Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 3 SEPTEMBER 2020 AT 10:00 VIA MICROSOFT TEAMS AND TELECONFERENCE

For queries in relation to Board Papers, or for an invitation to join the meeting via Microsoft Teams, please contact the Trust Secretary on trish.mills@walsallhealthcare.nhs.uk

A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
OPENING ITEMS					
1.	Patient Story	Information	Interim Director of Nursing	Verbal	12.00
2.	Apologies for Absence	Information	Chair	Verbal	12.20
3.	Quorum and Declarations of Interest	Information	Chair	ENC	
4.	Minutes of the Board Meeting Held on 4th June 2020	Approval	Chair	ENC	
5.	Matters Arising and Action Sheet	Review	Chair	ENC	
6.	Chair's Report	Information	Chair	ENC	12.25
7.	Chief Executive's Report	Information and Assurance	Chief Executive	ENC	12.35
8.	**PROVIDE SAFE HIGH QUALITY CARE**				
	8.1 Quality, Patient Experience and Safety Committee Report	Assurance/ Information	Chair of QPES	ENC	12.50
	8.2 Executive Report – Provide Safe High Quality Care Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Medical Director Interim Director of Nursing	ENC	12.55
	8.3 Mortality Report 8.4 Learning from COVID-19 Deaths	Assurance	Medical Director	ENC	13.20
9.	**CARE AT HOME**				
	9.1 Walsall Together Partnership Board Committee Report	Assurance/ Information	Chair of WTPB	ENC	13.35
	9.2 Executive Report – Care at Home Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of Integration	ENC	13.40
COMFORT BREAK – 14.00 TO 14.15					
10.	**VALUE OUR COLLEAGUES**				
	10.1 People and Organisational Development Committee Report	Assurance/ Information	Chair of PODC	ENC	14.15
	10.2 Executive Report – Value Our Colleagues Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of People & Culture	ENC	14.20
	10.3 People Plan	Information	Director of People & Culture	ENC	14.40

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
	10.4 BAME Colleagues Risk Assessments	Assurance	Director of People & Culture	ENC	14.50
	10.5 Workforce and Employment Inequalities	Assurance	Director of People & Culture	ENC	15.00
	10.6 Safe Staffing Report	Assurance	Interim Director of Nursing	ENC	15.10
	10.7 Freedom to Speak Up Annual Report and Strategy	Assurance	Director of People & Culture	ENC	15.15
	10.8 Responsible Officer Revalidation and Appraisal Update	Approval	Medical Director	ENC	15.20
11.	**USE RESOURCES WELL**				
	11.1 Performance, Finance and Investment Committee Report	Assurance/ Information	Chair of PFIC	ENC	15.25
	11.2 Executive Report – Use Resources Well Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance	Director of Finance/Chief Operating Officer	ENC	15.30
	11.3 Income/Budget Update	Information	Director of Finance	Verbal	15.50
12.	**WORK CLOSELY WITH PARTNERS**				
	12.1 Executive Report – Work Closely With Partners Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 3: Improvement Programme	Assurance	Medical Director	ENC	15.55
	GOVERNANCE AND WELL LED				
13.	Audit Committee Report	Assurance	Chair Audit Committee	ENC	16.05
14.	Committee Annual Reports and Terms of Reference	Approval/ Information	Director of Governance	ENC	16.10
15.	Improvement Programme Update	Information	Director of Governance	ENC	16.15
16.	Use of Trust Seal	Information	Trust Secretary	ENC	16.20
17.	Update on NHSI undertakings	Assurance	Trust Secretary	ENC	16.25
CLOSING ITEMS					
18.	Questions from the public				16.30
	Date of next meeting Thursday 1st October 2020				
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 3rd September 2020			
Declarations of Interest			**AGENDA ITEM: 3** **ENC: 1**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Danielle Oum Chair
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The report presents a Register of Directors' interests to reflect the interests of the Trust Board members. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	It's fundamental that staff at the Trust are transparent and adhere to both our local policy and guidance set out by NHS England and declare any appropriate conflicts of interest against the clearly defined rules.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at August 2020

Name	Position held in Trust	Description of Interest
Ms Danielle Oum	Chair	Chair: Health watch Birmingham
		Committee Member: Health watch England
		Chair: Midlands Landlord whg
		Non-Executive Director: Royal Wolverhampton NHS Trust
		Co-Chair of the NHS Confederation BME Leaders Network
		Co - Chair, Centre for Health and Social Care Leadership, University of Birmingham.
Mr John Dunn	Non-executive Director	No Interests to declare.
Mr Sukhbinder Heer	Non-executive Director	Powerfab Excavators Limited - manufacturing
		Evoke Education Technologies (UK) Limited - online education consulting
		Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity).
		Consilium Consulting (Cardiff) Limited - corporate finance
		Mind Matrix (Europe) Limited - IT
		Chester Rutland Limited- Property Consulting
		Persona Holdings Limited - consulting and advisory
		Birmingham Community Healthcare NHS Foundation Trust - NHS
		Black Country Healthcare NHS Foundation Trust - NHS
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision).
		Non-Executive Director – Birmingham and Solihull Mental Health Trust.
		Director of PG Consultancy
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd
		Associate Consultant at Provex Solutions Ltd
Ms Pamela Bradbury	Non-executive Director	Consultant with Health Education England
		People Champion – NHS Leadership Academy
		Partner, Dr George Solomon is a Non-Executive Director at Dudley Integrated Health and Care Trust

Mr B Diamond	Non-executive Director	Director of the Aerial Business Ltd.
		Partner - Registered nurse and General Manager at Gracewell of Sutton Coldfield Care Home
Mr P Assinder	Non-executive Director	Chief Executive Officer - Dudley Integrated Health & Care Trust
		Director of Rodborough Consultancy Ltd.
		Governor of Solihull College & University Centre
		Honorary Lecturer, University of Wolverhampton
		Associate of Provex Solutions Ltd.
Mr R Virdee	Non-executive Director	No Interests to declare.
Mr Richard Beeken	Chief Executive	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University.
		Director – Watery Bank Barns Ltd.
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
Mr Daren Fradgley	Director of Integration	Director of Oaklands Management Company
		Clinical Adviser NHS 111/Out of Hours
		Non-Executive Director at whg
Dr Matthew Lewis	Medical Director	Spouse, Dr Anne Lewis, is a partner in general practice at the Oaks Medical, Great Barr
		Director of Dr MJV Lewis Private Practice Ltd.
Ms Jenna Davies	Director of Governance	No Interests to declare.
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chattered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT
		Sister in Law – Head of Specialist Services St Giles Hospice
Ms Ann-Marie Riley	Interim Director of Nursing	On secondment from Nottingham University Hospitals NHS Trust
Ms Glenda Augustine	Director of Performance & Improvement	No interests to declare

RECOMMENDATIONS

The Board are asked to note the report

Walsall Healthcare NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 2 JULY AT 10:00 a.m. HELD VIRTUALLY VIA TEAMS

Present:

Ms D Oum	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director
Mr S Heer	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mrs A Baines	Non-Executive Director
Mrs P Bradbury	Non-Executive Director
Mr B Diamond	Non-Executive Director
Mr R Beeken	Chief Executive
Ms AM Riley	Interim Director of Nursing
Mr R Caldicott	Director of Finance
Mr N Hobbs	Chief Operating Officer

In Attendance:

Mr P Assinder	Associate Non-Executive Director
Mr R Virdee	Associate Non-Executive Director
Mrs S Rowe	Associate Non-Executive Director
Dr M Lewis	Medical Director
Mr D Fradgley	Director of Integration
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Mrs T Mills	Trust Secretary

Members of the Public: 0
Members of Staff: Jane Wilson and Pat Usher – Staffside; Kuldeep Singh for patient story
Observers: 1 Aileen Farrer – Healthwatch

The meeting started at 10.30am due to technical issues with Microsoft Teams

052/20 Patient Story

Mr Kuldeep Singh, Patient Experience Manager, presented stories from patients that were admitted to ward 17. The first patient praised the treatment received, both in the emergency department and in ward 17, however felt that the choice of food could be improved offering a wider choice, particularly for longer stay patients.

The second patient had been brought into the hospital by ambulance and had spent time in ITU before being transferred to ward 17. The Patient told of her frustrations of being ill with COVID-19 – not seeing her family and having to rely on nursing staff when she was used to doing things for herself. This patient pointed out that, although she recognised that COVID-19 raised challenges for staff, and that some staff went above and beyond for her, there were instances where the attitude of staff towards her was unacceptable and she felt she was being talked down to.

The Board recognised the patients' bravery in sharing their stories, particularly when they are at their most vulnerable in a hospital bed, and noted that it was

difficult to hear when patients do not have a good experience under our care. Mrs Riley informed the Board that as soon as the sister on the ward was made aware of the issues it was dealt with swiftly. With respect to food choices, a public consultation will begin on 13th July with catering, dietetics and patient experience to ensure we are offering the right choices for the diversity of our population.

It was agreed that future patient stories would reflect the different ethnic groups that make up our patient population.

053/20 Quorum and Declarations of Interest

The meeting was quorate and no further interests were declared over and above those noted on the register.

054/20 Minutes of the Board Meeting held in Public on 4th June 2020

The Minutes **were approved** as a true reflection of the meeting, subject to the following amendments:

Page 6, paragraph 2 should read 'DTC' not 'DCT'
Page 12, paragraph 1 should include the underlined word – 'Cancer waiting time has met both the 2 week standards…'

055/20 Matters Arising and Action Sheet

The action log was reviewed by the Board with the following noted:

183/19 – action closed, as the action to keep the BAF and Corporate Risk Register on the Board agenda monthly appears at 042/20 and is a more updated action.

041/20 – closed with an update from Mr Hobbs on anti-body testing.

043/20 - to remain open until the impact of track and trace can be determined.

056/20 Chair's Report

The Chair wished to recognise, on behalf of the Board, the hard work and long hours that have been worked by the Executive Directors and all staff in the organisation during the pandemic and into restoration and recovery, and extended the Board's appreciation.

The Chair and Non-Executive members noted that the quality of Board papers for this meeting were not at the level required to fulfil the Board's role of assurance. The expectation is that executive summaries would be completed by the executive lead, with that summary drawing out the salient points, successes, issues, risks and mitigations to deliver the objectives, with any re-prioritisation of resources made clear. Mr Beeken accepted that the papers had not met expectations of the Board. The Chair acknowledged that work is underway to

improve the quality and assurance in the reports. A task and finish group of Board Members will be convened to review reporting

The Chair's report set out the activities of the Chair and the Non-Executive Directors in line with and in support of the Trust's strategic objectives including Board development sessions on risk management; culture and systems required for outstanding well-led ratings; and the emergency department new build.

The Chair and Chairs of Board Committees also attended the workstream meetings of the improvement programme to get a better understanding of the programmes of work to deliver the strategic objectives.

The Chair and members of the board held the inaugural BAME (Black, Asian, Minority Ethnic) Cabinet to address workforce rate inequality and its impact on BAME colleagues in the Trust.

The Chair will be holding regular 'pull up a chair with the Chair' sessions in support of the Freedom to Speak Up Guardians.

ACTION

(a) Meeting between Board Chair, Committee Chairs, Mr Beeken, Mr Fradgley, Ms Davies and Mrs Mills to ensure expectations on assurance in Board papers is clear, and that they provide the right level of detail and analysis from the lead executives as to the risks and mitigating actions. Director of Governance

057/20 Chief Executive's Report

The Board were updated on overall progress on the Improvement Programme. Work continues on development of comprehensive Project Initiation Documents ("PIDs") for the 5 core workstreams of the programme and the Governance and Well-Led workstream; project management resources are in place; and formal programme governance has been reinstated for oversight. Mr Beeken provided a high level overview of each strategic objective as follows:

- Safe, High Quality Care – as the PIDs have been developed and scoped, the resource issues with respect to oversight, administration, communication and engagement have become more apparent throughout all the workstreams. This is also highlighted in this core workstream. This is being addressed with a resourcing proposal is which will come back to the Board.
- Care at home – critical to the future of this objective is the balance between financial resources of our aspirations on the Integrated Care Partnerships ("ICP"), with national expectations on recovery of constitutional standards, and that the balance is meeting our own expectations regarding health inequalities.
- Working With Partners – there has been a re-start of the Joint Executive Steering Group between the Trust, the Royal Wolverhampton Trust and the Dudley Group Foundation Trust which was well attended. In that session a more ambitious scope of joint work was agreed to more explicitly involve colleagues from Sandwell and West Birmingham Trust in the work so the

critical mass can drive delivery of Black Country contained specialist cancer services, and secondly expanding the rationale of the evidence base for changes made. Mr Beeken made it clear that the phrase functional integration is used to describe the coming together of clinical services and workforce to deliver them across acute hospitals in the Black Country to address any workface gaps, critical mass challenges, diseconomies of scale or better delivery of best practice benchmarks. It is distinct and separate from considerations in the longer term for more formal organisational collaboration.

- Valuing Colleagues – resourcing challenges are evident, particularly around staff engagement in this workstream, both in terms of capability and capacity, with development of a clear engagement methodology around improvement programme a key to success.
- Effective Use of Resources – a critical issue with this workstream is establishing a credible baseline for what constitutes current performance on productivity and efficiency because of COVID-19 mitigating factors, and setting realistic trajectories for improvement, within the context of the STP post-COVID recovery plan, the first draft of which is due by the end of July.

The Board queried whether the Trust's ambitions were sufficiently assertive given the opportunities which COVID-19 has provided over and above the challenges, particularly given the uniqueness of Walsall Together. Mr Beeken pointed out that this was not just a Trust issue, but one of a larger system in that initial discussions are focused on what the system can do together that it cannot do separately, and that over the coming months, the focus will be on determining what the reset is strategically in terms of workforce and estate and expected output we can achieve as a system. It was agreed that the executive would look further at the opportunities to be seized more assertively for the people of Walsall, and where the improvement programme may be refined to reflect that.

058/20 Safe, High Quality Care

The Board reviewed the Safe, High Quality Care risks (both strategic and corporate); performance and workstream update that had been reviewed by the Quality, Patient Experience and Safety Committee ("QPES").

Mrs Riley highlighted the following:

- The Care Excellence Strategy is the overarching approach with a multi-professional lens;
- The strategy is underpinned by the Pathways to Excellence and a number of projects are planned under this programme;
- There is a baseline for the CQC 'must do' and 'should do' actions and a new group has been formed to oversee this;
- Perfect Ward app will launch on 27th July;
- BAME Shared Decision Council is progressing;
- A review has been undertaken of KPIs and temporary staff to look at the establishment from a multi-professional angle. PODC will have oversight;
- Mental Health Steering Group has been established;
- Performance dashboards are being developed which will also indicate performance against our peers.

The Board commended the organisation on the initiatives in the workstream, recognising the significant work that has taken place, despite work pressures during COVID-19, to identify elements of the care excellence programme through a multi-professional lens, noting this was a step change for the Trust. Work is underway with divisions to identify their priorities to focus areas that will yield the greatest benefits to patients.

Dr Lewis noted concerns over performance metrics on VTE, Mental Capacity Act and discharge summaries and the need to look at data quality, and ensure it is being collected appropriately, and the Perfect Ward app will help with that, as will building on digital opportunities such as Medway and Vitals to influence behaviours. Clinical champions and accountability to deliver good quality clinical care is key to seeing improvement in performance over the coming months in these metrics.

Mrs Riley highlighted the development of the care excellence strategy, which will bring together a number of quality and professional strategies to set clear strategic quality priorities and ambitions which will be delivered through the Safe and High Quality care workstream of the improvement programme.

The level of pace in addressing some of the concerns noted in the papers and the high ratings of the risks was queried, with Mrs Riley pointing out that there has been a focus on understanding our ambition, identifying the gap and prioritising the reduction of harm and continuous learning projects, which is reflected in the significant amount of work with the PIDs. It was noted that clarity on how the Board and its Committees (both QPES and the People and Organisational Development Committee – "PODC") receive assurance against delivery of the strategy, impact and benefits of initiatives will be key.

Dr Lewis provided an update on the mortality review of COVID-19 related deaths, with further reporting through QPES in August and a wider STP review due in September. The Board heard that Dr Lewis and Mr Fradgley are working closely together to ensure constituency approach of mortality processes in the acute and community settings. The Trust has a system to ensure that lessons learnt about managing COVID-19 deaths are disseminated, which include a programme of grand rounds to share best practice and recent research; contributions to research trials; learning from clinical incidents and complaints; COVID-19 fast learning group; and the mortality surveillance group. The work that the STP is doing is also looking at social determinants with respect to COVID-19 deaths.

059/20 Care at Home

The Board reviewed the Care at Home risks and ambitions in the improvement programme. Performance was also reviewed and had been discussed at the Walsall Together Partnership Board ("WTPB").

Mr Fradgley pointed out there is reasonable stability now, and the WTPB is looking at the next strategic steps of the partnership, with work progressing to develop a single data path mapped against population health.

The Chair of the WTPB, Mrs Baines, commended the volume and wide ranging

nature of work and its increasing focus on health inequalities, noting that the partnership is maturing, and with that brings inevitable challenges working together as a set of partners. A review of effectiveness of the WTPB will assist in focusing on the next phase of the partnership, as will a planned internal audit on its governance .

The Board acknowledged the significant successes with respect to the care coordination and the medically fit for discharge metrics. Capacity issues in the locality team are a concern however the flows are being reviewed to address the risks and Board Committees will oversee this work.

The journey to ICP status will be mapped over the next 4-6 weeks, and the Board sought to ensure that future papers are clear on the ways in which the Board would be involved in this.

ACTION

Mr Fradgley – Journey to ICP status mapping to be presented to the Board in October.

060/20 Working with Partners

The Board reviewed the Working with Partners risks and ambitions in the improvement programme, noting that the Performance, Finance and Investment Committee ("PFIC") has oversight of this workstream.

The work was paused during COVID-19 but the collaborative group has re-started and reinforced their commitment to functional integration. The Board noted that the focus of this objective is the acute hospital partners, with significant achievements over recent years, notably with rheumatology and Black Country pathology services, cardiology, and stroke; and ongoing discussions for dermatology with a joint clinical lead appointed between ourselves and RWT. Radiology has been added to the services being considered, and the fellowship programme reinstated.

ACTION:

(a) Mr Hobbs: It was agreed that the next report will provide the data regarding the outflow of funds outside the Black Country and the inconvenience caused to patients being referred out of area whilst the collaboration is taking shape.
(b) Mr Hobbs: The benefits already derived from the collaboration from a financial and patient perspective to be incorporated into the Working with Partners programme, with any future business cases through PFIC to demonstrate the benefits of previous collaborations.

061/20 Valuing Colleagues

The Board reviewed the Valuing Colleagues risks (both strategic and corporate) and ambitions in the improvement programme. Performance was also reviewed and had been discussed at PODC.

The Board sought more information on the fairness and transparency of processes for recruitment. Mrs Griffiths confirmed that the process was not currently fit for purpose and whilst assurance is not possible at this stage, an immediate review of the way the Trust carries out recruitment and the criteria applied. Recruitment is being centralised and cultural ambassadors will play a larger role; confirm and challenge on the recruitment panels; interim WRES data which shows an improvement, People and organisational development will continue to oversee the development of further plans through July and August, and the policy will be reviewed by PODC in August.

062/20 Effective Use of Resources

The Board reviewed the Effective Use of Resources risks (strategic and corporate) and ambitions in the improvement programme. Performance on constitutional standards was also reviewed and had been discussed at PFIC. PFIC will review the BAF to provide a more updated position when it meets in July.

The Board commended the results for the 4 hour emergency access standard which have been the best at the Trust for five years, with June's performance improving further on May.

Risks and gaps in assurance include further assurance sought by PFIC on backlog maintenance investments; and through the restoration and recovery programme the infection control guidance for COVID-19 segregation has impacted elective surgical capacity and affects ability to use resources efficiently and minimise wait times for elective care. Both these issues will be discussed at the PFIC and QPES meetings in July.

The annual accounts for 2019/20 were endorsed by the Extraordinary Trust Board meeting on 22nd June and filed in line with national timeframes.

Month 2 reported a breakeven performance using the current financial regime enabling further funds related to COVID-19 and the Trust has requested £2.17m YTD to maintain that breakeven position.

Clarification as to what the funding approach will be from 1st August is not yet available, however work has commenced on expenditure trajectories for months 5-12 on a STP basis. PFIC will meet in extraordinary session on 22nd July to look at the new guidance which is expected by then, ambitions around workforce and activity performance, and discuss the setting of an emergency budget for the rest of the financial year.

The Board challenged whether the financial discussions were being shaped and driven by clinical, operational and people issues post COVID-19 and some of the good practice we want to implement. The Chair of PFIC, Mr Dunn, confirmed that prior to the extraordinary PFIC meeting on 22nd July, the demand profile is being developed to understand if any trade-offs are possible. If an emergency budget needs to be put in place from 1 August onwards there is time to debate this before the normal PFIC meeting. The Chair of the Board encouraged any non-PFIC members who wished to, to attend the extraordinary meeting.

Mr Assinder left the meeting at 13.10.

063/20 Governance and Well Led

The Board reviewed the Governance and Well-Led improvement programme update, noting that the recommendations from the NHSI review on governance and accountability were to be incorporated into the high level PIDs. Reporting of this workstream will be to the Board monthly. Externally facilitated Board development will also be procured to reaffirm this work.

064/20 COVID-19 BAF Risk S07

The Board reviewed BAF Risk S07 and noted that the impact of COVID-19 had been picked up in discussions and papers from the other workstreams. The document notes that the midwifery led unit was due to open in July, however due to staffing concerns that will now be September.

065/20 Emergency Department New Build – Full Business Case

The Board reviewed the full business case for the £36.2m capital funding through the 4th Wave STP capital schemes to deliver a new build Urgent Care Centre, Emergency Department (including Children's Emergency Department), co-located Paediatric Assessment Unit, and Acute Medical Unit in addition to refurbished retained estate to provide Ambulatory Emergency Care, Frailty and Imaging services.

This development will enable the Trust to respond to an increased flow of patients to Walsall resulting from the relocation of services in Sandwell and West Birmingham to the Midland Metropolitan Hospital site in 2022/23 and manage sustained annual increases in emergency care demand experienced in Walsall. Capital investment on the Walsall Manor Hospital site to provide this additional capacity has been given the highest priority in The Black Country Sustainability Transformation Plan.

The modern facilities and models of care are intended to give staff a service to be proud of, and to support improved recruitment and retention of staff in the various specialisms involved. Staff have been actively involved in the design and modelling of the development, and Clinical Directors, Matrons, Divisional Directors of Nursing and Divisional Directors have signed off the plans.

The designs are also built on extensive engagement with service users over the last 2 years including work with Healthwatch Walsall, the Emergency and Acute Medicine Friends and Family Forum, a Paediatrics Review with teenagers from a local school, and on site and online Service User Workshops with the design and architectural teams. The patient experience, including for vulnerable groups such as patients with Mental Health needs or who are immunocompromised, is at the heart of the design.

This business case seeks to improve the quality, safety and experience of patients receiving emergency care at the Trust, and will result in improvements to key clinical safety measures such as the proportion of patients seen within the

ED within 60 minutes of arrival, and the proportion of patients admitted or discharged within four hours of arrival.

The full business case was discussed by the Board in a development session on 18th June, and reviewed by the PFIC on 24th June who endorsed it to the Board for approval. QPES and PODC also reviewed the full business case for quality and safety, and workforce issues on 25th June.

The Board **approved the full business case**, and thanked all those involved for their diligence and hard work to bring this opportunity to the people of Walsall.

The next steps are approval by the CCG, planning permission through the council and final approval by NHSEI.

ACTION

(a) Sukhbinder Heer and Russell Caldicott - a review of the escrow framework to take place in view of COVID-19, particularly around timeframes and force majeure provisions.

066/20 Director of Nursing Oversight Report

The report was noted by the Board with the key elements also discussed at QPES and PODC as follows:

- RN vacancy rate is currently 9.73% with work being undertaken to review the reporting of nurse vacancies within the organisation.
- Nursing and Midwifery fill rates have improved from 85.69% in April to 90.58% in May but remain below the 95% target. However, occupancy varied in May between 60 to 89% with mean inpatient occupancy of 74%.
- There is a slight decrease in the total number of pressure ulcers that have developed in both hospital and community setting during the month of May but there were pressure ulcers attributed to proning practice in ICU.
- Although falls overall has reduced the number of falls per bed days has seen an increase.
- The prevalence of late observations has improved in month and has recovered from the deteriorating picture during the peak of Covid-19 to the best performance for the past 12 months
- There were 83 patients who were nursed in mixed sex accommodation due to managing Covid-19 streams. None of these patients had to share bathroom and toilet facilities with the opposite sex.
- Continued focus remains on improving the safeguarding adults and children's training compliance and alternative methods of delivering training to meet level 3 requirements have been developed.
- The 'Perfect Ward' app contract has been signed and the audit programme is in development. This programme will apply to nursing, midwifery, AHPs and medical teams.
- Shared decision making councils have started to be identified. The first of these met in June.
- A revised CQC action plan has been developed and incorporates any outstanding actions from previous inspections. Assurance on progress against the action plan will be monitored via a new CQC action plan oversight meeting

chaired by the Interim Director of Nursing.

067/20 Director of Safe Wards Quarterly Report

The report was received by the Board with the key elements as follows: The report was noted by the Board, noting the impact of conducting meetings following exception reports to address the root causes, positively impacting on quality of patient care. Administrative support is being put in place to ensure the reporting is timelier going forward.

068/20 Equality and Diversity Annual Report

The report was received by the Board with the key elements as follows: The report was noted by the Board as part of the assessment and had also been discussed at PODC, noting that there had been an increased focus on equality, diversity and inclusion in recent months that is not reflected in the report, as this was reporting on actions from 2019/20. Notwithstanding this the look forward needs be strengthened considerably. Mrs Griffiths pointed out an error in the report for the equality measures for band 7 and above by ethnicity, noting the figure should be 9.5% not 5.4% but does not include the medical workforce, but clearly there is work to do even at the 9.5% to be representative.

The Board noted the report and recognised this was a look back on 2019/20 which lists initiatives and actions, but not impact and outcomes, but is not representative of the Trust's ambitions for this area going forward.

ACTION

(a) Mrs Griffiths to develop a summary of the equality and diversity annual report to be used as a baseline

069/20 Quality, Patient Safety Committee Highlight report

The Committee met on 25th June and the Board noted the contents of its report and the Infection, Prevention and Control Board Assurance Framework.

070/20 Performance, Finance and Investment Committee Highlight Report

The Committee met on 24th June and the Board noted the contents of its report, including the overview on restoration and recovery.

071/20 People and Organisational Development Committee Highlight Report

The Committee met on 25th June and the Board noted the contents of its report.

072/20 Walsall Together Partnership Board Highlight Report

The Committee met on 17th June and the Board noted the contents of its report.

073/20 Audit Committee Highlight Report

The Committee met on 22nd June and the Board noted the contents of its report and the intent of the Committee to provide a bi-annual report to the Board on the management of risk in the organisation.

074/20 Charitable Funds Committee Highlight Report

The Committee met on 29th June and the Board noted the contents of its report and the drop in the value of the investment portfolio due to COVID-19.

075/20 Questions from the Public

No questions.

076/20 Date of Next Meeting

The meeting finished 1.35.pm
The next meeting of the Trust Board held in public will be on Thursday 3rd September 2020.

Resolution:
The Board resolved to invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960.

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3rd September 2020			
Trust Board Chair's Report			**AGENDA ITEM: 6** **ENC: 4**
Report Author and Job Title:	Danielle Oum, Trust Board Chair	**Responsible Director:**	Danielle Oum, Trust Board Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This is a regular paper providing oversight of Chair and Non-Executive Director activities. The paper includes details of key activities undertaken since the last Trust Board meeting.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Chair's Update

1. Chair's Action Taken

The Board approved a governance continuity plan in May 2020, which was due to expire on 31st July. As at that date we were still awaiting national guidance on the financial arrangements and process moving forward. Therefore on 28th July 2020 I took Chair's action to approve an extension of the governance continuity plan to 30th September 2020, or until a revised plan is developed and approved by the Board, whichever is the earlier – such revised plan being developed within two weeks of the guidance being received.

2. Board Walks

Board members were delighted to reinstate Board Walks through the months of June, July and August, albeit virtually. Board Walks provided an opportunity for non-executive directors to hear directly from staff the issues that were of real concern to them during the peak of COVID-19, and as they look towards restoration and recovery over the coming months.

We were hosted by members of staff from the acute and community settings, including the care home support team, acute medicine unit, Hollybank, microbiology and infection prevention and control, occupational health, pharmacy, IT, operating theatres, locality and rapid response teams. Staff told us of the unprecedented difficulties they faced due to the nature of the pandemic and the mark it left on them all and the families of those who very sadly lost their lives. The acute medicine unit and IT department told us of the profound effect losing colleagues to COVID-19 had on them individually and as a team.

Concern over PPE, particularly early on in the pandemic, was a theme across many areas. Although the Trust had sufficient stocks of PPE and followed Public Health England guidance throughout, there was some conflicting information on PPE levels which exacerbated anxiety and required reassurance from the microbiology teams. As we move into restoration and recovery, the Board is keenly aware of the need to balance the restoration of services in line with national guidance, with the real concerns that staff have expressed as to their readiness to cope with a potential second wave of COVID-19 – potentially coupled with winter flu and norovirus. Keeping patients and staff safe during this time is a priority for the Trust. Whilst the Board's quality, performance and people committees will look in detail at the clinical risks of restoring services, performance requirements to be met, and the effect on colleagues respectively, a focused session on restoration and recovery will be held prior to this public Trust Board meeting bringing those elements together.

During Board Walks, staff told us of the solidarity of their teams and of colleagues who supported each other in new environments and to face exceptional challenges. The COVID-19 summit which took place in July was an opportunity to hear the experiences of staff during the pandemic, and the themes and learnings from that summit form part of the approach to staff wellbeing in the coming months, harnessing the positive changes that have introduced during this very difficult time.

3. Provide Safe High Quality Care

I and other Non-Executive Directors attended the Reflective COVID-19 Summit on 27th July which took place as an online event. The aim of the day was to serve as an opportunity for sense-making of the experiences and changes that have come about due to the pandemic, and to appreciate the lessons learned from the Trust's response. Richard Beeken opened the day with an address of reflection and paid tribute to our patients and staff that were lost during this time.

The day included various talks, reflective videos and breakout groups to discuss themes collated as part of the Trust's recent COVID-19 evaluation project. Breakout sessions featured discussions and reflections from members of staff on the themes of staff and wellbeing; quality and safety; infection prevention; digital provisions; leadership, community and transition. I would like to thank all staff who took part in this event to share the learning from the pandemic to-date and build into preparations for any future infection surges.

4. Care at Home

I presented to the NHS Confederation Health Inequalities Webinar on the innovative partnership approaches of Walsall Together

5. Value Our Colleagues

The following events/activities relate to this objective:

I hosted a number of 'Pull up a Chair with the Chair" sessions in July and August which provided valuable opportunities for me to hold conversations with colleagues about their experiences of working in the Trust. I greatly appreciate the generosity of colleagues who shared their stories, providing invaluable learning that will inform the Trust's ability to truly Value Colleagues.

The BAME (Black, Asian, Minority Ethnic) Cabinet met on 10th July, 24th July, 7th Aug and 21st Aug. This subset of the Board serves to provide creative thinking and a sounding board in order to accelerate progress on workforce race inequality.

More than 400 responses were been received to a survey to shape the Trust's Equality, Diversity and Inclusion (EDI) Strategy. The EDI Strategy will set out the organisation's approach to delivering equality, diversity and inclusion for the benefit of both the patient population and staff who work for the trust and live in Walsall, in line with the aims and objectives of the Equality Act 2010 and the Public Sector Equality Duty.

Thank you to all who took the time to respond to this vital step in the Trust's commitment to equality, diversity and inclusion. I would like to thank Rajpal Virdee, Associate Non-Executive Director who chairs the Trust's EDI Group for his involvement in shaping the strategy.

This feedback, together with a Board development session later this month, will inform the strategy an implementation plan which will be shared with staff, patients and partners.

It was an honour to attend this year's Long Service event, celebrating the contribution of colleagues who have worked at the Trust.

I attended the People and Organisational Development Committee on 30th July where the wellbeing of colleagues was a focus as we move into restoration and recovery. The Board will ensure this is factored in to restoration and recovery when we hold a development session prior to this meeting.

6. Use Resources Well

I attended the Performance, Finance and Investment Committee on 29th July. Restoration and recovery issues and those related to finance guidance were discussed. These will factor in the development session to be held prior to this meeting.

The Nominations and Remuneration Committee met on 17th August with me as Chair. The Committee reviewed its effectiveness for the 2019/20 year and agreed revisions to its terms of reference.

7. Work Closely with Partners

Restoration and recovery was the focus of the fortnightly regional chairs' meetings and weekly Black Country STP meetings which I attended.

The Chair of Croydon Health Services NHS Trust and I met to understand the South West London system approach to tackling structural race and health inequalities and its applicability to the Black Country ICS.

I brokered meetings with the Vine Trust, TIN Smart Social and Walsall Together, Walsall Housing Group and Walsall College to explore opportunities for collaborative working to maximise the Trust's role as an anchor institution in order to promote socio-economic inclusion in the communities we serve.

It was a pleasure to be able to contribute to a filmed thought-piece for Warwick University on the importance of gender equality in science, health and housing.

8. Meetings/Events

I continue to participate in regular COVID-19 Updates sessions with executives and non- executive colleagues, and am contributing to an NHSEI review of lessons learnt from COVID-19 which will help inform preparations for any future waves

This month I had the pleasure of welcoming a new member of the executive team to the Trust. Glenda Augustine is the Director of Planning and Improvement. Glenda has a healthcare background, starting her career as a nurse and a midwifery and health visitor, and her role before joining us was as the Head of Intelligence, Knowledge Management and Innovation at the NHS England RightCare Transformation Programme.

MEETING OF THE PUBLIC TRUST BOARD 3rd September 2020			
Chief Executive's report			**AGENDA ITEM: 7** **ENC: 5**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	Daren Fradgley, Deputy Chief Executive
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report provides the Chief Executive's (CEO) overview of the risks to delivery of the Trust strategic objectives and actions the CEO will personally lead and sponsor, to address gaps in controls and assurance. It provides the Trust Board with a view into the delivery of our strategic objectives through the rapidly changing external tactical and strategic context. This month, the Board's attention is drawn to our own strategic objectives through the particular lens of the national, regional and local system expectations associated with the third phase of national incident management of the COVID-19 pandemic. Increasingly, the strategic ambitions of our organisation, as expressed through the refreshed wording of our objectives, are merging with the strategic ambitions of the NHS, as expressed through recovery and restoration planning expectations and the NHS People Plan. It is vital that we are comfortable as a Board that our response remains pertinent to the needs of our local population, however and that we can clearly articulate the evidence for our decisions should we choose to diverge from national or system direction at any point.		
Recommendation	Members of the Trust Board are asked to: • Note the content of the report • Discuss its contents • Determine whether there need to be any changes to the proposed focus of the CEO as reflected in this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report sets out the key immediate and strategic risks to the delivery of our Trust strategic objectives and describes the CEO's personal areas of intended focus to mitigate those risks. The Board are invited to discuss the report and any changes it wishes to see in CEO focus in the coming weeks and months.		

Resource implications	There are no resource implications associated with this paper.	
Legal and Equality and Diversity implications	There are no legal or equality and diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

CHIEF EXECUTIVE OFFICER'S REPORT

SEPTEMBER 2020

1. EXECUTIVE SUMMARY

The recovery and restoration agenda, particularly viewed through the lens of the phase three COVID response communication from Sir Simon Stevens, dominates our thinking and our actions at present. When the particular areas of focus of this agenda, such as elective recovery, tackling health inequalities and the changes to approach described in the NHS people Plan are considered, most of it dovetails nicely with the improvement programme work stream outputs and emerging timetables, much of which we have already determined to pursue, in order to deliver our strategic objectives and ambition.

There is always a balance to be struck however, between the centralised intentions and expectations of national policy and the locally determined priorities which meet the unique needs of our own population. To that end, I wish to publicly state that our priorities for the coming period of restoration, recovery and redesign of services will always be:

- Protecting the most vulnerable in Walsall, particularly through action we can take to reduce the health inequalities in the borough
- Maintaining the safest and most responsive urgent and emergency care system we can for winter 2020/21
- Reducing backlogs in urgent elective and cancer elective and diagnostic pathways
- Implementing the practical actions set out in the NHS People Plan, with a particular focus on staff health and wellbeing and a more inclusive and accountable culture in our Trust

Board colleagues will notice that we have adopted the new strategic objective descriptors in the Board Assurance Framework (BAF) and we use that framework not only to drive the content of this report but also the content of the whole Board agenda.

2. BOARD ASSURANCE FRAMEWORK

2.1 Safe, High Quality Care

I have long felt that one of the best indicators of patient safety and experience remains the 4 hour emergency access standard (EAS), more colloquially known as the "A&E 4 hour target". In July, the Trust achieved the national standard for emergency access, of 95%, for the first time in over 5 years. Moreover, that performance has lifted the Trust to 20th in the national rankings and 4th in the regional rankings, for the EAS. With fewer patients waiting more than 4 hours for their treatment in the Emergency Department, this will have materially impacted

patient mortality rates, clinical outcomes as well as patient experience. There are too many people to thank in this report who have contributed to this achievement, but all who have will, I hope, take confidence from the fact that we will continue to seek to provide the safest emergency and urgent care that we can, as we enter the difficult period of winter, for which we must plan with an eye on seasonal influenza, a natural increase in emergency demand (net of Walsall Together driven improvements) and of course, a potential second wave of COVID related hospitalisation.

The key outstanding risks within the BAF for this objective, relate to the delivery of the fundamentals of care more consistently as a Trust; the recovery of diagnostic and elective waiting list backlogs following COVID driven service disruption and the need to improve our approach to patient and carer involvement in service redesign and our improvement and strategic work.

As Chief Executive, I will, in the coming weeks and months, continue to ensure that our capacity planning for a safe winter is evidence based, thorough and takes no risks. I will also ensure that the organisation prioritises the delivery of the fundamentals of care through our care excellence work in the improvement programme which our Director of Nursing and Medical Director have successfully initiated as a multi-professional endeavour. I will continue to chair the Improvement Programme Board to assure myself that this prioritisation continues.

2.2 Care at Home

The clear and unapologetic focus of the national team, through Sir Simon Stevens' phase three letter to all health economies this month, is on mitigating the widening health inequalities which COVID has, at times, cruelly exposed in the last six months. In Walsall, already blighted by the post-industrial inheritance and indirectly affected by over 10 years of austerity, healthy life expectancy is deteriorating and the biggest outstanding BAF risk in my view, is the impact on people's health and health inequalities that the post COVID and post Brexit economic inheritance in Walsall.

We are the host provider for the multi-agency partnership (Walsall Together) which has been established to improve the health and wellbeing of our borough's population and as such, as CEO, I will take the following action over the next few weeks and months:

- Lead the discussions around the Partnership Board table regarding other agencies matching the bold resource shift the Walsall Healthcare Trust Board has already agreed to in 2020/21, allowing stepped changes in community team capacity and establishment
- Precipitate discussions within the partnership about how we collectively and individually support the most vulnerable and impacted parts of our community to mitigate the economic and health impact described above, and how we provide assurance to the Trust Board that this agenda is being moved forward
- Ensure that the national and system expectations regarding the development of an integrated care partnership (ICP) host contract, meets Walsall's needs and partner expectations. We must initially bring the Trust Board with us on that journey as host

provider, by setting out the ICP roadmap and options, by the autumn of this year. To this end a board development session is planned for this month which will set out the building blocks that are already in place and outlining what options for contractual delivery model and hosting arrangements

2.3 Working with partners

This strategic objective plays to the fact that we are unlikely to be able to deliver sustainable best practice in acute hospital services without transparent, evidence based partnerships with others across our system. By focusing on functional integration of clinical services, particularly by integrating the clinical workforce, we can collectively, as a Black Country system, deliver the service resilience, on a 7 day per week basis, we require.

Key successes of this critical work stream of our improvement programme is the re-establishment of the joint executive steering group on functional integration, between ourselves, the Dudley Group FT and The Royal Wolverhampton Trust. Importantly, and symbolically, Sandwell & West Birmingham Trust (SWBH) have now agreed to take an equal part in this steering group, which has thus far overseen the roll out of service integration plans in Dermatology and Urology, as well as the system People Board work on workforce bank collaboration. To complement the national strategy on imaging services, functional integration of Radiology services will be the next project to tackle between the Trusts and two workshops on this have already been held with the clinical and managerial teams. It is widely felt that the size and scope of the imaging services integration will require external facilitation and coordination.

