSIRF is central to overarching safety governance arrangements
3. Quality assure learning response outputs

Working under PSIRF, the Trust aims to utilise oversight systems that allow improvements to be demonstrated rather than solely seeking compliance with centrally mandated measures. Oversight will focus on engagement and empowerment rather than the more traditional command and control.

The Trust acknowledges the 'oversight mindset' principles that will underpin the processes put in place to allow PSIRF to be implemented in line with the oversight roles and responsibilities specification supporting document (NHS England 2022, p 3).

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Oversight and assurance arrangements will be developed through joint planning.

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality and Safety Advisory Group and Quality Committee. Safety reporting will comprise oversight question responses to ensure that the Trust Board has a formative and continuous understanding of organisational safety.

The Quality and Safety Advisory Group will provide assurance to the Quality Committee that PSIRF and any related workstreams have been implemented to the appropriate standards. This will include reporting on ongoing monitoring and review of the patient safety incident response plan, delivery of safety actions and improvement and monitoring of the balance of resources going into patient safety incident response versus improvement.

Divisions will be expected to report on their patient safety incident learning responses and outcomes. Divisions will have arrangements in place to manage the local response to patient safety incidents and ensure that escalation procedures as described in the patient safety incident response section of this policy are effective.

The Trust will implement a Patient Safety Incident Investigation Panel to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

The Trust will source necessary training such as the Health Education England patient safety syllabus and other patient safety training available as appropriate to the roles and responsibilities of its staff in supporting an effective organisational response to incidents.

Updates will be made to this policy and associated plan as part of regular oversight. A review of this policy and associated plan should be undertaken at least every four years alongside a review of all safety actions.

Complaints and appeals

Any complaints relating to this guidance, or its implementation can be raised informally with the Trust Patient Safety Specialist, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure here.

Part A - Document Control

Policy number and Policy version: OP04 Version 1.0	**Policy Title:** **Patient Safety Incident Response Policy**	**Status:** Final		**Author:** **Dee Johnson, Group Patient Safety Specialist** **Chief Officer Sponsor:** **Kevin Bostock, Group Chief Assurance Officer**
Version / Amendment History	Version	Date	Author	Reason
	1.0	October 2023	Group Patient Safety Specialist	Implementation of policy
Intended Recipients: All Staff				
Consultation Group / Role Titles and Date: **Sponsor of Policy and Chair of Trust Policy Group**				
Name and date of Trust level group where reviewed	Virtual approval via Chair of Trust Policy Group – October 2023			
Name and date of final approval committee	Sponsor and Chair of TPG sign-off – October 2023			
Date of Policy issue	25 October 2023			
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	November 2024 (Annual Review)			
Training and Dissemination:				
To be read in conjunction with: OP10 Risk Management and Patient Safety Reporting Policy OP60 Being Open (Duty of Candour)				
Initial Equality Impact Assessment (all policies): A national EIA has been completed and therefore an internal assessment is not required.				
Monitoring arrangements and Committee				
Document summary/key issues covered: This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out The Royal Wolverhampton NHS Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.				
Key words for intranet searching purposes	OP04, Safety, Patient, Incident, Response, PSIRF, Reporting, Patient Safety, Incident Response, Safety Incidents, Patient Safety Incident Response, Incident Response Plan			

The Royal Wolverhampton NHS Trust

Patient safety incident response plan

Effective date: 1 November 2023

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
Author	**Dee Johnson**	**Group Patient Safety Specialist**		
Reviewer				
Authoriser	**Kevin Bostock**	**Group Chief Assurance Officer**		**October 2023**

Contents

Introduction

This patient safety incident response plan sets out how The Royal Wolverhampton NHS Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The Royal Wolverhampton NHS Trust is registered with the Care Quality Commission to provide services in the following locations:

- New Cross Hospital
- Cannock Chase Hospital
- West Park Rehabilitation Hospital
- Community sites
- GP practices

The services provided include:

- Emergency and Urgent Care
- Surgery
- Maternity
- Diagnostic services
- End of Life care
- Services for children and young people
- Medical care including older people's care
- Critical Care
- Outpatients
- Community Services
- Day case services
- Therapy services
- Rehabilitation services
- GP services
- Pharmacy services

Further information can be found on the Trusts website.

Defining our patient safety incident profile

PSIRF sets the national requirements listed within the plan. The remainder of the plan is data driven, covering the last 3 years which has provided an insight into the key patient safety incident themes, patterns and trends, recurrence and the greatest opportunities for learning to improve patient safety outcomes.

The Trust engaged with key stakeholders using a dedicated profile and planning workstream, having reviewed Trustwide data from various sources to determine the Trust safety profile and identify the optimum methods of review to ensure maximum learning and effective plans to improve the quality and safety of services.

Our analysis included creating a list of the incident or issue types identified for each data source along with safety insights. The top 10 patient safety related themes were identified from each data source and then these were cross-referenced to find commonalities for inclusion as a feature in the plan. The list was agreed to take forward to the planning process.

The patient safety issues were identified through the following sources:

- Incident data 2020-21 to 2022-23
- Key themes from complaints, PALs, claims and inquests
- Key themes from specialist safety and quality groups (e.g., falls, pressure ulcers, Learning from Experience Group)
- Themes from learning from deaths reviews
- Trust and divisional risk registers
- Key themes from FTSU, safeguarding and staff survey
- Key themes from GIRFT
- Key themes from mortality reports
- ICS Quality surveillance reports
- Clinical audit data

Safety issues highlighted by the data

From the original data pull, we were able to identify 13 themes, although some themes were noteworthy in one data source, recurrence was a significant contributor in the consideration. These are shown in the table below:

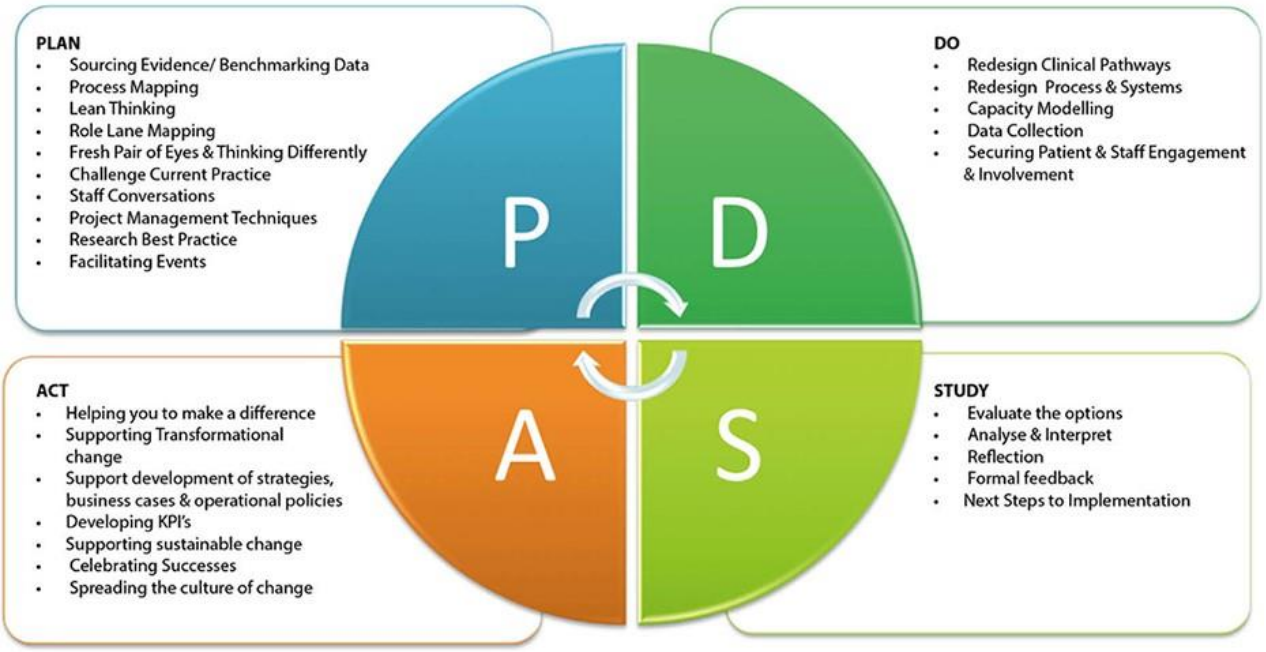
THEME	RESPONDING TO PATIENT CONDITION	FALLS	PRESSURE ULCERS	INFECTION PREVENTION AND CONTROL	COMMUNICATION – VERBAL/WRITTEN
DATA SOURCE	Claims Mortality Risks	Incidents	Incidents	Incidents SIs Quality Surveillance Risks	Complaints Mortality Quality Matters SIs Staff survey Incidents Risks
THEME	DIAGNOSTICS	ADMISSION/TRANSFER /DISCHARGE	MEDICATION	DELAYS (ALL TYPES)	BEHAVIOURS
DATA SOURCE	Claims SIs Risks	Incidents Quality Surveillance Complaints Safeguarding Risks	Incidents Complaints Safeguarding Risks	Claims Mortality Complaints SIs Quality Matters Risks	Complaints FTSU Mortality Safeguarding SIs Quality Surveillance Staff survey
THEME	STAFFING	INVOLVING PATIENTS IN CARE	INEQUALITIES IN CARE		
DATA SOURCE	Incidents Complaints Risks	Complaints Mortality Safeguarding	Complaints MH care (risks)		

Further details on the features within the themes are considered to identify and hone our overall profile. This leads to the priorities highlighted in local focus section below.

Whilst the list has been developed, we are conscious that it is not fixed. The Trust profile must retain flexibility in its approach to risk and learning, and therefore, where there is significant risk, opportunities for significant new learning and impacts on quality and safety of services, the Trust will retain capacity for additional PSII outside of the Trust profile where required.

Defining our patient safety improvement profile

The Trust has a comprehensive quality improvement programme across the organisation, using the Quality Service Improvement and Redesign (QSIR) methodology. The Plan, Do, Study, Act process forms the basis for our improvement work:



The quality improvement programme has patient safety as a theme of its work. The aim is that the use of QI methodology will help staff on the front line identify methods to deliver a safer service. The principles underlying this are to:

- Learn from accurate data from mortality, governance, benchmarking, complaints etc.
- Reduce unwarranted variability
- Develop safe reliable systems that support and empower staff to do the right thing, first time and record it correctly

Our improvement priorities are directly informed by our patient safety priorities, identified from patient safety investigations and identification of themes, as well as by key operational and pathway improvement priorities from across the organisation.

Future quality improvement priorities will be directly informed by implementation of the PSIRF, providing an opportunity to streamline and prioritise future improvement activity.

Our improvement priorities are supported by a specialist team of improvement practitioners, our Quality Improvement Team who provide support, facilitation and coaching for improvement activity across the Trust as well as providing a range of training/development opportunities to build capacity and capability at all levels of the Trust.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events 2018 criteria	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths thought more likely than not due to problems in care (meeting the learning from deaths criteria)	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of patients detained under MHA or where MCA applies and are thought more likely than not due to problems in care	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Deaths of a patient with learning disabilities (meeting the LeDeR criteria)	Referred to Learning Disabilities Mortality Review (LeDeR) PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Incidents meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Maternity incidents meeting HSIB criteria	Refer to HSIB for independent patient safety incident investigation	Respond to recommendations as required safety actions to feed into patient safety priorities and shared learning
Child deaths	Referred for Child Death Overview Panel PSII or other response may be required to support process	Respond to recommendations from referred agency/ organisation as required
Safeguarding incidents meeting criteria	Referred to Trust Safeguarding Lead	Respond to recommendations from referred agency/ organisation as required
NHS Screening incidents	Referred to PHE Imms and Screening Quality	Respond to recommendations from referred agency/ organisation as required

	Assurance for consideration of response	

Our patient safety incident response plan: local focus

Patient safety incident type or issue	Planned response	Anticipated improvement route
Patient pathway delays	PSII or MDT	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Transitions of care	PSII	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Diagnostic incidents	PSII or MDT	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Communication	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Responding to changes in patient condition	PSII or AAR	Areas for improvement and safety actions to feed into patient safety priorities and shared learning
Falls	Rapid review Quarterly thematic review	Joint Falls Steering Group
Pressure ulcers	Rapid review Quarterly thematic review	Tissue Viability Steering Group
Infection Prevention and Control	Refer to IPC investigation matrix Quarterly thematic review	Infection Prevention Group

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public. 12th December 2023		
Title of Report:	Maternity Services Report	Enc No: 10.4
Author:	Tracy Palmer	
Presenter/Exec Lead:	Mrs Katherine Cheshire Head of Midwifery	

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	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:
	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:**		

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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: 25 November 2023, TMC
	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

- Midwifery Workforce position indicates a minimum vacancy of 0.71 whole time equivalent (WTE). This is an improved position in comparison to September / October 2023.
- One to one care rates in established labour continue to be maintained at 100% for Q.2/3.
- The Trust continues to meet 100% of the standards in Safety Action1 *Are you using the Perinatal Mortality Review Tool to review all deaths*? NHS Resolution (NHSR): Maternity Incentive Scheme (MIS) year 5.
- There were no adverse outcomes for patients during August and September 2023 attributed to Midwifery red flag events.
- Clinical Negligence Scheme for Trusts (CNST) NHSR Maternity Incentive Scheme – The report outlines progress with Year 5 MIS 10 safety actions. The Directorate are currently on track to achieve all 10 Safety actions.

Advise

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

- The report outlines the absence and maternity leave rates for both Midwives and Midwifery Support workers.
- The report provides an update on current Serious Untoward Incidents (SUI) and Maternity and Neonatal Safety Incidents (MNSI) open cases. There are 7 open cases within the Directorate.
- NHS England and the East and West Midlands Operational Delivery Networks (ODNs) are presently reviewing Neonatal Critical Care workforce deficit across the Midlands. The review is near completion and Trusts will be informed of their findings in the New Year 2024. Funding provision to support Trusts with any training and recruitment gaps will be made available in 2024.

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

- Delivery suite Midwifery staffing levels are not meeting national standards of 85% per shift. 66% of shifts were staffed appropriately based on the acuity of patient in August and 55% of shifts were staffed appropriately based on the acuity of patient in September. This is however an improving picture in comparison to June and July's acuity data as newly appointed Midwives are in post and complete their induction process.

- An Independent review has been commissioned by the Integrated Care Board for the Black Country to review Still Birth rates in the Black Country.

- Nursing Staff trained at Qualified in Specialty (QIS) level equates to 46% of the total workforce. Progress has been made to increase numbers of QIS trained Registered Nurses (RNs) over the last year. A Developmental and Education plan is in place to improve numbers further during 2024 with the overall aim of reaching 80% of the total workforce trained in QIS as recommended by the British Association of Perinatal Medicine (BAPM).

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

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Maternity Services Report

Report to Trust Board Meeting to be held in Public 12th December 2023.

EXECUTIVE SUMMARY

The Royal Wolverhampton Midwifery and Neonatal Nursing Workforce Update

The report outlines the present position for both Midwives and Maternity Support Worker (MSW) deficit related to vacancy and maternity leave. The vacancy rate is now an improved position, however increased levels of maternity leave continue which is impacting on the Midwifery clinical workforce. Clinical areas have been over established where possible to mitigate risk to clinical care.

The report outlines Delivery Suite staffing levels based on the acuity of patient. The data is provided by the Birth Rate plus Acuity tool specific for Intrapartum areas.

The report provides data for Midwifery red flag events in August and September and triangulation with any related incidents.

The Report outlines the present vacancy for Neonatal Nurse staffing which has minimum vacancy. An update on the Nurses Qualified in Speciality (QIS) rates are also provided. Presently progress is being made to increase the level of QIS on Neonatal Intensive Care (NICU) which sits at 46%. The service continues to work closely with the Universities of Birmingham and Keele to support access to the Masters Level Post Graduate QIS Course.

Local Maternity Dashboard / Minimum data measures for Trust Board

The Perinatal Leadership Team undertake a monthly review of the local maternity dashboard monitoring the booking and birth rate data. Presently booking rates for women choosing to book at RWT are predicted to be marginally over plan of 5000 births. The Directorate has seen an increase in bookings over the last quarter which can be attributed to the increase in the introduction of 'The Single Point of Access' booking process and the aim to book women by 10 weeks gestation in line with best practice standards.

Presently predicted birth rates at end of calendar year for 2023 are predicted to be <5,200. Birth rates above this would require a review of out of area place of birth bookings. These are women that choose place of birth with RWT but receive antenatal care from outside our geographical boundaries.

Perinatal Mortality Report – Reporting monitoring and learning from Deaths.

100% of all Perinatal deaths continue to be reported, reviewed, and monitored in line with the National Perinatal Mortality Review Tool (PMRT) for CNST safety action 1.

Maternity and Neonatal Safety Incident (MNSI) / Serious Untoward Incidents (SUI) Report

The report provides an update on the MNSI and SUI's within the Perinatal Directorate. All open incidents are progressing through the MNSI and local Trust processes.

There are 5 MNSI cases – of the 3 are final reports 2 had safety recommendations. No themes were identified within the recommendations.

There are 2 incidents that have been reported through Trust SUI process, both cases were assigned a PMRT grade of C whereby different management may have made a difference to the outcome.

The Royal Wolverhampton NHS Trust

CNST Maternity Incentive Scheme Year 5 Progress Update.

The report provides an update on the progress with the Trusts Maternity Service CNST Maternity Incentive Scheme for Year 5. Presently the Perinatal Directorate are on track to achieve all 10 safety actions.

Three Year Single Delivery Plan for Maternity and Neonatal Service.

The report contains a high level summary for the priorities by The Perinatal Directorate to deliver on the recommendations and ambition of the Three-Year Single Delivery Plan for Maternity and Neonatal Services.

BACKGROUND INFORMATION

The Royal Wolverhampton Midwifery and Neonatal Nursing Workforce Update

Maternity Workforce

Table 1 demonstrates vacancy rates for Midwives and Maternity Support Worker (MSW) workforce. Currently there is a deficit of 0.71 (WTE) Midwifery posts an improved position in comparison to September data of 11.11 WTE. Newly appointed Midwives are now in post and progressing through their induction programmes.

There is minimum vacancy for Maternity Support Worker posts of 0.22 WTE.

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	3.21 >	0	0.4	0	1.6	0.43
Delivery suite	5.05.>	0.29	7.48	0	0	0.64
Midwife Led Unit	4.0. <	0.16 >	0.96	0	0	0.96
Community	3.35 <	0	2.2	0	0	0
Maternity Wards D10 D9	3.06 >	0.35 >	3.08	0.43	1	0.96
Sonography	3.26 <	0	0	0	0	0
Total	**0.71 <**	**0.22 <**	**14.12**	**0.43**	**2.6**	**2.03**

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 and is being presented at Divisional Business forum in early December 2023.

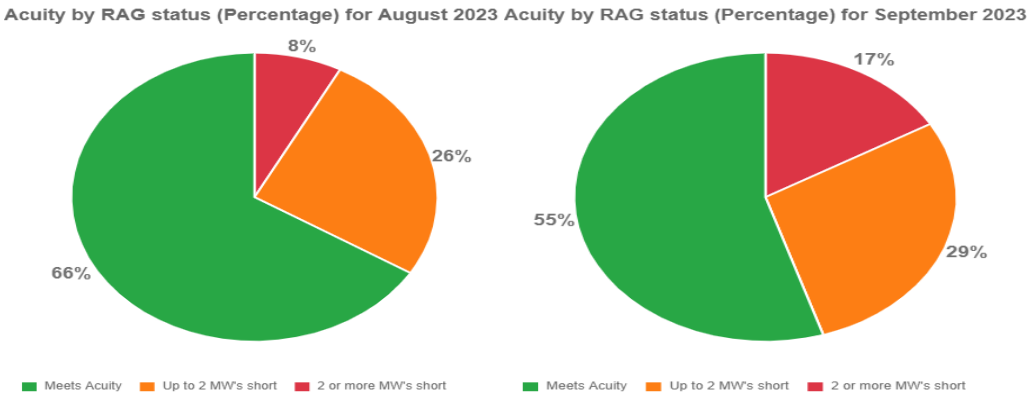
One to One Care rates in Established Labour

One to One Care rates in established labour continue to be maintained at 100% for in Q 2 and into Q3.

Table 2

Activity	Previous Year Average	August 2023	September 2023
1:1 Care rate in labour	99.5%	100%	100%

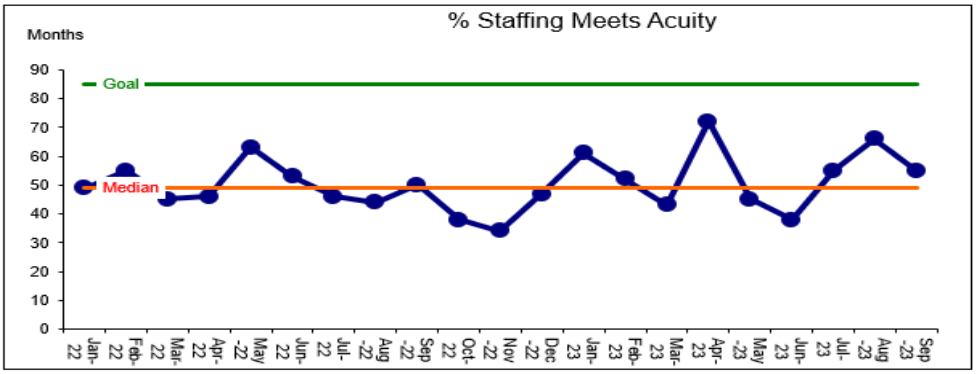
Data for % overall Midwifery Deficit per shift August and September 2023 based on acuity of patient.



Acuity by RAG Status (Percentage)

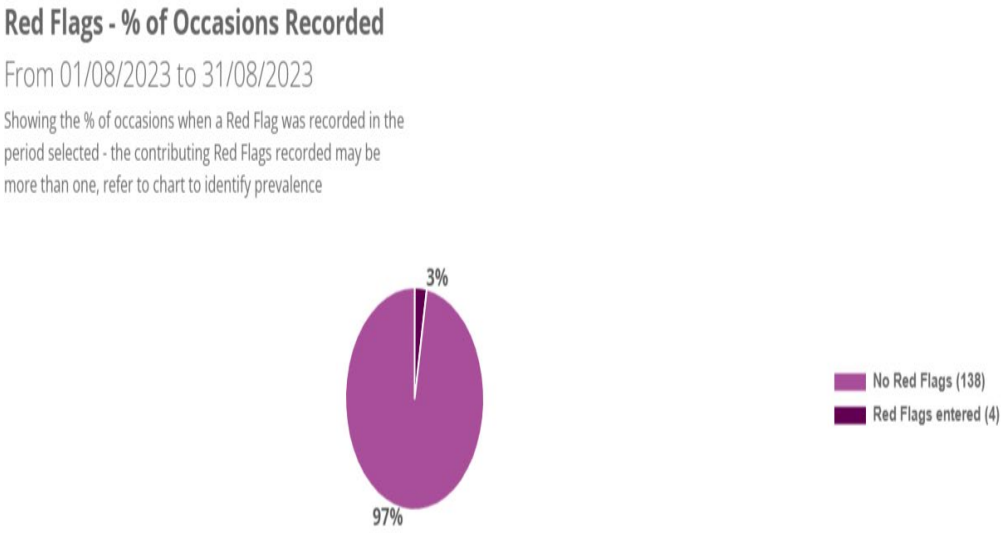
Month	Meets Acuity	Up to 2 Midwives short per shift	2 or more Midwives short per shift
August 2023	**66%**	**26%**	**8%**
September 2023	**55%**	**29%**	**17%**

Staffing Meets Acuity %

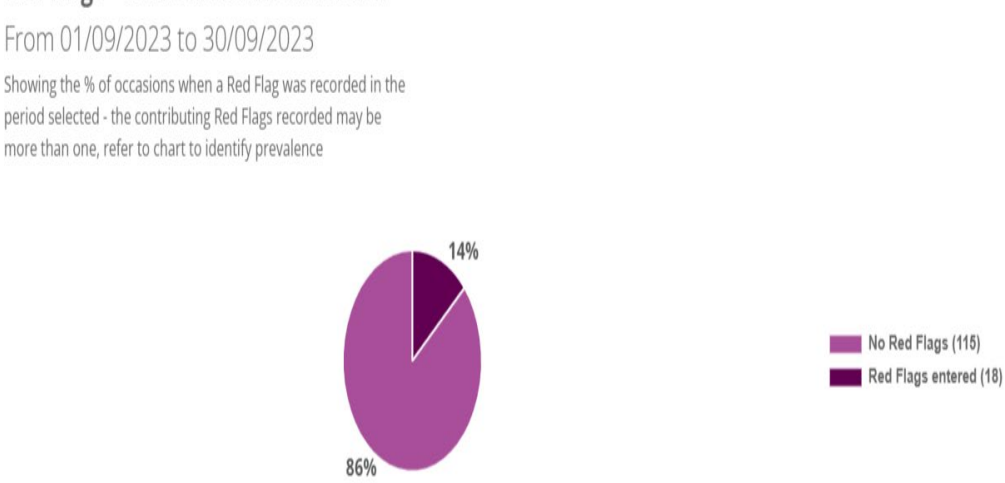


The run chart demonstrates a gradual improvement during August and September for staffing levels versus acuity of patient in comparison to June and July's data. This improvement has impacted positively in the number of Midwifery red flag events reported. Red Flag events are delays in providing care to a woman that are specifically attributed to Midwifery staffing deficit.

Red Flags Events August and September 2023



During August there were 4 red flag events equating to 3% of shifts recording a red flag attributed to midwifery staffing deficit.



In September there were 18 red flag events equating to 14% of shifts recording a red flag attributed to midwifery staffing deficit.

Following review and triangulation of incidents at the weekly Multi-professional Governance and Assurance meeting it identified that there were no adverse patient outcomes or harm directly attributed to Midwifery Red Flag events in August and September.

Action is to continue to monitor red flag events and triangulate any incident / complaint data.

Feedback on red flag data and incidents related to staffing are communicated back to staff in clinical areas via the monthly Matron workforce staffing report.

Neonatal Critical Care Transformation Review – Workforce and Staffing

In November 2023 Trusts received a letter from NHSE informing Chief Executive Officers (CEOs) that The East and West Midlands Neonatal Operational Delivery Networks (ODNs) with NHSE have performed an in-depth piece of work to review and understand the staffing deficits within the Neonatal Workforce across the Midlands region.

NHSE have informed Trusts that they are now in the final stages of the review, and that they will work closely with Trusts to agree trajectories for recruitment into key roles. Funding provision will be released to support training and recruitment during 2024.

The Royal Wolverhampton Neonatal Nursing Workforce Update

Table 3 indicates Whole Time Equivalent (WTE) vacancy for the Neonatal Nursing workforce.

There continues to be minimum vacancy for Neonatal support worker roles and Registered Nurses. Successful recruitment over the last year has meant that shifts staffed to BAPM numbers have remained compliant since January 2023

Table 3

Role	Band	Budget WTE	In post WTE	Vacant WTE
NSW	3	16.79	15.2	1.59
RN	5	43.93	41.86	2.07
RN	6	29.89	27.70	2.19
RN	7	9.34	15.06	0.4

.
The numbers of Nurses Qualified In Speciality (QIS) is gradually improving. The table below indicates predicted trajectories to improve compliance over the 2023/24 with an overall target to achieve total QIS workforce of 80%.

Table 4

QIS trajectory for QIS trained Nurses

QIS PREDICTIONS as of Aug 23			
Date of uplift	No of QIS B6	wte	QIS %
Current Aug 2023	44	37.69	46%
Nov-23	49	41.93	51%
Jan-24	52	44.65	54%
Nov-24	64	55.25	67%

Presently support, oversight, education, and development for Nurses in the clinical areas undergoing QIS training is provided by the Practice Education Facilitators (PEF's) and band 7 shift leaders all of which are QIS trained. Improvements in staffing levels will continue over the next few months with a plan to meet best practice standards of 80% by January 2024. To mitigate the risk for the deficit in QIS nurses, investment into increasing band 7 education roles have been agreed. The band 7 Nurses have QIS status and support the Nurses that are presently undergoing QIS training. They provide oversight, education, development support and mentorship. Over time as nurses qualify in speciality there will be less of a requirement for the band 7 educator role in this capacity, therefore they are factored into the overall trajectory for compliance with clinical QIS nurse workforce.

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting to be held in Public on 12th December 2023

Title of Report	Finance & Productivity Committee Chair's Report	Enc. No 10.5
Author:	J Dunn, Chair	
Presenter:	J Dunn, Chair	
Date(s) of Committee/Group Meetings since last Board meeting:	22nd November 2023	

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

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	N if none. Risk Description Is Risk on Risk Register: Y/N Risk Score (if 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:

Summary of Key Issues:

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	e) Develop a health inequalities strategy f) Reduction in the carbon footprint of clinical services by 1 April 2025 g) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	h) Improve population health outcomes through provider collaborative i) Improve clinical service sustainability j) Implement technological solutions that improve patient experience k) Progress joint working across Wolverhampton and Walsall l) Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

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

EXCEPTION REPORT FROM FINANCE & PRODUCTIVITY COMMITTEE CHAIR

EXTRA-ORDINARY FINANCE & PRODUCTIVITY MEETINGS

Advise:
Two additional extra-ordinary Finance & Productivity Committee Meetings took place (9th November & 16th November) to discuss the Medium Term Plan and a 1 hour meeting to discuss due diligence on the Trust's forecast outturn and the submission that the Trust will make to the ICB.

The Trust will need to achieve the forecast outturn and that there will be a need to revise some of the monitoring and control put into place for ERF, CIP 80% target and each of the Divisional run rates as they meet the requirement to hit the forecast outturn.

Following additional funding being made available to cover the costs of industrial action along with a relaxation in the target for Elective Recovery, the Trust's financial forecast outturn has been revised. The Committee considered a report which identified three improvements to the most likely forecast:

- £5.0m benefit from the additional funding
- £2.5m proposal to transfer capital resource to support the revenue position
- £4.6m stretch improvement to the current expenditure run rate

These revisions reduced the forecast deficit to £36.4m, however the report identified that plans to deliver the stretch improvement are yet to be fully developed and therefore carry risk. The committee robustly challenged the proposal and reached a decision to support the deficit reduction proposal. It was approved for submission to the ICB.

FINANCE & PRODUCTIVITY MEETING – 22 NOVEMBER 2023

ELECTIVE CARE RECOVERY (ECR) PROGRAMME

Advise:

- At the request of NHS England, the trajectories for 65 week breaches, total waiting list size, cancer backlog reduction and 28 day faster diagnosis have been updated.
- A further 2% reduction has been made to our ERF target by NHS England to account for the industrial action post April Our revised target now stands at 104.5% with our forecast for the year being 107%.
- Our waiting list has risen steadily since the turn of the year, primarily because of the continued instances of industrial action. We now expect the waiting list to remain static for the remainder of the year with the assumption that no further industrial action takes place – this is the expectation set by NHS England.
- The Trust delivered 100% of activity in October (compared to 2019/20) compared to a plan of 104%. On a value weighted activity basis, this equates to 104% (compared with a plan of 107%).
- Year to date, our activity performance stands at 104% (versus plan of 105%) and our value weighted activity performance at 106% (versus plan of 108%). For the remainder of the year M08 – M12 the target is 104%.
- The Trust has reforecast its trajectory for 65 week breaches. The plan remains to clear these by the end of March 24 but it was stressed that insourcing support is needed to achieve this. For information it was clarified that

insourcing and outsourcing contracts make a contribution and are not a cost pressure so the Trust still anticipates utilising the support to meet the trajectory.

Alert:

- The Trust remains in Tier 2 for cancer performance with no further clarity over the criteria for existing.
- The Trust is not currently achieving the 78-week breach standard with 61 breaches at the end of October compared to a target of zero. A plan remains in place to clear these by the end of November.
- The Trust has fallen below its trajectory for diagnostic recovery – this is isolated to non-obstetric ultrasound in particular with a recovery plan in place to utilise an insourcing provider.

Assure:

- The Trust has a route to zero for 78-week patients – it is expected that this will be achieved by the end of November 23.
- Our capped theatre utilisation in October was the fifth highest in the country and our uncapped utilisation was the fourth highest.
- The Trust is in line with its recovery trajectories for cancer backlog and the faster diagnosis standard.
- The Trust is meeting the national target to validate patients waiting over 12 weeks without an appointment/TCI date.
- There has been positive reduction in the diagnostic recovery waiting list which, if it continues, will allow the Trust to get to 85% by the end of the financial year.

In summary the Trust's forecast performance is linked to the financial outturn, there is a clear plan to hit the 65 week target, the 78 week target is tight but still on track to achieve the end of November. Cancer is on track and there is a good view of the Trust's theatre utilisation.

FINANCIAL PERFORMANCE

The Trust had a plan deficit for the year of £26.75m. The M07 financial position was a £4.98m deficit in month which was £3.26m adverse to the plan. This was broadly in line with the £48.5m year-end deficit forecast expectation at M06, which has subsequently had some additional stretch targets added following a national exercise and internal and ICB review. The YTD (year-to-date) position shows a £33.78m deficit, which is £7.61m adverse to plan.

Cash is £41.7m at the end of M07, £12.3m favourable to plan and forecast to be sufficient for the remaining financial year.

Capital is underspent by £6.9m YTD, £2.6m relating to PAS/EPR phasing changes and £4.2m related to timing and delays in PSDS grant funded schemes. The capital plan is being forecast to be achieved.

Alert:

Forecast Outturn: Included within the revised forecast outturn is the need for the Trust to develop a detailed plan to deliver a further £4.5m improvement which will be monitored by the Committee. The potential sources of opportunity are from additional ERF overperformance, Divisional net expenditure run-rate improvements, and cash backed CIP; above M06 forecast. We are also awaiting approval for the Capital to Revenue transfer (£2.55m) proposal but early indications suggest that NHSE will not support this.

NATIONAL & CONTRACTUAL STANDARDS (IQPR EXTRACT)

Alert:

There have been a high number of ambulance and walk-in figures in the Emergency Department, this is providing challenges to 12 hour and 60 minute performance. The Trust is still meeting the 4 hour turnaround well but the Trust is in high occupancy with beds, starting to see an increase in covid which is impacting on length of stay at the start of the winter position.

WINTER PLAN

Assure:

- Risks to delivery of the Winter Plan, along with their mitigations are detailed in the table below.

Risk	Mitigation
Continuing Higher volumes than plan above current levels	• Continuous monitoring and escalation and daily intervention to improve flow.
Staff sickness	• Trust processes in place • Winter vaccination programme launched • Divisional and Trust staff allocation meetings • Prioritising the wellbeing of our staff
Covid, Flu, Norovirus, etc. impacting on inpatient flow and nursing home closures	• IP processes and guidelines in place • Joint work with Capacity • IP input to Nursing Homes
Continued industrial action	• Strike planning to continue if further strikes announced • Team engagement and comms

Advise:

- Additional paediatric beds have been funded from January 2024. (£305k)
- Delivery of the Winter Plan will be monitored through Finance and Productivity Committee and the Trust Management Committee.
- Delivery of the OneWolverhampton Winter Plan will be monitored through the OneWolverhampton UEC Strategic Group, the ICB UEC Operational Group and UEC Delivery Board.

Contract Awards/REAFs – The following were endorsed to go to Trust Board:
Linear Accelerator Combined Service Care (REAF 1431)
Pathology Molecular Managed Service (REAF 1375)

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

MATTERS PRESENTED FOR INFORMATION OR NOTING
NHSI Monitoring Return
Annual Work Plan
Capital Report
Supplementary Finance Report
High Value Contract Report
Contracting & Business Development Report
Temporary Staffing Dashboard Report

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting to be held in Public on 12th December

Title of Report	Exception Report from the Finance & Productivity Committee Chair
Author:	J Dunn, Chair
Presenter:	J Dunn, Chair
Date(s) of Committee/Group Meetings since last Board meeting:	25TH October 2023

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

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	N if none. Risk Description Is Risk on Risk Register: Y/N Risk Score (if 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:

Summary of Key Issues:

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	e) Develop a health inequalities strategy f) Reduction in the carbon footprint of clinical services by 1 April 2025 g) Deliver improvements at PLACE in the health of our communities
Effective Collaboration	h) Improve population health outcomes through provider collaborative i) Improve clinical service sustainability j) Implement technological solutions that improve patient experience k) Progress joint working across Wolverhampton and Walsall l) Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

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

EXCEPTION REPORT FROM FINANCE & PRODUCTIVITY COMMITTEE CHAIR

Elective Care Recovery

Reminder : Elective Recovery Key Priorities for 2023/4

- To maximise planned activity undertaken, achieving !06% of activity in 2019/20
- To eliminate 78 week breaches by June 2023
- To eliminate 65 week breaches by June 2023 and see new outpatients by October 23
- Meet the cancer faster diagnostics standards by March 2024
- Increase the percentage of patients that receive a diagnostic test within 6weeks to 85% by the end of March 2024
- Reduce outpatient follow up activity by 25% compared to 2019/20 by March 2024

ASSURE

Elective Care Recovery

- The Trust has a route to zero for 78-week waiters.
- The Trust is in line with its recovery trajectories for cancer backlog and the faster diagnosis standard.
- The Trust is on its trajectory to clear 65 week waits by the end of March 24 although some first outpatients will breach the October standard In Urology, gynaecology, cardiology, rheumatology and community paediatrics.
- Detail was provided within the report to committee to demonstrate the Trust is maximising the usage of the independent sector.

ADVISE

Elective Care Recovery

- Having plateaued towards the end of 2022/23, our waiting list has risen steadily since the turn of the year, primarily because of the continued instances of industrial action.
- The Trust delivered 104% of activity in September (compared to 2019/20) compared to a plan of 107%. On a value weighted activity basis, this equates to 104% (compared with a plan of 107%).
- Year to date, our activity performance stands at 105% (versus plan of 107%) and our value weighted activity performance at 106 (versus plan of 108%).
- A plan has been developed to meet the requirement for 90% of patients waiting over 12 weeks to have been validated within the last 12 weeks, by the end of October 23.

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

Elective Care Recovery

- The Trust remains in Tier 2 for cancer performance with no further clarity over the criteria for existing.
- The Trust is not currently achieving the 78-week breach standard with 50 breaches at the end of September compared to a target of zero.

- The Trust is currently behind its trajectory for 65-week breaches with 1,145 breaches compared to a target of 479. The Trust expects to recover this performance by the end of the year in line with the additional activity that has been procured.
- The Trust has fallen below its trajectory for diagnostic recovery – this is isolated to non-obstetric ultrasound in particular with a recovery plan in place to utilise an insourcing provider.

Integrated Quality Performance Report (IQPR}

ADVISE/ASSURE

- ED Performance – performance continues to remain at a high level and is above the new national standard of 76% seen within 4 hours. The trust continues to benchmark well both locally and nationally.
- Cancer 2ww – the Trust continues to see high volumes 2ww referrals and this is driving current performance. The detailed review of cancer performance will be led by the Quality committee.
- Cancer 62 day - the impact of the referrals combined with delays within histopathology and some speciality constraints continues to impact performance and is subject to review at the Quality committee.

Winter Plan

- Reporting will continue within Elective Recovery and IPQR.
- Trust resilience against Winter pressures is a high risk, which has been reflected in the BAF.

Financial Outturn Forecast Review

- A report on the additional controls on Financial Governance was presented to the committee showing all had been activated, whilst the impact will be reflected in the financial performance the committee requested an effectiveness review,
- As reported last month, the revenue outturn projection for 2023/24 if forecasting that the original planned deficit of £26.75 m is not deliverable.
- Month 6 performance while showing an improvement is reporting an in month adjusted deficit of £3.4 m, this is favourable to plan , this leads to year to date deficit of £28,8m.
- The forecast outturn remains on target to meet the most likely outcome of £48.5m.
- There is £1 – 2m risk of achieving the target and a need to focus on the run rate, ERF and CIP improvement. The Committee requested clarification regarding the impact of the headcount. J Green to provide an update by 27th October 2023.

Financial Recovery Group

- The Committee has requested a CIP deep dive as an agenda item for the next meeting.

Contract Awards/REAFs –
CDC Phase 2 Contract Award – Endorsed
PSDS – HV Ring Main Works Contract Award – Endorsed
PSDS – Wrekin House Cladding Contract Award – Endorsed
Capital Review Group Terms of Reference Review – Approved.

ACTIVITY SUMMARY
Presentations/Reports of note received including those Approved

MATTERS PRESENTED FOR INFORMATION OR NOTING
NHSI Monitoring Return
Annual Work Plan
Capital Report
Supplementary Finance Report
Temporary Staffing Dashboard
High Value Contract Report

The Royal Wolverhampton NHS Trust

Report to the Trust Board Meeting to be held in Public on 12 December 2023		
Title of Report:	**Report of the Chief Financial Officer - Month 7**	Enc No: 10.6
Author:	Kevin Stringer Group Chief Financial Officer and Group Deputy Chief Executive	
Presenter/Exec Lead:	Kevin Stringer	

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 for assurance			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ 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. On Risk Register: Yes☒No☐ Risk Score (if applicable): 20		
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:
	Other	Yes☒No☐	Details: Statutory Duty

The Royal Wolverhampton NHS Trust

CQC Domains	Well-led the leadership, management and governance of the organisation, ensure it's providing high quality care that is 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		
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:22 November 2023
	Board of Directors	Yes☐No☒	Date:
	Other : TMC	Yes☒No☐	Date:24 November 2023

Summary of Key Issues using Assure, Advise and Alert
N/A

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

The Royal Wolverhampton NHS Trust

Report to the Trust Board Meeting to be held in Public on 12 December 2023		
Title of Report:	**Report of the Chief Financial Officer - Month 6**	Enc No: 10.6
Author:	Kevin Stringer Group Chief Financial Officer and Group Deputy Chief Executive	
Presenter/Exec Lead:	Kevin Stringer	

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 for assurance			

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ 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. On Risk Register: Yes☒No☐ Risk Score (if applicable): 20		
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:
	Other	Yes☒No☐	Details: Statutory Duty

The Royal Wolverhampton NHS Trust

CQC Domains	Well-led the leadership, management and governance of the organisation, ensure it's providing high quality care that is 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		
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:25 October 2023
	Board of Directors	Yes☐No☒	Date:
	Other : TMC	Yes☒No☐	Date:27 October 2023

Summary of Key Issues using Assure, Advise and Alert
N/A

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
October 2023 - Month 7

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

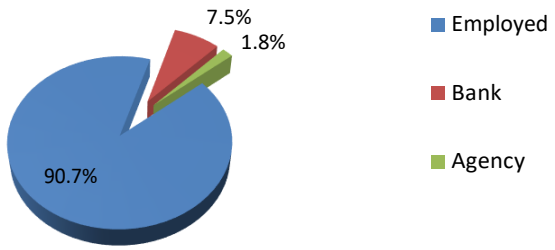
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Patient income	59.05	411.56
2. Other income	14.74	96.68
Total	**73.79**	**508.24**
Expenditure	**78.77**	**542.02**
Surplus/ (deficit)	**(4.98)**	**(33.78)**
Planned surplus/(deficit)	**(1.72)**	**(26.17)**
Variance to plan	**(3.26)**	**(7.61)**

Workforce

(see page 8)



Patient Income

Elective recovery fund activity to date is £1.78m above the revised national expectation. As per NHSE guidelines this is included in the October position. Other variable income relating to drug, devices and diagnostics is £0.2m above plan. All other income is within the block.

Actual Outturn

(see page 5)

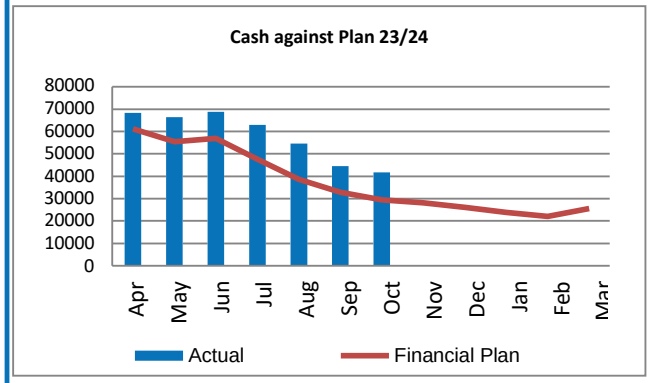
£5m deficit in month
(£3.3m adverse to plan)

£33.8m deficit year to date
(£7.6m adverse to plan)

Cash in the Bank

(see page 7)

Plan £29.4m
Actual £41.7m



Covid-19 Expenditure

In month 7 there was expenditure of £135k on testing and £41k on Covid Medicines Delivery Unit. (Year to date £784k and £286k respectively).

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

Cost Improvement Programme (CIP)

(see page 9)

In-month delivery of £2.01m against a target of £4.56m. Year to date achievement of £15.9m against the target of £16.7m.
The forecast CIP is £32.8m, which equates to 73% of the full year target. Of the £32.8m, £13.9m of the savings will be achieved recurrently.

Overview of Financial Performance
The Trust is reporting an in month adjusted deficit of £5m, this is £3.26m adverse to plan, this leads to a year to date deficit of £33.8m which is £7.6m behind plan.

Income is £0.3m favourable to plan in month and £2.4m adverse YTD. This is made up of Patient Care income being £736k favourable in month due to overperformance in variable elements of the contracts. This is offset by an under recovery of Capital Grant funding.
Year to date this is offset in the YTD position by recognising £4.3m less Capital Grant Funding Income than plan, as this is matched to capital expenditure profiles and there has been timing delays which will catch up later in the year (Excluded from National Performance monitoring).

In month pay expenditure has over spent by £0.5m. This is due to a number of reasons including: £0.6m for cover due to industrial action, £0.8m relating to temporary medical staffing covering gaps in the rota and other absences, £0.6m in nursing areas where there has been cover required for increased sickness, maternity and annual leave as well as some patient acuity requirements. This is partially offset by vacancies across the Trust.

Non-pay is also overspent in month by £0.85m. There are activity pressures of £0.5 relating to activity increases which are funded through ERF or variable contracts, along with £0.4m of activity pressure that are not linked to changes in income. Utilities are also overspent by £0.7m due to the combined heat and power plant continuing to be out of service and requiring additional electricity to be purchased. There are smaller underspends in other areas offsetting some of these overspends.

Drugs is underspent by £0.1m in month due to phasing of patients on high cost drugs.

Year to date the position is also overspent, Pay is £9.14m overspent including, £3.1m strike costs, £4.2m medical staffing cover, £4.3m nursing cover for sickness etc, vacancies in other areas partially offset this cost.
Non pay is underspent by £1.9m and Drugs is £0.8m overspent.

System Updates

The ICB is reporting a YTD deficit of £88.7m, £31.8m adverse to plan (1.9%) with 5 out of 8 organisations running deficit positions .

The system has a number of significant demand pressures including excess inflation, additional costs attributable to industrial action, UEC and Mental Health activity pressures and efficiency under delivery, partially being offset by ERF performance and non-recurrent balance sheet related items. The ICB is within the national agency cap target. Whilst YTD capital spends are currently underspent they are forecast to be utilised by the end of the financial year. Some additional funding has been allocated nationally along with activity requirements, the impact of these was still being finalised at the time of this report.

Capital

The Trust has five types of capital programme with a combined plan of £57.8m for the year; these are CRL totalling £21.3m, and PDC £6.2m, 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 or renewed leases £3.7m.

YTD capital is underspent by £6.9m, with a capital spend of £28.1m YTD. ICS CRL spend is broadly on plan and forecasting to be met.
PDC capital - there is an underspend of £2.6m due to delayed agreement (compared to plan) of EPR business cases and its expected PDC funding, however the Trust anticipates meeting assumed PDC CRL of £6.2m.
Grant funding has a YTD variance of £4.2m, due to timing of orders, with the Trust forecasting to spend all Grant approved capital funding projects.
IFRS 16 CRL YTD variance of £0.3m due to one 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							YTD	Move-
£m	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Avg	ment
Patient Income															
1 Plan	57.85	57.06	57.44	58.17	58.41	97.46	54.90	58.57	57.27	58.21	60.31	61.30	58.31	*58.42*	*(0.11)*
2 Actual	56.79	60.38	54.88	57.79	58.18	100.44	53.48	59.49	59.09	58.41	62.18	59.87	59.05	*58.75*	*0.29*
3 Variance	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	(1.42)	0.92	1.82	0.20	1.87	(1.42)	0.74	*0.33*	*0.41*
Non Patient Income															
4 Plan	13.26	12.41	21.15	13.07	14.23	30.98	16.32	15.75	16.37	12.57	13.34	12.22	15.20	*14.43*	*0.77*
5 Actual	19.22	13.75	16.99	14.40	18.15	17.82	14.65	16.99	12.99	12.44	13.13	11.74	14.74	*13.66*	*1.08*
6 Variance	5.97	1.34	(4.16)	1.33	3.92	(13.16)	(1.67)	1.24	(3.38)	(0.13)	(0.21)	(0.48)	(0.46)	*(0.77)*	*0.31*
Pay Expenditure															
7 Plan	42.71	42.54	43.20	40.89	43.28	82.72	45.35	47.17	45.88	46.48	48.56	46.60	47.73	*46.67*	*(1.05)*
8 Actual	43.60	42.16	40.52	42.64	42.71	82.05	46.78	48.56	47.93	47.10	50.55	47.73	48.24	*48.11*	*(0.13)*
9 Variance	(0.89)	0.38	2.69	(1.75)	0.57	0.67	(1.43)	(1.39)	(2.05)	(0.63)	(2.00)	(1.14)	(0.51)	*(1.44)*	*(0.92)*
Non Pay Expenditure															
10 Plan	17.14	17.10	18.15	17.43	19.31	18.47	19.07	18.44	17.54	19.59	17.84	15.14	19.04	*17.94*	*(1.10)*
11 Actual	17.23	17.78	15.75	15.85	17.87	24.20	17.52	16.54	17.59	18.61	18.47	16.10	19.89	*17.47*	*(2.41)*
12 Variance	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	1.55	1.89	(0.05)	0.97	(0.63)	(0.95)	(0.85)	*0.46*	*1.31*
Drugs Expenditure															
13 Plan	5.55	5.65	5.98	5.97	5.70	6.03	5.89	6.08	6.31	6.21	6.16	6.44	6.44	*6.18*	*(0.26)*
14 Actual	5.91	5.95	6.32	6.47	5.83	6.56	5.66	6.09	6.59	6.27	6.40	7.00	6.33	*6.34*	*0.00*
15 Variance	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	0.23	(0.02)	(0.28)	(0.06)	(0.24)	(0.56)	0.11	*(0.15)*	*(0.27)*
CIP over/ (under) achievement															
16 Variance	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	(1.39)	(0.57)	(0.08)	(1.53)	0.88	4.42	(2.72)	*0.29*	*3.01*
BCPS Savings over/ (under) achievement															
16 Variance	(0.01)	0.03	0.00	(0.14)	(0.10)	(0.07)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	*0.00*	*(0.00)*
Reserves supporting position															
17 Actual	1.47	1.59	(0.48)	2.50	0.95	(0.31)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	*0.00*	*0.00*
Other Non Operating Expenditure															
18 Plan	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	(3.79)	(3.81)	(3.85)	(3.87)	(3.68)	(3.73)	(3.96)	*(3.79)*	*(0.18)*
19 Actual	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	(3.77)	(3.78)	(3.75)	(3.77)	(3.83)	(3.87)	(3.89)	*(3.80)*	*(0.09)*
20 **Variance**	0.03	0.21	0.24	0.26	0.32	1.79	0.02	0.03	0.09	0.10	(0.15)	(0.14)	0.08	*(0.01)*	*(0.09)*
Total															
Plan	**1.65**	**0.62**	**9.81**	**1.54**	**1.10**	**17.18**	**(1.48)**	**(0.61)**	**0.13**	**(3.83)**	**(3.46)**	**(2.81)**	**(0.93)**		
Actual	**5.52**	**4.68**	**5.74**	**3.69**	**6.41**	**3.42**	**(5.60)**	**1.50**	**(3.79)**	**(4.92)**	**(3.94)**	**(3.09)**	**(4.56)**		
Variance	**3.87**	**4.06**	**(4.07)**	**2.16**	**5.31**	**(13.76)**	**(4.12)**	**2.11**	**(3.92)**	**(1.08)**	**(0.48)**	**(0.28)**	**(3.62)**		

Commentary on variances and trends:

Patient Income - For 2023/24 the income plan consists 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. Following NHS guidance, the variable element overperformance against the plan has been included in the position of £1.78m for this year so far, with a gain in month of £0.4m in month relating to a reduced ERF baseline for NHSE. Additionally up to October NHSE variable activity for diagnostic Imaging and Chemotherapy has over performed against plan by £0.2m..

Non-Patient Income - excluding grant funding for capital schemes, in month non-patient income increased by £3m compared to prior month. This was due to increases in LDA contract income £1.4m, as a revised contract value was received. Apprentice Levy training income £229k, Hosted Services (offset by increased costs) £916k, there were also increases in SLA values across divisions.

In terms of variance private patients over performed by £50k. Other Directorate income was under plan by £161k due to small SLA changes, and Education, Training and Research was over by £274k due to the revision to the LDA contract being backdated.

Pay - increased in month by £1.1m. This was due to increases in Strike costs £364k, Bank costs £756k, Agency £227k, Hosted services £131k, these increases were partially offset by reduced enhancement payments £205k and reduced substantive staff costs.

There was an overall overspend of £515k. Significant over spending areas were:
Division 1: £931k - Including Strike costs £174k, £210k cover for Medical staff rota gaps and absences, £364k for nursing and midwifery acuity and absence cover.
Division 2: £1.26m - Including Strike costs £385k, £440k cover for Medical staff rota gaps and absences, £376k for nursing and midwifery acuity and absence cover.

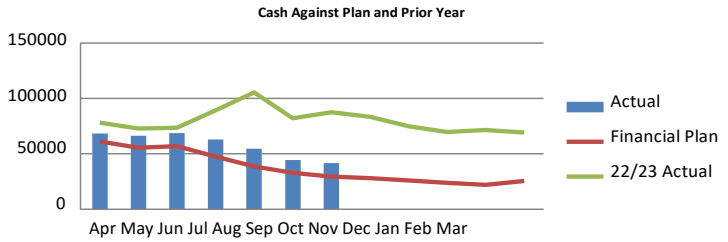
Non-Pay - An increase in the run rate compared to the previous month of £3.8m. There were one off benefits in the previous month worth £1.5m. There has also been an increase in hosted services expenditure of £900k Along with these there has been a increase in activity related costs.

In terms of variance there is an overspend of £848k.
Of this £336k was within Division 1 and was caused by activity in Cardiology and theatres.
Division 2 was overspent by £281k which all related to activity costs predominantly Insulin pumps £78k, CPAP £49k, Oncology £34k as well as smaller values in other directorates.
Estates and Facilities were also overspent by £147k. Of this £71k was due to electricity as the CHP was out of use and the balance was in estates maintenance due to the phasing of work.
Corporate were also overspent (£337k) due to International nurse recruitment ongoing course fees, interpreting charges and a backdated contract adjustment within procurement.

Drugs - Expenditure was £669k lower in month 7 than in month 6. This was due to high cost drugs usage linked to activity.
In month expenditure was underspent at £113k making the year to date position to £810k overspent, this is due to high cost drugs being funded on block contract whilst usage has increased.

Cash and Capital

Cash Position



The cash balance as at 31st October 2023 is £41.7m, a £2.8m decrease on the previous month and an increase of £12.3m on financial plan. The increase on plan is due to: £18.7m cash settlement of 22/23 pay award income netted out by £19.6m additional pay cost. Additional movements are £5.1m Staffs 22/23 income received in year; £1.4m additional LDA funding for Q1 & £9.1m lDA Funding received earlier than planned; £18.7m higher ICS income; £10.0m cash benefit due to the loan to DGFT; and £22.1m m reduced capital spend (£12.7m due to timing on projects & £9.4m due to reduction in PDC). This is netted out by £9.5m less cash for PDC (£2.2m due to timing of EPR scheme & £7.3m reduction in PDC) ; £2.1m less cash for PSDS due to timing of schemes; £25.5m additional pay costs and £20.5m 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:

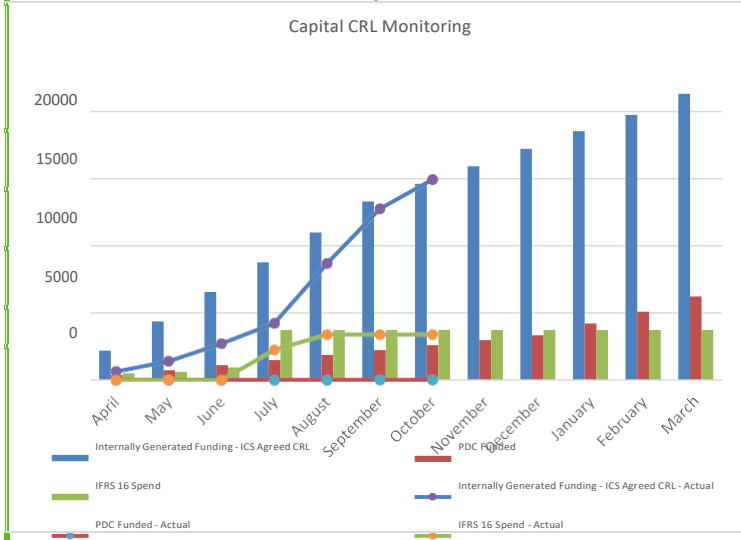
	M7 23/24	Cumulative	M6 23/24	Cumulative
Value	93%	96%	95%	96%
Volume	89%	94%	91%	94%

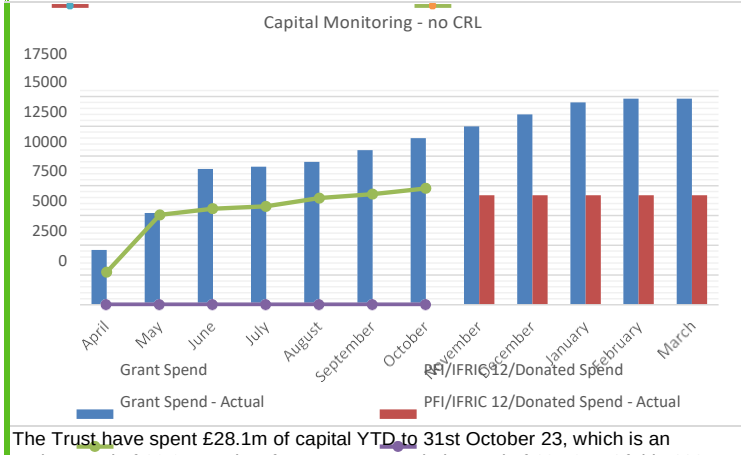
Debtor Days

Calculated Debtor Days for the year are:-

	M7 Actual	M6 Actual
Total	6.35	6.38
Being:-		
NHS	6.61	6.97
Non NHS	5.26	3.83

Capital





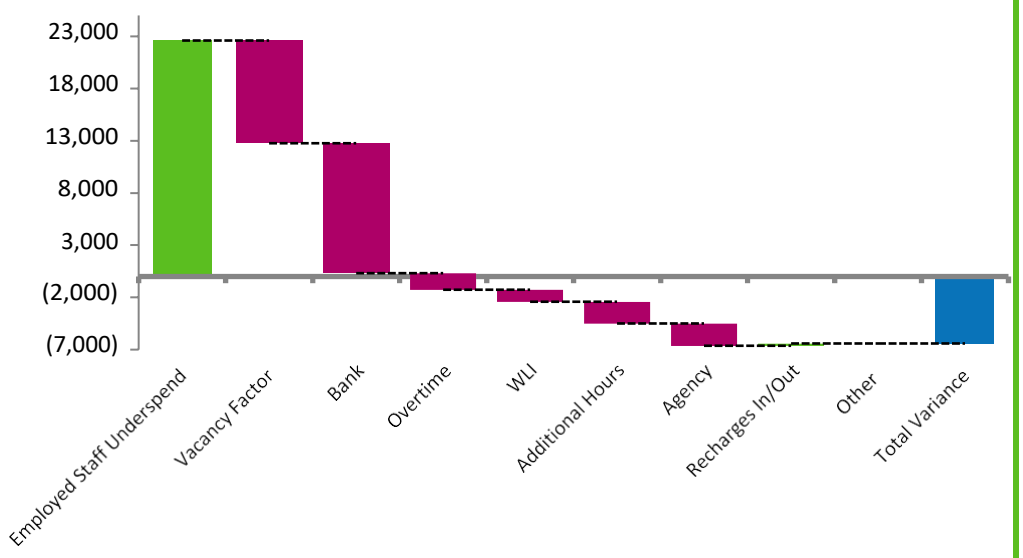
The Trust have spent £28.1m of capital YTD to 31st October 23, which is an underspend of £6.9m against forecast YTD capital spend of £34.9m. Of this £28.1m YTD spend:

Capital CRL Monitoring - £12.7m relates to capital spend which the ICS is measured against, this is an overspend of £0.3m against Plan due to timing of orders. The Trust envisages meeting the ICS CRL of £21.3m. There has been £0.0m spend YTD on PDC due to delay in approval of EPR business case creating variance to Plan of £2.6m. There was £3.4m spend YTD on IFRS 16 with only one lease left to be commercial agreed (anticipating November 23).

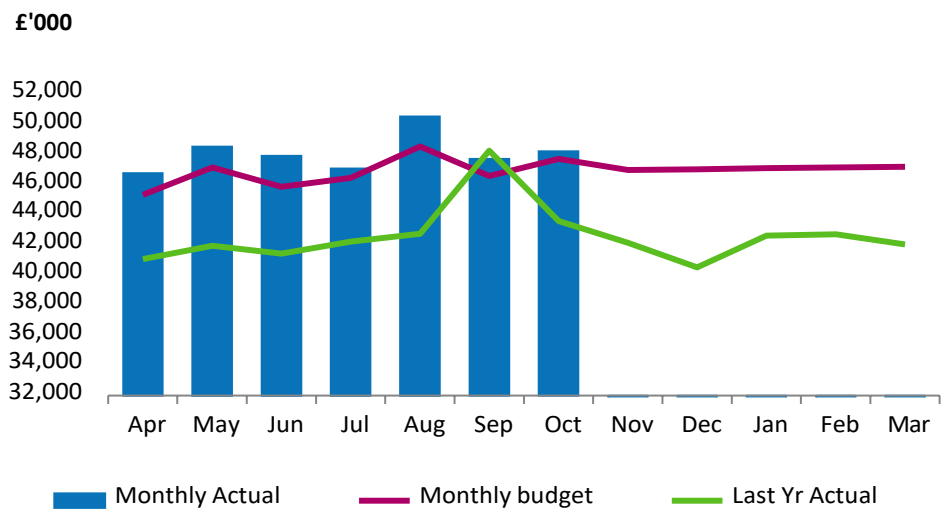
Capital Monitoring - non CRL - The balance of the capital YTD, £9.8m, relates to capital spend on grant funded items with £9.6m relating to PSDS Phase 3a and £0.2m relating to Phase 3b. This is variance of £4.2m against Planned Grant spend of £14.0m due to timing of orders. The Trust are forecasting to meet the reforecast capital expenditure spend for 23/24 of £57.8m

Pay Expenditure

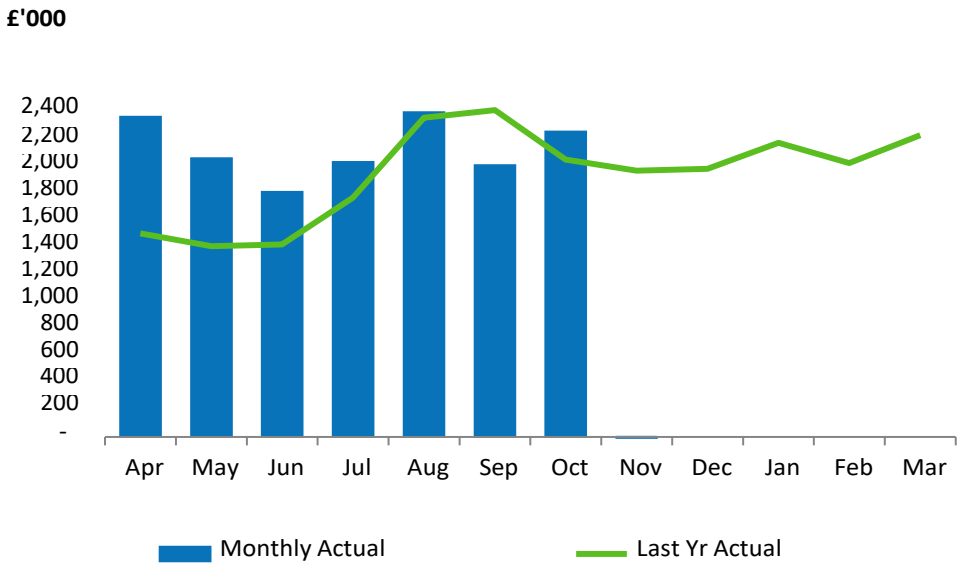
Year to Date Variance to plan



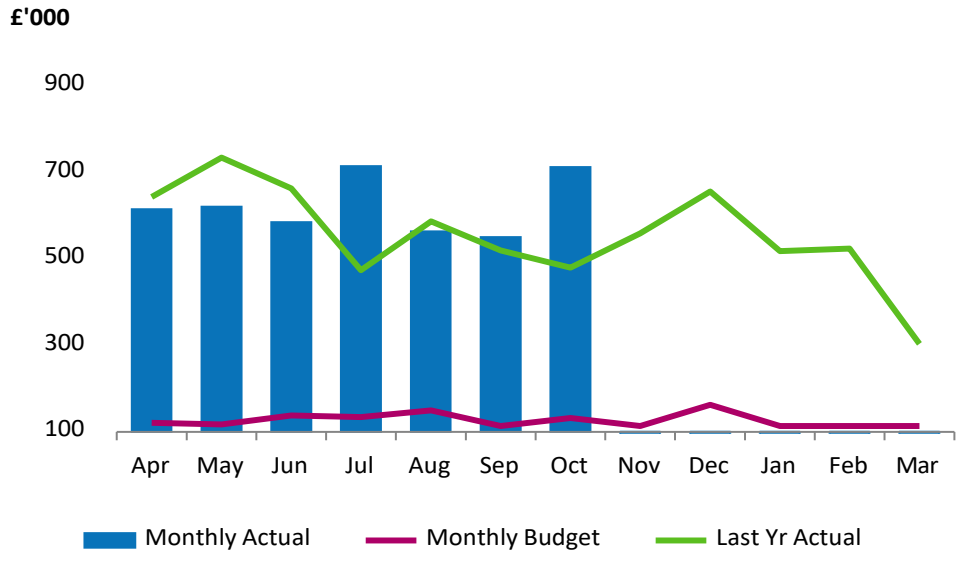
Total Pay Expenditure Trend



Bank Expenditure Trend



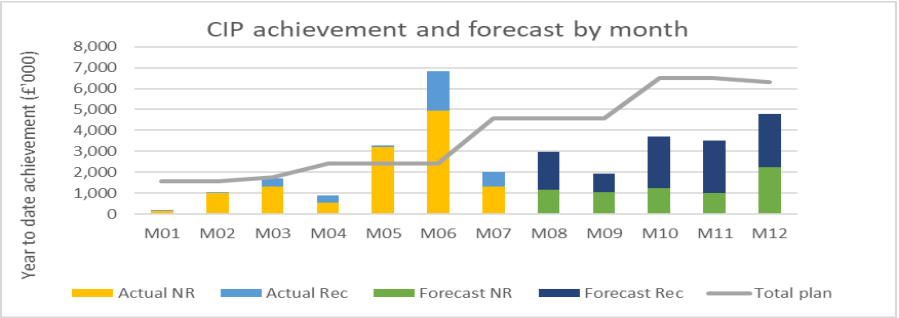
Agency Expenditure Trend



Cost Improvement

Division	YTD Plan	YTD Actual	Variance
Corporate	1,036	1,425	390
Division 1	4,799	2,701	(2,097)
Division 2	3,123	867	(2,257)
Division 3	2,118	996	(1,122)
Division 4	7	0	(7)
Estates And Facilities	1,057	637	(420)
Trustwide	4,598	9,286	4,688
Grand Total	**16,738**	**15,912**	**(825)**

Division	Total target	FOT total	Variance
Corporate	3,254	2,128	(1,126)
Division 1	15,080	4,443	(10,637)
Division 2	9,815	1,363	(8,452)
Division 3	6,657	1,991	(4,666)
Division 4	22	0	(22)
Estates And Facilities	3,322	1,121	(2,200)
Trustwide	7,003	21,764	14,761
Grand Total	**45,153**	**32,811**	**(12,342)**



Against an in-month target of £4.56m, £2.01m has been achieved, taking the year to date achievement to £15.9m against a target of £16.7m.

£32.8m of CIP's are forecast to be achieved (73% of total CIP target), of which £13.9m is expected to be achieved recurrently (30% of the annual target).

There has been a continued focus on identifying new schemes as well as reviewing existing schemes to identify whether non-recurrent savings can be made recurrently.

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				
389,967	58,310	59,046	736	Patient Activity Income	706,285	408,856	411,560	2,704
632	127	181	54	Other Patient Care Income	1,521	887	746	(142)
2,746	0	0	0	Top Up Income	0	0	8	8
29,977	5,705	5,980	274	Education, Training & Research Income	57,498	32,441	32,700	259
18,610	1,023	341	(682)	Non Patient Care Other Income	17,592	14,157	9,773	(4,384)
160	59	109	50	Private Patient Income	680	406	461	55
46,011	8,290	8,129	(161)	Income on Directorate Budgets	91,559	53,886	52,995	(891)
488,104	**73,513**	**73,785**	**272**	**Total Income**	**875,134**	**510,633**	**508,242**	**(2,391)**
				Expenditure				
301,327	47,725	48,240	(515)	Directorate Expenditure Budgets - Pay	563,238	327,755	336,899	(9,144)
115,037	19,038	19,886	(848)	Directorate Expenditure Budgets - Non Pay	225,592	126,653	124,723	1,930
41,172	6,444	6,330	113	Directorate Expenditure Budgets - Drugs	73,251	43,532	44,342	(810)
0	(2,723)	0	(2,723)	Cost Improvement Savings	(23,550)	(999)	0	(999)
0	0	0	0	BCPS Savings	0	0	0	0
457,536	**70,484**	**74,457**	**(3,972)**	**Total Expenditure**	**838,531**	**496,940**	**505,964**	**(9,023)**
30,567	**3,029**	**(672)**	**(3,701)**	**EBITDA Surplus/(Deficit)**	**36,603**	**13,693**	**2,279**	**(11,414)**
16,933	2,841	2,699	143	Depreciation	33,076	18,507	18,581	(74)
1,536	310	303	8	Interest Payable	3,715	2,165	2,074	91
(755)	(347)	(272)	(75)	Interest Receivable	(2,763)	(2,100)	(2,100)	(0)
7,372	1,158	1,158	0	Other Charges	13,900	8,108	8,107	1
25,086	**3,963**	**3,887**	**76**	**Other non operating items**	**47,928**	**26,680**	**26,662**	**18**
5,481	**(934)**	**(4,559)**	**(3,625)**	**Net Surplus/(Deficit) before Adjustments**	**(11,325)**	**(12,988)**	**(24,384)**	**(11,396)**
(18,269)	(787)	(422)	365	Adjustments as per NHSI reported position	(15,425)	(13,179)	(9,397)	3,783
(12,788)	**(1,722)**	**(4,982)**	**(3,260)**	**Adjusted Financial Performance as NHSI**	**(26,750)**	**(26,167)**	**(33,780)**	**(7,613)**

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2023/24 Balance Sheet as at 31st Oct 2023

	Oct 2023 Plan	Oct 2023 Actual	Sept 2023 Actual	Movement in Month	March 2023 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	508,666	496,306	496,238	68	486,739
Intangible Assets	7,618	5,307	5,429	(122)	5,860
Other Investments/Financial Assets	12	11	11	0	11
Trade and Other Receivables Non Current	1,397	1,415	1,415	0	1,415
PFI Deferred Non Current Asset	4,652	4,634	4,634	0	4,634
TOTAL NON CURRENT ASSETS	**522,345**	**507,674**	**507,728**	**(54)**	**498,660**
CURRENT ASSETS					
Inventories	8,347	8,854	11,744	(2,890)	8,347
Trade and Other Receivables	48,913	41,577	38,301	3,276	59,564
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	29,429	41,733	44,534	(2,802)	69,265
TOTAL CURRENT ASSETS	**86,689**	**92,163**	**94,579**	**(2,416)**	**137,176**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**609,034**	**599,837**	**602,307**	**(2,471)**	**635,836**
CURRENT LIABLILITES					
Trade & Other Payables	(105,607)	(91,026)	(97,474)	6,448	(114,207)
Liabilities arising from PFIs / Finance Leases	(6,199)	(8,969)	(8,969)	0	(13,462)
Provisions for Liabilities and Charges	(3,466)	(3,194)	(3,250)	56	(4,201)
Other Financial Liabilities	(9,664)	(23,814)	(14,660)	(9,154)	(10,424)
TOTAL CURRENT LIABILITIES	**(124,936)**	**(127,003)**	**(124,353)**	**(2,650)**	**(142,294)**
NET CURRENT ASSETS / (LIABILITIES)	**(38,247)**	**(34,840)**	**(29,774)**	**(5,066)**	**(5,118)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**484,098**	**472,834**	**477,954**	**(5,120)**	**493,542**
NON CURRENT LIABILITIES	(5,246)	(4,974)	(5,030)	56	
Trade & Other Payables	(287)	(244)	(250)	7	(287)
Other Liabilities	(9,424)	(9,118)	(9,673)	555	(5,470)
Provision for Liabilities and Charges	(1,780)	(1,780)	(1,780)	0	(1,780)
TOTAL NON CURRENT LIABILITIES	**(11,491)**	**(11,142)**	**(11,703)**	**561**	**(7,537)**
TOTAL ASSETS EMPLOYED	**472,607**	**461,692**	**466,251**	**(4,559)**	**486,005**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	305,195	305,676	305,676	0	305,676
Retained Earnings	59,447	48,048	52,607	(4,559)	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	186	190	190	0	190
TOTAL TAXPAYERS EQUITY	**472,607**	**461,692**	**466,251**	**(4,559)**	**486,005**

Appendix C Cash Flow Statement

2023/24 Cash Flow as at 31st October 2023

	Oct-23 Plan £'000	Oct-23 Actual £'000	Oct-23 Variance £'000	Oct-23 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**(4,243)**	**(16,302)**	(12,059)	(14,527)
Depreciation	18,352	18,581	229	13,353
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(13,999)	(9,296)	4,703	(9,299)
Interest Paid	(2,068)	(2,074)	(6)	(1,491)
Dividends Paid	0	(6,226)	(6,226)	(6,226)
Release of PFI /Deferred Credit	0	0	0	0
(Increase)/Decrease in Inventories	0	(507)	(507)	(468)
(Increase)/Decrease in Trade Receivables	9,200	17,300	8,100	23,064
Increase/(Decrease) in Trade Payables	9,559	195	(9,364)	(10,757)
Increase/(Decrease) in Trade Payables Ann Leave Acc	0	(1,188)	(1,188)	849
Increase/(Decrease) in Other liabilities	0	13,390	13,390	7,635
Increase/(Decrease) in Provisions	0	(915)	(915)	(979)
Increase/(Decrease) in Provisions Unwind Discount	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**16,802**	**12,958**	**(3,844)**	**1,154**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	1,203	2,100	897	1,525
Payment for Property, Plant and Equipment	(55,612)	(47,841)	7,771	(33,621)
Payment for Intangible Assets	(2,593)	(293)	2,300	(264)
Receipt of cash donations to purchase capital assets	11,999	9,283	(2,716)	9,283
Proceeds from sales of Tangible Assets	0	1	1	1
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(45,003)**	**(36,751)**	**8,252**	**(23,076)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(28,202)**	**(23,793)**	**4,408**	**(21,922)**
FINANCING				
New Public Dividend Capital Received	(7,261)	0	7,261	0
Capital Element of Finance Lease and PFI	(4,372)	(3,765)	607	(2,727)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(11,633)**	**(3,765)**	**7,868**	**(2,727)**
INCREASE/(DECREASE) IN CASH	**(39,835)**	**(27,558)**	**12,276**	**(24,649)**
CASH BALANCES				
Opening Balance at 1st April 2023	69,265	69,265	0	0
Closing Balance at 31st October 2023	29,431	41,733	12,302	(24,649)

The Royal Wolverhampton NHS Trust

Reference Pack

Report of the Chief Financial Officer

Finance Report
September 2023 - Month 6

Safe & Effective | Kind & Caring | Exceeding Expectation

Contents

Dashboard

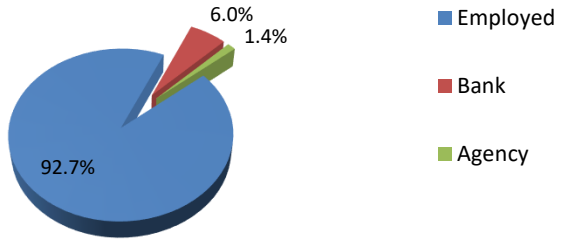
Income & Expenditure Position

(see page 5)

	In Mth Actual	YTD Actual
Income	**£'m**	**£'m**
1. Patient income	59.87	352.51
2. Other income	11.74	81.94
Total	**71.61**	**434.46**
Expenditure	**74.97**	**463.26**
Surplus/ (deficit)	**(3.36)**	**(28.80)**
Planned surplus/(deficit)	**(3.69)**	**(24.45)**
Variance to plan	**0.34**	**(4.35)**

Workforce

(see page 8)



Patient Income

Elective recovery fund activity to date is £1.38m above the revised national expectation. As per NHSE guidelines this is included in the September position. Other variable income relating to drug, devices and diagnostics is £0.3m above plan. All other income is within the block.

Actual Outturn

(see page 5)

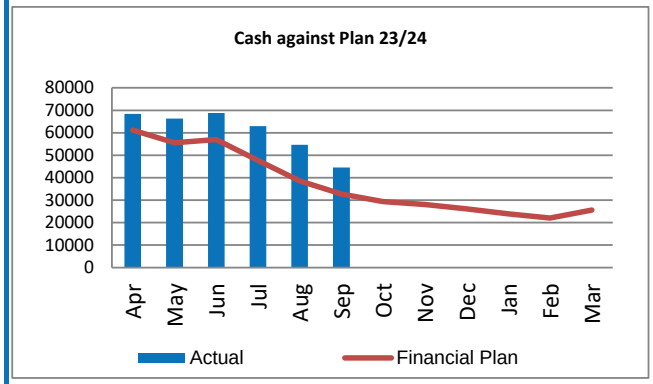
£3.4m deficit in month
(£338k favourable to plan)

£28.8m deficit year to date
(£4.35m adverse to plan)

Cash in the Bank

(see page 7)

Plan £32.8m
Actual £44.5m



Covid-19 Expenditure

In month 5 there was expenditure of £116k on testing and £53k on Covid Medicines Delivery Unit. (Year to date £649k and £245k respectively).

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

Cost Improvement Programme (CIP)

(see page 9)

In-month delivery of £6.84m against a target of £2.42m.
Year to date achievement of £13.9m against the target of £12.2m due to review of all CIP opportunities.
Total CIP forecast is £32.4m, against the £45.2m target, of which £13.6m is recurrent.

Overview of Financial Performance
The Trust is reporting an in month adjusted deficit of £3.4m, this is £338k favourable to plan, this leads to a year to date deficit of £28.8m which is £4.4m behind plan.

Income is £1.8m adverse to plan in month and £1.4m adverse YTD. This is made up of Patient Care income being £1.4m adverse in month due to increasing the income plan for the year as a result of the nationally reduced ERF baseline and one off prior year gains contributing to the CIP plan, it is £1.9m favourable YTD due to over performance against the national ERF target, ERF performance in month is £0.2m below plan due to industrial action. Year to date this is predominantly offset in the YTD position by recognising £3.7m less Capital Grant Funding Income than plan, as this is matched to expenditure and there has been timing delays which will catch up later in the year (Excluded from National Performance monitoring).

In month pay expenditure has over spent by £1.1m. This is due to a number of reasons including: £325k for cover due to industrial action, £379k relating to temporary medical staffing covering gaps in the rota and other absences, £497k in nursing areas where there has been cover required for increased sickness, maternity and annual leave as well as some patient acuity requirements. This is partially offset by vacancies across the Trust.

Non-pay is also overspent in month by £1.1m. There are activity pressures of £285k relating to activity increases which are funded through ERF or variable contracts, along with £103k of activity pressure that are not linked to changes in income. Utilities are also overspent by £114k due to the combined heat and power plant breaking down and requiring additional electricity to be purchased. International recruitment has also cost £285k in excess of budget in month due to the phasing of new staff arriving and existing staff visa and education costs. Drugs is also overspent by £482k of which £379k is on high cost drugs that are within block contracts therefore receiving no additional funding.

Year to date the position is also overspent, Pay is £8.6m overspent including, £2.4m strike costs, £3.5m medical staffing cover, £3.7m nursing cover for sickness etc, vacancies in other areas partially offset this cost.
Non pay is underspent by £1.2m and Drugs is £627k overspent.

System Updates

The ICB is reporting a YTD deficit of £79.2m, £27m adverse to plan (2.3%) with 5 out of 8 organisations running deficit positions .

The system has a number of significant demand pressures; excess inflation including prescribing totalling £15m, £14m of cost attributable to industrial action, UEC and Mental Health £6.5m, and efficiency under delivery of £6m, partially being offset by £1.5m ERF performance and £12.5m of non-recurrent balance sheet related items. The ICB is within the national agency cap target. Whilst YTD capital spends are currently underspent they are forecast to be utilised by the end of the financial year.

Capital

The Trust has five types of capital programme with a combined plan of £57.8m for the year; these are CRL totalling £21.3m, and PDC £6.2m, 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 or renewed leases £3.7m. This is a movement of £1.6m from M5 due to additional PDC for Additional Imaging Equipment (£0.3m) and CDC (£1.5m); additional ICS CRL due to transfers from three other providers within the ICS for their share of BCPS capital projects (£0.4m); offset by reduction in IFRS 16 Leases due to actual agreement of lease being lower than plan (£0.5m).

YTD capital is underspent by £7.4m, with a capital spend of £25.4m YTD. Against ICS CRL, there is an underspend of £0.6m 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 £21.3m by the end of the year.
PDC capital - there is an underspend of £2.0m due to delayed agreement (compared to plan) of EPR business cases and its expected PDC funding, however the Trust anticipates meeting assumed PDC CRL of £6.2m.
Grant funding has a YTD variance of £3.7m, due to timing of orders, with the Trust forecasting to spend all Grant approved capital funding projects. IFRS 16 CRL YTD variance of £0.3m due to one 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

	£m	22/23 Sep	Oct	Nov	Dec	Jan	Feb	Mar	23/24 Apr	May	Jun	Jul	Aug	Sep	YTD Avg	Move-ment
	Patient Income															
1	Plan	61.89	57.85	57.06	57.44	58.17	58.41	97.46	54.90	58.57	57.27	58.21	60.31	61.30	*57.85*	*3.45*
2	Actual	60.56	56.79	60.38	54.88	57.79	58.18	100.44	53.48	59.49	59.09	58.41	62.18	59.87	*58.53*	*1.34*
3	Variance	(1.33)	(1.06)	3.32	(2.56)	(0.38)	(0.23)	2.99	(1.42)	0.92	1.82	0.20	1.87	(1.42)	*0.68*	*(2.10)*
	Non Patient Income															
4	Plan	17.01	13.26	12.41	21.15	13.07	14.23	30.98	16.07	15.50	16.15	12.33	13.13	12.13	*14.64*	*(2.51)*
5	Actual	11.49	19.22	13.75	16.99	14.40	18.15	17.82	14.65	16.99	12.99	12.44	13.13	11.74	*14.04*	*(2.30)*
6	Variance	(5.52)	5.97	1.34	(4.16)	1.33	3.92	(13.16)	(1.43)	1.49	(3.16)	0.11	0.00	(0.39)	*(0.60)*	*0.21*
	Pay Expenditure															
7	Plan	46.92	42.71	42.54	43.20	40.89	43.28	82.72	44.11	47.15	45.61	48.01	48.55	46.60	*46.69*	*0.09*
8	Actual	48.28	43.60	42.16	40.52	42.64	42.71	82.05	46.78	48.56	47.93	47.10	50.55	47.73	*48.19*	*0.45*
9	Variance	(1.37)	(0.89)	0.38	2.69	(1.75)	0.57	0.67	(2.67)	(1.41)	(2.32)	0.90	(2.00)	(1.14)	*(1.50)*	*(0.36)*
	Non Pay Expenditure															
10	Plan	16.60	17.14	17.10	18.15	17.43	19.31	18.47	17.18	17.10	16.27	23.03	17.52	14.97	*18.22*	*3.25*
11	Actual	16.32	17.23	17.78	15.75	15.85	17.87	24.20	17.52	16.54	17.59	18.61	18.47	16.10	*17.75*	*1.65*
12	Variance	0.28	(0.09)	(0.68)	2.40	1.59	1.43	(5.72)	(0.34)	0.56	(1.32)	4.42	(0.95)	(1.12)	*0.47*	*1.59*
	Drugs Expenditure															
13	Plan	6.10	5.55	5.65	5.98	5.97	5.70	6.03	5.92	6.10	6.34	6.24	6.27	6.52	*6.17*	*(0.34)*
14	Actual	6.58	5.91	5.95	6.32	6.47	5.83	6.56	5.66	6.09	6.59	6.27	6.40	7.00	*6.20*	*(0.80)*
15	Variance	(0.48)	(0.36)	(0.30)	(0.34)	(0.50)	(0.12)	(0.54)	0.27	0.01	(0.25)	(0.04)	(0.13)	(0.48)	*(0.03)*	*0.45*
	CIP over/ (under) achievement															
16	Variance	(0.41)	(1.19)	(1.83)	(1.86)	(0.74)	(1.44)	0.58	(1.39)	(0.57)	(0.08)	(1.53)	0.88	4.42	*(0.54)*	*(4.96)*
	BCPS Savings over/ (under) achievement															
16	Variance	0.08	(0.01)	0.03	0.00	(0.14)	(0.10)	(0.07)	0.00	0.00	0.00	0.00	0.00	0.00	*0.00*	*0.00*
	Reserves supporting position															
17	Actual	1.58	1.47	1.59	(0.48)	2.50	0.95	(0.31)	2.85	1.09	1.30	(5.24)	(0.00)	0.00	*(0.00)*	*(0.00)*
	Other Non Operating Expenditure															
18	Plan	(3.27)	(3.78)	(3.78)	(3.78)	(3.80)	(3.84)	(3.83)	(3.79)	(3.81)	(3.85)	(3.87)	(3.68)	(3.73)	*(3.80)*	*0.07*
19	Actual	(3.53)	(3.75)	(3.57)	(3.54)	(3.54)	(3.52)	(2.04)	(3.77)	(3.78)	(3.75)	(3.77)	(3.83)	(3.87)	*(3.78)*	*(0.09)*
20	**Variance**	(0.26)	0.03	0.21	**0.24**	**0.26**	**0.32**	**1.79**	**0.02**	**0.03**	**0.09**	**0.10**	**(0.15)**	**(0.14)**	*0.02*	*0.16*
	Total															
	Plan	4.76	1.65	0.62	**9.81**	**1.54**	**1.10**	**17.18**	**(1.48)**	**(0.61)**	**0.13**	**(3.83)**	**(3.46)**	**(2.81)**		
	Actual	(2.66)	5.52	4.68	**5.74**	**3.69**	**6.41**	**3.42**	**(5.60)**	**1.50**	**(3.79)**	**(4.92)**	**(3.94)**	**(3.09)**		
	Variance	(7.42)	3.87	4.06	**(4.07)**	**2.16**	**5.31**	**(13.76)**	**(4.12)**	**2.11**	**(3.92)**	**(1.08)**	**(0.48)**	**(0.28)**		

Commentary on variances and trends:

Patient Income - For 2023/24 the income plan consists 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. Following NHS guidance, the variable element overperformance against the plan has been included in the position of £1.38m for this year so far. Additionally for September £133k of NHSE variable activity for diagnostic Imaging and Chemotherapy has been factored into the position.

Non-Patient Income - excluding grant funding for capital schemes, in month 6 non-patient income decreased by £1m compared to month 5. This was due to decreases in LDA contract income £372k, international nurse recruitment income £521k as well as a number of smaller changes in divisional SLA values.

In terms of variance private patients under performed by £15k. Other Directorate income was over plan by £50k due to small SLA changes, and Education, Training and Research was over by £478k due to research trading account budgets being realigned in month and being backdated, (offset in non pay - see below).

Pay - decreased in month by £2.82m. Of this £2m relates to the Medical Pay award back pay that was accounted for last month, there was also a decrease in Bank costs worth £799k, agency £48k and additional hours £64k. Pay costs in hosted services also reduced by £77k. There were increased industrial action costs amounting to £176k

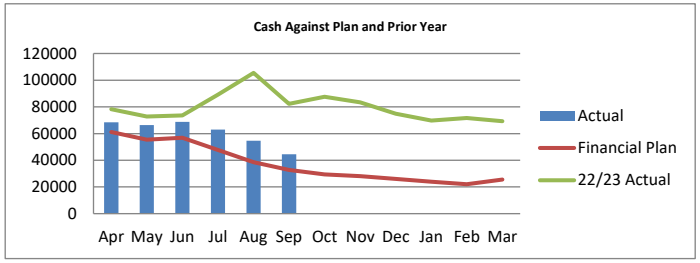
There was an overall overspend of £1.14m. Over spending areas were:
Division 1 £360k - Including Strike costs £47k, £168k cover for Medical staff rota gaps and absences, £326k for nursing and midwifery acuity and absence cover all offset by vacancies in other areas.
Division 2 £501k - Including Strike costs £119k, £77k cover for Medical staff rota gaps and absences, £276k for nursing and midwifery acuity and absence cover.
Division 3 £196k - Including £190k relating to backdated pay for GP's
Corporate £191k - including £82k backdated charges re combined management posts and previously agreed over establishments.
Estates & Facilities £309k - including £270k of previous months underspends being taken to CIP.

Non-Pay - A decrease in the run rate compared to the previous month of £2.37m. There has been one off benefits including a release of GRN's no longer required from the balance sheet of £850k, £236k in year accrual reduction for insulin pumps and £341k CNST additional rebate. Along with these there has been a reduction in activity related costs £665k. There was an increase in BCPS worth £233k.

In terms of variance there is an overspend of £1.1m.
Of this £896k was within Division 1 of which £588k related to a previous month adjustment to CIP along with activity related pressures worth £147k, £126k of which is related to activity funded through variable contracts.
Estates and Facilities were also overspent by £325k. £115k due to additional electricity being purchased due to the failure of the CHP, £60k related to planned maintenance delayed from prior months. Hotel services makes up the balance where there has been increased spend in waste disposal, domestics and catering.
R&D Trading accounts were over by £476k this related to other income - see above.

Drugs - Expenditure was £600k higher in month 6 than in month 5. This was due to high cost drugs usage linked to activity.
In month expenditure was overspent at £428k making the year to date position to £626k overspent, this is due to high cost drugs being funded on block contract whilst usage has increased.

Cash Position



The cash balance as at 30th September 2023 is £44.5m, a £10.1m decrease on the previous month and an increase of £11.8m on financial plan. The increase on plan is due to: £18.7m cash settlement of 22/23 pay award income netted out by £19.6m additional pay cost. Additional movements are £5.1m Staffs 22/23 income received in year; £1.4m additional LDA funding for Q1; £12.1m higher ICS income; £10.0m cash benefit due to timing of loan to DGFT; and £21.7m reduced capital spend (£14.4m due to timing on projects & £7.3m due to reduction in PDC). This is netted out by £8.1m less cash for PDC (£1.8m due to timing of EPR scheme & £6.3m reduction in PDC) ; £2.1m less cash for PSDS due to timing of schemes; £19.3m additional pay costs and £12.8m 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:

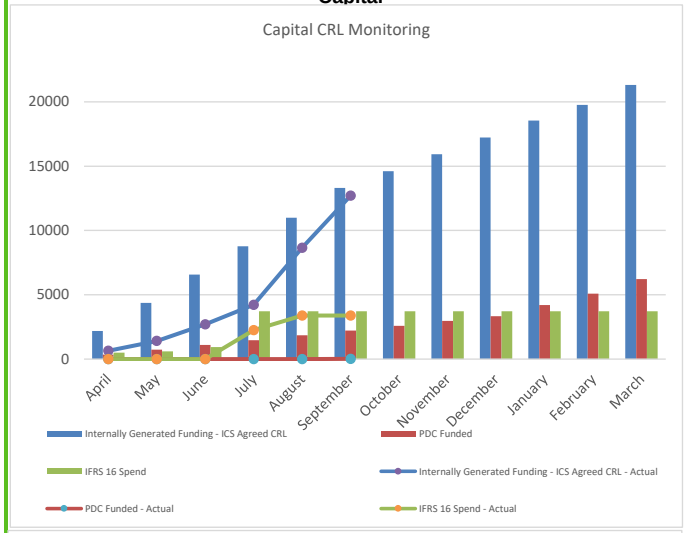
	M6 23/24	Cumulative	M5 23/24	Cumulative
Value	95%	96%	98%	96%
Volume	91%	94%	96%	95%

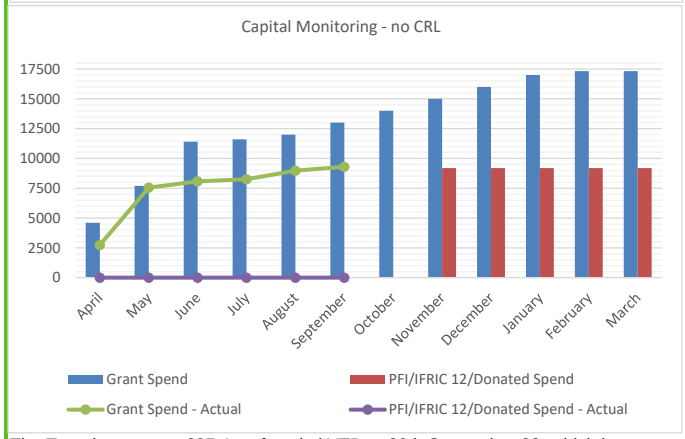
Debtor Days

Calculated Debtor Days for the year are:-

	M6 Actual	M5 Actual
Total	6.38	5.51
Being:-		
NHS	6.97	5.63
Non NHS	3.83	4.98

Capital





The Trust have spent £25.4m of capital YTD to 30th September 23, which is an underspend of £7.4m against forecast YTD capital spend of £32.2m. Of this £25.4m YTD spend:

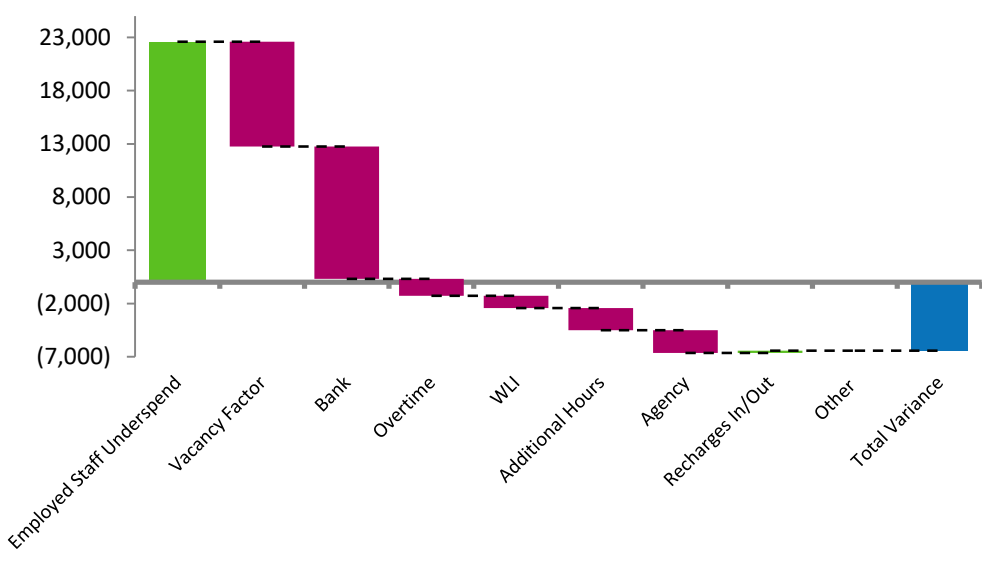
Capital CRL Monitoring - £12.7m relates to capital spend which the ICS is measured against, this is an underspend of £0.6m against Plan due to timing of orders. The Trust envisages meeting the ICS CRL of £21.3m. There has been £0.0m spend YTD on PDC due to delay in approval of EPR business case creating variance to Plan of £2.2m. There was £3.4m spend YTD on IFRS 16 with only one lease left to be commercial agreed (anticipating October 23).

Capital Monitoring - non CRL - The balance of the capital YTD, £9.3m, relates to capital spend on grant funded items with £9.1m relating to PSDS Phase 3a and £0.2m relating to Phase 3b. This is variance of £3.7m against Planned Grant spend of £13.0m due to timing of orders.

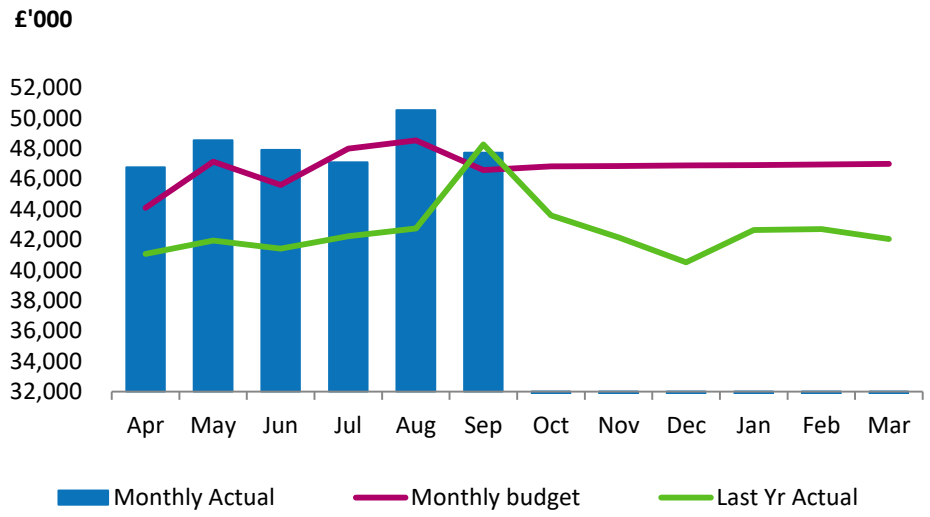
The Trust are forecasting to meet the reforecast capital expenditure spend for 23/24 of £57.8m (this includes additional PDC for Additional Imaging Equipment (£0.3m) and CDC (£1.5m); additional ICS CRL due to transfers from three other providers within the ICS for their share of BCPS capital projects (£0.4m); offset by reduction in IFRS 16 Leases due to actual agreement of lease being lower than plan (£0.5m).

Pay Expenditure

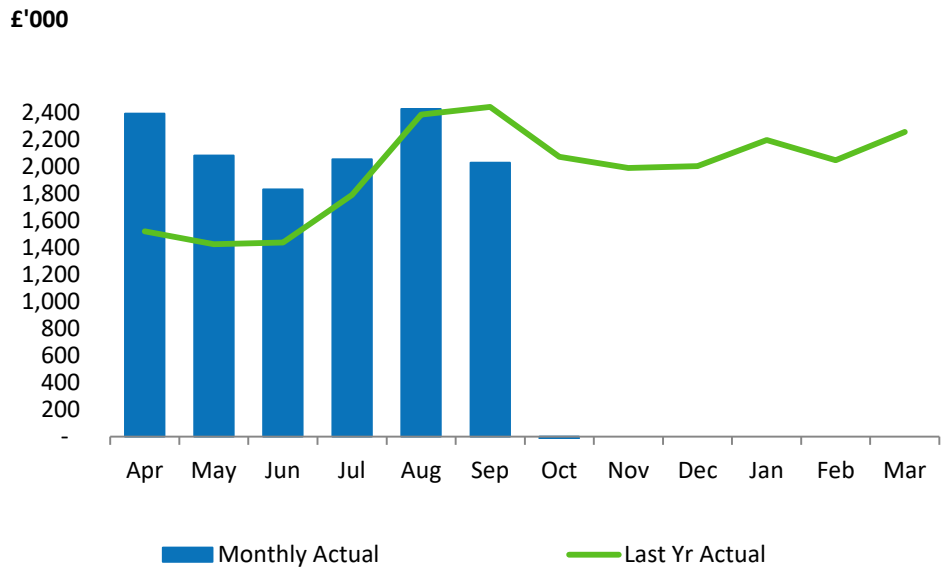
Year to Date Variance to plan



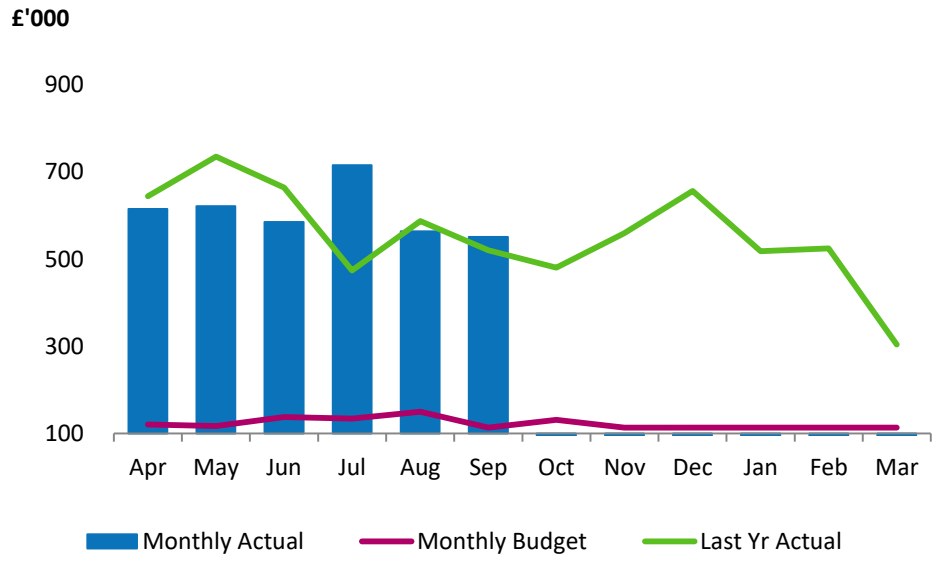
Total Pay Expenditure Trend



Bank Expenditure Trend



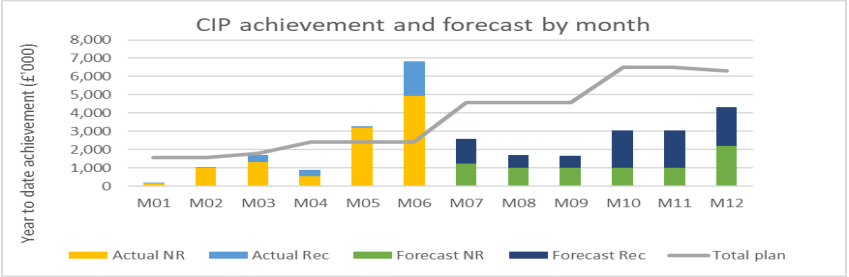
Agency Expenditure Trend



Cost Improvement

Division	YTD Plan	YTD Actual	Variance
Corporate	687	1,220	532
Division 1	3,185	2,515	(670)
Division 2	2,073	561	(1,512)
Division 3	1,406	779	(627)
Division 4	5	0	(5)
Estates And Facilities	702	549	(152)
Trustwide	4,122	8,279	4,157
Grand Total	**12,180**	**13,903**	**1,724**

Division	Total target	FOT total	Variance
Corporate	3,254	1,880	(1,374)
Division 1	15,080	4,097	(10,984)
Division 2	9,815	1,159	(8,656)
Division 3	6,657	1,949	(4,708)
Division 4	22	0	(22)
Estates And Facilities	3,322	1,461	(1,861)
Trustwide	7,003	21,814	14,811
Grand Total	**45,153**	**32,360**	**(12,792)**



Against an in-month target of £2.42m, £6.84m has been achieved, taking the year to date achievement to £13.90m against a target of £12.18m. The in month achievement is due to a full review of all CIP opportunities across the Trust and CIP's being recognised in month six that relate to the previous months of the financial year.

£32.36m of CIP's are forecast to be achieved (72% of total CIP target), of which £13.63m is expected to be achieved recurrently (42% of the forecast achievement and 30% of the total annual target).
As well as the focus on the overall CIP achievement there is a continued focus on making current non-recurrent savings recurrent.

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				
333,176	61,296	59,873	(1,423)	Patient Activity Income	706,887	350,546	352,514	1,968
555	127	111	(16)	Other Patient Care Income	1,521	760	564	(196)
2,136	0	0	0	Top Up Income	0	0	8	8
24,763	3,496	3,763	266	Education, Training & Research Income	52,360	26,736	26,720	(16)
12,725	1,028	350	(678)	Non Patient Care Other Income	17,592	13,134	9,433	(3,702)
103	73	58	(15)	Private Patient Income	676	347	352	5
38,631	7,406	7,455	50	Income on Directorate Budgets	87,207	44,346	44,866	520
412,088	**73,426**	**71,611**	**(1,816)**	**Total Income**	**866,242**	**435,870**	**434,457**	**(1,413)**
				Expenditure				
257,724	46,597	47,733	(1,136)	Directorate Expenditure Budgets - Pay	561,527	280,024	288,659	(8,634)
97,811	14,974	16,096	(1,122)	Directorate Expenditure Budgets - Non Pay	219,359	106,074	104,837	1,237
35,264	6,517	6,999	(482)	Directorate Expenditure Budgets - Drugs	72,960	37,385	38,011	(627)
0	4,418	0	4,418	Cost Improvement Savings	(24,392)	1,724	0	1,724
0	0	0	0	BCPS Savings	0	0	0	0
390,798	**72,506**	**70,828**	**1,678**	**Total Expenditure**	**829,454**	**425,207**	**431,507**	**(6,300)**
21,290	**920**	**783**	**(138)**	**EBITDA Surplus/(Deficit)**	**36,788**	**10,664**	**2,950**	**(7,713)**
14,276	2,647	2,695	(48)	Depreciation	33,076	15,666	15,882	(216)
739	(80)	14	(93)	(Interest Receivable) / Payable	1,137	102	(57)	158
6,318	1,158	1,160	(2)	Other Charges	13,900	6,950	6,949	1
21,334	**3,726**	**3,869**	**(144)**	**Other non operating items**	**48,113**	**22,717**	**22,775**	**(58)**
(44)	**(2,806)**	**(3,087)**	**(281)**	**Net Surplus/(Deficit) before Adjustments**	**(11,325)**	**(12,054)**	**(19,824)**	**(7,771)**
(12,451)	(888)	(269)	620	Adjustments as per NHSI reported position	(15,425)	(12,392)	(8,974)	3,418
(12,495)	**(3,694)**	**(3,356)**	**338**	**Adjusted Financial Performance as NHSI**	**(26,750)**	**(24,445)**	**(28,798)**	**(4,353)**

Note: In month reserves have been moved into pay and non pay to fund existing pressures this includes backdated budget.

Note : Adverse Variances in Brackets

Appendix B - Statement of Financial Position

2023/24 Balance Sheet as at 30th Sept 2023

	Sept 2023 Plan	Sept 2023 Actual	Aug 2023 Actual	Movement in Month	March 2023 Actual
	£000	£000	£000	£000	£000
NON CURRENT ASSETS					
Property,Plant and Equipment - Tangible Assets	506,990	496,238	494,287	1,951	486,739
Intangible Assets	7,366	5,429	5,548	(119)	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	**520,417**	**507,728**	**505,896**	**1,832**	**498,660**
CURRENT ASSETS					
Inventories	8,347	11,744	11,508	236	8,347
Trade and Other Receivables	48,913	38,301	35,643	2,658	59,564
Other Current Assets	0	0	0	0	0
Cash and cash equivalents	32,777	44,534	54,662	(10,128)	69,265
TOTAL CURRENT ASSETS	**90,037**	**94,579**	**101,813**	**(7,233)**	**137,176**
Non Current Assets Held for Sale	0	0	0	0	0
TOTAL ASSETS	**610,455**	**602,307**	**607,709**	**(5,401)**	**635,836**
CURRENT LIABLILITES					
Trade & Other Payables	(106,606)	(97,474)	(98,825)	1,351	(114,207)
Liabilities arising from PFIs / Finance Leases	(6,199)	(8,969)	(8,841)	(128)	(13,462)
Provisions for Liabilities and Charges	(3,558)	(3,250)	(3,321)	72	(4,201)
Other Financial Liabilities	(9,773)	(14,660)	(15,123)	462	(10,424)
TOTAL CURRENT LIABILITIES	**(126,135)**	**(124,353)**	**(126,109)**	**1,756**	**(142,294)**
NET CURRENT ASSETS / (LIABILITIES)	**(36,097)**	**(29,774)**	**(24,297)**	**(5,477)**	**(5,118)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**484,320**	**477,954**	**481,599**	**(3,645)**	**493,542**
NON CURRENT LIABILITIES	(5,338)	(5,030)	(5,102)	72	
Trade & Other Payables	(287)	(250)	(257)	7	(287)
Other Liabilities	(10,049)	(9,673)	(10,224)	551	(5,470)
Provision for Liabilities and Charges	(1,780)	(1,780)	(1,780)	0	(1,780)
TOTAL NON CURRENT LIABILITIES	**(12,116)**	**(11,703)**	**(12,261)**	**558**	**(7,537)**
TOTAL ASSETS EMPLOYED	**472,204**	**466,251**	**469,338**	**(3,087)**	**486,005**
FINANCED BY TAXPAYERS EQUITY					
Public Dividend Capital	303,860	305,676	305,676	0	305,676
Retained Earnings	60,379	52,607	55,694	(3,087)	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	186	190	190	0	190
TOTAL TAXPAYERS EQUITY	**472,204**	**466,251**	**469,338**	**(3,087)**	**486,005**

Appendix C Cash Flow Statement

2023/24 Cash Flow as at 30th September 2023

	Sep-23 Plan £'000	Sep-23 Actual £'000	Sep-23 Variance £'000	Sep-23 In Month Movement £'000
OPERATING ACTIVITIES				
Total Operating Surplus/(Deficit) (gross of control total adjustments)	**(4,601)**	**(12,932)**	(8,330)	(11,156)
Depreciation	15,536	15,882	346	10,654
Fixed Asset Impairments	0	0	0	0
Capital Donation Income	(12,999)	(9,297)	3,702	(9,301)
Interest Paid	(1,773)	(1,771)	2	(1,188)
Dividends Paid	0	(6,226)	(6,226)	(6,226)
Release of PFI /Deferred Credit	0	0	0	0
(Increase)/Decrease in Inventories	0	(3,397)	(3,397)	(3,359)
(Increase)/Decrease in Trade Receivables	9,200	20,576	11,376	26,339
Increase/(Decrease) in Trade Payables	11,369	(6,377)	(17,745)	(17,328)
Increase/(Decrease) in Trade Payables Ann Leave Acc	0	(1,019)	(1,019)	1,019
Increase/(Decrease) in Other liabilities	0	4,236	4,236	(1,519)
Increase/(Decrease) in Provisions	0	(859)	(859)	(923)
Increase/(Decrease) in Provisions Unwind Discount		0		0
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITES	**16,731**	**(1,184)**	**(17,915)**	**(12,987)**
CASH FLOWS FROM INVESTING ACTIVITIES				
Interest Received	1,042	1,828	786	1,253
Payment for Property, Plant and Equipment	(51,695)	(31,182)	20,513	(16,962)
Payment for Intangible Assets	(2,220)	(293)	1,927	(264)
Receipt of cash donations to purchase capital assets	11,999	9,282	(2,717)	9,282
Proceeds from sales of Tangible Assets	0	1	1	1
Proceeds from Disposals	0	0	0	0
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(40,874)**	**(20,365)**	**20,510**	**(6,690)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(24,143)**	**(21,548)**	**2,595**	**(19,677)**
FINANCING				
New Public Dividend Capital Received	(8,596)	0	8,596	0
Capital Element of Finance Lease and PFI	(3,748)	(3,183)	565	(2,144)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING	**(12,344)**	**(3,183)**	**9,161**	**(2,144)**
INCREASE/(DECREASE) IN CASH	**(36,487)**	**(24,731)**	**11,756**	**(21,822)**
CASH BALANCES				
Opening Balance at 1st April 2023	69,265	69,265	0	0
Closing Balance at 30th September 2023	32,778	44,534	11,756	(21,822)

The Royal Wolverhampton NHS Trust

Audit Committee, Trust Policy Group & Public Trust Board

Meeting Date:	5 December 2023 – Audit Committee 12 January 2024 – Trust Policy Group 12 February 2023 -Public Trust Board
Title:	GI02, Financial Management Policy (Incorporating Standing Orders, Standing Financial Instructions and Scheme of Delegation)
Purpose of the Report:	For full review as part of the Trust's policy process and recommendation for approval at February's Public Trust Board.
Action required:	TPG to recommend to Trust Management Committee and Audit Committee to recommend approval by Trust Board **Make a decision; Approve**
Assure	• Regular review and updating undertaken of SO's and SFI's.
Advise	• Minor amendments and updates made.
Alert	• No new or changed risks identified as a result of this review.
Author + Contact Details:	James Green - Tel 01902 481598 Email mailto: jmgreen@nhs.net Keith Wilshere - Tel 01902 307999 x84294 Email mailto: keith.wilshere1@nhs.net
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led.**
Trust Strategic Objectives	(delete those that do not apply to your Trust-wide procedural document) 1. Excel in the delivery of Care – We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement. 2. Support our Colleagues – We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations. 3. Improve the health of our Communities – We will positively contribute to the health and wellbeing of the communities we serve. 4. Effective Collaboration – We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.
Counter Fraud Checklist (with the exception of clinical policies)	Refer to the completed counter fraud checklist.
Financial Implications:	Does the Policy/Procedure commit the Trust to any additional (or new) expenditure (capital or revenue)? (This could include changes to equipment, items used etc) No
Equality and Diversity Impact	This policy has been assessed as not having an adverse impact of any one particular group of stakeholders.
ICT and Health Records implications	1. Does the policy/procedural document include significant or major changes that include IT systems or applications? No 2. Does the policy/procedural document imply or include any IT related capital investment in systems and/or hardware? No 3. Does the Policy/procedural document include procurement of, or relationship with external/third party IT providers (hardware, software,

	systems)? No 4. Does the Policy/procedural document comply with, or impact upon Cyber Security policy OP12? No 5. Does the policy/procedural document include any changes, or impact to the patient's Health Record? No
Publishing Requirements:	The Trust is expected to publish all documents unless there is a good reason why. Policies, procedures et al, will be published on the Trust's public website unless there is a good reason not to. The main reasons for not publishing: • Commercially confidential data or personal information. • Patient or public safety risk The answer to the next question is expected to be yes. However, if you indicate no, you will need to explain why. Can this document be published on the Trust's public page: **Yes**
Risks:	No new or changed risks identified.
Risk register reference:	BAF Reference
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	**1 Year**(s) review period (1 year being the shortest period of time and 4 years being the maximum review period that can be applied)

High Risk Policy? **Definition:** • Contains information in the public domain that may present additional risk to the public e.g. contains detailed images of means of strangulation. • References to individually identifiable cases. • References to commercially sensitive or confidential systems. If a policy is considered to be high risk it will be the responsibility of the author and chief officer sponsor to ensure it is redacted to the requestee.	**Yes**
Other formal bodies involved:	TPG and Audit Committee.

Report Details	
Title:	As per front sheet title
Item/paragraph 1.0	Proposed changes are as follows (most notable first): Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles.

IMPLEMENTATION PLAN

The Standing Orders and Standing Financial Instructions are in constant use and reference throughout the Organisation. Therefore, there is no specific implementation plan other than that the Trust must adhere to its Standing Orders and Standing Financial Instructions as part of enacting its establishment order.

Part B **Ratification Assurance Statement**

Name of document: GI02, Financial Management Policy

Name of authors: Keith Wilshere and James Green
Job Title: Group Company Secretary and Operational Director of Finance

I, Keith Wilshere / James Green the above-named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.

- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.

- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines (OP01).

- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.

- I have undertaken appropriate and thorough consultation on this document, and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.

- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.

- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author:

Date: November 2023

Name of Person Ratifying this document (Chief Officer or Nominee):
Job Title: Group Chief Financial Officer
Signature:

- I, the named Chief Officer (or their nominee) am responsible for the overall good governance and management of this document including its timely review and updates and confirming a new author should the current post-holder/author change.

To the person approving this document:

Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Administrator.

The Royal Wolverhampton NHS Trust

Policy Number

GI02

Title of Policy

Financial Management Policy

Contents

1.0 Policy Statement

The attached appendices provide managers with the good governance and financial framework they are required to adhere to as part of sound management practice in accordance with NHS guidelines and legislation, and the establishment order of the Trust.

The purpose of the policy is to provide all managers with guidance on their responsibilities in relation to enacting the Trust Statutory Instrument including the role and functioning of the Trust Board, and Tendering/Ordering/Contracting. To provide managers with a framework and guidance to aid budget management.

To ensure all managers are equipped with the information they require to ensure sound (financial) management at all levels within the organisation and to ensure sound (financial) control is delivered in accordance with NHS requirements.

All aspects of this document regarding potential Conflicts of Interest should refer first to the Conflicts of Interest Policy (OP109). In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflicts of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

Not applicable.

3.0 Accountabilities

The Trust Audit Committee are accountable for ensuring that elements of this policy are included within the Trusts internal audit programme, and for oversight of the implementation and running of the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

4.0 Policy Detail

Appendix 1 – Standing Orders

Appendix 2 – Standing Financial Instructions

Appendix 3 – Scheme of Reservation and Delegation

Appendix 4 – Budget Management Principles and Guidance

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	N/A

6.0 Equality Impact Assessment

This policy has been assessed as not having an adverse impact of any one group of stakeholders.

7.0 Maintenance

The policy will be reviewed by Chief Financial Officer annually to ensure any new guidance and any changes included as required and there must be a formal review by the Board at least every 3 years.

8.0 Communication and Training

This policy will be posted on the Trust Intranet and all staff will receive notification of changes through local directorate/department governance meetings and through inclusion of the key areas of change in the Trust's communications bulletins.

9.0 Audit Process

This is led by the Trusts Audit Committee who are accountable for ensuring that elements of this policy are included within the Trusts internal audit programme.

Operation of the Standing Orders is monitored by the Group Company Secretary at each Board Meeting and by the relevant Chair at each Board Committee.

The Standing Financial Instructions are constantly monitored by the Finance Team and is subject to a variety of regular audits and checks throughout the financial year.

10.0 References - Legal, professional, or national guidelines.

The relevant establishment orders for the Trust can be seen here The Royal Wolverhampton Hospitals National Health Service Trust (Establishment) Amendment Order 2012 (legislation.gov.uk) and here The Royal Wolverhampton Hospitals National Health Service Trust (Establishment) Order 1993 No. 2574 (legislation.gov.uk)

Part A - Document Control

Policy number and Policy version: GI02 V8.0	**Policy Title:** **Financial Management**	**Status:** Final	**Author:** **Group Company Secretary & Operational Director of Finance** **Chief Officer Sponsor:** **Group Chief Financial Officer/Group Deputy CEO**	
Version / Amendment History	Version	Date	Author	Reason
	V1	June 2011	Financial Controller	Implementation of Financial Management Policy
	V2	June 2013	Financial Controller	Minimal changes
	V3	July 2014	Financial Controller	Minimal changes
	V4	April 2019	Head of Financial Control and Assurance	Review of policy including Appendices with updates to all appendices to ensure relevant
	V5	May 2019	Head of Financial Control and Assurance Company Secretary	Inclusion of suggested amendments following initial presentation to Trust Board in April 2019.
	V5.1	Nov. 2020	Head of Financial Control and Assurance	Extension approved.
	V5.2	Nov. 2020	Head of Financial Control and Assurance	Extension approved.
	V5.3	June 2021	Head of Financial Control and Assurance	Updates to Appendix 1, Standing Orders and Appendix 3, Scheme of Reservation and Delegation – Approved via Trust Board June 2021

	5.4	Sept. 2021	Deputy Chief Financial Officer	Extension approved.
	6.0	January 2022	Deputy Chief Financial Officer	Full review of policy and Appendices.
	6.1	April 2022	Deputy Chief Financial Officer	Minor update to Appendix 4 (hyperlink page 23)
	6.2	January 2023	Deputy Chief Financial Officer	Extension approved.
	7.0	February 2023	Deputy Chief Financial Officer	Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles.
	8.0	November 2023	Group Company Secretary & Operational Director of Finance	Full Annual Review and updates

Intended Recipients: All Trust staff	
Consultation Group / Role Titles and Date: Company Secretary; Finance and Performance Committee, Trust Management Committee, Audit Committee, Trust Policy Group Chief Financial Officer, Deputy Chief Financial Officer.	
Name and date of Trust level group where reviewed	Audit Committee – December 2023 Trust Management Committee – January 2024 Trust Policy Group – December 2023
Name and date of final approval committee	Trust Board – February 2024
Date of Policy issue	February 2024
Review Date and Frequency (standard review frequency is 3 years unless otherwise indicated – see section 3.8.1 of Attachment 1)	February 2025 (Annual review)
Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees, and dissemination via Intranet.	
Publishing Requirements: Can this document be published on the Trust's public page: **Yes**	
To be read in conjunction with: GI02, Appendix 1 - Standing Orders	

GI02, Appendix 3 - Scheme of Delegation OP109, Conflicts of Interest Policy GP02, Anti-Fraud and Anti-Bribery Policy	
Initial Equality Impact Assessment (all policies): Completed Yes Full Equality Impact assessment (as required): Completed N/A If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board
Document summary/key issues covered. The attached appendices provide managers with the financial framework they are required to adhere to as part of sound management practice in accordance with NHS guidelines and legislation.	
Key words for intranet searching purposes	Financial Management Standing Orders Standing Financial Instructions Budget Management
High Risk Policy?	**No**

The Royal Wolverhampton NHS Trust

Standing orders – 2023 review and revision

Standing Orders	**Type: Standing orders** **Status: Public**

Developed in response to:	Governance Requirement, Code of Governance for NHS Provider Trusts (2023)
Contributes to CQC Standard number:	17

Consulted With	**Post/Committee/Group**	**Date**
Audit Committee		February 2023
Audit Committee		December 2021
Audit Committee		December 2023

Version Number	V5
Issuing Directorate	CEO Office
Ratified by:	Board of Directors
Ratified on:	1 February 2024 (Trust Board)
Implementation Date	February 2024
Next Review Date	February 2025
Author/Contact for Information	Keith Wilshere, Kevin Stringer, James Green & Michelle Collins
Policy to be followed by (target staff)	All Trust staff
Distribution Method	TrustNet, Website
Related Trust Policies (to be read in conjunction with)	Standing Financial Instructions Scheme of Reservation & Delegation Scheme of Responsibility, Authority & Decision

Document Review History

Revision history – v1.0		
2010	Reviewed at Trust Board 12/04/2010	
2013	Reviewed at Trust Board 24/06/2013	
2015	Reviewed at Trust Board 26/01/2015	
Revision history – v1.1		
2019	Reviewed at Trust Board 04/03/2019	Revisions as listed below.
Revision history – v2.0		
2021	Reviewed at Trust Board June 2021	Minor update/revision.
Revision history – v3.0		
2021	Reviewed at Trust Board February 2022	Review and minor updates as part of full review to overall policy
Revision history – v4.0		
2022	Reviewed at Trust Board February 2023	Review and updates to whole policy including alignment with Code of Governance (April 2023) and revision to Financial Authority Limits (January 2023) and revised structures including Group roles.
Revision history – v5.0		
2023	Reviewed at Trust Board February 2024	Review and updates to whole policy and review of Financial Authority Limits.

Contents **Page**

1. Foreword to Standing Orders

1.1 NHS Trusts are required by law to make **Standing Orders (SOs**), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

1.2 These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money.

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

(1) Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
(2) Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff, and suppliers, and in the use of information acquired during NHS duties.
(3) Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients, and the public.
(4) Additional documents, which form part of these "extended" Standing Orders are:
(5) Standing Financial Instructions, which detail the financial responsibilities, policies, and procedures to be maintained by the Trust.
(6) Schedule of Decisions Reserved to the Board of the Trust
(7) Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

1.4 These extended Standing Orders set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

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

1.6 This revision (v5) includes reference to and compliance with the NHS Code of Governance for NHS Provider Trusts (PR2076, October 2022, effective from April 2023). The revised Code of Governance includes expectations in line with the UK Corporate Governance Code (2018), the NHS Long-term Plan, the Health and Care Act 2022 and the requirements to participate constructively as part of the wider integrated care system (ICS) and the Integrated Care Board (ICB) as well as other system and provider organisations at place (OneWolverhampton) and as part of a system wide provider collaborative.

SECTION A

2. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS

2.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders [on which they should be advised by the Chief Executive Officer].

2.2 Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990 and other Acts relating to the National Health Service (including the Health & Social Care Act, 2012) UK Corporate Governance Code (2018), Health and Social Care Act (2022), the NHS Code of Governance (2022), the revised Fit and Proper Persons Test (2023) or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and in addition:

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

(2) **"Trust"** means the Royal Wolverhampton NHS Trust.

(2a) **"Group"** means the partnership arrangements between the Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust.

(2b) **"Joint Committee"** means the Joint Providers Committee (JPC) formed between the Boards of the four Trusts in the Black Country Provider Collaborative (BCPC).

(3) **"Board"** means the Chair, executive and non-executive members of the Trust collectively as a body.

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

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

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

(7) **"Chief Executive Officer"** means the chief officer of the Trust.

(8) **"Committee"** means a committee of the Board created and appointed by the Trust.

(8)a "**Group**" refers to meetings and groups other than the Board or Committees of the Board.

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

(10) **"Contracting and procuring"** means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

(11) **"Chief Financial Officer"** means the Chief Financial Officer of the Trust.

(12) **“Funds held on trust”** shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

(13) **"Member"** means executive or non-executive member of the Board as the context permits. “Member” in relation to the Board does not include its Chair.

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

(15) **"Membership, Procedure and Administration Arrangements Regulations"** means NHS Membership and Procedure Regulations [SI 1990 / 2024] and subsequent amendments.

(16) **"Nominated officer"** means an officer charged with the responsibility for discharging specific tasks within Standing Orders.

(17) **"Non-executive member"** means a member of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1[3] of the Membership, Procedure and Administration Arrangements Regulations. Non-executive members appointed by NHS England are regarded as voting non-executives. Non-executive members appointed by the Trust are regarded as Associate Non-executives.

(18) **"Officer"** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

(19) **"Executive member**" means a member of the Trust who is either an officer of the Trust or is to be treated as an officer by virtue of regulation 1[3] [i.e. the Chair of the Trust or any person nominated by such a Committee for appointment as a Trust member].

(20) **"SFIs"** means Standing Financial Instructions.

(21) **"SOs"** means Standing Orders.

(22) **"Deputy-Chair"** means the non-executive member appointed by the Board to take on the Chair’s duties if the Chair is absent for any reason.

SECTION B STANDING ORDERS

3. Introduction

3.1 Statutory Framework

The Royal Wolverhampton NHS Trust [the Trust] is a statutory body which came into existence on 1 April 1994 under The NHS Trust [Establishment] Order 1993 No 2574, [the Establishment Order]. This was amended under a statutory instrument 2012 No. 1837, NATIONAL HEALTH SERVICE, ENGLAND, The
Royal
Wolverhampton National Health Service Trust (Establishment) Amendment Order 2012 Amendment to Article 1 item 3.

3.2 Name of the Trust

The trust is to be called The Royal Wolverhampton National Health Service Trust instead of The Royal Wolverhampton Hospital National Health Service Trust.
Accordingly in article 1(2) of the Establishment Order in the definition of "the Trust", and in article 2 of the Establishment Order (establishment of the Trust), omit "Hospital".

(1) The principal place of business of the Trust is New Cross Hospital, Wolverhampton.
(2) NHS Trusts are governed by Act of Parliament, mainly the National Health Service Act 1977 [NHS Act 1977], the National Health Service and Community Care Act 1990 [NHS & CC Act 1990] as amended by the Health Authorities Act 1995 and the Health Act 1999.
(3) The functions of the Trust are conferred by this legislation.
(4) As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.
(5) The Code of Governance for NHS Provider Trusts (2022, implementation from April 2023) requires the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions [SFIs] setting out the responsibilities of individuals, and a Scheme of Delegation (SoD) summarising the delegated responsibilities.
(6) The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

3.3 NHS Framework

(1) In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further directions and guidance. These are normally issued under cover of a circular or letter.
(2) The Code of Governance for NHS Provider Trusts (2023) requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives [a scheme of delegation]. The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Code of Conduct makes various requirements concerning possible conflicts of interest of Board members.

(3) The Code of Practice on Openness (Nolan Principles) in the NHS sets out the requirements for public access to information on the NHS.

(4) The revised Fit and Proper Persons Test (FPPT) (2023) sets out the standards of probity required by and of senior managers and appointees within the Trust.

3.4 Delegation of Powers

The Trust has powers to delegate and arrange delegations. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions the Trust has powers to "make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee, group or joint committee appointed by virtue of Standing Order 4 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit or as the Secretary of State may direct". Delegated Powers are covered in a separate document [Reservation of Powers to the Board and Delegation of Powers] (SoD).

3.5 Integrated Governance

Trust Boards continue to develop integrated governance to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance better enables the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality, and financial objectives.

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

4.1 Composition of the Membership of the Trust Board

In accordance with the Membership, Procedure and Administration Arrangements regulations the composition of the Board shall be:

(1) The Chair of the Trust [Appointed by the NHS England (NHSE)

(2) Up to 6 non-executive members [appointed by the NHS England]

(3) Up to 5 executive members [but not exceeding the number of non-executive members] including:

- the Chief Executive Officer (Group Chief Executive Officer)
- the Chief Finance Officer (Group Chief Finance Officer)
- a medical or dental practitioner (Chief Medical Officer)
- a registered nurse or midwife (Chief Nursing Officer)
- a chief officer nominated by the Chief Executive Officer (in this case the Chief Operating Officer/Deputy CEO).

(4) Voting Executive Director Members are:

- Group Chief Finance Officer (and Group Deputy CEO),
- Chief Medical Officer,
- Chief Nursing Officer,
- Chief Operating Officer (and Deputy CEO),
- Group Chief Executive Officer.

(5) Non-voting Executive Director Members are:

- Group Chief Medical Officer,
- Group Chief People Officer,
- Group Chief Strategy Officer,

- Deputy Chief Executive Officer (if none of the 5 above in [4])

(6) Non-voting Associate Non-executive Director Members
At the discretion of the Chair and Trust Board, the Trust may appoint additional Associate Non-executive Directors through the same process and to the same standards as a voting NED's and for specified term periods. Associates are not members of the Remuneration Committee.

(7) Non-voting Group Chief Officer, Chief Officer, Group Directors, Director Members and very senior officers (in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors and very senior officers who will attend the Trust Board as defined by the Chief Executive Officer and in agreement with the Chair. These attendees are not included in relation to Quoracy.

(8) Non-voting Director Members (not in attendance at Trust Board).
At the discretion of the Chief Executive Officer, the Trust may appoint additional non-voting Directors who will not attend the Trust Board.

(9) Interim Appointments Voting Officer Responsibilities.
In the case of the Chief Executive Officer appointing an interim voting Chief Officer they are to be considered for all purposes in the Standing Orders as having the same responsibilities and role as a permanent appointee.

Shared Appointments/Job Shares:

(10) Where the voting Chief Officer role is shared, any vote cast must reflect the consensus view of those sharing the post. In the case of a divergence of view between those sharing the post no vote will be cast and/or the record will be that the Chief Officer concerned abstained.

(11) Taking into account the above flexibilities, the overall balance of the Board between Executive and Non-executive attendees should be maintained as far as possible e.g. a balance of Officers and Non-executives with the Chair as ensuring that Non-Executive Directors are the majority of Board attendees.

(12) The Chief Executive Officer, in agreement with the Chair, may identify and appoint special advisors to the Board to provide expert opinion and insight to support the Board in making informed decisions. For the purposes of the Standing Orders special advisors are expected to be recruited to the same standards as an Associate Non-Executive with the same governance responsibilities. Their renumeration will be as per an Associate Non-Executive unless recommended and agreed otherwise by the Chief Executive Officer and approved by the Remuneration Committee. Such appointees will be known or be referred to as Special Advisor to the Board.

4.2 Appointment of Chair and Members of the Trust

Paragraph 4 of Schedule 5A to the 1977 Act, as inserted by the Health Act 1999, provides that the Chair is appointed by the Secretary of State, but otherwise the appointment and tenure of office of the Chair and members is set out in the Membership, Procedure and Administration Arrangements Regulations.

4.3 Terms of Office of the Chair and Members

The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in Sections 2 to 4 of the Membership, Procedure and Administration Arrangements and Administration Regulations.

4.4 Appointment and Powers of Deputy-Chair

(1) Subject to Standing Order 4.4 [2] below, the Chair and members of the Trust may appoint one of their number, who is not also an executive member, to be Deputy-Chair, for such period, not exceeding the remainder of his term as a member of the Trust, as they may specify on appointing him / her.

(2) Any member so appointed may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The Chair and members may thereupon appoint another member as Vice-Chair in accordance with the provisions of Standing Order 4.4 [1].

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

4.5 Joint Members

(1) Where more than one person is appointed jointly to a post mentioned in regulation 2[4][a] of the Membership, Procedure and Administration Arrangements Regulations those persons shall count for the purpose of Standing Order 4.5.2 as one person.

(2) Where the office of a member of the Board is shared jointly by more than one person:

[a] either or both of those persons may attend or take part in meetings of the Board;

[b] if both are present at a meeting they should cast one vote if they agree;

[c] in the case of disagreements no vote should be cast;

[d] the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order

[e] 5.1.1 Quorum.

4.6 Role of Members

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

4.7 Executive Members

Executive Members shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation. These are referred to as (Group) Chief Officers (voting), (Group) Chief Officers (non-voting) and (Group) Directors (where defined by the Chief Executive Officer and agreed by the Chair) and very senior officers (where defined by the Chief Executive Officer and agreed by the Chair).

(1) Group Chief Executive Officer

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

(2) Group Chief Financial Officer

The Group Chief Financial Officer shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. They shall be responsible along with the Group Chief Executive Officer for ensuring the discharge of obligations under relevant Financial Directions.

(3) Non-Executive Members

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

(4) Chair

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

[b] The Chair shall liaise with the NHS Appointments Commission over the appointment of Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

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

[d] The provisions for the division of responsibilities and the role of the Chair, senior independent director, Non-Executive Directors, Board appointments and Conflicts of Interests is set out in further detail in the Code of Governance for NHS Provider Trusts (2023) and the revised Fit and Proper Persons Test (FPPT)(2023).

4.8 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

(3) The powers of the Trust established under statute shall be exercised by the Board meeting in public session except as otherwise provided for in Standing Order No. 5.17.3.

(4) The Board shall define and regularly review the functions it exercises on behalf of the Secretary of State. The Code of Governance for NHS Provider Trusts recommends an externally facilitated developmental review using the CQC Well-Led Framework every 3-5 years, according to circumstance. Any review must be identified in the annual report and any potential conflicts with those carrying out the report or any Board members declared as per Conflicts of Interest Policy.

(5) All members shall individually and collectively operate in line with the Nolan Principles of Public Life (the Nolan Principles) and meet the requirements of the revised FPPT (2023).

4.9 Schedule of Matters reserved to the Board and Scheme of Delegation

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

4.10 Lead Roles for Board Members

The Chair will ensure that the designation of Lead roles or appointments of Board members as required by the Department of Health and Social Care or as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement.

The lead roles for Non-Executive Directors and Executive Directors are set out in the lead roles descriptions held by the Group Company Secretary.

Retained Lead Roles:

- Maternity Board Safety Champion (NED)
- Wellbeing Guardian (NED)
- Freedom to Speak Up Guardian (NED)
- Doctors Disciplinary Lead (NED)
- Security Management Lead (NED)

Lead Sponsor Roles:

- Senior Independent Director (SID) (NED)
- Deputy to the Trust Board Chair (NED)
- Remuneration Committee Chair (NED)
- Joint Committee Deputy Chair (NED)

Other Lead Roles Identified and Agreed by the Trust:

- Green Plan Lead (NED)
- Mental Health Lead (NED)

5. Meetings of the Trust

5.1 Calling meetings

(1) Ordinary public meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.
(2) The Chair of the Trust may call a meeting of the Board at any time.
(3) One third or more members of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

5.2 Notice of Meetings and the Business to be transacted

(1) Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every member via the authorised electronic Board Papers system (ibabs Board Papers), so as to be available to members at least three working days before the meeting. The notice shall be signed by the Chair or by an officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any member shall not affect the validity of a meeting.

(2) In the case of a meeting called by members in default of the Chair calling the meeting, the notice shall be signed by those members.

(3) No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 5.6.

(4) A member desiring a matter to be included on an agenda shall make his / her request in writing to the Chair at least sufficient advance (no less than 4 working days) before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 4 working days before a meeting may be included on the agenda at the discretion of the Chair.

(5) Before each public meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's principal offices at least three working days before the meeting, [required by the Public Bodies [Admission to Meetings] Act 1960 Section 1 [4] [a]] and published on the Trust website or equivalent

5.3 Agenda and Supporting Papers

The agenda will be available to members at least 3 working days before the meeting together with supporting papers, whenever possible, shall accompany the agenda but will certainly be available no later than 3 working days before the meeting, save in emergency.

5.4 Petitions

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

5.5 Notice of Motion

(1) Subject to the provisions of Standing Orders 5.2 to 5.8 inclusive a member of the Board wishing to move a motion shall send a written notice to the Chief Executive Officer who will ensure that it is brought to the immediate attention of the Chair.

(2) The notice shall be delivered at least l0 working days before the meeting. The Chief Executive Officer shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

5.6 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 5.6 a member of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

5.7 Motions: Procedure at and during a meeting

(1) Who may propose

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

(2) Contents of motions

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

- the receipt of a report
- consideration of any item of business before the Trust Board
- the accuracy of minutes
- that the Board proceed to next business
- that the Board adjourns
- that the question be now put.

(3) Amendments to motions

- A motion for amendment shall not be discussed unless it has been proposed and seconded.
- Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board.
- If there are several amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

(4) Rights of reply to motions

a] Amendments

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

b] Substantive / original motion

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

(5) Withdrawing a motion

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

(6) Motions once under debate

When a motion is under debate, no motion may be moved other than: an amendment to the motion

- the adjournment of the discussion, or the meeting
- that the meeting proceeds to the next business
- that the question should be now put
- the appointment of an 'ad hoc' committee to deal with a specific item of business
- that a member / director be not further heard
- a motion under Section I [2] or Section I [8] of the Public Bodies [Admissions to Meetings] Act l960 resolving to exclude the public, including the press [see Standing Order 5.17].

(7) In those cases where the motion is either ‘that the meeting proceeds to the next business’ or ‘that the question be now put’ in the interests of objectivity these should only be put forward by a member of the Board who has not

taken part in the debate and who is eligible to vote.

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

5.8 Motion to Rescind a Resolution

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

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

5.9 Chair of meeting

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

(2) If the Chair and Deputy-Chair are absent, such member [who is not also an executive member of the Trust] as the members present shall choose shall preside.

5.10 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy, and regularity [including procedure on handling motions] and on interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

5.11 Quorum

(1) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members [including at least one member who is also an executive member of the Trust and one member who is not] is present.

(2) An officer in attendance for an executive member, but without formal acting up status may not count towards the quorum.

(3) If the Chair or member has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of a declaration of a conflict of interest [see SO No.9.1 to 9.4 inclusive] that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5.12 Voting

(1) Save as provided in Standing Orders 5.l3 - Suspension of Standing Orders and 5.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of members present and voting on the question. In the case of an equal vote, the person presiding [i.e.: the Chair of the meeting] shall have a second, and casting vote.

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

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

(4) If a member so requests, his / her vote shall be recorded by name.

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

(6) A manager who has been formally appointed to act up for an executive member during a period of incapacity or temporarily to fill a vacancy shall be entitled to exercise the voting rights of the executive member.

(7) A manager attending the Trust Board meeting to represent an executive member during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive member. An officer's status when attending a meeting shall be recorded in the minutes.

(8) For the voting rules relating to joint members see Standing Order 4.5.1 and 4.5.2.

5.13 Suspension of Standing Orders

(1) Except where this would contravene any statutory provision or any direction made by the Secretary of State or the rules relating to the Quorum [SO 5.11], any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the members of the Board are present [including at least one member who is an executive member of the Trust and one member who is not] and that at least two-thirds of those members present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

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

(3) No formal business may be transacted while Standing Orders are suspended.

(4) The Audit Committee shall review every decision to suspend Standing Orders.

5.14 Variation and amendment of Standing Orders

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

- upon a notice of motion under Standing Order 5.5
- upon a recommendation of the Chair or Chief Executive Officer included on the agenda for the meeting
- that two thirds of the Board members are present at the meeting where the variation or amendment is being discussed, and that at least half of the Trust's non-executive members vote in favour of the amendment

- providing that any variation or amendment does not contravene a statutory provision or direction made by the Secretary of State
- where periodic updates are required that do not change the circumstances of the Establishment Order or Secretary of State provision above.

5.15 Record of Attendance

The names of the Chair and Directors/members present at the meeting shall be recorded.

5.16 Minutes

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

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

5.17 Admission of public and the press

The public and press representatives may attend the meeting of the Board held in public. It is important to note the difference between a Board meeting held in public and a public meeting. In this case attendees not members of the Board are expected to observe only and if they have any questions or contributions relating to the business to be transacted that they provide these in advance to the Group Company Secretary as per the requirements published with the Board papers.

The Code of Governance for NHS Provider Trusts provides additional principles, guidance, and details in respect of the leadership of the Board and the role of the Chair, and these Standing Orders should be read in conjunction.

(1) Admission and exclusion on grounds of confidentiality of business to be transacted

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

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

(2) General disturbances

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

`That in the interests of public order the meeting adjourn for [the period to be specified] to enable the Board to complete its business without the presence

of the public'. Section 1[8] Public Bodies [Admissions to Meetings] Act l960.

(3) Business proposed to be transacted when the press and public have been excluded from a meeting

Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in [i] and [ii] above, shall be confidential to the members of the Board. Members and officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

(4) Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

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

Where a meeting is conducted in public, and a recording is made this will only be referred to for the production of the minutes. It may be placed in the public domain subject to the approval of the Board.

Otherwise, recordings are only permitted for reference in the creation of the draft minutes. Once the minutes are approved the recording must be deleted. The approved minutes are regarded as the definitive record.

(5) **Virtual Meetings**

Where circumstances do not allow for attendees in person, participation and observation to the public section will be made available on application to the Group Company Secretary. Virtual attendance to the confidential section will be by application to the Group Company Secretary and agreement of the Chair.

Virtual meetings will be maintained whilst restrictions prevent face-to-face meetings in person until such time as the restrictions are lifted. Virtual attendance will continue to be made available thereafter by application.

5.18 Observers at Trust meetings

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

6. Appointment of Committees and Sub-Committees

6.1 Appointment of Committees

(1) Subject to such directions as may be given by the Secretary of State for Health, the Board may appoint committees of the Trust.

(2) The Trust shall determine the membership and terms of reference of

committees and sub-committees and shall, if it requires, receive, and consider reports of such committees.

6.2 Joint Committees

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

(2) Any committee or joint committee appointed under this Standing Order may, subject to such directions as may be given by the Secretary of State or the Trust or other health bodies in question, appoint sub-committees/groups consisting wholly or partly of members of the committees or joint committee [whether or not they are members of the Trust or health bodies in question] or wholly of persons who are not members of the Trust or health bodies in question or the committee of the Trust or health bodies in question.

(3) The Board can under this Standing Order and in line with the directions of the Secretary of State, delegate specific hours duties and responsibility to the joint committee on behalf of the Sovereign Organisation. Such delegation is not in perpetuity and can be ended or withdrawn by the Board at any time.

(4) The Code of Governance for NHS Provider Trusts (2023) sets out further principles and expectations regarding partnerships, collaborations, joint committees, and cooperation with other NHS Organisations including the Integrated Care System(s) and Place Based Partnerships.

6.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

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

6.4 Terms of Reference

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

6.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees, they may not delegate executive powers to the sub-committee unless expressly and specifically authorized by the Board.

6.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board as defined by the Secretary of State. The Board shall define the powers of such appointees and

shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.7 Appointments for Statutory functions

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

6.8 Committees established by the Trust Board

The committees, sub-committees, and joint committees established by the Board are:

(1) Audit Committee

In line with the requirements of the NHS Audit Committee Handbook, NHS Code of Governance, and the Higgs report, an Audit Committee will be established and constituted to provide the Board with an independent and objective review on its financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS. The Terms of Reference will be approved by the Trust Board and reviewed on a periodic basis.

(2) Remuneration (and Terms of Service) Committee

In line with the requirements of the NHS Code of Governance, and the Higgs report, a Remuneration Committee will be established and constituted.

The purpose of the Committee will be to advise the Board about appropriate remuneration and terms of service for the Chief Executive Officer and other Executive Directors.

In line with the Code of Governance for NHS Provider Trusts (2023) based on the Financial Reporting Council (FRC) UK Corporate Governance Code (2018) (Provision 32) and the FRC Board Effectiveness Guidance Provisions (2018) the Committee should have a minimum membership of 3 voting NED's, the Chair should not Chair the Committee, and the Committee Chair should have at least 12 months prior experience as a member of the Remuneration Committee.

The Committee may ask the Senior Independent Director (SID) or the Chair of Audit Committee to not be part of the Remuneration Committee to be available in their independent role should the need arise.

The Annual Report should describe the work of the Committee including descriptions of:

- The process for appointments
- Its approach to succession planning
- How both above support diversity
- How the Board has been evaluated including any external input and resulting outcomes and action taken including any that will influence the Board composition
- How it enacts the Trust policy on diversity and inclusion including all characteristics
- A breakdown of the ethnic diversity of the Board and senior managers as per the NHS Workforce Race Equality Standard (WRES) alongside the ethnic diversity of the Trust workforce and local communities served

- The gender balance of senior management and their direct reports

(3) Charity Committee

In line with its role as a corporate trustee for charitable funds held in trust, the Board will establish a Charity Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission.

(4) Other Committees

The Board may also establish such other committees as required to discharge the Trust's responsibilities. These are:

- Quality Committee of the Board
- Finance and Productivity Committee of the Board
- People Committee of the Board
- Joint Provider Committee of the Board
- Integration Committee of the Board

Trust Management Committee is the senior operational decision-making committee reporting via the executive group to the Board.

7. Arrangements for the Exercise of Trust Functions by Delegation

7.1 Delegation of Functions to Committees, Officers, or other bodies

(1) Subject to such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee or sub-committee appointed by virtue of Standing Order 7.1, 7.3 and 7.5, or by an officer of the Trust, or by another body as defined in Standing Order 7.4 or 7.5 below, in each case subject to such restrictions and conditions as the Trust thinks fit.

(2) Section 16B of the NHS Act 1977 allows for regulations to provide for the functions of Trusts to be carried out by third parties. In accordance with The Trust [Membership, Procedure and Administration Arrangements] Regulations 2000 the functions of the Trust may also be carried out in the following ways:

- by another Trust
- jointly with any one or more of the following: NHS trusts or ICS
- by arrangement with the appropriate Trust or ICS, by a joint committee or joint sub-committee of the Trust and one or more other health service bodies.

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

7.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders [see Standing Order 7.2] may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair [or in his/her absence the Deputy-Chair]. The exercise of such powers by the Group Chief Executive Officer and Chair shall be reported to the next formal meeting of the Board in public session for formal ratification.

7.3 Delegation to Committees

(1) The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, or joint- committees, which it has formally constituted in accordance with directions issued by the Secretary of State. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board.

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

(3) In line with the Code of Governance for NHS Provider Trusts (2023) the terms of reference for Committees shall be approved at Public Board Meeting and thereby made available to the public.

7.4 Delegation to Officers

(1) Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint committee shall be exercised on behalf of the Trust by the Chief Executive Officer. The Chief Executive Officer shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Trust.

(2) The Chief Executive Officer shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive Officer may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

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

7.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

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

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

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

8. Overlap with other Trust Strategy and Policy Statements / Procedures, Regulations and the Standing Financial Instructions

8.1 Strategy and Policy statements: general principles

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

- In line with the Trust Policy for the creation of Policy (OP01), the Trust Board sets out the Strategic Direction of and for the Trust. All component Strategic Documents must be in accordance with and aligned to the Trust Strategic Objectives.
- The Trust Board is the approving body for all Trust Strategy documents.
- The approval of Trust-wide Policy documents is delegated to the Trust Management Committee.

8.2 Standing Financial Instructions

Standing Financial Instructions adopted by the Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

8.3 Specific guidance

Notwithstanding the application of SO 8.2 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000
- The NHS Code of Governance for NHS Provider Trusts (2023)
- The Fit and Proper Persons Guidance (2023)

9. Duties and Obligations of Board Members/Directors and Senior Managers under these Standing Orders

9.1 Declaration of Interests

Requirements for Declaring Interests and applicability to Board Members

(1) The NHS Code of Governance for NHS Provider Trusts (2023) requires Board members to declare interests which are relevant and material to the NHS Board of which they are a member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment. The Code of Governance provides further detail in section B – Conflicts of Interest and appointments on those matters considered to potentially impair a non-executive directors independence and that should therefore be considered as part of the recruitment process, must be declared on the public register, and must be reconsidered and reviewed at appraisal.

(2) Interests which are relevant and material

Interests that should be regarded as "relevant and material" are:

- Directorships, including non-executive directorships held in private companies or PLCs [except for those of dormant companies]
- Ownership or part-ownership of private companies, businesses, or consultancies likely or possibly seeking to do business with the NHS

- Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or voluntary organisation in the field of health and social care.
- Any connection with a voluntary or other organisation contracting for NHS services.
- Research funding/grants that may be received by an individual or his / her department.
- Interests in pooled funds that are under separate management.
- An employee of the organisation within the last two years.
- Has had or been part of a material business relationship with the Trust directly or indirectly.
- Has received remuneration other than their directors fee, of participates in any performance related pay scheme or is a member of the Trust's pension scheme.
- Has close family ties with any of the Trust's advisors, directors or senior employees.
- Holds cross directorships or has significant links with other directors for involvement with other companies or bodies – in any such cases written permission must be sought and gained from the Chair (non-executive directors) or the CEO (executive directors and senior staff) before taking up any of these potentially conflicting roles.
- Has served on the Trust Board for more than six years from the date of their first appointment – Please note Chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval.
- The Code of Governance specifies Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment and subject to the proviso above or anything in excess of six years. This can in special cases be extended beyond nine years for a limited time only where agreed with NHS England.
- For these purposes a Non-Executive Director becoming Chair will reset the start of their term.
- Is an appointed representative of the Trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the Board of Directors none the less considers a Non-Executive Director to be independent, has to be able to explain clearly why. (Please see relevant section of Code of Governance).

(3) Any member of the Board who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him / her [as defined in Standing Order 9.1 below and elsewhere] has any pecuniary interest, direct or indirect, the Board member shall declare his / her interest by giving notice in writing of such fact to the Trust as soon as practicable.

(4) Advice on Interests
If Board members have any doubt about the relevance of an interest, this should be discussed with the Chair or the Group Chief Executive Officer of the Trust and with the advice of the Group Company Secretary

(5) Financial Reporting Standard No 8 [issued by the Accounting Standards

Board] specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

(6) Recording of Interests in Board minutes
At the time Board members' interests are declared, they should be recorded in the Board minutes.

(7) Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

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

(9) Conflicts of interest which arise during a meeting
During a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision. [See overlap with SO 3.3.2]

(10) Any potential or actual Conflicts of Interest must be dealt with in line with the Trust Conflicts of Interest Policy OP109 and the Trust Anti-Fraud and Anti-Bribery Policy GP02.

9.2 Register of Interests

The Group Company Secretary on behalf of the Chief Executive Officer will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee members. The Register will include details of all directorships and other relevant and material interests [as defined in SO 9.3] which have been declared by both executive and non-executive Board members.

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

(2) The Register will be available to the public and the Chief Executive Officer will take reasonable steps to bring the existence of the Register to the attention of residents and to publicise arrangements for viewing it.

9.3 Pecuniary Interest

(1) Definition of terms used in interpreting 'Pecuniary' interest
For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

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

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

(4) "Pecuniary interest"

(5) Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if

- they, or a nominee of them, is a member of a company or other body [not being a public body], with which the contract is made, or to be

made or which has a direct pecuniary interest in the same, or

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

(6) Exception to Pecuniary interests

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

- neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or
- any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or
- those securities of any company in which they [or any person connected with him / her] has a beneficial interest do not exceed
- £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.
- Provided however, that where paragraph [c] above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 9.1.

(7) Exclusion in proceedings of the Trust Board

- Subject to the following provisions of this Standing Order, if the Chair or a member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration. They shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him / her in the interests of the National Health Service that the disability should be removed. [See SO on the 'Waiver' which has been approved by the Secretary of State for Health].
- The Board may exclude the Chair or a member of the Board from a meeting of the Board while any contract, proposed contract, or other matter in which they have a pecuniary interest is under consideration.
- Any remuneration, compensation, or allowance payable to the Chair or a Member by virtue of paragraph 11 of Schedule 5A to the National Health Service Act 1977 [pay and allowances] shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- This Standing Order applies to a committee or sub-committee and to a joint committee or sub-committee as it applies to the Trust and applies to a member of any such committee or sub-committee [whether or not they are also a member of the Trust] as it applies to a member of the Trust.

(8) Waiver of Standing Orders made by the Secretary of State for Health

(9) Power of the Secretary of State to make waivers

- Under regulation 11[2] of the NHS [Membership and Procedure Regulations SI 1999 / 2024 ["the Regulations"], there is a power for the Secretary of State to issue waivers if it appears to the Secretary of State in the interests of the health service that the disability in regulation 11 [which prevents a chair or a member from taking part in the consideration or discussion of, or voting on any question with respect to, a matter in which they have a pecuniary interest] is removed. A waiver has been agreed in line with sub-sections [2] to [4] below.

- Definition of 'Chair' for the purpose of interpreting this waiver
- For the purposes of paragraph 9.3.3[3] [below], the "relevant chair" is -

i. at a meeting of the Trust, the Chair of that Trust
ii. at a meeting of a committee
iii. in a case where the member in question is the Chair of that Committee, the Chair of the Trust
iv. in the case of any other member, the Chair of that Committee.

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

i. A member of the Trust who is a healthcare professional, within the meaning of regulation 5[5] of the Regulations, and who is providing or performing, or assisting in the provision or performance, of -
    1. services under the National Health Service Act 1977; or
    2. services in connection with a pilot scheme under the National Health Service Act 1997; for the benefit of persons for whom the Trust is responsible.

(11) Where the 'pecuniary interest' of the member in the matter which is the subject of consideration at a meeting at which they are present
i. arises by reason only of the member's role as such a professional providing or performing, or assisting in the provision or performance of, those services to those persons
ii. has been declared by the relevant chair as an interest which cannot reasonably be regarded as an interest more substantial than that of the majority of other persons who
    1. are members of the same profession as the member in question,
    2. are providing or performing, or assisting in the provision or performance of, such of those services as they provide or performs, or assists in the provision or performance of, for the benefit of persons for whom the Trust is responsible.

(12) Conditions which apply to the waiver and the removal of having a pecuniary interest
i. The removal is subject to the following conditions:

ii. the member must disclose his / her interest as soon as practicable after the commencement of the meeting and this must be recorded in the minutes
iii. the relevant Chair must consult the Chief Executive Officer before making a declaration in relation to the member in question pursuant to paragraph 11.3.3 [2] [b] above, except where that member is the Chief Executive Officer
iv. in the case of a meeting of the Trust:

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

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

9.4 Standards of Business Conduct

(1) Trust Policy and National Guidance

All Trust staff and members must comply with the national guidance contained in HSG[93]5 on 'Standards of Business Conduct for NHS Staff' and with any Trust policy derived therefrom and the subsequent requirements of the Code of Conduct in the NHS published by the Department of Health and Social Care in July 2004 and The Code of Governance (2023)y and the Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England issued by the Professional Standards Authority in November 2013, and the subsequent additional guidance published alongside the Code of Governance for NHS Provider Trusts (2023)as summarised in Trust Policy GP01 Corporate Governance – Principles of Public Life and the FPPT (2023).

(2) Interest of Officers in Contracts

i. Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which they or any person connected with him/her [as defined in SO 9.4.2.1] has any pecuniary interest, direct or indirect, the officer shall declare his/her interest by giving notice in writing of such fact to the Chief Executive Officer as soon as practicable.

ii. An officer should also declare to the Chief Executive Officer any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

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

iv. Senior Officers subject to very senior manager (VSM) after 2022 contracted terms and conditions must seek and gain in writing the CEO's permission before taking up a new declarable interest (as defined in these standing orders and Trust policy OP109).

(3) Canvassing of and Recommendations by Members in Relation to Appointments

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

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

(4) Relatives of Members or Officers

i. Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any member or the holder of any office under the Trust.

ii. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him / her liable to instant dismissal.

iii. The Chair and every member and officer of the Trust shall disclose to the Board any relationship between himself/herself and a candidate of whose candidature that member or officer is aware. It shall be the duty of the Chief Executive Officer to report to the Board any such disclosure made.

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

v. Where the relationship to a member of the Trust is disclosed, the Standing Order headed 'Disability of Chair and members in proceedings on account of pecuniary interest' [SO 9.3.7] shall apply.

9.5 Custody of Seal, Sealing of Documents and Signature of Documents

9.6 Custody of Seal

The common seal of the Trust shall be kept in a secure place by the Chief Executive Officer, or a manager nominated by him/her – currently the Trust Chief Financial Officer.

9.7 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Chair and an executive member and shall be attested by them.

9.8 Register of Sealing

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

9.9 Signature of documents

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

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

9.10 Issuing Standing Orders to Directors and Officers

The Chief Executive Officer shall ensure that a copy of the Standing Orders is provided to each Director of the Trust and to appropriate officers. All new appointees should be notified of, and understand, their responsibilities under both Standing Orders and Standing Financial Instructions.

10. Partnership Agreements

The Trust has established a process for the approval of Partnership Agreements (see OP09, Corporate Policy and Framework for the Governance of Partnership Agreements) The Board shall be considered the approving body for any proposed partnership agreements. Any agreements approved will be placed on the Partnership Agreements Register by the Company Secretary. The Trust Board will ensure that the register is reviewed at least annually.

References:

Code of governance for NHS provider trusts - https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

Appendix 1:

For Standing Orders.
Overview of those at Trust Board.

Membership & expected attendance	Required roles	Required other roles (**Includes)
Trust Board Executive Members (Voting and non-voting) required to be in attendance	• Chair • Group Chief Executive Officer • Voting Non-Executive Directors (6 excluding Chair) • Voting Executive Directors (4 + CEO)*	*Voting Executive Directors comprising: • Chief Operating Officer • Chief Medical Officer • Group Chief Finance Officer • Chief Nursing Officer Non-Voting Executive Directors comprising: • Group Chief Medical Officer • Group Chief People Officer • Group Chief Strategy Officer
Board Director Member (non-voting) required to be in attendance	• Associate Non-executive Directors • Group Company Secretary	**Comprising: • Director(s) of Finance • Director of Midwifery • Director of Nursing • Director(s) of People • Group Director of Assurance • Group Director of Communications and Stakeholder Engagement • Group Director of Place
Directors and others required to be in attendance for specific items		Potentially including (but not exclusive): • Group Chief Technology Officer • Group Director of Research • Group Director of Education • Group Head of Safeguarding • Group Director of Estates Development • Director of Infection Prevention and Control (DIPC) • Clinical Director of Pharmacy & Medicines Optimisation • Director of Infection Prevention • Freedom to Speak Up Guardian
Others as required/appropriate		

THE ROYAL WOLVERHAMPTON NHS TRUST

STANDING FINANCIAL INSTRUCTIONS

December 2023

Document Control

Name: Standing Financial Instructions	**Version:** V8 December 2022		**Status:** Final	**Author: Head of Financial Governance and Transactions** **Director Sponsor: Chief Financial Officer**
Version / Amendment History	Version	Date	Author	Reason
	V1	December 2010	Deputy Chief Financial Officer	Initial document
	V2	June 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN;
	V3	September 2014	Deputy Chief Financial Officer	Update of limits for West Midlands CRN; certain payroll documents; and Capital Business Case approval limits
	V4	March 2015	Deputy Chief Financial Officer	Update to Appendix A – Authorised Limits
	V5	May 2017	Financial Controller	Update to Appendix A – Authorised Limits
	V6	April 2019	Head of Financial Control & Assurance	Review by Head of Financial Control & Assurance including updates to job titles, inclusion of document control and general relevant update Update to Appendix A – Authorised Limits
	V7	November 2021	Deputy Chief Finance Officer	Scheduled review of policy
	V8	December 2022	Head of Financial Governance and Transactions	Update to Appendix A – Authorised Limits
	V9	December 2023	Head of Financial Governance and Transactions	Review by Head of Financial Governance and Transactions including updates to job titles, inclusion of document control and general relevant update

				Update to Appendix A – Authorised Limits

Intended Recipients:

This policy will apply to all persons employed by The Royal Wolverhampton NHS Trust. This incorporates community, acute staff, employees from other health or social care providers, educational establishments, volunteers, private contractors, agency workers working within Trust premises.

Consultation Group / Role Titles and Date: Company Secretary; Finance and Productivity Committee, Audit Committee, Chief Financial Officer, Operational Director of Finance, Deputy Chief Financial Officer.

Name and date of Trust level group where reviewed	Audit Committee December 2023 Trust Policy Group February 2024
Name and date of final approval committee	Trust Board February 2024
Date of Policy issue	February 2024
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	February 2025 annually

Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.

To be read in conjunction with: Standing Orders, Scheme of Reservation and Delegation, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy

Initial Equality Impact Assessment (all policies): **Completed Yes**

Full Equality Impact assessment (as required): **Completed NA**

If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.

Contact for Review	Head of Financial Governance and Transactions
Implementation plan / arrangements (Name implementation lead)	Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board

Document summary / key issues covered:

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

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

All directors and all members of staff should be aware of the existence of these documents and be familiar with all relevant provisions. These rules fulfil the dual role of protecting the Trust's interests and protecting the staff from any possible accusation that they have acted improperly.

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendment.

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STANDING FINANCIAL INSTRUCTIONS

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STANDING FINANCIAL INSTRUCTIONS

1. INTRODUCTION

1.1 General

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

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

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and any constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Chief Financial Officer/Operational Director of Finance.**

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer/Operational Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.1.5 The failure to comply with SFIs and SOs can in certain circumstances be regarded as a disciplinary matter.

1.1.6 If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported by the Chief Financial Officer/Operational Director of Finance to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Financial Officer/Operational Director of Finance as soon as possible.

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

1.2 Responsibilities and Delegation

1.2.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy and agreeing the long term financial model;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

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

(d) defining specific responsibilities placed on members of the Board and employees

as indicated in the Scheme of Reservation and Delegation document.

(e) The Board has resolved that certain powers and decisions may only be exercised by the Board in a formal session. These are set out in the Scheme of Reservation and Delegation and SOs.

The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Reservation and Delegation document adopted by the Trust.

1.2.2 The Chief Executive and Chief Financial Officer/Operational Director of Finance

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

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

1.2.3 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

1.2.4 The Chief Financial Officer/Operational Director of Finance

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

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

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

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

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

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

(a) the provision of financial advice to other members of the Board and employees.

(b) the design, implementation and supervision of systems of internal financial control.

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

1.2.5 Board Members and Employees

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

(a) the security of the property of the Trust.

(b) avoiding loss.

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

(d) conforming with the requirements of SOs, SFIs, Financial Procedures and the Scheme of Reservation and Delegation.

1.2.6 Contractors and their Employees

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

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

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with SOs, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services.

(b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

(c) review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisations activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

(d) monitoring compliance with SOs and SFIs.

(e) reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally this may need to be referred to NHS England and the Department of Health and Social Care, but this should be via the Trust Chief Financial Officer/Operational Director of Finance in the first instance.

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

2.1.4 The Local Accountability and Audit Act 2014 and The Local Audit (Health Services Bodies Auditor Panel and Independence) Regulations 2015 require the Trust to appoint external auditors. Audit Committee will ensure the Trust appoints external auditors.

2.1.5 Matters pertaining to fraud, bribery and/or corruption must be reported to the LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy.

2.2 Chief Financial Officer/Operational Director of Finance:

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

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function.

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards.

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

(d) ensuring that an annual internal audit report is prepared by the Internal Audit service provider for the consideration of the Audit Committee. The report must include:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;

(ii) major internal financial control weaknesses discovered.

(iii) progress on the implementation of internal audit recommendations.

(iv) progress against plan over the previous year.

(v) strategic audit plan covering the coming three years.

(vi) a detailed plan for the coming year.

2.2.2 The Chief Financial Officer/Operational Director of Finance, designated auditors, or LCFS are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

(b) access at all reasonable times to any land, premises, members of the Board or employees of the Trust.

(c) the production of any cash, stores or other property of the Trust under the control of any member of the Board or an employee's control; and

(d) explanations concerning any matter under investigation.

2.2.3 The Trust's Chief Executive and Chief Financial Officer/Operational Director of Finance are responsible for ensuring access rights are given to NHS Counter Fraud Authority (CFA) where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with the Government Functional Standard 013: Counter Fraud.

2.3 Role of Internal Audit and Counter Fraud

2.3.1 The purpose and objectives of the Internal Audit service provider are to review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures.

(b) the adequacy and application of financial and other related management controls.

(c) the suitability of financial and other related management data.

(d) the efficient and effective use of resources.

(e) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences.
(ii) waste, extravagance, inefficient administration.
(iii) poor value for money or other causes.
(iv) Any form of risk, especially business and financial risk but not exclusively so.

(f) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health and Social Care.

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

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

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

2.3.5 Internal Audit terms of reference shall have effect as if incorporated within these SFIs. The terms of reference cover the scope of the internal audit work, authority and independence, management responsibilities, coordination of assurance work, reporting and key outputs and the operational responsibilities.

2.4 External Audit

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

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Chief Financial Officer/Operational Director of Finance shall monitor and ensure compliance with the Government Functional Standard 013: Counter Fraud on fraud and corruption as specified in the NHS Tackling Fraud, Bribery & Corruption Policy & Corporate

procedures.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist and shall work with staff in NHS Counter Fraud Authority in accordance with the guidance issued by NHS Counter Fraud Authority.

2.5.3 The LCFS shall report to the Trust Chief Financial Officer/Operational Director of Finance and shall work with staff in the NHS Counter Fraud Authority in accordance with guidance issued by NHS Counter Fraud Authority.

2.5.4 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust.

2.5.5 The Local Counter Fraud Specialist will complete the annual Counter Fraud Functional Standard Return (CFFSR), which reviews the Trust's compliance against the Government Functional Standard 013: Counter Fraud. Any non or partial compliance against the standards will be reported to the Chief Financial Officer/Operational Director of Finance and Audit Committee, and action plans will be put in place with the aim of developing the level of compliance.

2.6 Security Management

2.6.1 In line with his/her responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health and Social Care guidance on NHS security management.

3. PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(i) A statement of the significant assumptions on which plan is based.

(ii) Details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Chief Financial Officer/Operational Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the Trust's aims and objectives set out in the Trust's business plan and its long-term financial model.

(b) accord with financial and other targets, and with workload and manpower plans.

(c) be produced following discussion with appropriate budget holders.

(d) be prepared within the limits of available funds.

(e) identify potential risks.

3.1.3 The Chief Financial Officer/Operational Director of Finance shall monitor financial

performance against budget and business plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Chief Financial Officer/Operational Director of Finance to enable budgets to be compiled and financial performance against budgets to be monitored.

3.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Chief Financial Officer/Operational Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget.

(b) the purpose(s) of each budget heading.

(c) individual and group responsibilities.

(d) authority to exercise virement.

(e) achievement of planned levels of service; and

(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring expenditure or income budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Financial Officer.

3.3 Budgetary Control and Reporting

3.3.1 The Chief Financial Officer/Operational Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) movements in working-capital.

(iii) movements in cash and capital.

(iv) capital projects spend and projected outturn against plan.

(v) explanations of any material variances from plan.

(vi) details of any corrective action where necessary and the chief Executive's and/or Chief Financial Officer/Operational Director of Finance view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) investigation and reporting of variances from financial, workload and manpower budgets.

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each budget holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the appropriate authorisation;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement.

(c) no permanent employees are appointed without the appropriate approval other than those provided for within the available resources and manpower establishment.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of a balanced budget.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contracting Procedures.

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organization in accordance with the prescribed deadlines.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Chief Financial Officer/Operational Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS).

(b) prepare and submit annual financial reports to the Department of Health and Social Care and NHS England certified in accordance with current guidelines.

(c) submit financial returns to the Department of Health and Social Care for each financial year in accordance with the timetable prescribed by the Department of Health and Social Care.

4.2 The Trust's Annual Report, Annual Accounts and financial returns to NHS England must be audited by an external auditor appointed by the Audit Committee in accordance with appropriate International Accounting Standards.

4.3 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors or by the Audit Committee (when specially delegated power to do so, under the authority of the Board).

4.4 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the Chief Financial Officer/Operational Director of Finance.

4.5 The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual report and accounts (including the auditor's report) will be published and presented to the public Annual General Meeting (typically before or round the end of September) (or earlier if specified by NHS England) each year and made available to the public for public inspection at the Trust's Headquarters and made available on the Trust's website.

4.6 The Chief Nursing Officer will prepare the Annual Quality Report in the format prescribed by NHS England/Care Quality Commission and in accordance with DHSC General Accounting Manual. The Quality report presents a balanced picture of the Trust's performance over the financial year and up to the agreed submission date.

4.7 The Chief Executive and Chairman shall sign off the "Statement of Directors' Responsibilities in Respect of the Quality Report" under the Health Act 2009 and the NHS (Quality Accounts) Regulations 2010.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Chief Financial Officer/Operational Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/Directions issued from time to time by the Department of Health and Social Care.

5.1.2 The Board will review and approve the banking arrangements as specified by the Department of Health and Social Care.

5.2 Bank and GBS Accounts

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

(a) establishing separate bank accounts for the Trust's non-exchequer funds/charitable funds.

(b) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made.

(c) reporting to the Board all arrangements and instances where the bank accounts become or may have become overdrawn, and the arrangements made with the Trust's bankers.

(d) monitoring compliance with DHSC guidance on the level of cleared funds.

(e) ensuring covenants attached to bank borrowing are adhered to.

5.3 Banking Procedures

5.3.1 The Chief Financial Officer/Operational Director of Finance will prepare detailed instructions on the operation of all Trust bank accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated, including the overdraft limit if applicable.

(b) those authorised to approve payments, bank transfers, sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Chief Financial Officer/Operational Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No-one but the Chief Financial Officer/Operational Director of Finance shall open a bank account in the name of the Trust.

5.4 Tendering and Review

5.4.1 The Chief Financial Officer/Operational Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money.

5.5 External Borrowing

5.5.1 The Chief Financial Officer/Operational Director of Finance will advise the Board concerning the Trusts ability to pay dividend on and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health and Social Care. The Chief Financial Officer/Operational Director of Finance is also responsible for reporting periodically to the Board concerning the public dividend capital (PDC) debt and all loans and overdrafts.

5.5.2 Any application for a loan or overdraft will only be made by the Chief Financial Officer/Operational Director of Finance or by an employee so delegated by them.

5.5.3 The Chief Financial Officer/Operational Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.5.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing required must be authorised by the Chief Financial Officer/Operational Director of Finance.

5.5.5 All long-term borrowing must be consistent with the plans outlines in the current approved financial plan as reported to the Department of Health and Social Care.

5.6 Investments

5.6.1 Temporary cash surpluses must only be held in such investments as authorised by the Department of Health and Social Care and authorised by the Board.

5.6.2 The Chief Financial Officer/Operational Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance and investments held.

5.6.3 The Chief Financial Officer/Operational Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Chief Financial Officer/Operational Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Chief Financial Officer/Operational Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall comply with any Department of Health and Social Care advice in setting prices for service agreements.

6.2.2 The Chief Financial Officer/Operational Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical Standards in the NHS shall be followed.

6.2.3 All employees must inform the Chief Financial Officer/Operational Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions in order to facilitate the timely raising of invoices and collection of debt.

6.2.4 Under no circumstances will the Trust accept cash payments in any currency in excess of £15,000 in respect of any single transaction or series of transactions which appear to be linked. Any attempts by an individual to effect payment above this amount should be notified immediately to |'the Chief Financial Officer/Operational Director of Finance.

6.3 Debt Recovery

6.3.1 The Chief Financial Officer/Operational Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 The Chief Financial Officer/Operational Director of Finance is responsible for ensuring systems are in place to prevent overpayments. Where overpayment occurs systems should be in place for their detection and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

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

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

(b) ordering and securely controlling any such stationery.

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, payable orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.5 Free of Charge/Donated Goods/Services

6.5.1 Free of charge or donated goods or equipment from any supplier or would be supplier to the Trust must not be used to avoid the procurement regulations.

6.5.2 A budget manager or budget holder must approve in writing the acceptance of such goods or services prior to delivery. If the goods are to be donated or accepted on loan, whether for service provision or testing, before such approval may be given:

(a) an official order number must be allocated if the acquisition by this method is part of a procurement process by the Trust;

(b) the owner must provide a written indemnity to the Trust, in a form approved by the Trust Company Secretary, which will be signed, if necessary, on the Trusts behalf by the Chief Executive or an officer authorised by the Chief Executive;

(c) responsibility for maintenance and other revenue consequences must be agreed in writing and must be approved in accordance with these SFIs.

6.5.3 The acceptance of any such goods or services must be confirmed in writing to the donor/owner and, except in the case of charitable donations, such confirmation shall include a notice that the acceptance does not amount to an express or implied obligation on the Trust to continue to use the goods/services or to purchase any goods/services.

6.5.4 The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded purchase.

6.5.5 Where there are revenue consequences arising out of the donation of any asset then the donation shall not be accepted or put into use until a budget has been agreed with the Chief Financial Officer/Operational Director of Finance in respect of the revenue consequences.

6.6 Payment in Kind to the Trust

6.6.1 A budget manager or holder may authorise the provision by the Trust of services to third parties in return for payments in kind provided:

(a) the value received is reasonably commensurate with the value given.

(b) the arrangement is confirmed in writing to the third party under the signature of a budget manager or budget holder and a copy retained.

(c) the confirmation includes a notice that the Trust reserves the right to joint ownership on terms to be agreed or fixed by arbitration of any intellectual property arising from the collaboration between the Trust and the third party.

(d) the confirmation includes a notice that the arrangement does not bind the Trust to continue any collaboration on the terms agreed or to purchase / use the benefits of any collaboration.

7. TENDERING AND CONTRACTING

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

7.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where Standing Order No. 5.13 Suspension of SOs is applied).

7.1.2 In particular, directors and officers should be aware of the definition of “pecuniary interest” as set out in Standing Order 9.3. Directors and/or officers with a pecuniary interest in a contract or potential contract should declare any such interest to the Chief Executive and should not participate in any process (including any evaluation) associated with the award of the contract.

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in SOs Orders and SFIs.

7.3 e-Tendering

The Trust should have policies and procedures in place for the control of all tendering activity carried out using an e-tendering system, this will incorporate reverse auction processes.

7.4 Capital Investment Manual and other Department of Health and Social Care Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care "Capital Investment Manual" and “Estate code” in respect of capital investment and estate and property transactions.

7.4.1 Management Consultancy

In the case of management consultancy contracts the Trust is required to seek prior approval from NHSE and shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and guidance from NHS England.

7.5 Formal Competitive Tendering

7.5.1 General Applicability

Except where identified under 7.5.3 below, the Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles.

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC). Prior approval from NHSE is required for Management Consultancy before engaging.

(c) the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens).

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure and should be read in conjunction with Standing Financial Instruction No. 8.

7.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated total expenditure or income does not, or is not reasonably expected to, exceed £50,000.

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with.

(c) regarding disposals as set out in SFIs No. 7.13; Formal tendering

procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record.

(e) where the requirement is covered by an existing contract.

(f) where framework agreements are in place and have been approved by the procurement department.

(g) where a consortium purchasing arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members.

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender.

(i) where specialist expertise is required and is available from only one source.

(j) when the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate.

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering.

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and is generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.4 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Fair and Adequate Competition

Other than where the exceptions set out in this SFI apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer/Operational Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.2 List of Approved Firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Chief Financial Officer/Operational Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

For building and engineering construction works, invitations to tender shall be made only to firms included on the approved list of tenderers complied in accordance with this instruction or on the separate maintenance lists compiled in accordance with Estatecode guidance (Health Notice HN(78)147).

Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equality Act 2010 and any amending and/or related legislation.

Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. For building and engineering construction works, firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.6.3 Financial Standing and Technical Competence of Contractors

The Chief Financial Officer/Operational Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors.

The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.6.4 Exceptions to using Approved Contractors

If in the opinion of the Chief Executive and the Chief Financial Officer/Operational Director of Finance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.6.5 Invitation to tender

(i) All invitations to tender shall be exclusively submitted through the Trusts chosen e-tendering portal and will follow the protocols within the package. The e-tendering system must be compliant with HMG Security Policy to be used up to and including HM Government Information Security Impact Level Three (Restricted) supporting Risk Management Accreditation Document Set (RMADS).

(ii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iii) Every tender for building or engineering works (except for maintenance work, when Estate code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

7.6.6 Opening Tenders

(i) The e-tendering system must maintain a full audit trail registering expressions of interest prequalification invitations, clarification questions and responses, date of invitation to tender and closure and any late responses.

(ii) The e-tendering system will automatically reject incomplete tenders.

7.6.7 Admissibility

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(iii) Where only one tender is sought and/or received, the Chief Executive and Chief Financial Officer/Operational Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.8 Late Tenders

(i) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the Chief Executive is satisfied that there is no reason to doubt the bona fides of the tender concerned.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

7.6.9 Acceptance of Formal Tenders

Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. A report explaining any such reasons shall be produced by the officer evaluating the tender responses and shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded; and

(b) that best value for money was achieved.

All tenders should be treated as confidential and should be retained for inspection.

7.7 Quotations: Competitive and Non-Competitive

7.7.1 General Position on Quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds; or is reasonably expected to exceed £10,000, but not exceed £50,000. Where the intended expenditure or income is not reasonably expected to exceed £10,000, competitive prices only are required. If, however the competitive prices which are received do exceed £10,000, then three written quotations shall be required.

7.7.2 Competitive Quotations

Wherever practical quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

Quotations should be in writing unless the Chief Executive, or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

All quotations should be treated as confidential and should be retained for inspection.

The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why, should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs except with the authorisation of either the Chief Executive or Chief Financial Officer/Operational Director of Finance.

7.8 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) if the Trust does not use the NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Chief Financial Officer/Operational Director of Finance.

7.9 Private Finance for Capital Procurement

When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate agency, as required by current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.10 Compliance Requirements for all Contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's SOs and SFIs;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable;

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;

(g) in all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.11 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts via framework approved suppliers.

7.12 Healthcare Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the Care Act 2014 and administered by the Trust. Service agreements, other than those with a Foundation Trust, are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

The Chief Executive shall nominate officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.13 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £10,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or building concerning which DHSC guidance has been issued but subject to compliance with such guidance.

7.14 In-house Services

7.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Chief Financial Officer/Operational Director of Finance representative. The evaluation team should include a non-

executive member of the Board, particularly if annual expenditure is over £250,000.

7.14.3 All groups should work independently of each other, and individual officers may be a member of more than one group, but no member of the in-house tender group may participate in the evaluation of tenders.

7.14.4 The evaluation team shall make recommendations to the Board.

7.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15 Applicability of SFIs on Tendering and Contracting to Funds held in Trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's funds and private resources.

8. SERVICE AGREEMENTS FOR PROVISION OF SERVICES

8.1 Service Level Agreements (SLAs) and Contracts

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with commissioners for the provision of NHS services.

All SLAs and contracts should aim to implement the agreed priorities contained within the Commissioning Agreement or the strategy of the Trust. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services;

(d) the NHS National Performance Assessment Framework.

8.2 Involving Partners and jointly managing risk

8.2.1 A good agreement will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.2.2 The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract and SLA's. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs). Where HRGs are unavailable for specific services, all parties should agree a common currency for application across the range of SLAs.

9. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

9.1 Payment to Board Members (Chairman and Non-Executive Directors)

9.1.1 The Trust will pay allowances to the Chairman and the Non- Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health and Social Care.

9.2 Remuneration and Terms of Service Committee (Executive Directors and Staff)

9.2.1 In accordance with SOs the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.2.2 The Committee will:

(a) Be responsible for overseeing and ratifying the appointment of candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service.

(b) Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the board, making use of the output of the board evaluation process as appropriate, and make recommendations to the board, as applicable, with regard to any changes.

(c) Establish and keep under review a remuneration policy in respect of executive board directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally determined pay.

(d) In accordance with all relevant laws, regulations and trust policies, decide and keep under review the terms and conditions of office of the trust's executive directors and senior managers earning over £70,000 or accountable directly to an executive director and on locally determined pay, including:

i. Salary, including any performance-related pay or bonus;

ii. Annual salary increase

iii. Provisions for other benefits, including pensions and cars;

iv. Allowances;

v. Payable expenses;

vi. Compensation payments.

(e) Ensure the annual performance of Board Directors is undertaken and evaluate on an exceptional basis the performance of Board Directors on the advice of the Chief Executive/Chairman. This will include consideration of this output when reviewing changes to remuneration levels.

(f) Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

9.2.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for its decisions but remain accountable for taking decisions on the remuneration and terms of service of executive members. Minutes of the Board's meetings should record such decisions.

9.2.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

9.3 Funded Establishment

9.3.1 The manpower plans incorporated within the annual budget will form the funded establishment.

9.3.2 The funded establishment of any directorate or department may not be varied in any way which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Executive or Chief Financial Officer/Operational Director of Finance or their delegated officer.

9.4 Staff Appointments

9.4.1 No Executive Director, Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) unless authorised to do so by the Chief Executive;

(b) within the limit of their approved budget and funded establishment.

(c) he or she is exercising economy and efficiency in the use of human resources.

9.4.2 Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

9.4.3 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.5 Payroll Arrangements

9.5.1 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer/Operational Director of Finance shall ensure that the chosen method is supported by appropriate terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

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

(a) specifying timetables for submission of properly authorised time records, expense claims and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

The Chief Financial Officer/Operational Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees, expenses and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act and General Data Protection Regulations (GDPR);

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit including BACS, or cash to employees and officers;

(i) procedures for the recall of cheques and bank direct credits, including BACS;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m)a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due from them to the Trust.

Appropriately nominated managers have delegated responsibility for:

(a) submitting and authorising time records, travel, subsistence and removal expenses claims and other notifications in accordance with agreed timetables;

(b) completing and authorising time records, travel, subsistence and removal expenses claims and other notifications in accordance with the Chief Financial Officer/Operational Director of Finance instructions and in the form prescribed by the Chief Financial Officer/Operational Director of Finance;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer/Operational Director of Finance must be informed immediately.

9.6 Contracts of Employment

9.6.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board, and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

9.7 Agency, Self-employed or Third Party Workers including Contract for Services

9.7.1 Where exceptional circumstances exist within a department and agency, self-employed workers or workers supplied via a third party are to be retained then:

(a) the contract may only be entered into by a budget holder having sufficient resources within the limit of their budget who is authorised for that purpose by the Chief Executive or his delegated officer; and

(b) the Chief Financial Officer/Operational Director of Finance shall be consulted if the contractor is not on the current list of authorised suppliers; and

(c) the Director of Workforce shall be consulted with regard to the remuneration package; and

(d) contractual provisions shall be in place which allow the Trust to seek assurance regarding the income tax and national insurance contribution obligations of the engagee and the ability to terminate the contract if that assurance is not provided; and

(e) appropriate arrangements shall be in place to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenues & Customs in line with current legal and regulatory requirements.

10. NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.2 The Scheme of Reservation and Delegation will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Scheme of Reservation and Delegation shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contract shall only be those approved by the Trust.

10.1.4 Before entering in to contracts for the supply of goods and services or works contracts and especially overseas contacts, taxation advice (including where appropriate customs advise) shall be obtained from the Chief Financial Officer. Agreement of the Chief Financial Officer and also where relevant the Director of Estates and Facilities shall be obtained before entering into any potentially novel or contentious arrangement with a supplier or contractor.

10.2 Requisitioning

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer/Operational Director of Finance (and/or the Chief Executive) shall be consulted.

10.3 System of Payment and Payment Verification

10.3.1 The Chief Financial Officer/Operational Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3.2 The Chief Financial Officer/Operational Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs, Scheme of Reservation and Delegation, and SFIs and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

(i) goods have been duly received, examined and are in accordance with specification and the prices are correct;

(ii) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

(iii) in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

(iv) in the case of expenses claims, authorisation confirms that the claims reflect travel and journeys which were necessary in discharging the employee's work-related duties, and that the claim has been submitted within 3 months of the expense being necessarily incurred;

(v) where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

(vi) the account is arithmetically correct, with discounts having being taken as appropriate;

(vii) VAT has been correctly accounted for with the recovery being identified where appropriate; and

(viii) the account is in order for payment.

(iii) A timetable and system for submission to the Chief Financial Officer/Operational Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI **10.4** below.

10.4 Prepayments

10.4.1 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

(b) The Chief Financial Officer/Operational Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the prevailing procurement rules (EU or otherwise) where the contract is above a stipulated financial threshold);

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.4.2 Exceptions to the requirements of section a and b above are:

(i) Service and maintenance contracts which require payment when the contract commences;

(ii) Minor services such as training courses, conference bookings;

(iii) Prepayments of up to £500 where a value for money and financial risk assessment demonstrates clear advantage in early payment.

10.5 Purchasing Cards

10.5.1 The Purchasing Card

The main purpose of the Purchasing Card Scheme is to simplify the purchase of low value goods by avoiding, wherever possible, the generation and handling of paperwork, whilst maintaining accountability and audit trails.

It may also be used for those suppliers whose only acceptable payment method is card payment and/or for those items which cannot be transacted through the traditional purchase order route.

Purchasing Cards are for use ONLY in relation to the business of the Trust, including RWT Charity.

Goods can only be delivered to Trust premises.

Each card is issued to a single named cardholder and has pre-agreed limits on the value of single transactions and monthly expenditure, and categories of spend.

10.5.2 When to use the Card.

When the Cardholder decides to use their card, they must consider;-

(i) If the item/service they wish to order falls within the categories for which their card is set up, and is the item/service allowed to be ordered via the card in accordance with this guidance document?

(ii) Will the cost be within their credit limit (including vat, Postage and Packing or Delivery charges)?

If the answer to either of these points is 'No', then normal purchasing procedures (NHS Supply Chain or E-Proc) should be followed.

The cardholder also needs to consider if the items/service represents best "Value for Money". Further advice on VFM and access to NHS Contracts is available by contacting any member of the Procurement Dept.

10.5.3 How to use the Card

A purchase should never be split to avoid control limits.

The Purchasing Card should never be used to withdraw cash, and this action will be blocked on card issue.

The Purchasing card should never be used where a contract or Framework Agreement is in existence

The Card is set up with permitted categories of spend. Card Holders are not able to purchase outside of these categories.

The Cardholder is responsible for the completion of the Transaction Log as per the Purchasing Card guidance. This allows spend against the card to be monitored and audited. The Cardholder should check that the details on the monthly statement agree to the transaction log. If they do not, the Cardholder should attempt to rectify missing payments with the supplier where possible before contacting the Card Administrator to report any fraudulent purchases made against the card.

10.5.4 Misuse of Purchasing Card

The Purchasing Card must be used only as instructed by the Trust and used solely for purchases on behalf of the Trust. Although the card bears the Cardholder's name, the account and therefore the liability remain with the Trust and RWT Charity. There is no consequential impact on personal credit status.

The use of the card for any purpose that is not in accordance with the Purchase Card guidelines in this document may result in disciplinary action.

If a Cardholder does not comply with the instructions within Purchase Card Procedure Manual, the card can be removed, and disciplinary action may be taken.

All statements will be checked and audited for misappropriation of Trust monies. Detailed analysis data is available from RBS and is be used by the Trust for audit purposes.

10.6 Official orders

10.6.1 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Chief Financial Officer/Operational Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.7 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer/Operational Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer/Operational Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with the prevailing rules on public procurement (EU or otherwise);

(c) where consultancy advice is being obtained, the procurement of such advice must have prior approval from NHSE and be in accordance with guidance issued by the Department of Health and Social Care and NHS England;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(e)they declare any pecuniary interests in contracts or potential contracts (as set out in SFI 7.1.(b)

(f) Other than the above exceptions, any officer receiving such an offer shall notify his/her manager as soon as possible, who will in turn, notify the Chief Financial Officer/Operational Director of Finance. This provision needs to be read in conjunction with the principles outlined in the national guidance contained in HSG 93(5) "Managing Conflicts of Interest" Feb 2017);

(g) Details of authorised hospitality shall be entered in a register maintained by the Chief Executive. Visits at suppliers' expense to inspect equipment etc., must not be undertaken without the prior approval of the Chief Executive.

(h) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer/Operational Director of Finance on behalf of the Chief Executive;

(i) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash or items brought using purchase cards. For clarification the Chief Financial Officer/Operational Director of Finance will determine the nature of expenditure which does not require control through an official purchase order and review this on an annual basis;

(j) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order which is clearly marked "Confirmation Order";

(k) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(l) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(m) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Financial Officer/Operational Director of Finance;

(n) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer/Operational Director of Finance;

(o) petty cash records are maintained in a form as determined by the Chief Financial Officer/Operational Director of Finance.

11. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital Investment

11.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) shall ensure that the capital investment is not undertaken without confirmation of affordability;

(c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the current Department of Health guidance) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(iii) appropriate project management and control arrangements are in place;

(iv) the appropriate Trust Personnel and external agencies have been involved; and

(v) that the Chief Financial Officer/Operational Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to NHSE and/or the Department of Health and Social Care in line with the current guidelines.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Department of Health and Social Care.

11.1.4 The Chief Financial Officer/Operational Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

11.1.5 The Chief Financial Officer/Operational Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, which as a minimum shall include reporting to the Board on:

(a) The individual scheme/projects;

(b) The source and level of funding; and

(c) The expenditure incurred against the annual profile.

11.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust.

11.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.1.8 The Chief Executive will issue a scheme of delegation for capital investment management and the Trust's SOs.

11.1.9 The Chief Financial Officer/Operational Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes as notified by the Department of Health and Social Care.

11.2 Private Finance (see SFI No. 7.9)

11.3 Contract Framework agreements

11.3.1 Contract framework agreements (including P22 schemes) should always be considered for all construction projects and used where in line with best practice as set out by HM treasury and the Cabinet Office as a set out in Health Building Notes – Strategic framework for the efficient management of health care estates and facilities. The management of contracts awarded under the P22 Framework Agreement shall follow the current guidelines issued by the Department of Health and Social Care.

11.3.2 All Contractual Framework Agreements should be reviewed at regular intervals, usually annually, to ensure anticipated benefits are being realised and that cost improvements and value for money objectives are achieved.

11.3.3 The Contractual Framework Agreement shall be subject to formal tender procedures and shall comply with the prevailing directives governing public procurement (EU or otherwise).

11.3.4 The Chief Financial Officer/Operational Director of Finance shall issue procedure notes governing the control, management, reporting and audit arrangements of the Contract Framework Agreement.

11.3.5 The committee overseeing the capital programme shall receive regular reports on the performance of the Contract Framework Agreement and detailed project progress reports on all on going schemes.

11.3.6 Any capital monies spent should be in accordance with the requirements laid down in the Manual for Accounts as issues by the Department of Health and Social Care.

11.4 External Borrowing (see SFI No 5.5)

11.5 Investments (see SFI No 5.6)

11.6 Leases

11.6.1 Where it is proposed that leasing shall be considered in preference to capital procurement then the following should apply:

(a) the selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the procurement department;

(b) All proposals to enter into a leasing agreement shall be referred to the Chief Financial Officer/Operational Director of Finance before acceptance of any offer;

(c) The Chief Financial Officer/Operational Director of Finance shall ensure that the proposal demonstrates best value for money; and

(d) The proposal shall be agreed in writing by the Chief Financial Officer/Operational Director of Finance prior to acceptance of any offer to the lease.

In the case of property leases the guidance in the Health Building Note – Strategic framework for the efficient management of healthcare estates and facilities shall be followed.

11.7 Asset Registers

11.7.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer/Operational Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.7.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual as issued by the Department of Health and Social Care.

11.7.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects' certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

11.7.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.7.5 The Chief Financial Officer/Operational Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.7.6 The value of each asset shall be established and indexed to current values in accordance with methods consistent with the requirements issued by the Department of Health and Social Care.

11.7.7 The value of each asset shall be depreciated using methods and rates as specified by the Department of Health and Social Care.

11.7.8 The Chief Financial Officer/Operational Director of Finance of the Trust shall calculate and pay PDC dividend as specified by the Department of Health and Social Care.

11.8 Security of Assets

11.8.1 The overall control of fixed assets is the responsibility of the Chief Executive.

11.8.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer/Operational Director of Finance, this procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.8.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer/Operational Director of Finance.

11.8.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

11.8.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

11.8.6 Where practical, assets should be marked as Trust property.

12. STORES AND RECEIPT OF GOODS

12.1 General Position

12.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

12.2 Control of Stores, Stocktaking, Condemnations and Disposal

12.2.1 Subject to the responsibility of the Chief Financial Officer/Operational Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer/Operational Director of Finance. The control of any

Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as NHS property.

12.2.3 The Chief Financial Officer/Operational Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4 Stocktaking arrangements shall be agreed with the Chief Financial Officer/Operational Director of Finance and there shall be a physical check covering all items in store at least once a year. External Audit and Internal Audit will be consulted on appropriate levels of stocktaking to ensure the trust has control but not onerous stock counting. High value items will be counted at least once per year.

12.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

12.2.6 The designated manager shall be responsible for a system approved by the Chief Financial Officer/Operational Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated manager shall report to the Chief Financial Officer/Operational Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

12.3 Goods Supplied by NHS Supply Chain

12.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer/Operational Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge. If there are any discrepancies these should be reported to the Chief Financial Officer/Operational Director of Finance or delegated officer to avoid overpayments where such discrepancies cannot be resolved via the procurement team.

13. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and Condemnations

13.1.1 The Chief Financial Officer/Operational Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Chief Financial Officer/Operational Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer/Operational Director of Finance;

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer/Operational Director of Finance will indicate whether the articles are to be

converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer/Operational Director of Finance.

13.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer/Operational Director of Finance who will take the appropriate action.

13.2 Losses and Special Payments

13.2.1 Procedures

The Chief Financial Officer/Operational Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their supervisor, line manager and head of department, except where fraud, bribery or corruption is suspected in which case a referral must be made to LCFS for investigation in accordance with the Trust's Local Anti-Fraud and Anti-Bribery Policy. The senior officer must immediately inform the Chief Executive and the Chief Financial Officer/Operational Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer/Operational Director of Finance and Chief Executive.

13.2.3 Where a criminal offence is suspected, the Chief Financial Officer/Operational Director of Finance must immediately inform the police if theft or arson is involved.

13.2.4 In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer/Operational Director of Finance must inform the relevant LCFS, NHS Counter Fraud Authority and the External Auditor of all frauds.

13.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer/Operational Director of Finance must immediately notify:

(a) the Board,

(b) the External Auditor.

13.2.6 Within limits delegated to it by the Department of Health and Social Care, the Board shall approve the writing-off of losses.

13.2.7 The Chief Financial Officer/Operational Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

13.2.8 For any loss, the Chief Financial Officer/Operational Director of Finance should consider whether any insurance claim can be made.

13.2.9 The Chief Financial Officer/Operational Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

13.2.10 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health and Social Care.

13.2.11 All losses and special payments must be reported to the Audit Committee and the Trust Board at regular intervals.

14. INFORMATION TECHNOLOGY

14.1 Responsibilities and Duties of the Chief Financial Officer/Operational Director of Finance

14.1.1 The Chief Financial Officer/Operational Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and GDPR 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as the Director or Data Protection Officer (DPO) may consider necessary are being carried out.

14.1.2 The Chief Financial Officer/Operational Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

14.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

14.2.1 The Medical Director shall publish and maintain a Freedom of Information (FOI) Publication Scheme or adopt a model Publication Scheme approved by the information Commissioner.

14.2.2 In the case of computer systems which are proposed General Applications (i.e., normally those applications which the majority of Trusts in the Region wish to sponsor jointly) all responsible directors and employees will send to the Chief Financial Officer/Operational Director of Finance:

(a) details of the outline design of the system.

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.3 Contracts for Computer Services with other health bodies or outside agencies

14.3.1 The Chief Financial Officer/Operational Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy (in line with GDPR), accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer/Operational Director of Finance shall periodically seek assurances that adequate controls are in operation.

14.3.3 Where computer systems have an impact on corporate financial systems the Chief Financial Officer/Operational Director of Finance need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Chief Financial Officer/Operational Director of Finance's staff has access to such data, and;

(d) such computer audit reviews as are considered necessary are being carried out.

14.4 Risk Assessment

14.4.1 The Chief Executive shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15. PATIENTS' PROPERTY

15.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead-on arrival.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.3 The Chief Financial Officer/Operational Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.

15.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer/Operational Director of Finance. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

15.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

15.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

15.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

15.8 Patients' income, including pensions and allowances, shall be dealt with in accordance with current Department of Health and Social Care and Department of Social Security instructions and guidelines.

16. FUNDS HELD ON TRUST

16.1 Corporate Trustee

16.1.1 The discharge of the Trust's corporate trustee responsibilities is distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

16.1.2 The Chief Financial Officer/Operational Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

16.1.3 The Trust will comply with Charities Commission latest guidance and best practice.

16.2 Accountability to Charity Commission and Secretary of State for Health and Social Care

16.2.1 The trustee responsibilities must be discharged separately, and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

16.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

16.3 Applicability of Standing Financial Instructions to funds held on Trust

16.3.1 In so far as it is possible to do so these SFIs will apply to the management of funds held on trust.

16.3.2 The over-riding principle is that the integrity of each Trust must be maintained, and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17. ACCEPTANCE OF GIFTS BY STAFF

17.1.1 The Chief Financial Officer/Operational Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff (see SFI 10.6 (d)) This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these SOs and SFIs.

18. RETENTION OF RECORDS

18.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS England and Department of Health and Social Care guidelines.

18.2 The records held in archives shall be capable of retrieval by authorised persons.

18.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed before the specified guidance limits at the express authority of the Chief Executive or Chief Financial Officer/Operational Director of Finance. Proper details shall be maintained of records and information so destroyed.

19. INTERNATIONAL FINANCIAL REPORTING STANDARDS (IFRS)

19.1 The Trust is required to report all its financial transactions in compliance with IFRS subject to amendments issued by the Department of Health and Social Care through the NHS Manual of Accounts. It is important that the reporting requirements of IFRS are anticipated and provided for when making decisions which have an impact on the Trust's financial position. This is particularly the case in respect of capital investment, leasing, use of external private finance and contractual relationships with other parties. The Chief Financial Officer/Operational Director of Finance and his team should be consulted for advice in such instances.

20. RISK MANAGEMENT AND INSURANCE

20.1 Programme of Risk Management

20.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health and Social Care assurance framework requirements, which must be approved and monitored by the Board.

20.1.2 The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; internal audit, clinical audit, health and safety review;

(f) a clear decision of which risks shall be insured;

(g) arrangements to review the risk management programme;

(h) appropriate levels of external accreditation.

20.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis for the effectiveness element under the Annual Governance Statement (within the Annual Report and Accounts) as required by current Department of Health and Social Care guidance.

20.2 Insurance: Risk Pooling Schemes

20.2.1 The Board shall decide if the Trust will insure through the various schemes administered through the NHS Resolution (NHSR) or self-insure for some or all of the risks. If the Board decides not to use the NHSR risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

20.3 Insurance arrangements with commercial insurers

20.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, four exceptions when Trusts may enter into insurance arrangements with commercial insurers. The exceptions are:

1) insuring motor vehicles owned or leased by the Trust including insuring third party liability arising from their use;

2) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

3) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for an NHS purpose the activity may be covered in the risk pool.

   Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

4) Where it is necessary to ensure that the Trust is able to continue providing a service where adequate levels of insurance are not available under any of the schemes administered by the NHSR, the Trust arranges a policy in the name of "the employees of the Trust" or "members, for the time being, of a specific team". In such cases, the premium must be:

   i. Paid by the use of charitable funds, providing the Trust establishes through the Charities Commission, or other relevant regulatory bod, whether this is an appropriate use of funds, or
   ii. Paid by members of the team and then reimbursed by the Trust, or
   iii. Paid by the Trust, provided this is with the recognition, and approval, of the Chief Finance Officer and/or internal audit.

In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer/Operational Director of Finance should first consult the NHSR and then the Department of Health and Social Care.

20.4 Arrangements to be followed by the Board in agreeing Insurance cover

20.4.1 Where the Board decides to use the risk pooling schemes administered by the NHSR the Chief Financial Officer/Operational Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer/Operational Director of Finance shall ensure that documented procedures cover these arrangements.

20.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer/Operational Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer/Operational Director of Finance will draw up formal documented procedures for the management of any claims

arising from third parties and payments in respect of losses which will not be reimbursed.

20.4.3 All the NHSR risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible' element). The Chief Financial Officer/Operational Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

APPENDIX A

SCHEDULE OF AUTHORISED LIMITS

TENDERING, ORDERING, CONTRACTING – EXPENDITURE

Competitive quotations to apply	£20,000 to £50,000
Competitive tendering to apply	above £50,000

Authority to waive competitive process:-

Head of Procurement/Estates	up to £25,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer/Operational Director of Finance	above £25,000

Authority to accept other than lowest quote:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer/Operational Director of Finance	up to £1,000,000
Trust Board	above £1,000,000

Approval to contract awards (including extensions):-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer/Operational Director of Finance	up to £1,000,000
Trust Board	above £1,000,000

NB – All contract awards above £50,000 to be reported to Trust Board for information

Evaluation Panel to include a Non-Executive Director	£1,000,000 & above

Note – The above limits apply equally to asset disposals.

CONTRACTING – Income

Approval to sign contracts other than for the provision of Healthcare by RWT:-

Head of Procurement/Estates	up to £50,000
Chief Executive/Deputy Chief Executive/Chief Financial Officer/Operational Director of Finance	up to £1,000,000
Trust Board	above £1,000,000

CONTRACTING – Agreements for the Provision of Healthcare Services by RWT:-

Approval to sign contracts where RWT is the provider of Healthcare services to NHS and other Commissioners:-

Executive Director	up to 10% of Trust turnover
Trust Board	above 10% of Trust turnover

REQUISITIONS

Revenue:-

Budget Holder e.g., Ward Manager	}	
Budget Manager (Corporate)	}	up to £5,000
Senior Budget Manager –		
Senior Matron/Matrons/Head of Midwifery	}	
Heads of Nursing (Nursing Budgets Only)	}	
Group Manager/Directorate Manager/Head of Clinical Service	}	up to £15,000
Deputy HR Director	}	
Director of Education & Training	}	
Budget Holder		
Pharmacy (drugs only) -		
Senior Pharmacist/Principle Pharmacist (drugs only)		up to £25,000
Deputy and Assistant Director of Pharmacy (drugs only)		up to £50,000
Director of Pharmacy Services (drugs only)		up to £100,000
Other -		
Deputy Chief Operating Officer	}	
Divisional Medical Director	}	up to £50,000
Director of Digital Technologies ~~Head of IT Services~~	}	
Divisional Manager Estates and Facilities	}	
Clinical/Research Network –		
Lead Research, Management & Governance Manager		up to £5,000
Research Delivery Divisional Managers		up to £5,000
Industry Operations Manager		up to £15,000
Chief Operating Officer		up to £50,000
Black Country Pathology Services –		
Budget Holder		up to £5,000
Service Manager		up to £10,000
Deputy Group Operational Manager		up to £15,000
Group Operational Manager		up to £25,000
Clinical Director		up to £50,000
Executive Responsible Budget Officer –		
Executive Director/Operational Director of Finance		up to £100,000
Chief Executive **and** Chief Financial Officer/Operational Director of Finance		over £100,000

Capital:-

Team Manager (Capital)/Team Manager (Project and Estates)	up to £50,000
Head of Estates Development	up to £500,000
Chief Financial Officer/Operational Director of Finance	up to £750,000
Chief Executive **and** Chief Financial Officer/Operational Director of Finance	over £750,000

NB – Above capital limits are subject to agreement of Business Cases (where Applicable) and inclusion within a Board approved Capital Programme

Capital schemes requiring Business Cases to be approved by value

Trust Board	£1,000,000 capital and/or £1,000,000 revenue cost (whether non-recurrent or recurrent), and above

Capital schemes requiring Business Cases to be approved by NHSE, DHSC and HM Treasury

£20,000,000 up to £35,000,000 capital value for all categories of investment except IM&T which has a lower upper threshold of £30,000,000 (The delegated limit for a Trust is the lower of 3% turnover and £20,000,000 and is reviewed annually. This may be reduced should the Trust go into deficit.) to be approved by NHSE
Capital values above these upper limits and up to £50,000,000 require additional approval from DHSC, and above £50,000,000 then requires HM Treasury approval.

Note – Officers will need to judge where schemes below this level will require Board approval, because of other issues of significance

Charity Funds – following approval from Charity Trustees of the commitment of charitable funds the delegated officers below authorise payment as per the values set out:–

Divisional/Directorate Funds -

Group Managers/Directorate Managers	up to £5,000
Deputy Chief Operating Officer	up to £10,000
Chief Executive and Chief Financial Officer/Operational Director of Finance	up to £50,000

General Funds -

Chief Executive and Chief Financial Officer/Operational Director of Finance	up to £50,000

All Funds -

Trust Board, acting as Trustees	above £50,000

PAY

All Starter, Change and Termination Forms:–

Clinical Directorates and Divisions –
Senior Matron/Matron/Head of Midwifery/Head of Nursing (Nursing Budgets Only)
Group Manager/Directorate Manager (Non Nursing Budgets Only)
Divisional Manager Estates and Facilities
Deputy Chief Operating Officer
Divisional Medical Director

Division 4
Heads of Service that directly report to Deputy Chief Operating Officer

Corporate Functions –
Executive Director (or delegated Deputies at Executive Director's discretion)

Clinical Research Network –
Lead Research, Management and Governance Manager
Industry Operations Manager
Research Delivery Divisional Managers
Chief Operating Officer

Subject to:

- **Consultant appointments to be countersigned by Medical Director**
- **Any appointment/changes outside National Terms and Conditions/Agreed Trust Policy to be countersigned by HR Director and Chief Financial Officer (or in exceptional circumstances, where the Executive Director is absent, to delegated Deputies, named at Executive Director's discretion).**

Junior Doctors (ROTATION ONLY) and Temporary Bank Medical Staff – Starter and Termination Forms: -
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Bank Nurses – Starter, Change and Termination Forms:-
Head of Workforce
Senior Resourcing Manager/Head of Resourcing
Resourcing Manager

Trust Volunteers – Starter and Termination forms

(Required for the purpose of payment of volunteer expenses only)
- Head of Patient Experience

All turnaround documents, timesheets and expenses forms:-
As above prime payroll documentation authorised officers plus

Budget Holders/Managers

The Budget Manager is able to devolve responsibility for the sign off to a Delegated Senior Manager.

For Removals Expenses only – Director/Deputy of Human Resources/Head of Workforce, and additionally, for Medics Removals and Interview Expenses, specifically Senior Resourcing Manager.

Expenses of Non-Executive Directors/Chair and Chief Executive:-

Expenses of Non Executive Directors/Chair	– Chief Executive
Expenses for Chief Executive	- Chair and Chief Financial Officer

LOSSES COMPENSATIONS AND SPECIAL PAYMENTS

Approval limit of Chief Financial Officer/Operational Director of Finance/Deputy Chief Financial Officer	up to £5,000
Audit Committee	above £5,000

Note – all losses, compensation and special payments to be reported to the Trust Board

EXCEPTIONAL AUTHORISATION ARRANGEMENTS

In the absence of the Chief Executive and Chief Financial Officer/Operational Director of Finance
(For areas where Delegated Deputies are specifically not identified above.)

Deputy Chief Executive
Non Executive Director, only in the absence of the Deputy Chief Executive

The Royal Wolverhampton NHS Trust

Document Control

Reference Number and Policy name: Scheme of Reservation and Delegation	**Version:** V65		**Status:** Final	**Author:** Group Company Secretary and Operational Director of ~~Deputy Chief~~ Financeial ~~Officer~~ **Director Sponsor:** Chief Financial Officer
Version / Amendment History	Version	Date	Author	Reason
	V1	March 2009	Financial Controller	Implementation of Scheme of Reservation and Delegation
	V2	April 2019	Company Secretary and Head of Financial Control and Assurance	Review of document in line with amendments made to SO's and SFI's
	V3	June 2021	Company Secretary and Head of Financial Control and Assurance	Review of document in line with amendments made to SO's and SFI's
	V4	November 2021	Company Secretary and Deputy Chief Financial Officer	Review of document in line with amendments made to SO's and SFI's
	V5	December 2022	Group Company Secretary and Head of Financial Governance and Transactions	Review of document in line with amendments made to SO's and SFI's
	V6	December 2023	Group Company Secretary and Head of Financial Governance and Transactions	Review of document in line with amendments made to SO's and SFI's
Intended Recipients: This policy will apply to all persons employed by The Royal Wolverhampton NHS Trust. This incorporates community, acute staff, employees from other health or social care providers, educational establishments, volunteers, private contractors, agency workers working within Trust premises.				
Consultation Group / Role Titles and Date: Company Secretary; Finance and Performance Committee, Audit Committee, Chief Financial Officer, Operational Director of Finance~~Deputy Chief Financial Officer~~.				
Name and date of Trust level group where reviewed	Audit Committee February 2023 Trust Policy Group – February 2023			
Name and date of final approval committee	Trust Board February 2023			

Date of Policy issue	February 2023
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	February 2024 annually

Training and Dissemination: Senior managers briefing, Divisional management forums, approving committees and dissemination via Intranet.	
To be read in conjunction with: Standing Orders, Standing Financial Instruments, Conflicts of Interest Policy, and Anti-Fraud and Anti-Bribery Policy	
Initial Equality Impact Assessment (all policies): **Completed Yes** **Full Equality Impact assessment (as required):** **Completed NA** If you require this document in an alternative format e.g., larger print please contact Central Governance Department on Ext 5114.	
Contact for Review	Head of Financial Governance and Transactions
Implementation plan / arrangements (Name implementation lead)	Chief Financial Officer
Monitoring arrangements and Committee	Audit Committee Approval by Trust Board
Document summary / key issues covered: This document sets out the powers (be that decisions, authorities or duties) reserved to the Board of Directors and the powers which may be delegated to sub committees, directors and other officers. The Scheme of Reservation and Delegation together with the Standing Orders, the Standing Financial Instructions and all other Trust policies provides a comprehensive framework for the Trusts business conduct. It sets out levels of decision-making in the current management structure of the Trust.	

VALIDITY STATEMENT

This document is due for review on the latest date shown above. After this date, policy and process documents may become invalid. The electronic copy of this document is the only version that is maintained. Printed copies must not be relied upon to contain the latest updates and amendments.

THE ROYAL WOLVERHAMPTON NHS TRUST

SCHEME OF RESERVATION AND DELEGATION

NOTE: For authorised limits see Appendix A to Standing Financial Instructions February 2023

SCHEME OF RESERVATION AND DELEGATION

CONTENTS PAGES

NOTE: For authorised limits see Appendix A to Standing Financial Instructions

SCHEME OF RESERVATION AND DELEGATION

DECISIONS RESERVED TO THE BOARD

General Enabling Provision

The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

Regulations and Control

1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.
2. Suspend Standing Orders.
3. Vary or amend the Standing Orders.
4. Ratify any urgent decisions taken by the Chair~~man~~ (or Deputy~~Vice-~~ Chair~~man~~) and Chief Executive in public session in accordance with SO 7.2
5. Approve a scheme of delegation of powers from the Board to committees as per the approved terms of reference.
6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.
7. Require and receive the declaration of officers' interests that may conflict with those of the Trust.
8. Approve arrangements for dealing with complaints.
9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.
10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action.
11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers.
12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.
13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board.
14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
15. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 7.6.
16 Discipline members of the Board or employees who are in breach of statutory requirements or SOs.

Appointments

1. Appoint the Deputy Chair~~Vice Chairman~~ of the Board.
2. Appoint and dismiss committees (and individual members) that are directly accountable to the Board.
3. Appoint, appraise, discipline and dismiss the Chief Executive.
4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies.
5. Appoint Executive Directors.

Strategy, Plans and Budgets

1. Define the strategic aims and objectives of the Trust.
2. Approve proposals for ensuring quality and developing governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.
3. Approve the Trust's policies and procedures for the management of risk.
4. Approve Outline and Full Business Cases for Capital Investment.
5. Approve budgets.
6. Approve Trust's proposed organisational development proposals.
7. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
8. Approve PFI proposals.
9. Approve the opening of bank accounts.
10. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 ~~£500,000~~ over the period of the contract. For Revenue Only contracts the limit required for board approval is £1,000,000~~£250,000.~~
11. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) approved by the Board.
12. Approve Trust Strategic Documents in line with Trust Strategic Objectives.
13. Partnership Agreements

Policy Determination 1. Approve management policies as delegated within the Scheme of Delegation.
Audit 1. Approve the appointment (and where necessary dismissal) of External Auditors and advise the Audit Committee on such matters. 2. Receive the annual management letter from the external auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee.
Annual Reports and Accounts 1. Receive and approve the Trust's Annual Accounts. 2. Receive and approve the Annual Accounts for funds held on trust.
Monitoring 1. Receive such reports as the Board sees fit from committees in respect of their exercise of delegated powers. 2. Continuously appraise the affairs of the Trust by means of the provision of information to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. Receive reports from Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ on financial performance.

DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

AUDIT COMMITTEE	**Meeting Purpose/Remit:** The Audit Committee provides the Board with a means to undertake and obtain independent and objective reviews of financial systems / financial information and help ensure compliance with relevant law, guidance, and codes of conduct. The Audit Committee's role has been enhanced to take a wider view over internal controls across the whole of the Trust's activities. The Committee will: **1. Internal Control** The Committee shall review the establishment and maintenance of an effective system of internal control. In particular, the Committee will review:- • The Annual Governance Statement, and the related Head of Internal Audit Opinion, prior to the endorsement of the Annual Accounts by the Trust Board. In order to undertake such a review, the Audit Committee will need to seek assurance from the activities of the Quality Governance Assurance Committee (QGAC), Finance and Productivity Committee ~~Performance and Finance Committee~~ (P&FC), and the People and Organisational Development Committee (PODC), not least to ensure that, between the Audit Committee and the QGAC, full coverage is achieved. • the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and the operational effectiveness of such policies and related procedures • the policies and procedures for all work related to fraud, bribery and corruption as set out in the Government Functional Standard 013: Counter Fraud and as required by the NHS Counter Fraud Authority. • the timeliness of the implementation of agreed action plans arising from all audit reports within the purview of the Committee • the policies and procedures for security within the Trust **2. Internal Audit** The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. This will be achieved by: • The consideration of the provision of the Internal Audit service, the audit fee and any questions of resignation and dismissal • The review and approval of the Internal Audit strategy and annual plans, ensuring that these are consistent with the audit needs of the Trust, including the needs of the QGAC, P&FC and PODC. • The review of progress against the agreed annual internal audit plan • The consideration of the major findings of internal audit reviews and management's response • Ensuring that the quality of the Internal Audit service is maintained and that the service has appropriate standing within the Trust • Ensuring co-ordination between the Internal and External Auditors to optimise audit resources • The review of an Annual Report, provided by the Head of Internal Audit, summarising audit activities during the year • Note: for the purposes of the above section, references to Internal Audit are deemed to include Counter Fraud work **3. External Audit** The Committee shall review the work and findings of the External Auditor and consider the implications of, and management response to, their work. This shall be achieved by: The consideration of the appointment and performance of the External Auditor

	The discussion with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Audit Plan, and ensure co-ordination, as appropriate, with other External Auditors in the local health economy Reviewing External Audit reports, including the agreement of the annual audit letter before its submission to the Trust Board, together with the appropriateness of management responses. Reviewing and agreeing any additional work beyond the review of the accounts and Annual Report/Annual Quality reports **4. Financial Reporting** The Audit Committee shall review the Annual Accounts before submission to the Board, focusing particularly on: The Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee Changes in, and compliance with, accounting policies and practices; Unadjusted mis-statements in the Annual Accounts Major judgmental areas Significant adjustments resulting from the audit. Review and approval of the Value For Money (VFM) statement. Undertake reviews of single tenders as and where appropriate at each meeting. The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board. In line with the Code of Governance for NHS Provider Trusts (2023) the Audit Committee will ensure it satisfies and addresses the provisions that define the main role and responsibilities under section D as reflected in the appropriate sections of the annual accounts and Annual Report. **Counter Fraud** The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. The Committee should review arrangements by which staff of the Trust may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters. The Audit Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. Note: for the purposes of the above section, references to counter fraud are deemed to also include arrangements to counter bribery and corruption. **Security Report** The Audit Committee shall receive regular reports regarding all aspects of security in the Trust specifically relating to physical security of people, buildings and property. Incidents reporting including severity actions and learning. Role and function of security staff. Any other security related oversight. **Losses and Compensations** The Committee shall approve all Losses and Compensations. The Chair will be informed prior to the meeting of any novel or high value losses and compensations as agreed with the Chief Financial Officer/Operational Director of Finance. ~~Chief Financial Officer (CFO).~~

	Other The Committee shall review proposed changes to Standing Orders, the Scheme of Reservation and Delegation, and Standing Financial Instructions, and advise the Board accordingly. The Committee shall examine the circumstances associated with each occasion when Standing Orders are waived. Where requested by the Board, the Committee should review the content of the Annual Report/ Quality Account and Accounts and advise the Board on whether, taken as a whole, it is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance and strategy In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this should include the Quality Governance and Assurance Governance Committee and any risk management committees that are established. The Audit Committee Chair will actively consult with and take recommendations from the Chairs of other Committees of the Board for the internal audit programme. Where an internal audit or other audit is undertaken where responsibility crosses with other Committees of the Board the report recommendations and actions will be shared with the respective and appropriate Committees. It may be agreed that those Committees then agree oversight for the Governance of the completion of the actions and resulting impact. The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities. The trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed

	• an explanation of how the audit committee (and/or auditor panel has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services. Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced, and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy. The board should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. The board should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. In the annual accounts, the board should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.
REMUNERATION AND TERMS OF SERVICE COMMITTEE	**Meeting Purpose/Remit:** 1. The Committee shall be established to consider, endorse or reject matters relating to terms of service for the Chief Executive and other Executive Director posts. 2. The Remuneration Committee will agree the framework by which the remuneration and conditions of the Chief Executive and other Executive Directors will be set. 3. The framework will be managed by the Chief Executive, assisted by the Director of Human Resources, but will allow for the following:- a] That the Remuneration Committee will agree the parameters within which pay and conditions will be negotiated, and will be satisfied as to their affordability; b] That negotiations on pay and conditions will be led by the Chief Executive for Executive Directors and the Chair for the Chief Executive; c] That the Chief Executive will be empowered to negotiate within the parameters set at points 6.8 (2) of the Standing Orders and 9.2 of the Standing Financial Instructions but will report the outcome of these negotiations to the Remuneration Committee. 4. Advice to the Remuneration Committee should include all aspects of salary, including any performance related elements and bonuses, provisions for other benefits, including pensions and cars, terms and conditions, as well as arrangements for

	termination of employment and other contractual terms. 5. The Remuneration Committee should be mindful that all NHS bodies are parts of the public sector and their work, including the pay of their employees, and must be publicly defensible. 6. The Remuneration Committee should record in writing the basis for its recommendations. 7. The Remuneration Committee will ensure it undertakes an effectiveness self-assessment at least every 2 years (as a minimum). The Committee will: 1. To make such recommendations on the remuneration and terms of service of the Chief Executive and Executive Directors to ensure they are fairly rewarded for their contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provision of any national arrangements for staff where appropriate. 2. To monitor and evaluate the performance of the Chief Executive and individual Executive Directors as to the corporate performance of the Trust. The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.

COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
~~QUALITY, GOVERNANCE ASSURANCE COMMITTEE~~RWT QUALITY COMMITTEE	**Meeting Purpose/Remit:** To provide assurance to the Board that patient care is of the highest achievable standard and in accordance with all statutory and regulatory requirements. To provide assurance of proactive management and early detection of risks across the Trust. The Committee will: 1. To review all relevant indicators of patient experience/satisfaction, patient care and patient safety and to assure itself that good practice is being disseminated and that any deficiencies are put right. 2. Promote continuous quality improvement through a culture which encourages open and honest reporting and an educative and supportive approach to the management of risk. 3. To approve the Terms of Reference and membership of its reporting subgroups (and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 4. Co-ordinate the monitoring of risks utilising the Board Assurance Framework (BAF)/Trust Risk Register framework (TRR) to assess the effectiveness of controls, assurances/gaps in assurance and further action. 5. To manage specific BAF risks delegated to the committee, providing assurance updates to Trust Board. 6. Utilise the assurance reporting processes to inform the Audit Committee and Trust Board on the management of risk and proposed internal audit work. 7. To oversee the Governance and Risk Management Framework and any ~~supporting delivery~~supporting delivery plans and Risk management policies OP10 across the Trust. 8. To review the Annual Governance Statement together with any accompanying Head of Internal audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. 9. To receive the Clinical Audit annual report and annual Clinical Audit plan ensuring it is consistent with the audit priorities of the Trust. 10. To examine any relevant matters referred to it by the Board of Directors or Audit Committee. 11. To monitor and report on quality and safety performance to the Trust Board. 12. To review a report on themes from incidents, claims, complaints and related areas, to inform risk management or improvement actions.
CHARITY COMMITTEE	**Constitution:** The Royal Wolverhampton NHS Trust Charity is registered with the Charity Commission, registration number 1059467. In line with this registration the Board of Directors collectively are the 'Corporate Trustee'. The Board of Directors as trustee, approved the establishment of the Charitable Funds Committee (known as 'the Committee' in these terms of reference) for the purpose of:- a) Ensuring the stewardship and effective management of funds which have been donated, bequeathed and given to The Royal Wolverhampton NHS Trust Charity for charitable purposes. b) Determining an investment strategy and arrangements for the investment of funds which are not immediately required for use. c) Coordinating the provision of assurance to the Board of Directors, acting as the Corporate Trustee of the funds, that the funds are accounted for, deployed and invested in line with legal and statutory requirements. d) Considering and approving the Annual Accounts for charitable funds for submission to the Board of Directors, acting as the Corporate Trustee of the funds. The Committee will:

	Assurance a) Manage the affairs of The Royal Wolverhampton NHS Trust Charity within the terms of its declaration of trust and appropriate legislation and ensure statutory compliance with the Charity Commission regulations. b) Ensure systems and processes are in place to receive, account for, deploy and invest charitable funds in accordance with charity law. c) Scrutinise requests for use of charitable funds to ensure that any such use is in accordance with the aims and purposes of any charitable fund or donation and are clinically and ethically appropriate. Committee members will bear in mind due diligence to Charity Commission and Trust guidance regarding the ethical use of funds and acceptance of donations. d) Receive and approve periodic income and expenditure statements. e) Receive and approve Annual Accounts and consider the Annual Report from the auditors, before submission to the Board of Directors Investments f) Consider and agree an investment strategy for the safe and secure investment of funds not immediately required for use, taking into account any appropriate ethical considerations. g) Appoint and review external investment advisors and operational fund managers. h) Review the performance of investments on a regular basis with the external investment advisors to ensure the optimum return from surplus funds. Fundraising i) Ensure a fundraising strategy is prepared and monitored which complies with Charity Commission guidance and legislation. j) Ensure systems and processes are in place to receive, account for, deploy and invest funds raised in accordance with charity law. k) Ensure systems, processes and communications are in place around fundraising, staff engagement and funding commitments. l) Ensure a cohesive policy around external media and communication. m) Ensure effective communication regarding 'whistleblowing' relating to fundraising, donations or subsequent use of funds.
TRUST MANAGEMENT COMMITTEE	**Meeting Purpose/Remit:** • The TMC will provide a formal platform for the major decision making process regarding clinical and non-clinical operations. It informs and supports the CEO and Executive Team in delivering the Strategic objectives of the Trust. • The TMC will review performance of the organisation and agree actions where required. The TMC will delegate responsibility for specific aspects of performance and management to a number of subgroups and working groups. The Trust Management Committee is the senior cross Trust operational management meeting. It reports to the Executive Directors meeting Chaired by the CEO who reports a summary of activities to the Trust Board. The Committee will: 1. The TMC will advise on and be responsible to the Trust Board on all matters relating to Trust operations. This will include responsibility for the following activities:-

	• Direct and monitor progress with implementation of key Trust strategies • Approval of Trust wide policies and procedures • Recommend to Trust Board strategies for the Trust for approval. • Approve business cases to deliver key Trust strategies and the corporate business plan which are in excess of £100,000 but below £1,000,000. ~~£500,000.~~ • Monitor delivery of the Trusts Estate strategy • Monitor and redress as appropriate financial performance across operational service areas • Monitor the delivery of the Trust Nursing & Midwifery programme, ensuring effective integration into operational areas • Monitor the operational performance and implementation of the ICT Digital strategy • Receive advisory reports on the operation of governance, risk management and compliance deliverables across the Trust. • Approve annual sign off of the IG Toolkit requirements. • Receive regular updates and advice from the Finance, HR, Governance Chief Officers to ensure effective operational integration with the following: - Policy – Strategy - Developments - National & local strategies, policies and developments - Legal issues 2. To monitor the delivery of the Trust Strategic aims and objectives. 3. To review and act upon operational performance information including the Quality and Performance KPI/Activity Report, financial position and key governance reports. 4. Receive and comment upon service delivery change plans. 5. Review Divisional risk registers to be assured on the progressive management and identification of risks. 6. To approve the Terms of Reference annually and membership of its reporting subgroups and oversee the work of the sub-groups, receiving reports for consideration and action as necessary. 7. Review all reports to the Committee with a view to extrapolating risks to inform the Board Assurance Framework (BAF)/Trust Risk register or Divisional risk registers. 8. Review new/existing red and high amber risks across the Trust to inform appropriate progression and/or escalation. 9. Promote a culture within the Trust which encourages open and honest reporting of risk and an educative and supportive approach to the management of risk. 10. To examine any relevant matters referred to it by the Board of Directors or other Board Sub Committee. 11. Seek opinions on potential innovation and development opportunities. 12. Ensure the Committee undertakes an effectiveness self-assessment at least every 2 years (as a minimum).
PEOPLE ~~& ORGANISATIONAL DEVELOPMENT~~ COMMITTEE	**Meeting Purpose / Remit:** The purpose of the committee is to provide the Board with assurance that: • The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care. • Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the Trust's values. • The Trust is meeting its legal and regulatory duties in relation to its employees.

	• Where there are human resource risks and issues that may jeopardise the Trust's ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee. • The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture. To provide assurance on the following key areas of workforce governance: • Resourcing • Skills • Leadership • Organisational Development & Culture • Staff Engagement • Wellbeing • Productivity • Equality, Diversity and Inclusion The Committee will: The purpose of the committee is to provide the Board with assurance that: • The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care • Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the trust's values • The Trust is meeting its legal and regulatory duties in relation to its employees • Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee. • The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture. To provide assurance on the following key areas of workforce governance: • Resourcing • Skills • Leadership & organisational effectiveness • Engagement & Culture • Wellbeing • Productivity

~~PERFORMANCE & FINANCE &~~ PRODUCTIVITY COMMITTEE	**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. The Committee will: 1. Utilise the assurance reporting processes (BAF/TRR) to inform the Trust Board of Finance, performance, investment or related risk and redress actions. 2. Review annual plan modelling assumptions and in particular capital and revenue allocations as well as activity and investment assumptions. 3. Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval. 4. Approve the development of financial and contractual reporting in line with best practice. 5. Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur. 6. To receive and review the trust wide and divisional reports on finance and contractual performance and CIP before they are presented to the Board. The focus will be on forecast outturn, risks to delivering the plan and the mitigation plans. 7. Review expenditure against the agreed capital plan. 8. Review any matters which impact adversely on the financial performance or reputation of the Trust. 9. Oversee the development of Service line reporting. 10. Approve financial returns prior to submission to any external accountable authority, e.g. reference costs, ERIC, etc. (other than NHSE monthly returns due to timeliness) 11. Ensure the appropriate training and support is in place for budget holders/managers. 12. To make arrangements as necessary to ensure that all members of the Board and senior officers of the trust maintain an appropriate level of knowledge and understanding of key financial issues affecting the Trust. 13. Periodically review financial policies and procedures including scheme of delegation etc. to ensure that they are still relevant and appropriate. 14. Review financial and contractual performance against the main healthcare contracts. 15. Receive reports regarding contract negotiations and progress in agreeing contracts with the Commissioning bodies. 16. In line with the NHSE, assess if any proposed investments should be reported to NHSE/ICS in the annual planning process or in year prior to financial closure. 17. To receive and undertake investment appraisals of submitted developments and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's policy and external requirements to ensure that capital investments and transactions comply with the latest NHSE guidance. Ensure risks of any investments are properly evaluated and risk management arrangements put in place, including:- • Obtaining independent professional advice where appropriate. • Evaluate, scrutinise and monitor investments. • Ensure Investments are supported by relevant stakeholders. • To examine any relevant matters referred to it by the Board of Directors. 18. To examine any relevant matters referred to it by the Board of Directors. 19. To receive reports regarding new business and tender opportunities and the progress of tenders. 20. To receive and discuss updates regarding ~~STP/~~ICS developments and requirements.

INTEGRATION COMMITTEE	**AT THE TIME OF THIS DOCUMENTS REVIEW NOTE THAT THE TERMS OF REFERENCE FOR THIS COMMITTEE HAD NOT BEEN APPROVED** 1. Constitution The Board of Directors resolve to establish a Committee of the Board to be known as the Integration Committee. The Committee in its workings will be required to adhere to the Constitution of The Royal Wolverhampton NHS Trust. The Committee has no executive powers, other than those specifically delegated in these terms of reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Committee. 2. Authority 2.1 The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. 2.2 The Committee is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions. 2.3 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions. 3. Purpose 3.1 The purpose of the Committee is to provide the Board with assurance concerning the strategy and delivery plans for the Trust's Community, Strategic Objective. 3.2 The Committee will ensure that the performance and development of adult and children/young people community based services/primary care and the Trust's role in the development of the Place Based Partnership is meeting the objectives described within the Annual Operating Plan. 3.3 The Integration Committee will be the assurance group connecting the Place governance to the Trust Board. The committee will ensure the Board is sighted on the progress of the Place Based Partnership and will act as a critical friend as required. 3.3.1 The committee will receive assurance on the Trust's role to support the Place Based Partnership in developing a local strategy that is built on consensus and has the means for delivery. 3.3.2 The committee will ensure assurance oversight of the RWT services in scope for the Place Based Partnership. 3.3.3 The committee will ensure assurance oversight of the wider community services and development of the vision for community services and out of hospital model of care. 3.4 The committee will seek assurance and oversight on the wider work in the Community strategic objective relating to the following areas:

	o Socio Economic development o Sustainability and the Green Strategic plan o Widening participation o Regeneration plans with partners o Anchor institution

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTABLE OFFICER MEMORANDUM

DELEGATED TO	DUTIES DELEGATED
CHIEF EXECUTIVE	Accountable through NHS Accounting Officer to Parliament for stewardship of Trust resources
CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure the accounts of the Trust are prepared under principles and in a format directed by the SofS. Accounts must disclose a true and fair view of the Trust's income and expenditure and its state of affairs. Sign the accounts on behalf of the Board.
CHIEF EXECUTIVE	Sign a statement in the accounts outlining responsibilities as the Accountable Officer. Sign a statement in the accounts outlining responsibilities in respect of Internal Control.
CHIEF EXECUTIVE	*Ensure effective management systems that safeguard public funds and assist the Trust Chair~~man~~ to implement requirements of corporate governance including ensuring managers:* • "have a clear view of their objectives and the means to assess achievements in relation to those objectives • be assigned well defined responsibilities for making best use of resources • have the information, training and access to the expert advice they need to exercise their responsibilities effectively."
CHAIR~~MAN~~	Implement requirements of corporate governance.
CHIEF EXECUTIVE	Achieve value for money from the resources available to the Trust and avoid waste and extravagance in the organisation's activities. Follow through the implementation of any recommendations affecting good practice as set out on reports from such bodies as the Audit Commission and the National Audit Office (NAO).
CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Operational responsibility for effective and sound financial management and information.

CHIEF EXECUTIVE	Primary duty to see that CFO discharges the above function.
CHIEF EXECUTIVE	Ensure that expenditure by the Trust complies with Parliamentary requirements.
CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Chief Executive, supported by Chief Financial Officer/Operational Director of Finance,~~Chief Financial Officer~~, ensures appropriate advice is given to the Board on all matters of probity, regularity, prudent and economical administration, efficiency and effectiveness.
CHIEF EXECUTIVE	If CE considers the Board or Chair~~man~~ is doing something that might infringe probity or regularity, he/she should set this out in writing to the Chair~~man~~ and the Board. If the matter is unresolved, he/she should ask the Audit Committee to inquire and if necessary refer to the Department of Health and Social Care, NHS England
CHIEF EXECUTIVE	If the Board is contemplating a course of action that raises an issue not of formal propriety or regularity but affects the CE's responsibility for value for money, the CE should draw the relevant factors to the attention of the Board. If the outcome is that he/she is overruled it is normally sufficient to ensure that the advice and the overruling of it are clearly apparent from the papers. Exceptionally, the CE should inform the Department of Health and Social Care, NHS England. In such cases, the CE should as a member of the Board vote against the course of action rather than merely abstain from voting.

SCHEME OF DELEGATION DERIVED FROM THE CODES OF CONDUCT AND ACCOUNTABILITY

DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
BOARD	Approve procedure for declaration of hospitality and sponsorship.
BOARD	Ensure proper and widely publicized procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
ALL BOARD MEMBERS	Subscribe and adhere to the Code of Governance and the revised Fit and Proper Persons Test requirements~~Conduct~~.
BOARD	Board members share corporate responsibility for all decisions of the Board.
CHAIR AND NON EXECUTIVE/ OFFICER MEMBERS	Chair and non-executive members are responsible for monitoring the executive management of the organisation and are responsible to the SofS for the discharge of those responsibilities.
BOARD	The Board has six key functions for which it is held accountable by the Department of Health and Social Care on behalf of the Secretary of State: 1. to ensure effective financial stewardship through value for money, financial control and financial planning and strategy; 2. to ensure that high standards of corporate governance and personal behaviour are maintained in the conduct of the business of the whole organisation; 3. to appoint, appraise and remunerate senior executives; 4. to ratify the strategic direction of the organisation within the overall policies and priorities of the Government and the NHS, define its annual and longer term objectives and agree plans to achieve them; 5. to oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary; 6. to ensure effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs.

DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
BOARD	It is the Board's duty to: 1. act within statutory financial and other constraints; 2. be clear what decisions and information are appropriate to the Board and draw up Standing Orders, a schedule of decisions reserved to the Board and Standing Financial Instructions to reflect these, 3. ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives for the main programmes of action and for performance against programmes to be monitored and senior executives held to account; 4. establish performance and quality measures that maintain the effective use of resources and provide value for money; 5. specify its requirements in organising and presenting financial and other information succinctly and efficiently to ensure the Board can fully undertake its responsibilities; 6. establish Audit and Remuneration Committees on the basis of formally agreed terms of reference that set out the membership of the sub-committees, the limit to their powers, and the arrangements for reporting back to the main Board.
CHAIR~~MAN~~	It is the Chair~~man~~'s role to: 1. provide leadership to the Board; 2. enable all Board members to make a full contribution to the Board's affairs and ensure that the Board acts as a team; 3. ensure that key and appropriate issues are discussed by the Board in a timely manner, 4. ensure the Board has adequate support and is provided efficiently with all the necessary data on which to base informed decisions; 5. lead Non-Executive Board members through a formally-appointed Remuneration Committee of the main Board on the appointment, appraisal and remuneration of the Chief Executive and (with the latter) other Executive Board members; 6. appoint Non-Executive Board members to an Audit Committee of the main Board; 7. advise the Secretary of State on the performance of Non-Executive Board members.

CHIEF EXECUTIVE	The Chief Executive is accountable to the Chair~~man~~ and Non-Executive members of the Board for ensuring that its decisions are implemented, that the organisation works effectively, in accordance with Government policy and public service values and for the maintenance of proper financial stewardship. The Chief Executive should be allowed full scope, within clearly defined delegated powers, for action in fulfilling the decisions of the Board.
CHAIR AND DIRECTORS	Declaration of conflict of interests.
BOARD	NHS Boards must comply with legislation and guidance issued by the Department of Health and Social Care, NHS England on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money. The Board must on a comply, demonstrate or explain basis, ensure it is aware of and acting in accordance with the NHS Code of Governance for NHS Provider Trust (2023).

SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
SECTION A - 2	CHAIR~~MAN~~	Final authority in interpretation of Standing Orders (SOs).
4.4	BOARD	Appointment of Deputy~~Vice~~ Chair~~man~~
5.1	CHAIR~~MAN~~	Call meetings.
5.9	CHAIR~~MAN~~	Chair all Board meetings and associated responsibilities.
5.10	CHAIR~~MAN~~	Give final ruling in questions of order, relevancy and regularity of meetings.
5.12	CHAIR~~MAN~~	Having a second and casting vote
5.13	BOARD	Suspension of Standing Orders
5.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders
5.14	BOARD	Variation or amendment of Standing Orders
7.3	BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference.
7.2	CHAIR~~MAN~~ & CHIEF EXECUTIVE	The powers which the Board has reserved to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive.
7.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
9.1	THE BOARD	Declare relevant and material interests.
9.2	CHIEF EXECUTIVE	Maintain Register of Interests.
9.4	ALL STAFF	Comply with national guidance contained in HSG (93/5) “Standards of Business Conduct for NHS Staff” and with any Trust policy derived therefrom and The NHS Code of Governance for NHS Provider Trusts (2023).

SO REF	DELEGATED TO	AUTHORITIES/DUTIES RESERVED OR DELEGATED
9.3	ALL	Disclose any pecuniary interest (direct or indirect) in any contract entered into (or about to be entered into) by the Trust.
9.4 (2)	ALL	Disclose relationship between self and candidate for staff appointment. (CEO to report the disclosure to the Board.)
9.5	CHIEF EXECUTIVE / DEPUTY CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
9.9	CHIEF EXECUTIVE/EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Approval of all financial procedures.
1.1.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Advice on interpretation or application of SFIs.
1.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Duty to disclose any non-compliance with Standing Financial Instructions to the Chief Financial Officer/Operational Director of Finance as soon as possible.
1.2.2	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure financial targets and obligations are met and has overall responsibility for the System of Internal Control.
1.2.2	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.2.3	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.

1.2.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Responsible for: a) ensuring that the Standing Financial Instructions are maintained and regularly reviewed; b) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies; c) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; d) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ include:

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		(a) the provision of financial advice to other members of the Board and employees; (b) the design, implementation and supervision of systems of internal financial control; (c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
1.2.5	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions, financial procedures and The Scheme of Reservation and Delegation.
1.2.6	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income is made aware of these instructions and the requirement to comply.
2.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control.
2.1.2	CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
2.1.3 & 2.2.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
2.2.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
2.2.3	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER~~	Responsible for ensuring access rights are given to NHS Counter Fraud Authority where necessary for the prevention, detection and investigation of cases of fraud, bribery and corruption, in accordance with the Government Functional Standard 013: Counter Fraud.
2.3	INTERNAL AUDIT SERVICE PROVIDER	Review, appraise and report in accordance with guidance from Department of Health and Social Care and Social Care and best practice.
2.4	AUDIT COMMITTEE	Ensure cost-effective, efficient External Audit.
2.5	CHIEF EXECUTIVE & CHIEF FINANCIAL	Monitor and ensure compliance with the Government Functional Standard 013: Counter Fraud on fraud and corruption as specified in the NHS Tackling Fraud, Bribery & Corruption Policy & Corporate procedures.

	OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	
2.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health and Social Care on NHS security management.
3.1 & 3.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
3.1.6	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure adequate training is delivered on an on going basis to budget holders.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
3.2.1	CHIEF EXECUTIVE	Delegate budgets to budget holders.
3.2.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
3.3.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Devise and maintain systems of budgetary control.
3.3.2	BUDGET HOLDERS	Ensure that: (a) no overspend or reduction of income that cannot be met from virement is incurred without appropriate consent; (b) approved budget is not used for any other than specified purpose subject to rules of virement; (c) no permanent employees are appointed without the appropriate approval other than those provided for within available resources and manpower establishment.
3.3.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities.
3.5	CHIEF EXECUTIVE	Ensure the submission of monitoring returns
4.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Preparation of annual accounts and reports.
5.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories.
5.5.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	The CFO/ODoF~~CFO~~ will advise the Board on the Trust's ability to pay dividend on PDC and report, periodically, concerning the PDC debt and all loans and overdrafts.
5.5.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Any application for a loan or overdraft will only be made by CFO/ODoF~~CFO~~ or by an employee delegated by them
5.5.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.5.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure that the process for approving short term borrowings is consistent with the Board-approved Treasury Management Policy/Guidelines.
5.6.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Will advise the Board on investments and report, periodically, on performance of same.
5.6.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Prepare detailed procedural instructions on the operation of investments held.
6.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collecting and coding of all monies due

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
6.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Responsible for appropriate recovery action on all outstanding debts
7.6.3	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER~~	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
7.6.7	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER~~	Where one tender is received will assess for value for money and fair price.
7.6.9	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with SFIs except with the authorisation of the Chief Executive.
7.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
7.7.4	CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or Chief Financial Officer/Operational Director of Finance~~Chief Financial Officer~~.
7.9	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
7.9	BOARD	All PFI proposals must be agreed by the Board.
7.10	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
7.11	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
7.14	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
7.14.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the

		Trust.
8.1.1	CHIEF EXECUTIVE	Shall ensure that the Trust enters into suitable Service Level Agreements (SLAs) with commissioners for the provision of NHS services
8.2	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from SLAs
9.2.1	BOARD	Establish a Remuneration Committee
9.2.2	REMUNERATION COMMITTEE	Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments. Advise the Board on and make recommendations on the remuneration and terms of service of the CE, and other executive members employed by the Trust. Monitor and evaluate the performance of individual executive members.
SFI REF	**DELEGATED TO**	**AUTHORITIES/DUTIES DELEGATED**
9.2.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and the basis for recommendations.
9.5	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure that the chosen method for payroll processing is supported by appropriate terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
9.6	NOMINATED MANAGER	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
10.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
10.2	REQUISITIONER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
10.3.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Shall be responsible for the prompt payment of accounts and claims.

10.3.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFIs and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Reservation and Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
10.4(a)	APPROPRIATE OFFICER	Make a written case to support the need for a prepayment.
10.4(b)	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Approve proposed prepayment arrangements.
SFI REF	**DELEGATED TO**	**AUTHORITIES/DUTIES DELEGATED**
10.4(c)	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform CFO if problems are encountered).
10.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
10.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer/Operational Director of Finance.
11.1.1	CHIEF EXECUTIVE	(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; (b) shall ensure that the capital investment is not undertaken without confirmation of affordability; (c) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
11.1.2	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
11.1.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Assess the requirement for the operation of the construction industry taxation deduction scheme.

11.1.5	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
11.1.7	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
11.1.9	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
11.7.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from CFO).
11.7.5	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
11.7.8	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Calculate and pay PDC dividend in accordance with Department of Health and Social Care and Social Care requirements.
11.8.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
11.8.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Approval of fixed asset control procedures.
11.8.4	BOARD, EXECUTIVE MEMBERS AND ALL SENIOR STAFF	Responsibility for security of Trust assets including notifying discrepancies to CFO/ODoF, and reporting losses in accordance with Trust procedure.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
12.2.1	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to CFO responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
12.2.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Responsible for systems of control over stores and receipt of goods.
12.2.1	CLINICAL DIRECTOR OF PHARMACYAND MEDICINES OPTIMISATION	Responsible for controls of pharmaceutical stocks
12.2.1	DIVISIONAL MANAGER, ESTATES AND FACILITIES	Responsible for control of stocks of fuel oil and coal.
12.2.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Set out procedures and systems to regulate the stores.
12.2.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Agree stocktaking arrangements.
12.2.5	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Approve alternative arrangements where a complete system of stores control is not justified.
12.2.6	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.

	FINANCE~~CHIEF FINANCIAL OFFICER~~	
12.2.6	NOMINATED OFFICERS	Operate system for slow moving and obsolete stock, and report to CFO evidence of significant overstocking.
12.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supply Chain stores.
13.1.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
13.2.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
13.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the CE and CFO.
13.2.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Where a criminal offence is suspected, CFO/ODoF must inform the police if theft or arson is involved. In cases of fraud and corruption CFO must inform the relevant LCFS.
13.2.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
SFI REF	**DELEGATED TO**	**AUTHORITIES/DUTIES DELEGATED**
13.2.6	BOARD	Approve write off of losses (within limits delegated by DHSC).
13.2.8	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF~~	Consider whether any insurance claim can be made.

	~~FINANCIAL OFFICER~~	
13.2.9	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Maintain losses and special payments register.
14.1.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Responsible for accuracy and security of computerised financial data.
14.1.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
14.2.1	CHIEF MEDICAL OFFICER	Shall publish and maintain a Freedom of Information Scheme.
14.2.2	RELEVANT OFFICERS	Send proposals for general computer systems to CFO/ODoF
14.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
14.3.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall need to be satisfied that: (a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy; (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; (c) Chief Financial Officer's staff has access to such data, and; (d) such computer audit reviews as are considered necessary are being carried out.

14.4	CHIEF EXECUTIVE	Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.
15.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
15.3	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE ~~CHIEF FINANCIAL OFFICER~~	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients.
SFI REF	**DELEGATED TO**	**AUTHORITIES/DUTIES DELEGATED**
15.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
16.1.2	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
17.1	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff.
18.1	CHIEF EXECUTIVE	Retention of document procedures in accordance with NHSE and DHSC Guidelines
20.1.1	CHIEF EXECUTIVE	Risk management programme exists.
20.1.1	BOARD	Approve and monitor risk management programme.
20.2.1	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.

20.4	CHIEF FINANCIAL OFFICER/ OPERATIONAL DIRECTOR OF FINANCE~~CHIEF FINANCIAL OFFICER~~	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer/Operational Director of Finance ~~Chief Financial~~ Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer/Operational Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer/Operational Director of Finance ~~Chief Financial Officer~~ will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

(Scheme of reservation & delegation February ~~2023~~2024)

Reference(s):

Code of governance for NHS provider trusts – https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/

Document Control

Reference Number and Policy name: Budget Management Principles and Guidance	**Version:** V4		**Status:** Final	**Author:** Head of Financial Governance and Transactions **Director Sponsor:** Chief Financial Officer
Version / Amendment History	Version	Date	Author	Reason
	V1	September 2010	Deputy Chief Financial Officer	Initial set-up of SOP
	V2	April 2019	Head of Financial Control and Assurance	Review of SOP to ensure meets current process, with tweaks to reflect current practice
	V3	November 2021	Deputy Chief Finance Officer	Scheduled review of policy
	V3.1	April 2022	Deputy Chief Finance Officer	Update made to hyperlink on page 23.
	V4	December 2023	Head of Financial Governance and Transactions	Review of SOP to ensure meets current process, with tweaks to reflect current practice
Intended Recipients: All managers with budgetary responsibility				
Consultation Group / Role Titles and Date: Finance & Productivity Committee; Audit Committee; Trust Management Committee; Chief Financial Officer; Operational Director of Finance; Deputy Financial Officer; Head of Financial Management				
Name and date of Trust level group where reviewed			Trust Policy Group – February 2024 Trust Management Committee – January 2024	
Name and date of final approval committee			Audit Committee – December 2023 Trust Board – February 2024	
Date of Policy issue			February 2024	
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)			Annually	

The Royal Wolverhampton NHS Trust

THE ROYAL WOLVERHAMPTON NHS TRUST

BUDGET MANAGEMENT PRINCIPLES AND GUIDANCE

CONTENTS

SECTION 1 - FOREWORD

1. It is the Trust Board's philosophy that the responsibility for achieving the Trust's objectives should be devolved to the lowest practical level. Accordingly, departmental managers are responsible for their departments' contributions towards overall objectives - including the provision of services within specific resource levels.

2. This document identifies budget responsibilities that are consistent with the Trust's management structure and philosophy. Each executive director of the Trust is accountable for the financial performance of their area of responsibility.

3. Although devolution is the Board's philosophy, it must be remembered that ultimate responsibility for the Trust's overall budgetary and cash control lies with the Board. Budget Holders must strictly observe the budgetary limits and control procedures defined by the Board.

4. You are also advised to ~~read the~~attend Budget Manager Training ~~booklet~~, which is available ~~from your Finance Manager~~ as face to face training or on line, both are sourced through My Academy. It provides a basic explanation of the information that appears on budget reports, how to interpret them and how to complete some of the financial processes that ensure that your reports are timely and accurate.

5. The Finance and Information Directorate are happy to provide additional training on any aspect of budgetary control or financial procedures. This can be arranged for individual managers or groups of staff. Please speak to your Finance Manager for further details, or Deputy Chief Financial Officer (ext. ~~85376~~81598).

SECTION 2 - STANDING FINANCIAL INSTRUCTIONS

1. Standing Financial Instructions are issued for the regulation of the conduct of the Trust, its directors, officers and agents in relation to all financial matters. The Board is responsible for ensuring that adequate Standing Financial Instructions are adopted and adhered to.

2. This document is written to supplement the broad policy statements relating to budgets, as documented in Section 3 of Standing Financial Instructions.

3. Notwithstanding the budgetary limits identified within this budget policy document, the Authorised Limits (particularly as they apply to requisitioning, procurement and payment) identified in Standing Financial Instructions must always be observed.

SECTION 3 - FINANCIAL ADVICE

1. The Chief Financial Officer/Operational Director of Finance's duties, powers and responsibilities in relation to the Trust's overall financial performance are set out in Statutory Financial Regulations and in the Trust's Standing Financial Instructions.

2. In order to discharge such responsibilities, the Financial Management Section of the Finance Department has been organised into teams, each headed by a Finance Manager to provide financial monitoring, advice and support to budget managers. Thus each budget holder in the Trust will have a named contact point on day-to-day budget issues, and will also have access to a designated senior member of the Department, a Finance Manager, for detailed professional advice and support. Regular contact with both is essential and is encouraged.

3. Financial advice and support will include:-

   - Provision of monthly budget statements
   - Assistance with, variance analysis, in supporting managers to understand under or overspends, and the identification and monitoring of appropriate corrective actions.
   - Provision of estimated resource allocations, revenue consequences of capital proposals, other developments and changes in activity levels.
   - Costing of changes to services, including the impact on service level agreements or contracts with commissioners.
   - Development of annual cost improvement programme savings initiatives.
   - Assistance in the development of the budget holder's services in line with agreed strategic priorities and policies
   - Evaluating planning proposals emanating from the budget holder for inclusion in the annual budget and strategic and annual planning cycle
   - Developing business plans and business cases
   - Training in financial issues

4. In the modern NHS it is likely that most major decisions made by budget ~~holders or~~holders or managers in the Trust will have some impact upon either spending or income levels. As part of the management process, early identification and full discussion and disclosure of the financial effects of development or savings proposals is of great importance. In the clinical arena this will include the impact of significant changes to drug therapies, care pathways or clinical techniques etc. In support of this, all reports should indicate clearly the financial effects of any proposals - both on the income and expenditure of the budgets directly affected and on other areas or departments - prior to implementation. These financial implications MUST be agreed with the Finance Directorate in advance of submission for approval and the figures reported shown as having been so agreed (see also Service Developments and Business Cases under Section 5 below)

Commented [MG1]: And the identification and monitoring of corrective action.

5. To comply with these ~~requirements~~requirements, it is obviously necessary for any paper or report which has a financial impact to be agreed with finance staff at as early a stage as possible.

SECTION 4 - BUDGETS - GENERAL PRINCIPLES

1. A number of general principles underpin the Trust's approach to financial management and will impact on the further development of budgets within the Trust.

(a) Levels of budgetary responsibility

It is important to clarify individual responsibilities and to ensure both that accountability lines are clear and that such accountabilities are consistent with the Trust's wider management arrangements. Levels of responsibility are:

Budget Holder:-

Budget holders will normally be ward/departmental managers, who are responsible for day to day management of the budget.

Monitoring Officer:-

Monitors performance of a designated group of budget holders, ensuring that action is taken to bring about individual and collective balance. In the clinical operational areas, monitoring officers would normally be ~~members of~~members of the Clinical Directorate teams.

Divisional/Corporate Director:-

Monitors performance of his/her division or directorate, ensuring that appropriate action is being taken and that, as a minimum, the division's/directorate's overall position is in balance.

It follows from the above that the budget holder is responsible for ensuring that his/her department operates within budgetary limits. In the exceptional cases where there is a possibility of this not being the case, discussion needs to take place with monitoring officer/director to identify how such a position will be accommodated within an overall balanced division/directorate.

A detailed list of these is available from Finance.

(b) Openness

In the interests of "no surprises", it is important that issues impacting upon the ability to achieve budgetary targets are communicated at an early stage – both up and down the Trust.

(c) Scope of budgetary responsibility

Activity and Income

The Trust's ability to spend is constrained by the amount of income it can reasonably expect to generate from its commissioners and the risk associated with such expectations. It is, therefore, important that expenditure levels respond to changes in service level agreements and contracts and to in year activity levels. The Trust will incorporate - where appropriate - income into budget reports and budget managers will be responsible for ensuring a balanced position across both income and expenditure.

Ability to control and internal recharges

It is a basic budgetary principle that responsibility should rest where control can actually be exercised, although there are circumstances where this is impractical from a systems viewpoint e.g. postage. However, there are areas where it is felt that internal recharging arrangements may have some beneficial impact (as demonstrated, for example by the devolution of the drugs budget).

This approach will only be pursued where there are significant benefits in accountability and decision-making and where recharges can be supported by robust activity data.

(d) Value for Money and Efficiency

Measurement of Performance at Service Level

The Trust will develop measures that allow performance to be measured at service level e.g. specialty or HRG. This will assist in identifying areas for operational improvement and growth or where savings in expenditure may be possible. Directorates are expected to contribute to this process by working with the Finance Directorate to analyse this information and develop action plans. Directorates should work with the Service Efficiency team to develop their pipelines of efficiency; the Service Efficiency team will support the development of PIDs. This should support the transaction of financial efficiency.

This will include benchmarking data on clinical performance and reference costs, for instance under the Trust's Model ~~Hospital~~Health, Clinical Excellence and Getting It Right ~~First Time~~First-Time programmes and will develop productivity measures that link budget performance with activity and ~~outcome indicators~~outcome indicators.

This work is supported by the Trust's Patient Level Costing and Service Line Reporting systems (see Section 12).

SECTION 5 – TRUST BUSINESS PLANNING AND BUDGET SETTING PROCESS

Business Planning

1. Budget setting is part of the wider Trust business planning process. The income to fund budgets comes from contracts with commissioners (~~CCGs~~ ICBs, ~~and~~ NHSE and Local Authorities)~~/LA~~), service level agreements (SLAs), and from charges (e.g. catering, accommodation etc.). Income from commissioners makes up over 8~~9~~0% of the total. One of the main aims of Business planning is to identify service developments, ~~cost pressures~~cost pressures, efficiencies and levels of activity required to achieve national and local targets. Actual levels of activity achieved by the Trust will determine the level of funding available to fund these plans. The Trust is now moving towards forms of contract with a shared risk basis e.g. ~~Shared~~ Aligned Incentive~~s~~ Contract. This is in ~~line with~~line with National Guidance and the Standard NHS Contract also increasingly moving towards shared risk basis. Negotiations take place with commissioners each year to agree target levels of activity. Trust will always seek to work ~~with Commissioners~~with Commissioners for maximum income to meet activity completed with the NHS standard Contract being used as a last resort.

2. Contracts with commissioners consist of funding for agreed activity levels, and include an uplift determined each year to fund:

   - Pay award and inflation increases.
   - National cost pressures (e.g. new drugs).
   - Less a real reduction in funding in anticipation of increased efficiency.

3. The implication of the efficiency requirement in contract pricing is that the Trust must achieve a productivity gain each year, there may also be an additional local efficiency requirement~~.~~ Efficiencies~~This~~ will require either reductions in cost, or increases in activity that produce more income than increased cost. This increased productivity is the only mechanism available to the Trust to fund new developments and cost pressures. It is important that service developments, whether avoidable or unavoidable, are identified as early as possible to include in the business planning process (see Section 7**:** Cost Pressures/ Unfunded Developments).

4. The annual process of identifying service developments, cost pressures and levels of activity required to achieve national and local targets, and agreeing these with commissioners takes place according to an agreed timetable in order that contracts with commissioners and an income and expenditure (I&E) plan can be approved by the Trust Board prior to the start of the financial year, as well as to enable submission of plans to monitoring organisations. The Chief Financial Officer is responsible for establishing a Trust Budget each year for approval by the Trust Board.

5. The ~~Long Term~~Long-Term Financial Model (LTFM) will also be updated each year to assist the forward planning process.

Budget Setting

6. Meetings will be held, in accordance with an agreed timetable, between budget holders/monitors and members of the Finance Department designed to establish a package of agreed budgets for inclusion in the Trust's Annual I&E plan. This process will normally take place between ~~November~~ October and February. A more detailed set of guidance on budget setting is ~~embedded as an Appendix at the end of this section.~~ issued each year at the start of the process.

Commented [JP2]: Can't see this is included

7. Budgets will be based on planned levels of activity and income, based on the outcome of contract agreements, and priorities agreed by the Trust Board that are reflected in the Trust's strategic objectives and business plans. Budgets will be drawn up so that at aggregate level they are contained within income levels and are consistent with the achievement of the Trust's overall financial targets.

8. The Finance Department is responsible for assisting budget holders in the preparation of budgets. This will normally entail a ~~two stage~~two-stage process, as ~~follows:~~ follows: -

(a) Baseline budget

This is essentially a calculation of the costs of sustaining existing levels of agreed recurrent staffing and non-pay expenditure. The full year effect of part year changes will be incorporated and any ~~non recurrent~~non-recurrent adjustments will be negated. The bases of producing baseline budgets will be:-

- agreed establishment costed using -

(i) Pay rates prevailing at budget setting, including actual incremental points of staff in post (subject to ~~these~~ bandings being consistent with funded establishment); and

(ii) Effect of forecast increments (subject to ~~the Trust's~~the Trust's overall financial position). Posts vacant at the point of budget setting will be funded at the relevant pay scale ~~t minimum of scale~~point ~~on the relevant payscale a~~as determined in the annual budget guidance issued for the financial year.

(iii) Anticipated "vacancy factor" (see Section 6)

- Non pay budgets at full year effect "rollover" levels.

Whilst discussions around baseline budgets may identify cost pressures, these can only be accommodated at this stage if self-funded within the budget.

Where appropriate, the baseline activity level underpinning the baseline expenditure budget will be explicitly agreed.

(b) Post-baseline adjustments

These adjustments are significantly linked to income from planned activity and contracts and would include, subject to funding being identified:-

- Service developments/
  cChanges in activity (both increases and decreases) and Changes in activity (both increases and decreases)
- Ccost pressure funding where approved.ng
  Cost improvements
  Cost pressure funding
  Cost improvements

- ~~Changes in activity (both increases and decreases)~~
- ~~Cost pressure funding~~
- ~~Cost improvements~~

9. Once budgets have been agreed, they will be updated normally for changes in pay rates or price levels. Such changes will always be subject to the Trust's overall financial position.

10. The Finance and Information Directorate will be responsible for agreeing the monthly phasing of income and expenditure plans with operational divisions and directorates at the start of the year. In order for this to be undertaken on an informed basis, divisions/directorates will need to develop phased plans for delivering agreed activity levels. The "default" option for monthly budget phasing will be twelfths – and any changes from that position will only be implemented where it is agreed that such a change will make a significant impact.

~~10.~~11. Budget setting guidance is updated and distributed on an annual basis and the latest guidance can be obtained via the relevant Finance Leads/Manager

Cost Improvement Programme

~~11.~~12. The Trust will need to achieve financial efficiencies each year (see Section 3). This leads to a gap between planned income and planned expenditure each year which will need to be filled by efficiency savings. Plans to achieve efficiency savings are summarised in the Trust's Cost Improvement Programme and savings otherwise known as CIPs. CIPs may relate to income or expenditure, though income CIPs are likely to require engagement with the paying organisation.

~~12.~~13. Once identified CIPs are taken from budgets recurrently or non-recurrently. Non-recurrent CIPs are reflections of underspends in year where there is no ongoing plan to reduce costs or increase income. Non-recurrent CIPs demonstrate to regulators that the Trust has identified ways to improve its financial position in year, but they do nothing to improve the underlying financial position. Amounts saved non-recurrently in one year will need to be saved again in the following year and will need to be added to the CIP requirement for the following year.

~~13.~~14. The budget setting process will identify the financial gap between planned income and planned expenditure. The Board will then need to take a view on the level of CIP that should be delivered to address this gap. This will depend on the size of the gap, whether financial mitigations can be found outside of the Cost Improvement Programme, and on the level of CIPs that the Board considers can be delivered without adversely affecting patient care. ~~CIPs greater than 5% of budgets are widely considered unachievable and are likely to be challenged by regulators.~~

~~14.~~15. Responsibility for managing the delivery of the Trust's Cost Improvement Programme rests with the Operational Teams, though they will be supported by the Service Efficiency Team to identify opportunities, consider the impact on patient care, plan for delivery, manage implementation, monitor progress and ensure outcomes. Service transformation ~~is~~will be ~~the~~ key to delivering sustainable, value for money services, and high-value CIPs. ~~It is essential that operational and financial managers make a significant contribution to this through their~~

Commented [MG3]: This needs correcting its budget holders responsibility to deliver these, the SET team are responsible for identifying opportunities, supporting the planning and implementation of improvements, monitoring and managing performance.

~~understanding of services. Operational teams will need to identify and develop proposed schemes alongside the Service Efficiency Team and consider their impact on patient care.~~ Financial support will be required to evaluate the deliverability and realism of schemes, the impact to financial flows, VFM and efficiency position (including economic benefits), and also to use financial information to identify opportunities and appropriate KPIs to realise benefits~~.~~

~~15~~16. The earlier CIPs can be identified; the more likely they are to be delivered at the time they are needed, so work on identifying efficiencies needs to be ongoing throughout the year. A successful CIP programme is likely to plan more than one year in advance. If we only start to identify CIPs at the start of the financial year, we are unlikely to reach our target.

15. Once the Trust-wide CIP target has been set, targets will be set for Divisions and Directorates. The default for this is that a percentage target will be applied proportionally to reach the required total. Certain areas will be exempted from this, usually where the costs are not controllable or are matched equally by income.

16. Monitoring and approval of the CIP is discussed further in Section 8 below. Once a CIP is identified as likely it will generate a Project Initiation Document (PID) and subsequent budget changes will need to be consistent with this PID.

17. Once identified and implemented, CIPs are removed from budgets recurrently or non-recurrently to reflect the fact that spend is no longer required or additional income has been generated. There are three special cases:

- Where budget can be removed due to never beingen spent in recent years. This helps to reduce the planned financial gap at budget setting, by removing budgets that are no longer required, but has no impact on actual spend. Savings of this type should be declared where possible to assist with realistic planning but will not improve the Trust's actual financial performance.
- Where savings can be made but cannot be taken out of budgets, because they relate to reducing overspends. In some cases the Trust may consider funding cost pressures on agency or WLI payments, which will allow CIPs to be identified against these areas. In any case the Trust's financial position will improve if costs are reduced, so savings of this type should be pursued with equal importance as savings from budgets, even if they are not counted against the Trust's CIP target.
- Where spend can be reduced but is linked to reduction in income, or where income can be increased but at a cost. In these cases the net position should be considered in budget setting.

Planned Activity Changes

18. Planned changes to activity levels will clearly affect the budgets that divisions/directorates require. A review of the impact of activity will take place each year according to a process agreed by the Chief Operating Officer with the Chief Financial Officer.

19. Increases in planned income that are agreed to be recurrent by the Chief Financial Officer/Operational Director of Finance (following discussion with the Chief Operating Officer) can be used to fund recurrent developments, subject to the procedure on business cases (see below). They can also be used (net of any additional recurrent expenditure) to meet annual recurrent cost improvement (CIP) targets.

20. The process around in-year income performance is described in Section 8 below. The main distinction to income variances is that they will not normally be treated as recurrent within the financial year.

Service Developments and Business Cases

21. It is essential that service developments/improvements/changes are not actioned without (a) a clear identification of potential impacts on income and costs and (b) agreement over funding (c) demonstration of efficient use of resources, including existing capacity. A business case procedure and documentation has been developed and is available on the intranet to ensure that there is a clear statement of the impact of any proposed change and that the case is approved at the appropriate level with the Trust.

22. Recurrent developments/changes must not be agreed unless the business case (detailing, amongst other things, income and expenditure impact) has been authorised in accordance with the agreed approval process.

23. The Trust's Business Case Process should be utilised and this can be obtained from relevant Finance Managers.

24. ~~Budget setting guidance is updated on an annual basis and the latest guidance can be obtained via relevant Finance Manager~~.

SECTION 6 – STAFFING ESTABLISHMENTS

1. Staffing costs represent a significant proportion of the budget. It is extremely important that managers control and operate within their agreed establishments and net pay budgets (i.e. after reduction for vacancy factor* -see below).

2. Ability to recruit to funded posts may also be subject to the overall (i.e. including non pay) position of a manager's budget. Managers are required to refer to the Trust's existing vacancy control procedure before any new or replacement post is advertised, and this must be approved at Divisional and Executive Directors vacancy panels, which must include appropriate finance managers.

Definition

3. An establishment is a maximum number and grade/mix of staff that a manager is permitted to employ. Agreed establishments include (where appropriate) an element for annual leave, study leave and sickness cover. In no case may a budget manager exceed establishment and/or pay budget without prior approval by the budget holder in line with delegated levels of authority as defined by the SFIs.

Funding

4. Given that baseline budget funding will be by reference to actual increment point of staff in post, it follows that, within a grade, should staff at a higher point be replaced by those at a lower point, then no CIP can be declared. However, this "one off" gain will be available for budget holders to use to offset the vacancy factor (see below), as no funding adjustments to reflect in-year changes in incremental points would normally be made. Any excess budget over and above vacancy factor can be declared non recurrently to CIP.

Manpower Statistics

5. Budget and actual manpower information is produced on a whole time equivalent (WTE) basis. These are derived by taking the hours actually worked (including paid leave and sickness) and dividing by the standard hours in a working week for that grade. Thus, for any member of staff covered by Agenda For Change, the WTE of that individual, if working for 45 hours per week would be:

Actual hours worked	45		
----------	----	=	1.20 WTE
Standard hours for grade	37½		

Vacancy Factor

6. In costing pay budgets, in many areas an explicit reduction is made to gross establishment costings in respect of a "vacancy factor". This acknowledges the fact that staff turnover will result in vacancies; that vacant posts are not always filled immediately; and that leavers are often replaced by staff at a lower incremental point.

7. It should be noted that without this vacancy factor, the Trust's budgets would not be financially sustainable and that establishments would then need to be reduced.

The real terms value of the vacancy factor will be maintained by annual uplifts to reflect the rate of increase in the paybill (both inflation and any incremental drift).

8. Vacancy factors are normally rolled over from year to year within individual budgets and are not therefore sensitive to changing circumstances in each area. As part of the annual budget setting process, divisions/directorates have the freedom to reallocate vacancy factor within their overall areas of control; however, the requirement to achieve aggregate vacancy factor remains.

Changes to Establishment

9. These may only occur

   (a) as part of an approved and funded change in service provision, reflected in an agreed Business Case

   (b) As a consequence of an agreed virement (requesting a transfer of resources within or between budgets – see also section 10), identifying source of internal funding

   (c) As part of a Cost Improvement Programme (CIP) which has been approved via a "Project Initiation Document", through the Financial Recovery Group (FRG).

   (d) No change will be reflected in budgets or establishments unless specific approval has been obtained and funding identified, as confirmed by one of the above completed processes – if in doubt, please consult your Finance Manager. All costings of changes to establishments must be undertaken by the Financial Management Department.

10. Changes to the grades attached to posts must be agreed in accordance with Trust HR policies, and any increased cost will normally fall to be met from within the department or directorate.

11. It should be noted, that due to the greater levels of difficulty in controlling non-pay budgets, establishment variation proposals involving the transfer of funds from non-pay to pay are unlikely to be approved without a clear demonstration of the recurring non-pay cost reduction. (See section 10, paragraph 5).

SECTION 7 - COST PRESSURES/UNFUNDED DEVELOPMENTS

1. A significant element of the financial pressures experienced by the Trust emanates from so-called "cost pressures". In reality, a large proportion of such pressures would more accurately be called "unfunded service developments"- often arising from changes in clinical practice and/or product designed to improve the quality of patient care.

2. Clearly, implementing such changes - where resulting in an increased cost - is likely to have a detrimental impact on the budget holder's responsibility not to overspend.

3. It is important, therefore, to pre-empt this and any such changes should be identified in advance. The procedure on business cases provides a framework for considering service changes that potentially impact on costs reviewing this guidance may help in considering cost pressures. It is important that the budget holder takes a view on whether the cost pressure can be financed by virement (see Section 10) within his/her budget. Should this not be the case, discussions will need to be held within the directorate or division to agree whether the development should proceed and, if so, how funding will be provided. In exceptional cases, the relevant director may wish to bring a proposal to the Executive Directors' Team, it is expected that this would be in the form of a business case, prior to the service change.

4. It is important to identify any cost pressures arising from changes in activity levels, revised national guidance (e.g. NICE) and inflationary pressures as part of the annual budget setting process (see Section 5). This will enable the finance team to work with departments, directorates and divisions to ensure the financial pressure is either built into budget or mitigated in other ways.

SECTION 8 - MONITORING

1. All levels of Trust management shall receive monthly statements detailing actual performance against income and expenditure budgets. The level of detail will vary according to need, with, for instance, budget holders having the greatest level of detail and the Trust Board receiving summarised information. At each level reported there will be exception reports detailing material variances.

2. Although it is the budget holder's responsibility to manage within the agreed budget, monthly budget reports will also be monitored, in summary form, by the monitoring officer/director as part of the accountability relationship within the Directorate/Divisional structure. The monitoring officer must ensure that where overspending is occurring the necessary corrective action is taken.

3. At a Directorate and Divisional level it is important to monitor both Income and Expenditure. The combined total of income minus expenditure is referred to as contribution. By taking the values for budgeted income and expenditure (including CIP reduction), the planned contribution is known. This would then be compared to the actual values and the variance must remain positive. An example is shown below:

	Plan/ Budget	Actual	Variance	
Income	3,000	3,200	200	Over performance
Expenditure				
Pay	(1,500)	(1,400)	100	Underspend
Non Pay	(750)	(850)	(100)	Overspend
CIP Target	150		(150)	
Sub Total	**(2,100)**	**(2,250)**	**(150)**	Overspend
	900	**950**	**50**	Net contribution greater than plan

4. In order to avoid problems and mitigate financial risks, budget holders will be included in forecasting to project income and spending forward to the year end. This will take into account performance to date and any known future issues. Finance staff will lead this process and agree forecasts with budget holders. Corrective actions may be required to ensure that the planned contribution for each Division and Directorate is achieved by year end

5. Formal processes of forecasting the Divisional/Directorate and Trust end of year positions will take place regularly during the financial year.

In Year Variances

5. The policy for reflecting budget changes relating to planned changes to activity and income is stated in Section 5 above. Where there is an in-year variance

(either positive or negative) against planned income levels the relevant directorate will need to work with their Finance Manager to identify the financial impact.

~~6.~~ The National Tariff Payment System sets out a variable element where by certain elective activity, diagnostic imaging and high cost drugs & devices are paid for on a volume basis. All over activity is fixed on a block payment negotiated for the year. There will be no additional income for growth in activity associated with the fixed element in year, however levels of activity and associated funding are reassessed during contract negotiations. Trusts are expected to work towards any national elective target set. . ~~Payment by Results (PbR) mechanism ensures that the Trust is paid for actual activity undertaken. Commissioners will normally, however, expect the Trust to work within agreed targets for planned activity e.g. elective admissions, and divisions/directorates cannot assume that over-performance will be paid. However nationally moving towards a shared risk basis so providers and commissioners will be discussing activity and performance removing PbR.~~

~~6.~~
7. ~~Whilst Payment by Results is predominantly paid on a Cost and Volume basis with each activity generating a tariff and income, some activity is paid for under block contracts or alternative arrangements such as collar and cap, or marginal prices.~~ The finance team will work with Directorates to ensure that they are aware of how specific activities are funded by commissioners so that financial impact of changing activity levels can be understood.

8. The Finance Directorate will provide monitoring information on performance against all contract targets in terms of both financial and activity detail. This will include quarterly reconciliations with commissioners to ensure activity levels are agreed with and monitoring alongside the ~~shared~~ aligned ~~aligned~~ incentives payment contracts.

Commented [MW4]: Jenny - Does this need updating? PbR isn't a phrase now?

9. Meetings are held regularly with commissioners to monitor contracts and agree action on variances. Any such action will be communicated to divisions/ directorates to enable activity plans to be amended in-year if necessary.

Cost Improvement Programme (CIP)

10. The monitoring of budgets will also include monitoring the delivery of CIP, to ensure the targets set during budget setting are achieved.

11. As CIP's are achieved the CIP target within a directorate will be reduced, crediting budgets where the CIP has been identified from.

12. In order to achieve the required contribution for a directorate the balance of unmet CIP will be shown within the overall position as a budget reduction

13. The system for monitoring CIP delivery is maintained by the finance team in conjunction with the Service Efficiency Team. Monthly reports are produced for each directorate to enable their ongoing monitoring and review.

14. Directorate and Divisional CIP delivery is monitored through the Service Efficiency team in collaboration with Financial Management. This is reported through Finance Recovery Group (FRG) to Finance and Productivity (F&P)

Committee.

SECTION 9 - OVER AND UNDERSPENDS

1. Managers are required to ensure that budgets are managed in such a way as to avoid overspends. In exceptional circumstances, should overspends against individual budgets occur it will be the relevant director's responsibility to ensure that such overspends are justified and can be accommodated within an overall balanced position across the division/directorate and the overall required contribution is maintained (where a service is income generating).

2. Underspends will be available for use by the manager/directorate in accordance with the policy on virement, as set out in Section 10. Within this general policy, the following should be noted:-

   (a) Underspends arising from activity shortfalls that result in reduced income levels will be applied to offset such income losses through the calculation of variances against contribution, including the requirement to achieve a cost improvement programme.

   (b) Development reserves not required for their original purpose cannot automatically be retained and a written proposal for any alternative use should be approved by the Chief Executive and Chief Financial Officer/Operational Director of Finance. This would usually be in the form of a business case.

   (c) The ability to retain underspends within a particular department/directorate will be subject to the Trust's overall financial position as determined by the Chief Financial Officer/Operational Director of Finance.~~Chief Financial Officer.~~

   (d) Due to the inflexible nature of the NHS financial regime, the ability to carry underspends from one year into another is very limited, and will only be exercised in exceptional circumstances (e.g. "Earmarked" funding) as agreed in advance by the Chief Financial Officer/Operational Director of Finance~~Chief Financial Officer~~, via the relevant finance team.

SECTION 10 - VIREMENT

1. Virement is the movement of funds from one budget head to another. Thus virement could be between expenditure lines in the same budget or between two (or more) separate budgets, either within or across directorates. Virement will also be either in-year only (non-recurrent) or recurrent.

2. A virement policy exists to ensure that budget adjustments have been carried out with the approval of the budget holder and, where appropriate, with the approval of the responsible Divisional team, Director, Chief Executive and Chief Financial Officer/Operational Director of Finance. ~~Chief Financial Officer.~~

3. This virement policy excludes the re-phasing of budgets, the input of baseline budgets at the start of the year and release of Trust reserves into budgets

4. Subject to virement being in accordance with the Trust's overall objectives, the delegated limit for an individual budget manager and Division or Corporate Directorate) is set out below, and is in line with authorised signatory levels as dictated in Standing Financial Instructions.

5. As outlined in Section 6, paragraph 11, it is unlikely that proposals to transfer from non-pay to pay budgets will normally be approved. Should such a request be made this will require 'sign off' by both the Divisional Manager (and Corporate Directorate equivalent) and the designated Finance Manager.

Authorisation level	Authorisation Required
Up to £5,000 (Within an individual budget Holders area of responsibility)	Budget Holder Finance Manager
= £5,000 up to £14,999 (Or less than £5,000 across Budget Holders responsibility)	Releasing Budget Holder Receiving Budget Holder Receiving Directorate Manager Releasing Directorate Manager Finance Manager
= £15,000 up to £99,999	as above plus Divisional Manager (Or Corporate Directorate equivalent)
= £100,000	as above plus Chief Executive/ Chief Financial Officer/Operational Director of Finance. ~~Chief Financial Officer~~

All virements which include Nursing Staff must also be authorised by the relevant Head of Nursing (who will have agreed changes with Nursing Directorate).

6. A virement may be requested through one of the following routes:

~~(a)~~ Using the form provided by your Finance Manager. Assistance in completing

this can be gained from your Financial Management team. The authorisation of this form can be done either by physical signature or email from the relevant signatories to the Finance Team.

~~(b)~~ An email describing the budget transfers required, forwarded through the relevant signatories to the Finance Team.

~~(c)~~(a) Minutes/Notes of a 'budget surgery' meeting which have been signed/approved by the relevant signatories and sent on to the Finance Team

6. All virements which include a movement of pay budgets will be sent from finance to Human Resources (HR), to ensure that establishment records retained in HR and the Electronic Staff Record System are updated.

7. Where virement is used for non-recurrent purposes (e.g. purchase of equipment) any consequent recurrent costs should be established, and funding identified, before the funds are committed.

SECTION 11 - RESERVES

1. Limited reserves will be held at Board level under the control of the Chief Financial Officer/Operational Director of Finance.~~Chief Financial Officer~~. These will include a reserve to fund the in-year effects of pay awards and non-pay inflation. Other specific corporate reserves may be established with the approval of the Trust Board.

2. At the start of the year, and as part of the agreed income and expenditure plan, a reserve will be agreed for activity changes and service developments (largely in the Operations Directorate). Funding from this reserve will normally only be released into budgets as and when appointments are made (pay) or the service commences (non-pay).

3. In the event that specific reserves (e.g. for pay and prices) prove to be insufficient the Board will determine the appropriate course of action.

4. Within the constraints of the available resources, the creation of contingency reserves at divisional/directorate level is encouraged. Clearly, such reserves should be identifiable and the position on these should be included in the monthly reporting processes. These should first be utilised for resolving any unexpected pressures in year.

SECTION 12 – PATIENT LEVEL COSTING/SERVICE LINE REPORTING

1. The Costing Team produce patient level financial (and operational) information ~~each month~~quarterly using Patient Level Information and Costing System (PLICS) software. Because the information is produced at patient level, it can also be grouped together to look at the financial characteristics of e.g. all of a specific consultant's patients, or all patients of a particular specialty. Dividing all of the Trust's patients into their relevant Service Lines (i.e. collection of one or more specialties) also enables Service Line Reporting (SLR).

2. The key aims of Patient Level Costing (PLC) are:

   - To provide better information on the Trust's activities to support local decision-making.
   - To ensure the costing process is as transparent as possible and that any areas needing improvement are more easily located.
   - To improve the level of accuracy of ~~Reference Costs~~National Cost Collection data and therefore the national tariff which is based upon ~~Reference Costs~~the National Cost Collection.

3. The key roles of the Costing Team within this process are:

   - To produce PLICS reports in a timely fashion ~~at the end of each month~~by least quarterly.
   - To ensure that these reports are accessible to relevant Trust staff via either access to the costing software analytics or an alternative analytics software so ~~loaded into Qlikview documents on the intranet where~~ they can be viewed and manipulated. ~~by Trust staff.~~
   - To communicate via e-mail to colleagues within and outside the Finance Department when the new PLICS~~Qlikview~~ reports are available each month. ~~at : https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf~~
   - To look to constantly improve the reports' accuracy by e.g. internal/external benchmarking, using more refined costing methods.
   - To work with colleagues within and outside the Finance Department to enable greater understanding of ~~the Qlikview documents~~PLICS.
   - To communicate to colleagues where there are anomalies within the reports requiring further investigation.