Key risks to the delivery of our objective here are ensuring a meaningful collaboration with SWBH to maximise the critical mass of the system clinical workforce and secondly, ensuring that wider organisational collaboration and potential realignment, don't dominate the functional integration space, thereby crowding out this hugely important work. The functional integration agenda has been thrown into even sharper focus by the recovery and restoration work all organisations must deliver, as we seek to claw back elective and diagnostic backlogs. That work must be delivered on a system basis and we must assure ourselves that we have maximised the capacity we can deliver in a world of "living with COVID", by sharing that capacity between Trusts where appropriate and necessary.

The key actions for me as CEO on this agenda in the coming weeks and months will be to promote true assurance to the Trust Board, via the improvement programme work stream on working with partners, that our plans for functional integration are hitting the milestones we have agreed. In addition, I will work with Glenda Augustine, our newly appointed Director of Planning & Improvement, on the wider organisational collaboration agenda, with NHS Improvement and system partners. This will allow Ned Hobbs and Matthew Lewis, as Chief Operating Officer and Medical Director, the space to lead on the service and workforce collaboration in parallel.

2.4 Valuing colleagues

In recent weeks, we are pleased to have been able to confirm a continuation of our wider and expanded health and wellbeing offer to our staff, such as the Haven Room and an expansion to the wider occupational health offer. It is our absolute intention to continue and to develop this support, so that we make Walsall the very best place to work.

The work on health and wellbeing of our staff will need to be underpinned by an approach to rapidly increasing the inclusivity and civility of the culture in the Trust, also. To that end, it is pleasing to see an increase in the number of sources of cultural and behavioural issues being formed and coordinated (for example, Freedom to Speak Up Guardians, BAME shared decision making council, executive and non-executive walkabouts and conversations). This is, in turn, generating some concerning evidence of toxic behaviour from managers and staff alike, not consistent with Trust values. This is itself, the biggest risk we face in the delivery of this objective – the undermining of all of our good work on health and wellbeing and staff engagement, by influences which have contributed to poor organisational reputation in staff opinion surveys for years.

As CEO, over the next few weeks and months, I commit to work closely with Catherine Griffiths, our Director of People & Culture, to overtly seek out evidence of that toxic behaviour and tackle it quickly and incisively, with targeted organisation development and HR support. In addition, I will ensure that the “greater good” for the Black Country system is pursued in the workforce collaboration agenda, by seeking to persuade all partner organisations that organisational protectionism in the workforce field, will not resolve our longer term, system problems in that regard. A fully collaborative and integrated approach to temporary nursing, midwifery and medical staffing is essential.

2.5 Use resources well

The cost efficiency freedoms afforded all Trusts during the national phases 1 and 2 of the COVID response have been pragmatic and welcome. It has allowed a shift in investment to the community team establishments and has allowed the Trust to maintain its non-elective bed occupancy and services at a safe and responsive level throughout. Whilst, at the time of writing, there still is no formal agreement reached between the Treasury and DHSC on the funding settlement for the rest of the financial year, we have been advised that a similarly pragmatic approach to core income on a block payment basis is likely to continue but is not confirmed. Whilst outwardly that is reassuring, the fact that any top up income for Trusts incurring additional costs needs to be both prospectively agreed and managed across an entire system, as opposed to by Trust, means that we must tread with caution and have accurate, predictable plans for both temporary workforce expenditure and the forthcoming winter.

The risks to achieving the optimum use of resources remain the inefficiencies associated with managing elective recovery to strict infection prevention segregation and procedures, means we have not yet established a baseline of efficiency measurement from which we can improve. Another significant risk to this strategic objective remains the large backlog maintenance schedule and equipment replacement schedule, both of which may hamper both elective and diagnostic recovery as well as operational flexibility in future years. We do

not yet have the assurance we seek as a Board on this risk and must continue to explore tactical options available to us, to mitigate this risk.

My main areas of focus on use of resources in the coming weeks and months will be:

- Ensuring the Board receives an assuring approach to financial efficiency as we exit this financial year, which is both challenging yet realistic in the context of the COVID service inefficiencies described above
- Protect Walsall's immediate interests and mitigate risk wherever possible through system wide negotiations on core capital availability for 2021/22
- Ensure that any approach to functional integration between Black Country Trusts or indeed wider organisational collaboration, has a robust long term financial model for Walsall Healthcare NHS Trust and other system partners, which demonstrates that we are maximising aggregate financial efficiency as a system, greater than the sum of the individual parts

3. RECOMMENDATIONS

The Board are asked to note and discuss the content of this report and determine whether there should be any changes to those set out in this report, to the focus and attention of the CEO in the immediate future.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
Quality, Patient Experience and Safety Committee Highlight Report			**AGENDA ITEM: 8.1** **ENC: 6**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Pam Bradbury - Non Executive Director.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Quality and Patient Safety Committee meetings on 30th July and 27th August 2020. Of note are: 1. The Trust Board requested QPES to provide an update on histopathology performance rates which had initially been impacted by the Covid-19 pandemic. The Committee was assured at their July meeting that there had been a significant improvement in performance. Routine work was at 94% in 10 days or fewer for June which was above target. Urgent work was at 91% in 5 days or fewer for June which was just below the target of 95%, however, this had also been impacted by a machinery breakdown. This has now been resolved and it was expected that the target would be achieved in August. 2. Significant work is underway in the Safe, High Quality Care improvement programme workstream. The project briefs are complete for the workstream, and finalisation of the project initiation documents has been boosted by an additional resource. Focus is on completing the project benefits ahead of a Board development session in October. 3. Venous Thromboembolism ("VTE") compliance for July was 93.70% which remains below the compliance target of 95% but demonstrates a continued improvement and a number of ward areas are achieving the 95% target. 4. The prevalence of late observations has improved again in month to 89.70% in July 2020 from 89.10% in May 2020 which is the best performance since March 2019 5. The total number of Trust acquired pressure ulcers in July 2020 is 21; this is a decrease from the 31 reported in June 2020. The majority of these pressure ulcers have development within the		

	community setting 6. The trust has continued to see a reduction in the prevalence of falls per 1000 bed days continuing to achieve a performance of less than 6.1 per 1000 beds days as recognised as the national average by the Royal College Physicians The Board's attention is drawn to the following escalations: 7. The average inpatient friends and family score dipped to 87% from 89% in June. Staff attitude, implementation of care, communication and environment featured both positively and negatively in the comments. 8. The Trust was identified as performing worse than expected in the CQC 2019 Adult Inpatient Survey and as a result was issued with an outlier notification letter. All areas where the Trust performed worse than other Trusts have been included in the Perfect Ward audit schedule. 9. Adults and children's safeguarding training e-Learning has improved across levels 1 and 2. Level 3 training continues to be of concern but improvements in month have been made. 10. A preliminary report from Royal College of Surgeons identified problems with data collection and registration in Trauma and Orthopaedics. 11. Whilst there is good identification of issues, and inputs to address them being presented to it, the Committee reiterated the need for clarity on the impact of improvements on patients, and asked for these to be included, as well as triangulated learning, in future reports. 12. The Quality Account was scheduled for review at the August meeting, however it was not presented due to internal delays and late stakeholder input. Whilst the deadline for completion of the Quality Account was extended nationally to 5th December, the Committee expressed its disappointed that it was unable to review the Quality Account, having reviewed the Quality Priorities in July. The next meeting of the Committee will take place on 24th September 2020
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.
Risk in the BAF or Trust Risk Register	This report aligns to the BAF risk for safe high quality care and COVID-19

Resource implications	There are no new resource implications associated with this report.	
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee has met twice since the 2nd July Trust Board meeting, with those meetings taking place on 30th July and 27th August 2020. Both meetings were chaired by Mrs Pam Bradbury, Committee Chair and Non-Executive Member of the Trust Board and were quorate.

The Committee reports each month on escalations for the attention of the Trust Board and key issues from the meeting. In addition to the key matters on the front sheet of this report, the following were discussed by the Committee.

1. COVID-19 Restoration and Recovery Update

The Committee were updated on the operational restoration and recovery of clinical services impacted by the first surge in Covid-19 admissions to the hospital. A Board development session on restoration and recovery will be held prior to this Trust Board meeting dealing with the financial, people and quality issues, however the Committee discussed theatre capacity, elective surgery and diagnostic waiting times and pressures on community services ahead of that session. The quality impact assessment processes for restoration and recovery is being strengthened and the Committee will discuss this in more detail in September.

2. Hospital Acquired Covid-19 Infections

The Trust's position against requirements set out in the letter received from NHS England and NHS Improvement regarding healthcare associated Covid-19 infections was reported to the Committee in July. It was noted that healthcare associated infections and outbreaks were subject to review. The National Medical Examiner's Office has requested details of healthcare workers who have died of Covid-19, and the Trust has reported three. The Medical Director anticipates receiving the full report from the National Medical Examiner's Office in due course and will share that with the Committee.

3. Mortality

The Committee reviewed the quarterly mortality report and the approach to reviews of COVID-19 related deaths at its August meeting. Reports on both these matters are on the agenda for this Trust Board meeting.

4. Effectiveness Review and Terms of Reference

At the 30th July meeting the Committee approved its annual report and revisions to the terms of reference are on the Trust Board agenda for the September meeting. The Committee's revised cycle of business will be reviewed in September.

5. Risk Management

BAF risk S01 – safe, high quality care – which has a current risk rating of 20 was reviewed by the Committee in July and August. Additional information has been articulated to further rationalise current scoring. The Faculty of Research and Clinical Education (FORCE) and the Perfect Ward App have been added as current controls. Assurances, and gaps in

assurance have also been amended in month. The Committee reviewed three corporate risks, all of which had been reviewed in month and the risk description revised for two of the risks. The Committee discussed the requirement to review risk no. 2051 related to volumes of patients with COVID-19, given that it was articulated during the pandemic and both the risk and the mitigations have changed.

BAF Risk- S01- Safe and High Quality Care (Quality of Care)
Risk Owner; Director of Nursing
Date of Review; 17th August 2020

Strategic Objective;

Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022

Risk Appetite;

The Trust has a low risk appetite for compromising quality and safety of patient care

	Impact	Likelihood	Score
Initial Risk Rating	**5**	**5**	**25 (Major)**
Current Risk Rating	**5**	**4**	**20 (Major)**
Target Risk Rating	**5**	**2**	**10 (Moderate)**

Risk

- The Trust fails to deliver excellence in care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.

Rationale for current score

- Lack of a clear quality strategy impacts on our ability to accurately monitor and assure care outcomes
- Significant gap in the Trust's approach to patient engagement and patient involvement.
- Impact of pandemic of COVID-19 resulting in changes in practice and delivery of care from central government command and control resulting in reactive policy and clinical practice changes
- Failure to complete CQC Must and Should Do actions
- Gaps in the number and quality of clinical guidance's and policies and procedures to ensure safe and quality care
- Quality reviews have been commissioned in light of concerns that have been raised about delivery care through anonymous and overt routes (including safeguarding and CQC)
- Initial concerns into audit and data registration have been raised by the Royal College of Surgeons (awaiting final report)
- Duty of Candour below target

Future risks

- Resources to deliver the improvement programme.
- Resources to deliver the Care Excellence Programme
- Potential second wave of Covid-19
- Dependence on the success of interdependencies from other workstreams.
- Failure to develop and maintain relationships with key stakeholders.
- Finance and resources.
- Maintaining alignment between SHQC Programme priorities and the activities taking place in Divisions
- Communications across the organisation to share programme objectives

	performance level • Failure to deliver 7 Day Services to provide uniform levels of care throughout the week • Failure to demonstrate that the trust is identifying and addressing inequalities in health	
Controls • Quality Review 6 monthly reviews in place with NHSEI/CQC • Clinical Guidelines/Policies and Standard Operating Procedures in place • Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels • Staffing meetings twice a day with agreed escalation process. • Patient Experience group in place • Robust governance and quality standards managed and monitored through the governance structures of the organisation, performance reviews and the CCG/CQC • Clinical audit programme & monitoring arrangements • Safety Alert process in place • Freedom to speak up process in place • Covid-19 SJR have been undertaken for all deaths • Learning from death framework supporting local mortality review. • GIRFT Meetings reinstated • Registration for the regulated activity of assessment for medical treatment for persons detained under the MHA 1983 at Manor Hospital now in place with the CQC. • Review process for out of date Guidelines and SOPs instated. • Faculty of Research and Clinical	**Assurance** • Quality Governance process are in place with oversight and escalation process in place throughout the organisation. Escalations are reported to QPES each month. • Quality, Patient Experience and Safety Committee meets monthly and provides assurance to the Board on quality outcomes • Duty of Candour is reported quarterly, and patient experience is reported monthly to QPES • CQC report (2019) showed improvement and the Trust was rated as 'outstanding' for caring • External Performance review meetings in place with NHSEI/CQC/CCG • External review undertaken on the SI processes • Improvement programme in place to oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality Care. • Development of a Mental Health Steering Group • Development of new CQC action oversight group • Implementation of key Improvement Task and Finish groups such as Trust cancer pathways, end of life, deteriorating patient, MCA and VTE • Patient priorities for 2021 identified, which	**Future Opportunities** • Improvement programme offers consistency in methodologies and documentation used across transformation programmes • Care Excellence Programme offers a structured process to achieve excellence in care outcomes, patient/public experience and staff experience • Availability and implementation of new technologies as a clinical or diagnostic aid (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine). • Development of Prevention Strategy • ~~Lack of Harm Free Care Strategy~~ • Development of a Quality Assurance Framework • Development of Care Excellence strategy

Education (FORCE) established to promote research and professional development in the trust • Perfect Ward app allows local oversight of key performance metrics	will form part of Quality Account objectives • ~~Launch of Perfect Ward App confirmed~~	
Gaps in Control • VTE performance continues to be below the Trust Target • Deterioration in the Trust's complaints response performance • Mental Capacity Act compliance below the Trust's Standards • Out of date clinical Policies, Procedures and SOP's • Training performance is not meeting set targets • Quality Impact Assessment process is not yet established within the trust	**Gaps in Assurance** • Outstanding CQC 'MUST' and 'SHOULD' do actions remain outstanding • Trust CQC rating requires improvement • Quality Concerns raised to CQC • A number of national audits outcomes remain below national average • NHSEI review insufficient assurance on infection control standards • External audit Assurance relating to the annual quality account has been deferred owing to COVID-19 • Inconsistent evidence both through quality governance structures and performance reviews, of practice having changed as a result of learning from incidents and feedback	**Link to Corporate Risk** • 274: Failure to resource backlog maintenance and medical equipment replacement costs results in the organisation being unable to deliver fundamental clinical services and care • 2066: Lack of registered nurses and midwives • 2051: Inability to mitigate the impact of Covid-19, results in possible harm and poor patient experience to the people of Walsall (Risk Score=16) • 1986: Delays in access to Tier 4 in-patient psychiatric care for Children and Young People (CYP) (Risk Score =16)

July 2020 updates highlighted in yellow

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
No.	Sleeping Accommodation Breaches	0	0	63	83	63	0	209	0	0	?	H
No.	HSMR (HED) nationally published in arrears	110.8	145.44						100	110.28	?	
No.	SHMI (HED) nationally published in arrears	95.49							100	110.73	?	
Rate	Crude Mortality Rate	3.96	5.72									
No.	Number of Deaths in Hospital	88	138	198	95	71	71	435		1093		
%	% of patients who achieve their chosen place of death	73.33%	51.72%	65.28%	59.65%	72.31%	67.27%	66.27%		57.63%		
No.	MRSA - No. of Cases	1	0	0	0	0	0	0	0	4	?	
No.	Clostridium Difficile - No. of cases	4	5	4	3	3	3	13	26	36		
%	Sepsis - % of patients screened who recieved antibiotics within 1 hour - ED		80.90%									
%	Sepsis - % of patients screened who received antibiotics within 1 hour - Inpatients											
%	Deteriorating patients: Percentage of observations rechecked within time	84.03%	80.94%	79.70%	86.40%	89.09%	89.70%		85.00%		?	
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.73	0.83	1.52	0.73	1.05	0.86					
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.17	0.1	0.24	0.48	0.69	0.38					
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	10	11	15	7	12	10	44		128		
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	5	3	7	14	20	11	52		86		
No.	Falls - Total reported	79	91	75	68	58	57	258		932		
Rate	Falls - Rate per 1000 Beddays	4.81	5.32	5.63	6.52	4.75	4.66		6.1		P	

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
No.	Falls - No. of falls resulting in severe injury or death	0	0	0	0	3	0	1	0	20		
No.	Falls - Avoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0	0	0			0	0	16		
No.	Falls - Unavoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0	0	0			0		4		
%	VTE Risk Assessment	94.04%	90.75%	84.24%	91.13%	92.83%	93.67%	90.91%	95.00%	92.22%		
No.	National Never Events	0	0	0	0	0	0	0	0	1		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	2	5	4	3	16	7	30		94		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	0	1	0	0	0	0	0		5		
No.	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	32	27	16	18	30	24	88		287		
No.	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	15	5	6	6	6	6	24		29		
%	% of total incidents resulting in moderate, severe harm or death	3.97%	2.80%	2.70%	2.83%	3.54%	3.27%	0.03		2.37%		
%	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	15.15%	15.79%	24.24%	14.04%	13.98%		0.16	12.00%	14.30%		
No.	No. of reported medication incidents level 3, 4 or 5 (one month in arrears)	0	0	0	1	2		3	0	4		
Rate	Midwife to Birth Ratio	28.1	31.9	32.0	29.6	33.4	32.7		28			
%	One to One Care in Established Labour	98.51%	99.13%	100.00%	98.36%	99.10%	99.07%	99.15%	100.00%	99.20%		
%	C-Section Rates	30.58%	29.55%	29.63%	33.94%	30.03%	29.62%	30.72%	30.00%	30.16%		
%	Instrumental Delivery	7.12%	7.99%	6.91%	7.42%	6.48%	6.79%	6.88%	10.00%	7.52%		
%	Induction of Labour	38.83%	38.81%	39.73%	38.27%	39.01%	43.95%	40.30%		39.09%		

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	11.21%	10.25%	12.94%	15.61%	14.81%		14.55%	10.00%	11.50%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours	82.93%	83.52%	89.77%	88.65%	90.10%	88.73%	89.29%	100.00%	84.59%		
%	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards) (one month in arrears)	70.00%	53.06%	33.33%	98.31%	62.69%	87.04%	76.62%	90.00%	69.32%		
%	Compliance with MCA 2 Stage Tracking	48.72%	26.67%	73.91%	64.44%	75.00%	36.84%	63.55%	100.00%	62.61%		
%	Complaints - % responded to within 30 working days	70.59%	37.93%	27.59%	20.00%	53.85%	77.78%	42.67%	80.00%	43.45%		
%	Complaints - % responded to within 45 working days	70.59%	51.72%	27.59%	40.00%	69.23%	77.78%	49.33%		59.82%		
No.	No. of Open Complaints	70	69	55	43	39	42					
No.	No. of Closed Complaints	12	15	8	6	9	23	46		211		
No.	Longest Wait for an Open Complaint	369	398	414	431	139	143					
No.	Clinical Claims (New claims received by Organisation)	13	14	14	5	14	6	39		132		
No.	No urgent op to be cancelled for a second time	0	0	0	0	0	0	0	0	0		
%	% of RN staffing Vacancies	9.39%	9.05%	8.88%	7.95%	7.42%		8.08%		9.71%		
%	Friends and Family Test - Inpatient (% Recommended)	94%	95%		89%	89%	87%		96%			
%	Friends and Family Test - Outpatient (% Recommended)	92%	92%		88%	88%	88%		96%			
%	Friends and Family Test - ED (% Recommended)	74%	83%		85%	85%	81%		85%			
%	Friends and Family Test - Community (% Recommended)	98%	98%						97%			
%	Friends and Family Test - Maternity - Antenatal (% Recommended)	99%	100%						95%			

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	Friends and Family Test - Maternity - Birth (% Recommended)	100%	98%						96%			
%	Friends and Family Test - Maternity - Postnatal (% Recommended)	93%	100%						92%			
%	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	99%	97%						97%			
%	PREVENT Training - Level 1 & 2 Compliance	89.99%	90.73%	90.65%	90.70%	90.64%	92.12%		85.00%			
%	PREVENT Training - Level 3 Compliance	78.36%	79.24%	79.97%	80.82%	82.68%	85.44%		85.00%			
%	Adult Safeguarding Training - Level 1 Compliance	96.45%	96.46%	95.47%	96.55%	95.07%	96.34%		95.00%			
%	Adult Safeguarding Training - Level 2 Compliance	83.37%	84.31%	84.14%	86.38%	88.94%	91.22%		85.00%			
%	Adult Safeguarding Training - Level 3 Compliance	59.32%	58.50%	58.30%	56.77%	55.96%	58.83%		85.00%			
%	Children's Safeguarding Training - Level 1 Compliance	88.94%	87.73%	86.46%	88.42%	89.81%	92.27%		95.00%			
%	Children's Safeguarding Training - Level 2 Compliance	86.63%	86.35%	86.43%	86.94%	86.54%	88.44%		85.00%			
%	Children's Safeguarding Training - Level 3 Compliance	80.76%	81.29%	78.97%	78.89%	79.46%	82.18%		85.00%			

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
RESOURCES												
No.	Total Deliveries	291	335	297	277	323	314	1211	3739	3661		

Safe, High Quality Care Update August 2020

Exec Leads: Matthew Lewis / Ann-Marie Riley

WHT Improvement Leads: Joyce Bradley / Tom Johnson

Caring for Walsall together

Defining our view of Outstanding

We lay out below our view of 'Outstanding' in relation the scope of this workstream:

1. Our Patients voice will be heard equally and their clinical outcomes and experiences will demonstrate we deliver outstanding care, meeting the needs of the population we serve

2. We will work collaboratively with patients, families and/or carers to ensure we promote a shared decision making approach to plan and deliver evidence based, individualised, person centred care

3. We will deliver against CQC inspection requirements and continually monitor our adherence to maintaining those outcomes

4. We will have a Care Excellence Strategy that sets out our clinical priorities until 2023 in support of our objective of achieving Outstanding rated services by 2022

5. We will outperform our peers in national benchmarks including staff experience

6. We will deliver harm free care that is evidence based and best practice

7. We will improve clinical outcomes for patients by implementing evidence based care

Safe, High Quality Care Core Team and Responsibilities

Core Team Members:

Executive Leads:

- Matthew Lewis
- Ann-Marie Riley

Improvement Support:

- Joyce Bradley
- Tom Johnson

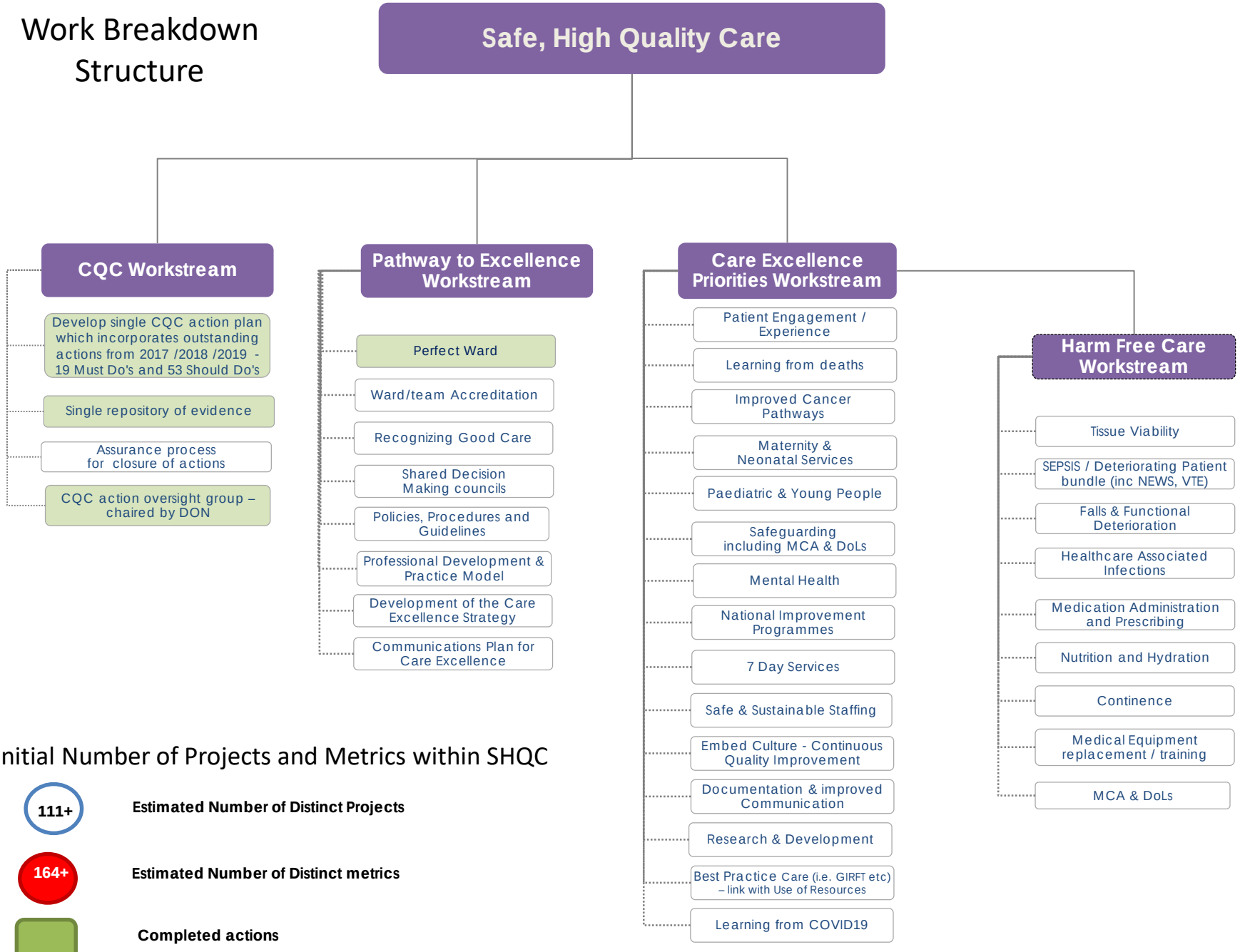
Core Team Members:

- Manjeet Shehmar
- Alison Doyle
- Caroline Whyte
- Charlotte Hill
- Lorraine Moseley
- Nicola Boyes
- Dave Dingwall
- Divisional Clinical & AHP reps
- Marsha Belle - Valuing Colleagues rep

Responsibilities:

- Oversee the development of the workstream aligned to the Trust strategic objective
- Responsible for making recommendations to the Improvement Programme Board regarding the sequencing of the workstream priorities
- Drive and monitor the continued development of the Improvement Programme workstream, providing support / unblocking issues where appropriate.
- Ensure that Workstream Core Team risks and issues are monitored, documented and managed effectively.
- Ensure that specialist support resources are being identified and utilised effectively in support of programme delivery.
- Ensure that inter-dependencies are transparent, understood & managed
- Oversee workstream delivery, being an escalation point for risk / issues and conduit
- Responsible for reporting and presenting overall progress and risks / issues to IP Board
- Responsible for reporting and presenting overall progress and risks / issues to relevant Board Committees

Work Breakdown Structure



Initial Number of Projects and Metrics within SHQC

111+ **Estimated Number of Distinct Projects**

164+ **Estimated Number of Distinct metrics**

Completed actions

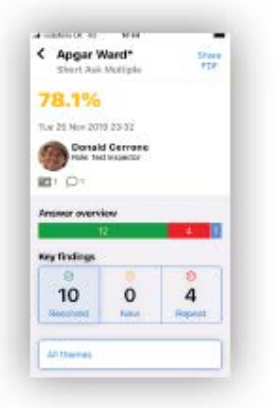
SHQC - Spotlight on our success this month: Perfect Ward App roll-out

It is a smart inspection app that replaces the manual paper audit process. It provides live, automated reporting of quality outcomes, patient and staff experience.

- Live in 56 areas from theatres to community localities
- 10 audit sets, Maternity, Environment, Documentation, Medicine Management, Director of Nursing Rounding, Infection Control and Prevention, Assurance, Organisational, Harm free Care and Covid
- Audits daily, weekly, monthly, quarterly and annually
- Example below of process

Choose inspection type

Easy inspection process



Instant results

Instant reports of trends and improvement

Standardisation of reporting

Safe, High Quality Care – CQC Actions update – August 2020 IP Board / QPES

Lead(s):	Ann-Marie Riley, Diane Hallilley	**Core Team:**	Governance Team, DoNs
Progress to date:	• Analysis of 2015/ 2017/18 & 19 CQC recommendations (initial list from the CQC reports suggests a total 19 MUST DO and 53 Should DO actions that we are reviewing assurance evidence for • Single CQC Action Log with Dashboard of action status • Evidence repository established • CQC Action Plan Oversight Group mobilised	**To be completed:**	• Finalise CQC action plan following August CQC action plan oversight meeting • Continue delivery on current projects • Mobilise task and finish groups for further priority actions identified from CQC Action Plan Oversight Group
Dependencies:	• Policies and SOPs – process to be developed for Trust-wide development and update approval – Governance • Implementation of the Trust EPR Programme	**Risks / Issues / Support Required:**	• **Risk:** Governance team support / capacity. **Issue:** . Non-recurrent funding for key SHQC resources (end July) • **Support Required:** Informatics support (to be scoped)
Overall Status:	PID Development - Amber Progress - Green	**IP Board Comments:**	

Safe, High Quality Care – Pathway to Excellence update – August 2020 IP Board / QPES

Lead(s):	Alison Doyle / Kerry Jones	**Core Team:**	DoN, DDoN, DIV DoNs
Progress to date:	• Forward Together staff survey included in Care Excellence Strategy • Draft Care Excellence Strategy in development • BAME Shared Decision-Making Council established • Perfect Ward went live 30 July first set of metrics will be available in September (for August data set) • Scoping policies, procedures, SOP's commenced, Core team agreed next meeting to be arranged. Programme of work to update clinical policies established • Quality Account priorities identified and aligned to the SHQC programme	**To be completed:**	• Governance structure to be confirmed re agreed process to sign off policies, procedures and SOP's task and finish group being set up to deliver behind plan • Train shared decision-making facilitator (will be supported by Nottingham University Hospitals) Shared decision council interest identified in Neonatal, PAU, IT , W29, W2, Health Visitors and Maternity and these will be able to launch following the training taking place
Dependencies:	• External company for Perfect Ward application • Digital team • Staff engagement • Governance team to support identification of governance process and task and finish group	**Risks / Issues / Support Required:**	• **Risk:** Competing priorities with restoration and COVID-19 • **Issue:** Staff engagement to roll out. Non-recurrent funding for key SHQC resources (end July) • **Support Required:** Divisional Management teams to release staff to be involved in implementation of perfect Ward
Overall Status:	PID Development - Amber Progress - Green	**IP Board Comments:**	

Safe, High Quality Care – Care Excellence Priorities (1) update – August 2020 IP Board / QPES

SROs:	Alison Doyle / Manjeet Shehmar	**Core Team:**	Charlotte Hill, Lorraine Moseley, Kerry Jones, Caroline Whyte
Progress to date:	• Learning priority programmes and key outcome measures that will be monitored via the Care Excellence programme agreed • FORCE working with Deteriorating Patients group • FORCE undertaking gap analysis against delivery of safe and effective training programmes • Core competencies launched training requirements being developed • MCA/DOLS conference 23/7/20 - Green • Cancer Pathways - Amber • GIRFT – regional teams involved and will be linked with divisional performance reviews • Learning from COVID-19 – fast learning groups, in-hospital mortality reviews to be reported August - Green • Learning from COVID-19 - community mortality reviews to be reported September – Green • COVID19 Reflective Summit – 27/07/20 • 7 day services - to link with Effective use of Resources workstream • Patient experience & Involvement section has been populated • Commitment to becoming a research active organisation – section populated • Invite extended invite to Core team to include Divisional teams • Care Excellence meeting includes Divisional TOT reps and Divisional QI & Research Leads • Just and Learning Culture – Looking at the SI process within the Trust • Valuing Colleagues link for support for the SAS Doctors • Public consultation underway for #WalsallFoodFaves and 'what matters to you'	**To be completed :**	• Trust Dashboard of Clinical Outcomes and benchmarking • Full implementation of IT enablers • Workforce reviews continue • Develop implementation and training models on going • Workstream Comms and Engagement Plan • First meeting of the Care Excellence meeting to take place • Patient priorities to be developed for delivery over 20/21
Dependencies, Risks – Issues – Support Required and Overall Status are on the next slide			

Safe, High Quality Care – Care Excellence Priorities (2) update – August 2020 IP Board / QPES

SROs:	Alison Doyle / Manjeet Shehmar	**Core Team:**	Charlotte Hill, Lorraine Moseley, Kerry Jones, Caroline Whyte
Dependencies:	• Implementation of Just and Learning Culture (Valuing Colleagues) • Partners – working with tertiary centres • Digital enablement / Digital Transformation • Significant informatics and analytics resource required • Comms and Engagement • Admin support	**Risks / Issues / Support Required:**	• **Risk:** National workforce and recruitment gaps. Patient representatives for SHQC • **Issue:** Clinical Engagement – clear comms req'd. Non-recurrent funding for key SHQC resources (end July • **Support Required:** Digital / Informatics / Comms and Engagement / Admin
Overall Status:	PID Development - Amber Progress - Green	**IP Board Comments:**	
Continued from previous slide			

Safe, High Quality Care – Harm Free Care update – August 2020 IP Board / QPES

Lead(s):	Caroline Whyte / Alison Doyle / Manjeet Shehmar	**Core Team:**	Refer to PID for specific task and finish teams
Progress to date:	• Review of practice, evidence and learning related to falls, mobility function, nutrition and hydration, Tissue Viability and continence in progress. • Deteriorating patient bundle has been completed, Critical care outreach workforce review being undertaken. Performance for timely observations improving • FORCE developing a training programme. • VTE action plan and task and finish group in progress. Thrombosis committee established. Funding for clinical lead approved. • Medical devices – Clinical Lead identified • Review of the acuity scoring continues and staff reporting red flags(where staffing levels could impact on quality and safety) • Data extraction agreed for Power BI	**To be completed:**	• Review and objectives to be set against outcomes for Tissue Viability and Falls teams • Review of critical outreach team staffing and roles – ongoing • Communication for training & implementation of plan for Deteriorating patient bundle • External support for Benchmarking being sought • Ensure patient/public involvement and engagement as we develop the Care Excellence Strategy • Developing higher level team assurance question sets across patient and staff experience • Development of dashboards for Ward units via new Intranet system
Dependencies:	• Accountability on Trust performance review • Informatics & Analytics support • Project Management support to facilitate reporting • Trust Governance team to support Care Excellence approach	**Risks / Issues / Support Required:**	• **Risk:** Competing priorities with restoration and COVID-19 • **Issue:** Reporting of harm incidents may increase with greater awareness and increased staff engagement • **Support Required:** analytical support
Overall Status:	PID Development - Amber Progress - Green	**IP Board Comments:**	

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	COVID-19 2nd wave	G	
	Project support resource – interim roles not substantively funded. Scale of support required yet to be fully assessed.	R	Resourcing paper being produced for IP Board
	Analytics support – significant informatics and analytics support required to track progress and provide assurance via collating evidence of KPIs.	R	outcomes from resourcing paper not cascaded to core team
	Clinical engagement – Clear engagement strategy needed	A	Need Trust wide engagement plan
	Management of inter dependencies within Improvement Programmes	A	IP Board to review
Issues	A lot of new processes and systems being implemented (Pathway to excellence, Perfect ward) – organisational fatigue	A	Comms Strategy to provide clarity on impact
	Staff focus on restoration and recovery plans impacting pace of delivery	A	
Dependencies	Workforce and culture development and requiring Valuing Colleagues involvement	G	Dependency meeting held SHQC, GWL, VC
	Digital transformation	G	Discussed with Keith Dibble

Programme Dependencies Matrix – August 20

Originating Workstream	Description	Dependent Workstream(s)	Dependency recognised	Actions Required	Owner	Status
Safe, High Quality Care	Culture change developed through Pathway to Excellence and link to wider Valuing Colleagues programme: Shared Decision Making - Reward & Recognition - Talent Mgmt / Career Progression– Roles / Skills – Leadership Development –	Valuing Colleagues	Yes	Specialist resource to deliver this is the key area of focus e.g. design work – engage workforce modeller and new roles planner – discuss at execs next week	Catherine Griffiths	
	CQC Mandatory – Stat / Man Training Compliance	Valuing Colleagues	Yes	This is an enabling action owned by VC, and that SHQC reporting on this should be related to risk assessment only	Catherine Griffiths	
	Digital transformation – implementation of new systems including EPR, Blue spear, Video conferencing etc	Effective use of Resources	Yes	This is an enabling element owned by EUoR but will have clinical checks and sign off for safety prior to implementation (Design Advisory Group and Operations Group oversee this)	Keith Dibble	
	Trust Governance Processes and alignment to Care Excellence approach	Governance & Well Led	Partially	Meeting between A-MR and Jenna to confirm meeting structure	Jenna Davies to ask Ann to set up	

Programme Dependencies Matrix – August 20

Originating Workstream	Description	Dependent Workstream(s)	Dependency recognised	Actions Required	Owner	Status
Safe, High Quality Care	Functional collaboration with other providers / tertiary centres	Working with Partners	No	Ensure monthly updates are provided on the change and any risks highlighted / confirmed and shared with A-MR / ML / JD	Ned Hobbs / Dave Dingwall	
	KLOEs driving ongoing internal audit processes	Governance & Well Led	Yes	Process will be developed and deployed by clinical audit. Perfect Ward metrics will also be aligned to PIR evidence base. Alison / Di sitting on each Core Team	Alison / Di	
	Safer staffing levels	Effective use of Resources / Valuing Colleagues	Yes	Safer staffing reported to QPES – SHQC PID being developed to assume responsibility for safe and effective staffing (remove from EUoR portfolio). VC PIDs to be updated to address need to be undertaking scenario planning as part of workforce planning -	Joyce Bradley Polly Kaur	Complete
	CQC Mandatory – Preventing never events	Governance & Well Led	Yes	Governance sets process but Divisional compliance to be reinforced through SHQC and wider IP – SHQC PID to be reviewed	Joyce Bradley / Tom Johnson	

Workstream Development – Next Steps Approach

We have agreed the following approach to further developing and mobilising this workstream:

Tasks Week	31/08/20	07/09/20	14/09/20	21/09/20	28/09/20
Further development of the agreed 4 PIDs - update of implementation plans and stakeholders					
Update the Programme Status Tracker					
Perfect Ward task and finish group					
Discuss with Information Services dashboard of metrics for SHQC					
Development of the SHQC Dashboard					
Continue consultation for Care Excellence Strategy					
Development of Care Excellence Strategy					
Care Excellence Meeting established, first meeting 7th September					
Improvement Programme Benefits Analysis Workshop					

MEETING OF THE PUBLIC TRUST BOARD **Thursday 3rd September 2020**			
Quarterly Hospital Mortality Report			**AGENDA ITEM: 8.3** **ENCLOSURE: 8**
Report Author and Job Title:	Dr Manjeet Shehmar Deputy Medical Director	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The Mortality Report is presented to the Quality, Patient Experience and Safety Committee and the Trust Board on a quarterly basis. • Hospital Standardised Mortality Ratios (HSMR) (rolling 12 months to May 2020) is 116* • Summary Hospital-level Mortality Indicator (SHMI) (rolling 12 months to April 2020) is 115.0.* • Monthly SHMI Feb 2020 95.49 *Update to Healthcare Evaluation Data (HED) data has been delayed and has not been uploaded in time for this report.		
Recommendation	Members of the Trust Board are asked to note: • Performance data • Key areas for attention • Future actions and developments		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001: Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm. • CRR 2051: Inability to mitigate the impact of Covid-19, results in possible harm and poor patient experience to the people of Walsall. • Performance against SHMI is recorded on the trust risk register		
Resource implications	• Refurbishment of a potential location for the Medical Examiner and Learning From Deaths teams • Additional resource taken to complete Covid Mortality Reviews		
Legal and Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and Learning Disabilities Mortality Review (LeDeR) recommendations. • National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Quarterly Hospital Mortality Report

Introduction

This report details:

1. **Performance** data relevant to the trust, compared with regional and national comparator sites, where appropriate
2. **Key areas for attention**, together with analysis, actions and outcomes
3. **Future actions** and developments in understanding mortality data

1. PERFORMANCE

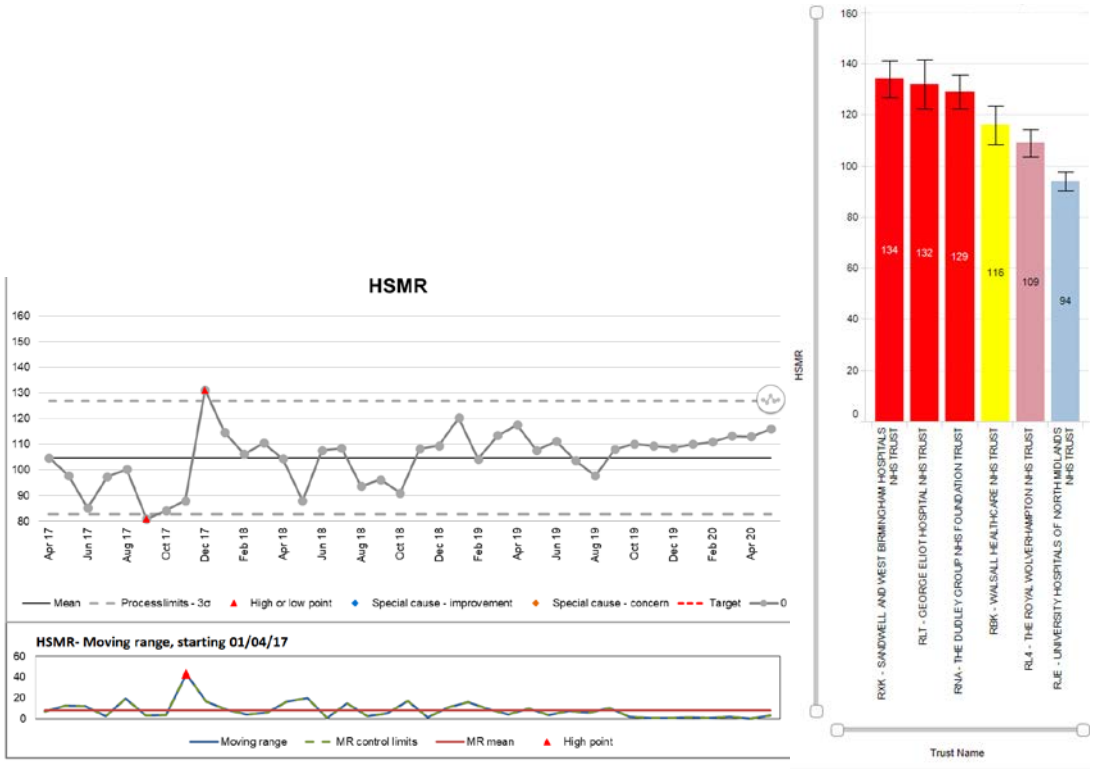
National Benchmarks

The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index (SHMI). Delays in reporting SHMI are due to data issues with NHS Digital and HED. There is a delay in updating HED data and therefore data for HSMR is only available to March 2020 and for SHMI to February 2020.