4. The key roles of the users of PLICS reports within this process are:

   - To provide timely patient activity and financial data each ~~month~~ quarter where necessary for the production of the PLICS reports.
   - To familiarise themselves with the PLICS reports~~Qlikview documents~~ and seek assistance from the Costing Team or Finance colleagues where

necessary in order to use them fruitfully.

- To feedback to the Costing Team where there are concerns about the accuracy of the model.

- To communicate to colleagues where there are anomalies within the reports requiring further investigation.

- ~~To communicate to colleagues where there are anomalies within the reports requiring further investigation.~~

The Royal Wolverhampton NHS Trust

Report to the Trust Board Meeting to be held in Public On 12 December 2023		
Title of Report:	Audit Committee Chair Assurance Report	Enc No: 10.6.3
Author:	Julie Jones	
Presenter/Exec Lead:	Julie Jones	

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

Recommendations:
The Board is asked to note the feedback for assurance of the continuation of the Audit function from the meeting of the Audit Committee on 5 December 2023.

Implications of the Paper:			
Risk Register Risk	The work of the Audit Committee considers all strategic risks of the Trust.		
Changes to BAF Risk(s)	None		
Resource Implications:	A number of the actions arising from this meeting will require limited staff resource to address. At the meeting it was also agreed to undertake an additional internal audit review of procurement.		
Report Data Caveats	Subject to review and approval of the minutes of the meeting by the committee.		
Compliance and/or Lead Requirements	CQC	Yes☐No☒	Details:
	NHSE	Yes☒No☐	Details: Counter fraud
	Health & Safety	Yes☐No☒	Details:
	Legal	Yes☒No☐	Details: FOI, KPMG update, counter fraud
	NHS Constitution	Yes☒No☐	Details: FOI
	Other	Yes☒No☐	Details: CIP, counter fraud
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		
EDI Impact	No impact on reserved characteristics noted from the assurances received.		
Report Journey	Working/Exec Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

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

Summary of Key Issues using Assure, Advise and Alert
Assure • Positive assurance was received from the Q1 Security & Car Parking Report, • The internal audit review of the Freedom of Information Act Framework concluded with 'substantial assurance'. • The internal audit review of Key Financial Controls – Cash Management concluded with 'substantial assurance'. • The Local Counter Fraud Specialists are continuing to give positive assurance and drive a counter fraud culture at the Trust. • External auditors KPMG gave an update on technical accounting developments in the health sector. • The committee reviewed and suggested updates to its Terms of Reference that will be referred to the Board for approval. • The Board is asked to approve Losses and Special Payment write-offs as recommended by the committee. • The Board is asked to approve G102 Financial Management Policy as recommended by the committee (included as agenda item 10.6.2).
Advise • The committee approved to change the 2023/24 internal audit plan to include a review of the procurement framework. • Proposed changes to the ICB operating model and the role and impact of One Wolverhampton and the Black Country Provider Collaborative were discussed.
Alert • The Committee discussed the Trust's strategic objectives and the risks that may prevent them from being achieved in the Board Assurance Framework. • The Committee discussed the current Trust and system deficit position (SR15), the potential need to access cash loan support next financial year and the timeframe to return to positive surpluses and repay any cash loan support. • In view of the financial position and its impact on the restoration of services post-pandemic (SR16) the Committee noted the need to make significant transformational change and that a step change in approach is needed. The Chairs of Quality Committee (QC), Finance & Productivity Committee (F&PC) and People Committee (PC), who are members of this committee, undertook to drive this through their respective committees. • The internal audit of the Cost Improvement Programme reported a negative assurance conclusion of '*partial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied or effective*'. Urgent recommendations are being addressed and will be reported back to the February 2024 meeting of the committee. • The internal audit of Workforce Retention reported a negative assurance conclusion of 'partial assurance' because exit interviews are not mandatory and therefore the Trust is unable to use exit interview data to drive a formal retention strategy. This will be followed up at QC and PC.

The Royal Wolverhampton NHS Trust

Paper for the Trust Board Meeting to be held in Public on 12 December 2023

Title of Report	**Charity Committee Board Report Update**	Enc No. 10.7
Author:	Professor Martin Levermore MBE	
Presenter:	Professor Martin Levermore MBE	
Date of Committee Meetings since last Board meeting:	Tuesday 17 October 2023	

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

Recommendations:

- That the Board **receive and note** the intention to resume the rebrand exercise that had been paused on the website build begin immediately to ensure the Charity Development grant can be drawn by 1st December 2023.
- That the Board **receive and note** the intention that the Trust website provider is used for the Charity's website and that the rebranding of the charity take place alongside the web build.
- That the Board **endorses** the intention that Sarasin & Partners remains managing the Charity's asset portfolio, current position valuation of £1,329,411 at estimated yield of 3%.
- That the Board **endorses** the intention to reappoint WR Partners WR Partners as the Charity's auditors for another year.
- That the Board **endorses** the intention to stablish a 'General Purpose Legacies' Fund that will allow any unrestricted legacies to be more widely distributed beneficially across all RWT sites instead of just the New Cross site.

ALERT

- None to report

ADVISE

- Two significant risks:
  1) fraud management override controls, and
  2) fraud and income recognition, led by audit regulations, the internal auditors, RSM, reported that they found no matters or issues with these areas.
- The Review of the financial controls and governance arrangements will be brought to the next Charity Committee meeting in January 2024.

ASSURE

- Charity income for 2022/23 was £862k, fantastic given the Charity had just come out of Covid and ongoing economic climate.
- Net asset value, on 31st March 2023, stood at £2.725m.
- The Charity's financial statement has been prepared and filed on an ongoing basis.
- The Charity has supported a wide range of projects across many of Trusts' departments and directorates, many of which are highlighted in the Charity's Annual Report.

Implications of the Paper	
Changes to BAF Risk(s) & TRR Risk(s) agreed	Risk Description: None Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable): N/A

Compliance and/or Lead Requirements	Charity Commission	Yes☒No☐	Details: Well-led, financially sound and undertakes is charitable objectives
	Health &	Yes☒No☐	Details: Provides a safe environment for its

	Safety		staff and volunteers
	Legal	Yes☒No☐	Details: Meets its statutory obligations
	Other	Yes☐No☒	Details:

Summary of Key Issues:

- Business Cases (BC) when being presented to Charity's Committee should be clearer on how the business case aligns not only to public benefit but specifically to Charity's objectives.
- For the Charity to maintain making a real difference to patients of the Trust, their families and the staff it undertakes raising money to fund additional comforts; more advanced, specialist equipment, not generally funded by the NHS; this including items that improve the environment and patient experience; research and training. As such, and to ensure donors' intention that their contribution be used as soon as possible, greater communication and awareness is needed at departments and directorates level to make each familiar with the charitable funds available and to encourage them to put forward business cases for consideration.
- Over the previous years the Charity sector like many sectors has faced many challenges it will be incumbent on Trustees and staff to take more innovative and co-creation methods towards attracting funds; this will necessitate increasing the visibility, profile and understanding of the charity within the hospitals and our local community with a clear goal of increasing the value of monetary and non-monetary donations we receive year upon year.

Links to Charity's Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • Prioritise the treatment of patients • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community, staff and NHS Trust
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Equality Standards
Improve the Healthcare of our Communities	• Develop a health inequalities strategy • Reduction in the carbon footprint by 1 April 2025 • Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Improve population health outcomes • Implement technological solutions that improve staff and patient experience • Progress joint working across Wolverhampton • Facilitate research that improves the quality of care

Report Journey/ follow up action commissioned	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date: 22/11/2023

EXCEPTION REPORT FROM PROFESSOR MARTIN LEVERMORE COMMITTEE CHAIR

MATTERS FOR THE BOARD's ATTENTION

There are no urgent matters requiring board attention or need for delegatory powers.

ACTIVITY SUMMARY APPROVALS:

- Care, Create, Conserve – Funded by the National Lottery Heritage Fund, Arts and Heritage project the Charity has contribute 5% of the project cost; provides opportunity to display all RWT medical artifacts and art that had been collating and curating over the years in a publicly accessible.
- Neonatal Chairs - £40.2k, these chairs provide mothers who have just given birth the opportunity to go straight to neonatal unit with having access to these more comfortable chairs that benefit in promoting close and interactive bonding, and breast feeding.
- Acute Paediatric Mural Artwork - £14.2k, the Paediatric areas are not child friendly and not a calming environment for children, mural will improve an area of hospital that has not been decorated for the last 20 years whilst ensuring child friendly space.
- The Proactive Risk-Based and Data-Driven Assessment of Patients at the End of Life (PRADA) - £125k, R&D project to determine the accuracy of a clinical data algorithm to allocate end-of-life prognosis amongst hospital in-patients, a patient centric data integration model permitted the development of a digital health care system (PRADA) which allows the use of advanced analytics to accurately determine end-of-life prognosis among those where it was otherwise unknown and promote anticipatory care for better outcomes.

Fund Raising:

- £330k income in year to date and a £91k legacy had been received that has started the Hope project at £60k.

Note: Volunteers have played a crucial role in the continuation of staff services, and the development of new initiatives, such as the Staff Wellbeing Hub, and the new Charity's volunteer role aims to reduce DNA rates by calling and reminding patients of their upcoming appointments, assisting with overcoming barriers to attending appointments, or cancelling those no longer needed.

Matters presented for information or noting:

Board to note Charity's annual report and accounts for 2022/2023

Chair's comments on the effectiveness of the meeting:

All participants were highly engaged on all parts of the agenda. It was reassuring to hear from the clinicians when presenting their business cases and understand better how impactful the support of the Charity will have on their areas. Indeed, it was of value to be informed of co-production between patients and clinicians when preparing the business cases for charity to review. Overall, the meeting was extremely effective in reaching decisions, providing constructive challenge and to be able to scrutinize information from operational staff to gain a good level of assurance on the performance and conduct of the Charity.

Chairs Summary Log for Charity Committee, date of Log 22/11/03

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• No areas of concern currently	• Charity's Rebranding and Web build • Arts and Heritage project will display medical artifacts and art that had been collating and curating over the years in a public space in the Centre of Wolverhampton. This will further extend the Trust's and Charity's viability in the local community.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• £330k income in year to date and a £91k legacy had been received. • Currently, volunteers have achieved over 9,500 hours this year so far. • Volunteers have played a crucial role in the continuation of staff services. • Over 150 volunteers attended Charity's Award event.	• Charity Development grant for rebranding and web build • Arts and Heritage Group approval of 5% contribution to lottery grant. • Sign off year end accounts 2022/23 • Investment into pioneering End-of-Life digital health research.

The Royal Wolverhampton NHS Trust

Report to the Trust Board Meeting to be held in Public on 12 December 2023		
Title of Report:	The Royal Wolverhampton NHS Trust Charity 2022/23 Annual Report and Accounts	Enc No:10.7.1
Author:	Professor Martin Levermore MBE	
Presenter/Exec Lead:	Professor Martin Levermore MBE	

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 2022-23 Annual Report and Accounts for the Royal Wolverhampton NHS Trust Charity.

The Board is asked to note the Audit findings from WR Partners and the Representation letter, which support the 2022-23 Accounts process.

Implications of the Paper:			
Risk Register Risk	Yes☐ No☑ 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 year'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: Statutory Duty
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.		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	N/A		
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: 17/10/2023
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
N/A

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations

Charity Annual Report and Accounts 2022/23

The Royal Wolverhampton
NHS Trust Charity
Registered Charity No. 1059467

Contents

The Royal Wolverhampton
NHS Trust Charity

Message from our Chair Martin Levermore

As the incoming Chair I am delighted to present the 2022/23 Annual Report of the Royal Wolverhampton NHS Trust Charity.

I wish to thank the outgoing Chair, Mrs Sue Rawlings, for her years of commitment and sterling leadership of the Charity that enabled the success the Charity has achieved to date.

Over the previous years the Charity sector like many sectors has faced many challenges and without our many supporters and the tireless work of fundraisers, both in the hospital and in our surrounding community and businesses our RWT Charity would not be in the robust place that it is today. People who have given of their time, effort and generosity which we greatly thank you all. We have again received vital support from partners and funders.

Our new charity team has taken big steps forward to help develop and grow the Charity, we are greatly appreciative to Amanda and the team, not forgetting the invaluable support from members of the Communications and Finance teams for their hard work.

We welcome Katy Ball as our dedicated Charity Accountant which was a post planned as part of our Strategic Review, and I would like to thank Emma Greybanks who has so effectively looked after us financially up to this point.

This year, we were again able to support a wide range of projects across many departments and directorates, many of which are highlighted in the body of this report.

I want to thank all who have done so much to help us support our staff, patients, and their families. We are so grateful to all of you, without whom we could not have achieved so much. It is great privilege to be Chair of this very important Charity and I look forward to work with all to make a difference to our patients, families and staff.

Martin Levermore
Chair of the Charitable Funds Committee

About The Royal Wolverhampton NHS Trust Charity

At The Royal Wolverhampton NHS Trust Charity, we are dedicated to improving the experience of and outcomes for our staff, patients, and our local community. The people and patients of The Royal Wolverhampton NHS Trust (RWT) are at the heart of what we do.

Our mission is to enhance patient care and help families and carers in Wolverhampton, by transforming hospital and community-based services. We do this through funding "added extras" - items, projects, research, staff training and services - that are over and above those provided by the NHS. This is what drives our charity, inspires our fundraisers, and connects us to Wolverhampton's warm, friendly, and diverse population.

We work alongside RWT, raising funds to support our staff to deliver the very best possible care and to help adults and children across Wolverhampton and surrounding areas. With the help of our wonderful community, our fundraising efforts make a real difference to patient outcomes.

Whether people come to hospital for routine procedures, medical investigations, or for lifesaving, cutting edge treatment, we understand that needing NHS care can be a worrying time. Every day the RWT Charity's fundraising helps to ensure that visits to our hospitals and our services are as comfortable, reassuring, friendly and positive as possible.

Trust Overview

RWT is one of the largest healthcare providers in the Black Country and West Midlands, providing primary, secondary, community and tertiary care services to a combined population of 450,000 people. The Trust provides 850 beds at our New Cross site (including intensive care beds and neonatal cots), 56 rehabilitation beds at West Park Hospital, and 54 beds at Cannock Chase Hospital. It is the largest employer in Wolverhampton, with more than 10,500 staff. This means that the Charity supports in the region of 460,500 beneficiaries year on year.

The Trust provides services in the following locations:

- Cannock Chase Hospital - General Surgery, Orthopaedics, Breast Surgery, Urology, Dermatology, Medical Day Case investigations and treatment (including Neurology and Endoscopy) Inpatient rehabilitation beds
- Community Services - More than 20 community sites providing services for children and adults, Walk-in Centres, and Therapy and Rehabilitation services
- Primary Care - Nine GP practices.
- New Cross Hospital - Secondary and tertiary services, Maternity, Accident & Emergency, Critical Care and Outpatients
- West Park Hospital - Rehabilitation, Inpatient and Day Care services, Therapy services and Outpatients

The Trust also successfully hosts Black Country Pathology Services (BCPS) and the West Midlands Local Clinical Research Network (WMCRN) and has done since its establishment in April 2014.

The Trustees' Mission

The mission of the charity is to make a real difference to RWT patients, their families and the staff that treat them, above and beyond what is provided by the NHS. We support the Trust to realise its vision to be an NHS organisation that continually strives to improve the outcomes and experiences for the communities it serves.

Public Benefit

In planning the Charity's activities, careful consideration is given to the Charity Commission's public benefit guidance. We must also comply with the duty in Section 4 of the Charities Act 2011. We support the work of the Trust, however, there is a clear distinction between what the Trust is required to provide as an NHS organisation and what is additional public benefit. The application of charitable funds leads to the enhancement of patient care and experience – regardless of our patients' background or personal circumstances.

Charity funds are used to provide the following:

- Additional facilities to enhance the healing environment
- Additional equipment to enhance patient care and experience
- Opportunities for additional staff training, above and beyond mandatory training
- Opportunities for further medical knowledge through research

Getting involved and supporting your local hospital and patients of the Trust couldn't be easier. Simply call the Fundraising Team on (01902) 447293 or contact us on social media:

TheRWTCharity on Twitter

Facebook

@therwtcharity on Instagram

Financial review

The Statement of Financial Activities can be found below as at 31 March 2023 with comparatives to the previous year. The complete set of Accounts can be found on pages 71-86.

Income

£862k

Total Incoming Resources	Unrestricted £000	Restricted £000
Donations and Legacies - £611k	162	449
Grants - £85k	26	59
Fundraising - £84k	80	4
Investment income - £82k	44	38
Total - £862k	**312**	**550**

Statement of Financial Activities

	Unrestricted £000	Restricted £000	Endowment £000	2022/23 £000	2021/22 £000
Total incoming resources	312	550	0	**862**	886
Total expenditure	(402)	(524)	0	**(926)**	(750)
Net gains/(losses) on investment	(146)	(97)	0	(243)	(24)
Net income/ (expenditure)	**(236)**	**(71)**	**0**	**(306)**	**112**
Transfer between funds	0	0	0	0	0
Total brought forward	2,026	923	82	3,031	2,919
Total at 31 March 2022	**1,790**	**853**	**82**	**2,725**	**3,031**

Expenditure

£926k

	Unrestricted £000	Restricted £000
Raising funds - (£161k)	(151)	0
Charitable activities - (£764k)	(250)	(524)
Other expenditure - (£1k)	(1)	0
Total - (£926k)	**(402)**	**(524)**

Did you know you can also increase your donation without having to pay more? Included in the Donations and Legacies and Fundraising income above, is an additional £6k which has been raised through the Gift Aid scheme in 2022/23.

giftaid

How does Gift Aid work?

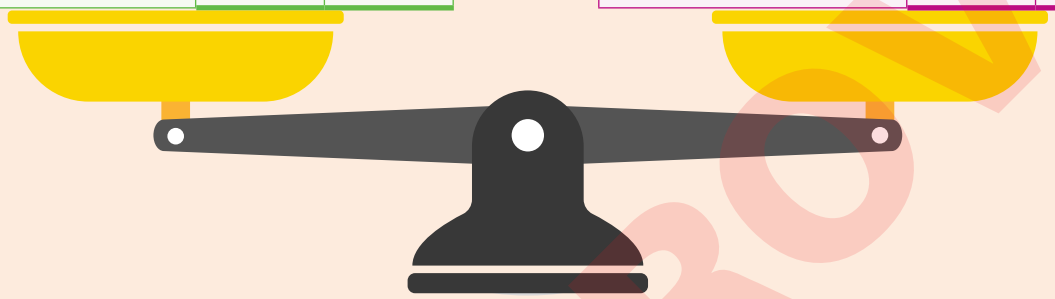
Gift Aid is a scheme run by the government that enables charities to increase the value of donations made by reclaiming basic rate tax that has been paid on the gift. At the moment, we can claim 25p per £1 donated, so on a gift of £100, we will actually receive an extra £25, at no cost to the donor.

The Balance Sheet as at 31 March 2023 can be found below with the comparatives to the previous year.

Balance Sheet

	2022/23 £000	2021/22 £000
Fixed Asset Investments	**2,449**	2,691
Debtors & Prepayments	**45**	42
Cash	**390**	806
Creditors	**(160)**	(508)
Net Assets	**2,725**	**3,031**

	2022/23 £000	2021/22 £000
Endowment funds	**82**	82
Restricted funds	**852**	923
Unrestricted funds - Designated	**1,705**	1,921
- Non-designated	**86**	105
Total Funds	**2,725**	**3,031**



A few helpful definitions:

Throughout this report you may see some terminology you aren't familiar with. Hopefully these next few paragraphs will help you understand the Charity's financial position.

Fixed asset investments - investments held in Shorter (low risk) or Longer (higher risk) Term Investment Portfolios.

Current assets - cash held plus debtors. Debtors - money paid in after the year end relating to the year, accrued income - money due in for activities taken place in the year, prepayments - payments made in year relating to the next year and so have been removed from the Statement of Financial Activities expenditure.

Current liabilities - creditors falling due within one year for money owed to others for expenses chargeable in the year.

Liabilities - creditors falling due after more than one year for money owed to others for expenses chargeable for previous years.

Net assets - Total assets minus total liabilities.

Endowment funds - represent funds that are held as capital in perpetuity so that only the income is available for distribution.

Restricted income funds - represent money which is held by the Trustees which can only be used for specified purposes. These funds are supervised either by the Fund Advisors within the ward, department or specialty concerned or the Chief Executive and Chief Financial Officer for more generic purposes.

Unrestricted income funds - are funds available to be spent within the objects of the Charity which can legally be spent wholly at the discretion of the Trustees. In practice, respecting the non-binding preferences expressed by donors, the Trustees have sub categorised the unrestricted income funds under two headings.

- **Designated (earmarked) funds -** represent separate funds which the Trustees have created to accord with sections 90 and 91 of the National Health Service Act 1977 which require that the Trustees respect, as far as practicable, the specific intentions of the gifts received through wards, departments and specialties. By designating funds the Trustees ensure that those gifts are channelled towards charitable purposes in those areas. These funds are supervised by Fund Advisors from the wards, departments and specialties concerned.
- **Non-designated funds (general/reserves) -** represent those funds available for distribution by the Trustees at their discretion which have not been restricted or earmarked and can be used as reserves should the need arise. These funds are supervised by the Chief Executive and Chief Financial Officer.

Annual Summary and Charity Objectives

The last 12 months have been very different to the previous year for various reasons - with the main one being the cost-of-living crisis having an impact on us all. Fundraisers have, however, been able to participate in events again which is great news, but sadly people have also found times hard physically, emotionally, and financially. They may have lost loved ones through COVID-19 or have been impacted by long COVID, and jobs have been at risk from the effects of the cost-of-living crisis.

Not only has this impacted our fundraisers but our staff and patients. Staff have been struggling with the current climate and this has had an impact on their lives. We have been able to support patients and staff over the last 12 months with the following to offer support and comfort to those who find themselves in hospital and for those looking after them:

- Patient and staff Christmas presents to help bring some joy to those in hospital over the festive period, whether being cared for or providing the care
- Rocking R gaming consoles for our Children's Ward
- Staff Wellbeing Hub, supporting families with free breakfast and access to essential food items
- Activity packs for patients living with dementia
- Toys for Paediatric patients across the Trust
- Arts and crafts activities for patients on the Neurological Rehabilitation Unit
- Hats and scarves for patients with cancer
- Water bottles for patients undergoing radiotherapy
- DAB radio, LED Lighting, electronic diffuser and sensory projector for Maternity birth rooms
- Comfortline therapy chairs for chemotherapy treatment at Cannock Chase Hospital

Aim

The Charity actively supports projects that enhance the delivery and experience of care for all patients and their families. This includes the provision of additional equipment or equipment that is of a higher specification than NHS funding can provide, funding projects that enhance the healing environment, provision of funding for additional training and any other resources that will help make a real difference.

We are grateful for all the support we receive; however, we have further aspirations to enhance patient care and experiences that require us to be ambitious in our income generation activities. We will strive to increase the value of monetary and non-monetary donations we receive year upon year.

We will support our NHS colleagues' commitment to ensuring everyone has equal access to our services, saving lives and improving health outcomes for our diverse community with a key focus on:

- Staff wellbeing
- Improving the patient experience
- Opportunities to further medical knowledge through research
- Engaging with our local community
- Developing partnerships
- Tackling health inequalities

Due to the exceptional circumstances and the uncertainty of the current environment, this strategy intentionally focuses on our direction for a shorter timeframe than usual - the 2022/ 23 and 2023/ 2024 financial years. This allows us to develop our usual longer-term strategy once there is more certainty over the environment in which we operate.

Our work

Fundraising and working within our community

Nine fundraisers from Trust run and raise over £4,000

Nine fundraisers from RWT completed the London Landmarks Half Marathon (LLHM) 2022, clocking up more than £4,000 for its Charity.

The LLHM is the first half marathon (13.1 miles) to take runners through the heart of the capital on a closed road route that showcases the city's iconic landmarks.

The event started at The Strand, before crossing and re-crossing Waterloo Bridge, passing Covent Garden, the Thames, St Paul's Cathedral, the Bank of England, the Tower of London and the Houses of Parliament before finishing in Downing Street.

Louise Porter and Jan Share, Therapy Assistants at the Gem Centre, wanted to take on the challenge after losing nearly 10 stone between them during the COVID-19 lockdown. The friends completed the half marathon together in a time of two hours, 55 minutes and 27 seconds.

Louise said: "We never believed we would run it in under three hours, but we ran all the way and never stopped to walk.

"We were very emotional. Having our families there was amazing, but you couldn't do it without all the support from the crowd, entertainment and all the charities there cheering you on.

"When we saw the 13-mile marker, we turned the corner and saw the finish line. Jan grabbed my hand and we sprinted to the finish."

Five other members of staff who entered are part of the New Cross Harriers. Kirstie Rice, Consultant Biomedical Scientist in Cytology, Winsome Bonnie, Administration Officer in the Diabetic Centre, Satbinder Suman, founder Karen Kendall and Desiree Galizia, Medical Laboratory Assistant in the Microbiology Department, train with the group, which started three and a half years ago to improve fitness and meets weekly after work. Kirstie, Karen and Desiree all work for Black Country Pathology Services, based at New Cross Hospital.

The New Cross Harriers members finished in close succession of each other between the times of 2:50:00 and 3:04:00.

"Unfortunately I pulled something in the back of my leg quite early on which was very painful, but Kirstie and Dessie came back and ran with me," said Satbinder, a Diabetic Educator/Support Worker. "The camaraderie we have between us is great."

Karen, a Senior Biomedical Scientist and Clinical Operations Manager, said: "It was a fabulous day, with perfect conditions and so well organised – I'm going to do it again next year!

"Three and a half years ago I said to Kirstie 'shall we start a running club? She said 'yes' and more people have joined us. We're lucky to have such lovely people."

The other two entrants from the Trust were Dr Mohamed Shariff, Anaesthetist and Clinical Fellow, and Laura Butterworth, a Staff Nurse for the Care Co-ordination Team in Adult Community, who has run several marathons and half marathons in the past.

Dr Shariff completed the course in an excellent time of 1:47:17 while Laura clocked 4:17:31 after unfortunately getting lost en route.

The group raised a total of £4,351.81 plus Gift Aid for the Trust Charity.

Rachel Robinson, former Digital Engagement and Fundraising Officer at the Charity, said: "We are very proud and grateful to our colleagues who took on the challenge. They all did fantastically, and it's been a pleasure to be involved in this experience with them."

New Cross Harriers before the race from left: Desiree Galizia, Kirstie Rice, Karen Kendall, Winsome Bonnie and Satbinder Suman

Before taking part: Louise Porter and Jan Share

After the race: from left: Satbinder Suman, Winsome Bonnie, Desiree Galizia and Kirstie Rice

RWT Singers tune up for competition.

A group of NHS singers hit all the right notes after reaching the semi-finals of a singing competition.

The RWT Singers pictured before a concert prior to COVID-19, with Choir Director Martin Trotman

The RWT staff choir, The RWT Singers, qualified for the semi-finals of the Midlands Choir of the Year competition.

For the semi-final, each group had to sing at least two songs in six minutes led by their Choir Director Martin Trotman, The RWT Singers performed Pink's What About Us, Hold Back the River by James Bay, and True Colours by Cyndi Lauper. Hold Back the River was the choir's acapella number.

The choir reached the semi-finals in 2020 but the competition was cancelled due to COVID-19 restrictions. The group re-entered and again reached the semi-finals with new songs. While the group failed to reach the finals last July at Lichfield Cathedral, members still enjoyed the experience and opportunity.

Jayne Harper, Choir Organiser, is one of the six founder members of The RWT Singers from when it started in October 2016, following an idea from then Chief Nurse, Cheryl Etches.

A retired Patient Access Manager who worked for the Trust for 43 years, Jayne, from Moseley Green, Wolverhampton, said: "Just to be accepted into the competition is great."

An inclusive group, the 22-strong RWT Singers has nurses, a doctor, a clinical scientist, a physiotherapist, a nursing tutor, procurement and governance staff, patient access staff and volunteers among its members.

But the friendly group is always on the lookout for new members, who enjoy songs from Earth, Wind & Fire, Queen, Bob Marley, Diana Ross, Wilson Phillips, Rihanna, Rag'n'Bone Man, Coldplay and Stormzy, to name a few artists.

"We welcome anyone and everyone," added Jayne. "The only criteria is that you're a staff member or former staff member.

"It's so relaxing and you lose yourself. When we perform a concert or go round the wards it's so rewarding."

Before lockdown, the group sang in Wolverhampton city centre on Armed Forces Day, in Sainsbury's, a baby memorial service, staff carol service, summer and Christmas concerts and on many wards within the Trust, including the dementia and paediatric wards.

"When we sang to patients with dementia, one wife turned to me and said it was the first time she'd seen her husband smile in 18 months. His face lit up and she was thrilled," added Jayne.

The group is supported by the RWT Charity but wasn't able to raise funds for two years due to COVID-19.

"It's such a boost to be together and singing in front of people after lockdown. Staff need to know there's a choir in the Trust and come and join us!" said Jayne.

Anyone interested in joining the RWT Singers should email Jayne at: jayne.harper56@gmail.com

Doctors on the run raise £2,500

A group of medics went on the run to raise almost £2,500 for equipment to help vulnerable children attending their department at Wolverhampton's New Cross Hospital.

Eight members of staff from A21 Paediatric Assessment Unit at RWT joined more than 13,000 people in the Great Birmingham Run 2022, with seven running the 10k race and one completing the half marathon (13.1 miles).

Ambra Righetti, Trainee Paediatric Advanced Nurse Practitioner, had the idea to use the race as a fundraising event and a total of £2,434 was raised.

The money will contribute towards buying an ultrasound (USS) machine for the ward to help cannulate children, in particular those who visit often.

She said: "The day was brilliant and the atmosphere was great. There were professional runners and a lot of people running for charities, like us. The race was tough but seeing people running next to you kept everyone going.

"Everyone did their best and was such an achievement just being there and finishing the race. A big thank you to all the running gang members, it was such a lovely day full of fun, laughs and good exercise.

"We also had a flamingo (colleague Dr Ash Holt) joining us for the race – you had to see the faces of the little children, it was ace!

"We did not have a target but the generosity of people allowed us to raise nearly £2,500, which was more than expected."

Rachel Robinson, former RWT Digital Engagement Fundraising Officer, said: "Thanks to all the runners from A21 for their magnificent efforts – and for raising a fantastic amount of money."

A special mention goes to Dr Julie Brent, Consultant Paediatrician, who was the only member of the team to complete the half marathon (13.1 miles).

Despite it being her first attempt at the distance for 10 years, she achieved a personal best time of two hours and 14 minutes.

Dr Brent said: "I run every week, 8.5 miles but slowly, so decided I would do the half marathon instead as more of a challenge."

At 53, mother of three teenage boys Dr Karen Davies, Consultant in General Paediatrics and Paediatric Rheumatology, has been running for two decades and was the most senior of the group who ran the race.

Running her first race was Dr Katie Shelley, Paediatric Registrar, 36. The mother of two has worked on A21 since September 2020, but also previously in 2014.

Dr Shelley completed the couch 2 5K running programme last year and had trained for the race since the autumn.

Also running the 10k were Paediatric Consultants Dr Minoth Kanagaratnam, Dr Holt and Dr Kiran Sastry and Paediatric Registrar Dr Katie Crombie.

Starting and finishing in the city centre, the Great Birmingham Run 10k took runners past the Bullring, along Pershore Road to Cannon Hill Park which marks the halfway point, before looping round Edgbaston Cricket Ground and past Calthorpe Park, before a final section through Digbeth.

Runners, pre race, pictured from left: Dr Minoth Kanagaratnam, Dr Elke Reunis (who has since left the organisation), Dr Julie Brent, Dr Ash Holt, Dr Katherine Shelley and Ambra Righetti

Staff scale Snowdon and raise £3,450

More than 30 energetic RWT walkers put their best feet forward to climb Mount Snowdon to raise more than £3,000 for its Charity.

Each year, colleagues Claire Flatt, Lead for Nursing, Midwifery and Allied Health Professionals Leadership Development, Laura Roberts, Executive Assistant, and Claire Young, Deputy Director of Education and Training, invite colleagues, staff, friends and family to join them on a new #RWTchallenge. This raises money for the RWT Charity, as well as a nominated charity from which patients benefit.

The walkers' efforts raised more than £3,200 for this year's chosen charity, The Macmillan Cancer Support Centre at New Cross Hospital.

Starting from the village of Llanberis, the Snowdon Sunset Walk took the group along a challenging nine-mile route which included 950 metres of ascent, including a tough trek up the Llanberis Path, the longest way to the summit. The walk concluded at the summit of Snowdon for sunset, before the descent back down got underway after dark.

Claire said: "We hoped to get a rare view of billions of stars splashed across the night sky, however we were met with 40mph winds, and it was too cloudy at the top for the sunset.

"But we did manage to catch it as we came down under the clouds and we got some fantastic photos of a bright orange sky.

"It was still a fantastic experience. Well done to everyone who smashed the #RWTchallenge and thank you to everyone who has helped us raise over £3,450!

"I'm already thinking of next year's challenge, although most people don't seem up for my idea of a skydive!

Walkers on their trip to climb Snowdon

"Not only do our annual challenges support our chosen charities, but they will also help our own physical and mental health."

Kelly Pritchard, Macmillan Information and Support Centre Manager at New Cross Hospital, said: "The walkers put in amazing effort and we're so thankful to them. The funds they raised will go towards treatment comfort packs for cancer patients."

Amanda Winwood, Charity Development Manager for The RWT Charity, said: "We are so proud of you all for pushing yourselves and raising an amazing amount of money for our charity.

"It was brilliant seeing your updates throughout the challenge and felt like we were there with you. I can't wait to see what challenge you set for next year."

Charities help take the heat off staff

Staff working in hospitals and community services across Wolverhampton were given a helping hand in last year's heatwave, thanks to the efforts of the RWT Charity.

The Charity, which worked in partnership with Walsall healthcare NHS Trust's Well Wishers charity, sorted out fruit, drinks and ice creams for staff.

They were treated to a free ice-cream at Cannock Chase, New Cross and West Park hospitals thanks to Charity funding and the Charity Team secured bottles of water from Tesco in Willenhall and Morrisons in Cannock.

Amanda Winwood, RWT Charity Development Manager, said: "The Charity was pleased to organise ice-cream trucks to keep our staff cool during the heatwave, making it a little easier to work in such temperatures.

"We would like to thank our local corporate supporters and supermarkets in offering bottles of water to help keep staff hydrated."

Inspirational girl born at 25 weeks raises money for 'incredible' unit

An inspirational schoolgirl who defied the odds after being born at 25 weeks has helped her mum to write a book to raise money for the 'incredible' Wolverhampton Neonatal Unit (NNU) which saved her life.

Naiyana Aikens was born on 13 November 2014, weighing just 1lb 8oz and looking like "a tiny baby bird." Her mother Shemayne Walker, a Therapeutic Radiographer at RWT, had an emergency caesarean section at New Cross Hospital after going into premature labour and Naiyana was rushed straight to the NNU.

Shemayne, from Bushbury, said she wanted to write the book to help other parents with babies in NNU.

'My Neonatal Journey' is an emotional story about Naiyana's journey from a very ill baby to the thriving seven-year-old she is today and the fantastic care she received from the NHS.

Naiyana said: "I hope that families read the book and see that their baby can grow big and strong like me."

Shemayne said: "It is a short story to introduce people to Naiyana's journey. Niayana is now thriving but at the time when she was born it was very much an hour by hour, day by day case. I wish I could have seen how well she would do in the future then, to give us hope.

"I hope this book will help other parents. The journey of a premature baby is very unpredictable and at times overwhelming but at the same time watching your little miracle thrive daily is inspiring in so many ways."

First time mum Shemayne was admitted on to the Maternity Unit at New Cross Hospital after her waters broke at 24 weeks.

She said: "I was immediately admitted and put on bed rest. At 25 weeks I went into premature labour which was very scary. I had a C-section and even though it was a terrifying moment I felt calm and relaxed thanks to the staff. I could never thank them enough.

"Naiyana was rushed straight to the Newborn Intensive Care Unit (NICU). It was hours later until I was able to go and see her.

"As she was born at 25 weeks, I expected her to be small, yet I still felt shocked by her size. Her dad described it best – she was "a tiny baby bird". At this early stage I could not picture her as a full-term baby, and soon realised that I had to take things one day at a time.

"I couldn't take Naiyana home for five months so visiting the NNU became my obsession. I wanted to be as involved in her care as I could possibly be.

"I became numb to the once overwhelming sounds of bleeping coming from the machines and grew more confident in putting a nappy on her tiny frame, navigating the small openings in the incubator. This new found skill was later tested when Naiyana had a stoma."

Naiyana developed Necrotising Enterocolitis (NEC) and was transferred to Chelsea and Westminster Hospital as an emergency for a specialist operation.

"The surgery was successful - just over 40 centimetres of Naiyana's bowel was removed and a stoma formed. She then spent a month in London before being transferred back to New Cross Hospital," Shemayne said.

"Naiyana had a reversal of her stoma a month later at Birmingham Children's Hospital and recovered well. We realised how resilient our little daughter was, despite how nerve-wracking it was for us as parents.

"Over a total of five months Naiyana had three operations, went from a ventilator to Continuous Positive Airway Pressure (CPAP), oxygen and then no breathing support. She had a Nasogastric feed and night pump to help her thrive before advancing to formula via bottle, with the support of an amazing dietitian.

"I will never forget the amazing care and supportive staff on the unit. They were incredible."

Naiyana was discharged from hospital five months later to continue her recovery at home with mum, brother Eshay Aikens, three, and dad Anthony Aikens.

Sarah Crowshaw, Neonatal Ward Manager, said: "We are grateful for the fundraising by Naiyana and Shemayne's inspirational story. This is a great way to share their story of their neonatal journey with other families and a personal record for Naiyana to keep forever. The fundraising will help the NNU continue to support babies and families who experience our neonatal care."

Former ICCU patient thanks staff after recovery

A COVID-19 survivor made an emotional return to New Cross Hospital's Integrated Critical Care Unit (ICCU) to thank "amazing" staff for her care.

Angie Fleming began to feel unwell and was classed as COVID-19 high risk due to being diagnosed with leukaemia in 2020.

After testing positive she deteriorated rapidly and was ventilated.

"It was a truly frightening experience. I was struggling to breathe, and I wasn't sure if I was going to make it. I have now got post-traumatic stress disorder (PTSD) from my time in ICCU, it was the worst time of my life, " Angie, 51, said.

"After I woke from my induced coma I remember seeing some of the staff's faces and hearing them talking. They were all so kind to me. They were all so upbeat and cheery. They are an amazing team – so respectful and lovely.

"My family said the staff were also very easy to contact for an update at any time as I was in hospital while there were visiting restrictions. The staff also did a diary for me with messages while I was ventilated that I could read when I woke up."

Due to her outstanding care, Angie, who lives in Cannock, asked if she could return to New Cross to thank staff for their kindness. She met with the team outside ICCU.

Kathy Harvey, Senior Sister on ICCU, said: "There is nothing better than seeing patients who were severely unwell, back home with their family. We don't normally see patients after they go home so it is lovely Angie took time to come and see us and meet some of the staff who cared for her. It is a real team effort to care for our patients."

One of the members of staff who looked after Angie was Sister Judy Rockfort. She said: "I am really proud

to see how well Angie is doing. It was a very emotional visit. This is one of the rewards of nursing - seeing our patients do well."

Liefah Misa and Jade James also came to meet Angie so she could thank them with chocolate.

Angie, who is business support administrator for the Countywide Day Services for people with a learning disability, went on to recover at home with her daughter Holly.

Keen swimmer makes waves for charity

Fundraiser Debbie Brackstone has certainly made a splash for New Cross Hospital's Integrated Critical Care Unit (ICCU) – raising almost £2,000 after a 21-mile swim of Lake Windermere to thank staff for caring for her friend who contracted COVID-19.

Debbie on her swim

Debbie's friend Angie Fleming was cared for on the ICCU in December last year and returned to New Cross Hospital to thank staff for their kindness and outstanding care.

Working for Staffordshire County Council as the Countywide Day Service Manager during the week, Debbie loves to swim long distances in her spare time. She completes many endurance swims purely for the challenge and does one significant fundraising event every year.

Debbie, of Stafford, said: "I had planned on completing Windermere anyway, but after finding out about the extraordinary care Angie received, it provided an even greater incentive to accomplish it.

"Lake Windermere is 21 miles both ways, and I couldn't touch the boat or the ground beneath her. I planned to do it in 45-minute blocks, then give myself one minute to rest in between."

Ten months of preparation were endured, including five weeks that included a six or seven-hour swim on a Saturday, followed by a four-hour swim on a Sunday, leading up to the event.

Despite the thorough training in a mixture of pools and the River Trent, Debbie admitted the actual event was tough.

"It's the mental side of the swim that's more difficult than the physical," she said. "When you're out there it's so important to stay 'in the now', appreciating what is around you. It's honestly where I'm happy – I love the isolation and moments of mindfulness.

"Although, I wasn't happy at the halfway point (six hours in), as I knew I could have gone faster!"

Twelve hours and 56 minutes later, Debbie completed the 21-mile swim across Lake Windermere and, most importantly, she managed to raise an incredible £1,869 for the RWT Charity.

Debbie with Angie and staff from ICCU

Grateful patient donates £1,420

From left to right, Sanjiv Petkar, Graham Ellis, Amanda Winwood, Eldon Foster and Saib Khogali, Clincal Lead and Consultant Interventional Cardiologist

A retired bookmaker who says he owes his life to a Wolverhampton consultant made a generous donation to the unit where he was treated.

Graham Ellis, 78, from Bridgnorth, donated £1,420 to the Cardiothoracic Trust Fund based at the Heart and Lung Centre at New Cross Hospital through the RWT Charity after having a defibrillator fitted to regulate his heartbeat.

Money was raised by 40 golfers playing in a four-ball tournament at Chesterton Valley Golf Club near Bridgnorth, before a meal afterwards at The Plough pub in Claverley.

Graham had a heart attack on the golf course while on holiday in Thailand, so he had a stent inserted to keep his right coronary artery open, and has since had a further two stents and a defibrillator fitted at New Cross Hospital. For the latter, he was discharged on the same day.

So, it's little surprise that the father of two daughters and granddad of five was only too happy to hand over the cheque to Sanjiv Petkar, Consultant Electrophysiologist at RWT.

Graham, who owned betting shops in Old Hill, Gornal and Bridgnorth, as well as spending many years as an on-track bookie, was accompanied to the cheque presentation with his long-time friend Eldon Foster, who owns Rudge Heath Stores on Wolverhampton Road.

A raffle at Rudge Heath Stores raised around £700, a collection in the pub after the golf day raised a further £200 and concessions from the golf club and pub for entry and the meals respectively accounted for the rest of the money.

"Mr Petkar saved my life and that's why we made this donation," said Graham. "I am so grateful. When I was in Thailand I was given two hours to live – I thought I had indigestion and I had to come off the golf course!

"But Mr Petkar put the defibrillator in and I haven't had any problems since. This treatment has given me a new lease of life.

"This is an annual fundraiser and this time I was only too happy to donate it to the people who saved my life. Mr Petkar and his team are brilliant. I no longer drink alcohol and I'm certainly looking after myself."

Mr Petkar said: "Graham had quite a lot of damage to his heart muscle and was having quite a lot of extra heart beats – a lot of 'sparking' and the pump was weak.

"So we put in a defibrillator to protect him. It's like a pacemaker, but a pacemaker is for slow heartbeats and a defibrillator is for slow and fast heartbeats.

"That monitors his heartbeat. If there is a problem it will give treatment and it can also shock him.

"So it's much quicker than a paramedic. The gadget talks to his device and it sends all the information via satellite to our pacemaker clinic here in hospital.

"Recently he had chest pain and he attended on more than one occasion. So he has now had another stent put into a different place but his symptoms have subsided significantly and he no longer has chest pain.

"Medication will still be there and he has to look after himself, but we can add a third wire to the two he already has to support the pumping function.

"We're keeping that in reserve, so along with medication and a good lifestyle, that should help Mr Ellis."

He added: "We are very thankful for this donation and grateful that Graham has considered the Heart and Lung Centre.

"The NHS does a lot but there is always more that can be done for patients, and that is where this substantial amount will help."

Amanda Winwood, The RWT Charity Development Manager, said: "It was so lovely to meet Graham and share in his journey. We thank him for his wonderful donation, which will be used for the benefit of our patients."

Panto stars bring cheer to Paediatric Ward

Ian Adams, who plays Widow Twankey in this year's panto Aladdin at Wolverhampton's Grand Theatre, slapped on the greasepaint and donned his full dame's costume to join Rebecca Fisher and Faye Campbell, who play the Princess and Elizabeth Darling respectively on the tour.

On the tour, the actors present a condensed, 40-minute version of the panto to children featuring the main characters, written by Ian. Over the last six years, the tour has been seen by some 6,000 children across England and Wales.

"It's a way of promoting the pantomime to children, as well as tell them all the history of panto," said Ian, 62, who was playing Widow Twankey for the second time at the Grand. "We also put on workshops where we teach kids songs and jokes.

"It's also a way of introducing theatre to children, many of whom might not have seen any live theatre before. I first saw live theatre at the age of five and was hooked. It also teaches the children what to expect if they see it."

Previously appearing in variety with stars such Danny La Rue, Bernie Clifton, Don Maclean and Ray Alan and dummy Lord Charles, Ian has done panto for 22 years.

The cast of Intro to Panto Primary Schools Tour with Scarlett Moreton

Rebecca, from Burntwood, said: "We received a great reaction from the children – they absolutely love it and it was wonderful to see their faces."

Being in a healthcare setting was nothing new for Faye, 24, from Tettenhall, as she recently played a student midwife in the BBC daytime soap Doctors.

Faye, who has also starred as Cinderella at the York Theatre Royal, said: "It was great fun and the children really enjoyed it. It's great to engage with them and see them smile."

Patient Lilly-Mae Whitney, aged 10 from Wheaton Aston, was one of those who saw the cast. Dad Tom Whitney said: "It was great to see them – they really cheered her up and it was wonderful to see her smile."

Safa Mudassir, 15 from Claregate, persuaded the cast to do a Tik Tok and appear on Facetime and said: "It's really nice of them to come and see us. I'm going to see the panto now!"

Caroline Moreton, from Bilston, was with her eight-year-old daughter Scarlett. "Their costumes are really bright. We're hoping to see the panto as a birthday treat," said Caroline.

The visit was organised by The RWT Charity and Amanda Winwood, Charity Development Manager said: "Thanks to the cast – we were delighted to see the actors and it was wonderful to see the impact, with wide smiles on the children's faces."

Liz Luton, Play Leader on Paediatrics, said: "The children loved it. It's great that the actors came in and to see the patients' faces made it all worthwhile."

The cast of Intro to Panto Primary Schools Tour with Lilly-Mae Whitney

Couple's £1,000 donation after cancer scare

A grateful couple donated £1,000 from their ruby wedding celebrations to RWT's breast care unit.

Karen and Barry Palmer, who both work for the Trust, decided to celebrate their ruby anniversary along with a surprise renewal of their wedding vows. Instead of presents, they asked for donations from the 95 guests attending the ceremony, at the Park Hall Hotel and Spa in Wolverhampton, to support care for breast cancer patients.

Karen and Barry Palmer renewing their vows

Diagnosed following a routine mammogram last August 2021, Karen had surgery to remove the cancerous tissue as a day case in October 2021 before undergoing five sessions of radiotherapy. She had another mammogram which thankfully came back all clear.

"My cancer showed up on a routine mammogram but I'd always checked myself and couldn't find anything, so it just shows how important it is to have your mammogram," said Karen.

Karen, a Biomedical Scientist in Cytology, had all her treatment at New Cross Hospital and was delighted with the care she received.

"From day one, the minute I was diagnosed, I was seen quickly and the care I received was fantastic," said Karen.

"A huge thank you too to the pathologists and laboratory staff for diagnosing me so promptly, and to the staff at Cannock Chase Hospital, where I had my mammogram and biopsies taken.

"The breast care service was brilliant too – there were a couple of times where I rang up and asked questions and they were really prompt in getting back to me."

Relieved at Karen's treatment and recovery, the couple arranged to renew their wedding vows, telling only their sons, with the rest of the invited guests thinking they had been invited to an anniversary party.

The date for the renewal was 12 August 2022 – almost exactly a year after Karen's diagnosis – and virtually 40 years since they tied the knot, on August 14, 1982 at St Thomas's Church Wednesfield, the day after Karen's 21st birthday.

For their vow renewal, the couple presented each other with new rings, Karen's naturally containing a ruby stone, before they departed on a second honeymoon – a cruise around the Mediterranean.

"We set up a post box at the party for people to make donations and we thought we might raise £200 to £300, so didn't expect anything like we received," said Barry, a Clinical Technologist in Medical Physics and Clinical Engineering at New Cross Hospital. Collections were also made in their respective workplaces, which went towards the total.

The ceremony also helped raise awareness. "Some relatives and friends of mine had been putting off going for their mammograms, but they've now decided to get screened," said Karen.

Karen and Barry Palmer pictured now and on their wedding day in 1982

Sadly, breast cancer runs in Karen's family. Her mum Ida Jones underwent a lumpectomy (removal of cancerous breast tissue) at New Cross 27 years ago and had a mastectomy following a second bout of breast cancer. Two of Ida's sisters also had the disease and although Doris survived, sadly, the eldest, Jane died.

"When I was first diagnosed, I was in floods of tears and thought it was the end of the world," added Karen. "Our eldest son Jonathan was due to get married in August 2022 and I didn't think I'd be here for that or perhaps not have my hair, so I had a lot of negative thoughts.

"Then I looked at my mum who overcame breast cancer and I realised there is hope. But I couldn't have got through it without Barry. Since this has happened, I'm a lot more chilled about things. You just have to cherish every day and every moment of your life."

Caroline Jones, Consultant Nurse in Breast Cancer, said: "We are delighted to receive such a generous donation. Hopefully this story will encourage everyone to be breast and chest aware and always report anything new or usual to their GP."

Amanda Winwood, Charity Development Manager, said: "It's wonderful Karen has recovered and we're thrilled at the lovely gesture Karen and Barry have made to breast cancer patients.

"It's important to highlight that both men and women should check their breasts and chests and report any changes."

Lady Tiffany is star of the show!

A donation to benefit youngsters on New Cross Hospital's Children's Ward was made in memory of a three-year-old patient whose family worked hard with staff to take her mind off her treatment.

A projector and a cinema screen were bought for the ward and donated to the RWT Charity thanks to a fundraising Disney walk led by Tiffany Benjamin-Mcfarlane's brother.

Tiffany, known affectionately as Lady Tiffany, died on 20 September 2020 due to complications from extensive bleeding to her brain and lungs when she was born.

Her mum Stacey, who also has son, Ricardo, created Lady Tiffany's Tributes which is a legacy set up in her honour.

Tiffany spent most of her life on the Children's Ward. During her time here, her family were fortunate enough to make many memories together which were supported by her medical team.

The Wolverhampton-based family decided to help other families in their position to make memories and offer distractions for other children in hospital.

Stacey said: "One of our fondest memories with Lady Tiffany was when Ricardo wanted to take her to the cinema.

"As she was too unstable to leave the ward, the medical team helped borrow a projector from another department so we could watch The Polar Express on Christmas Eve. We all wore matching pyjamas and it felt like we were able to escape from our current situation for a while.

"We wanted to purchase a projector to be kept on the ward so other families and children could have the same pleasure as us whenever they need it – from ward movie nights to intimate family moments.

"Ricardo asked his cousins and friends to dress up as Disney characters to do a sponsored three mile walk from the hospital to the cemetery where Tiffany is buried to raise the money. They had all been to parties of hers on the ward, so it was a way for them all to say thank you. Adults wore her favourite colour - pink.

She added: "We feel privileged to be able to make this donation. Lady Tiffany taught us to make the most of our time on the ward and we hope other families can make happy memories during their stay in her memory.

"Due to the COVID-19 pandemic, there were some delays installing the projector on the ward, but it was up in time for the Queen's funeral which meant all the children were able to come together and have the opportunity to watch it."

Liz Luton, Play Leader at the Trust, said: "We are so grateful to Stacey and her family for donating the projector and screen to the Children's Ward.

"This will enable us to have cinema nights for the patients and their families. It will also be lovely at Christmas time for us to show some movies to get everyone in the festive spirit. Previously we have loaned a projector from our IT department for this to happen; now that we have one of our own it gives us the flexibility to use it as often as we like. It will be well used in so many different ways."

Stacey and Ricardo also do craft donations to mark various occasions in Tiffany's memory from Halloween and Christmas to Valentine's Day and Easter. They also make up toiletry and activity packs for parents and teenagers.

Young fundraiser's £1,500 charity climb

Carl, 43, and Logan expect to spend eight hours walking up and down Snowdon. Taking the Llanberis Path – which is the longest but easiest of the six routes to the summit at 4.2 miles – they will ascend 3,166 feet, or 965 metres. But with the walk from the caravan site in Llanberis, they will end up trekking around 12 miles altogether.

The pair often go for walks with mum Jodie, 40, at weekends, and when Carl mentioned they were walking up Snowdon and a colleague offered to sponsor them, the fundraiser was hatched.

Carl asked Logan, who was born five weeks premature at New Cross Hospital and spent a few days on the Neonatal Unit, where he would like the money raised to go.

When told children have to spend Christmas in hospital after thinking they would be sent home, Logan decided to raise money to buy presents for those spending the festive period in hospital.

"Logan loves his karate, but he's a caring kid who's generous, good mannered and puts others before himself," said Carl.

"At school recently one of his friends didn't have any money to buy sweets from the tuck shop so Logan gave him his money and he had none – he just said he'd get his another day.

"He was really surprised that the children have to stay in hospital over Christmas so said he wants to buy things, so hopefully with the money raised, we will be able to buy X-boxes and tablets. It will put a few smiles on people's faces.

"Logan was very lucky as the care he had was amazing on all department wards, so Logan and us as a family will be forever grateful to the hospital, and we're delighted to be giving something back to the hospital."

As soon as they set up the Just Giving page, they were inundated with donations. Their initial £500 target set on Friday was smashed and by Wednesday, it had reached £1,500.

"We didn't expect the response we've had – it certainly puts pressure on us to get the job done!" admitted Carl. "Thanks so much to everyone who has donated."

As for the walk, Carl says they are prepared for challenging conditions and Logan is unfazed by the distance – even if he thought he get out of it!

"We often go away in our motorhome and go on long walks and Logan has walked 10 miles before," added Carl, who is a senior operations co-ordinator at logistics firm Pallet-Track.

"The weather doesn't look favourable – 50mph winds are forecast, and at the top, it could be three or four degrees C and driving rain.

"When I first told Logan what we were doing he said he'd wait at the bottom for me with a pint, but when he thought about who he as doing it for, he quickly agreed to do it. We've got kitted out at Go Outdoors, which gave us a discount, so we should be fine.

"We're going to start at first light so the plan is to climb 200 feet by sunrise, then hopefully we'll be at the summit by 11am and in the pub by 3pm!"

Logan's exploits are being featured in an assembly today by his headteacher Philip Salisbury at Woodfield Primary School in Penn, while Carl is compiling a blog on their adventure and has set up a WhatsApp group to keep people informed of their progress.

Logan and dad Carl, ready for their walk up Snowdon

Care for "miracle" baby prompts £1,000 donation

A loving family donated more than £1,000 to help Wolverhampton's vulnerable babies after their "miracle" daughter who weighed just half a bag of sugar at birth reached her 14th birthday.

Talitha Caris Sond weighed just 1lb 2oz when she was born at 23 weeks and six days at New Cross Hospital on 27 October, 2008. Fourteen years later, her parents were reunited with the consultant who helped save her life.

Talitha didn't have a heartbeat for four hours and was declared clinically dead before being revived by the care and skills of staff at RWT's Neonatal Unit (NNU).

Parents Teerth and Usha Sond were told to expect the worst and warned their daughter could be deaf, blind and with a brain injury. But after heart surgery and five months in the unit, she pulled through and is now a healthy teenager, loving life.

Her name is taken from the bible, in the gospel of Mark, chapter five, when Jesus said: "Talitha koum" which means 'little girl, arise'.

Tragically, Talitha's sister, Aniya Gabriella Sond, died just two weeks after being born at New Cross on 2 October, 2012, spending her short life on the same unit.

But the couple were so impressed by the care and treatment their daughters had at New Cross they set up a charity called Voices of the Voiceless (VOTV). Through that, they wanted to do something to support other families in a similar situation. They would like the money to go towards incubator care.

Teerth said: "This is a story of hope – Talitha is a miracle child. As soon as you go to the Neonatal Unit, you think 'is my child going to be OK?' But we saw the work of the staff there and we want to support their work.

"One day in the womb is like seven days in an incubator so the womb should be the most secure place for a baby, and we want to make a contribution towards incubator care for neonatal babies.

"We thought we were going through the same with Gabriella as we did four years previously with Talitha, but this time we saw the other side of the coin.

Dad Teerth Sond, Sarah Crowshaw, Neonatal Unit Ward Manager, Amy Addiss, Senior Sister, Lucy Ageoye, Neonatal Staff Nurse, Ann Hazel (behind, almost hidden), Personal Assistant to Senior Management Team, Sarah Downes-Baugh, Neonatal Staff Nurse, Babu Kumaratne (in navy), Consultant Neonatologist, SmartglazeUK co-director Gurpal Sehmi, Louise Forsyth (in lilac uniform), Neonatal Support Worker, and SmartglazeUK co-director Charles Deward, and front, Talitha Sond

"The Nurses and Doctors did their best to save her but she suffered internal bleeding and died at 5pm on 16 October 2012. A member of staff (Chew Grainger, Neonatal Junior Sister, now retired) was with us when Gabriella breathed her last breath and she cried – the compassion she showed was real.

"Even though she had tears, Gabriella never had a voice to speak out, but through her short life, VOTV was born. If I could carry a legacy that through my daughter's death others have survived, I have done my job."

Teerth, 49, and Usha, 46, were reunited with Babu Kumararatne, Consultant Neonatologist, who helped saved Talitha's life, along with other NNU staff to present a cheque for £700 to the RWT Charity, with the extra money coming in cash donations.

Teerth is co-owner of home improvement firm SmartglazeUK and a registered pastor and minister at the Fellowship of Servants in All Saints, Wolverhampton.

A total of £300 was raised by the Fellowship of Servants' congregation, with VOTV contributing £400. A further £200 came from Smartglaze customer Harry Semhon, and £100 from Teerth's parents Hari Ram and Gurimoto Kaur. An additional £50 came from Jass Singh, another SmartglazeUK customer, took the total to £1,050.

In remembering Aniya Gabriella's life, Teerth takes a quote from Corrie ten Boom, a Dutch lady and Christian writer who survived the Nazi concentration camp after trying to protect Jews in her home and said: "The measure of a life, after all, is not its duration, but its donation."

Teerth added: "This is Aniya Gabriella's story through VOTV. Through VOTV many babies lives have been saved." If anyone else would like to make a donation, they should email VOTV at info@votv.org.uk

The couple, who have three other children, were joined at the presentation by fellow SmartglazeUK co-directors Gurpal Sehmi and Charles Deward.

Alfie's Smile raises nearly £1,200 for Children's Ward

A schoolboy brain cancer survivor raised almost £1,200 for the Children's Ward where he was treated at New Cross Hospital.

Alfie Hinks, aged 13 from Bentley Bridge, has now been cancer free for nearly two years, after being diagnosed on September 16, 2019 with a medulloblastoma, or brain tumour. He had been suffering headaches, vomiting, losing weight and losing his balance.

Alfie Hinks with the cheque

Three days later, he underwent a 12-hour operation at Birmingham Children's Hospital (BCH) to remove most of the tumour and was in hospital for three months.

Chemotherapy at BCH and radiotherapy at Birmingham's Queen Elizabeth Hospital followed while Alfie had to learn to walk and talk again, because the tumour had affected his cognitive ability, mobility and eyesight.

Throughout this time, Alfie was a patient at RWT, having his transfusions, scans and check-ups at New Cross Hospital.

He was able to 'ring the bell' to signal his recovery after his final chemotherapy session on 3 November 2020. As he recovered, Alfie decided he wanted to raise money for the hospitals that saved his life and he set up Alfie's Smile, which is in the process of becoming a registered charity.

A total of 280 family and friends of Alfie's raised £2,372 from a black tie ball held at Jacks Café and Bar in St John's Retail Park in Wolverhampton city centre. The funds raised are being split equally between the Children's Ward at New Cross and BCH.

Top prize was a champagne party for 70 people including a DJ and canapes which was won by Tru Hair of Shipley who made Alfie's hairpiece, their first for a child.

Items such as framed presentations of boxer Tyson Fury and footballers Fabio Silva and Rayan Ait-Nouri from Wolves and Liverpool's Fabio Carvalho were auctioned off.

The winner of Ait-Nouri's generously handed it back and it now sits proudly on Wolves fan Alfie's bedroom wall. The youngster was even mascot for Wolves' final home game of last season, against Norwich City.

Alfie and his family have now chosen items from a wishlist to benefit young patients, and he returned to the ward with mum Kerry Hinks, 38, brother Louie, aged three and sister Darcie, one to deliver the good news to staff.

"I want the money to go to oncology patients with cancer and I'd like to buy children games to play and video games," said Alfie.

Alfie is now on a phased return back at Coppice Performing Arts School in Wednesfield, with one-to-one tuition to help him.

"We're so grateful and thankful for the treatment Alfie has had and to the Children's Ward," said Kerry, a children's services senior family support worker at City of Wolverhampton Council who has been married for 10 years to John, a project manager for water treatment firm H20 in Cheslyn Hay.

"I think I had Steph (Friedl, Paediatric and Oncology Clinical Nurse Specialist) on speed dial! Alfie initially saw Dr Marita Macken and Dr Julie Brent at New Cross and Dr Martin English at BCH and his care was amazing throughout his treatment."

Mum of two Steph Friedl looked after Alfie when he was at New Cross. She said: "Alfie was so poorly when he was diagnosed, but throughout his intensive treatment, he showed such courage and determination to get through it, even though he has faced – and continues to face – many challenges.

"He definitely kept us on our toes and at times showed us who was the boss and in control, which was great to see!

"It is so nice for the team here at New Cross to continue to review Alfie to see how confident he has become. It's also lovely that he continues to have that 'Alfie Smile' which we all love."

Kirsty Lewis, Senior Matron, Children's Acute Services, said: "We are so grateful to Alfie's smile for choosing to support children's services here at RWT.

"Alfie has first-hand experience of being a patient with us and so he has brilliant insight into what we need to make things better and more comfortable for our oncology patients.

"His suggestion of more video gaming facilities and equipment will be top of our list and I have no doubt our future children and young people will be just as grateful to Alfie as we are."

Amanda Winwood, Charity Development Manager, said: "It was lovely to see Alfie looking so well – and cheeky – he certainly kept us all entertained!

"We're delighted he and his family and friends have raised so much money and are so thankful he has chosen to donate it to the Children's Ward."

Mum Kerry Hinks, Alfie's sister Darcie Hinks, patient Alfie Hinks, Steph Friedl, Paediatric Oncology Clinical Nurse Specialist, Kirsty Lewis, Senior Matron, Children's Acute Services, and Nicola Bradshaw, Senior Sister on Ward A2

Three Peaks leads to £2,000 for charity

"Sore thighs and toes – but definitely worth the pain" – so says a Nurse who raised £2,000 by scaling the Three Peaks for charity.

Nicki Teruel, Urology Clinical Nurse Specialist at RWT, climbed 11,180 feet (3,408 metres, over two miles) scaling Ben Nevis, Scafell Pike and Snowdon to raise money for the British Association of Urology Nurses (BAUN).

The hike up and down the highest mountains of Scotland, England and Wales was organised by line manager Clare

Nicki Turuel on the top of Scafell Pike

Waymont, Urology Consultant Nurse and President of BAUN, who joined Nicki climbing Ben Nevis.

BAUN is a charity which allows urology Nurses to expand their knowledge and further their education to the benefit of their patients.

"I'm more of a runner than a mountaineer," said mum of two Nicki, who took around 30 hours to climb the three mountains, including driving between them.

Setting out for Ben Nevis, Nicki, who has worked at New Cross Hospital since she started her nurse training in 2000, and Clare started the climb with the weather in their favour, taking eight and a half hours, two hours longer than planned. A friend, Abbie Matthews, joined them on the walk.

One of the group struggled which meant they took four and a half hours to reach the top and most of the descent was in darkness. Two of the party went on ahead but Nicki stayed with her companion.

Some unexpected drama followed, however. "We lost the path – it was so scary. There was a waterfall and my logic was to follow the side of it, as it was going downhill," said Nicki, who lives in Sedgley.

"But I didn't realise there was a ravine and quite a drop – which I was heading for. The other two girls screamed I needed to go up.

"I scrambled to the top of a steep bank on my hands and knees and eventually found some rocks which led to the path. I was so relieved."

At Scafell Pike, the group set off at 6am, taking around five hours to get up and down the mountain.

"There was only two of us climbing Scafell and I'm so glad we didn't do that one in the dark," said Nicki.

"But we had to traverse a waterfall and the terrain is very rocky. You think you're almost at the top but there are about four or five false summits before you get there."

Finally, it was on to Snowdon, and, fortified by a McDonald's meal, Nicki made it to the top and back down in four and a half hours.

"By this time, my thighs and toes were very sore," admitted Nicki. "We took the Miners' Track, which is the shortest route, yet probably involves the most rock climbing.

"The views there were absolutely spectacular – definitely worth all the pain. But the descent was really steep, which put extra pressure on the legs.

"We did laugh though as the sheep were bleating what sounded like "Claaaarrre"! I think we were a bit delirious by this point!

"We may not have managed to do it in 24 hours, however we completed it, which is a major achievement for us."

Nicki, who prepared for the trek by running the Great North Run, clocking two hours, 16 minutes, and raised £670 for Macmillan, was indebted to colleague Helen Heap, who chauffeured her for the whole 1,000 mile trip.

"I had no prior mountaineering experience, apart from climbing Snowdon as a training hike beforehand," she added.

Nicki Turuel on the top of Ben Nevis (left) and Snowdon

Sunny's walk raises more than £3,400

A grateful breast cancer patient raised more than £3,400 for two wards at New Cross Hospital – with a little help from her friends.

Despite being unable to walk just two weeks beforehand, Sunny Mohindra-Payne, 48, climbed The Wrekin – Shropshire's third highest peak at 1,335 feet (407 metres).

In front of Snowdrop Millennium Chemotherapy Suite in Deanesly Centre, from left, Sunny Mohindra-Payne, husband Trevor Payne, Nicola Barding, Next store manager, Telford Forge branch, daughter Yasmine Payne and Louise Tongue, Staff Nurse on Snowdrop Millennium Chemotherapy Suite

And she raised £3,455.11 for The Royal Wolverhampton NHS Trust Charity to thank staff who looked after her on Snowdrop Millennium Chemotherapy Suite in Deanesly Centre, and Durnall Unit.

It was a real family affair too, as Sunny was joined by 35 of her family, friends and work colleagues, including husband Trevor, 52, daughters Yasmine, 27, and Anisa, 26 and son Kyan, 14 on the two-mile walk, which took around an hour and 20 minutes to complete.

Sunny, who manages the Next clothing store in Bentley Bridge, Wednesfield and lives in Wolverhampton, was joined by her counterpart at the Telford Forge branch Nicola Barding, who helped organise the event and made it a real 'work social'.

Along with the tough gradient of the walk, another challenge was the dark, as the trek was done in the evening to allow as many store managers and assistant store managers as possible to take part after the stores had shut for the day. As a reward, they celebrated at the summit, raising a glass and lighting sparklers to celebrate Sunny's achievement and to toast her recovery.

"I didn't think I'd be able to do it because two weeks before it, I couldn't walk, but with the aid of sticks and with Trevor's arm around me, I managed it," said a relieved Sunny.

"The Doctors and Nurses deserve this donation because they have been amazing to me and that's what has got me through this. It's quite daunting when you come into hospital for cancer treatment, but they make you feel so comfortable and confident.

"The store managers wanted to do something for me and then they asked me to choose a charity, so I asked for it to be for the people who had looked after me because they do such a great job."

Nicola, 39, from Codsall, said: "Sunny is a really loved colleague and friend at Next and when we found out she was poorly we wanted to do something to show how much we care for her and support her.

"We came up with the idea of a walk up The Wrekin because we thought it would be a fun thing to do as a group of store managers and it quickly escalated to include Sunny's family and friends.

"It's fantastic that we were able to raise this sum of money for such a worthy cause."

After being diagnosed on Valentine's Day 2022 when she was referred following the discovery of a lump, Sunny had the tissue removed, then underwent chemotherapy.

"Since I've been diagnosed, some of the ladies at work are being more vigilant in checking themselves, and if what has happened to me helps one person, then it's a good thing," she added. "You never think it can happen to you, but this proves it can.

"I just ignored it for a bit but I showed it my daughter and she said 'let's get you to the doctor's today' so we did. I would urge everyone to check themselves regularly and if they spot anything, see a doctor."

In front of the bell rung by patients when they have completed their cancer journey, from left, Louise Tongue, Staff Nurse on Snowdrop Millennium Chemotherapy Suite, Sunny, Trevor, Yasmine and Nicola

Along with her donation, Sunny also treated staff to samosas on her visits for chemotherapy. The money will be split 70-30 in favour of Snowdrop.

Gill Williams, Sister on Snowdrop Millennium Chemotherapy Suite, said: "We're very grateful for this donation. We'll make sure this money isn't just to the benefit of staff but for the patients as well.

"We recognise that no one wants to come to hospital, so when they come here, they realise it's not all doom and gloom and we try to give them the best patient experience possible. The patients make it easier for us as well because they're so lovely."

Amanda Winwood, The RWT Charity Development Manager, said: "We're delighted to see Sunny is recovering from cancer and are full of praise for her efforts in doing the walk so soon after her treatment. We're also really grateful for her generous donation."

Gaming gift will bring joy to children

Gaming cart, with Jess Miree from RockinR, Kirsty Lewis, Senior Matron, Children's Acute Services, Amanda Winwood, Charity Development Manager, and front, Alfie Hinks

Children with cancer can now play FIFA from hospital after a £2,600 medical gaming cart was donated from young fundraisers – provided by an organisation hit by a double tragedy.

Patient Alfie Hinks, 13, raised almost £1,200 for the Children's Ward where he was treated at New Cross Hospital. Alfie, from Bentley Bridge, was diagnosed with a medulloblastoma, or brain tumour, in September 2019.

Although he has now made a full recovery, Alfie spent a lot of time on the Children's Ward over a two-year period before being given the all clear and said he wished he could have been able to do gaming when he was having his treatment.

Logan Munday, aged six, from Goldthorn Park, raised £1,800 by climbing Snowdon and wanted the money to go to children spending Christmas in hospital.

A total of £1,400 has come from Logan towards the gaming cart, and £1,200 from Alfie, whose money was half the total he raised from a black-tie ball and auction through his own charity Alfie's Smile. Logan's remaining money bought toys for the Children's Ward.

Their wishes turned into reality with The Royal Wolverhampton NHS Trust Charity's purchase of a medical gaming cart from TheRockinR.

Situated in the playroom on Ward A21 at New Cross, the cart, which is height adjustable and lockable, comes complete with 21 of the newest games – all restricted to age 12 – access to Netflix, Disney+, the internet and streaming services.

TheRockinR was the gaming name of Reece Miree, who tragically died of a brain tumour at the age of 11 in March 2018.

Unable to cope with Reece's death, his mum Carol took her own life in 2021 at the age of 47, devastating husband and Reece's dad Jonny Miree.

Despite losing two close family members, former Marine Jonny, 51, and daughter Jess Miree, 24, who are based in Wakefield, near Leeds, have continued to dedicate their lives to TheRockinR, which is now a national charity that has distributed more than 350 medical gaming carts to UK hospitals.

Jonny said: "Reece continued to do gaming until the very end of his life. It gave him satisfaction and belonging, knowing he was part of an online community he could take part in 24 hours a day. Without this, I'm certain that Reece's battle with cancer would have been far worse."

Jess said: "We do this in Reece's name and to make people's lives easier is great for us because we can see the difference it makes first-hand.

"The Xbox is much better than the PlayStation because the games are more age appropriate."

Kirsty Lewis, Senior Matron, Children's Acute Services, said: "We're really grateful to Alfie, Logan and TheRockinR for this gaming cart because we wouldn't be able to provide this without the donations.

"Video games are a really good distraction from the worries and anxieties of being in hospital. We find the children really respond well and it takes their mind off their treatment."

Alfie, who tried out the gaming cart, said: "This is great – it takes your mind off things when you're having your treatment."

His mum Kerry, 38, said: "This is wonderful – Alfie could have done with something like this when he was in hospital, but it will benefit children who have to spend time on the ward."

Amanda Winwood, RWT Charity Development Manager said: "We're delighted to be able to present this to the Children's Ward. It will make a real difference to our younger patients when they come in for their treatment, making their lives – and those of their families and staff – a little easier and less stressful."

Foodbanks opened for staff

Foodbanks have opened at two Black Country hospitals as part of a package to support healthcare staff coping with the cost of living crisis.

Free hot drinks and free bread for toast or a cereal bar are also being offered to all 16,000 staff across both RWT and partners Walsall Healthcare, as well as a subsidised hot meal for £1.50 each.

Jo Flavell, Health & Wellbeing Specialist, Prof. David Loughton CBE, Group Chief Executive, Amanda Winwood, RWT Charity Development Manager, and Julie Smith, who is part of the Domestics team assisting in the Staff Wellbeing Hub, pictured outside the new Hub at New Cross Hospital

Amanda Winwood, Joanne Flavell, Julie Smith, Mark Ondrak, Zoe Marsh, David Loughton

The Staff Wellbeing Hub at Wolverhampton's New Cross Hospital and the Manor Lounge at Walsall Manor Hospital include a small food and essential items shop, while a temporary foodbank at the Manor Hospital has opened. The respective Trust charities are supporting the foodbanks.

The Trusts were alerted to the need to support colleagues from July and August onwards after being told some were struggling to afford to come to work because of the cost of living crisis.

At New Cross, there is already a stream of regular customers at the hub for breakfast and the foodbank, while the same is expected at the Manor.

Professor David Loughton CBE, Group Chief Executive of both Trusts, introduced subsidised hot meals for staff at £1.50 each, available from outlets at each main hospital site.

"We have a duty of care to support our staff and their wellbeing is our focus, so this gesture has been made to support them at a challenging time for so many people in our society," said Professor Loughton. "Sadly, there is a real need for this service, and, we're keen to do everything we can to help our colleagues.

"By doing this we know our staff are there for our patients, and they will not be going without a small meal or access to essentials.

"We are pleased to be able to offer this but extremely concerned too; our organisations are at risk of increased staff absence due to stress and the potential of increased vacancies if colleagues cannot afford to work due to the cost of living crisis."

The foodbanks are open to all staff, including those working in the community and Cannock Chase Hospital and West Park Hospital.

Donations of goods to both foodbanks are gratefully accepted. Anyone interested in donating should contact Amanda Winwood at Wolverhampton via email at: amanda.winwood@nhs.net

Children bring Christmas cheer to patients

Children from St Terera's Primary School with left, Amie Rogers, Charity Fundraising and Lead Digital Engagement Officer, and, far right, Amanda Winwood, Charity Development Manager

Children from a Wolverhampton school brought some festive cheer to patients who will be spending Christmas in hospital.

Pupils from St Teresa's Catholic Primary School in Parkfields made Christmas cards and sang carols at New Cross Hospital, with the cards being distributed to patients and staff.

Headteacher Stacey McHale said: "Part of our Christian values is that we encourage the children to think of those in most need at Christmas.

"So, by making handmade cards and singing carols we aim to spread some of that love and peace at Christmas time."

Children also raised more than £100 from their Christmas jumper day which they donated to Save The Children.

Mercy, aged seven, made a card with pop-up Christmas trees. The Year 3 pupil said: "We celebrate Advent when Jesus was born and we give thanks to God. We're going to give the cards to people in hospital to cheer them up and give them a smile at Christmas time."

Pastoral teacher Emma Price said: "The children made cards for patients who won't be home for Christmas and to thank staff and sang at New Cross Hospital. We thought it would be a really nice way for the school to give back and show community spirit."

Amanda Winwood, The Royal Wolverhampton NHS Trust's Charity Development Manager said: "It was lovely to see the colourful designs the children had produced with their cards and we're very grateful for what they have done.

"Their efforts will help bring some cheer to patients as well as boost staff who are working at Christmas.

"It was also lovely having the children visit to spread some cheer with Christmas carols and songs – they all did an amazing job and sounded wonderful."

Children from St Terera's Primary School

Alex's Everest Base Camp walk raises over £4,000

An intrepid accountant had a 50th birthday with a difference – trekking to Mount Everest Base Camp to raise over £4,000 in honour of his late brother.

Alex Howes, who works for the Clinical Research Network West Midlands (CRN WM), hosted by The Royal Wolverhampton NHS Trust, walked 130 kilometres (miles) to South Base Camp in Nepal and back. In doing so, he reached a height of 5,364 metres – nearly three and a half miles.

He was raising money after his eldest brother Stuart died suddenly of a heart attack at the age of 53 on 6 September 2021.

Having previously scaled 5,800 metres to the summit of Mount Kilimanjaro, Africa's highest peak, last August when he raised £4,200, Alex is used to challenging walks, but admitted this 11-day trek topped them.

"The summit at Kilimanjaro was the hardest physical thing in my life – however, Everest Base Camp was harder," said Alex.

"It wasn't as wintry or as snowy as I expected, although there was thick ice at the camp. It was eight days uphill but coming down was worse because it was really steep, and because I'd been walking for so long."

Most mornings he would start walking at 8am but on two days he began at 6am and he would walk anything from eight to 14 hours a day.

Days three and six were 'rest' days when he acclimatised, which still involved walking for four hours. Other challenges included avoiding eating meat, due to health and safety concerns, while it was so cold at night

Alex Howe celebrating his achievement

that a glass of water next to Alex's bed froze!

"My birthday fell on one of the rest days and the 'tea house' (hotel) where we stayed the night provided me with a cake," he added.

"At night the weather was so cold. The altitude of the highest hotel was 5,200 metres and that was when my water froze. The air was so thin that I'd wake up gasping for breath and you'd be tired even bending down to tie your shoelaces!"

As if those challenges weren't enough, Alex also had to watch out for the resident yaks (ox-like mammal), which have been known to literally boot walkers off the path!

Alex's achievements are even more remarkable after he was partly paralysed at the age of 19, following a road accident.

A fall saw Alex land on the left hand side of his head, resulting in him being totally paralysed down the right hand side of his body, spending nearly 12 months in hospital, also receiving speech therapy and occupational health.

Half of the money – £1,852.50 – went to the RWT Charity to be spent at the Heart and Lung Centre at New Cross Hospital, while the other half went to the British Heart Foundation.

Amanda Winwood, RWT Charity Development Manager, said: "Alex chose an unusual way to celebrate his 50th birthday but his walk showed how dedicated he is to raise money in honour of his late brother Stuart.

"This outstanding contribution will provide much-needed funds to support patients at our Heart and Lung Centre and we're very grateful for his efforts."

Corrie star helps fund donation

From left: Mckala Harrold, Sue Huddart, Senior Podiatrist, Dr Rajeev Raghavan, Consultant, Jean Shears, Senior Matron for Renal and Diabetes, and Kirsty Hadlington, Mckala's friend

A Coronation Street star pulled in the punters to help a serial fundraiser donate £2,520 to Wolverhampton's Diabetes Centre.

Andrew Whyment, who plays Kirk Sutherland in the long-running ITV soap, was the star guest for Mckala Harrold's latest annual fundraiser for the RWT Charity.

Actor Andrew, 41, appeared at Gilbert's Bar in Willenhall with locals paying £10 a ticket to see him. Other proceeds from Mckala's Facebook page Celebrity Random Raffle also enabled the fundraiser, from Bilston, to donate the same £2,500 sum to the Air Ambulance.

Celebrity Random Raffle hosts a twice-weekly raffle with people paying 20p or a £1 a go. Membership of the page stands at 3,000.

Over the last four years Mckala has persuaded Danny Miller, who was formerly Aaron Dingle in Emmerdale, Jamie Lomas – Hollyoaks' Warren Fox – Coronation Street's Maria Connor, played by Samia Longchambon, and Eastenders' Jack Branning, played by Scott Maslen, to make celebrity appearances.

Every year Mckala's appeals raise money for causes close to her heart, and this time it was the turn of the Diabetes Centre at New Cross Hospital and the Air Ambulance.

Mckala's father Keith Harrold, 71, has Type 2 diabetes, while friends, Marley Dodd aged eight, and Janine Oakley, who helps her fundraise, have Type 1 diabetes.

"My dad has been receiving treatment at the Diabetes Centre and they have done wonders for him," said Mckala, 47, from Bilston. "So this donation is a small thank you for the care they provide to him and hundreds of patients across the city. The NHS does a fantastic job.

"We were thrilled to see 'Kirk' and he loved it – he was singing karaoke and dancing with everyone. It was a great night."

Jean Shears, Senior Matron for Renal and Diabetes, said: "This money will make a massive difference and we are really grateful for it. We will make sure it's put to good use."

Mckala's fundraisers have previously seen £6,000 handed over to the Trust's Neonatal Unit (NNU) a year ago, £4,000 to the RWT's Integrated Critical Care Unit in 2021 and £3,000 to Animal Shelters in Willenhall in 2020.

Amanda Winwood, Charity Development Manager, said: "Mckala never fails to amaze us with her fundraising. We're delighted she has decided to donate this sum to the Diabetes Centre and I'm sure patients will feel the benefit."

Mckala says has the Trust to thank for her life. Her and twin sister Sally-Ann Whitehouse were born prematurely to mum Angela Harrold, also from Bilston, at New Cross weighing just three pounds and two pounds 10 ounces respectively.

They spent eight months on the NNU before they were finally allowed home.

Andrew Whyment, aka Kirk Sutherland, singing karaoke, and with Mckala Harrold and her friend Janice Oakley

Just the tonic for young patients

A sing song to help the medicine go down could be just what the doctor ordered for young patients at New Cross Hospital if a charity appeal hits the right note with supporters.

The RWT Charity has been working with the Ex-Cathedra Singing Medicine Team which brings its songs and games to poorly youngsters in hospital to improve their health and wellbeing.

And in February, the Charity launched an appeal to prescribe Singing Medicine to Wolverhampton patients for a whole year after seeing how delighted they, their parents and Trust staff have been by recent visits.

Little Euriel, aged two, pictured, is just one of many patients who has enjoyed this very special treatment while in hospital.

His mum, Marthr Makah, said: "His face just lit up with the singing games and he was waving, dancing and playing. It has really made me smile when I'm tired and worried too so thank you!"

Marianne Ayling who started the Singing Medicine project back in 2004 at Birmingham Children's Hospital, said: "We have so many stories of seeing children benefit from singing play such as this.

"One little boy we entertained was crying and coughing so badly that he was struggling to breathe. But sitting up with us, listening, then joining in meant his breathing calmed down and his coughing stopped. This helps worried parents too, of course because we all know how distressing it is to see young children in hospital."

Clare Acton, Acute Paediatrics Matron at the Trust said having Singing Medicine on the ward had boosted staff morale too.

"We can have difficult days and are supporting parents and carers in some challenging circumstances when their children are poorly. To walk around the corner and hear such lovely singing boosts our mood too," she said.

"It is really good for our patients' wellbeing and their cognitive development and it's lovely to see their smiles and hear their laughter."

Amanda Winwood, Charity Development Manager, said she hoped supporters would get behind such a worthwhile charity appeal.

"We want to raise £30,000 to be able to fund Singing Medicine for a year at New Cross Hospital which we know will make a real difference to our young patients, their parents and carers," she said.

"Watching the joy on children's faces when Singing Medicine has visited has been priceless. The effect this has on patients can't be underestimated and we are determined to reach our fundraising goal."

To support please contact the charity team on rwh-tr.fundraisingteam@nhs.net or donate at Just Giving - Singing Medicine at RWT.

Memorial wall mural created for much-loved Pete

Pete Moxon's former colleagues Rosemary Steel (left) and Andy Pritchard in front of the mural.

A memorial wall mural has been created as a touching tribute to an "outstanding" Wolverhampton clinician who died unexpectedly.

Pete Moxon, who was the Clinical Service Lead for Respiratory and Sleep Physiology at RWT, passed away on 17 October 2022 at the age of 51.

Most recently Chair of the Association for Respiratory Technology and Physiology (ARTP) standards committee, Pete was hugely respected both regionally and nationally in his field and served RWT for more than 21 years. In 32 years with the NHS, he also spent six years at Walsall Healthcare NHS Trust prior to joining RWT.

Among Pete's many achievements during his distinguished career was his introduction of a drive-through spirometry service at New Cross Hospital during COVID-19, which had such a significant impact in reducing spirometry waiting lists.

As a tribute to him and his work, colleagues, friends, family and the ARTP clubbed together to raise £2,350 via a JustGiving page to create a piece of vinyl wall art.

Measuring some 12 feet long, the stunning full colour vinyl now takes pride of place in the patient waiting area in the Respiratory Centre, Ward B1 at New Cross Hospital, where Pete worked. The remaining shortfall was met by The RWT Charity.

The mural depicts Fair Oak Pools on Cannock Chase, where Pete, who lived with his family near Chasewater, used to walk Peny, his nine-year-old Welsh black Labrador-cross-Collie.

Andy Pritchard, Acting Chief Respiratory Physiologist and Acting Clinical Service Manager at RWT, said: "Pete was a fantastic friend, colleague and role model. He always strived to ensure the Respiratory Physiology team was such a positive place to work.

"Pete cared so much about our profession and worked tirelessly to improve standards and promote excellence, his contribution to Respiratory Physiology and the wider NHS was enormous.

"For the mural, we wanted to include a picture of Pete, the text, departmental logo etc., and the design team did a great job of putting it all together in a fabulous contemporary design.

"The whole team thinks it's brilliant. It looks even better in reality than on the screen and we're very happy with it. In the short time it's been up, it's received many positive comments from patients."

An inscription on the mural reads: "This mural commemorates the outstanding contribution made by Pete Moxon to the development and delivery of respiratory physiological services across Wolverhampton and Cannock.

"Pete dedicated his 32-year NHS career to improving professional standards, enhancing patient experience, promoting excellence in respiratory measurement and representing healthcare scientists at the highest level."

Pete's family was invited to the official unveiling and love the mural. Together with wife Jane for 24 years and married for 15 years, he left daughter Olivia, 18 and son Finley, 12.

His widow Jane said: "This mural is such a fantastic tribute to Pete and the contribution he made to the NHS. He put his heart and soul into everything he did, he believed in his team and cared very deeply for every one of them.

"We are all truly devastated by his passing away so suddenly. We all continue to be so very proud of him and his achievements, he will be forever missed."

Dr Helen Ward, Respiratory Consultant at RWT, said: "Pete was a wonderful and dedicated colleague to work with and this is a wonderfully fitting tribute to him and his work."

Pete's uniform still keeps a watchful eye over the Respiratory Centre as a teddy bear sits proudly wearing part it next to his framed photo.

Pete's family in front of the mural erected in his honour.

Golfers raise £4,500

Dean Gritton, Group Manager, Renal and Diabetes at RWT, Brett Healey, Senior Diabetes Specialist Nurse, Dr Rajeev Ragavan, Consultant and Clinical Director at RWT, Tracey Gamston, Ladies Captain at South Staffordshire Golf Club, and Wendy Cotterill, former Ladies Captain at South Staffordshire Golf Club.

Generous golfers clubbed together to raise £4,500 to support the treatment of diabetes patients in Wolverhampton.

Members of South Staffordshire Golf Club nominated The RWT Charity as their chosen cause for the year in recognition of diabetic colleague Wendy Cotterill.

Mum of three Wendy, 64, has been a patient at the Wolverhampton Diabetes Centre at New Cross Hospital for more than 20 years after being diagnosed with type 1 diabetes at the age of 27.

The retired restaurant owner from Tettenhall was ladies' captain of the club but was unable to raise funds during her year as skipper due to the COVID-19 lockdown, so Tracey Gamston, who succeeded her, decided to raise money for the same charity.

A series of events including a black-tie summer ball, a raffle, a disco with a live band, a festive afternoon tea and donations in lieu of sending Christmas cards – which alone raised £200 – pushed the total to £4,500.18.

Caring and compassionate people from all over the community joined together – 120 packed out the ball, the tea was serenaded by the Brewood Singers choir singing carols and many businesses in Tettenhall donated prizes for the raffle.

"It's a fantastic amount of money to raise in the current climate," said Tracey, who also thanked all the members for their support during her year. "Everyone has done something to help. The male members came to the summer ball and we had some lovely prizes for the raffle.

"I chose the charity because Wendy has been a great support to me so I wanted to support her. The summer ball was such a success that it will become an annual event."

Dr Rajeev Ragavan, Consultant and Clinical Director at RWT, Brett Healey, Diabetes Specialist Nurse at RWT and Dean Gritton, Group Manager, Renal and Diabetes at RWT, attended the presentation and the group received a complimentary four-ball to play at South Staffs.

Dr Ragavan said: "What they've done for us is wonderful – I'm thunderstruck by the amount raised and it's been very gratefully received.

"Diabetes is an increasingly very common condition and it affects some people's life and health a lot with its complications, so the contribution is very welcome as it will go towards helping patients with this condition.

"This is only possible because of patients like Wendy who aren't shy of raising the profile of diabetes or saying they're living with it. I said to Wendy, 'one can carry a small burden for an hour or a day, but living with a chronic disease like diabetes is a big burden for life'."

Dr Ragavan said the money will be used to buy communication devices and educational material to aid better care in outpatients for diabetes.

Grandmother of one Wendy, a former buyer for the NHS and a South Staffs member for nine years, said: "We're so pleased with the amount raised and Tracey has been fabulous."

Amanda Winwood, Charity Development Manager, said: "We're delighted at the fantastic response South Staffs have had to their fundraising and thank them very much. Their generosity will help diabetes patients like Wendy."

Arts and Heritage

RWT Arts and Heritage Group

Purpose

Established in 2020, the purpose of the Arts and Heritage Group (AHG) is to produce projects which use the arts to enhance the experience of patients, staff, visitors, and the wider community, and to increase historical awareness in relation to Wolverhampton's hospital heritage. We were fortunate enough to appoint an Arts and Heritage Co-ordinator into post and she started in November 2022.

Membership

The AHG is made up of representatives from across RWT, as well as nominated lay members and representatives from external partnered organisations. Additionally, the role of Arts and Heritage Project Co-ordinator was created to identify, develop, and deliver projects which work towards the group's aims.

The AHG is responsible for the implementation of the Arts and Heritage Strategy, supporting and guiding the work of the Project Co-ordinator, and advising on fundraising to deliver planned projects and activities.

Further details on the membership of the AHG can be found in the group's Terms of Reference.

Audience

The projects and activities delivered by the AHG will seek to benefit patients and their families, visitors, and the wider community in Wolverhampton. AHG activity will offer this audience with opportunities for creative freedom, self-expression, and the improvement of wellbeing. This contributes towards RWT and Walsall Healthcare's joint strategic aims to excel in the delivery of care and improve the health and wellbeing of our communities.

Projects will also be delivered that benefit staff at RWT. In some cases, these projects will respond to the input and ideas from RWT's several Employee Voice Groups (EVGs). This works towards RWT and Walsall Healthcare's joint strategic aim of supporting our colleagues, by elevating and celebrating the diverse voices across the workforce.

Locations

Arts and heritage projects will take place across Wolverhampton. Some activity will take place at RWT's sites; where a project generates a creative output for display, these will likely be installed at New Cross Hospital. Other projects, particularly those with a community focus, will take place in city centre locations to make them as accessible and inclusive as possible. Activity delivered in partnership with local arts and heritage organisations may utilise the venues or spaces these organisations can offer. Furthermore, projects which have a digital output will be shared online, through RWT's website and social media.

Art & Heritage Group Aims

The aims of the AHG are informed by RWT's values and strategic aims outlined below. The following three areas of focus provide a framework for the projects and activities carried out by the AHG.

To contribute to and enhance the healing environment for patients, visitors, and our wider community (Care)

To develop community connections between RWT and local arts and heritage individuals and organisations (Community)

To explore and exhibit the history of healthcare in relation to RWT, its workforce, and the wider city (Colleagues)

To contribute to and enhance the healing environment for patients, visitors, and our wider community (Care)

To develop community connections between RWT and local arts and heritage individuals and organisations (Community)

To explore and exhibit the history of healthcare in relation to RWT, its workforce, and the wider city (Colleagues)

Healing Environment

RWT is proud to provide high-quality care across its sites. The AHG will contribute to and enhance the healing environment at RWT by pursuing the following objectives:

- To deliver a programme of participatory art activities for patients, their families, staff, and the wider community, that offer opportunities for creativity, expression, and the improvement of wellbeing
- To commission local artists and art facilitators to deliver workshops, drop-in sessions, and take-away art packs
- To generate creative outputs which can be displayed and exhibited, brightening the built environment and fostering a more therapeutic and welcoming atmosphere at RWT sites

Community Connections

- RWT strives to be a collaborative and community-focused organisation. The AHG will develop community connections by pursuing the following objectives:
- To forge stronger ties between RWT and the wider community of Wolverhampton, through collaborations and partnerships with local artists, facilitators, community groups, and arts and heritage organisations
- To engage with and contribute towards arts and heritage activities happening within the community and across the city
- To facilitate community co-creation projects which elevate the voices of Wolverhampton and celebrate the city's diverse heritage

History of Healthcare

RWT has a rich history of healthcare provision. The AHG will explore and exhibit the history of healthcare and its advancements in Wolverhampton by pursuing the following objectives:

- To exhibit and interpret items from the Royal Hospital Heritage Collection, which includes medical artefacts, records, and artworks, and make this accessible to the public through the development of a central resource
- To deliver supporting projects and activities which engage the wider community, including staff, with the heritage of where they live and work
- To provide opportunities which enable the wider community to contribute to the telling of this history, and find ways to increase its relevance for the people of Wolverhampton today

Workshop launched by Charity

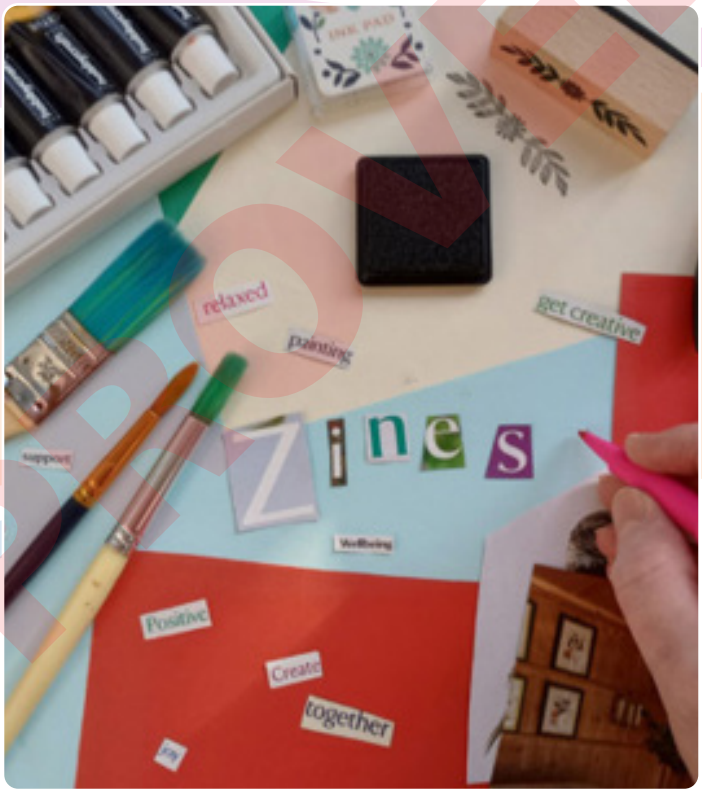
Budding artists were invited to try new skills at a series of workshops offering people the chance to produce a mini magazine for patients and visitors to New Cross Hospital.

Weekly workshops at Wolverhampton Art Gallery took place through February and March 2023. No prior skills were needed, and participants didn't have to bring any materials – just a willingness to try new things.

Alexandra Hatfield at one of her workshops

The course, funded by The RWT Charity, aimed to improve people's wellbeing by offering the opportunity to connect with others and practice creative mindfulness. Through the sessions, participants learnt new skills and produced their own artwork to keep or give as gifts.

The four workshops featured different mediums such as painting and printmaking, and produced art which could be brought together into a zine, or mini magazine.



Elinor Cole, Arts and Heritage Co-ordinator, said: "Zines are a brilliant way to boost mood and create connection. These workshops offered people an exciting opportunity to try their hand at something new.

"We're really looking forward to re-introducing arts activity that will benefit the community, as well as those visiting or being treated at New Cross."

Each workshop was led by a different local artist or arts group. These included Alexandra Hatfield from Cannock-based Saredon Studios, and Alex Vann and Gary O'Dowd from Real Arts Workshops.

As well as keeping their finished pieces, participants received three printed copies of their zine to gift to friends or family.

Printed canvasses of several artworks created during the workshops were displayed at New Cross Hospital.

Copies of the zines were distributed around New Cross Hospital in waiting rooms and wards, to boost wellbeing among patients, visitors, and staff.

Legacies

It's a common myth that only the rich and famous leave money to charity when they die. This couldn't be any further from the truth. The reality is that without gifts left in wills by people like you, many of the charities we know, and support wouldn't even exist.

Often donors have experienced first-hand the high level of care and expertise on offer at RWT Tand want to ensure future patients continue to have access to cutting-edge technology and excellent facilities.

Over the years, the legacies left by compassionate donors have been a vital source of funding for our charity. A staggering £454,868.02 was donated in legacies in the year leading up to 31 March 2023 alone!

Leaving a legacy to 'The Royal Wolverhampton NHS Trust Charity' allows you to play a supporting role in helping patients, staff, and families long into the future. The money that the charity receives from the wills of donors is used according to their wishes, to pay for research, fund projects and buy equipment.

Thankfully 74% of the UK population support charities and when asked, 35% of people say they'd happily leave a gift in their will once family and friends had been provided for. The problem is only 7% actually do. That's why, if we all leave some money in our wills for charity as well as our family, we can make a huge difference.

Leaving a gift in your will is a wonderful act of selflessness, and 'Your Trust Charity' is extremely grateful to all those donors who consider supporting The Charity in this manner.

Riley's life transformed after £442,000 donation

An "amazing" facility built at New Cross Hospital from a former patient's generous donation of £442,000 has transformed the life of a young boy receiving treatment for leukaemia.

The sum of £442,142 – one of the largest received by The RWT Charity – came from Michael Worrall, who chose to donate the money through a gift in his will.

Worrall Suite, from left: Dr Julie Brent, Prof. David Loughton CBE, Group Chief Executive, Kirsty Lewis, Senior Matron for Children's Acute Services and Rick Williams, solicitor

Mr Worrall, who didn't have any close family, was a former patient at New Cross Hospital who died on 15 September 2016 at the age of 78. His donation has funded The Worrall Suite – two new specialist cubicles to treat children with cancer on the Children's Ward.

Patient Riley Weaver-Harrison was one of the first to use the new suite. Seven-year-old Riley, from Cannock, has Acute Lymphoblastic Leukaemia (ALL), a type of blood cancer that starts from white blood cells in the bone marrow which requires regular chemotherapy to control it.

He also has neutropenia, condition which means he has a low number of white blood cells and weakens the immune system.

When first diagnosed at the age of five, he missed nine months of schooling and his illness means he is more susceptible to viruses and infection.

Riley has to be monitored closely and has spent much of the last two years in hospital – a minimum of two days at a time, mostly in the Worrall Suite.

Each cubicle – which are about three times the size of the side room Riley used to have to use – is equipped like a wet room with a spacious air-conditioned bedroom and en suite, with plenty of natural light.

As the suite is away from the wards, the risk of infection is reduced, while there's even an X-box console to help keep young patients occupied. Like Riley, other young oncology patients benefit from the Worrall Suite.

"We're immensely grateful for this facility and the amazing generosity of Mr Worrall," said Riley's mum Sara Weaver-Harrison, a therapeutic support worker.

"As soon as Riley gets to hospital, all the Nurses, Doctors and oncology staff joke that it's called the 'Riley Suite'! When he comes in, he walks to it like it's his own – a second home.

"Before the suite was opened, Riley was in a room near the nurses' station and struggled to sleep at night with the telephone ringing. Going there has massively changed his life and brought him some happiness."

Rick Williams, Mr Worrall's solicitor, of R N Williams & Co, said: "Mike was a kind, generous man who, unfortunately was struck down by cancer. He spent long and painful times in hospital, having had part of his vocal organs removed, but remained cheerful and his usual helpful self.

"He saved his earnings and wanted to make a difference. Mike instructed me to make sure any funds he left and which were surplus should be used for the benefit of the children in the cancer wards at New Cross Hospital. Mike would be very impressed at what has been done.

"I'm glad the children and their families who use the facilities are aware that a man they didn't know wanted to make their lives better."

Additional funds were used to buy educational equipment, including a laptop, for older children to occupy them during their treatment. A plaque commemorating Mr Worrall's generous gesture was also unveiled.

Kirsty Lewis, Senior Matron for Children's Acute Services, said: "We're so incredibly grateful for the extremely kind and generous bequest from Mr Worrall. Many of our oncology patients spend a considerable amount of time on the ward."

"These new cubicles mean we're able to care for them in a specially-adapted environment in their local hospital which offers them increased protection from infection while they undergo treatment.

"Our new cubicles also offer increased comfort for families with parent beds and televisions."

Riley Weaver-Harrison in the Worrall Suite

Corporate and External Donations

Charity receives donation from Bilston Rotary Club

From left, Councillor Phil Page, Councillor Greg Brackenridge, the Mayor of Wolverhampton, Andy Baker, President of the Bilston Rotary Club and Amie Rogers, RWT Charity Community and Events Fundraiser

Swimmers made a splash to raise £1,500 for The RWT Charity to coincide with Bowel Cancer Awareness Month.

Six people of all ages swam 20 lengths of the pool at Bert Williams Leisure Centre in Wednesfield to raise the money for Bilston Rotary Club, which donated the money to the Trust's Charity.

All six have some connection to Bilston, whether they live in the town or are part of the Bilston Rotary Club.

Andy Baker, club president, said: "One of the reasons Bilston Rotary chose to raise money for bowel cancer within the Deanesly Centre (at New Cross Hospital) was because a wife of one of the members was diagnosed with bowel cancer in 2020.

"Her care and treatment by the department, throughout the whole procedure was excellent. This prompted our club to show our grateful thanks. She is now clear of this terrible disease."

Phil Page, Bilston Councillor, whose 11-year-old grandson Alex Solomon took part and raised £200, added: "We all thought it was a great idea to raise money so nominated The Royal Wolverhampton NHS Trust Charity on this occasion, along with Good Shepherd Relief in Need."

Councillor Greg Brackenridge, Mayor of Wolverhampton, said: "It's been an absolute pleasure to be present when the cheques were presented by the Bilston Rotarians to the Trust for bowel cancer treatment in the sum of £1,500 and also £4,000 to the Good Shepherd in Wolverhampton.

"I'm very proud that the Rotarians in Bilston do so much for all local charities, including my own, the Mayor's charities of Wolverhampton.

"So I'd like to thank everyone involved and wish them the very best in their fundraising efforts in the way they support the vulnerable people in our community."

Rachel Robinson, former Digital Engagement Fundraising Officer for The RWT Charity, said: "We're delighted Bilston Rotary Club choose to donate this money to our charity and are pleased the care the member's wife received has resulted in her getting the all clear. The money will go towards continuing to enhance the care patients receive.

"We are also very grateful to the swimmers for their efforts – well done everyone!"

Generous support received from Crafting for Communities

Crafting For Communities is a charity that crafts for the community making useful items that bring joy or relieve discomfort to our patients. They make and distribute between 3 – 5,000 items per month for our community. The RWT Charity has been fortunate enough to receive regular deliveries of items such as knitted heart pairs, teddies and toys, Neonatal clothing, scarves and hats, toiletry packs, care bags for cancer patients, sensory items, period pouches, worry monsters and worry worms to help support patients in hospital.

The charity has 16 hubs throughout the Dudley borough and beyond, including Kidderminster, Birmingham, Wolverhampton and South Staffordshire. The group has around 2,700 Facebook members who either make, volunteer or support. Without its fabulous team of volunteer drivers distributing to the hubs and the communities it supports, charities like ours wouldn't be able to bring joy and comfort to patients.

Stroke patient, Ann, was overjoyed to receive a blanket and twiddle muff. She said: "This will help keep me warm when it drops cold at home in my flat".

We would like to express our gratitude to Crafting For Communities for its continuous support over the years and we hope to continue our work together in the future.

Pictures show items we have received from Crafting For Communities.

Hair stylists donate vouchers for Nurses Day

Nurses at RWT already tried to be a cut above the rest but they definitely were after a generous donation on International Nurses Day.

Hair stylists Urban Coiffeur of Wednesfield donated 400 cups of coffee and vouchers offering 20 per cent discount off any haircut and/or styling as a thank you to staff at the Trust.

Sarah Shinton, who runs the business on Wood End Road with business partner Sonia Sparrow, made the generous offer after being treated as a patient at Wolverhampton's New Cross Hospital.

"I had a molar pregnancy (where there's a problem with a fertilised egg, which means a baby and a placenta do not develop the way they should) and had to undergo a lot of treatment at New Cross," said Sarah.

"I had chemotherapy every other day for six months so I really got to know some of the nurses well and got an insight into how hard they work.

"I was looked after really well and it made me think about giving back to the community, so I thought I'd start by doing this."

Children get a cuddle after gift of teddy bears

Play leader Dil Uppal with Brielle Foster-Matthews 5yrs in the sensory room on the childrens ward, New Cross Hospital.

Young patients attending New Cross Hospital can now receive a cuddle from their own teddy bear after a generous donation from the Freemasons.

Teddies for Loving Care (TLC) started as a way of providing much-needed comfort to children in Emergency Departments, helping to reduce the shock and distress of their experience.

The initiative is managed by Freemasons who also volunteer their time to run the scheme. Since its inception in 2001, more than three million teddies have been distributed to hospitals and organisations throughout England and Wales.

A total of 162 individually sealed bears have been handed over for young patients who attend New Cross Hospital and the community to make their journey a little bit brighter.

James Cairns, TLC representative from the Freemasons, visited the hospital to make the donation and Dil Uppal, Play Leader, met with staff from The RWT Charity to accept them on behalf of Children's Services.

James said: "A hospital visit can be a frightening experience for a young child, especially in an emergency situation. Every child that receives a teddy gets to take it home."

Dil said: "Thanks so much to the Freemasons for the kind donation of teddies. The patients absolutely love them. They put a smile on every child's face. They are very comforting for those who are having surgery too. They help to make the patients have a more relaxed and comfortable stay with us."

Amie Rogers, Community and Events Fundraiser at The Royal Wolverhampton NHS Charity said: "A huge thank you to Jim and Freemasons for their generous donation of teddies. They really make a difference to our young patients during their visit to hospital."

The work of TLC is funded through the generous donations of Freemasons, their families and supporters of the programme. Many Freemasons also volunteer hundreds of hours each year to manage the scheme, deliver bears to hospitals and other organisations and campaign to raise funds and increase awareness through events and talks.

The TLC teddy has become an invaluable tool for healthcare staff and a real comfort for children, used to calm them down, reward them for being brave or to demonstrate procedures. Often the bears distract poorly children so Nurses and Doctors can get their jobs done quickly and efficiently.

Patients benefit from rehab equipment

Pictured from left, Paul Baugh, Secretary of the Fund, Lou Jones, Group Manager, Phil Chew (on bike), Clare Banks, Matron for Rehabilitation, Ray Briggs, Cyril Barrett, Chair and Trustee of the Fund and John Humphries

Patients at West Park Hospital can now benefit from new rehabilitation equipment thanks to a generous donation of more than £13,000.

The 5/344 Transport and General Workers Union Benevolent Scheme (ex-Goodyear workers) bought three pieces of equipment costing a total of £13,398.95 to help patients in rehabilitation.

Two Metomed movement therapy bicycles in the gym will help wheelchair users and patients recovering from strokes, while a SaeboMAS Mini machine assists in strengthening upper arm muscles.

Clare Banks, Matron for Rehabilitation, said: "On behalf of the patients and staff at West Park Hospital, I would like to express my gratitude to Cyril and the TGWU for their very generous donation.

"The new equipment will enable patients who have suffered a neurological event to improve their rehabilitation outcomes as they will have access to specialist exercise bikes that will improve the strength in their arms and legs.

"The patients are very excited to start using this equipment. Thank you so much."

Two ex-members of the Fund now work at West Park Hospital – Porters John Humphries and Phil Chew – while Paul Baugh, Secretary of the Fund, and Ray Briggs, who both joined the presentation, are ex-members too.

The donation is the latest in a long series from the 5/344 Transport and General Workers Union Benevolent Fund, which has now donated more than £440,000 to projects at RWT over the last five years.

Cyril Barrett, Chair and Trustee of the Fund, said: "We have many ex-Goodyears workers who have been supported by staff at West Park Hospital, including a friend of mine who had a stroke and is sadly no longer with us.

"On behalf of the Fund, we are grateful for the dedication and commitment of the medical teams, doctors, nurses and volunteers who provide outstanding care to the local community."

Donation helps stroke patients

Stroke and neurology patients at RWT are benefiting from a helping hand thanks to a charity's generous donation of more than £5,000.

Willenhall Area Relief Rehabilitation And Nursing Trust (WARRANT) has provided £5,775.90 to pay for the E-LINK Upper Limb Exerciser rehabilitation equipment at West Park Hospital.

Many of the 500 outpatients on Stroke Services' caseload will be using the games-based treatment tool to treat the many impairments that can result from a stroke, through upper limb exercises and pinch grip attachments.

Patients can access more than 30 different games from the Upper Limb Exerciser on a one-to-one basis to enable functional, repetitive movements, and the resistance can be graded for improving the difficulty of the exercise.

Grip attachments help improve grip strengths and games support information processing and spatial awareness.

Jane Bisiker, Clinical Specialist Occupational Therapist for Stroke Services, said: "Thanks to the generosity of an ongoing supporter, both inpatients and outpatients will benefit from this donation, and it will make such a difference to the rehabilitation of our patients.

"There is a range of grips and movements so patients can do a lot of upper limb work on their arms and shoulders. You can grade it from very little resistance then improve it to strengthen your range.

"The patients love it – I have not known anyone who doesn't enjoy it because it's fun, engaging and works you really hard without realising it."

Patient Ray Whitehouse, who is a regular user of the equipment

Jane also said the equipment saves staff valuable time preparing exercises and even offers a competitive element for patients should they want it.

"Without it, we would have to rely on a lot of pen and paper work which is very time consuming because it would involve preparing a lot of materials, whereas with this, you can click the bits you want and grade it as you go.

"There's also a motivational aspect for the patient because they can improve their scores each time they use it."

Realistic goals can be set and achieved, addressing specific therapeutic objectives. Baseline measurements of a patient's comfortable range of motion (ROM) can be taken and used for exercise.

Patient Ray Whitehouse, 78, suffered a stroke in 2000 which affected his left side and left him unable to walk, use his left arm or read.

The retired insurance broker and father of two from Wightwick, Wolverhampton, used the games-based treatment tool at West Park Hospital to help his cognitive ability.

He said: "I would definitely recommend it. It's improved things for me.

"I couldn't look to the left and now I look a lot more to the left than I did before."

Amanda Winwood, Charity Development Manager at the Trust, said: "We're very grateful for the support WARRANT has provided to purchase these items. The equipment will really help our stroke patients with their rehabilitation."

The Upper Limb Exerciser is the latest piece of equipment WARRANT has helped with after the charity previously purchased several specially-adapted bicycles for stroke patients, costing around £3,500 each.

Grateful former Mayor raises £2,000

A former Black Country Mayor who underwent radical cancer treatment at New Cross Hospital donated £2,000 to charities – half of which will benefit cancer patients in the future.

Steve Waltho climbed 20 peaks in the Lake District in March, just four months after his cancer removal surgery in November 2021 to raise money for The RWT Charity.

The 66-year-old, who is a former Dudley Mayor, was diagnosed with an enlarged prostate in 2014 after going to his doctor with symptoms of a water infection. Further tests conducted by his GP showed a high Prostate Specific Antigen (PSA) reading, which was followed by a biopsy.

Steve, who lives in Kingswinford, was then monitored regularly until an MRI scan in November 2020 which showed progressive prostate cancer.

He said: "I was put on hormone treatment to stop any spread until my robotic prostatectomy surgery in early November 2021.

"The surgery went well and after that I wanted to give something back to show a little gratitude and took to the hills which have been such a prominent source of fitness, peace and fundraising in my life.

"I'll be eternally grateful for the brilliance of Mr Pete Cooke, consultant urological and robotic surgeon, and his team at New Cross Hospital for giving me an extension to my life. There's no way of telling what my quality of life might have been now or even if I'd still be here without it but at the moment I feel ok and back to being as active as a 66 year old might expect."

Steve's brother-in-law Neil Holt, 64, who has learning difficulties, also wanted to raise money so supported Steve's challenge on a family holiday in Wales. In April, the duo climbed the highest peak in the Preseli Hills in Wales to further add to the funds.

Steve added: "When Neil learned of my desire to raise money he also wanted to add to the total by suggesting his own event in Wales. He's an absolute inspiration to all who know him and he wanted to donate to a charity for people with disabilities. As I am honorary patron of Access In Dudley (AID) it was an absolute no-brainer to split the donation and hand over £1,000 to AID and give £1,000 to The RWT Charity to be used for future prostate cancer patients.

"I'd like to say a big thank you to everyone who has sponsored me along this journey."

Amie Rogers, community and events fundraiser for The Royal Wolverhampton NHS Charity, said: "We are very grateful to Steve and his family for this fantastic support. It was great to meet Steve and hear about his fantastic care by Mr Cooke and his team. Thank you again for this generous donation."

Steve also dedicated the fundraising to former Dudley Council colleague Councillor David Vickers who sadly passed away with prostate cancer.

From left to right Steve Waltho, Consultant Peter Cooke and Neil Holt

COVID-19 survivor launches book

One of Wolverhampton's first COVID-19 patients returned to New Cross Hospital to launch his book and thank staff for the 'outstanding care' he received during his illness.

Darren Buttrick, from Coven, decided to write the book 'Fifteen Minutes and Counting; Never Stop Fighting' about his COVID-19 experience as he wanted to give something back to the staff who saved his life. He has also donated his blood plasma to help other sufferers and in 2021 became the most prolific donator in the UK, donating 24 times, the maximum allowed in a 12-month period.

The father of three, who works in Telecommunications, said he had been told by his family - wife Angela and daughters Freya 17, Maia 17 and Esme 15, colleagues and friends - he had an inspiring story to tell.

He said: "I also wanted to leave a legacy and raise money for The Royal Wolverhampton NHS Trust Charity so patients will benefit from the sales of the book. This was never about me, but another way of giving back.

"I enlisted the support of StoryTerrance and a ghost writer to write my story. It was very emotional writing it and I hope the staff like it. They saved my life and I will always be eternally grateful to them for their outstanding care.

"I hope the book inspires others and shows people it is tough out there but never give up."

The 51-year-old was so ill when he was rushed to hospital in March 2020 and was given 15 minutes to "phone his family and say his final goodbyes."

This is where the title of the book came from as Darren said all he remembers in those 15 minutes is messages of "love, don't give up and keep fighting."

He describes 'the darkest day' as when he was intubated and put into a coma. After spending 10 days on ICCU, however, he was finally discharged after receiving what he describes as "second to none" care from staff at New Cross Hospital.

Darren said he particularly wanted to thank four members of staff - Sergio Fernandez, Catherine Watkins, Dawn Southey and Kate Holden.

He returned to New Cross Hospital with copies of his book and a special cake to thank the team.

Sergio, Staff Nurse on ICCU, said it was good to see how well Darren was doing. He said: "It shows what we do is important, and it is so rewarding to see Darren doing well. It feels like a great achievement, and I am overwhelmed to be mentioned in the book. It is nice recognition."

Kate Holden, Critical Care Outreach Practitioner, said it was very emotional to see Darren again.

She said: "Darren was one of our first COVID-19 patients and I remember intubating him on the ward before ICCU. We really didn't know much about COVID-19 at the time, and it was really unknown. To see him come out the other side and see him back fit and well is lovely."

Catherine Watkins, Specialist Physiotherapist, said she remembers Darren's story giving her hope.

"At the time we hadn't seen many survivors so to see Darren come off the ventilator and go home gave us some hope in a very scary time, "she said.

"I've worked in intensive care for 37 years and, looking back, you can't imagine the enormity of it all and how emotional it all was, as we thought all our patients might die. When Darren woke up we were so relieved that someone had survived.

"We were very frightened of the unknown and Darren's story was uplifting for us all."

Senior Advanced Nurse Practitioner Dawn Southey said: "It is fantastic what Darren has done with helping others and donating blood plasma. To see Darren do so well and be a part of that story is wonderful."

The book is available to purchase on Amazon, with all profits being donated to The RWT Charity.

Singers' charity donation

From left: Vangie Griffin, Amie Rogers, RWT Charity Fundraising and Lead Digital Engagement Officer, Dr Sanjiv Petkar, Stephen Robins, Heather Johnson, Lynne Slater, Trish Hooper and Kayne Round – all from Songbirds in Harmony – and Amanda Winwood

A ladies choir donated more than £4,200 to help put a song in the hearts of patients at New Cross Hospital.

During 2022/23 and 2023/24, Songbirds in Harmony from Hednesford donated £4,240.37 to The RWT Charity after choosing it as its charity of the year.

Trish Hooper, who is the secretary and founder member of the choir, has been a cardiology patient for nearly 20 years and nominated the charity of RWT, which hosts the Cardiology team in the Heart and Lung Centre.

A ballot put to the choir's 28 members at its AGM saw the Trust's charity receive the highest number of votes.

Money raised from the group's three concerts and other fundraising events, held during the year, will go towards buying a screen and camera system to help patients and families with cardiac education.

"It's humbling and very rewarding knowing we've contributed to purchasing a piece of equipment to help that team and department," said Trish, 58. "As a close group of ladies, we've raised money while doing what we love – singing."

Trish, a mother of three and grandmother of three, has a history of atrial fibrillation, when abnormal electrical impulses override the heart's natural pacemaker, causing a highly irregular pulse rate.

She has undergone numerous procedures, including several cardioversions – a procedure that uses quick, low-energy shocks to restore a regular heart rhythm – and ablations, which uses small burns or freezes to help break up the electrical signals causing irregular heartbeats.

Trish, who lives in Hednesford, said: "The choir always strives to support local charities, but as this one is so personal after having received such amazing treatment, it's all the more special and emotional.

"Every member of staff has been kind, courteous and caring. On the nursing side Andy Lapper has been so supportive over the years, always returning reassuring messages and phone calls in tough times.

"Also, Dr Sanjiv Petkar works tirelessly – he's a huge asset to the department and is extremely well respected."

Steve Robins, Interim Group Manager, Cardiology and Cardiothoracic Services at RWT, said: "It was a pleasure to meet this dedicated group which cares so much for its local community.

"We really appreciate being chosen for this donation and the team will ensure it goes towards the care and support of our patients. Thank you so much."

Dr Petkar, Consultant Cardiologist at RWT, said: "Over the years, Trish has had the benefit of cutting-edge treatments and I'm happy that because of these interventions we've been able to improve her condition.

"It's also very kind of her to think how the local expertise can be extended to other patients. I'm confident the money raised will make a huge difference to our patients undergoing cardiac rehabilitation. We are extremely grateful."

Amanda Winwood, Charity Development Manager, said: "What a wonderful way to raise money! We're very grateful to Trish and her colleagues for their generosity and thank them very much for choosing to donate their fundraising efforts to our charity this year."

Formed in 2011, Songbirds In Harmony is an all-female, three-part harmony choir. It can be contacted via its email info@songbirdsinharmonyuk.com or website, Songbirds in Harmony UK.

Sensory room opened after £20,000 boost

Cyril Barrett and Kirsty Lewis in the sensory room

A sensory room has opened to support younger patients at New Cross Hospital following a £20,000 donation from ex-Goodyear workers.

The brightly-painted facility, which cost £20,638 and is on the Children's Ward, A21, includes two mobile sensory trolleys, a soft play area, large reclining seats, and an infinity mirror and was funded by The 5/344 Transport and General Workers Union Benevolent Charity.

There are different pads on the wall which change the colour of the lighting when pushed and the room has bluetooth access so patients can pair their phones and listen to their own music.

It has been designed to offer a safe, comfortable space for children and young people with physical health conditions, developmental delay or additional sensory needs. But it is also just a relaxing and calm space for any of the patients on the ward.

The donation completes a remarkable legacy of generosity that has seen the group donate more than £400,000 of equipment to the Trust since 2016.

Cyril Barrett, Chair and Trustee of the scheme, said: "We've seen the tremendous difference our donations have made to the Trust and hopefully this room will have the same effect on the children and the staff here.

"We've bought many pieces of equipment for community initiatives in and around Wolverhampton, but in particular for The Royal Wolverhampton NHS Trust, to whom we have donated over £400,000 worth of equipment.

"We hope the decency, kindness and care shown by the ex-union Goodyear workers of Wolverhampton and the Black Country will not be forgotten.

"This has been a passion of ours. If you can complete a project that puts a smile on the faces of the patients and their families, what more of a legacy can we leave in our lives?"

Addressing members of The 5/344 Transport and General Workers Union Benevolent Charity, Sue Rawlings, Chair of The RWT Charity, said: "Thank you on behalf of the Board, staff and patients for everything you and your colleagues have done which have made such a big difference and equally, I'm sure this swansong will do the same. Your efforts will not be forgotten."

Kirsty Lewis, Senior Matron, Children's Acute Services, said: "The sensory room is such a lovely bright, colourful and safe space for the patients. We feel very lucky to have this on our ward at Wolverhampton as not every Children's Ward has one, so we're very grateful to the scheme for funding it.

"Some of our children with complex health needs have been here for a long time and it's really hard on the child and the families. So for them to be able to come into a room like this, away from their bed space with a break from clinical procedures and doctors and nurses, is really wonderful."

Sensory room group photo, from left:- Mark Jenkins, trustee, The 5/344 Transport and General Workers Union Benevolent Charity, Paul Bough, secretary of The 5/344 Transport and General Workers Union Benevolent Charity, Amanda Winwood, Kirsty Lewis, Kate Jenks, Group Manager, Acute and Community Paediatrics (Children and Young People), Sue Rawlings, Barry Malia, management committee member of The 5/344 Transport and General Workers Union Benevolent Charity, and Cyril Barrett.

Charity granted £220,000 to give HOPE

A charity has won a grant of £220,000 to help up to 1,000 vulnerable people in Wolverhampton over the next two years.

The RWT Charity, in partnership with Wolverhampton Voluntary and Community Action (WVCA) was awarded £220,000 from NHS Charities Together for project Holistic Opportunities Preventing Exclusion (HOPE).

As part of the bid, RWT will recruit, train, manage and support a full-time Link Volunteer Co-ordinator, a part-time Link Administration Officer, and up to 200 volunteers per year. These will work alongside the city's Social Prescribing Service, run by WVCA, to help tackle loneliness, isolation, depression and anxiety.

There are currently more than 3,000 referrals a year to the Social Prescribing Service, following a spike in referrals for mental health in the last two years following the COVID-19 pandemic.

This is mainly due to increased loneliness and isolation and the mental and physical impact of that. Other reasons include bereavement and the effects on physical health from Long Covid.

HOPE will work alongside the service – which identifies and refers people to improve their wellbeing – including linking them to community services such as social groups, sporting activities, and groups focusing on areas of interest, such as gardening and arts and crafts.

Around a third of the grant – £75,000 – will be available to apply for to fund small, grass roots community groups to offer activities aimed at improving social connectivity. These bids will be assessed by the steering group.

HOPE will also focus on supporting people experiencing Long Covid, carers and those needing support with pain and medication management and these funds will be used to deliver a range of support, including:

Safe spaces for carers to socialise with those they care for and with others in a similar circumstance

From left: Lindsey Goodall, Community and Events Fundraising Officer, The RWT Charity, Elinor Cole, Arts and Heritage Co-Ordinator, The RWT Charity, Alison Dowling, Head of Patient Experience and Public Involvement at RWT, Eleanor Morris, Deputy Head of Patient Experience (Strategy and Engagement) at RWT and Ian Darch, Chief Executive of WVCA

Physical activities such as walks, art activities, knitting and yoga

Healthy eating, 'knit and natter' and art therapy

Alison Dowling, Head of Patient Experience at RWT, said: "This is the first time we've really been able to work in partnership with the voluntary sector and we're excited about the opportunities this can bring for volunteers. I wish to sincerely thank the Trust's Charity and in particular Chair Sue Rawlings for the support and vision for this project."

Eleanor Morris, Deputy Head of Patient Experience at RWT, added: "We hope by boosting social prescribing programmes, more support can be provided to people experiencing loneliness and isolation and it encourages more connection with community activities.

"We hope the programme will provide meaningful difference to people and even help reduce pressures on frontline NHS services."

Ian Darch, Chief Executive of WVCA, said: "We're delighted to be working with RWT on the HOPE project which will play an important role in improving the wellbeing of local people.

"Tackling loneliness reduces mental and physical illness. Ultimately, if people are supported to remain well, the pressure on the health and social care system will reduce."

Amanda Winwood, Charity Development Manager from The RWT Charity, said: "We are so grateful to have been successful with the grant from NHS Charities together and we look forward to the positive difference we can make to the people of Wolverhampton.

"Reducing isolation will hopefully give confidence to our community and open other opportunities for them and focusing on their wellbeing."

Opportunities to apply for a small grant and to volunteer with the HOPE project are now open.

Volunteering at RWT

Introduction

The Trust is fortunate to have the support of volunteers, unpaid members of our local community, who offer their time willingly to help.

As always, we hold the provision of a positive patient experience at the forefront of our volunteering activity, and we aim to place volunteers into roles which complement, but do not replace, paid members of staff. Volunteers add an important 'extra' factor to helping us provide a positive patient and visitors' experience at RWT.

Review of 2022- 2023: Community Clinical Volunteer role

Following on from the success of our Community Clinical Volunteer role which was established during the COVID-19 pandemic to support Trust areas most in need, we decided to continue offering this role during 2022-2023. This support also ensures a ready supply of volunteers to help the Trust during winter pressures.

During the last 12 months, we have carried out recruitment in this role in five additional cohorts, July 2022, September 2022, January 2023, and July 2023 and an additional cohort of NHS Cadets in March 2023. From these cohorts combined, we have recruited a total number of 150 volunteers. We have also attended two Trust recruitment days which were the July 2022 and January 2023 cohorts.

NHS Cadets is a national programme for young people who receive training by St John's Ambulance and information on the variety of roles within the NHS.

Specific roles that volunteers have supported during this time can be seen below:

Arts in Health Programme

The Arts in Health Programme returned in April 2023 since it had to be stood down due to the COVID-19 pandemic. The programme is funded by the Arts and Heritage Group that is within The RWT Charity. The funds provide craft resources that enable the programme to be delivered by RWT volunteers. The Volunteer Services Team worked in collaboration with the Arts and Heritage Co-ordinator to create a programme of activities that occur twice a month. The programme is designed to encourage engagement and interaction between patients at West Park Rehabilitation Hospital who are recovering from a form of neurological trauma. As well as encourage engagement in the craft sessions, volunteers complete an evaluation form at the end of each session. These forms will be used at the programme's review in September. The review will confirm whether the programme continues, and whether there is scope to expand this service to the other two Trust sites, New Cross and Cannock Chase Hospitals.

Staff Wellbeing Hub

Since December 2022, RWT volunteers have been supporting The Charity's Staff Wellbeing Hub initiative, a food bank, and essential items service to help support staff during the cost-of-living crisis. So far, volunteers have given more than 500 hours of their time to mainly support the afternoon service on the Hub, but more recently, extended their support to the busier morning shifts. The Hub is a great addition to our volunteer opportunities, providing variety and a non-clinical, but essential, support service to our staff.

Roles in Clinical Areas

In the past year (1 July 1022 – 10 August 2023), volunteers have contributed 8,648 hours of their free time to support the Trust. This includes 6,785 hours at New Cross Hospital, 961 hours at Cannock Chase Hospital, 601 hours at West Park Rehabilitation Hospital, 152 hours in the local community and 149 hours of other supportive roles such as the Bereavement Hub service, and Patient Involvement Partner activities. Community roles were the vaccination clinics during the autumn and spring.

New Cross Hospital is where most of our overall volunteer opportunities are. In the past year, the Trust areas with the most volunteer support were Acute Medical Unit (758 hours), C18 Elderly Care (569 hours), Staff Wellbeing Hub (508 hours), Discharge Lounge (485 hours), C21 Stroke (444 hours), D7 General Surgery (395 hours) and Emergency Department (382 hours). Other areas with high levels of support were A16 Appleby Suite, B14 Cardiology, C55 Same Day Emergency Care and C56 Frailty and Dementia.

At Cannock Chase Hospital, the main areas supported were Fairoak Ward (517 hours) and the Endoscopy Unit (304 hours). In 2023, we have added several additional opportunities that include Hilton Main and Hollybank Ward.

West Park Rehabilitation Hospital provides volunteer placements within Ward 1, Ward 2 or the Neurological Rehabilitation Unit. Our reports show equal levels of volunteer support across each ward.

Holistic Opportunities Preventing Exclusion (HOPE)

The Trust has been awarded two years' funding by NHS Charities Together, to provide a volunteer programme aimed at alleviating social isolation and loneliness in the community of Wolverhampton. Working alongside Wolverhampton Voluntary Community Action (WVCA), the project aims to place volunteers alongside the Social Prescribing service, to support vulnerable people in the community referred in. There is also additional funding for the WVCA to deliver a Commissions programme, in which community groups can bid for small pots of funding to develop activities. The project will be reported on more fully in the next Charity annual review.

Looking Forward 2023- 2024

We want to improve the experience of volunteers who wish to use their volunteer opportunity to form career or educational pathways into the NHS. We will use the National Volunteer Certificate to enhance this - 16 volunteers have already completed it.

Building on successes during 2022- 2023, we will also aim to improve opportunities for volunteers with a disability or long-term condition and work with services to remove barriers.

We will expand our HOPE volunteer programme and community volunteering opportunities.

We will continue to raise the profile of volunteering and staff awareness of what is involved in supervision of volunteers.

And we will continue to work with The RWT Charity and recruit volunteer Charity Ambassadors.

Events made a welcome return

We were thrilled to be able to bring back face-to-face events in June last year.

Kicking off the celebration of the Queen's Platinum Jubilee, we hosted a Jubilee Fair.

A fun day was had by all at the event which included special guests, our staff choir. The RWT Singers treated visitors to a right royal performance, finishing with the National Anthem and a speech by Group Chief Executive, Professor David Loughton CBE.

The marquee outside the Emergency Department hosted several stalls managed by community partners and Trust staff members. Items on sale included handbags, handmade soaps, shampoos and wood crafts.

Amanda Winwood, Charity Development Manager, said: "It was lovely to see staff and community partners engaging and marking this special occasion. Thank you to all those who helped make the fair a huge success and for giving their time to bring some cheer."

In addition, an event originally planned for April 2020, The RWT Charity Fashion Show was a chance for guests to shop 'til they dropped!

We teamed up with SOS Charity Fashion Shows to host this fabulous event, featuring a number of NHS workers strutting their stuff on the catwalk, and rails of ladies' high street clothing which were available to purchase at up to 75 per cent off normal retail price.

Thank you so much to family, friends, colleagues, and members of the community who came along. We're also grateful to SOS Charity Fashion Shows, corporate supporters and local businesses who donated prizes for the raffle, and Fordhouses Cricket Club for hosting us.

We're thrilled to reveal that we raised a fantastic £709!

The funds raised will help us to fund additional resources, equipment and projects which will benefit young patients and their families being cared for at RWT.

Celebrating the Platinum Jubilee

In June 2022, the late Her Majesty The Queen became the first British Monarch to celebrate a Platinum Jubilee, after an incredible 70 years of service.

RWT is proud of its heritage and its connection to the Royal family following the historic build of The Royal Hospital. The build was only possible thanks to charitable donations from Victorian businessmen in Wolverhampton that determined that the town (as it was then) was worthy of a hospital as a replacement to a six-bedded Dispensary. A total of £18,000 was raised which purchased land from the Duke of Cleveland and a hospital with 84 beds was built.

The hospital opened its doors on 1 January 1849 to 'patients who are such unable to pay for medicine and advice and are destitute of funds to make provision for them'. It was run by a self-supporting Board of Governors and was totally dependent on charity for its complete running costs. The original staff consisted of a Matron, one Physician, one Consulting Surgeon, three Surgeons, one House Surgeon and a Secretary. The House Surgeon, Edward Hayling Coleman, had, in 1847, carried out the third-ever operation using anaesthesia, in England. During the first year of operation, 408 inpatients and 2,853 outpatients were treated at the hospital.

A Children's Ward was established in 1862, overturning a rule which had excluded the treatment of children under six years old in hospital.

A new wing for inpatients and a new outpatient block were added in 1872 to reduce overcrowding.

In 1873 official recognition from the Royal College of Surgeons, gave the Royal Hospital approval as a teaching hospital.

As the hospital moved into the 20th century, many modern facilities were introduced. Electricity replaced gas lighting and, in 1900, the operating theatre was lit by electricity.

In 1875 an organisation was founded in Parkdale by a Mrs EA Whitehouse with a sum of £50 for the Outdoor Blind. A meeting was held under the support of the Briscoe family, Edward Banks retired architect ,and Dr W Millington to raise charitable donations to establish an Eye Infirmary to ease the significant pressure faced by the Cleveland Road Hospital for conditions such as Ophthalmia Neonatorum (which was increasingly becoming widespread due to social conditions of the day). Initially, only 10 beds were provided and there was an average, daily queue of 50 people waiting outside for treatments. All patients were treated irrespective of their ability to pay or provision of a subscriber ticket from employer, Minister of Religion, or benefactor to the services.

Children's Ward 1975

Electrotherapy and Patient with Respirator

New Cross began its life on the 60-acre site in Wednesfield Road as a large public workhouse in 1904. Following the First World War and the general economy of the country improving, central government ordered that workhouses were to be converted to public hospitals, funded by the local authority and free to general use.

By the year 1912, The Royal Hospital had developed a 53-bed Nurses' home, a new wing of beds dedicated to King Edward VII, its own motorised ambulance provided by Wolverhampton Police Force, an electric lift and a new laboratory. In the ten years immediately after the war, the hospital added many new departments and wards including operating theatres and VD clinics.

Prince of Wales

On 13 June 1923, HRH The Prince of Wales visited the hospital to present its Royal Charter of Incorporation, establishing it as a legally constituted body. That same year saw the General Nursing Council approve the hospital for Nurse training. Five years later, on 28 December 1928, HM King George V declared that from then on, the Wolverhampton and Staffordshire General Hospital should be known as The Royal Wolverhampton Hospital.

College of Nursing, and initially they sought support in The Society of Registered Male Nurses, whose membership was so strong in the West Midlands that its annual congress was held in Wolverhampton in 1959.

The 1950s saw the Eye Infirmary become the fourth largest workload eye centre in the UK and it was now becoming evident from the Commonwealth that much of its eye service provision was being provided by a doctor formerly trained in Chapel Ash. In 1958, the first International Ophthalmic Nurses Conference was held.

With the development of the NHS in 1948 there was larger and wider provision of medical care.

The first separate facilities for the treatment of women's diseases or obstetrics did not come until the establishment of the Women's Dispensary in 1886 which changed its name to the Wolverhampton and District Hospital for Women in 1889. The objective was to treat women "afflicted with diseases peculiar to their sex" and it consisted of inpatient and outpatient departments. The hospital was financed by voluntary donations and was initially in a house in St Mark's Place until it moved to new purpose-built accommodation at Park Road West in 1904.

In 1926 there was a proposed merger with the Maternity Home at the District Nursing Association (but not the Nursing Association). The merger did not take place because the Hospital for Women strongly held on to the principles of voluntary hospitals whereas the Maternity Home seemed to have been a fee-based institution. Both the Hospital for Women and District Nursing Association and Maternity Home combined with the Royal Hospital, Wolverhampton, in 1928.

In 1975, gynaecological services were transferred to New Cross and the hospital was renamed West Park Hospital housing mainly 'geriatric' patients. The building was finally demolished in 1978 and new accommodation was built for West Park Hospital.

Princess Anne Walkabout

The new Maternity Unit was opened by Princess Anne in May 1971, finally encompassing gynaecology within a two-to-three-year period and providing total care including a Neonatal Unit just like its predecessor at West Park. The Tettenhall Road 'Beeches' and Bath Road unit were no more and subsequently the West Park site came under Primary Care control with considerable new building. Renovation plus provisions of care for a wide age group of conditions and patients took place. The hospital was largely demolished in 1978 to make way for West Park Hospital.

In the 1980s many of the specialities from The Royal moved away to New Cross Hospital and over the next decade the wards closed. A full transfer of all departments was seen including Cancer Care, ENT, Paediatric and A&E Departments. But as the 148th anniversary of the hospital approached it was closed in 1997.

Special thanks to Roy Stallard for sharing his wealth of knowledge of The Royal Hospital.

Christmas has arrived at New Cross Hospital!

Staff, patients, and guests gathered together at New Cross Hospital for a Christmas extravaganza – featuring market stalls, music and special guests.

The event, organised by The RWT Charity, saw the area outside the Emergency Department and all the Christmas trees around the site lit up.

Local businesses sold a selection of goodies – everything from bags to candles and perfume, and the Trust's Choir, The RWT Singers, serenaded the crowd with carols and seasonal songs.

And some of the Trust's oldest and youngest patients received a visit from Santa Claus alongside special friends George and Mistletoe – two reindeer straight from the North Pole.

The visit, made possible thanks to the Phoenix Children's Foundation Charity, lifted everyone's spirits.

Patient Derek Rushton, 88, who was recovering from a stroke, was one of the first to meet the festive duo. He said: "It has been really enjoyable."

Doris Halifax, 94, was also taking time out from the hospital's stroke ward to greet the guests. She said: "I just can't believe what I'm seeing. It's a lovely surprise."

Trust staff were equally as delighted, as the smiles widened each time the reindeer were spotted in the marquee outside of the Diabetes centre – the first base on their tour across the site.

Cathy Mincher, Medical Secretary, said: "It's just so lovely. Things like this are really good for your mental health and wellbeing too. The reindeer have a real calming effect. How often do you get to say you've seen a reindeer while at work!"

Jane Haynes, Domestic Support Worker, also dropped by to say hello. She said: "It's really starting to feel Christmassy here at the Trust."

Santa's little helpers then made their way up to the garden on the children's ward.

Seven-year-old Riley Weaver-Harrison is battling leukaemia and spends a lot of time in hospital, but there was no doubt the event helped cheer him up.

Riley's mum, Sara Weaver-Harrison said: "It's brilliant to have Santa and his reindeer here today. It's definitely brought a smile to his face." Riley added: "That was excellent!"

Jessica Mayo from Wolverhampton is mum to three-year-old Zara Moyo who was on site for some allergy tests. She said: "Zara was so excited to meet the reindeer – she hasn't stopped talking about them since. It's a great experience, especially for the children who are here for a long period of time."

And when it came to the light switch-on, Karl Henry, former Wolves captain, hit the big red button with the help of two young fundraisers –13-year-old Alfie Hinks and six-year-old Logan Munday.

He said: "It's an absolute privilege to be asked to turn on the Christmas tree lights – especially with such fantastic young fundraisers by my side. I was born here at the hospital and received lots of treatment here over the years for asthma. I'm delighted to be able to support the charity team and be here at this wonderful event."

Amanda Winwood, Charity Development Manager, said: "The RWT Charity strives to go above and beyond to improve patient experiences, and what better time of year is there than the festive period to bring about some cheer to patients, families and staff members. It's something both adults and children can enjoy.

"Thank you to everyone who came and supported us during the Christmas Fair – it was definitely a day to remember."

A stylish sum raised

Dedicated followers of fashion were wowed by a range of styles for all shapes and sizes in a fundraising fashion show that netted a very smart £821 for The RWT Charity.