Mortality Metrics by Month

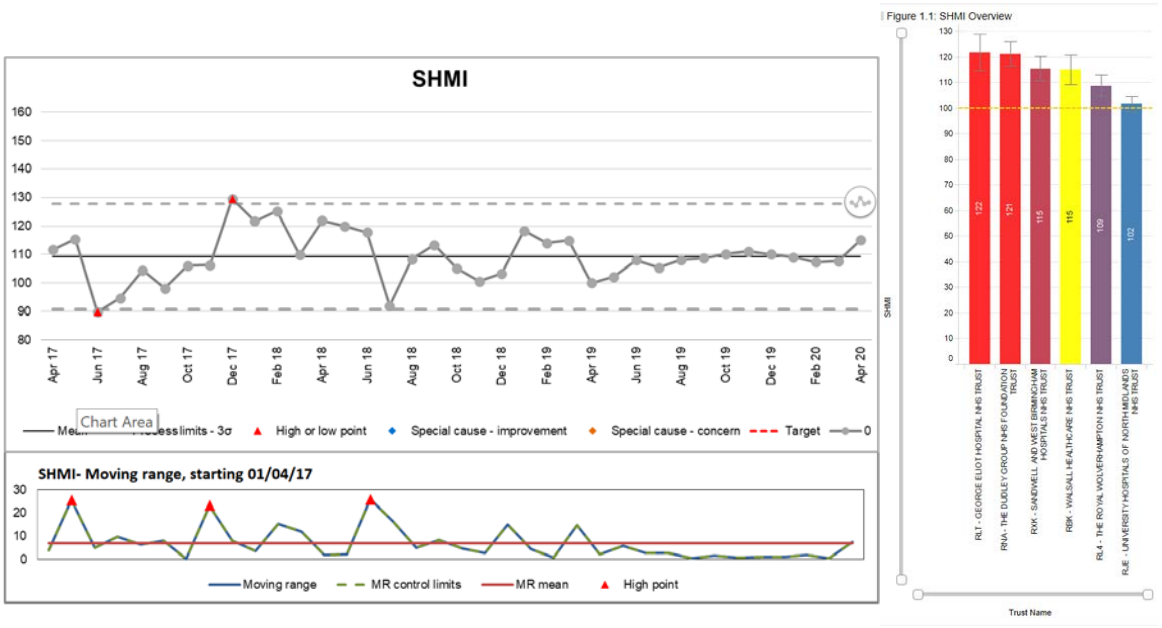
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
HSMR	91.00	108.20	109.40	117.90	101.50	112.00	114.41	103.98	106.15	101.94	97.00	103.45	114.76	108.06	129.51	118.72	110.80	145.44
SHMI	105.10	100.50	102.30	117.00	111.90	119.55	97.48	99.69	108.80	110.03	112.61	120.11	116.66	106.76	110.11	100.59	95.49	
Crude Mortality	3.6	4.0	4.5	4.7	4.0	4.2	4.6	4.0	3.5	3.2	3.1	3.2	3.7	3.9	4.9	4.2	4.0	5.7
	All figures presented above are taken from HED																	

HSMR 2017 – 2020



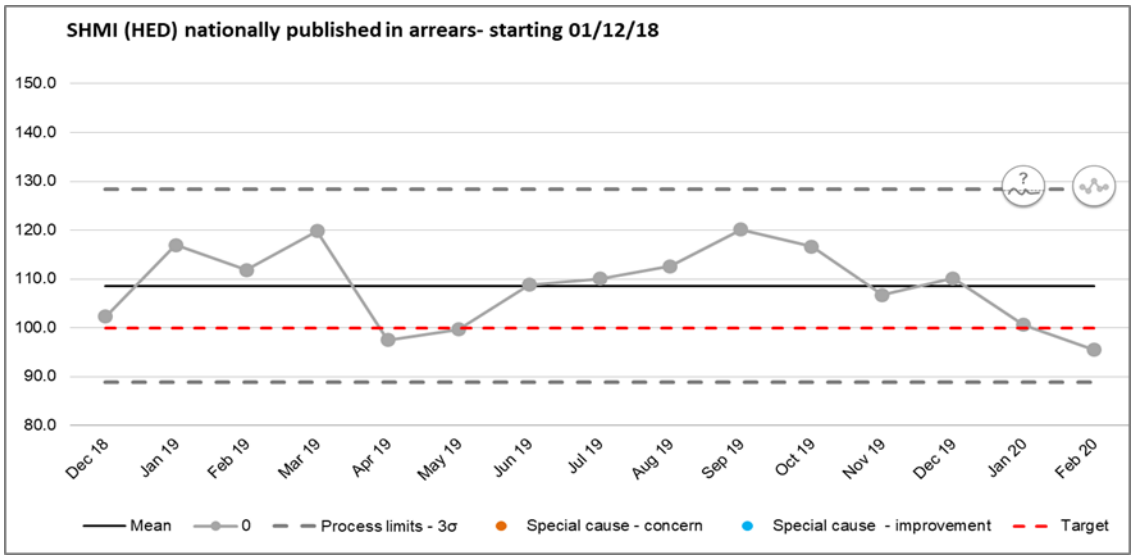
*Rolling 12 month data now being used instead of YTD

SHMI 12 month rolling 2016 – 2020*

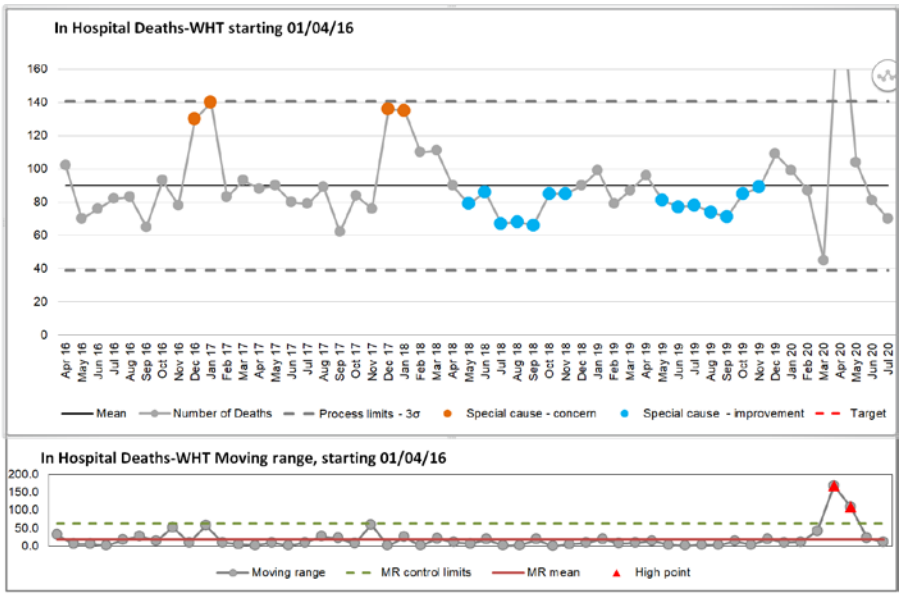


*Rolling 12 month data now being used instead of YTD

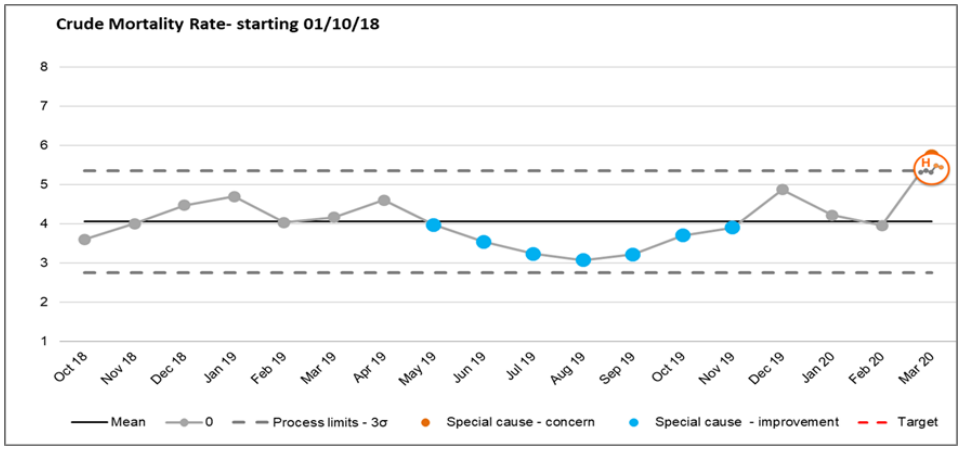
Monthly SHMI



In hospital deaths 2016 – 2020



Crude Mortality 2015 – 2020 (deaths per 1000)



Top 10 Diagnoses of death*

Diagnosis Groups	Category	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Rolling Total
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	Deaths	17	9	14	15	11	7	16	13	24	22	17	23	188
	HSMR	112.44	82	118.29	108.2	79.53	63.63	136.54	87.77	131.27	101.22	112.66	168.32	
2 - Septicemia (except in labor)	Deaths	13	9	9	6	6	3	8	13	8	6	11	14	106
	HSMR	79.04	64.62	90.57	78.57	85.56	42.74	99.93	142.06	101.25	65.79	152.4	196.39	
108 - Congestive heart failure; nonhypertensive	Deaths	7	6	5	1	3	7	6	4	10	6	3	3	61
	HSMR	150.52	186.3	139.55	29.94	158.7	196.07	154.02	72.89	178.61	154.3	60.16	93.32	
129 - Aspiration pneumonitis; food/vomitus	Deaths	8	8	6	7	3	4	3	5	4	3	7	3	61
	HSMR	176.42	151.37	110.76	161.61	110.5	112.9	68.27	142.13	102.72	91.29	153.56	88.17	
157 - Acute and unspecified renal failure	Deaths	1	3	3	4	5	5	4	6	6	4	4	3	48
	HSMR	35.8	60.33	190.01	138.25	126.28	154.16	137.74	206.85	165.41	140.21	116.41	106.19	
127 - Chronic obstructive pulmonary disease and bronchiectasis	Deaths	4	4	3	0	1	1	2	4	1	6	1	5	32
	HSMR	154.04	154.61	109.71	0	52.58	77.45	112.01	104.05	29.59	147.3	40.77	397.56	
226 - Fracture of neck of femur (hip)	Deaths	3	3	1	0	1	4	4	2	2	2	3	3	28
	HSMR	255.83	196.63	81.3	0	63.57	181.56	210.11	113.16	168.34	110.18	131.42	99.51	
159 - Urinary tract infections	Deaths	2	2	3	2	2	1	5	2	0	4	0	1	24
	HSMR	137	120.21	154.76	113.75	145.17	43.45	240.75	164.36	0	277.97	0	63.15	
68 - Senility and organic mental disorders	Deaths	2	3	2	1	0	2	1	2	1	4	2	3	23
	HSMR	255.04	177.09	84.82	142.82	0	197.32	63.43	202.64	78.4	158.38	182.82	147.24	
125 - Acute bronchitis	Deaths	1	1	1	3	1	2	1	0	3	5	1	2	21
	HSMR	70.42	47.71	85.44	211.49	158.87	139.83	98.08	0	193.65	286.04	47.89	176.47	

*HED updated to March 2020

Glossary of Terms

HSMR Hospital Standard Mortality Rate
SHMI Standard Hospital Mortality Index
NQB National Quality Board
CQC Care Quality Commission
NHSI NHS Improvement
SJR Structured Judgement Review
ME Medical Examiner
MEO Medical Examiner Officer
LeDeR Learning Disability Mortality Review Programme
LD Learning Disability
DNAR Do not attempt resuscitation
MCA Mental Capacity Act
SI Serious Incident
RCA Root Cause Analysis
MTLC Medicine and Long Term Conditions division
LFD Learning from Death
CuSuM Cumulative Summary, a performance indicator demonstrating persistent deviation from the mean
PALS Patient Advisory and Liaison Services
CCG Clinical Commissioning Group
MSG Mortality Surveillance Group
MDT Multidisciplinary Team

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Thursday 3rd September 2020			
Hospital Mortality – Learning from COVID Deaths			**AGENDA ITEM: 8.4** **ENCLOSURE: 8a**
Report Author and Job Title:	Dr Manjeet Shehmar Deputy Medical Director	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report covers a specific request from the Chair of Public Trust Board to provide assurance around COVID-19 related deaths and the process of learning. The report is based on three papers which were presented to QPES on 27th August 2020 [with acknowledgements to lead authors]: 1. Learning from Hospital Deaths [Manjeet Shehmar] 2. Learning from COVID Deaths in ICU [Adi Kuravi] 3. Learning from Nosocomial COVID Deaths [Hamza Duffaydar] By 17th August 2020, 1066 patients had tested positive for COVID-19 and 225 patients had died. Data presented through these reports has been acquired at different times through the pandemic and, therefore, the figures presented may vary. **1. Hospital Deaths** By 27th June 2020, 206 patients had died; a Structured Judgment Review (SJR) was carried out by a group of senior consultants on the 195 case notes that were available for analysis (97%). The standard of care was considered adequate, good or excellent (scores 3, 4 or 5) in 186 cases; care was poor or very poor (1, 2) in 9 cases, which were subsequently raised through the incident reporting system. Of the 206 patients who died, 70% were White, 13% Asian, 5% Black and 1% Mixed race (11% not known). According to SJR, the quality of care did not correlate with age, gender or ethnicity. The mean age of death was 76 years, with 58% male. The highest proportion of deaths occurred on ICU (21%). Comorbidity, such as hypertension, diabetes and ischaemic heart disease, present in 95% of deaths (91% nationally), especially in people from Black, Asian and Minority Ethnic communities. Frailty was identified in 66% of deaths when frailty was assessed on admission. Problems with documentation were noted, which were partly addressed with a dedicated clerking proforma and which will be helped with the introduction of electronic patient records in future. **2. COVID deaths in ICU** Detailed analysis of deaths on ICU has been carried out and compared with the national data that is collected through the Intensive Care National Audit & Research Centre (ICNARC) audit.		

Out of 88 admissions to ICU, there were 46 deaths (52%), which is marginally higher than the national ICU mortality rate (40%). In terms of ethnicity, 50 admissions were white (25 died), 30 were Asian (25 died), 4 were black (3 died) and 4 were not known. There was no significant correlation between risk of death after admission to ICU and gender or ethnicity.

There are numerous examples of improvements in care that were demonstrated during the pandemic, including clinical developments (e.g. remdisivir, dexamethasone, heparin, fluid replacement and proning), communication (electronic referrals) and the management of deteriorating patients.

3. Nosocomial COVID deaths

Analysis of data up to 7th June 2020 showed that 104/616 (17%) positive patients had 'definitely' or 'probably' contracted the infection during their hospital stay (nosocomial infections). When data for 'definite' cases (11%) are considered, the rate of healthcare associated infections is comparable to data from two other English trusts[1] [2] and one multicentre study from UK and Italy[3]; 43/104 of these patients died.

Reductions in nosocomial infections were observed after changes in practice, including:

- increased use of personal protective equipment (PPE)
- routine testing (and retesting) of admissions
- restricting access for visitors
- improved levels of mandatory training audit performance for hand hygiene and infection prevention & control (IPC)

Other relevant reports (available, in preparation or anticipated)

- Walsall Care Home mortality report – CCG (draft completed July 2020)
- Black Country & West Birmingham Community mortality report – STP (due to be presented to STP in September 2020)
- Medical Examiner report concerning deaths of healthcare workers in Walsall Healthcare Trust (submitted directly to National Medical Examiner on 17th August 2020; awaiting feedback from National Medical Examiner to trust)

Conclusions

The Medical Directorate coordinated a fast-learning group to identify and share best practice and to support research activity. Updates were shared regularly through emails, Microsoft Teams, Daily Dose and Trust Grand Round meetings.

Specific learning has been identified and shared in relation to presenting features, assessment, treatment, escalation, multidisciplinary communication and documentation.

[1] https://www.medrxiv.org/content/10.1101/2020.05.08.20095687v1
[2] https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa816/5860253
[3] https://www.journalofhospitalinfection.com/article/S0195-6701(20)30344-3/fulltext

Recommendation	The Trust Board is requested to gain assurance from the contents of this report and to acknowledge the learning points that have been identified.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001: Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm. • CRR 2051: Inability to mitigate the impact of COVID-19, results in possible harm and poor patient experience to the people of Walsall. • Performance against SHMI is recorded on the trust risk register	
Resource implications	• Additional resource was required to complete all these reviews against COVID funding.	
Legal and Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. • There is a differential impact of COVID-19 on people with specific characteristics. • National legislation relating to the review of child and perinatal deaths has been implemented.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
Walsall Together Partnership Board Highlight Report			**AGENDA ITEM: 9.1** **ENC: 9**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Anne Baines - Non Executive Director.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Walsall Together Partnership Board meeting on 22nd July 2020. The Walsall Healthcare Trust members of the Walsall Together Partnership Board also met on 26th August 2020. This report sets out key escalations (below) for the attention of the Trust Board, assurances, issues discussed and work underway. 1. There has been a reduction in nursing capacity in Locality Teams during July and August as staff redeployed during COVID-19 have now returned to their substantive functions. Although the number of new referrals into Locality Teams remains lower than usual, additional staff are being recruited in order to meet the anticipated future demand in localities, acknowledging that the lower referrals in part reflects the reduction in hospital-based elective activity that would have generated demand (e.g. wound care). 2. The overall status of the Programme Plan is 'green'. There are 2 items that have been delayed in starting and 1 item that is now overdue.: (a) Approval of the Tier 0 – Resilient Communities – Plan is overdue. It was presented at the July Walsall Together Partnership Board and the leadership team has been asked to review certain elements. An updated position will be reported to the September Partnership Board. (b) The above delay is impacting on the Grant Funding Programme within Resilient Communities and this is currently showing as a delayed start. (c) The integration of primary and community mental health services is delayed. Black Country Healthcare have paused their transformation initiatives during COVID-19. Revised timescales are expected in September. The Partnership Board will have their next meeting on 23rd		

	September.	
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.	
Risk in the BAF or Trust Risk Register	This report aligns to the BAF risks for Care at Home (S02)	
Resource implications	There are no new resource implications associated with this report.	
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☐	Care at home ☒
	Partners ☐	Value colleagues ☐
	Resources ☐	

WALSALL TOGETHER PARTNERSHIP BOARD

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee met on 22nd July 2020, with the meeting Chaired by Mrs Anne Baines, Committee Chair and Non-Executive Member of the Walsall Healthcare Trust Board. The meeting was quorate.

Due to annual leave arrangements of the partner organisations, the meeting scheduled for August did not proceed, however the Walsall Healthcare Trust members of the Walsall Together Partnership Board ("Partnership Board") met on 26th August to review operational performance, the restoration and recovery plans, and the overall programme plan. This was not a quorate meeting of the Partnership Board however the outcomes are set out in this report.

The Committee reports to all Partner Boards each month on key issues from the partnership board meeting.

1. Local Data on COVID-19 and Impact

In July, the Walsall Council presented the most up to date data on the number of COVID-19 cases and mortality, as well as its outbreak management plans setting out roles and responsibilities where there is a spike in cases or a second wave. The Council is taking a proactive approach to its COVID-19 advice, and the impact of this is encouraging as there have been no large outbreaks in the borough.

The Council's data provided clarity on the areas of deprivation in the borough and the correlation to the number of COVID-19 infections and deaths. The Cheshire Liverpool Public Health Network's recent review also brought into focus the positive and negative impact on community networks; the increase in those claiming universal credit; school closures exacerbating of inequalities in educational attainment; inequalities in accessing good quality and safe public green space; and the effect of lockdown on food security and food need.

The data is being used to re-balance services, and more resources are being focused to the areas in most need through the Resilient Communities tier.

A Head of Intelligence role will be created to ensure the partnership is using all the data sources in order to respond in an agile way while the partnership model is being built.

A future Partnership Board development session will look at look at the ways in which efforts might be focused in areas of deprivation, possibly focusing on smaller areas and broadening that out.

2. Walsall Together Service User Group

The Walsall Together Service User Group had their first meeting which took place during lockdown and was very successful. The partnership board heard in July that the diabetes workshop which the group held had over 60 participants dial in and share their experiences. Due to the success of the diabetes workshop there are plans to run cardiology workshops in August and September.

The need to be clearer on communication with the public on the services available to them was identified through the workshop, and a partnership board development session will be held to look at the communications strategy. The partners reviewed the Walsall Together animation and logo

which is designed to give a clear message on the partnership objectives, and that will continue to be refined with the input from the service user group and partners.

3. Operational Performance and Restoration and Recovery

The operational performance pack presented in July was representative of the all partners at this meeting, and it was noted that this was a good sign and will continue to evolve and mature.

The August meeting reviewed referrals to the care coordination service which remain high, with 27% receiving advice from the service; 40% dispositioned to Rapid Response; and 30% to Locality Teams.

Medically Stable For Discharge performance remains strong with a significant decrease in the number of patients in May, June and July, reflecting the now embedded COVID-19 actions. The suspension of Decision Support Tools (DSTs) will be lifted from 1st September. There are over 60 patients awaiting a DST which will require a minimum of 12 weeks additional activity to clear the backlog; this is impacting on bed-based pathways. Work is underway on how that might be mitigated and will be reported to the Partnership Board.

Length of stay of patients discharged in-month from intermediate care domiciliary pathways has reduced marginally in July, however it remains above the local target of 21 days.

The Care Homes position is largely unchanged with one COVID-19 death recorded during July. Care Homes continue to request swabbing via national online portal, however proactive testing has been interrupted due to a product recall (expected to be resolved by September).

At the July meeting all partners were asked to bring their restoration and recovery plans forward to the September meeting to ensure all are sighted on the plans in a joined up way, and that will be reported to the Trust Board in October.

The Trust members of the Partnership Board discussed restoration and recovery when they met on 26th August together with the questionnaire sent to the community teams as part of the learning from Covid approach. These responses will inform decisions on what practices continue, are altered, or stopped for restoration and should there be a second wave. A 'you said we did' response is being developed and will be monitored by the partnership board.

Restoration of services including podiatry, wound care, diabetes, respiratory, continence, falls and osteoporosis is continuing with a focus on not going back to the way things were done previously, but learning from what worked well during Covid.

4. Walsall Together Programme

A revised programme plan was developed following the approval of the business case, and this was reviewed by the partnership board in July following realignment after Covid. The Partnership Board approved the revised objectives for delivery this financial year, and the revised project governance. An update to the resilient communities tier was presented, with preventative services focusing on strengthening social networks to prevent issues such as isolation, inactivity, workplace absence and unemployment will provide the bedrock of the community health and wellbeing services. The funding sources for this work requires further discussion and a set of issues and risks, and options for resourcing will come back to the Partnership Board.

The Trust members of the Partnership Board reviewed progress on the programme plan when they met on 26th August. In addition to the escalations noted on the front sheet of this report, the members noted:

- Recruitment to posts funded through the Walsall Healthcare Trust (WHT) investment is in progress;
- Discussions are in progress with the external training provider and the respective health and social care operational teams to restart the Strengths Based Practice (SBP) training programme that was paused at the start of COVID-19.
- Good progress has been made across Tiers 3 and 4 with the project group focussing on mapping the interdependencies across care coordination, ICS, Rapid Response and the Integrated Front Door.
- There has been an increased focus on identifying priorities within the programme plan that will support the roadmap to a formal ICP contract.
- Discussions are underway to engage an Academic Partner in undertaking an evaluation of Walsall Together. The focus will be on lessons learnt through COVID-19, especially in regard to our partnership with the voluntary sector and also how the inclusion of Housing in partnership has impacted on outcomes.
- Estates work is gaining momentum both in terms of the One Public Estate project and the development of the Local Estates Forum.

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
Care at Home Executive Report			**AGENDA ITEM: 9.2** **ENC: 10**
Report Author and Job Title:	Michelle McManus Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Executive Director of Integration, Deputy CEO
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This paper provides an overview of the risks to delivery of the Care at Home strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Walsall Together, successes and areas for improvement.		
Recommendation	Members of the Trust Board are asked to NOTE the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk- S03 Failure to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities.		
Resource implications	There are no new resources implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal, equality and diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

WALSALL TOGETHER REPORT
SEPTEMBER 2020

1. PURPOSE OF REPORT

This report provides the board with an update on the Care at Home strategic objective which is coordinated by Walsall Together. It provides an overview of the risks to delivery, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance, successes and areas for improvement.

2. KEY AREAS OF SUCCESS

Referrals to the Care Coordination Centre continue to climb to 700 per which is the initial target (27% receive advice from the service; 40% are dispositioned to Rapid Response; 30% are dispositioned to Locality Teams). The service as designed is become the urgent front door into community services. This will be extended within the next few months to align to access into the social care aspects of the integrated teams In line with the increase in Care Coordination Centre activity, patient referrals into Rapid Response remained positive compared to previous months and the avoidance of conveyance to hospital remains strong at above 90%. There is no doubt that this performance is have a significant impact on the ability to keep patients in the community and away from hospital-based pathways and formalised urgent care. It is the intention to get this function academically validated and written up by one of the local universities as a case study.

As the demand continues to rise in a positive direction on these two services, work is underway to look at alternative workforce options to mitigate a pressure on roles that are not plentiful such as nurses. The Trust has recently recruited an experienced Paramedic to advise on skill transfer in this area together with a Clinician who has extensive experience in NHS111. It is planned this will open a diversification in the workforce allow growth without skill pressure.

Medically Stable for Discharge (MSFD) performance remains strong with a significant and sustained decrease in the number of patients in May, June and July, reflecting the now embedded COVID-19 actions. The Trust maintains a positive position of some 50 patients in this area concurrently and more importantly demonstrates a length of stay reduction for Walsall patients to 2.5 days and 4.5

The Care Homes position is largely unchanged from last month and the previous month. Patient numbers in Care Homes is slowly increasing and only one COVID-19 death was recorded during July. Care Homes continue to request swabbing via the national online portal, however proactive testing has been interrupted due to a product recall (expected to be resolved by September). There is no doubt that the robust intervention that has widely been reported to committees and Trust Board in previous months has enabled a quicker recovery in this area. I continued support team is

currently be concluded with the Walsall Together partners to ensure that this support is retained not only in the event of a potential wave 2 but for the future as well. It is important to note that the care homes themselves are partners in this arrangement and support from and to the response as been hugely appreciated.

A piece of work is underway with partners to consolidate the sharing of information that has recently built in Covid. A screen shot below provides the board a view on the progress that has been made to date on live data presentation across the partnership.

It is the intention to establish a virtual intelligence team across the partnership to provide a common information picture and reporting. The principle being a data presentation that represents the inequalities in Walsall and how the partnership responds to them. In discussion with partners it has been agreed that a joint head of intelligence will be appointed by the partnership and hosted by Walsall Housing Group (whg) given their strength on both the public voice and presentation of information.

The Trust is working in partnership with the CCG and St Giles Hospice to transfer the specialist palliative care beds into the Walsall Together partnership. Whilst it should be noted that St Giles have been an exceptional partner with the Trust over the last nine years, it is of strategic importance that these beds are retained as part of the partnerships End of Life work.

The redesign of outpatients has been progressive through the Covid response. This has been coordinated by the care at home team which has reinforced the need to look at different delivery models for the future. Thinking has already begun about what outpatient services align directly with the Walsall Together offer with through an SLA model with the hospital divisions or directly managed by community. This work will continue as part of the improvement programme. In addition, a refocus on the Bedside Mobility Tool (BMAT) is being relaunched as part of the improvement programme and has broad clinical and executive sponsorship.

Following approval of a revised programme plan in July, the transformation element of Walsall Together is on track to deliver in 2020-21:

- Discussions are in progress with the external training provider and the respective health and social care operational teams to restart the Strengths Based Practice (SBP) training programme that was paused at the start of COVID-19. There is a meeting in early September to agree the format of the training, which is likely to be virtual.
- Good progress has been made across Tiers 3 and 4 with the project group focussing on mapping the interdependencies across care coordination, ICS, Rapid Response and the Integrated Front Door. A detailed updated and associated project documentation is scheduled to be presented to the WTP Board in September.
- Estates work is gaining momentum both in terms of the One Public Estate project and the development of the Local Estates Forum (LEF). Regarding the latter, there is a proposal to consider how this forum can be aligned to the Walsall Together governance to consider the future of the local estate in the context of the partnership and the changing requirements post-COVID-19.

3. AREAS OF CONCERN

There has been a reduction in nursing capacity in Locality Teams during July and August as staff redeployed during COVID-19 have now returned to their substantive functions. This is in addition to staff being able to take annual leave in established volumes planned that during early parts of the year have been on lower rates. The clinical risk and delays are currently manageable within the current demand and capacity process but the ability to flex on any surge has been greatly diminished. To quantify this, both the volume of contacts (up 11%) and risk profile of patients changing to higher acuity have been sighted in PFIC and QPES and oversight is ongoing.

Although the number of new referrals into Locality Teams remains lower than usual, the flow into the teams from repeat visits required for known patients and referrals from primary acre have filled the reduction of new referrals and now overtaken this activity. A review of the skill mix profile in each of the teams is underway and whilst the response during Covid has been exceptional, it has highlight the need for other skills sets in the team to deal with less complex issues such as continence that can be resolved swifter with other grades of staff. Localities, acknowledging that the lower referrals in part reflects the reduction in hospital-based elective activity that would have ordinarily generated demand (e.g. wound care).

Decision Support Tools (DSTs) have been suspended at national level during COVID-19 and this is impacting on our interim, bed-based pathways and numbers of MSFD. At 61 people on interim pathways, this is significantly higher than COVID levels (5-10 waiting). Length of stay of patients discharged in-month from intermediate care domiciliary pathways has reduced marginally in July, however it remains above the

local target of 21 days. The suspension of DSTs will be lifted from 1st September and the backlog will require a minimum of 12 weeks additional activity to clear will undoubtedly present a pressure of discharge capacity. To mitigate this a conversation is already underway with Council and CCG Commissioners about how we can retain the key elements of the Covid process whilst restarting the DST nationally mandated process.

Recruitment to posts funded through the Walsall Healthcare Trust (WHT) investment is in progress. A significant number of applications have been received for some posts, which is impacting on timescales in some areas. Applications for some of the more senior and specialist nursing roles has been limited and the Division is likely to need to recruit less specialist staff alongside a training and development programme to ensure we can deliver the skill mix required in the model. A budget for training and development was included in the investment case to mitigate such a risk and is already being worked up. Board members will also note that alternative roles are already in development and testing in the case of Paramedics as an example

The integration of primary and community mental health services has been delayed. Black Country Healthcare have paused their transformation initiatives during COVID-19. Revised timescales are expected to be confirmed at the Clinical & Professional Leadership Group (CPLG) in September. Communication throughout this process has been positive and a productive session with the BCHC Executive Team was held in late July to work through next steps.

Restoration and recovery of planned services are currently challenged due to availability of open clinic space. This has been discussed at length in QPES and plans are underway to secure dedicated clinic space for community teams in centres such as Pelsall Village and Darlaston with other options being considered for the future. As services transfer, the need for more local community space will become more prevalent.

4. REPRIORITISATION OF RESOURCES

The Walsall Together Programme Plan has been reviewed in the context of COVID-19 and resources available to deliver the transformation during the remainder of 2020-21. Additional investment to date has been through WHT and resources in the programme office have been assigned to support implementation and delivery of benefits associated with this investment.

There has been an increased focus on identifying priorities within the programme plan that would support the roadmap to a more formal integrated care contract, should this be the desired direction of travel. These priorities include deployment of the population health module, creating of a living directory for community and voluntary services, and ensuring we have a robust, single model for social prescribing in Walsall. Discussions are also underway to engage an Academic Partner in undertaking an evaluation of Walsall Together. The focus will be on lessons learnt through COVID-19, especially regarding our partnership with the voluntary sector and also how the inclusion of Housing has impacted on citizen outcomes. The outcomes framework which has alluded the partnership due to CCG key role changes and Covid is now a key area of focus in advance of the Trust Board development session later this month to understand delivery options.

5. CONTROLS AND ASSURANCE

The Walsall Together Partnership Board continues to meet monthly and is well attended. The August meeting was postponed due to leave of many key partners but the Trust Members held an internal assurance meeting to maintain Trust oversight

The Walsall Together Senior Management Team now meets twice per week giving focus to a) operational oversight and b) delivery of the transformation;

The Clinical and Professional Leadership Group (CPLG) meets monthly, Chaired by the Director of Public Health. The Group ensures clinical and professional oversight and input into the Walsall Together programme. The Group is currently looking at how it can better support the partnership's approach to tackling health inequalities and the development of a Population Health Management Strategy.

Governance and reporting mechanisms between the Walsall Together programme and the Care at Home workstream in the Improvement Programme have been aligned. The key metrics that will demonstrate delivery of benefits will be agreed through the September reporting cycle and routine reporting will be fully operational from October. The Care at Home workstream gives focus to all elements of the Walsall Together programme where WHT has responsibility for delivery and also has oversight of the wider programme.

A comprehensive outcomes framework and dashboard to provide assurance on services in scope is still in development. However, a Senior Data Analyst has now been

appointed (expected to start in early October) and a Head of Intelligence is being recruited by Walsall Housing Group (WHG) to work on behalf of the partnership.

6. RECOMMENDATIONS

Board members are asked to NOTE the information within this report.

BAF Risk- S03
Risk Owner; Director of Integration
Date of Review; 5th August 2020

Strategic Objective;

Care at Home – We will host the integration of Walsall together partners addressing health inequalities and delivering care closer to home

Risk Appetite;

The Board is prepared to accept a high risk appetite on the development of integrated pathways across partner organisations to deliver sustainability. It is accepted that the Trust placed based partnership should directly influence demand on the Trust's acute services.

	Impact	Likehood	Score
Initial Risk Rating	**4**	**4**	**16 (Major)**
Current Risk Rating	**4**	**3**	**12 (Moderate)**
Target Risk Rating	**4**	**2**	**8 (Low)**

Risk;

~~Failure to develop and cultivate effective partnerships within the local integrated care partnership, impacts on the Trust's ability to deliver care in patients homes, or in local community setting which results in;~~

- ~~Poor Patient experience~~
- ~~Poor patient outcomes~~
- ~~Continued reliance on acute and emergency based care provision~~

Failure to understand population health and inequalities, integrate place based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities.

Rationale for current score

- Continuation of engagement with PCNs but it is not as progressive as required at this point
- Maturing place-based teams in all areas of Walsall on physical health and Social Care. Additional integration required for Mental Health although planning underway but not committed yet.
- Communications Lead now in post and broader stake communications underway
- Commencement of system data but this is very much in its infancy
- Walsall Together shortlisted for national governance award
- Risk Stratification process for COVID developed with partners which demonstrates the evolving maturity of the partnership
- Substantial improvements in medically stable for discharge before and during Covid 19
- Virtual clinics and community outpatients progressing at a quicker pace now Covid response in place
- Partnership approach agreed for mortality reviews with care homes

Future risks

- Insufficiently robust evidence of impact
- Insufficiently promotion of success narrative
- Inability to deliver enough investment up front to change demand flows in the system.
- National influences on constitutional targets moves focus from place to STP
- Retention of inspirational and committed leadership
- Estates – ability to fund the full business case offering (4 Health & Wellbeing Centres)
- Misalignment of provider strategies created by mergers or form changes or senior personnel turnover
- Lack of uninterrupted community clinic space due to Covid Restrictions

Controls

- Executive Director recruited
- Non-Executive Director appointed

Assurance

- Walsall Together Committee in place overseeing assurance of the partnership

Future Opportunities

- Further development of the Governance around risk sharing

• Business case approved by Partners • Alliance agreement signed by Partners • Governance structure in place and working. • Development of a S75 nearing completion and operational practices in place • Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee	• STP oversight of 'PLACE' based model • NHSi support of Walsall Together • Walsall Together included on Internal Audit Programme • Risk management now underway at a locality level. • Divisional quality board now starting to look at the integrated team response.	• S75 Deployment based on other services • Pooled resources and pathway redesign such as out patients • PCN partnership alignment and risk share • Covid-19 offers an opportunity to increase the pace of delivery and more importantly stress test benefits before substantive deployment • Strategic partnership(s) with major primary care organisations to further accelerate vertical and horizontal integration of care in the borough • Formal contract through an ICP mechanism • Formal working with other partners to support their ability to achieve additional income and support via a partnership approach
Gaps in Control • Lack of investment across the health economy impacts on the delivery of the Partnership – not withstanding the recent investment from the Trust • Commissioner contracts to be aligned to Walsall Together • Data needs further aligning to project a common information picture	**Gaps in Assurance** • NHSi Walsall Together assurance meeting deferred owing to COVID-19 • Internal Audit not commenced • Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections	**Links to Corporate Risk Register** Risks in this area relate to Walsall Together programme risks the biggest ones are associated with the limited investment. None programme risks relating to Community Services at the current time. These are updated through the divisional structure. Each organisation retains its own risk log although the section 75 presents the opportunity to start to brings the logs together

Walsall Together Partnership Operational Update

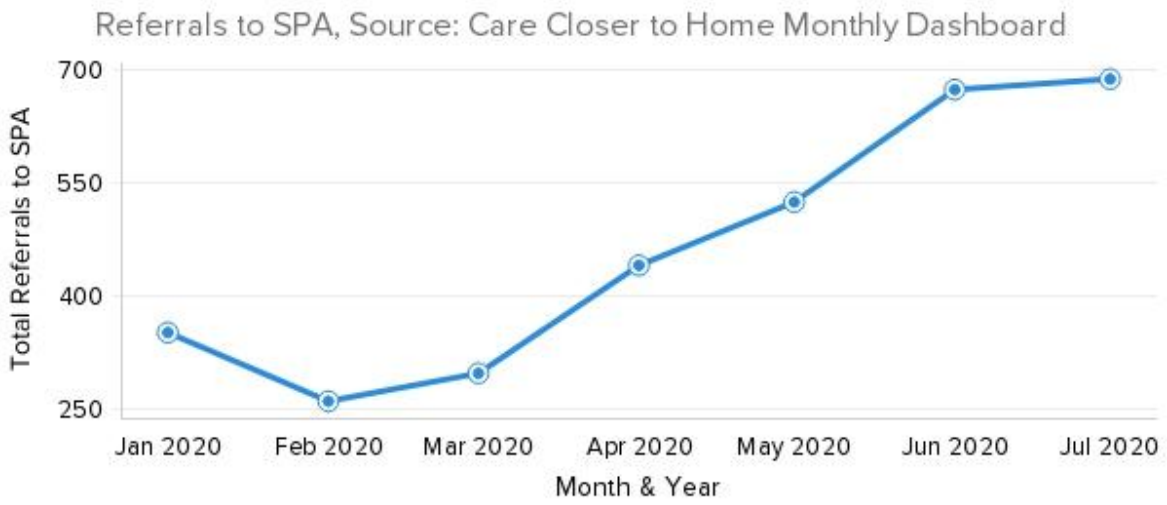
Daren Fradgley
Director of Integration / Deputy CEO

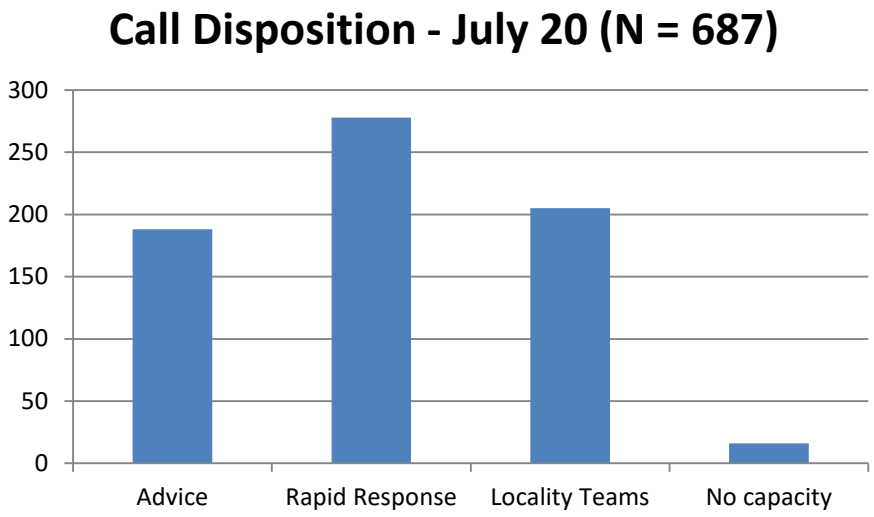
Care Coordination Service

Data Source: Care Closer to Home Monthly Dashboard

The number of referrals for the Care Coordination Centre (previously known as SPA) remains high.