The charity staged a winter show following the success of a similar show back in the spring – and organisers were thrilled to double ticket sales this time round with 140 guests attending. Bringing a touch of glamour to the event were ten members of staff from the Trust who all took to the catwalk to model the clothes being showcased by SOS Charity Fashion Shows at Fordhouses Cricket Club.

High quality ladies' high street clothing was on offer at up to 75 per cent off normal retail prices and brands on sale included Topshop, Wallis, Next, Evans and Warehouse, from sizes six to 30.

Amanda Winwood, Charity Development Manager, said: "We had another fabulous night of fashion and fundraising.

"We £560 from tickets in advance, another £127 on the door and from the raffle £134 giving our total of £821. And our staff models were amazing – easily giving Kate Moss and Ashley Graham a run for their money!

"We'd like to thank SOS Charity Fashion Shows for another successful partnership and the team at the venue for letting us use it free of charge. All proceeds will be added to our 2022 Christmas Appeal which is used to bring festive joy to our patients and service users at this time of year."

Amanda added that 17 businesses had also been supportive by donating raffle prizes and these included, TK Maxx, Boots at Bentley Bridge, Tesco, Wolverhampton, Morrisons, Willenhall, Costa Wolverhampton, Abi Rogansky bags, Travelling Boutique, Paul's Fragrances and SOS Charity Fashion Show.

Charities score as £700 raised from football match

Both teams together at Silverdale FC. RWT are in white shirts, with Well Wishers wearing blue shirts.

Charity was the big winner as staff from RWT and Walsall Healthcare NHS Trust tackled each other on the football pitch for the first time, with nearly £700 raised.

Spectators paid £5 to watch, while every player, including substitutes, paid £10 each to play and there was a raffle, which all contributed to an overall figure raised of £691.61, split between The RWT Charity and Well Wishers, Walsall Healthcare's charity.

The money was put towards a sensory garden for the Stroke Rehabilitation Unit at Hollybank House, Willenhall, which is a joint service for both Trusts.

Well Wishers won 7-1 in the game at Silverdale FC, Walsall, after RWT took an early lead. Right midfielder Ryan Bellingham put RWT in front after a mistake by Well Wishers goalkeeper, but then the tables turned in Walsall's favour.

Left winger Aiden Justin was in four-midable form with four goals while captain Ben Malpass netted twice and substitute Conor Meehan the other as Well Wishers led 4-1 at half-time.

There was an executive flavour to the teams too, with Well Wishers featuring Ned Hobbs, Chief Operating Officer, and Russell Caldicott, Chief Financial Officer, while Emily Smith, Head of Communications, played for RWT and was the only woman involved.

Ben, Assistant Communications Officer for Digital, said: "It was a good day for us on the pitch and a great example of collaborative working between the Trusts to raise that amount of money.

"We're a group of lads who enjoy playing together so we were over the moon to get the win and to carry on our winning streak."

RWT captain Adam Loftus said: "It was a great day for the respective charities – to raise nearly £700 is exceptional and we're delighted to play a part in that.

"A few of the lads have already mentioned a rematch. It was a case of stepping into the unknown for us."

Georgie Westley, Well Wishers' Fundraising Manager, said: "We were really pleased with the way everything went, and to raise the amount of money we did was the icing on the cake. Hopefully this is the first of many joint initiatives between the charities. Thank you to everyone who supported the event."

Amanda Winwood, RWT Charity Development Manager, said: "As one of the first joint charity efforts, we're very proud and delighted that this has been a success – even if we wished the result had been better on the pitch! Thanks to everyone involved and hopefully it's kickstarted more collaborative working with Well Wishers."

NHS Charities Together Grants

BAME End of Life project

Project End Date - March 2023

Beginning in March 2021 this project was delivered in partnership with Compton Care to improve and support patients and their families from the BAME community, who were living with a complex and incurable condition.

The project provided a key link for patients and their families to help access care and the necessary support, liaising between services providing specialist support to patients and families across Wolverhampton.

The project had a key support worker whose aim was to empower patients to increase their choices for end-of-life care from community and acute settings, ensuring care was accessed in the right time and setting.

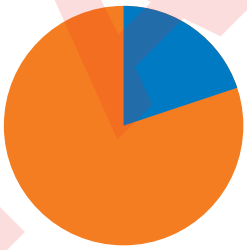
Project outcomes:

- Due to delays with projects starting because of COVID-19, numbers were not as expected, but a turnaround in 2022 was much better
- More than 50 individual employees from both organisations have benefited from the advice and support given by the Support Worker which included setting up a masterclass in Cultural Awareness which was delivered by staff at Compton Care in partnership with their Chaplaincy Team
- The catering Team at Compton Care re evaluated its menu choices for provision in the coffee shop and the hospice. This ensured a culturally appropriate menu for families of those receiving care at the hospice
- Recruitment of a new BAME Support Worker after the original one left
- BAME Support Worker given access to RWT community systems to be able to actively pull patient information
- BAME Support Worker included in meetings with Care Co-ordination Team and collaborative working
- Difficulties with working across two organisations generated complexities in terms of referral processes, new processes identified, and improvement seen
- Project Steering Group set up with regular meetings
- Fifty nine patients supported and signposted to other agencies

Survey Results

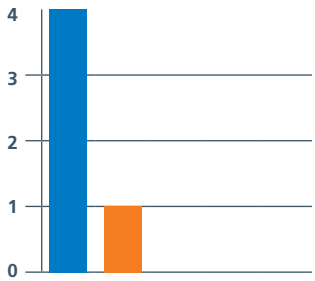
1. Please confirm if you are the patient or the family / friend / carer:

Patient	1
Family / friend / carer	4



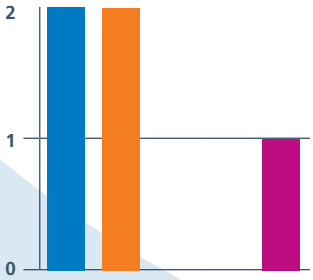
2. I felt I was treated with respect and dignity:

Strongly Agree	4
Agree	1
Neither Agree or Disagree	1
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	0



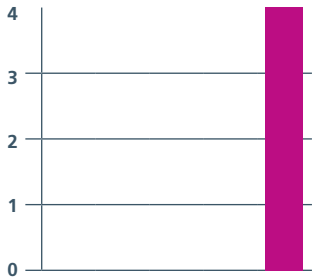
3. I received helpful guidance on practical issues (e.g. financial):

Strongly Agree	2
Agree	2
Neither Agree or Disagree	1
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	1



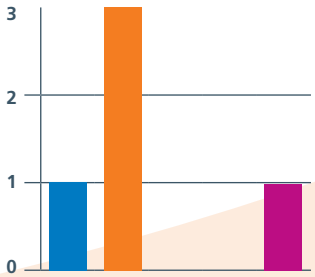
4. I felt supported with my advance wishes and requirements:

Strongly Agree	0
Agree	0
Neither Agree or Disagree	0
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	5



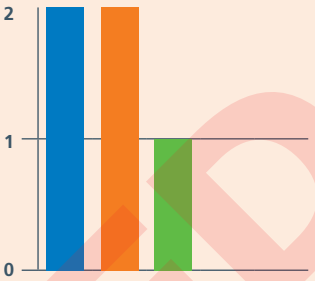
5. I felt relaxed and reassured with my family and friends:

Strongly Agree	1
Agree	3
Neither Agree or Disagree	0
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	1



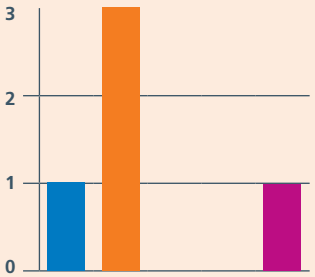
6. I felt my emotional needs and feelings were managed well:

Strongly Agree	2
Agree	2
Neither Agree or Disagree	1
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	0



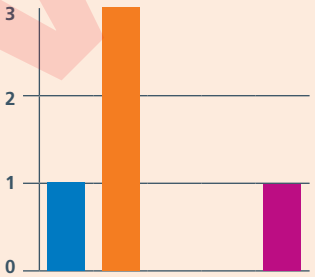
7. I felt the service allowed me the freedom to do what mattered to me:

Strongly Agree	1
Agree	3
Neither Agree or Disagree	0
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	1



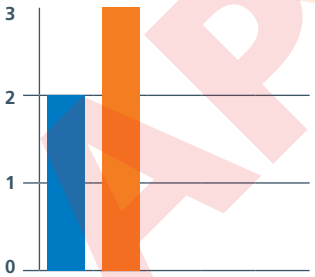
8. I felt I had access to the right services and at the right time:

Strongly Agree	1
Agree	3
Neither Agree or Disagree	0
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	1



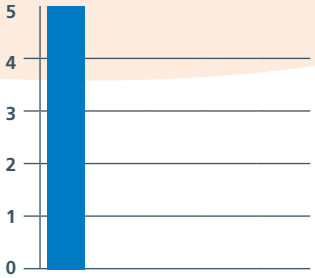
9. I was provided with information in a way that I understood:

Strongly Agree	2
Agree	3
Neither Agree or Disagree	0
Disagree	0
Strongly Disagree	0
Don't Know	0
N/A	0



10. Overall, how was your experience of our service:

Very Good	5
Good	0
Neither Good or Poor	0
Poor	0
Very Poor	0
Don't Know	0



11. What was good about the service?

Great	Laugh	Appointments	Appreciate
Service	Happy	Helpful	Understanding
Explanations	Interpreter	Sessions	Help
Thanks	Wonderful	Given	Supported
Referrals	Eye-opener	Making	Lovely

Holistic Opportunities Preventing Exclusion (HOPE) project

Project start date April 2023

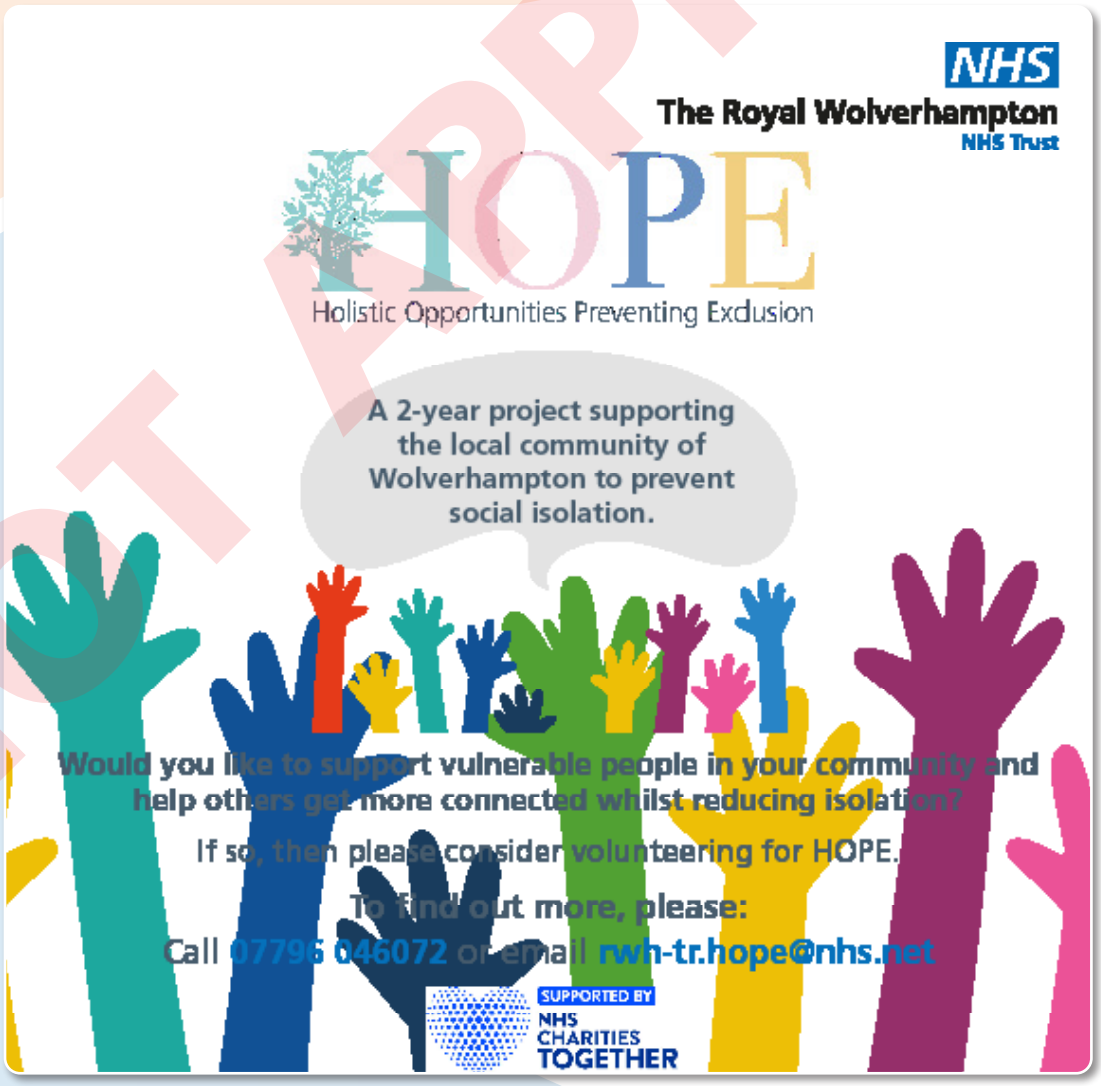
Our charity won a grant of £220,000 to help up to 1,000 vulnerable people in Wolverhampton over the next two years. Working in partnership with Wolverhampton Voluntary and Community Action (WVCA), the project has been awarded £220,000 from NHS Charities Together for project Holistic Opportunities Preventing Exclusion (HOPE).

From left: Lindsey Goodall, Community and Events Fundraising Officer, The RWT Charity, Elinor Cole, Arts and Heritage Co-Ordinator, The RWT Charity, Alison Dowling, Head of Patient Experience and Public Involvement at RWT, Eleanor Morris, Deputy Head of Patient Experience (Strategy and Engagement) at RWT and Ian Darch, Chief Executive of WVCA

The grant will allow us to:

- Recruit, train, manage and support a full-time Link Volunteer Co-ordinator
- Take on a part-time Link Administration Officer
- Recruit up to 200 volunteers per year.

Around a third of the grant – £75,000 – will be available for organisations to apply for to fund small, grass roots community groups to offer activities aimed at improving social connectivity. These bids will be assessed by the steering group.



Some of the items bought through The Charity

Charity Spend

Neonatal Unit – Cuski products – £1033.50

Cuski nests, swaddle wraps and bean bags for or premature babies for neonatal positioning and development care.

Paediatrics – Sensory room – £26,000

Following a donation of £20k from The 5/344 Transport and General Workers Union Benevolent Charity we were able to create a sensory room which is a bright, colourful and safe space for patients. We feel very lucky to have this at RWT as not every Children's Ward has one. Some of our children with complex health needs are here for a long time and it's really hard on the child and the families. So, for them to be able to come into a room like this, away from their bed space with a break from clinical procedures and doctors and nurses, is wonderful.

Orthopaedics
TV and DAB radio – £483

Some entertainment to support patients in our outpatient department and help pass the time.

Music therapy is shown to be good for the heart and reduce blood pressure making people feel more relaxed.

Oncology – Comfortline2 Therapy chairs

Comfort chairs were purchased for the Deanesly Centre. Comfortline chairs provide patients with a more comfortable and positive experience when receiving their treatment which is often over a long period of time.

Paediatrics – RockinR gaming system - £2,600

When speaking to some of our younger patients they identified they missed gaming, so two young fundraisers decided to raise some funds and purchase a system. Logan, aged six, climbed Snowdon with his dad and raise £1,400 and Alfie, aged 13, held a charity ball with his family and raised £1,200 to support this project. Situated in the playroom on Ward A21 at New Cross, the cart, which is height adjustable and lockable, comes complete with 21 of the newest games – all restricted to age 12 – access to Netflix, Disney+, the internet and streaming services and can be moved to the individual bed space.

Vascular – Handheld Dopplers - £3,011

A Doppler ultrasound is a non-invasive test that can be used to estimate the blood flow through your blood vessels by bouncing high-frequency sound waves (ultrasound) off circulating red blood cells. A regular ultrasound uses sound waves to produce images, but can't show blood flow.

How you can support us

Getting involved and supporting your local hospital and community services couldn't be easier. You might consider attending one of our events or even host your own and help us raise vital funds.

Donations can be made in the following ways:

Direct into bank account:

Contact the charity team on 01902 694473 for details and reference.

By post:

Please make cheques payable to The Royal Wolverhampton NHS Trust Charity.

Please write on the back of the cheque which fund you would like to donate to, e.g. General Purposes Trust Fund, and send to; Charity Office, Location A27 OPD, New Cross Hospital, Wolverhampton, WV10 0QP

By a donation on our 'Just Giving' site:

https://www.justgiving.com/royalwolvesnhstrust

Please complete a donation form and return it along with your donation to the RWT charity.

Did you know you can also increase your donation without having to pay more? An additional £36,000 was raised through the Gift Aid scheme in 2021/22.

How does Gift Aid work? Gift Aid is a scheme run by the government that enables charities to increase the value of donations made by reclaiming basic rate tax that has been paid on the gift. At the moment, we can claim 25p per £1 donated, so on a gift of £100, we will actually receive an extra £25, at no cost to the donor.

Great! Can I Gift Aid my donations?

To qualify for Gift Aid, you need to be a UK taxpayer and have paid enough tax to cover the amount of tax reclaimed by all charities on all your donations for each tax year (6 April one year to 5 April the next). Apart from tax on income from a job or self-employment, other types that are acceptable are:

- Tax deducted at source from savings interest
- Tax on state pension and/or other pensions
- Tax on investment or rental income (including tax credits on UK dividends)
- Capital Gains Tax on gains

Other taxes such as VAT and council tax do not qualify, nor does any non-UK tax.

When completing your donation form or donating via an online platform, simply complete the gift aid declaration, provide your postal address and we'll do the rest!

Looking Ahead

Our objectives for 2023-2024

- We will increase the visibility, profile and understanding of the charity within the hospitals and our local community.
- We will strive to increase the value of monetary and non-monetary donations we receive year upon year, to ensure that we can continue to enhance the care and experiences of patients, their families, and our staff.
- We will deliver an effective, accessible grants programme to support Trust improvements to services and the patient environment.
- We will actively encourage applications to fund projects that further enhance and improve the health and wellbeing of staff and volunteers.
- We will actively encourage applications to fund research projects that will further medical knowledge through research.
- We will actively seek opportunities for collaboration with our colleagues from both statutory and non-statutory organisations and build and strengthen partnerships with key health and voluntary sector organisations to deliver greater impact.
- We will embrace the digital agenda and utilise opportunities to raise further awareness of the charity with stakeholders as well as actively support projects that embrace technology and innovative ways of working.

Trustees – Custodians of the Charity

The Royal Wolverhampton NHS Trust is the Corporate Trustee of the Charitable Funds governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

The Charity has the authority to recruit up to eight trustees who together make up the Board of Trustees. They are unpaid volunteers who set the strategy for the Charity and make sure it is implemented. Trustees elect a Chairman from amongst their number who chairs the meetings of the Board of Trustees and takes a more active role in supporting the Charity Chief Executive in the management of the Charity.

Trustees are appointed under arrangements made by the Secretary of State for Health under Section 51 of the NHS Act 2006. Vacancies are advertised and all potential Trustees must be interviewed and recommended by a panel consisting of two members of the Charity and one external assessor. Candidates must show knowledge of, and an interest in, the hospital and the community it serves and be willing to give the time necessary. Trustees are also selected to give the Charity a good mix of relevant professional skills, such as finance, investment and fundraising.

Trustees serve a fixed term of no more than four years (renewable to a usual maximum of ten years in total). New Trustees receive an induction pack consisting of the governing documents, previous trustee reports and accounts, relevant Charity Commission guidance, and policies and procedures of the Charity. They are also given a tour of the Trust. Appropriate training is provided in areas including Charity law and administration, investment management and charity finance. The Charity's professional advisors provide helpful guidance, and membership of NHS Charities Together gives the Trustees access to regular conferences and training events.

The Charity has a Corporate Trustee: The Royal Wolverhampton NHS Trust. The members of the NHS Trust Board who served during the financial year were as shown in the table below;

Trustee	Role within The Royal Wolverhampton NHS Trust
Mr K Bostock	Group Director of Assurance
Prof. A-M Cannaby	Group Chief Nursing Officer
Lord Carter	Strategic Advisor to the Board (from a February 2023)
Ms L Cowley	Non-Executive Director
Dr U Daraz	Associate Non-Executive Director(from 1 February 2023)
Mr A Duffell	Group Chief People Officer
Mr J Dunn	Non-Executive Director, Chair of Finance and Performance Committee (from 4 July 2022), Chair of Remuneration Committee (from 4 July 2022)
Mr R Dunshea	Non-Executive Director, Senior Independent Director (to 31 August 2022), Chair of Audit Committee (to 31 August 2022)
Mr S Evans	Group Chief Strategy Officer
Ms S Evans	Group Director of Communication and Stakeholder Engagement
Prof. S Field	Chair, Non-Executive Director
Ms A Harding	Associate Non-Executive Director(from 1 February 2023)
Mr J Hemans	Non-Executive Director, Chair of People and Organisational Development Committee
Ms A Heseltine	Associate Non-Executive Director
Ms D Hickman	Director of Nursing
Ms J Jones	Non-Executive Director, Chair of Audit Committee (from 4 July 2022)
Mr M Levermore	Non-Executive Director
Prof. D Loughton CBE	Group Chief Executive Officer, Chair of Management Committee
Ms M Martin	Non-Executive Director (to 3 July 2022), Chair of Finance and Performance Committee (to 3 July 2022), Chair of Remuneration Committee (to 3 July 2022)
Ms G Nuttall	Chief Operating Officer
Dr J Odum	Group Chief Medical Officer
Ms T Palmer	Director of Midwifery
Ms S Rawlings	Non-Executive Director, Chair of Trust Charity
Mr K Stringer	Group Chief Financial Officer/Deputy Chief Executive
Prof. L Toner	Non-Executive Director

How we organise the Charity

The main Charity, The Royal Wolverhampton NHS Trust Charity, registered charity number 1059467, was entered on the Central Register of Charities on 27 November 1996 in accordance with the Charities Act 2011. The Charity is constituted of circa. 94 individual funds. The notes to the accounts distinguish the types of fund held and disclose separately all material funds. Please refer to pages 71-86.

Charitable funds received by the Charity are accepted, held and administered as funds and property on trust for purposes relating to the health service in accordance with the National Health Service Act 2006 and the National Health Service and Community Care Act 1990. The Charity has no employees but reimburses the NHS Trust for the financial and other services it provides. The Charity relies on the NHS Trust to identify the appropriateness of funding requests.

The Royal Wolverhampton NHS Trust as the Corporate Trustee has devolved responsibility for the on-going management of funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee. This Committee was formed in 2006.

The names of those people who served as agents for the Corporate Trustee, as permitted under the NHS Trusts (Membership and Procedures) Regulations 1990 were as follows:

Prof. Steve Field CBE -	Chairman
David Loughton CBE -	Group Chief Executive
Kevin Stringer -	Group Chief Financial Officer
Sue Rawlings -	Non-executive Director
Roger Dunshea -	Non-executive Director
Julie Jones -	Non-executive Director
Lisa Cowley -	Non-executive Director

Principal Charitable Fund Advisers to the Board

The Chief Executive of the NHS Trust (David Loughton CBE) and Chief Financial Officer (Kevin Stringer) have day to day responsibility for the management of the Charitable Funds under a scheme of delegated authority by the Corporate Trustee. They must personally and together, on behalf of the Corporate Trustee, approve all expenditure over £10,000 with an upper limit of £50,000. Expenditure in excess of £50,000 on a particular project must be authorised by the Trust Board of the Corporate Trustee.

Mr Kevin Stringer was the principal officer overseeing the day to day financial management and accounting for the Charitable Funds during the year.

Principal Office

The principal office for the Charity is:

Group Chief Financial Officer
The Royal Wolverhampton NHS Trust
Hollybush House
New Cross Hospital
Wolverhampton
WV10 0QP

Wider Networks

RWT Charity is one of over 400 NHS linked charities in England and Wales who are eligible to join NHS Charities Together. As a member charity, we have the opportunity to discuss matters of common concern and exchange information and experiences, join together with others to lobby government departments and others, and to participate in conferences and seminars which offer support and education for our staff and members of the charitable funds committee.

Related Party Relationships

The Charity holds a related party relationship with The Royal Wolverhampton NHS Trust. The transactions with these parties have been disclosed in note 17 of these financial statements.

Trustees of the Charity

Professor David Loughton CBE Chief Executive

Appointed 2004

Professor Loughton's first Chief Executive appointment was at the University Hospitals Coventry and Warwickshire NHS Trust in 1986 where he successfully led the organisation through two hospital mergers, developed a new medical school with Warick university and reached financial closure of a new £400m hospital.

He then started as Chief Executive of the Royal Wolverhampotn NHS Trust (RWT) in 2004. He has led the organisation from one of the most financially challenged in the NHS, to being financially sound, whilst at the same time gaining a national and international reputation for improving patient safety and experience. He starts as Chief Executive of Walsall Healthcare NHS Trust in 2021, which has seen improvements in both staff and patient satisfaction.

RWT hosts the National Institute for Health Research (NIHR) in the West Midlands and Professor Loughton is the Chair of the Wedt Midlands Cancer Alliance.

Committee Attendances in 2022-2023: 2/4

Declaration of interests

- National Institute for Health Research – Member of Advisory Board
- Chair of West Midlands Cancer Alliance
- Chief Executive Officer

Professor Steve Field Chair of the Board

Appointed 1 April 2019

Professor Field holds a number of roles at various organisations including Chair at Walsall Healthcare NHS Trust, Trustee at Nishkam Healthcare Trust and a Trustee for Pathway Healthcare for Homeless People.

Prior to his role of Chair, he was Chief Inspector of General Practice, Primary Medical Services, and Integrated Care at the Care Quality Commission (CQC). He has held several board positions in the NHS including, Deputy National Medical Director at NHS England, Regional Postgraduate Dean for NHS West Midlands, and Chair of the NHS Inclusion Health Board at the Department of Health. He also held the position of Chair of The Royal College of GPs and has been a faculty member at the Harvard Macy Institute of Harvard University in the USA. He has been awarded a number of honorary degrees and also holds academic appointments at the University of Birmingham and the University of Warwick.

Committee Attendances in 2022-2023: 0/4

Declaration of interests

- Nishkam Healthcare Trust Birmingham – Trustee
- Chair, Walsall Healthcare NHS Trust
- Honorary Professor - University of Birmingham
- Honorary Professor – University of Warwick
- Director of EJC Associates
- Trustee for charity, Pathway Healthcare for Homeless People (from 04/08/20 to 01/04/22)
- Advisor to Health Holding Company and Board Member of Makkah Health Cluster, Kingdom of Saudi Arabia

Kevin Stringer
Chief Financial Officer

Appointed 2009

Mr Stringer is a qualified accountant with the Chartered Institute of Management Accountants (CIMA) and holds a Masters qualification in Business Administration (MBA). With more than 34 years of experience in the NHS, 21 of those years as a Director, he has experience of commissioning and provider organisations.

His experience covers:

- Primary Care, Community Services and Commissioning (with successor organisations being Walsall CCG and Birmingham cross-city CCG)
- Secondary and Tertiary Care (at University Hospitals of Coventry and Warwickshire, Sandwell and West Birmingham Hospitals)
- Specialist Secondary Care (Birmingham Children's Hospital Foundation Trust where he helped the Trust secure FT status)
- Regional NHS Planning and Oversight (West Midlands Regional Health Authority) .

His role is to provide professional advice to the Board and wider Trust to ensure delivery of the Board's financial strategy, key statutory financial targets and ensure good internal control.

He is a member and advocate for Healthcare Financial Management (HFMA) having been a past Chair of the West Midlands Branch where he is now the Treasurer.

Committee Attendances in 2022-2023: 4/4

Declaration of interests

- Treasurer, West Midlands Branch – Healthcare Financial Management Association
- Member of CIMA (Chartered Institute of Management Accountants)
- Midlands and Lancashire Commissioning Support Unit - brother-in-law is the Managing Director
- Interim IT Director and SIRO at Walsall Healthcare NHS Trust
- Interim Director of Finance at The Dudley Group NHS Foundation Trust
- Group Chief Financial Officer at Walsall Healthcare NHS Trust
- Daughter works on the administration Bank at the Royal Wolverhampton NHS Trust

Roger Dunshea
Non-Executive Director

Appointed April 2014

Mr Dunshea has worked in the NHS in Scotland, Wales, and England in a variety of positions including Staff Nurse, Project Manager, Clinical General Manager and Executive Director roles. Between 1997 and 2013 he was a Director with OFWAT (the economic regulator of the water sector in England and Wales) with responsibilities covering finance, information systems, human resources, and procurement. He has been the Chair of Governors at a Central Birmingham High School and a Non-Executive Director with the Shrewsbury and Telford NHS Trust.

His other current roles are independent member of the Welsh Government's Education and Public Services audit and risk assurance committee and Chair of the audit committee of the Geological Society. He is volunteer warden with Natural England. He is a Chartered Public Finance Accountant and Fellow of the Geological Society.

Committee Attendances in 2022-2023: 2/2

Declaration of interests

- Geological Society of London – Member of Audit Committee
- Independent member of the Welsh Government Audit and Risk Committee for Education and Public Services
- Independent Member of Judicial Appointments Commissions ARAC

Sue Rawlings
Non-Executive Director

Appointed July 2013 (Served as an Associate Non-Executive Director from October 2012).

Re-appointed as an Associate Non-Executive Director in October 2021.

Ms Rawlings is a Chartered Certified Accountant who has worked in the public, private and voluntary sector. For 20 years, until 2020, she was a partner of the consultancy firm RHCS, a well- established, highly skilled consultancy firm working with a range of cross sector clients from the voluntary community/charitable and public sectors. She has extensive experience in evaluating the effectiveness of public expenditure and has worked, for example, with the British Red Cross in various parts of the country, conducting needs assessments, developing performance monitoring, and carrying out evaluations.

She worked with voluntary and community sector organisations to develop their business planning, their future sustainability and identify their impact. Previously a local improvement advisor appointed via IDeA to the Regional Improvement Efficiency Partnership in the West Midlands, she is also a Trustee of both Telford Christian Council Supported Housing Charitable Company and Telford Churches Together Charity.

Committee Attendances in 2022-2023: 4/4

Declaration of interests

- Trustee and Company Director of Telford Christian Council Supported Housing – STAY
- Trustee and Director of Faith based Charity in Telford – Telford Christian Council

Lisa Cowley
Non Executive Director

Appointed February 2022

Ms Cowley joins Trust Board bringing a wealth of experience gained in large, national and regional, health, social care and third sector organisations. She has held senior leadership positions, both as an employee and in a charitable trustee capacity, ensuring she brings a strong foundation in financial, business and operational planning, project evaluation and impact monitoring, amongst other expertise. She is particularly skilled at developing partnerships across the voluntary and public sector, including the evolution of the VCSE Alliance as part of the development of Integrated Care Systems. In her current role, Ms Cowley is Chief Executive Officer (CEO) of Beacon Vision, one of the region's most established and well-known health and social care charities, where she has been in post for more than four years. She has bought many positive improvements to the charity and is passionate about making a difference to the lives of people living with sight loss across the West Midlands. In addition to her unwavering dedication to Beacon's charitable objectives, she is committed to building long-term sustainability, actively seeking new ways to improve and develop increased integrated, cooperative and progressive health and social care systems to support beneficiaries. Previous roles have included Deputy CEO of the Black Country Living Museum, where she implemented significant change programmes and oversaw complex funding bids and projects of national heritage significance. Ms Cowley has also been involved in complex projects during her time at organisations such as the RSPB and The British Horse Society, where she developed and implemented the charity's national volunteer programme. A highlight from her earlier career includes a pivotal role in the redevelopment of the world's first 'skyscraper' in Shrewsbury. She is originally from Wolverhampton, having returned after completing her degree at the University of Liverpool. Her personal interests include a passion for horses and horse riding.

Committee Attendances in 2022-2023: 4/4

Declaration of interests

- Healthy Communities Together Project Sponsor for Beacon Centre for the Blind
- Chief Executive for the Beacon Centre for the Blind

Julie Jones
Non Executive Director

Appointed August 2022 (Served as an Associate Non-Executive Director from February 2022).

Ms Jones is a fellow of the Institute of Chartered Accountants in England & Wales who, after 15 years in external audit at a leading accounting firm, has spent the last 10 years in executive finance director positions in the not for profit and public sector. She is currently the Chief Financial Officer of a secondary school academy in Solihull and is an Associate Director of a company providing internal audit services to academy schools nationwide. She has more than 20 years' experience as a Non-Executive Director in social housing and higher education and is currently a member of the Audit & Assurance Committee of Walsall Housing Group, and Trustee and Treasurer of two local charities. She was previously the Chair of Audit Committee at Birmingham and Solihull CCG.

Committee Attendances in 2022-2023: 3/4

Declaration of interests

- Associate Director of Academy Advisory
- Member of Audit and Risk Committee Walsall Housing Group
- Trustee of Solihull School Parents' Association
- Director of Leasehold Management Company Cranmer Court Residents Wolverhampton Limited
- Chief Financial Officer of Heart of England Academy

Structure, Governance and Management

All the Charity's funds are pooled for investment purposes and the official pooling scheme was registered with the Charity Commission on 24 June 1998.

For management purposes all funds held and received by the Charity fall into one of the following categories:

- Endowment funds - funds where the capital must be held in perpetuity and only the income generated can be used for charitable purposes
- Restricted funds - funds received which have specific restrictions set by the donor
- Unrestricted funds - funds received which have no restrictions attached to their use.

Within the unrestricted category separate designated funds have been established which reflect the wishes of donors to help named wards and departments in the hospital. Subsequent donations and gifts received by the Charity that are attributable to the already established funds are added to those fund balances. Where the donations and gifts are not attributable to already established funds, new funds are set up. In this way the Corporate Trustee fulfils the legal duty to ensure that all funds are spent in accordance with the objectives of each fund and that the wishes of donors are always considered.

Unrestricted funds form the largest category with £1,791,000 of funds at 31 March 2023. There are charitable funds for most clinical specialties (e.g. medicine or ophthalmology) and for some wards and departments within specialties.

Non-Executive members of the Trust Board are appointed by the NHS Appointments Commission and Executive members of the Board are subject to recruitment by the NHS Trust Board. Members of the Trust Board and the Charitable Funds Committee are not individual Trustees under Charity law but act as agents on behalf of the Corporate Trustee.

Acting for the Corporate Trustee, the objective of the Charitable Funds Committee is to provide strategic direction to the Charity and ensure that it is managed and administered in accordance with the Charity's purposes. The Committee is responsible for:

- Determining a charitable funds strategy and setting annual objectives
- Ensuring that charitable funds are managed in line with the measures and actions set out in the strategy
- Ensuring any fundraising elements of the strategy work within recognised good practice frameworks and identify methods of fundraising appropriate for the Charity
- Determining a charitable funds investment policy and monitoring performance of any investments made in line with governing documents and the Trustee Act 2000
- Appointing and considering the performance of any investment advisors or managers

- Ensuring Trust policies and procedures are adequate, that financial controls are in place to account for all funds received and that governance arrangements are appropriate and effective
- Ensuring that timely annual reports and accounts are produced and an unqualified external audit opinion is received.
- The accounting records and the day-to-day administration of the funds are dealt with by the Finance Department located at The Clinical Skills and Corporate Services Centre, New Cross Hospital, Wolverhampton WV10 0QP.

Risk Management

The major risks to which the Charity is exposed have been identified and considered. They have been reviewed and systems established to mitigate those risks. The Trustee is confident that reliance can be placed on the management arrangements in place, which include internal and external audit services, to minimise any risk to the funds. The most significant risks identified are the possible losses from a fall in the value of the investments and the level of reserves available to mitigate the impact of such losses.

The investments are held by the Investment Fund Managers who act in accordance with the agreed investment policy and are subject to regular review. In addition, unrealised gains and losses are allocated to funds at agreed intervals. Procedures in place ensure that both spending and firm financial commitments remain in line with income. Income is covered by the Standing Financial Instructions and there is an agreed boundary for the receipt of donations. This policy has been communicated to staff.

There is an agreed expenditure and reserves policy together with a tight approval procedure which gives the Corporate Trustee confidence that the expenditure will remain within the limits of the Charity's resources.

Objectives and activities for the public benefit

This can be found at the beginning of this report on page 5.

Investment Management

Surplus funds are pooled and invested in order to maximise income, whilst minimising risk for the Charity.

Income and cash, gains and losses are distributed equitably across the Charity funds. The income from investments amounted to £82,397 (£77,879 in 2021/22).

Throughout 2022/23 the investments were split into two portfolios.

- A Shorter Term Portfolio which aims to achieve a consistently attractive level of income, coupled with the potential for long-term capital appreciation whilst aiming to preserve the value of the capital over the short-term
- A Longer Term Portfolio which is invested to achieve long-term capital and income growth. Achieved with a broadly diversified global portfolio covering the world's principal stock, bond and currency markets, together with investments in "alternative" assets such as property and hedge funds.

During the year the Trustees requested both the Shorter and Longer Term Portfolios continue to hold a 50:50 split of the overall investments.

At the year end the Shorter Term Portfolio held £1,069,146 and the Longer Term Portfolio held £1,380,183. Both portfolio's were split between investment types. The two portfolio's together were split in the following way. £1,106,793 – 45.2% (2022: £1,290,563 – 48%) was invested in equity based investments, £1,265,201 – 51.6% (2022: £1,306,414 – 48.5%) was invested in longer fixed interest bearing government and other securities and £77,343 – 3.2% (2022: £94,025 – 3.5%) was held as liquid assets including cash. This total sum invested decreased by £241,674 from 2021/22.

The Charity does not own any investment properties.

The Charity has an investment policy that was reviewed in November 2022. See page 66.

A reflection on the last 12 months, from Sarasin & Partners LLP.

Investment returns for the past 12 months have been a tale of two halves. With Russia's invasion of Ukraine came rising inflation, which, added to the supply shock created by the COVID-19 pandemic, caused central banks to raise interest rates faster and higher than many had anticipated. This, along with mounting recessionary concerns, triggered falls across both equity and bond markets over the following months.

October, by contrast, brought a sense of optimism as data releases began to imply that inflation was showing signs of nearing a peak. This optimism was further strengthened by the rapid reopening of China in early 2023 and falling wholesale gas prices in Europe. Since this point, and in spite of the many oscillations in sentiment and a banking crisis in Europe & the US in March, returns for equity investors have rebounded strongly. The resurgence has been led by a relatively narrow set of US listed technology companies, which have benefitted from the renewed excitement in large language models and the advances in machine learning. Over the entire period, the net result is that returns from equities have been broadly flat.

Having had limited exposure to fixed income in 2022, falling capital values have meant that the yields on offer, particularly from high-quality, investment grade corporate bonds, look increasingly attractive. This has provided an opportunity to start adding back to positions, which had been roughly half-weighted, to a more neutral level by the end of the twelve months.

The portfolios have benefitted from our continued focus on high quality businesses with strong balance sheets and meaningful pricing power, with companies like Merck & Co (diversified pharmaceuticals), National Instruments (software and hardware for engineers and scientists) and Broadcom (semiconductors and infrastructure software) contributing strongly to performance.

With regards to income, distributions for the long-term portfolio were kept flat, as was projected this time last year, thus maintaining our commitment to produce sufficient income for the Trust. We expect income receipts to again be matched over the next 12-month period, which we hope will assist with the Trust's financial planning.

Policies

Investment Policy

The Royal Wolverhampton NHS Trust Charity seeks to produce the best financial return within an acceptable level of risk.inflation over the long term whilst generating an income to support the on-going activities of The Royal Wolverhampton NHS Trust Charity.

The investment objective for the short term portfolio is to preserve the capital value with a minimum level of risk. Assets should be readily available to meet unanticipated cash flow requirements.

The Royal Wolverhampton NHS Trust Charity has approximately a 50/50 split for investments between long term and short term, in order that unanticipated cash flow needs can be met.

The Charity's ethical investment policy precludes direct or indirect investment in companies that generate more than 10% of revenues from alcohol, armaments, gambling, pornography and will not invest in tobacco.

Expenditure policy

The charitable funds that the Charity manages, and from which grants are made, are held as endowment funds (expendable or permanent), restricted funds and unrestricted funds (designated or non-designated).

It is the Trustees' policy to ensure that all grants made from these funds are used in accordance with the purposes of the individual fund and The Royal Wolverhampton NHS Trust Charity's purposes and aims.

Individual funds' purposes include research, equipment, and patient and staff welfare.

The definitions of endowment, restricted and unrestricted funds are detailed below:

- Endowment funds – funds where the capital must be held in perpetuity and only the income generated can be used for charitable purposes
- Restricted funds – fund received which have specific restrictions set by the donor
- Unrestricted funds – funds received which have no restrictions attached to their use.

All of the different types of funds have fund advisors who facilitate local decision making and offer expertise in the particular area of the fund.

The fund advisors have delegated powers and responsibility to authorise expenditure in line with the Trust's Authorised Limits Schedule contained within the Standing Financial Instructions (SFI's). The fund advisors can make recommendations on how to spend the money within their designated area up to a level of £5,000 per transaction subject to any specific donor wishes. The deputy chief operating officers have delegated powers and responsibility to authorise transactions up to £10,000. For expenditure in excess of these limits they make recommendations to the chief executive and chief financial officer who have authority limits up to £50,000. Any transactions over this limit must go to the Trust Board for authorisation.

All of The Royal Wolverhampton NHS Trust Charity's restricted and unrestricted funds can be spent at any time. Grants from these funds are applied for by fund advisors

Reserves policy

The Corporate Trustee acknowledges that it is the donors' intention that their contributions be used as soon as possible to enhance the service provided by the Trust. Consequently, it is the policy of the Charity that significant reserves are not held. The Charity does not intend to increase fund balances unless this is as a result of significant donations or legacies. However, from time to time, balances are held in particular areas until sufficient funds have been donated to make specific purchases.

The trustee has established a reserves policy as part of their plans to provide long term support to the services provided by The Royal Wolverhampton NHS Trust. The Trustee calculates the reserves as that part of the Charity's unrestricted income funds that is freely available, after taking account of the designated funds, which have been earmarked for specific service purposes, in accordance with the stated Charity Objectives.

Total funds of the charity were £2,725,000 (2022 £3,031,000) of which £1,791,000 (2022: £2,026,000) are unrestricted funds, £852,000 (2022 £923,000) restricted funds and £82,000 (2022: £82,000) were endowment funds

The free reserves currently stand at £86,000 and are calculated as follows:

- Total unrestricted funds £1,791,000
- Less designated funds (£1,705,000)
- Total free reserves £86,000

The Trustees intend that designated funds are spent within a reasonable period of receipt and therefore, foresee a need only to maintain reserves sufficient to provide certainty of funding to cover the administrative, fundraising and governance costs of the Charity in the short term. The Trustee aims to maintain free reserves in unrestricted funds at a level which equates to approximately a year of non-designated, unrestricted charitable expenditure. The Trustee considers that this level will provide sufficient funds in the short term, to cover costs in the event of unforeseen circumstances which prevented the operation of the Charity in the longer term.

The Trustee reviews the balance held in designated funds, in accordance with the provisions of the NHS Acts relating to charitable funds, to determine whether these funds are likely to be committed in the near future and the extent to which there is a continuing need identified for any particular designated fund(s). Any inactive funds are closed and transferred appropriately. Additionally, within the level of designated funds held, the Trustee ensures that there are sufficient funds held to cover a fluctuation in the value of funds held in investments.

The policies specific to the Charity reserves are as follows:

- To maintain systems to forecast levels of expenditure and income to determine reserve requirements
- To ensure the level of reserves are secured
- To monitor and review the policy periodically to ensure it remains suitable for the Charity's need
- The Corporate Trustee has reviewed the reserves policy in the light of the Charity Commission's published guidance CC19 – Charities' Reserves.

Further details

Principal professional advisers

Auditors - External
WR Partners
Belmont House
Shrewsbury Business Park
Shrewsbury
SY2 6LG

Auditors - Internal
RSM UK
Festival Way
Festival Park
Stoke-on-Trent
ST1 5BB

Bankers
Cooperative Bank plc
1-2 Dudley Street
Wolverhampton
WV1 3EN

Solicitors
Browne Jacobson
44 Castle Gate
Nottingham
NG1 7BJ

Investment Fund Managers
Sarasin & Partners LLP
Juxon House
100 St Paul's Churchyard
London
EC4M 8BU

Full accounts

This annual report comments on some of the features of the full accounts which are provided on the following pages for your information. Copies of the full accounts have been lodged with the Charity Commission and carry an unqualified audit report.

The text and accounts shown in this report were approved by the Trustees on 17 October 2023 and is signed on their behalf by the Chair.

Martin Levermore -
Chair of the Charitable Funds Committee

Statement of Trustees' responsibilities

The Trustees are responsible for preparing the Trustees' report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England & Wales requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the Charity and of its incoming resources and application of resources, including its income and expenditure, for that period. In preparing these financial statements, the Trustees are required to:

- Select suitable accounting policies and then apply them consistently
- Observe the methods and principles of the Charities SORP (FRS 102)
- Make judgments and accounting estimates that are reasonable and prudent
- State whether applicable UK Accounting Standards (FRS 102) have been followed, subject to any
- Material departures disclosed and explained in the financial statements
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustees are responsible for keeping adequate accounting records that are sufficient to show and explain the Charity's transactions and disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust deed. They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Disclosure of information to auditors

Each of the persons who are Trustees at the time when this Trustees' report is approved has confirmed that:

- So far as that Trustee is aware, there is no relevant audit information of which the charity's auditors are unaware, and
- That Trustee has taken all the steps that ought to have been taken as a Trustee in order to be aware of any relevant audit information and to establish that the charity's auditors are aware of that information.

Approved by order of the members of the board of Trustees on 17 October 2023
and signed on their behalf by:

Martin Levermore
Chair of the Charitable Funds Committee

Independent Auditor's Report to the Trustees of The Royal Wolverhampton NHS Trust Charity

Opinion

We have audited the financial statements of The Royal Wolverhampton NHS Trust Charity (the 'charity) for the year ended 31 March 2023 which comprise the Statement of financial activities, the balance sheet, the statement of cash flows and the related notes, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- Give a true and fair view of the state of the charitable company's affairs as at 31 March 2023, and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- Have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- Have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charitable company in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charitable company's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the trustees' annual report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

In the light of the knowledge and understanding of the charitable company and its environment obtained in the course of the audit, we have not identified material misstatements in the directors' report.We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 requires us to report to you if, in our opinion:

- Adequate accounting records have not been kept, or returns adequate for our audit have not been received from branches not visited by us; or
- The financial statements are not in agreement with the accounting records and returns; or
- Certain disclosures of directors' remuneration specified by law are not made; or
- We have not received all the information and explanations we require for our audit

Responsibilities of trustees

As explained more fully in the trustees' responsibilities statement, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We have reviewed the susceptibility of the charity's financial statements to material misstatement and identified the principal's risks, implementing a series of testing procedures to provide us with sufficient comfort to issue our opinion.

We reviewed the charities regulatory environment to ensure we could that it had acted in accordance with the framework relevant to the charity and its environment and identify any instances on non-compliance.

We also assessed the charity's internal control procedures to ensure we could appropriately scrutinise these controls and establish whether our understanding of the control environment was sufficient to supplement our additional testing procedures.

The engagement team consisted of a team that the engagement partner believes is equipped with the relevant level of technical and charity awareness to carry out our work to the required standard.

A further description of our responsibilities is available on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the charitable company's members those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charitable company and the charitable company's members as a body, for our audit work, for this report, or for the opinions we have formed.

WR Partners

For and on behalf of WR Partners
Chartered Accountants & Statutory Auditors
Belmont House
Shrewsbury Business Park
Shrewsbury
Shropshire
SY2 6LG

Charity Accounts 2022-2023

Statement of Financial Activities incorporating income and expenditure account for the year ended 31 March 2023

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2022/23 Total funds £000	2021/22 Total funds £000
Incoming resources						
Voluntary income:						
Donations and legacies	3	188	449	0	**637**	484
Grants	3	0	59	0	**59**	257
Other trading activities	3	80	4	0	**84**	67
Investments	12	44	38	0	**82**	78
Total incoming resources		**312**	**550**	**0**	**862**	886
Expenditure on:						
Raising funds	4	(151)	0	0	**(151)**	(101)
Charitable activities	4	(249)	(524)	0	**(773)**	(645)
Other expenditure		(1)	0	0	**(1)**	(4)
Total expenditure		**(402)**	**(524)**	**0**	**(926)**	(750)
Net gains/(losses) on investment		(146)	(97)	0	**(243)**	(24)
Net income/expenditure		**(236)**	**(71)**	**0**	**(306)**	112
Transfer between funds		0	0	0	**0**	0
Net movements in funds		**(236)**	**(71)**	**0**	**(306)**	112
Reconciliation of funds:						
Total funds brought forward		2,026	923	82	**3,031**	2,919
Fund balances carried forward at 31 March 2023		**1,791**	**852**	**82**	**2,725**	3,031

Balance Sheet as at 31 March 2023

	Note	Unrestricted funds £000	Restricted funds £000	Endowment funds £000	2022/23 Total funds £000	2021/22 Total funds £000
Fixed assets						
Investments	11	1,514	853	82	**2,449**	2,691
Total fixed assets		**1,514**	**853**	**82**	**2,449**	2,691
Current assets						
Debtors	13	45	0	0	**45**	42
Cash and cash equivalents	14	390	0	0	**390**	806
Total current assets		**436**	**0**	**0**	**436**	848
Creditors: Amounts falling due within one year	15	(160)	0	0	**(160)**	(508)
Net current assets/(liabilities)		**276**	**0**	**0**	**276**	340
Total assets less current liabilities		**1,791**	**852**	**82**	**2,725**	3,031
Net assets		**1,791**	**852**	**82**	**2,725**	3,031
The funds of the Charity						
Endowment funds	16			82	**82**	82
Restricted income funds	16		852		**852**	923
Unrestricted income funds	16	1,791			**1,791**	2,026
Total Charity funds		**1,791**	**852**	**82**	**2,725**	3,031

Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2023	2022
	£000	£000
Net income/(expenditure) for 2022/23 (as per the Statement of Financial Activities)	(306)	112
Adjustment for:		
(Gains)/losses on investments	243	24
Dividends, interest and rents from investments	(82)	(78)
(Increase)/decrease in debtors	(4)	(18)
Increase/(decrease) in creditors	(349)	362
Net cash provided by (used in) operating activities	**(498)**	402

Cash Flow	**Total funds 2022/23 £000**	Total funds 2021/22 £000
Cash flows from operating activities:		
Net cash provided by (used in) operating activities	(498)	402
Cash flows from investing activities:		
Dividends, interest and rents from investments	82	78
Net cash provided by (used in) investing activities	82	78
Change in cash and cash equivalents in the reporting period	(416)	480
Cash and cash equivalents at the beginning of the reporting period	806	326
Cash and cash equivalents at the end of the reporting period	**390**	806

1. General information

The Royal Wolverhampton NHS Trust Charity is an unincorporated charity in England. The address of the registered office is given in the charity information on page 60 of this report.

2. Accounting policies

a) Basis of preparation

The financial statements have been prepared in accordance with the Charities SORP (FRS 102) - Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102)(issued in October 2019), the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011.

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair' view. This departure has involved following the Charities SORP (FRS 102) published in October 2019 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Royal Wolverhampton NHS Trust Charity meets the definition of a public benefit entity under FRS 102. Assets and liabilities are initially recognised at historical cost or transaction value unless otherwise stated in the relevant accounting policy.

After making enquires, the Trustees have a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. The Charity therefore continues to adopt the going concern basis in preparing its financial statements.

The key risks to the Charity's continuing going concern status are a fall in income from donations or investment income but the Trustee has arrangements in place to mitigate those risks (see the risk management (page 65) and reserves (page 66) sections of the annual report for more information).

b) Funds structure

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as:

- a restricted fund or
- an endowment fund.

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Endowment funds arise when the donor has expressly provided that the gift is to be invested and only the income of the fund may be spent. These funds are sub analysed between those where the trustee has the discretion to spend the capital (expendable endowment) and those where there is no discretion to expend the capital (permanent endowment).

The Charity has three permanent endowment funds, all of which are invested within the long term portfolio and the return from this investment is transferred into either an unrestricted fund or a restricted fund dependent on the restrictions placed on the fund by the donor.

Designated funds are unrestricted funds earmarked for a particular area so where donations are received for individual wards or departments, these are transferred to a fund designated for that particular ward or department. These funds are held for general, day to day needs as opposed to long term projects.

c) Incoming resources

All income is recognised once the Charity has entitlement to the income, it is probable (more likely than not) that the income will be received and the amount of income receivable can be measured reliably.

Where there are terms or conditions attached to incoming resources, particularly grants, then these terms or conditions must be met before the income is recognised as the entitlement condition will not be satisfied until that point. Where terms or conditions have not been met then the relevant income is not recognised in the year but deferred and shown on the balance sheet as deferred income.

d) Gifts in kind

Gifts in kind, such as food and care packages are not accounted for when they are accepted and immediately distributed unless a single donation is material.

Gifts of tangible assets such as microwaves and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed.

Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed.

e) Incoming resources from legacies

The recognition of income from legacies is dependent on establishing entitlement, the probability of receipt and the ability to estimate with sufficient accuracy the amount receivable. Evidence of entitlement to a legacy exists when the Charity has sufficient evidence that a gift has been left to them (through knowledge of the existence of a valid will and the death of the benefactor) and the executor is satisfied that the property in question will not be required to satisfy claims in the estate. Receipt of a legacy must be recognised when it is probable that it will be received and the fair value of the amount receivable, which will generally be the expected cash amount to be distributed to the Charity, can be reliably measured.

f) Incoming resources from endowment funds

The incoming resources received from the invested endowment fund are transferred to the restricted or unrestricted fund as per the donors request.

g) Other incoming resources

Income tax recoverable in relation to donations received under Gift Aid or deeds of covenant is recognised at the time of the donation.

Other income is recognised in the period in which it is receivable and to the extent the goods have been provided or on completion of the service.

h) Resources expended and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- there is a present legal or constructive obligation resulting from a past event
- it is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- the amount of the obligation can be measured or estimated reliably

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

i) Recognition of expenditure and associated liabilities as a result of grant

The Charity is not a grant giving organisation.

j) Allocation of support costs

Support costs are those costs which do not relate directly to a single activity. These include some staff recharges, costs of administration, external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on an appropriate basis. The analysis of support costs and the bases of apportionment applied are shown in note 6.

k) Fundraising costs

The costs of generating funds are those costs attributable to generating income for the charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the charity's objects. The costs of generating funds represent fundraising costs which include expenses for fundraising activities and a recharge paid to a related party, The Royal Wolverhampton NHS Trust (see note 17). The recharge is used to pay the salaries and support costs of the Charity's fundraising team.

l) Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 6.

m) Fixed asset investments

Investments are a form of basic financial instrument. Fixed asset investments are initially recognised at their transaction value and are subsequently measured at their fair value (market value) as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation and disposals throughout the year. Quoted stocks and shares are included in the Balance Sheet at the current market value quoted by the investment analyst, excluding dividend. Other investments are included at the trustee's best estimate of market value.

The main form of financial risk faced by the charity is that of volatility in equity markets and investment markets due to wider economic conditions, the attitude of investors to investment risk, and changes in sentiment concerning equities and within particular sectors or sub sectors. Further information on the RWT Charity investments can be found in note 11.

n) Debtors

Debtors are amounts owed to the charity. They are measured on the basis of their recoverable amount.

o) Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90-day notice interest bearing savings accounts.

p) Creditors

Creditors are amounts owed by the charity. They are measured at the amount that the charity expects to have to pay to settle the debt.

Amounts which are owed in more than a year are shown as long-term creditors.

q) Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening carrying value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening carrying value (or purchase date if later).

r) Staff costs and pensions

The Charity does not have any staff. All staffing costs are recharged from The Royal Wolverhampton NHS Trust.

3 Income

a) Analysis of Donations, Legacies and Grants

	Unrestricted funds	Restricted funds	Total 2022/23	Total 2021/22
Donations from individuals	124	6	130	308
Corporate donations	25	1	26	40
Legacies	13	442	455	136
Grants	26	59	85	257
	188	**508**	**696**	**741**
2021/22 Total funds £000	*707*	*34*	*741*	

Donations from individuals are gifts from members of the public, relatives of patients and staff.
Donations of goods, to the value of £24,472 2022/23 (£9,839 2021/22), are included in income valued at their market value. All of these donations have been distributed during the year.

b) Analysis of Other Trading Activities

	Unrestricted funds	Restricted funds	Total 2022/23	Total 2021/22
Community	29	4	33	14
Individuals	11	0	11	0
Events	40	0	40	53
Corporate	0	0	0	0
	80	**4**	**84**	67
2021/22 Total funds £000	*65*	*2*	*67*	

4 Expenditure

a) Analysis of Raising Funds

	Unrestricted funds £000	Restricted funds £000	Total 2022/23 £000	Total 2021/22 £000
Fundraisers costs	130	0	130	87
Support costs	21	0	21	14
	151	**0**	**151**	101
2021/22 Total funds £000	*101*	*0*	*101*	

b) Analysis of Charitable Activities

	Grant funded activity £000	Support Costs £000	Total funds 2022/23 £000	Total funds 2021/22 £000
Purchase of new medical equipment	40	0	40	306
Patients welfare and amenities	171	37	208	270
Staff welfare and amenities	49	10	59	69
Building work	464	0	464	0
Research	1	0	1	0
	726	47	773	645
2021/22 Total funds £000	*599*	*46*	*645*	

5 Grant funding

The charity did not undertake any direct charitable activities on its own account during the year. All of the charitable expenditure was in the form of grant funding.

Grants were approved in favour of the partner organisations, principally the RWNHST to carry out activities that will benefit patients and their families. The Charity incurred expenditure with third parties in pursuance of those grants or reimbursed expenditure incurred by them.

6 Allocation of support costs and overheads

Support and overhead costs are allocated between fundraising activities and charitable activities.
The bases of allocation used are as follows:

- Time: based the charity's two staff members' timesheets.
- Direct allocation: where a cost is wholly attributable to a particular activity.
- Expenditure: this is a proportion based on the fund balance at the start of the year. This is used where the trustee considers this is a more equitable treatment to avoid disadvantaging funds with high volume, low value transactions.
- Salaries: this is proportionate to staff salaries where costs are related to the employed staff.

	Raising funds £000	**Charitable activities £000**	**Total 2022/23 £000**	Total 2021/22 £000	Basis
Internal audit	1	2	3	0	Direct
External audit	2	6	8	7	Direct
Financial services	16	36	52	49	Time
Support admin costs	0	0	0	0	Time
Other administration costs	2	3	5	4	Expenditure
	21	**47**	**68**	60	
2020/21 Total funds £000	*14*	*46*	*60*		

7 Trustee remuneration, benefits and expenses

Remuneration for the Board of The Royal Wolverhampton NHS Trust is provided in The Royal Wolverhampton NHS Trust 2022/23 published Accounts available on the Trust website, and as such remuneration and expenses with regards to the Charitable Funds Committee are not separately identified.

8 Analysis of staff costs and remuneration of key management personnel

The Charity has no employees (2021/22 none). Costs for staff incurred by The Royal Wolverhampton NHS Trust are recharged to the Charity in the form of a Financial Services management fee along with the salaries for the Fundraising team. The management fee for the year amounted to £52,252 (2021/22 £49,228) and the Fundraisers' salaries amounted to £111,649 (2021/22 £80,603). The Charity does not directly pay salaries national insurance or pension contributions (2021/22 £Nil).

Analysis of staff costs recharged by The Royal Wolverhampton NHS Trust

	2023	2022
	£0	£0
Fundraisers salary	**112**	81
Financial services	**52**	49
	164	130

9 Transfers

There were transfers of £41,664 (2021/22 £5,022) during the year, between New Cross General Purpose Legacies and Arts and Heritage.

10 Auditor's remuneration

External auditors' remuneration of £7,800 including VAT (2021/22 £6,600 including VAT) related solely to the audit with no other additional work undertaken (2021/22 £Nil).

11 Investments

Movement in fixed asset investments	**31 March 2023 £000**	31 March 2022 £000
Market value at 1 April	**2,691**	2,715
Less disposals at carrying value	**0**	0
Add: additions to investments at cost	**0**	0
Add net gain (loss) on revaluation	**(242)**	(24)
Market value as at 31 March	**2,449**	2,691

Net movement is made up of the revaluation of investments (£241,674) at the year end and £8.96 increase in the balance of cash held to £10.35 as part of the investment portfolio.

Analysis of market value	**31 March 2023 £000**	31 March 2022 £000
Investments listed on Stock Exchange	**2,449**	2,691
	2,449	2,691

Fixed asset investment by type	**31 March 2023 £000**	**31 March 2023 %**	31 March 2022 £000	31 March 2022 %
Equities	**1,107**	**45.2**	1,291	48.0
Fixed Income (Inc Bonds)	**894**	**36.5**	853	31.7
Property	**61**	**2.5**	82	3.0
Other	**310**	**12.6**	371	13.8
Liquid Assets (Inc Cash)	**77**	**3.2**	94	3.5
	2,449	**100**	2,691	100

The Trustee's consider the value of the investments to be supported by their underlying assets.

12 Analysis of gross income from investments and cash on deposit

	31 March 2023 £000	31 March 2022 £000
Investments listed on Stock Exchange	**82**	78
	82	78

13 Debtors

Amounts falling due within one year:	31 March 2023 £000	31 March 2022 £000
Prepayments and accrued income	**45**	42
	45	42

14 Cash and cash equivalents

	31 March 2023 £000	31 March 2022 £000
Co-Operative Bank Account	**390**	806
	390	806

15 Creditors

Amounts falling due within one year:	31 March 2023 £000	31 March 2022 £000
Trade creditors	**83**	490
Other creditors	**12**	13
Deferred Income	**65**	5
	160	508

16 Analysis of charitable funds

a) Endowment funds

i) Analysis of endowment fund movements

ii) Details of permanent endowment funds

	31 March 2023	31 March 2022
	£000	£000
A General Purposes Fund	**26**	26
B W.H.Fowler Trust	**14**	14
C Nell Phoenix Fund	**42**	42
	82	82

Name of permanent endowment	Description of the nature and purpose of each permanent endowment
A General Purposes Fund	to earn interest for the benefit of the non designated fund of the RWT Charity
B W.H.Fowler Trust	to earn interest for the benefit of the designated Maternity & Gynaecology fund within the Obstetrics and Gynaecology area
C Nell Phoenix Fund	to earn interest for the benefit of the restricted fund which is to provide musical entertainment for nursing staff

b) Restricted funds

i) Analysis of restricted fund movements

	Name of fund	31 March 2022	Income	Expenditure	Transfers	Gains & losses	31 March 2023
		£000	£000	£000	£000	£000	£000
A	Joan Jones	102	4	-2	0	-10	**94**
B	Edith Mary Jeavons	4	0	0	0	0	**4**
C	Nell Phoenix Fund	37	2	-6	0	-3	**30**
D	Cystic Fibrosis Funding	2	0	0	0	0	**2**
E	Sheila Whiting Legacy	71	3	-1	0	-9	**64**
F	Marjorie Ferguson Legacy	1	0	0	0	0	**1**
G	CCH General Purpose - Legacies	20	1	0	0	-3	**18**
H	Rotary Dowding	230	9	-5	0	-22	**212**
I	Millicent Jessica Dwight - Legacy	19	1	0	0	-4	**16**
J	Swan Fund	5	4	0	0	0	**9**
K	Cancer Centre Fund	30	1	-1	0	-3	**27**
L	Kenneth Arthur Hollins - CCH Dialysis Centre	84	3	-2	0	-8	**77**
N	New Cross General Purposes - Legacies	256	9	-5	-47	-19	**194**
O	RWT Singers	3	7	-7	5	-1	**7**
P	Individual funds < £500	1	0	0	0	0	**1**
Q	Arts & Heritage Fund	1	1	-12	42	-4	**28**
R	COVID-19	57	63	-41	0	-11	**68**
S	Mr Worrall Legacy	0	442	-442	0	0	**0**
		923	550	-524	0	-97	**852**

b) Restricted funds continued

ii) Details of restricted funds

Name of fund		Description of the nature and purpose of each fund
A	Joan Jones	to provide medical equipment to the Renal, Oncology, Vascular and Cardiac Units
B	Edith Mary Jeavons	to provide medical equipment to RW Trust
C	Nell Phoenix Fund	to provide musical entertainment for nursing staff
D	Cystic Fibrosis Funding	to support patients and their families who suffer with Cystic Fibrosis
E	Sheila Whiting Legacy	to support Rheumatology services at Cannock Hospital
F	Marjorie Ferguson Legacy	to support the services provided at the Rehabilitation Day Unit at Cannock Hospital
G	CCH General Purpose - Legacies	to support services at Cannock Hospital
H	Rotary Dowding	to support services at Cannock Hospital
I	Millicent Jessica Dwight Legacy	to provide equipment to RW Trust
J	Swan Fund	to support End of Life Care with in the Trust
K	Cancer Centre Fund	to provide a top class facility for Cancer Patients in the area
L	Kenneth Arthur Hollins - CCH Dialysis Centre	to provide support within the Cannock Hospital Dialysis Centre
M	Special Fund for Nano Bubble Pump	for the provision of a Nano Bubble Pump
N	New Cross General Purposes - Legacies	to support services at New Cross Hospital
O	RWT Singers (Choir)	to improve staff morale and enhance patient and visitor experience around the Trust
P	Individual Funds <£500	Lindsay Clift Memorial Fund is to support patient safety by way of training or providing vital monitoring equipment, Calabar Wolverhampton VISION 2020 Link is to support staff training with links to other countries, Arts in Health Trust Fund is to support delivery of the Trust's Arts In Health Programme
Q	Arts & Heritage	to provide additional resources that; contribute to and enhance the healing environment, therapeutic art activities for patients, their families and staff and to record the history of and the advancements of healthcare at RWT.
R	COVID-19	to provide support to patients and staff as part of the COVID-19 recovery
S	Mr Worrall Legacy	to support children in hospital who have cancer

c) Unrestricted funds

i) Analysis of unrestricted funds movements

		31 March 2022	Income	Expenditure	Transfers	Gains & losses	31 March 2023
		£000	£000	£000	£000	£000	£000
Designated funds							
A	Anaesthetics	80	8	-12	0	-6	**70**
B	Medical Directorate	338	29	-68	0	-22	**277**
C	Haematology & Oncology	440	58	-88	0	-30	**380**
D	Cardiac Services	320	24	-33	0	-23	**288**
E	Renal Unit	39	28	-22	0	-3	**42**
F	Obstetrics & Gynaecology	73	4	-8	0	-6	**63**
G	Ophthalmology	97	5	-15	0	-7	**80**
H	Orthopaedics	106	5	-12	0	-7	**92**
I	Paediatrics	166	81	-56	0	-14	**177**
J	Surgical Directorate	77	8	-7	0	-6	**72**
K	Clinical Support	3	0	0	0	0	**3**
L	Wolverhampton Medical Institute	9	0	0	0	-1	**8**
M	Other Smaller Funds	90	5	-7	0	-6	**82**
N	Community Nursing	6	0	-1	0	0	**5**
O	Research Funds	77	2	-8	0	-5	**66**
		1,921	257	-337	0	-136	**1,705**
Non-designated funds							
P	General Purposes Funds	105	55	-64	0	-10	**86**
		2,026	**312**	**-401**	**0**	**-146**	**1,791**

c) Unrestricted funds continued

ii) Details of unrestricted funds

Name of area		Description of the nature and purpose of each area
A	Anaesthetics	benefit of the Anaesthetics Directorate
B	Medical Directorate	benefit of the Medical Directorate
C	Haematology & Oncology	benefit of the Deanesly Centre and Cancer Services
D	Cardiac Services	benefit of the Cardiothoracic Directorate
E	Renal Unit	benefit of the Renal Unit
F	Obstetrics & Gynaecology	benefit of the Maternity & Gynaecology Directorate
G	Ophthalmology	benefit of the Ophthalmic Directorate
H	Orthopaedics	benefit of the Orthopaedic Directorate
I	Paediatrics	benefit of the Paediatric Directorate
J	Surgical Directorate	benefit of the Surgical Directorate
K	Clinical Support	benefit of Clinical Support Services
L	Wolverhampton Medical Institute	benefit of the Wolverhampton Medical Institute
M	Other smaller funds	benefit of Emergency Department, Ambulatory Care, Ear Nose and Throat, Theatres, Therapy Services, Nurse Training, Chaplaincy etc.
N	Community Nursing	benefit of the Community Nursing Teams
O	Research Funds	to support Research projects at the Trust
Unrestricted funds - Non designated funds		
P	General Funds	benefit of New Cross Hospital

Trustees have exercised their discretion to set aside part of the unrestricted funds for designated purposes. The designation applied has taken account the wishes expressed by the donor when the funds were given. Designated funds remain unrestricted as Trustees can remove the designation at anytime.

17 Related party transactions

During the year neither the Corporate Trustee nor members of the key management staff or parties related to it has undertaken any material transactions with or received any remuneration or expenses from The Royal Wolverhampton NHS Trust Charity. As part of the normal course of business the Charity has made payments totalling £835,013 (2021/22 £355,610) to The Royal Wolverhampton NHS Trust as Corporate Trustee of the Charity. In 2022/23 an amount of £83,212 (2021/22 £489,691) was owing to the Trust at 31 March 2023. The total income of the Corporate Trustee in the year ended 31 March 2023 amounted to £899,891,000 (2021/22 £817,270,000) and the adjusted retained surplus amounted to £90,000 (2021/22 £4,454,000).

18 Commitments

The Charity has commitments totalling £45,195 at 31 March 2023 (2021/22 £35,559) arising from requisitions placed for which the relevant goods and services have not been received. These commitments relate to unrestricted and restricted funds.

19 Donations in kind

Donations in kind have been made to aid the Charity's mission to support The Royal Wolverhampton NHS Trust. Donations to the value of £24,472 (2021/22 £9,839) have been included in the accounts this year for items of clothing, toys for the children's ward, knitted blankets, sensory items and other kind gifts that help make the patients stay better. All of these items will be used for some time to come. We also received several offers of kindness for the staff and patients of the Trust and the wider community for items such as care packages, hand creams, lip balms, food and drink. The value of these items were estimated at £12,034 (2021/22 £8,781).

When received, all items were distributed as soon as possible and shared amongst the whole of the Trust.

Designed and produced by The Department of Clinical Illustration, New Cross Hospital, Wolverhampton - Tel: 01902 695377

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The Royal Wolverhampton
NHS Trust Charity
Registered Charity No: 1059467

The Royal Wolverhampton
NHS Trust

New Cross Hospital
Wolverhampton
WV10 0QP

External Dial Tel: 01902 695566
Internal Dial Tel: 85566

WR Partners
Chartered Accountants
Belmont House
Shrewsbury Business Park
Shrewsbury
SY2 6LG

Dear Sirs

The following representations are made on the basis of enquiries of management and staff with relevant knowledge and experience such as we consider necessary in connection with your audit of the charity's financial statements for the year ended 31 March 2023. These enquiries have included inspection of supporting documentation where appropriate. All representations are made to the best of our knowledge and belief.

General

1. We have fulfilled our responsibilities as trustees as set out in the terms of your engagement letter under the Charities Act 2011 for preparing financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice), for being satisfied that they give a true and fair view and for making accurate representations to you.

2. All the transactions undertaken by the charity have been properly reflected and recorded in the accounting records.

3. All the accounting records have been made available to you for the purpose of your audit. We have provided you with unrestricted access to all appropriate persons within the charity, and with all other records and related information requested, including minutes of all management and trustee meetings and correspondence with The Charity Commission.

4. The financial statements including the agreed adjustments in the sum of £Nil are free of material misstatements, including omissions.

5. The effects of uncorrected misstatements in the sum of £813 (as set out in the appendix to this letter) are immaterial both individually and in total.

Internal control and fraud

6. We acknowledge our responsibility for the design, implementation and maintenance of internal control systems to prevent and detect fraud and error. We have disclosed to you the results of our risk assessment that the financial statements may be misstated as a result of fraud.

7. We have disclosed to you all instances of known or suspected fraud affecting the entity involving management, employees who have a significant role in internal control or others that could have a material effect on the financial statements.

8. We have also disclosed to you all information in relation to allegations of fraud or suspected fraud affecting the entity's financial statements communicated by current or former employees, analysts, regulators or others.

Assets and Liabilities

9. The charity has satisfactory title to all assets and there are no liens or encumbrances on the charity's assets, except for those that are disclosed in the notes to the financial statements.

10. All actual liabilities, contingent liabilities and guarantees given to third parties have been recorded or disclosed as appropriate.

11. We have no plans or intentions that may materially alter the carrying value and where relevant the fair value measurements or classification of assets and liabilities reflected in the financial statements.

12. We confirm that the balance owed to the Royal Wolverhampton NHS Trust at the year-end was £83,212.

Funds

13. We confirm that the split of funds between restricted, unrestricted and endowed, and treatment of funds in the Statement of Financial Activity are appropriate.

Accounting Estimates

14. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

Loans and Arrangements

15. The charitable company has not granted any advances or credits to, or made guarantees on behalf of, directors other than those disclosed in the financial statements.

Legal Claims

16. We have disclosed to you all claims in connection with litigation that have been, or are expected to be, received and such matters, as appropriate, have been properly accounted for, and disclosed in, the financial statements.

Laws and Arrangements

17. We have disclosed to you all known instances of non-compliance or suspected non- compliance with laws and regulations whose effects should be considered when preparing the financial statements.

Matters of Material Significance

18. We confirm that there have not been any Matter of Material Significance which require reporting.

Related Parties

19. Related party relationships and transactions have been appropriately accounted for and disclosed in the financial statements. We have disclosed to you all relevant information concerning such relationships and transactions and are not aware of any other matters which require disclosure in order to comply with legislative and accounting standards requirements.

Subsequent Events

20. All events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed.

Going Concern

21. We believe that the charity's financial statements should be prepared on a going concern basis on the grounds that current and future sources of funding or support will be more than adequate for the charity's needs. We have considered a period of twelve months from the date of approval of the financial statements. We believe that no further disclosures relating to the charity's ability to continue as a going concern need to be made in the financial statements.

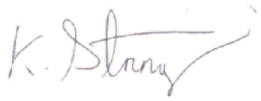
Grants and Donations

22. All grants, donations and other income, the receipt of which is subject to specific terms or conditions, have been notified to you. There have been no breaches of terms or conditions in the application of such income.

We acknowledge our legal responsibilities regarding disclosure of information to you as auditors and confirm that so far as we are aware, there is no relevant audit information needed by you in connection with preparing your audit report of which you are unaware.

Each director has taken all the steps that he ought to have taken as a director in order to make themself aware of any relevant audit information and to establish that you are aware of that information.

Yours faithfully



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Signed on behalf of the board of trustees

Date 25.10.23

The Royal Wolverhampton NHS Trust Charity

Year End: 31 March 2023
Proposed/unrecorded journal entries
Date: 01/04/2022 To 31/03/2023

N3. 2

Prepared by	Reviewed by	Final Review
NM4 09/10/2023		
RI Review	**EQC Review**	

Number	Date	Name	Account No	Reference	Debit	Credit	Proposed Net Income (Loss)	Proposed Amount Chg	Recurrence	Misstatement
		Net Income (Loss)					-306,000			
PF1	31/03/2023	Other debtors < 1 year	1841	H10	4,500					
PF1	31/03/2023	Legacy 1	3601	H10		4,500				
		Being the understatement of income from legacies SC 31/3/23								
					4,500	4,500	-301,500	4,500		
PF2	31/03/2023	Other creditors	2091	M4	1,313					
PF2	31/03/2023	Expenditure	6110	M4		1,313				
		Being the overstatement of recharges in wages from the Trust SC 15/9/23								
					1,313	1,313	-300,187	1,313		
PF3	31/03/2023	Other debtors < 1 year	1841	H8		5,000				
PF3	31/03/2023	Legacy 1	3601	H8	5,000					
		Being the error on the recognition of legacy income found in susbtantive testing SC 13/9/23								
					5,000	5,000	-305,187	-5,000		
					0	0	-305,187	0		
					10,813	**10,813**	**-305,187**	**813**		

Audit Findings Memorandum

Year ended 31 March 2023

Royal Wolverhampton NHS Trust Charity

17th October 2023

Contents

The purpose of this memorandum is to highlight the key issues affecting the financial statements of The Royal Wolverhampton NHS Charity Trust for the year ended 31 March 2023. It is also used to report to management and those charged with governance in order to meet the mandatory requirements of International Standard on Auditing (UK & Ireland) 260.

The matters raised in this and other reports that will flow from the audit are only those which will have come to our attention arising from, or relevant to, our audit that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses.

This report has been prepared solely for your use and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

Acknowledgements

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during the course of our audit.

1. Overview

1.1 Overview of audit scope

We have performed our work in accordance with the requirements of the International Standards on Auditing ("ISAs") (UK), for those entities as set out in our Service Plan.

1.2 Overview of approach

Our audit approach is risk based; emphasis placed on the audit areas considered to be of higher risk. In completing our work, we have not had to alter or change our approach to that we communicated to you at the start of the audit within the Service Plan.

We have updated our knowledge of your systems and controls, and tested those controls upon which we intended to place audit reliance. We have supplemented our testing of controls with substantive tests of detail and/or substantive analytical review procedures.

1.3 Status of the audit

Our audit of the financial statements is substantially complete and subject to resolution of the outstanding queries set out on page 4 we anticipate our audit opinion to be unmodified.

1.4 Completion timetable

The timetable to completion has been agreed as follows:

	Date
Board meeting to approve financial statements	17 October 2023
Audit report approval	October 2023
Accounts filing deadline	31 January 2024

Materiality

The concept of materiality applies to the preparation of the financial statements and the audit process and applies to monetary misstatements, disclosure requirements, adherence to acceptable accounting practice and applicable law.

Misstatements, including omissions, are considered to be material if they, individually or in aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

We have determined the financial statement materiality based on the factors noted in the table below.

Our assessment of materiality has been revised from that considered at the planning stage on receipt of the draft financial statements.

We also design our procedures to detect errors in specific accounts at a lower level of precision. Accordingly, Directors' remuneration and key management personnel remuneration materiality has been reduced to £Nil due to it being material by nature.

Entity	Benchmark	Overall Materiality	Trivial
The Royal Wolverhampton NHS Trust Charity	2% of total income	£17,000	£900

2. Status of the audit and audit opinion

Our work is substantially complete and there are currently no matters of which we are aware that would require modification to our audit opinion, subject to the satisfactory completion of the matters detailed below:	
●	Receipt and audit of outstanding information: bank letter
●	Completion of audit testing: review of the above
●	Final subsequent review
●	Receipt of the signed management representation letter

Impact

- ● Not considered likely to result in material adjustment or change to disclosures within the financial statements
- ● Potential to result in material adjustment or change to disclosures within the financial statements
- ● Likely to result in material adjustment or change to disclosures within the financial statements

Anticipated audit opinion

Subject to all of the matters discussed within this document being cleared, we anticipate our audit opinion to be unmodified

3. Summary of key audit findings

3.1 Significant and elevated audit risks

Risk Area Identified	Risk Level	Risk and audit findings	Assessment	
Fraud – management override of controls	Significant	Under ISA 240 (UK) there is a non-rebuttable presumed risk that the risk of management override of controls is present in all entities.	We have not identified any matters in relation to management override of controls	
Fraud – Income recognition	Significant	Under ISA 240 (UK) there is a presumed risk that revenue may be misstated due to the improper recognition of revenue.	We have not identified any matters relating to improper revenue recognition	

3.2 Going concern

We are required to obtain sufficient appropriate audit evidence about the appropriateness of management's use of the going concern basis of accounting.

Assessment of Going Concern	Commentary
Managements assessment Management have undertaken the following to assess the appropriateness of the going basis of accounts preparation: • Prepared and assessed monthly management accounts • Managements assessment of going concern.	Management have concluded that is a going concern and have prepared the financial statements on that basis.
Audit work performed We have considered if there are any factor or events which may indicate that the going concern basis may not be appropriate. We have reviewed managements supporting documentation, including assumptions to determine if these are reasonable	We have not identified any factors that cast doubt over the entity's ability to continue as a going concern to date.

Audit assessment	We are satisfied that the preparation of the financial statements on the going concern basis is reasonable.	

3.3 Other matters for discussion

All matters identified during out audit for discussion with you have been considered resolved.

3.4 Summary of corrected and uncorrected misstatements

We set out below details of the :

- Adjustments noted and made to the accounts during the course of the audit following discussion and agreement with you; and
- Details of potential adjustments identified during the course of our audit work.

Management should consider the misstatements identified during the course of our audit work in conjunction with the above findings.

Corrected misstatements

The adjustments identified during the course of the audit and reflected in the accounts following discussion with you are set out below. The aggregate impact of these adjustments are as follows:

	2023 £	2022 £
Deficit per draft accounts	(306,000)	303,000
P 13 adjustments	-	-
Corrected misstatements	-	(191,000)
Deficit per audited accounts	(306,000)	**112,000**

Uncorrected misstatements

The potential adjustments identified during the course of the audit which have not been reflected within the accounts are set out below. The aggregate impact of the uncorrected misstatements is as follows:

	2023 £	2022 £
Deficit per audited accounts	(306,000)	112,000
Uncorrected misstatements		1.389
Legacy recognition	(500)	
Wages recharges overstated	1,313	
Deficit per audited accounts	**(305,187)**	**113,389**

5. Other matters

5.1 Other audit and accounting areas

We set out below the other matters which auditing standards require us to communicate to you

Area	Commentary	Assessment
Accounting estimates	In addition to the identified key accounting estimates and judgement, we have considered the other accounting estimates and have no matters to bring to your attention.	
Accounting policies	We have not noted any accounting policy changes or policies which do not comply with FRS	
Related parties	We are not aware of any related parties or related party transactions which have not been disclosed.	
Laws and Regulations	You have not made us aware of any significant incidences of non-compliance with laws and regulations and we have not identified any matters from our audit work.	
Matters in relation to fraud	We have previously discussed the risk of fraud and documented this in our service plan. Our work performed to obtain reasonable assurance about whether the financial statements are free from material misstatement, whether due to fraud or error, is included within our draft audit opinion. No matters have been identified from our audit work and we have not been made aware on any matters by management or the board.	
Accounts disclosures	Our review found no material omissions in the financial statements.	
Other information	We are required to consider and give an opinion (within our audit report) on whether other information published together with the with audited financial statements (including the directors report) is materially inconsistent with the financial statements or our knowledge obtained during the audit or is materially misstated. No material inconsistencies have been identified to date and we plan to issue an unmodified audit opinion in this regard.	

5.2 Other audit and accounting areas

Area	Commentary	Assessment
Audit evidence and explanations/significant difficulties	All information and explanations requested from management have been provided.	
Written representations	A letter of representation has been requested from the Board. Specific representations have been requested in respect of the following: - Funds classification - Creditor balances with NHS hospitals - No matters of material significance have arisen or been reported either during the course of the year or subsequent to the year end	
Subsequent events	Under International Standards on Auditing 560, we are required to confirm whether there have been any subsequent events since the year end impacting the financial statements as drafted which have not been disclosed within the financial statements.	
Independence and ethics	We can confirm that we have re-evaluated our firm's independence in connection with the audit and we are not aware of any factors affecting our independence or objectivity and thus our ability to continue to act as auditors. The self review and management threats arising from our assistance in the provision of non-audit services, have been sufficiently addressed by appropriate safeguards including independent internal reviews, the existence of informed management, and the involvement of other relevant individuals who are required to approve all adjustments impacting the financial statements. Informed Management: - Katy Ball	

5. Design and operating effectiveness of systems and procedures

This section of our report includes recommendations for improvements in systems that were identified during the course of our audit work:

	High Risk – Matters that are considered fundamental against which management should take action as soon as possible
	Medium Risk – Matters that are considered significant that should be addressed within 3 – 6 months
	Low Risk – Matters that are not considered fundamental but where improvements can be made

	Observation		Implication	Recommendation	Management Response
1	*Legacies are recognised upon receipt of money into the bank*		*Income may be under/overstated.*	*If a solicitors letter states an amount to be received legacy income should be recognised upon receipt of the letter*	*Legacy note to be updated to make recognition criteria clearer.*

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public on Tuesday 12 December 2023		
Title of Report:	Chief Medical Officer's Report	Enc No: 10.8
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. Detailed papers are listed below and can be accessed via the reading room.

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 None Risk Description Is Risk on Risk Register: Yes☐No☐ Risk Score (if applicable):		
Resource Implications:	(if none, state 'none') Revenue: None Capital: None Workforce: None Funding Source: n/a		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☐No☐	Details:
	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:**		

The Royal Wolverhampton NHS Trust

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

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

The Royal Wolverhampton NHS Trust

Report of the Chief Medical Officer

Report to Trust Board Meeting to be held in Public on Tuesday 12th December

EXECUTIVE SUMMARY

The report covers the following functions:

- Schwart Round Reports
- NIHR Research Report
- RWT Research & Development Report

BACKGROUND INFORMATION

Schwartz Rounds

- Embedded within RWT for 7 years
- 8 events held in 2022/3 with 366 attendees (99% recommendations to colleagues)
- Challenges with attracting diverse range of staff groups with underrepresentation in medical and non-clinical staff groups
- Future plans to embrace hybrid meetings (face to face and on line); engagement with EVGs and links to Trust values

NIHR Research Report

- RWT confirmed as host for the West Midlands Regional Research Delivery Network (RRDN) until 2030
- Transition from CRN to RRDN progressing well with key leadership appointments made (RRDN Director from April 2024 – Prof Matt Brookes)
- West Midlands CRN is fulfilling its duties within the Performance and Operating Framework and contract with DHSC.
- RN WM continues to perform well against the NIHR CRN High Level Objectives (Commercial studies, Non commercial studies and Participant experience)
- Improvement of commercial research activity in-year.
- CRN WM is forecasting a breakeven year end position

RWT Research & Development Report

- Research activity to date in 2023/24 as per strategic objective
- Impact of pandemic has resulted in reduced commercial activity and income. Risk included in Directorate Risk Register
- The time taken to recruit patients to commercial studies has steadily reduced from an average of 578 days to 136 days (target is 70 days).
- The number of commercial studies opening has increased since April 2023
    - Recruitment is currently behind 2018/19 and 5-year average performance.
    - Resources have been diverted to prioritise commercial activity.
    - We currently have commercial studies in the pipeline for Oncology, Haematology, Rheumatology, Respiratory, Ophthalmology and Cardiology.
- University collaborations continue to grow.
- A joint Research Celebration event was held for RWT and WHT on 15th September.
- Research Department representatives attended Black Country Provider Collaborative Summit in October 23.

- The Group Director for Research and Development has met with the research teams at The Dudley Group of Hospitals and Sandwell and West Birmingham who have agreed to work collaboratively across the Black Country.

RECOMMENDATIONS

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

Any Cross-References to Reading Room Information/Enclosures:

- NIHR CRN WM Trust Board Report
- CRN WM Master risk register (Nov 23)
- CRN Partner Satisfaction Survey 2022
- Schwartz Round Annual Report Dec 2023
- Schwartz Round Annual Report 2022-23 (Pack B)
- Schwartz Rounds Evaluation 2022-23
- Trust Board Research Report Nov 23
- Trust Board Research Report Nov 23 Ref pack Appendix 1
- Trust Board Research Report Nov 23 Ref pack Appendix 2

The Royal Wolverhampton NHS Trust

Report to the Trust Board Meeting to be held in Public on 12 December 2023		
Title of Report:	NIHR Clinical Research Network West Midlands	Enc No: 10.8.1
Author:	Carly Craddock (Chief Operating Officer) / Pam Devall (Deputy Chief Operating Officer & Transition Lead)	
Presenter/Exec Lead:	Carly Craddock	

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.

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: Offering research opportunities to patients

	Other	Yes☒No☐	Details: NIHR CRN Performance Operating Framework
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. Please provide an example/demonstration: None identified.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: via email 28/11/2023
	Board Committee	Yes☒No☐	Date: TMC 24/11/2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☒No☐	Date:

Summary of Key Issues using Assure, Advise and Alert

Assure
CRN WM with the leadership of the appointed Transition Lead, is meeting its milestones for transitioning to the Regional Research Delivery Network.

Improvement of commercial research activity in-year.

The report advises the Committee that, as Host of the Clinical Research Network, West Midlands it is fulfilling its duties within the Performance and Operating Framework and contract with DHSC.

Advise
N/A

Alert
The Network Director post has been appointed to, which is an internal appointment. The two additional Director posts for the RRDN (Strategic and Operations) are being ring fenced internally, this means three current senior leadership posts will be vacant within the CRN WM contract April 2024 and June 2024 consecutively, which is three to six months prior to the end of the current contract. We are awaiting guidance from the CRN Coordinating Centre as to how this is likely to be managed. This will be the same situation for all current local CRNs.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement

Improve the Healthcare of our Communities	• Deliver improvements at PLACE in the health of our communities
Effective Collaboration	• Facilitate research that improves the quality of care

The Royal Wolverhampton NHS Trust

NIHR Clinical Research Network West Midlands

Report Trust Board Meeting to be held in Public 12/12/23

EXECUTIVE SUMMARY

RWT as Host of the National Institute for Health and Care Research (NIHR) Clinical Research Network, West Midlands (CRN WM) is responsible for ensuring the effective delivery of research 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).

Through a competitive process RWT has been awarded the contract to Host the new Regional Research Delivery Network West Midlands (RRDN WM) from October 2024 – March 2030 with a budget of circa £35 million a year. Plans are well underway to transition from the current CRN WM to RRDN WM.

The CRN WM is forecasting a breakeven year end position.

In Aug 2023 we received the results of our annual partner satisfaction survey, for 2022. Overall, Partners were satisfied with CRN WM senior leadership. The main action from the survey is to increase visibility of the equality, diversity and inclusion work ongoing within the network and the region.

One new risk has been identified since the last report. This is in relation to paying public contributors. We are working with the various departments to put a process in place and this is being piloted currently.

BACKGROUND INFORMATION

1.0 Performance

- In 2023/24 we have three High-Level Objectives. We are on-track to achieve the ambitions for these objectives at the end of the year.

HLO Study Delivery [commercial studies] Quarter 2 Ambition Met

Support Sponsors to deliver their NIHR CRN Portfolio Studies to recruitment target

Percentage of open to recruitment **commercial contract studies** which are predicted to achieve their recruitment target (Ambition: 80%)

Q2 In the CRN West Midlands -

HLO Study Delivery [non-commercial studies] Quarter 2 Ambition Met

Support Sponsors to deliver their NIHR CRN Portfolio Studies to recruitment target

Percentage of open to recruitment **non-commercial studies** which are predicted to achieve their recruitment target (Ambition: 80%)

Q2 In the CRN West Midlands -

81%

+1% of 80% ambition

176 of 217

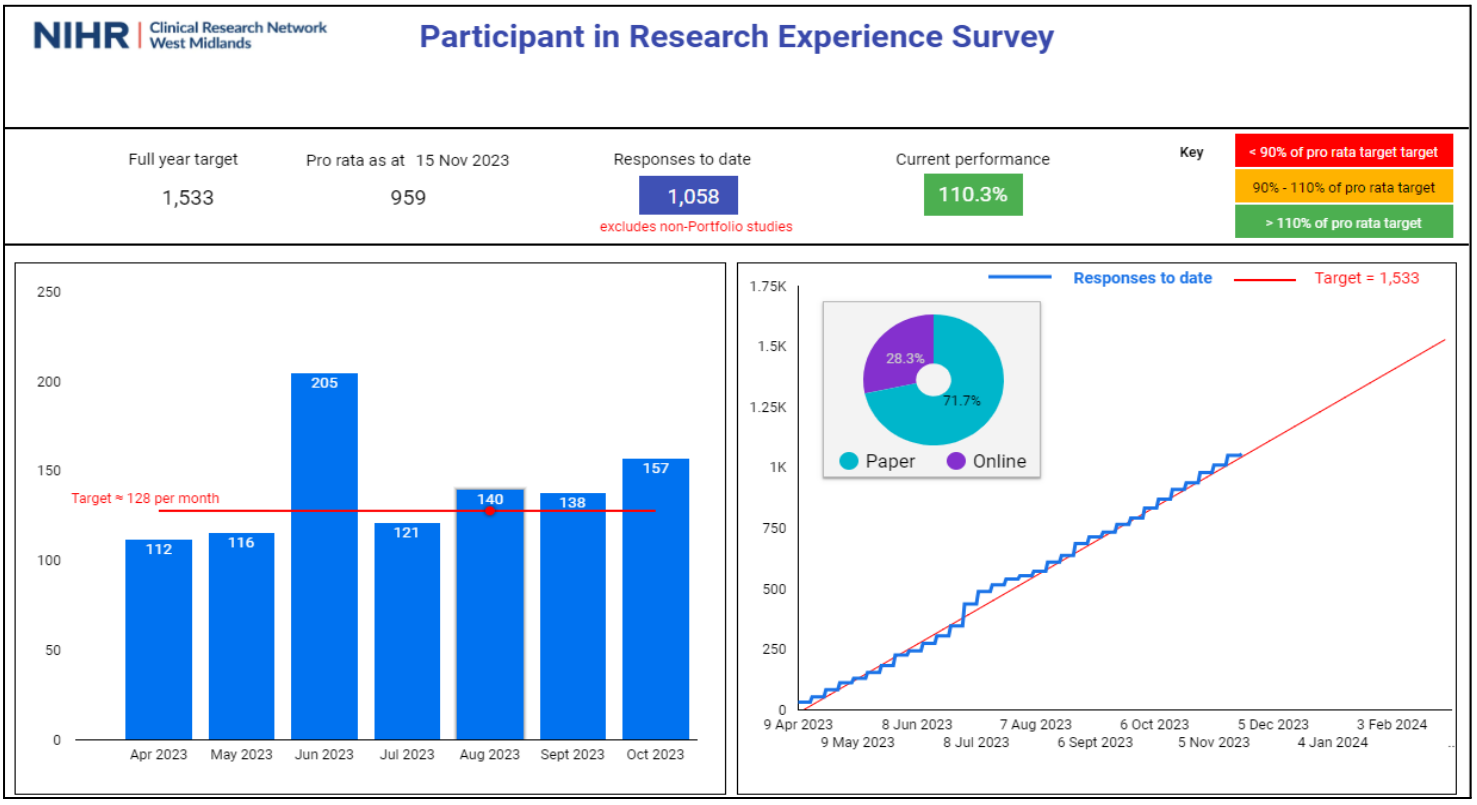
studies predicted to achieve their recruitment target

Rating of studies that are currently open to recruitment

HLO Q2 Participant Experience - On Target

Demonstrate to people taking part in health and social care research studies that their contribution is valued

Number of NIHR CRN Portfolio study participants responding to the PRES, each year



Although the High Level Objectives do not include recruitment/study numbers, we monitor this as a measure of site engagement and levels of research activity across the region. We provide activity reports to individual partner organisations (NHS), monitor recruitment of participants in different settings, as well as within Integrated Care Systems.

The percentage of commercial recruitment has increased due to a primary care commercial study.

Q2 Research Activity

28,550
participants have been recruited

687
studies have recruited

27
recruiting Trusts/CCGs

Study Route	Recruitment	Studies Recruited	Studies Supported	New Studies
Commercial	4,402	116	203	176
Non-Commercial	24,148	571	773	89
WM Totals	**28,550**	**687**	**976**	**265**

We are actively recruiting across all organisations including schools and Local Authorities. We are engaging with private pharmacies, prisons and dentists currently.

Site Type	Total	Interventional	Observational	Large Interventional	Large Observational	Commercial
Acute Trusts	**12090**	2397	3811	3151	3210	421
Non-Acute Trusts	**2374**	507	1299	259	258	51
Primary Care	**10169**	438	2,082	1,159	2,577	3,913
Non-NHS	**3,917**	150	384	3,365	1	17
WM Total	**28550**	**3492**	**7576**	**7934**	**6046**	**4402**

2.0 Life Sciences Industry

- We have a number of innovative initiatives underway as part of our strategy, and that have come about through developing collaborations with commercial companies and business development activities.
- Commercial recruitment has increased (and is higher than this time last year) mainly due to one primary care commercial study.

3.0 Contractual requirements

- All organisations that receive funding from CRN WM have a signed contract.
- There are 44 contract support documents that provide further detail of requirements as part of the Performance Operating Framework. We regularly review these to monitor potential non-compliance in-year. Currently we are meeting all of these requirements.

4.0 Financial position

- We received additional funding in 23/24 with some of this being ring fenced funding for clinical support departments (pharmacy, pathology, radiology) in order to address research delivery challenges in these departments. This has all now been allocated.
- We are forecasting a surplus of £69k at M7. Plans have been put in place to forecast for a break even position at year end.
- We are currently budget setting for 24/25 so we can inform partner organisations of indicative funding by the end of Dec 2023 to support their budget planning.

5.0 Transition from CRN WM to RRDN WM

- All 5 out of 15 milestones that should be met by the current time, have been met.
- The RRDN Network Director post has been appointed to and will be in post for April 2024.
- The two full-time Director posts (Strategy and Operations) are being interviewed for the end of November 2023. 2 part-time roles (Health and Care Director) will be advertised Dec 2023. All will be in post for June 2024.
- We are holding monthly meetings with all staff to update on the transformation and transition
- For each of the 20 service functions of the RDN/RRDNs, each Local Clinical Research Network has nominated a business lead to be involved in the baselining and task and finish groups currently

underway in order to prepare options papers for DHSC. These will be completed by end of December 23. Further refinement will then take place Jan/Feb 2024.
- Public announcement of RDN CC host and RRDN host 15 November 2023

6.0 Staff Engagement/Wellbeing

- We have had the results of our cultural assessment and have started staff-engagement groups to work up suggestions of how we can improve our levels of psychological safety. There was lots of positive feedback from staff also.

7.0 Partner Engagement

- We have added a further project as part of our Progression Plan which relates to recruitment and retention of research related staff. This has been identified as a strategic issue for partners and as a region. We are facilitating these working groups to work better as one system.
- We had 66 submissions for Partner Organisation awards. The award ceremony is taking place 30 November 2023.
- Our annual partner satisfaction survey had a 100% response rate. Partners overall satisfaction was 94%. The main improvements to make are to ensure we have participant/carer/public voice throughout what we do. This has been delayed due to payment mechanisms.

8.0 Risk Register

- One new risk added to the register due to a complaint. A lay member was not paid for their contribution due to various internal process reasons. These have now been addressed and we are piloting a new way of managing these. Further public involvement has been limited until we know this process works well. Since TMC we have agreed to close this risk now as the process is working successfully.

RECOMMENDATIONS

The Committee is asked to note the content of the report.

Pack B - Any Cross-References to Reading Room Information/Enclosures:

- Summary of 2021 and 2022 partner satisfaction survey results
- Public announcement of RDN CC host and RRDN host - 15 Nov 2023
- Risk Register Nov 2023

NIHR | Clinical Research Network West Midlands

Partner Satisfaction Survey 2022: Comparison to 2021

1.0 Introduction

The Performance Operating Framework, our business delivery contract between the Local Clinical Research Network (LCRN) Host and the Department of Health and Social care (DHSC), stipulates that every year we request feedback on satisfaction of our Partner Organisations. Partner Organisations (POs) are defined as organisations that are in receipt of more than £50,00 per annum from the LCRN.

The 2022 Partner Satisfaction Survey and CRN West Midlands quantitative results can be found here. We are still awaiting qualitative results.

2.0 Increasing the Response Rate

In 2021 21 out of 28 partners responded (75%). In 2022 we achieved a 100% response rate.

3.0 Question Response Comparisons

See Table 1.

Table 1. Comparison of 2021 and 2022 surveys

Question/Area of Focus	2021	Mar 2022	Comments
Response Rate	75%	100%	
Overall Satisfaction	100%	94%	
Q4. I am satisfied with the LCRN Leadership Team's engagement with my Partner organisation	Agree 76% S Agree 14%	Agree 79% S Agree 10%	1 PO disagreed
Q5. I am satisfied with the LCRN Leadership Team's support of my Partner Organisation	Agree 71% S Agree 24%	Agree 76% S Agree 21%	2% increase in 'agree'
Q6. I am satisfied with the LCRN Leadership Team's responsiveness to Partners' suggestions for improvement	Agree 67% S Agree 19%	Agree 66% S Agree 24%	4% increase overall
Q7. I am satisfied with the execution of my LCRN partner organisations Category A contract	Agree 67% S Agree 24%	Agree 72% S Agree 21%	5% increase in agree, 2% overall increase - new process implemented mid 2023
Q8. I am satisfied with the level of LCRN Partnership Group decision making regarding the distribution of LCRN funding	Agree 67% S Agree 24%	Agree 59% S Agree 24%	Decrease, 10% disagree/somewhat disagree
Q9. I am satisfied with the formal review of LCRN annual business plans and reports by the LCRN Partnership Group	Agree 67% S Agree 10%	Agree 66% S Agree 21%	Overall increase in agree/somewhat agree

Q10. I am satisfied with the level of activity data and reports provided to my Partner Organisation and to the LCRN Partnership Group	Agree 76% S Agree 14%	Agree 66% S Agree 21%	Decrease
Q11. I am satisfied that participants, carers and the general public are appropriately represented within the LCRN Partnership Group	Agree 81% S Agree 10%	Agree 55% S Agree 31%	Large decrease
Q12 (qualitative)			
Q13. I am satisfied with the LCRN Leadership Team's plans to bring clinical and applied research to under-served regions and communities with major health needs Change of wording in 2022: Clinical and applied research is reaching under-served regions and communities with major health needs in the LCRN region	Agree 67% S Agree 10%	Agree 10% S Agree 34%	Large decrease, is this contributed to by change in wording? LCRN to pull together a report on what is happening via the LCRN and across the region
Q14. I am satisfied with the research Impact of my Partner organisation Change of wording in 2022: The research conducted by my Partner organisation has impact	Agree 71% S Agree 29%	Agree 52% S Agree 34%	Large decrease

The Royal Wolverhampton NHS Trust

Report to the Public Trust Board On 12th December 2023		
Title of Report:	Schwartz Rounds – RWT Annual report April 2022 - end March 2023	Enc No.10.8.2
Author:	Louise Nickell – Group Director of Education and Training	
Presenter/Exec Lead:	Dr Brian McKaig	

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 for 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:	Estimated annual costs for licence and catering = £3,000 covered by CEO budget recurrently		
Report Data Caveats	This is a standard report using the previous year's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well-led, Caring
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☒No☐	Details: Staff wellbeing
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☐No☐	Details:
CQC Domains	**Caring: Well-led:**		
Equality and Diversity Impact	Being monitored through demographic feedback around attendance		
Report Journey/Destination or matters that may have been referred to other Board Committees	People and OD Group	Yes☒No☐	Date:14th September 2023
	People Committee	Yes☒No☐	Date: 22nd September 2023
	TMC	Yes☒No☐	Date: 27th October 2023
	Trust Board	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure **Positive assurances & highlights of note for the Board/Committee** • The report provides assurance around the value of Schwartz rounds, through good evaluation data from all Schwartz Round participants.
Advise **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought** • The report advises the committee in terms of actions to address around greater inclusion in Schwartz Rounds by some groups of non-clinical staff, and some groups of clinical staff.
Alert **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee** • 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 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	
Effective Collaboration	

Schwartz Rounds – RWT Annual report April 2022 – end March 2023

EXECUTIVE SUMMARY:

This report provides assurance that the Schwartz Round programme is well embedded in the organisation after initiation 7 years ago. The report details:

- The range and scope of Schwartz Rounds topics and the governance arrangements to support the programme of work.
- The excellent participant feedback, notably 99% would recommend the Rounds to colleagues.
- Over the past 12 months total attendees were 366, the average attendance was 46.
- Adaptations in the last 12 months includes virtual Rounds alongside face-to-face Rounds.
- Doctoral research conducted as a case study of RWT, demonstrates value to Rounds beyond wellbeing, in the areas of reflection, situated learning and practice impact.
- Schwartz Rounds continues to provide a forum for staff engagement and support for a small financial investment (£3k = annual licence fee and refreshments).

Schwartz Round Programme 2022-23:

- The most challenging aspect is the work involved to gain commitment to deliver Rounds, and all the preparation work leading up to successful delivery. However, a delivery plan is programmed months in advance.
- In the year April 2022 to March 2023, the Schwartz Rounds offered virtual rounds whereby staff could join via MS Teams. The feedback received complimented the hybrid approach, allowing staff from across other sites to attend the rounds. The rounds were more accessible however feedback was received to state that some attendees didn't feel the same engagement with the panel members online that they have felt when attending in person.
- Panel preparation can be time consuming but is shared between the 3 facilitators.

Schwartz Rounds delivered:

- Since inception, the organisation has supported 57 Rounds (from September 2016 up to end March 2023), with 1924 individual attendances, with an average attendance at each Round of 34 individuals.
- Between April 2022 - end March 2023 the organisation supported 8 Rounds, with 366 individual attendances, with an average attendance at each Round of 46 individuals.
- The topics delivered during April 2022 - end March 2023 are listed below, and full evaluation of each session, as well as overall evaluation of the 12 months of Schwartz Rounds is included in Appendix 2.

Date	Title	Panel
April 2022	'The day I made a difference'. (Positive experiences)	Sally Horton, Louise Tisdale
May 2022	Round Cancelled	
June 2022 - VIRTUAL	'The lonely leader' (Challenges for leaders around their leadership role: e.g., vulnerability, loneliness etc.)	Doreen Black, Yvonne Higgins, Katy Thorpe
July 2022	'Making decisions about resuscitation – It's OK to die'	Natasha Thomas, Tom Lowde, Henna Nabi

August 2022	No Schwartz Round scheduled – summer holidays planned break	
September 2022	'What it feels like to be a new starter at RWT'	Dr Alphonsus Ezonfade, Dr Dawar Ayyaz, Dr Francesca Rees, Dr Luke Ironside
October 2022	'Menopause – Me and my Workplace' Positive menopause experience in the workplace	Russell Hanks, Julie Sharp, Diane Davies
November 2022	'Caring at home and at work – the juggling act for parents and adult carers'	Keely Evans, Dr Amy Thompson
December 2022	'Mind, Body, and Christmas Spirit – a tale of adventure for charitable causes'	Dr Sally Edwards (Swim English Channel for Cystic Fibrosis) & Sukdeep Dhadda (trekking Everest Base Camp in Nepal) & Alex Howes (Climbed Kilimanjaro for British Heart Foundation)
January 2023	No Schwartz Round scheduled - winter pressures planned break	
February 2023	Incivility and Disrespect 'Facing incivility and disrespect head on'	Debra Baker, Rohini Devi, Alexandra Marley
March 2023	Round Cancelled	

Issues/Concerns:

- Less than ideal mix around Round attendance from some areas of non-clinical staff and some areas of clinical staff - a requirement for increasing engagement.
    - Plans to address this include Schwartz Round steering group wider representation. Chair has attended all Employee Voice Groups.
- Due to increased working pressures, sometimes engagement at the Schwartz Round Steering Groups has been lower than usual.
    - Steering Group members list to be reviewed and revised.

RWT operational evaluation
Feedback forms and evaluation:

- All participants are encouraged to complete a comprehensive feedback form following every Schwartz Round, and the results of these from April 2022 - end March 2023 are included in Appendix 1.
- Evaluation scores are high for Schwartz Rounds overall (within the last 12 months, 99% of attendees would recommend Schwartz Rounds), and thus provide quantitative data around success, although the qualitative data provided by the free text comments provide a richer dataset and provide evidence of impact of the Rounds.

RWT Future Plans:

- To continue in offering both virtual and face-to-face sessions for Schwartz Rounds to ensure staff from all sites and working arrangements can attend reaching a wider audience group.
- Holding a celebration event (date TBC) to undertake a reflexive approach around practice change.

Pack B:

- **Appendix 1: Schwartz Round evidence base and references**
- **Appendix 2: RWT Quantitative feedback**
- **Appendix 3: RWT Qualitative feedback**

PACK B:

SCHWARTZ ROUNDS BACKGROUND

Schwartz Rounds Purpose & Origins:

- Schwartz Rounds allow time and space for staff to discuss the non-clinical, social, and emotional aspects around caring for patients/working in healthcare - thus supports staff wellbeing.
- Boston Lawyer (Kenneth Schwartz) was a lung cancer patient, and he was so impressed with the compassionate care he received, he asked staff what would help them most in being able to do their jobs. They came up with the concept of Schwartz Rounds as a forum to discuss confidentially and compassionately what it feels like to work in healthcare.
- Whilst originating in the US, it has been in the UK since 2009, and strong evidence base around staff benefits has been demonstrated with >220 UK organisations taking part (including NHS, Veterinary practices, Prisons, Care homes, Education settings etc.)
- Schwartz Rounds is cited in the People Plan.

Schwartz Rounds Benefits:

- Patient care enhanced - improved empathy. Maben et al (2018)
  - Improved staff well-being: Poor psychological wellbeing reduced from 25% to 12%.
- Staff health and wellbeing and patient care and satisfaction linked by the Boorman report, (Boorman, 2009), reduced levels of stress.
- Increased staff engagement, (West & Dawson, 2002).
- Culture of compassion and promoting shared values.
- Greater team working.
- Reduced sickness absence/Turnover.
- 'Time out' opportunities.
- Networking/sharing common purpose.
- Organisation seen as less hierarchical.
- Role-modelling opportunity- especially through senior staff attending and contributing.

RWT SCHWARTZ ROUNDS THEMATIC ANALYSIS

Themes from compiled feedback and discussion at the steering group are:

- Staff value the mix of virtual and face-to-face Rounds- enabling greater access and supporting human connectivity.
- Stories shared are highly impactful- with impact seen at an individual level and wider- supporting cultural change and OD.
- The programme is planned but flexed to support topic change- this supports an emergent and responsive approach according to organisational needs.

RWT SCHWARTZ ROUNDS RESEARCH

Doctoral research recently completed examined Schwartz rounds within RWT using a case study qualitative design, the data collection tool was semi-structed interviews of a mixture of

attendees, panellists, and facilitators. Using a Reflexive thematic Analysis approach to the data, the following themes were identified:

1. Caring for the Carers- staff care is complex, important and can be a hidden workload.
2. The concept of a safe space- overcomes fear, provides safety, and builds trust. Ripple effect is seen. Schwartz Rounds operates as its own Community of Practice. The safe space support staff connectivity.
3. Reflection and reflexivity. The stories direct reflection, reflection supports the liminal space, being 'in their shoes' through powerful stories, all of these promote reflexivity.
4. Learning- Situated learning occurs at individual, team, and organisational levels.
5. Practice impact- Powerful stories prompt personal change. Clinical insight develops. Work 'actions' result counter-culturally to the Schwartz Round ethos.

RWT OPERATIONAL DELIVERY

Schwartz Round Steering group:

- A Schwartz Round Steering group has been established since March 2016 and meets monthly to support planning of future Rounds and evaluate progress. The Steering group is an important resource in establishing and maintaining a successful Schwartz Round programme in the organisation.

Certification/CPD/Reflective practice:

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

Governance:

- Governance of the Rounds is through the facilitators in terms of the Round content, with the Schwartz Round Steering Group appraising the Rounds and the evaluation data. Monthly reports about each Round are discussed within the Schwartz Round Steering Group agenda, with a summary report as part of the annual report to People Committee and TMC.
- Peer Governance of the Rounds has been provided by an organisational Mentor, and through the Point of Care Foundation which holds the licence to practice Schwartz Rounds in the UK and sets the organisational standards around the Rounds.
- RWT also belongs to the Schwartz Round Community of Practice, which is a group of organisations all practicing Schwartz Rounds. The sharing of good practice and lessons learnt are part of the rationale for this Community of Practice.

RWT OPERATIONAL EVALUATION

Feedback forms and evaluation:

- The Schwartz Round Steering group examined the evaluation information to date and determine the key priorities upon which to focus on future evaluation of outcomes and the associated methodology. This was determined to be a mixture of qualitative and qualitative data, to provide a rich dataset.
    - The quantitative data is detailed in Appendix 2
    - The qualitative data is detailed in Appendix 3

RWT Schwartz Rounds sustainability:

- Finances- estimated annual costs for contract and food is £3K- a small investment given the staff benefits and staff feedback from Rounds.
- Active membership of Schwartz Round Steering Group to ensure positive engagement.
- Multiple sites – engagement. This has been explored through the Steering Group
- Sustaining quality through peer review
    - Point of Care Foundation receive our feedback data every 6 months.
- Annual report to People Committee and TMC/TB
- Learn from other organisations- feedback from other organisations is that organisational support is high initially, but long-term sustainable support can be a challenge (especially around financial support and embedding Rounds)

Appendix 1: Schwartz Rounds evidence base and references:

- Established in many countries. USA > 20 years.
- Schwartz Centre for Compassionate Healthcare research (Lown, 2010)- teamwork, less stress, participants more likely to attend to patients psychological and emotional needs, empathy, (also enhanced by increased attendance of Schwartz Rounds)
- UK evidence around compassionate care – Two pilot sites, (Goodrich, 2012).
- Qualitative evidence base is good. Around 220 NHS trusts and hospices in UK undertaking Rounds
- Longitudinal research study highlighted benefits
    - *'Rounds have been shown to offer unique support compared to other interventions. Organisational level interventions for staff wellbeing are scarce and Rounds uniquely straddle both individual and organisational levels.*
    - *Providing high quality healthcare has an emotional impact on staff, which often goes unnoticed. Rounds offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them. Attendance is associated with a statistically significant improvement in staff psychological wellbeing.*
    - *Reported outcomes included increased empathy and compassion for patients and colleagues and positive changes in practice'.*
- Maben J, Taylor C, Dawson J, Leamy M, McCarthy I, Reynolds E, et al. A realist informed mixed-methods evaluation of Schwartz Center Rounds® in England. Health Serv Deliv Res 2018;6(37).
- Impact report 2020 - Point of Care Foundation
- Boorman, S., 2009. NHS health and wellbeing review.
- Goodrich, J., 2012. Supporting hospital staff to provide compassionate care: Do Schwartz Centre Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, March, 105, (3), pp. 117-122
- Lown, B., Manning, C., 2010. The Schwartz Centre Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centred communication, teamwork, and provider support. Academic Medicine. 85, (6), pp. 1073-1081
- West, M. A, Dawson, J. F., 2002. Employee engagement and NHS performance. Kings Fund Report

https://www.pointofcarefoundation.org.uk/

Appendix 2 – Quantitative Feedback – Feedback Summaries from Rounds 50 to 57 (April 2022 to March 2023)

Appendix 2 - Quantitative Feedba

Appendix 3: Qualitative Feedback: Individual's reflective pieces, and participants' collated feedback free text data.

Personal Reflection of Session	
Date: 23/03/2022	Session title: **My experiences of working with refugees**
Round Summary: The round explored the roles of one of the teams working in the community with the recent influx of refugees into the city. The complexities of the roles and the many hats they must wear were highlighted as they explained about not only the housing issues, but often the more complex social and health issues that surround the needs of these people entering our country.	
Themes discussed within Round: The round brought to light the complex environment these staff members are navigating every day to ensure that each refugee has the right care. The basic human needs of them and their families being met in hotel facilities is not ideal, but these staff members worked tirelessly to ensure that the families had access to the right social and health services to meet their needs.	
How these themes relate to me/my practice/my wellbeing: It made me realise the scale of the social issues within the city and the complexity of the demographic we serve. The multiple cultures within the city and the differing health needs associated with refugees being moved to Wolverhampton. I have a newfound respect for other professions, particularly those that we don't often hear about within the Acute hospital setting. The work this team are doing is truly inspiring !!	
How I have gained insight into how others think/feel in caring for patients/colleagues: It was wonderful to hear the support for this team and the like mindedness of the audience. Whilst we have been through the pandemic, it was still very clear that there is lots of good work going on and the appreciation of this was palpable.	
Key points learned from today's Schwartz Round which will change how I relate to or communicate with patients and/or colleagues, or reflection on how I might do things differently: It has given me food for thought. I need to educate myself on cultural differences and how these can be woven into everyday practice within my current role.	

Personal Reflection of Session	
Date: 06/12/2022	Session title: **Mind, Body, and Christmas Spirit**
Round Summary: Nice stories about personal challenge and tenacity.	
Themes discussed within Round: - Personal Challenge - Loss - Resilience	
How these themes relate to me/my practice/my wellbeing: Support to help with your goals is always available.	
How I have gained insight into how others think/feel in caring for patients/colleagues: Always good to hear other perspectives.	
Key points learned from today's Schwartz Round which will change how I relate to or communicate with patients and/or colleagues, or reflection on how I might do things differently: It's good to give and you can learn a lot about yourself in the process.	

- **Participants' collated feedback free text data (2022-23)**

Round 50 feedback

Number in attendance must be added in order for the calculations to be made.
Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	27th April 2022		
Title of Round	The day I made a difference		
Number in attendance	35	**Number of forms returned**	28

	Completely disagree		Disagree somewhat		Neither agree nor		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my daily work.	0	0%	1	4%	2	7%	7	25%	18	64%
I gained knowledge that will help me to care for patients	0	0%	0	0%	5	18%	6	21%	16	57%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	2	7%	7	25%	19	68%
The group discussion was helpful to me.	0	0%	0	0%	2	7%	9	32%	17	61%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	8	29%	20	71%
I have gained insight into how others care for patients.	0	0%	0	0%	0	0%	3	11%	25	89%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	6	21%	22	79%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	3	11%	25	89%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	4%	3	11%	17	61%	7	25%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	5	18%	1	4%	0	0%	0	0%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcar	
	0	0%	4	14%	2	7%	4	0%	0	0%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	12	43%	0	0%		
	Other (please state)									
	Physicians Student and Staff Nurse, Physician Associate									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	18	64%	6	21%	2	7%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Interesting to hear perspectives and themes around patient care and support. Can inspire and motivate individuals. Really enjoyed being part of the panel.
Excellent session, inspiring stories of services we usually hear little of.
Thank you to both panel members for sharing their very powerful stories.
Being admin staff it's great to head stories from clinical staff and other areas where they have made a difference. Very insightful.
Thank you for sharing experiences. It was really nice to learn about your roles and also to reflect on experiences. It will definitely impact our future practices. Thank you.
It was lovely to hear about recognising when you've done well and made an impact, knowing that you are allowed to stop and feel self pride in these circumstances is a great reminder for the future.
Good experience, useful to know other people's stories.
It was very lovely to hear everyone's experiences and especially to gain insight into services that we often take for granted. Amazing stories from the panel and a wonderful reminder of all the good work and compassionate people that continue to defy the odds.
Both stories were great and very inspirational.
It was my first Schwartz Round. It gave an interesting perspective on making a difference to patients and insight into areas I was unaware of until today. P.S it's good to talk.
Very thought provoking session. Thank you for sharing your stories.
It was nice to see people share stories about their patients and how that made an impact on them and how they made an impact on the patient.
Totally enjoyed this Schwartz Round. Very insightful as it is my first one and look forward to future rounds.
Good experience, very insightful to see how other professions work. All panelists were very clear and had good stories.
Lovely session. Incredibly insightful and heartwarming. It was lovely that everyone was sharing their thoughts, opinions, and stories and interesting to understand how different professions are required to aid in patient's healthcare.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	5
	25 -29	10
	30-44	8
	45-59	5
	60-64	
	65 +	
	Prefer not to say	
How would you describe your ethnicity?	Asian	9
	Black	5
	White British	14
	Mixed/Multiple ethnic background	
	Arab	
	White other	
	Other	
	Prefer not to say	
What gender do you identify as?	Male	7
	Female	19
	Other	
	Prefer not to say	
Is your gender the same as you were assigned at birth?	Yes 26 No 0	
	Prefer not to say	
How would you describe your marital status?	Single	18
	Married, committed in civil partnership	7
	Divorced	1
	Widow	
	Prefer not to say	
Do you consider yourself to have a disability?	Yes 0 No 26	
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight 26	
	Gay/Lesbian 0	
	Other 0	
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?	Yes 0 No 25	
	Prefer not to say	

Round 51 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	21st June 2022		
Title of Round	The Lonely Leader - VIRTUAL		
Number in attendance	55	**Number of forms returned**	34

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	1	3%	0	0%	1	3%	5	15%	27	79%	0	0%
I gained knowledge that will help me to care for patients	0	0%	1	3%	4	12%	11	32%	12	35%	6	18%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	0	0%	11	32%	23	68%	0	0%
The group discussion was helpful to me.	0	0%	0	0%	0	0%	5	15%	29	85%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	1	3%	5	15%	28	82%	0	0%
I have gained insight into how others care for patients.	0	0%	0	0%	6	18%	8	24%	16	47%	4	12%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	4	12%	30	88%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	4	12%	30	88%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	0	0%	16	47%	18	53%

Professional affiliation (only 8 completed this section)										
	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	2	6%	0	0%	0	0%	11	32%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	6	18%	2	6%	8	24%	1	3%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	4	12%	0	0%		
	Other (please state)									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	10	29%	15	44%	8	24%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Thank you to everyone who shared their stories.
I was interested in today's topic as it spoke to me
I would really appreciate if more Schwartz rounds are held virtually
exceptional stories told by very senior individuals who expressed very eloquently their feels of loneliness as well as the relief when asking others for help. fabulous shared stories from attendees which were also very emotional and helpful
My 1st this Trust enjoyable experience, enlightening, great reflections to relate to ....
Thank you to all the contributors - really useful.
Thank you for the safe forum and opportunity to hear and contribute experiences regarding leadership
Very insightful for my first Round, in relatively new to a leadership role so this was an excellent topic to touch upon and learnt so much especially insights into the clinical staffs stories throughout covid. Thank you
appreciated the honest of the speakers. Gave me lots to think about. Made me realize that people in very senior posts who can appear "scary" can be experiencing the same anxieties and vulnerabilities as the more junior leaders. Louise was an excellent facilitator,
I hope I can attend more meetings but unfortunately working on very busy ward prevents that. My off day is Friday, any possibility that it can on different days of the week each time? Thank you excellent meeting
Thank you for a well facilitated and valuable topic/session.
I think it is very important for staff to feel supported in their jobs so they can provide on going high quality compassionate care to patients and the Schwartz round offers a mechanism of supporting staff and highlighting the importance that health and wellbeing matter. What I found was this session also gave me an opportunity to reflect on the talks and their experiences of delivering care when they felt very isolated and lonely - feelings I could relate to very well.
I was surprised that Covid played such a part in the round. It clearly is still having an emotional impact on some people. I wonder if the Trust needs to do more to enable recovery? It also reinforced for me the importance of SRs and the positive impact they have for staff and how they are valued.
Thank you so much for a fantastic, uplifting round. I learnt a lot from the speakers and the contributions about leadership and making mistakes.
I found this session really informative and relatable. It was reassuring that everyone was feeling the same and yet no-one ever perceives that others are feeling this way due to how they hold themselves. It evidenced the higher in leadership and management you are, there is an expectation you are coping well when really we all have our days and are all human requiring that nurturing, praise and time to talk.
Really felt this round was very useful, very relevant to my role, very emotive. Thought the speakers were really honest and personal which really added to the session. My only comment would be, when discussing leadership within our organisaiton, and people feeling vulnerable, I would have loved to hear a senior MALE colleague as one of the panel members. I think that women are much better at being 'vulnerable' and also 'imposter syndrome' is apparently much more prevalent in females, so I would have loved to hear a male senior manager share his experience also (although, the male contributors to the discussion were excellent).
Happy to answer all the questions but why are we asked about our age, whether we have been pregnant in the last 12 months, disability, marital status, etc.? Will it help decide future topics? What is this information used for?
It was encouraging to know that we all have faced loneliness at times during the pandemic and I could relate to all of the stories in some capacity. It demonstrated to me how we are all human and that we all need to connect with people in times of adversity, no matter how difficult it is to ask for that help.
Thank you for providing it online - I would not have attended otherwise
Very relevant and timely.
Excellent to focus on leadership, for those in senior positions or those feeling isolated in their roles
Excellent subject, fantastic examples given/described
great session, open and honest and a great platform, thanks to all involved; great speakers :)
Very grateful to have been able to attend the Schwartz Round
Very good. I am about to start a new role as Matron and the round has given me the confidence to ask for help.

Diversity monitoring information:		Responses
How old are you?	24 or under	1
	25 -29	1
	30-44	12
	45-59	15
	60-64	4
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	3
	Black	2
	White British	24
	Mixed/Multiple ethnic background	1
	Arab	1
	White other	1
	Other	2
	Prefer not to say	0
What gender do you identify as?	Male	7
	Female	26
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes - 34 No - 0	
	Prefer not to say	
How would you describe your marital status?	Single	8
	Married, committed in civil partnership	22
	Divorced	3
	Widow	0
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 2 No - 31	
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight - 31 , Gay/Lesbian - 1, Other - 0	
	Prefer not to say	0
Have you been pregnant or had a baby in the last 12 months?	Yes - 1 No - 32	
	Prefer not to say	

Round 52 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	12th July 2022		
Title of Round	Making decisions about resuscitation - It's OK to die		
Number in attendance	50	**Number of forms returned**	36

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my daily work.	0	0%	0	0%	3	8%	7	19%	26	72%
I gained knowledge that will help me to care for patients	0	0%	0	0%	3	8%	7	19%	26	72%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	4	11%	9	25%	23	64%
The group discussion was helpful to me.	0	0%	0	0%	0	0%	7	19%	29	81%
The group discussion was well facilitated.	0	0%	0	0%	2	6%	4	11%	30	83%
I have gained insight into how others care for patients.	0	0%	1	3%	1	3%	5	14%	28	78%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	3	8%	33	92%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	2	6%	34	94%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	3%	3	8%	17	47%	14	39%

Professional affiliation (only 8 completed this section)										
	Medical & Dental		**Student**		**Untrained Nurse**		**Trained Nurse/Midwife**		**Ancillary**	
	7	19%	1	3%	0	0%	12	33%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior**		**Technician/Healthcare Scientist**	
	0	0%	0	0%	2	6%	3	8%	0	0%
	Maintenance		**Non Executive**		**Other**		**Healthcare Support**			
	0	0%	0	0%	10	28%	0	0%		
	Other;									
	Physician Associate, Adult Nursing, MSW, Nurse Associate Apprentice									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	13	36%	14	39%	7	19%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Some good views from the attendees
It was a good round, I heard a lot about Schwartz Round, but hadn't got an opportunity to attned. It gave me good insight in RESPECT form.
Great session.
Thoughtful and relevant.
Very helpful to share insights across a range of clinical experiences.
Reinforced how important it is to be honest with patients and ensure you always take time to listen regardless of profession.
The discussions definitely cement the topic. Respect - it does have an important role in managing patients wishes and regards to their care. Its good facilitation for the first time Emma. There were hands on the side outstide your peripheral vision that may be missed so it's helpful audience diverts you to them. Well executed. Very reflective responses to audience feedback.
Very useful and helpful.
Amazing experience and deep insight. Definitely attend again.
Great round.
This was a really good round with excellent discussion and reflective opportunity to think about the process of Respect, and the human connection required for difficult conversation.
Very interesting and thought provoking discussion. Thank you.
The topic was very interesting.
This made me reflect deeply about Respect forms and how to have these discussions.
Great set up, good stories.
Fascinating session tackling some very tricky issues. The humanity of the storytellers shone through their reflections. Worthwhile discussion which will help the audience to reconsider how they deal with these kinds of scenarios. Thank you to everyone who participated.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	3
	25 -29	4
	30-44	16
	45-59	9
	60-64	3
	65 +	1
	Prefer not to say	0
How would you describe your ethnicity?	Asian	10
	Black	4
	White British	18
	Mixed/Multiple ethnic background	2
	Arab	0
	White other	1
	Other	0
	Prefer not to say	0
What gender do you identify as?	Male	7
	Female	27
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes - 33 No - 0	
	Prefer not to say	0
How would you describe your marital status?	Single	10
	Married, committed in civil partnership	19
	Divorced	3
	Widow	0
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 2 No - 31	
	Prefer not to say	0
How do you describe your sexual orientation?	Heterosexual/Straight - 28 Gay/Lesbian - 0 Other - 1	
	Prefer not to say	1
Have you been pregnant or had a baby in the last 12 months?	Yes - 0 No - 23	
	Prefer not to say	0

Round 53 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	13th September 2022		
Title of Round	What it feels like to be a new starter at RWT		
Number in attendance	56	**Number of forms returned**	28

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	0	0%	0	0%	2	7%	8	29%	16	57%	1	4%
I gained knowledge that will help me to care for patients	0	0%	1	4%	1	4%	3	11%	14	50%	8	29%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	0	0%	7	25%	20	71%	0	0%
The group discussion was helpful to me.	0	0%	0	0%	2	7%	5	18%	20	71%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	1	4%	3	11%	23	82%	0	0%
I have gained insight into how others care for patients.	0	0%	2	7%	1	4%	3	11%	18	64%	3	11%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	1	4%	7	25%	19	68%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	1	4%	4	14%	22	79%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	4%	3	11%	12	43%	7	25%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	3	11%	4	14%	0	0%	5	18%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	6	21%	3	11%	1	4%	1	4%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	3	11%	0	0%		
	other; Clinical Research Assistant									
	Physician Associate, SPEF Pre Registration									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	10	36%	6	21%	7	25%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
I thought this Schwartz Round was exceptional and very helpful.
Really nice environment to share our worries. I really appreciated that people came to discuss my concerns with me afterwards. Thank you.
Interesting and engaging, always like to discover ways to help our medics.
Todays session was excellent and had a varied experience shared by all.
Excellent round. Lots of interesting discussion. Allowed me to reflect and have a better understanding of being new in a Trust. This has helped me know how to support others.
Didn't expect it to just be medics on the panel, was expecting it to be multiprofessional stories.
I found the session very useful and reflective. The discussions and reflections were beneficial. Brave panellists.
Really valuable experiences shared as NQ - good discussions and lessons learned where we can still improve and make a difference.
This was my first round, what can I say! Excellent! Excellent! Excellent!
Lessons learnt can be built into training sessions for students and supervisors.
Good to hear that new doctors feel the same as students so will help to improve inductions that we carry out with the pre-registration team.
Feel too medically focused. Could have done with Nursing, AHP, clerical etc. representation on the panel.
Thank you for your stories - some of your situations really related to my experiences. It would have been helpful to have stories from other disciplines - AHP, admin, porters etc.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	7
	25 -29	5
	30-44	5
	45-59	9
	60-64	1
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	5
	Black	4
	White British	13
	Mixed/Multiple ethnic background	1
	Arab	0
	White other	0
	Other	0
	Prefer not to say	0
What gender do you identify as?	Male	4
	Female	19
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes = 23 No = 0	
	Prefer not to say	0
How would you describe your marital status?	Single	10
	Married, committed in civil partnership	12
	Divorced	0
	Widow	0
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes = 0 No = 23	
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight = 22 Gay/Lesbian = 0 Other = 1	
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?	Yes = 0 No = 20	
	Prefer not to say	

Round 54 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	4th October 2022		
Title of Round	Menopause - Me and my workplace		
Number in attendance	56	**Number of forms returned**	33

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	0	0%	0	0%	0	0%	5	15%	27	82%	1	3%
I gained knowledge that will help me to care for patients	0	0%	1	3%	2	6%	4	12%	14	42%	12	36%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	2	6%	7	21%	23	70%	1	3%
The group discussion was helpful to me.	0	0%	0	0%	2	6%	4	12%	27	82%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	2	6%	5	15%	26	79%	0	0%
I have gained insight into how others care for patients.	1	3%	0	0%	3	9%	2	6%	14	42%	12	%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	6	18%	2	6%	25	76%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	2	6%	2	6%	29	88%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	0	0%	2	6%	19	58%	10	30%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	2	6%	0	0%	2	6%	5	15%	2	6%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	11	33%	4	12%	2	6%	1	3%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	1	3%	0	0%		
	other; Clinical Research Assistant									
	Senior Therapy Assistant									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	18	55%	11	33%	3	9%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Very well facilitated round with great interaction from the audience. Gained an insight into the difficulties menopause brings.
Interesting insight into current situation.
I thought it was very interesting.
Really enjoyed it. Don't usually come to Schwartz Rounds as difficult to get time from work so needs to be relevant to be allowed to attend. This was relevant. Thank you.
Very useful - thank you.
Very informative.
Provided a nice, open, welcoming space for everyone to share their thoughts.
Thoroughly enjoyed the meeting and found it helpful and insightful.
Was nice to hear other people's experiences and know your not the only one who is going through this.
Good representation on the panel and inclusion of a man on the menopause round.
Excellent topic and presentation and very informative. Really enjoyed it.
Thank you to the panel members, great to see such a positive male role model.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	1
	25 -29	0
	30-44	5
	45-59	25
	60-64	1
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	4
	Black	2
	White British	21
	Mixed/Multiple ethnic background	1
	Arab	0
	White other	1
	Other	1
	Prefer not to say	0
What gender do you identify as?	Male	0
	Female	30
	Other	1
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes - 28 No - 0	
	Prefer not to say	
How would you describe your marital status?	Single	8
	Married, committed in civil partnership	19
	Divorced	3
	Widow	1
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 2 No - 28	
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight 28 Gay/Lesbian 0 Other 1	
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?	Yes = 0 No = 24	
	Prefer not to say	

Round 55 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	15th November 2022		
Title of Round	Caring at home and at work, the juggling act for parent and adult carers		
Number in attendance	32	**Number of forms returned**	25

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	1	4%	4	16%	2	8%	0	0%	18	72%	0	0%
I gained knowledge that will help me to care for patients	1	4%	1	4%	6	24%	4	16%	4	16%	9	36%
Today's Round will help me work better with my colleagues.	0	0%	1	4%	1	4%	8	32%	15	60%	0	0%
The group discussion was helpful to me.	1	4%	1	4%	0	0%	6	24%	17	68%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	1	4%	3	12%	20	80%	0	0%
I have gained insight into how others care for patients.	0	0%	2	8%	3	12%	4	16%	11	44%	4	16%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	2	8%	23	92%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	2	8%	23	92%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	4%	3	12%	13	52%	4	16%

Professional affiliation (only 8 completed this section)	**Medical & Dental**		**Student**		**Untrained Nurse**		**Trained Nurse**		**Ancillary**	
	2	8%	1	4%	0	0%	5	20%	0	0%
	S&P		**Admin & Clerical**		**AHP**		**Senior Manager/Executive**		**Technician/Healthcare Scientist**	
	0	0%	10	40%	1	4%	1	4%	0	0%
	Maintenance		**Non Executive**		**Other**					
	0	0%	0	0%	4	16%				
	Other (please state)									
	Physician Associate,									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	3	12%	13	52%	4	16%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Very useful and insightful - will attend more in future.
Thought provoking. Generalised assumptions that people have and opinions, important to be non-judgemental.
Thank you.
Really insightful reflections. Well facilitated. Thank you.
Really insightful.
Yes would have been nice to hear from an adult carer (non-parent)
This round was really good to hear the experiences of staff struggling to be parents as well as health professionals. Lots of opportunity for us all to reflect.
My dad passed away only 4 weeks ago and I was his carer, all a bit raw for me to contribute. What I would have liked to have said is that it was important for me to be seen and told that I was more important than my role (which I was by both departments I work for). Now dealing with bereavement - getting older a woman's guilt doesn't get easier!
An excellent round that I felt I could relate to on so many levels. Nice to know the feeling of 'mom guilt' is felt by others and I'm not alone.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	2
	25 -29	4
	30-44	8
	45-59	8
	60-64	1
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	7
	Black	1
	White British	12
	Mixed/Multiple ethnic background	0
	Arab	0
	White other	0
	Other	0
	Prefer not to say	0
What gender do you identify as?	Male	4
	Female	16
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes - 20 No - 0	
	Prefer not to say	
How would you describe your marital status?	Single	8
	Married, committed in civil partnership	9
	Divorced	1
	Widow	1
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 0 No - 19	
	Prefer not to say	0
How do you describe your sexual orientation?	Heterosexual/Straight - 19	
	Gay/Lesbian - 0	
	Other - 0	
	Prefer not to say	
Have you been pregnant or had a baby in the last 12 months?	Yes - 1 No - 10	
	Prefer not to say	0

Round 56 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	6th December 2022		
Title of Round	Mind, Body and Christmas Spirit - A tale of adventure for charitable causes		
Number in attendance	32	**Number of forms returned**	16

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	0	0%	0	0%	4	25%	6	38%	4	25%	2	13%
I gained knowledge that will help me to care for patients	0	0%	0	0%	4	25%	3	19%	4	25%	5	31%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	4	25%	6	38%	6	38%	0	0%
The group discussion was helpful to me.	0	0%	0	0%	2	13%	5	31%	9	56%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	4	25%	12	75%	0	0%
I have gained insight into how others care for patients.	0	0%	0	0%	3	19%	4	25%	5	31%	4	25%
I plan to attend Schwartz Centre Rounds again.	0	0%	0	0%	0	0%	3	19%	12	75%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	3	19%	13	81%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	6%	0	0%	7	44%	6	38%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	3	19%	0	0%	0	0%	3	19%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcar	
	0	0%	5	31%	2	13%	0	0%	0	0%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	2	13%	0	0%		
	Other (please state)									
	Physician Associate, Specialist									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	2	13%	8	50%	5	31%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Excellent round - positive. Lots of discussion.
Very inspiring stories for wonderful causes.
I haven't been able to attend for a long time due to other commitments, but I am glad I could today. I was reminded that behind the staff member, we are all individual humans, that are working on overcoming adversity and our own issues. Patients / staff / members of the public - we all have our struggles and aims. It's good to be mindful of that.
Nice to end the year on a positive thank you.
Great to hear what our colleagues achieve outside of work, its all character building and experiences beyond work can help build relationships and connectivity with patients and colleagues.
Inspirational stories, incredibly strong minded staff members. Good advise on setting goals and how that can relate to your job.
Excellent, very motivational round.

Diversity monitoring information:		**Responses**
How old are you?	24 or under	1
	25 -29	0
	30-44	9
	45-59	5
	60-64	1
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	3
	Black	0
	White British	11
	Mixed/Multiple ethnic background	1
	Arab	0
	White other	0
	Other	0
	Prefer not to say	0
What gender do you identify as?	Male	2
	Female	13
	Other	0
	Prefer not to say	0
Is your gender the same as you were assigned at birth?	Yes - 15 No - 0	
	Prefer not to say	0
How would you describe your marital status?	Single	4
	Married, committed in civil partnership	10
	Divorced	1
	Widow	0
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 1 No - 14	
	Prefer not to say	0
How do you describe your sexual orientation?	Heterosexual/Straight - 15 Gay/Lesbian - 0 Other - 0	
	Prefer not to say	0
Have you been pregnant or had a baby in the last 12 months?	Yes - 0 No - 8	
	Prefer not to say	0

Round 57 feedback

Number in attendance must be added in order for the calculations to be made.

Data entered represents actual numbers - for example if 30 forms were collected and on 3 of these, the 'completely disagree' column was ticked for one particular response then enter '3' in this column. On pressing return, the adjacent white box will automatically show 10%. Add '0' if nobody has ticked a box. Please don't leave any 'required' / blue boxes blank

Organisation	The Royal Wolverhampton NHS Trust		
Date	14th February 2023 (VIRTUAL)		
Title of Round	Facing incivility and disrespect head on		
Number in attendance	50	**Number of forms returned**	26

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree		N/A	
The stories presented by the panel were relevant to my daily work.	0	0%	0	0%	1	4%	3	12%	21	81%	0	0%
I gained knowledge that will help me to care for patients	0	0%	0	0%	4	15%	10	38%	6	23%	6	23%
Today's Round will help me work better with my colleagues.	0	0%	0	0%	2	8%	10	38%	14	54%	0	0%
The group discussion was helpful to me.	0	0%	1	4%	0	0%	5	19%	20	77%	0	0%
The group discussion was well facilitated.	0	0%	0	0%	0	0%	3	12%	23	88%	0	0%
I have gained insight into how others care for patients.	0	0%	0	0%	4	15%	8	31%	12	46%	2	8%
I plan to attend Schwartz Centre Rounds again.	1	4%	0	0%	1	4%	8	31%	16	62%	0	0%
I would recommend Schwartz Centre Rounds to colleagues.	0	0%	0	0%	0	0%	4	15%	22	85%	0	0%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	1	4%	7	27%	15	58%	3	12%

Professional affiliation (only 8 completed this section)	Medical & Dental		Student		Untrained Nurse		Trained Nurse/Midwife		Ancillary	
	2	8%	0	0%	0	0%	5	19%	0	0%
	S&P		Admin & Clerical		AHP		Senior		Technician/Healthcare Scientist	
	0	0%	7	27%	4	15%	6	23%	1	4%
	Maintenance		Non Executive		Other		Healthcare Support			
	0	0%	0	0%	1	4%	0	0%		
	Other (please state)									

How many Rounds have you attended before? (only 8 completed this section)	0		1-5		5+	
	11	42%	9	35%	6	23%

Please add your comments and feedback on today's Schwartz Centre Round (optional)
Thanks all
Really useful topic for us all to reflect on
Good reflections on how others handle issues that arise in the working environment.
Thank you for sharing your stories, great space for reflection, and a relevant subject for everyone.
Thank you to all of the presenters, and organisers - a very thought provoking session.
For those of us not based at New Cross it is very positive to have the opportunity to attend virtually. While I could come across from The Gem Centre this involves either a 15 minute walk either way or playing parking roulette both trying to find a space at New Cross and again on return to The Gem Centre. In addition it adds significantly to the time I have to allocate to attend as I have to build in travel time. This is why I have not been able to attend before today. Thank you for providing the opportunity to attend virtually.
A great topic. Sometimes there can be a more subtle version of uncivility, which may be harder to address. As it may not have happened. The speakers were all great today and the session was really good. Thank you
This was my first experience of a Schwartz round and I found it very beneficial. I have had a few difficult months and can relate to how colleagues feel and its very sad to hear this is how people feel across the Trust. I have been in Healthcare for 30 years and have never experienced a culture like this. I have recently been offered support and CBT which I will pursue.
Was really interesting to her from staff roles different to myself & the challenges being faced.
A good safe space
Excellent round, relevant and current topic
This round made me think about what I say and how I receive information. I liked the comment about asking someone if they are ok, it may inflate the situation, de-escalation may be advantageous
I felt that the round was effective from the point of view that people were able to share traumatic experience but that we needed to move towards more positive support having aired those experiences. I think that psychologically, this might not have been a positive airing for some people
Good discussion, honest expressions of feelings and emotions and proper discussion
I enjoyed it and it shines a light on what we deal with every single day, i now want to investigate further some training in this topic

Diversity monitoring information:		**Responses**
How old are you?	24 or under	0
	25 -29	0
	30-44	8
	45-59	13
	60-64	4
	65 +	0
	Prefer not to say	0
How would you describe your ethnicity?	Asian	3
	Black	1
	White British	16
	Mixed/Multiple ethnic background	2
	Arab	0
	White other	1
	Other	2
	Prefer not to say	0
What gender do you identify as?	Male	4
	Female	20
	Other	0
	Prefer not to say	1
Is your gender the same as you were assigned at birth?	Yes - 23 No - 0	
	Prefer not to say - 2	
How would you describe your marital status?	Single	4
	Married, committed in civil partnership	18
	Divorced	0
	Widow	1
	Prefer not to say	0
Do you consider yourself to have a disability?	Yes - 2 No - 22	
	Prefer not to say	
How do you describe your sexual orientation?	Heterosexual/Straight - 23 Gay/Lesbian - 1 Other - 0	
	Prefer not to say - 1	
Have you been pregnant or had a baby in the last 12 months?	Yes - 1 No - 23	
	Prefer not to say	

Organisation	The Royal Wolverhampton NHS Trust	**Number of Rounds held in the last 12 Months**	**8**
Average number in attendance over the last 12 Rounds	46	**Actual number in attendance over the last 12 Rounds**	**366**
Actual number of forms returned over the last 12 Rounds	**226**	**Percentage of forms returned over the last 12 Rounds**	62%

	Completely disagree		Disagree somewhat		Neither agree nor disagree		Agree somewhat		Completely agree	
The stories presented by the panel were relevant to my daily work.	2	1%	5	2%	15	7%	41	18%	157	69%
I gained knowledge that will help me to care for patients	1	0%	4	2%	29	13%	48	21%	96	42%
Today's Round will help me work better with my colleagues.	0	0%	1	0%	15	7%	65	29%	143	63%
The group discussion was helpful to me.	1	0%	2	1%	8	4%	46	20%	168	74%
The group discussion was well facilitated.	0	0%	0	0%	7	3%	35	15%	182	81%
I have gained insight into how others care for patients.	1	0%	5	2%	21	9%	37	16%	129	57%
I plan to attend Schwartz Center Rounds again.	1	0%	0	0%	8	4%	35	15%	180	80%
I would recommend Schwartz Center Rounds to colleagues.	0	0%	0	0%	3	1%	24	11%	198	88%

Please rate today's Schwartz Round	Poor		Fair		Good		Excellent		Exceptional	
	0	0%	6	3%	21	9%	116	51%	69	31%

Professional affiliation										
	Medical & Dental		**Student**		**Untrained Nurse**		**Trained Nurse**		**Ancillary**	
	26	12%	7	3%	2	1%	46	20%	2	1%
	S&P		**Admin & Clerical**		**AHP**		**Senior Manager/Executive**		**Technician/Healthcare Scientist**	
	0	0%	49	22%	20	9%	25	11%	4	2%
	Maintenance		**Non Executive**		**Other**					
	0	0%	0	0%	37	16%				
	Other (please state)									
	Physicians Student and Staff Nurse, Physician Associate, Adult Nursing, MSW, Nurse Associate Apprentice, SPEF Pre Registration, Senior Therapy Assistant									

How many Rounds have you attended before?	None		1-5		5+	
	85	38%	82	36%	42	19%

Comments and feedback from participants at Rounds over the last twelve months
Interesting to hear perspectives and themes around patient care and support. Can inspire and motivate individuals. Really enjoyed being part of the panel.
Excellent session, inspiring stories of services we usually hear little of.
Thank you to both panel members for sharing their very powerful stories.
Being admin staff it's great to head stories from clinical staff and other areas where they have made a difference. Very insightful.
Thank you for sharing experiences. It was really nice to learn about your roles and also to reflect on experiences. It will definitely impact our future practices. Thank you.
It was lovely to hear about recognising when you've done well and made an impact, knowing that you are allowed to stop and feel self pride in these circumstances is a great reminder for the future.
Good experience, useful to know other people's stories.
It was very lovely to hear everyone's experiences and especially to gain insight into services that we often take for granted. Amazing stories from the panel and a wonderful reminder of all the good work and compassionate people that continue to defy the odds.
Both stories were great and very inspirational.
It was my first Schwartz Round. It gave an interesting perspective on making a difference to patients and insight into areas I was unaware of until today. P.S it's good to talk.
Very thought provoking session. Thank you for sharing your stories.
It was nice to see people share stories about their patients and how that made an impact on them and how they made an impact on the patient.
Totally enjoyed this Schwartz Round. Very insightful as it is my first one and look forward to future rounds.
Good experience, very insightful to see how other professions work. All panelists were very clear and had good stories.
Lovely session. Incredibly insightful and heartwarming. It was lovely that everyone was sharing their thoughts, opinions, and stories and interesting to understand how different professions are required to aid in patient's healthcare.
Thank you to everyone who shared their stories.
I was interested in today's topic as it spoke to me
I would really appreciate if more Schwartz rounds are held virtually
exceptional stories told by very senior individuals who expressed very eloquently their feels of loneliness as well as the relief when asking others for help. fabulous shared stories from attendees which were also very emotional and helpful
My 1st this Trust enjoyable experience, enlightening, great reflections to relate to ....
Thank you to all the contributors - really useful.
Thank you for the safe forum and opportunity to hear and contribute experiences regarding leadership
Very insightful for my first Round, in relatively new to a leadership role so this was an excellent topic to touch upon and learnt so much especially insights into the clinical staffs stories throughout covid. Thank you
appreciated the honest of the speakers. Gave me lots to think about. Made me realize that people in very senior posts who can appear "scary" can be experiencing the same anxieties and vulnerabilities as the more junior leaders. Louise was an excellent facilitator,
I hope I can attend more meetings but unfortunately working on very busy ward prevents that. My off day is Friday, any possibility that it can on different days of the week each time? Thank you excellent meeting
Thank you for a well facilitated and valuable topic/session.
I think it is very important for staff to feel supported in their jobs so they can provide on going high quality compassionate care to patients and the Schwartz round offers a mechanism of supporting staff and highlighting the importance that health and wellbeing matter. What I found was this session also gave me an opportunity to reflect on the talks and their experiences of delivering care when they felt very isolated and lonely - feelings I could relate to very well.
I was surprised that Covid played such a part in the round. It clearly is still having an emotional impact on some people. I wonder if the Trust needs to do more to enable recovery? It also reinforced for me the importance of SRs and the positive impact they have for staff and how they are valued.
Thank you so much for a fantastic, uplifting round. I learnt a lot from the speakers and the contributions about leadership and making mistakes.
I found this session really informative and relatable. It was reassuring that everyone was feeling the same and yet no-one ever perceives that others are feeling this way due to how they hold themselves. It evidenced the higher in leadership and management you are, there is an expectation you are coping well when really we all have our days and are all human requiring that nurturing, praise and time to talk.
Really felt this round was very useful, very relevant to my role, very emotive. Thought the speakers were really honest and personal which really added to the session. My only comment would be, when discussing leadership within our organisaiton, and people feeling vulnerable, I would have loved to hear a senior MALE colleague as one of the panel members. I think that women are much better at being 'vulnerable' and also 'imposter syndrome' is apparently much more prevalent in females, so I would have loved to hear a male senior manager share his experience also (although, the male contributors to the discussion were excellent).
Happy to answer all the questions but why are we asked about our age, whether we have been pregnant in the last 12 months, disability, marital status, etc.? Will it help decide future topics? What is this information used for?
It was encouraging to know that we all have faced loneliness at times during the pandemic and I could relate to all of the stories in some capacity. It demonstrated to me how we are all human and that we all need to connect with people in times of adversity, no matter how difficult it is to ask for that help.
Thank you for providing it online - I would not have attended otherwise
Very relevant and timely.
Excellent to focus on leadership, for those in senior positions or those feeling isolated in their roles
Excellent subject, fantastic examples given/described
great session, open and honest and a great platform, thanks to all involved; great speakers :)
Very grateful to have been able to attend the Schwartz Round
Very good. I am about to start a new role as Matron and the round has given me the confidence to ask for help.
Some good views from the attendees
It was a good round, I heard a lot about Schwartz Round, but hadn't got an opportunity to attned. It gave me good insight in RESPECT form.
Great session.
Thoughtful and relevant.
Very helpful to share insights across a range of clinical experiences.
Reinforced how important it is to be honest with patients and ensure you always take time to listen regardless of profession.
The discussions definitely cement the topic. Respect - it does have an important role in managing patients wishes and regards to their care. Its good facilitation for the first time Emma. There were hands on the side outstide your peripheral vision that may be missed so it's helpful audience diverts you to them. Well executed. Very reflective responses to audience feedback.
Very useful and helpful.
Amazing experience and deep insight. Definitely attend again.
Great round.
This was a really good round with excellent discussion and reflective opportunity to think about the process of Respect, and the human connection required for difficult conversation.
Very interesting and thought provoking discussion. Thank you.
The topic was very interesting.

This made me reflect deeply about Respect forms and how to have these discussions.
Great set up, good stories.
Fascinating session tackling some very tricky issues. The humanity of the storytellers shone through their reflections. Worthwhile discussion which will help the audience to reconsider how they deal with these kinds of scenarios. Thank you to everyone who participated.
I thought this Schwartz Round was exceptional and very helpful.
Really nice environment to share our worries. I really appreciated that people came to discuss my concerns with me afterwards. Thank you.
Interesting and engaging, always like to discover ways to help our medics.
Todays session was excellent and had a varied experience shared by all.
Excellent round. Lots of interesting discussion. Allowed me to reflect and have a better understanding of being new in a Trust. This has helped me know how to support others.
Didn't expect it to just be medics on the panel, was expecting it to be multiprofessional stories.
I found the session very useful and reflective. The discussions and reflections were beneficial. Brave panellists.
Really valuable experiences shared as NQ - good discussions and lessons learned where we can still improve and make a difference.
This was my first round, what can I say! Excellent! Excellent! Excellent!
Lessons learnt can be built into training sessions for students and supervisors.
Good to hear that new doctors feel the same as students so will help to improve inductions that we carry out with the pre-registration team.
Feel too medically focused. Could have done with Nursing, AHP, clerical etc. representation on the panel.
Thank you for your stories - some of your situations really related to my experiences. It would have been helpful to have stories from other disciplines - AHP, admin, porters etc.
Very well facilitated round with great interaction from the audience. Gained an insight into the difficulties menopause brings.
Interesting insight into current situation.
I thought it was very interesting.
Really enjoyed it. Don't usually come to Schwartz Rounds as difficult to get time from work so needs to be relevant to be allowed to attend. This was relevant. Thank you.
Very useful - thank you.
Very informative.
Provided a nice, open, welcoming space for everyone to share their thoughts.
Thoroughly enjoyed the meeting and found it helpful and insightful.
Was nice to hear other people's experiences and know your not the only one who is going through this.
Good representation on the panel and inclusion of a man on the menopause round.
Excellent topic and presentation and very informative. Really enjoyed it.
Thank you to the panel members, great to see such a positive male role model.
Very useful and insightful - will attend more in future.
Thought provoking. Generalised assumptions that people have and opinions, important to be non-judgemental.
Thank you.
Really insightful reflections. Well facilitated. Thank you.
Really insightful.
Yes would have been nice to hear from an adult carer (non-parent)
This round was really good to hear the experiences of staff struggling to be parents as well as health professionals. Lots of opportunity for us all to reflect.
My dad passed away only 4 weeks ago and I was his carer, all a bit raw for me to contribute. What I would have liked to have said is that it was important for me to be seen and told that I was more important than my role (which I was by both departments I work for). Now dealing with bereavement - getting older a woman's guilt doesn't get easier!
An excellent round that I felt I could relate to on so many levels. Nice to know the feeling of 'mom guilt' is felt by others and I'm not alone.
Excellent round - positive. Lots of discussion.
Very inspiring stories for wonderful causes.
I haven't been able to attend for a long time due to other commitments, but I am glad I could today. I was reminded that behind the staff member, we are all individual humans, that are working on overcoming adversity and our own issues. Patients / staff / members of the public - we all have our struggles and aims. It's good to be mindful of that.
Nice to end the year on a positive thank you.
Great to hear what our colleagues achieve outside of work, its all character building and experiences beyond work can help build relationships and connectivity with patients and colleagues.
Inspirational stories, incredibly strong minded staff members. Good advise on setting goals and how that can relate to your job.
Excellent, very motivational round.
Thanks all
Really useful topic for us all to reflect on
Good reflections on how others handle issues that arise in the working environment.
Thank you for sharing your stories, great space for reflection, and a relevant subject for everyone.
Thank you to all of the presenters, and organisers - a very thought provoking session.
For those of us not based at New Cross it is very positive to have the opportunity to attend virtually. While I could come across from The Gem Centre this involves either a 15 minute walk either way or playing parking roulette both trying to find a space at New Cross and again on return to The Gem Centre. In addition it adds significantly to the time I have to allocate to attend as I have to build in travel time. This is why I have not been able to attend before today. Thank you for providing the opportunity to attend virtually.
A great topic. Sometimes there can be a more subtle version of uncivility, which may be harder to address. As it may not have happened. The speakers were all great today and the session was really good. Thank you
This was my first experience of a Schwartz round and I found it very beneficial. I have had a few difficult months and can relate to how colleagues feel and its very sad to hear this is how people feel across the Trust. I have been in Healthcare for 30 years and have never experienced a culture like this. I have recently been offered support and CBT which I will pursue.
Was really interesting to her from staff roles different to myself & the challenges being faced.
A good safe space
Excellent round, relevant and current topic
This round made me think about what I say and how I receive information. I liked the comment about asking someone if they are ok, it may inflate the situation, de-escalation may be advantageous
I felt that the round was effective from the point of view that people were able to share traumatic experience but that we needed to move towards more positive support having aired those experiences. I think that psychologically, this might not have been a positive airing for some people
Good discussion, honest expressions of feelings and emotions and proper discussion
I enjoyed it and it shines a light on what we deal with every single day, i now want to investigate further some training in this topic

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board on 12th December 2023		
Title of Report:	Research & Development Report	Enc No: 10.8.3
Author:	Pauline Boyle, Group Director of Research and Development	
Presenter/Exec Lead:	Pauline Boyle, Group Director of Research and Development	

Action Required of the Board/Committee/Group
Discussion Yes☒No☐
Recommendations: The Trust Management Committee is asked to note the contents of this report.

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: 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
	Life Sciences Vision	Yes☒No☐	Details: Research to address the Country's health, wealth, and resilience
CQC Domains	Well-led		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	None		
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

- Several workstreams have been identified to support the positive culture of research across the organisation.
- Research activity to date in 2023/24 as per strategic objectives and NIHR High Level Objectives.
- Research Scholarship awarded to Dr Sandeep Hothi.
- All publications generated by staff will be reported.
- Director interviews for the new Regional Research Delivery Network took take place 20 September.
- RWT has agreed to Host the Regional Research Leadership Office for the West Midlands, in addition to Hosting the West Midlands Regional Research Delivery Network.
- University collaborations continue to grow.
- Research Department representatives attended Black Country Provider Collaborator Summit in October.
- A joint Research Celebration event was held for RWT and WHT on 15th September.
- A draft five-year research strategy will be presented at the next TMC meeting.
- The Group Director for Research and Development has met with the research teams at The Dudley Group of Hospitals and Sandwell and West Birmingham who have agreed to work collaboratively across the Black Country.

Advise

- Research activity update.
- Following a recruitment process, we were unable to appoint to the Professor of Midwifery and Professor of Nursing positions. We plan to readvertise for Associate Professor positions.
- The time taken to recruit patients to commercial studies has steadily reduced from an average of 578 days to 136 days (target is 70 days).
- Impact of pandemic has resulted in reduced commercial activity and income. Risk included in Directorate Risk Register. The number of commercial studies opening has increased since April 2023.f
- The research team have experienced difficulty in booking suitable rooms for commercial sponsor companies to visit the Trust for site initiation meetings – potential for reputational risk.
- The number of enquiries from Trust researchers for advice and sponsorship support continues to increase.

Alert

- Recruitment is currently behind 2018/19- and 5-year average performance. Resources have been diverted to prioritise commercial activity. We currently have commercial studies in the pipeline for Oncology, Haematology, Rheumatology, Respiratory, Ophthalmology and Cardiology.
- The time taken to set up studies is behind the national target but has decreased significantly. Some delays are outside of our control however, we have reviewed our process and made changes. This review is under constant scrutiny, and we now have an escalation process in place, should studies be at risk of delays in set up.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement. • We will deliver financial sustainability by focusing investment on the areas

	that will have the biggest impact on our community and populations.
Support our Colleagues	• Improve 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. • Implement technological solutions that improve patient experience. • Progress joint working across Wolverhampton and Walsall. • Facilitate research that improves the quality of care.

Research & Development Report

Report to Trust Management Committee to be held on 24th November 2023

EXECUTIVE SUMMARY

This report is to inform the Trust Management Committee (TMC) of research activities at The Royal Wolverhampton NHS Trust.

The information provided will focus on:

- Number of Studies open, in set up and in the pipeline (Appendix 1, charts 2.1 & 2.2))
- Number of Home-Grown Studies (Appendix 1, chart 3)
- Recruitment by Specialty (Appendix 1, table 1 & Appendix 2))
- Recruitment over the previous 5 years (Appendix 2)
- Academic developments (Summary)
- Responsibilities as Host of Regional Research Delivery Network (Summary)

BACKGROUND INFORMATION

- The recent Lord O'Shaughnessy report articulated the decline of commercial activity within the UK and the detrimental impact upon both opportunities for our patients as well as a significant loss of income. The Royal Wolverhampton NHS Trust has prioritised trials that meet the needs of our population, those that can offer new novel treatments as well as income generating.
- This R&D report reflects research activity currently being undertaken within the Trust. Recruitment is behind our 2018/19- and 5-year average performance. Research recruitment is above the five-year average in the following specialities:
    - Cancer
    - Hepatology
    - Paediatrics
    - Musculoskeletal Disorders

- Renal

- The study set up process have been revised and the number of studies opening has increased significantly with thirty-six studies open this financial year, of which ten (28%) are commercial. The R&D team aim to confirm studies within 30 days of receiving a full study pack and commencing the assess, arrange and confirm process. Timelines have been adversely impacted by lack of engagement from sponsor, however the team have made significant changes to process to decrease the time it takes to set up a study.
- The average time period from site selection to first participant recruited has also decreased over the past few months from 578 days in June ’23 to 136 days in October ’23 for commercial studies and 122 days in June ’23 to 106 days in October ’23 for non-commercial studies.
- The Trust continues to support home grown research (research undertaken by staff) and has seen a rise in the number of grants awarded.
- Research Celebration event was held on the 15th of September attendance from across RWT & WHT.
- The Trust is committed to developing relationships with academic partners and potential collaboration discussions are ongoing. A second meeting with Aston University took place on 10 October.
- The Trust continue to work closely with Wolverhampton University to support the current Professoriates as well new appointments and new studies.
- The Trust continues to work with Birmingham University on joint appointments and new studies.
- The Trust continues to work with Keele University and has recently published a paper on this collaboration.
- Through a competitive process Dr Sandeep Hothi has successfully been awarded a two-year Research Scholarship by the NIHR Clinical Research Network.
- In collaboration with the library service, we will routinely report on new publications generated by our staff. 197 publications have been submitted by RWT staff to date in 2023. These can be accessed directly via the following link to the RWT Publications Repository: https://rwt.dspace-express.com/
- Following a strategy development day, a draft five-year strategy will be presented at the next meeting.
- As Host of the new Regional Research Delivery Network, we are required to appoint a Director for the new network. Competitive interviews took take place on 20 September 2023.
- The slow recovery of commercial study activity at national level has resulted in significant reduction in commercial income and remains a significant risk for 2023/24. R&D Directorate are focused on an ambitious programme of capacity review and planning to tackle these challenges. Participation in research brings financial benefits to the Trust and partner health providers via direct income, free of charge provision of standard care medication for trial participants and also through indirect savings resulting from patients following research pathways, drug and treatment costs. Research income is received from the R&D department by a number of Trust services

(Labs/Pharmacy/Radiology/Chemotherapy and Radiotherapy) to fund staff costs for research support. The collective value of this to date in 2023/24 is £235k.

Mechanisms are being put in place to capture the savings gained by research activity – information will be available in the next report.

- The following risks are being managed within the R&D Directorate:

  1. R&D Accommodation – current R&D accommodation, including lack of adequate clinical facilities, impacting on the ability deliver clinical research. Risk Level: Amber.

Action: Discussions ongoing regarding provision of a new facility which supports the Trusts clinical research ambitions.

2. Reduction in commercial research income – reduction at national, and local level. Consequent severe cost pressure within R&D, with the potential to destabilise Trust research activity. Risk Level: Amber

Action: The reduction in commercial research income remains a significant risk for 2023/24. The R&D Directorate are undertaking a capacity, resilience, and growth review to address these challenges. Trust finance team putting in place programme of work to ensure robust financial systems for R&D moving forward.

RECOMMENDATIONS

- Focus on commercial research activity in response to O'Shaughnessy report and to bring income into the Trust.
- Ongoing review of study set-up and recruitment metrics to ensure compliance with NIHR HLOs.
- Continue to collaborate with academic partners to support our workforce.

Any Cross-References to Reading Room Information/Enclosures:

Appendix 1 – 2023/24 Research Activity Data

Appendix 2 - HLO Report

The Royal Wolverhampton NHS Trust

2023/24 Research Activity Data

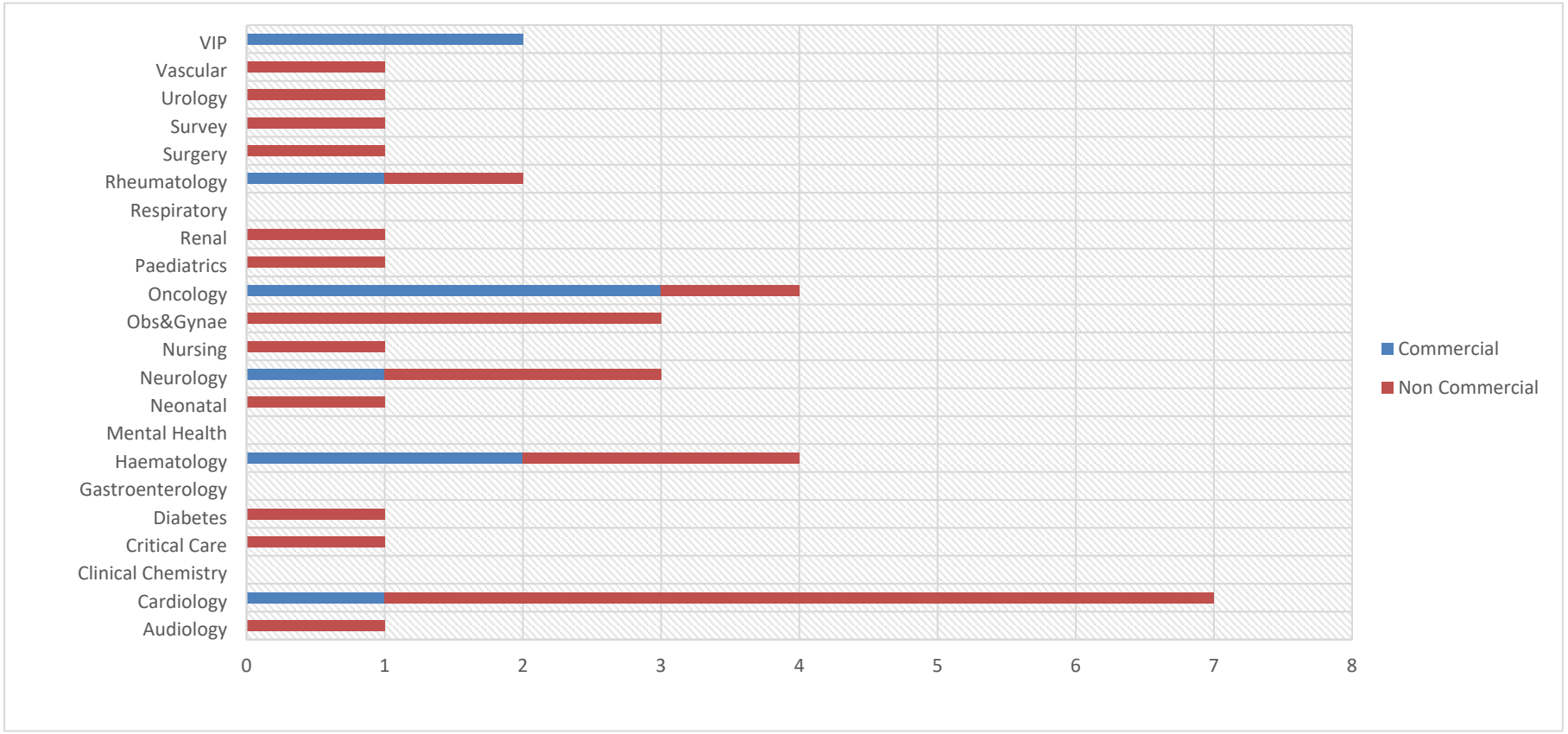
1 Research Recruitment 2023/24

880 participants have been recruited across 62 studies between 1/4/2022 to 31/10/2023. All recruits are into NIHR portfolio studies. The following table provides details:

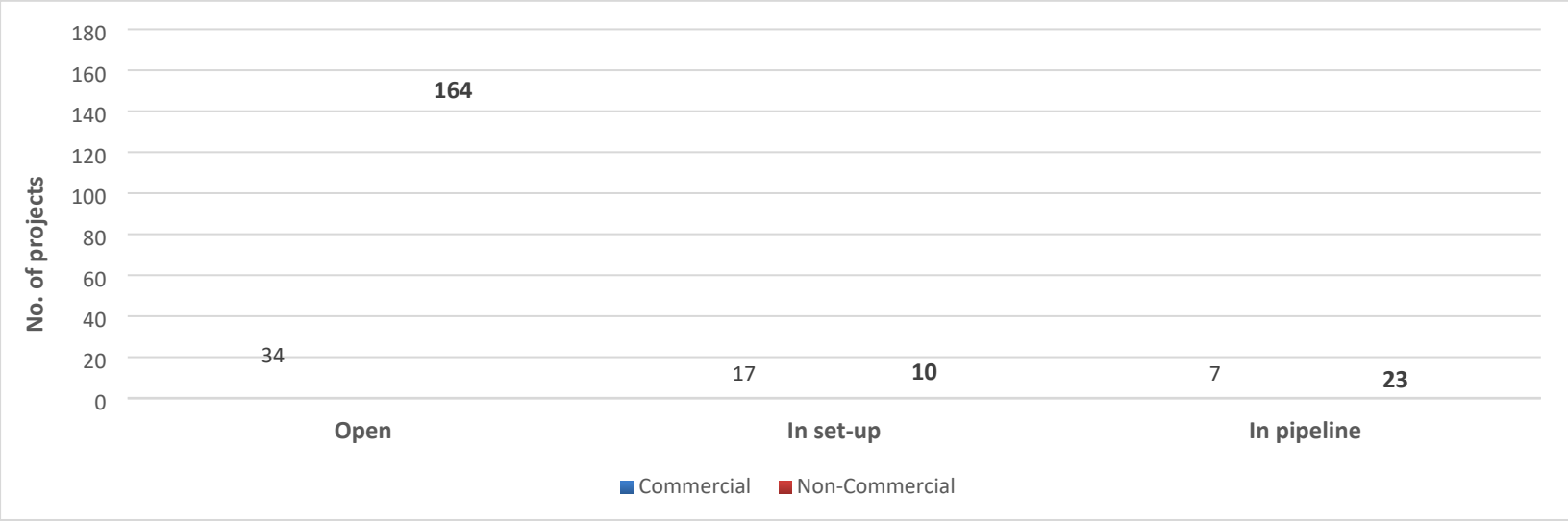
Specialty	**Recruits per Study Type / (No. of recruiting studies)**					**Total**
	Portfolio Non-Commercial	**Portfolio Commercial**	**Non-Portfolio Non-Commercial**	**Non-Portfolio Commercial**	**Trust Sponsored (Own Account)**	
A&E						
Cardiothoracic	91 (7)	6 (1)			4 (1)	**101 (9)**
Diabetes						
Gastroenterology	54 (6)				16 (1)	**70 (7)**
Haematology	7 (4)	8 (3)			15 (1)	**30 (8)**
ICU	5 (3)					**5 (3)**
Neonatal	22 (2)					**22 (2)**
Neurology/Stroke	4 (2)	18 (1)				**22 (3)**
Nursing						
Obstetrics	186 (6)					**186 (6)**
Oncology	5 (3)	4 (3)				**9 (6)**
Ophthalmology	1 (1)					**1 (1)**
Paediatrics	14 (2)					**14 (2)**
Primary Care	18 (2)					**18 (2)**
Renal	187 (2)	1 (1)				**188 (4)**
Respiratory						
Rheumatology	178 (6)	1 (1)				**179 (7)**
Surgery	27 (1)					**27 (1)**
COVID						
Corporate						
Total	**807 (49)**	**38 (10)**			**35 (3)**	**880 (62)**

The Royal Wolverhampton NHS Trust

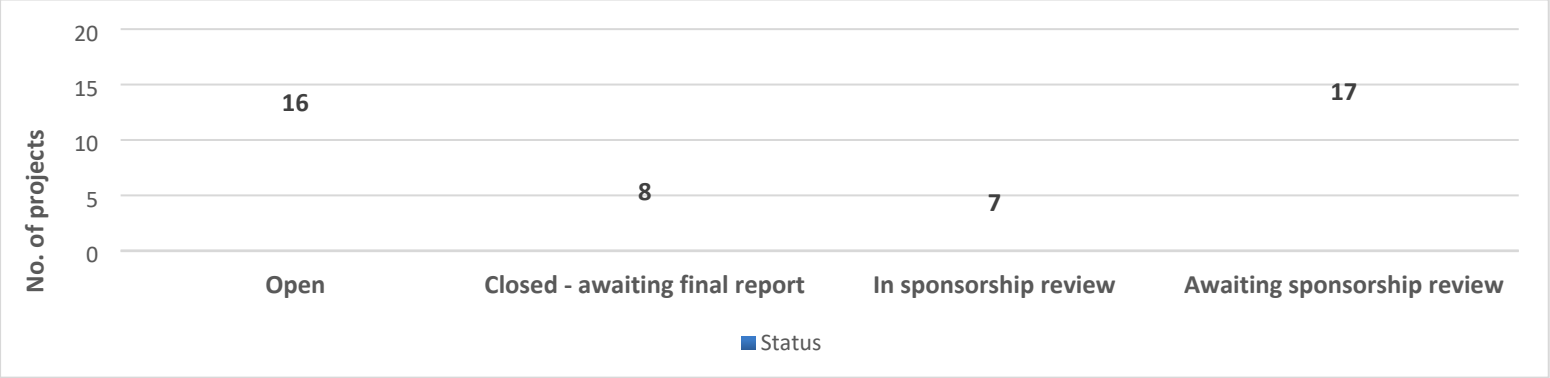
2.1 New Studies opened 2023/24 by specialty @ 31/10/2023



2.2 Project status @ 31/10/2023



3. Trust Led/Sponsored research



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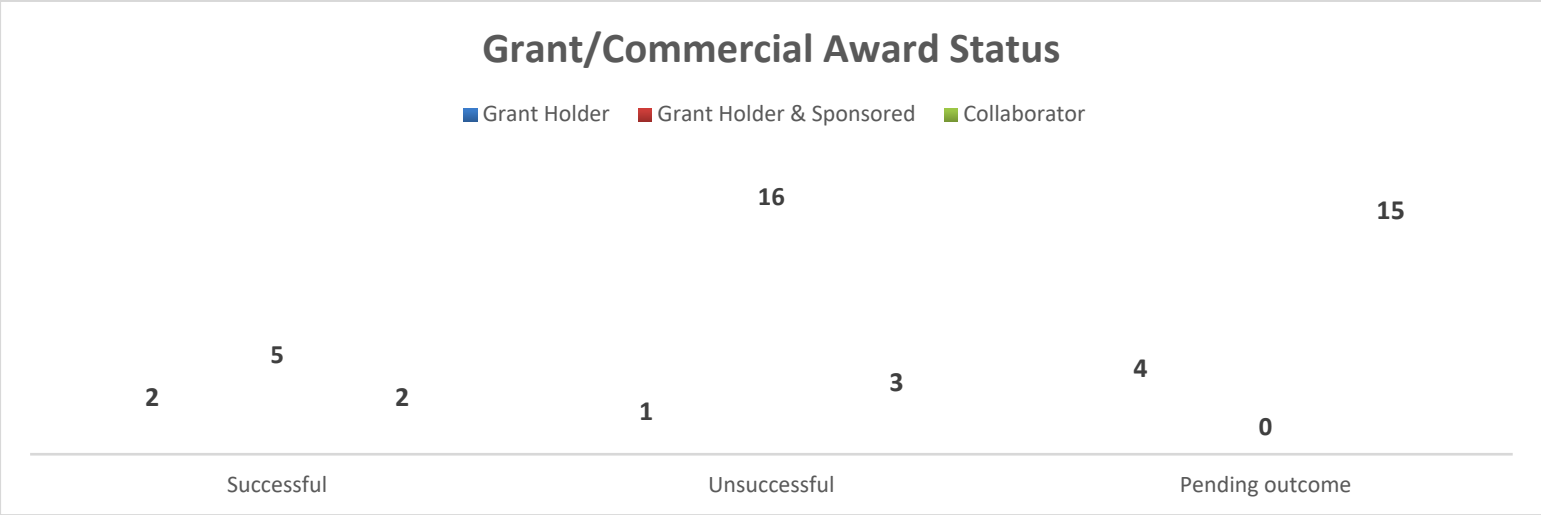
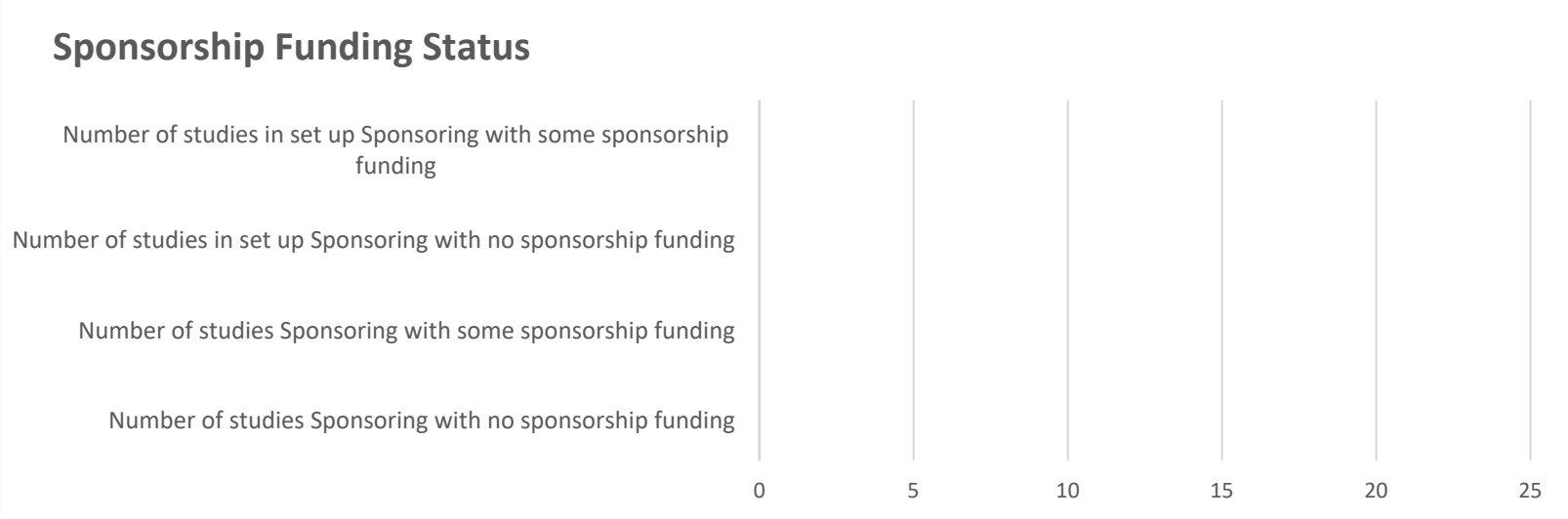
The below table shows current grant funding status of Trust-led studies:



The below table shows proportion of studies with external funding for sponsorship:



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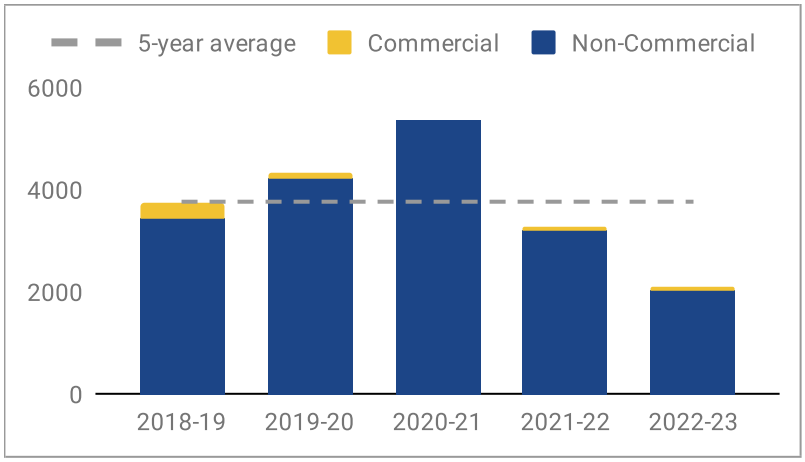
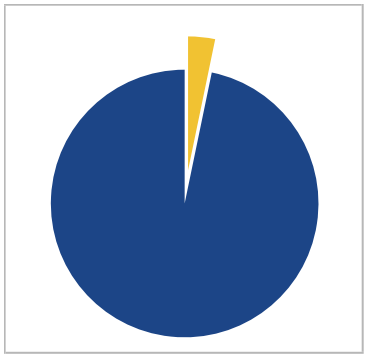
Data as at 13/11/2023

Activity Overview for RWT: https://lookerstudio.google.com/s/mdwkxUWQkR8

Recruitment over previous 5 years

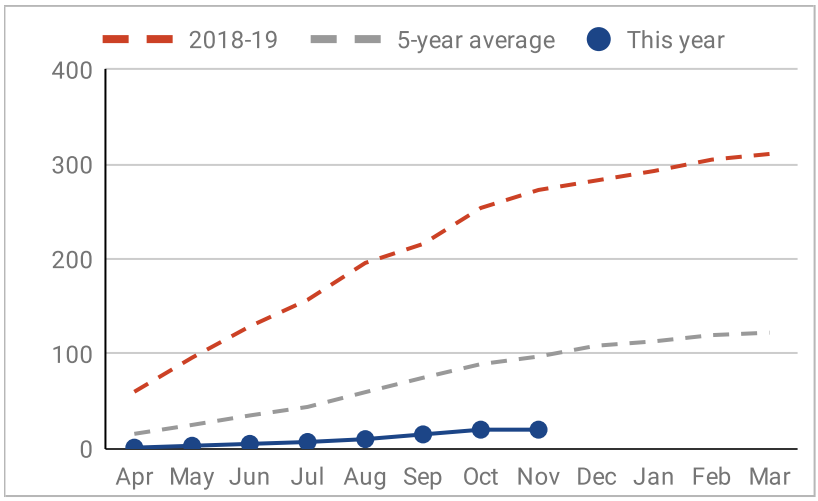


Average **3,765** per annum



3% commercial recruitment over 5 years

2023-24 Commercial — 20 recruits

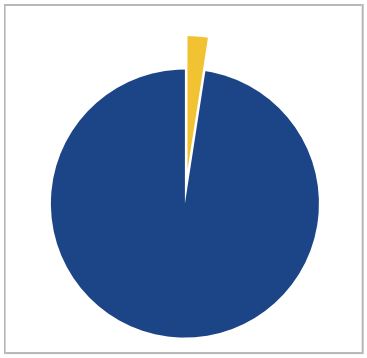


2018-19	311
5-year average	122

Pro rata to end of last month

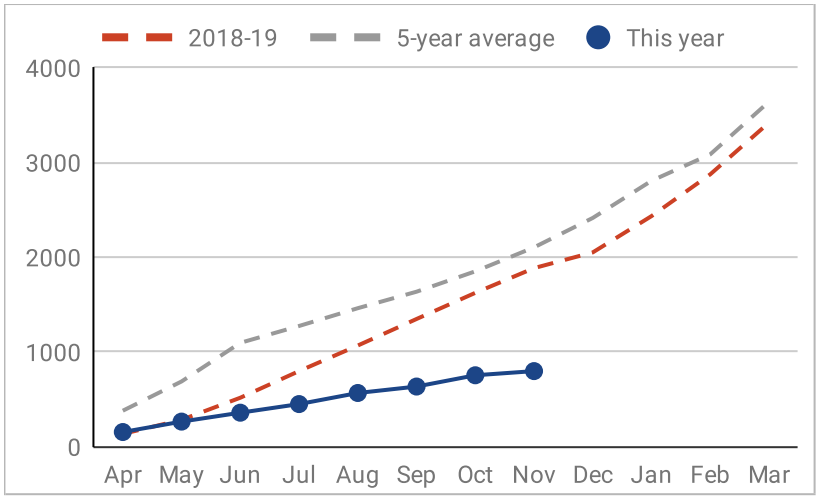
92% behind 2018-19

78% behind 5 year average



2% commercial recruitment so far this year

2023-24 Non-commercial — 799 recruits



2018-19	3,422
5-year average	3,643

Pro rata to end of last month

54% behind 2018-19

59% behind 5 year average

Recruitment by Specialty (counted to end of October)

	Pro rata to end of month 7			2023-24 compared with	
	2018-19	5yr avg.	2023-24	2018-19	5yr avg.
Ageing	0	0	**0**		
Anaesthesia, Perioperative Medicine and P	0	8	**0**		-100%
Cancer	68	47	**54**	-21%	15%
Cardiovascular Disease	396	164	**101**	-74%	-38%
Children	77	24	**30**	-61%	25%
Critical Care	0	6	**5**		-17%
Dementias and Neurodegeneration	3	0	**0**	-100%	
Dermatology	36	7	**0**	-100%	-100%
Diabetes	13	9	**0**	-100%	-100%
Ear, Nose and Throat	0	0	**0**		
Gastroenterology	268	181	**15**	-94%	-92%
Genetics	88	17	**0**	-100%	-100%
Haematology	4	3	**1**	-71%	-67%
Health Services Research	100	23	**0**	-100%	-100%
Hepatology	5	8	**32**	510%	300%
Infection	29	619	**0**	-100%	-100%
Mental Health	0	5	**1**		-80%
Metabolic and Endocrine Disorders	4	0	**0**	-100%	
Musculoskeletal Disorders	179	120	**147**	-18%	23%
Neurological Disorders	1	2	**0**	-100%	-100%
Ophthalmology	9	11	**1**	-89%	-91%
Oral and Dental Health	235	272	**0**	-100%	-100%
Primary Care	0	0	**0**		
Public Health	0	0	**0**		
Renal Disorders	26	31	**188**	616%	506%
Reproductive Health and Childbirth	538	460	**163**	-70%	-65%
Respiratory Disorders	5	4	**0**	-100%	-100%
Stroke	23	16	**4**	-82%	-75%
Surgery	4	46	**31**	786%	-33%
Trauma and Emergency Care	68	99	**2**	-97%	-98%

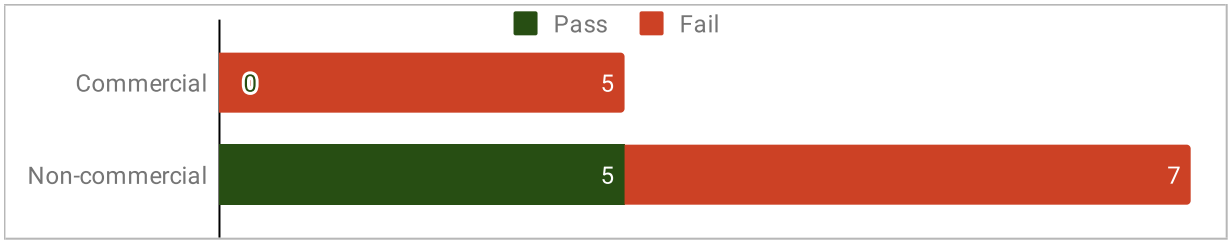
Study Startup

	Commercial	Non-commercial
Number of sites opened this financial year	9	18
Sites with first recruit in this financial year (even if opened in previous years)	4	19
Median days from "Selected" to "1st recruit" (Target: 70 days)	136	106
Number of Open studies with zero recruitment to date (regardless of open date)	8	14

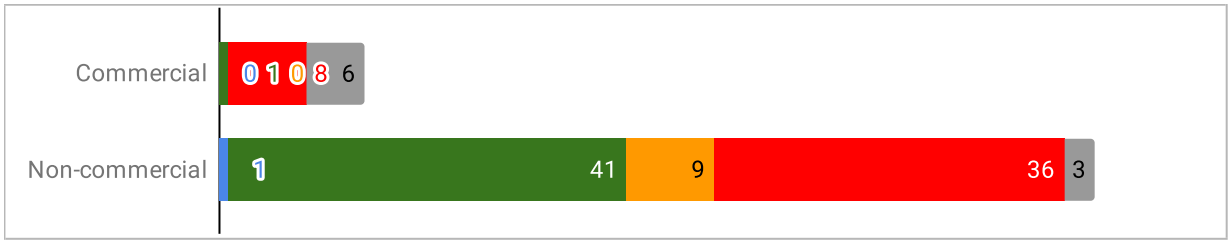
Efficient Study Delivery - Recruitment to Target

Based on data in ODP. Site-level metrics are not affected by Reset.

Sites already closed this year



No of Open sites by RAG rating



Target achieved | Recruitment >= pro rata target | >= 70% of pro rata target | < 70% of pro rata target | Missing data

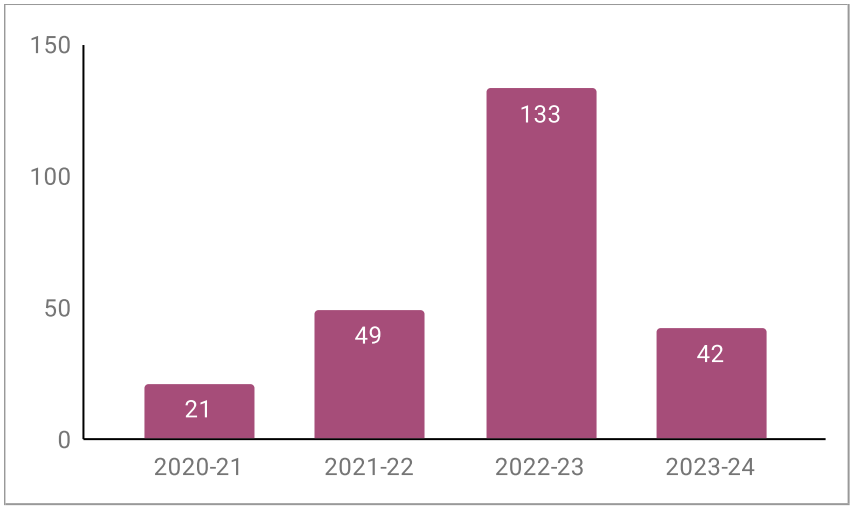
Reset

0	Sponsored studies in Reset (open, in setup or suspended)

Study-level status, showing the "Agreed Intention" between Sponsor and Funder

On track	0
In discussion with Funder	0
Off track	0
Blank	0

PRES Responses



PRES report for RWT:

https://lookerstudio.google.com/s/h40XdYcvf54

The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting – to be held in Public On Tuesday 12th December 2023		
Title of Report:	Chief Operating Officer Report	Enc No: 10.9
Author:	Gwen Nuttall – Chief Operating Officer	
Presenter/Exec Lead:	Gwen Nuttall – Chief Operating 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: Multiple risk on TRR relevant to the papers and are indicated on the front sheet. On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None No Change to BAF SR16 Risk Description Is Risk on Risk Register: Yes☒No☐ Risk Score (if applicable): BAF SR16		
Resource Implications:	(if none, state 'none') none Revenue: Capital: Workforce: Funding Source:		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Well Led, Safe, Responsive, Effective
	NHSE	Yes☐No☐	Details:
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details:Civil Contingencies Act
CQC Domains	**Safe: Effective: Caring: Responsive: Well-led:**		

The Royal Wolverhampton NHS Trust

Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate. Please provide an example/demonstration:		
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:P&F Nove 23, TMC Nove 23
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure Reduction in Cancer backlog (patients waiting over 62 weeks) Reduction in the numbers of patients waiting over 65 weeks for appointment or treatment.
Advise Trust has received partial assurance for EPRR Core Standards Winter Plan actions all implemented.
Alert Deterioration in ambulance handover delays.

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

The Royal Wolverhampton NHS Trust

Report of the Chief Operating Officer
Report to the Trust Board Meeting to be held in Public on Tuesday 12th December 2023.

Executive Summary

This report cover the following reports

- Winter Plan
- Integrated Quality Performance Report
- Emergency Preparedness, Response and Resilience
- Trust Management Committee

Background Information

Winter Plan

- All actions are underway as described in October Board Report and aligned with national expectation against key performance metrics and the implementation of the High Impact Priority Interventions
- Winter Actions from Wolverhampton Place are included in the reading room.
- Deterioration in ambulance handover in October, recovery actions are underway.
- Bed mitigation plan still rated as Amber/Red.
- Additional Paediatric capacity has opened earlier than planned due to pressures.

Integrated Quality Performance Report

- Improvement in patients waiting longer than 78 and 65 weeks for treatment
- Improvement in the numbers of patients waiting over 62 days for cancer treatment.
- Metrics for Out of Hospital, contained in the report and now discussed in depth at the Integration Committee.

Emergency Preparedness, Response and Resilience

- Trust submitted self-assessment in August 23.
- Peer reviewed by ICB and Regional Emergency Planning Response Team
- Significant challenge has resulted in an agreed self-assessment score of partial compliance.

Trust Management Committee

- Key discussion and debate related to performance, finance, patient safety and governance
- Summary notes of meetings are included in the reading room

Recommendation

The Board are asked to note the content of this high level report. Detailed reports have either been discussed on the agenda (Winter Plan and IQPR) or are contained within the reading room.

Other item to note in the reading room, One Wolverhampton Winter Plan update for Nove 23.

The Royal Wolverhampton NHS Trust

Report to the Trust Board to be held in Public on 12 December 2023		
Title of Report:	Emergency Preparedness, Response & Resilience (EPRR) Annual Assurance 2023 – 2024	Enc No: 10.9.1
Author:	Head of Emergency Preparedness, Response & Resilience (EPRR)	
Presenter/Exec Lead:	Chief Operating Officer / Deputy Chief Executive	

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

Recommendations:

The Board is asked to note the contents of the report for assurance for 2023 - 2024 and actions to be undertaken to ensure the Trust becomes fully compliant with the EPRR core standards in 2024 – 2025.

Implications of the Paper:			
Risk Register Risk	Yes ☒ No ☐ Risk Description: 1542 Failure to comply with the Civil Contingencies Act 2004, resulting in the Trust not having effective planning arrangements in place to respond to emergency situations and the Trust's inability to respond with a potential impact on patient care/safety. Potential adverse media attention due to Trusts inability to respond, resulting in reputational impact on the Trust and litigation. On Risk Register: Yes☒No☐ Risk Score: 6 (Yellow)		
Changes to BAF Risk(s) & TRR Risk(s) agreed.	None		
Resource Implications:	None		
Report Data Caveats	N/A		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Safe: Effective: Caring: Responsive: Well-led:
	NHSE	Yes☒No☐	Details: EPRR Framework & EPRR Core Standards
	Health & Safety	Yes☒No☐	Details:
	Legal	Yes☒No☐	Details: Civil Contingencies Act 2004

	NHS Constitution	Yes☒No☐	Details: • Equality of treatment and access to services • High standards of excellence and professionalism • Cross community working • Accountability through local influence and scrutiny
	Other	Yes☐No☒	Details:
CQC Domains	Safe: Effective: Caring: Responsive: Well-led:		
Equality and Diversity Impact	In being awarded the Race Code mark, the Trust agreed to increase its awareness and action in relation to the impact of Board & Board Committee business on people with reserved characteristics. Therefore, the Committee must consider whether anything reviewed might result in disadvantaging anyone with one or more of those characteristics and ensure the discussion and outcome is recorded in the minutes and action taken to mitigate or address as appropriate.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date:17 November 2023
	Board Committee	Yes☒No☐	Date:TMC 24 November 2023
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure The Trust self-assessment against the core standards was for substantial compliance. The Trust has a degree of compliance, full or partial against all the 62 assessed standards.
Advise Following external review of the self-assessment standards the recommendation was that the Trust scored partial compliance against some of the standards and overall, the external recommendation and assessment is for that to be reported to the Trust Board.
Alert The Chemical / Biological suits to be worn in any major incidents where chemicals or other biological substances are suspected will need replaced in the next 12 months and there will be financial implication., not currently budgeted for incurred.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	1. Embed a culture of learning and continuous improvement. 2. Safe and responsive urgent and emergency care
Support our Colleagues	a) Improve overall staff engagement.
Improve the Healthcare of our Communities	NA
Effective Collaboration	a) Improve population health outcomes through provider collaborative.

The Royal Wolverhampton NHS Trust

Emergency Preparedness, Response & Resilience (EPRR) Annual Assurance 2023 – 2024

Report to Board to be held in Public on 12 December 2023.

EXECUTIVE SUMMARY

All NHS Organisations are required to undertake an annual assurance process involving a self-assessment against the EPRR core standards and a deep dive; for 2023 – 2024 the deep dive is in Training.

The Trust submitted their completed self-assessment in August 23 to the ICB and following their review and assessment, took part in a series of confirm and challenge sessions, firstly with the ICB and subsequently with both the ICB and NHS EPRR. The review of the submission and self-assessment were completed by 26 October 2023. Following this, the local health resilience partnership (LHRP) will peer review this process to confirm self-assessment and ICB/NHS EPRR review and the outcome of this is anticipated to be completed by 29 November 2023.

On submission in August 23, the Trust self-assessed itself as substantially compliant. Post submission the Trust has been challenged by the ICB and the regional NHS EPRR Team on that self-assessment and the degree of compliance on several standards. As stated, the Trust's own assessment was one of substantial compliance, the NHS EPRR assessment was originally returned as non-compliant.

The Trust, in conjunction with the ICB, reviewed the NHS EPRR assessment and following challenge from the Trust and submission of further evidence, the initial non-compliant assessment has been reviewed and is proposed to be accepted at 77%, partially compliant.

The Trust was assessed against 62 core standards and is deemed fully or partially compliant with all the standards. No standards are non-compliant.

The detailed updated EPRR core standards position, along with key actions, post the confirm and challenge sessions is set out in Appendix 1, along with the assurance ratings criteria in Appendix 2.

BACKGROUND INFORMATION

All NHS Organisations are required to undertake a self-assessment against the 62 EPRR core standards for 2023 – 2024, the outcome of which should be shared in public, once agreed with Integrated Care Boards (ICB) and NHSE EPRR Team and the Local Health Resilience Forum (LHRP)

Integrated Care Boards (ICBs) are required to work with their organisations and Local Health Resilience Partners (LHRP) to agree a process to gain confidence with organisation ratings and provide an environment that promotes the sharing of learning and good practice.

NHS England regional heads of EPRR are required to submit the assurance ratings for each of their organisations and a description of their regional process before December 2023.

These core standards are the basis of the EPRR annual assurance process, which the Trust must assure themselves against these standards.

For this year's submission, there were ten core domains:

1. Governance
2. Duty to assess risk.
3. Duty to maintain plans.
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10. Hazmat/CBRNe, Hazardous Material/Chemical biological radiological nuclear and explosives.

The Trust was also required to undertake a 'Deep Dive' review to gain additional assurance into a specific area. For 2023 – 2024 it was Training.

RECOMMENDATIONS

To receive as assurance and note the outstanding actions to be undertaken to ensure the Trust is fully compliant with the EPRR core standards in 2024.

Reading Room Information & enclosures:

- Emergency Preparedness, Resilience and Response (EPRR) annual assurance guidance July 2023.
  NHS England » Emergency preparedness, resilience, and response: annual assurance

- Emergency Preparedness, Resilience and Response (EPRR) Core Standards July 2023.
  NHS England » Emergency preparedness, resilience, and response: core standards

- NHS Emergency Preparedness, Resilience and Response Framework updated June 2022 updated Sept 2023
  NHS England » NHS Emergency Preparedness, Resilience and Response Framework

Appendix 1 – EPRR Core standards self-assessment position agreed with ICB.

Appendix 2 – Organisation assurance ratings produced by NHSE.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
Domain 1 - Governance					
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations
Domain 2 - Duty to risk assess					
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain Plans					
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.
Domain 5 - Training and exercising					
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board
Domain 6 - Response					

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
Domain 8 - Cooperation					
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
Domain 9 - Business Continuity					
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 10 - CBRN					
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART										
Domain: Capability										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through periods of significant local or regional demand pressure.	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies.	Y						
H5	**HART**	**Protected training hours**	l Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H6 Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing Physical Competency Assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. The Trust must then implement appropriate support for individuals on a restriction of practice.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.	Y						
Domain: Administration										
H12	**HART**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H13	**HART**	**Identification appropriate incidents / patients**	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.	Y						
H14	**HART**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
H15	**HART**	**Recording resource levels**	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
H16	**HART**	**Record of compliance with response time standards**	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y						
H17	**HART**	**Local risk assessments**	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H18	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H19	**HART**	**Safety reporting**	Organisations must have a robust and timely written process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 24 hours of the risk being identified.	Y						
H20	**HART**	**Receipt and confirmation of safety notifications**	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	Y						
H21	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										

H22	**HART**	**Initial deployment requirement**	Four HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						
H23	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.	Y						
H24	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel onlscene at strategic sites of interest within 45 minutes. These sites were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their IRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						
H25	**HART**	**HART Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region	Y						
Domain: Logistics											
H26	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).	Y						
H27	**HART**	**Interoperable equipment**	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.	Y						
H28	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.	Y						
H29	**HART**	**Fleet compliance with national specification**	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.	Y						
H30	**HART**	**Equipment maintenance**	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).	Y						
H31	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H32	**HART**	**Capital estate provision**	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y						
SORT Domain: Capability											
S1	**SORT**	**Maintenance of national specified MTFA capability**	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.	Y						
S2	**SORT**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	Y						
S3	**SORT**	**Interoperability**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.	Y						
S4	**SORT**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).	Y						
Domain: Human Resources											
S5	**SORT**	**SORT establishment**	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non□compliant.	Y						
S6	**SORT**	**Completion of a Physical Competency Assessment**	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.	Y						
S7	**SORT**	**Staff competency**	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Y						

S8	**SORT**	**Training records**	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.	Y							
S9	**SORT**	**Provision of clinical training**	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.	Y							
S10	**SORT**	**Staff training requirements**	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	Y							
S11	**SORT**	**Arrangements to manage staff exposure and contamination**	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.	Y							
S12	**SORT**	**CBRN Lead trainer**	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.	Y							
S13	**SORT**	**FFP3 access**	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).	Y							
S14	**SORT**	**IOR training for operational staff**	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).	Y							
Domain: Administration											
S15	**SORT**	**Effective deployment policy**	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).	Y							
S16	**SORT**	**Identification appropriate incidents / patients**	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).	Y							
S17	**SORT**	**Change Management Process**	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.	Y							
S18	**SORT**	**Record of compliance with response time standards**	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators on request.	Y							
S19	**SORT**	**Notification of changes to capability delivery**	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y							
S20	**SORT**	**Recording resource levels**	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y							
S21	**SORT**	**Local risk assessments**	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y							
S22	**SORT**	**Lessons identified reporting**	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.	Y							
S23	**SORT**	**Safety reporting**	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.	Y							
S24	**SORT**	**Receipt and confirmation of safety notifications**	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.	Y							
S25	**CBRN**	**HAZMAT / CBRN plan**	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.	Y							
S26	**SORT**	**SORT Audit and inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.	Y							
S27	**SORT**	**SORT capability funding**	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.	Y							
Domain: Response time standards											
S28	**SORT**	**SORT Readiness to deploy**	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.	Y							
S29	**SORT**	**SORT response time**	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y							

S30	**SORT**	**SORT Mutual Aid**	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.	Y							
Domain: Logistics											
S31	**SORT**	**PPE availability**	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).	Y							
S32	**SORT**	**Equipment procurement via national buying frameworks**	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.	Y							
S33	**SORT**	**Equipment maintenance**	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.	Y							
S34	**SORT**	**SORT asset register**	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national Equipment Data Sheets. The register must include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y							
S35	**SORT**	**PRPS - minimum number of suits**	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y							
S36	**SORT**	**Individual / role responsible for SORT assets**	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.	Y							
S37	**SORT**	**CBRN countermeasures**	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).	Y							
S38	**SORT**	**Water supply for clinical decontamintion**	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.	Y							
S39	**SORT**	**Equipment Vehicles**	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available spilt over the organisations geographical area based on a local Trust assessment of risk.	Y							
S40	**SORT**	**Equipment vehicle readiness**	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene.	Y							
S41	**SORT**	**Vehicle Tracking**	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident.	Y							
Mass Casualty Capability **Domain: Capability Alignment Standards**											
M1	**MassCas**	**Mass casualty response arrangements**	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.	Y							
M2	**MassCas**	**Arrangements to work with NACC**	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.	Y							
M3	**MassCas**	**EOC arrangements**	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared.	Y							
M4	**MassCas**	**Casualty management arrangements**	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y							
M5	**MassCas**	**Casualty Clearing Station arrangements**	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation.	Y							
M6	**MassCas**	**Management of non NHS resource**	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y							
M7	**MassCas**	**Mass Cas Audits and Inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England.	Y							
Domain: Mass Casualty Equipment											
M8	**MassCas**	**MCV accommodation**	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability.	Y							
M9	**MassCas**	**Maintenance and insurance**	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty Officer informed.	Y							
M10	**MassCas**	**Mobilisation arrangements**	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) assets maintain a 30-minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non operational.	Y							
M11	**MassCas**	**Mass oxygen delivery system**	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance).	Y							
M12	**MassCas**	**Drug and pharmaceutical stock management**	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.	Y							
M13	**MassCas**	**Fleet compliance with national specification**	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.	Y							
M14	**MassCas**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.	Y							
Command and control (C2) **Domain: Generic Standards**											
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England.	Y							
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the National Command and Control Guidance published by NARU.	Y							
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS ambulance strategic commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y							
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y							
Domain: Resource											

C5	C2	Command role availability	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.	Y						
C6	C2	Support role availability	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.	Y						
C7	C2	Recruitment and selection criteria	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	C2	Contractual responsibilities of command functions	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.	Y						
C9	C2	Access to PPE	The NHS Ambulance Trust must ensure that each commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.	Y						
C10	C2	Suitable communication systems	The NHS Ambulance Trust must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	C2	Risk management	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles.	Y						
C12	C2	Use of JESIP JDM	NHS ambulance commanders at all levels must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	C2	Command decisions	NHS ambulance command decisions at all three levels must be made within the context of the legal and professional obligations set out in the National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work provisions.	Y						
Domain: Record keeping										
C14	C2	Retaining records	All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	C2	Decision logging	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs.	Y						
C16	C2	Access to loggist	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one operational commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for additional logs to be kept by non:trained loggists should the need arise.	Y						
Domain: Learning Lessons										
C17	C2	Lessons identified	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP.	Y						
Domain: Competence										
C18	C2	Strategic commander competence - National Occupational Standards	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.	Y						
C19	C2	Strategic commander competence - nationally recognised course	Personnel that discharge the strategic commander function must have successfully completed a nationally recognised strategic commander course (nationally recognised by NHS England / NARU). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C20	C2	Tactical commander competence - National Occupational Standards	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.	Y						
C21	C2	Tactical commander competence - nationally recognised course	Personnel that discharge the tactical commander function must have successfully completed a nationally recognised tactical commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C22	C2	Operational commander competence - National Occupational Standards	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their command.	Y						
C23	C2	Operational commander competence - nationally recognised course	Personnel that discharge the operational commander function must have successfully completed a nationally recognised operational commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C24	C2	Commanders - maintenance of CPD	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the minimum requirements for the role.	Y						

C25	C2	Commanders - exercise attendance	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.	Y						
C26	C2	Training and CDP - suspension of non-compliant commanders	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y						
C27	C2	Assessment of commander competence and CDP evidence	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake 'dip sampling' of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.	Y						
C28	C2	NILO / Tactical Advisor - training	Personnel that discharge a NILO or Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	C2	NILO / Tactical Advisor - CPD	Personnel that discharge the NILO or tactical advisor function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to:date competence in the NILO or tactical advisor discipline.	Y						
C30	C2	Loggist - training	Personnel that discharge the loggist function must have completed a loggist training course which covers the elements and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C31	C2	Loggist - CPD	Personnel that discharge the loggist function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	C2	Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor	The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).	Y						
C33	C2	Medical Advisor of Forward Doctor - exercise attendance	Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise	Y						
C34	C2	Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures	Commanders (strategic, tactical and operational) and the NILO and tactical advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in compliance with these principles	Y						
C35	C2	Control room familiarisation with capabilities	Control starts with receipt of the first emergency call, therefore emergency control room supervisors (or equivalent) must be aware of the ambulance service's operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)	Y						
C36	C2	Responders awareness of NARU major incident action cards	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust's major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.	Y						
JESIP Specific Core Standards										
J1	JESIP	Incorporation of JESIP doctrine	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency emergency response within NHS Ambulance Trusts.	Y						
J2	JESIP	Operations procedures commensurate with Doctrine	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	JESIP	Review process	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine	Y						
J4	JESIP	Access to JESIP products, tools and guidance	All NHS Ambulance Trusts must ensure that commanders and command support staff have access to the latest JESIP products, tools and guidance.	Y						
J5	JESIP	Awareness of JESIP - Responders	All relevant front-line NHS ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene.	Y						
J6	JESIP	Awareness of JESIP - control room staff	NHS ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets.	Y						
J7	JESIP	Training records - staff requiring training	NHS ambulance service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J8	JESIP	Command function - interoperability command course	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Y						
J9	JESIP	Training records - annual refresh	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e:learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J10	JESIP	Commanders - interoperability command course	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y						
J11	JESIP	Participation in multiagency exercise	At least every three years, all NHS ambulance commanders (at strategic, tactical and operational levels) must participate as a player in a joint exercise with at least Police and Fire Service command players where JESIP principles are applied.	Y						
J12	JESIP	Induction training	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J13	JESIP	Training records - 90% operational and control room staff are familiar with JESIP	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.	Y						

Over arching changes:	Domain 10 - CBRN renamed to Domain 10 - HazMat/CBRN Domain 10 standards reordered amd renumbered

Previous standard detail					New standard detail			
Ref	**Domain**	**Standard**	**Detail**	**2023 Changes**	**Ref**	**Domain**	**Standard name**	**Standard Detail**
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	No change	**1**	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	No change	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	No change	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	No change	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	No change	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	No change	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	No change	**7**	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	No change	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Standard detail has been updated to emphasise the importance of joint working and collaborative planning with emergency services and health partners following lesson identified through JOL working group.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	No change	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	No change	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	No change	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	No change	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	No change	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	No change	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	No change	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	No change	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.

19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	No change	19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.	No change	20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	No change	21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	No change	22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	No change	23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	No change	24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	No change	25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Domain 6 - Response								
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	No change	26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	No change	27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No change	28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	No change	29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	No change	30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	No change	32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	No change	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	No change	34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	No change	35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	No change	36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.	No change	37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	No change	38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.

39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	No change	39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	No change	40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	No change	41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	No change	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.	No change	43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								
44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	No change	44	Business Continuity	Business Continuity (BC) policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	No change	45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	No change	46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change	47	Business Continuity	Data Protection and Security Toolkit (DPST)	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	No change	48	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	No change	49	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change	50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	No change	51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	No change	52	Business Continuity	BCMS continuous improvement process	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change	53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	No change	54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 10 - HazMat/CBRN								
				New Standard	55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Amended wording of standard so not specific to telephony advice.	57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Standard detail amended to include specific elements of Hazmat/CBRN plan	58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Standard detail amended and supporting information developed with evidence of risk assessments.	56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Standard detail amended to incroporate wet, dry, interim and improvised decontamination where necessary and availibilty of staff.	59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be deployed within 30 mins to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)

59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Standard detail amended to reflect need to ensure equipment is in line with organisational Hazmat/CBRN risk assessments	**60**	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Standards merged.	**65**		**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.					
61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Standards merged.	**61**	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations Where applicable, the PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment					
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Standard detail amended to reflect need to ensure the organisation has processes in place to manage waste, including but not limited to PPE.	**62**	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		**63**	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.					
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Hazmat/CBRN Training standards have been consolidated from four into two standards	**64**	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles of 'Remove, Remove, Remove' and isolation when necessary. (This includes (but is not limited to) acute, community
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.					
				New standard	**66**	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme
					67	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response.

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - EPRR Training											
DD1	EPRR Training	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	Y	TNA included in training portfolio. DD1	Fully compliant				
DD2	EPRR Training	Minimum Occupational Standards	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Y	Commander Portfolios included in training portfolio DD1	Fully compliant				
DD3	EPRR Training	EPRR staff training	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	Y	TNA Assessment developed included in training portfolio, DD1 Plus CS 02. EPRR Policy OP02, v2.0 Sept 2022. Refer to pg9.	Fully compliant				
DD4	EPRR Training	Senior Leadership Training	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	Y	TNA Assessment developed, along with confirmation of training/exercises taken over the last 2 years in Training portfolio evidence.DD1	Fully compliant				
DD5	EPRR Training	Access to training materials	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Y	The Trust has staff who have undertaken the Principles of Health Command, details included in training portfolio evidence DD1 with a plan for more to attend this training , once more dates are released/available.	Fully compliant				
DD6	EPRR Training	Training Data	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	Y	We have an e-learning package for Strategic & Tactical/On Call Managers which is recorded as a mandatory requirement on the Trust's MyAcademy system. As well as undertaking scenario based training with newly appointed Trust on call managers. CS 02. EPRR Policy OP02, v2.0 Sept 2022. Refer to pg9. CS 22. Example of training materical for silver command training August 2023 CS 22. EPRR strategic & tactical elearning screenshots.	Fully compliant				
DD7	EPRR Training	Monitoring	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Y	Training and exercises are included in the Trust's Annual Report, which goes to the Trust Board & Trust Management Committee along with general activites linked to EPRR and monitored through the 6 monthly Emergency Planning Group chaired by AEO.	Fully compliant				
DD8	EPRR Training	JESIP doctrine	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	Y	EPRR lead & EPSO have attended JESIP training - Oct 2017. JESIP doctrine is also readily available on EPRR web site with the latest updates for staff to have access to. Plus is available for Strategic Commanders the Trust's IBAB system, along with access to JESIPs app.	Fully compliant				
DD9	EPRR Training	Continuous Improvement process	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements.	Y	A process is set out in CS02 EPRR Policy 02, attachemt 2 .	Fully compliant				
DD10	EPRR Training	Evaluation	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Y	CS 22. Examples of evaluation forms (tactical command training)	Fully compliant				

Appendix 2

Organisational Assurance Rating (NHSE) 2023

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are required to achieve.
Substantial	The organisation is 89-99% compliant with the core standards they are required to achieve.
Partial	The organisation is 77-88% compliant with the core standards they are required to achieve.
Non-compliant	The organisation compliant with 76% or less of the core standards they are required to achieve.

The Royal Wolverhampton NHS Trust

Report to Trust Board (public session)		
Title of Report:	RWT 2023/24 Winter Plan update	Enc No: 10.9.2
Author:	Kate Shaw, Deputy Chief Operating Officer, Division 2 Gwyneth Kidd, Service Improvement Programme Manager, Division 2	
Presenter/Exec Lead:	Kate Shaw, Deputy Chief Operating Officer, Division 2 for Gwen Nuttall, Chief Operating Officer	

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

Recommendations:

The Board is asked to discuss progress on this year's winter plan.
The plan is a subsection of the OneWolverhampton Winter Plan in recognition of the required joint working and responsibilities that need to be taken across the Health and Care System. The two plans align across the Wolverhampton Place. The Place plan has been reviewed and assessed by the Black Country UEC Delivery Board. An update on the OneWolverhampton Winter Plan is appended to this paper and is available in the reading room.

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)	None. Risks identified within the Winter Plan and included below.		
Resource Implications:	Workforce and finance included in Winter Plan. ICB funding of £305,517 for Paediatric beds from January 2024 has been allocated. No further funding identified at this time.		
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, Effective, Responsive, Well-led
	NHSE	Yes☒No☐	Details: In line with NHSE Winter Plan
	Health & Safety	Yes☐No☐	Details:
	Legal	Yes☐No☐	Details:
	NHS Constitution	Yes☐No☐	Details:
	Other	Yes☒No☐	Details: ICB Urgent and Emergency Group (with OneWolverhampton plan) - Sept 23.
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: 10 October 2023
	Board of Directors	Yes☒No☐	Date: 10 October 2023
	Other	Yes☒No☐	Date: Finance and Productivity – 22 November 2023, TMC – 24 November 2023

Summary of Key Issues using Assure, Advise and Alert

Assure

Risks to delivery of the Winter Plan, along with their mitigations are detailed in the table below.

Risk	Mitigation
IC's above current levels	• Continuous monitoring and escalation
Staff sickness	• Trust processes in place • Winter vaccination programme launched • Divisional and Trust staff allocation meetings • Prioritising the wellbeing of our staff
Transport failure	• Escalation and utilisation of alternative provider as now
Covid, Flu, Norovirus, etc. impacting on inpatient flow and nursing home closures	• IP processes and guidelines in place • Joint work with Capacity • IP input to Nursing Homes
Continued industrial action	• Strike planning to continue if further strikes announced • Team engagement and comms

Advise

Additional paediatric beds have been funded from January 2024 (£305k)

Delivery of the Winter Plan will be monitored through Finance and Productivity Committee and the Trust Management Committee.

Delivery of the OneWolverhampton Winter Plan will be monitored through the OneWolverhampton UEC Strategic Group, the ICB UEC Operational Group and UEC Delivery Board.

Alert

Potential mitigation schemes identified in the report are not funded (£596K) and will not be progressed.

Schemes identified in the OneWolverhampton plan (to which the RWT plan is aligned) are funded through Service Development Funds (SDF)

The bed mitigation plan in the document was initially assessed as Amber / Red in September 2023 as the identified bed gap was not fully mitigated. The plan was therefore given partial assurance at the UEC Delivery Board in October with a verbal update to the Trust Board on the 10 October 2023. The same rating remains in place following the ICB UEC Board in November 2023.

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

The Royal Wolverhampton NHS Trust

RWT Winter Plan 2023/24 update

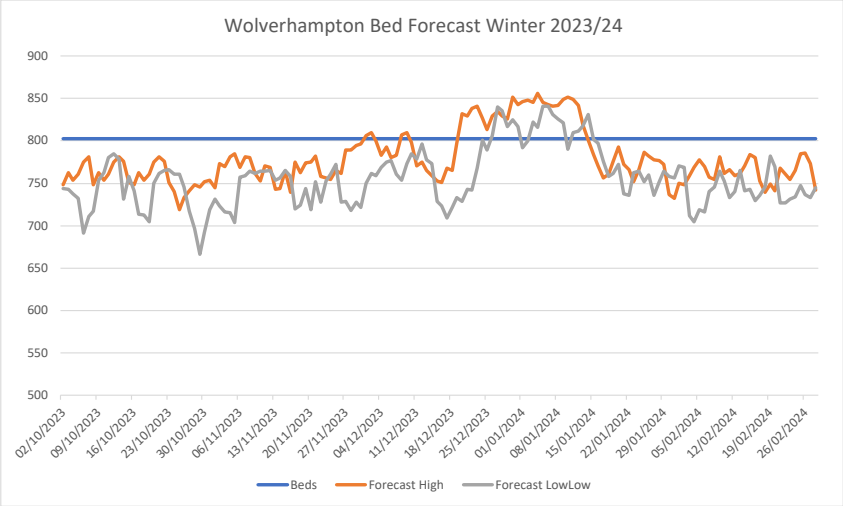
Report to Trust Board (public session), to be held on 12 December 2023

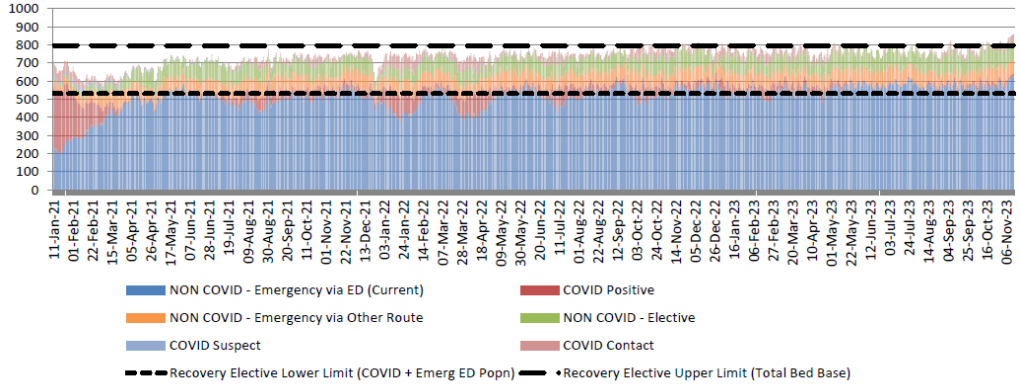
EXECUTIVE SUMMARY

Following submission to Trust Board on 10 October 2023, this paper and accompanying presentation provide a progress update on the Trust's plan for the ongoing management of winter pressures. It focuses on the priority areas within NHS England's Winter Plan which in turn is built on the Urgent and Emergency Care Recovery Plan published earlier this year. The plan is a subsection of the OneWolverhampton Winter Plan in recognition of the required joint working and responsibilities that need to be taken across the Health and Care System.

Structures remain in place and are working well to maintain involvement and engagement with partners at Executive, clinical and operational levels.

Bed capacity modelling has been undertaken within the Trust and within the ICB. This is based on actual activity from August 2022 to March 2023 and currently shows a gap of between 37 and 53 inpatient beds. It assumes that elective and cancer activity continues throughout the winter. The Trust has exceeded its bed capacity in recent weeks as shown below.





Indicator	02-Nov-23	03-Nov-23	04-Nov-23	05-Nov-23	06-Nov-23	07-Nov-23	08-Nov-23
Current Daily Non COVID Emerg Growth %	-0.17%	-6.33%	6.58%	1.67%	3.78%	-0.47%	-0.16%
Daily Non COVID Emerg Growth Rolling 7 days	0.42%	-0.83%	-0.56%	-0.48%	-0.03%	0.33%	0.70%

A number of schemes and initiatives are in progress to mitigate the bed capacity gap which can be seen in the table below. A number of these are expansions and further developments of existing services and schemes whilst some are new. The mitigations are cross referenced against the High Impact Priority Interventions, as set out in the UEC Recovery Plan, and a RAG status against these are shown below, with a full detailed position provided in the presentation.

Scheme	Worst Case	Best Case	Detail	Progress update
Virtual Wards	10	15	Increased use of current including South Staffordshire	Capacity in place
Medicine Model of Care (MMC)	12	12	Based on 2 beds Respiratory, Older Adult Medicine, Diabetes; 3 beds Renal and Gastro	Implemented on 6 November 2023
Discharge ready (MFFD)	8	12	10-15% of 80	Consistently below average numbers since July 2023
Same Day Discharge Centre (SDDC)	3	3	Enhanced discharge service (adults) commencing November	Opened on 6 November 2023 as planned
Paediatric Inpatient Capacity	8	10	Additional inpatient capacity	5 beds to open by end November, and 5 by end December. Currently running over 26 bed capacity
Total	**41**	**52**		

The Acute Respiratory Infection Hub is on target to open on 4 December 2023 at the Phoenix Health Centre, delivered by Unity Primary Care.

Ref	Action	RAG Status
1.	Same Day Emergency Care	
2.	Frailty	
3.	Inpatient flow and length of stay (acute)	
4.	Community bed productivity and flow	
5.	Care transfer hubs	
6.	Intermediate care demand and capacity	
7.	Virtual Wards	
8.	Urgent Community Response	
9.	Single point of access	
10.	Acute Respiratory Infection Hubs	
11.	Paediatric Inpatient Capacity	

BACKGROUND INFORMATION

The Urgent and Emergency Care (UEC) Recovery Plan outlined five key objectives:

1. Increasing capacity
2. Growing the workforce
3. Improving discharge
4. Expanding and better joining up of health and social care outside of hospital
5. Making it easier to access the right care first time

Building on the Recovery Plan, the NHS Winter Plan for 2023/24 consists of three key components:

1. High-impact priority interventions (taken form the UEC Recovery Plan)
2. Clear roles and responsibilities for each part of the system

3. System level resilience and surge planning

The plan states that all interventions over winter should contribute to two key ambitions for UEC of:

- 76% of patients being admitted, transferred, or discharged within four hours of arrival in an Emergency Department (ED) by March 2024
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24 – requiring consistent ambulance handovers from ambulance to ED team

The Trust has worked hard and delivered improvements in terms of the UEC Recovery Plan and the two key ambitions above since implementing and sustaining a number of changes as part of last year's Winter Plan. The current performance on these is provided within the presentation.

As last year, the combined pressure of improving cancer waiting times and delivering elective recovery whilst simultaneously managing increasingly complex non-elective demand, is putting significant strain on the Trust and the wider system. These challenges are only expected to increase during the winter months when emergency care services face greater pressure as a result of patients being more acutely unwell with a longer stay in hospital longer. These usual pressures are expected to be exacerbated this winter, as a result of:

- High general non-elective demand
- Noroviruses, influenza, and the potential unpredictability of any emerging covid variants
- Surges in Respiratory Syncytial Virus (RSV) in children
- Challenges in the social care market to assist with discharges
- Ongoing industrial action for doctors in training and consultants
- Potential increase in staff absence due to increase in covid, flu or other seasonal illness.

All of the above give rise to the need for a Winter Plan demonstrating increased resilience to support these pressures whilst at the same time recognising some of the constraints currently faced including vacancies in the workforce, current levels of sickness, and staff fatigue.

SUMMARY

- The Trust has a series of winter plan schemes, most of which build on actions from Winter 22/23, including virtual ward, intermediate care and care co-ordination.
- There is a detailed plan to redesign the current medical model of care as outlined briefly in the paper. Additional detail is to be shared at future meetings.
- Intention is to retain elective operating throughout the winter period by utilising the ring-fenced capacity at New Cross and Cannock Chase. This is to ensure the Trust achieves the expected measure of having no patient wait over 65 weeks at the end of March 2024.
- The predicted shortfall in bed capacity has a mitigation plan, however this is deemed amber / red risk, due to the number of risks that will likely exist in the winter period, be those levels of flu or covid or staff sickness or ambulance conveyances from other regions.
- Only additional schemes that are funded have been agreed to progress. Other schemes will not progress unless funding is available.
- The plan is aligned with the OneWolverhampton Winter Plan, which has been signed off by the OneWolverhampton Place Board.
- Actions will be monitored daily, weekly and all reviewed at the end of the winter period to assess success and impact in preparation for Winter 2025.

RECOMMENDATIONS

It is recommended that the Board discuss the RWT Winter Plan.

Reading Room Attachment

Progress Update on the OneWolverhampton Winter Plan – incorporating delivery of the schemes funded through the Adult Social Care Discharge Fund.

Matt Wood – Head of the Programme and Transformation Office, OneWolverhampton

Wolverhampton has been awarded approximately £3.5m through the Adult Social Discharge Fund (ASCDF) to support winter pressures. The funding is split between the Integrated Care Board (ICB) and the City of Wolverhampton Council (CWC), with £1.5m allocated to the ICB and £2m allocated to the City of Wolverhampton Council (CWC). The funding can only be used to support expedited discharge and, as such, cannot be used to support preventative or discharge avoidance approaches.

This funding has been used to mobilise 20 schemes across acute, council, mental health, and community and voluntary sector services. These initiatives have been devised to bolster provision and support the effective and safe discharging of patients. They have been agreed upon by a Partnership working group and endorsed by the OneWolverhampton Urgent and Emergency Care Strategic Working Group (UECSWG) – Chaired by Gwen Nuttall, Chief Operating Officer (COO) at the Royal Wolverhampton NHS Trust (RWT).

The spreadsheet below provides a detailed update for each of the funded schemes. They have been RAG-rated based on their delivery to date with spend used as a proxy measure. Green schemes are those that have delivered as expected, amber schemes are those whose delivery is below expected, and red schemes are those that are not yet delivering. Work is ongoing to understand the qualitative impact of these schemes in addition to the spend and this will be presented to the UECSWG in January.

Several of the red schemes represent contingency funds and, as such, it is expected that they would remain red at this stage. Similarly, the RWT Care Coordination Scheme is listed as red as this funding was initially allocated to support the implementation of a new telephony system and increase call-handling capability for the service. The telephony funding has instead been secured through capital funds so spending against this scheme remains at zero.

Conversations are taking place this week to understand whether the red schemes will likely deliver within the winter timeframe. Alternative schemes are also being worked up, including expanding existing successful schemes, that would be funded if red schemes are stood down.

In addition to this, a RAG rated overview is provided for the RWT winter schemes, in order to present a full picture of the plans for this winter.

No	Scheme Name	Brief Description of Scheme	Commissioner	Year 1 (23/24)	Responsible Officer and Project Lead	RAG - Year End Estimate
1	**Hospital Enhanced Social Work**	Additional social worker capacity to support timely assessment and discharge of patients to include out of area hospital discharges.	CWC	£440,375	Rachel Murphy & Tracey Chappell	£440,375
2	**Enhanced PST**	Additional brokerage staff capacity to support timely assessment and discharge of patients to include out of area hospital discharges.	CWC	£41,000	Helen Winfield	£41,000
3	**Home Assisted Reablement Programme**	Additional hours of HARP assistance provided for reablement to support discharge and make sure people identified as benefiting from reablement were able to be supported on the correct pathway.	CWC	£40,638	Tom Denham	£30,600
4	**Additional OT Capacity**	Recruitment of additional OTs to support timely discharge for pathways 1-3.	CWC	£300,000	Jo Turnbull	£62,752
5	**Bariatric Reablement Service**	Dedicated service to enable people that are identified as bariatric to access a bed based reablement service as part of their planned return home when it is identified that a home discharge is not possible.	CWC	£185,403	John Linighan	£98,089
6	**Pathway 1 Seasonal Reablement at Home**	Contingency funding to support additional winter demand / capacity pressures.	CWC	£125,000	Rachel Murphy & Tracey Chappell	£124,071
7	**Pathway 2 Seasonal Spot Beds**	Contingency funding to support additional winter demand / capacity pressures.	CWC	£400,000	Rachel Murphy & Tracey Chappell	£276,053
8	**BCHT Enhanced Mental Health Social Worker**	A designated, locality-based, named social worker to oversee or undertake assessments of patients requiring adult social care support.	CWC	£50,473	Marcus Law	£48,531
9	**CWC Community equipment Service**	Funding additional equipment to support hospital discharge in a timely manner	CWC	£52,500	John Linighan	£52,500

No	Scheme Name	Brief Description of Scheme	Commissioner	Year 1 (23/24)	Responsible Officer and Project Lead	RAG - Year End Estimate
10	**Pathway 3 Block Booked Contingency**	Funding to enable additional block-booked beds to be commissioned (e.g. complex beds) and / or to support increased costs in Care Homes.	ICB	£100,000	Gurbi Cox	0
11	**BCHT Structured IP Day Support (RETHINK)**	In-reach work on wards to help patients and staff identify support to achieve discharge and connection with outreach services.	ICB	£34,956	Marcus Law	£7,000
12	**BCHT Additional Step-Down Capacity**	Accommodation and support for people MFFD and waiting for additional support packages, (24-hour ongoing support prior to discharge home or to onward package of support).	ICB	£50,000	Marcus Law	£50,000
13	**BCHT Welfare Rights Workers**	Supporting patients with a successful discharge from a mental health ward (e.g. financial advice, information and solutions around benefit entitlement).	ICB	£55,000	Marcus Law	0
14	**RWT Enhancing Care Co-ordination**	Improving the infrastructure of Care-Co to enable increased and wider support for hospital discharge and enhancing the workforce to include a dedicated Social Worker, prescribing Pharmacist, additional call handlers and digital infrastructure.	ICB	£119,664	Rachael Brown	0
15	**RWT Intermediate Care (to incorporate RASC and Homefirst)**	Supporting early facilitated discharge for patients waiting for start dates of social care funded packages of care. RASC will help to bridge the gap, impacting on the number of patients on the medically fit lists while reducing deconditioning for patients and improve flow.	ICB	£650,000	Rachael Brown	£510,900
16	**RWT Virtual Wards**	Supporting the delivery of Virtual Wards in conjunction with Community Infrastructure funding. In line with the 2022/23 commitment made. Increased use of current provision including South Staffordshire.	ICB	£221,519	Jodie Winfield	£221,519

No	Scheme Name	Brief Description of Scheme	Commissioner	Year 1 (23/24)	Responsible Officer and Project Lead	RAG - Year End Estimate
17	**Care Homes**	To provide increased support to Care Homes, linking in to the OW Care Homes Workshop / Steering Group	Joint CWC / ICB	£5,000	Tracey Jones & Molly	£5,000
18	**Delirium Patients**	Develop delirium pathways and test out different pathways out to establish future approach.	Joint CWC / ICB	£50,000	Gurbi Cox & Tracey Chapell	£0
19	**NWB Patients**	Trial / test out alternative placement arrangements for NWB patients to determine future ongoing approaches / arrangements.	Joint CWC/ICB	£50,000	Gurbi Cox & Jo Turnball	£0
20	**Community / Voluntary Sector**	Increase in social prescribing support capacity to meet additional demand.	Joint CWC / ICB	£72,000	Jenny Wallbank	£72,000
21	**RWT Medicine Model of Care**	Specialist consultants rostered to cover all floors in Emergency Services, specifically to avoid admission; redirect activity; and facilitate timely discharge – 12 beds	RWT		Kate Shaw	
22	**RWT Discharge Ready (MFFD)**	Plan to further reduce by 10-15% (8 to 12 beds)	Joint CWC, ICB, RWT		Kate Shaw, Rachel Murphy, Gurbi Cox	
23	**Same Day Discharge Centre (SDDC)**	Enhanced Discharge service (adults) commenced 6 November 2023 – 3 beds	RWT		Kate Shaw Bev Morgan	
24	**Paediatric Inpatient Capacity**	Plans have been submitted to mobilise up to an additional 10 beds to support with additional paediatric capacity.	ICB	£305,517	Sian Thomas	
25	**Acute Respiratory Infection Hubs**	ARI service to commence 4 December 2023.	ICB	£186,000	Kam Ahmed	£186,000

RWT Winter Plan:
Update to Trust Board

Kate Shaw, Deputy COO, Division 2

12 December 2023

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

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Introduction

- The RWT Winter Plan was presented to Trust Board on 10 October 2023
- It focuses on the priority areas within NHS England's Winter Plan which in turn is built on the Urgent and Emergency Care Recovery Plan published earlier this year
- It is a subsection of the OneWolverhampton Winter Plan in recognition of the required joint working and responsibilities that need to be taken across the Health and Care System

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Alignment to the Urgent and Emergency Care (UEC) Recovery Plan

- Five key objectives:
    1. Increasing capacity
    2. Growing the workforce
    3. Improving discharge
    4. Expanding and better joining up of health and social care outside of hospital
    5. Making it easier to access the right care first time
- Building on the Recovery Plan, the NHS Winter Plan for 2023/24 consists of three key components:
    1. High-impact priority interventions (taken from the UEC Recovery Plan)
    2. Clear roles and responsibilities for each part of the system
    3. System level resilience and surge planning
- The plan states that all interventions over winter should contribute to two key ambitions for UEC of
    - 76% of patients being admitted, transferred, or discharged within four hours of arrival in an Emergency Department (ED) by March 2024
    - Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24 – requiring consistent ambulance handovers from ambulance to ED team

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UEC Activity and Performance

The Trust is currently one of around twenty organisations within England routinely meeting the 76% 4-hour performance target.

Hospital	April 23 %	May 23 %	June 23 %	July 23 %	August 23 %	September 23 %	October 23 %
The Royal Wolverhampton NHS Trust	79.95%	79.52%	76.58%	78.96%	78.21%	78.36%	77.43%
Birmingham Women's And Children's NHS Foundation Trust	85.19%	85.96%	82.83%	91.07%	90.77%	85.55%	74.87%
The Dudley Group NHS Foundation Trust	74.52%	73.38%	72.93%	74.50%	72.82%	74.12%	72.52%
South Warwickshire NHS Foundation Trust	83.28%	73.00%	76.31%	76.24%	73.78%	72.53%	71.90%
George Eliot Hospital NHS Trust	75.13%	77.60%	77.43%	75.47%	70.02%	72.70%	71.69%
Walsall Healthcare NHS Trust	77.36%	79.75%	75.67%	75.38%	75.06%	74.15%	69.80%
University Hospitals Coventry And Warwickshire NHS Trust	76.64%	73.70%	71.53%	73.91%	72.74%	70.88%	69.46%
University Hospitals Of Derby And Burton NHS Foundation Trust	66.69%	68.37%	67.67%	71.77%	69.42%	69.36%	67.87%
Sandwell And West Birmingham Hospitals NHS Trust	74.86%	72.69%	70.99%	70.44%	69.14%	66.90%	66.82%
University Hospitals Of North Midlands NHS Trust	70.05%	69.37%	68.82%	69.61%	68.59%	69.90%	65.31%
Wye Valley NHS Trust	59.64%	57.65%	59.28%	56.30%	55.59%	53.96%	56.85%
University Hospitals Birmingham NHS Foundation Trust	53.78%	54.43%	53.03%	53.04%	54.74%	54.02%	54.00%
The Shrewsbury And Telford Hospital NHS Trust	54.25%	55.33%	53.58%	51.86%	51.64%	50.80%	51.51%
England	77.31%	76.80%	73.34%	73.99%	72.98%	71.64%	70.25%

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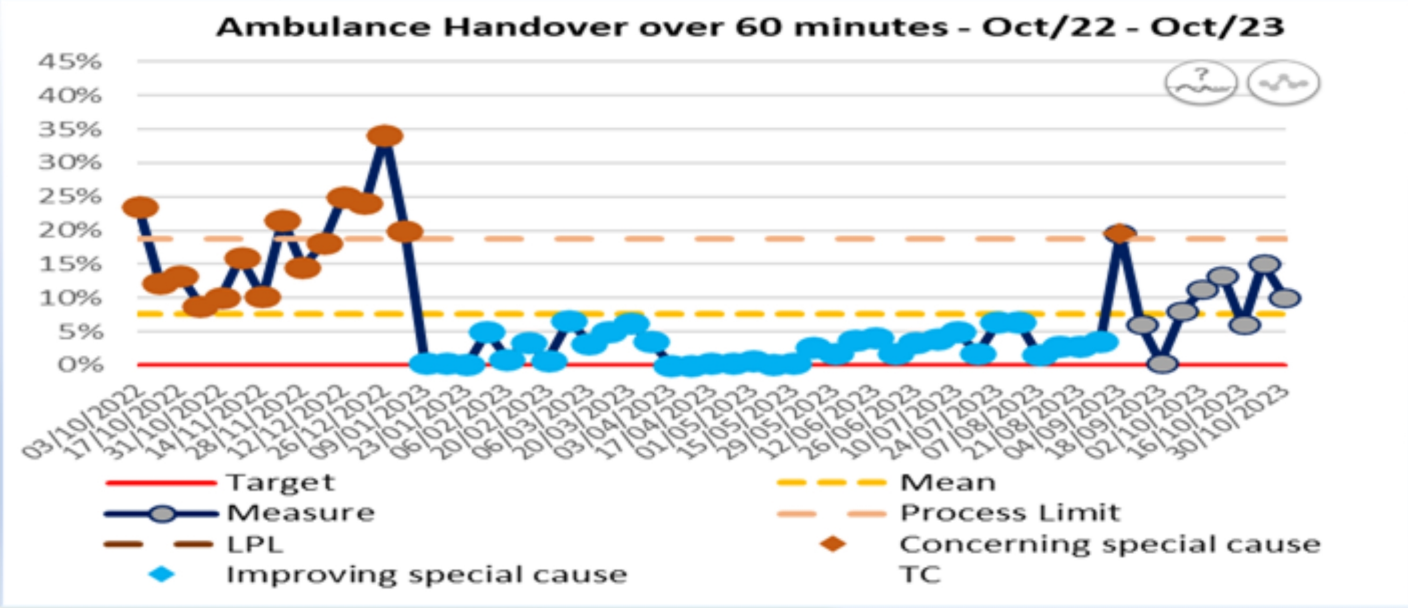
UEC Activity and Performance



Nx Ambulance Handover > 60 mins

	Target	Actual
Oct-22	0%	14.62%
Nov-22		14.47%
Dec-22		22.81%
Jan-23		6.71%
Feb-23		2.07%
Mar-23		4.95%
Apr-23		0.14%
May-23		0.89%
Jun-23		3.45%
Jul-23		4.29%
Aug-23		3.46%
Sep-23		7.91%
Oct-23		10.85%

Offloading ambulances as quickly as possible remains a priority. Recent performance has been challenged as ambulance numbers, ED attendances (including walk-ins) and patient complexity have increased.

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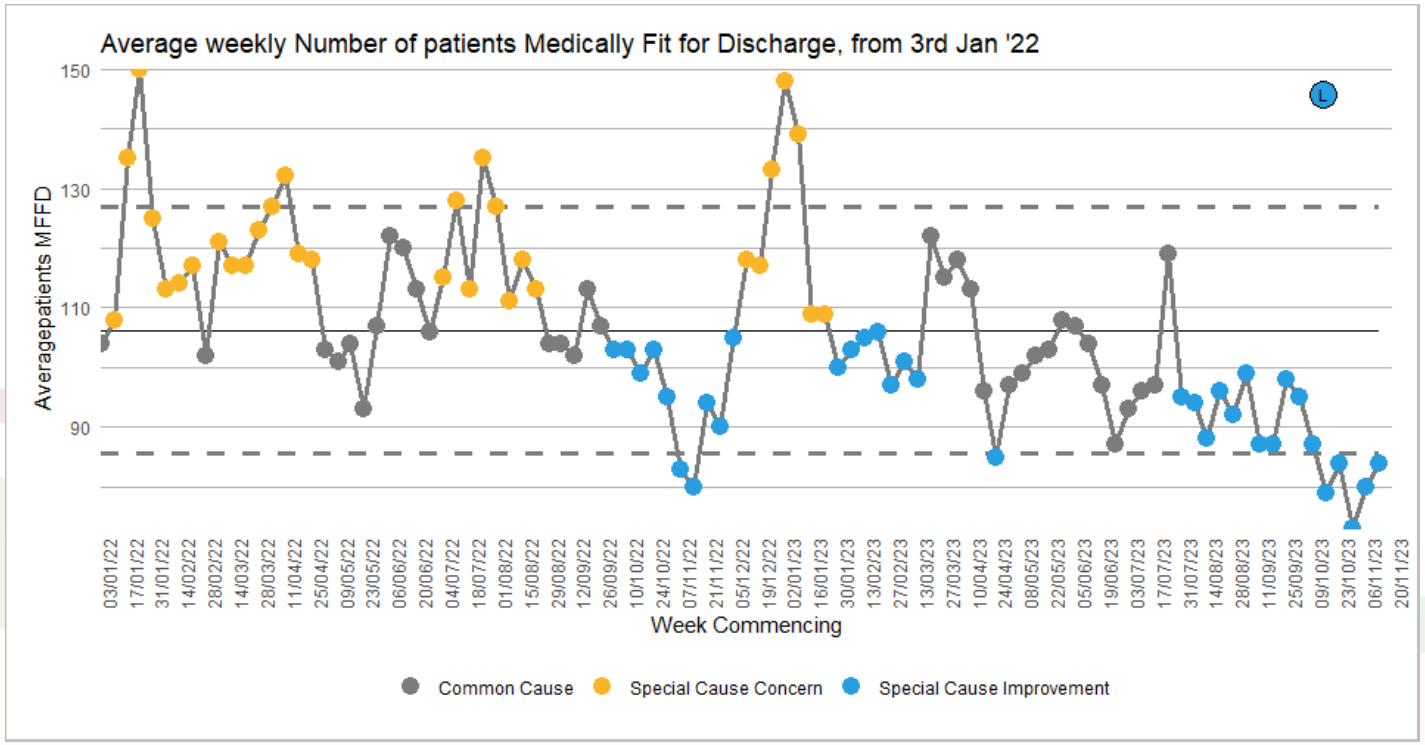
Discharge ready (MFFD) patients

The numbers of discharge ready (MFFD) patients has greatly reduced since the beginning of the year, with a consistent below average number since July 2023.



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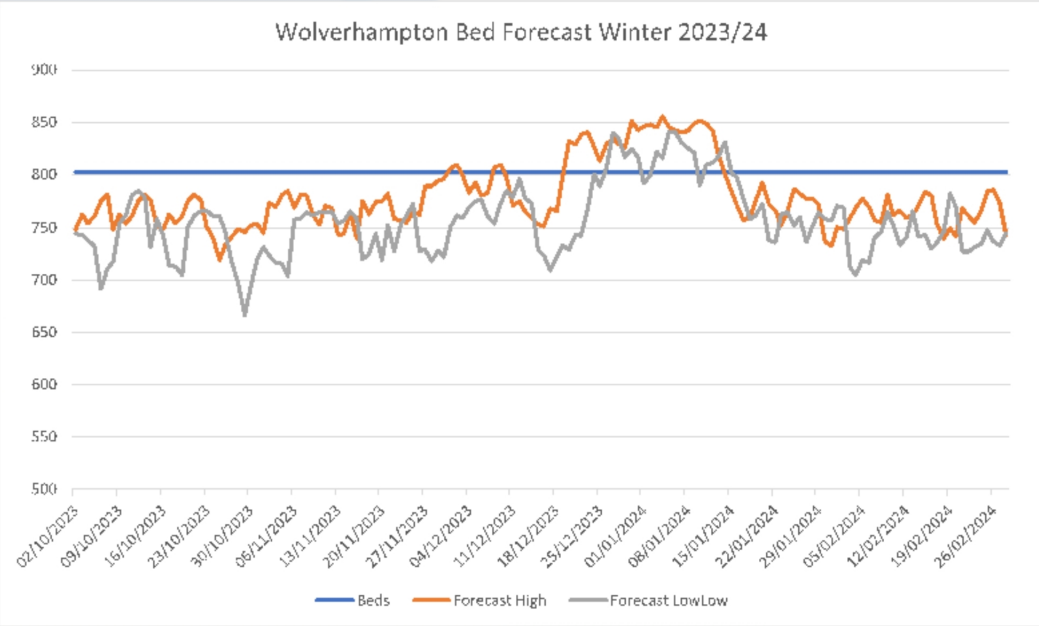
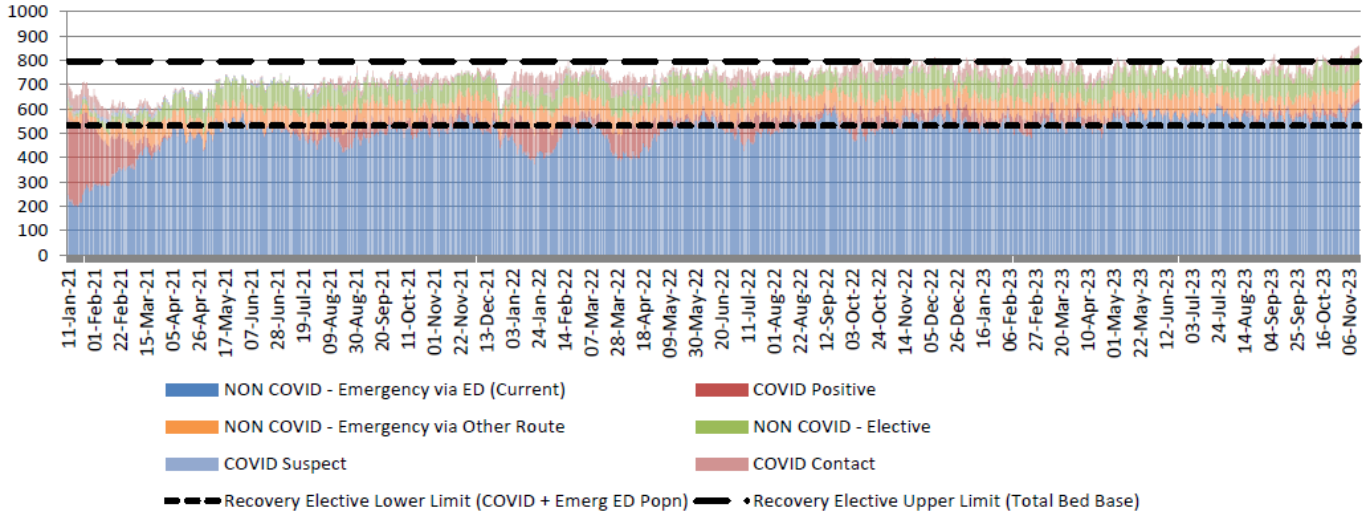
Modelling and assumptions





Indicator	02-Nov-23	03-Nov-23	04-Nov-23	05-Nov-23	06-Nov-23	07-Nov-23	08-Nov-23
Current Daily Non COVID Emerg Growth %	-0.17%	-6.33%	6.58%	1.67%	3.78%	-0.47%	-0.16%
Daily Non COVID Emerg Growth Rolling 7 days	0.42%	-0.83%	-0.56%	-0.48%	-0.03%	0.33%	0.70%

Capacity modelling for winter shows a gap of between 37 and 53 inpatient beds for winter. The plan assumes that elective and cancer activity continues throughout the winter period, the Trust has exceeded its bed capacity in recent weeks as shown above.

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Mitigating the bed capacity gap

The plans and initiatives set out in the Winter Plan continue to progress to mitigate the bed capacity gap which can be seen in table below.

Initiative	Worst case	Best case	Detail	Progress update
Virtual wards	10	15	Increased use of current including South Staffordshire	Capacity in place
Medicine Model of Care	12	12	Based on 2 beds Respiratory, Older Adult Medicine, Diabetes; 3 beds Renal and Gastro	Implemented on 6 November 2023
Discharge Ready (MFFD)	8	12	10-15% of 80	Consistently below average numbers since July 2023
Same Day Discharge Centre (SDDC)	3	3	Enhanced discharge service (adults) commencing 6 November	Opened as plan on 6 November 2023
Paediatric Inpatient Capacity	8	10	Additional inpatient capacity	5 beds to open by end November, and 5 by end December. Currently running over 26 bed capacity
Total	**41**	**52**		

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Progress against the High Impact Priority Interventions

Progress against the high-impact priority interventions as set out in the UEC Recovery Plan is shown below.

Ref	Action	Update	RAG status
1.	Same Day Emergency Care	• RWT currently offers medical, frailty, surgical (including gynaecology) and head and neck SDEC services • The Paediatric model currently runs alongside the PAU • The Medical SDEC currently operates 24 hours a day while the Frailty, Surgical and Head and Neck SDEC services operate 12 hours a day, 7 days a week • Plans to establish an integrated Medical SDEC are underway, pending development of an AMU workstream	
2.	Frailty	• Frailty SDEC has been providing a 7-day service for older frail adults since September 2022 • Capacity for 9 patients who are drawn either from ED or directly from WMAS via the Care Coordination team • HOT clinics in place to ensure patients can be seen by a consultant on day of referral • All complemented by the Community frailty virtual ward. There are 35 'beds' and supports up to 70 patients per month based on an average LoS of 14 days. supports expedited discharge and admission avoidance	
3.	Inpatient flow and length of stay (acute)	• The North Bristol model for ambulance recovery has been reviewed and implemented at RWT since early January 2023. A Push model has been established whereby on each weekday, one patient is moved directly from either ED or AMU to a base ward at 09.30 and 11.30. This has meant that our ambulance handover times have greatly reduced. • 4-week ED streaming pilot commenced March this year - 09:00-21:00 seven days per week. Total of 1260 patients streamed to alternative locations • Audit of walk-in patients to ED undertaken 6 and 7 Nov to understand opportunities for navigating away from ED	

Progress against the High Impact Priority Interventions (continued)

Ref	Action	Update	RAG status
4.	Community bed productivity and flow	• Successful recruitment to enhance the hospital social work team. • Adult Social Care Discharge Funding will be used to support additional capacity within the Personalised Support Team (PST). This additional resource will ensure timely assessment and discharge of patients to further reduce discharge delays • The Home Assisted Reablement Programme (HARP) will also be enhanced – offering an additional 50 hours of reablement per week – increase in capacity to support pathway 1 discharges and further reduce discharge delays • Expansion of the Community Occupational Therapy Team (COTT) will be undertaken to support the review of patients discharged into D2A services • Dedicated Bariatric Reablement service is being established • A package of Care Home Support will be expanded to encourage the use of Care Coordination as a single point of access • Pathway 3 budget will be transferred to the ICB to ensure consistency of approach	
5.	Care transfer hubs	• Enhanced Care Coordination service will be provided through RWT's Adult Community Team. This service offers a range of options, including access to virtual consultations and pharmacy. The existing provision will be enhanced through the addition of an integrated social worker, an integrated prescribing pharmacist and additional call handlers. A more robust telephony system is being implemented from February 2024 to manage the increased demand seen by the service • Ongoing work as part of the Care Closer to Home Strategic Working Group to grow Care Coordination. This includes broadening the scope of partners involved, including mental health, social care, housing, and others. An inaugural workshop has been planned to scope the possibilities. Initial efforts will focus around linking the social care front door with Care Co to ensure a no wrong front door approach	
6.	Intermediate care demand and capacity	• A number of schemes have been commissioned using the Adult Social Care Discharge fund, full detail of this can be found in the One Wolverhampton Winter Plan	

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Progress against the High Impact Priority Interventions (continued)

Ref	Action	Update	RAG status
7.	Virtual Wards	Bed numbers are not attached to each pathway - allows more fluidity and flexibility. Overall bed capacity of 98 beds, with the ambition to maintain 80% occupancy. Clinical pathways include: • Respiratory; COVID, oxygen weaning, asthma, COPD and ARI • Frailty • Paediatric • Palliative/ Supportive care • Awaiting diagnostics • General Medicine Average LoS of 14 days equates to up to 196 patients per month being cared for at home as opposed to in an acute bed. Additional funding has been received to support the virtual ward of £222k	
8.	Urgent Community Response	• RWT's Rapid Intervention Team (RIT) has extended its operating hours to provide a 24/7 Urgent Community Response service	
9.	Single point of access	• Ongoing work as part of the Care Closer to Home Strategic Working Group to grow Care Coordination. This includes broadening the scope of partners involved, including mental health, social care, housing, and others. An inaugural workshop has been planned to scope the possibilities. Initial efforts will focus around linking the social care front door with Care Co to ensure a no wrong front door approach	
10.	Acute Respiratory Infection Hubs	• Contract awarded, to be established from beginning of December at the Phoenix Health Centre	
11.	Paediatric Inpatient Capacity	• 5 beds to open by end November, and 5 beds by end December. Currently running over 26 bed capacity	

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The Medicine Model of Care (MMC)

Since the submission of the Winter Plan to Trust Board on 10 October 2023, the MMC has been progressing. An update on each of the workstreams is summarised below.

Group / Area	Actions complete	Actions outstanding / issues	RAG status
Ward Efficiencies	• Agreed aim of group to ensure patients are discharged earlier in the day • Commenced auditing of ward huddles and dedicated Jr Dr to focus on TTO's to support earlier discharge of patients	• Medic to chair group going forward	
Bed Configuration	• All moves completed, formal handover to Div 3 on 1 November		
Specialist Input	• Agreed operational hours to be 09:00 to 17:00 Monday to Friday with a view to increasing this into the evening in the near future • Formally commenced from 6 November	• Inconsistencies across Directorates in terms of how the cover is operationalised • Plan for evening cover to be worked through and agreed • Formal plan required for Cardiology and Onc & Haem input	
Integrated SDEC	• Initial proposal shared with teams at follow up away day on 25 October	• Development of new model • Currently paused until AMU workstream concluded	
Same Day Discharge Centre (SDDC)	• Operational on C41 from Monday 6 November.	• Requires additional funding for Pharmacy	

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Summary

- The Trust has a series of winter plan schemes, most of which build on actions from Winter 22/23, including virtual ward, intermediate care and care co-ordination.
- There is a detailed plan to redesign the current medical model of care as outlined briefly in the paper. Additional detail is to be shared at future meetings.
- Intention is to retain elective operating throughout the winter period by utilising the ring-fenced capacity at New Cross and Cannock Chase. This is to ensure the Trust achieves the expected measure of having no patient wait over 65 weeks at the end of March 24.
- The predicted shortfall in bed capacity has a mitigation plan, however this is deemed amber / red risk, due to the number of risks that will likely exist in the winter period, be those levels of flu or covid or staff sickness or ambulance conveyances from other regions.
- Only additional schemes that are funded have been agreed to progress. Other schemes will not progress unless funding is available. We are seeking funding over and above that allocated for additional paediatric beds.
- The plan is aligned with the OneWolverhampton Winter Plan, which has been signed off by the OneWolverhampton Place Board.
- Actions will be monitored daily, weekly and all reviewed at the end of the winter period to assess success and impact in preparation for Winter 25.

Any questions?

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The Royal Wolverhampton NHS Trust

Paper for submission to the Trust Board Meeting to be held in Public on 12 December 2023

Title of Report	Exception Report from the People Committee	Enc No: 11.1
Author:	Adam Race, Director of Operational Human Resources and Organisational Development	
Presenter:	Allison Heseltine, Non-Executive Director & Chair of People Committee	
Date(s) of Committee Meetings since last Board meeting:	27 October 2023 & 24 November 2023	

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

Implications of the Paper			
Changes to BAF Risk(s) & TRR Risk(s) agreed	No change. SR17 reviewed. Risk Description - Equality and Diversity Is Risk on Risk Register: Yes☒No☐ Not Applicable☐ Risk Score (if applicable): 16		
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 discussed:

Key Issues discussed by the Committee were:

- Sickness absence, whilst improving, remains slightly above target. Actions are in place and the Committee will receive detailed updates on a bi-monthly basis.
- Update on Industrial Action.
- Deep Dive – Black Country Pathology Services.
- E-Rostering.
- People Strategy Development and identification of risks.
- The staff survey response rate was below anticipated levels. This will be reviewed with updates to the Committee in due course.
- Increased scrutiny on compliance with agency rules and temporary staffing generally with further data being brought to the committee as part of its reports.
- The Committee has reviewed the Workforce Grip and Control Checklist and is assured that actions are in place as appropriate.
- Update on the workforce planning process and the oversight the Committee will take in future.
- Deep Dive - Allied Health Professionals.
- The Board Assurance Framework has been reviewed.

Links to Trust Strategic Aims & Objectives	
Excel in the delivery of Care	• Embed a culture of learning and continuous improvement • 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 Collaboration	• Improve population health outcomes through provider collaborative • Improve clinical service sustainability • Implement technological solutions that improve patient experience

Report Journey/Destination Significant follow up action commissioned	Working/Executive Group	Yes☐No☒	Date:
	Board Committee	Yes☒No☐	Date: As above
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:
Any Changes to Workplan to be noted	Yes☐No☒		Date:

The Royal Wolverhampton NHS Trust

EXCEPTION REPORT FROM PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE CHAIR

ALERT

The absence rate for the rolling 12 months, whilst slightly above target continues to improve and has done for 6th consecutive month. This remains a focus for the People Committee and updates on attendance management have been included in the Committee's schedule of business bi-monthly. At the October meeting, the Committee requested assurance on triangulation between the data being used by HR and the nursing dashboard reported at Quality Committee and was advised at the November meeting that this was in place.

ADVISE

The Committee received an update on industrial action at both of its meetings.

October Meeting

The Committee was advised of the formal establishment of the Trust Joint Partnership Forum, engaging staff side representatives from across both organisations. The scope of the meeting it to take forward key work across both Wolverhampton and Walsall in partnership with the respective staff sides collectively. The first meeting was scheduled for 20 November 2023.

The Committee was advised of the recent request from NHS England in relation to scrutiny of temporary staffing expenditure, with a particular focus on compliance with the agency rules. Further reporting will be required to Board.

The Committee received a draft of the Joint People Enabling Strategy for review and comment. It was noted that as part of the further development of this strategy risks would need to be identified and mitigating actions put in place.

November Meeting

The Committee were advised that the Trust's staff survey response rates were lower than anticipated, in part due to challenges with a new supplier who was selected to provide alignment to the wider Black Country. Further work will be done soon after the survey closes to capture reasons for the low response rate and to ensure actions are put in place to improve the response rate next year. This will be reported to the Committee along with the results.

The Committee noted that the planning round for 2024/25 had commenced and that work was underway to develop the workforce plan. The Committee agreed to receive the updated plan as appropriate and to review performance against plan on a regular basis in 2024/25.

The Committee noted the increased scrutiny on temporary staffing usage and will consider data relating to this important aspect of the workforce as part of reports from January, ahead of this data being incorporated into routine reporting to the Board. Linked to the discussion on the Grip and Control checklist, the Committee were assured that the specialist banks, such as the AHP bank that was decentralised had similar controls. The Committee was assured that controls were in place for the AHP bank using the TempRe system.

ASSURE

October meeting

The Committee received a deep dive from Black Country Pathology Service. The update included a presentation on the organisational and culture development programme that was underway in BCPS. It also highlighted key challenges, such as shortages of specialist staff, along side key successes such as the low absence levels and high levels of wellbeing activity. This update was noted for assurance.

The Board Assurance Framework Risk was reviewed and no changes proposed.

November Meeting

The Committee received the Grip and Control checklist setting out the Trust's position in respect of the suggested actions and was assured on the action in place to ensure effective pay control.

The Committee received the Workforce Race Equality Scheme report and action plan. These documents had been published as required. The plan is a subset of the Trust's wider EDI delivery plan which will continue to be monitored through regular updates to the People Committee. This is contained in the reading room for the Board.

The Committee received a presentation from Ros Leslie, Chief AHP, setting out the deep dive that had been undertaken into this workforce group. The update covered the demographic of this workforce, apprenticeship activity, vacancy position; with hotspots in chiropody, dietetics and occupational therapy, and also retention. Elevated turnover was noted in a number of areas, however, the Committee was assured that the issues were well understood with actions in place to address. The report noted specific success with International Recruitment. The report included information and actions surrounding Speak Up and HR cases, EDI, Health and Wellbeing as well as key leadership activity for AHPs.

The Board Assurance Framework Risk was reviewed and no changes proposed.

ACTIVITY SUMMARY

Presentations/Reports of note received including those Approved

October Meeting

Executive Workforce Report

The Executive Workforce Report was noted, which included performance information relating to vacancies, turnover, retention, sickness, appraisal and mandatory training. Four of the six workforce indicators were performing well whilst sickness remained an area of focus. The report also provided updates on the Trust position in relation to:

- The Sexual Safety Charter
- The Trust's status as the West Midlands Regional Hub of the Institute of Health and Social Care Management
- Rostering, it was noted that there were challenged relating to net hours balance (hours owed to the Trust/ by the Trust) and work ongoing to resolve these issues.

Black Country Provider Collaborative (BCPC)

The Committee received an update on the work of the BCPC, which from a people perspective was focussed largely on reducing vacancies, aligning processes and supporting the ease of movement of staff across the collaborative.

Employee Relations

The Committee received the regular employee relations report for assurance. The report included an overview of employment tribunal cases, casework and organisational change together with report on sickness. As set out elsewhere in this report, the Committee was keen to see triangulation between the data in this report and the nursing dashboard and agreed a regular update on absence management to come to the Committee.

Health and Wellbeing Report

The Committee received the regular update on Health and Wellbeing. The report provided an update on the health and wellbeing offer, including the Health and Wellbeing Conference, Mental Health First Aider training (noting 159 within the Trust), financial wellbeing support and the joint work with Walsall Healthcare.

November Meeting **Key Updates** A summary of key updates was provided including: - An update on industrial action. - The work at a national level related apprentices in the NHS given the focus on this supply route in the NHS Long Term Workforce Plan. Updates on apprenticeships will continue to be reported to the Committee.
Matters presented for information or noting. ***October Meeting*** The October meeting received for information: - Minutes of the Operational Workforce Group - Minutes of the People and Organisational Development Group - Notes from the Attract and Retain Steering Group ***November Meeting*** The November meeting received for information: - Minutes of the Operational Workforce Group - Minutes of the People and Organisational Development Group - Notes from the Attract and Retain Steering Group - Academy Steering Group Minutes and Action Log - Staff Survey Oversight Group - Health and Wellbeing Dashboard Update
Chair's comments on the effectiveness of the meeting: The meetings were noted as informative and helpful and benefited from high quality papers, with robust, supportive challenge from all members, particularly non-executive members.

Chair's Summary Log for People Committee, date of Log 24/11/2023

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE	MAJOR ACTIONS COMMISSIONED/WORK UNDERWAY
• Sickness Absence continues to be above target. Detailed reports on performance and actions scheduled bi-monthly.	• E-Rostering further work to ensure quality of data and performance of metrics. • The People Enabling Strategy remains in development along with the identification of any risks that arise. • The Staff Survey Response rate was below anticipated – work underway to understand drivers and future action. • Further scrutiny of agency staffing to be received by the Committee.
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE**
• Update on Industrial Action was received. • Deep Dives from Black Country Pathology Services and Allied Health Professionals • **The Board Assurance Framework was reviewed. No changes are proposed.**	• To receive detailed updates on attendance management bi-monthly. • Committee to receive update on workforce plan and performance against for 2024/25.

The Royal Wolverhampton NHS Trust

Report to the Trust Board On 12th December 2023		
Title of Report:	Executive Summary Workforce Report	Enc No: 11.2
Author:	Emma Ballinger, Associate Director of People	
Presenter/Exec Lead:	Alan Duffell, Group Chief People Officer	

Action Required of the Board			
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: 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 Board 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: 24th November 2023
	Board of Directors	Yes☐No☐	Date:
	Other	Yes☐No☐	Date:

Summary of Key Issues using Assure, Advise and Alert
Assure This report provides the Board with information and assurance on key workforce metrics and an update on key workforce matters. Four of the six workforce indicators are meeting the agreed targets/ thresholds vacancy rate, turnover, 12-month retention and mandatory training. Appraisal compliance and sickness absence are rated amber, however the in-month sickness rate does meet the trust target.
Advise Vacancy rates meet the target at 2.70% Retention is meeting the target at 90.23% Mandatory training compliance is above target at 95.00% Turnover has improved slightly again in month to 9.65% and is meeting the target.
Alert The Board is alerted to: - Sickness absence rates for the rolling 12 month period are slightly 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.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	
Support our Colleagues	• Be in the top quartile for vacancy levels • Improve in the percentage of staff who feel positive action has been taken on their health and wellbeing • Improve overall staff engagement • Deliver improvement against the Workforce Equality Standards
Improve the Healthcare of our Communities	
Effective Collaboration	

The Royal Wolverhampton NHS Trust

Executive Summary Workforce Report

Trust Board

December 2023

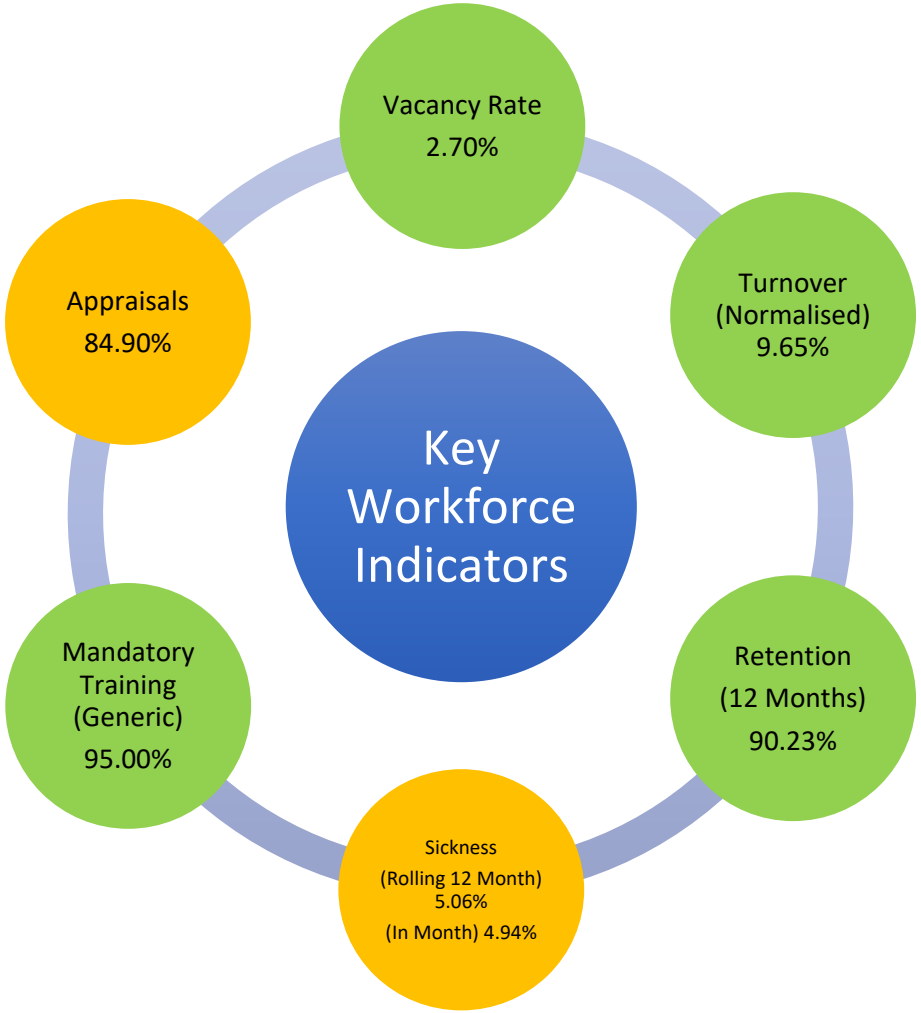
Summary

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

Four of the six workforce indicators are meeting the agreed targets/ thresholds vacancy rates, turnover, 12-month retention and mandatory training. Appraisal compliance and sickness absence are rated amber, however the in-month sickness rate has met the Trust target for the last two months.

- Normalised turnover is 9.65%, improving slightly in month and for the ninth consecutive month. The retention rate is up from last month and meeting the agreed standard at 90.23% having now improved for six consecutive months.
- Vacancy rate has increased by 0.39% in month but it continues to meet the target at 2.70%. Over the last month the number of staff employed has increased by 69 WTE. Recruitment continues to outpace turnover. The increase in the workforce is predominantly a rise in month in Nurses and Midwives employed by the Trust with data including new starters from the newly qualified nurse intake.
- Attendance levels (rolling 12 months) have improved again in September. The in-month performance for this indicator is 4.94% which is just below the target maximum at 5.00% whilst the rolling 12-month figure has remained stable to 5.06%.
- Performance in relation to generic Mandatory Training continues to meet the external target of 85%. Current performance is stable at 95.00%. Role specific mandatory training compliance has remained consistent at 94.70% and above the target. In relation to appraisal, compliance rates have improved slightly in month and are now at 84.90%. This indicator is rated amber and below the target of 90%.
- The fill rate through the bank in October was 72% for registered nursing staff and 86% for healthcare assistants. The medical staff bank fill rate was 81% exceeding the target of 60%.

The Royal Wolverhampton NHS Trust



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

Turnover has improved slightly again this month to 9.65% and is continuing to meet the target. Turnover performance is now meeting the standard for all but Additional Clinical Services, AHP and Estates and Ancillary. Noting that additional Clinical Services and Estates and Ancillary was just slightly above target.

The vacancy level has risen in month from 2.31% to 2.7% but continues to meet the target. This indicator is meeting the target for all staff groups except AHPs.

Absence levels in month remain high but have improved slightly now at 4.94% just below the target maximum. Absence levels for rolling 12-month attendance levels continue to be impacted by COVID-19 absence and are slightly above target at 5.06% showing an improvement over the last three months.

Mandatory training (generic) compliance rates have decreased by 0.1% in month and continue to exceed the 85% target.

Appraisal compliance has increased slightly in month however it not meeting the Trust target of 90%.

The Royal Wolverhampton NHS Trust

Summary Items by Exception

Industrial Action

There remain risks in relation to the potential for future industrial action being taken by medical and dental staff in the NHS which may impact the Trust both in terms of performance and in relation to the financial position. At the time of writing no industrial action is planned by any of the staff groups with a mandate for the same and progress has been made in the government's discussions with unions representing consultants. A revised pay offer has been made for this group and the medical trades unions are now seeking the views of their membership, with the result expected in late January. The following mandates are in place or being sought:

Consultant Medical Staff

- The BMA have a mandate to call for Consultant member to take industrial action until 26 December 2023 and there is currently further ballot of the Consultant membership being conducted by the BMA. This later ballot closes on 18 December and would provide a mandate for further industrial action to 17 June 2024 if the majority of members vote in favour of further such action.
- The Hospital Consultants and Specialists Association (HCSA) have recently balloted their membership on industrial action with a 76% 'yes' vote based on a 52% turnout. This provides a mandate for further action to May 2024. The HCSA report fewer than 10 members at RWT.

Specialty and Specialist Doctors

- The BMA have similarly balloted their SAS doctor members in a ballot which closes on 18 December. As with the ballot of Consultant members, should the membership vote in favour of industrial action, the mandate would run to June 2024.
- The HCSA have balloted their SAS membership alongside the Consultant membership and have a mandate for industrial action running to May 2024.

Junior Doctors

- The BMA have a mandate to call on their Junior Doctor membership to take industrial action until February 2024.
- Th HCSA are currently balloting their Junior doctor membership in a ballot that closes on 20 December 2023.

In the event that the trade unions call for industrial action, the Trust would manage this in accordance with the business continuity plan

Executive Summary Workforce Report

The Royal Wolverhampton NHS Trust

Trust Board
12th December 2023

Safe & Effective | Kind & Caring | Exceeding Expectation

Alan Duffell
Group Chief People Officer

Executive Summary

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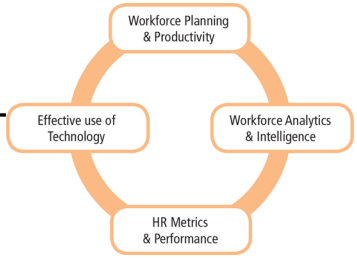
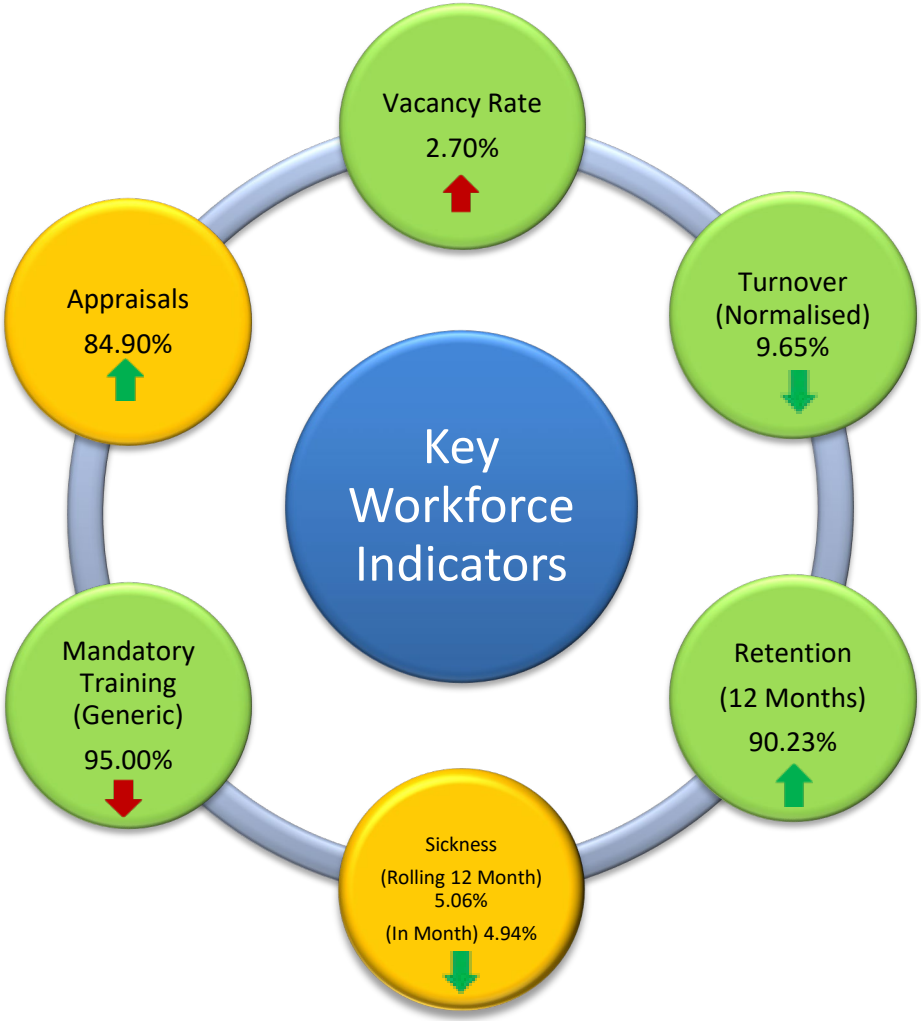
- The fill rate through the bank in October was 72% for registered nursing staff and 86% for healthcare assistants. The medical staff bank fill rate was 81% exceeding the target of 60%.

The report also provides updates on industrial action, rostering and e-job planning.

Key Workforce Metrics





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Summary Items

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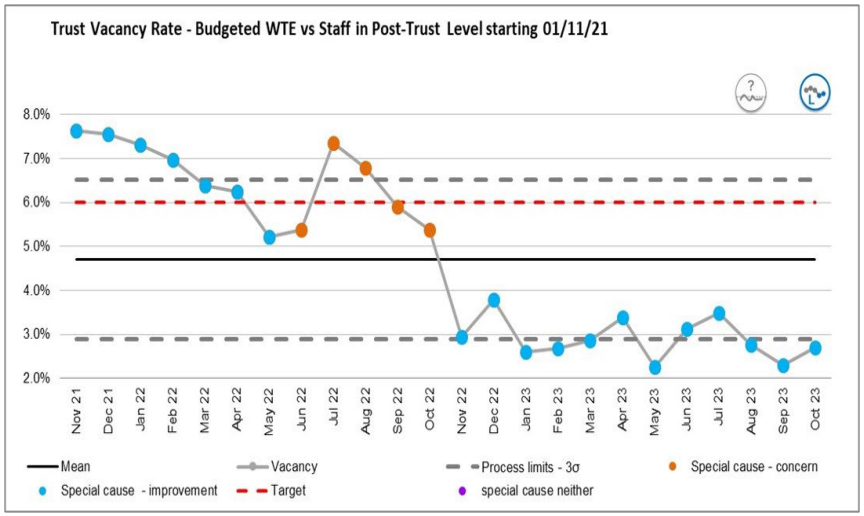
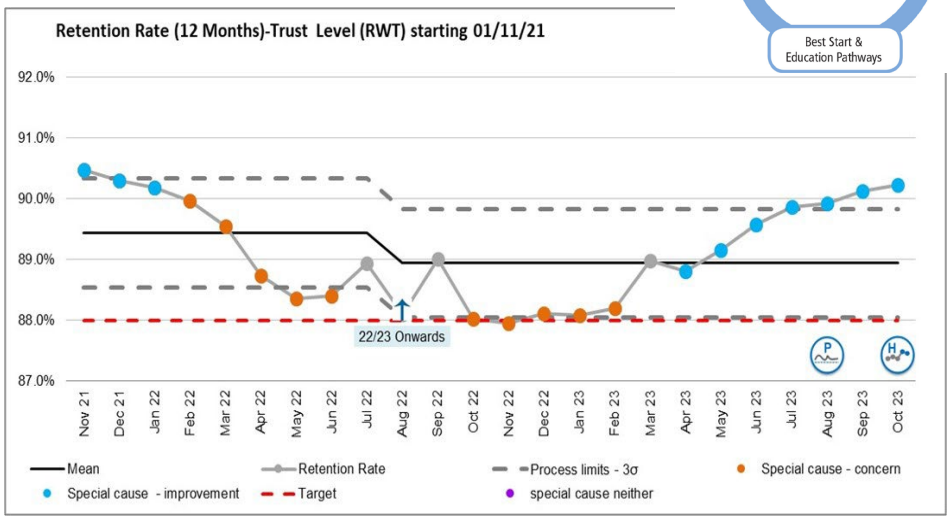
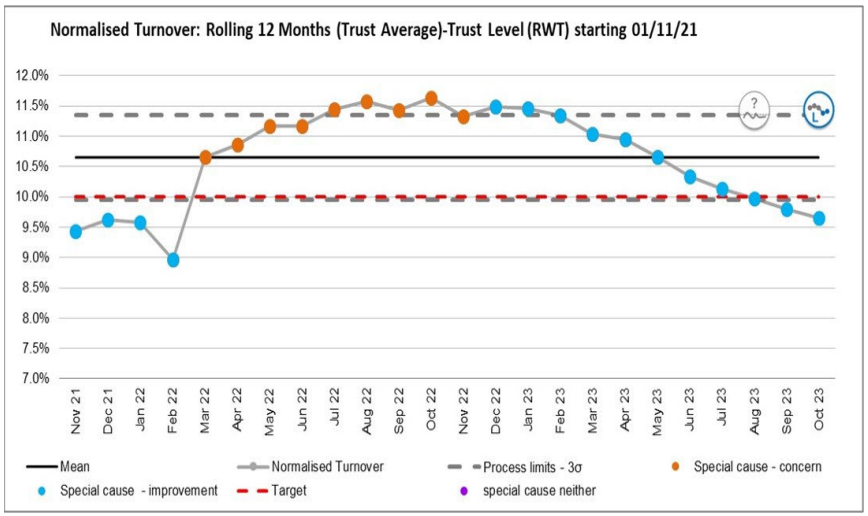
Attract, Recruit & Retain

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

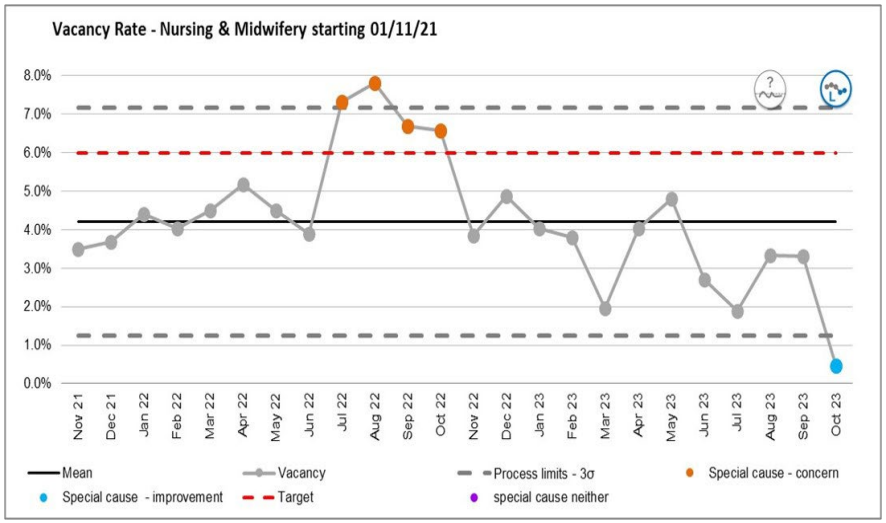
- Whilst the vacancy levels are performing well overall, there continue to be hotspots and there is a lead time, particularly in relation to international and newly qualified nurses where the recruitment will have reduced the vacancy level, but a period of consolidation is required before they can take on the full range of required duties as a registered healthcare professional.