The dispositions from the calls are outlined below with 40% going to Rapid Response, 30% to locality teams and 27% receiving advice from the call centre.



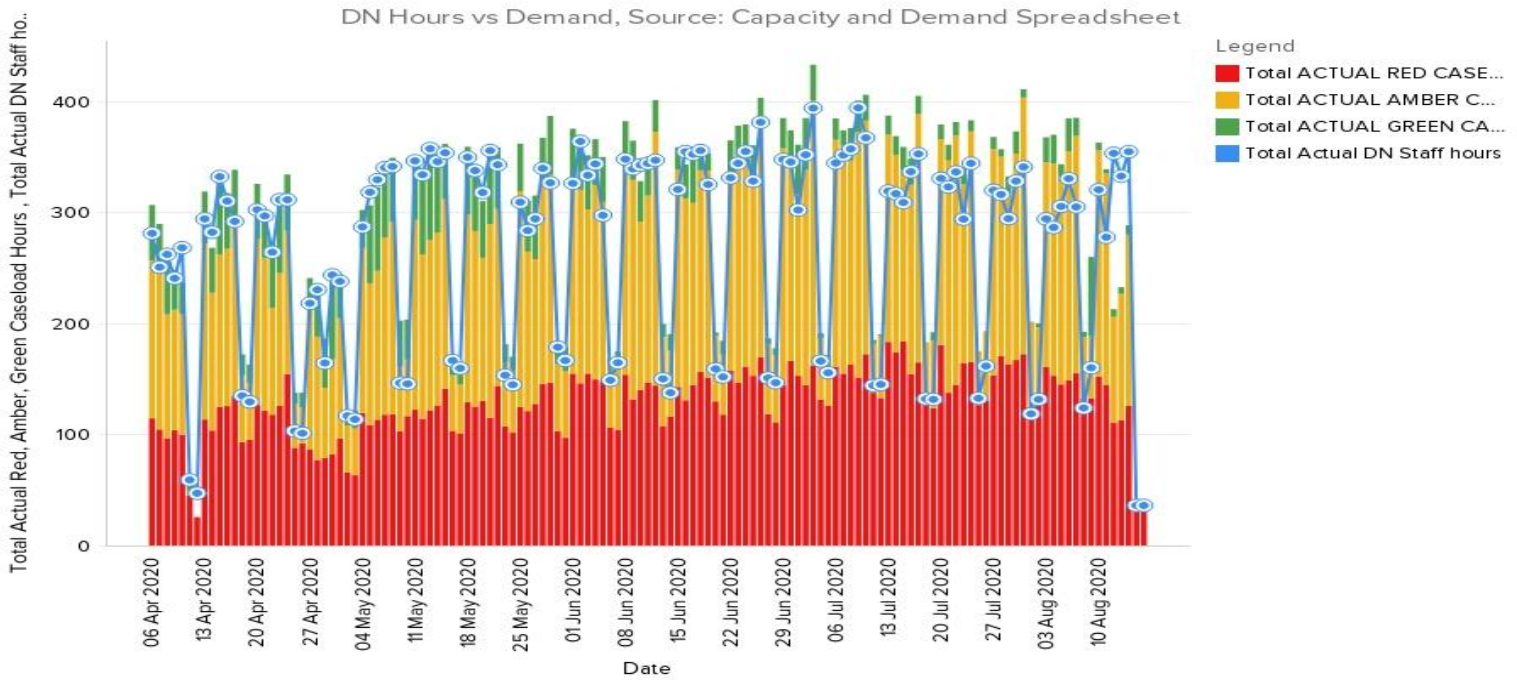


Walsall Together

Community Work Streams

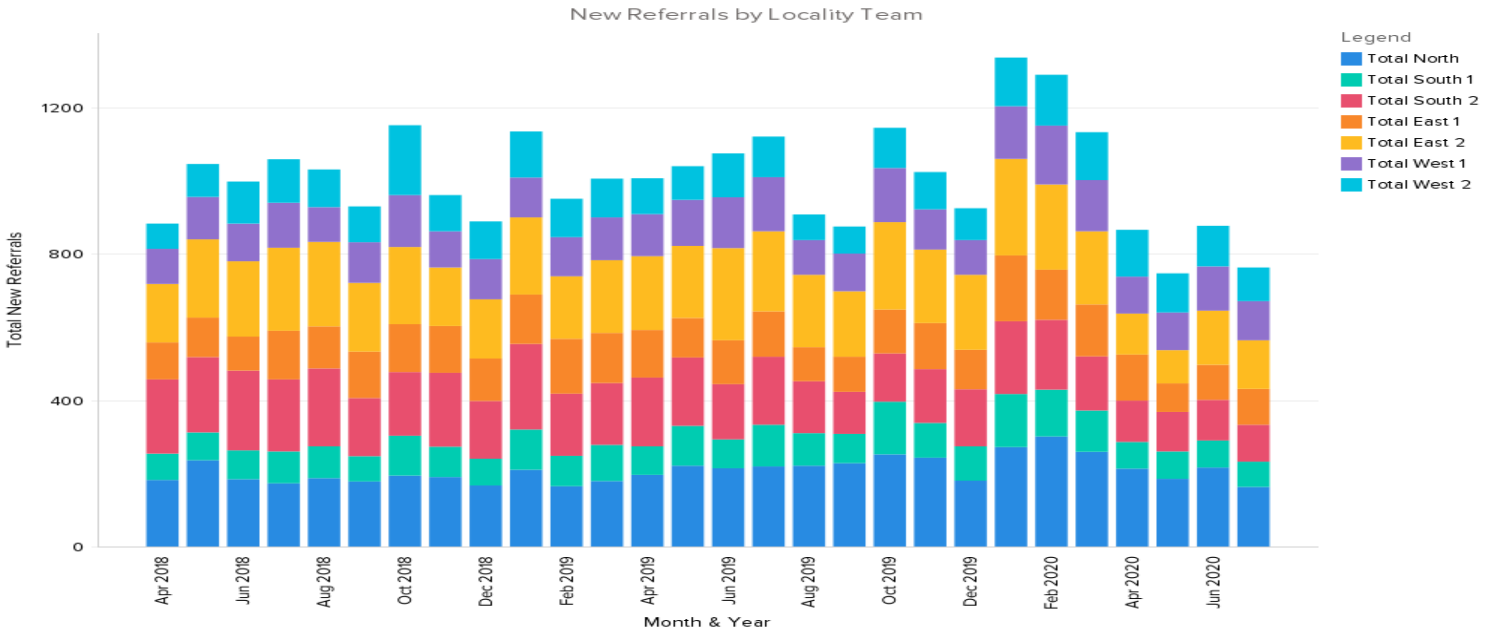
Community Nursing Capacity and Demand

- The chart shows that the availability of community nursing hours increased during the COVID-19 period, leading to fewer cancellations of visits than before. This pattern has changed during July and August. With staff being deployed out of locality teams to their original functions, there has been a concomitant reduction in capacity.
- Additional staff are being recruited in order to meet the identified demand in localities.



Community Work Streams

Locality Teams New Referrals



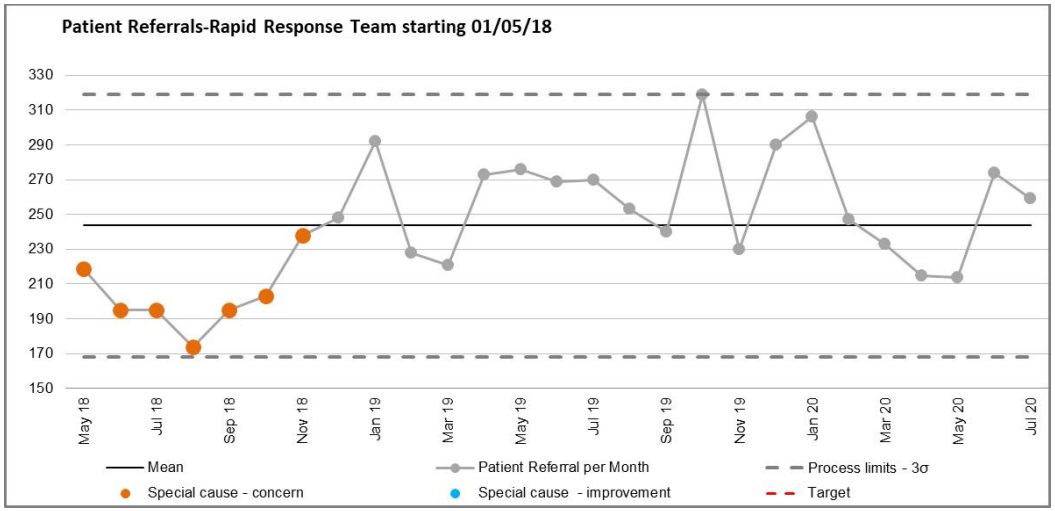
- The number of new referrals remains lower than usual and in part this reflects the reduction in hospital-based elective activity that would have generated demand (e.g. wound care)

Walsall Together

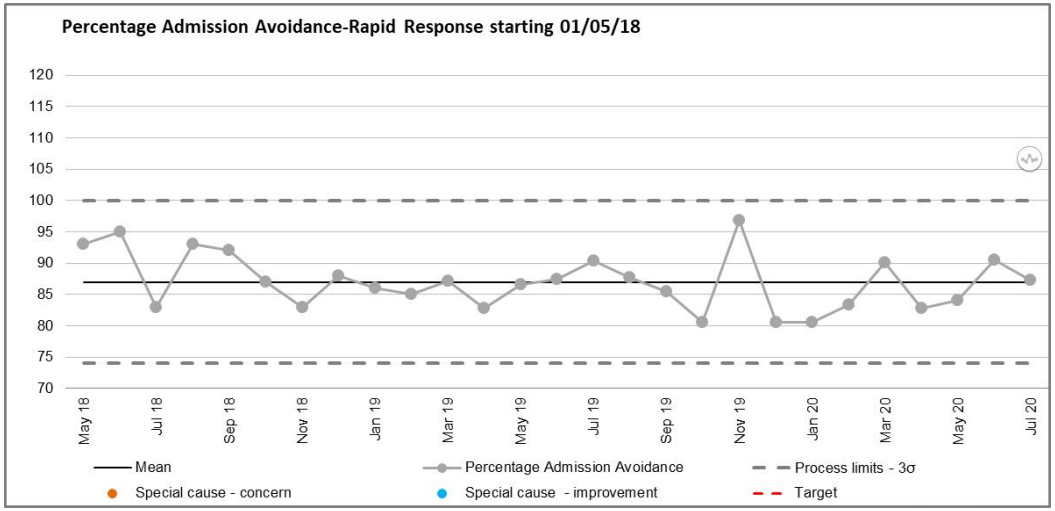
Rapid Response

Data Source: Care Closer to Home Monthly Dashboard

In line with the increase in Care Coordination Centre activity, patient referrals into Rapid Response remained high in July compared to previous months.



The second graph shows that avoidance of conveyance to hospital remains strong



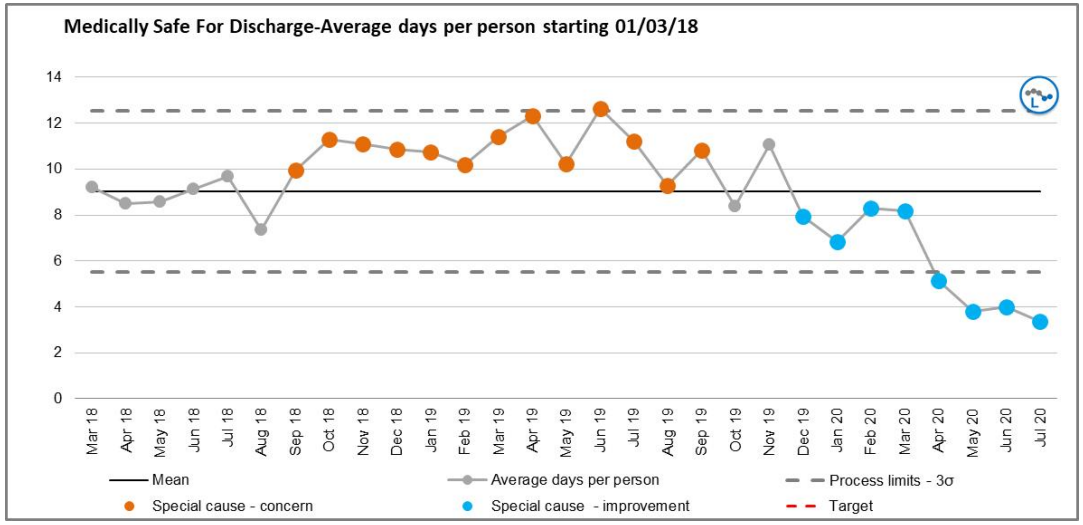
Walsall Together

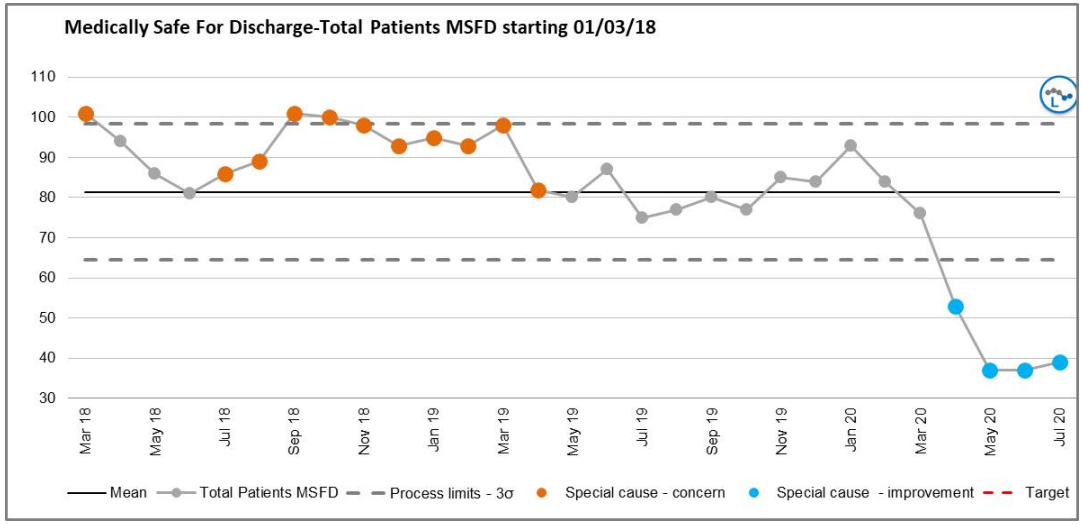
Medically Stable for Discharge (MSFD)

Data Source: MSFD List

Performance in this area continues to remain strong. There has been a significant decrease in the number of MSFD patients on this pathway during May, June and July, which reflects the now embedded COVID-19 actions that are aimed at reducing both numbers and length of stay.

The suspension of DSTs will be lifted from 1st September 2020. There are currently over 60 patients in community beds awaiting a DST which the Intermediate Care Service will have to address, while also dealing with new demand. It is envisaged that the backlog reduction will require a minimum of 12 weeks additional activity.





Walsall Together

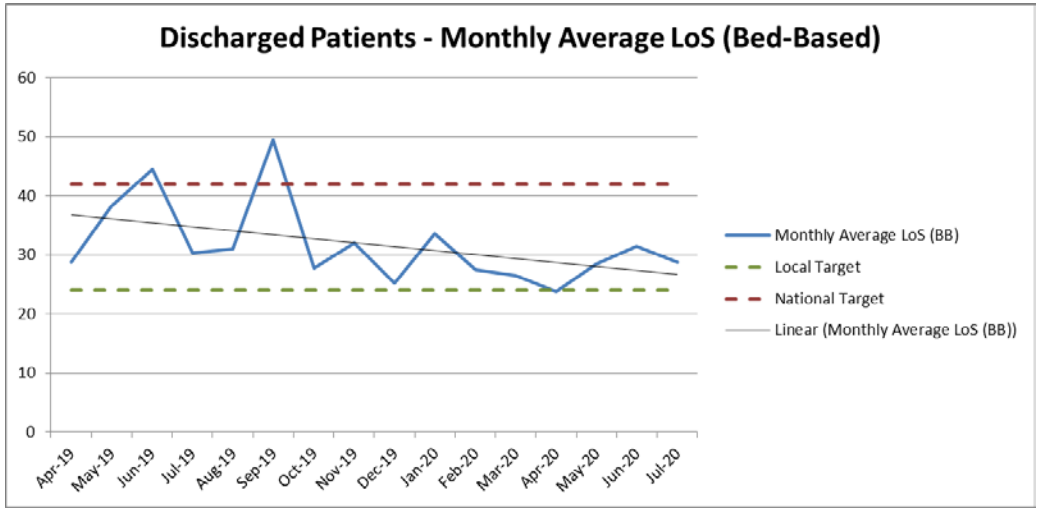
Intermediate Care Services

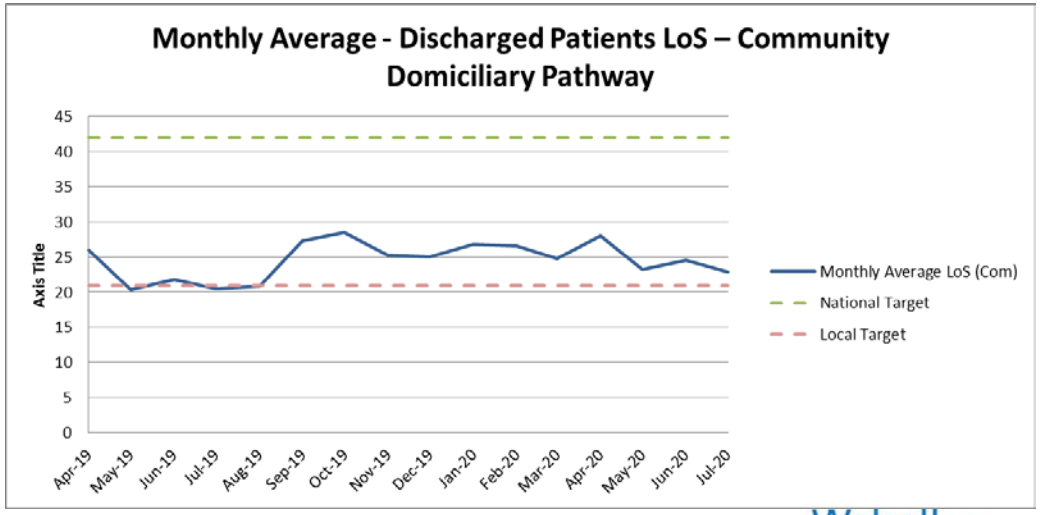
Domiciliary and Bed-Based Pathways

Data Source: ICS Weekly Dashboard

Bed-Based: As referred to in the previous slide, a key issue in this pathway is the growing number of patients occupying beds who are awaiting DST. These assessments have been suspended at national level, so people have to stay on interim pathways. At 61 people, this is significantly higher than COVID levels (5-10 waiting). DSTs will be resumed from 1st September 2020.

Domiciliary: The length of stay (LoS) of patients discharged in-month reduced marginally in July, however it remains above the local target of 21 days.





Walsall Together

Care Home Update

- Daily data collection continues between the Quality in Care team and homes:
  - Resident numbers continue to increase slowly
  - Deaths have returned to normal levels last month and remain
  - 1 COVID-19 death since start of July
  - Public Health monitoring symptomatic patients/staff when reported

- Care homes continue to request swabbing via national online portal
  - Some supply issues due to Randox product recall
  - Expect usual supply levels to return by September
  - Proactive testing interrupted by supply issues
  - Public Health are managing occasional reporting of symptomatic patients

- Risk stratification currently not identifying any issues of concern
- No current outbreaks

- There is a weekly SITREP call between Public Health Walsall and Public Health England

Walsall Together

Care Homes Update

Total Number of Homes
57

Total Number of Beds
1769

Total Number of Residents
1286

Total Number of Staff
1971

Total Staff Absence
97

Total Number of Deaths (Self-Reported)
297

Suspected COVID Deaths (Self-Reported)
141

Walsall Together

Care at Home Workstream
Outpatients Transformation

WHT Project Lead: Keith Dibble
WHT Improvement Lead: Jane Hayman

Caring for Walsall together

Outpatients Transformation – Short Term Milestone

We have agreed the following approach to further developing and mobilising this workstream:

Tasks / Week	06.04.20	04.05.20	01.06.20	06.07.20	03.08.20	07.09.20	05.10.20	02.11.20	07.12.20	04.01.20
Convert all routine / non urgent outpatient appointments										
Implement A&G across appropriate Specialities										
Implementation of RAS in identified services										
Implementation of partnership Community OP model in agreed Specialities										
Development of Community services OP										

Outpatient Ambition

Service / Speciality	Virtual Clinics Pre-Covid (%)	Virtual Clinics Current (%)	Virtual Clinics Indicated Future state New & FU combined (%)	Virtual Clinics New OP Appts Future state (%)	Virtual Clinics FU Appts Future State (%)	Planned Movement Code*	Advice and Guidance / RAS	Comments
Audiology	0	<10	<10				N/A	
Breast Surgery	0	40	<30	0	100%			High cancer volumes
Cardiology	0	80	70	25%	85%		RAS	Community link options
Clinical Haematology	0	30	<20				A&G	
Colorectal Surgery	0	60	40	30%	70%		A&G	High cancer volumes
Dermatology	0	80	70	0%	85%		A&G	Pilot speciality for video consultations
Diabetic Medicine	0	60	60	75%	85%		A&G	
Dietetics	0	70	60				A&G	
ENT	0	70	80	40%	60%		A&G	
Gastroenterology	0	80	80	30%	85%		RAS	
General Medicine	0	80	70	20%	85%		tbc	
General Surgery	0	60	40	30%	70%		A&G	
Geriatric Medicine	0	20	20	0%	90%		N/A	
Gynaecological Oncology	0	<10	<10					High cancer volumes
Gynaecology	0	60	60				A&G	
Medical Oncology	0	<10	<10				N/A	Cancer speciality
Nephrology	0	80	70	60%	85%		tbc	
Neurology	0	80	70	25%	85%		A&G	
Obstetrics	0	<10	<10				N/A	
Ophthalmology	0	<10	<10				A&G	Restoration timetable to be confirmed
Oral Surgery	0	<10	<10					
Orthodontics	0	<10	<10	0%	100%			
Orthoptics	0	<10	<10	0%	100%			
Paediatrics	0	50	60	0%	100%		A&G / RAS	Pilot speciality for video consultations
Pain Management	0	50	50	80%	20%		RAS	Within MSK
Physiotherapy	0	60	60				RAS	Within MSK
Podiatry	0	<10	<10	95%	95%		A&G	
Respiratory Medicine	0	80	70	20%	80%		A&G / RAS	
Rheumatology	0	70	70	80%	20%		tbc	
Trauma and Orthopaedics	0	60	40	30%	70%		RAS	Within MSK
Urology	0	75	25	20%	80%		A&G	

Code*

Blue = Reduction

Amber = No Change

No Colour = Increase

Programme	**Walsall Together Horizon 2 Plan 2020/21**
SRO	Daren Fradgley, Executive Director of Integration
SMT Lead	TBC - Director of Transformation
Project Manager	Walsal Together Programme Office
Date updated	18/08/2020
Version	2.1
Today	18/08/2020
Next Gateway	WTP Board July 2020

% Complete 12%

RAG status G

Status summary

#	High	Medium	Low	Total	*Delayed*	*Overdue*
Not started	8	2	-	10	*2*	-
In progress	33	-	-	33	-	*1*
Completed	5	1	-	6	-	-
Total tasks	**46**	**3**	**-**	**49**	***2***	***1***
Delayed	2	-	-	2		-
Overdue	1	-	-	1	-	

Milestone #	Action #	Description	Verto Project Alignment	Programme Lead	Trust	Investment RAG	Priority	Start date	Due date	Status	Delayed (days)	Overdue (days)	Date completed*	Comments
1		**Resilient Communities**									-	-		
	1.01	Approval of revised Workstream Plan for Resilient Communities	RESCOM	Michelle McManus		Red	High	01/06/2020	22/07/2020	In progress	-	27		To be re-presented to WTP Board in September
	1.02	Identify investment to deliver Resilient Communities	RESCOM	Michelle McManus		Red	High	22/07/2020	19/08/2020	In progress	-	-		Discussion re requirements for WTP Board in September
	1.03	Infrastructure for Grant Funding Programme	Grant Funding	Michelle McManus		Red	High	01/08/2020	31/10/2020	Not started	17	-		Dependent on items above
	1.04	Stakeholder event and award of grants	Grant Funding	Michelle McManus		Red	High	01/10/2020	30/11/2020	Not started	-	-		Dependent on items above
	1.05	Assess quality of provision and develop Living Directory	VCSE Provision	Michelle McManus		Red	High	01/09/2020	31/03/2021	Not started	-	-		ICP Requirement
	1.06	Commission academic partner - Wolverhampton University	VCSE Provision	Michelle McManus		Red	Medium	01/09/2020	30/09/2020	Not started	-	-		Will also support ICP work
	1.07	Social precribing offer aligned to all place based teams and accepting referrals	Social Prescribing	Michelle McManus		Green	High	01/05/2020	31/08/2020	In progress	-	-		Social prescribing meeting in
	1.08	Single social prescribing model aligned across system partners	Social Prescribing	Michelle McManus		Green	High	01/07/2020	31/03/2021	In progress	-	-		Social prescribing meeting in
	1.09	Framework for coproduction and established mechanisms across all Tiers	Coproduction	Michelle McManus		Green	Medium	01/09/2020	31/03/2021	Not started	-	-		
											-	-		
2		**Place Based Teams and Specialist Community Services**									-	-		
	2.01	Agree pilot MDT pathway	MDTs	Jane Sillitoe		Green	High	01/01/2020	31/03/2020	Completed	-	-		
	2.02	Roll out of MDT model in all localities	MDTs	Jane Sillitoe		Green	High	01/01/2020	31/08/2020	Completed	-	-		
	2.03	Recruitment of additional MDT coordinators (1 per Locality)	MDTs	Jane Sillitoe		Green	High	01/07/2020	31/08/2020	In progress	-	-		WHT Investment Case
	2.04	Further develop MDT pathway to utilise data sharing through EMIS	MDTs	Jane Sillitoe		Green	High	01/04/2020	30/06/2020	Completed	-	-		
	2.05	Agree staffing model and pathway for specialist MDTs	MDTs	Jane Sillitoe		Green	High	01/04/2020	30/09/2020	In progress	-	-		WHT Investment Case
	2.06	Integrate Community Geriatrician offer into place based teams	Frailty	Jane Sillitoe		Green	High	01/08/2020	31/12/2020	In progress	-	-		Post out to advert
	2.07	Scoping of appropriate outpatient activity including diagnostics to be delivered in the	Outpatients	Jane Sillitoe		Green	High	01/07/2020	30/09/2020	In progress	-	-		
	2.08	Recruitment of additional posts for Place Based Teams	PBTs	Jane Sillitoe		Green	High	01/07/2020	30/09/2020	In progress	-	-		WHT Investment Case
	2.09	Alignment of primary and community mental health services to place-based teams	PBTs	Jane Sillitoe		Green	High	01/08/2020	31/12/2020	Not started	17	-		Waiting on update from BCH
	2.10	Training and development for PBTs	PBTs	Jane Sillitoe		Green	High	01/08/2020	31/03/2021	In progress	-	-		WHT Investment Case
	2.11	Organisational development and further integration of PBTs	PBTs	Jane Sillitoe		Amber	High	01/04/2020	31/03/2021	In progress	-	-		Additional paper re workforce in August
	2.12	Enhanced support to care homes new model	Care Homes	Michael Cox		Green	High	01/07/2020	31/10/2020	In progress	-	-		Paper to WTP Board in July
	2.13	Integration of children's services - Health Visiting and School Nursing	HV/SN	Jane Sillitoe		Green	High	01/07/2020	31/03/2021	In progress	-	-		
	2.14	Family safeguarding model	N/A	Michelle McManus		Green	High	01/04/2020	31/03/2021	In progress	-	-		Governance via Safeguarding Board
											-	-		
3		**Intermediate Care Services**									-	-		
	3.01	Formal pilot of step-up offer for Intermediate Care Service	ICS Step Up	Michelle McManus		Green	High	01/07/2020	30/11/2020	In progress	-	-		PID expected August
	3.02	Expansion of care coordination (SPA) to 24/7	CCC	Michelle McManus		Green	High	01/07/2020	30/09/2020	In progress	-	-		WHT Investment Case
	3.03	Expansion of Rapid Response to operate 6:00am to 12:00 midnight	Rapid Response	Michelle McManus		Green	High	01/07/2020	30/09/2020	In progress	-	-		WHT Investment Case
	3.04	Alignment of pathways across Tier 3 including with WMAS 111/999	ICS Step Up	Michelle McManus		Green	High	01/08/2020	31/03/2021	In progress	-	-		T3 Project Group re-established
	3.05	St Giles Hospice transfer of provision	Hospice	Michael Cox		Amber	High	01/07/2020	31/10/2020	In progress	-	-		
	3.06	Establishment of stroke and neuro rehab at Holly Bank House	Stroke	Michelle McManus		Amber	High	01/04/2020	30/09/2020	In progress	-	-		
	3.07	Additional capacity for IV therapies to be delivered in the community	IV Therapy	Michelle McManus		Green	High	01/07/2020	30/09/2020	In progress	-	-		WHT Investment Case
	3.08	Organisational development and integration of teams	ICS Step Up	Michelle McManus		Green	High	01/09/2020	31/03/2021	Not started	-	-		
											-	-		
4		**Acute and Emergency Services**									-	-		
	4.01	Integrated front door aligned to FES, PBTs, UTC and ICS	Integrated Front Door	Michelle McManus		Amber	High	01/05/2020	30/11/2020	In progress	-	-		PID expected in September, aligned to T3
	4.02	BMAT evaluation and handover to WHT (MLTC Division)	Mobilisation	Michelle McManus		Amber	Medium	01/04/2020	31/08/2020	Completed	-	-		Handed over to WHT Falls project lead
											-	-		
5		**Digital Transformation**									-	-		
	5.01	Data sharing agreement in place		Frank Botfield		Green	High	01/01/2020	31/03/2020	Completed	-	-		
	5.02	Partner data sets agreed and populated in the shared care record system		Frank Botfield		Green	High	01/04/2020	30/09/2020	In progress	-	-		
	5.03	Testing of available shared care record data with localty MDTs (PDSA)		Frank Botfield		Green	High	01/04/2020	30/09/2020	In progress	-	-		
	5.04	Full roll out for shared care record across all users and services		Frank Botfield		Green	High	01/10/2020	31/03/2021	Not started	-	-		
	5.05	EPaCCS proof of concept (testing the software compatibility with current systems)		Frank Botfield		Green	High	01/01/2020	31/03/2020	Completed	-	-		
	5.06	EPaCCS pilot in 3 GP practices				Green	High	01/04/2020	30/09/2020	In progress	-	-		
	5.07	Roll out of EPaCCS		Frank Botfield		Green	High	01/10/2020	31/03/2021	Not started	-	-		
	5.08	Strategy for deployment of the population health module across place based teams		Frank Botfield		Green	High	01/10/2020	31/03/2021	Not started	-	-		
											-	-		
6		**System Enablers**									-	-		
	6.01	Development of a proposal for OD covering Board, SMT and wider workforce	Workforce	Michelle McManus		Amber	High	01/01/2020	30/09/2020	In progress	-	-		
	6.02	Review of Strengths Based Practice project post-COVID-19	SBP	Simon Cooper		Amber	High	01/05/2020	31/08/2020	In progress	-	-		Paper expected August
	6.03	Head of Terms for shared occupancy buildings between WHT and Walsall Council	N/A	Michelle McManus		Amber	High	01/07/2020	30/09/2020	In progress	-	-		
	6.04	One Public Estate - Acadis commission to deliver the OPE business case	N/A	Jane Sillitoe		Green	High	01/04/2020	31/03/2021	In progress	-	-		
	6.05	Review of all community estate and development of a WT Estates estrategy	N/A	Jane Sillitoe		Red	High	01/06/2020	31/03/2021	In progress	-	-		Strategic Estates Lead required
	6.06	Development of a Communications Strategy for Walsall Together	N/A	Michelle Beddow		Amber	High	01/07/2020	30/09/2020	In progress	-	-		
	6.07	Recruitment to Senior Data Analyst (WTPO and Family Safeguarding joint appointment)	N/A	Frank Botfield		Green	High	01/07/2020	30/09/2020	In progress	-	-		
	6.08	Development of a robust operational performance dashboard for services in scope	N/A	Frank Botfield		Green	High	01/08/2020	31/10/2020	In progress	-	-		
											-	-		

Programme	**Walsall Together Horizon 2 Plan 2020/21**
SRO	Daren Fradgley, Executive Director of Integration
SMT Lead	TBC - Director of Transformation
Project Manager	Walsal Together Programme Office
Date updated	18/08/2020
Version	2.1
Today	18/08/2020
Next Gateway	WTP Board July 2020

Milestone #	Action #	Description	Timeline - 2020/21 Months														
			1/1	1/2	1/3	1/4	1/5	1/6	1/7	1/8	1/9	1/10	1/11	1/12	1/1	1/2	1/3
1		**Resilient Communities**															
	1.01	Approval of revised Workstream Plan for Resilient Communities															
	1.02	Identify investment to deliver Resilient Communities															
	1.03	Infrastructure for Grant Funding Programme															
	1.04	Stakeholder event and award of grants															
	1.05	Assess quality of provision and develop Living Directory															
	1.06	Commission academic partner - Wolverhampton University															
	1.07	Social precribing offer aligned to all place based teams and accepting referrals															
	1.08	Single social prescribing model aligned across system partners															
	1.09	Framework for coproduction and established mechanisms across all Tiers															
2		**Place Based Teams and Specialist Community Services**															
	2.01	Agree pilot MDT pathway															
	2.02	Roll out of MDT model in all localities															
	2.03	Recruitment of additional MDT coordinators (1 per Locality)															
	2.04	Further develop MDT pathway to utilise data sharing through EMIS															
	2.05	Agree staffing model and pathway for specialist MDTs															
	2.06	Integrate Community Geriatrician offer into place based teams															
	2.07	Scoping of appropriate outpatient activity including diagnostics to be delivered in the															
	2.08	Recruitment of additional posts for Place Based Teams															
	2.09	Alignment of primary and community mental health services to place-based teams															
	2.10	Training and development for PBTs															
	2.11	Organisational development and further integration of PBTs															
	2.12	Enhanced support to care homes new model															
	2.13	Integration of children's services - Health Visiting and School Nursing															
	2.14	Family safeguarding model															
3		**Intermediate Care Services**															
	3.01	Formal pilot of step-up offer for Intermediate Care Service															
	3.02	Expansion of care coordination (SPA) to 24/7															
	3.03	Expansion of Rapid Response to operate 6:00am to 12:00 midnight															
	3.04	Alignment of pathways across Tier 3 including with WMAS 111/999															
	3.05	St Giles Hospice transfer of provision															
	3.06	Establishment of stroke and neuro rehab at Holly Bank House															
	3.07	Additional capacity for IV therapies to be delivered in the community															
	3.08	Organisational development and integration of teams															
4		**Acute and Emergency Services**															
	4.01	Integrated front door aligned to FES, PBTs, UTC and ICS															
	4.02	BMAT evaluation and handover to WHT (MLTC Division)															
5		**Digital Transformation**															
	5.01	Data sharing agreement in place															
	5.02	Partner data sets agreed and populated in the shared care record system															
	5.03	Testing of available shared care record data with localty MDTs (PDSA)															
	5.04	Full roll out for shared care record across all users and services															
	5.05	EPaCCS proof of concept (testing the software compatibility with current systems)															
	5.06	EPaCCS pilot in 3 GP practices															
	5.07	Roll out of EPaCCS															
	5.08	Strategy for deployment of the population health module across place based teams															
6		**System Enablers**															
	6.01	Development of a proposal for OD covering Board, SMT and wider workforce															
	6.02	Review of Strengths Based Practice project post-COVID-19															
	6.03	Head of Terms for shared occupancy buildings between WHT and Walsall Council															
	6.04	One Public Estate - Acadis commission to deliver the OPE business case															
	6.05	Review of all community estate and development of a WT Estates estrategy															
	6.06	Development of a Communications Strategy for Walsall Together															
	6.07	Recruitment to Senior Data Analyst (WTPO and Family Safeguarding joint appointment)															
	6.08	Development of a robust operational performance dashboard for services in scope															

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 10.1** **ENC: 11**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Phil Gayle - Non Executive Director.
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The report provides the key messages from the People and Organisational Committee meeting on 30th July and 27th August 2020. Of note are: • There are 29 overarching projects in the Valuing Colleagues workstream of the improvement programme. All project briefs, implementation plans, quality impact and equality, diversity and inclusivity assessments are complete. The focus for the coming month is on completing the project benefits ahead of an improvement programme Board development session in October. The Committee suggested that wider stakeholder mapping is carried out as part of a cross-cutting piece of work across all workstreams. • The Trust Board requested the Committee to review the immediate, short and long term plans to address discrimination, which it did in July and August. A paper is on the Trust Board agenda for this meeting, and the attention of the Board is drawn to the action plans for the Board's Pledge, with the Board's input sought to those plans. The Committee recognised the initiatives planned and already on foot in this area, and requested the action plans to place emphasis on outcomes. • The Committee reviewed the action plan to address the NHS People Plan and were assured that those actions, delivered through Valuing Colleagues workstream of the improvement programme, will meet requirements the People Plan. Implementation will be monitored by the Committee. The Trust Board has received a paper on this item at this meeting. • Reductions in sickness absence have helped to mitigate increased temporary staffing usage, booked in response to COVID-19.		

	• Trust-wide mandatory training compliance levels are at 86% (target is 90%), with several divisions continuing an upward trend of improvement above 90%. The Board's attention is drawn to the following escalations: • The Trust Board requested the Committee to review quantitative measures i.e. compliance with completion of risk assessments for Black, Asian, Minority Ethnic ("BAME") colleagues, and qualitative measures i.e. the quality of the conversations and proportion of assessments resulting in change in workplace practices. These were reviewed at both the July and August meetings and a report is included on the Board agenda for this meeting. The Committee expressed concern that the percentage of risk assessments for BAME colleagues remained at 87%, however noted an increase in percentages for all colleagues receiving risk assessments at 67.5%. The Committee requested the executive to look at other Trusts in the region and nationally to see whether a different approach to BAME colleagues could be adopted to increase levels of compliance, noting that the Trust's performance regionally is lagging. • Appraisal compliance is getting worse in most areas, with some hitting the target sometimes and others not reaching the target of 90%. A different approach to appraisal meetings has begun to bear some early fruit in improved compliance levels. The next meeting of the Committee will take place on 24th September 2020.	
Recommendation	Members of the Trust Board are asked to note the report and the escalations for its attention.	
Risk in the BAF or Trust Risk Register	BAF S05 – Culture (lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care)	
Resource implications	There are no new resource implications associated with this report.	
Legal, Equality and Diversity implications	This Committee supports the Trust's approach to delivering equality, diversity and inclusion for the benefit of the patient population and staff who work for the Trust and who live in Walsall. .	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE (PODC)

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee has met twice since the 2nd July Trust Board meeting, with those meetings taking place on 30th July and 27th August 2020. The July meeting was chaired by Mr Phil Gayle, Committee Chair and Non-Executive Member of the Trust Board, with the August meeting chaired by Mr Ben Diamond, Non-Executive member of the Trust Board. Both meetings were quorate.

The Committee reports each month on escalations for the attention of the Trust Board and key issues from the meeting. In addition to the key matters on the front sheet of this report, the following were discussed by the Committee.

1. BAME Colleagues

The Trust Board requested the Committee to provide assurance to the Board on the measures in place to address the impact of COVID-19 on BAME colleagues. This was reviewed in the July meeting and measures include:

- Occupational Health clinics for any staff referred following a risk assessment
- Individuals supported to continue roles whilst being protected.
- Within a surgical department a robust approach to assessing the impact of COVID on usual activity such as clinics, surgery, etc, has enabled clinicians to be assessed and elective operating restarted as clear measures to protect individual clinicians are in place.
- Vulnerable ITU staff enabled to return to clinical working with the mitigation of full PPE and no direct COVID +ve patient contact.

Other measures taken include work from home; only operating on fully screened/isolated patients; restricting duties for example limiting face to face contact in favour of virtual clinics; redeployment into other areas; staggered start and finish times facilitate social distancing at work. Details of the proportion of assessments resulting in a change in workplace practices will be reviewed by the Committee in September.

2. Effectiveness Review and Terms of Reference

At the 30th July meeting the Committee approved its annual report and revisions to the terms of reference are on the Trust Board agenda for the September meeting. The Committee's revised cycle of business will be reviewed in September.

3. Risk Management

BAF risk S05 – culture –was reviewed by the Committee in July and August BAF. Following discussions in July, particularly around colleague readiness for restoration and recovery, the overall BAF risk rating was increased from 16 to 20 when it was presented in August to indicate the increased impact score from 4 to 5. The four corporate risks received review in month and were presented to the Committee.

MEETING OF THE PUBLIC TRUST BOARD 3rd September 2020			
VALUING COLLEAGUES – EXECUTIVE UPDATE			**AGENDA ITEM: 10.2** **ENC: 12**
Report Author and Job Title:	Catherine Griffiths – Director of People and Culture	**Responsible Director:**	Catherine Griffiths – Director of People and Culture
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒ This report requires the following action: 1. Note the update to Trust Board on actions taken relating to the Improvement Programme through People and Organisational Development Committee ("PODC") and supporting groups. 2. Note that the actions within the National People Plan have been mapped against the work-packages within the improvement programme and amendment made to ensure all content is reflected. 3. Note the BAF risk mitigations measures and performance against key workforce metrics and note the work on the valuing colleagues element of the accountability framework has been completed. 4. Note that PODC have received a report on HR/Organisational Development interventions planned in response to colleague experience, freedom to speak up concerns relating to organisation culture. 5. Note that PODC have received a report on risk assessment compliance for all colleagues and an initial qualitative report on colleague experience of the process for colleagues from a black, Asian and minority ethnic background. 6. Receive positive assurances arising from the improvement programme work and note gaps in assurance and plans to address these gaps.		

Executive Summary	This report provides an overview of the risks to delivery of the valuing colleagues strategic objective and provides an update on the mitigations in place to manage the risks identified, as well as the actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance relating to the improvement programme valuing colleagues work-stream and performance against the valuing colleagues strategic objective, successes and areas for improvement.
Recommendation	Members of the Trust Board are asked to note the report and in particular note the Organisational Development ("OD") work initiated to provide assurance and feedback for colleagues raising concerns including racism and inequality based on protected characteristic and members are asked to note that additional subject matter expertise is required to complete this work. In addition members of the Trust Board are asked to note that the actions scheduled within the National People Plan have been mapped across the valuing colleagues work-stream of the improvement programme and that these seek to mitigate the BAF risk SO5.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk SO5 to provide positive assurance the mitigations in place to manage this risk and the related corporate risks.
Resource implications	There are resource implications that flow from recommendations in the report. In the short-term the resource requirements are being met from base budgets. The improvement program and OD approach will require investment beyond the base budget in order to achieve the milestones and progress envisaged by 2022. The investment case will be considered through trust governance including PODC, Performance, Finance and Investment Committee and Quality, Patient Experience and Safety Committee before further recommendation to Trust Board.
Legal and Equality and Diversity implications	There are significant issues relating to equality arising from matters addressed in the report. The Trust Board has been presented with the evidence base for differential staff experience based on ethnicity, disability, age, sexuality, gender, religion and other protected characteristics. This goes to the heart of both the Trust Board pledge and the Trust values and supporting behaviours. The mitigating actions planned seek to ensure that swift and decisive action is taken to address

	toxic behaviours and cultures. In addition to ensure the systems the Trust relies upon can delivery equality of outcome relating to career progression, development, promotion, talent management and recruitment such that the workforce is representative of the communities it serves and can be seen as an anchor institution within Walsall.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Valuing Colleagues – Trust Board Pledge and

1. EXECUTIVE SUMMARY

The Trust Board made a pledge relating to valuing colleagues as follows:

"We the Trust Board, pledge to demonstrate through our actions that we listen and support people. We will ensure that the organisation treats people equally, fairly and inclusively with zero tolerance of bullying. We uphold and role-model the Trust values chosen by you"

The evidence available demonstrates that the pledge is not met consistently across the Trust. There are areas of good practice from which we need to learn; equally there are areas of toxicity within the culture which run counter to the trust values and which are normalised in some areas, the toxicity is extreme and includes racism, differential experience for those with disabilities, homophobia, disproportionate opportunity based on age and other protected characteristics defined within the Equality Act. Without decisive action to tackle poor and discriminatory practice and behaviours, the ability to demonstrate the Trust truly values colleagues will not be achieved and the authenticity and credibility of the Trust Board pledge compromised. The purpose of the 'valuing colleagues' enabling work-stream of the improvement programme is to deliver workforce improvement so colleagues recommend the Trust as a place to work and as a place to be treated. Colleague experience has a direct correlation with patient experience and outcomes.

In addition, the Trust has a role to play as an anchor institution and employer within Walsall to tackle the social inequalities within the borough which have been further exposed through Covid-19 and the disproportionate outcomes evidenced. Despite all the challenging evidence within the Trust and within wider society, there is also the chance to take hold of the opportunity this presents to make a lasting difference to health outcomes by having influence at the system level. Specifically, the ability to offer sustainable employment as a Real Living Wage employer can make a real and lasting difference for current and for future generations. This ambition may be at risk or may not be fully realised unless the Trust can address its own organisational culture and make the Trust a healthy place to work and a place people will recommend.

There are foundations in place for improvement and for a more people focused view of service delivery, with clarity on the expectation for colleagues and line managers/leaders within the trust. There is a route-map for leadership development and system review to make key people management processes more equality focused, such as appraisal, talent management, access to career development and training, promotion, recruitment and attraction as well as investing in colleague wellbeing and support for achieving sustainable attendance at work and a healthy organisation that follows a just culture approach to employment relations and learning from events.

The workforce metrics performance element of this report takes a standard set of quantitative metrics and tracks performance over time. The aim is to provide assurance to the Trust Board via PODC that the Trust remains on target for each metric and if this is not the case to identify planned action to address the gaps in assurance.

The emergency response to Covid-19 had a negative impact on compliance for a number of the workforce metrics. PODC routinely challenges performance, controls in place and the ability to bring metrics back in line to targets set by the Trust Board.

Whilst the workforce metric report is well established and offers a long term view through SPC data on trends against key targets, the measures are quantitative measures of performance. These support an analysis of performance that contributes to use of resources and the effective management of these indicators at divisional level, monitored through PODC and the executive led performance reviews contributes as a control on temporary workforce use and the standards required by CQC for statutory and mandatory training and appraisal. These are important measures however leave a gap in assurance relating to the qualitative measures of organisational culture and the staff experience of working in Walsall. The Accountability Framework is being updated to provide measures of colleague experience through the lens of valuing colleagues this is complete and will be deployed to complement the hard measures used to evaluate workforce performance metrics. This control mechanism is a vital way of ensuring colleague experience and colleague voice is acknowledged and to ensure that the values and behavioural framework are followed in all areas of the trust.

The measures specifically address the BAF risk that a 'lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care'. Hence the qualitative measures on performance relate to colleague engagement and morale within the trust, the friends and family scores, the equality of colleague experience relating to recruitment, retention, progression, access to development and promotion, as well as identifying metrics of concern such as FTSU concerns raised, ER casework particularly bullying and harassment, violence, high absence, turnover and high levels of stress and anxiety, it will draw on exit data, survey and focus group work to identify improvement and action required to improve the organisational culture and staff experience. The valuing colleagues element of the accountability framework is complete and the qualitative metrics will be part of the performance review meetings with a template for reporting from all divisions once they have been reviewed by PODC in September.

The valuing colleagues work-stream of the improvement programme details the actions supporting the delivery of the Organisation Development Framework, which is a change programme designed to improve two key outcome measures (recommending the trust as a place to work and a place to be treated) to be top quartile by 2022.

2. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework current risk score has been increased from 16 to 20 [major risk] for the following reasons:

- Potential second wave of COVID impacting on the physical and psychological health of individuals and workforce availability.
- Data and information shared via staff feedback mechanisms evaluating impact of COVID identifies staff and line managers being fatigued and fearful of the impact that a second wave will have on individuals and staffing levels.
- Data and information from staff engagement events have identified the existence of toxic climates in several areas/departments across the Trust where colleagues have shared stories of unreasonable treatment based on their race, disability, ethnicity and sexuality.

The above points impact the delivery of the Trust Board pledge, the following control is in place to mitigate the risk:

- Colleagues in at risk groups have been identified and managed appropriately according Wellbeing Review and Stratified Risk Assessments. The compliance currently is as follows: % BAME colleagues; % other vulnerable groups and % whole workforce. PODC reviewed qualitative data arising from colleague experience of the risk assessment process and the adjustments as a result at the August meeting and will review further during September for a more detailed analysis of action taken and assurances or gaps in assurance evident.
- PODC reviewed the planned actions and interventions (as an emerging control mechanism) relating to the toxic climates in several areas/departments across the Trust, these are framed as short interventions to complete by October, followed by some longer term OD interventions that will require investment decisions relating to the valuing colleagues workstream. In particular, the various colleague listening and engagement events: Pull up a Chair, Team Talk on Values (led by external OD consultant) and Board Talks, have resulted in rich data, insight into colleague experience and themes of significant concern. Subject Matter Experts at senior level HR/OD have been engaged, PODC have reviewed the interventions and the FTSU Guardians will ensure there is a feedback mechanism for colleagues.

The following assurance is in place to mitigate the risk:

- PODC receive monthly updates regarding to assure robust arrangements in place to support colleagues through the impact of COVID.
- BAME decision making forum has been established to advise and guide the Trust in its understanding of issues facing colleagues from BAME backgrounds in the workplace and what measures can be taken to improve their experiences.

The following gaps in assurance remain:

- The private Trust Board colleague experience, Freedom to Speak Up Guardians, Board Talks, Pull up a Chair, NHS Staff Survey, WRES qualitative data and evidence highlight racism as a significant issue, the controls have started, however until action is visibly evidenced it is not be possible to give assurance to Trust Board that this is controlled and sufficient steps taken to eliminate. PODC are reviewing the detailed interventions and will escalate matters to Trust Board in highlight reports.
- There are themes emerging relating to equality of experience and treatment relating to disability, age, sexuality, religion – visible evidence of effective action is required to provide assurance to Trust Board on control and elimination.

The BAF is at appendix 1

3. PERFORMANCE REPORT

Specific priorities currently are to restore the statutory and mandatory training levels back to target compliance and as a priority to ensure all infection prevention support interventions are completed, with target date for compliance by September 2020. The risk of not doing so is detailed in the corporate risk register and PODC took assurance on behalf of the Trust Board on actions to achieve full compliance. The appraisal compliance rates are recovering from a low point of 66% in June 2020 following emergency response and PODC have commissioned a deep dive into performance across the Trust with a profile for full recovery and reporting by November 2020, this work is also vital because it goes to the equality of access to development, talent mapping, training and career progression.

The Trust Board can take assurance on levels of absence due to sickness; there have been significant interventions at trust level over the last 12 months and through divisional management teams to focus on colleague health and wellbeing and to provide appropriate support, reasonable adjustments and management of long-term sickness absence. Although Covid related absence resulted in a significant spike between April and June, the normalised position remains at 1% below that for the same period in the previous year, this was also the case for January and February 2020. The outturn for July 2020 was 4.3% Trust-wide; this is the first time absence has been below 5% since August 2018.

Retention rates have stabilised and remain just below target, although this target has been set to provide stability this must be balanced with the need to ensure the workforce model is dynamic enough maintain a workforce that consistently works to the values and behavioural framework as a priority contributor to managing for improvement. In addition, the workforce model needs to be sustainable for the future by introducing new and entry level roles which can support the Trust's ambitions as an anchor employer.

The performance report is at appendix 2

4. IMPROVEMENT PROGRAMME

There are 29 overarching projects in the valuing colleagues work-stream, these are structured into three sub-work-streams as follows:

- Leadership, Culture and OD
- Organisation Effectiveness
- Making Walsall (and the Black Country) the best place to work

Progress on defining the scope of the programme has been maintained throughout the emergency response to Covid-19 and the delivery on some work-packages has been accelerated during this period. All project briefs, implementation plans and all QIA/EIA assessments are complete. Stakeholder engagement is assessed as making good progress, additional communication resource is in place and plans are being finalised to ensure the engagement resource for the divisions is in place. The benefits assessments are not yet complete and here progress has been slower, but this will be addressed in September.

The National People Plan was published on 31st July 2020 and PODC received a report identifying the areas where further assurance and work is required. The requirements of the National People Plan have been mapped against the work-packages planned within the improvement programme and amendments will be made to address assurance gaps. The key assurance gaps (work not yet initiated) are:

- Approach to Flexible Working
- Workforce Supply and approach to International Recruitment
- Workforce sharing agreements at system level

These will be incorporated into the improvement programme work-packages and further information on each presented to PODC and the STP People Board. Whereas for other areas work has been initiated, there is still significant work to reach the outcomes and targets identified within the improvement programme. The definition of benefits and priorities will provide the assurance to trust board that the programme is meeting both outcomes and milestones planned.

The Improvement Programme is at appendix 3

5. RECOMMENDATIONS

- Members of the Trust Board are asked to note the report and in particular note the OD work initiated to provide assurance and feedback for colleagues raising concerns including racism and inequality based on protected characteristic and members are asked to note that additional subject matter expertise is required to complete this work.
- In addition members of the Trust Board are asked to note that the actions scheduled within the National People Plan have been mapped across the valuing colleagues work-stream of the improvement programme and that these seek to mitigate the BAF risk SO5.

APPENDICES

1. BAF SO5
2. Performance Report – Workforce Metrics
3. Improvement Programme update

Walsall Healthcare NHS
NHS Trust

July 2020 Workforce Metrics

Executive Lead Name: Catherine Griffiths
Executive Lead Title: Director of People and Culture

Document Author Name: Sebastian Smith – Cox
Document Author Title: Workforce Intelligence, Planning & Analytics Lead

Contents

Walsall Healthcare NHS
NHS Trust

Workforce Performance Summary

In addition to the continuation of improvement initiatives outlined within previous reports, the following outcomes/benefits were realised during July 2020;

Appraisal Compliance

- Interventions focused on elevating confidence in taking a different approach to appraisal meetings have begun to bear some early fruit in improved compliance levels.
- The targeted support of managers with a significant number of outstanding appraisals helps to ensure colleagues receive a high-quality appraisal experience; with the new PDR (Personal Development Review) form helping to guide both managers and colleagues through the process.
- The development of a PDR Analytics dashboard has enabled Talent Management colleagues to pinpoint services/demographics of concern; whilst the up-coming extraction of qualitative information from PDR paperwork will help to inform Training Needs Analysis and Job Plans.

Sickness Absence

- Reductions in sickness absence have helped to mitigate increased temporary (temp.) staffing usage, booked in response to COVID-19.
- Whilst bank & agency expenditure has increased by 40%, compared to 19/20, a reduction in temp. staffing shifts booked concerning sickness absence prevented a continuation agency expenditure levels incurred during Feb – May 2020.

Mandatory Training Compliance

- Trust-wide compliance levels have now stabilised above 85%, with several divisions continuing an upward trend of improvement above 90%.
- Improved Safeguarding compliance is providing a foundation for safe and compassionate patient care, at a time when many users of healthcare services might be in a vulnerable circumstance.

Walsall Healthcare NHS Trust

SPC Summary Dashboard - Retention (24 Months)

*Exclusions Apply – See Appendix A	July 2020 Outturn	Numerator: FTE (24 Months+ Service)*	Denominator: June 2019 FTE*	Will We Meet The Target? (85%)	Is Performance Stable?	Analysis Page
WH Trust	**82.8%**	2646.77	3196.82	No	Yes	8
Adult Community	**139.2%**	411.95	295.93	Yes	Getting Better	-
Estates & Facilities	**90.7%**	224.22	247.18	Yes	Getting Worse	-
MLTC	**71.1%**	473.31	665.70	No	Getting Worse	-
Surgery	**84.5%**	549.58	650.52	Sometimes	Getting Worse	-
WCCSS	**67.0%**	622.16	928.15	No	Getting Worse	-
Chief Executive Directorate	**50.0%**	4.00	8.00	No	Getting Better	-
Finance Directorate	**84.6%**	69.26	81.89	Sometimes	Yes	-
Governance Directorate	**67.4%**	22.47	33.31	No	Getting Worse	-
Informatics Directorate	**83.3%**	94.29	113.17	Sometimes	Yes	-
Medical Directorate	**38.5%**	6.40	16.63	Sometimes	Getting Worse	-
Nurse Directorate	**107.5%**	76.46	71.10	Yes	Yes	-
Operations Directorate	**201.1%**	24.13	12.00	Sometimes	Getting Better	-
People & Culture Directorate	**98.0%**	61.95	63.24	Sometimes	Getting Better	-
Transformation & Strategy	**66.0%**	6.60	10.00	Sometimes	Yes	-

Walsall Healthcare NHS
NHS Trust

SPC Summary Dashboard – Sickness Absence

	July 2020 Outturn	Numerator: FTE Days Lost During July 2020	Denominator: FTE Days Available During July 2020	Will We Meet The Target? (4.5%)	Is Performance Stable?	Analysis Page
WH Trust	**4.3%**	4861.03	113593.79	Sometimes	Yes	8
Adult Community	**4.2%**	712.61	16891.86	Sometimes	Yes	-
Estates & Facilities	**8.1%**	641.45	7870.79	**No**	**Getting Worse**	-
MLTC	**4.1%**	944.10	22811.65	Sometimes	Yes	-
Surgery	**4.7%**	1072.62	22889.68	**No**	Yes	-
WCCSS	**4.5%**	1231.97	27393.68	Sometimes	**Getting Better**	-
Chief Executive Directorate	**0.0%**	0.00	279.00	**Yes**	Yes	-
Finance Directorate	**2.1%**	59.20	2766.99	Sometimes	Yes	-
Governance Directorate	**0.0%**	0.00	882.47	Sometimes	**Getting Better**	-
Informatics Directorate	**0.7%**	28.34	3946.72	Sometimes	**Getting Better**	-
Medical Directorate	**0.7%**	4.00	584.04	Sometimes	Yes	-
Nurse Directorate	**3.1%**	93.13	3010.46	Sometimes	Yes	-
Operations Directorate	**4.0%**	46.40	1156.38	Sometimes	Yes	-
People & Culture Directorate	**1.0%**	61.95	2762.87	Sometimes	Yes	-
Transformation & Strategy	**0.0%**	0.00	347.20	Sometimes	**Getting Better**	-

Walsall Healthcare NHS Trust

SPC Summary Dashboard – Mandatory Training Compliance

	July 2020 Outturn	Numerator: Competencies Completed	Denominator: Competencies Required	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**85.7%**	37314	43547	No	Yes	8
Adult Community	**96.1%**	6661	6932	Sometimes	Getting Better	-
Estates & Facilities	**86.0%**	3187	3706	No	Yes	-
MLTC	**79.3%**	6344	8000	No	Yes	-
Surgery	**80.1%**	6849	8546	No	Getting Worse	-
WCCSS	**87.8%**	9634	10977	Sometimes	Getting Worse	-
Chief Executive Directorate	**72.8%**	59	81	No	Getting Better	-
Finance Directorate	**93.6%**	842	900	Sometimes	Getting Better	-
Governance Directorate	**90.2%**	258	286	Sometimes	Yes	-
Informatics Directorate	**94.9%**	1253	1320	Sometimes	Yes	-
Medical Directorate	**94.4%**	170	180	Sometimes	Getting Better	-
Nurse Directorate	**92.9%**	1089	1172	Sometimes	Getting Better	-
Operations Directorate	**83.0%**	293	353	Sometimes	Yes	-
People & Culture Directorate	**90.3%**	880	974	Sometimes	Yes	-
Transformation & Strategy	**88.3%**	106	120	Sometimes	Yes	-

Walsall Healthcare NHS
NHS Trust

SPC Summary Dashboard – Annual Appraisal Compliance

*Exclusions Apply – See Appendix A	July 2020 Outturn	Numerator: Appraisals Completed*	Denominator: No. Colleagues Eligible For Appraisal*	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**73.5%**	2408	3275	**No**	**Getting Worse**	8
Adult Community	**90.9%**	471	518	Sometimes	Yes	-
Estates & Facilities	**68.1%**	235	345	Sometimes	**Getting Worse**	-
MLTC	**67.7%**	373	551	**No**	**Getting Worse**	-
Surgery	**63.7%**	414	650	**No**	**Getting Worse**	-
WCCSS	**86.6%**	681	786	Sometimes	**Getting Worse**	-
Chief Executive Directorate	**66.7%**	4	6	Sometimes	Yes	-
Finance Directorate	**50.6%**	39	77	**No**	**Getting Worse**	-
Governance Directorate	**34.8%**	8	23	**No**	**Getting Worse**	-
Informatics Directorate	**47.4%**	55	116	**No**	**Getting Worse**	-
Medical Directorate	**100.0%**	10	10	Sometimes	Yes	-
Nurse Directorate	**62.9%**	56	89	Sometimes	**Getting Worse**	-
Operations Directorate	**53.8%**	14	26	**No**	Yes	-
People & Culture Directorate	**66.2%**	47	71	Sometimes	**Getting Worse**	-
Transformation & Strategy	**14.3%**	1	7	**No**	**Getting Worse**	-

Walsall Healthcare NHS
NHS Trust

Workforce Metrics

Workforce Profile	As at 31/03/2020	Target	2020/21												YTD Change - Since 31/03/20
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Substantive Staff FTE	3598.64		3612.02	3622.55	3667.89	3679.03	-	-	-	-	-	-	-	-	80.38
Substantive Staff FTE (Ex. Rotational Drs)	3513.84		3526.82	3537.75	3583.09	3596.23	-	-	-	-	-	-	-	-	82.38
Substantive Staff Headcount	4238		4246	4275	4302	4321	-	-	-	-	-	-	-	-	83
Bank Staff Only Headcount	919		967	995	1012	988	-	-	-	-	-	-	-	-	69
% Staff from a BME Background	28.09%		28.12%	28.24%	28.03%	28.19%	-	-	-	-	-	-	-	-	0.10%

Workforce Profile BY Staff Group (FTE)	As at 31/03/2020	Target	2020/21												YTD Change - Since 31/03/20
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Add Prof Scientific and Technic	121.77		122.34	122.69	120.69	122.27	-	-	-	-	-	-	-	-	0.50
Additional Clinical Services	619.10		615.85	616.39	623.22	625.37	-	-	-	-	-	-	-	-	6.27
Administrative and Clerical	807.03		804.47	806.79	819.07	825.11	-	-	-	-	-	-	-	-	18.09
Allied Health Professionals	221.43		222.60	221.93	225.53	228.17	-	-	-	-	-	-	-	-	6.74
Estates and Ancillary	252.47		250.75	250.13	250.23	250.06	-	-	-	-	-	-	-	-	-2.41
Healthcare Scientists	45.22		45.52	43.93	42.93	43.62	-	-	-	-	-	-	-	-	-1.60
Medical and Dental	363.71		364.51	360.34	358.94	356.24	-	-	-	-	-	-	-	-	-7.47
Nursing and Midwifery Registered	1159.93		1155.45	1145.99	1145.11	1146.82	-	-	-	-	-	-	-	-	-13.10
Students	8.00		30.53	54.36	82.16	81.36	-	-	-	-	-	-	-	-	73.36

Workforce Profile	2019/20	Target	2020/21												YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Change in Workforce Profile WTE (Ex. Rotational Drs)	-		12.98	10.93	45.33	13.14	-	-	-	-	-	-	-	-	-
Starters WTE	482.66		57.27	27.53	46.49	28.69	-	-	-	-	-	-	-	-	159.97
Leavers WTE	547.19		21.69	26.12	16.15	25.15	-	-	-	-	-	-	-	-	89.12
TUPE in WTE	0.00		0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-	0.00
TUPE Out WTE	1.40		0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-	0.00

Turnover % (Normalised) - Rolling 12 Months	2019/20	Target	2020/21												2020/21 Average
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Overall Turnover	10.98%	10%	10.10%	10.37%	9.04%	7.57%	-	-	-	-	-	-	-	-	9.27%
Add Prof Scientific and Technic	16.74%	10%	15.66%	17.56%	18.54%	18.73%	-	-	-	-	-	-	-	-	17.62%
Additional Clinical Services	9.66%	10%	8.85%	9.64%	10.53%	8.98%	-	-	-	-	-	-	-	-	9.50%
Administrative and Clerical	10.24%	10%	10.34%	9.80%	5.52%	3.35%	-	-	-	-	-	-	-	-	7.25%
Allied Health Professionals	17.41%	10%	14.63%	13.52%	13.72%	12.48%	-	-	-	-	-	-	-	-	13.59%
Estates and Ancillary	7.73%	10%	6.96%	6.91%	5.84%	5.87%	-	-	-	-	-	-	-	-	6.40%
Healthcare Scientists	5.56%	10%	6.60%	7.50%	2.14%	4.55%	-	-	-	-	-	-	-	-	5.20%
Medical and Dental	6.30%	10%	5.28%	5.66%	6.32%	6.96%	-	-	-	-	-	-	-	-	6.05%
Nursing and Midwifery Registered	12.06%	10%	10.77%	11.40%	10.15%	8.07%	-	-	-	-	-	-	-	-	10.10%

Workforce Metrics

Retention	2019/20	Target	2020/21												2020/21 Average
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Retention Rate (12 Months)	90.96%		91.24%	89.69%	90.07%	90.76%	-	-	-	-	-	-	-	-	90.44%
Retention Rate (24 Months)	81.96%	85%	82.14%	82.09%	82.39%	82.79%	-	-	-	-	-	-	-	-	82.35%
Retention Rate (5 Years)	60.58%		63.13%	62.75%	63.56%	63.47%	-	-	-	-	-	-	-	-	63.23%

Retention Rate (24 Months)	2019/20	Target	2020/21												2020/21 Average
	Mar-19		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Add Prof Scientific and Technic	83.90%	85%	71.73%	71.18%	73.18%	72.16%	-	-	-	-	-	-	-	-	72.06%
Additional Clinical Services	78.39%		80.55%	81.19%	80.49%	80.61%	-	-	-	-	-	-	-	-	80.71%
Administrative and Clerical	86.84%		89.61%	88.88%	89.97%	90.54%	-	-	-	-	-	-	-	-	89.75%
Allied Health Professionals	72.46%		76.26%	74.60%	75.52%	76.39%	-	-	-	-	-	-	-	-	75.69%
Estates and Ancillary	90.41%		87.80%	88.02%	88.84%	89.44%	-	-	-	-	-	-	-	-	88.52%
Healthcare Scientists	81.50%		75.37%	75.37%	73.55%	78.96%	-	-	-	-	-	-	-	-	75.81%
Medical and Dental	85.04%		84.24%	84.07%	85.08%	85.72%	-	-	-	-	-	-	-	-	84.78%
Nursing and Midwifery Registered	80.09%		78.92%	79.22%	79.16%	79.44%	-	-	-	-	-	-	-	-	79.18%

Sickness Absence	2019/20	Target	2020/21												2020/21 Average
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
% Sickness Absence In Month	6.82%	4.50%	8.34%	5.99%	4.93%	4.28%	-	-	-	-	-	-	-	-	5.89%
% Sickness Absence (Rolling 12 Months)	5.61%	4.50%	5.83%	5.82%	5.75%	5.63%	-	-	-	-	-	-	-	-	5.76%
FTE Days Lost	73437		8986	6733	5405	4861	-	-	-	-	-	-	-	-	6496
% Short Term Sickness	30.27%		28.21%	22.98%	26.72%	28.53%	-	-	-	-	-	-	-	-	26.61%
% Long Term Sickness	69.73%		71.79%	77.02%	73.28%	71.47%	-	-	-	-	-	-	-	-	73.39%
Estimated Cost of Sickness £	£6,433,476		£835,103	£564,120	£446,924	£404,236	-	-	-	-	-	-	-	-	£562,596

Top 3 Sickness Reasons (FTE Days Lost)	2019/20	Target	2020/21												% Change - (YTD Avg)
	Monthly Avg.		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Anxiety/stress/depression/other psychiatric illnesses	1523.2		2075.5	2087.0	1701.9	1457.1	-	-	-	-	-	-	-	-	20.16%
Back Problems	436.4		438.7	610.6	602.4	580.6	-	-	-	-	-	-	-	-	27.86%
Gastrointestinal problems	574.0		379.0	368.2	404.5	454.9	-	-	-	-	-	-	-	-	-30.02%

Education / OD	2019/20	Target	2020/21												2020/21 Average
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Core Mandatory Training	81.59%	90.00%	82.33%	82.44%	83.46%	85.69%	-	-	-	-	-	-	-	-	83.48%
Appraisal	80.27%	90.00%	75.05%	72.85%	71.68%	73.53%	-	-	-	-	-	-	-	-	73.28%

Workforce Metrics

Walsall Healthcare NHS
NHS Trust

Agency Spend (£000's)	2019/20	Target	2020/21												YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Agency Spend	**£10,087**		£1,298	£1,137	£814	£700	-	-	-	-	-	-	-	-	£3,949
Nursing and Midwifery Registered	£5,155		£842	£617	£536	£258	-	-	-	-	-	-	-	-	£2,253
Qualified Scientific, Therapeutic and Technical	£703		£185	£185	£185	£185	-	-	-	-	-	-	-	-	£739
Support to Clinical Staff	£148		£2	£41	£9	£13	-	-	-	-	-	-	-	-	£65
of which support to nursing staff	£45		£15	£15	£15	£15	-	-	-	-	-	-	-	-	£59
NHS Infrastructure Support	£576		£213	£271	£289	£271	-	-	-	-	-	-	-	-	£1,044
Medical and Dental	£3,505		£315	£315	£107	£224	-	-	-	-	-	-	-	-	£961
of which Consultants	£992		£128	£126	£48	£85	-	-	-	-	-	-	-	-	£386
of which Career/Staff Grade	£1,376		£101	£103	£57	£119	-	-	-	-	-	-	-	-	£380
of which Trainee Grades/Trust Grade	£1,137		£86	£86	£2	£20	-	-	-	-	-	-	-	-	£195

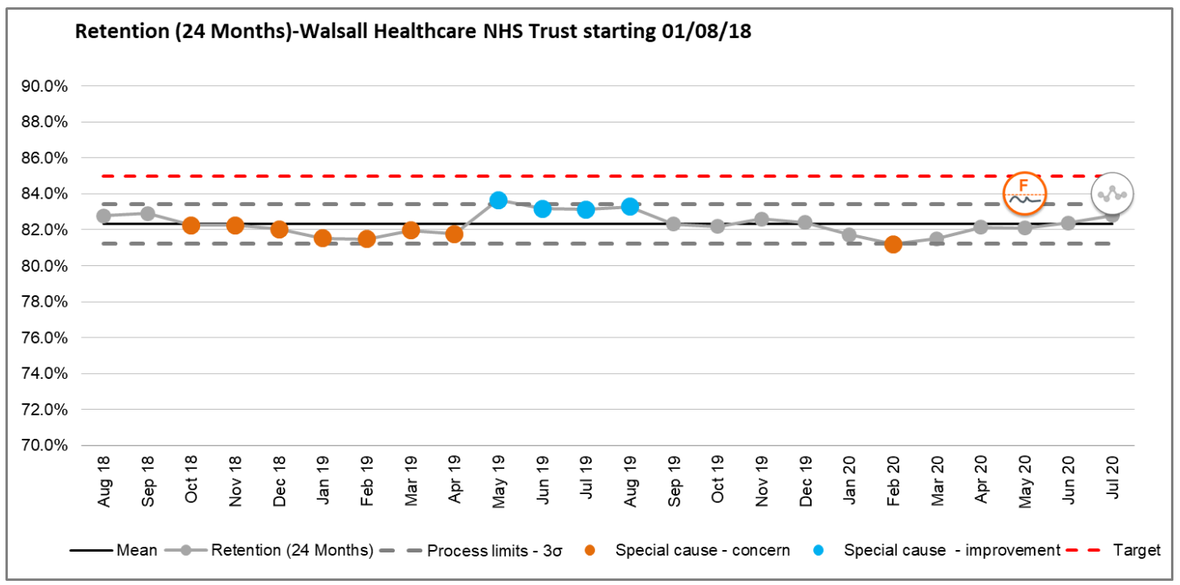
Bank Spend (£000's)	2019/20	Target	2020/21												YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Bank Spend	**£15,073**		£1,653	£1,524	£2,143	£1,744	-	-	-	-	-	-	-	-	£7,065
Nursing and Midwifery Registered	£4,267		£448	£441	£439	£459	-	-	-	-	-	-	-	-	£1,787
Qualified Scientific, Therapeutic and Technical	£0		£0	£0	£0	£0	-	-	-	-	-	-	-	-	£0
Support to Clinical Staff	£3,458		£379	£338	£341	£319	-	-	-	-	-	-	-	-	£1,378
of which support to nursing staff	£3,240		£1,263	£1,263	£1,263	£1,263	-	-	-	-	-	-	-	-	£5,051
NHS Infrastructure Support	£1,028		£441	£441	£441	£441	-	-	-	-	-	-	-	-	£1,766
Medical and Dental	£6,320		£729	£611	£1,257	£862	-	-	-	-	-	-	-	-	£3,459
of which Consultants	£3,658		£368	£327	£566	£471	-	-	-	-	-	-	-	-	£1,731
of which Career/Staff Grade	£1,880		£213	£150	£274	£270	-	-	-	-	-	-	-	-	£906
of which Trainee Grades/Trust Grade	£782		£148	£134	£418	£121	-	-	-	-	-	-	-	-	£822

Establishment Gap By Staff Group (FTE)	2019/20	Target	2020/21											
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Total Establishment Gap	**358.86**		**348.66**	**312.07**	**282.79**	**262.14**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additional Clinical Services	92.30		58.31	24.59	-2.08	-15.92	-	-	-	-	-	-	-	-
Administrative and Clerical	73.68		88.75	88.32	77.25	72.38	-	-	-	-	-	-	-	-
Allied Health Professionals	21.08		24.04	22.98	21.32	17.88	-	-	-	-	-	-	-	-
Estates and Ancillary	39.17		43.73	47.02	46.75	47.69	-	-	-	-	-	-	-	-
Healthcare Scientists	3.18		0.46	2.15	1.97	2.88	-	-	-	-	-	-	-	-
Medical and Dental	33.25		38.52	38.34	44.06	47.23	-	-	-	-	-	-	-	-
Nursing and Midwifery Registered	95.07		96.77	90.59	102.04	103.42	-	-	-	-	-	-	-	-
Professional and Scientific	1.13		-1.92	-1.92	0.08	-4.82	-	-	-	-	-	-	-	-
Students	0.00		0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-

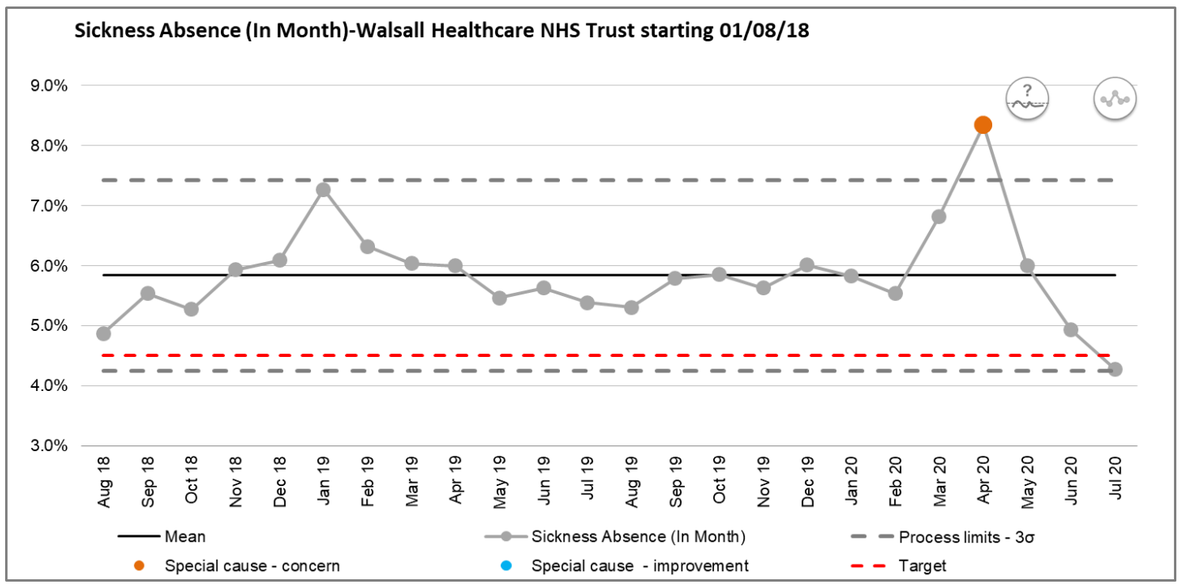
Trust Analysis & Performance Drivers

What Does The Data Tell Us?					
Are We Hitting The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

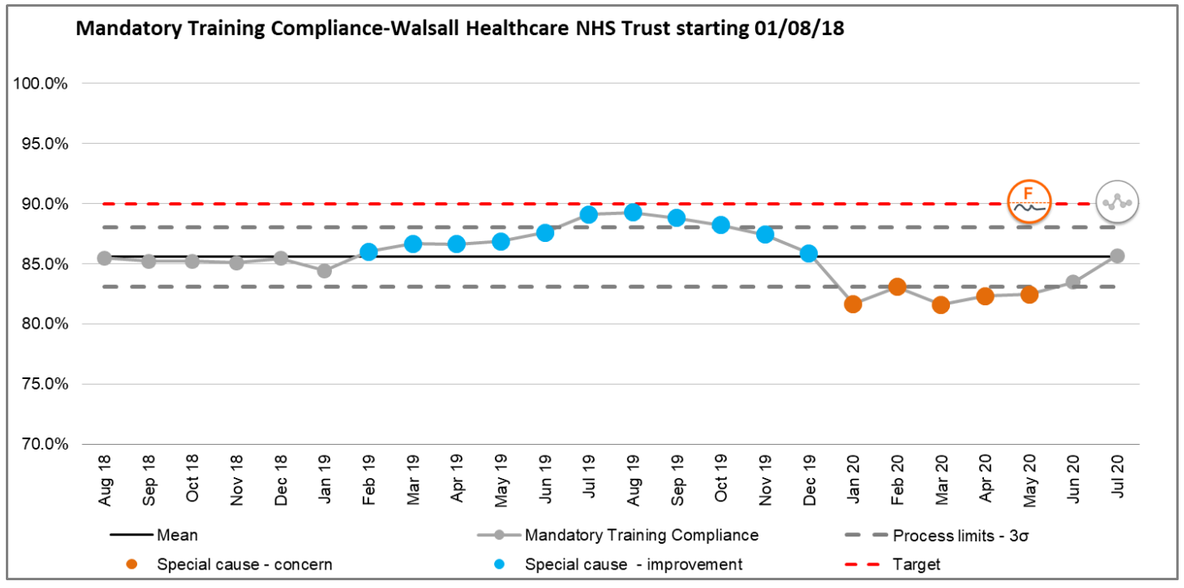
Walsall Healthcare NHS
NHS Trust



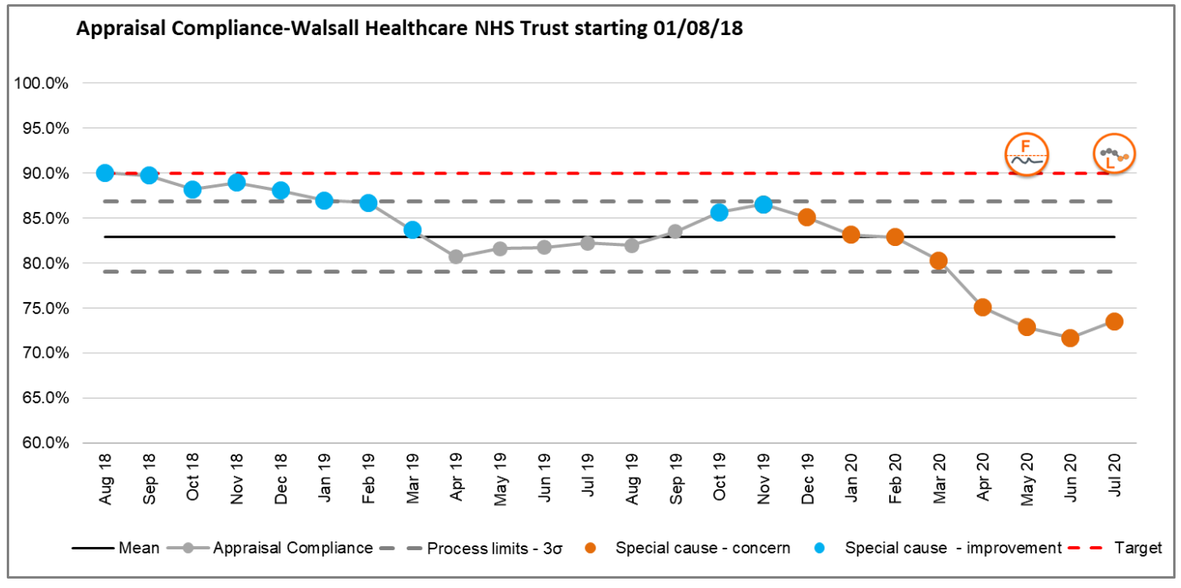
- Retention rates remain stable around an 82% average.
- High Retention = Admin/Estates/Medical | Low Retention = Scientific



- Continued falls in absence produced a 4% drop since April 2020.
- Sickness is currently 1% lower than at this point during 2019/20.