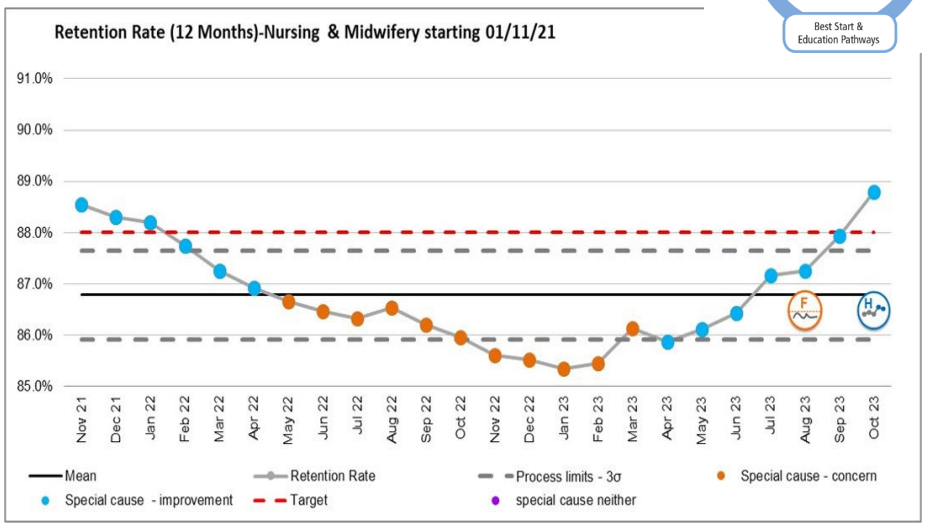
Key Actions & Progress

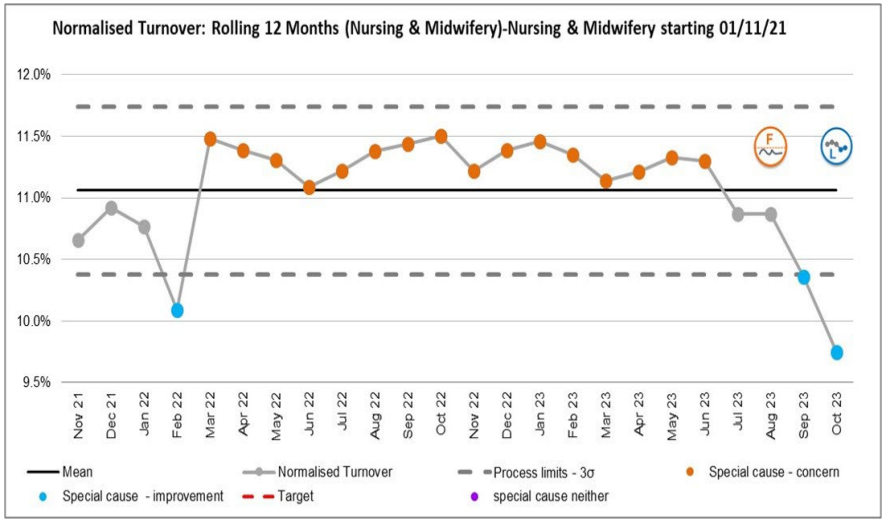
- The Retention Rate at 12 months is meeting the 88% target at 90.23%.
- Turnover is below target at 9.65%.
- The vacancy rate is meeting the target consistently, this is for all staff groups except AHPs.
- Active work continues to identify hard to fill posts and with a focus on AHP and Healthcare science posts.
- Starters continue to outpace leavers with the net increase in month predominantly in medical staff group.
- 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

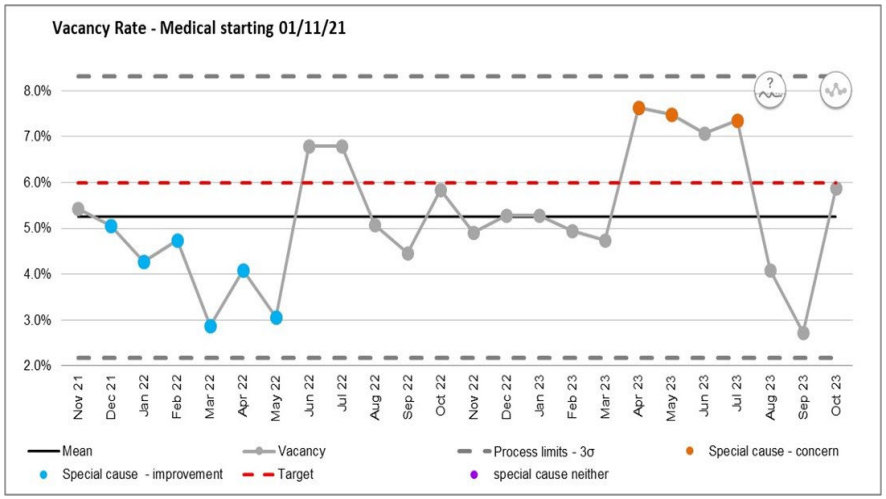
- Nursing turnover, has improved in month to 9.75% and is now meeting the 10% target. Work life balance is a key driver of turnover. Increased turnover is also driven by staff who deferred retirement/ may otherwise have left in prior years now leaving the service/ Trust. Wider review of this suggests 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.

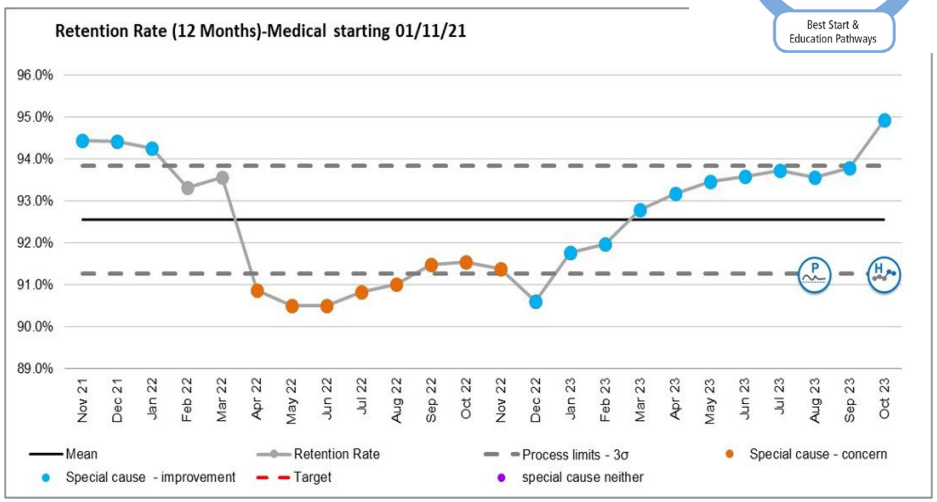
Key Actions & Progress

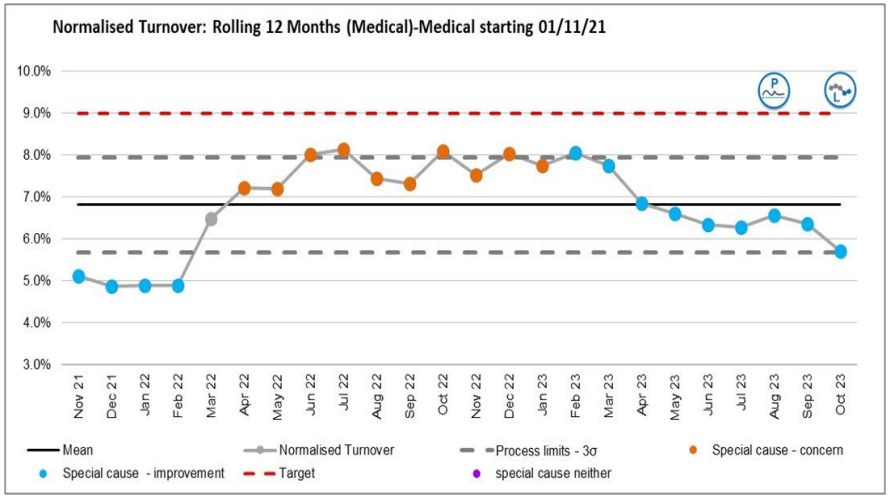
- The vacancy rate for nursing and midwifery staff is meeting the target at 0.47% just over 14 vacancies for nursing staff. This is as a result of the newly qualified nurses joining the workforce.
- There are 76 WTE international/ newly qualified nurses in the pipeline working towards their pin.
- Recruitment has slowed for this staff group given the favourable vacancy position.

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

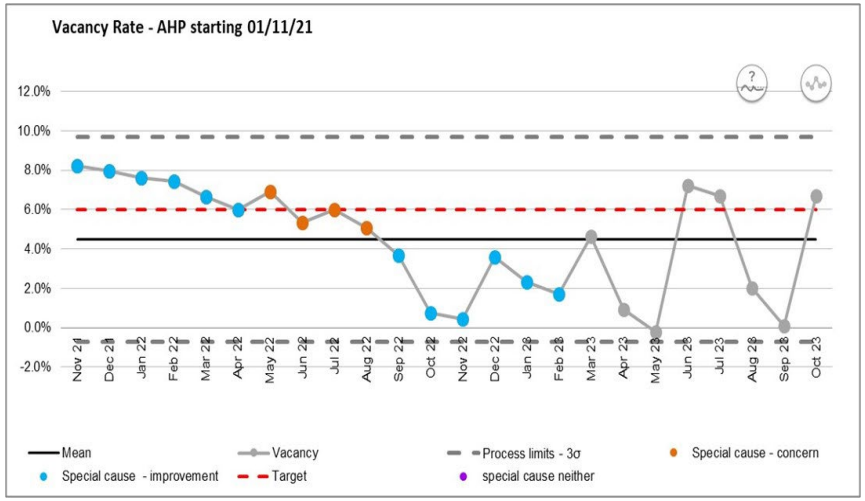
- Whilst the overall position is hugely positive, there are some hotspots in key services where vacancy levels give cause for concern.
- High-cost agency spend in Microbiology covering vacancy has now ceased.

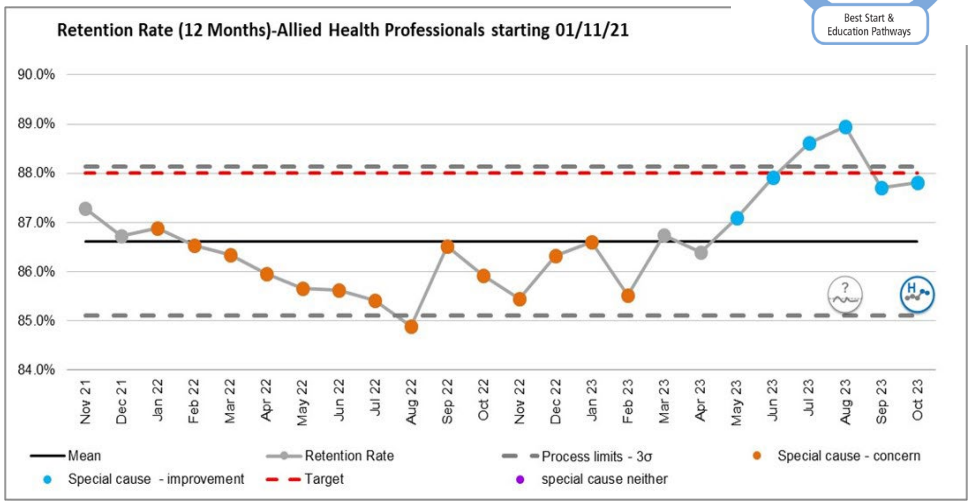
Key Actions & Progress

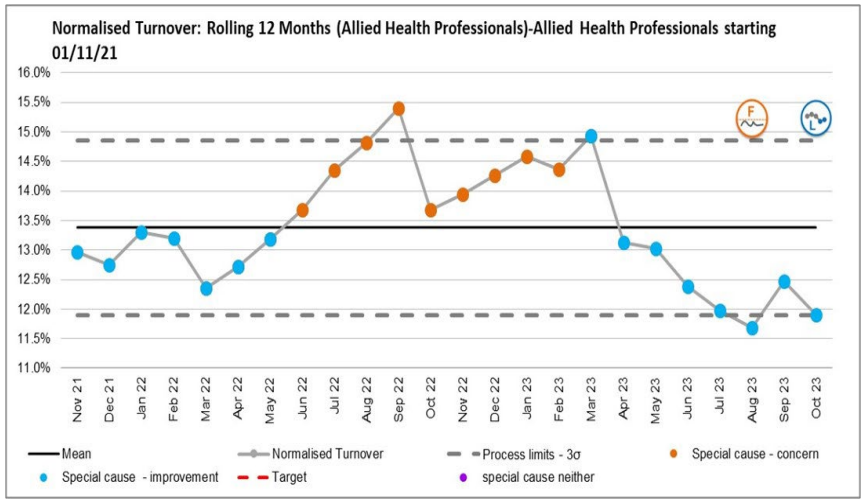
- The vacancy rate has increased in month to 5.88% but still meeting the target.
- All recruitment and retention metrics for medical staff are being met with further improvements seen in both retention and turnover over recent months.

Attract, Recruit & Retain

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better





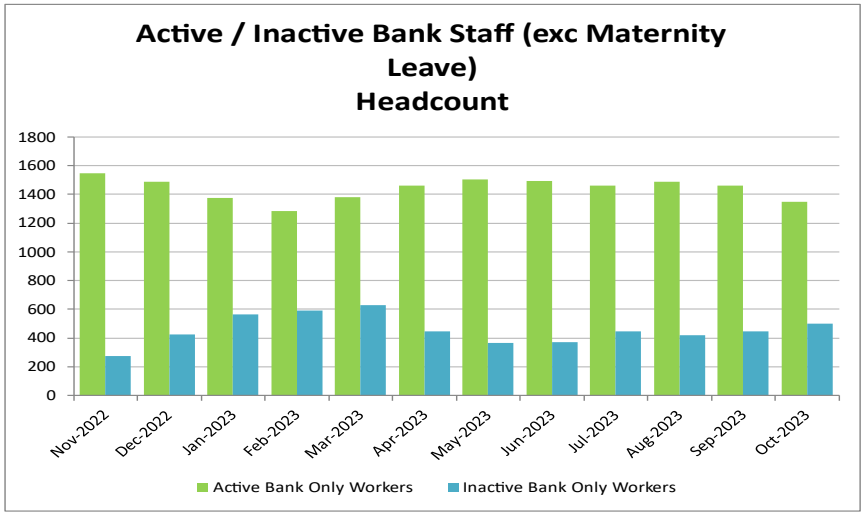


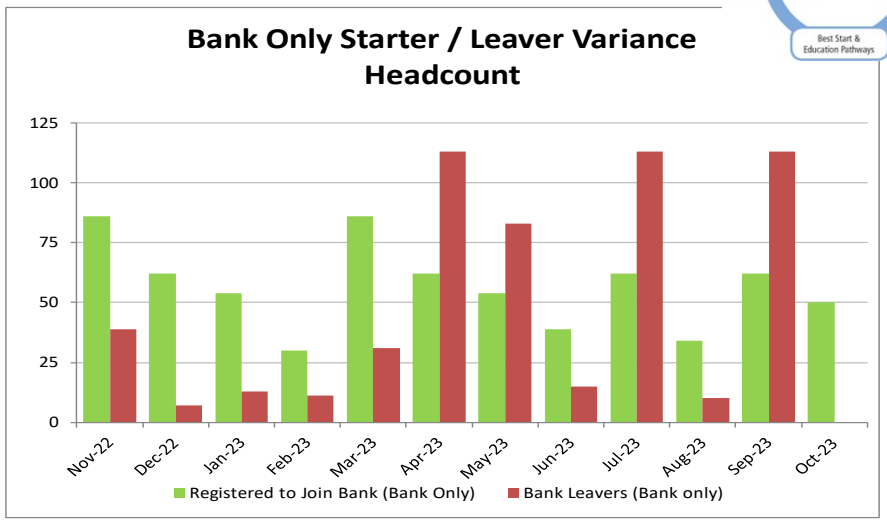
Key Issues & Challenges

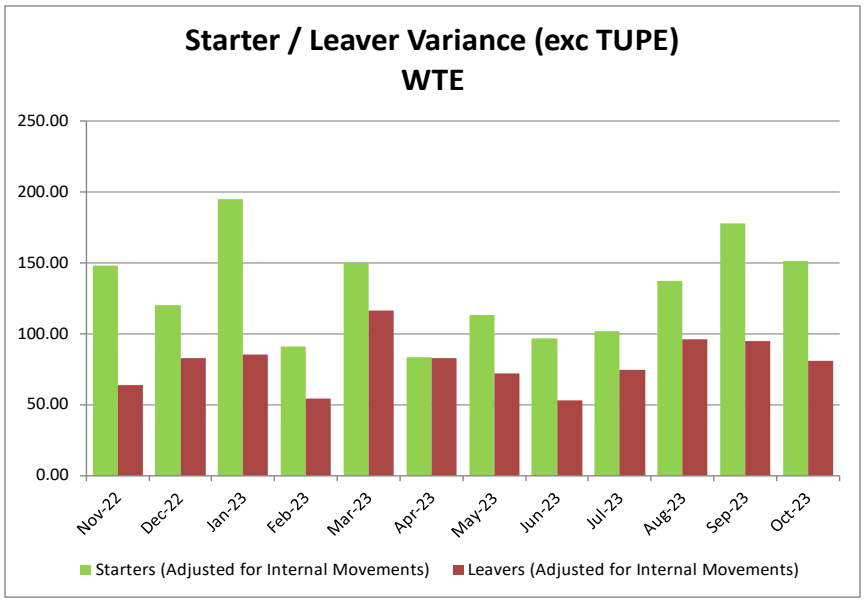
- Metrics for AHPs cover Podiatry, Dietetics, Occupational Therapy, Physiotherapy, Orthoptics, Radiography (diagnostic and therapeutic), Orthotics, Speech and Language Therapy (SaLT), and Operating Department Practitioners (ODPs).
- Turnover for AHPs is elevated but it has improved in month.
- AHP vacancy levels are no longer meeting the Trust target.

Key Actions & Progress

- AHP retention rate has improved in month.







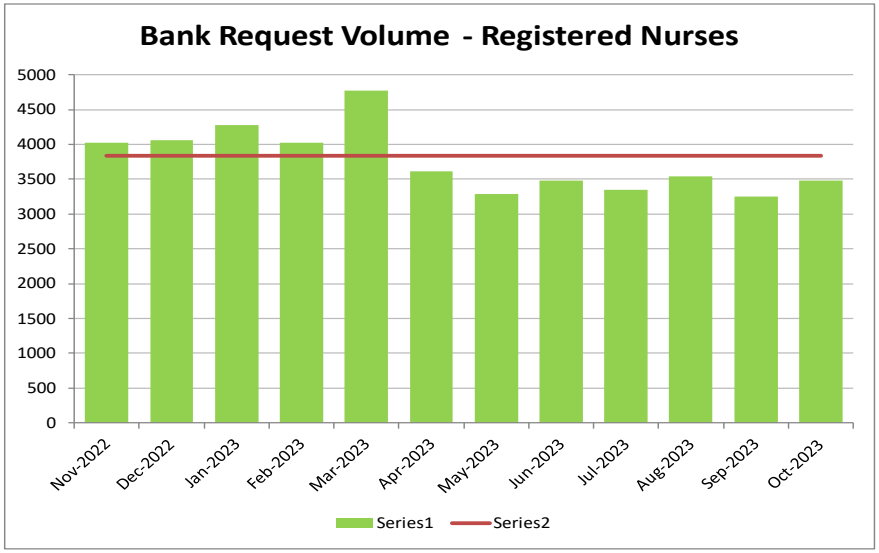
Key Issues & Challenges

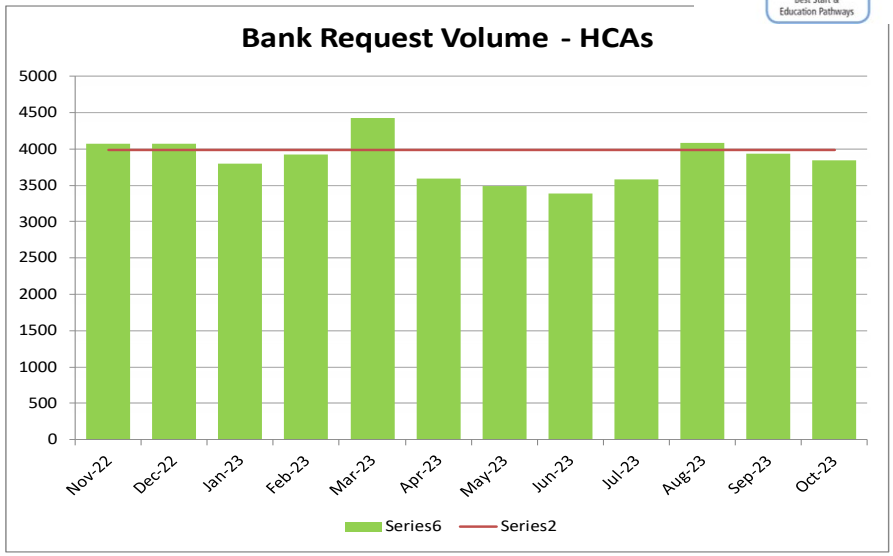
- 651 Late requested shifts (within and over 24 hours of the start time of the shift), 463 of these shifts have been identified that prior notice may have been given, in addition 202 requests were requested more than 24 hours after the start time of the shift which is having a negative impact on fill rates – an increase of 149 last minute requests from September

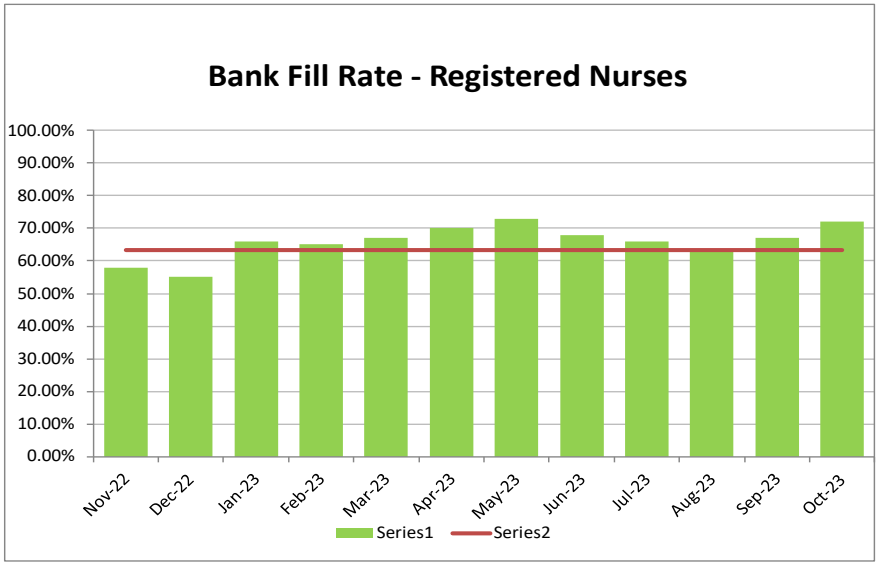
Key Actions & Progress

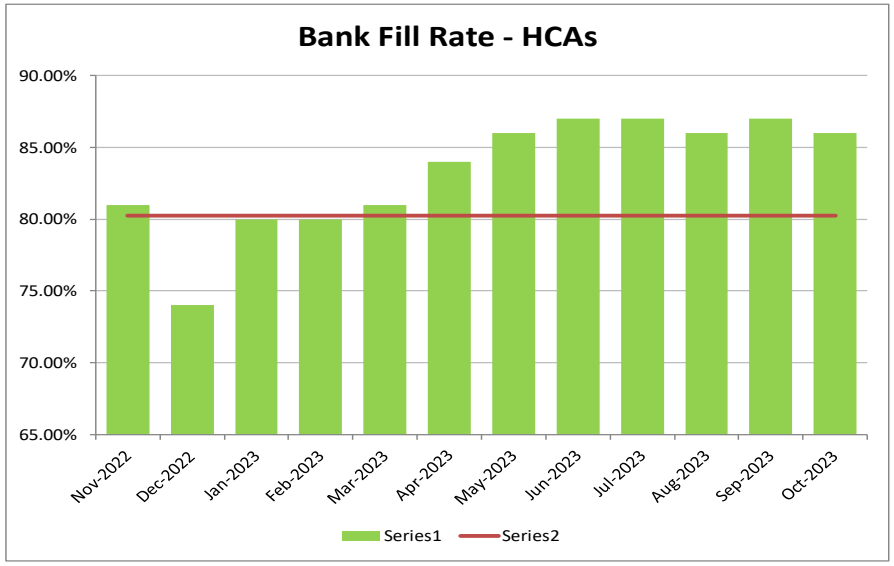
- £45 per hour Enhanced Rate for Sonographers in Maternity extended until the end of November.
- Increase in fill rate for ED, 523 Requests – 50% fill rate in October compared to 505 requests and 46% fill rate in September
- Fill Rate increased by 6% for Qualified Bank Staff in October from 66% in September to 72% in October, Fill rate trust wide has increased by 2% in October 2023
- Students on placement with the Trust – 10 Conditional Offers made, 8 completed pre-employment checks and ready to start work
- 66 Internal new starters registered – 42 Qualified, 19 Unqualified and 5 Admin

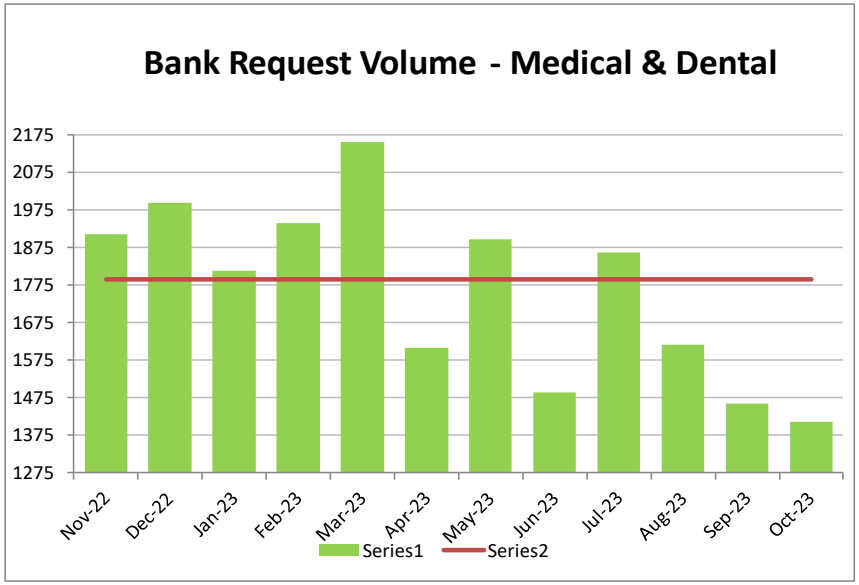

Employer Branding, Attraction, Recruitment & Retention
Career Pathways & Succession Planning
Best Start & Education Pathways
Apprentices & Graduates


Bank Request Volume - Registered Nurses
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Nov-2022
Dec-2022
Jan-2023
Feb-2023
Mar-2023
Apr-2023
May-2023
Jun-2023
Jul-2023
Aug-2023
Sep-2023
Oct-2023
Series1
Series2


Bank Request Volume - HCAs
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Series6
Series2

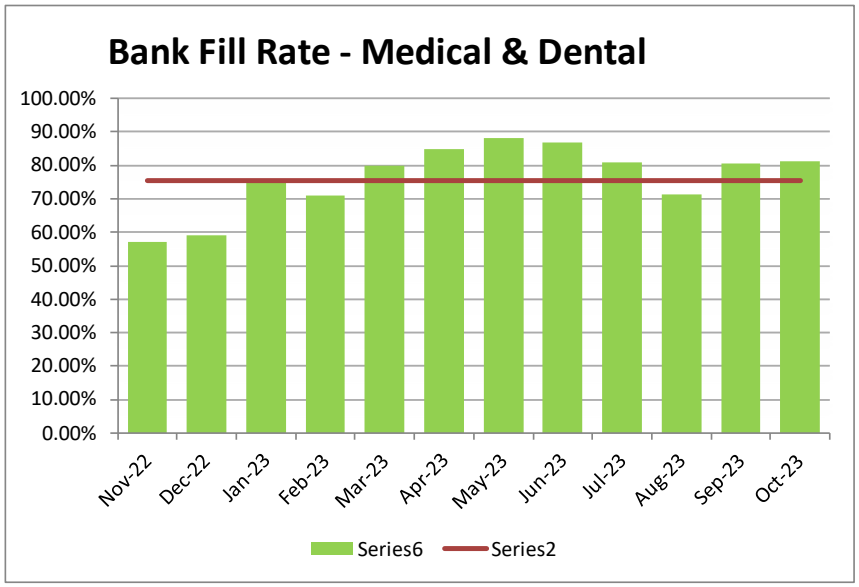

Bank Fill Rate - Registered Nurses
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Series1
Series2


Bank Fill Rate - HCAs
90.00%
85.00%
80.00%
75.00%
70.00%
65.00%
Nov-2022
Dec-2022
Jan-2023
Feb-2023
Mar-2023
Apr-2023
May-2023
Jun-2023
Jul-2023
Aug-2023
Sep-2023
Oct-2023
Series1
Series2



Key Issues & Challenges

- Collaborative bank shifts continue to be booked at a steady rate throughout the majority of the specialties across the Trust. Collab bank utilised in ENT, ED,Gen Med and Gen Surg.
- Clinical system accesses for medical collab 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 collab bank worker.
- Health Roster rollout and training currently being reviewed and junior Doctor to roll out to begin in coming months.
- The onboarding process for bank workers has been streamlined making it a quicker process to join the medical bank
- Improvement in onboarding process has reduced payment delays for new bank workers.



Key Actions & Progress

- Medical bank fill rate has sustained its increase from circa 40% to 80%. This improvement is due to medical staff joining the medical locum bank internally and externally, there is improvement to be made on this number and we should see an improvement with the streamlining of the on boarding process.

Education / Organisational Development	BCPS	Corporate	Division 1	Division 2	Division 3	Estates	Grand Total
Mandatory Training - Statutory Topics	91.40%	96.00%	94.40%	95.00%	95.80%	97.10%	95.00%
Mandatory Training - Policy Required	94.50%	97.10%	93.50%	93.80%	95.90%	98.40%	94.70%
Appraisal	80.40%	81.90%	83.90%	86.40%	85.40%	90.90%	84.90%

Mandatory Training - Statutory Topics	Aug-23	Sep-23	Oct-23
225 Black Country Pathology Service	91.40%	91.60%	91.40%
225 Corporate Division	96.10%	96.30%	96.00%
225 Division 1	94.60%	94.40%	94.40%
225 Division 2	94.70%	95.40%	95.00%
225 Division 3	95.50%	95.50%	95.80%
225 Division 4	85.70%		
225 Estates & Facilities Division	97.30%	97.40%	97.10%
Grand Total	95.00%	95.10%	95.00%

Appraisals	Aug-23	Sep-23	Oct-23
225 Black Country Pathology Service	86.90%	84.90%	80.40%
225 Corporate Division	82.30%	81.00%	81.90%
225 Division 1	83.50%	81.90%	83.90%
225 Division 2	86.70%	87.50%	86.40%
225 Division 3	85.10%	85.40%	85.40%
225 Division 4	100.00%		
225 Estates & Facilities Division	92.10%	91.10%	90.90%
Grand Total	85.40%	84.80%	84.90%

Mandatory Training - Policy Required	Aug-23	Sep-23	Oct-23
225 Black Country Pathology Service	94.10%	94.40%	94.50%
225 Corporate Division	96.80%	97.00%	97.10%
225 Division 1	93.30%	93.30%	93.50%
225 Division 2	93.00%	93.40%	93.80%
225 Division 3	95.90%	95.90%	95.90%
225 Division 4	88.20%		
225 Estates & Facilities Division	98.30%	98.50%	98.40%
Grand Total	94.40%	94.50%	94.70%

Key Issues & Challenges

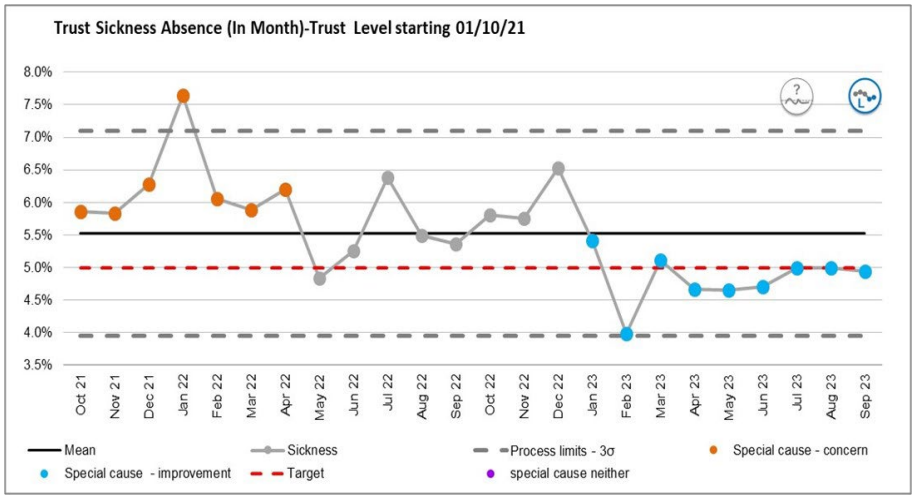
- Appraisal compliance is not meeting the target across the board and the last time this target was met was in December 2019.
- Particular focus is needed in BCPS and Corporate where performance is most challenged.
- Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals

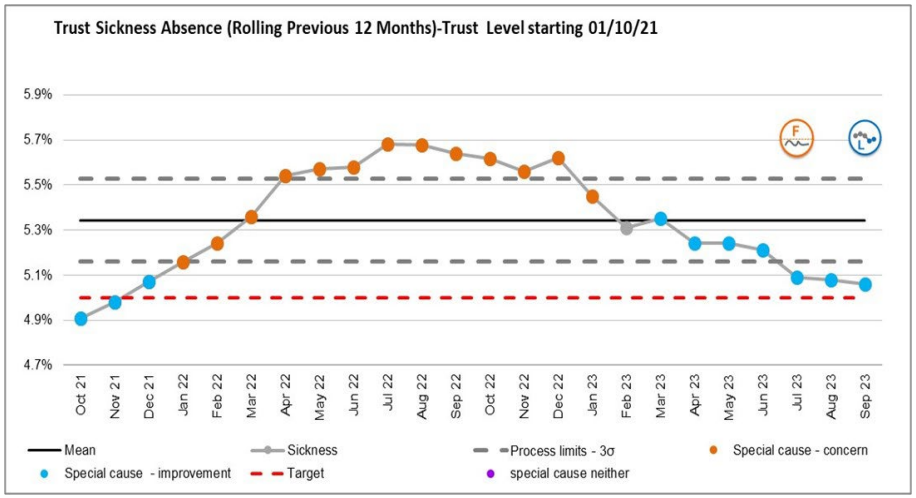
Key Actions & Progress

- This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.
- Within Divisions, directorates and departments have been required to produce recovery plans for the delivery of appraisal activity and this will be managed through the Divisions.
- Mandatory training, both Tier 1 and Tier 2 continues to meet the Trust target.

Health & Wellbeing

What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better





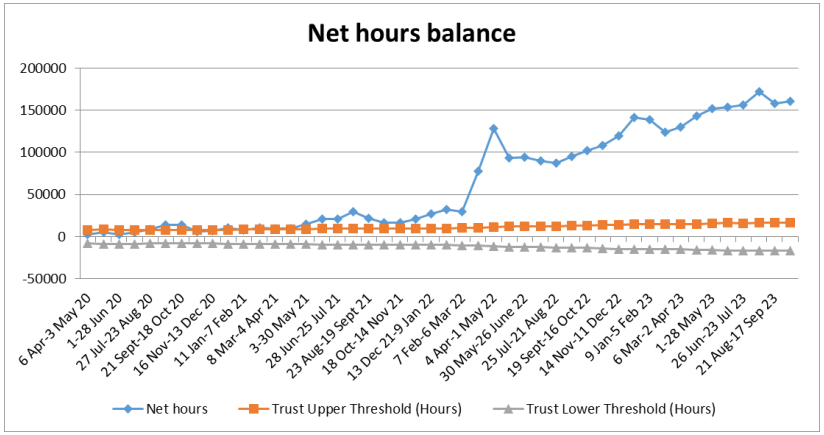
Key Issues & Challenges

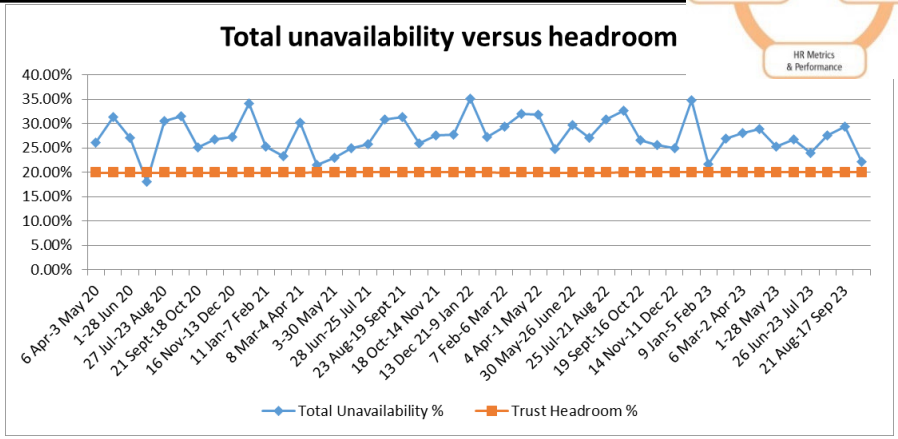
- The rolling 12-month absence rate remains above the Trust target at 5.06% despite an improvement in month and for the fifth consecutive month.
- In month sickness absence has remained stable at 4.94%, meeting the 5% target.
- Occupational Health referrals increased in September to 271 from 253 in August. The average for 2022/23 was 213 referrals per month and 2023/24 is showing an increase on that with an average of 233 referrals per month.

Key Actions & Progress

- HR colleagues have been reviewing cases where staff are experiencing the highest levels of absence to ensure appropriate escalation within divisional structures.
- HR teams continue to sensitively support the management of long and short term sickness absence cases as appropriate in the current circumstances.
- Considerable work has been done to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.
- The flu and COVID-19 vaccination campaigns commenced in September, during the first month 882 people were vaccinated, 609 front line staff.
- Occupational Health colleagues have been focussed on the vaccination campaign. As a result, appointments with nurses have only been made within the required timeline in 26%, 54% of referrals requiring a doctor were seen on the required timeline in September.

Productivity – e-Rostering Metrics





Definition: Net hours are the planned versus delivered contracted hours
Trust threshold: Within 2% (over or under) total contracted hours

Definition: Any period of absence from core service delivery
Trust threshold: 20% total headroom allowance

Key Issues & Challenges

The Trust's net hours balance remains outside of agreed thresholds (2% total contracted hours). For the current reporting period, this equated to just over 160k of unused contracted hours; a slight increase from the previous report, the majority of the net hours outside of threshold relate to hours accrued historically in prior winter COVID waves.

Sickness, parenting (maternity, paternity, adoption leave), and other leave (authorised leave in line with policy) remain contributory factors, the latter two reasons for which are both excluded from headroom percentages.

- Annual leave, 10.46% - below policy thresholds (11-17%)
- Sickness, 5.65% - outside of policy thresholds (3.24%)
- Study, 1.97% - within policy thresholds (2%)
- Other leave, 0.98% - not factored into headroom
- Working day, 0.79% - not factored into headroom
- Parenting, 2.32% - not factored into headroom

Total unavailability remains outside of the Trust headroom percentage (20%) at 22.19%. However, this is an improvement from last month's report (29.41%) and positive in comparison to last year's figures (26.56%).

Key Actions & Progress

- Net hours continue to be prioritised as part of training sessions. Staff are also advised to view the extra net hours training video.
- Dedicated remote and face to face net hours sessions continue to identify net hours issues and bring the department's net hours balances down. Dental Nursing, LCRN, Colorectal Nursing and Phoenix UTC have seen further hours reductions with more identified. Further sessions have arranged for LCRN with many being requested and co-ordinated by the E-rostering Team.
- Data cleansing exercise underway on net hours.

Net Hours by Division:

- BCPS continues to remain within thresholds, though there was a 1000 hour variance this month.
- Division 1 has increased by around 1000 net hours.
- Division 2 has reduced by around 3000 net hours.
- Division 3 has increased by around 7000 net hours. - was contributed to by the Speech and Language Therapy rosters not being populated accurately (approx. 6000 hours). Rectified this month.
- Corporate has reduced by around 800 net hours.
- Division 1 net hours are much more stable due to net hours work, Division 2 and corporate are seeing improvements.

Job Plan Status		
Column1	Number	Percentage
Not published	0	0%
Users with expired job plans	98	19%
In discussion	399	78%
Awaiting 1st sign off by Manager	12	2%
Awaiting 1st sign off by Clinician	1	0%
Awaiting 2nd sign off	4	1%
Awaiting 3rd Sign off	0	0%
Locked Sown	1	0%

Summary Update

e-Job Planning

The Job Planning Round for 2023/24 was concluded in August and a new round commenced on 1 November, with the status of all job plans reset.

Actions are in place through Divisional Medical Directors to move job plans through the process, with the expectation that all job plans move to discussion stage by the end of November. Further work was required in Obstetrics and Gynaecology, Critical Café and General Surgery due to the need to split into sub specialties.

At People Committee the Deputy Medical Director agreed to bring a detailed update on Job Planning to the a future meeting.

e-Rostering Update

Currently Medical E rostering is on hold and is not currently rolled out to any area.

Plans are in place to roll-out rostering to medical staff in 2024.

Workforce Metrics - Trust Board
M7: Data Effective 31st October 2023
Full Trust

The Royal Wolverhampton NHS
NHS Trust

B01	Workforce Profile	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B01.1	Substantive Staff WTE	9999.33		10002.13	10043.43	10086.45	10114.26	10154.55	10234.30	10303.52						155.22	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	9795.87	9787.26	9852.83	9925.11						104.84	Inc Permanent, Fixed Term, & Locums; Exc Rotational Drs
B01.3	Substantive Staff Headcount	11,371		11,379	11,428	11478.00	11496.00	11550.00	11636.00	11727.00						179	Inc Permanent, Fixed Term, & Locums with WTE on Payroll
B01.4	Bank Staff Only Headcount	2,017		1,918	1,881	1883.00	1898.00	1931.00	1883.00	1866.00						-86	
B01.5	Agency LMS Headcount	156		157	156	156	156	166	169	167.00						10	
B01.6	% Staff from a BME background	35.66%		36.41%	37.08%	0.36	0.36	0.37	0.37	0.37						1.08%	
B01.7	TUPE In WTE	0.00		0.00	0.00	0.00	0.00	0.00								0.00	
B01.8	TUPE Out WTE	19.11		10.08	1.00	2.33	3.33	2.00	7.33	8.27						36.21	
	Data Owner: Workforce Planning & Business Intelligence																

B02	Changes to Workforce Profile	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B02.1	Change in Workforce Profile WTE (Exc Rotational Doctors)			-31.47	-6.23	21.65	14.09	60.74	55.93	16.53						60.74	
B02.2	Starters WTE (Exc Rotational Doctors)			114.67	119.62	75.30	87.96	75.70	121.82	134.58						729.65	Leavers current month target calculated as 1/12th of 10.5% of in-month Staff in Post
B02.3	Leavers WTE (Exc Rotational Doctors)			82.70	72.09	52.93	74.24	96.15	95.01	80.89						554.01	
	Data Owner: Workforce Planning & Business Intelligence																

B03	Workforce Profile by Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD Change Out-turn	Comments
B03.1	Add Prof Scientific and Technic WTE	276.83		275.48	279.64	279.36	278.70	284.20	288.52	290.06						7.37	
B03.2	Additional Clinical Services WTE	1,907.91		1,895.79	1,910.29	1,906.21	1,897.02	1,878.92	1,874.79	1,857.97						-28.99	
B03.3	*Add Clin Serv: Newly Qualified / Overseas Nurses Awaiting PIN*	114.52		*111.60*	*146.23*	*123.69*	*92.59*	*93.27*	*90.33*	*76.13*						-21.25	
B03.4	Administrative and Clerical WTE	2,162.10		2,170.84	2,172.89	2,175.61	2,179.55	2,185.26	2,200.42	2,214.88						23.16	
B03.5	Allied Health Professionals WTE	568.46		566.16	564.26	565.01	578.98	581.78	584.21	603.89						13.32	
B03.6	Estates and Ancillary WTE	596.55		600.58	602.90	610.40	613.48	613.77	612.95	612.30						17.22	
B03.7	Healthcare Scientists WTE	499.42		499.13	501.73	504.20	506.26	509.95	518.32	515.48						10.53	
B03.8	Medical and Dental WTE (Exc Rotational Doctors)	788.59		794.69	798.53	804.85	800.81	795.07	795.83	796.57						6.48	
B03.9	Medical and Dental WTE (Rotational Doctors)	316.91		314.59	320.61	317.70	318.39	367.30	381.47	378.41						50.39	
B03.10	Nursing and Midwifery Registered WTE	2,863.55		2,865.87	2,873.58	2,905.12	2,923.07	2,920.30	2,962.80	3,019.96						56.75	
B03.11	Students WTE	19.00		19.00	19.00	18.00	18.00	18.00	15.00	14.00						-1.00	
	Data Owner: Workforce Planning & Business Intelligence																

B04	Vacancy Rate by NHSI Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B04.1	Total	2.87%	6.00%	3.40%	2.26%	3.12%	3.48%	2.77%	2.31%	2.70%						2.86%	Staff in Post WTE vs Budgeted WTE in ESR
B04.2	Allied Health Professionals	4.66%	6.00%	0.93%	-0.20%	7.23%	6.71%	2.04%	0.09%	6.70%						3.36%	Refined calculation 2019/20: removal of recharges and reserves from Budgeted WTE therefore not directly comparable to previous figures
B04.3	Healthcare Scientists	15.00%	6.00%	1.29%	-1.78%	5.57%	-1.27%	2.79%	3.02%	3.68%						1.90%	Staff Group definitions determined by NHS Improvement
B04.4	Medical & Dental	4.75%	6.00%	7.63%	7.48%	7.08%	7.36%	4.08%	2.72%	5.88%						6.03%	Staff in Post ajusted for St Helen's employed Rotational Doctors and removal of Chair / NEDs
B04.5	NHS Infrastructure Support	5.98%	6.00%	3.65%	4.91%	4.57%	5.34%	5.49%	4.73%	2.98%						4.52%	
B04.6	Other ST&T	-10.47%	6.00%	-0.26%	-1.07%	-2.79%	2.84%	5.80%	-2.75%	-3.08%						-0.19%	
B04.7	Registered Nursing, Midwifery and Health Visiting Staff	1.96%	6.00%	4.03%	4.80%	2.69%	1.89%	3.33%	3.31%	0.47%						2.93%	
B04.8	Support to Clinical Staff	-0.04%	6.00%	2.18%	1.68%	0.71%	1.46%	0.55%	1.20%	2.87%						1.52%	RAG ratings updated effective May 21
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B05	Vacancies by NHSI Staff Group	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B05.1	Total	296.27		352.02	352.11	325.05	315.85	289.31	244.44	285.74						309.22	
B05.2	Allied Health Professionals	27.98		5.36	-1.13	44.73	41.78	12.18	0.55	43.47						20.99	Staff in Post WTE vs Budgeted WTE in ESR
B05.3	Healthcare Scientists	91.08		6.70	-8.86	30.12	-6.51	14.90	16.35	20.01						10.39	Refined calculation 2019/20: removal of recharges and reserves from Budgeted WTE
B05.4	Medical & Dental	56.40		93.90	92.55	87.48	91.05	49.46	32.99	73.42						74.41	Staff Group definitions determined by NHS Improvement
B05.5	NHS Infrastructure Support	86.86		52.08	68.66	63.98	77.77	79.48	66.19	41.36						64.22	Staff in Post ajusted for St Helen's employed Rotational Doctors and removal of Chair / NEDs
B05.6	Other ST&T	-22.04		-0.60	-2.53	-6.26	6.69	13.52	-5.99	-6.73						-0.27	
B05.7	Registered Nursing, Midwifery and Health Visiting Staff	57.44		120.91	145.65	80.70	56.51	101.09	105.13	14.46						89.21	
B05.8	Support to Clinical Staff	-1.45		73.67	57.77	24.30	49.57	18.68	41.45	99.75						52.17	
	Data Owners: Finance & Workforce Planning & Business Intelligence																

B06	Turnover	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B06.1	% Total Workforce Turnover (Rolling previous 12 months)	12.56%		12.50%	12.18%	11.83%	11.49%	11.27%	11.02%	10.92%						11.60%	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%	10.13%	9.97%	9.79%	9.65%						10.21%	
B06.3	% Normalised: Additional Professional, Scientific, and Technical	12.36%	10.00%	10.72%	9.61%	9.04%	8.39%	7.55%	7.68%	7.85%						8.69%	
B06.4	% Normalised: Additional Clinical Services	10.95%	10.00%	10.91%	10.16%	10.17%	10.44%	10.33%	9.98%	10.29%						10.33%	
B06.5	% Normalised: Administrative and Clerical	10.37%	10.00%	10.55%	10.36%	9.42%	9.04%	9.06%	9.26%	9.45%						9.59%	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%	11.97%	11.68%	12.47%	11.90%						12.39%	
B06.7	% Normalised: Estates and Ancillary	11.39%	10.00%	10.88%	10.10%	10.00%	10.03%	9.14%	9.42%	10.18%						9.96%	RAG ratings updated effective May 21
B06.8	% Normalised: Healthcare Scientists	13.68%	10.00%	13.40%	13.03%	12.61%	12.53%	11.56%	10.50%	9.76%						11.91%	
B06.9	% Normalised: Medical and Dental (Exc Rotation Drs & Clinical Fellows)	7.75%	10.00%	6.86%	6.61%	6.35%	6.29%	6.57%	6.37%	5.71%						6.39%	
B06.10	% Normalised: Nursing and Midwifery Registered	11.14%	10.00%	11.21%	11.33%	11.30%	10.87%	10.87%	10.36%	9.75%						10.81%	
	Data Owner: Workforce Planning & Business Intelligence																

B07	Retention Rate	31st Mar 2023 Out-turn	Target	2023-2024 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 Average	Comments
B07.1	Retention Rate (12 months)	88.98%	88.00%	88.81%	89.15%	89.57%	89.86%	89.93%	90.13%	90.23%						89.67%	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%	84.40%	83.70%	84.81%	84.97%						85.77%	
B07.3	Retention Rate (24 months)	80.41%	0.00%	80.08%	80.05%	80.37%	80.28%	80.32%	80.64%	80.62%						80.34%	
	Data Owner: Workforce Planning & Business Intelligence																

B08	Sickness Absence (1 month in arrears)	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Average	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B08.1	% Sickness Absence (In Month)	5.00%	5.00%	4.67%	4.65%	4.71%	5.00%	4.99%	4.94%	Avail Dec						4.83%	
B08.2	% Sickness Absence (Rolling previous 12 months)	5.00%	5.00%	5.24%	5.24%	5.21%	5.09%	5.08%	5.06%	Avail Dec						5.15%	
B08.3	WTE Days lost to Sickness	11,084.90		13,643.37	14,431.76	141,194.97	15,599.04	15,643.10	£15,036.58	Avail Dec							
B08.4	% Short Term Sickness	2.16%		2.17%	2.18%	2.13%	2.06%	2.04%	2.04%	Avail Dec							
B08.5	% Long Term Sickness	3.15%		3.07%	3.06%	3.08%	3.03%	3.04%	3.02%	Avail Dec							
B08.6	Estimated Cost of Sickness (£)	£1,091,089		£1,278,411	£1,434,332	£1,411,327	£1,517,389	£1,514,615	£1,467,121.40	Avail Dec							
Data Owner: Workforce Planning & Business Intelligence																	

B09	Flu Campaign	2022-23 Season Out-turn	Target	2023-2024												2023-24 Cumulative	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B09.1	Front Line Staff Vaccinated (Cumulative)	3828							609	2973						2091	
B09.2	Non Front Line Staff Vaccinated (Cumulative)	1619							273	882						882	Seasonal reporting only.
B09.3	Total (Cumulative)	5051							882	2,973						2973	Figures reported here those submitted to Public Health England for month-end periods. Figures can fluctuate due to leavers percentage.
B09.4	% Front Line Staff Vaccinated (Cumulative)	61.73%	TBC						6.58%	22.51%							
Data Owner: Workforce Planning & Business Intelligence																	

B10	Open Employee Relations Cases - Number of Cases	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Average	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B10.1	Open Formal Grievances Cases + Open Bullying & Harassment Cases	41		32	19	17	20	22	22	19						22	
B10.2	Open Capability Cases	2		2	3	1	1	1	2	2						2	
B1103	Open Disciplinary Cases	36		36	35	34	31	31	26	29						32	
Data Owner: HR Employee Relations																	

B11	Freedom to Speak Up	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Cumulative	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B11.1	New Genuine Whistleblowing Cases Raised	0														0	Cases reviewed and confirmed as Whistleblowing by FtSU Guardian. Discuss
B11.2	Number of Concerns Raised through FTSU Guardian In Month	14		9	15	15	17	13	30	23						122	
Data Owner: Freedom to Speak Up Guardian																	

B12	Apprenticeships	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Cumulative	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B12.1	Number of New Apprentices Started in Month	3		35	2	4	0	5	15	4						65	
B12.2	Number of Existing Staff Converted to Apprentices in Month	2		5	4	0	5	5	40	25						84	
Data Owner: Education & Training																	

B13	Education / Organisational Development	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Average	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B13.1	Trust Induction	90.00%	0.00%	89.80%	90.10%	90.10%	90.50%	90.50%	91.70%	91.40%						86.08%	
B13.2	Local Induction	94.30%	0.00%	94.50%	94.90%	95.10%	95.10%	95.00%	95.00%	94.70%						81.91%	
B13.3	Mandatory Training - Tier 1 - Statutory Topics (Formerly "Generic")	85.00%	85.00%	95.10%	95.40%	95.60%	95.30%	95.00%	95.10%	95.00%						95.13%	
B13.4	Mandatory Training - Tier 2 - Policy Required (Formerly "Specific")	94.30%	85.00%	94.30%	94.50%	93.40%	94.10%	94.40%	94.50%	94.70%						92.91%	
B13.5	Appraisal	90.00%	90.00%	83.70%	83.60%	84.80%	85.50%	85.40%	84.80%	84.90%						79.62%	
Data Owner: Education & Training																	

B14	Temporary Staffing Spend - Agency	2022-23 Total	Target	2023-2024												2023-24 Cumulative	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B14.1	Agency Spend - Total	£7,594,396		£721,813	£716,067	£675,764	£787,028	£697,280	£641,515	£865,739						£5,105,206	
B14.2	Agency Spend - Nursing & Midwifery	£0					£59,311	£19,720	£4,521	£0						£83,552	
B14.3	Agency Spend - Medical Staff	£6,298,177		£607,200	£618,914	£494,966	£555,732	£548,651	£519,996	£756,735						£4,102,195	
B14.4	Agency Spend - Other	£1,296,219		£65,325	£97,153	£180,798	£171,985	£128,909	£116,997	£109,005						£870,172	
Data Owner: Finance																	

B15	Temporary Staffing Spend - Bank	2022-23 Total	Target	2023-2024												2023-24 Cumulative	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B15.1	Bank Spend - Total	£37,183,785		£3,594,410	£3,766,081	£2,900,147	£3,517,677	£3,619,858	£2,809,823	£3,556,219						£23,764,215	
B15.2	Bank Spend - Nursing & Midwifery	£7,607,648		£751,216	£670,679	£526,752	£546,802	£671,645	£528,839	£676,196						£4,372,128	
B15.3	Bank Spend - Medical Staff	£13,584,214		£1,193,826	£1,672,126	£1,059,523	£1,448,222	£1,181,245	£777,284	£1,277,814						£8,610,038	
B15.4	Bank Spend - Other	£15,991,923		£1,649,368	£1,423,277	£1,313,873	£1,522,653	£1,766,969	£1,488,407	£1,601,366						£10,765,912	
Data Owner: Finance																	

B16	Bank Fill Rate	31st Mar 2023 Out-turn	Target	2023-2024												2023-24 Average	Comments
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
B16.1	Registered Nursing Shifts Filled	67.00%	85.00%	70.00%	73.00%	68.00%	66.00%	63.00%	67.00%	72.00%						68.43%	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%	87.00%	86.00%	87.00%	86.00%						86.14%	
B16.3	Medical Staff Shifts Filled	80.00%	60.00%	85.00%	88.00%	87.00%	80.88%	71.39%	80.56%	81.30%						82.02%	
Data Owner: Resourcing and LMS																	

B17	e-Rostering	6th Mar 2023 Out-turn	Target	2023-2024												2023-24 Average	Comments
				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		
B17.1	% Rotas Set 6 Weeks in Advance (42 Days)	63.00%	80.00%	57.00%	64.00%	45.00%	71.00%	67.00%	71.00%	70.00%						49.44%	Reporting periods 4 weeks (28 days)
B17.2	Unused Hours	130152.80	-Roster WTE * 6h	143,274	151,847	93,941	157,071	173,323	160,374	163,479						115,923	RAG ratings updated effective Jan 21
B17.3	% Staff on Annual Leave	15.60%	14.00%	16.78%	16.78%	16.02%	12.57%	16.91%	18.60%	10.46%						12.01%	Jump in Net Hours explained in relevant PPT slide
Data Owner: e-Rostering																	

The Royal Wolverhampton NHS Trust

Report to the Trust Board (Public) Meeting On 12 December 2023		
Title of Report:	Reducing Agency Staffing Usage	Enc No: 11.2.3
Author:	Adam Race, Director of Operational Human Resources and Organisational Development	
Presenter/Exec Lead:	Adam Race, Director of Operational Human Resources and Organisational Development	

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:

RECEIVE the update contained in this paper for assurance of the Trust's compliance with NHSE's requirements relating to reducing temporary staffing costs (reporting and actions).
NOTE the Trust's commitment to incorporate enhanced reporting on agency/off-framework agency usage within the standard Board workforce performance metrics going forwards.
APPROVE the processes set out at Annex 3.

Implications of the Paper:			
Risk Register Risk	Yes ☐ No ☒ Risk Description: On Risk Register: Yes☐No☐ Risk Score (if applicable) :		
Changes to BAF Risk(s) & TRR Risk(s) agreed	State None if None Risk Description Is Risk on Risk Register: Yes☐No☒ Risk Score (if applicable):		
Resource Implications:	None		
Report Data Caveats	This is a standard report using the previous month's data. It may be subject to cleansing and revision.		
Compliance and/or Lead Requirements	CQC	Yes☒No☐	Details: Safe, Well-led
	NHSE	Yes☒No☐	Details: Agency Rules
	Health & Safety	Yes☒No☐	Details: Safe Staffing
	Legal	Yes☐No☒	Details:
	NHS Constitution	Yes☐No☒	Details:
	Other	Yes☐No☒	Details:
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. There are no identified equality implications of the matters contained in this paper.		
Report Journey/Destination or matters that may have been referred to other Board Committees	Working/Exec Group	Yes☒No☐	Date: 29 November 2023
	Board Committee	Yes☐No☒	Date:
	Board of Directors	Yes☐No☒	Date:
	Other	Yes☐No☒	Date:

Summary of Key Issues using Assure, Advise and Alert

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

- Much of the Trust's agency expenditure is over price cap, driven predominantly by the nature of the agency usage and as a result of the cap not reflecting inflationary pay pressures since 2016.
- There is a small amount of off-framework agency usage in hard to fill specialties.
- There is a small amount of admin agency, largely in the exempt specialty (Clinical Coding) and in the recognised area of agency spend (IT)

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

- There are some areas of additional approvals set out in the report.

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

- The Trust has low levels of agency usage, incurring around 1.5% of the pay expenditure against a target of not more than 3.7%.
- Additional reporting will be put in place to Board on Agency expenditure.

Links to Trust Strategic Aims & Objectives (Delete those not applicable)	
Excel in the delivery of Care	• Safe and responsive urgent and emergency care • We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our community and populations
Support our Colleagues	• Be in the top quartile for vacancy levels

THE ROYAL WOLVERHAMPTON NHS TRUST

Report to the Trust Board on 12th December 2023

Reducing Agency Staffing Usage

1. Introduction

1.1 There has been a significant level of additional scrutiny on temporary staffing usage and cost at NHS provider and system level in recent weeks by NHSE England. Most recently, on 18th October the Regional team wrote to the Black Country ICB Chair to advise that the costs of using temporary staffing are a significant driver of the Midlands' system financial deficit. The letter set out that the Black Country system's run rate suggests an outturn temporary staffing expenditure of £260.2m for 2023/24, £79.4m above plan and required urgent action to reduce these costs at system and regional level.

1.2 Prior to this on 10 October, Professor Nina Morgan, Regional Chief Nurse NHS England – Midlands, wrote to Midland providers and ICBs to advise that as at month 5 (August 2023) the Midlands region was failing to deliver the 3.7% national target for agency expenditure, with the Midlands having the second highest percentage of WTE agency staff nationally (2.5% vs. national average 2.2%). This letter outlined that this position is unsustainable from both a quality patient care and financial perspective and outlined some immediate actions, which are summarised at paragraph 1.6 below.

1.3 At a recent performance update to the West Midlands Chief Executives and Chairs on 18th September 2023, data highlighting off-framework agency usage for the Midlands systems was shared, which highlighted the Black Country and West Birmingham ICS as having one of the highest levels of off-framework agency usage (6.2%), see data table below.

Rank	Row Labels	Total Shifts	Off framework shifts	% OF agency shifts
1	**Nottingham and Nottinghamshire Health and Care ICS**	**12,044**	**1,050**	**8.7%**
2	**Joined Up Care Derbyshire ICS**	**6,377**	**415**	**6.5%**
3	**The Black Country and West Birmingham ICS**	**10,516**	**654**	**6.2%**
4	Herefordshire and Worcestershire ICS	8,347	510	6.1%
5	Northamptonshire ICS	6,859	361	5.3%
6	Shropshire and Telford and Wrekin ICS	8,761	281	3.2%
7	Coventry and Warwickshire ICS	9,064	199	2.2%
8	Staffordshire And Stoke On Trent ICS	8,526	166	1.9%
9	Leicester, Leicestershire and Rutland ICS	14,105	261	1.9%
10	Birmingham and Solihull ICS	18,263	202	1.1%
11	Lincolnshire ICS	5,068	46	0.9%
	Grand Total	**107,929**	**4,145**	**3.8%**

NB Figures for June 2023 only, not YTD

1.4 In total the three systems with the highest off-framework agency usage accounted for 51% of the total off-framework agency usage for the Midlands region (based on data for the month of June 2023). Subsequently, NHS England have written to ask that all NHS Trusts/NHS Foundation Trusts organisations take several actions to reduce agency staffing expenditure to deliver the 3.7% national target, this includes providing assurance that organisations are compliant with the Agency Rules and are implementing a new Agency Toolkit.

1.5 This paper provides the Board with a summary of the Trust's agency staffing usage, including off-framework agency, and sets out the actions and measures that are in place to continue to reduce such staffing usage, with a particular focus on addressing agency/off-framework agency use. The paper also provides the Board with assurance that the Trust is fully implementing the actions and requirements from NHSE, including fully embedding the Agency Rules and NHSE agency toolkit. The paper seeks board level sign-off of the process for authorisation of break glass clauses, as required by the agency rules.

1.6 NHSE has asked that providers take the following actions:

a. Identify granular data on off-framework procurement of agency shifts (staff group/location etc) and work with framework providers to source alternative provision.
b. Report performance in reducing non-compliant agency spend to public Trust Boards to improve transparency.
c. Demonstrate compliance to report progress on temporary staffing expenditure on a routine monthly basis to their Boards, with specific reference to the progress to reduce agency off-framework procurement, admin and estates agency and price cap breaches.
d. By 31 October 2023, confirm in writing that the Agency Rules and the Toolkit are understood by the Executive Team, and that there is evidence of a commitment to the application of this policy to the activities of their organisation.
e. By 31 October 2023, provide a gap analysis detailing any variation between the organisation's current compliance and the Agency Rules requirements.
f. By 31 October 2023, provide a plan with clear actions, timescales, and trajectory to achieve full compliance with the Agency Rules requirements.
g. Review their escalation processes for approving agency spend above price caps to ensure decisions are taken at the appropriate level of seniority and/or clinical expertise.
h. Update organisational rate escalation ('break glass') policy ensuring this provides the appropriate level of rigour and discuss/approve this policy at Trust Board level.
i. Receive monthly reports on the top ten most expensive and top ten longest serving agency staff and the plans to replace these staff with more affordable workforce solutions.

2. RWT's Latest Agency Staffing Position – October 2023

2.1 The Trust continues to use temporary staffing to fill substantive vacancies within the Trust. The use of this temporary staffing should be considered in the context of the overall pay costs.

2.2 At the end of October agency costs are forecast to be £820k in excess of plan at year end:

Division	**2023/24 Forecast**	**YTD**	**FYE**
BCPS	£1,209,998	£770,702	£1,415,404
Division 1	£1,416,701	£895,272	£1,534,752
Division 2	£3,772,663	£2,196,375	£3,765,213
Division 3	£1,414,179	£1,079,572	£1,850,696
Corporate	£339,263	£193,044	£330,933
Trustwide	- £179,990	- £126,133	- £216,225
Total	**£7,956,507**	**£5,122,215**	**£8,780,943**

2.3 During October, the total number of bank and agency shifts requested totalled 16,980 with 14,097 (83%) of those being filled by the Trust internal bank and 1,050 (6.2%) shifts filled by agency staff, the remaining 1,833 shifts remained unfilled.

3. Summary of Agency Rules

3.1 The Agency Rules have several elements:

- A cap on agency expenditure
- Price caps, set by NHS England, apply to the total amount a Trust can pay per hour for an agency worker. The price caps were set at 55% above the basic substantive pay rate in 2016 which takes into account holiday pay, employer national insurance, employer pension contribution and agency fee. The price caps have not been uplifted.
- Mandatory compliance with approved frameworks.
- Specific rules for admin and estates staff which allow for agency staff usage only for:
    - Special projects
    - Exempt specialties – Clinical Coding
    - Exceptional patient safety risk
    - Specialist IT roles

  For all but exempt specialties, the Trust must seek approval from the ICB and where certain thresholds are met the ICB must forward the business case to NHSE for a final decision.

4. Agency/off-Framework Agency Position

4.1 The latest available data relating to agency and particularly off-framework agency usage at ICS level is reporting on October 2023, which highlights the following levels of off-framework agency usage across Black Country providers.

- ICS: 5.3%
- SWBH: 1.7%
- RWH: 4.2%
- Dudley: 0.0%
- Walsall: 17.9%
- Black Country Healthcare: 5.5%

4.2 RWT's off-framework position in October 2023 was 4.2%, equating to 44 shifts where off-framework agencies were used, against the total of 1,050 agency shifts worked.

4.3 Off-framework usage at RWT relates entirely to a hard to fill specialist consultant vacancy in haematology/ oncology. The agency in use have applied to join a framework and anticipate that they will be on the framework from December 2023. The use of this agency was approved by the Deputy Chief Executive.

4.4 Of the shifts filled by agency staff, these fell into the following staff categories:

Staff Group	Agency Shifts worked October 2023
Medical & Dental	474
Nursing, Midwifery & Health Visiting*	0
Healthcare Assistants & Other Support	8
Admin & Estates	118
Scientific, Therapeutic & Technical	143
Healthcare Science	307

Table 1, (located within the reading room - **Annex 1**), summarises the total bank and agency usage for October 2023, broken down by staff group, shift type and framework status as reported each month to NHSE.

* *Whilst there has been no nurse agency spend in this reporting period, there continues to be a requirement to care for mental health in-patients in the Emergency Department and inpatient areas and there will likely be some further agency utilisation for this staff group over the remainder of the financial year.*

4.5 Total agency spend year to date (to 31 October 2023) is £5,122k, 1.5% of total pay. This is delivering against the national target of 3.7%. However, the Trust is committed to focus on reducing this further, through focused action as captured below.

4.6 The Trust's price cap compliance rate was 54% with detail as shown in the table below (further detail available at Annex 1):

Staff Group	Agency Shifts worked October 2023	Shifts filled Above Price Cap	Compliance Rate
Medical & Dental	474	397	16%
Nursing, Midwifery & Health Visiting	0	0	
Healthcare Assistants & Other Support	8	0	100%
Admin & Estates	118	0	100%
Scientific, Therapeutic & Technical	143	47	67%
Healthcare Science	307	0	100%

4.7 The very limited admin and estates agency usage relates to:

- Coding – 45%
- Payroll – 9%
- IT – 46%

5. Action to Reduce Temporary Staffing usage and costs

5.1 Additional controls have been put in place for the use of bank nursing staff, with approval required from Senior Sister and above.

5.2 Regular reporting on agency usage, to include the most expensive and longest serving agency staff, will take place through monthly Finance Recovery Group Meetings. These meetings will ensure a comprehensive set of actions to reduce temporary staffing, with a focus on agency/off-framework agency usage. This forum reports upwards to the Finance and Productivity Committee which provides senior level challenge and assurance on workforce grip and control.

6. Agency Rules Compliance Reporting

6.1 An off-framework report has now been created that will report this data monthly to the Board, in future as part of the executive workforce report. This will be reported as part of the Temporary Staffing Report to Finance and Performance Committee and included in the standard Board people metrics.

6.2 Additional elements related to the agency rules have also been included to give a fuller picture around temporary staffing usage. This addresses the new requirements of the regional NHSE team in respect of regular Board reporting.

6.3 The elements within the report will be:

- Price cap overrides
- Framework Overrides
- Bank over £100
- Admin & Estates Agency

The report to Finance and Performance Committee will also include the most expensive and top ten longest serving agency staff.

6.4 For each element, and where available, hours, cost and a notional FTE value have been created.

7. Agency Rules and the Toolkit

7.1 The regional NHSE team have distributed a toolkit to support organisations to apply the NHS England Agency Rules. This was circulated by the ICB Chief People Officer on 17th October. The Human Resources and Finance teams have jointly reviewed the toolkit and are incorporating this framework as part of the Trust's overall approach to reducing temporary staffing usage and spend.

7.2 The executive received an overview of the agency rules, with a gap analysis as to the Trust's compliance with those rules with the application of the toolkit during the week of 23 October 2023. Any gaps identified is now reflected in the Trust's process for agency reduction.

7.3 Bank and agency usage is currently reported to the Trust's Finance and Productivity Committee, each month and is also captured within the Trust Board metrics. Reporting on progress to reduce

agency off-framework procurement, admin and estates agency and price cap breaches is currently captured but will formally be included in the Board reporting cycle from December 2023 as part of this report and as part of the executive workforce report thereafter.

7.4 The Trust has undertaken a gap analysis to identify any variations between the organisation's current compliance and the Agency Rules requirements. Having undertaken this piece of work, assurance can be provided that the Trust is compliant with the majority of the Agency Rules requirements. However, there are some areas, principally around the application of the price cap, break glass escalation and the use of admin and estates workers, which require some additional actions and controls.

7.5 A plan with clear actions, timescales, and trajectory to achieve full compliance with the Agency Rule requirements has been developed (the plan is available in the reading room - **Annex 2**) and was approved by the Trust Executive. The Trust will be fully compliant with the Agency Rules by 31st December 2023.

7.6 Proposals for additional controls requiring Board sign off (as per NHS England requirements) are set out in **Annex 3**.

8. Conclusions

8.1 The table below identifies the actions required by NHSE, with a status rating and next steps for achieving full compliance.

	Action	Status	Assurance & Next Steps
1.	Demonstrate compliance to report progress on temporary staffing expenditure on a routine monthly basis to their boards, with specific reference to the progress to reduce agency off framework procurement, admin and estates agency and price cap breaches.		• Temporary staffing is currently reported to the Finance and Productivity Committee. • Reporting will be expanded to cover off framework procurement, admin and estates agency and price cap breaches for the December Board and information has been included in the Executive Workforce Report.
2.	By 31 October 2023, confirm to us in writing that the Agency Rules and the Toolkit is understood by the Executive Team, and that there is evidence of a commitment to the application of this policy to the activities of their organisation.		The Trust Executive Team are fully briefed and engaged in supporting the actions to reduce temporary spend. Written confirmation to NHSE has been provided as part of a system response to the regional team by the due date.
3.	By 31 October 2023, provide us with a gap analysis detailing any variation between the organisation's current		

	compliance and the Agency Rules requirements.		**Annex 2** details the gap analysis to the agency rules including the actions, and timescales to achieve full compliance
4.	By 31 October 2023, provide us with a plan with clear actions, timescales, and trajectory to achieve full compliance with the Agency Rules requirements.		
5.	Urgently review escalation processes for approving agency spend above price caps to ensure decisions are taken at the appropriate level of seniority and/or clinical expertise.		Robust control process in place with approvals for agency usage and spend at appropriate levels.
6.	Update organisational rate escalation ('break glass') policy ensuring this provides the appropriate level of rigour and discuss/approve this policy at Trust Board level.		Annex 3 of this report includes escalation process for consideration by the Board.
7.	Receive monthly reports on the top ten most expensive and top ten longest serving agency staff and the plans to replace these staff with more affordable workforce solutions.		This reporting is in place through the monthly Finance Recovery Group chaired by the Deputy CEO.

9. Next Steps

9.1 In addition to the action set out above, the following actions are being taken to address temporary staffing usage, and particularly agency/off-framework procurement:

9.2

a. Grip & Control

- Incorporate a focus on non-framework agency usage within the Financial Recovery Group, chaired by the Trust Chief Operating Officer / Deputy Chief Executive. Note, there is one approved post not on the framework.
- Incorporate temporary staffing usage, including agency/ non-framework agency, into the divisional finance review meetings.
- Workforce optimisation – additional e-rostering and controls for nursing staff and complete implementation for medical and AHP staff.
- Minimum staffing levels to be reviewed across medical rotas (in line with strike requirements) to ensure agency/ temporary staff only booked where required.

b. Targeted substantive recruitment:

- Ensure targeted recruitment in place for posts where vacancies are driving high cost agency or other temporary staffing solutions.

10. Recommendations

The Trust Board is asked to:

1) **RECEIVE** the update contained in this paper for assurance of the Trust's compliance with NHSE's requirements relating to reducing temporary staffing costs (reporting and actions).
2) **NOTE** the Trust's commitment to incorporate enhanced reporting on agency/off-framework agency usage within the standard Board workforce performance metrics going forwards.
3) **APPROVE** the processes set out at Annex 3.

Annex 1 - Agency Return Data

Staff Group	1. Total Shifts Requested (Bank & Agency)	2. Shifts Filled by Bank	3. % of Shifts Filled by Bank (Auto-calculate)	4. Shifts Filled by Agency	5. % of Shifts Filled by Agency (Auto-calculate)	6. Shifts Unfilled (Auto-calculate)
Medical & Dental	1,733.0	1,060.0	61.2%	474.0	27.4%	199.0
Nursing, Midwifery & Health Visiting	3,486.0	2,518.0	72.2%	0.0	0.0%	968.0
Healthcare Assistants & Other Support	3,846.0	3,293.0	85.6%	8.0	0.2%	545.0
Admin & Estates	1,697.0	1,579.0	93.0%	118.0	7.0%	0.0
Scientific, Therapeutic & Technical	196.0	40.0	20.4%	143.0	73.0%	13.0
Healthcare Science	1,809.0	1,493.0	82.5%	307.0	17.0%	9.0
Other	4,213.0	4,114.0	97.7%	0.0	0.0%	99.0
Total	**16,980.0**	**14,097.0**	**83%**	**1,050.0**	**6.2%**	**1,833.0**

Staff Group	1. Shifts Filled by Agency	Total Agency Rules Overrides	
		2. On Framework Above Price Cap	3. Off Framework
Medical & Dental	**474.0**	**397.0**	**44.0**
Core	389.0	330.0	44.0
Unsocial	85.0	67.0	0.0
Nursing, Midwifery & Health Visiting	**0.0**	**0.0**	**0.0**
Day	0.0	0.0	0.0
Night/Saturday	0.0	0.0	0.0
Sunday/Bank Holiday	0.0	0.0	0.0
Healthcare Assistants & Other Support	**8.0**	**0.0**	**0.0**
Day	4.0	0.0	0.0
Night/Saturday	4.0	0.0	0.0
Sunday/Bank Holiday	0.0	0.0	0.0
Admin & Estates	**118.0**	**0.0**	**0.0**
Day	118.0	0.0	0.0
Night/Saturday	0.0	0.0	0.0
Sunday/Bank Holiday	0.0	0.0	0.0
Scientific, Therapeutic & Technical	**143.0**	**47.0**	**0.0**
Day	122.0	38.0	0.0
Night/Saturday	10.0	5.0	0.0
Sunday/Bank Holiday	11.0	4.0	0.0
Healthcare Science	**307.0**	**0.0**	**0.0**
Day	258.0	0.0	0.0
Night/Saturday	24.0	0.0	0.0
Sunday/Bank Holiday	25.0	0.0	0.0
Other	**0.0**	**0.0**	**0.0**
Day			
Night/Saturday			
Sunday/Bank Holiday			
Grand Total	**1050.0**	**444.0**	**44.0**

Appendix

The Royal Wolverhampton NHS Trust

Agency Reduction Plan

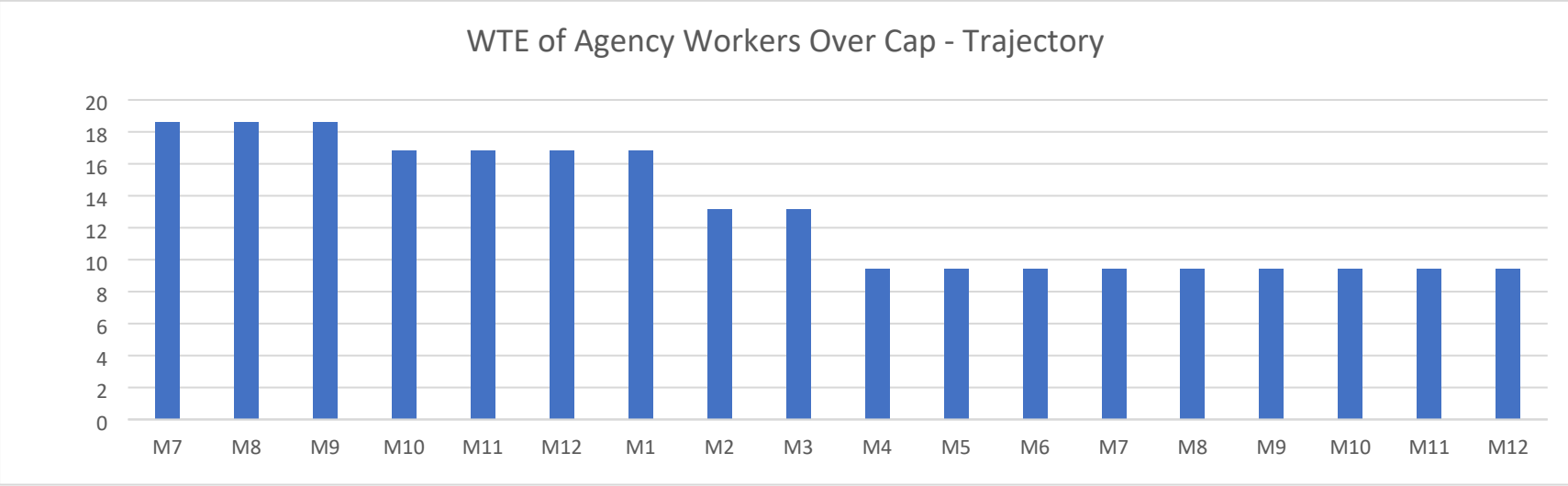
Area	Issues	Action	By When	Owner
Board Reporting	Agency usage and compliance with agency rules not currently reported to Public Board.	Formal Board Reporting to be established via Finance and Productivity Committee.	December 2023	Director of Operational Human Resources and Organisational Development
Override Process Review	Requirement to formally review override process as set out in Regional CNO letter to ICB Chairs	Review processes for agency rule overrides and approval. Revised process approved at Trust Board	December 2023	Director of Operational Human Resources and Organisational Development
Admin and Estates Roles	Small number of admin and estates agency roles in place in the Trust. Likely requirement for additional admin agency usage in the near term associated with the IT staff as part of the special projects.	Director Level review of all agency usage with service leads and exit plans agreed where appropriate. Ensure efforts to avoid/ minimise agency usage in place and process for approval/ notification of NHS is followed prospectively.	December 2023 As per project timelines	Directors Deputy Chief Executive
Improved Framework Compliance	2.5% of agency usage off framework.	Review of off-framework agency usage (1 doctor) and consider actions to cease off-framework usage through Trust governance process – including Finance and Productivity Committee, People Committee and the Board.	December 2023	Deputy Chief Executive & Director of Operational Human Resources and Organisational Development

Area	Issues	Action	By When	Owner
Improved Price Cap Compliance	Price cap compliance 54% (M6)	Review of agency over price cap and consider actions to cease off-framework usage through Trust governance process – including Finance and Productivity Committee, People Committee and the Board.	December 2023	Deputy Chief Executive & Director of Operational Human Resources and Organisational Development

Trajectory

The Trust has undertaken a detailed review of agency expenditure, with particular focus on high-cost agency (over – cap) and off framework. It should be noted that all such agency has been approved in accordance with the exemptions/ break glass provisions contained in the rules to ensure patient safety. All off framework posts are reviewed and currently approved at Deputy Chief Executive level, this will continue.

As would be expected the posts where agency, and particularly high-cost agency are known national shortage areas, therefore, there are likely to be some areas where the Trust will still need to make use of the break glass clauses. A trajectory for increased compliance with price caps is shown below from M7 2023/24 to 2024/2025:



There is one post covered by an off-framework agency and on current trajectory we envisage that that will be a post covered by an on-framework provider by the end of the year.

Non-Clinical Agency Request Process

Agency usage and requests are the last resort when all other recruitment and temporary staffing solutions have been exhausted. This includes, fixed term contracts, absorption and redistribution of tasks, direct bank recruitment and contacting the Temporary Staffing Team to fill the role with bank workers who are ready to start at short notice.

The Trust is required to reduce agency spend in line with the ICS target. Therefore, all agency requests will be scrutinised and require both internal and external authorisation. Internally, the relevant Director or Deputy COO approval is required before submitting to the Chief Operating Officer, Chief Finance Officer and Director of HR and OD for a decision. Should the request receive internal approval, the request will be submitted to the ICB for review. If the role criteria (outline below) are triggered, subsequent NHSI approval will be required prior to engaging a worker.

Page 2 of this document contains a full process flow to support decision making, whilst page 3 contains the application document for completion.

Process Points to Note:

- All non-clinical agency requests will need approval by the ICB. Requests and relevant authorisation will be facilitated by the Trust Temporary Staffing Team.
- Exit plans will be required for all agency requests

* **Additional NHSE sign off required if agency request meets any of the following criteria:**

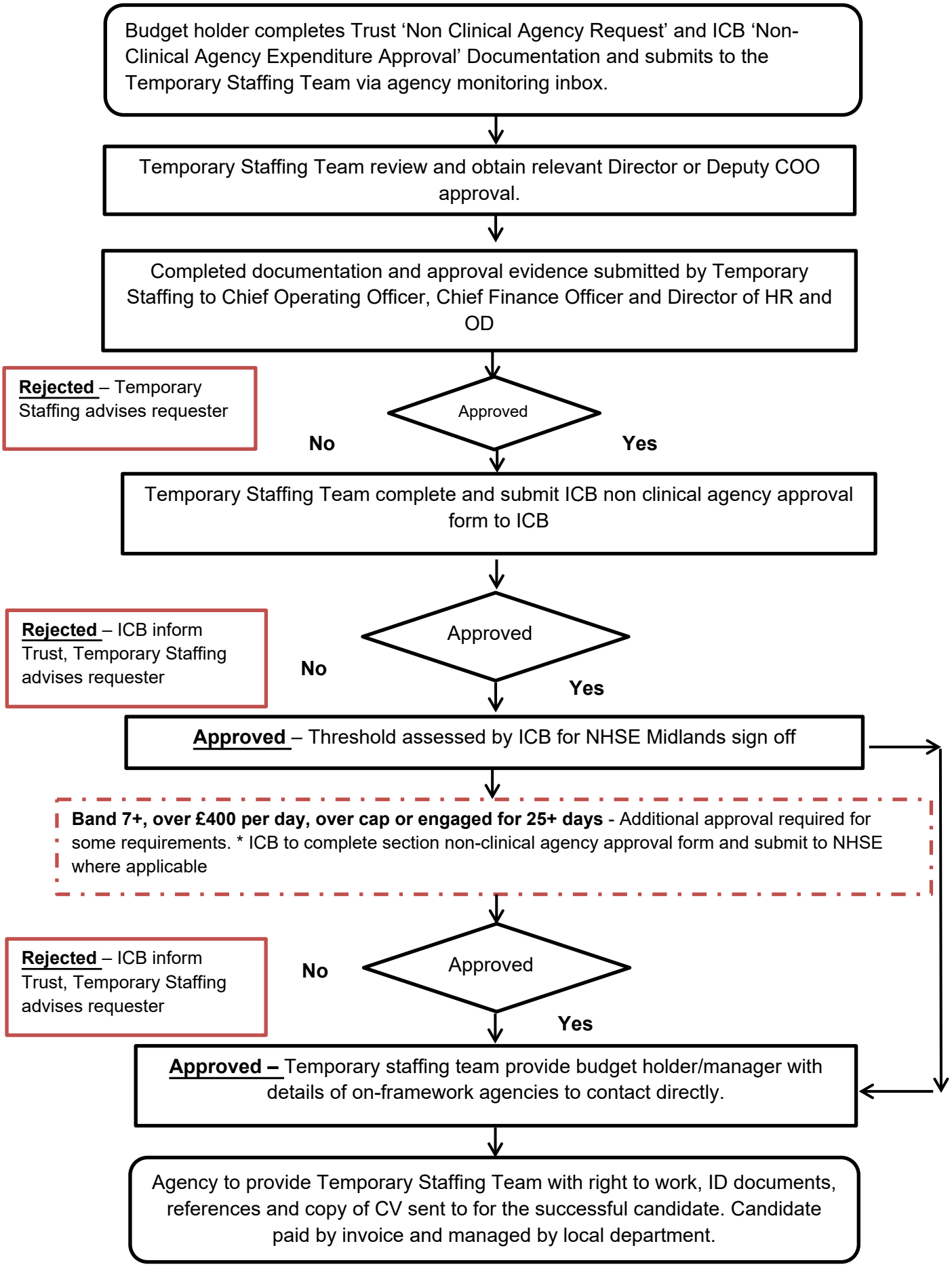
a) Agenda for Change Band 7 or higher
b) Have a rate of over £400 per day.
c) Engagement longer than 25 working days
d) Off framework and or above agency price cap

- If an approved agency worker is engaged, the Temporary Staffing Team will check compliance with NHS employment check standards with the provider agency before the first day.
- Where an agency worker is utilised, the line manager must complete monthly agency worker submissions (per worker) by 5th of each month via the sharepoint portal, this is administered by the Temporary Staffing Team.

Key Contacts:

- Temporary Staffing Team (via the agency usage monitoring inbox) – rwh-tr.agencyusagemonitoring@nhs.net
- General Resourcing Manager (Acting)– Amy Hobson-Obhrai – amy.hobson@nhs.net

Process Flow Non-Clinical Agency Request



Non clinical agency request pro-forma			
Manager/Budget Holder Details			
Recruiting Manager:			
Department:			
Budget Holder:			
Role Requirement Details			
Job Title (s)			
Grade/Band: All agency must be within price cap. Further approval required if worker request higher rate. If it is anticipated that the request will not be within cap – a % increase must be requested and monitored			
Reason for request:	☐ Additional demand / resource ☐ Emergency requirement ☐ Other ☐ Pandemic ☐ Project work ☐ Specialist skills required ☐ Elective recovery/WLI ☐ Planned Leave ☐ Unplanned Leave ☐ Vacancy		
Position number or substantive or previous postholders name:			
Shift Type	☐Day ☐ Night/ Saturday ☐ Sunday / Bank Holiday ☐ On call		
Hours and Whole Time Equivalent			
Assignment start date: *if additional time is required a further request must be submitted		**Assignment end date:**	

Standard Recruitment Methods: **What actions have been taken to avoid agency usage?**	
Project description/ delivery / Post Implications/Considerations: Justification for agency workers and posts Outline any risk to organisation patient safety, WL.	
Substantive recruitment/ Exit plan	
Approvals	
Budget Holder Signature and date:	
DCOO Signature and date	
Chief Operating Officer	
Approved ☐ Declined ☐	
Name and Date:	
Chief People Officer/ Director of Director of Human Resources and Organisational Development	
Approved ☐ Declined ☐	
Name and Date:	
Chief Finance Officer	
Approved ☐ Declined ☐	
Name and Date:	

Nursing Agency Request Process

The Trust is required to reduce agency spend in line with the ICS target. Therefore, all agency requests will be scrutinised require approval by the Divisional Head of Nursing prior to engagement.

Process Points to Note:

- All requests and agency bookings will be facilitated by the Temporary Staffing Team wherever possible.
- If an approved agency worker is engaged, the Temporary Staffing Team will check compliance with NHS employment check standards with the provider agency before the first assignment
- Any off-framework or over hourly price cap booking will require additional authorisation by the Chief Operating Officer. Temporary Staffing with facilitate this.
- Any off-framework terms and conditions must be reviewed by Procurement and must be approved by the Group Director of Procurement. Temporary Staffing will facilitate this.
- Where an agency worker is utilised, the line manager must complete monthly agency worker submissions (per worker) by 5th of each month via the SharePoint portal, this is administered by the Temporary Staffing Team.
- All extensions to bookings will require additional application and approval.
- Temporary Staffing Team operating opening hours of Monday to Friday 8-5pm and Weekend and Bank Holidays 10-4pm. Closed Christmas day. For all emergency requests for cover outside of these times, the on-call manager will be required to approve agency usage. See page 2 for process flow.

Process Flow Nursing Agency Request

Matron or Ward / Department Manager identifies a requirement for short term / specialist emergency cover and completes the 'Clinical Agency Request' document , with approval from the Head of Nursing and submits to Temporary Staffing Team *(rwh-tr.agencyusagemonitoring@nhs.net)*

Yes

No

Out of Hours Request:

A copy of the completed agency request form is sent to the 'On Call Manager' copied to the Temporary Staffing team.

On call manager reviews and responds to requester indicating approval or otherwise via email, copying in Temporary Staffing Team.

Site team contacts on framework agencies with assignment details

Agency provides candidate details and recruitment compliance pack to the manager. If rate is over cap, the on-call manager will seek approval from the exec on-call.

Site team confirms candidate to be engaged with agency and provides assignment instructions. Manager advise temporary staffing of booking details.

Temporary Staffing Team review and disseminate to on-framework agencies

Temporary Staffing Team receive and collate submissions, including recruitment compliance packs (Right to Work, ID, registration details). manager to review. Complaint candidates details issued to manager. If over cap, Temporary Staffing team seek approval from Chief Operating Officer/ Deputy Chief Executive.

Manager confirms candidate to be engaged with Temporary Staffing Team.

Temporary Staffing confirm candidate with agency. Shifts offered directly to candidate who is provided with appropriate manager details and reporting instructions.

Nursing Clinical Agency Request			
Manager/Budget Holder Details *all fields mandatory			
Manager/ budget holder name and email address:			
Department:			
Cost code:			
Job Finance Code:			
Name and email address for CV's to be submitted if different to manager:			
Role Requirement Details			
Job Title (s):			
Grade/Band: All agency must be within price cap. Further approval required if worker request higher rate.			
Reason for request:	☐ Additional demand / resource ☐ Emergency requirement ☐ Other ☐ Specialist skills required ☐ Planned Leave ☐ Unplanned Leave ☐ Vacancy		
Shift Type:	☐Day ☐ Night/ Saturday ☐ Sunday / Bank Holiday ☐ On call		
Position number or substantive or previous postholders name:			
Hours and Whole Time Equivalent:			
Assignment start date: *if additional time is required a further request must be submitted		**Assignment end date:**	
Approvals			
Budget Holder Name/ Signature and date:			
Name and Date:			

Please send the completed document to the Temporary Staffing Team (via the agency usage monitoring inbox) – rwh-tr.agencyusagemonitoring@nhs.net

****** Please note, any off-framework or above price cap booking will require additional authorisation by the Chief Operating Officer.*****

Medics Agency Request Process

The Trust is required to reduce agency spend in line with the ICS target. Therefore, all agency requests will be scrutinised and require internal authorisation. The relevant Directorate or Group Manager will need to authorise agency usage prior to any workers being engaged.

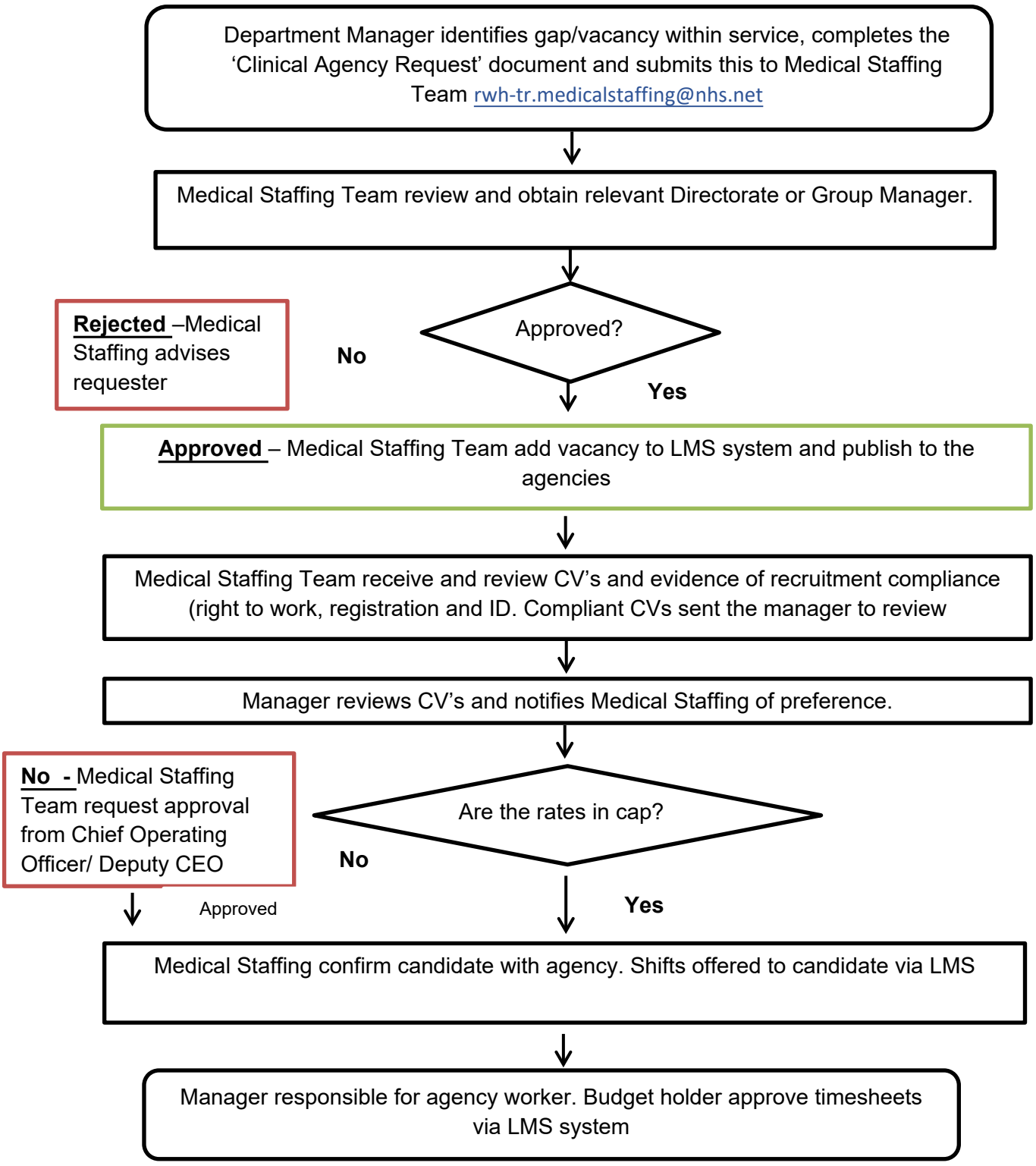
Process Points to Note:

- All requests will be added to the LMS system by the Medical Staffing Team
- If an approved agency worker is engaged, the Medical Staffing Team will check compliance with NHS employment check standards with the provider agency before the first day.
- Any off-framework or over hourly price cap booking will require additional authorisation by the Chief Operating Officer / Deputy Chief Executive. Medical Staffing with facilitate this.
- Any off-framework terms and conditions must be reviewed by Procurement and must be approved by the Group Director of Procurement. Medical Staffing will facilitate this.
- Exit plans will be required for all agency requests
- All extensions to bookings will require additional application and approval.

Key Contacts:

- Medical Staffing Team (via the agency usage monitoring inbox) – rwh-tr.medicalstaffing@nhs.net

Process Flow Medical Agency Request



Clinical Agency Request			
Manager/Budget Holder Details *all fields mandatory			
Manager/ budget holder name and email address:			
Department:			
Cost code:			
Job Finance Code:			
Name and email address for CV's to be submitted if different to manager:			
Role Requirement Details			
Job Title (s):			
Grade/Band: All agency must be within price cap. Further approval required if worker request higher rate. If it is anticipated that the request will not be within cap – a % increase must be requested and monitored			
Reason for request:	☐ Additional demand / resource ☐ Emergency requirement ☐ Other ☐ Pandemic ☐ Project work ☐ Specialist skills required ☐ Elective recovery/WLI ☐ Planned Leave ☐ Unplanned Leave ☐ Vacancy		
Position number or substantive or previous postholders name:			
Shift Type:	☐Day ☐ Night/ Saturday ☐ Sunday / Bank Holiday ☐ On call		
Hours and Whole Time Equivalent:			
Assignment start date: *if additional time is required a further request must be submitted		**Assignment end date:**	

Standard Recruitment Methods: What actions have been taken to avoid agency usage? Reduce services, roster require, skills mix review	
Project description/ delivery / Post Implications/Considerations: Justification for agency workers and posts Outline any risk to organisation patient safety, WL.	
Substantive recruitment/ Exit plan: *** not required for RMN ***	
Approvals	
Budget Holder **Name/ Signature and date:**	
Group/Directorate Manager	
Approved ☐ Declined ☐	
Name and Date:	

Please send the completed document to the Temporary Staffing Team for Nursing, AHP and Healthcare Scientists (via the agency usage monitoring inbox) – rwh-tr.agencyusagemonitoring@nhs.net and Medical Staffing Team for Doctors via rwh-tr.medicalstaffing@nhs.net

****** Please note, any off-framework or above price cap booking will require additional authorisation by the Chief Operating Officer.*****

AHP and HSS Clinical Agency Request Process

The Trust is required to reduce agency spend in line with the ICS target. Therefore, all agency requests will be scrutinised and require internal authorisation. The relevant Directorate or Group Manager will need to authorise agency usage prior to any workers being engaged.

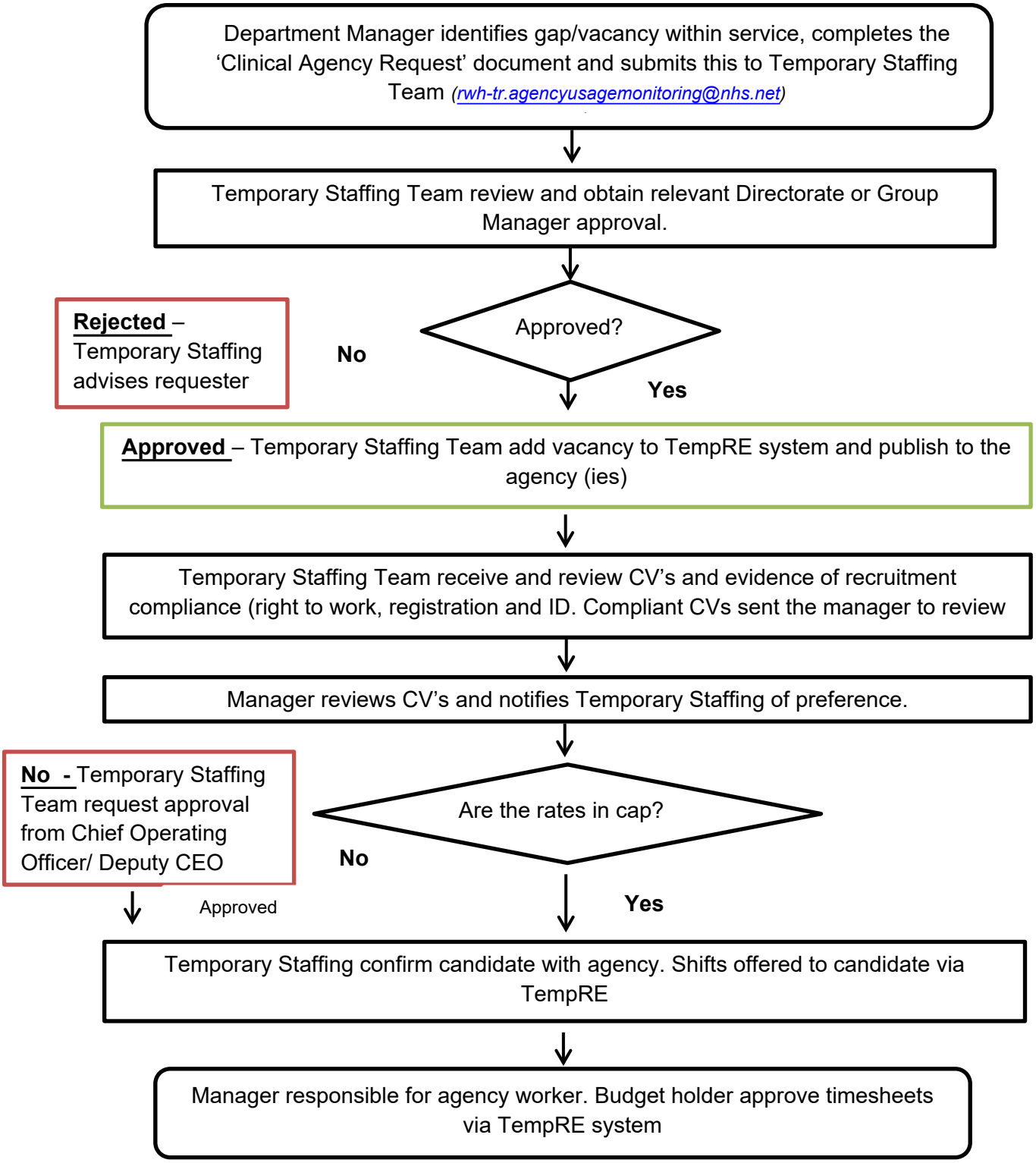
Process Points to Note:

- All requests will be added to the Tempre system by the Temporary Staffing Team
- If an approved agency worker is engaged, the Temporary Staffing Team will check compliance with NHS employment check standards with the provider agency before the first day.
- Any off-framework or over hourly price cap booking will require additional authorisation by the Chief Operating Officer / Deputy Chief Executive. Temporary Staffing with facilitate this.
- Any off-framework terms and conditions must be reviewed by Procurement and must be approved by the Group Director of Procurement. Temporary Staffing will facilitate this.
- Exit plans will be required for all agency requests
- All extensions to bookings will require additional application and approval.

Key Contacts:

- Temporary Staffing Team (via the agency usage monitoring inbox) – rwh-tr.agencyusagemonitoring@nhs.net

Process Flow AHP and HSS Clinical Agency Request



Clinical Agency Request			
Manager/Budget Holder Details *all fields mandatory			
Manager/ budget holder name and email address:			
Department:			
Cost code:			
Job Finance Code:			
Name and email address for CV's to be submitted if different to manager:			
Role Requirement Details			
Job Title (s):			
Grade/Band: All agency must be within price cap. Further approval required if worker request higher rate. If it is anticipated that the request will not be within cap – a % increase must be requested and monitored			
Reason for request:	☐ Additional demand / resource ☐ Emergency requirement ☐ Other ☐ Pandemic ☐ Project work ☐ Specialist skills required ☐ Elective recovery/WLI ☐ Planned Leave ☐ Unplanned Leave ☐ Vacancy		
Position number or substantive or previous postholders name:			
Shift Type:	☐Day ☐ Night/ Saturday ☐ Sunday / Bank Holiday ☐ On call		
Hours and Whole Time Equivalent:			
Assignment start date: *if additional time is required a further request must be submitted		**Assignment end date:**	

Standard Recruitment Methods: What actions have been taken to avoid agency usage? Reduce services, roster require, skills mix review	
Project description/ delivery / Post Implications/Considerations: Justification for agency workers and posts Outline any risk to organisation patient safety, WL.	
Substantive recruitment/ Exit plan: *** not required for RMN ***	
Approvals	
Budget Holder **Name/ Signature and date:**	
Group/Directorate Manager	
Approved ☐ Declined ☐	
Name and Date:	

Please send the completed document to the Temporary Staffing Team for Nursing, AHP and Healthcare Scientists (via the agency usage monitoring inbox) – rwh-tr.agencyusagemonitoring@nhs.net and Medical Staffing Team for Doctors via rwh-tr.medicalstaffing@nhs.net

****** Please note, any off-framework or above price cap booking will require additional authorisation by the Chief Operating Officer.*****

The Royal Wolverhampton NHS
NHS Trust

New Cross Hospital
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

Integrated Quality and Performance Report
October 2023

Contents

Key to KPI Variation and Assurance Icons

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

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

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

Executive Summary

Obs on time: improvement in performance seen during October 23. A dashboard for incorporating and triangulating different metrics is being discussed. Amendments have been sent to informatics to be developed with a prototype presented to Deteriorating Patient Group.

C.diff: 10 cases in month against a target of 4. Back to Basics and launch of the Infection Prevention joint Delivery Plan began week commenced 9th October 2023 and continued with a focus on C diff during week commencing 23rd October 2023.

MRSA: one case during October 23.

CHPPD (total nursing): This has dipped slightly in month but remains stable and above target. Newly Qualified Nurses (Oct 23) are now placed, with 5 currently still unallocated.

Smoking at delivery: performance saw slight deterioration in month. Smoking is monitored monthly on the maternity dashboard and element 1 of the 'Saving Babies Lives Care Bundle' SBLCB V3.

RTT incomplete pathway: the overall target has seen some slight improvement in month but remains in the lower control limit.

RTT 78+ week wait: we saw a month end position of 61 against a revised target of 70. This number has increased from the previous month but continues to be mostly Urology patients. This is monitored daily and reviewed 3 times per week at PTL meetings with a view to achieving zero by the end of November 23.

Diagnostics: performance is showing an overall improving trend. The largest waits continue to be in non-obstetric ultrasound. Remedial action plans are in place with an expectation that performance improves throughout 2023/24 and these continue to be monitored against individual trajectory targets and are reported at the weekly performance meeting.

ED 4 hour: performance remains static and continues to be above the new national standard of 76%. Patterns in daily activity are being reviewed, with particular focus on high attendances on a Monday and Tuesday. Rotas to be reviewed to adjust work patterns to bolster.

Cancer: The reporting of cancer targets changed on 1st October 23 with the focus only being on 31 day combined, 62 day combined and 28 day FDS targets, however, we will continue to monitor the 2ww target at this has a significant impact on all targets. Referrals remained high during October 23 particularly in Breast, Gynaecology, Head & Neck and Lung. Overall referrals in month were 15% higher than we saw in the same period last year.

Executive Summary (continued)

RIT referrals/patients accepted and seen: referral numbers saw an increase during October 23 and are now currently above the average expected numbers. We continue work with WMAS and care homes and the use of docobo for appropriate escalation into the team.

Virtual ward: overall the performance is demonstrating an improving trend. There is to be an expansion of pathways in line with nationally submitted plan with review of activity and coding to ensure accurate reporting.

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 vacancy rate: showing overall improving trend, this indicator continues to meet the target.

Turnover (normalised): this target continues to show overall improvement, remaining within target.

Retention (12 months): slight improvement during October 23, remaining above target.

Appraisals: overall this continues to show an improving trend, 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): showing an overall improving trend, remaining below target. Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

Corporate Scorecard Summary

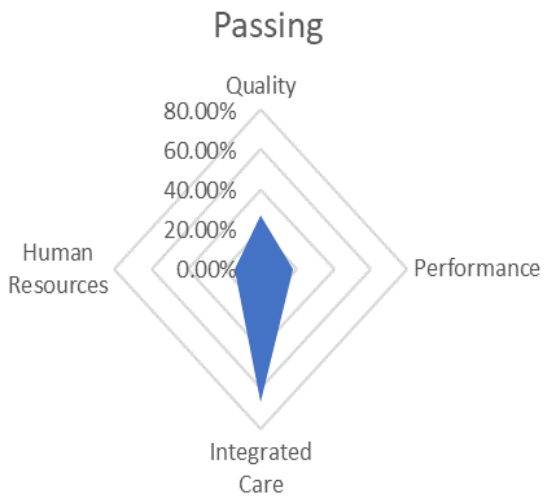
Quality				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Observations on time	>90%	89.85%		
Clostridioides difficile	4	10		
MRSA Bacteraemia	0	1		
CHPPD (total)	>/= 7.6	8.1		
Smoking at delivery	<7%	9.3%		

Performance				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RTT - Incomplete Pathway	92%	55.90%		
RTT - 78+ Weeks	0	61		
Diagnostic 6 week wait	>99%	60.67%		
ED - 4 hour wait	76%	77.05%		
Cancer 2 week wait	93%	75.00%		
Cancer 62 day combined	85%	35.14%		

Integrated Care				
Key Performance Indicators	Plan	Actual	Variation	Assurance
RIT referrals received		1,364		
Patients accepted and seen		1,355		
Virtual Ward		346		
Care Coordination referrals accepted		3,329		

Human Resources				
Key Performance Indicators	Plan	Actual	Variation	Assurance
Trust Vacancy Rate	6%	2.70%		
Turnover (normalised)	10%	9.65%		
Retention (12 months)	88%	90.23%		
Appraisals	90%	84.90%		
Sickness (monthly)	5%	4.94%		

Indicator Summary

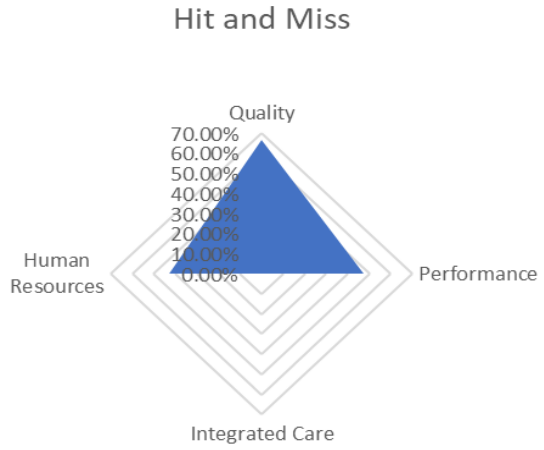


Quality - Duty of candour elements 1&2, serious incidents reported within 48 hours and midwife to birth ratio.

Performance - Cancelled ops as % of electives, urgent cancelled ops for 2nd time and E-discharge summary.

Integrated Care - Patients offered HIV test & Crisis response.

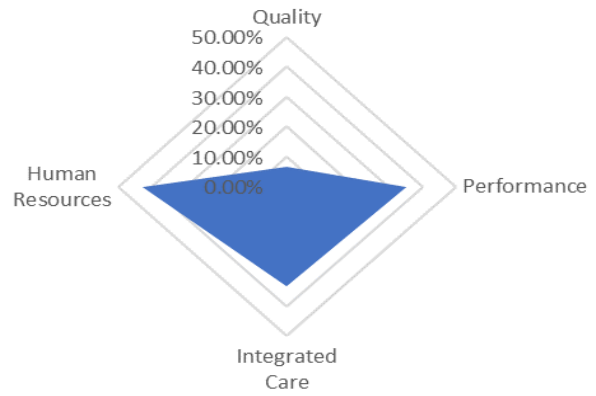
Human Resources: Mandatory training (generic)**.**



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, cancer 2ww and 28 day FDS.

Human Resources: Vacancy rate, retention & sickness rate monthly**.**



Quality - Observations on time.

Performance - RTT incomplete %, diagnostic waits, ED attend >12 hours, ambulance handover <15 minutes, cancer 31 day combined and 62 day combined.

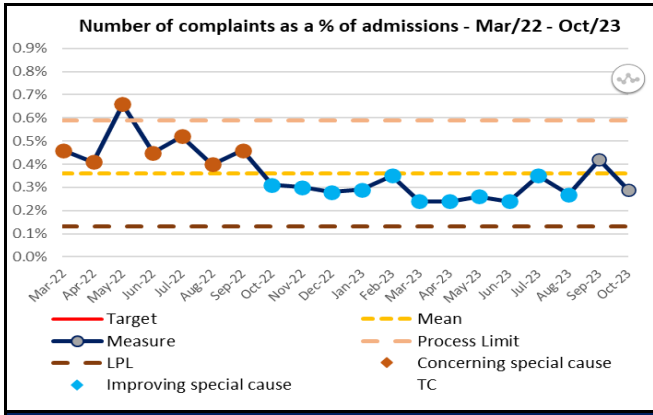
Integrated Care - Sexual health appointments offered**.**

Human Resources: Turnover, appraisals & sickness rate (rolling 12 months)**.**

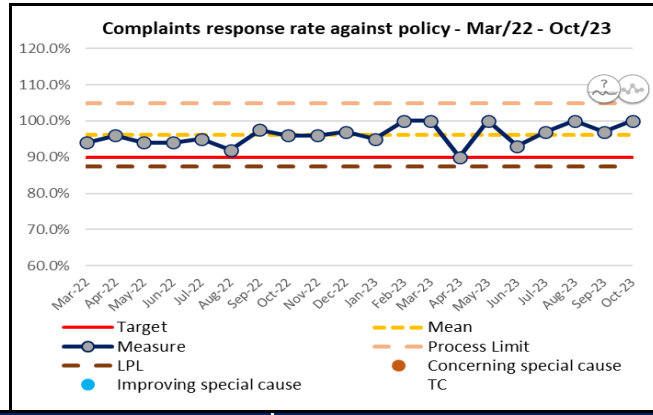
Quality

Metric - Patient Experience	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Number of complaints as a % of admissions	Surveillance			0.26%	0.24%	0.35%	0.27%	0.42%	0.29%
Complaints response rate against policy	90%		?	100.0%	93.0%	97.0%	100.0%	97.0%	100.0%
FFT response rates - Trust wide	Surveillance			19.0%	14.0%	14.0%	16.0%	15.0%	15.0%
FFT recommendation rates - Trust wide				86.0%	83.0%	85.0%	87.0%	85.0%	86.0%
Observations on time (Trust wide)	>90%	H	F	84.8%	85.8%	87.6%	86.0%	87.3%	89.9%
Duty of Candour - Element 1: notifying patients and families of the incident and investigation taking place. Due 10 working days after incident is reported to STEIS	0		P	0	0	0	0	0	0
Duty of Candour - Element 2: sharing outcome of investigation with patients/relatives. Due 10 working days after final RCA report is submitted to CCG	0		P	0	0	0	0	0	0
Metric - Patient Outcomes	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Pressure ulcers - STEIS reportable cases	Surveillance			0	1	1	0	0	0
Pressure ulcers per 1,000 occupied bed days				0.95	1.14	1.03	1.61	1.32	2.10
Falls rate with harm per 1,000 occupied bed days				0.04	0.04	0.00	0.00	0.04	0.00
Patient falls - rate per 1,000 occupied bed days		L		2.36	2.80	3.29	2.68	3.43	2.32
Crude mortality rate				1.29%	1.65%	1.49%	1.76%	1.63%	1.80%
RWT SHMI		L		0.9063	0.8867				

Metric - Patient Safety	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Clostridioides difficile	4			6	2	10	4	10	10
MRSA Bacteraemia	0			0	0	0	0	0	1
E.Coli	Surveillance			14	15	19	27	28	34
Medication error - incidents causing serious harm	0			0	0	0	1	0	N/A
Serious incident reporting - report incidences within 48 hours	0			0	0	0	0	0	0
Never events	0			0	0	1	0	0	0
Mental Health ED patient attendance numbers	Surveillance						416	383	407
Metric - Patient Safety (continued)	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Care hours per patient - total nursing & midwifery staff actual	>/= 7.6			8.4	8.4	8.3	8.3	8.3	8.1
Care hours per patient - registered nursing & midwifery staff actual	>/= 4.5			5.1	5.2	5.1	5.1	5.2	5.0
Midwife to birth ratio	</=30			29.0	29.0	29.0	28.0	26.0	26.0
Sepsis screening - ED	>/= 90%			100.0%	96.0%	100.0%	100.0%	100.0%	N/A
Sepsis screening - Inpatients (reported quarterly)	>/= 90%			92.00%		87.50%			
Thrombus - Hospital acquired (VTE numbers) per 1,000 occupied bed days (reported quarterly 1 month in arrears)	Surveillance			0.6		0.69			
Metric - Maternity	Target	Variation	Assurance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Oct-23
Smoking at delivery	<7%			10.3%	10.0%	11.6%	11.1%	8.8%	9.3%
Babies being cooled (born here)	Surveillance			1	0	0	0	1	2

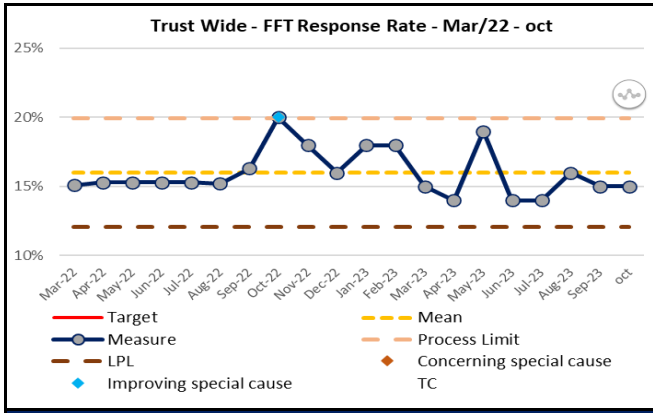


Oct-23
0.29%
Variance Type
Metric is showing common cause variation

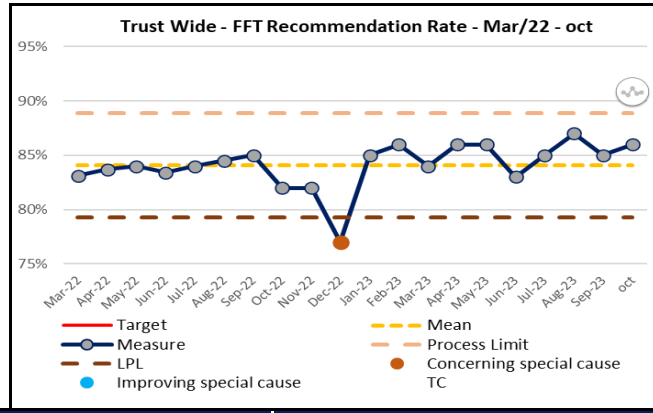


Oct-23
100.0%
Variance Type
Metric is showing common cause variation
Target
90.0%
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Complaints: There were 37 formal complaints received in October 2023. This represents a 26% increase when compared with the previous month. ED remains an area to note having received the most complaints. However, it should be noted that it also experienced a reduction in the volume when compared to the previous month and the same reporting period for the previous year. In terms of themes, the categories of general care of patient and attitude had the most complaints aligned to them. Whilst Diabetes was also as an area of note in the previous month, it is pleasing to see that they also have experienced an 80% reduction in the volume received this month. **Complaints Response:** 43 complaints were closed, of which 23 were closed within 30 working days. Of the 20 complaints that took longer than 30 days, all gained consent to breach from the complainant.	The Patient Experience Team will undertake a refresh and recap of the ED Managing Violence and Aggression training. There has historically been a reoccurring theme of complaints for ED relating to attitude. This has been somewhat reduced in recent months following the delivery of anti-aggression/positive communication training. However, upon a deep dive of complaints for ED this period, it is noted that there are two complaints relating to this theme and the PE team will revisit the previously delivered training to reinform the principles of positive communication with key staff.	The Patient Experience Team will continue to monitor complaints performance and provide proactive support to the Directorates and Divisions. Attendance at Divisional Governance meetings by the Patient Experience Team to discuss complaints and FFT performance, trend analysis and agree actions is custom and practice.

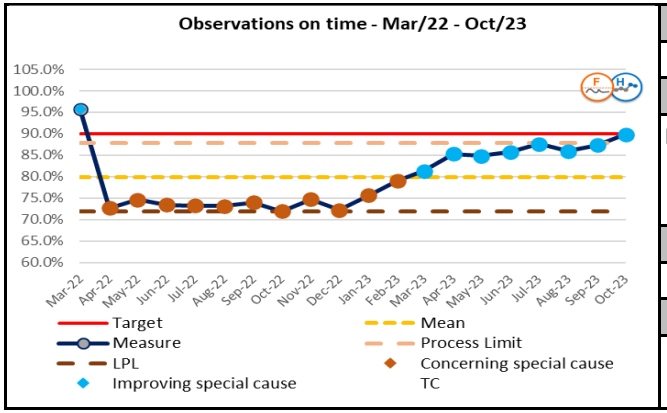


Oct-23
15.0%
Variance Type
Metric is showing common cause variation

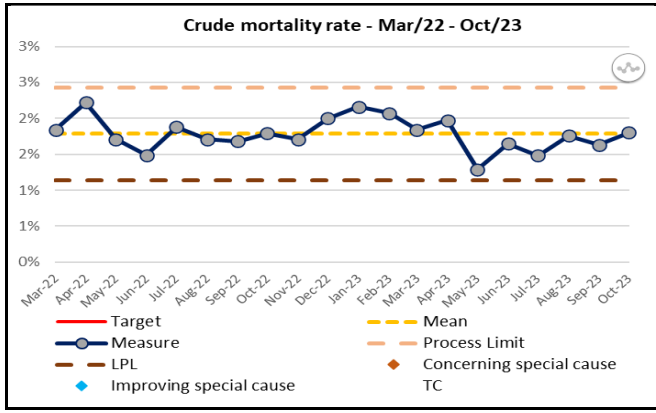


Oct-23
86.0%
Variance Type
Metric is showing common cause variation

Summary	Actions	Assurance
FFT: The overall Trust wide response rate for October 2023 was 15% with 86% recommending and 10% not recommending the Trust. Whilst the recommendation rate has seen a positive 1% increase, the non recommendation rate has seen the reverse. The overall Trust wide response rate has remained consistent with the previous month.	Noting the reduction in the recommendation rate for Division 3, the Patient Experience Team are currently delivering outreach on some wards to assist in achieving a positive improvement in the score. .	The Patient Experience Team will continue to monitor FFT performance and provide proactive support to the Directorates/Divisions and triangulate with other feedback mechanisms. Attendance at Divisional Governance meetings by the Patient Experience Team to discuss complaints and FFT performance, trend analysis and agree actions is custom and practice.

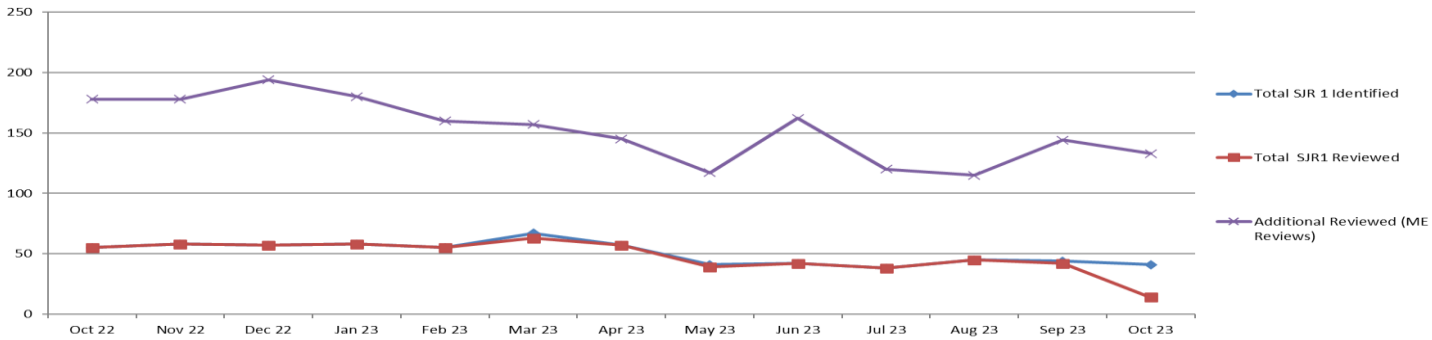


Oct-23
89.9%
Variance Type
Metric is showing higher cause variation (improving)
Target
90%
Achievement
Metric is currently failing the target

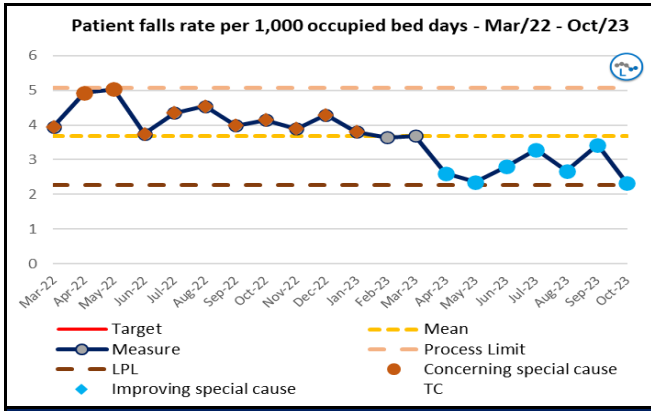


Oct-23
1.80%
Variance Type
Metric is showing common cause variation

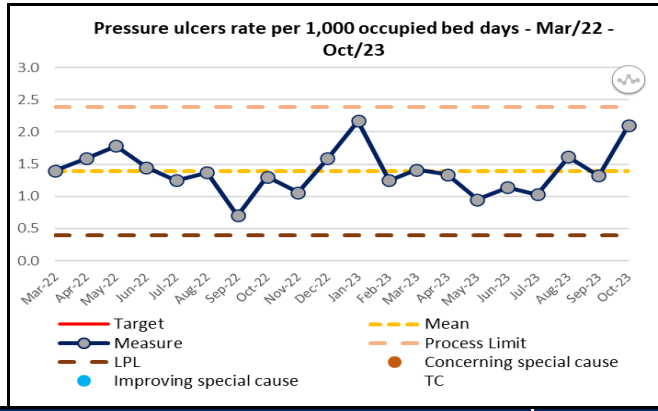
Scrutiny of Deaths - Period 1st October 22 to 29th October 23 (as at 30th October 2023)



Summary	Actions	Assurance
Observations on time: Performance was 89.9% in October 2023 and this represents an increase of 2.53% when compared with the previous month.	A daily report has been developed for ward managers to understand which patients are on NEWS2 Scale2, along with a sticker to be approved at DPG. The aim of these interventions is to reduce NEWS2 Scale2 being used inappropriately. A dashboard for incorporating and triangulating different metrics is being discussed. Amendments have been sent to informatics to be developed with a prototype presented to Deteriorating Patient Group.	Monitoring and progress continue to be discussed at the Deteriorating Patient Group and other relevant forums. The Quality team continues to work with wards individually regarding tips to improve observations on time and correct application of NEWS2 Scale2.
Mortality: The SHMI was 0.8867 and remained within the expected range. At last reported position to MRG Chair as at 30th October 23, there were 35 outstanding SJRs awaiting review.	Of the SJRs completed during quarter 3 reported to MRG Chair on 2nd November 2023, 3 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.

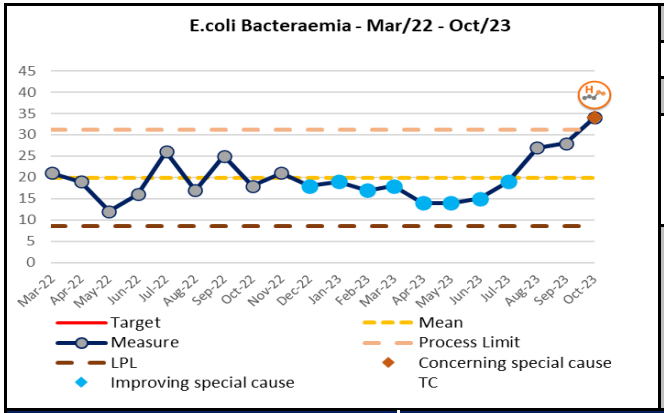


Oct-23
2.32
Variance Type
Metric is showing lower cause variation (improving)

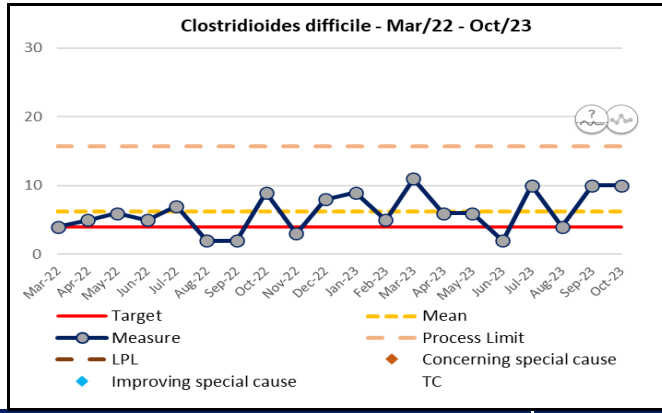


Oct-23
2.10
Variance Type
Metric is showing common cause variation

Summary	Actions	Assurance
Falls: In total, there were 79 falls reported in October 2023, compared to 94 in September 2023, which represents a decrease of 16%. Ongoing main themes from incidents include: -Falls in patients with cognitive conditions. -Quality and frequency of risk assessment completion.	The bed rails policy for RWT remains under review following the NPSA alert to ensure any requirements are captured. This is to be completed by end of March 2024 in line with NPSA alert. Safety focused Shared Decision Making Councils (SDMCs) have been merged to become a Safety SDMC, with the first meeting is due to be held in November 2023.	The falls assessment and enhanced risk assessment tool pilot has been concluded and the tool will be included in the risk assessment booklet in the coming months. This has been collaborative work with Frailty and Mental Health colleagues, specifically to strengthen the assessment processes for patients with cognitive conditions. Progress with improvement actions remains in line with the agreed improvement plans, with additional actions and learning as required.
Pressure Ulcers: In total, 44 pressure ulcer incidents were reported in October 2023, in comparison to 36 reported in September 2023. From a moisture associated skin damage (MASD) perspective, 59 MASDs were reported in October 2023, in comparison to 64 reported in September 2023.	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. Assessment training on using Purpose T continues to be available weekly and sessions on how to complete nursing documentation have recommenced and this is now in the process of being introduced to the Emergency Departments. Other actions include a pilot of MASD assessment tool and provision of staff education regarding mattress maintenance and actions to be taken when concerns are identified.	

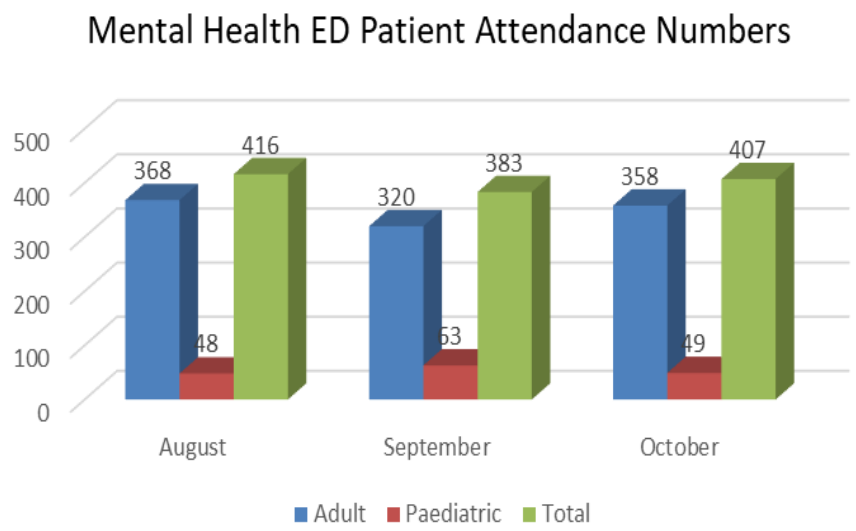


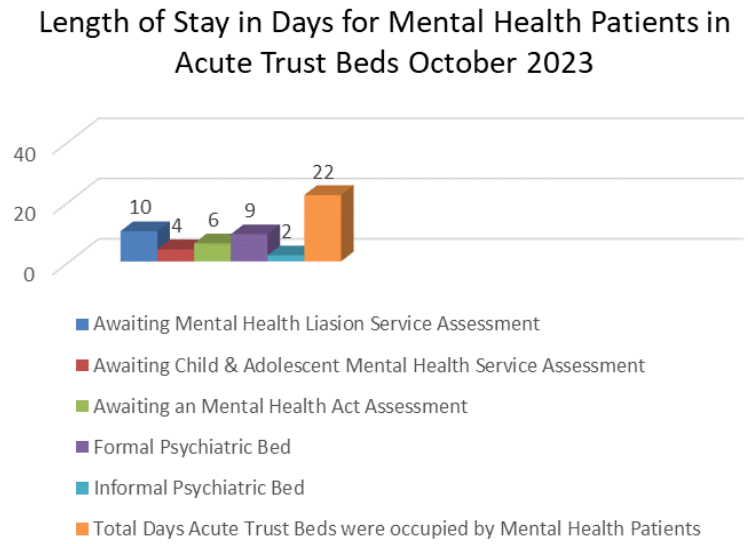
Oct-23
34
Variance Type
Metric is showing higher cause variation (concern)



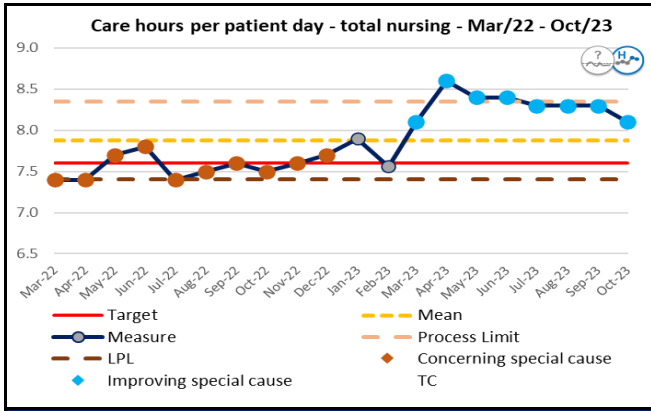
Oct-23
10
Variance Type
Metric is showing common cause variation
Target
4
Achievement
Metric is currently failing the target

Summary	Actions	Assurance
HCAI: C.difficile saw 10 cases against the target of 4 during October 2023. In addition, there were a total of 34 E.coli cases reported. There was 1 case of MRSA Bacteraemia cases during October 2023.	IP team are involved in collaborative working groups with NHSE for Gram negative bacteraemia, C. difficile and Surgical Site Infection. In terms of gram negative bacteraemias, whilst recognising they are endogenous, which makes them complex to prevent, the Trust continues to focus on the actions it is able to take to drive their reduction. In addition to our collaborative working with NHSE, we continue to progress actions via the Catheter Working Group, and these include introduction of the catheter packs (completed), launch of a catheter passport (in progress) and ongoing focus on adequate patient hydration and cross referencing with other work programmes e.g. eat, drink, dress, move. Work with the Emergency Department on a Quality Improvement Project to focus on timely sampling of patients with loose stools remains in place. The number of stool samples obtained where Cdiff is identified has increased if comparing with the same quarter in the previous year. Whether this be due to increased awareness of the need to sample or higher community prevalence cannot be determined, however, the ability to take appropriate action at the point of entry to minimise the potential for transmission is a positive. A permanent location for the Patient Equipment Cleaning Centre (PECC) has been identified and is currently undergoing refurbishment work. PECC is temporarily located in the old Discharge Lounge to support with the cleaning of patient equipment. In addition, ward decant for the deep clean programme took place between the 25th September and 3rd November 2023, utilising C41 as the decant ward. The limited window of opportunity was due to the Same Day Discharge Centre (previously referred to as Discharge Lounge) now being located on C41. Antimicrobial week is due to commence. Trustwide C diff week commenced on 6th November 2023.	An action plan is in place for Clostridioides difficile which includes, increased education for staff, increased audits including commodes and antimicrobial ward round is informed by the regional c.difficile collaboration work. An overarching IP Delivery Plan has been launched and is being progressed.

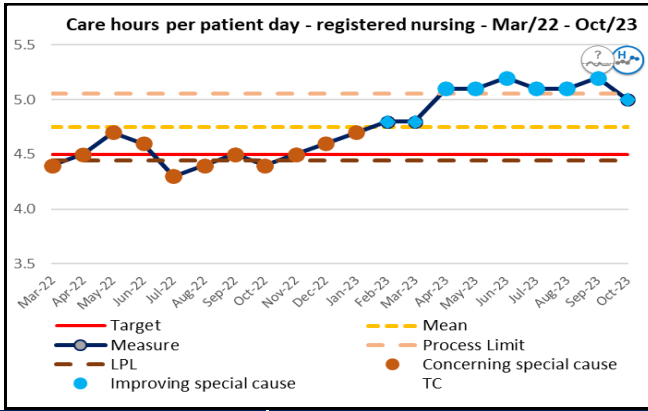




Summary	Actions	Assurance
Mental Health: The acuity within the emergency department remained high, a large proportion of patients present with acute mental health crisis had evidence of a relapse due to non-compliance with medication and treatment plans. Across the system there were delays in access to psychiatric admission beds, social care placement and social care assessment, all of which contribute to an increased length of stay. In October, patients who required a mental health specialist bed waited a total of 11 days in the Emergency Department awaiting to access those beds. In terms of sections, the activity in October was as follows: Section 17 leave: 9 patients Section 5(2): 1 patient Section 2: 2 patients Section 3: 1 patient It is evidenced the wait times for informal psychiatric bed are longer than a mental health act required admission.	The newly appointed Mental Health team based at RWT and Mental Health Act Administrators are now monitoring Mental Health Act activity trust wide and enhancing all reporting through governance processes. The Mental health team are meeting with the external mental health provider monthly to ensure transparency and discussion around incidents occurring within RWT. This meeting reports to the Mental Health Steering Group bi-monthly.	The Royal Wolverhampton NHS Trust has invested in specialist mental health staff. Team 0.5 – head of nursing for mental health 1.0 matron for mental health 1.0 clinical nurse specialist for mental health 1.0 mental health act administrator The clinical team are now fully recruited as of November 2023. Moving forward the team will work closely with the team at WHT to review services and provide clear pathways for mental health patients to support safe, high, quality care. The head of nursing for mental health is developing a clear action plan and timetable for the team to move forward and strategically build sustainable policy and process for mental health patients within the organisations. This will be available from the 1st December 2023.