- 4th successive month of improvement, with compliance now at 86%.
- All competencies show progression towards the target trajectory.



- Compliance levels are beginning to stabilise following decline.
- Compliance remains is lowest amongst Scientific & Admin Colleagues.

Appendix A – Risk Assessment Completion Update

By Site Location	Staff in Post					Risk Assessment Completed						
	WHITE	UNKNOWN	BAME	Total	BAME %	WHITE	UNKNOWN	BAME	Total	BAME %	NON-BAME %	Overall %
WH Trust Overall	2650	24	1012	3686	27.5%	1606	14	883	2503	87.3%	60.6%	67.9%
Acute	2073	22	911	3006	30.3%	1144	13	787	1944	86.4%	55.2%	64.7%
Community	577	2	101	680	14.9%	462	1	96	559	95.0%	80.0%	82.2%

- Effective 20 August 2020, the overall risk assessment completion rate was 68%.
- Amongst BAME colleagues completion was 87% and for Non-BAME colleagues it was 61%.

- The community-based workforce is ethnically less diverse than services within an acute setting.
- A risk assessment completion rate of 95% amongst BAME community-based colleagues reflects a demographic with 15% fewer BAME colleagues vs. the acute workforce.

- Completion rates amongst ‘At Risk Groups’, as defined by NHS England & Improvement, are as follows;

Demographic Category	Staff in Post	Risk Assessment Completed	
	Total	Total	Overall %
BAME staff aged 55+	162	146	90.1%
White staff aged 60+	219	149	68.0%
Male	707	485	68.6%
At-Risk Groups Overall	**1088**	**780**	**71.7%**

Appendix B - Supplementary Comments

- Sickness Absence outturns have been normalised through the exclusion of COVID-19 illnesses. Separate updates of COVID-19 absence rates are shared daily with operational leads.
- Workforce Profile figures are reflective of Permanent and Fixed Term colleagues.
- Turnover figures are 'normalised' through the exclusion of Rotational Doctors, Students, TUPE Transfers and End of Fixed Term Temp contract.
- Absences totalling 28 calendar days or more are classified as being Long-Term.
- The 'Estimated Cost of Absence' is taken from the Electronic Staff Records (ESR) System and based upon the salary value of colleagues absent but not inclusive of potential on-costs.
- Retention Calculation: No. Employee with XX or more months of service Now / No Employees one year ago (Rotational Doctors, Students, TUPE Transfers & Fixed Term colleagues are excluded from both the numerator and denominator)
- Establishment Gap information is reflective of budgeted and actual workforce figures taken from the finance ledger, effective month-end. Due to this, establishment gaps are indicative of gaps within the financial establishment, and importantly, not necessarily wholly related to on-going or historical recruitment campaigns.
- Training & Appraisal compliance is calculated using exclusion lists detailed within the Appendix of this document.
- As of January 2020, 'Core Mandatory' compliance is reflective of the national Core Skills Training Framework.;

  - Conflict Resolution
  - Fire Safety
  - Equality, Diversity and Human Rights
  - Information Governance and Data Security
  - Health, Safety and Welfare
  - Load Handling
  - Patient Handling
  - Infection Prevention and Control Level 1
  - Infection Prevention and Control Level 2
  - Adult Basic Life Support
  - Safeguarding Children Level 1
  - Safeguarding Children Level 2
  - Safeguarding Children Level 3
  - Safeguarding Adults Level 1
  - Safeguarding Adults Level 2
  - Safeguarding Adults Level 3
  - Prevent Level 1 & 2
  - Prevent Level 3

Walsall Healthcare NHS
NHS Trust

Appendix C - HR KPI RAG Rating Scales

Safeguarding Children Level 1	<85%	86% - 95%	>=95%
Safeguarding Children Level 2	<76%	76% - 85%	>=85%
Safeguarding Children Level 3	<76%	76% - 85%	>=85%
Safeguarding Adults Level 1	<85%	86% - 95%	>=95%
Safeguarding Adults Level 2	<76%	76% - 85%	>=85%
Safeguarding Adults Level 3	<76%	76% - 85%	>=85%
PREVENT Level 1 & 2	<76%	76% - 85%	>=85%
PREVENT Level 3	<76%	76% - 85%	>=85%
All Other Mandatory Training Attendance	<81%	81% - 90%	>=90%
Appraisal rate	<81%	81% - 90%	>=90%
Sickness Absence %	>3.7%	3.39% - 3.7%	<=3.39%
Turnover	>11%	10% - 11%	<=10%

Walsall Healthcare NHS
NHS Trust

Appendix D - Training & Appraisal Exclusion Lists

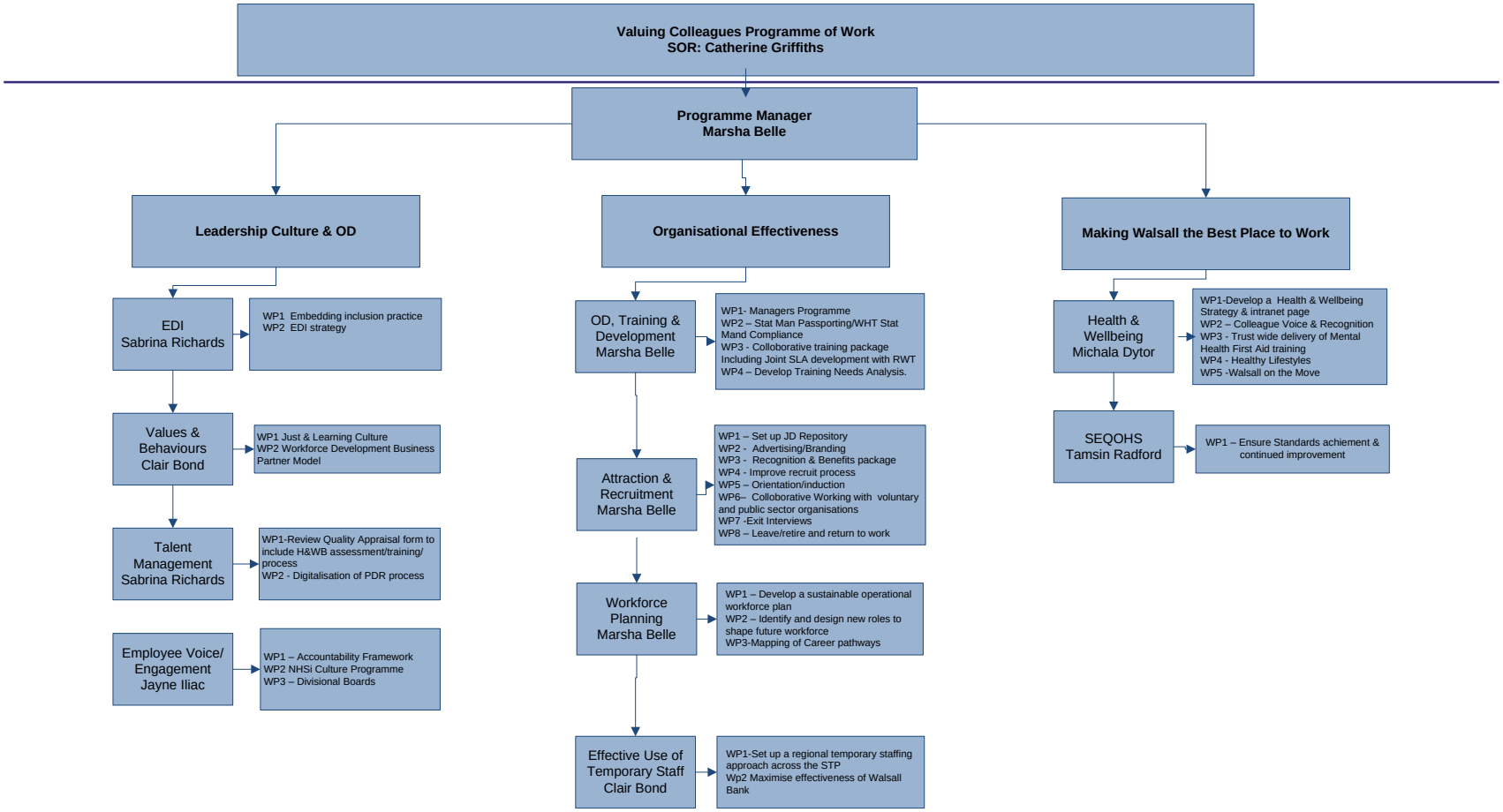
Training	Annual Appraisal
• Bank Staff* • Rotational Doctors (FY1s/FY2s)* • Students* • Anyone on Career Break* • Anyone on External Secondment* • Anyone on Suspension* • Anyone on Maternity Leave*** • Anyone Long-Term Sick***	• Bank Staff* • Rotational Doctors (FY1s/FY2s)* • Students* • Anyone on Career Break* • Anyone on External Secondment* • Anyone on Suspension* • Anyone Managed Externally** • Anyone on a fixed-term contract.** • Anyone who has been employed by the Trust for less than 1 calendar year.** • Anyone on Maternity Leave*** • Anyone Long-Term Sick***
** Ratified August 2013* *** Ratified Oct 2014* **** Ratified July 2018*	

Valuing Colleagues Workstream Development and Mobilisation Monthly Update August 2020

Exec Lead: Catherine Griffiths
WHT Improvement Lead: Polly Kaur

Caring for Walsall together

Work Breakdown Structure



Monthly Project Tracker

Project Admin								Risk Summary Status			
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead		PID Development	Project Delivery	Project Resource Availability	Benefits Realisation
LC&OD 1	Leadership Culture & OD	EDI	EDI Strategy	Sabrina Richards	All Divisions	Sabrina Richards		Blue	Green	Green	Amber
LC&OD 2			Roll out EIA Process	Sabrina Richards	All Divisions	Sabrina Richards		Blue	Green	Green	Amber
LC&OD 3		Values & Behaviours	Just & Learning Culture	Clair Bond	All Divisions	Clair Bond		Blue	Amber	Green	Amber
LC&OD 4			Workforce Development Business Partner Model	Clair Bond	All Divisions	Clair Bond		Blue	Amber	Green	Amber
		Employee Voice/Engagement	Accountability Framework	Jayne Iliac	All Divisions	Simon Johnson		Blue	Green	Green	
			Divisional Boards	Jayne Iliac	All Divisions	Jayne Iliac		Grey	Grey	Red	Grey
			NHSi Culture Programme	Jayne Iliac	All Divisions	Simon Johnson		Blue	Green	Green	
LC&OD 6		Talent Management	Review Quality Appraisal form to include H&WB assessment/training	Sabrina Richards	All Divisions	Sabrina Richards/Michala Dytor		Blue	Green	Green	Amber
LC&OD 7			Digitilisation of PDR process	Sabrina Richards	All Divisions	Sabrina Richards/Steve Bagley		Amber	Green	Green	Amber
ORGEFF 1	Organisational Effectiveness	OD, Training & Development	Managers Programme//	Marsha Belle	All Divisions	Karen Bendall		Blue	Amber	Green	Amber
ORGEFF 2			WHT Stat Man Training/Passporting	Marsha Belle	All Divisions	Karen Bendall		Blue	Green	Amber	Amber
ORGEFF 3			Collaborative training package including joint SLA development with RWT	Marsha Belle	All Divisions	Karen Bendall		Green	Amber	Green	Amber
ORGEFF 4			Develop Training Needs Analysis.	Marsha Belle	All Divisions	Karen Bendall		Green	Green	Amber	Amber
ORGEFF 5		Attraction & Recruitmen	Set up JD Repository	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 6			Attract/Advertise	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 7			Attraction Package & Policies	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 8			Improve recruit process	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 9			On Boarding	Marsha Belle	All Divisions	Reece Hodgen		Green	Amber	Amber	Amber
ORGEFF 12			Leave/Retire & return to work/Exit	Marsha Belle	All Divisions	Reece Hodgen		Green	Amber	Amber	Amber
ORGEFF 13		Workforce Planning	Develop a sustainable operational workforce plan	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 14			Identify and design new roles to shape future workforce	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 15			Mapping of Career pathways	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 16		Effective Use of Temporary Staff	Set up a regional temporary staffing approach across the STP	Clair Bond	All Divisions	Clair Bond		Blue	Green	Amber	Amber
ORGEFF 17			Wp2 Maximise effectiveness of Walsall Bank	Clair Bond	All Divisions	Clair Bond		Blue	Green	Amber	Amber
MWBP2W 1	Making Walsall the Best Place to Work	Health & Wellbeing	Develop a Health & Wellbeing Strategy & intranet page	Michala Dytor	All Divisions	Michala Dytor /Yamsin Radford		Blue	Amber	Amber	Amber
MWBP2W 3			Trust wide delivery of Mental Health First Aid training	Michala Dytor	All Divisions	Michala Dytor		Blue	Green	Amber	Amber
MWBP2W 4			Healthy Lifestyles	Michala Dytor	All Divisions	Michala Dytor		Blue	Amber	Amber	Amber
MWBP2W 5			Walsall on the Move	Michala Dytor	All Divisions	Michala Dytor		Blue	Green	Amber	Amber
MWBP2W 6		SEQOHS	Ensure Standards achiement & continued improvement	Tamsin Radford	All Divisions	Tamsin Radford		Blue			

Benefits Tracker

We are working through the relevant qualitative (accountability framework) and quantitative metrics to provide assurance of programme delivery. There are number of workforce indicators which will form part of the assurance reporting framework, however Valuing Colleagues Core Team Members have scheduled a Benefits Workshop to agree a set of indicators which map back to outcome measures in preparation for the Board Development session at the end of September 2020

		Target	2020/21										
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Workforce Profile	2019/20													
Starters WTE	482.66		57.27	27.53	46.49	-	-	-	-	-	-	-	-	-
Leavers WTE	547.19		21.69	26.12	16.15	-	-	-	-	-	-	-	-	-
Turnover % (Normalised) - Rolling 12 Months	2019/20 Mar-20													
Overall Turnover	10.98%	10%	10.10%	10.37%	9.04%	-	-	-	-	-	-	-	-	-
Add Prof Scientific and Technic	16.74%	10%	15.66%	17.56%	18.54%	-	-	-	-	-	-	-	-	-
Allied Health Professionals	17.41%	10%	14.63%	13.52%	13.72%	-	-	-	-	-	-	-	-	-
Nursing and Midwifery registered	12.06%	10%	10.77%	11.40%	10.15%	-	-	-	-	-	-	-	-	-
Sickness Absence	2019/20													
% Sickness Absence in Month	6.82%	3.39%	8.34%	5.99%	4.93%	-	-	-	-	-	-	-	-	-
% Sickness Absence (Rolling 12 Months)	5.61%	3.39%	5.83%	5.82%	5.75%	-	-	-	-	-	-	-	-	-
Education / OD	2019/20													
Core Mandatory Training	81.59%	90.00%	82.33%	82.44%	43.46%	-	-	-	-	-	-	-	-	-
Appraisals	80.27%	90.00%	75.05%	72.85%	71.68%	-	-	-	-	-	-	-	-	-
Agency / Bank Spend (£000's)	2019/20													
Total Agency Spend (£000's)	£10,087		£1,298	£1,137	-	-	-	-	-	-	-	-	-	-
Total Bank Spend (£000's)	£15,073		£1,653	£1,524	-	-	-	-	-	-	-	-	-	-
Establishment Gap	2019/20 Mar-20													
Total Establishment Gap (FTE)	358.86		348.66	312.07	-	-	-	-	-	-	-	-	-	-

Domain		Year 1												Year 2												Year 3											
		Apri	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apri	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apri	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Leadership & Culture & OD																																					
EDI	Refresh EDI Strategy	P	P	I	I	I	S	S	S	S	S	S	S																								
	Re-launch PDR (digitalisation)	P	P	I	I	I	S	S	S	S	S	S	S																								
	Embedding EIA process	P	P	I	I	I	S	S	S	S	S	S	S																								
	Talent outcomes dashboard designed and framework established										P	P	I	I	I	I	S	S	S	S	S	S	S	S	S												
	EDS2 assessment carried out for key services across the Trust										P	P	I	I	I	I	S	S	S	S	S	S	S	S	S												
	Year 2 of EDI strategy implementation plan deliverables										P	P	I	I	I	I	S	S	S	S	S	S	S	S	S												
	TNA summary plan produced										P	P	I	I	I	I	S	S	S	S	S	S	S	S	S												
	Talent framework implementation linked to succession planning																			P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S
	Year 3 EDI Strategy implementation plan deliverables																			P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S
	EDS2 assessment carried out for key services across the Trust																			P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S
Values & Behaviours	Just & Learning Culture	P	P	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Business Partner Model	P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Talent Management	Digitilisation of PDR Process	P	P	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Develop PDR Training Package	P	P	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Annual PDR Process	P	P	P	P	P	P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Organisational Effectiveness																																					
Workforce Planning	Commence Validation and Cleansing of ESR Data	P	P	P	P	P	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S
	Implementation of Workforce Planning tool	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Set up JD Repository for priority group 1	P	P	P	P	P	I	I	I	I	I	S	S																								
	Continue to validate and cleanse ESR data										P	P		P	I	I	I	I	I	I	I	S	S	S	S												
	Set up JD Repository for priority group 2										P	P		P	I	I	I	I	I	I	I	S	S	S	S												
	Continue to validate and cleanse ESR data																							P	P	P	I	I	I	I	I	I	S	S	S	S	S
	Continue joint BCP training																							P	P	P	I	I	I	I	I	I	S	S	S	S	S
	Set up JD Repository for priority group 3																							P	P	P	I	I	I	I	I	I	S	S	S	S	S
OD Training & Development	Set up Leadership Programme	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Joint BCP Workforce planning	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Increase stat and mand compliance	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Attraction & Recruitment	Set up Repository of generic JDs	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Attract - Advertising	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Review recruitment Policies	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Improve the no. of days from advert to appt	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Leave/review/return to work	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	On Boarding	P	P	P	P	P	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
Making Walsall the Best Place to Work																																					
SEQOHS	Achievement of SEQOHS	P	P	P	I	I	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	SEQOHS visit from inspectors and forming "Aiming for excellence"										P	P	P	I	I																						
	SEQOHS project ongoing to aim for excellence, liaison with STP partners																				P	P	I	I	I	I	I	I	I	I	I	I	S	S	S	S
H&WB	Development of HWB Strategy	P	P	P	I	I	I	I	I	I	I	I	I																								
	Embedding of strategy										P	P		I	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Commencement of data amalgamation to inform HWB strategy developments										P	P		I	I	I	I	I	I	I	I	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S
	Re-evaluating HWB strategy																							P	P	P	I	I	I	I	I	I	I	I	S	S	S

Key	
P	Planning
I	Implementation
S	Sustain

Leadership & OD – Work Stream Development IP Board
August 2020

Project Admin								Risk Summary Status			
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead		PID Development	Project Delivery	Project Resource Availability	Benefits Realisation
LC&OD 1	Leadership Culture & OD	EDI	EDI Strategy	Sabrina Richards	All Divisions	Sabrina Richards		Blue	Green	Green	Amber
LC&OD 2			Roll out EIA Process	Sabrina Richards	All Divisions	Sabrina Richards		Blue	Green	Green	Amber
LC&OD 3		Values & Behaviours	Just & Learning Culture	Clair Bond	All Divisions	Clair Bond		Blue	Amber	Green	Amber
LC&OD 4			Workforce Development Business Partner Model	Clair Bond	All Divisions	Clair Bond		Blue	Amber	Green	Amber
		Employee Voice/Engagement	Accountability Framework	Jayne Iliac	All Divisions	Simon Johnson		Blue	Green	Green	
			Divisional Boards	Jayne Iliac	All Divisions	Jayne Iliac		Grey	Grey	Red	Grey
			NHSi Culture Programme	Jayne Iliac	All Divisions	Simon Johnson		Blue	Green	Green	
LC&OD 6		Talent Management	Review Quality Appraisal form to include H&WB assessment/training	Sabrina Richards	All Divisions	Sabrina Richards/Michala Dytor		Blue	Green	Green	Amber
LC&OD 7			Digitilisation of PDR process	Sabrina Richards	All Divisions	Sabrina Richards/Steve Bagley		Amber	Green	Green	Amber

Risks/ Issues									
Category	Description	Impact	S	P	R	Mitigation	S	P	R
Risk	Slippage against roll out of annual PDR process due to COVID and Operational Recovery Mode	Training needs will not be identified and therefore could impact on quality of care for patients and a de-skilled workforce	4	3	12	Balance Scorecard monitoring of PDR completion KPI/Quality Audits/Roll out of annual PDR cycle	3	3	9
Risk	There is insufficient Comms and Engagement capacity to involve wider internal stakeholders in the design and delivery of work packages	Lack of buy in and ownership to endorse new ways of working will impact on the realisation of benefits across the programme of work	4	3	16	Successful negogiation with CSU to secure additional engagement and comms resource	3	3	9

Dependancies		
Description	Action	RAG
EDI Project	Weekly Workstream Meetings are being held to manage interdependancies across workpackagers	
Training and Development Project	Weekly Workstream Meetings are being held to manage interdependancies across	
Dependency against Health and Well being Project	Weekly Workstream Meetings are being held to manage interdependancies across	

Organisational Effectiveness– Work Stream Development IP Board
August 2020

Project Admin								Risk Summary Status			
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead		PID Development	Project Delivery	Project Resource Availability	Benefits Realisation
ORGEFF 1	Organisational Effectiveness	OD, Training & Development	Managers Programme//	Marsha Belle	All Divisions	Karen Bendall		Blue	Amber	Green	Amber
ORGEFF 2			WHT Stat Man Training/Passporting	Marsha Belle	All Divisions	Karen Bendall		Blue	Green	Amber	Amber
ORGEFF 3			Collobrative training package including joint SLA develop;ment with RWT	Marsha Belle	All Divisions	Karen Bendall		Green	Amber	Green	Amber
ORGEFF 4			Develop Training Needs Analysis.	Marsha Belle	All Divisions	Karen Bendall		Green	Green	Amber	Amber
ORGEFF 5		Attraction & Recruitmen	Set up JD Repository	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 6			Attract/Advertise	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 7			Attraction Package & Policies	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 8			Improve recruit process	Marsha Belle	All Divisions	Reece Hodgen		Blue	Green	Green	Amber
ORGEFF 9			On Boarding	Marsha Belle	All Divisions	Reece Hodgen		Green	Amber	Amber	Amber
ORGEFF 12			Leave/Retire & retun to work/Exit	Marsha Belle	All Divisions	Reece Hodgen		Green	Amber	Amber	Amber
ORGEFF 13		Workforce Planning	Develop a sustainable operational workforce plan	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 14			Identify and design new roles to shape future workforce	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 15			Mapping of Career pathways	Marsha Belle	All Divisions	Marsha/Seb		Blue	Green	Green	Amber
ORGEFF 16		Effective Use of Temporary Staff	Set up a regional temporary staffing approach across the STP	Clair Bond	All Divisions	Clair Bond		Blue	Green	Amber	Amber
ORGEFF 17			Wp2 Maximise effectiveness of Walsall Bank	Clair Bond	All Divisions	Clair Bond		Blue	Green	Amber	Amber

Risks/ Issues									
Category	Description	Impact	S	P	R	Mitigation	S	P	R
Issue	Insufficient capacity to deliver a structured Leadership Development Programme	Delays to roll out Leadership Development Programme would impact on benefits realisation	4	3	12	On going review of resource requirement via weekly huddle meetings with work stream leads and identifying alternative subject expert matter to support with delivery. Moving Improvement work into BAU	3	3	9
Issue	Strategic viability of Temporary & Bank Staffing cross projects needs to be agreed at STP level	Financial assumptions initially calculated may not be realised	4	3	12	STP is carrying out further validation of original financial assumptions	4	3	12

Dependancies		
Description	Action	RAG
EDI Project	Weekly Workstream Meetings are being held to manage interdependancies across workpackagers	
Health Education England Plan (Education Commissioning)/STP NHSi Sustainability	Working in partnership with orgnasiations to manage dependancies	
Health and Well being Project	Weekly Workstream Meetings are being held to manage interdependancies across	

Making Walsall the Best Place to Work – Work Stream Development IP Board August 2020

Project Admin								Risk Summary Status			
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead		PID Development	Project Delivery	Project Resource Availability	Benefits Realisation
MWBP2W 1	Making Walsall the Best Place to Work	Health & Wellbeing	Develop a Health & Wellbeing Strategy & intranet page	Michala Dytor	All Divisions	Michala Dytor /Yamsin Radford		Blue	Amber	Amber	Amber
MWBP2W 3			Trust wide delivery of Mental Health First Aid training	Michala Dytor	All Divisions	Michala Dytor		Blue	Green	Amber	Amber
MWBP2W 4			Healthy Lifestyles	Michala Dytor	All Divisions	Michala Dytor		Blue	Amber	Amber	Amber
MWBP2W 5			Walsall on the Move	Michala Dytor	All Divisions	Michala Dytor		Blue	Green	Amber	Amber
MWBP2W 6		SEQOHS	Ensure Standards achiement & continued improvement	Tamsin Radford	All Divisions	Tamsin Radford		Blue			

Risks/ Issues									
Category	Description	Impact	S	P	R	Mitigation	S	P	R
Issue	Still waiting for suitable accomodation to relocate occupatioanal health team.	If this is not identified project will not meet SEQOHS criteria. Any move will cause delay to the project	4	4	16	Working with Estates to agree suitable location	4	3	12
Issue	Decision still outstanding to house Haven and H&WB Hub as	if a resolution is not agreed then this will have a detrimental on benefits realisation of this project	4	4	16	Working with Estates to agree suitable location	4	3	12

Dependancies		
Description	Action	RAG
EDI Project	Weekly Workstream Meetings are being held to manage interdependancies across workpackagers	

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3rd September 2020			
NHS People Plan			**AGENDA ITEM: 10.3** **ENC: 13**
Report Author and Job Title:	Clair Bond, Deputy Director of People & Culture	**Responsible Director:**	Catherine Griffiths, Director of People & Culture
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The NHS People Plan was published on the 30 July 2020, outlining actions that organisations, employers and staff will need to take between now and March 2022. The actions within the NHS People Plan fall under nine headings: • Health and wellbeing • Flexible working • Equality and diversity • Culture and leadership • New ways of delivering care • Growing the workforce • Recruitment • Retaining staff • Recruitment and deployment across systems An assessment of current actions and planned interventions reflected in the Valuing Colleagues improvement programme has been undertaken against the set of recommendations arising from the NHS People Plan. The People and Organisational Development Committee ("PODC") have reviewed the actions and will be monitoring their implementation.		
Recommendation	The Trust Board is asked to note the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The following risk is held on the BAF; "*Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care*". The Valuing Colleagues Improvement Programme will draw together work already underway at the Trust and work planned into		

	a single plan. The plan will reinforce the focus on the experience and wellbeing of our staff and the need for continuous improvement at organisational and process level.	
Resource implications	Resource requirements have been assessed and escalated through the Improvement Board.	
Legal and Equality and Diversity implications	The legal implications of not making improvements in relation to equality, diversity and inclusion may result in legal challenges in the form of judicial reviews, legal costs implications associated with employment tribunals and poor organisation reputation. This also has implications for the organisation in relation to meeting its Public Sector Equality Duty 2011	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

NHS People Plan 2020-21

1. PURPOSE OF REPORT

The purpose of the report is to inform the Trust Board of the work undertaken to date by the Trust against the recently published NHS People Plan.

2. BACKGROUND

The NHS People Plan was published by NHS I/E on 30 July 2020 detailing actions for employers, national bodies and systems, a summary of these actions were also produced in a summary table format. The People and Culture directorate has reviewed the actions and RAG rated accordingly, which PODC has reviewed at their 27th August meeting.

The actions have also been referenced against the current People and Culture Directorate Valuing Colleagues Improvement work programme to establish where we are to date with our various work-streams and PIDS.

The People Plan covers the following areas:

- Health & Wellbeing
- Flexible Working
- Equality & Diversity
- Culture & Leadership
- New Ways of Delivering Care
- Growing the Workforce
- Recruitment
- Retaining Staff
- Recruitment & Deployment Across Systems

Published alongside the People Plan for 2020/21 is the 'Our NHS People Promise' challenging all to make the NHS a better place to work, its themes and words have come from colleagues who work in the NHS and have said what would improve their working experience.

3. DETAILS

The following highlights the Trust's position under each of the People Plan action area. The RAG rating is defined as:

Green	Completed
Amber	Initiated
Red	Not started

Health & Wellbeing

This area covers health and wellbeing for all colleagues and the Trust position overall is Amber with actions already started and in progress.

Areas not covered currently by the Valuing Colleagues Programme are identified as travel plans, car-parking, establishment of Agile working group which will be incorporated in to the health and wellbeing project initiation document.

The plan identifies the benefits of cross-working between Infection Control, Health & Safety and Occupational Health.

Flexible Working

Whilst there is a Flexible Working policy in place, the People Plan clearly defines expectations of organisations going forward. This area has been predominantly RAG rated as Red as there is a considerable amount of work to be reviewed and updated in order to satisfy this area. There are gaps where work is yet to begin such as implementing the Carers passport, as well as a change in approach to the whole concept of flexible working throughout the Trust, for example, development of organisational flexible working statement supporting a cultural change.

The establishment of the Agile working group will support the progress of flexible working.

Equality & Diversity

The EDI Strategy supports the areas within the People Plan and overall is Amber. All work identified has begun and is progressing.

Culture & Leadership

Significant work/guidance has yet to be published by NHS E/I for implementation. We have established staff networks, such as BAME counsel - a model to be replicated for other networks, and staff inclusion plan. The Valuing Colleagues work and project initiation documents support this work and are aligned to the Organisational Development, Training and Development and Talent Management.

New Ways of Delivering Care

Work is already in progress, identifying this area as Amber, with local development of procedures to support colleague development, such as Personal Development Reviews and Talent Mapping. We are also working in partnership with Health Education England (HEE).

Growing the Workforce

This sits within the Organisational Development, Training & Development and Workforce Planning project initiation documents, and is overall Amber, with work already established with Clinical Education Faculties developing and building upon a blended learning approach.

Recruitment
Actions are already embedded in the Attraction and Recruitment and Workforce Planning project initiation documents. An area to focus on and identified as Red is the NHS People Plan ambition to be a lead-recruiter for international recruitment and the on-boarding of new recruits.

Retaining Staff
Whilst significant work has begun, this is an area to further develop and which aligns to the Trust's ambition of making Walsall the Best Place to Work. The health and wellbeing, SEQOHS, Attraction and Recruitment, Workforce Planning project initiation documents all cross-over and are interlinked to ensure delivery of this ambition.

Recruitment & Deployment Across Systems
Local partnership working with various organisations has already driven this work. However a Red area for attention is to establish and develop workforce sharing agreements in order to deliver integrated working between employing sectors, such as Health and Social Care whereby employees are better supported with transferable / recognised terms and conditions.

4. RISK

The Trusts overall position is good with the People and Culture Valuing Colleagues Improvement work programme aligned to the NHS People Plan.

The timeliness of delivery for the actions may be affected should, for example, an emergency response be required and resources temporarily diverted.

5. RECOMMENDATIONS

The recommendation to the Board is to note the content of the report for information and note the oversight of the action plan is with PODC.

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3rd September 2020			
BAME Colleagues – Risk Assessment and Working Environment			**AGENDA ITEM: 10.4** **ENC: 14**
Report Author and Job Title:	Clair Bond, Deputy Director of People & Culture	**Responsible Director:**	Catherine Griffiths, Director of People & Culture
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	The purpose of this paper is to provide an update regarding the key developments in relation to the completion of Risk Assessments for all colleagues, focusing on those at a greater risk if they were to contract COVID-19. At the time of writing this report (19 August 2020) 87% of BAME colleagues and 66.5% of all colleagues had received a risk assessment. This is a significant increase from progress reported to the Committee in July whereby compliance levels were recorded as 75% for BAME colleagues and 37% for all colleagues. NHS England and NHS Improvement have requested assurance that all NHS staff receive a risk assessment by the 2 September 2020. The People and Organisational Development Committee have reviewed the attached report and key issues are noted in their highlight report.		
Recommendation	The Trust Board are asked to note the contents of this report in particular the clarification on sources of assurance to capture compliance with the approach to completing a COVID19 risk assessment for all colleagues.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The following risk is held on the BAF; "*Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care*". The COVID pandemic has highlighted the impact of health and social inequalities and the measures taken by the Trust provide an opportunity to further understand this impact for colleagues at Walsall Healthcare NHS Trust enabling the development of actions/interventions to improve inclusivity. CRR 2093: *Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust*. The risk assessments seek to understand if adjustments to roles or additional measures in the working environment to protect the health, safety and wellbeing of staff.		
Resource implications	Many of the actions and interventions outlined within the report have been put into place and line managers are expected to undertake wellbeing reviews and stratified risk assessment conversations.		

Legal and Equality and Diversity implications	The legal implications of not making improvements in relation to equality, diversity and inclusion may result in legal challenges in the form of judicial reviews, legal costs implications associated with employment tribunals and poor organisation reputation. This also has implications for the organisation in relation to meeting its Public Sector Equality Duty 2011	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

COVID risk assessment; update report for Trust Board

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

Introduction

The purpose of this paper is to provide an update regarding the key developments in relation to the completion of required Wellbeing Review and Risk Assessments for all colleagues, focusing on those at a greater risk if they were to contract COVID-19.

Update to July PODC

- By the 20 July 2020 75% of BAME colleagues and 37% of all colleagues had received a risk assessment.
- By the 30 July 2020 87% of BAME colleagues and 57% of all colleagues had received a risk assessment.
- Qualitative feedback survey developed.

This month's report will cover the following areas:

- Update regarding the number of risk assessments that have been completed.
- Actions taken to address the gaps.
- Early analysis of feedback received from the survey to understand staff experience of the risk assessment process
- Measures in place to address impact of COVID-19 on BAME colleagues

NHS England and NHS Improvement have set the deadline for all staff to have receive a risk assessment by the **2 September 2020**.

This paper provides an outline of some of the measures that have been put in place to address the impact of COVID-19 on colleagues (see appendix 1). Our understanding and insight into this will grow following analysis of the feedback from the survey as described further on in this report.

Walsall Healthcare NHS
NHS Trust

Progress

The national requirement as set by NHSE/I was that 100% of staff at increased risk of COVID receive a risk assessment by 31st July 2020. The Trust requirement was that 100% of all colleagues should receive a Wellbeing Review and Stratified Risk Assessment by the 24 July 2020. The Trust has failed to achieve the local and national target.

Division	Risk Assessments Completed	
	BAME %	Overall %
*All	87.15%	66.52%
Adult Community	92.59%	73.96%
Chief Executive Directorate	N/A	37.50%
Transformation & Strategy	100.00%	41.67%
Estates and Facilities	95.59%	77.92%
Finance Directorate	96.30%	89.29%
Governance Directorate	100.00%	96.43%
Informatics Directorate	100.00%	91.55%
Medical Directorate	62.50%	25.00%
MLTC	78.33%	36.11%
Nurse Directorate	65.00%	45.19%
Operations Directorate	66.67%	29.63%
People & Culture Directorate	91.30%	71.26%
Surgery	86.82%	75.52%
WCCSS	92.59%	71.08%

By the 19 August 2020 the following number of Wellbeing Reviews and Risk Assessments had been completed

a) 87% of BAME colleagues
b) 66.5% of all colleagues had received a risk assessment.
c) 71% of staff groups identified with a risk factor (BAME, White over 60 and all men).

Across the Trust a total of 44 colleagues have declined a risk assessment. Analysis of this data identifies a majority of these staff work in the WCCSS division. Contact is being made with each individual to understand their reasons and to offer support.

Walsall Healthcare NHS
NHS Trust

Benchmarking Performance

By the 30 July 2020 the following progress had been achieved.

- 87% of BAME colleagues
- 57% of all of all colleagues
- 55% of staff groups identified with a risk factor (BAME, White over 60 and all men).

By the 19 August 2020 the following progress had been achieved

- 87% of BAME colleagues
- 66.5% of all colleagues
- 71% of staff groups identified with a risk factor (BAME, White over 60 and all men).

The NHSE/I Regional Workforce Team advised that at the 31st July 2020, when benchmarked against the performance of other Trusts in the BCWB STP that none of the BCWB Trusts achieved 100% for both BAME or all risk assessments.

Across the Midlands region the following was reported: -

- An average return of 96% *of risk assessments completed for staff who are known to be from a BAME background.*
- *An average return of* 88% *of risk assessments completed for staff who are known to be 'at-risk'*
- *An average return of* 66% *of all staff were reported to have had a risk assessment.*
- Walsall were <u>not</u> in the bottom 5 for the % BAME Assessments**.**
- ***Walsall were in the bottom 5 for % staff "At Risk" Assessments***.
- None of the BCWB Trusts were in the bottom 5 for % All Staff Assessments.

It should be noted by the Committee that there is little standardisation between Trusts within the region with regard to the approach taken and methodology applied.

Walsall Healthcare NHS
NHS Trust

Gap Analysis

In accordance with NHS England and NHS Improvement requirements, we continue to publish our achievement rates by division / directorate and by professional staff group (defined by ESR) publically via the intranet. The table below sets out the number of risk assessments completed by professional staff group as at 19 August 2020.