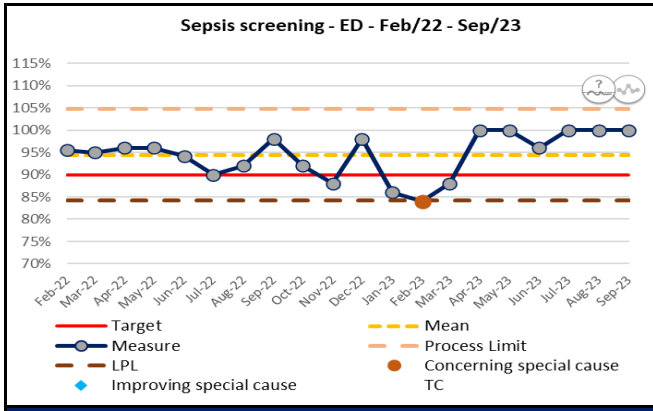


Oct-23
8.1
Variance Type
Metric is showing higher cause (improving)
Target
>7.6
Achievement
Metric is currently passing the target

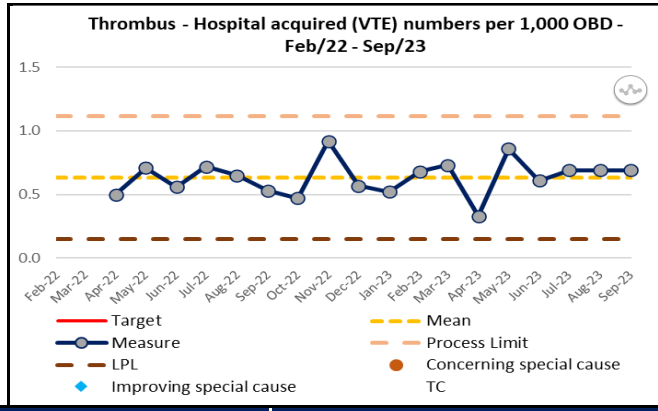


Oct-23
5.0
Variance Type
Metric is showing higher cause (improving)
Target
>4.5
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Care Hours per Patient Day (CHPPD): The Trust's average for October 2023 was 8.09, which represents a small decrease of 0.21 in month. The model hospital dashboard shows a national median to be 8.4 (August 2023). Adult inpatient range was between 4.7 - 10.9 (Mean 6.8) Critical care/Neonatal range was between 25.4 - 29.2 (Mean 27.3) Emergency portal range was between 7.6 - 9.0 (Mean 8.3)	Monthly review, of supernumerary shift and unavailability by the Divisional Heads of Nursing are in place. Monthly reviews of Net hours to be shared with the Divisional Heads of Nursing as an additional challenge from finance at budget meetings.	Newly Qualified Nurses (Oct 23) are now placed, with 5 remaining unallocated. Proactive actions are being taken to allocate these nurses and retain within our workforce. Contract with Yeovil regarding international recruitment has ceased as pipeline due to current positive vacancy position.

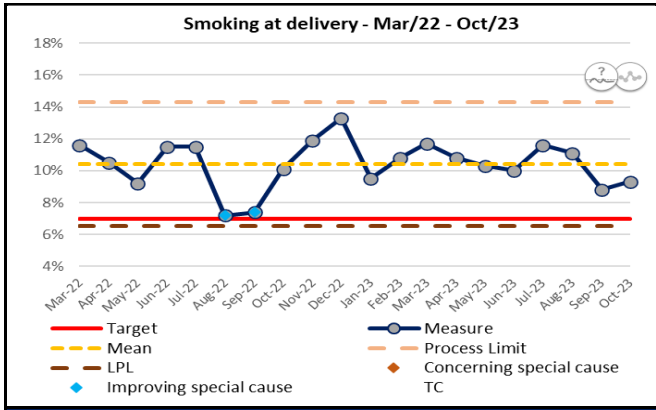


Sep-23
100.0%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target

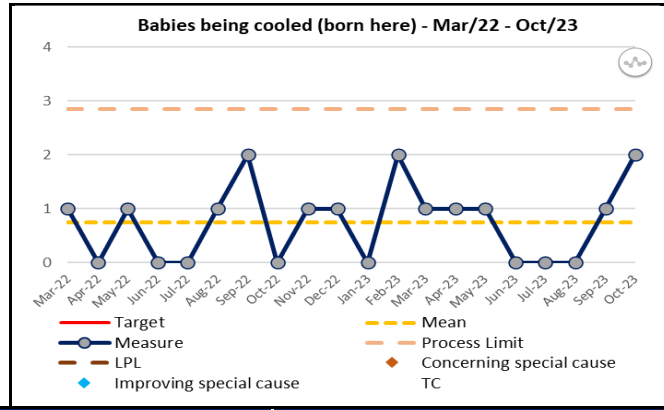


Quarter 2 23/24
0.69
Variance Type
Metric is showing common cause variation

Summary	Actions	Assurance
Sepsis screening in ED: Not available at the time of reporting.		Oversight of sepsis and deteriorating patient agenda and specific actions remain via the Deteriorating Patient Group.
VTE: 50 hospital associated VTE were reported during quarter 1 (0.69 per 1,000 occupied bed days). New VTE cases are identified through radiology reports, discharge coding and the bereavement office. The summary is taken from a review of patient notes, vitals, EPMA and badgernet systems and a VTE level 1 RCA report compiled.	A review of datix categorisations has taken place. Additional VTE categories have been added to enable data extraction around themes which will also feed into a VTE dashboard which is a current work stream in progress. There was 1 STEIS reportable incident in July 2023 which is currently under investigation.	A local RCA is being completed for the STEIS reportable incident to establish if there is any learning across Adult Community Services as the patient had been known to the services following hospital discharge in May 23. Checks are also in place to ensure reported incidents are cross checked for involvement of other services which may influence outcomes/care.



Oct-23
9.3%
Variance Type
Metric is currently showing common cause variation
Target
<7%
Achievement
Metric is currently failing the target



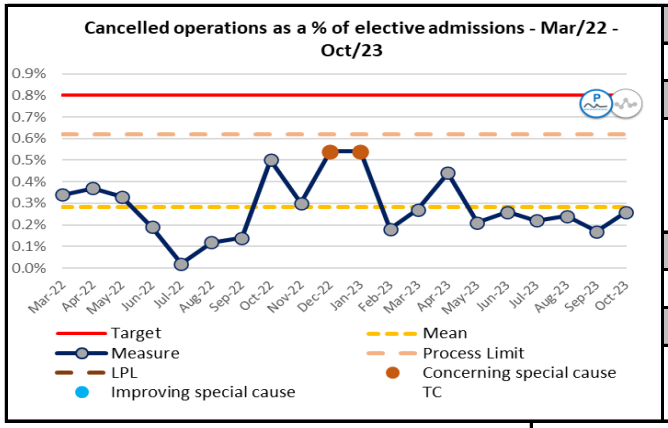
Oct-23
2
Variance Type
Metric is currently showing common cause variation

Summary	Actions	Assurance
Maternity: Smoking times at delivery (SATOD) - Smoking at time of Delivery rates has increased slightly this month to 9.3% - this remains higher than the national ambition (<7%). Wolverhampton has high levels of deprivation, 24/317 highest in England, the prevalence of smoking in pregnancy is highest in areas with the highest levels of deprivation.	Since the introduction of a maternity lead tobacco dependency service in 2019, the rates of smoking at time of birth have fallen faster than the National average. However, they remain above the National average. Short term funding from the ICB has enabled the appointment of two WTE Tobacco Dependency Advisors (TDAs) for one year from June 2023.	Smoking is monitored monthly on the maternity dashboard and element 1 of the 'Saving Babies Lives Care Bundle' SBLCB V3. Dedicated Midwifery lead for SBLCB has now commenced in post. Dedicated Midwifery lead for Public Health, including smoking cessation services for oversight.
Babies being cooled - there were 2 babies cooled during October 2023.	Case one: This case has been discussed by the Directorate and assigned 'PMRT C' (different management may have made a difference to the outcome). Case two: This case has been reviewed by the Directorate and it was identified that an MRI scan was normal and no significant concerns regarding the care and management have been identified. However, the risk assessment was incorrect.	Case one: Division has been informed as this case currently meets the SI reporting criteria. Advice is awaited from the governance team in light of PSIRF implementation. Review is being undertaken and learning actions will be implemented once fully identified. Case two: Ensuring accuracy of Aspirin risk assessments has been raised with community teams via the Community Midwifery Learning infographic and the impact will be monitored via the established governance process.

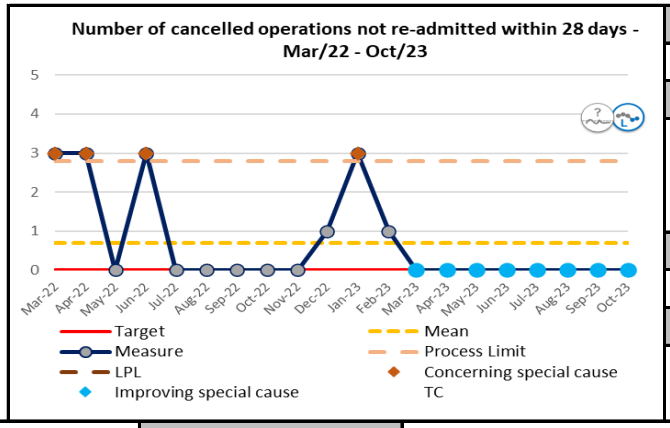
Performance

Metric - Patient Experience	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Number of cancelled operations on the day of surgery for non-medical reasons				12	15	11	12	9	15
Cancelled operations as a % of elective admissions	<0.8%		P	0.21%	0.26%	0.22%	0.24%	0.17%	0.26%
Number of cancelled operations not re-admitted within 28 days	0	L	?	0	0	0	0	0	0
Number of urgent cancelled operations cancelled for a 2nd time	0		P	0	0	0	0	0	0
Patients with no criteria to reside				60	51	76	60	51	47
Metric - Waiting Times	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
RTT - % of patients on an incomplete pathway	92%	L	F	58.43%	57.16%	55.88%	54.99%	54.75%	55.90%
RTT - number of patients waiting 78+ weeks		L		85	39	53	39	50	61
Total Incomplete Number		H		77,180	81,398	83,699	85,933	86,959	86,605
Diagnostic Test - % of patients waiting 6 weeks or more	>99%	H	F	52.73%	56.14%	57.86%	53.60%	56.82%	60.67%
Metric - Urgent Care	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Total time spent in ED (4 hours) - New Cross Hospital	76% (from Apr 23)		?	69.05%	66.89%	68.84%	68.05%	67.84%	68.41%
Total time spent in ED (4 hours) - Combined				79.08%	76.12%	78.34%	77.93%	77.79%	77.05%
% of ED attendances >12 hours	0		F	7.02%	6.20%	6.75%	6.41%	8.18%	9.90%
Ambulance handover within 15 minutes	65%		F	66.37%	57.33%	58.34%	55.19%	51.54%	43.54%
Ambulance handover within 30 minutes	95%		?	95.48%	88.71%	87.85%	88.60%	82.64%	77.46%
Ambulance handover >60 minutes	0%		?	0.89%	3.45%	4.29%	3.46%	7.91%	10.85%
% of emergency admissions via Emergency Department				41.80%	40.46%	41.62%	41.85%	40.03%	39.35%

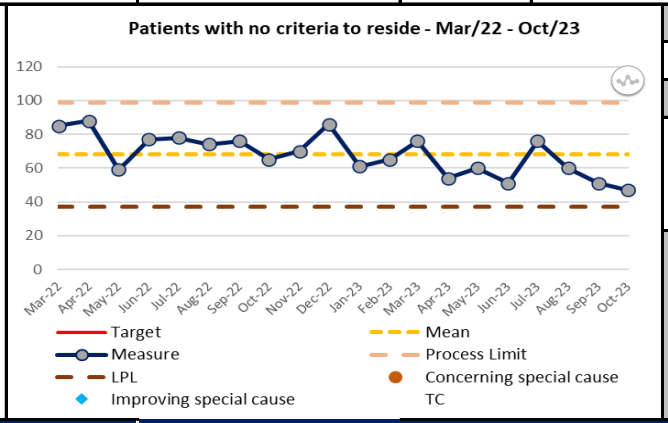
Metric - Stroke	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Patients admitted with primary diagnosis of stroke should spend greater than 90% of their hospital stay on a dedicated stroke unit	80%			100.00%	100.00%	100.00%	90.14%	81.25%	71.00%
Stroke patients will be assessed and treated within 24 hours	60%			83.00%	80.12%	66.01%	76.00%	83.33%	75.28%
Metric - Organisational Efficiency	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Electronic discharge summary within 24 hours of patient discharge	>/= 90%			96.01%	95.34%	95.23%	94.25%	96.02%	95.31%
Metric - Cancer Waiting Times	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
2 Week Wait - Cancer Referrals	93%			87.69%	79.05%	73.53%	75.62%	75.86%	75.00%
31 Day Combined	96%			77.01%	82.43%	84.70%	86.79%	83.89%	82.45%
62 Day Combined	85%			41.08%	39.37%	38.53%	47.31%	42.86%	35.14%
28 Day Faster Diagnosis Standard	75%			68.60%	76.14%	74.43%	75.02%	73.58%	73.12%



Oct-23
0.26%
Variance Type
Metric is showing common cause variation
Target
<0.8%
Achievement
Metric is currently passing the target

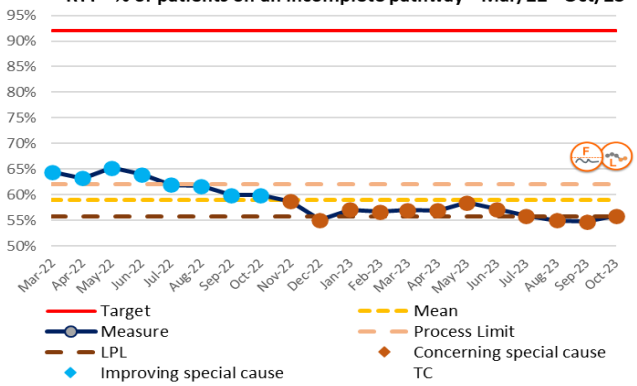


Oct-23
0
Variance Type
Metric is showing lower special cause (improving)
Target
0
Achievement
Metric is currently passing the target

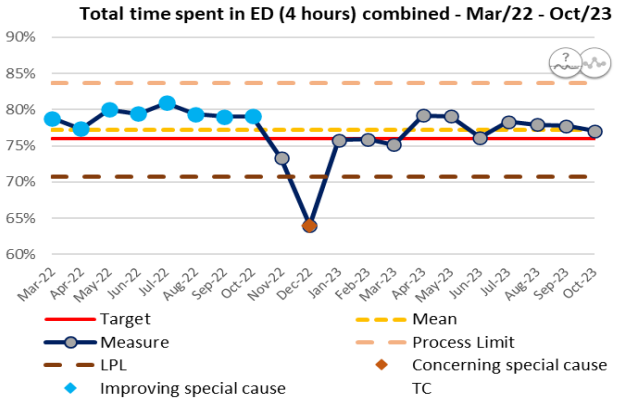


Oct-23
47
Variance Type
Metric is showing common cause variation

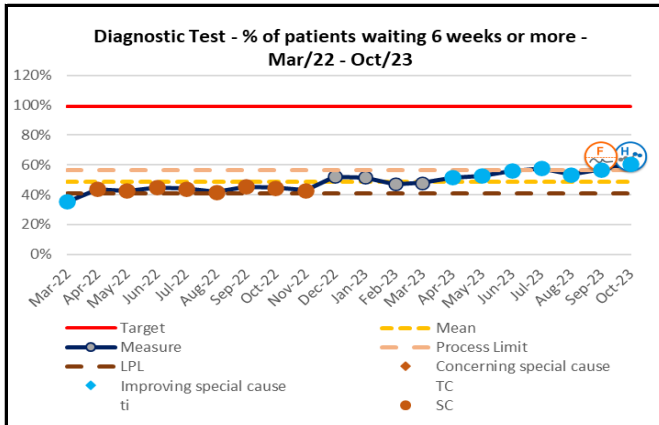
Summary	Actions	Assurance
Cancelled Operations: We remain below target. There were no patients who had been cancelled on the day that were not rebooked within 28 days.	All cancelled operations on the day of surgery are reported daily and root cause analysis (RCA) is completed	RCA's are circulated to Deputy COO's on a weekly basis as part of the weekly performance meeting.
Patients with no criteria to reside: at the end of October 23 we had 47 patients in a hospital bed that were medically fit for discharge. This is an improvement of 4 patients when compared with the previous month.	Daily medically fit for discharge meetings where every patient is reviewed. Daily escalation telephone calls to local authority and community teams.	The huddle tool is used internally to communicate between all departments.



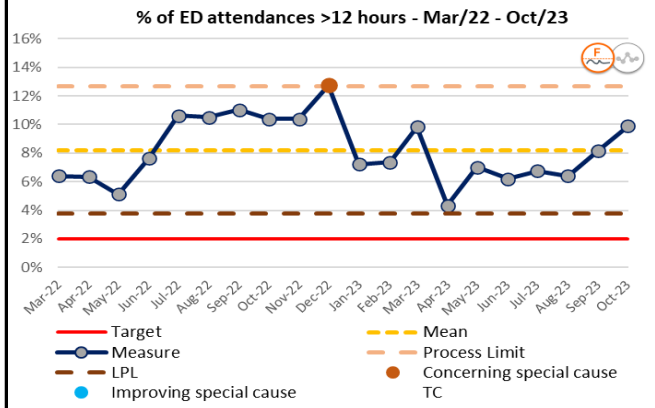
Oct-23
55.90%
Variance Type
Metric is showing lower special cause (concern)
Target
92%
Achievement
Metric is currently failing the target



Oct-23
77.05%
Variance Type
Metric is showing common cause variation
Target
76%
Achievement
Metric is currently passing the target

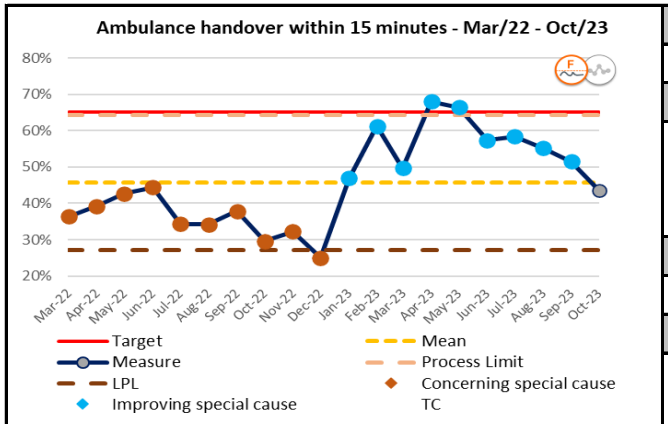


Oct-23
60.67%
Variance Type
Metric is showing higher special cause (improving)
Target
>99%
Achievement
Metric is currently failing the target

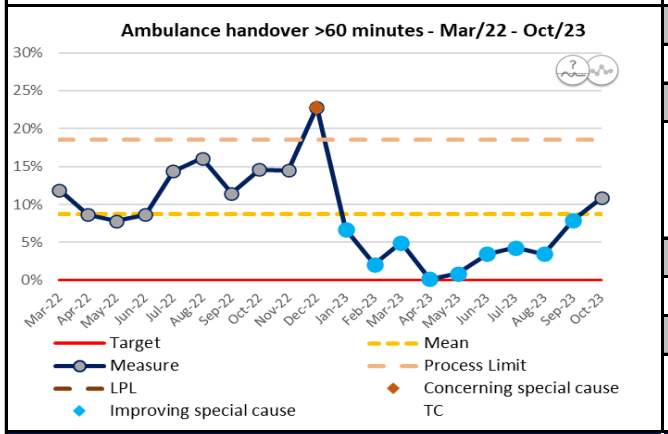


Oct-23
9.90%
Variance Type
Metric is showing common cause variation
Target
<2%
Achievement
Metric is currently failing the target

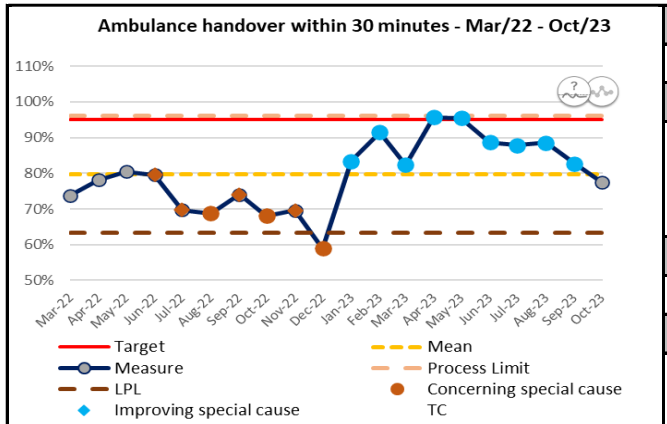
Summary	Actions	Assurance
RTT: 61 patients were reported as waiting 78+ weeks at month end against a target of 70. This number is mostly now Urology patients. However, this is unlikely to be at zero until around the end of November 23.	Daily reporting and monitoring of long waiting patients. We continue to use mutual aid where appropriate and available.	These patients are monitored at the PTL meetings 3 times per week where each patient is reviewed on an individual basis.
Diagnostics: This is showing an overall improving trend over the past 7 months.	U/S scans remain the biggest issue due to large backlog (overall performance excluding U/S is 77.59%). Overall endoscopy overdue planned numbers are continuing to reduce.	All modalities have individual trajectories and action plans to work towards. This is monitored at the weekly performance meeting.
ED: Nationally RWT ranked 8th out of 121 Trusts for the month (compared with 9th in the previous month), and locally RWT ranked 1st out of 14 Trusts (compared with 2nd in the previous month).	Implementation of Immediate Care Clinician (ICC) to provide rapid treatment for patients. Patterns in daily activity being reviewed with particular focus on high attendances on a Monday and Tuesday. Rotas to be reviewed to adjust work patterns to bolster.	The 4 hour target changed from 1st April 23 and is now 76%. Trust has maintained a strong position regionally and nationally.



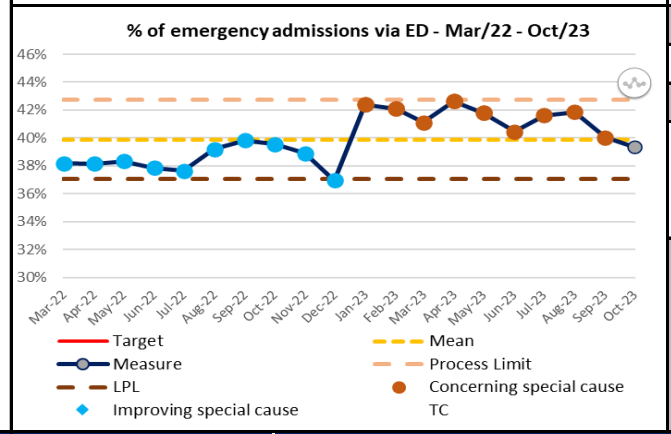
Oct-23
43.54%
Variance Type
Metric is showing common cause variation
Target
65%
Achievement
Metric is currently failing the target



Oct-23
10.85%
Variance Type
Metric is showing common cause variation
Target
0%
Achievement
Metric is currently failing the target

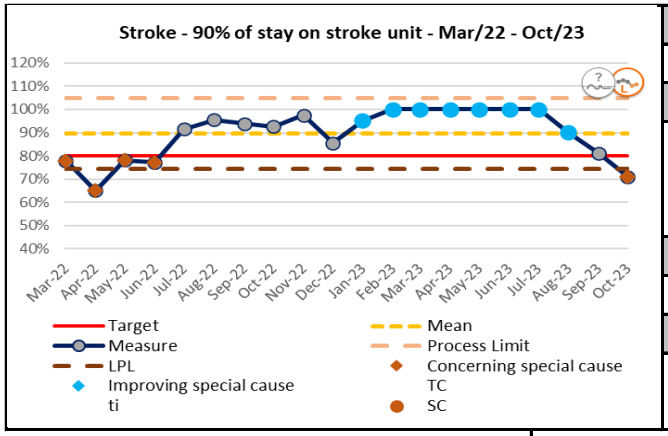


Oct-23
77.46%
Variance Type
Metric is showing common cause variation
Target
95%
Achievement
Metric is currently failing the target

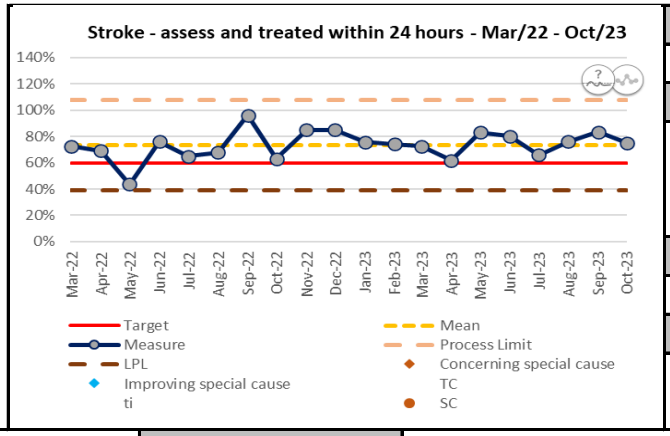


Oct-23
39.35%
Variance Type
Metric is showing common cause variation

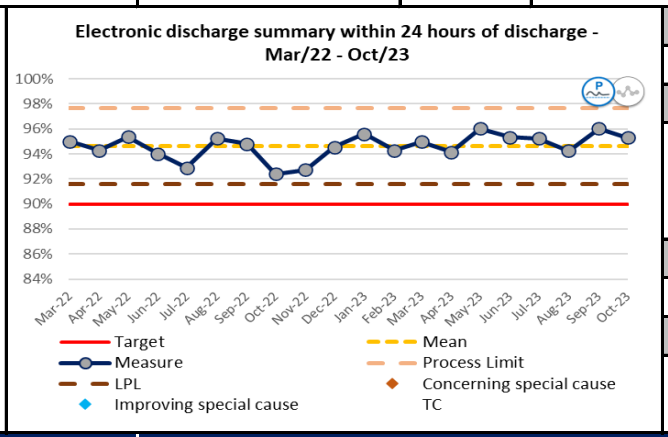
Summary	Actions	Assurance
Ambulance Handover: Overall ambulance handover continues to showed some deterioration during October 23. The longest waiting ambulance in month was 6 hours and 53 minutes**.**	Criteria Led Handover continues in Divisions 1 & 2 to expedite timely transfers. A workstream specifically focusing on improving 4 hour performance is in place with a review of administrative processes of discharging patients, barriers to achieving 4 hour target and patterns in breaches. Push Pilot continues, 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 October 23. This was mainly seen in patients attending SDEC.		Discussed in detail at the weekly performance meeting.



Oct-23
71.00%
Variance Type
Metric is showing lower special cause (concern)
Target
80%
Achievement
Metric is currently failing the target

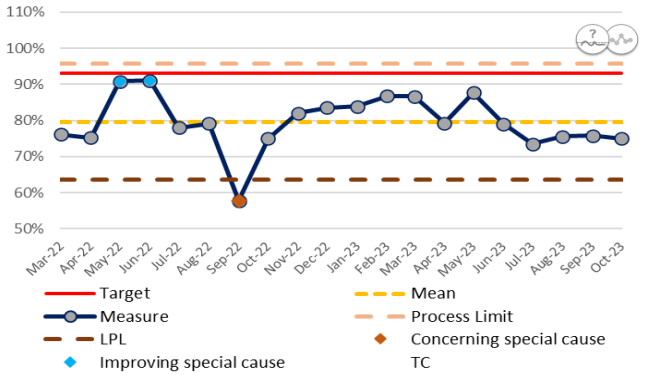


Oct-23
75.28%
Variance Type
Metric is currently showing common cause variation
Target
60%
Achievement
Metric is currently passing the target

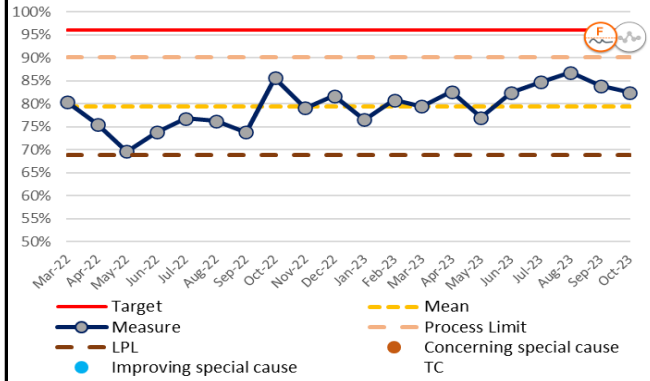


Oct-23
95.31%
Variance Type
Metric is currently showing common cause variation
Target
90%
Achievement
Metric is currently passing the target

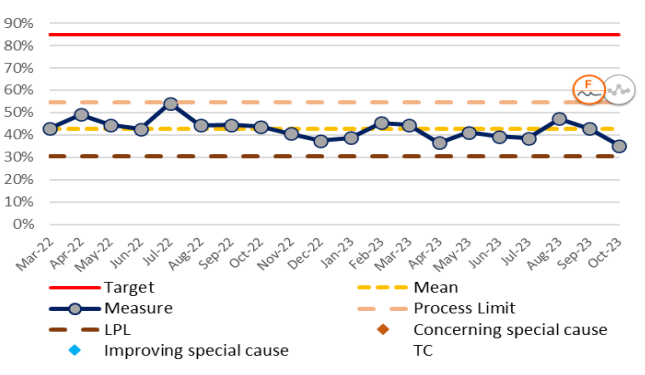
Summary	Actions	Assurance
Stroke: Patients spending 90% of time on a stroke ward has taken a downward trend in the past 3 months, however, it currently remains above target.	A data quality issue has been identified for this metric. The team are currently working with the information department to rectify this and resume accurate timely reporting.	
Stroke: Performance has declined slight during October 23, however, remains above target 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.



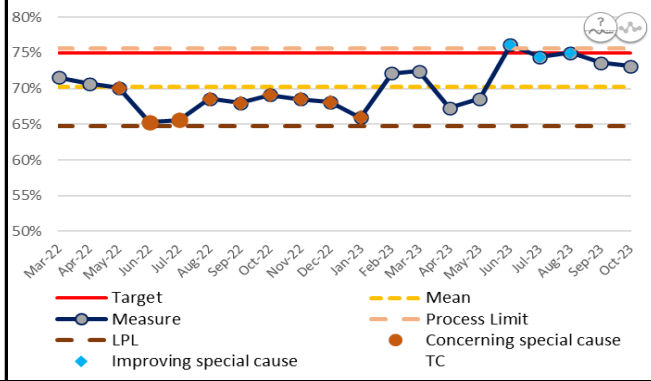
Oct-23
75.00%
Variance Type
Metric is showing common cause variation
Target
93%
Achievement
Metric is currently failing the target



Oct-23
82.45%
Variance Type
Metric is showing common cause variation
Target
96%
Achievement
Metric is currently failing the target



Oct-23
35.14%
Variance Type
Metric is showing common cause variation
Target
85%
Achievement
Metric is currently failing the target



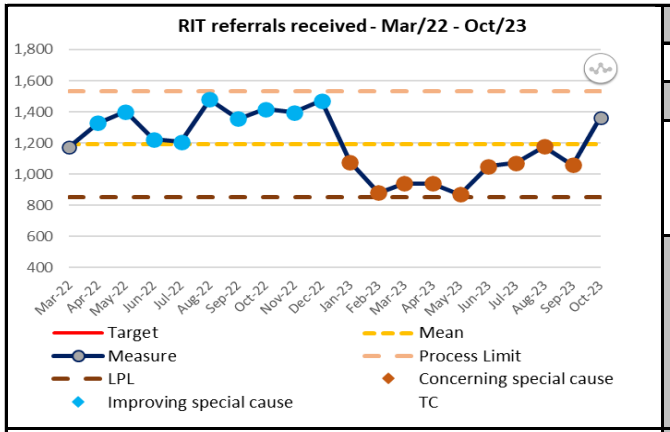
Oct-23
73.12%
Variance Type
Metric is showing common cause variation
Target
75%
Achievement
Metric is currently failing the target

Summary	Actions	Assurance
Cancer: 2ww referrals remained high during October 23 particularly in Breast, Gynaecology, Head & Neck and Lung. Overall referrals in month were 15% higher than we saw in the same period last year. **The reporting of cancer targets changed on 1st October 23 with the focus only being on 31 day combined, 62 day combined and 28 day FDS targets, however, we will continue to monitor the 2ww target at this has a significant impact on all targets.**	Locum Breast Surgeon in place to provide ad hoc cover. Meeting planned for 13th November 23 with primary care (GP with special interest) around potential support in Hysteroscopy.	All cancer indicators are monitored at the weekly Trust performance meeting along with a separate weekly PTL meeting focussing on individual pathways and patients.

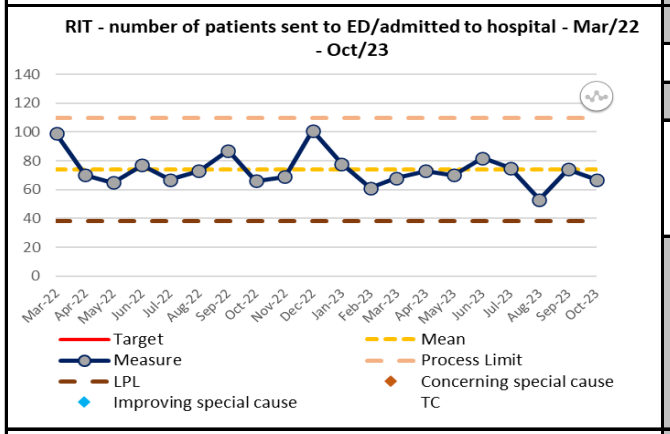
Integrated Care

Metric - Sexual Health (a month in arrears)	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Total number of appointments against block contract	>/=4,500	H	F	3,672		3,275			
% appropriate patients offered HIV test	>/=95%	H	P	100.0%		98.3%			
Metric - Community Nursing (Rapid Intervention Team)	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Referrals received				871	1,051	1,072	1,178	1,059	1,364
Patients accepted and seen (actuals)				858	1,030	1,062	1,154	1,052	1,355
Number of patients sent to ED/admitted to hospital by RIT's				70	82	75	53	74	67
% of referred patients who are sent to ED/admitted				8.15%	7.96%	7.06%	4.67%	7.03%	4.94%
Number of referrals from West Midlands Ambulance Service				49	64	63	68	56	62
Night visiting service (initial)		L		229	245	251	265	217	131
Rapid response (initial)		H		741	886	1,014	1,099	1,019	1,287
Crisis response (within 2 hours)	>/=35%		P	76.5%	79.4%	83.9%	81.7%	81.7%	69.3%
Metric - Virtual Ward	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Virtual ward (initial)		H		118	143	196	184	197	346
Metric - Rapid Access Care	**Target**	**Variation**	**Assurance**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**
Rapid access social care (initial)				63	76	87	92	73	80

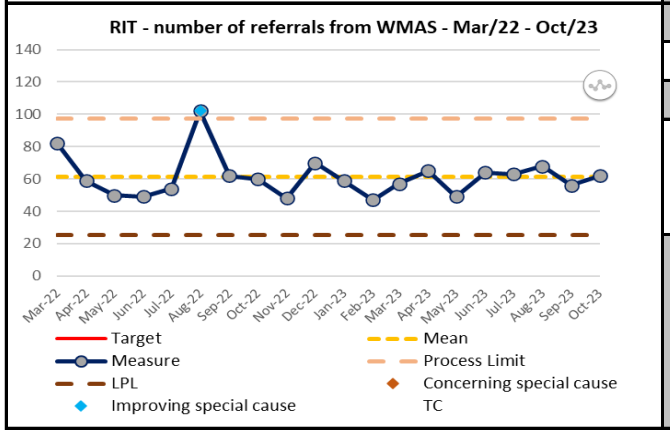
Metric - Care Co-ordination	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Total number of referrals accepted				2,786	2,368	2,609	3,152	2,998	3,329
Number of referrals closed				892	955	441	458	476	441
Number signposted to ED				53	43	52	46	61	57
Number referred onto SDEC				38	21	63	47	37	109
Number referred on to community				1,788	1,336	2,043	2,587	2,416	2,709
Number of referrals sustained (admission avoidance)				12	4	6	12	5	8
Number of referrals admitted to hospital				3	9	4	2	3	5



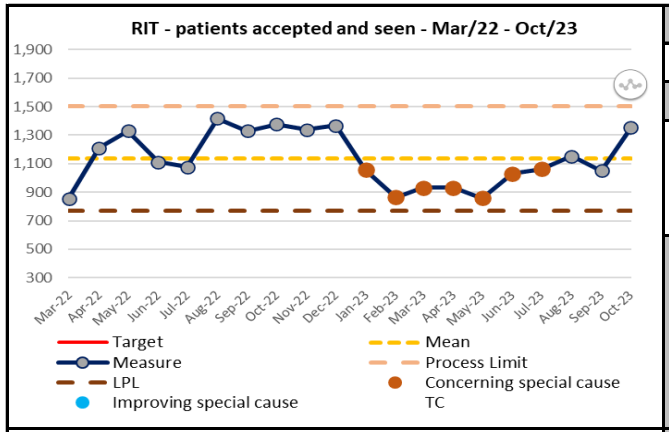
Oct-23
1,364
Variance Type
Metric is showing common cause variation



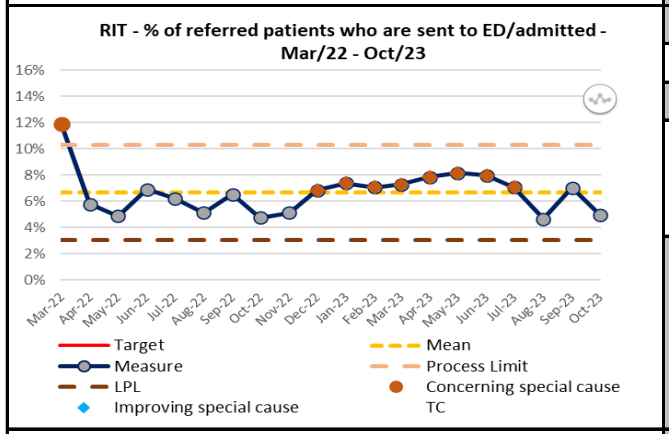
Oct-23
67
Variance Type
Metric is showing common cause variation



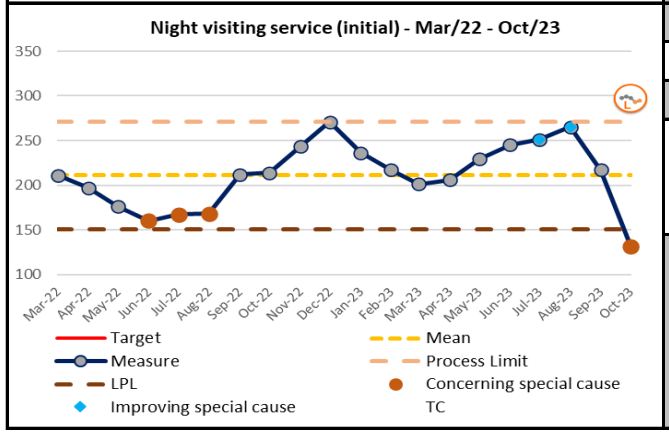
Oct-23
62
Variance Type
Metric is showing common cause variation



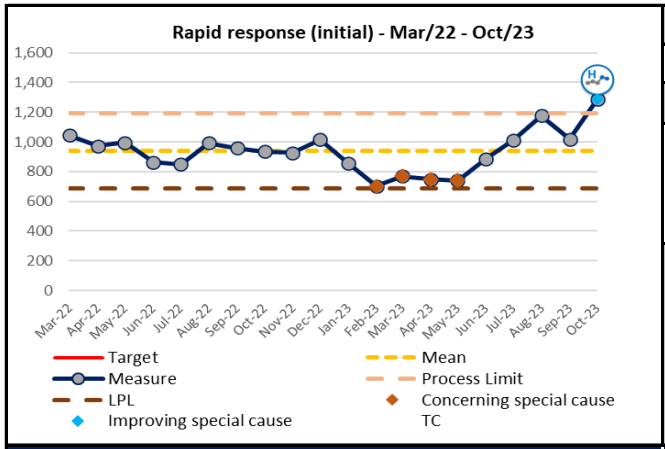
Oct-23
1,355
Variance Type
Metric is showing common cause variation



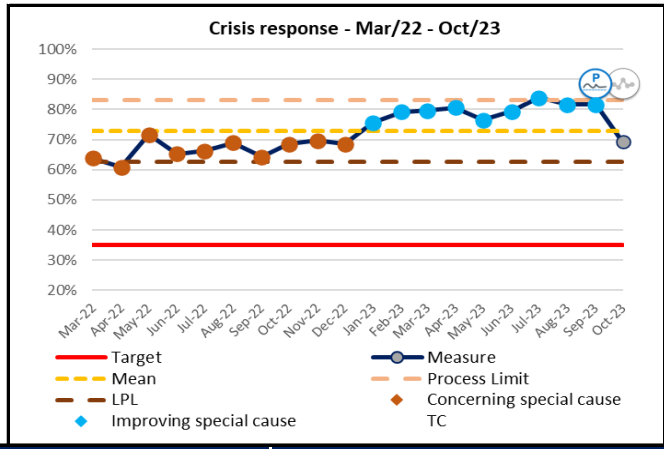
Oct-23
4.94%
Variance Type
Metric is showing common cause variation



Oct-23
131
Variance Type
Metric is showing lower special cause (concern)

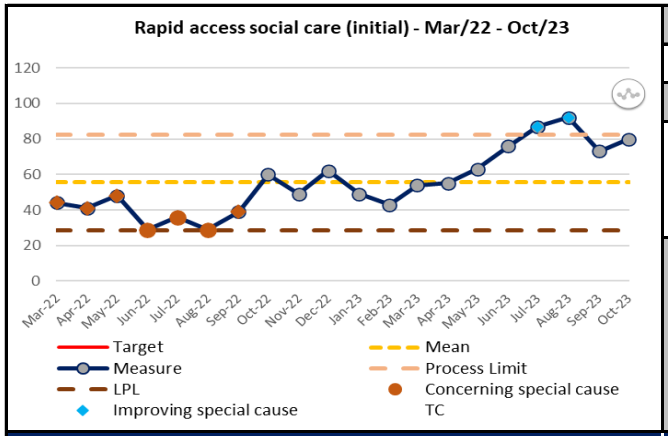


Oct-23
1,287
Variance Type
Metric is showing higher special cause (improving)

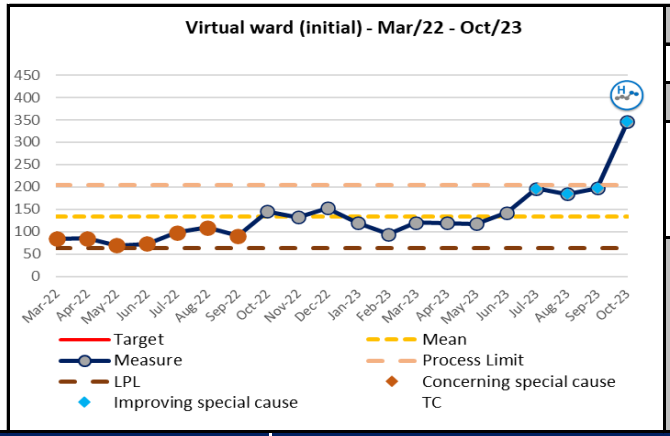


Oct-23
69.3%
Variance Type
Metric is showing common cause variation
Target
35.0%
Achievement
Metric is currently passing the target

Summary	Actions	Assurance
Community Nursing (Rapid Intervention Team): Referral numbers saw an increase during October 23 and are now currently above the average expected numbers. We continue work with WMAS and care homes and the use of docobo for appropriate escalation into the team.	Ongoing promotional work with WMAS to maintain use of community pathways. Care homes are encouraged to use the service when possible and appropriate. Falls response has been suspended whilst new procedures are being drawn up.	WMAS DOS lead aware and continues to promote service and alternate pathways to crews.
Night Visiting Service: Referrals into the night visiting services dipped further during October 23, this is being monitored closely. Although admission numbers have fallen slightly, these remain 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.	Establish process for non-compliance and breach reporting mechanism on a daily basis. Develop KPI for referral to triage time and triage to escalation.	Performance has remained consistently high and remains above target.

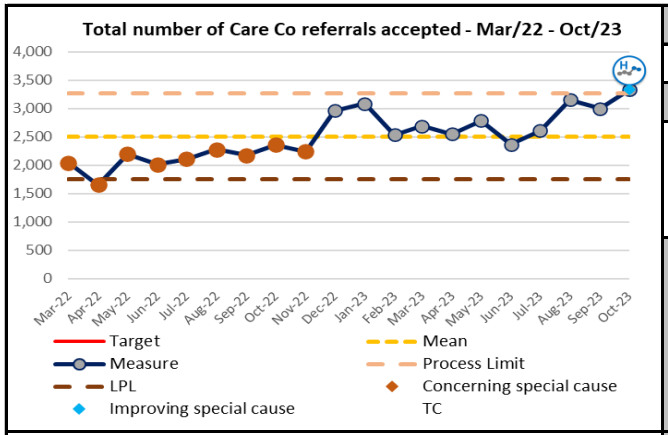


Oct-23
80
Variance Type
Metric is showing common cause variation

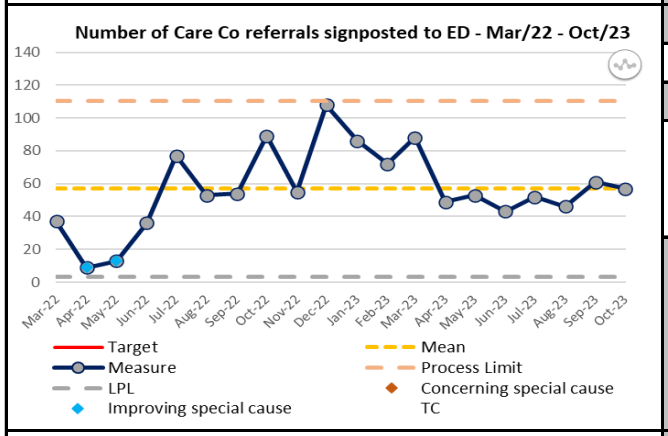


Oct-23
346
Variance Type
Metric is showing higher special cause (improving)

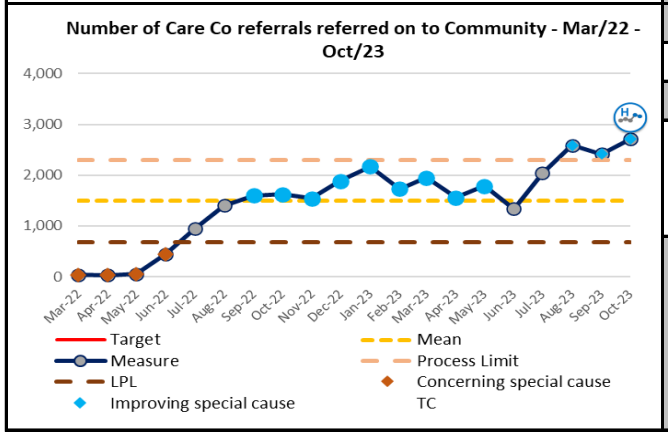
Summary	Actions	Assurance
Rapid access to social care: Increased End Of Life patients on the caseload. Handoff to Social Care continues to be an on-going cause for concern. An overall improving trend.	An escalation processes is in place for handover delays.	Capacity issues are reported in the bed meetings and D2A daily Performance monitored by Directorate and Division.
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 with review of activity and coding to ensure accurate reporting.	A dashboard is used to monitor use against national submission, and evaluation of the impact.



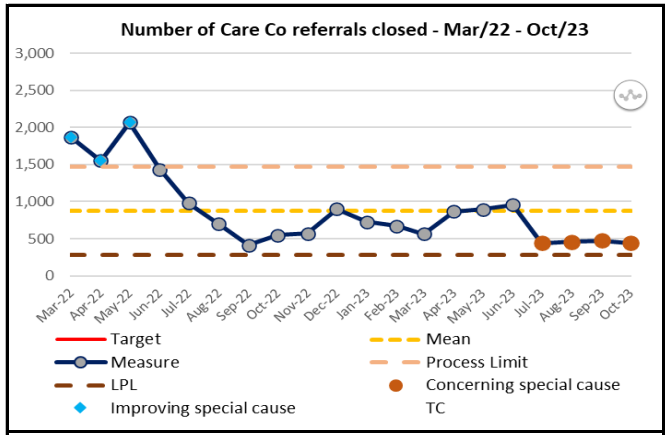
Oct-23
3,329
Variance Type
Metric is showing higher special cause (improving)



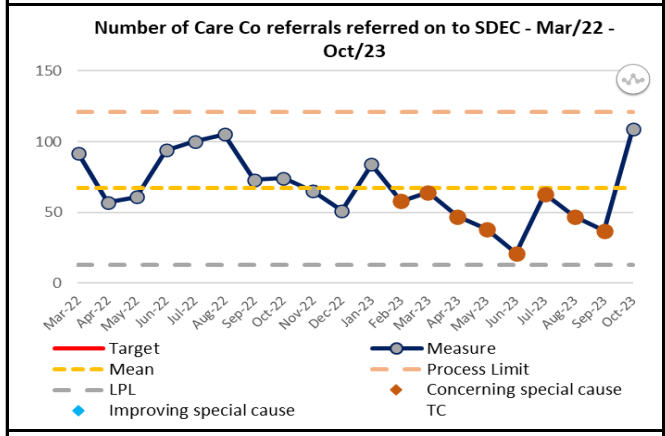
Oct-23
57
Variance Type
Metric is showing common cause variation



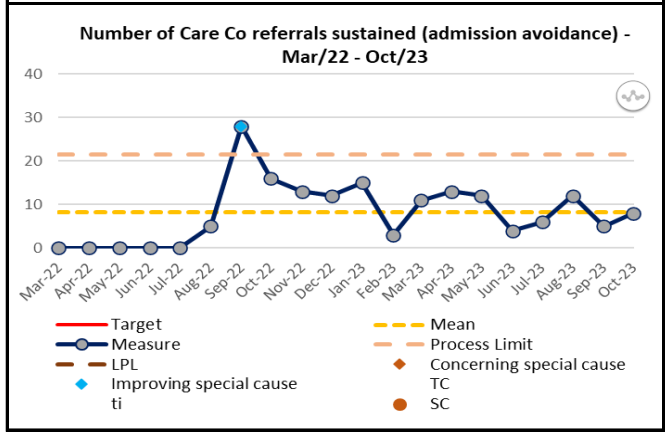
Oct-23
2,709
Variance Type
Metric is showing higher special cause (improving)



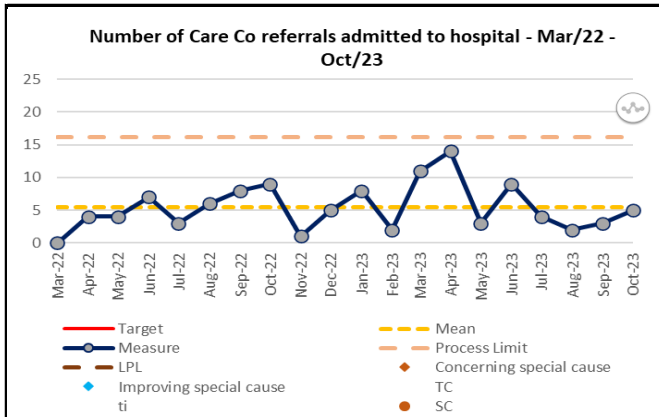
Oct-23
441
Variance Type
Metric is showing common cause variation



Oct-23
109
Variance Type
Metric is showing common cause variation



Oct-23
8
Variance Type
Metric is showing common cause variation

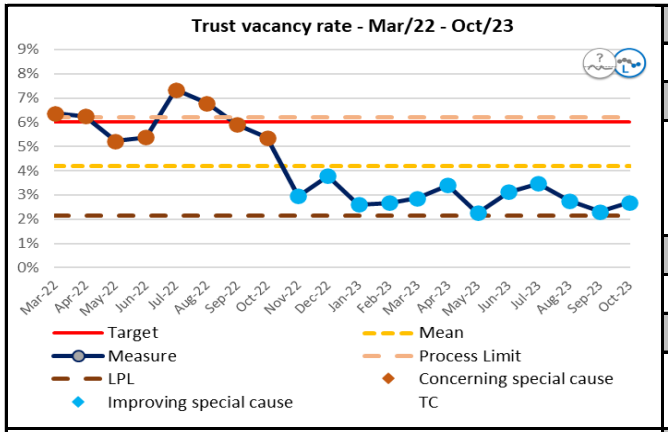


Oct-23
5
Variance Type
Metric is showing common cause variation

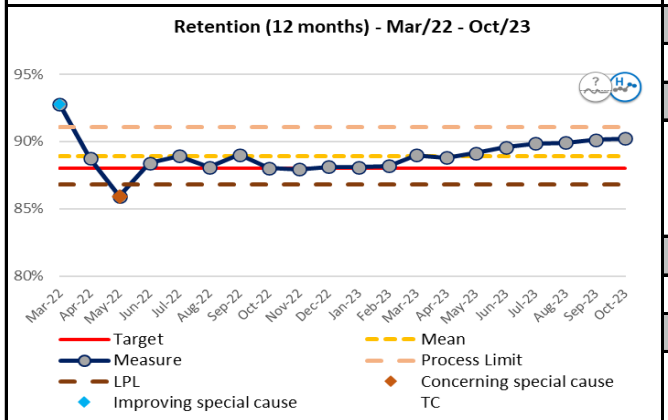
Summary	Actions	Assurance
The Care Coordination Centre streamline all referrals into Adult Community Nursing Services. They are there to help patients, relatives and other professionals ensure they access the right services they need. They triage all contacts made to the service, ensuring onward referrals 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

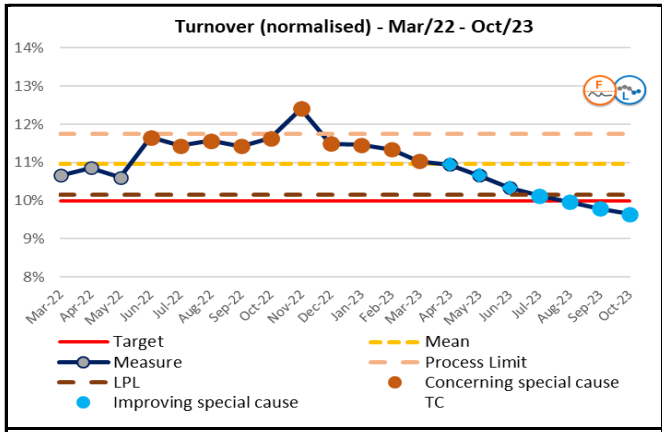
Metric	Target	Variation	Assurance	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Trust Vacancy Rate	6%	L	?	2.26%	3.12%	3.48%	2.77%	2.31%	2.70%
Turnover (normalised)	10%	L	F	10.66%	10.34%	10.13%	9.97%	9.79%	9.65%
Retention (12 months)	88%	H	?	89.15%	89.57%	89.86%	89.93%	90.13%	90.23%
Appraisals	90%	H	F	83.60%	84.80%	85.50%	85.40%	84.80%	84.90%
Mandatory Training (generic)	85%		P	95.40%	95.60%	95.30%	95.00%	95.10%	95.00%
Sickness (in month)	5%	H	?	4.65%	4.71%	5.00%	4.99%	4.94%	
Sickness (rolling 12 months)	5%	H	F	5.24%	5.21%	5.09%	5.08%	5.06%	



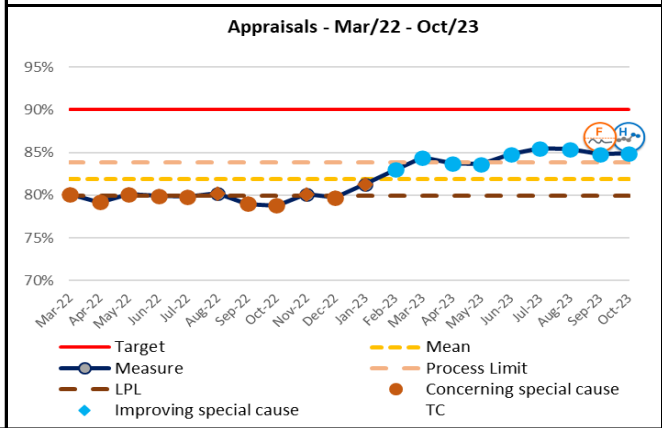
Oct-23
2.70%
Variance Type
Metric is showing lower special cause (improving)
Target
<6%
Achievement
Metric is currently passing the target



Oct-23
90.23%
Variance Type
Metric is showing higher special cause (improving)
Target
>88%
Achievement
Metric is currently passing the target

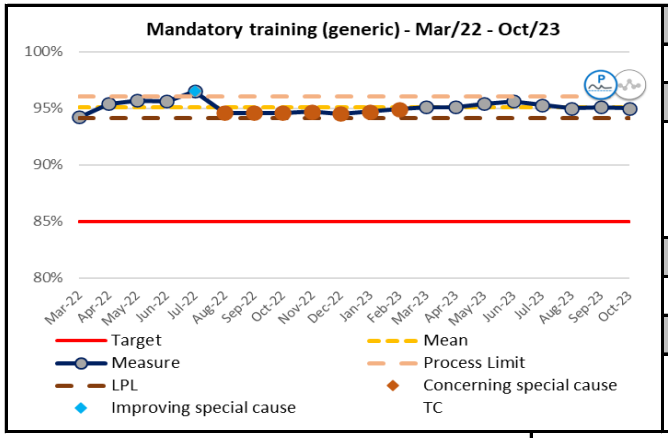


Oct-23
9.65%
Variance Type
Metric is showing lower special cause (improving)
Target
<10%
Achievement
Metric is currently passing the target

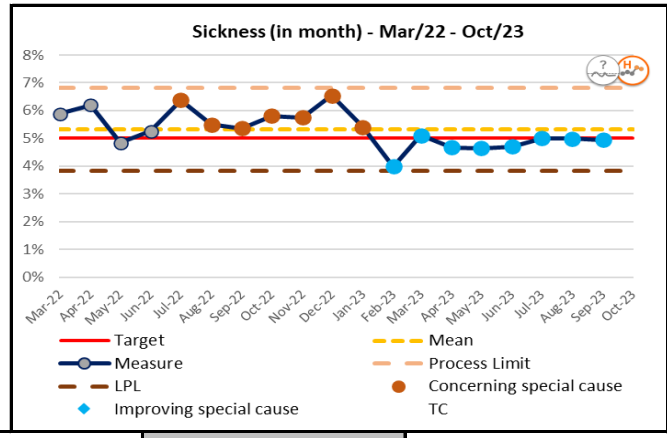


Oct-23
84.90%
Variance Type
Metric is showing higher special cause (improving)
Target
>90%
Achievement
Metric is currently failing the target

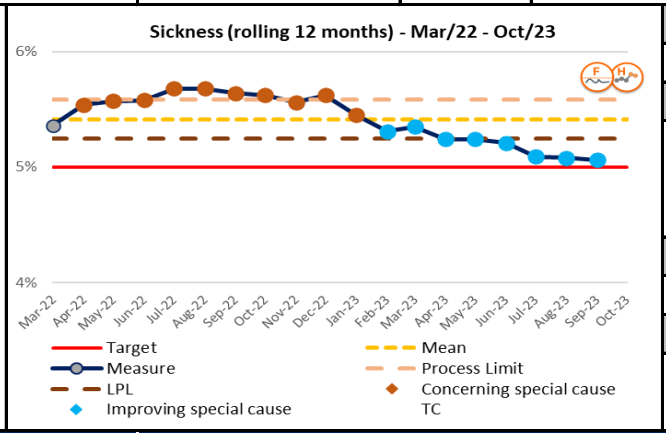
Summary	Actions	Assurance
Trust Vacancy Rate: showing an overall improving trend for past 12 months, and remains within target.	The number of international/ newly qualified nurses working towards their pin is decreasing as the individuals qualify and the pipeline slows in response to the Trust's favourable position.	The vacancy and turnover rates are continuing to meet the target.
Retention/Turnover: Both turnover and retention continue to show overall improvement. Both of these indicators are currently achieving their respective targets.		
Appraisals: appraisal performance is showing an overall improving trend, although compliance remains static and below target. Service pressures have had and continue to have a profound effect on the ability to undertake timely appraisals.	Divisions, directorates and departments have been required to produce recovery plans for the delivery of appraisal activity and this will be managed through the Divisional structure.	This matter has been discussed at Operational Workforce Group in some detail with commitment from Divisions offered to deliver improvements in appraisal compliance.



Oct-23
95.00%
Variance Type
Metric is showing common cause variation
Target
>85%
Achievement
Metric is currently passing the target



Sep-23
4.94%
Variance Type
Metric is showing higher special cause (concern)
Target
<5%
Achievement
Metric is currently passing the target



Sep-23
5.06%
Variance Type
Metric is showing higher special cause (concern)
Target
<5%
Achievement
Metric is currently failing the target

Summary	Actions	Assurance
Mandatory Training (generic): compliance rates have dipped very slightly when compared with the previous month, however, this remains above target.		
Sickness: Both indicators are showing an overall improving trend. Monthly sickness rate remains on target. The rolling 12 month sickness rate remains very slightly above target.	HR colleagues have been reviewing cases where staff are experiencing the highest levels of absence to ensure appropriate escalation within Divisional structures. The flu and COVID-19 vaccination campaigns commenced in September 2023.	Considerable work has been undertaken to develop the wellbeing support offer, including psychological and practical wellbeing support for staff.

The Royal Wolverhampton NHS Trust

Minutes of the People and Organisational Development Committee

Date	**Friday, 22nd September 2023**	
Venue	**Via MS Teams**	
Time	**10:30am**	
Present:	**Name**	**Role**
	Emma Ballinger	Associate Director of People Transformation & Culture
	Kevin Bostock	Group Chief Assurance Officer
	Umar Daraz	Associate Non-Executive Director
	Alan Duffell	Group Chief People officer
	Angela Harding	Associate Non-Executive Director
	Allison Heseltine (Chair)	Non-Executive Director
	Amy Hobson	Resourcing Manager
	Lyndsey Ibbs-George	Divisional Manager, Estates & Facilities
	Mark Ondrak	Staffside Lead
	Adam Race	Director of Operational HR and OD
	Amy Sykes	Head of Workforce Transformation and Organisational Development
	Ananth Viswanath	Deputy Medical Director
	Keith Wilshere	Group Company Secretary
	Claire Young	Group Deputy Director of Education & Training
In Attendance:	Maria Dent	Executive PA to Group Chief People Officer
	Gurdeep Anglin	Divisional HR Manager
Apologies:	Chrissla Davis	Deputy Director of Nursing
	Simon Evans	Group Chief Strategy Officer
	Lewis Grant	Deputy COO, Division 1
	Tracey King	Interim Head of Resourcing
	Ros Leslie	Chief Allied Health Professional (AHP)
	Kate Shaw	Deputy COO, Division 2 – Emergency & Medicine
	Seb Smith-Cox	Group Head of Workforce Intelligence & Planning
	Laura Willis	Acting Group Head of Corporate Learning Services
	Cath Wilson	Deputy Director of Nursing

Agenda Item No		Action
1.	**STANDING ITEMS**	
1.1	**Apologies for Absence and Welcome to the Meeting** Apologies were noted and recorded as above.	
1.1.2	**Quoracy of the Meeting** A Heseltine reported that unfortunately due to unforeseen circumstances, the Committee did not have an operational representative or nursing representative. However, L Ibbs-George and A Race agreed to inform colleagues of any issues that arose from the meeting. A Heseltine congratulated A Race on his confirmed appointment as the Director of Operational HR and OD.	
1.2	**Declarations of Interest** No additional declarations of interest were recorded.	
1.3	**Confirmation of the Minutes from the Last Meeting, 28th July 2023** The minutes from the 28th July 2023 were agreed as a true record of the meeting.	
1.4	**Review of Action Log and Matters Arising:** **Action 2023/031 – E-rostering – Six Weekly Sign Off Target** A Race advised that the e-rostering metrics were contained within the Exec workforce report and the figures showed improvement year on year. He stated the Nursing and Midwifery Oversight Group reviewed the data and confirmed that there was an action plan which was being promoted by the Divisional Heads of Nursing, therefore, he proposed that this remained at the six weekly sign off target and the Committee kept a watching brief on this data going forward. This was agreed. Action closed. **Action 2023/039 - from Health and Wellbeing Steering Group – Junior Doctors** A Race advised that P Nar had had some difficulty in following up with the doctor who had raised this particular concern at the Health and Wellbeing Steering Group, which was around the stress experienced by the trainee doctors and related specifically around the correct salary payment for trainee doctors who were less that full time trainees. He advised that this was a complicated process, which was not unique to RWT and was currently with the medical staffing team and divisions to address the onboarding process. He advised that the next Steering Group meeting was scheduled within the next couple of weeks and P Nar would report back following the meeting . Action 2023/039 ongoing. **New Joint People Strategy** A Duffell reported that in relation to the Joint People Strategy, the proposal was to bring a draft copy of the strategy for the Committee's oversight and review to the October People Committee, with the final version due to the November meeting for approval prior to submitting to Trust Board for formal sign off.	

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1.4.1	**Retire and Return Data Analysis (Action 2023/023)** A Race provided a brief update on behalf of Seb Smith-Cox. The report provided a brief analysis of retire and return data which looked back over the last five years. Key points to note: • 1,200 staff had retired over that period of time, approximately half of those had returned to work for a period of time but there had been a reduction in the number of nursing staff returning. • There had been a drop in the number of people accessing retirement during the early covid period of 2020 and 2021, who had stayed to support the Trust during this period. • Some research referred to in the Nursing Times had considered that if staff had deferred their retirement, once they had reached a decision to retire, the trend was to fully retire rather than to consider retire and return. A Duffell advised that from October 2023 there would be changes to the NHS pension scheme options available to staff who would be able to retire and return with a 24 hour break, or they could take their full or part pension without having to retire and remain in employment with one requirement to reduce their pensionable pay by 10%, which would most likely be by staff reducing their hours. Going forward, the Trust would need to keep a watching brief on this, especially for nursing staff, in order to be fully sighted of the impact of this change to working hours. A Viswanath commented that the report was useful and asked whether staff who joined the bank were being recorded as well as those who returned substantively and whether there was any national figures on this to benchmark the Trust against. A Race advised that the report dealt only with substantive staff and did not record those who stayed and worked on the bank, but the majority of staff generally returned substantively as part of an agreed plan. He informed that no national benchmarking data was available.	
2.	**Key Updates and Workforce Performance s**	
2.1	**Key Updates**	
2.1.1	**Industrial Action** A Duffell advised that the industrial action by the Consultants and Junior doctors was expected to continue throughout the current financial year, the mandate for the junior doctors was valid through until February 2024 and there had been very little movement on negotiations between the BMA and the Government.	
2.1.2	**UNISON Campaign – Band 2 to Band 3 roles** A Duffell reported that, nationally, UNISON and a number of other unions were promoting some high level campaigns to look at a number of clinical band 2 roles with a view that these should be band 3 roles, early discussions have been held with the Trust's Staffside Lead on this. A Harding queried the drivers behind UNISON's campaign and was there any equal pay implications. A Duffell stated that he believed that under Agenda for Change and the job matching process, there should not be any equal pay issues. His view around the drivers for the campaign was that the unions believed that	

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	the roles and responsibilities undertaken by some of the clinical band 2 posts aligned against a band 3 role and any change would also lead to an enhancement in salary for their members. A Race advised that in 2018 further clarity was provided on some of the job evaluation profiles with some very specific elements in terms of clinical duties. UNISON followed up on this at a number of Trusts and this was now being picked up nationally, therefore, as advised initial conversations and partnership working with Staffside colleagues was ongoing to explore the position at RWT.	
2.1.3	**Black Country Provider Collaborative - Workforce** A Duffell proposed that a regular update on the Black Country Provider Collaborative work was provided to the committee on a regular basis to ensure that the Committee were sighted of the ongoing work and progress. He reported that the current workforce areas of focus were: (i) How to make it easier for individuals and staff to work across all four organisations (ii) How to align processes and systems across the four organisations (iii) How do we minimise the vacancy level across the four organisations The Collaborative was also assessing : (iv) Scaling of services in corporates areas across the four Trusts (v) Clinical networks services - to review and work collectively to support patients across the Black Country A Duffell advised that in relation to mandatory training, the Collaborative had agreed to align the mandatory training requirements and provision across the four Trusts and RWT had been the only Trust who submitted an expression of interest to carry out this work. This work was now being led by Brian McKaig and Louise Nickell. A Heseltine agreed that a regular update report to the Committee would be informative and appreciated.	**Action: 2023/40** **A Duffell** **M Dent**
2.2	**Executive Workforce Report** A Duffell commented that the six key metrics reported were in a good position presently at either green or amber. He stated that the national NHS Staff survey was due to be launched imminently and advised that the four provider collaborative Trusts would be using the same provider company which would allow for the provision of individual Trust reporting as well as the benefit of comparison reporting across the Black Country collaborative. A Race drew the Committee's attention to the vacancy rate given the focus on the workforce plan and the financial challenges. He reported that the international nursing fellows and the newly qualified nurses would transfer into the nursing line and this would stabilise this workforce and advised that recruitment for international nurses had been paused. The growth over the previous month had largely been driven by the rotational doctors joining the Trust. A Heseltine noted that the sickness absence position was going in the right direction, however, there were a number of hotspot areas and she queried the focus given to these areas. A Race advised that there was a detailed sickness absence improvement plan in place and proposed that additional detailed	**Action:2023/041**

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	information on the delivery of the plan was included within the next update report which was due to the October People Committee.	**J Shillingford**
2.3	**Model Health System Update** A Race advised that the update from the Model Health System was brought to the Committee on a regular basis to provide benchmark data against peer organisations and to identify areas where RWT may learn from other organisations. He advised that the data available was based on activity unit for the 2021-22 financial year and, at a summary level, RWT was based in the middle of quartile 2. A Heseltine noted the report and the Trust's position, but it would be important to continue to progress and develop as a Trust, as well as linking in with other organisations. In response to a question by U Daraz around the elevated leaver rates for midwives, medical and dental, A Race stated that the medical and dental was probably a product of the clinical fellowship model as there was no natural rotation in these roles. In terms of the midwives, he queried whether this was an age demographic area but agreed to look into for further clarification with a 'destination on leaving' update report from ESR. He noted that the Trust was average for turnover. A Viswanath stated that it was reassuring that, in terms of the metrics, the Trust was in the middle or above average position and queried whether granularity of this data by directorates and divisions was available for the directorates and divisions to use. A Duffell advised that the granular data did not exist and the data available was used for reassurance and to also identify any areas where further focus was needed in any other particular area. A Race stated that this data provided triangulation of our own data, in identifying areas of good practice and in identifying any problematic areas. A Heseltine remarked that following the recent high profile Lucy Letby case, which was not just around Freedom to Speak Up, but around interrogating the data and, although this data was from a different perspective, the Trust was interrogating the data to identify any outlier areas. A Duffell remarked that there was two workstreams that had come out from this case, one was to make the best use of the data available, the other was around the cultural work that was ongoing across Wolverhampton and Walsall and importantly, one of the key themes, was to demonstrate that the organisation was here to listen to staff.	**Action:2023/042 A Race**
2.4	**Key Updates from the Operational Workforce Group (OWG) and the People & Organisational Development Group (PODG)**	
2.4.1	A Race advised that the key areas of discussion by the OWG were: • The Workforce Plan had been reviewed with the operational divisions and Estates and Facilities to understand the plan and scrutinise the workforce growth, this would be brought back to OWG in October and the Exec team were fully cited on this and on the appropriate actions being taken. • The group discussed the NHS Emeritus Consultants national Scheme for retired or partially retired consultants from around the country who could provide remote work to support elective activity. It was recognised that there were some limitations around streaming the work so that it	

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	could be done entirely remotely and operationally and it was felt that colleagues would prefer to engage with known retired colleagues. However, it was agreed to consider the programme going forward for any specialties where this may add some greater value. • The group reviewed the hard to fill report and would continue to this on a monthly basis.	
2.4.2	A Race advised that the key areas of discussion by PODG were: • The group discussed the appraisal performance and the benefit to the slimmed down appraisal paperwork which enabled meaningful conversations and allowed for an appraisal sensitive to the individual. The revised paperwork had made a significant impact on the completion rates. The group had reflected on the medical appraisals process where the appraisals rates were in high figures, (i) The consultant could choose their appraiser, which did not necessarily need to be the line manager (ii) There was an increased role of the regulator (iii) The infrastructure of the revalidation team supported the process from scheduling of appraisals and room reservations Unfortunately, the supporting infrastructure was not available to offer to nursing colleagues and it was felt that the role for the regulator for nurses was not needed, however, colleagues were keen to explore the option of staff being able to choose their appraiser and this would be taken forward to a future PODG for further consideration. • The group initially discussed how the HR team could work with the nurse education teams around the shared decision making machinery to make more mainstream and this would be brought back to PODG for further discussion.	
3.	**Formal Review / Sign Off**	
3.1	**Schwartz Rounds – Terms of Reference (TOR) (for approval)** C Young advised that the TOR for the Schwartz Round were largely unchanged but had been updated to reflect the Trust strategic objectives, updated the change the People Committee's name and updated to engage the Steering Group in the planning and arranging of the Schwartz Rounds . The Committee approved the Terms of Reference. U Daraz commented that from an external perspective, the Schwartz Rounds were a great initiative provided by the Trust.	
4.	**Strategic Focus Areas**	
4.1	**Schwartz Rounds Annual Report** C Young provided a brief update on the annual report for the Schwartz Rounds, which had been running for approximately 7 years and was the only forum available to all staff groups where the hierarchy was not key, all staff were	

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	welcome to attend and talk about the emotional impact of working in healthcare in a confidential environment. The key points to note: • Schwarts Rounds were well received by attendees and 99% would recommend these sessions. • Attendance numbers continued to increase and, as well as the regular face to face sessions, the group had also trialled virtual rounds which has enabled further reach to colleagues based within the community sites. • A doctoral research conducted as a case study of RWT, had demonstrated the value of the Rounds beyond wellbeing, in the areas of reflection, situated learning and practice impact. • For a relatively small cost, the Rounds were financially supported by the Chief Executive which covered the license fee and refreshments. A Heseltine thanked C Young for the update and acknowledged the positivity of the Schwartz Rounds and the amount of work required to facilitate this initiative to enable time and space for staff to be able to attend.	
4.2	**Deep Dive on Estates and Facilities** L Ibbs-George presented an update on the deep dive report on the Estates and Facilities Division; key points to note: • There was a diverse workforce, totalling 996 and the headcount had remained static over the last 12 months, with approximately 40% male and 60% female. • Recruitment within the Medical Physics area remained a challenge and was an ongoing issue. Recruitment within Estates was becoming challenging due to the hugely increased salaries within the private sector. However, in both areas, there was a successful apprenticeship programme in place to 'grow our own' and to support going forward. • Facilities was the biggest workforce within the Division but recruitment was not an issue in this area with the majority of applicants living within a fairly small radius of the Trust. • Sickness absence within the Division was just above the Trust target and all cases were being managed within policy and supported by HR colleagues. A monthly review meeting was held with the service managers to review each case and assess whether any needed to be escalated or de-escalate, whether any referral to Occupational Health required and to ensure support and guidance was being provided to our staff. • Mandatory training compliance overall was currently at 97.7% and the appraisal had remained above 90% over the last 12 months since the introduction of the new paperwork and staff were keener to engage. • The Division had undertaken a large project to train its managers and supervisors in QSIR and the QSIR team have also developed a specific half-day training package for the Division which was being rolled out and was being well received. A Duffell remarked that there was a higher proportion of staff with an age profile over 55 years and a lower number under 25 and queried whether this had any impact on sickness absence levels and secondly, was there more to be done to encourage the younger generation to take up roles within the Division. L Ibbs-George acknowledged that due to the change in the pension retirement age, staff remained in their roles, therefore, fewer opportunities to recruit, and, due to	

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	the physical nature of these roles, staff were impacted by musculoskeletal issues, which was of concern. She reported that the Division worked with the Prince's Trust and other organisations to bring younger people into the Trust and if the placements were successful, these individuals were encouraged to join the Trust bank. A Harding commented that the deep dive report contained a large amount of factual information and queried what the key points were from a strategic perspective such as succession planning. L Ibbs-George agreed that the report was very factual. She stated that there were no concerns around recruitment in Facilities. Medical Physics had struggled for a number of years to recruit but had recently been successful in retaining three out of four apprentices within the department. However, due to the private sector and higher salaries, Estates was beginning to become an area of concern and although the Trust could offer a better work-life balance and better terms and conditions, there had been some losses of staff in middle management that had come through the apprentice route. She also noted that with the changes in technology, such as the development of the solar farm, the skills required was very different. She stated that the division was ensuring that succession planning was ongoing. A Duffell proposed that staff from the Division could be invited to attend the 'Staff Voice' section of the Trust Board meeting and suggested that he and L Ibbs-George discuss further outside of the meeting. In response to a question from A Duffell regarding the approaching national staff survey and expected returns from staff, L Ibbs-Geoge stated that she was confident that staff would complete the survey and there was a newly appointed Operations Manager who had been engaging with G Anglin and colleagues, so it was felt that the department was heading in the right direction. She advised that the Communications Team had recently spent 'A Day in the Life' with the Catering Team which had been shared widely on social media and staff had appreciated being brought to the forefront and feeling valued. The department would continue to work with the Communications Team to highlight and raise awareness of the important contributions provided by the E&F teams to the Trust. A Heseltine informed that she had recently visited the Portering Team on one on the recent Executive visits and it had been a very positive and welcoming visit. A Race informed that the deep dive reports, as do the majority of the reports, were presented to OWG or PODG for support and challenge. In regards to the format of the deep dive reports, this had been reviewed and revised on a couple of occasions by the committee, however, he would be happy to re-look at the format with A Harding outside of the meeting.	**Action:2023/043** **A Duffell** **L Ibbs-George** **Action:2023/044** **A Race** **A Harding**
4.3	**Workforce Resourcing and Productivity, including Retention** A Hobson presented an update on the report on behalf of T King, Interim Head of Resourcing, key points to note: • Vacancy rate remains positively low at 3.4%	

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	• Time to hire for general resourcing continued to improve at 46.8 working days which measured from the point of advertising until all pre-employment checks had been completed. • The pre-employment checks were challenging but currently reported at 18.4 days. • The nursing vacancy position, which was reported on prior the recent establishment control, was at 36.93 WTE and it had been agreed to pause advertising for band 5 apart from key areas. • There were now only 10 newly qualified nurses requiring allocation and most had their pins ready from September, this was an improvement on the previous year. • Bank recruitment for band 2 and band 5 roles has also been paused for nursing areas but would be reviewed regularly given the focus on winter pressures, but the fill rate remained stable. • HCA vacancies were prioritised for those individuals who had supported the Trust through the Princes Trust employability roots and had joined the bank with a view to achieving their care certificate. This remained a positive scheme and workflow. • There was a planned calendar of recruitment events, but with the low vacancy position, a number had been stood down. However, the team were now focussing on the hard to fill and more challenging roles. One of these being a qualified dietician and the team has sought out an apprentice route with Sheffield Hallam University as the provider and a bespoke engagement event was planned. • NHS Employers had recently published some guidance around the authentication for the international recruitments. The teams would take forward and introduce an enhanced checking process. • The cost of the certificates of sponsorship were increasing for the applicant and the Trust and a costing exercise would be undertaken. • The medical vacancy position was at 7.5%, a slight reduction on previous and over 200 junior doctors had joined the Trust during the recent rotation. • A number of consultants interviews were scheduled over the coming months to try to reduce the reliance on agency. A Duffell queried whether the time to hire data was from the advert to the provisional or final offer, A Hobson confirmed that this was from the point of advert until the conditional offer and this included all pre-employment checks such as such as reference, DBS, occupational health. A Race commented that a number of the pre-employment checks were outside of the team's control, however, the automation provided by the TRAC system which followed up with reminders had proved beneficial. In response to a question by A Viswanath as to whether the time to hire metrics could be provided for medic resourcing via the TRAC system as well as for general resourcing, A Hobson stated that she would work closely with Luke Thornhill, Deputy Head of Resourcing for Medical to generate some data of value.	**Action:2023/045 A Hobson**
4.4	**Staff Engagement and Surveys** A Sykes provided a brief update on the report presented, key points to note:	

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	• Preparations underway for the national NHS staff survey. As advised the survey provider had been changed and therefore, would allow for better comparison reporting across the Black Country. • There had been some searching questions added to the survey and the team has worked with the Safeguarding team to provide signposting for staff should any support be sought. • There were also additional questions added to seek staff's view on the current cost of living crisis and to seek staff's view on whether issues had changed following on from the previous survey results. • Key messages within the communications plan was to highlight the positive changes that had taken place as a result of last year's survey and to promote that the RWT was an organisation that listened and would take staff feedback seriously. The plan was linked to the People Promise elements. • The Survey mode this year was split between 60% online and 40% paper. • The recent national quarterly Pulse Survey had seen an improvement in the response rate. A Duffell advised that at the Dudley Group of Hospitals, all survey were issued out electronically only. He also commented that at a number of Trusts, some of the staffing groups were outsourced, such as Estates and facilities staff, which would therefore impact on the overall response rates. A Race noted that in previous years, a couple of hospitals with the best response rates had used paper only surveys and had given allowed time and a coffee break for staff to complete. Further analysis on this would be considered when planning for the next national survey.	
5.	**KEY RISKS**	
5.1	**New Risks** The committee agreed that no new risks had been identified during the meeting discussions.	
5.2	**Board Assurance Framework (BAF) - SR17 Equality, Diversity, Inclusion** A Duffell reported that he believed that there had been no evidence reported that had impacted any change to the current EDI BAF risk. This was agreed by K Bostock who stated that due to the ongoing positive work reported, the Committee may wish to consider reducing some of the risk rating at a future meeting. A Race advised that there had been some progress in some areas around the EDI risk, but there was still some further work required in other areas, and suggested that the EDI risk remained at the current rating until the next refresh of data due at the end of the financial year.	
5.3	**Action 2023/018 – Review possible Risk around the Retention Position** A Race stated that in regards to the possible risk around the retention position that the Committee had agreed to re-evaluate, given the improvement in turnover, the improvement in the retention position and the positive vacancy position, he proposed that this action was closed at this point in time and the retention position reviewed within the regular oversight of data. This proposal was fully supported by the Committee, action 2023/018 closed.	

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6.	**Committee's Objectives – Areas of Focus** • To examine the issues, data and impact in relation to staff turnover and retention • To monitor the ongoing sickness absence position and the wellbeing of the workforce, and actions being taken to address • To monitor Equality, Diversity & Inclusion areas of concern It was noted that the Committee had discussed and addressed the three areas of focus during the meeting.	
7.	**Any Other Business**	
7.1	**Reports to the Committee** A Heseltine requested that any reports due were submitted on time for publication ahead of the meeting and that the front cover page was fully completed in all sections. If reports were late for any reason, she requested that colleagues informed A Duffell and A Race accordingly.	
8.	**Evaluation of Today's meeting** A Duffell stated that there had been a good spread of content covered within the meeting, reports were detailed and had allowed for stimulated conversation. A Race acknowledged the contribution from across the virtual room from all members of the Committee.	
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 : • Receiving the retire and return data • Industrial action update • The band 2 to band 3 UNISON proposal for HCA/clinical staff • Sickness absence plan • Model Hospital data – particularly around the midwifery data • The Estates and Facilities deep dive update report • Staff survey preparations update • Watching brief on possible retention risk and agreement to review this data within the normal course of business	
10.	**Date and time of Next Meeting** 9.30am-11.30am, 27th October 2023 via MS Teams	

The Royal Wolverhampton NHS Trust

Minutes of the People Committee

Date	**Friday, 27th October 2023**	
Venue	**Via MS Teams**	
Time	**10:30am**	
Present:	**Name**	**Role**
	Umar Daraz	Associate Non-Executive Director
	Lewis Grant	Deputy COO, Division 1
	Angela Harding	Associate Non-Executive Director
	Allison Heseltine (Chair)	Non-Executive Director
	Lyndsey Ibbs-George	Divisional Manager, Estates & Facilities
	Ros Leslie	Chief Allied Health Professional (AHP)
	Priyanka Nar	Head of Occupational Health and Wellbeing
	Mark Ondrak	Staffside Lead
	Adam Race	Director of Operational HR and OD
	Julie Shillingford	Head of HR Advisory
	Kevin Stringer	Group Chief Financial Officer
	Laura Willis	Acting Group Head of Corporate Learning Services
In Attendance:	Maria Dent	Executive PA to Group Chief People Officer
	Deepa Patel	HR Manager, Black Country Pathology Services
	Dr Branko Perunovic	Chief Medical Officer, BCPS
Apologies:	Emma Ballinger	Associate Director of People Transformation & Culture
	Chrissla Davis	Deputy Director of Nursing
	Alan Duffell	Group Chief People officer
	Ananth Viswanath	Deputy Medical Director
	Cath Wilson	Deputy Chief Nurse
	Claire Young	Group Deputy Director of Education & Training
	Cath Wilson	Deputy Director of Nursing

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1.	**STANDING ITEMS**	
1.1	**Apologies for Absence and Welcome to the Meeting** Apologies were noted and recorded as above.	
1.2	**Declarations of Interest** No additional declarations of interest were recorded.	
1.3	**Confirmation of the Minutes from the Last Meeting, 22nd September 2023** The minutes from the 22nd September 2023 were agreed as a true record of the meeting.	
1.4	**Review of Action Log and Matters Arising:**	
	Action : 2023/037 – Grip and Control – National Checklist A Race informed that the grip and control checklists on finance and financially driven workforce controls had been taken through the recent Finance and Performance Committee. He advised that following discussion, it had been agreed to reintroduce job planning compliancy reporting into the Executive workforce report to ensure that the People Committee were sighted on this. Ongoing review and discussion would also be taken to the Financial Recovery Group, but an update on the process would be sought, should any further assurance be required by this committee. A Race proposed to bring the grip and control checklist to the November meeting for the Committee to review and consider; the next submission to the ICB was due in December. Action c/fwd.	
	Action 2023/039 – Action from Health and Wellbeing Steering Group – Junior Doctors P Nar informed that the Consultant who had raised the initial concern on stress experienced by doctors in training due to incorrect salary payments had not received any feedback from the doctor in training as to the particular issues of the concern raised but advised that once these were known she would follow through with the correct leads. She advised that this action was still logged with the Health and Wellbeing Steering Group, so would be followed up in due course. A Race advised that there were two areas of concern around the junior doctors salary, one was around the submission of timesheets and payment of additional hours but there had been some significant progress made in this area. The other was around the contract and salary for junior doctors who worked less than full time. This was complex process and needed the engagement of several parties to ensure that the pay generated was correct which was often not achieved until after the doctor was in post. He proposed that this was followed through by the Health and Wellbeing Steering Group and explored with the Junior Doctors Forum Group, the Committee agreed. Action 2023/039 closed.	
	Action 2023/042 – Model Health System Data: Elevated Midwives Leavers Rate	

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	A Race provided an update on the data available:
	• 46 midwives had left the Trust in the last year
	  ○ 11 had retired so were excluded from the analysis
	  ○ The largest number of staff, ie 46%, had transferred to another NHS organisation
	  ○ 4 had moved abroad
	  ○ 4 had moved into no employment
	  ○ A small number had moved into private sector employment
	
	A Race agreed to circulate the data for information via email.	

1.5	**Update / Feedback from Trust Board** A Heseltine commented that three areas to note from a Trust Board perspective: • Sickness absence - the Trust Board were interested to note the improving sickness absence position but were interested to have sight on the focus around any hotspot areas and areas of concern; U Daraz agreed that the Trust Board were keen to ensure that monitoring and tracking processes were in place. • PA Consulting work, as previously mentioned - medical staff job planning; • Cancer recovery plan – it was important to note that the financial cost and the requirement in having the staff in place to support this recovery plan, ensuring that the right people were in the right place to support this programme. A Harding noted that given the current financial challenges and resource implications, the Trust would need to be mindful of the requirement to strike the balance of doing the right thing and doing that cost effectively.	
2.	**Key Updates and Workforce Performances**	
2.1	**Key Updates**	
2.1.1	**Dedicated Roles for EDI – Steve Barclay Letter** A Race reported that all NHS Trust's had received a letter from Steve Barclay, Secretary of State, in which he had instructed that Trusts should not recruit to dedicated EDI Lead roles. This had been met with strong responses from several NHS organisations due to the value and importance of these roles and the requirement of specialised expertise in this area to ensure that the work to improve the staff experience and indeed our patients care and experience, continued. He advised that the Trust currently had a vacancy for this role which was currently being carried out by Kerry Flint on an interim post. U Daraz queried whether this letter would have any impact in terms of the Trust strategy in driving forward the EDI agenda across the geographical footprint of the Trust. A Race advised that in regards to resourcing, the Trust had a number	

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	of statutory duties to comply with in terms of EDI and the public sector and the Executive Team would discuss this at their next meeting in terms of next steps. In terms of the strategy, this needed to be driven by the demand, needs and priorities for the Trust and this work would need to be resourced accordingly.	
2.1.2	**Article from NHS Provider : Underpayment of Doctors** A Heseltine queried RWT's position following a recent article by NHS Providers regarding the underpayment of fellowship doctors at Dudley, Walsall and the QE. A Race advised that the RWTs fellowship's programme, under the Medical training initiative, brought in doctors to the NHS on a time limited period to 'earn, learn and return'. At a recent local LNC meeting, the group had discussed and it had been strongly agreed by both management and Staffside, that the Trust was not recruiting to entry level posts or newly qualified doctors from overseas, these doctors were experienced and as such should be paid accordingly and the fellowship pay scale did not include the bottom point scale. In response to a query from A Heseltine around tax and national insurance for these doctors, K Stringer agreed to review, but he understood that all RWT doctors were paid on salary, where in the article some doctors were paid on a stipend, ie treated as educational. A Race agreed with this, each doctor received an employment contract.	**Action:2023/046 K Stringer**
2.1.3	**Joint Group Partnership Forum** A Race advised that a Joint Group Partnership Forum had been established with Staffside colleagues from Wolverhampton and Walsall to take forward work on a number of policies collaboratively and in partnership. The first meeting had been scheduled for the 20th November 2023 and a standard agenda devised to include updates on the development of culture, development of EDI agenda, embedding of the just and learning culture, alignment of policy work and to enable the ease of staff working across the two organisations. A Harding queried whether the work included HR management systems, A Race advised that the meetings were with trade union colleagues in terms of work therefore very little in relation to the electronic systems in place. However, he reported that the systems were largely aligned, although operated by each Trust differently.	
2.1.4	**Scrutiny on Agency Position and Compliance with Agency Rules** A Race informed that there was a considerable amount of scrutiny on the agency position and compliancy with the agency rules which fell into four categories: • Overall cap on spend with agencies at 3.7% of the pay bill • Requirements around rates of pay • Procurement of agencies must be via one of the recognised procurement framework • Specific requirements for admin and estates agency workers He advised that a considerable amount of work was ongoing to ensure all were aware of the agency rules and a response was due to the Centre on the Trust's	

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	current position within the next week. He advised that the Board would be updated on the controls and compliancy in December and this would be overseen by the Performance and Finance Committee, but noted that the People Committee should also be sighted on this. K Stringer advised that this area was receiving national prominence and focus and Sir David Nicholson, the Trust Chair, was taking a keen interest. He agreed that the People Committee members should be sighted on the data for oversight and understanding. He advised that temporary staffing costs were high generally and all Trust's across the System were being asked to clarify and justify the current position and to identify actions to address going forward.	
2.2	**Executive Workforce Report** A Race provided a brief update on the Executive Workforce noting that the organisation performance data was reporting a positive position. To note: • The vacancy rate continued to reduce, • turnover and retention heading in the right direction • sickness absence was slightly elevated but the rolling sickness absence was also heading in the right direction • Mandatory training continues to perform well • Appraisal compliance rates required further work	
2.2.1	**Industrial Action Update** A Race advised that notification had been received from the BMA that they would be balloting consultant members for an extended mandate to take industrial action and this ballot was due to close just before Christmas.	
2.2.2	**Sexual Safety Charter in Healthcare Organisational Charter** A Race informed that the Sexual Safety charter had been launched which the Trust had signed up to. This was around embedding sexual safety within the organisation, making sure that all our staff were safe from sexual violence and sexually inappropriate behaviours in the workplace. There were a number of pledges and actions to deliver and an action plan was being devised and would be presented initially to the Executive Team and brought back to the People committee.	
2.2.3	**Institute of Health and Social Care Management (IHSCM)** A Race advised that RWT, alongside Walsall, hosted the Institute of Health and Social Care Management for the West Midlands. This was a membership organisation which all staff were able to sign up to and it provided leadership development, resources, degree apprentices, e-learning and coaching.	
2.2.4	**Rostering** A Race reported that the Rostering position had also been discussed by the Finance and Performance Committee. He advised that there were some significant challenges around net hours balance and a huge amount of work had been undertaken understand the issues causing this which had been identified as the system not being used as effectively as it might be, absence not being coded correctly, so essentially a data quality issue. This was mainly from a nursing perspective and he and Debra Hickman were reviewing.	

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	A Heseltine queried whether the incorrect coding of sickness absence reporting was caused by having to report absences on several systems, A Race advised that the rostering system linked into to the payroll system, so only one reporting system. He clarified that absences on the rostering system also included other absences such as study leave etc whereby staff were otherwise engaged in Trust duties but not recorded correctly on the rostering system.	
2.2.5	**Division 4** In response to a query from U Daraz on Division 4, A Race stated that this division had included the cancer services management team, service efficiency team and emergency planning team, however, these areas had now transferred either into the Division 3 or Corporate and Division 4 had been dissolved.	
2.2.6	**Appraisal compliance** U Daraz queried the timelines around the appraisal compliance action plans, A Race advised that the recovery plans were local within the directorate and divisions so unable to provide the timeline. These were managed by the directorate and reported through the workforce report and the granular reports that the Divisions receive. A Heseltine noted that the appraisal paperwork had recently changed and following a recent Board Walkabout, some staff had commented that this had made the process more difficult as it was less prescriptive. She queried the training of staff, particularly junior staff who were carrying out appraisals and the availability of a crib sheet. A Race stated that he had not heard of this being raised as a challenge previously and commented that a crib sheet would not be unhelpful. In terms of wider training for managers, that was currently being worked up as part of leadership development, however, appraisal training was also available via the Education and Training suite of training programmes. L Ibbs-George commented that within the Estates and Facilities Department, the new appraisal paperwork had been beneficial and a lot easier for staff to navigate. The compliancy rate for the Division had improved and she would be reluctant to change this to a more complicated form. L Grant advised that appraisal performance was followed up within the Division on a regular basis but the new paperwork had not been cited as a constraint.	
2.2.7	**Bank Usage Reporting Data** K Stringer commented that Trust Board and F&P were focussing on the bank figures and queried the data reported on bank usage given the significant growth in staff and the low vacancy position. He queried who owned the data, how was the Trust planning to run the rosters correctly and how would the un-used hours be addressed moving forward. A Race confirmed that there was a focus on this issue led by the Nursing, Midwifery and AHP Workforce Group which was chaired by Debra Hickman, and he was deputy Chair. He advised that the dataset had been developing over time to understand the real granularity of issues, some of which was from new areas using the system but not using to its full extend on a day to day basis. One of the other reasons was that some of the hours covered the rostering period over the winter and spring of 2021-2022 where it was known that staff were redeployed to other areas for shifts but this was not necessarily recorded correctly at that time. He commented that a decision may need to be taken on an amnesty on the historical data but this needed further discussion with	

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	the Heads of Nursing prior to senior sign off. He had fed back the discussions from F&P Committee to Deb Hickman with a view to accelerating some of the actions that were data orientated.	
2.3	**Key Updates from the Operational Workforce Group (OWG) and the People & Organisational Development Group (PODG)**	
	A Race advised that a number of the key areas of discussion by the OWG and PODG had been previously discussed during the meeting but advised that the Temporary Staffing Dashboard had been taken formerly to the OWG in order to review from an operational perspective with divisional colleagues. He advised that nursing agency had increased but this was a specific need for nursing in ED psychiatric nursing for a specific cohort of patients. He advised that work was underway within the Division to review the best way forward to support these patients and staff.	
2.4	**Black Country Provider Collaborative Update Report** A Race provided a brief update on behalf of A Duffell, on the report available, he advised that there were three main areas of focus of work across the Provider Collaborative: (i) Reducing vacancies, (ii) aligning processes and (iii) supporting easier movement across the Collaborative He advised that some of these areas of work included international recruitment for AHPs, occupational health and wellbeing immunisation and vaccinations, policy alignment, management of change, dress code uniformity, on call payments, review of ESR usage, review of the current memorandum of understanding, single procurement of the staff survey, reviewing employment contracts, a People Digital group established and provision of mandatory training across the System. A Heseltine queried whether there were any identified timeframes against the ongoing projects and assurance that these project were being monitored, A Race advised that there were some timeframes identified and this work was monitored by the Provider Collaborative Executive Board.	
3.	**Formal Review / Sign Off**	
3.1	**Draft Joint People Enabling Strategy** A Heseltine requested colleagues to review the draft Joint People Enabling Strategy and provide any comments directly back to A Race; it was agreed to send out a word version for review and any amendments. The next iteration would be brought back to People Committee for sign off ahead of going to Trust Board for formal approval.	**Action: 2023/047 A Race All**
4.	**Strategic Focus Areas**	
4.1	**Deep Dive: Black Country Pathology Services**	

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	B Perunovic shared a presentation which provided an update on the current position within BCPS, on the ongoing consolidation workforce projects, and the organisational development and culture programme. D Patel highlighted the key points from the deep dive report: • Due to national shortage of Consultants in Microbiology and Histopathlogy the group had recruited a number of Advanced Clinical Fellows into these positions. • The sickness absence rates had reduced significantly over the past two years, long term absentees were being managed in line with Trust policy and regular monthly sickness absence workshops were held with managers. • A supporting staff with anxiety, depression and stress training programme had been rolled out to managers to support the mental health and wellbeing of our staff. • Mandatory training and appraisal compliance had improved significantly over the past 12 months with the appraisal compliance rate at 86.9%. • A workforce development manager had been appointed to work with service leads to identify training initiatives for staff development opportunities. A Harding thanked B Perunovic and D Patel for the insightful presentation and update on the team and services of BCPS. She queried whether there was an expectation that the staff survey response this year would see an improvement given the ongoing engagement work with staff. B Perunovic reported that there were still a number of ongoing changes and reorganisation for certain groups of staff within BCPS and believed that it would be a matter of time for these changes to embed with staff, but with good leadership and support this would change. In response to a question from A Harding as to whether there was there was sufficient support in terms of the communication and engagement plan aligned to the reorganisation of services; B Perunovic commented that there was always more that could be done in communicating with staff, however, all avenues and channels were explored. A Heseltine noted that although a lot of training had been carried out with managers, the service did not have a mental health first aider; D Patel agreed that this was worthwhile considering over the next year.	
4.2	**Employee Relations Update Report** J Shillingford provided the key highlights from the report presented. **Sickness Absence :** • The Trust's absence rates had shown a consistent improvement on the same quarter in 2022 with the September rate at 4.94% which given the rise in covid and flu during the month evidenced that the action plans were taking effect. • Implementation of the action plan had commenced but capacity within the Advisory team had been reduced over recent months due to vacancies and annual leave over the summer months but a new appointee was due to commence and two further posts were being recruited to.	

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	• Attendance management training sessions were offered Trust wide but a number of late cancellations received due to operational priorities. • The Advisory team would continue to offer demand training sessions for specific areas over the winter months as the Trust wide ones were generally stood down due to low take up, again due to operational pressures. • The Health and Wellbeing Team, as part of the Leadership pathway, would include the wellbeing conversations training and had proposed to develop an online training model, however, the current training package and copyright was owned by the University Hospitals of North Midlands, so the team were looking at developing a new training package. • Fortnightly reviews of long terms absence cases were ongoing to ensure all were managed in accordance with policy and an action plan was in place. Staff suffering serious illnesses such as cancer were not escalated. • Monthly reporting on short term sickness absence was now available to enable trends and hotspots to be identified and addressed. • The Trust's toolkit had been updated to incorporate elements from the NHSE toolkit. A Heseltine fully supported the Trust's process for those seriously ill members of staff. A Heseltine commented that through the deep dive reports, sickness absence has been reviewed in detail for the areas reviewed, however the nursing sickness absence reported at around 6.8% and at Quality Committee, this week, there were a number of wards reporting a higher percentage. Unfortunately, C Wilson was not in attendance to provide an update on this, but this was not mentioned in the report presented so she requested for a review of the areas showing higher sickness rates. J Shillingford advised that she did not receive a full breakdown of staffing groups but would go back and request this data to review. A Heseltine advised that this had been reported in D Hickman's report; A Race advised that this was the CNO report which was also presented to TMC and he agreed to forward on to J Shillingford so that a triangulation of the data could be undertaken. In response to a query from A Harding regarding staff's attitude to attending the absence manager training sessions; J Shillingford advised that there was no issue in staff booking on to these training sessions, but unfortunately staff tended to be unable to attend due to operational pressures and had to cancel at short notice. The team had looked at alternative options such as online, however, feedback from staff was that they preferred the opportunity to attend in person which allowed for confidential group discussion and interaction. As mentioned, the Trust wide sessions were stood down over the busy winter period, but the team offered to go out to provide the training for individual teams within each division. A Race advised that this had been discussed at the OWG with divisional colleagues and it was recognised that it was a priority that managers attended this training. A Heseltine queried whether as part of the grip and control focus, from a financial perspective, sickness absence needed to be brought back to this Committee. A Race stated that this issue had been discussed previously and was an area of focus for the Board. He proposed that the triangulation of data around the nursing report was carried out and brought back to the Committee	**Action: 2023/048 J Shillingford** **Action 2023/049**

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	for review and then the Grip and Control brought back bi-monthly (see Action : 2023/037).	
4.3	**Health and Wellbeing Update Report** P Nar provided key highlights from the report presented and reviewed the dashboard data available. Key points to note: • First career wellbeing conference held in March 2023 with a varriety of support sessions available for staff across three sites either face to face or virtually • The Task and Finish Group had started work on developing a policy for managers to provide support and guidance toolkits for new starters within the organisation. • The wellbeing conversation training continues but also looking at developing an e-learning module for easier access. • The Trust had 159 mental health first aiders and training continues. • A pilot had started in providing direct mental wellbeing for post graduate doctors in training which was supported by the specialist mental wellbeing nurse in Occupational Health who visited the Doctors mess and a designated mailbox has been set up. • To support physical wellbeing the department had subscribed to national initiatives such as Walking Month, National Fitness Day and had offered virtual exercise sessions to staff. • Health check sessions were offered to all staff at the three sites. • Financial wellbeing sessions offered by HSBC Bank to provide staff with ideas on how to manage their finances and provided an understanding of credit reports, budget planning, debt management etc. • Funding secured via the Black Country ICS to pilot an improve well app and RWT had chosen adult community services to pilot this service. • Collaboration work continues with colleagues at Walsall and a joint initiative calendar would be devised for next year where both organisations would focus on the same events. • Ideas and initiatives were shared with colleagues at Dudley too. U Daraz queried whether it was possible to provide a comparison on work related and personal stress data reported for June, July and August Q2 2023 with the data reported for Q2 2022; P Nar agreed to follow up. A Heseltine noted that there were a number of additional staffing groups now available and queried the uptake by staff; P Nar commented that uptake was low but had improved on the previous year. To support, she reported that there was also a Health and Wellbeing Newsletter shared with staff, the OH team were attending senior meetings and offered bespoke session to promote the services and forums widely available for staff. A Heseltine commented that generally occupational health was thought of as physical health service and queried whether the team had the required skill set to support stress and anxiety illnesses which were on the increase. P Nar acknowledged that mental health illnesses were increasing but the team had recruited the specialist mental health wellbeing nurse to support. A Race advised that there had been a deliberate change in skill set within the OH team who had recruited a registered mental health nurse, with a view to training in the Occupational health qualification, in order to provide a multidisciplinary team. He advised that there was a funded post for a psychologist but the Trust	**Action: 2023/050 P Nar**

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	had not been able to recruit to this post, therefore, the department was reviewing its approach but also needed to be mindful of working collaboratively with Walsall to ensure the right skill set across the Group and also in line with the ICB initiatives and projects.	
5.	**KEY RISKS**	
5.1	**New Risks** The committee agreed that from the discussions during the meeting, no new risks had been identified. A Race advised that once the People Strategy was brought back, the Committee may need to consider any risks aligned to it.	
5.2	**Board Assurance Framework (BAF) - SR17 Equality, Diversity, Inclusion** A Race reported that BAF SR17 had been reviewed, there had been progress in some areas but a worsening position in others, therefore he proposed that the BAF was kept under review but no change to the current rating. A Heseltine stated that there may be changes to come out from the S Barclay letter once clarification had come through.	
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, and actions being taken to address • To monitor Equality, Diversity & Inclusion areas of concern A Heseltine reported that the Committee had briefly discussed the retention position and the other two areas had been covered off and addressed during the meeting.	
7.	**Any Other Business**	
7.1	**Meeting Schedule – Regularity of Meetings** A Race advised that there was a drive to align the Committee's across the four organisations within the Black Country and the proposal was to reinstate the April meeting to bring the Committee meetings to 10 per year. He advised that the workplan would be reviewed and revised to accommodate the additional meeting date. A Heseltine noted that with the scope of work to be covered, she agreed with this proposal and stated that should any extra-ordinary meetings be required, these could be schedule during August and December months. A Harding stated that given the pressure on the production of reports required, she proposed that the agenda for the April meeting could focus on a more strategic discussion. A Race proposed that a general update was provided to	

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	ensure Non-Exec members were kept fully up to date with current issues ahead of any Board meetings as well as a strategic update.	
8.	**Evaluation of Today's meeting** K Stringer stated that the discussions during the meeting had been informative and helpful. Going forward he suggested that committee were kept informed of Bank staffing and the drivers to understand this and a focus on the Agency Framework A Race agreed that there had been a rounded discussion which had allowed the opportunity for members to provide comment on the issues that were affecting staff and the Trust.	
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 : • Triangulation of sickness hotspots in relation to the employee relations report • Deep Dive for Black Country Pathology Services • E-Rostering • People Strategy – and any future potential risks • BAF – reviewed • Work moving forward – to understand the drivers around Bank and Agency Framework	
10.	**Date and time of Next Meeting** 9.30am-11.30am, 24th November 2023 via MS Teams	

The Royal Wolverhampton NHS Trust

Minutes of the Quality Governance Assurance Committee:

Quorum: 4 members must be present consisting of 2 Executive Directors and 2 NED members. No tabled papers except with Chair's approval.

Date	**Wednesday 25th October 2023**
Venue	**Virtual (via MS Teams due to COVID 19)**
Time	**1.00pm to 3.00pm**

	Name	**Role**
Present:	Louise Toner **(LT)** Chair	Non-Executive Director
	Kevin Bostock **(KB)** (Part)	Director of Assurance
	Allison Heseltine **(AH)**	Non-Executive Director
	Debra Hickman **(DH)**	Chief Nursing Officer
	Julie Jones **(JJ)**	Non-Executive Director
	Cody Long **(CL)**	Deputy Director of Assurance
	Gwen Nuttall **(GN)**	Chief Operating Officer
	Dr J Odum **(JO)**	Group Chief Medical Officer
	Tracy Palmer **(TP)**	Director of Midwifery & Neonatal Services
	Dr G Pickavance **(GP)**	Non-Executive Director
	Alison Lathe **(AL)**	Meeting Administrator

Apologies:	Maria Arthur	Deputy Director of Assurance
	Dr B McKaig	Chief Medical Officer
	Michelle Metcalfe	Group Deputy Director of Assurance
	Martina Morris	Deputy Director of Nursing

Attendees:	Iresha Pathirage **(IP)**	International Leadership Fellow

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1	**Apologies for absence** Apologies were noted.	
1.1	**Declarations of Interest** There were no declarations of interest.	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 27th September 2023**	
2.1	**QGAC Minutes – September 2023**	
2.2	**Committee Issue Log** **1429** – TP advised there is no national recommendations that are worked to around failed instrumental devices. RWT estimate about four per month with the birth rates. This is an alert on the dashboard and anything less may mean there is an issue with the obstetricians or the junior grades not considering second stage C-Section. Anything above this may alert obstetricians to look at training issues and whether second stage sections were considered. This is on there as a prompt, and the team are reviewing the dashboard to assess what is informative and useful. A green would be a four, anything higher or lower would be an alert. AH noted this has gone up to five this month and asked if it could be a training issue. TP said this is a possibility, and each case is looked at individually. Agreed to close. DH clarified an item regarding the Safeguarding report, as the dates and titles did not make clear the reporting period. Agreed to close. A separate meeting was offered by Dr McKaig to cover the QSAG meeting with LT, but it was decided to continue as normal. **1401** – DH said this was going through P&F and had already been approved by Trust Board, and the formulation of the winter plan takes on learning from previous years. DH is unsure the metrics from the Divisional report at QSAG have been captured by the Chair's Report. It came through QSAG and there was not anything for escalation or concern. GN said this is two parts, as Care Coordination is not within the hospital in terms of utilisation, and is definitely a part of the winter plan. The PUSH model is part of the internal acute side. AH said that in the report, two outcomes had swapped being high and being low, but she is satisfied this has been resolved. Agreed to close. **1402** – KB stated that this has been updated by M Arthur. The main issue has been long term sickness within the Health & Safety team, which has taken capacity due to being a small team. Agreed to close.	

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3	**Matters arising from the Minutes** Action log updated accordingly.	
4	**Regular Reports**	
4.1	**Cancer Improvement Plan (for information only) – G Nuttall** GN said some of metrics go back to August as there is a six-week final sign off. There are some green results showing recovery along with some challenges. GN provided the committee with assurance that the 28 day faster diagnostic standard metric is being achieved. For Quarter 2, the metric is 70% of patients to have their diagnosis within 28 days, and the Trust will achieve just over 70% for that FDS target. The end of year target is 75% by the end of March in Quarter 4. There is a breakdown by speciality of tumour sites that are more challenged than others, and information is provided in the paper. Reductions continue to be seen in the 62 day backlog, with the largest number still being with Urology pathways; there are over 100 patients on the prostate and kidney tumour pathways. The backlog at the time of the meeting was 226. The trajectory for the end of the year, as agreed with the Integrated Care Board (ICB) and NHSE, is 217. Good progress has been made and the expectation is that the target will be met by the end of March. This does have an impact on the 62 day performance metric of treating 70% of patients within 62 days. This is the national metric and within the IQPR currently stands at 30%. The patients waiting over 62 days must be treated, but this does mean there is a smaller percentage being treated within this metric. In conjunction with discussions with both the ICB and NHSE, the actions being undertaken is working out by tumour site when the Trust will recover to get to 70% of patients being treated within 62 days. The three tumour sites that are presenting the greatest challenge are first Urology, second Gynaecology, and third Lung, which is due to receipt of late tertiary referrals. Work is being done to achieve the 70% of patients being treated, and it will likely be this metric going forward that may determine where the Trust is in the tiering. In all other terms the Trust is green, but the 62 day metric is a red flag for the organisation. LT asked if this means that NHSE and the ICB could put the Trust into Tier 1. GN said it is possible, but currently the Trust has the support of NHSE Midlands, as they can see the actions that are being taken and that everything else is improving. They are comfortable with the Trust being in Tier 2, and more funding has been received to support the cancer metrics. GP asked if the Trust gets any kind of leeway for taking patients from elsewhere. GN said the rationale is that the expectation is not 100% of patients being treated within 65 days, which allows for the complexity of some patients who will take longer, and the late tertiary referrals. The larger cancer centres are pushing back on this as no one is achieving it due to being reliant on the timeliness of the referrals from other organisations.	

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	IP asked if the 62 day trajectory target for the backlog clearance is for end of March 2024. GN confirmed that there should be no more than 217 patients waiting over 62 days at the end of March. IP clarified further that by March there should be 70% within the 62 days. GN confirmed, but also said it is unlikely to be achieved. GP asked about Faecal Immunochemical Test (FIT) testing not being 100% as when doing referrals she cannot refer without doing a fit test. She also mentioned the teledermatology and the IT issues have been problematic. GN said that, in respect of FIT Testing, RWTs numbers are good, and the metrics are over 75%. There are issues nationally with recording the FIT testing as there are people who are bounced back if they are referred without the FIT test being done. JO supported this, saying that the FIT testing compliance figures have gone up, as the colorectal team have focused on this. Teledermatology has been rolled out in anticipation of the work with Primary Care and the whole system. Its implementation has been patchy which is partly to do with the introduction and understanding of the technology, as well as the time it takes for the images to be undertaken. There will be involvement from the commissioners to review how the imbursement schedules may look for the time taken for the images to be taken. There is still some debate regarding Teledermatology which has been escalated and will go through a formal process of review. There are currently two proposals: 1. Payment as an item for service, for images or images that are sent over for each patient. 2. Photographic hubs for images to be sent to, either as a diagnostic hub or a localised and cohorted PCN practice. There is no solution as yet. Some GPs are sending the images as they can manage the technology, however there are many that cannot, and they are waiting for a solution. In principle it is a better and more convenient system, and the feedback from patients has been very positive. AH asked about a part of the report which mentions pathways being closed and data changing. GN said that from the beginning of October there are new guidances as to how the metrics are counted, in particular the 31 day and the 62 day metric. These new standards mean some pathways can be closed and counted as treated at different times. The expected impact nationally is that performance will improve slightly. Screening pathways, for example, will count towards targets, and the Trust as a large screening centre may find it has a detrimental impact on some of the Gastrointestinal (GI) pathways. Overall, however, the new standards are not excepted to make a material impact for the Trust due to the nuances of what is being counted. GN went on to say that the Trust is still very reliant on mutual aid for Urology. The longer term system plans for renal tumours are underway to send to Dudley. Northampton are providing mutual aid for prostates and there has been a good uptake of patients wanting to travel to Northampton for robotic surgery. A key action is to reduce waiting times for patients' Oncology appointments. Gynae and upper GI are affected by long waits.	

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	LT asked if it is just prostates that are going to Northampton, which GN confirmed. LT queried the 62 day information on the report, as the upgrade, screening, and traditional figures that are separated out, whether this would be how it will be reported going forward. GN said this will all be counted in one 62 day metric. It had been separated out to aid in identifying where there are challenges, this will change to a composite figure. Lt also asked what the upgrades figure relates to. GN gave the example of a patient who has an appointment with gynae and is then referred onto another tumour site and that cancer is diagnosed, that would be an upgrade. LT commented that overall it is a slowly improving picture, but there are still some specific challenges with diagnostics remainings a significant issue, particularly around endoscopy and ultrasound. GN clarified that the endoscopy metrics are improving, as there is the outsourcing. The ultrasound does not have much of an affect on cancer metrics and is more routine. Histopathology remains a key challenge. There is some initial improvement being seen; instead of single figure turnaround times within ten days, this is starting rise to 20 or 30% of improvement. LT asked if there was a reason for the improvement, GN said there is some additional staff, an uptake in consultants doing additional sessions, and the outsourcing for some of the other routine histopathology continues. There are also actions within acute around identifying patients who are on cancer pathways and the marking of samples related to clinically urgent patients.	
4.2	**CQI Report** No representative was available. LT commented that there was a lot of great information within the report, however there is nothing that quantifies the outcomes. AH agreed and said there are actions that have likely taken place through the project and have built on what has already being done. LT said it was good to see Estates involvement, with positive feedback form the porters following a walkabout. GN said many of the QI projects get linked with the Trust's service efficiency and some of the Continuous Improvement Process (CIP) schemes, though the aim is to make sure it is seen as Quality Improvement and not just see IP. GN suggested for the head of the QI team and the head of the Service Efficiency Team to link in together to bring this to a close.	
4.3	**Integrated Quality & Performance Report August 2023 – D Hickman** DH said that in the September meeting there was talk of higher numbers of pressure ulcers, however in the last figures there is a downturn. When analysing the data it can be seen that the improvement plan and the summit work continues to link into this. The pressure injuries, patient falls, observations, etc., all link to the fundamentals of care programme that was in place. The Trust has revised and restarted the programme in September with more focus on understanding and culture, given the skill mix challenges that are in the workforce. There may have been assumptions made or areas overlooked, but as this has grown and the dialogue continues the programme has evolved.	

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	There was a dip in the falls rate in the previous month, but there has been a slight upturn the following month, and a conversation was had at Performance & Finance (P&F). One of the themes seen is related to cognitive ability in dementia delirium, which is flagged in the fundamentals and work continues with this. Risk assessment tools are being looked at to consider how they link with frailty and mental health. More actions are planned, and the first Safety Decision Making Council comes online in November. Moisture associated lesions were up in month which relate to hydration and continence, and that is why the fundamentals are important. There has been an upturn in month for C Difficile, and there is a lot of activity behind the C Diff programme. The Infection Prevention (IP) Delivery Plan has been supported by the executive team and there has been support from the Non-Executives as well. There was a specific focus following the IP Delivery Plan launch around C Diff. When the analysis of the cases was looked at, there was no transmission between those cases, so although the numbers are up this is not due to transmission. When the data across the Black Country is taken into consideration, the Trust is one of the better performing organisations, though there is still the issue to tackle. Ward decant has recommenced, but this is a limited window as the facility will be supporting the winter plan. The Patient Equipment Cleaning Centre (PECC) will be returning as a new location has been sourced, and this will focus on inpatient wards, encompassing ED and the trolleys. The Frailty pathway continues to be explored, as well as the antibiotic prescribing that underpins it. The RWT microbiologists are working on this. E Coli has had a significant increase for the second month in a row, however there is no direct theme. What is being picked up is that there are quite a few complex cases linked to either urological or biliary disorders. There is more work to be done, in particular to see how this relates to the backlog. GP asked about the C diff not being transmitted between the patients, if this meant it is coming from the Community rather than something caused by the hospital. If this is the case, is there anything the Trust can target with prescribing, certain practices, or people to reduce this. DH said some of these will be acquired within the hospital, hence why the environmental and cleaning factors were referenced. Part of the regional and national work looked at a more global picture about Community acquisition and prevalence. The QI work showed there was missed opportunity around timely and early sampling that can be improved. DH said it is a complex picture with multi-factors that are affecting to the upturn. GP asked if there are any figures for the Community baseline, as if the figures are going up then there may be a correlation. DH said that more evidence is needed, and that the target numbers decided at one point need considering regionally and nationally. JJ asked about the stroke patients number being still within guidelines percentage but going down, if this continues on the current trajectory is there anything in place to stem this trend. GN said this has been mentioned at the P&F committee, and there has been an increase in the number of strokes into the Trust, which was seen early in summer and again in	

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	September. This meant there were stroke outliers in different areas for a shorter period of time. GN has been assured in October the performance has not deteriorated and is not expecting the trend to continue. This was not about people with strokes not being diagnosed, but capacity on the stroke ward because of the increased numbers. GN is expecting the number to come up and the metric will be achieved and remain in compliance. AH asked if the PECC reduces the ward cleaning done by housekeeping and nursing. DH said it does not, rather it adds another layer of decontamination particularly to the equipment. The PECC enables a deeper level of cleaning than is able to be done on the wards. AH said historically where there a number of C diff cases in one clinical area it does increase the loading on cleaning, DH agreed and stated that the enhanced cleaning is still in place, and an additional clean was done on a weekly basis. AH asked if the cleaning audits are all green. DH said these go through Infection Prevention and Control Group (IPCG), and the audits look at various aspects so are not always green. LT asked about the Sepsis Screening, as screening in ED is 100%, but lower in inpatients where the number of patients being administered antibiotics within one hour is not achieved. LT stated that she was under the impression there was a dedicated sepsis team to improve sepsis screening and administration of antibiotics. DH said the screening is happening in terms of recognising the requirements, however the antibiotic administration is not being achieved in the hour. The ED team have put together a number of actions to aid in this and the team will monitor their effectiveness. GN said there was the first Integration Committee meeting happened previous to the Quality Committee meeting, which will likely look at the cancer metrics, and the dashboard and metrics have been agreed for the integration committee. These will still come to the IQPR so Quality Committee will not lose sight of these metrics. LT asked about the ambulance handovers, if there was anything about the 15 minutes or 60 minute waits. GN said there has been some deterioration in September, and this is a national pattern. There have been small increases in ambulance conveyances in October, however the challenge is the increase in acuity of people walking in, the waiting room being acute, and people are having to be moved into resuscitation rather than a cubicle from the waiting room. There are challenges around length of stay unrelated to delays with social care. West Midlands Ambulance Service (WMAS) have a policy of saying to patients that if there are delays then the patients should take themselves to ED. There have been some incidents in the waiting room of ED, which may have happened regardless, but the location has been a challenge. DH added that through Executive Significant Event Review Group (ESERG), where individual cases are discussed, there was a request to do a thematic analysis. One was done earlier in the year and supported by the ED team, which was found to be helpful. The plan is to do this again to ensure nothing has been missed.	
4.4	**Patient Experience Bi-Monthly Report** This report has been to the Board meeting previous to Quality Committee, however due to the September QSAG meeting being cancelled it has come through to Quality Committee.	

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	AH noted there has been an upheld Ombudsman's report, and asked if there was any background that could be provided as to whether it was fully or partially upheld, and how it went to the Ombudsman. DH has had a dialogue with the Head of Patient Experience and Public Involvement and can liaise with AH over the finer details.	**DH**
	AH asked about the early resolution for Patient Advice and Liaison Service (PALS), as her understanding is that PALS is there to facilitate a resolution before issues get to a complaints stage, or what had happened on the ward that meant it could not be dealt with there. DH will liaise with Patient Experience.	**DH**
	AH also asked about a maternity complaint where a child was found to have a cataract, and asked if there is a training issue that should be looked at. DH will liaise with Patient Experience.	**DH**
	JJ asked if complaints are accompanied by a subject access request, and if the Trust complies with this within the Information Commissioner's Officer (ICO) deadline. DH said there is a separate report around the ICO deadlines and compliance and that she does not believe there is any noncompliance with this, but will check with Patient Experience.	**DH**
	LT asked about a complaint that has been assigned to Maternity but perhaps did not sit with that team. DH confirmed this was appropriate as in was an infant involved.	
4.5	**CNO Report – D Hickman** It was acknowledged that many of the points within the CNO report are also in the IQPR , but DH highlighted a comprehensive piece of work done around the fundamentals of care standards. Up to this point of the year this has been carried out with the matrons, band sevens and band sixes, with the band five cohort being the largest in the organisation and will be finished translated through by the end of the year. This will ensure everyone has the information around what does good look like, and the expectations around accountability and responsibility. The Trust continues in a positive vacancy position and there has been good student outturn and the overseas recruitment is moving forward. The unregistered numbers reflects an over establishment position, but it is important to recognise there are clinical fellows that have started with the Trust as unregistered practitioners. An anomaly has been picked up where colleagues such as ward admin and ward assistance are being captured with healthcare support workers. When skill mix is spoken of, it is around direct patient care and patient contact, which can lead to the impression of being over-established. LT noted the report mentioned that the My Assure and Stroke Health Assure audit templates are now functional, and enquired what these are. DH said there was an issue with the platform where not all of the audits were available to the teams. This is an issue with the company, and while it is mostly resolved there are still a few audits that are inaccessible to view, receive, and get the data from. The Assurance Team Information Management & Technology (IM&T) members are aware and working with the company to resolve. This is also being reviewed as WHT is on a different platform.	

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	JJ said the report alerted that there are some team member shortages within child and adult safeguarding. From an educational setting the types of referrals to Multi-Agency Safeguarding Hub (MASH) are getting more complex and graver. JJ asked if there is a risk that is increasing with these, and what the Trust are doing to not only address the safeguarding concerns that are presented, but also objectively identifying concerns and making referrals. DH said the Safeguarding team would agree that there is a growing need as the activity has increased. The issues for the team have been related to sickness and natural turnover of the team where people have had promotions, etc. Recruitment has occurred and been successful, while the issues around sickness have resolved. All the mandatory requirements, as seen through the reporting, have been achieved. Work is being done with individuals from maternity services and children's services around child safeguarding and doing pathfinder work. LT asked about the nurses recruited through the Computer based Test (CBT) test centre in Nigeria now being required to do three attempts at the exam and what would happen if they failed at the third attempt. DH said they would not meet the requirements for remaining on the register, however none of the individuals were identified as fraudulently acquiring their CBT. They will have the option, if they meet the Occupational English Test (OET) standards, and the visa and Certificate of Sponsorship (COS) requirements then the Trust could support them if it chooses to in a Healthcare Support worker role if they would want to do that, but they would not be able to remain as a registrant.	
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – September 2023 – Chair's Report – D Hickman** From the Falls Report, there is a National Patient Safety Agency (NPSA) alert in relation to the beds situation and the bedrails. There is a Task and Finish group which has been started and through medical devices there is strong assurance around the beds. The gap may be around the trolleys, which will be about service contracts and not necessarily decontamination. LT said in the last meeting there was mention in the Pressure Ulcer report of there being an issue with the beds alarming with faults that were not being picked up, and there was a plan to replace the mattresses. DH said there are 100 new hybrid mattresses on order, but there is also question of whether there is a replacement programme moving forward. There is a revised assessment that recognises some of the failures are not as the mattresses are being inflated, it is taking a while for the pump to shut down. LT asked about the financial risks associated with the Commissioning for Quality and Innovation (CQUIN), DH said the targets have been hit for CQUIN. LT asked for clarification in respect of the Alert section of the Pressure Ulcer Report where there was mention of learning from deaths, and patients admitted with wounds, with something being presented to the medical examiners in October. DH said this meeting has not happened yet, but there was talk at September's Quality Committee about pressure ulcer being featured on a death certificate. This will be about the conversation with the experts similar to how something like infection would be managed on the death certificate. LT said	

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	the report suggested there were issues in Community, and asked whether the Trust has data on the quantity and how these are being managed. DH said that the same data for pressure injury and moisture associated, is collected in the Trust and in the community. LT asked about the observation that when the Rapid Improvement Facilitator is not present, there is a return to how things were before. DH said there is the Quality Team, but there is a challenge with the requirement and input. There are people on fixed term posts, but there is not currently the necessary revenue to make them substantive. With time there may be an evidence based case to support that need. DH also raised the Resuscitation Group, and the improvement with the cardiac arrest trolley and Basic Life Support (BLS) compliance. LT asked about the report, as in the Assure section there are three out of five topics in BLS compliance, but then in Advise it states a reduction in BLS compliance in two out of five topics. DH believed this was due to the range of components and levels within BLS. The plan for Patient Safety Incident Response Framework (PSIRF) has been submitted and signed off by the Chief Executive and the communication working group has been set up. From the NCEPOD Hard to Swallow (Dysphagia) advisory notes, there was one red risk about a gap with Speech and Language Therapist (SLT) and front door activity as opposed to inpatients, however there are no reported incidents relating to this. In Divisional, skill mix has featured, reiterating the concerns about the acutely unwell when first admitted. LT asked about the Division 2 Exception Report, in the Advise section it states a new medical model of care is in development and asked for some elaboration as to what this meant. GN said it is partly referenced in the Winter Plan, and fundamentally means the medical teams are redesigning how the Trust manages patients when they are coming into the organisation, when they do arrive, and then how they are managed internally. The question is how patients can be managed differently, as not every patient may need a bed, or if they do they potentially do not need to be in a bed for as long as they currently are. The development of this is looking at the Community, the out of hospital model, and changing the thought process internally around the management model. This has been designed by the clinicians and the multidisciplinary team with the nursing staff, who will attend a Board Development workshop to help with awareness. AH asked about accountability and responsibility at a clinical level regarding the Medical Devices gaps in adherence to policy, and the Tissue Viability report where it states that where specialists or sisters are away the standards seem to slip. DH said some of this will be resolved when the band five's have completed their fundamentals of care standards. Operationally the teams are working hard to ensure that the appropriate process is applied and is evident where there are lapses. There would need to be an understanding of each case.	
6	**Assurance Reporting / Themed Reviews / Business**	
	None to report.	

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7	**Themed Review Items**	
	None to report.	
8	**Issues of Significance for Audit Committee** None noted. **Issues of Significance for the Trust Board** LT will raise the cancer metrics.	
9	**Any Other Business** LT noted that Ophthalmology has been spoken of a lot, and there have been walkabouts in the eye hospital and audits done. There will now be a meeting across the Midlands to look at the orthoptist workforce as there is an acute shortage. As a result of the walkabout there has been a Birmingham and Solihull (BSOL) meeting, however RWT and WHT where unable to be present. A bigger meeting is planned with Wolverhampton, Walsall, Dudley, Sandwell and West Birmingham with a view to having an Assistant Practitioner in Orthoptics. The representatives from the workforce in the first meeting noted that to get Orthoptic training the only options are Leeds, Sheffield and London. They felt what is needed is a pre-qualifying Masters programme for orthoptists so the workforce will be gained in two years. The assistant practitioner orthoptists could then be able to top up to degree level to improve their skills.	
10	**Evaluation of Meeting** JJ asked that papers are uploaded in a more timely manner to enable review before the meeting.	
11	**Date and time of Next Meeting:** **Wednesday 22nd November 2023 at 1.00pm to 3.00pm, Via MS Teams**	

The Royal Wolverhampton NHS Trust

Minutes of the Quality Governance Assurance Committee:

Quorum: 4 members must be present consisting of 2 Executive Directors and 2 NED members. No tabled papers except with Chair's approval.

Date	**Wednesday 27 September 2023**
Venue	**Virtual (via MS Teams due to COVID 19)**
Time	**1.00pm to 3.00pm**

	Name	**Role**
Present:	Louise Toner **(LT)** Chair	Non-Executive Director
	Kevin Bostock **(KB)**	Director of Assurance
	Allison Heseltine **(AH)**	Non-Executive Director
	Debra Hickman **(DH)**	Chief Nursing Officer
	Julie Jones **(JJ)**	Non-Executive Director
	Alison Lathe **(AL)**	Meeting Administrator
	Dr B McKaig **(BM)**	Chief Medical Officer
	Michelle Metcalfe **(MM)**	Group Deputy Director of Assurance
	Gwen Nuttall **(GN)**	Chief Operating Officer
	Tracy Palmer **(TP)**	Director of Midwifery & Neonatal Services
	Iresha Pathirage **(IP)**	International Leadership Fellow

Apologies:	Lisa Hall	Senior Matron Infection Prevention
	Martina Morris	Deputy Director of Nursing
	Dr G Pickavance	Non-Executive Director
	Keith Wilshere	Group Company Secretary

Attendees:	Claire Hope **(CH)**	Deputy Head of Safeguarding
	Emma Spooner **(ES)**	Matron for Infection Prevention

Item No		Action
1	**Apologies for absence** Apologies were noted.	
1.1	**Declarations of Interest** There were no declarations of interest.	
2	**Minutes of the Previous Quality Governance Assurance Committee dated 26 July 2023**	
2.1	**QGAC Minutes – July 2023** Accepted as a true record. AH noted her title was recorded incorrectly, AL to amend.	**AL**
2.2	**Committee Issue Log** **1401** – DH said this was due to go through QSAG, however that meeting did not go ahead. DH asked the group if they know if this paper has gone through any other meetings. GN said this is scheduled to go to Non-Elective Flow Improvement Group (NEFIG) early October. The RWT and Wolverhampton Place Winter Plan is on the agenda for the Trust Board and GN will be sharing this with the Board prior to the meeting, which makes mention of Care Coordination. It is still to go through P&F but has been approved by Place Board. **1400** – DH believes this can be closed as conversations are taking place outside of this meeting with relevant colleagues. GN has been liaising with the Clinical Director for Gynaecology, however no outcome has been reached yet due to annual leave. The group agreed for this action to be closed. **1402** – M Arthur was unable to attend and sent an update to AL. She stated that what is being described is the team's lack of capacity to keep up with training requirements due to the sheer volume of people needing the training. Currently the risk number is not known. Carried forward for update. **1335** – BM believes this should have been closed from the last meeting as the revised risks have been sent. KB confirmed, action to be closed. **1340** – BM said this has been closed so needs to be closed on Action Log. **1336, 1338, 1339, 1337** – KB has confirmed these can be closed. **1342, 1341** – AH said she had received a list from an assurance point of view and asked where they are held for ownership and how is this being disseminated across the Trust. DH said this was linked in with section 42; the ones that don't meet the criteria sit with Patient Experience, and the ones that do meet the criteria sit with the safeguarding team for oversight and wrap around. Closed.	

Commented [LT1]: Does this mean both risks are being closed?

Item No		Action
3	**Matters arising from the Minutes** Action log updated accordingly.	
4	**Regular Reports**	
4.1	**Cancer Improvement Plan (for information only) – G Nuttall** GN apologised for a late paper, explaining that the Core Cancer Improvement Plan is an operational plan that she is looking to remove and replace with an overview plan, which has come to the group for this meeting. The overview document is an enhancement and is more RWT focused. It goes to the ICB cancer group and NHSE for the performance meetings. The aim is to have a consistent process internally and externally to inform discussions. GN stated that there was confirmation the day before the meeting that the Trust remains on Tier 2 for cancer performance. There had been a discussion whether the Trust should go to Tier 1 based on the 62 day metric as the Trust is in the lower quartile nationally. The view of the ICB and NHSE is that the Midlands is in Tier 2 due to being green in respect of the 28 day Faster Diagnosis Standard, the backlog for 62 and 31 day waits is improving. GN expanded that with the improvement of 62 days there are 232 people waiting over 62 days, and the end of year trajectory is to be 217. GN forecasts that the Trust will achieve this aim. GN noted for alerting is Urology. The Renal pathway has been discussed at previous meetings with Russell's Hall being utilised for mutual aid and this will continue going forward. Patients have been treated at Frimley Park, and any patients wishing to transfer to Frimley Park will be able to do so as it is an open offer for mutual aid. There have been no reports of adverse outcomes for the patients treated at Frimley Park or at Russell's Hall. Also under Urology is our performance regarding patients with Prostatic Cancer. The number has come down in August and September from 93 to 70. Mutual aid is available from Northampton if the patient chooses to be treated there, and the team is looking to refer at least six patients in the latter part of October and November. The skin pathway presents another challenge for 62 days around Histopathology reporting however, there has been some improvements seen in the turnaround time. One of the mitigations is the development of the Mohs surgery as a Black Country Service based at New Cross Hospital. The first two patients have been treated successfully at the time of the meeting. GN advised and provided assurance that performance against the 28 day faster diagnosis standard remains compliant, with the end of year March trajectories to be at 75%. The performance in Quarter 1 and Quarter 2 were green. Nationally the reporting of the two week cancer referral route will cease from the beginning of October, however the Trust will still be recording and reporting on this as it is a key metric as to whether the 28 day faster diagnosis will be achieved.	

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	GN has included some benchmarking as this was a request from the last meeting, and provides insight on other organisations. GN highlighted Gynae as a pathway of concern around capacity and volume. Significant changes have been made around triaging and substantial improvement has been seen for the two week standard. There are still challenges in reducing the numbers and the diagnostic element. The 31 day metric around sub anti-cancer drugs and radiotherapy, which is presenting challenges but there has been some progress, as seen in July. There are challenges in waiting times for Oncology in terms of start dates, the most significant of which being the Urology pathway. While there are improvements, such as locums in Oncology, there will need to be further work done. GN summarised that while the document is a work in progress it should provide clarity on advise, alert, assure. There has been an agreement that this report will come to Quality Committee as the main committee for cancer issues as it will link in with the other reports in a more rounded way. LT felt the new format is clearer, and commented that overall the Trust's position is improving, but there are drops in places which seem to be related to capacity issues, sickness, etc. GN said in terms of the backlog there are consistent improvements with good plans in place but it is slow moving. In some specialities there is not the flexibility if there are strikes or sickness, which makes it difficult to recover. The Trust has turned to external companies for recruitment in some areas. JJ mentioned there was a provider collaborative session a few weeks ago, as there is the mutual aid from Dudley and the Trust is working with Frimley Park, and asked if the Trust is working smartly to insure against issues such as long-term sickness, annual leave, and strikes where possible. GN said that not all organisations do or are planned to do all of the cancer tumour sites. RWT is the tertiary centre for most of the cancer sites mentioned. She speculated that this is something that will develop and evolve across the provider collaborative. BM agreed that the demand and capacity across the Black Country is uncertain. It can be difficult to get accurate data around capacity and demand due to the different catchment areas. Though mutual aid can be beneficial, as everyone is accessing aid in the same area it widens the national view. There is a good narrative in the meetings, but there can be resistance from staff members and patients having to move to different hospitals. While this is moving in the right direction, it may take years to resolve. AH asked where the Trust is with 7 day diagnostics and whether it is happening. GN said that in Urgent and Emergency Care it is, for routine provision of some cancer treatments there is not full 7day working. As part of the CDC the Trust is looking to develop diagnostics, some of which will be linked to cancer to increase workforce to six days and ideally seven days in the longer term. Additional work is being done for endoscopy, on Saturdays through an outsourced company, as well as MRIs and CTs. Ultrasounds are being looked at to increase to six days a week from January.	

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4.2	**Trust Risk Register – M Metcalfe** MM explained that the data was pulled on 17th September, so there may have been changes in the interim time before the meeting. There was a meeting the day prior to this meeting with the Executives and Divisions present to discuss the Risk Register which MM said was quite productive. MM has taken the paper as read. Five Risks have been removed from the Trust Level Risk Register, with explanation and assurances as to where they now sit or if they are now closed provided further down in the report. Of the five, four are now being managed at operational level and one is being merged with other Risks. There are 21 Risks overall being managed, seven of which are in the red category, and there was some time spent discussing at the Risk Register meeting. MM directed the group to the executive sponsors for these risks if they have any further queries. MM assured the group that the Risks listed as overdue have been reviewed, which is the update since the report was produced. LT asked about Risk **1984** around Ophthalmology and whether this has been picked up by Finance and Productivity. There are 7824 patients overdue and another 4580 to be added to that list in the next 30 days with no appointments available. LT asked what the plan was to manage these patients. BM said that one of the main issues was the level of harm that was being seen, particularly in the glaucoma cohort. While this has not been resolved, in the triage process and identification of those that are higher risk the harm is not being seen, and so believes the system is working to mitigate the harm. Ophthalmology is nationally one of the most challenged specialities in terms of capacity, and managing that demand involves financing support at weekends which has been intermittent. It can be viewed as difficult to resolve due to financial needs for follow up patients, particularly those who are seen for glaucoma. In Staffordshire, these patients are seen by optometrists through a private company managed externally. In Wolverhampton, there is difficulty as commissioners will not authorise that pathway as it is an additional cost for which the money is not available. The Trust would have to commission rather than it coming from the central monies, but this would be to the detriment elsewhere. LT asked whether this is something the ICB will not change their minds about. BM advised that in the last few months there has not been any movement. With outpatients Ophthalmology are using the faster programmes to streamline as much as possible, however a lot of referrals do need to be seen. Where possible, the team tries to reduce outpatient follow up by utilising optometrists is the community and minimise people coming back to the Directorate. GN expanded on this saying that she has had conversations with the lead on commissioning who has been having conversations with the ICB and there has been no movement. While it is appropriate and clinically right for patients, the financial element is more severe with potential cost pressure.	