Department	Risk Assessments Completed	
	BAME %	Overall %
*All	87.15%	66.52%
Add Prof Scientific and Technic	90.70%	86.15%
Additional Clinical Services	81.36%	54.08%
Administrative and Clerical	94.68%	71.92%
Allied Health Professionals	93.94%	70.78%
Estates and Ancillary	95.71%	81.21%
Healthcare Scientists	100.00%	56.52%
Medical and Dental	73.66%	60.62%
Nursing and Midwifery Registered	92.09%	65.64%
Students	62.50%	33.82%

BAME colleagues working in estates and ancillary roles have experienced the biggest increase in the number of completed risk assessment – increasing by 28% since 20 July 2020. The number of all staff having completed risk assessments in this area rose by 64% in the same time period.

There has also been a 40% increase in the number of AHP colleagues receiving a risk assessment and an increase of 27% of all nursing/midwifery staff in the same time period.

Walsall Healthcare NHS
NHS Trust

Addressing the Gaps

The following steps have been taken to work with leaders across the organisation to ensure that all colleagues have received a wellbeing review and stratified risk assessment: -

1. Divisional and Corporate Directorate Leadership Teams have been contacted to highlight where the completion of wellbeing reviews and stratified risk assessments are recorded as outstanding.
2. A new proforma has been developed for colleagues to independently complete and initiate a wellbeing review and stratified risk assessment conversation with their line manager.
3. A new ESR competency has been created to record the dates that a wellbeing review and a stratified risk assessment are undertaken. From the 1 September 2020 line managers will be supported to take responsibility for updating this record in the same way that they currently do for IPDR's.
4. Divisional and Corporate Directorate Leadership Teams will hold formal conversations known as 'counselling' conversations in line with the Trusts disciplinary policy with any leaders where it is recorded team members who are available for work and have not actively declined a wellbeing review and risk assessment by 31 August 2020. The HR team will provide advice and guidance at this stage.

Walsall Healthcare NHS
NHS Trust

Survey Feedback

Throughout August, colleagues have been asked to a survey (available digitally and in paper form) seeking to understand the experience of colleagues when completing a wellbeing review and stratified risk assessment. At the time of writing this report only a small sample of completed questionnaires had been received. PODC were provided with the completed digital surveys as at 10th August, however key feedback / headlines include: -

a) A significant number of comments received outlining the view that the process is a 'tick box exercise'.

b) A majority (62%) of risk assessment conversations have been initiated by line managers and 78% reported that they were assured their personal details would remain confidential. 49% advised that the risk assessment had increased their sense of safety in the workplace and 65% felt that they could raise concerns with their line manager.

c) A majority (68%) of respondents felt that their line manager took a genuine interest in their health, wellbeing and safety at work. 16% reported that they did not feel this. Comments received focused around line managers being unfamiliar with the process or colleagues being asked to complete the assessment with no follow up conversation with their manager.

d) There was a greater awareness of support for colleagues via HWB, OH, antibody tests as opposed to swab tests, travel to work, childcare and accommodation.

e) Most respondents fed back that adjustments were not required in response to their individual needs.

The survey questions are at appendix 1 below and will continue to be published and available for completion both digitally and by hand until the end of September 2020. PODC will continue to receive regular feedback.

Next Steps and recommendations

The Trust Board are asked to note the following: -

- The NHS England and NHS Improvement have set a target for all NHS staff to have received a risk assessment by the 2 September 2020. To support line managers and colleagues, a self-risk assessment has been developed with the explicit expectation that the conversation between a line manager and colleague is still required. This is in response to feedback received that forms were being completed and meetings to discuss identified risks.

- The expectation that divisional and directorate leadership teams will hold line managers to account in accordance with the disciplinary policy for any wellbeing reviews and risk assessments not completed by 31 August 2020.

- The intention to maintain focus on the feedback survey between now and the end of September 2020 to understand the experience of colleagues and the adjustments / measures that have been put into place.

Appendix 1

Walsall Healthcare NHS
NHS Trust

Risk Assessment Quality Assurance

To understand the experience of colleagues who have completed a wellbeing review and stratified risk assessment and to gain an insight into the types of adjustments being identified a survey has been developed. The content of the survey has been shared with a wide variety of stakeholders to ensure appropriateness and inclusivity.

The survey has been sent to colleagues where it has been confirmed a risk assessment has been completed. The survey is intended to be completed on an anonymous basis to encourage uptake, however there is an opportunity for colleagues to provide their details if they would like to discuss any aspect of their concerns. The outcome of the survey will be reported through to PODC.

1. How proactive was your line manager in initiating the risk assessment process?
2. During the meeting did you feel your line manager took a genuine interest in your health and wellbeing?
3. Reflecting on the meeting what do you think the manager could have done to improve it?
4. How comfortable did you feel sharing personal information with your manager?
5. Have you been offered any additional support which is available through the trust?
6. As a result of the risk assessment, where required, what adjustments were put into place?
7. Have you been redeployed?
8. Was the basis on which you were redeployed satisfactorily explained?
9. Are you assured that the risk assessment would be kept confidential?
10. Has the risk assessment conversation made you feel safer at work?
11. Did you feel you could raise concerns with your line manager?
12. How confident are you that any concerns you have raised will be addressed?
13. Are you at any greater risk of COVID through any of the following factors?
14. Do you have any concerns or suggestions about the process and support arising from that process?

MEETING OF THE PUBLIC TRUST BOARD **Thursday 3 September 2020**			
Addressing Workforce and Employment Inequality.			**AGENDA ITEM: 10.5** **ENC: 15**
Report Author and Job Title:	Clair Bond, Deputy Director of People & Culture	**Responsible Director:**	Catherine Griffiths, Director of People & Culture
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report addresses workforce and employment inequalities at the Trust, which have been raised through various means such as the Freedom to Speak Up Guardians; Pull Up a Chair with the Chair; Board walks; staff stories to the Board, COVID-19 Summit and colleague COVID risk assessments. The terms of reference for the People and Organisational Development Committee ("PODC") have been updated to provide that the Committee seeks sources of assurance that demonstrate the Trust Board's compliance to its pledge to "*Demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you*". This attached report sets out proposed metrics for this, which have been reviewed by PODC at their meeting on 27th August. These metrics are a combination of quantitative and qualitative measures and provide a base line assessment against which future activity and progress can be assessed. An overview of plans in place to address unreasonable treatment of colleagues in response to individual/service cultural hotspots at the Trust has been reviewed by PODC and will be monitored by them, escalating concerns to the Trust Board. Workforce inequalities have wider implications for the local population. Evidence shows that fair treatment of staff is linked to a better experience of care for patients. Improving our performance on diversity and inclusion will play an important role in Walsall becoming a better place to work and build a career. Slide 10 sets out the actions which are being taken to grow Walsall Healthcare NHS Trust as an anchor employer. These will be monitored by PODC.		

Recommendation	Members of the Trust Board are asked to discuss the indicators proposed to measure progress against the Trust Board Pledge.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The following risk is held on the BAF; "*Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care*". The COVID pandemic has highlighted the impact of health and social inequalities and the measures taken by the Trust provide an opportunity to further understand this impact for colleagues at Walsall Healthcare NHS Trust enabling the development of actions/interventions to improve inclusivity.	
Resource implications	It is envisaged that in order to implement any actions to improve equality diversity and inclusion practice, resources will be required. A proposal along with a resource plan is currently being developed and will be shared with the Executive Team in due course.	
Legal and Equality and Diversity implications	Walsall is now the 25th most deprived local authority district (out of 317) and therefore addressing social and health inequalities linked to local residents being unemployed, low income, living in poor housing or poor education and/or employment opportunities is critical to improve health outcomes. The legal implications of not making improvements in relation to equality, diversity and inclusion may result in legal challenges in the form of judicial reviews, legal costs implications associated with employment tribunals and poor organisation reputation. This also has implications for the organisation in relation to meeting its Public Sector Equality Duty 2011	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

Addressing workforce & employment inequality.

August 2020

Caring for Walsall together

Walsall Healthcare NHS
NHS Trust

Contents / Plan

Walsall Healthcare NHS
NHS Trust

Introduction

The Trust Board has been examining inequalities exposed by the coronavirus pandemic and amplified by the global response to the Black Lives Matter movement in the context of feedback relating to the experience of colleagues from minority groups at Walsall Healthcare NHS Trust.

When considering how inequalities in the workforce can be addressed we recognise our wider social responsibility to help to improve health outcomes by increasing employment opportunities within the Walsall population.

The terms of reference for PODC have been updated and require that the Committee seeks sources of assurance that demonstrate the Trust Board's compliance to its pledge to "***demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you***".

The purpose of this report is to: -

- Provide oversight of the Trust's approach to addressing workforce and social inequalities.
- Provide assurance that appropriate immediate action has been taken and longer term plans are being developed to address concerns raised from the powerful accounts of lived experience of workforce inequality and cultural concerns at Walsall Healthcare NHS Trust.
- Propose how PODC will receive assurance through a combination of quantitative and qualitative measures and to provide a base line assessment against which future activity and progress can be assessed including an overview of plans in place to address unreasonable treatment of colleagues a Walsall Healthcare NHS Trust.

Walsall Healthcare NHS
NHS Trust

Workforce Inequalities

Addressing race inequalities in our workforce is critical on multiple levels. Experiences of discrimination can cast a long shadow and the impact on our people can be profound as has been evidenced by the powerful personal stories that have been shared with the Board and our Freedom to Speak Up Guardians.

Looking at the workforce data and the progress against the Workforce Race Equality Standard (WRES) is important, but it is only part of the story. What matters fundamentally is the lived experience of staff in their everyday work.

We know from personal accounts from staff and the qualitative data and information available that at Walsall Healthcare NHS Trust our colleagues from minority groups are; -

- **Under represented at senior level, outside of the medical profession;** From Band 7 and above only 9.5% of workforce are from a BAME background.
- **More likely to experience discrimination.**
- **Less likely to progress their careers.**
- **More likely to report bullying, harassment and abuse from patients and colleagues** 31% of our BAME colleagues reported experiencing harassment, bullying or abuse from staff compared to 27% of white colleagues. (Staff Survey 2019)

In response, the Trust is clear that addressing workforce inequalities is a high priority and multiple strategies are required at organisational, team, and individual level are required to run in parallel to immediate steps to address discriminatory behaviours and practices which are in clear breach of our Trust values.

Walsall Healthcare NHS
NHS Trust

Workforce Inequalities; lived experience

The lived experience of staff have brought home the depth and strength of feeling about how colleagues from minority groups experience inequalities in different work environments across the Trust. The personal accounts provides greater depth and meaning to the qualitative information taken from the NHS Staff Survey, WRES and WDES data.

Our 2019 staff survey results indicate that BAME colleagues are more likely to experience harassment, bullying or abuse from staff (White staff (26.80%) BME staff (31.33%)). A review of employment relations cases since August 2019 has identified that 25% of all grievances and 27% of all Bullying & Harassment cases involved colleagues from BAME backgrounds.

A number of distressing accounts have been shared and the People and Culture Team have ensured that appropriate plans are in place to take action and address concerns raised, with such plans being monitored by PODC. These plans include the deployment of a number of strategies at team and individual level to demonstrate that concerns are dealt with and that longer terms plans to improve inclusion and enhance accountability for actions and behaviours are developed.

Examples of remedial responses / strategies include; reflective conversations with line managers, appointment of additional HR/OD capacity and capability to support areas with complex and multifaceted needs such as A&E, Health Visiting etc, mediation, formal investigations into misconduct and behaviours that fall outside of the Trust values.

Walsall Healthcare NHS
NHS Trust

Improving systems to address inequality

Simultaneous to practical interventions in response to individual and interpersonal experiences, a number of sustainable and strategic approaches are being progressed as summarised below.

System	Intended outcome	Target Date	Current Position
Talent Management	Digitalised PDR process that automatically feeds TNA framework and enables proactive monitoring of career development / aspirations of colleagues from minority groups.	31 March 2021.	• PDR process updated • Manual analysis of professional & development needs undertaken.
Workforce representation of BME staff in management roles.	To increase the proportion of BAME staff in Band 8a and above roles from 35 to 45 by March 2022. To increase the proportion of BAME staff at B7 level from 76 to 97 by March 2022 (this would provide 25% BME representation at B7 level)	31 March 2022.	• Recruitment policy updated • Recruitment training for managers developed • Cultural Ambassadors appointed and to be trained in September 2020.
Managers developing cultural competency	All managers to participate in the multi faceted EDI management & leadership development programme to understand their roles and responsibilities in relation to EDI. EDIC and staff networks will be involved in the design, pilot and evaluation of the development programme.	31 March 2021	• EDI training “Equally Yours” in collaboration with Walsall Council rolled out from Oct 2020 onwards for targeted areas. • EDI e-learning package supporting EDI Policy ready from Sept 2020 • STP commissioned development programme read y from Nov 2020. • Evaluation of multifaceted EDI development planned for Jan 2021.
Increasing Employee Voice	Development opportunity, representation of minority groups in decision making, fostering collaboration and innovation. Psychologically safe routes for raising concerns	Ongoing evaluate Feb 2021.	• BAME Decision Making Forum established • F2SU strategy endorsed by PODC • Governance of EDIC to support staff networks being reviewed.

Walsall Healthcare NHS
NHS Trust

Board Pledge

The safety, health and wellbeing of all staff is paramount and is the number one priority of line managers. It is recognised that if we do not look after colleagues and support them to look after themselves and each other, we cannot deliver safe, high-quality care. COVID-19 has focused our attention in this area and the Trust Board has reaffirmed the pledge made in May 2018.

"We will demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you".

The terms of reference for PODC have been updated and the Committee is required to seek and provide assurance that demonstrate to our staff that the Trust Board is meeting the pledge. To enable this a series of key performance indicators have been identified which can be viewed at divisional / directorate level and organisational level have been proposed. These proposed measures are also embedded within the divisional / Trust accountability framework and the Valuing Colleagues Improvement Programme.

The agreed objectives of the Equality, Diversity and Inclusion Strategy will be clarified at the end of October 2020 and will be monitored for assurance at PODC on a quarterly basis.

A number of the improvement measures centre on the results of the national staff survey (NSS) to measure progress. The 2019 NSS provides a baseline and the 2020 NSS results (due in March 2021) will provide an early insight into the effectiveness of actions taken/in place. The 2021 NSS (due in March 2022) will indicate the intended shift in organisational culture and inclusion. PODC will monitor indicators on a quarterly basis to seek assurance that actions taken are delivering the intended impact at organisational, team and individual level within Walsall Healthcare NHS Trust and its local population.

Walsall Healthcare NHS
NHS Trust

Trust Board Pledge – suggested assurance metrics

Proposed Measure	Current position	Improvement target by 31 March 2022.
Employee Engagement Index Score *determined by a combination of measures relating to; motivation of staff, ability of staff to contribute to improvements and recommendation of Trust as place to work / be treated.*	NHS Staff Survey. 2019 index score of 6.6	Increase in line with peer benchmark [1] (2019 benchmark was 7.1).
Improved Equality, Diversity & Inclusion Index Score	NHS Staff Survey 2019 index score of 8.8	Increase in line with peer benchmark (2019 benchmark was 9.2).
% of staff saying the organisation takes a positive interest in their health and wellbeing.	NHS Staff Survey. 2019: 26.5%	Increase in line with peer benchmark (2019 benchmark was 27.8%).
No of SA days taken as a result of bullying and harassment.	4.64 additional days of SA for bullying. (based on 2019 staff survey data and average length of sickness absence)	Eliminating additional days sickness taken as a result of bullying (0 days).
Improved B&H Index Score	NHS Staff Survey 2019 index score of 7.6	Increase in line with peer benchmark (2019 benchmark was 8.2).
Reduction in **voluntary** turnover rates *indicating a greater level of workforce stability* [2]	July 2020. retention rate 82% Attrition rate of <24 months service 31%	Increase retention rate to 85% Decrease attrition rate of <24 months service by 4%.
No of promotions of staff from minority groups	Methodology to measure and baseline to be determined.	

1 2019 NHS Staff Survey benchmark average score from a peer group of 47 other combined acute and combined community trusts.
2 Stability factor does not take into account dismissals, redundancies , clinical rotations.

Walsall Healthcare NHS
NHS Trust

Trust Board Pledge – suggested assurance metrics

Proposed Measure	Current position	Improvement target by 31 March 2022.
No of mangers completing EDI training [3]	0%. EDI training content developed roll out plan / delivery model to be completed end of August with first sessions booked for September 2020. STP Module content due to endorsed by EDIC– due to be available Nov 2020.	All new line managers to attend training from September 2020. 100% existing line managers to complete training by 30 March 2021.
Increase in the number of staff feeling safe to speak up (F2SU index) [4]	2019 Staff Survey index score of 6.3 2019/20 F2SU concerns – 64% non employment/BH matters (36% B&H)	Increase in line with peer benchmark (2019 benchmark was 6.8) Greater proportion of F2SU concerns focused on non employment issues (90%)
Increased BAME representation in B7 and above roles	9.5% BAME representation from B7 and above (excluding senior medics)	To increase the proportion of BAME staff in B7 and above roles to reflect representation of BAME workforce. [5]
% of staff reporting a high quality IPDR conversation	2019 Staff Survey index score of 5.3 for quality of appraisals. Quality baseline to be determined from planned audit in December 2020.	2020 Staff Survey index score in line with average 5.5. Internal quality audit of IPDR showing at least 80% positive responses

3. STP Black Lives Matter work stream commissioning bespoke develop offering focused on tackling workforce inequalities.
4. FTSU Index / Safety Culture Index – NHS Staff Survey Q17 & 18. Greater level of F2SU contacts re non employment matters together with increased levels of employment concerns dealt with via early resolution indicates stronger management skills / leadership culture.
5. Currently 28% of workforce are BME background. Improvement target for March 2022 to increase BME representation at B7 and above from 9.5% to 20% (B7 BME representation currently 19.5% and B8a and above BME representation currently 21%)

Walsall Healthcare NHS
NHS Trust

Addressing employment inequality across Walsall

Workforce inequalities also have wider implications for the local population of Walsall. Evidence shows that fair treatment of staff is linked to a better experience of care for patients. Improving our performance on diversity and inclusion will play an important role in Walsall becoming a better place to work and the employer of choice for local residents to begin and build a career.

Outlined below are some of the very initial actions that are being taken to grow Walsall Healthcare NHS Trust as an anchor employer, a position that we continue to develop supported by our implementation of the Real Living Wage from April 2020. Targets will follow more detailed discussions with partners.

Action	Intended outcome	Target Date	Current Position
Bulk recruitment for Domiciliary roles	In collaboration with Walsall Housing Group support unemployed residents to apply for and secure housekeeping / porter roles (currently 30 vacancies).	October 2020	Meeting with WHG lead undertaken. Action plan to be completed by Sept 2020 Bulk recruitment to begin in October 2020
Apprenticeship Ambassador	Enhance the employment opportunities across the borough of Walsall and develop joint apprenticeships with health and social care partners Walsall Housing Group, Walsall College, Walsall Council, police, voluntary sector and others	Dec 2020	• Attended Ambassador meeting on Tues 11th August • Meeting scheduled to discuss application to take place 25/08 • Attendance at Health Futures UTC Open Day event (17th Oct) and Careers Fair for students from year 10 to year 13 on 12th Oct
Work experience	Increase employment opportunities for disadvantaged young people and people with learning difficulties	Dec 2020	• Work experience model under review due to impact of COVID19

Walsall Healthcare NHS
NHS Trust

Conclusion & Recommendations

There are no quick solutions to address workforce and employment inequalities and everyone in the organisation has a role to play. A strategic mind-set is required and we need to prepare for the 'long haul' because change of this nature and at scale cannot happen overnight. It requires constant attention.

The Trust Board are asked to recognise that the Valuing Colleagues Improvement Programme is the vehicle by which the strategic equality, diversity and inclusion objectives of the Trust will be delivered. This approach will also meet the relevant actions set out in the NHS People Plan (July 2020)

Walsall is now the 25th most deprived local authority district (out of 317) and therefore as the largest employer in Walsall we continue to progress positive action to address employment inequalities across the borough in the acknowledgement that these tentative steps can contribute to improving the overall health prospects of the people of Walsall.

The Trust Board is asked to discuss the proposed indicators and improvement targets which can be used to measure progress against the Trust Board Pledge.

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3 September 2020			
Safer Staffing Report			**AGENDA ITEM: 10.6** **ENC: 16**
Report Author and Job Title:	Caroline Whyte Deputy Director of Nursing	**Responsible Director:**	Ann-Marie Riley Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	RN vacancy rate is currently 7% - equal to 80 WTE. 38 WTE student RNs are expected to convert to substantive during September and October. Nursing and Midwifery fill rates overall have exceeded the 95% target with an increase to 95.8% in July from 88.8% in June. However, occupancy varied in May between 50 to 93% with mean inpatient occupancy of 74%. Overall temporary staffing use in nursing has increased in July but is still less than has previously been recorded pre Covid19. Reasons for this are substantive staff redeployments, ward closures during the pandemic and reduced occupancy across wards. There were 270 hours of RN and 407 hours of CSW redeployment organised through the daily staffing meetings in July to support safe staffing across the Trust. NHSi agency cap breaches have continued to reduce and off framework use has remained at zero. Bookings of temporary staff for absence and Covid backfill did not exceed the number of sickness absence / shielding hours lost. Allied Healthcare Professionals have a gap of 33 WTE. Issues identified with collating information and single route of information. Additional controls to ensure accuracy of booking reasons for additional capacity; and to ensure efficient use of resources to support patients who require enhanced supervision remain in development. A self-assessment of the NHSI Developing Workforce Safeguards Guidance (2018) is underway and will be presented to PODC and QPES once completed		
Recommendation	The Board is requested to note the contents of the report, which have also been discussed at the 27th August meeting of the People and Organisational Development Committee		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Objective No 1: We aim to deliver experience in care as measured by the CQC rating of 'Outstanding' by April 2022. Corporate Risk No 11: Failure to assure safe nurse staffing levels.		

Resource implications	COVID impact - staff are working in different ways and locations; risk to staff health and well-being; impact on training and continual professional development	
Legal and Equality and Diversity implications	COVID-19 has impacted disproportionally on males and people who are from BAME background	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

1.0 Nurse Staffing Update

There is a body of empirical evidence demonstrating the impact of inadequate nurse staffing levels and skill mix to poor patient outcomes, patient experience and staff experience. Safe staffing continues to be nationally recognised in a number of high profile publications:

- Hard Truths: The Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013)
- The Berwick Report (2013)
- The Keogh Review (2013)
- The Cavendish Review (2013)
- Safe midwifery staffing for maternity settings: NICE guideline NG4 (NICE 2015)
- Supporting NHS providers to deliver the right staff with the right skills in the right place at the right time: Safe, sustainable and productive staffing (National Quality Board 2016)
- Care Hours Per Patient Day (Lord Carter 2016)
- Safe, sustainable and productive staffing – an improvement resource for neonatal care (National Quality Board June 2018)
- Safe, sustainable and productive staffing – an improvement resource for children and young people inpatient wards in acute hospitals (National Quality Board June 2018)
- Safe, sustainable and productive staffing –an improvement resource for adult inpatient wards in acute hospitals (National Quality Board January 2018)
- Safe, sustainable and productive staffing - an improvement resource for maternity services(National Quality Board January 2018)
- Developing Workforce Safeguards (NHSI Oct 2018)

The National Quality Board (NQB) provides co-ordinated leadership for quality on behalf of the national bodies: Department of Health, Public Health England, NHS Improvement/England, Care Quality Commission and the National Institute of Care Excellence.

NHSI will assess Trusts' compliance with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time based on patients' care needs, acuity, dependency and risks, and Trusts' should monitor it from ward to board.

NHIS will assess trusts' compliance using information collected through the Single Oversight Framework (SOF) and they also ask that Trusts include a specific workforce statement in their annual governance statement.

NHSI state that by implementing NHSI Developing Workforce Safeguards (2018) recommendations, and strong, effective governance, Boards can be assured that their workforce decisions will promote patient safety and so comply with the Care Quality

Commission's (CQC) fundamental standards, Use of Resources assessment and the Board's statutory duties.

The recommendation highlights are as follows:

1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.

2. Trusts must ensure three components are used in their safe staffing processes and NHSI will check this in their yearly assessment:
    - evidence-based tools (where they exist)
    - professional judgement
    - outcomes

3. NHSI will base their assessment on the annual governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.

4. NHSI will review the annual governance statement through their usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures.

5. As part of the yearly assessment NHSI will also seek assurance through the SOF, in which a provider's performance is monitored against five themes.

6. As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

7. Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The board should discuss the workforce plan in a public meeting.

NQB guidance contains further principles Boards must follow:

8. Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board every month.

9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance 5 and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.

11. As stated in CQC's well-led framework guidance (2018) 6 and NQB's guidance 7, any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.

12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA.

13. Given day-to-day operational challenges, NHSi expect trusts to carry out business-as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments.

14. Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix

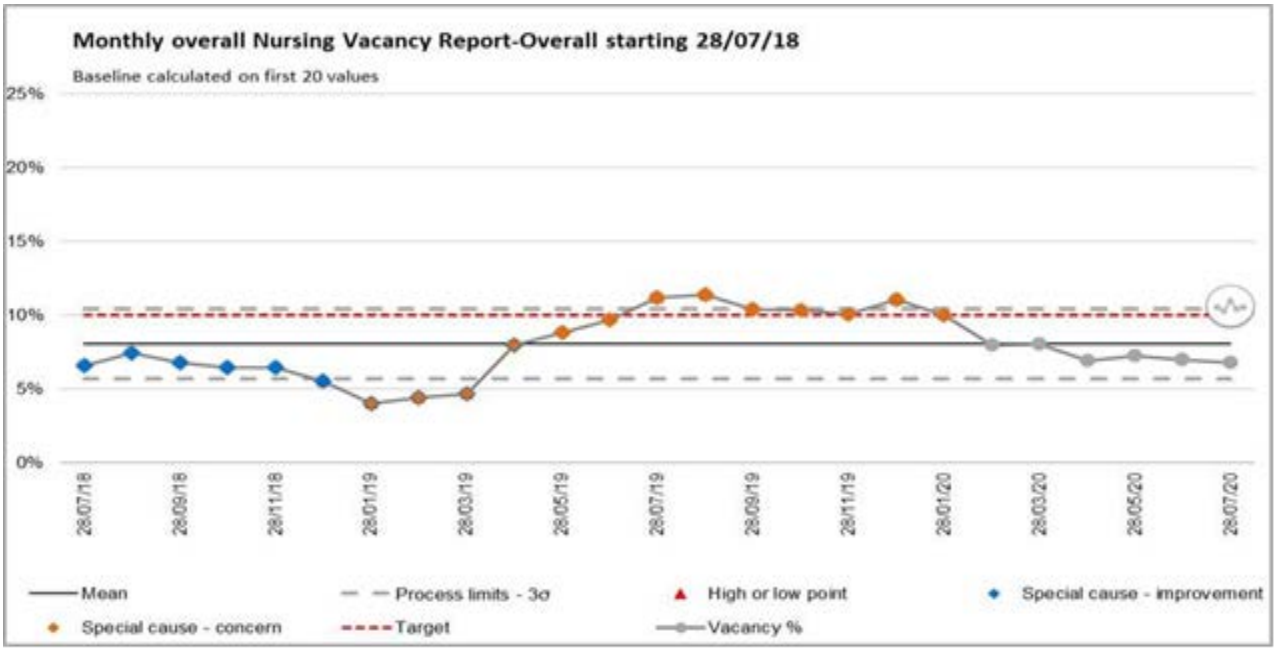
We are in the process of undertaking a self-assessment against the NHSI Developing Workforce Safeguards Guidance (2018) and a report will be presented to the People and Organisational Development Committee once completed.

1.1 Vacancy Position

The RN vacancy rate has fallen slightly in July and is at 7% which is 80wte vacancies (Chart 1). As referred to in last month's report we have now reviewed the RN vacancies and excluded the nursing associates (NA) vacancy that was previously included as well as the planned student nurse starters. 38wte students are currently working in the organisation and these students are expected to convert to substantive RN positions in September and October 2020, pending Examination Board sitting. The cost related to these students is being centrally funded.

The Nursing and Midwifery recruitment strategy is under review and will be aligned to support operational changes to service re-design to ensure the safest staffing levels possible are achieved whilst Covid-19 challenges remain.

Chart 1: Nursing and Midwifery vacancy % (excluding Nurse Associates)



As previously reported, in December 2018, 26.38 WTE NA's were added into ward establishment budgets with a plan to replace hard to recruit RNs (Band 5). In December 2019, a further 32.94 WTE was added to ward budgets and Band 5 monies were converted to cover the costs, making a total of 59.32 WTE NA posts. Unfortunately the numbers of NA trained or available externally for recruitment does not match the WTE numbers placed into the budgets. As of the end June 2020, 15.18 WTE Nursing Associates are in post leaving a vacancy position of 76.69%. The vacant gaps for these positions are predominantly filled with either bank or agency Band 5 nurses and lead to an additional £6.31/hr (potential >£10k/wk) cost pressure for every shift filled with a bank B5 RN. The NA role is currently counted in the RN:Pt ratio within the establishment and this will be reviewed during the establishment review process to ensure we report RN:Pt ratio in line with national guidance. Areas will also be required to complete a detailed QIA for every area with an NA deployed (or where the role is funded within the establishment) in line with NHSI Developing Workforce Safeguards Guidance (2018).

A paper detailing the Nursing Associate position is to be discussed at the People and Organisational Development Committee in August 2020.

1.2 Temporary Staffing Analysis of Hours used

Nurse agency use has followed the same trend as for June, with end of July seeing a slight reduction in Agency hours used (see Chart 2). We saw an increase in Tier 1 use and this is aligned to our avoidance of more expensive Tier 2 Agency use (see Chart 6). Matrons also ensure that in the twice daily staffing meetings we seek opportunities to redeploy personnel where this is safe to do so. In July, before consideration of escalation to bank/agency,

Matrons redeployed 270 hours of substantive RN and 407 hours of CSW from reviews during staffing approval meetings.

Bank shift utilisation (see Chart 3) has continued to increase during July and some of this can be attributed to lower levels of staff absence and therefore more staff available to work. Covid-19 Bank pay rates will have contributed to this positive effect also. Bank staff now have access to a mobile application where they can see and book into bank shifts helping avoidance of shifts that could potentially require agency.

Overall temporary staffing (see Chart 4) use in nursing is remaining within control limits and is less than pre Covid.

Bank as a proportion of our temporary staffing use has remained higher than normal within July (see chart 5). Bank staff pay rates have been increased by £3 per hour during the Covid-19 period and these remain in use to date. Agency use by Tier has changed significantly since March (see chart 6). There is a sustained effort in Tier 2 avoidance and strategies are in place to support areas before consideration of expensive agency. The majority of Tier 2 use during July was within our Emergency Department, support from Corporate Nursing has been given to drive a reduction in Tier 2 use within ED.

NHSi Agency Cap Breaches (see Chart 7) have continued to be reported weekly to NHSi. There was no Off Framework use within July 2020. The number of cap breach shifts has continued to see a positive downward trend.

Chart 2: Nurse agency usage (in hours)

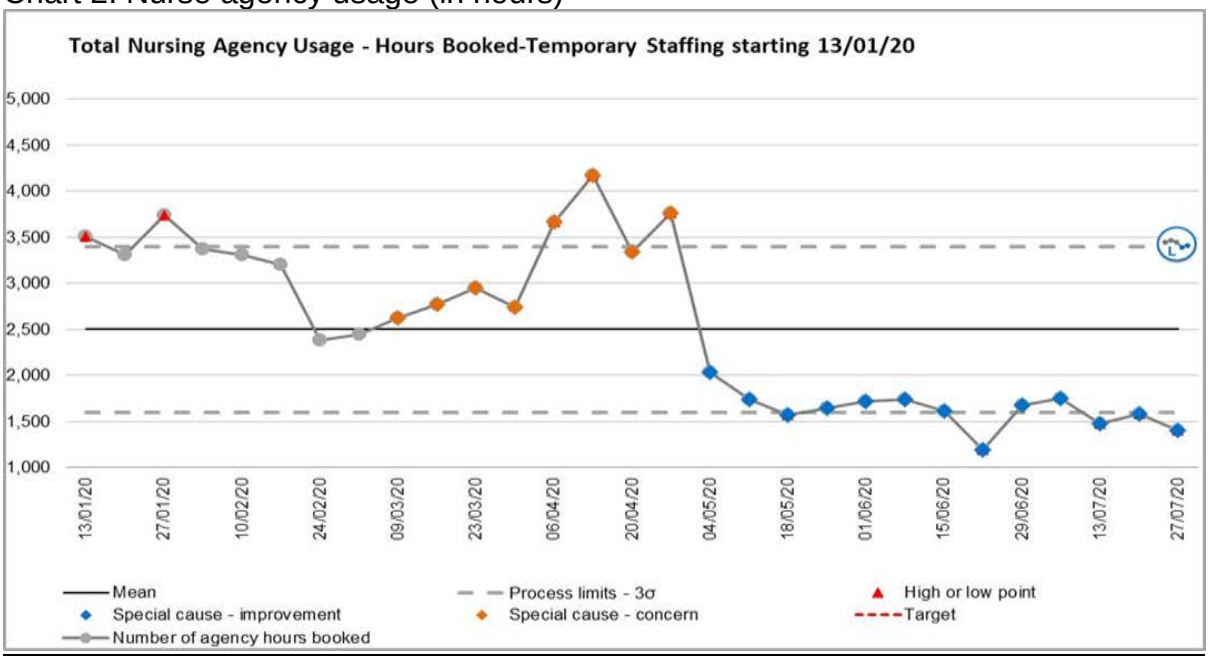


Chart 3: Nurse bank usage (in hours)

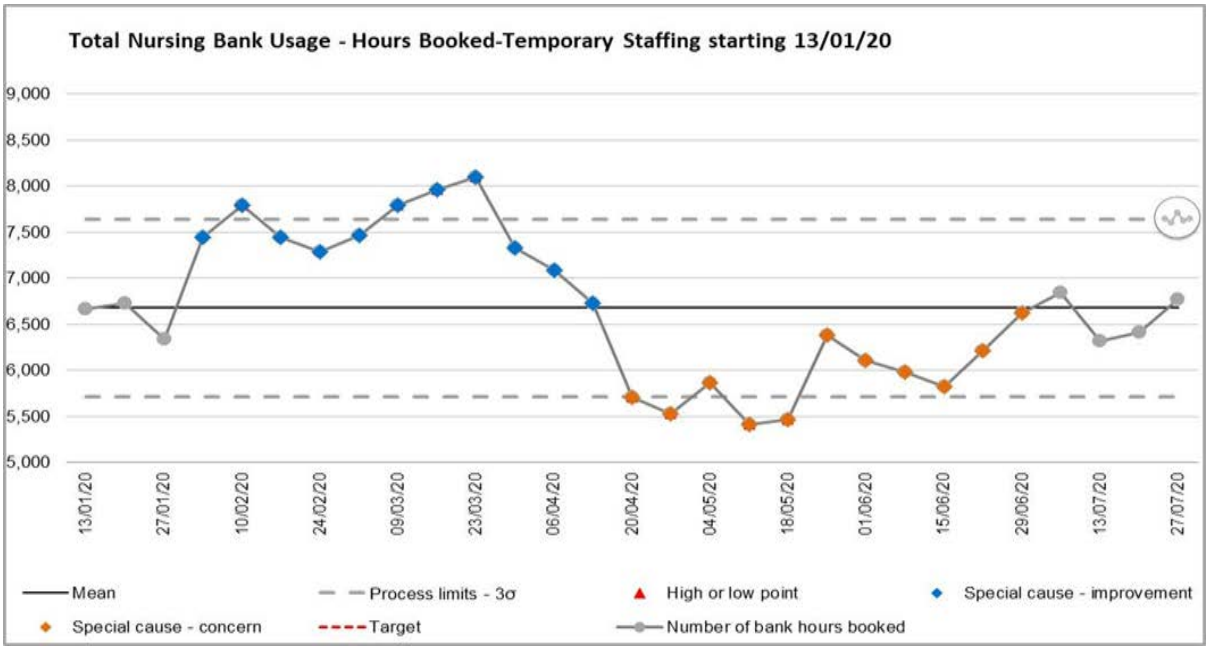


Chart 4: Total nurse temporary staffing use (in hours)

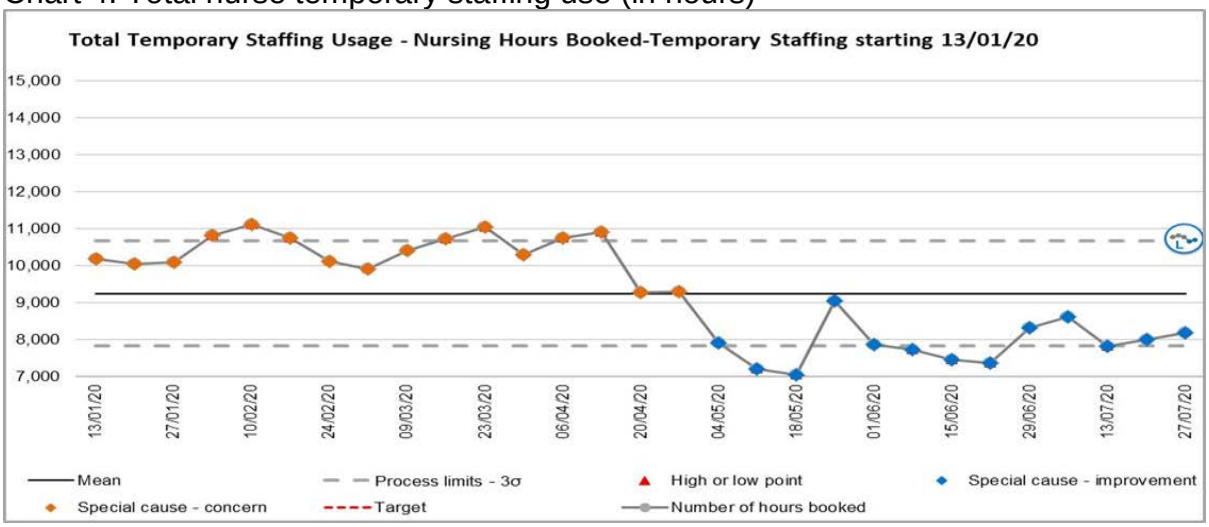


Chart 5: % of nurse bank shifts as a proportion of temporary shifts filled

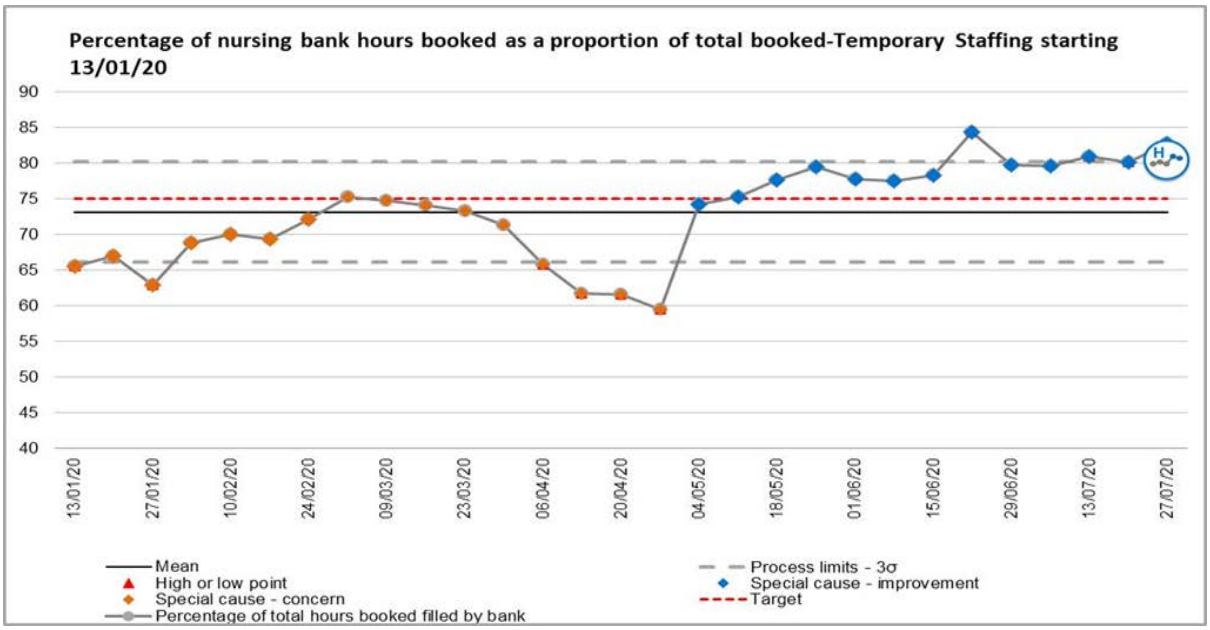


Chart 6: Agency use by tier

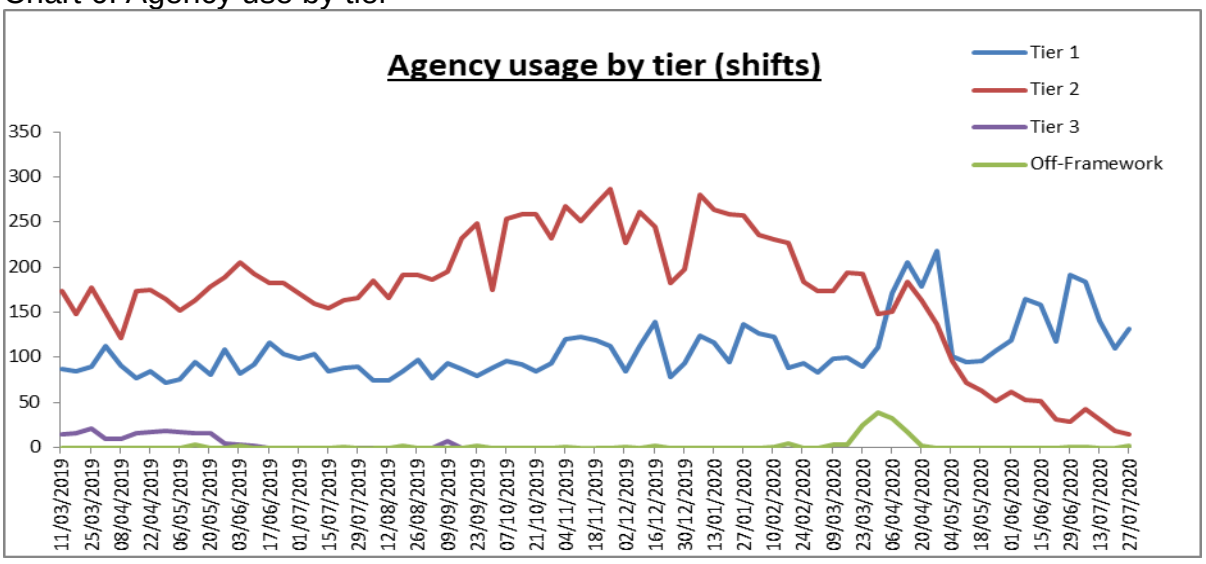
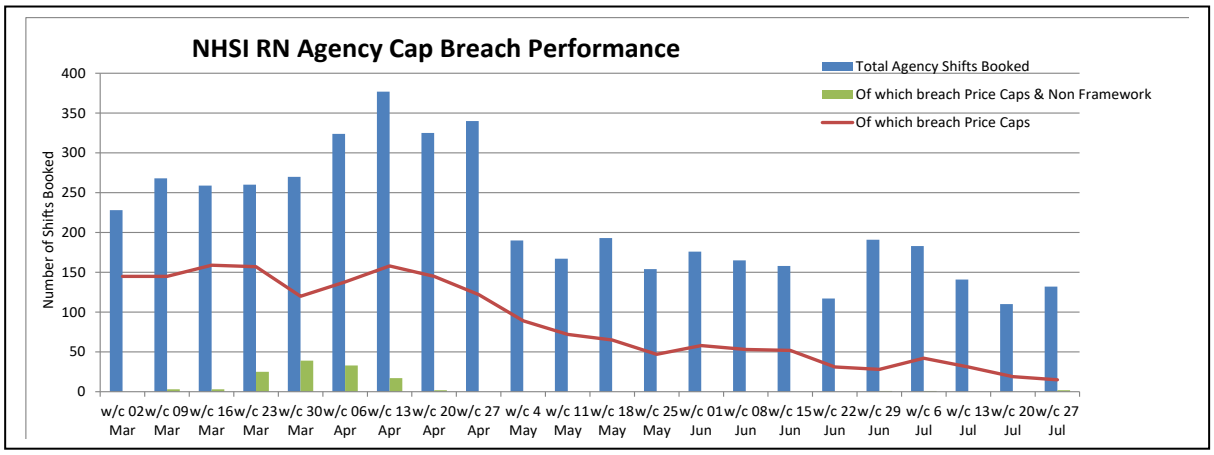