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	AH asked if the ICB believes we are already being paid for this work, if there are patients being referred, or if the ICB do not see the issue. BM said his understanding is that the ICB believe they are paying the Trust for the patient's care, and if the service was moved elsewhere the funding would follow the patient. What is not recognised is that there are 9000 patients waiting to be seen and the Trust's staff needs to be working on that waitlist and not work that could be done elsewhere. LT queried Risk **5482** around emergency CT brain scanning in ED, and the Sentinel Stroke National Audit Programme (SSNAP) which is carried out, and asked if there was an implication for this. BM said CT is available 24/7, but the key thing is doing a CT angiogram which requires specific radiographers to be on site. This would benefit a small cohort of individuals who would be suitable for thrombectomy, which is one of the metrics looked at by SSNAP. The radiology department are working to develop on call staff who are available 24/7 but it is an expensive resource and it is being looked at what other activity this section of staff could provide. LT asked further around a proposed pilot that gives direct access to CTA scans. BM believes this could be related to patients who are directly transferred from West Midlands Ambulance Service (WMAS). Communication happens between the Stroke team and the transferring team with the intention of individuals going directly into CT rather than being further assessed in ED.	
4.3	**Board Assurance Framework** Report not available.	
4.4	**CNO Report – D Hickman** DH stated that the Trust has been successful in recruitment with vacancy numbers dropping significantly, combined with good student outputs. This is the first cohort of increased numbers reaching the end of their three year course, and there have not been the delays or extensions that were seen last year. In counter to this, there are skill mix challenges and the workforce needs a significant amount of support from different areas. There are programmes in place, some of which the Trust has enhanced particularly around the international pipeline, which are starting this month for new arrivals, but also looking back at the last few cohorts. This will need to be tested in terms of impact and output. There has been a further update from NMC employers around the CBT issue around computer based testing for international recruits. The Trust know the number of individuals affected, and they will be working with the NMC to redo their CBT in this country, however there has been no other correspondence from the NMC regarding their other findings and whether the Trust has been affected. The education team is supporting and working closely with the individuals who have chosen not to do a follow-up CBT in country or equally have failed that CBT. DH noted that Infection Prevention has a report later within this meeting and believes the relevant details will be discussed there. AH asked if the Pharmacy Summit mentioned in the CNO report has happened yet. DH confirmed the Medicine Summit started the day prior, with a regional CQC pharmaceutical	

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	inspector attending, which was found to be helpful. Audit information and review data was covered, and has been well-attended from a pharmaceutical, nursing, and AHP perspective.	
4.5	**CQI Report** Due to QSAG being postponed, and the presenters being unavailable due to annual leave, this will be deferred to the next meeting.	
4.6	**Integrated Quality & Performance Report August 2023 – G Nuttall & D Hickman** DH highlighted the rise in pressure ulcers as a key area for discussion. A themed analysis has been undertaken with some headlines highlighted, and there will be more work to do with the actions from that. There is a rise in mattress failures, but these are not picked up as part of the checking process done as it takes 30 to 40 minutes to operate and deflate, so more work needs to be done for repairing and updating. There are some SIs with some complexity of patients and pressure injuries occur. There are some educational components to the previously mentioned workforce challenges, which the TV team are working on. LT recognised that other Trusts are having significant issues in terms of increasing incidents of pressure ulcers, and it is not just RWT. DH said that intercepting it early with the detailed analysis that is underway will inform the action plan put in place. There are a number of summits running alongside some of these measures, which will inform the actions and ongoing work. LT asked if there is any issue in community that DH is aware of. DH said there nothing featured in this report as we did not see the warm spell through July and August. In September there was an increase in moisture associated damage rather than pressure injury. GN raised that the stroke metrics continue to remain above the standard trajectory, and what is not shown in the report is the increase in numbers across June, July and August being conveyed into the organisation. The performance of the stroke ward and maintaining those metrics is good. A consultant is a lead for the stroke network and has noted there seems to be a national pattern, which could be heat related but there may be other elements, such as post-covid. Going forward GN expects to go into more detail around the community metric, and referrals into Virtual Ward are going to be crucial for winter planning, in additional to the previously mentioned Care Coordination elements.	
4.7	**Patient Experience Bi-Monthly Report** Due to QSAG being postponed, paper unable to come to this meeting, this will be deferred to the next meeting.	
5	**Subgroup Reports**	
5.1	**Quality & Safety Advisory Group Meeting – September 2023 – Chair's Report**	

Item No		Action
	Meeting did not go ahead due to the number of apologies and not being quorate. Reports to be carried over to the October meeting.	
6	**Assurance Reporting / Themed Reviews / Business**	
6.1	**Infection Prevention BAF – E Spooner** ES took the report as read. There are currently two risks on the Risk Register, one of which has already been mentioned, the other is Risk **5777** which was closed following discussion at IPCG in May. Infection Prevention have received their national targets and new objectives from NHS England and NHS Improvement (NHSEI) which the team is working towards. There have been no cases of MRSA bacteraemia and there is still the zero tolerance for MRSA. There has been 16 cases against a target of 24 MRSA bacteraemia with one being identified last month. There have been 14 MRSA acquisitions year to date. There have been 28 C Difficile positives against a trajectory of 53 with four in the last month. The IP Delivery Plan has been agreed and will launch early October as a joint collaboration between RWT and Walsall. This is a three year plan that will support the recently published Quality and Safety Enabling Strategies. There continues to be work done with the gloves off campaign and raising awareness. There has been an increase in the number of covid patients, however at the time of the meeting there were only 18 covid positives across the Trust. This is being seen as increasing both locally and nationally with the risk of the new variant. The Respiratory Illness Risk Assessment has been recently reviewed and updated which has gone to Trust Board where no changes were made. The team are in the process of formulating the Winter Preparedness campaign with the Comms team. AH asked about the triangulation between the CNO and IQPR papers, the night visits and the SIs. One of the SIs was related to carbapenemase-producing Enterobacteriaceae (CPE) and C Diff, which was identified as PPE issues and cleaning the commodes on night visits. This suggests that there is something not happening with basic cleaning, and AH asked what is being done to prevent these SIs. ES said the deep clean programme had been delayed but has now started and the plan is to get as many wards cleaned as possible. There have been challenges from a capacity perspective which caused the delay. The Patient Equipment Cleaning Centre (PECC) is planned to start in their new location in November which will help ensure equipment is cleaned thoroughly as well as areas. Although the PECC is not set up yet, the deep clean team are cleaning ad hoc across ward areas to ensure equipment is cleaned as part of that process which will continue to improve as PECC is set up.	

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	DH added that all the information is shared widely, and also from DH, GN and BM. The investigation and dialogues are shared with the individuals key to the area at all levels and the whole team as part of the SI process. In some instances, but not all, this is down to individual behaviours and involves the stop and challenge at the point of occurrence. The delivery campaign is due to relaunch week commencing 9th October focuses on a back to basics approach and what is required to keep patients and staff safe from transmission. In the data around the transmission of CPE it was patient to patient, and while there are some Estates and environmental issues, but fundamentally it is in practice, which has been shared widely with nursing, medical and AHP teams. In terms of C Diff, in addition to the local level deep clean as ES mentioned, there are also QI pieces or work running in conjunction. There has been communication with some of the lowest reporting organisations to find out if they have practices they can share. AH asked whether there is assurance that outside of the deep clean, wards are being cleaned appropriately on a day-to-day basis with the audits matching in particularly those areas. DH said that in terms of what the housekeeping services undertake and the dip sampling there are a very small minority of identified issues of variation in team or other inconsistencies. When looking at the ward audits there's some education to be done as the audits are not always reflecting what is being seen in practice.	
6.2	**Maternity Services Governance Report (to include Perinatal Mortality Report) – Tracey Palmer** TP said that the vacancies number is decreasing. At the time of the report being written there were 11 whole time equivalents, and at the time of the meeting this had come down to just under six with people starting to come into post. The challenge is with the skill mix, and the plan is to integrate these staff members in to clinical areas. There is some challenge with the international nurses, with some taking more time to integrate into clinical services, however this was predicted and there is a plan for these midwives. In the acuity and staffing data it can be seen that the trust is not meeting the national standards, however this data has been taken before the plans had been put in place to move staff and redeploy. This is reviewed by the duty manager seven days a week to look at the team as a whole. The assurance is that the team is always managing to protect the intrapartum areas, and one to one rates in labour are 100%. As new starters come in to clinical practice the team is confident that the acuity data will start to shift in a positive direction. One of the 'must do's' from the CQC report is to protect the staffing triages; the audits deteriorated in July which was due to higher activity and higher annual leave during the summer months. When reviewed, this was seen to be that when staff are redeployed to areas of greater need the acuity of triage is lower. This was found to be appropriate but it needs to be captured so there is evidence for CQC. Logs are being kept of when staff members are redeployed, who is redeployed, their grading and for how many hours, which is captured in the Opal status which is received daily.	

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	TP included the Perinatal Mortality Report for the purposes of completion. Over the summer it was seen there is a peaking of perinatal mortality rates across paediatrics, which has been discussed at the Local Maternity and Neonatal System (LMNS) Board Meeting. It was agreed that a joint piece of work will be carried out together as LMNS. There are arrangements being put in place with Walsall to provide assurance that the data is being looked at critically and lessons can be learned from those deaths. From the dashboard the numbers of bookings are plateauing out and births are going up. This is due to the exports and is being monitored closely, with just over 5000 births at year end. There is concern over a peak in stillbirths in July which has prompted a rapid review of those cases with Walsall. In the formal compliance there has been a spike of five with the main themes being clinical care. There is a deep dive into this taking place to see if there is anything concerning, but thus far nothing has flagged. The Healthcare Safety Investigation Branch (HSIB) report has been included, and from the quarterly meeting they are not concerned there are any major themes from the mentioned cases. The insights and peer reviews that have been completed; the peer review report has been received and is being checked for factual accuracy while the insights report is still awaited. JJ noted that on the dashboard there is a failed instrumental delivery which has gone up to five and is green, and asked why the scoring is that more than seven is red, four to six is green, and less than three is amber. JJ proposed that would more failed deliveries that were failed instrumental be worse. DH suggested these have been transposed the wrong way around on the grid, TP said she would check this and let the group know. LT asked about the anonymised Clinical Negligence Scheme for Trusts (CNST), and that while positive around many areas, but noticed in the lessons learned **8807** there is talk of a delay in blood products, and asked TP to elaborate. TP said this was around the process of requesting blood and there is specific training required, however the person requesting had not had this training. This has now been dealt with and the training is part of the mandated induction training for nurses and midwives. LT also asked about **8203** about intrauterine death and consultants not being advised, and wondered what the circumstances would be to contact a consultant. TP said when an intrauterine death confirmed on scan, there is a national requirement to have it confirmed by a consultant, and there had been a delay in that happening. LT queried the Mothers and Babies: Reducing Risk through Audits and Confidential Enquires (MBRRACE-UK) report from 2021, in that there are some areas where RWT do not provide information but where there is information it is thorough. PT said the data is informed from the Perinatal Mortality Review Tool (PMRT), and if there are fields where the data is missing or have not completed because the information was not ready at the time, this caused the gaps. There is now a board meeting every month which is multidisciplinary with external reviewers present where the data from the PRMNT is looked at in detail. Before the data is submitted the expectation is that those fields would be completed, and the hope is that there will be an improvement with a new process put in place for the next report. The next report will be for 2022 and is expected to be released in November.	TP

Item No		Action
7	**Themed Review Items**	
7.1	**Mortality Quality Improvement Plan – Dr B McKaig** This report is due to go to Board, but has not been discussed at QSAG due to the meeting's cancellation. The Summary Hospital Mortality Indicator (SHMI) is now just below 0.9 which is very low. Pneumonia has been difficult for a significant period of time in terms of mortality and the SHMI was previously 125. The team have been working on the metrics and CQUINs and there has been improvement over that last six to twelve months and now the SHMI has come down to 112 or 113. This seems to be a true reflection of improvements being made in care as a result of the CQUIN and compliance. Similarly, the SHMI score for strokes has come down with SSNAP being carried out. BM believes that with the way that the mortality review process has been structured, when consistent spikes are seen outside of what is expected, it is probably a true reflection of the quality of care the Trust provides. There has been input from the Neonatal team which shows the rigor that is input around neonatal deaths. The team highlighted that they are keen to establish a formal peer review process for where there are deaths that have been graded as C: Different care may have resulted in a different outcome and D: Different care would definitely have resulted in a different outcome, and where there is poor care. This is not yet formalised and BM has plans to meet with the lead in the region for Neonatal Mortality to ensure these are being picked up and there is equality. The MBRRACE data where before the Trust was poorly performing within the West Midlands is now showing significant improvements which is a positive report. AH asked if the Structured Judgement Reviews (SJR) awaiting allocation have just been allocated, or are there any issues with getting people to do these reviews. BM said it usually has to do with availability, as it is within the job plans, but can be delayed slightly due to annual leave, etc. BM said there is enough capacity within the system of SJR reviewers to allow this.	
7.2	**Safeguarding Assurance Report (Adults and Children) – C Hope** CH took the report as read and gave the key highlights. There are two risks that remain open, however the MCA risk has now reduced from red to amber after a meeting with the Governance team and DH. A significant amount of work has been done within the team and the Trust Safeguarding Group, there has been additional MCA training across the Trust, an updated action plan, and meetings with clinicians. The number of DoLS applications continues to improve again with 163 applications in Quarter 1 in comparison to 130 in Quarter 4 before that. This is the highest number ever submitted for RWT, and CH is still seeing an upwards trajectory.	

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	Safeguarding compliance training across the Trust remains very good, with many training courses having compliance above 96%. The new Oliver McGowan Learning Disability and Autism training introduced in March is already up to 96% compliant. There have been 11 safeguarding enquiries against the Trust in Quarter 1, and while this is an increase one inquiry relates to several areas and is therefore probably statistically in line with what would usually be seen. The biggest theme was neglect and acts of omission. Quarter 1 also saw improvements in compliance with Initial Health Assessments for Children and Young People in care, as well as safeguarding supervision within 0 to 19 service. A point of note is the number of domestic homicide reviews that the team are participating in is increasing, with CH believing there to be five at the moment which is not good. The number of Multi-Agency Safeguarding Hub (MASH) Health Check in Quarter 1 increased by 16%, which is the highest number of local authority checks since records began which is also worrying. LT asked about the Safeguarding compliance in Level 3. CH said the Trust is within ICB requirements, level 3 is just above 85% in some areas but this is within expectations. A new level 3 Safeguarding Adult package is being developed and should be easier to use. The hope is that once this is implemented the compliance will improve. The team are looking to combine the Level 2 and Level 3 Safeguarding Children training and assessment in an effort to improve compliance. AH said the second paper seems more like a toolkit ensuring everything is covered for the year and may lead people to believe it is an old paper where it is in fact an updated paper. CH said the paper is an ICB tool that is required to be used and comes with the dates on. AH suggested adding a title at the top to indicate this is an updated paper, to which CH agreed.	CH
8	**Issues of Significance for Audit Committee** None noted. **Issues of Significance for the Trust Board** None noted.	
9	**Any Other Business** LT noted there were multiple papers with the same enclosure number, asked AL to ensure the papers are not enclosed this way going forward. AL confirmed. **Urology Senate Report** BM requested to bring this report to the group as the QSAG meeting was cancelled, so it is seen before it goes to the Board. BM asked if the preference was to defer to the next meeting and delay going to Board. KB noted there has been a lot of conversations around Urology,	**AL**

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	with the ICB wishing to do a joint review with RWT. KB believed it would be better for the report to be circulated so it can then go to Board. BM said the report in general is supportive of the merging of services and the opportunities that will present. The recommendations from the report are reasonable and the action plan is well advanced. BM has presented the report at the ICB meeting, and asked AL to circulate to the group so it can be viewed before going to Board next month. **RWT Quality Committee Planner** DH raised that the planner for Quality Committee needs to be reviewed. The Patient Experience report was due to be presented at QSAG before this meeting, but because of the cancelled QSAG it has been deferred. This paper will go on to Part B, but DH is conscious that there are reports that have not had a dialogue at a sub-board committee. LT said a meeting had taken place between herself, Julian Parkes, who chair the Quality Committee at Walsall, KB and Maria Arthur to review what is seen through Quality Committee at RWT and what is seen at WHT to ensure consistency across the groups. LT asked what the plan was in regard to the cancelled QSAG meeting. BM explained he and AL had gone through the agenda and deferred the papers to the October meeting, with the intention of extending the meeting time to cover the reports. As there would have been a short amount of time before the next QSAG meeting, there would not have been time to fit in a meeting before the next one. LT said this could potentially make the next Quality Committee challenging with the amount of items to go through QSAG. BM offered to arrange a meeting with LT separately to go through the QSAG agenda items. **Safety in Waiting Times Report** GN had asked around Patient Safety on the waiting list, which was brought to the Elective Group for ICB to discuss, and whether it was something for discussion at Quality Committee. GN asked for AL to send a copy of the report to the group for review, which then can be noted in the report for Board.	AL AL
10	**Evaluation of Meeting** LT noted there was a long discussion around the cancer report, but that was not unexpected.	
11	**Date and time of Next Meeting:** **Wednesday 25th October 2023 at 1.00pm to 3.00pm, Via MS Teams**	

Minutes of the Finance & Productivity Committee

Date	Wednesday 20th September 2023
Venue	via MSTeams
Time	8.30am

Present:	
John Dunn	Non-Executive Director (Chair)
Lisa Cowley	Non-Executive Director
Gwen Nuttall	Chief Operating Officer & Deputy Chief Executive Officer
Simon Evans	Group Chief Strategy Officer
Professor Martin Levermore	Associate Non-Executive Director (Part Attendance)

In Attendance:	
Tim Shayes	Deputy Group Chief Strategy Officer
Mark Greene	Deputy Chief Finance Officer
Keith Wilshere	Trust Secretary
Dean Gritton	Group Manager, Oncology, Haematology, Radiotherapy & Palliative Care
James Green	Operational Director of Finance
Stew Watson	Group Director of Estates Development
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

092/2023	**Apologies for Absence** Apologies were received from K Stringer, A Duffell, A Race and Lord Carter. J Dunn informed the Committee that the business cases and investment cases on the agenda would not be discussed at today's meeting and that they would be discussed at an external extraordinary meeting instead. J Dunn also informed the Committee that the ICB are meeting with the 4 CEO's, CFOs and Chair for the 4 Trusts within the group on Friday 22nd September to review the forecast year end position and to discuss the deficit.	
093/2023	**Declarations of Interest** There were no declarations of interest.	
094/2023	**Minutes of Meeting Held on 23rd August 2023** The minutes of the meeting from 19th 23rd August 2023 were agreed.	
095/2023	**Action Points from the Previous Meetings**	
095.01	Formal Directive re REAF Governance Process (Action 1232) – J Dunn confirmed that K Stringer has shared the directive regarding the formal REAF governance process with the Audit Committee and that it now needs to be circulated. J Green to ensure that this information is circulated.	**JG**
095.02	Cancer Deep Dive Pack (Action 1377) – G Nuttall stated that she would share a copy of the pack with the Committee once it has been taken to Quality Committee. **Action closed.** J Dunn clarified that Quality Governance and Assurance Committee will lead on discussions regarding cancer plans whereas the Performance & Productivity Committee (PFC) will examine cancer performance criteria.	

095.03	School Stroke Awareness Package (Action 1378) – L Cowley confirmed that an initial update has been provided to G Nuttall and J Odum and that discussions are progressing. **Action closed.**	
096/2023	**Performance**	
096.01	Elective Care Recovery (ECR) Programme – J Dunn asked T Shayes to ensure that the summary for the ECR is refreshed each month going forwards. T Shayes provided the following highlights from the report: Advise: • 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. Only the latter was known when we devised our trajectory and therefore incorporated. • The Trust delivered 110% of activity in August (compared to 2019/20) compared to a plan of 113%. On a value weighted activity basis, this equates to 106% (compared with a plan of 108%). • Year to date, our activity performance stands at 104% and our value weighted activity performance at 105%. J Dunn queried the performance percentage that has been agreed to offset Industrial Action. A discussion took place and T Shayes and G Nuttall clarified that the value weighted activity has been reduced nationally for the year to 106.5% but that the income element hasn't yet been clarified from April to September 2023. J Green clarified that 2% costs have been identified within the finance plan for April. J Dunn clarified that the Trust would not receive the 2% to offset strike costs and the extra value on ERF. Alert: • The Trust remains in Tier 2 for cancer performance with no further clarity over the criteria for existing. • 984 patients (876 outpatients and 108 admitted patients) either had their appointment cancelled or rearranged as a result of the Junior Doctor in August. This activity is being re-arranged but to the detriment of other patients who would have otherwise utilised this capacity. This is in addition to capacity that was not booked to in anticipation of strike action. • The Trust had 39 78-week breaches at the end of August, primarily in Urology. • Our diagnostic performance has dropped below trajectory in month, primarily in Ultrasound. Further options are now being explored to improve performance. Assure: • The Trust now has a route to zero for 78 week patients – it is expected that this will be achieved by the end of November 23. • The Trust is in line with its recovery trajectories for cancer backlog and the faster diagnosis standard. • The Trust is on its trajectory to clear 65 week waits by the end of March 24 although some first outpatients will breach the October standard In Urology, Gynaecology and Cardiology. J Dunn queried if a plan was in place to reach zero for 78 week patients. T Shayes and G Nuttall confirmed that a plan was in place to achieve this by the end of November 2023. L Cowley queried if the plan took into consideration the impact of Industrial Action. T Shayes confirmed that it does. L Cowley queried how RWT's 78 week performance compared to other Trusts. T Shayes stated that RWT was an outlier within the Black Country, however, RWT's position has now changed as Sandwell & West Birmingham have the most breaches across the Black Country. However, there are still significant 78 week	**TS**

	breaches across the big providers within the Black Country. T Shayes anticipated that RWT would be an outlier in a positive sense by the end of November 2023. G Nuttall confirmed that the Trust has been clear with Trust Board regarding 78 week breaches for Urology and informed the Committee that she is pleased to confirm a route is in place to clear the 78 week breaches for Urology. G Nuttall informed the Committee that national 78 week performance is deteriorating and that the Trust will be one of the few organisations who are improving 78 week performance. G Nuttall stated that there is a need to ensure outsourcing is managed well due to inflation pressures. M Levermore queried if covid pressures had been built into the winter plan. G Nuttall clarified that the impact of covid or flu had not been built into elective recovery and that cancellations due to sickness could impact. G Nuttall informed the Committee that the Winter Plan will be submitted to Trust Board and for elective planning it makes the assumption that ring fenced capacity maintains that this will be ring fenced. G Nuttall clarified that sickness and covid impact has been built into bed modelling going forward. M Levermore briefed the Committee on a Home Office announcement of an influx of migrants within the Trust's catchment area over the winter period. G Nuttall and M Levermore to discuss the potential impact on planning assumptions outside of the meeting. L Cowley queried the impact of not achieving the 65 week October deadline. G Nuttall clarified that the Trust has consistently said the target would not be met by October since it was introduced July/August 2023 and assured that plans are in place to achieve the 65 week target for Gynaecology and Cardiology by the end of November and Urology by the end of December. A review will be completed to validate any risk arising from the delay in achieving the target. L Cowley stated that she would liaise with G Nuttall re outpatient transformation. T Shayes clarified that the performance pack is being adapted to reflect outpatient transformation plans in the coming months and that he would be happy to work with L Cowley regarding the development of the outpatient section going forwards. L Cowley asked for clarity regarding the 85% diagnostic target and whether a timed plan is in place for ultrasound to address performance. T Shayes clarified that the 85% diagnostic target applies at Trust level but confirmed that the reality was the Trust was being performance managed on achieving 85% at modality level. T Shayes confirmed that the short-medium plan for ultrasound was that the implementation of the booking process would improve performance until the Community Diagnostics Centre (CDC) became live at Cannock Chase Hospital (CCH). T Shayes clarified that the partial booking process hasn't delivered the improvement on performance that was anticipated and that the long term plan to improve performance would be the implementation of CDC at CCH. In the meantime alternative options are being explored. **J Dunn summarised the following for advice to Trust Board:** **There will be revisions to cancer targets and the tiering system.** **J Dunn summarised the following for assurance to Trust Board:** • **A plan is in place to reach zero for the 78 week performance by the end of November 2023.** • **Further work and a plan is in place for Urology.** • **The Trust will breach the 65 week standard in October for Urology, Gynaecology and Cardiology. However, plans are in place to deliver the 65 day performance target by the end of March 2024.** • **Outpatient transformation is being reviewed.**	**GN/ML**

	J Dunn summarised the following for alert to Trust Board: • **Concerns were expressed reading the increased waiting list and the impact following Industrial Action which has affected productive capability and output.** • **Further work needs to take place to achieve the outpatient target and to build a plan.** • **Further work needs to take place to create a plan to address Diagnostic Ultrasound performance until the CDC becomes live at CCH.** The Committee noted the report.	
096.02	<u>Protecting and Expanding Elective Capacity Board Self-Assessment</u> – T Shayes submitted the report for information and clarified that the self-assessment is due to be submitted on 30th August. L Cowley asked if a note could be added to the "assured section" within the table to highlight which Committee would be leading on the item. T Shayes noted the request and confirmed that he would circulate a revised report. The Committee noted the report.	**TS**
096.03	<u>National & Contractual Standards (IQPR Extract)</u> – T Shayes reported that ambulance handover remains static compared with the previous month but shows an improving trend. J Dunn noted that has been an increase in admittances from Staffordshire and Shropshire but that the position has stabilised. J Dunn noted that the number of patients Medically Fit For Discharge (MFFD) has reduced to 60, an improvement of 16 patients from the previous month but expressed concerns regarding delays in discharging patients outside of the Wolverhampton area. T Shayes stated that the actions being taken to expedite the discharge process will form part of the winter plans. L Cowley queried why there had been a reduction in breast 2 week wait performance and 62 day wait screening. G Nuttall clarified that the reduction in performance for breast symptomatic screening referrals was due to sickness and annual leave. G Nuttall assured L Cowley that this has now been rectified in September. G Nuttall stated that she would investigate the reduction in 62 day wait screening and would report back on her findings. **To Trust Board for advice:** • **G Nuttall clarified the changes to the 28 faster day diagnosis standard. The target was 70% in Q2 and 75% for Q4, the Trust has achieved forecast performance for the 28 day standard, it looks like underperformance within the report as the metrics are recorded quarterly.** • **G Nuttall clarified that an action plan was put in place to address 31 day treatments and that those improvements are being made and are reflecting in performance, particularly for radiotherapy.** L Cowley requested further narrative on how many MFFD patients are outside of area and how many are long stays. G Nuttall agreed to provide a breakdown of patients who do not meet the criteria to reside. G Nuttall clarified that the stroke metric on page 17 was showing as 100% which is incorrect but that the figure for August was correct. G Nuttall stated that the report will be updated. **J Dunn summarised the following for advice to Trust Board:** • **ED performance has improved throughout September.** • **G Nuttall will provide further information on medically fit patients who are out of area and length of stay.** • **Highlight the improvement to the reduction of MFFD patients to 60. J Dunn congratulated the team on their hard work given the size of the hospital.** • **Further detailed work of the Winter Plan is taking place.**	**GN** **GN**

	G Nuttall clarified that in worst case scenario winter planning it shows a bed deficit that the Trust will be unable to bridge which is a potential risk going forwards. J Dunn asked G Nuttall to circulate the Winter Plan with all Committee members prior to Trust Board. S Evans suggested that the Winter Plan be submitted to the Integration Committee going forwards, when the meeting is fully established The Committee noted the report.	**GN**
097/2023	**Financial Performance**	
097.01	Forecast Outturn – J Green outlined the contents of the report which provided members with a briefing on the forecast outturn calculations for the 2023/24 financial year. The report informed the Committee that the revenue forecast outturn position is expected to deteriorate from the planned deficit of £26.75m. The deterioration ranges from £12.3m to £39m, with the Most Likely scenario being £21.8m worse than plan. The report alerted the Committee that the forecast deterioration ranges from £12.3m under the Best Case scenario, £21.8m Most Likely, and £39m Worst case. J Green outlined the risk assessment, CIP and revenue forecast outturn for the most likely scenario to the Committee. J Green noted an error on 'best case column' on slide 10 and stated that he would amend the report in advance of the Trust Board meeting. J Green also highlighted the cash scenario forecast to the Committee. Under the Worst Case scenario the Trust would require cash loans from either System Partners or NHSE beginning January 2024, this includes the agreed cash transfer to The Dudley Group from WHT and RWT. J Green outlined the next steps: • Continuation of Divisional Finance reviews, challenging Divisions to reduce the rate of expenditure • Further development of pipeline efficiency schemes by the Efficiency Team supporting Divisions • Detailed review of pay/workforce growth (already underway) with a focus on Bank usage reduction as the substantive level of staff increases • Incorporation of any System wide identified benefits arising from the output of the work undertaken by the appointed System partner (PA Consulting) • Executive Team review and challenge of financial performance to drive improvement. J Dunn expressed concerns stating that the best case scenario was aspirational and not achievable as it was reliant on external factors i.e. NHSE. J Dunn asked that J Green emphasise this at upcoming meetings and that the best case for the Trust is the "most likely" case. L Cowley queried the cash transfer to The Dudley Group, highlighting that J Jones from Audit Committee was very clear that a cash transfer should not be completed without board agreement if placing the Trust in a deficit cash position. M Levermore also queried the impact of not transferring the £20m in terms of the likelihood of not being able to pull down any loans and the impact on patients if the funds were not transferred. M Levermore requested a breakdown of the investments that have led to the £12.5m deterioration. J Green clarified that the values were quantified on slide 7 of the report. J Green agreed further discussions need to take place across the ICS regarding the cash position. L Cowley queried which Committee would be discussing the close monitoring and management of staffing mix and bank, whether it would be at PODC or F&P Committee. J Dunn clarified that this would form part of the forecast outturn plan which would be monitored by F&P Committee and that the mechanisms would be driven by PODC, while being reported to F&P against the financial outturn. G Nuttall confirmed that PODC will sign off the processes that teams will take forward and clarified that processes are in place	**JG**

	for the use of agency and vacancy control panel and that accountability would sit with F&P Committee. G Nuttall confirmed that there was a need to look into this in more detail going forwards. **Trust Board alert:** • **'Most Likely' is the Trust's current position.** • **Further work is taking place to reduce the run rate, which would give an upside to £48m within the 'Most Likely' scenario.** • **Continued focus and drive is taking place to improve recurrent CIP.** • **The Committee asked J Green to stress that the Trust's best case is the "Most Likely" scenario at the ICB meeting on 22nd September.** • **The Committee will continue to examine ways to reduce the risk of £7.8m.** The Committee noted the likely deterioration in financial performance for the 2023/24 financial year, acknowledged the deteriorating cash balance position, and the potential need for cash loans under the Worst Case scenario and received the report for assurance and for onward briefing to the Trust Board.	
097.02	Monthly Financial Report – M Greene provided the following highlights from the report:	
097.02.01	System Update – The ICB is reporting a YTD deficit of £71m, £25m adverse to plan (2.1%) with 6 out of 8 organisations running deficit positions. The system has a number of significant demand pressures, including Mental Health and prescribing, as well as the cost of industrial action and excess inflation. There was also CIP underperformance of £8m (largely within 4 organisations), and £3.5m of agency spend above plan; although at 2.5% of gross staff expenditure, this is still within system cap. These are partially supported by other underspends elsewhere. The ICB has a YTD underspend against its planned capital allocation spend of £18.1m (58%) but is forecasting to spend its total allocation of £86.3m.	
097.02.02	Overview of Financial Performance – The Trust is reporting an in month adjusted deficit of £4.6m, this is £850k adverse to plan, this leads to a year to date deficit of £25.4m which is £4.7m behind plan. Income is £1.8m favourable to plan in month and £0.3m favourable YTD. In month pay expenditure has overspent by £2.0m. This is due to a number of reasons including: £278k for cover for the junior doctors strike, £647k relating to temporary medical staffing covering gaps in the rota and other absences, £801k in nursing areas where there has been cover required for increased sickness, maternity and annual leave as well as some patient acuity requirements. There is also an overspend in month of £500k due to the medical pay award being accrued in month, but the Trust receiving insufficient funding to cover the costs. Non-pay is also overspent in month by £859k. Year to date the position is also overspent, Pay is £7.5m overspent including, £2.2m strike costs, £3.1m medical staffing cover, £3.2m nursing cover for sickness etc, vacancies in other areas offset this cost. Non pay is overspent by £2.5m of which £3m relates to activity case mix and £691k on utilities due to the broken CHP and £200k water increases which has now been repaired.	
097.02.03	CIP – In-month delivery of £3.30m against a target of £2.42m. Against a YTD target of 9.76m, £7.07m has been delivered, of which 25% is recurrent. The Trust is forecasting savings of £23.83m, of which £12.6m is forecast to be achieved recurrently, this equates to 28% of the total CIP target.	
097.02.04	Cash Against Plan – £38.6m planned v £54.7m actual.	
097.02.05	Covid 19 Expenditure – In month 5 there was expenditure of £118k on testing and £43k on Covid Medicines Delivery Unit. (Year to date £534k and £192k respectively). Income is received for both of these services to offset the costs.	
097.02.06	Capital – The CRL is £2.3m YTD, the Trust is managing some forecast pressures for year end.	

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

	In Month Actual	YTD
Income	£'m	£'m
Patient Income	62.18	292.64
Other Income	13.13	70.21
Total	**75.32**	**362.85**
Expenditure	**79.91**	**388.29**
Surplus/(Deficit)	**(4.60)**	**(25.44)**
Planned Surplus/(Deficit)	**(3.75)**	**(20.75)**
Variance to Plan	**(0.85)**	**(4.69)**

097.02.06 BPC Metric – M Green stated that the Trust was meeting the national standards.

097.02.06 Walsall Debt – Work continues to take place to resolve £1.7m of the WHT debt.

The Committee received and noted the report that had been submitted for assurance.

Advice to Trust Board:
The Trust position and System position will be submitted for advice to Trust Board.

097.03 Financial Recovery Group Report – D Gritton provided an update as follows:

097.03.01 2023/24 CIP Summary – Against an in-month target of £2.4m, the Trust has achieved £3.3m; £0.9m favourable against plan. This is largely due to additional non-recurrent schemes being identified in the month, many of which include YTD catch up. YTD CIP delivery is £7.1 against a plan of £9.8; £2.7m adverse. 33% of the in-month achievement is recurrent, however only 25% of the year to date achievement is recurrent. Due to the phasing of the efficiency plan, the savings required to hit the plan increase in each quarter (plan savings are £2.4m in each month of Q2, £4.6m in each month of Q3 and £6.4m in each month of Q4). The CIP forecast and pipeline schemes have been reviewed in detail and savings of £21.3m are expected to be achieved in year, with 59% of these expected to be delivered recurrently (£12.64m). The full year recurrent value of schemes is £13.4m.

D Gritton stated that Division 1 held a surgery where each Directorate reported on a dashboard which will be worked through on a monthly basis for GIRFT, Model Hospital and CIP. This will be rolled out across other Divisions going forward. The ICB combined pipelines have been examined and some possible opportunities have been identified

D Gritton gave an update on Medicines Management, explaining that the first Rheumatology biosimilar is underway with an in year value of £135k, Gastroenterology biosimilar switch is underway with a value of £83k. D Gritton informed the Committee that progress has been made with Lucentis in Ophthalmology, the 12 – 16 week swap over has identified a potential £750k in year saving. D Gritton stated that a PID is also being developed for FP10 prescriptions. L Cowley queried the saving for Lucentis as Black Country Ophthalmology had identified £2.4m savings for RWT. G Nuttall clarified that the savings identified for Lucentis are prudent and that savings will be recalculated once embedded.

J Dunn asked that D Gritton liaise with J Green regarding any emerging potentials. **DG/JG**

L Cowley expressed concerns that under 18s were excluded from DNAs and that there was some evidence to suggest that they have the highest level of non-attendance. L Cowley also raised concerns that the current DNA campaign was less engaging than it should be. D Gritton stated that the volunteers are contacted the patients and agreed to share the feedback once it was available.

	The Committee noted the report.	
097.04	Grip & Control Verbal Update – J Dunn asked how grip and control was being reported to the Committee and requested an update. J Green confirmed that a response has been submitted into the ICB and that he will work with G Nuttall to produce a report for F&P Committee so that the Committee can provide a plan and give the Trust Board some assurance. G Nuttall confirmed that an update will be provided and that some HR updates are required across the ICS/ICB. M Levermore queried the impact of restrictions on recruitment on natural waste i.e. retirement. G Nuttall clarified that a weekly Vacancy Control Process (VCP) takes place via the Directorates/Divisions/Executive Directors who sign off the vacancies on a weekly basis, so if someone retires the process is clear when reviewing and scrutinising the applications.	**JG/GN**
098/2023	**Board/Pre-Board Approval Reports**	
098.01.01 098.01.02 098.01.03	J Dunn clarified that an extraordinary meeting will be scheduled to take place for the business cases and contract awards that did not meet the requirements for the meeting today. Public Sector Decarbonisation Scheme (PSDS) Phase 3C Progress (System Bid) Update – S Watson outlined the requirements of the formal application for the next phase of capital funding, informing the Committee that an application will need to be lodged via the on-line portal on 10th October 2023. Solar Farm Progress – S Watson clarified that the alignment of the HV Ring Main works, the installation of the additional boundary fencing, the finalisation of the National Grid works and approval of the Project Agreement for the operation and maintenance of the site all require completion before the Trust can look to commence receiving the clean green energy from the Solar Far. **The Committee noted the progress completed to date and the further work which required completion.** The Committee: • Noted the progression under Phase 3B of the PSDS programme and the significant efforts currently taking place to ensure the programme is delivered in line with the funding conditions for RWT and WHT together with WMAS and SWB. • The Committee noted the position regarding the progression and delivery of the Solar Farm and the aspects of work that remain outstanding before the Trust can look to utilise the energy set to be generated by this new facility. • The Committee noted that further endorsement and approvals of the Solar Farm operational and maintenance contract (along with other PSDS Technologies) will be presented to the Committee soon following the final review of the Trust Finance teams and the provision of the final contract documentation by the Trust Legal Team. • The Committee noted the position and potential direction of travel of the Phase 3C application process alongside our Black Country partners and the role in which RWT teams will continue to play in this process. M Levermore queried if capital funding is front ended or retrospective. S Watson clarified that the Trust undertakes the investment and draws it back down after providing evidence to funders.	
0992023	**Governance**	
099.01	BAF Update – The revised BAF update was discussed and noted any issues for the following risks:	

099.01.01	SR15 – The review recommendation was that the Trust consider moving the score to 5 x 5 = 25 unless the gap in funding predicted for year-end can be closed significantly. The Committee agreed to the revised score. A discussion took place regarding the risk definitions. G Nuttall challenged the proposal stating that despite the current financial difficulties it was not impacting on clinical services and that there was concern regarding clinical harm. Further discussion took place amongst the Committee members and it was felt that the criteria should be re-examined. J Green to revise the percentage of turnover so that the criteria can be revised. The Committee noted the score but queried if the rules that give the score are correct in the financial situation and asked that J Green and K Wilshere to have a debate with the Executives and report back on the findings. No change to the score at present.	**JG/KW**
099.01.02	SR16 – The level of risk was agreed.	
099.01.03	SR18 – The level of risk was agreed. N Bruce has been asked to attend future Finance & Productivity Committee meetings and a quarterly update will be added to the work plan once timings have been agreed.	
099.01.04	9a Emerging Risk Wolverhampton ICP/Place Collaboration – The need for the risk was discussed. S Evans queried if the Integration Committee should review and consider the risk for a recommendation to P&F Committee. L Cowley agreed with the suggestion and stated that there was likely to be a potential review of all of the Committees to consider which BAFs would be discussed at each meeting, with the introduction of the new Committee. The merging risk would be retained here until Integration Committee decide. The Committee agreed that there was nothing further to add to the watch list. The Committee noted the BAF update.	**LC**
100/2023	**Reports to Note**	
100.01	NHSI Monthly Return – The report was noted.	
100.02	Annual Work Plan – The work plan was noted.	
100.03	Capital Report – The report was noted.	
100.04	Supplementary Finance Report – The report was noted.	
100.05	Temporary Staffing Dashboard – The report was noted.	
100.06	High Value Contract Report – High Value Contracts for upcoming approval: • Car Parking & Security Services (renewal 31/12/23) – to be added to FPC October agenda. • Supply Sleep Therapeutics & Consumables (renewal 1/9/23) – to be agreed outside of the meeting process due to contact renewal date. • Pathology Molecular Managed Service (renewal Q4 23/24) – To be added to FPC October agenda.	
100.07	Contracting & Business Development Update – S Evans informed the Committee that the Trust was likely to receive funding for the Pediatrics Business Case and that he would brief the Committee once written confirmation has been received. The report was noted.	

100.08	Sustainability & Green Plan Update – The report was noted.	
101/2023	**Any Other Business**	
101.01	Meeting Reflection – The Committee felt that there had been good challenge and a lot of necessary debate had taken place.	
101.02	CEO Highlights – Nothing further was raised.	
102/2023	**Date and Time of Next Meeting**	
	The next meeting is scheduled to take place on Wednesday 25th October at 8.30am via MSTeams. All report leads were asked to ensure that their reports are emailed in pdf format to claire.richards12@nhs.net by 12noon on Friday 20th October.	

Minutes of the Finance & Productivity Committee

Date	Wednesday 25th October 2023
Venue	via MSTeams
Time	8.30am

Present:	
John Dunn	Non-Executive Director & Deputy Chair (Finance & Productivity Committee Chair)
Lisa Cowley	Non-Executive Director
Gwen Nuttall	Chief Operating Officer & Deputy Chief Executive Officer
Professor Martin Levermore	Associate Non-Executive Director
Kevin Stringer	Group Chief Financial Officer
Alan Duffell	Group Chief People Officer
James Green	Operational Director of Finance
Tim Shayes	Deputy Group Chief Strategy Officer (Part Attendance)
Mark Greene	Deputy Chief Finance Officer (Part Attendance)
Dean Gritton	Group Manager, Oncology, Haematology, Radiotherapy & Palliative Care
Adam Race	Director of Operational Resources & Organisational Development
Claire Richards	Executive PA to Group Chief Strategy Officer (Minutes)

Attendance	
N Joy-Johnson	Director of Procurement – North Midlands & Black Country Procurement Group
S Watson	Director of Estates Development

103/2023	**Apologies for Absence** Apologies were received from Lord Carter, S Evans and N Bruce.	
104/2023	**Declarations of Interest** There were no declarations of interest.	
105/2023	**Minutes of Meeting Held on 20th September 2023** The minutes of the meeting from 20th September were agreed.	
106/2023	**Action Points from the Previous Meetings**	
106.01	Formal Directive re REAF Governance Process (Action 1232) – J Dunn confirmed that K Stringer has shared the directive regarding the formal REAF governance process with the Audit Committee and that it now needs to be circulated. J Green confirmed that a letter had been produced and shared for comment. The letter is being finalised and will be distributed to Budget Managers during the next week. **Action completed.**	
106.02	ECR Summary (Action 1404) – J Dunn asked T Shayes to ensure that the summary for the ECR is refreshed each month going forwards. T Shayes confirmed that the summary is refreshed each month and will continue to be, the targets themselves do not change frequently which explains the similarity between reports. **Action completed**.	
106.03	Home Office Announcement (Action 1405) – G Nuttall and M Levermore to discuss the potential influx of migrants impact on planning assumptions outside of the meeting once the Home Office information is available.	**ML/GN**

106.04	Amendment to Self-Assessment Table (Action 1406) – T Shayes circulated a revised self-assessment to L Cowley and J Dunn advising that F&P Committee will oversee all metrics in the first instance, some are reported on currently but the remaining will be added in future months (as advised in email). **Action completed**.	
106.05	62 Day Wait Screening (Action 1407) – The action was updated to show that the reduction in 62 day wait screening was due to a combination of breach reasons as opposed to a specific theme – 11 breaches in total, of which 3 were complex pathways, 2 pathology delays, 2 patient choice, 2 diagnosis delays and 2 late tertiary referrals. **Action completed.**	
106.06	Stroke Metric Amendment IQPR (Action 1408) – The report was updated, the figures have been checked and are correct. **Action completed.**	
106.07	Winter Plan Circulation (Action 1409) – G Nuttall confirmed that the Winter Plan has been circulated to J Dunn. J Dunn stated that Trust Board had asked for measures to be included for Elective Recovery. G Nuttall stated that the Winter Plan actions will be discussed at the next Finance & Productivity Meeting. **Action completed.**	
106.08	Forecast Outturn Amendment to Slide 10 (Action 1410) – J Green amended slide 10 and presented the report to Trust Board. **Action completed.**	
106.09	Emerging CIP (Action 1411) – Regular meetings and process is in place to capture emerging schemes. **Action completed.**	
106.10	Grip & Control Report (Action 1412) – The report has been provided as an agenda item, see item 107.03 within the minutes. **Action completed.**	
106.11	BAF SR15 (Action 1413) – The Committee members asked that the risk criteria be re-examined. Proposed use of national escalation levels as proxy for financial impact agreed to be proposed and included in the next revision of Board Assurance Framework in November 2023. **Action completed.**	
106.12	9A Emerging Risk Wolverhampton ICP/Place Collaboration For Discussion at Integration Committee (Action 1414) – L Cowley confirmed that the risk has been moved to the Integration Committee and that they will see how the risk emerges. **Action completed.**	
107/2023	**Performance**	
107.01	Grip & Control Update – The paper reported that the Trust is in a relatively strong position with regards to the reported financial controls and governance checklist which will be regularly reviewed through FRG with regards to agreement of required improvement actions where sub-optimal, monitoring delivery of agreed actions, and ensuring existing controls remain suitable in the context of a changing environment and other best practice examples. J Dunn queried how effective the measures were and sought assurance. G Nuttall referred to the mechanisms highlighted within the report which are linked to financial spend, alongside workforce and operational and quality elements. G Nuttall felt that the challenge would be around the robustness of the process and clarified that some areas are better than others and that there were still some challenges around Procurement which are being explored. G Nuttall also stated that some of the key actions regarding workforce and pay rostering will take time to implement. J Dunn agreed that there were a lot of comprehensive actions in place and queried whether it was delivering. A Race confirmed that the grip and control checklist was progressing well and was being implemented but felt that the output would be unknown until the financial outcome becomes clear.	

	A Duffell informed the Committee that Sir David has asked for a Workforce Overview and that this is being worked through and clarified that numbers are unlikely to reduce unless exploring redundancy or reducing of services. J Dunn confirmed that those options were not being explored. J Dunn queried if redeployment options could be considered to ease bank/temporary staffing costs. A Duffell confirmed that this was an area of focus. L Cowley expressed concerns regarding item 4 Financial Improvement Communications and felt that this needed further development. J Green outlined the Communications in place. L Cowley asked that this narrative be included within the status. J Dunn stated that a key piece of work was needed to link the priorities with a robust communication plan. J Dunn asked that the People Committee look into this. L Cowley queried if the amendment referred to against the Committee ToR item 5 had been completed. The ToR will be amended to include an additional point "To allow recommendations to the ICB for remedial actions if necessary and increase the Trust NED representation". **Action closed.** L Cowley requested clarification regarding the Workforce and Pay slide regarding the accurate recording of rostering and contracted hours. A Duffell stated that there was a variation between contracts and shift set up on the system which has to be adjusted and reflected back at Divisional levels. A Duffell confirmed that the system tells the Divisions the data and they work through this with the teams. L Cowley queried where the action would be reported. J Dunn confirmed that the reporting would need to come to Finance & Productivity Meetings going forwards. A Duffell to report back at the next meeting. J Dunn summarised that the Committee has received a lot of assurance and that there were a lot of actions in place, however, due to the immaturity of the actions the Committee are unable to give full assurance to Trust Board at this point. The Committee will revisit this again to see if Grip & Control is helping in our financial challenge.	**JG** **AD**
107.02	<u>Elective Care Recovery (ECR) Programme</u> – T Shayes provided the following highlights from the report: Advise: • Having plateaued towards the end of 2022/23, our waiting list has risen steadily since the turn of the year, primarily because of the continued instances of industrial action. • The Trust delivered 104% of activity in September (compared to 2019/20) compared to a plan of 107%. On a value weighted activity basis, this equates to 104% (compared with a plan of 107%). • Year to date, our activity performance stands at 105% (versus plan of 107%) and our value weighted activity performance at 106 (versus plan of 108%). • A plan has been developed to meet the requirement for 90% of patients waiting over 12 weeks to have been validated within the last 12 weeks, by the end of October 23. Alert: • The Trust remains in Tier 2 for cancer performance with no further clarity over the criteria for existing. • The Trust is not currently achieving the 78-week breach standard with 50 breaches at the end of September compared to a target of zero. • The Trust is currently behind its trajectory for 65-week breaches with 1,145 breaches compared to a target of 479. The Trust expects to recover this performance by the end of the year in line with the additional activity that has been procured. • The Trust has fallen below its trajectory for diagnostic recovery – this is isolated to non-obstetric ultrasound in particular with a recovery plan in place to utilise an insourcing provider.	

	Assure: • The Trust has a route to zero for 78-week patients – it is expected that this will be achieved by the end of November 23 through the plans detailed within. • The Trust is in line with its recovery trajectories for cancer backlog and the faster diagnosis standard. • The Trust is on its trajectory to clear 65 week waits by the end of March 24 although some first outpatients will breach the October standard In Urology, gynaecology, cardiology, rheumatology and community paediatrics. • Detail is provided within the report to demonstrate the Trust is maximising the usage of the independent sector. T Shayes also stated that there is greater emphasis from NHSE to encourage Trusts to maximise the use of the independent sector or insourcing. J Dunn summarised that performance had been good in month but highlighted an issue with the 78 week target due to consultant illness. J Dunn queried if a plan was in place to address long term performance across the specialities providing difficulties. T Shayes stated that the insourcing proposals are running for a number of months and are providing medium term support going forwards. L Cowley reported that she had asked some additional performance questions outside of the meeting and had received useful feedback from G Nuttall and T Shayes. L Cowley queried if there was a way to identify savings that had been made to off-set the costs from the implementation of the Waiting List Validation measure. L Cowley stated that she would be happy to liaise with G Nuttall outside of the meeting regarding some potential opportunities which could assist with virtual ward and Ophthalmology. G Nuttall clarified that the demand and capacity plan targets are known for next year and that this will be modelled. There are 3 – 4 specialities which require more detailed work; Urology, Gynaecology, Ophthalmology, Oncology and Neurology (inc SaTH) which are listed in a priority order. G Nuttall stated that validation has become a centralised focus and that the most affordable way for the Trust to complete this is via text as it is quite resource intensive. J Dunn asked G Nuttall to submit a Demand and Capacity Update to the January Finance & Productivity Committee Meeting. This item has been added to the work plan. **Action closed.** J Dunn noted the success of the activity and performance to date. The Committee noted the report.	
107.03	National & Contractual Standards (IQPR Extract) – G Nuttall highlighted page 17 of the report and stated that overall ED performance against the 4 hour wait has been stable during September. G Nuttall informed the Committee that the Trust benchmarks well nationally and is 1 out of 10 Trusts achieving over 76% for time spent in ED. However, there is some deterioration in waiting times for handovers and delays for waiting times in the Emergency Department. The Trust is benchmarking in the top quartile nationally and there are concerns regarding ambulance handovers nationally. The acuity of patients has increased, there has been an increase in covid cases (from 10 to 20 on average) and the Trust has received an increase in ambulance conveyances from neighbouring Trusts. There has been a slight deterioration in the time patients spent on the stroke award in August and September due to an increase in strokes, which also occurred during the Summer. However, G Nuttall assured the Committee that performance in October has not deteriorated any further and is comfortable that the metric can be maintained. The Cancer 62 day first treatment metric significantly reduced this month, G Nuttall informed the Committee that the metric will remain low as the back low reduces. J Dunn summarised that performance has been stable, the ED is recognised within the upper quartile, the Trust is seeing ambulance handovers from adjacent sites, the Trust is	

	starting to see some pressure but patients are presenting with more acute illnesses and are walking into the Trust due to the increased ambulance waits. J Dunn stated that the Trust has good stable performance as a whole but queried if how resilient the Trust performance is if there is an impact of caused by winter pressures and covid patients. G Nuttall clarified that the Trust plan was amber/red and that it carried high risk as the Trust does not have the ability to open further capacity and are reliant on the actions detailed within the plan. G Nuttall stated that a lot of the actions within the plan were community based and the Trust was reliant on the use of the Virtual Ward. G Nuttall stated that the use of the Wolverhampton Virtual Ward is really good and is over what was predicted. The Trust will continue to perform over the levels that the Trust can staff safely. G Nuttall highlighted opportunities with the Staffordshire Virtual Ward. There are no plans to convert the elective wards. J Dunn summarised that whilst performance has been high, the Trust's resilience against winter pressures is a high risk. G Nuttall clarified that a mitigated plan is in place but that delivery is high risk and that this had been reflected in the BAF. M Levermore referred to page 13 of the report and queried if the Trust was moving away from standard practice which was resulted in an increase in falls. G Nuttall suggested that this query be taken to the Quality Committee Meeting for discussion. The item was discussed at Quality Committee and fed back to M Levermore. **Action closed.** The Committee noted the report.	
108/2023	**Financial Performance**	
108.01 108.01.01 108.01.02	<u>Monthly Financial Report</u> – K stringer provided a brief update and highlighted the need to understand issues with the deficit plan and most likely forecast outturn. K Stringer highlighted a focus on agency breaches on and engagement of staff 'off framework' (national contracting arrangements), the number of shifts, values and price cap breaches for staff engaged through framework arrangements. K Stringer stated that the Trust needs to focus on the data being sent to the ICB, identifying responses why off framework agencies are being used, the value and any trajectories which need to be improved. K Stringer informed the Committee that Sir David Nicholson has asked K Stringer and A Duffell to look into this in more detail. J Dunn summarised that the Trust is still on trajectory to meet the 'Most Likely' outturn but that there are risks there. <u>Overview of Financial Performance</u> – M Greene provided an update on the month 6. The Trust is reporting an in month adjusted deficit of £3.7m, this leads to a year to date deficit of £28.8m which is £4.4m adverse to plan. The run rate has improved in month but the Trust is still adverse to plan. The Trust has released £8.5m YTD benefit from the balance sheet, which is £2.1m more than planned to release at this point in the year. Capital spend has increased but is still behind the original plan however the Trust is forecasting to achieve planned spend by year end. M Greene clarified that the nil spend against on PDC is due to the delays experienced by the EPR business case but is forecast to be achieved. <u>Cash Against Plan</u> – The cash balance as at 30th September 2023 is £44.5m actual against £32.8m planned. M Greene highlighted that cash is being looked at across the ICB as a number of organisations will experience cash challenges by the end of next year. J Dunn summarised that during month 6 the Trust has a deficit of £28.8m YTD compared to ta full year planned deficit of £26.75m, most likely position is £48m, there has been some improvement on run rate but there has been no major change and that there is a need to maintain the current run rate. A Race clarified the agency rules for Wolverhampton and referred to the report that Sir David Nicholson had requested for Trust Board. A Race stated that the report would be submitted to Finance & Productivity Committee in November ahead of the Trust Board Meeting. A Race clarified that the Trust was reporting 2.4% off framework for agency which	

is related to a Doctor hard to fill speciality who will move onto agency framework in December. The Trust is 45% above cap for agency which is primarily due to Doctor costs which is on par with comparator Trusts but that work is progressing to try to reduce it going forwards. J Dunn asked if the same degree of control in terms of expenditure was in place for Doctors that were in place for Nursing staff. A Race confirmed that there was a similar sign off procedure within the Division but because of the rates of pay or anything off framework it requires additional sign off by G Nuttall. G Nuttall confirmed that controls were in place and in terms of non-framework Doctors sometimes costs are cheaper and that the Trust tries to use framework where possible, however, the price paid per hour is higher than inflation and it is a national impact. G Nuttall confirmed that the Trust has standardised bank rates and that there is planned further challenge around management of rotas going forward. A Duffell stated that medical staff are paid by Pas completed and that job planning is examined by People Committee.

108.01.03 Covid 19 Expenditure – In month 5 there was expenditure of £116k on testing and £53k on Covid Medicines Delivery Unit. (Year to date £649k and £245k respectively). Income is received for both of these services to offset the costs.

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

	In Month Actual	YTD
Income	£'m	£'m
Patient Income	59.87	352.51
Other Income	11.74	81.94
Total	**71.61**	**434.46**
Expenditure	**74.97**	**463.26**
Surplus/(Deficit)	**(3.36)**	**(28.80)**
Planned Surplus/(Deficit)	**(3.69)**	**(24.45)**
Variance to Plan	**0.34**	**(4.35)**

108.01.05 J Dunn summarised good performance in month 6 and that there needed to be more focus on temporary staffing going forwards. The Committee received and noted the report that had been submitted for assurance.

108.02 Forecast Outturn Update – J Green outlined the contents of the presentation, providing members with a briefing on the forecast outturn calculations for the 2023/24 financial year. Members were briefed that the revenue forecast outturn position is expected to deteriorate from the planned deficit of £26.75m. The Committee were alerted that the forecast deterioration ranges from £12.3m under the Best Case scenario, £21.8m Most Likely, and £39m Worst case. The Worst Case scenario would also require that the Trust require need cash loans from either System Partners or NHSE beginning January 2024.

During the past month it has been signalled to Dudley Group NHSFT the Trust will be unable to transact the planned cash support of £20m owing to the deteriorated financial position and have advised that a solution across the whole ICS needs to be negotiated to address the cash shortage in a number of organisations. All providers have since agreed that a proposal will be considered through the Directors of Finance Group aimed at addressing the challenge within the System if possible but failing that to seek cash loans from NHS England.

Divisional reviews have again taken place to understand and challenge the financial performance, however limited improvements have been identified through those sessions. They will continue on a monthly basis. In addition to the financial reviews, meetings regarding workforce growth have been undertaken with Divisions to understand the reason for the growth in workforce since end of March.

Next Steps were outlined as follows:

	The Trust is not formally requesting a revision to the Trust plan at this point in time, however, it is the most likely outcome as the Trust progresses through the next few months. The timing of any revision to plan will need to be synchronised with Trust Board meetings and be in place before the end of Q3. During months 6-8 the following next steps will be actioned with the intention to improve the position wherever possible, but also to refine the current estimated outturn position. • Continuation of Divisional Finance reviews, challenging Divisions to reduce the rate of expenditure • Further development of pipeline efficiency schemes by the Efficiency Team supporting Divisions • Further scrutiny of pay/workforce growth with a focus on Bank usage reduction as the substantive level of staff increases • Incorporation of any System wide identified benefits arising from the output of the work undertaken by the appointed System partner (PA Consulting) when known. • Executive Team review and challenge of financial performance to drive improvement K Stringer queried if the Trust has reconciled headcount at Trust and Speciality level. J Green stated that there is a breakdown of the bridge dating back to 2018/19 and that further work is taking place to look into the data. K Stringer asked J Green to provide the information by 27th October. A Duffell and J Dunn also requested a copy of the headcount data once available. J Dunn queried what the risk was of the Trust not achieving the "Most Likely" outturn. J Green stated that the remaining risk was the run rate, delivery of ERF and Winter pressures. J Dunn asked J Green to quantify the amount. G Nuttall stressed the importance of focusing on elective activity over the next couple of months. J Dunn requested clarification regarding the run rate. G Nuttall stated that she was expecting improvements to the run rate going forwards and that the target would be achieved. J Dunn stated that it was key to provide assurance to Trust Board that plans are in place to achieve or improve on the run rate. L Cowley queried if the system challenge and support cost contracts are linked to cost savings i.e risk and reward payment. K Stringer confirmed that the PWC support was not linked to a cost saving and that he would investigate if the PA Consultancy contract was and report back on his findings. L Cowley expressed concerns regarding this and asked that K Stringer pass on the Committee's concerns where possible. K Stringer informed the Committee that he had requested a risk and reward payment contract to be put into place during the assessment process and that the concerns had already been expressed. A Duffell confirmed that the Trust is looking to hold the current vacancy position at present. G Nuttall stated that there needed to be a discussion on how the PA work is being proposed and discussed once it is made available. K Stringer referred to slide 7 within the pack and asked for more detail against the run rate difference to the deficit plan and why and percentage turnover of CIP. J Dunn summarised that; excluding those items outside of the Trust's control (e.g. strike cost reimbursement, funding for excess inflation, etc.) there is £1 – 2m risk of achieving the target, there is a need to focus on run rate, ERF and CIP improvement. J Dunn highlighted a need to understand the impact of the headcount and J Green will be providing an update to K Stringer and the Committee by 27th October. Discussion took place regarding the cash flow and prudent action has taken place to ensure the cash situation at RWT is maintained and discussions are taking place at System level regarding this. The Committee noted and discussed the content of the report. The Committee received the report for assurance and onward briefing at Trust Board.	**JG** **JG** **KS**

108.03	National Cost Collection Update – The Committee were asked to review the costing plan and supporting information for the National Cost Collection (NCC) of 2022/23 patient level costing information. The assurance report was submitted as a requirement of the Approved Costing Guidance. The report confirmed that there is an adequately resourced costing team with the necessary costing software needed to successfully complete the NCC on time. There is a project plan in place which the team is working in-line with and a series of validation checks are in place to test the outputs prior to submission. There have been a number of improvements made over the year to improve the quality of costing information as a result of post submission reviews of 2021/22 information. The costing team asked that the Committee approves the current plan and process in place as being sufficient to assure the Trust Board on the plan to complete the mandated costing submissions for 2022/23. A second NCC report will also be submitted before December which will outline the outputs of the collection. The Committee noted the contents of the report and received assurance. The Committee approved the current process in place as being sufficient to assure the board on the plan to complete the mandated costing submissions for 2022/23.	
108.04 108.04.01 108.04.02 108.04.03 108.04.04	Financial Recovery Group Report – J Dunn stated that the Committee would complete a deep dive into CIP at next month's meeting. The work plan has been updated to reflect the request and the deep dive has been included within the agenda. **Action closed.** D Gritton stated that the team had now received the slide pack from PA Consultancy and that work would progress to go through the pack to see if any opportunities are available to the Trust. D Gritton stated that the information pack contains information regarding Outpatients, PIFU and work with the Health & Justice Commissioners. D Gritton highlighted some potential funding which may be available via Health & Justice Commissioners and stated that he would share this information with J Green. D Gritton stated that the pack also includes information regarding drug saving opportunities and work with blue tech and the list of biosimilar work which needs to progress. G Nuttall stated that there was a need to provide quarterly updates on Outpatients, drug elements and to do deep dives within the pack at future meetings. L Cowley raised concerns regarding negative feedback she had received regarding the DNA campaign and fed this back to the Committee. G Nuttall reported that the campaign had followed national guidance and that this would be picked up via patient groups separately. The Committee noted the report.	
109/2023	**Financial Planning**	
109.01	Long Term Financial Plan (LTFP) – J Dunn stated that an extraordinary meeting will be arranged to discuss the paper in depth. J Green confirmed that a separate 1 hour workshop meeting will be arranged within the next 2 weeks to allow more focus time. The planning paper sets out the estimated financial plan over the next 5 year period based on currently know assumptions. J Dunn asked J Green to agree a timeframe for when the meeting can take place. M Levermore queried if J Green had assumed any reduction in headcount or other forms of cost reduction to assist with recovery. J Green stated that a reduction in headcount had not been specifically included and that the plan allows for a modest amount of activity growth. The plan assumes ERF continues and assumes that the Trust achieves the CIP at 4% each year. M Levermore asked what other assumptions had been built into the plan to achieve greater income. J Green stated that achieving the CIP plans may manifest in a	**JG**

	reduction in headcount but the plan at present doesn't specifically describe a reduction in WTEs. L Cowley felt that an unfunded inflation line should be specifically identified within the plan going forward. The Committee noted the report.	**JG**
109.02	Supplies & Procurement Report – N Joy-Johnson provided the following highlights from the report: • The RWT 2023-24 forecast Trust Procurement related bottom line savings position of £3,280,229. • The report provided an update on the existing North Midlands and Black Country Procurement Group (NMBC) model. • The report provided an update on the Wider Procurement collaboration/consolidation across the Staffordshire & Stoke-on-Trent and Black Country Integrated Care Systems (ICS's), including a key update on the outcome of the recent review of the future Procurement target operating model in the Black Country ICS led by the Black Country ICB/Provider Collaborative Executive. • N Joy-Johnson highlighted further workforce challenges, supply chain resilience challenges and third-party goods and services inflationary pressures. Work continues with supply chain partners to address and resolve product resilience issues. • N Joy-Johnson provided the Committee with an update on working with the new NHSE Central Commercial Function (CCF) and NHS Supply Chain and other National Partners. • N Joy-Johnson ensured that the Committee were briefed on the developments on Ecommerce: Atamis, GS1, Inventory Management and Catalogue Management Capability. • The report provided an update on Clinical Procurement – an update on Clinical Standardisation and Sustainability and an update on the Key Black Country Pathology Procurement Related Work Streams. K Stringer stated that PA Consultancy had suggested working with Dudley and Sandwell to drive more savings out by aligning work plans. K Stringer queried if this would be an opportunity. N Joy-Johnson stated that this was already happening and it is not an updated position. N Joy-Johnson stated that he would be meeting with PA Consulting on 26th October 2023 as a first initial meeting. The Committee received and noted the update.	
110/2023	**Board/Pre-Board Approval Reports**	
110.01	CDC Phase 2 Contract Award – The proposal sought approval to provide additional Ultrasound Rooms that are needed to complement the new Community Diagnostic Centre (CDC) which will significantly increase capacity across the majority of diagnostic modalities to become a full CDC in the Northern Hub at Cannock Chase Hospital. The report provided assurance that contracts are being awarded in line with Trust Standing Orders. The Capital costs are being funded by CDC NHSE Capital Funding, included in the Trusts Capital Programme and supports the Estates Strategy 2020-2025 previously approved by the Trust Board. The CDC Phase 2 Contract Award has been deemed value for money and is suitable to endorse. To allow the funding to be expended in line with conditions that are needed to place orders with contractors to commence works on site as soon as is possible. The report recognised that challenges remain in accessing Capital Funding as the project moves forward with the 23/24 delivery programme to ensure that a contract can be awarded in line with CDC National Capital Funding conditions in a timely manner.	

	Following the review of the quotations confirming value for money and that rates for the prescribed works are in line with the Trust Contractor Frameworks the report recommended that the Committee agree to endorse the award of the contract to William Goughs & Sons Ltd at the cost of £765,480.01 (Incl VAT) together with the associated costs outlined above and to commence the works in line with the funding programme requirements. The capital costs are funded by NHS England's CDC National Capital Funding allocation and included in the Trusts Capital Programme, each of which supports the Estates Strategy 2020-2025 previously approved by the Trust Board. **The Committee endorsed and approved the report.**	
110.02	PSDS – HV Ring Main Works Contract Award – The paper sought endorsement of a further award under the Phase 3B Programme. The report noted from previous updates, that RWT led on securing funding across the wider Black Country via a "system bid" (under Phase 3B) and that it has now also lodged a similar bid under the Phase 3C opportunity in October 2023 alongside other Black Country ICS partners. Following the interviews and review of the quotations which confirmed value for money the report recommends that the Committee agree to endorse the award of this contract to ESM Power Ltd at the cost of £2,805,768.87 (£3,366,922.64 inclusive of VAT) and to commence the works in line with the programme requirements. The capital costs are funded by PSDS Phase 3B and support the Estates Strategy 2020-2025 previously approved by the Trust Board. J Dunn queried if all legal requirements had been met via a procurement exercise. S Watson confirmed that this was the case. J Dunn queried if S Watson could assure the Committee that the Contract Award was offering value for money. S Watson assured the Committee that the Contract Award complies with Standing Orders and was a competitive process and the Trust Development Cost Manager has confirmed that it is value for money. J Dunn asked for an update on commercial risk. S Watson stated that he was confident that the project was able to be delivered during the projected time and that elements had been built into the review to allow for any risks. **The Committee endorsed the placing of the Contract Award as set out in the report, to be funded by the PSDS Phase 3 capital grants funding. The Committee asked that S Watson liaise with the Finance & Productivity if costs increase higher than 10% in the paper. S Watson agreed that this was built into the existing Standing Orders.**	
110.03	PSDS – Wrekin House Cladding Contract Award – The paper sought endorsement of a further award under the Phase 3B Programme. The report noted from previous updates, that RWT led on securing funding across the wider Black Country via a "system bid" (under Phase 3B) and that it has now also lodged a similar bid under the Phase 3C opportunity in October 2023 alongside our other Black Country ICS partners. Following the review of the quotation confirming value for money and that rates for the prescribed works are in line with the Trust Contractor Frameworks the report recommended that the Committee agree to endorse the award this contract to William Gough & Sons Ltd at the cost of £1,575,532.01 (£1,890,638.41 inclusive of VAT) and to commence the works in line with the programme requirements. The capital costs are funded by the Public Sector Decarbonisation Scheme phase 3B and support the Estates Strategy 2020-2025 previously approved by the Trust Board. K Stringer queried if the cladding was fireproof and met the correct regulations. S Watson confirmed that this was the case. **The Committee endorsed the placing of a Contract Award as set out in the report, to be funded by the PSDS Phase 3 capital grants funding.**	

110.04	PSDS – Programme Update – The report provided an update on the delivery of key strategic projects under the PSDS Initiative and also provides an update on potential future funding opportunities. S Watson informed the Committee that the Trust had submitted a bid for Phase 3C iteration, however, Salix have changed the application process and have asked all organisations to apply in 2 weeks' time via a ballot system. S Watson stated that he would submit an update on the Operational Contract for the Solar Farm at the next Finance & Productivity Committee Meeting. The Committee: • Noted the progression under Phase 3B of the PSDS programme and the significant efforts currently taking place to ensure the programme is delivered in line with the funding conditions for RWT and WHT together with WMAS and SWB. • Noted the position regarding the progression and delivery of the Solar Farm and the aspects of work that remain outstanding before the Trust can look to utilise the energy set to be generated by this new facility. • Noted that further endorsement and approvals of the Solar Farm operational and maintenance contract (along with other PSDS Technologies) will be presented to the Committee soon following the final review of the Trust Finance teams and the provision of the final contract documentation by the Trust Legal Team. • Noted the position and potential direction of travel of the Phase 3C application process alongside our Black Country partners and the role in which RWT teams will continue to play in this process. • To receive further reports, where appropriate, to endorse spending on any further aspects of PSDS programme of works in the future. **The Committee noted the position regarding the delivery of contact works under the PSDS capital programme and understand recent activity associated with seeking further capital funding.** J Dunn stated that he would like to meet with S Watson to discuss the Wrekin House capital project outside of the meeting. G Nuttall stated that the operational elements are still being worked through and that an update will be provided when this has been agreed. J Dunn requested an update on the North Hub going forwards. G Nuttall confirmed that the Trust was progressing discussions with the ICB. K Stringer informed the Committee that he has asked Dr J Odum to write to D Wake to ensure that the process is clear.	**JD/SW**
110.05	Linear Accelerator Combined Service Care (REAF 1431) – K Stringer clarified that the old contract has been extended. The report will be withdrawn from this meeting and will be re-submitted for discussion at Finance & Productivity Meeting in November and then onto Trust Board in December.	
111/2023	**Governance**	
111.01	Review ToR For Captial Review Group – The revised ToR were reviewed and approved.	
1121/2023	**Reports to Note**	
112.01	NHSI Monthly Return – The report was noted.	
112.02	Annual Work Plan – The work plan was noted and the changes arising from the meeting will be incorporated and circulated at the next meeting.	
112.03	Capital Report – S Watson clarified that capital was back on track with targeted spend profile. The report was noted.	

<table>
<tr><td>112.04</td><td><u>Supplementary Finance Report</u> – The report was noted.</td><td></td></tr>
<tr><td>112.05</td><td><u>Temporary Staffing Dashboard</u> – The report was noted and it was agreed that the report would be developed and re-added into the main agenda section from next month onwards. The workplan has been adjusted action complete.

L Cowley queried if porting of staff between organisations to create a more flexible workforce could be an option to explore. A Duffell stated that this had been examined and that mechanisms are in place to allow it, however, due to travel costs it was not always financially viable.</td><td></td></tr>
<tr><td>112.06</td><td><u>High Value Contract Report</u> – High Value Contracts for upcoming approval:

<table>
<tr><th>Description</th><th>REAF</th><th>Contract Renewal Date</th><th>F&P Target Date</th></tr>
<tr><td>Pathology Molecular Managed Service</td><td>1375</td><td>New BCPS network contract – target go live Q4 23/24</td><td>22/11/23</td></tr>
<tr><td>Teletracking System</td><td>TBC</td><td>01/01/2024</td><td>22/11/23</td></tr>
</table>
</td><td></td></tr>
<tr><td>113/2023</td><td>Meeting Reflection Time</td><td></td></tr>
<tr><td></td><td>There was nothing further raised, the Committee agreed that there had been sufficient debate at the meeting.</td><td></td></tr>
<tr><td>114/2023</td><td>CEO Highlights</td><td></td></tr>
<tr><td></td><td>This item will be removed from the agenda going forwards. Action completed.</td><td></td></tr>
<tr><td>115/2023</td><td>Date and Time of Next Meeting</td><td></td></tr>
<tr><td></td><td>The next meeting is scheduled to take place on Wednesday 22nd November at 8.30am via MSTeams. All report leads were asked to ensure that their reports are emailed in pdf format to claire.richards12@nhs.net by 12noon on Friday 17th November.</td><td></td></tr>
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The Royal Wolverhampton NHS Trust

Minutes Trust Management Committee of the Board

Date	22/09/2023
Time	13:30 - 15:30
Location	MS Teams Virtual Meeting
Chair	Gwen Nuttall
Attendees	Keith Wilshere, Suneta Banga, Dr Odum, Adam Race, Nicki Ballard, Debra Hickman, Tracy Palmer, Dr McKaig, Gwen Nuttall, Prof. Singh, Nick Bruce, Alison Dowling, Shyam Menon, Beverley Morgan, Timothy Shayes, James Green, Martina Morris, Stew Watson, Iresha Pathirage, Cathy Higgins, Katherine Cheshire, Maria Arthur, Ananth Viswanath, Sian Thomas, Simon Evans, Joanna Macve, Linsday Ibbs-Geroge, Lewis Grant, Hannah Murdoch, Stephanie Cartwright, Graham Danks, Anita Macqueen, John Murphy, Magda Zajac

1 **Apologies for absence: Angela Davis, Alan Duffell, Kevin Stringer, Louise Nickell, Lee Dowson, Damian Murphy, Cath Wilson, Sally Evans, David Loughton, Kevin Bostock.**

2 **Declarations of interest**

There were no new or changed Declarations of Interests to those published on the Trust Web Site

3 **Minutes of the meeting of the Trust Management Committee held on 21st July 2023**

The minutes were approved unchanged.

4 **Matters arising from the minutes**

There were no matters arising from the minutes.

5 **Action Points list**

Digital Services – Deloittes Presentation
Trust Management Committee 21 July 2023

"*A further consultation be arranged with Mr Miah and members of the Committee who wished to have more insight with the product offered by Deloittes."*

Mr Bruce said Mr Miah was invited back and those interested from the last TMC attended a second presentation. He said it was decided that a more technical meeting needed to be arranged with Mr Miah. He felt a collection of solutions that had been offered from different suppliers including triage, care coordination and care centre solution but were not specifically Deloitte's solutions. Ms Nuttall said the action be closed and anything be brought back to TMC should it be required.

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 an increase in the waiting list due to the impact of continued strikes, which also had an effect upon delivery of services. He said there was continued focus on the number of patients waiting over 78 weeks and over 65 weeks. He said the target was to achieve zero patients waiting over 78 weeks by the end of November. He mentioned the next target was to clear the 65 week cohort by end of March. He said the Trust remained in Tier 2 for Cancer performance.

The Report was received and noted.

8 By Exception Papers – no items this month

9 Monthly Reports

9.1 Integrated Quality and Performance Report

Ms Hickman highlighted there continued to be an over trajectory with *C-Difficule*. She said no specific trend was identified but the fluctuation related to some environmental challenges particularly around decamp which continued to be pushed back for various reasons. She said colleagues were aware of this. She said cleaning within ward areas, department areas and compliance with policy was important. She said there had been communication with South Warwick Hospital as they had shown a significant decrease in *C-Difficule* cases. She mentioned decant was planned to commence next week. She said processes were being looked at on how to get trolleys deep cleaned in the Emergency Department (ED), which should take place in November.

Ms Hickman also mentioned there had been an increase in pressure ulcers and an analysis was being undertaken.

Ms Nuttall said there were 39 patients waiting over 78 weeks at the end of August which was positive news. She said the waiting times in ED the 4 hour standard, the expectation was that organisations would achieve 76% at the end of March. She said there was an incentive as part of winter planning, if organisations achieved over 80% in quarter 4 there would be a distribution of potentially some capital monies to organisations who achieved this target. She said the Trust had said it would aim for that target. She said the combined performance for RWT

placed the Trust nationally within the top 20. She said ambulance handovers remained in a positive position nationally. She said work for cleaning of the Ambulance Receiving Centre (ARC) was to commence on the 2 October. She finally mentioned a detailed cancer report was included within the agenda for the today's meeting.

The Report was received and noted.

9.2 Division 1 Quality, Governance and Nursing Report

Ms Macqueen highlighted there had been medication safety issues within the division, in particular the processes of duplicate medications with paper charts and electronic prescribing. She said a task and finish group had been created to review the issue.

Ms Cheshire said maternity activity remained high. She said progress was being made to achieve Clinical Negligence Scheme for Trusts (CNST) and Saving Babies Lives. She said the Trust would be reporting to National Health Service England (NHSE) areas which the Trust could not achieve and where mitigations were in place. She said it was recognised there was an issue with incidents which remained open for maternity over 45 days and there was positive compliance with the neonatal services. She said the issue was to be would be addressed when perinatal services would be brought into one for the governance structures. She said detailed work had been undertaken for women booking by 10 weeks and the Trust was above the national average which had been identified in the Local Maternity and Neonatal System (LMNS). She also mentioned Quality Improvement (QI) work was being undertaken to look at the variations between Community Teams and learning from excellence where there were better standards and learning could be shared. She said direct referrals for women had been opened to enable women to access a barcode and register the pregnancy themselves. She said the Trust was below the required compliance of the venous thromboembolism (VTE) level and QI work was being undertaken. She also mentioned there was an improvement with neonatal staffing. She finally mentioned neonatal service had been awarded GOLD BLISS Baby Charter accreditation and the Trust was the first neonatal intensive care unit in the region to achieve the award which was positive news.

Ms Palmer said the diversion on saving babies lives was around scanning capacity which should not effect the ability to achieve CNST Year 5 and would update the Committee in due course.

Mr Danks provided an update in relation to Black Country Pathology Services (BCPS). He said Sandwell and West Birmingham were to go live on 24 October and it was anticipated the Trust would also go live at that date. He said work was being undertaken on the installation of equipment at RWT which should be completed at the end of year. He mentioned Walsall Healthcare Trust (WHT) were to go live in May next year with the limb solution and equipment solution. He said it was anticipated there would then be full connection across the Black Country. He said work was being undertaken for histopathology performance. He highlighted there would be a change in pathway from 28 day to 10 days for the pathology element.

Mr Danks finally mentioned staff survey outcomes were not positive which was due to the transfer of services together with the department working on a 24/7 basis.

Ms Nuttall asked all to note the governance element regarding some Serious Untoward Incidents (SUIs) that had been reported. She said these being the retained products and conception and transmissible disease which had taken up a considerable amount of time. Dr McKaig mentioned he had attended a joint table top meeting with Sandwell and West Birmingham Hospital about retained products of conception which he believed had now been resolved and plans were in place. He said it was identified at the meeting that protocols and policies across the 4 acute Trusts needed to be alligned within some services. He said the second issue was transmissible disease results which was due to a glitch in IT systems and had created a significant issue. He said this was close to being resolved and it was anticipated there would be minimal harm to patients, although there had been 4 patients who had a delay of a significant diagnosis for upwards of 2 years but had not resulted in serious harm. He said a wider piece of work may be required with Sally Roberts around how to link all governance elements of BCPS back into the 4 acute organisations.

Mr Danks said he believed Ms New from the Division was attending local meetings which resulted in more linkage with each of the sites. He also mentioned the team were now reporting governance at the partnership meetings with each of the 4 Trusts. He said more work was required.

Ms Arthur asked that her team be consulted if further work was required in relation to governance issues. Mr Danks said it may assist for Ms Arthur to arrange a meeting with himself and Ms New.

Action: Dr McKaig to provide an update at the next TMC meeting following his scheduled meeting with Sally Roberts to discuss how to link all governance elements of BCPS back into the 4 acute organisations. Ms Arthur and Mr Danks to be included in that meeting.

The Report was received and noted.

9.3 Division 2 Quality, Governance and Nursing Report

Ms Morgan highlighted the Division were developing a Medical model of care under the work which was completed for the Right Patient Right Place Programme. She said there were 5 task and finish groups in progress with phase 1 to be completed by the end of October. She said positive progress was being seen with the Push Model which was being used for early morning patients. She finally mentioned the Nursing Skills Mix Risk, was a joint Risk with Division 1 and a programme of work was in place.

Ms Nuttall said the Medical Model of care which was presented to Executive Directors was positive and wider work may be required once embedded and would be a good presentation moving forward.

Ms Hickman thanked all Heads of Nursing and said there was strong leadership with the programme which was due to be launched with cohort 60. She said it should be recognised there would be many cohorts and how that would be used and rolled out across the Division could be challenging.

The Report was received and noted.

9.4 Division 3 Quality, Governance and Nursing Report

Ms Ballard introduced the report and said there was an ongoing action plan for paediatrics to improve observations on time. VTE compliance remained variable, however low numbers. She said there had been an increase in Infection Prevention Control (IPC) attributions particularly within Community. She said the Cancer Services tracking and Improvement Team were now in the Division. She alerted staffing hotspots being Dietetics and Health Visitors. She said there was ongoing recruitment and half of the Health Visitor vacancies would be filled by the end of the month which was positive news.

The Report was received and noted.

9.5 Executive Workforce Summary Report

Mr Race highlighted the vacancy rate was below 3% normalised turnover below 10% and the target was reached for retention of staff. He said there was an improvement with sickness rates and the completion of appraisals. He also mentioned the continued industrial strike action for Doctors. He said a pay award was made to medical staff of 6% which would go live next month and would include back pay. He finally mentioned the staff survey would be launched next week.

The Report was received and noted.

9.6 Chief Nursing Officer Report

Ms Hickman said the success with recruitment was recognised which had enabled the Care Hours per Patient Day (CHPPD) to obtain stability. She said there was a significant amount of support and oversight which was still required. She said due to the fact that the majority of recruitment was based on Clinical Fellowships through an international route. She said this was having an impact on skills mix. She said currently there were 13 students outstanding at the Trust that needed to be placed in the organisation and whom required support. She said work was taking on place on how to best support the students to be located within areas, whilst recognising the challenges with finances and workforce plan.

Ms Hickman also mentioned letters had been received from the Nursing and Midwifery Council (NMC) on the Computer Based Test (CBT) challenges. She said work was still in progress with individuals who had been effected being supported and the request was if there was no fraudulent activity identified for them to resit. She said there was a focus now on the International English Language Test System IELTS together with focussing on occupational health sign off.

Ms Hickman said there had been an increase in the number of Deprivation of Liberty Safeguards (DoLS) activity and thanked staff for their contribution together with the support from the Safeguarding Team. She said a review was required on the Mental Capacity Act. She finally mentioned she and senior colleagues had been undertaking nighttime assurance visits which were highlighting some concerns with operational standards overnight compared to day time activity. She said there was focus on how to review senior leadership and presence overnight and how to gain that assurance particularly around nighttime activity.

The Report was received and noted.

9.7 Finance Position Report

Mr Green said the year to date deficit was at £25 million and the end of year plan in March was £26.75 million. He said that had been submitted to the Integrated Care Board (ICB) and the Finance and Productivity Committee. He said various meetings were to take place to discuss the overall performance of the system. He said the Trust was under pressure to improve the system with focus on workforce. He said there was a growth in substantive staff but not a decrease in bank usage and this was being reviewed. He said the Cost Improvement Plan (CIP) identified two thirds and there was pressure to achieve that to 90% identified. Prof. Singh asked for Medical workforce and Clinical workforce the Clinical Fellowship Programmes whether there was a focus on staff spefically at RWT compared to the Acute Collaborative for bank and agency staff. He felt clarification was required on the figures and asked for a discussion with Mr Green after the meeting.

Ms Nuttall said the focus was on workforce numbers and the discretionary spend element on bank and agency staff.

Action: Mr Green and Prof. Singh to arrange a meeting to clarify figures for bank and agency staff for the Medical workforce and Clinical workforce.

The Report was received and noted.

9.8 Capital Programme Update

Mr Watson highlighted the revenue/capital position remained a challenge. He said it was disappointing to note that the proposal for the North Hubs, the fund that was targeted for that spend was rejected. He said the Trust was still to develop the project and other sources of capital was being looked into. He reminded all there was additional off site parking available at the Wolverhampton Swimming and Fitness Centre to support challenges on the New Cross site whilst development work was taking place on the site.

The Report was received and noted.

9.9 Operational Finance Group Minutes

Mr Green said said the minutes were for noting

The Minutes were received and noted.

9.10 Financial Recovery Group Update

Ms Nuttall said there was currently a gap of £16 million against the CIP identification target of £45 million. She said there was some positive movement in month 5. She said operationally all were aware of the Going Further Faster Programme of work around improvement to outpatients fundamentally. She said with focus on DNA reduction and patient initiated follow ups. She said Mr Gritton and the team were leading the programme with support with Dr McKaig and Ms Nuttall. She recommended if teams at the Trust were not involved with the programme that they contact Mr Gritton and the team with regard to the opportunities with outpatients. She said included within the update were details of schemes which were to be delivered. She also mentioned the Project Information Documents (PIDs), CIP schemes had been approved at the Finance Committee.

The Report was received and noted.

9.11 Black Country Provider Collaboration- verbal update

Mr Evans said the first informal Joint Provider Board Development session took place. He said all four Boards had met jointly with attendance of over 100 people. He said priorities were discussed for each organisation and how they were contributing to the work programme of the Black Country Provider Collaborative. He also mentioned the next Clinical Summit was to take place 27 October.

The Report was received and noted.

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

10.1 Black Country Pathology Services Report

Ms Nuttall confirmed the item was discussed within item 9.2 of the agenda**.**

The Report was received and noted.

10.2 Digital Programme and Strategy Update Report

Mr Bruce highlighted the EMR Contracts Awards which was the PAS replacement and wider EPR deployment. He said the data breach indemnity discussions and activity discussions around growth metrics had all been concluded successfully. He said the position was to recommend the signing of the contract. He said the governance structure and implementation plans were being reviewed. He said positive work had taken place with Care Flow Connect.

Mr Bruce said a new monitoring and protection software had been implemented for Cyber Security. He said the Trust was the first to have a regional Cyber Security across RWT and Walsall Healthcare NHS Trust (WHT) which was on call in the region and positive news. He also mentioned the convergence pathway which was in place between RWT and WHT. He said the aim was to converge systems onto a cloud based platform which would enable them to be scalable and accessible. He mentioned appendix 2 and the positive work undertaken by the information team in building the foundation for Strategic Data Universe which was expansion of the data warehouse. He said this was working towards a new information portal which was due to be released in the next financial year.

Ms Nuttall mentioned the EPR system for the PAS replacement and recommending Keely Evans who was to be the programme lead together with other staff members in Mr Bruce's team to present at a TMC meeting. She said it was a significant piece of work which would effect all staff.

Action: Mr Bruce and members of his team to provide a presentation at a TMC Meeting on the EPR system for the replacement of the PAS system.

The Report was received and noted.

10.3 Property Management Updates

The Report was received and noted.

10.4 Patient Experience Report

Ms Dowling said there had been a reduction of complaints within the Emergency Department (ED) of 30% which was positive news. She said there was focus on work with operational teams to improve the patient experience metrics particularly with Friends and Families Test (FFT). She mentioned some national CQC survey results had recently been published. She said the national inpatient survey was published in September which had positive results. She said the Trust was in the top 5 for hospital and ward operations and procedures.

Ms Dowling finally mentioned the team had been working with the Service Efficiency Team to plan and deliver a new volunteer led appointment support role particularly with gynaecology and ophthalmology to assist with reducing Did not Attend (DNA) rates and overcome barriers for patients attending for appointments.

Ms Nuttall mentioned the inpatient experience results were positive. Ms Hickman asked whether Comms had been circulated. Ms Dowling said she would liaise with the Comms team.

Action: Ms Dowling to liaise with the Comms teams for the positive inpatient experience results.
The Report was received and noted.

10.5 Contracting & Business Development update

Mr Evans said results were awaited from NHS England relating to Paediatrics High Dependency Unit (HDU) funding. He also mentioned the tender opportunities were mentioned within the report.

The Report was received and noted.

10.6 Sustainability Report

Mr Evans introduced the report and said a lot of positive work was being undertaken at the Trust. He said positive press was being received regionally and nationally. He said focus was required on the use of anaesthetic gases and this was being reviewed by a working group. He mentioned focus was also required on converting Fleet to electric vehicles. He said there was a large cost implication for this and would need to be reevaluated dependant upon the outcome of national news.

The Report was received and noted.

10.7 Quality Improvement (QI) Team Update

Mr Evans said QI was one of the biggest cultural things that needed to be embraced in everything the Trust undertook. He said many people had been trained in the methodology and on how to use the methodology. He said it was positive to see huddle boards across the organisation. He said thought needed to be given as to how to take this further within the organisation to embrace continuous improvement as the first principle. He encouraged all to think about how to take a continued improvement approach.

Mr Evans also mentioned in October the Board would be signing off the self assessment which mentions the extent to which to take the next step on the QI journey. He said support was available from teams members should it be required by staff.

The Report was received and noted.

10.8 Digital Innovation Update Report

Ms Nuttall said the report was received and noted and any feedback to be sent to Alvina. Ms Nuttall said if required the report to be brought back to the next meeting.

The Report was received and noted.

10.9 Cancer Services

Ms Nuttall said the report was presented in a new format and welcomed feedback. She said cancer performance was under significant scrutiny linked together with to ensure if there was any patient harm that was captured and improved. She also mentioned the cancer metrics were to be amended from October. She said the 3 cancer metrics to be reported on would be 31 days, 62 days and the 28 day faster diagnosis. She said the 2 week cancer referral metrics had been removed from national reporting. She said the Trust would however still be monitoring the time that any cancer referrals came into the Trust at the date of which they are booked. She said against the 28 days faster diagnostics metric the Trust was achieving that target, which was a phased quarterly achievement metric being 73% for this quarter and the Trust was above that. She said against the local trajectory for reducing the number of patients on the 62 days the Trust was slightly ahead of the trajectory. She said there were challenges on some of the 62 days metrics in urology pathways, prostate and renal. She said there were ongoing internal actions taking place together with mutual aid being provided. She said there were also challenges with Skin cancer linked with volume and histopatholgy turnaround times. She also mentioned gynaecology was the other tumour site particularly effected. She said the information contained within the report was information produced to the ICB with RWT focus.

The Report was received and noted.

10.10 Nursing Workforce Skills Mix Report

Ms Hickman said the report focussed on the impact of budget setting moving forward. She said manual collection had taken place for the report based on the NHSEI review which took place. She highlighted for Division 1 there was a question as to where a business case required for a certain service. She said that would go through the business case route and no ask through skills mix, together with Division 2 no ask

through skills mix and changes were within. She said division 3 was subject to the paediatric business case which would take place over the next 3 years. She mentioned risk assessments had been undertaken where there were either new roles i.e. paramedics or where there were Allied Health Professions (AHPs) that featured as a significant part of the clinical care delivery provision. She said risk assessments were being reviewed where there had been a reduction. She also mentioned the action plan including within the report was based on the review which took place from NHSEI.

The Report was received and noted.

10.11 Health and Safety Report

Ms Arthur highlighted there was positive compliance with training. She said work was being undertaken for job specific health and safety training for managers. She said there had been an increase in health and safety incidents together with an increase in near miss incidents. She said the top 3 reporting themes were sharps, slips trips and falls for staff and manual handling incidents. She mentioned the work being undertaken. She said 26 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (Riddor) incidents had been reported. She said there had been no breaches to safety alert time frames. She said there had been some improvement in quality of risk assessments.

Ms Arthur mentioned a new audit programme had been implemented Podium audit programme which was positive. She said focus was on the increase in violence and aggressive incidents. She mentioned the zero tolerance policy was being met as one red card was issued during the year. She said a letter had been received from the Health and Safety Executive (HSE) that they intended to undertake focus visits on arrangements the Trust had in place for managing violence and aggression. She said the Trust was undertaking due diligence checks for assurance. She said there was a gap with manual handling training which required focus. She also mentioned the increase in stress referrals to Occupational Health. She said this was not work related and had not caused any additional work related sickness. She said this was being monitored. She said this was also being supported by a range of health and well being activities.

The Report was received and noted.

10.12 Infection Prevention report

Dr Macve introduced the report and said the target for *C-difficule* was 53 which was based on numbers for the year up to November 2022. She said the Trust had 28 by the end of August whereas there should have only have been 20. She said the Trust was also above its internal trajectory. She asked all to note the target was based on actual number from previous years and not a rate. She said at the end of July only 1 acute Trust in the West Midlands was below trajectory. She said there was a MRSA batamenia that occurred to a patient which moved to another Trust. She said the case was reviewed and the sample had been taken through a canula and the patient was a symptomatic and it was felt this was only potentially a contaminant and not a true MRSA. She said the Trust was below the trajectory for MRSA batermine. She also mentioned the Trust was above external target for Clebsiele. She said there were 39 new cases of CPE to date and the most the Trust had in previous years was 53 and an increase was anticipated.

Ms Hickman said there was a National and Regional increase in outbreaks of Covid and some Trusts had reintroduced blanket mask wearing. She said the Trust was reviewing its risk assessment to what approach to take and communication would be circulated should there be a change. She said currently the numbers were low within the hospital. She also mentioned the Covid, and flu vaccination programme had commenced and asked all to encourage staff to be vaccinated.

The Report was received and noted.

10.13 Maternity Services report

Ms Palmer said currently there were 6 whole time vacancies, and the trajectory was on track to be fully established by the end of the year. She said there were issues with international midwifes as it was taking longer to integrate them into clinical services, a plan was in place. She said the date in relation to acuity and staffing the Trust was not meeting the national recommendations in line with the RCM . She said this was being monitored and plans were in place to improve Midwifery to birth ratio and acuity / staffing comliance. She said the Trust was triangulating any incidents relating to any red flag events which were events that were directly attributed to midwifery staffing deficit. She mentioned that the data is providing an assurance that there were no direct adverse outcomes or pateint harm as a consequence of or directly related to any of red flag events during June/July. She said this was being monitored and an update would be provided to the next meeting.

The Report was received and noted.

10.14 Trust approach to introducing phased 'gender inclusive' toilets

Mr Evans said this was an important topic to ensure that every single staff member at the Trust was supported in every way possible. He said particularly for some Trans staff who did not necessarily currently experience that. He said the Trust was looking to identify a suite of facilities across the organisation which would become gender inclusive toileting facilities and anyone could use those facilities. He said there would be focus on single cubicles which would be completely gender inclusive. He said the Trust was also looking to ensure that in all facilities there was a poster campaign to support this. He said this would also highlight that the Trust was a fully inclusive and supportive organisation and staff should feel supported. He said the roll out week would be November. He mentioned Staff Side Unions and regional groups they were supportive of this and had provided support.

Resolved: that the Trust approach to introducing phased 'gender inclusive' toilets be approved

10.15 Executive Walkabout Action Summary Update Report

Mr Wilshere said this was a summary of feed back the Executives and Non Executive walkabouts undertaken over the last 6 months. He welcomed feedback on the benefits of the walkabouts and the summary report provided.

The Report was received and noted

11 Business Cases

11.1 Division 1- none this month

11.2 Division 2

11.2.1 NICE TA802 Cemiplimab

Resolved: that the Business Case for NICE TA802 Cemiplimab be approved

11.2.2 NICE TA798 - Durvalumab

Resolved: that the Business Case for NICE TA798 - Durvalumab be approved

11.2.3 NICE TA789 - Tepotinib

Resolved: that the Business Case for NICE TA789 - Tepotinibfor be approved

11.2.4 NICE TA786 - Tucatinib

Resolved: that the Business Case for NICE TA786 – Tucatinib be approved

11.2.5 NICE TA725 - Abemaciclib

Resolved: that the Business Case NICE TA725 - Abemaciclib be approved

11.2.6 NICE TA 707 - Nivolumab

Resolved: that the Business Case for NICE TA 707 - Nivolumab for be approved

11.3 Division 3

11.3.1 Additional Staffing within Acute Paediatrics Business Case

Mr Evans said there was an action for Mr Greene to ensure that funding was within the budget for the business case. Mr Green said the funding was £1.5 million and the case was within this years financial budget. He said the issue was the increase going forward and he felt there was an action to understand what may be possible to limit within that resource. He said there was no funding to increase for that to £2.2 million which was year 3 of the business case. Mr Evans said it would be virtually approved pending a conversation offline between the Division and a virtual investment group would take place to approve the Business Case.

Resolved: that the Business Case for Additional Staffing within Acute Paediatrics be approved subject a discussion between the Division on the financial budget and be presented virtually at an investment group meeting for approval.

11.3.2 Paediatric Level 2 HDU Business Case

Mr Watson said the capital level was deferred at the September Capital Review Group (CRG) and further discussions were to take place for the Business Case to be brought to CRG in October. Ms Nuttall confirmed discussions were taking place.

Resolved: The Business Case for Paediatric Level 2 HDU be deferred to October TMC

11.4 Corporate

11.4.1 Education Leads and Postgraduate Medical Education Expansion

Dr McKaig said funding was from NHSE and asked whether that had been approved through investment committee. Mr Evans said that had not been through the investment Committee.

Resolved: the Business case for the Education Leads and Postgraduate Medical Education Expansion was deferred to October TMC.

12 Outline/proposals for change

13 Policies/Strategies

13.1 Policies, Procedures, Guidelines and Strategies Update

13.1.1 Director Sponsor Reports

Resolved: That the Director Sponsor Reports be received and noted

13.1.2 SOP02, Attendance at Strategy Discussions (Children's Safeguarding) Standard Operating Procedure

Resolved: That the SOP02, Attendance at Strategy Discussions (Children's Safeguarding) Standard Operating Procedure be approved

13.1.3 SOP29, Dragon Medical Workflow Manager SOP (New)

Resolved: That the SOP29, Dragon Medical Workflow Manager SOP (New) be approved

13.1.4 SOP19 Private Patient Procedure (Previously OP70)

Resolved: That the SOP19 Private Patient Procedure (Previously OP70) be approved

13.1.5 HS12, Decontamination of Re-Usable Medical Devices

Resolved: That policy HS12, Decontamination of Re-Usable Medical Devices be approved

13.1.6 OP65, Capacity Management Policy

Resolved: That the OP65, Capacity Management Policy be approved

13.1.7 CP69, Medical Handover Policy

Resolved: That the CP69, Medical Handover Policy be approved

13.1.8 OP47, Interpreting and Communication Policy and Procedure

Resolved: That the OP47, Interpreting and Communication Policy and Procedure be approved

13.1.9 Stats - Searched for Policies on TrustNet

Resolved: That the Stats - Searched for Policies on TrustNet be recieved and noted

13.1.10 Audit of Policy Awareness

Resolved: That the Audit of Policy Awareness report be received and noted

13.1.11 (New) SOP30, SOP for use of Portable Bladed Fans in the Clinical Environment

Resolved: That the (New) SOP30, SOP for use of Portable Bladed Fans in the Clinical Environment be approved

13.1.12 MP10, Temperature Monitoring for Medicines Storage (formerly Medicine Cold Chain Policy)

Resolved: That the MP10, Temperature Monitoring for Medicines Storage (formerly Medicine Cold Chain Policy) be approved

13.1.13 OP20, Management of the Deceased Patient

Resolved: That the OP20 Management of the Deceased Patient policy be approved.

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

No new Risks were identified.

15 AOB

Ms Hickman said Infection Prevention (IP) week was to commence on the 9 October with the launch of the IP Delivery Plan. She asked all to raise awareness thats Executive Sponsors would be attended during that week for stands at the Trust.

Ms Nuttall mentioned the Winter Plan for this year was a Wolverhampton Place led Winter Plan with specific RWT components. She said bed modelling would be a challenge and a potential risk, a shortfall was predicted in acute beds by 28.

18 Date and time of the next meeting 24 November 2023

The Royal Wolverhampton NHS Trust

Minutes of the Trust Management Committee of the Board

Subtitle	RWT TMC
Date	27/10/2023
Time	13:30 - 15:30
Location	MS Teams Virtual Meeting
Chair	Kevin Stringer
Attendees	Kevin Stringer, Nicky Ballard, Lee Dowson, James Green, Cathy Higgins, Suneta Banga, Lindsay Ibbs-George, Dr Ros Leslie, Cody Long, Anita McQueen, Andrew Morgan, Beverley Morgan, Hannah Murdoch, Alvina Nisbett, Tracy Palmer, Adam Race, Kate Shaw, Tim Shayes, Stew Watson, Catherine Wilson, Prof Singh, Claire Young, Radhika McCathie, Dr Ananth Viswanath

1 **Apologies for absence: Nick Bruce, James Cotton, Prof Loughton, Louise Nickell, John Murphy, Dr McKaig, Dr Odum, Gwen Nuttall, Sian Thomas, Simon Evans , Stephanie Cartwright, Alan Duffell, Pauline Boyle, Debra Hickman, Doreen Black, Keith Wilshere, Lewis Grant, Sally Evan**

2 **Declarations of interest**

There were no new or changed Declarations of Interests to those published on the Trust Web Site.

3 **Minutes of the meeting of the Trust Management Committee held on 22nd September 2023**

The minutes were approved unchanged.

4 **Matters arising from the minutes**

There were no matters arising from the minutes.

5 **Action Points list**

Action item 1. EPR System

"*Mr Bruce and members of his team to provide a presentation at the TMC Meeting on the EPR system for the replacement of the PAS system."*

Resolved the item be presented at November TMC Meeting

Action item 2. Black Country Pathology Service (BCPS) Report

"Dr McKaig to provide an update at the next TMC meeting following his scheduled meeting with Sally Roberts to discuss how to link all

governance elements of BCPS back into the 4 acute organisations. Ms Arthur and Mr Danks to be included in that meeting"

Update: Initial meeting with Integrated Care Board (ICB) and BCPS planned for 8/11

Resolved: an update be provided at November TMC meeting

Action item 3. Business case for the Education Leads and Postgraduate Medical Education Expansion

"The Business case for the Education Leads and Postgraduate Medical Education Expansion was required to go through Investment Committee and was deferred to October TMC."

Business case was approved at Investment Group and is on the agenda for todays meeting.

Resolved: it was agreed the action be closed

Action item 4. Finance Position Report

"Mr Green and Prof. Singh to arrange a meeting to clarify figures for bank, agency staff Clinical Fellows for the Medical workforce and Clinical workforce."

Mr Green said the meeting was in the process of being arranged.

Resolved: an update be provided at November TMC meeting

Action item 5. Business Case for Paediatrics Level 2 HDU

"The Business Case for Paediatrics Level 2 HDU to be presented to October CRG meeting and be deferred to October TMC"

Mr Watson confirmed year 1 of the business case was approved at the Capital Review Group with further conversations to take place regarding year 2.

Resolved: it was agreed the action be closed

Action item 6. Inpatient Experience Survey Results

"Ms Dowling to liaise with the Comms teams for the positive inpatient experience results."

Ms Dowling confirmed the action had been actioned

Resolved: it was agreed the action be closed

Acton item 7. Business Case for Additional Staffing within Acute Paediatrics

"The Business Case for Additional Staffing within Acute Paediatrics be approved subject a discussion between the Division on the financial

budget and be presented virtually at an investment group meeting for approval."

Mr Green said the virtual meeting had not taken place and he will liaise with Mr Evans outside the meeting

Resolved: an update be provided at November TMC meeting

6 Key Current Issues/Topic Areas - none this month

7 Elective Care Recovery

Mr Shayes highlighted the increase in waiting lists was due to Industrial Action which had taken place. He said the Trust remained in Tier 2 for Cancer and Long Waited Elective Performance. He said the Trust had a plan in place for route to zero for the end of November. He said the Trust was on course to meet the 65 week target by the end of March. He also mentioned the Trust was ahead of trajectory for reduction in back logs in Cancer. He said however the back log would not be sustainable to meet the 62 day performance standard which was an area of focus and a challenging position.

Mr Stringer said there was a discussion at Finance and Productivity Committee (P&C) about waiting list validation. Mr Shayes said there was a requirement for the whole of the waiting list to be validated on a 12 week basis which meant people would periodically recieve text messages to identify whether they still required treatment. He said it had been identified at times the Trust was unaware of people who had received treatment elsewhere or whomno longer required treatment. He said if patients were awaiting surgical treatment and stated that they wished to be removed from the waiting list, there would be a clinical review by a clinician prior to discharge.

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 Wilson highlighted there had been increase in pressure ulcers and decrease in falls, a review was being undertaken. She said ongoing work was examining how faculty linked in with Mental Health. She also mentioned the Infection Prevention (IP) Delivery Plan launch took place together with a focussed *C-Difficule* week. She said there had been an increase of 10 *C.Difficule* cases in September and there no

transmissions between the cases. She said the decant was temporarily open for cleaning. She also mentioned the Patient Equipment Centre was being repurposed in the basement which would assist with cleaning and would include ED Trolleys. She said there had been an increase in E-Coli cases, there was not a theme, but complex cases had been identified.

Mr Stringer asked whether there were 4 cases per month of *C-Difficule*. Ms Wilson confirmed that was correct. She said this was due to a number of issues including cleanliness and early sample collecting. She said a Quality Improvement (QI) project was being underway on swifter samples in Emergency Department (ED).

Mr Dowson said Ms Wilson mentioned the folds had increased but looking at the report the 8th month in a row they were below average which could count as sustained improvement. Ms Wilson agreed.

Ms Shaw said the Trust continued to deliver the 4-hour Emergency Department (ED) performance target. She said performance was low in September. She said the Trust was struggling with the over 12 hours that deteriorated. She said off load performance continued to be a challenge. She said the Trust was managing to offload over 80% of patients in September within 30 minutes. She said there were challenges with acuity across the Black Country and West Midlands in terms of volume of patients coming in but also acuity, dependency complexity. She said stroke performance in terms of time spent in a dedicated stroke area had deteriorated in line with some operational pressures, but it was also felt there may be a data quality issue. She said data needed to be checked to ensure activity was being captured accurately.

Mr Stringer mentioned once the data check for stroke had been completed, if the data stayed the same would an improvement trajectory be created to identify any key issues. Mr Stringer asked for an update to be provided to the next meeting.

Action: Ms Shaw to provide information on any key issues identified once the analysis of data had been completed for stroke.
Resolved: the report was agreed and noted

9.2 Division 1 Quality, Governance and Nursing Report

Ms Macqueen highlighted the Divisional Skills Mix continued to be at risk. She said the new cohort of internationally recruited nurses commenced in September and the Division was supporting the

programme. She said a support plan was in place to improve medication errors and observations on time. She said a Medical Safety Group had been created for those areas that did not have Electronic Prescribing and Medicines Administration (EPMA) and where there was duplication of medication.

Resolved: the Report was received and noted.

9.3 Division 2 Quality, Governance and Nursing Report

Ms Morgan introduced the report and highlighted the embedding of the Push Model and monthly metrix was being collated to support its impact. She also mentioned an ED visit was to take place from the Integrated Care Board (ICB) on 22 November. She said challenges were being experienced in ED with volume and acuity of walk in patients, their complexity and time to triage. She said a piece of work was being undertaken to align triage walk in times to a specific escalation model. She said that had been compounded by the West Midlands Ambulance Service (WMAS) Standing Operating Procedure (SOP) that at 2 hours there was a different conversation with the public for them to make their own way to ED if they were possibly able to do so. She said there had been 2 deaths which related to triage times.

Mr Stringer asked whether incident reviews were being undertaken and lessons were being learnt. Ms Morgan confirmed a complete review was taking place of the walk in area of ED. She said the dynamic complexity and volume had changed and there were many factors included within the WMAS SOP.

Mr Dowson said as there were issues with flow, ambulances were held more and people were aware of that thereby making their own way to the hospital. He asked what the increase in acuity related to. Ms Morgan said metrix needed to be reviewed continuously.

Ms Shaw said a piece of work was being undertaken by OneWolverhampton Urgent and Emergency Care (UEC) Group to review the volumes of walk ins. She said audits were to be undertaken to understand what was within the walk in cohort. She said an update would be provided to the Committee. She also mentioned this was part of the Winter Plan which was to be presented to the Committee at the meeting taking place in November.

Mr Watson asked whether the Ambulance Receiving Centre (ARC) had impacted to the volume in order to provide additional beds. Ms Shaw said yes the ARC had made a significant positive difference. She said

the Trust was now a net importer of intelligently conveyed ambulances particularly from Shropshire and Russells Hall.

Ms Morgan said the Trust was receiving circa 10 thousand patients who walk in each month.

Mr Dowson said the ARC was positive in receiving patients from ambulances and getting the ambulances out. He said the underlying issue was flow of patients within the Trust which needed to be addressed.

Mr Stringer said there was clearly concern around the way in which patients were presenting was complex. He asked for a piece of work to be undertaken from Ms Morgan and Ms Shaw with partners to understand whether processes needed to be changed on the way patients were assessed. Mr Stringer asked for this information to be brought back to the next meeting together with the Winter Plan.

Action: Ms Morgan and Ms Shaw to provide information as to whether processes needed to be changed on the way patients were assessed to assist with flow of patients at ED.

Resolved: the Report was recieved and noted.

9.4 Division 3 Quality, Governance and Nursing Report

Ms Ballard said there was an ongoing action plan on Observations on Time. She said Venous thromboembolism (VTE) compliance remained variable. She said staffing hotspots were dietetics and health visiting. She said there was one reported Community attribution which was awaiting scrutiny.

Resolved: the Report be received and noted.

9.5 Executive Workforce Summary Report

Mr Race highlighted there was positive performance across the key indicators relating to retention, turnover and vacancy rates. He said an area of concern was sickness. He said ongoing work was taking place. He mentioned a request had been received for focus on agency spend. He said the areas of focus were overall spend, price cap compliance and off framework agencies.

Mr Race finally mentioned the British Medical Association (BMA) had given the Government until the beginning of November to present a credible offer around pay for Consultants. He said notification had been

received that the Specialist, Associate Specialist and Specialty Doctors (SAS) had indicated that they would vote for strike action if they were formally asked in relation to their pay which effected approximately 50 Doctors at the Trust and may be a potential challenge.

Resolved: the Report be received and noted.

9.6 Chief Nursing Officer Report

Ms Wilson introduced the report and highlighted the positive vacancy rate for nursing and midwifery staff. She said the Trust had received a National Patient Safety Alert for medical beds, trolleys, bed rails, grab handles and lateral turning device. She said a steering group was addressing those issues. She also mentioned the investigation into the international nurse Computer Based Test (CBT). She said scoping had been completed and no advice had been received that any of the nurses at the Trusts were fraudulent. She said, however all nurses who went through that test centre would have to repeat their CBT.

Resolved: the Report be received and noted.

9.7 Finance Position Report

Mr Green highlighted £28.8 million deficit year to date and the Trust was £4.3 million worse than had been planned. He said there had been a reduction in bank spend and there were increases in strike costs. He said there was a reduction in non-pay run rate and £1.5 million was non recurrent benefit being a rebate for Clinical Negligence Scheme for Trusts (CNST). He said other providers within the Black Country were also reporting deficits. He said collectively at the end of month 6 that would amount to £79 million which included the Trust's deficit across the Black Country. He said the Trust was receiving scrutiny from the Integrated Care Board (ICB) particularly regarding growth of workforce. He said work was being undertaken with Divisions on workforce.

Prof. Singh referred to several factors relating to the deficit position including income, block funding shortfalls, patient influx from other areas, inflation, mandated services not fully funded, national initiatives lacking recurrent revenue funding including for consumables, and the increasing volume of work referred to and undertaken by the Trust. He encouraged continuing dialogue between clinicians and managers to understand and work together on the pressures and issues.

Action: Mr Green to provide the presentation slide which refers to the drivers of the different of the deficit slide

Resolved: the Report be received and noted.

9.8 Capital Programme Update

Mr Watson said there was more scrutiny oversight and challenge from the ICB on capital. The Trust was at £27.5 million cash with extra funding received through the decarbonisation programme. He said another bid had been submitted for the more decarbonisation work. He asked all to mention to staff if parking on the grass verges care should be taken during the challenging weather. He said off site carparking was available at Wolverhampton Fitness and Swimming Centre in Bentley Bridge. He said it was anticipated the current phase of works for Wrekin House would be completed by December 2024.

There was a discussion about hospital transport vehicles and the car parking difficulties at the Trust.

Resolved: the Report be received and noted.

9.9 Financial Recovery Group Update

Mr Green highlighted there had been an increase in the reported delivery against Cost Improvement Plan (CIP) being £13.9 million against a plan year to date of £4.1. He said there was a focus to develop more schemes and report them. He also mentioned the outpatient transformation programme and the Trust had saved approximately 1£0 thousand appointments since April which was positive. He also mentioned a presentation took place on Medicines opportunities across the Trust one element being spend on drugs and how savings could be made by switching to similar suppliers of drugs. He said the scheme was in progress. He also mentioned unrecovered income of approximately £0.5 million due to the non completion of Blue Tec forms.

Resolved: the Report be received and noted.

9.10 Clinical Black Country Provider Collaboration - verbal update

Resolved: The item be deferred to the meeting in November.

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

10.1 EPRR Core Standards

Resolved: the report was deferred to November's meeting

10.2 Schwartz Round Annual Update

Ms Young highlighted virtual rounds had been introduced this year which were positive. She said a calender of events had been prepared for next year's Schwartz Rounds.

Resolved: the Report be received and noted.

11 Business Cases

11.1 Division 1 - none this month

11.2 Division 2 - none this month

11.3 Division 3 - none this month

11.4 Corporate

11.4.1 Education Leads and Postgraduate Medical Education Expansion

Ms Young said the business had been approved at investment group.

Resolved: the Business Case for Education Leads and Postgraduate Medical Education Expansion be approved

12 Outline/proposals for change

13 Policies/Strategies

Lead Group Company Secretary Keith Wilshere
Action to approve and note update

13.1 Policies, Procedures, Guidelines and Strategies Update

13.1.1 HR01, Work life Balance / Family Friendly (Leave) Policy

Resolved: HR01, Work life Balance / Family Friendly (Leave) Policy be approved

13.1.2 HR02, Agile Working Policy

Resolved: HR02, Agile Working Policy be approved

13.1.3 HR49, Leave for Official Duties Policy

Resolved: HR49, Leave for Official Duties Policy be approved

13.1.4 OP31, Legal Services Policy

Resolved: OP31, Legal Services Policy be approved

13.1.5 OP41, Induction and Mandatory Training Policy

Resolved: OP41, Induction and Mandatory Training Policy be approved

13.1.6 OP108, Domestic Abuse Policy

Resolved: OP108, Domestic Abuse Policy be approved

13.1.7 HR10, Managing Allegations of Behaviour Indicating Unsuitability to Work With Children and Adults with Needs for Care and Support

Resolved: HR10, Managing Allegations of Behaviour Indicating Unsuitability to Work With Children and Adults with Needs for Care and Support be approved

13.1.8 SOP22, Safeguarding Team Process for Managing Section 42 Enquiries

Resolved: SOP22, Safeguarding Team Process for Managing Section 42 Enquiries be approved

13.1.9 CP10, Policy for Withdrawing or Withholding Clinically Assisted Nutrition and Hydration in Adult Patients Who Lack Capacity to Consent to Treatment

Resolved: CP10, Policy for Withdrawing or Withholding Clinically Assisted Nutrition and Hydration in Adult Patients Who Lack Capacity to Consent to Treatment be approved

13.1.10 CP52, Intrathecal Chemotherapy Policy

Resolved: CP52, Intrathecal Chemotherapy Policy be approved

13.1.11 CP03, Management of Ligature Risk

Resolved: Policy CP03, Management of Ligature Risk be approved

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

Mr Stringer asked whether the assessment issues in ED where on the Divisional Risk Register and being dealt with. Ms Shaw confirmed they were on the Divisional Risk Register, had been reviewed and were to placed on the Trust Risk Register.

15 AOB – none this month

16 Date and time of the next meeting 24 November 2023

Minutes of the Charitable Funds Committee

DATE Tuesday 25 July 2023
TIME 11.00 am
VENUE Conference Room, Hollybush House and via MS Teams

PRESENT

Mr Martin Levermore	Non-Executive Director (Chair)
Ms Lisa Cowley	Non-Executive Director
Mr Kevin Stringer (part)	Group Chief Financial Officer and Group Deputy Chief Executive

IN ATTENDANCE

Mr Mark Greene	Deputy Chief Financial Officer
Mrs Katy Ball	Charity Finance & Assurance Manager
Ms Amanda Winwood	Charity Development Manager
Ms Hannah Murdoch	Head of Communications
Mrs Zoe Lees (observer)	Treasury & Charitable Funds Officer
Mrs Anne-Louise Stirling	EA to Group Chief Financial Officer & Group Deputy Chief Executive
Mr Tom Lindsey (part)	Sarasin & Partners
Prof Baldev M Singh (part)	Consultant Physician in Diabetes & Clinical Director of IT
Ms Alvina Nisbett (part)	Associate Director of Digital Innovation

Item No		Action
	As the newly appointed Chair of the Charitable Funds Committee, M Levermore introduced himself to members of the committee.	
0723/14	**Apologies for Absence** Mrs Sally Evans, Ms Julie Jones	
0723/15	**Minutes of the previous meeting held on the 15 March 2023** The minutes of the Charitable Funds Committee meeting held on the 15 March 2023 were reviewed and approved by the committee.	
0723/16	**Charitable Funds Committee Action Log** The committee reviewed the list of Action Points and agreed upon, which items had been actioned and could be closed.	
0723/17	**Declarations of Interest** No interests were declared.	

Item No		Action
0723/18	**Sarasin & Partners Annual Review of Investments** T Lindsey presented the Annual Review of Investments report to members of the committee highlighting areas of interest and of note to members. Members noted that the charity had two portfolios a 'longer-term portfolio' and a 'shorter-term medium-term portfolio'. Referring to page 2 of the report T Lindsey drew members attention to the longer-term portfolio and advised that over the last three months investments had moved to a fully global equity allocation. He advised that this was thought to be more beneficial and reiterated to members of the committee this change had been reported previously. Referring to the detail on page 3, T Lindsey advised that in particular this year the equity market had been driven by a small marginal group of companies in the US and of the seven detailed, members noted that the charity owned shares in Apple, Microsoft, Alphabet and Amazon. T Lindsey reported that whilst the stock market had been driven by energy previously this year information technology had been the biggest driver of returns over the year to date with energy being the weakest, this had resulted in a huge variation in the leadership in the stock markets. M Greene raised the question as to how the charity portfolio performance compared to the same risk-based portfolio for other clients. T Lindsey advised that they were very similar with the same strategic asset allocation invested and, therefore, the level of returns achieved were very similar. Turning to page 11 'Shorter Term Portfolio', which members noted ran alongside the long-term portfolio, T Lindsey confirmed that the same changes to the equity component had been made with the same key themes emerging. The Chair referred to the five-year strategy in relation to investments and enquired how close to the benchmark or above the line would the charity investments be if the same strategy was continued to the end of the year. T Lindsey replied it was hard to give a definitive answer as only part way through the financial year, but he hoped that the positive trend seen in the first half of the year would continue. **RESOLVED:** The Chair thanked T Lindsey for his detailed presentation and comprehensive answers to questions raised by the committee.	
0723/19	**Report of the Charity Development Manager** A Winwood presented the Charity Development Manager's report outlining progress of work undertaken since the last meeting of the committee in March. A Winwood advised the committee that aside from the report presented she needed to update members on the Charity Ball which had been scheduled to take place in July. Members noted that due to low uptake of tickets the event had been cancelled as it was not financially viable to take place.	

Item No		Action
	She reassured members that in relation to deposits paid for the venue, casino, and band the deposits had been retained for future events that would be happening later in the year. Members were advised that the Winter Wellness support for a Band 2 post had successfully been processed. A Winwood reported that there was a large demand for the Wellness Hub by staff and advised that the uptake figures for breakfast were showing a large increase in numbers over the last couple of weeks. She advised that it would be helpful to reinforce to staff that the Hub was for those members of staff in crisis and proposed that a communication brief be sent out to staff to remind them of this. Referring to *Appendix 1 'Annual Charity KPIs'* – A Winwood advised members that Q1 showed a very positive position with a notable increase in *'In Memoriam and Legacies'* being noted. A Winwood advised that the charity branding was an area for committee discussion. She reiterated the success of the charity securing a £30k grant from NHS Charities Together, which required expending within a 12-month timeframe. The grant would facilitate a rebranding and refresh of the current charity website. It was noted that an external company via NHS charities Together had contacted A Winwood to ascertain the requirements of the refresh and it was noted the company in question would be submitting a quote. A Winwood advised that a basic website would be in the order of £14K, but with a payment system built in the cost would be around the £18 - £20k mark. A Winwood also advised the committee that the Trust's Clinical Illustration team had edited the current charity logo, but had retained the existing design of a tree which portrayed the charity being the centre of the community. The committee noted on page 6 the proposed new designs and colour options along with a new charity logo of 'RWTC'. A Winwood addressed the committee asking for any comments she advised that the new website would be based on the new charity logo and also reiterated that the timeframe for spending the grant was within a twelve-month period. The Chair enquired about the Charity Strategy going forward and the direction it should be going in. A Winwood advised that the strategy was already in place when she had commenced in post and remained current until next year. She advised that moving forward staff needed to be made aware of the work of the charity and that further education was required, in order that staff could promote the work of the charity further. She advised that by rebranding the charity this refresh would hopefully engage staff and achieve more links to CSR (corporate social responsibility) and encourage businesses in supporting the work of the charity.	**A Winwood**

Item No		Action
	L Cowley advised the committee that from experience she had concern that the logos as presented would not be mobile accessible due to the multi colours and different imagery and advised that this was an area that would need to be addressed with the appointed web company. She expressed concern over the rebrand of the logo advising that RWTC may not be the best choice to promote the charity with staff and may be taken as an NHS acronym. It was also agreed that following a similar tendering exercise L Cowley would share with A Winwood a list of potential website companies for the charity to go out to tender to. L Cowley raised that at the last meeting of the committee discussion had taken place on spend plans being drawn up and implemented and designated funds being reviewed regularly. K Ball reassured the committee that although only newly appointed in post that spend plans and reaching out to budget managers would be one of the main areas of focus going forward. M Greene advised the committee that planned charity training had been cancelled because of the operational needs of the Trust, but agreed that this was an area that needed to be focused on moving forward. A Winwood confirmed that part of the training and education of staff centred around that if a particular fund was less than £1k it would be reviewed and if it had been dormant for 12 months, then there was the potential to merge into another fund within that division. The Chair advised that in view of the detail and the questions posed around the design of the logo a decision should be deferred to the next meeting of the committee, in order that further strategic thinking could be undertaken. H Murdoch concurred with the committee and advised that this would be followed up outside of the meeting and considered again at the October meeting. H Murdock asked if it would be appropriate for an internal team within the Trust to provide a quote for the new website development. K Stringer responded that it was not possible for an inhouse bid to be competing against external bids. However, if an internal team had the necessary skills, they would need to demonstrate this along with the proposed process. However, if this option was not viable then an external set of bids would need to be pursued. H Murdoch agreed that if an internal proposal was put together the committee could then assess if the necessary skill sets were being met. A Winwood undertook to check this option was feasible with NHS Charities Together and report back to the committee.	**L Cowley** **Deferred to October meeting** **A Winwood**
0723/20 0723/20.1	**<u>Business Cases over £5k – For approval/discussion</u>** <u>Acute Paediatric Mural Artwork - £14.2k</u> A Winwood presented the Business Case for the Paediatric Mural artwork to be commissioned. She advised that currently the NICE Guidance for Babies, children, and young people's experience of healthcare was not being met within the Paediatric Department and that the business case presented for approval sought support to use charitable funds to meet the costs of mural art themed, redecoration of paediatric priority areas as detailed in the report.	

Item No		Action
	Members noted that an artist had been identified who had experience of undertaking artwork within a paediatric setting. A Winwood advised that following contact with the artist the total cost would be £15k for 14 areas and that a potential start date for the work to commence would be in August. M Greene advised that whilst it was understandable to use someone who was recognized it was also a shame to not potentially give any local aspiring artists a chance to tender for the work. L Cowley advised that whilst she was supportive of the work, she had concerns that the work could be commissioned without undertaking a full competitive tender exercise. Following discussion, the Chair concluded that whilst the Business Case for the mural artwork was approved at a cost of £15k the financial/governance constraints of the charity had to be met before proceeding. He asked A Winwood to contact the Paediatric Manager and ascertain if there were any further suitable artists. It was agreed that rather than waiting for the next meeting of the committee A Winwood would report back to the committee for final approval via email. The Chair requested that following the completion of the artwork that suitable communications were sent out to staff to promote the work of the charity.	**A Winwood** **A Winwood**
0723/20.2	<u>Infrastructure, Insights, and Interventions £119k from New Cross General-Purpose Legacies</u> Professor Singh presented to the committee a report on creating an infrastructure to build advanced analytics capability for inpatient flow and end-of-life digital health care pathways. He advised members of the committee that the request was for a grant of £119,133 from charitable funds to accelerate the establishment of the already established RWT data warehouse function to build on the already high-level digital health care. The committee heard from A Nisbett that a considerable amount of time and work had gone into the project to date and the next level of funding was essential for work to continue. The committee enquired about the PhD fees detailed in the report and how this element would work in respect of payback to the charity. In particular if the individual member of staff would be liable for repaying the fees if they left employment of the Trust. Professor Singh advised that the accountability for the funding would fall to himself and agreed that this stipulation could be put forward by the charity, but the individual doing the PhD would not be held accountable. The Chair enquired what benefit the charity would receive in return for the funding of the project. Professor Singh confirmed that any future publications would be linked back to the charity and the investment put forward. There would also be clear links for the funding invested meeting the criteria stipulated by the charity.	

Item No		Action
	L Cowley advised Professor Singh that the report did not account for inflationary uplifts the detailed amounts were standard for years 1 – 3 and did not take account of inflation. *K Stringer left the meeting.* The Chair thanked Professor Singh and A Nisbett for attending and presenting the report and business case for charity funding. He advised that the committee needed to consider the eligibility from both a charity perspective and from a financial perspective and would advise of the committee's outcome at the end of the meeting. The committee agreed that the strategy and the concept put forward was acceptable from a charity point of view. However, the funding eligibility needed to be checked as the charity would be committing to a three-year funding cycle and in addition any risk factors needed to be fully understood and a plan of mitigation put forward. K Ball advised that the source of funding would be from the General Purposes Charity Fund, which did not have any restrictions attached to it. The Chair summarised that in principle the Business Case was approved for funding for three years providing further information could be provided on the Intellectual Property element and the PhD funding risk factor explored. L Cowley advised that it would be beneficial to have an independent source drafting the Intellectual Property rather than it being drafted inhouse. Additional caveats would be that appropriate reporting of progress was provided to the committee on a regular basis and that any future publications the charity was cited in them. A L Stirling advised the committee that K Stringer had advised of his support for the project prior to him leaving the meeting. **RESOLVED:** The committee approved and were supportive of the proposal put forward subject to some additional information being provided and the finer details being shared with the responsible officers. A total of £119,000 plus the inflationary element added in for future years was approved by the committee.	**A Winwood/ K Ball to follow up with Prof Singh**
0723/21 0723/21.1	**Reports of the Charity Finance Team to 31/12/22** **Finance Reports to 31 March 2023 (pre-year-end apportionments)** K Ball presented the report of the Charity Finance team to 31 December 2022. She advised the committee that work was underway to complete the end of year position which was subject to audit week commending the 11 September 2023. Members noted that the net movement of funds for 2022/23 was £(315)k a decrease; the total income was £854k less expenditure of £(926)k and an unrealised loss of £(243)k. The restated opening fund balance at 1 April 2022 was £3,032k and the closing fund balance at 31 March 2023 was £2,717k.	

Item No		Action
	K Ball reported that in addition to the information that had already been reported in Q4, a total of £23,000 had been received on interest on investments. She reported that at the end of the financial year there was a total of £2.7 million in funds and £82,000 of those were endowment funds, 936 were restricted and £2.1 million were unrestricted.	
0723/21.2	**Summary Finance Report to 30 June 2023 (pre-year-end apportionments)** K Ball presented the Summary Finance Report to members of the committee. She advised that with regard to the first quarter of 2023/24, the net income resources were £58,000 which was the same as the period for 2022/23. However, it was noted that both income and expenditure had been higher in Q1 and the charity received a large legacy of £91,000 in May which pending any set conditions would be added to the General Purpose Fund. The committee noted that two grants had been received in this financial year; the Hope project and the Windrush Day grant. L Cowley referred to the restricted and unrestricted funds held by the charity and in particular the New Cross General-Purpose Fund which was detailed as a restricted fund. She queried that this should be unrestricted as the fund received legacies that were not specified for a particular area. K Ball agreed to look into this and report back to the committee. L Cowley referred to her earlier discussion regarding the expenditure of funds and the spend plans for funds going forward. She advised that in terms of sound financial governance an annual discussion should be held and that the restricted funds reviewed and spend plans established. This would need to be reported to the appointed charity auditors and the CCA for transparency. **RESOLVED:** The Chair asked that the financial governance for funds be reviewed, and the detail reported back to the committee to ensure that departments were making good use of the funds donated.	**K Ball** **K Ball**
0723/22	**Implementation Plan** K Ball advised members of the committee that the Implementation Plan was detailed on the committee's workplan for presentation at each meeting of the committee. She explained that the report would cover all areas relating to the Charity eg, spend plans, aims of the charity etc. **RESOLVED:** The Implementation Plan will be presented to the next meeting of the committee in October 2023 and each meeting going forward.	
0723/23	**Charitable Funds Committee Workplan 2023 and 2024** The committee noted the detail of the workplan for both 2023 and 2024.	

Item No		Action
	K Ball suggested to the committee that a modification to the workplan to include the review of funds and their individual spend plans going forward would facilitate this area being monitored and reviewed going forward. **RESOLVED:** The Chair concurred that this was a good idea and asked that this item for discussion be added to the workplan.	**K Winchurch**
0723/24 0723/24.1	**Any Other Business** WR Partners Service Plan The committee noted that WR Partners had been engaged to undertake the audit of the charity for the current financial year. The scope of the work to be undertaken was noted in the report. The Chair referred to page 12 of the report and asked that the details of the Trustees of the charity be updated to reflect the current changes. K Ball agreed to liaise with WR Partners to ensure that this was amended and asked for any further comments on the detail of the report. She assured member that the audit was very much in line with last year's audit. L Cowley enquired when the contract expired for the current auditors and when a retendering exercise would need to be undertaken. K Ball advised the committee that she would look into the detail of the contract and report back the findings at the next meeting of the committee.	**K Ball** **K Ball**
0723/24.2	Stripe K Ball presented a report to members of the committee for information purposes. She advised that an incident had occurred with an online payment which had highlighted an area of risk that needed to be addressed to alleviate any problems going forward. **RESOLVED:** The committee duly noted the detail of the report.	
0723/24.3	Business Case – Neonatal K Ball advised the committee that a further business case had come to light following the issuing of the committee's agenda and papers. She advised that the report would be circulated following today's meeting. The committee noted that the Business Case was in relation to six reclining chairs at a cost of £22.6k and six non-reclining chairs at a cost of £17.6k, these were new items and not replacement items. K Ball confirmed that the current funding available was approximately £70k. **RESOLVED:** Following consideration the committee agreed that the business case would be reviewed in detail once the full report had been circulated by K Ball.	**K Ball**

Item No		Action
0723/25	**Meeting Evaluation** The Chair concluded that the meeting despite running slightly over had been a good productive session. Several items were discussed at the meeting, and it was agreed that ongoing items to be discussed further were: - • logo for the charity and how this linked into a future Charity Strategy • spend plans and the governance around unrestricted and restricted funds, and that this would now be reviewed on an ongoing basis The committee had agreed the Infrastructure Business Case presented by Professor Singh subject to certain caveats.	
0723/26	**Date and Time of Next Meeting** Tuesday, 17 October 2023 at 11 am in the Board Room, Corporate Services Centre or via MS Teams	

The Royal Wolverhampton NHS Trust

MEETING OF THE INTEGRATION COMMITTEE

HELD ON MONDAY 24TH DAY OF OCTOBER 2023
VIRTUALLY VIA MICROSOFT TEAMS

Members Present

Mrs Lisa Cowley **(Chair)**	Non-Executive Director
Mrs Stephanie Cartwright	Group Director of Place
Mr Umar Daraz	Non-Executive Director
Mrs Debra Hickman	Chief Nursing Officer
Mrs Gwen Nuttall	Deputy Chief Executive and Chief Operating Officer
Dr Gillian Pickavance	Non-Executive Director

In Attendance

Mr Brad Allen **(Minutes)**	Executive Assistant
Mrs Rachael Brown	Group Manager – Primary Care and Adult Community Services
Dr Simon Harlin	Divisional Director – Community Services, Walsall Healthcare NHS Trust

Apologies

Dr Brian McKaig	Chief Medical Officer
Mrs Sian Thomas	Deputy Chief Operating Officer – Division 3 and

001/023	Welcoming Remarks, Apologies, and Confirmation of Quorum
	Mrs Cowley welcomed all members and attendees to the meeting and declared the meeting to be quorate in line with the committee's draft terms of reference. Formal apologies were received and noted as above.
002/023	**Declarations of Interest**
	There were no declarations raised by members for noting.
003/023	**Place Presentation**
	Mrs Cartwright introduced the presentation as set and gave a brief update on the partnership's structure and history, sighting that the OneWolverhampton Partnership had formed approximately eighteen months ago and works with various stakeholders such as the Local Authority, The Royal Wolverhampton NHS Trust, Primary Care Networks, Health Watch, Black Country Healthcare NHS Trust and the Voluntary Sector, with a shared agenda to deliver the best care for local populations, driven by outcome data sharing agreements to reduce local inequalities. Members were then invited to ask any questions.

	Each place will continue to have their own independent place partnerships, but would strive to work together to achieve the-best outcomes. Mr Daraz then referred to the Clinical and Professional Leadership Group (CPLG), noting that the local University was not included at both board level and at the delivery group. Mrs Cartwright that a number of General Practitioners had highlighted this and that this would be investigated further to review their attendance. Mrs Hickman summarised that OneWolverhampton was still undergoing evolution due to its infancy, with various stakeholder groups still at various stages of maturity. She advised this had been discussed and reviewed at Trust Board away days and that both the partnership and stakeholders would need to recognise equally where and how the local University could contribute towards its functionality. Mrs Cowley referred members to a potential duplication of enablers within the partnership and sought assurance as to how this could be avoided. Mrs Cartwright stated that workstreams would be created to support out of hospital care, with a large piece of work being undertaken by Mr Matthew Dodd, who is undertaking a piece of work across both community services in Walsall and Wolverhampton, and also across community providers across the Black Country, with the aim of the forum to ascertain narrative around estate availability/potentials. Dr Pickavance agreed and stressed the importance of having the right partners involved to ensure partnership working and effectiveness. Mrs Cowley summarised that one aim of the committee was to review the functionality of the OneWolverhampton Partnership, but emphasised the requirement to look at integration as a prime subject, as well its cultural elements to support best patient care. The importance of reviewing how the committee monitors the effectiveness, its finances and stakeholder engagement and their representation was discussed by a number of members, and it was suggested that this remain a standing item of the committee for sufficient oversight. There were no further comments from members. **RESOLVED** That committee note the contents of the report and **approve** that Place remain a standing item on all future agendas.
004/023	**Stakeholder Map**
	Committee **noted** that this area of discussion had been covered within the previous Place Presentation for their reference.

005/023	Board Metrics and Corporate Risk Register
	Mrs Cartwright introduced the item and sighted the committee on three metric recommendations for review. They were as follows: • Two Hour Emergency Responsiveness. • Increase in patients to virtual wards. • Reduction in patients medically fit for discharge. Mrs Cowley suggested that committee review the risks but also have input as to what other members may feel appropriate to include as the group progresses. Dr Pickavance referenced Medically Fit for Discharge patients and queried the possibility of discharging some patients from outside of the borough to their local care home providers. Mrs Nuttall advised patients would go through the transfer of care process, which does sometimes depend on where homes are positioned. Mrs Nuttall also emphasised the need to monitor patient metrics and gave examples of patients from other areas and how they were dealt with, suggesting a brief breakdown of figures be presented to committee at future meetings for their oversight. Members were in agreement with this to identify themes and provide mitigatory measures where necessary. Mrs Cowley sought agreement from committee to monitor the risks as presented by Mrs Cartwright, as well as receive briefings on wider metrics for reference. Members agreed to this proposal. Mrs Cowley referred committee to the tabled emerging risk from the Finance and Productivity committee and invited Mrs Cartwright to provide an overview. Mrs Cartwright sighted committee that the emerging risk had the potential to escalate within the committee should the Trust become the host provider. Mrs Cartwright advised this had also been escalated to the Trust Board for reference and suggested that this be monitored by the committee at future meetings. **RESOLVED** That committee **agree** the metrics as set out, with any future risks be included within future reports for oversight.
006/023	**Delegation**
	Mrs Cartwright introduced the item and shared the System Operating Model paper for committee reference, sighting that there were 28 recommendations to the model and that conversations were taking place around the accountability of the host and lead provider. Mrs Cartwright stated that there is potential that the Royal Wolverhampton NHS Trust could be the host provider, but this still in discussion with the

	partnership. Mrs Cartwright assured colleagues that further narrative would be provided when received. Mrs Cowley queried what the service impacts would be should the Royal Wolverhampton NHS Trust be made host of the provider and how risks and recommendations would be monitored. Mrs Hickman stressed the importance of managing and building relationships with all stakeholders should the Trust be selected as the place host. Mrs Cartwright concurred and advised committee that a task and finish group would be established to support this. Dr Harlin suggested it may be beneficial for members to review place working initiative learning points from Walsall Healthcare to aid implementation. Mrs Cowley agreed and suggested that feedback be sought from other Place Partnerships within the Black Country. Dr Pickavance summarised that there had been historic tensions between primary care providers and acute Trusts, but this could be alleviated through improved levels of communication. Mrs Cowley summarised contributions from members and suggested that Delegation remain a standing item on future agendas to monitor progress. Mrs Cartwright stated that there were already some colleagues in position that work specifically on Place, including a Consultant in Public Health who is employed by Royal Wolverhampton. *Mrs Nuttall and Mr Daraz left the meeting at 16:02.* There were no further comments from members. **RESOLVED** That committee note the contents of the report for their assurance and that Delegation remain a standing item on all future agendas.
007/023	**Place Performance Pack**
	Mrs Brown presented the presentation as set out and gave members the opportunity to ask any questions. Mrs Cartwright referred members to data around virtual wards and suggested that some areas had experienced issues with capacity, then queried what had been a success and how any risks were mitigated as they arose. Mrs Brown responded to advise that any patient who is admitted to the Emergency Department are automatically on-boarded by the service, which in turn supports the reduction in re-admittance figures. Mrs Brown also placed on record her thanks to Respiratory Consultants at the Trust for their support with this initiative.

	Mr Daraz referenced Docobo and queried whether plans were in place to ensure local care homes were involved. Mrs Brown clarified that it had already been introduced and had proven useful as a communications platform to troubleshoot issues in good time. Dr Pickavance raised the issue of identifying where workforce contributions would be identified to support virtual ward initiatives, and requested a breakdown to be included in future reports. Mrs Cowley agreed with Dr Pickavance's comments sighting the importance of reviewing capacity levels. Mrs Hickman suggested that triage of patients across the borough poses challenges and suggested that a review of Integrated Care System (ICS) data take place to support its improvement. Mrs Hickman also emphasised that committee look to work with Walsall Healthcare to support patient triage, which could also lead to wider Black Country partnership working. Mrs Cowley commented that ensuring that financial elements are tracked and monitored could prove beneficial to show organisations how money can be saved, and suggested it could be useful to work collaboratively with other organisations to support this. Dr Pickavance queried what conversations had taken place with General Practitioners (GPs) around virtual ward initiatives. Mrs Brown responded to advise that some communications had been sent to GPs, but there was an overall lack of understanding on their part as to what the service can offer. Mrs Cartwright referenced wider Primary Care and education within the presentation and questioned how much of Primary Care understood the breadth of services on offer. It was agreed that Mrs Cartwright would review this outside of the meeting. **ACTION:** **Mrs Cartwright to collate a communications piece to distribute to Primary Care to summarise what services are on offer to the wider population.** There were no further comments from members.
008/023	**Terms of Reference**
	Mrs Cartwright introduced the report as set out and requested feedback from members. Several members stated that a number of amendments were needed, specifically to the weighting of the One Wolverhampton Board within the terms of reference.

	It was **resolved** that the terms of reference be distributed to members for comment with a deadline of Friday 3rd November 2023.
009/023	**Cycle of Business**
	Members **resolved** to approve the Cycle of Business as set out, sighting that due to the committee's infancy, further standing items of business could be added where necessary.
010/023	**Any other Business**
	There were no further items of business raised by members for discussion.
011/023	**Escalations to the Trust Board**
	There were no items of escalation raised by members for referral to the Trust Board.
012/023	**Date and Time of the Next Meeting**
	Committee noted that the next meeting would take place on Tuesday 30th January 2024 via Microsoft Teams.

Signed:

Committee Chair: Mrs Lisa Cowley

Date: Tuesday 28th November 2023