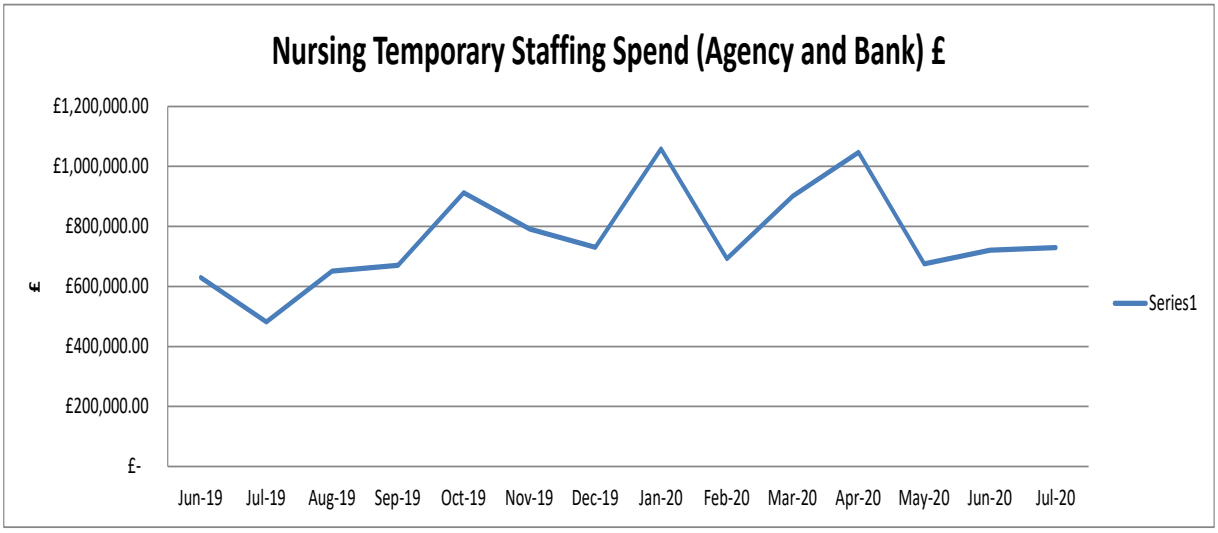
Chart 7: Agency cap performance



Nursing Agency and Bank spend (taken from Finance Weekly Tracker) shows the levels of peak demand and spend associated with that relating to the winter and Covid-19 period (see Chart 8). Nurse Temporary Staffing spend has remained on similar levels to June 20 with an increase of 8k in month.

In all instances, Temporary Staffing fill is first sought from Bank Staff after consideration of need and potential redeployment first.

Chart 8: Nursing temporary staffing spend



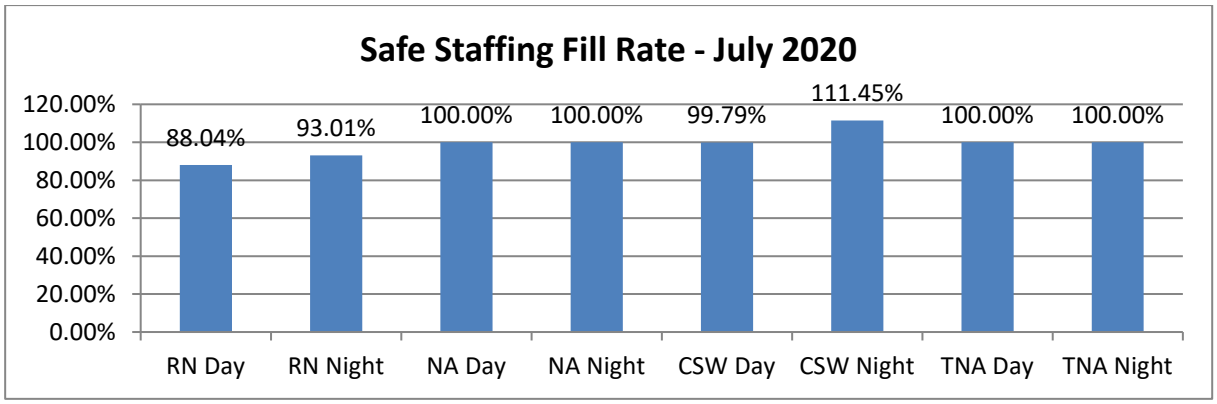
As reported last month, additional controls are to be put in place to provide greater assurance for temporary staffing bookings where the request is for additional capacity or to provide enhanced supervision. We are reviewing the current list of booking reasons and aim to reduce this, and we are also scoping the feasibility of requesting a vacancy number in order to book bank/agency shifts against a vacancy so we can better manage these requests.

1.3 Staffing Fill Rates

Lowest fill rate was seen in the day RN at 88.04% (see Chart 9) this is an improvement of 4% on last month. Reduced bed capacity within ward areas has meant that where fill was sought it was considered safe to not escalate shifts on some days. Bed occupancy in medicine and surgery varied in June between 50 to 93% with mean inpatient occupancy of 74%.

Redeployed staffs have supported maintaining good fill rates as well as the use of Student nurses within the ward areas who have worked as CSW staff. Student nurses used in this instance can have their costs reclaimed via Covid-19 central funds. In July we redeployed 270 hours of substantive RN and 407 hours of CSW from reviews during staffing approval meetings to support areas with staffing gaps.

Chart 9: Ward areas fill rates



1.4 Staff sickness and Temporary staffing cover

Registered Nursing sickness absence has reduced during July (Chart 10) and CSW sickness absence (Chart 11) has also reduced and is similar to the levels seen in the same period last year.

Chart 10: Sickness Absence RN

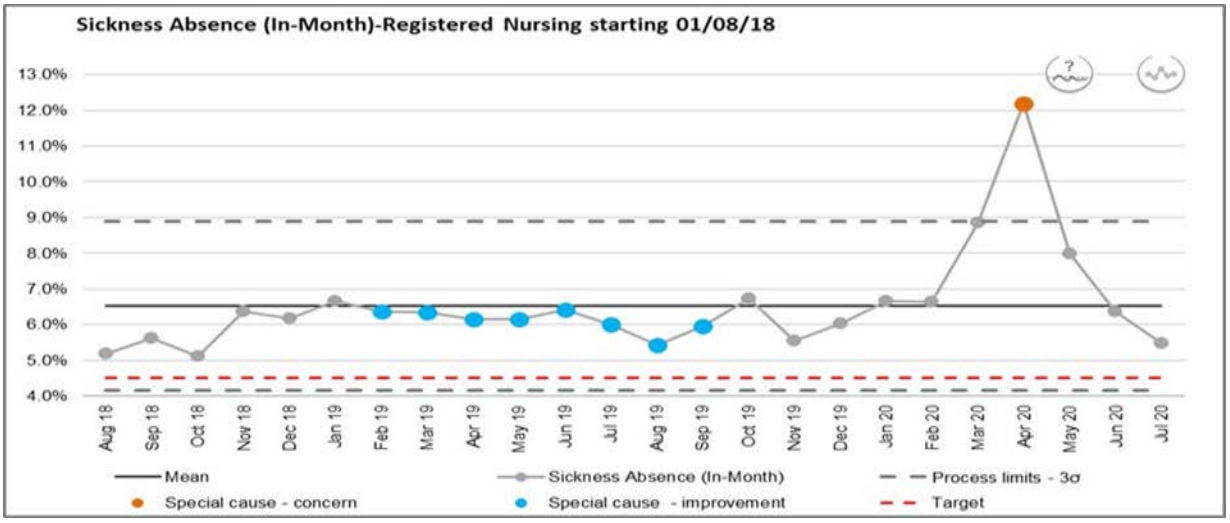
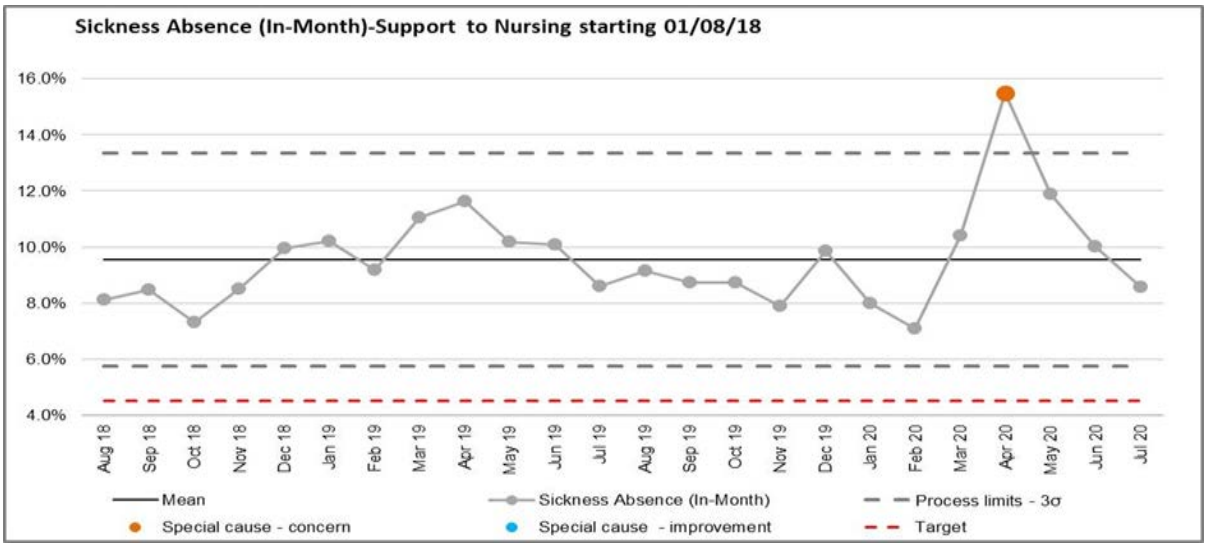


Chart 11: Sickness Absence CSW



There is still an additional impact of staff who are shielding due to Covid-19 and a decrease of usual availability to work on the Bank as well as a necessity to backfill some of those hours lost. Data collected from departments during July has indicated that within that month there was 3200 hours of RN shielding staff within the Acute sector of the hospital and 640 hours in the community sector. For CSW's in Acute this is 1720 hours and 120 hours in the community.

The shielding RN staff would have normally contributed more than 960 hours of bank work per month and for CSWs more than 300 hrs. RN shifts are the shifts that could incur extra cost when filling with Tier 1 Agency if all other alternatives are exhausted.

In addition, not counted for backfill are the staff who are working from home whom we are not seeking cover to replace based on the assumption that they are still contributing to patient care. These staff are not recorded as absent within our ESR systems. For RNs in July this comes to a total of 292 hours and 37.5 hours for CSW.

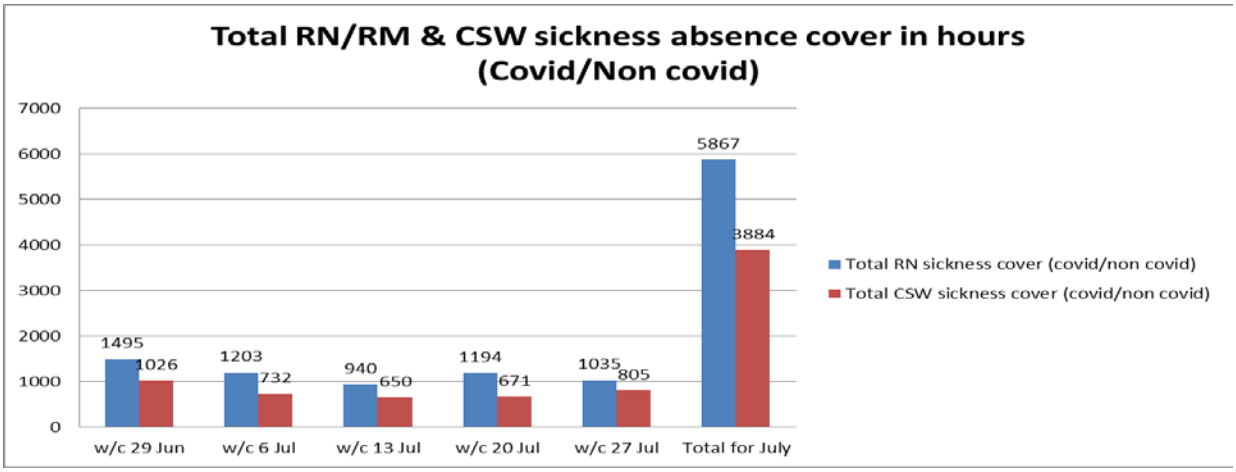
The tables below show the impact of the acute shielding hours combined with absences and the comparison of the temporary staffing requests.

Table 1: Acute Area sickness absence in July (Covid and Non Covid)

Type of absence	Where?	FTE Days Lost	3/7ths of FTE Day lost*	Conversion to hrs (@11.5hrs)
RN/RM sickness absence and Covid related Absence (ESR data)	Acute wards only	933.61	400.12	**4,601.38**
RN staff shielding (Ward data)				**3,200**
Combined sickness absence and shielding hours (RN)				**7801 hrs**
CSW sickness absence and Covid related Absence (ESR data)	Acute wards only	978.73	419.46	**4,823.76**
CSW staff shielding (Ward data)				**1,720**
Combined sickness absence and shielding hours (RN)				**6543 hrs**

Notes-excludes maternity/ shielding and 'other' absences. Converted to reflect lost working hours of Long days

Chart 12: Temporary Staffing bookings for Nursing and CSW sickness absence



**all Covid backfill bookings in Temp Staffing are for both sickness and shielding cover

Combined sickness / absence (Covid and non-Covid) RN/RM plus a need for staff shielding cover during July gave a total gap of 7801 hours. Bookings for sickness and Covid backfill was 5867 hours (see Table 1 and chart 12) so bookings did not exceed the requirement.

Combined sickness / absence (Covid and non-Covid) CSW plus a need for staff shielding cover during July giving a total gap of 6543 hours. Bookings for sickness and Covid backfill was 3884 hours (see Table 1 and chart 12).

1.5 Community Temporary Staffing Spend

Community temporary staffing spend across all localities saw an increase in July to 35k as they were still managing Covid-19 related care. Absence was high within the community division at a time when demand was also high. RN/RM Community total absence was 8143 hours, CSW 2169 hours which are both increased since June. Community also had 640 hours of RN shielding and 120 hours of CSW shielding. The cost of covering these absences alone would be £190k- costs indicate only 18% of the gap has been filled with temporary staffing. The Division do not use Agency.

Ordinarily spend would be much lower on Temporary Staffing in Community:

- June 28k
- May £22k
- April £21k
- March £1.4k

Community reviews through the Nursing Workforce Transformation meetings have commenced, which haven't previously occurred within the Trust. This has included reviewing the baseline inclusions of their vacancy reporting etc. There was recognition that some alignment and review of budget lines needs to occur within that Division for improved clarity of where roles sit and which services may have depleted levels of staff in post. The

Divisional Business Advisor has been requested to review budget lines for the Division so that they can be cross referenced with bookings in the Workforce Transformation Meetings.

The Finance Weekly Tracker detail is not sufficient for a validation of bookings by reason due to the work in the community being recorded on paper timesheets. The detail of bookings by reason is not recorded on timesheets. Nursing will work with Finance to explore the inclusions for Community in the Finance Weekly Tracker.

2.0 Allied Healthcare Professionals Update

Work has commenced to gather the Allied Healthcare Professional information re vacancy and gaps within the workforce. Currently there is not a single route of oversight that gathers this information and a lot of the information is held within Divisions. Work will continue to determine how this information could be sourced and avoid the risk of 'double counting'. Work is also continuing to gather information on bank bookings per department for analysis and appropriate challenge to be put into place. Information gathered so far from service leads is shown in Table 2 and shows a total gap of 33.21 WTE.

Table 2: AHP Vacancy Gap

	Band 5 Vacancy	**Band 6 Vacancy**	**Band 7 Vacancy**	**Band 8+ Vacancy**
Physiotherapy	0.5 WTE	7.61 WTE	Over established 0.52	0
Dietetics	0	Over established 1.0 WTE (funded by paeds business case)	0	0
SLT	Over established 2.0 WTE	0.39 WTE	0.99 WTE	Over established 0.20
Podiatry	0	0	0	0
ODP's	3.96 WTE due to start	1.22 WTE	1.0 WTE ODP 2.0 WTE RGN	0
Radiography	6 WTE	1 WTE	2.49 WTE	0
Audiology	0	0	0	0
Clinical Psychology	0	0	0	0.2 WTE
Specialist complimentary therapy	0	0	0	0
Sonography	0	0	0	0
Bereavement services	0	0	0	0
Orthoptics	0	0.04	0.04	0
OT acute	0.4 WTE	1.69 WTE	0	0
Palliative Care	0	0	0	1.68 WTE (mat leave and secondment)
TOTAL GAP	**12.86 WTE**	**11.95 WTE**	**6.52 WTE**	**1.88TE**

3.0 Perfect Ward and Ward / Department Performance

The Safe High Quality Care Improvement workstream have launched the new Perfect Ward App. The question sets were developed collaboratively with clinical teams and services. Most audits are live within the system and any issues with question sets are currently being tested and amended. There are specific question sets included to gain staff experience data and these questions will be stress tested at different levels via audits conducted by the ward/dept leader, Matrons and Director of Nursing. Audits currently being scoped for Executives and Non-executives.

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3 September 2020			
Freedom to Speak Up Annual Report			**AGENDA ITEM: 10.7 ENC: 17**
Report Author and Job Title:	Kim Sterling Val Ferguson Freedom to Speak Up Guardians	**Responsible Director:**	Catherine Griffiths Director of People and Culture
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	Analysis of the number of concerns generated though Freedom to Speak Up (FTSU) for the financial year 2019 to 2020 is supplied. A revised strategy on FTSU and improvement plan is presented for the Board's approval. This report, and the revised strategy, was reviewed by the People and Organisational Culture Committee at its 30 July and 27th August meetings, with that Committee charged with monitoring the FTSU improvement plan.		
Recommendation	The Board is requested to: 1. Note the report and discuss the contents within 2. Approve the FTSU strategy, vision and objectives and support publicity campaign with re-launch of the strategy at national Speak Up Month in October. The strategy was endorsed by the People and Organisational Development Committee on 27th August 2020 and recommends the strategy to the Trust Board for approval.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The work programme described within this report will provide positive assurance to the Trust Board on the following BAF risk S05 - Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.		
Resource implications	There are some cost implications associated with following this programme of work, all resource will be aligned through existing budgets.		
Legal and Equality and Diversity implications	Black, Asian or minority ethnic ("BAME") employees often face more barriers than non BAME employees when raising concerns. The data available is not yet sufficient to reliably determine and evidence equality and diversity impacts. This is being addressed through collecting concerns electronically through the incident reporting system, Safeguard and work being undertaken by the Equality, Diversity and Inclusion Group. Inequalities relating to propensity for speaking up are evidenced for individuals with a protected characteristic. Further data and		

	exploration of this is required at Trust level.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Freedom to Speak Up Annual Report

1. PURPOSE OF REPORT

This report presents the number of concerns and themes raised by colleagues through the Freedom to Speak Up (FTSU) route in 2019/2020, and to update the Trust Board on the development of Speaking Up within the Trust.

In addition the FTSU strategy, vision, and the 2020/21 objectives is attached for approval, having been reviewed by the People and Organisational Development Committee at their meeting on 27th August and endorsed for approval at Trust Board.

The provision of FTSU benchmarking information is included.

2. BACKGROUND

Establishing a route for staff to raise concerns was borne out of the Francis Report review and the role of the FTSU Guardian (FTSUG) was established (http://freedomtospeakup.org.uk/).

The role of the FTSUGs is to listen to and escalate concerns from colleagues. The FTSUG works with the trust to improve the culture of the organisation so the openness, transparency and speaking up is normalised as day to day business.

The trust enlisted support of NHSI to examine the FTSU function in the Trust with a view to improving its reach and effectiveness. Several sessions with one of NHSI's Advocacy and Learning (FTSU) officers and the FTSUGs, culminated in a board development session in May 2020.

The FTSU strategy, vision and objectives were shared with the board and members asked for their input to shape the key strategic objectives. Now finalised, the intention is to launch the revised strategy in October as part of the campaign in Speak Up month in October.

The National Guardian's Office (NGO) has brought together the four questions from the NHS Staff Survey to form the FTSU Index. These questions relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident.

This allows trusts to see how an aspect of their speaking up culture compares with other trusts. The index once again suggests a positive speaking up culture is associated with higher-performing organisations as rated by the Care Quality Commission (CQC).

The survey questions that have been used to make up the FTSU index are:

• % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)

• % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)

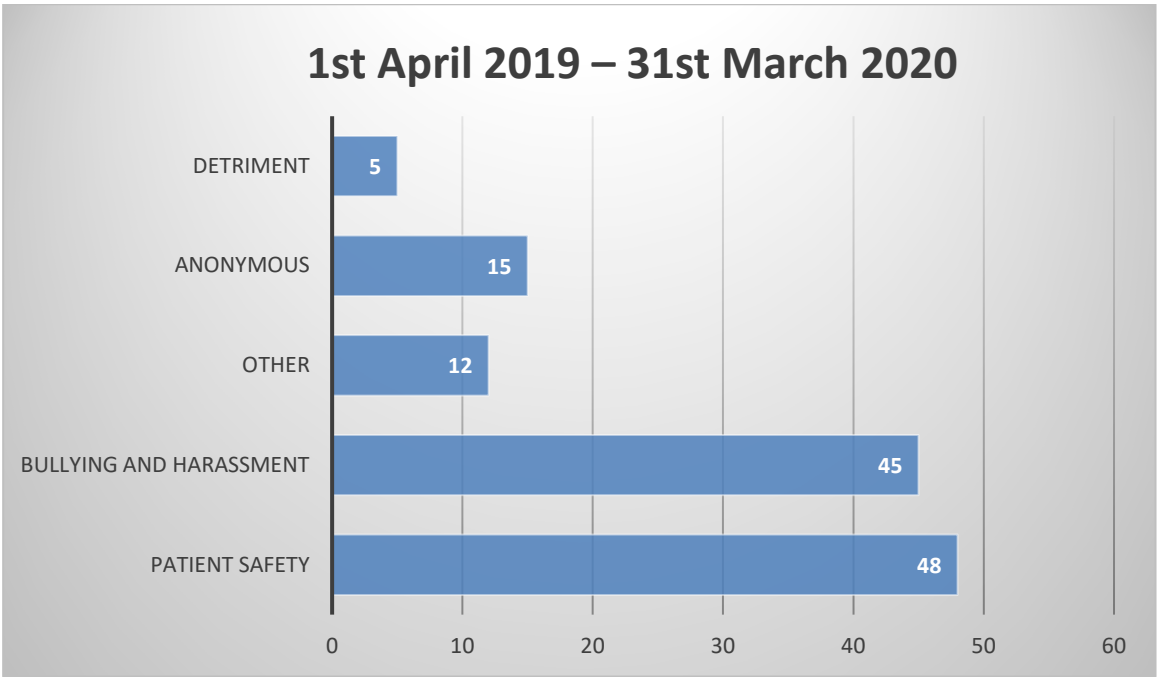
• % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)

• % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

Further benchmarking of FTSU was executed to develop WHT FTSU improvement plan. The plan was compiled after a thorough examination of NGO case review findings. A gap analysis of the published case review recommendations against the FTSU processes in Walsall was carried out. The case reviews are published by the NGO and can be accessed here: https://www.nationalguardian.org.uk/case-reviews.

3. DATA

The total concerns raised (1st April 2019 to 31st March 2020) are illustrated below. Please note that one concern may have an element of more than one theme.



Although employees can raise and log their concerns via the incident reporting system Safeguard, this method is the least preferred option. There is a belief that traceability is possible and individuals can be identified and thus risk detriment.
This perception deters the use of this portal and further extensive is required to promote the use and staff confidence in use Safeguarding reporting.

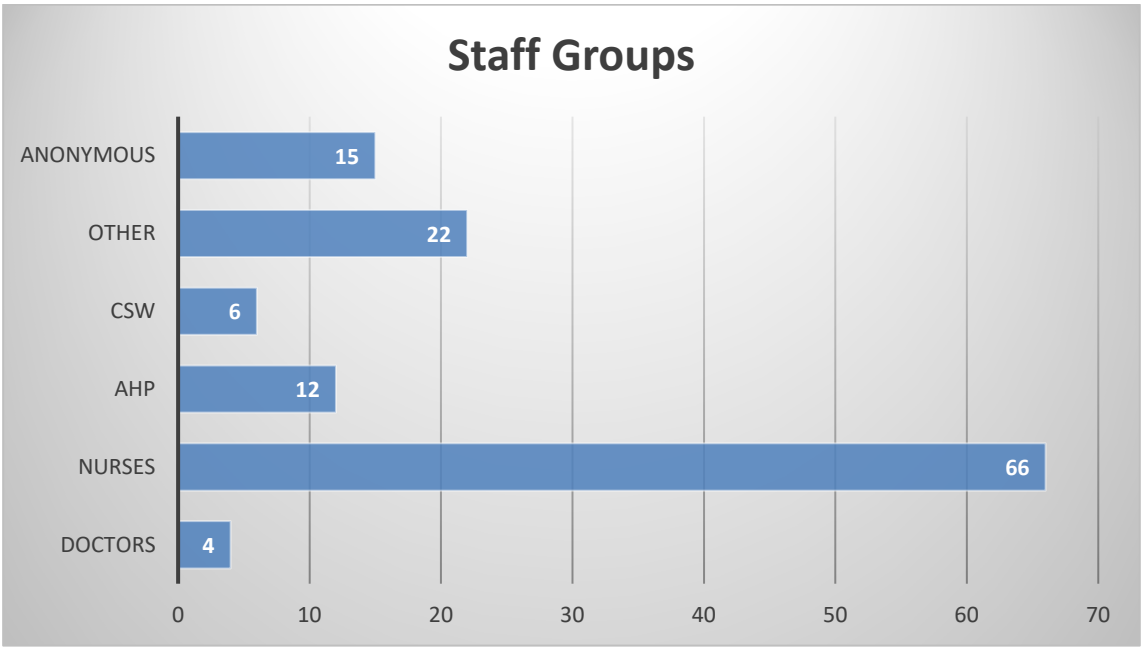
Analysis of themes

36% of the concerns for the year highlighted elements of bullying and harassment in the workplace. Previous quarters were 12% (Q1), 14.4% (Q2), 1.6% (Q3) and 40% (Q4) respectively.

The basis of most of these concerns stems from the perception of staff that they are not being treated ”fairly” and “equally” with regards to roster and annual leave allocation. Others report unprofessional attitudes and behaviours that do not uphold the Trust Values.

38.4% of the concerns were patient safety centred and included access to treatment, transportation, equipment resources and insufficient capacity affecting patient care. All serious patient safety concerns are escalated to the responsible executive for immediate action.

Who raised Concerns?



52.8% of the concerns raised in this period were by nurses. FTSUGs have set up weekly meetings to engage with the nursing teams in both the acute and community sectors.
As previously reported the FTSU team receive minimal concerns from the Midwifery Division and a programme of engagement is being developed to mitigate this.

The Division of Medicine and Long term condition generated the highest percentage of concerns predominantly from Pharmacy and Accident and Emergency departments.

4% of concerns were raised by doctors. Junior medical team have a robust reporting system through “exception reporting” which captures work load/rotation issues. The FTSU

information has been supplied to the medical education for incorporation into the junior doctor induction programme to support and encourage access to Speaking Up.

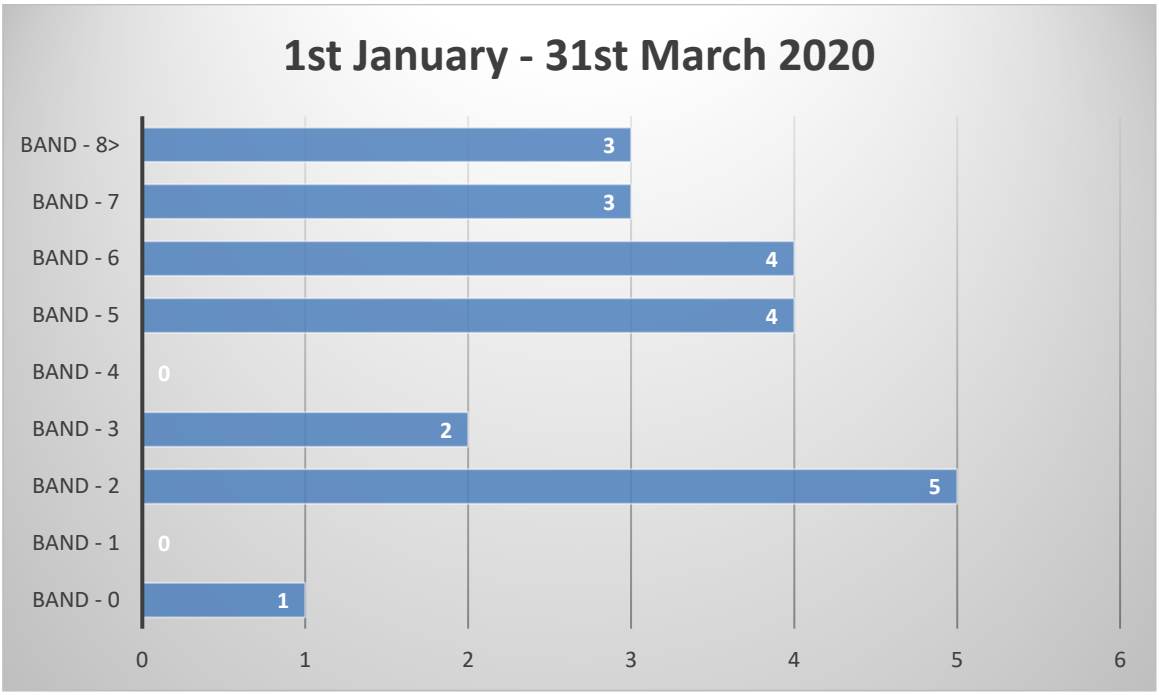
No concerns were received from the ancillary (house-keeping and portering) services. Further engagement is required with this group of staff to improve their accessibility to FTSU.

12% of staff raising concerns requested that their identity be withheld for reporting. Staff who disclose concerns, report that they had witnessed their colleagues attempting to ascertain who has spoken up.

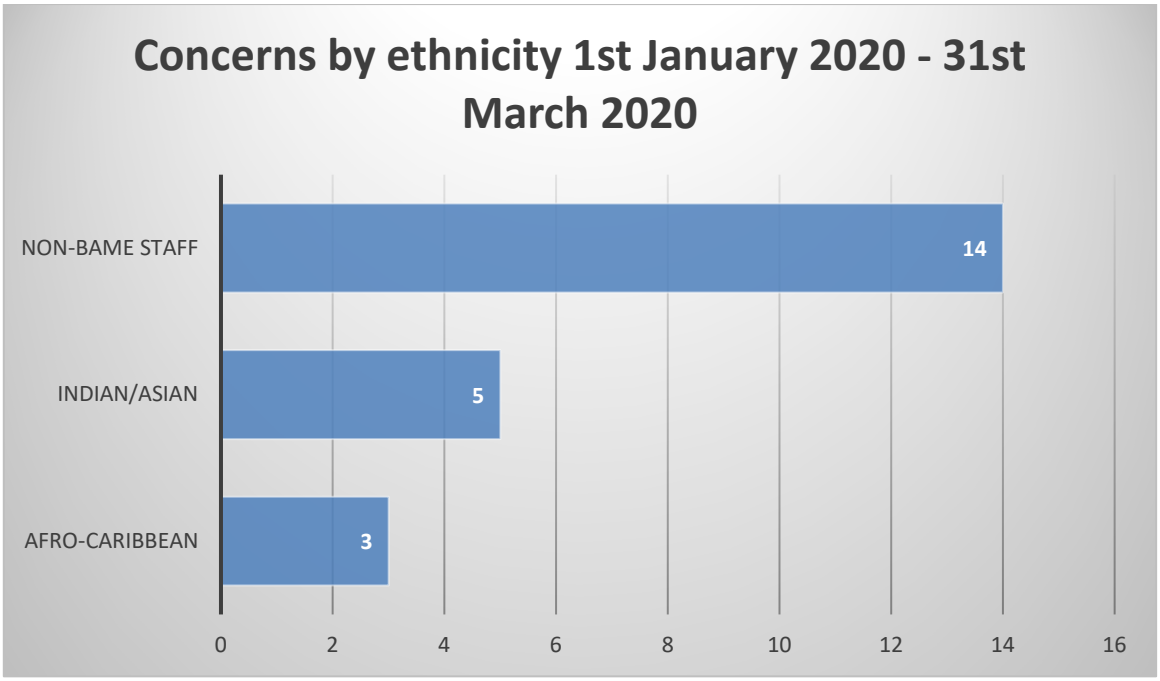
Reassurance that any detriment will be followed up and strict confidentiality maintained is always discussed at the commencement of any meeting with a staff member raising a concern.

The importance of collating data with regards to the grade and ethnicity of staff raising concerns was discussed at recent Equality and Diversity Inclusion meetings. This data was collated from 1st January 2020 and is reported for the first time.

Concerns generated by Grade



Concerns generated by Ethnicity



The concerns from people of BAME origin represents 36% of the concerns received. This is disproportionally higher as 27.6% of WHT staff are from a BAME background.

Conclusion on data captured

From analysis of the data, it can be seen that the majority of concerns are raised by nurses and pre-dominantly relate to patient safety. This equates to 48 of the 125 concerns raised closely followed by 45 with an element of bullying and harassment.

Covid19

The coronavirus pandemic is an unprecedented national emergency. In response to this a multi-disciplinary Colleague Health and Wellbeing group was set up to escalate and resolve staff issues specifically pertaining to Covid 19.
During the initial period of the pandemic, the number of concerns received via FTSU fell. This has been mirrored in other trusts within the region and highlighted by fellow FTSUGs in network meetings.

The main concerns generated via FTSU and reported to this group fell into three broad themes:

- PPE
- Re-deployment
- Shielding

Issues raised were swiftly actioned however; feedback to the FTSUGs to close cases was often overlooked and resulted in concerns remaining open. In order to mitigate this, it is suggested that the raising concerns policy is revised to include an escalation system with accountability for resolution and closure resting with the responsible executive.

FTSU Index

	Worst	Best	Walsall
2019	68%	87%	77%
2020	68.5%	86.6%	75.5%

The value for the organisations with the worst and best score remains almost the same for both years. However, WHT's score has decreased in line with the poor results generally from the staff survey. As the trust moves towards its goal of outstanding and the implementation of the FTSU strategy improvement should be reflected in future FTSU index data.

4. RECOMMENDATIONS

The Board is requested to:

(a) Note the report and discuss the contents within
(b) Approve the FTSU strategy, vision and objectives and support publicity campaign with re-launch of the strategy at national Speak Up Month in October.

APPENDICES

Freedom to Speak Up Strategy

Walsall Healthcare NHS
NHS Trust

Freedom to Speak Up Vision and Strategy 2020

Caring for Walsall together

Safe, high quality care
Care at home
Partners
Value colleagues
Resources

Freedom to Speak Up Vision and Strategy for Walsall Healthcare Trust

Purpose

Sir Robert Francis's "Freedom to Speak Up" review published in February 2015 highlighted the need to ensure that NHS staff feel safe to raise concerns, confident that they will be listened to and the concerns will be acted upon. The review identified a number of principles and actions including the creation of the National Guardian Office and a requirement for each NHS Trust in England to appoint a Freedom to Speak up Guardian.

The 20 key principles underpin the NHS's commitment to work at developing the right culture and environment for speaking up.

This strategy should be read alongside the Trust's Raising Concerns (Whistleblowing) at Work Policy which will reviewed as required to meet national guidance and best practice.

Speaking up is about letting your voice be heard if you feel there is anything getting in the way of providing good care and/or ensuring positive patient experience. The safety of our patients should be at the fore-front of everything we do, and we must take responsibility for reducing risk and the prevention of harm.

If things go wrong, we need to make sure that lessons are learnt and changes are made to ensure long term and permanent improvement. It is important that everyone feels empowered to speak up so that potential harm is prevented. Speaking up should be part of normal day–to-day practice for all employees of the Trust. The speaking up approach is assessed through the Care Quality Commission inspection as part of the Well Led domain. We will demonstrate the development of a healthy speaking up culture, moving away from blame and focus on what needs to be done to safeguard patients and improve experience for our staff.

There is a journey for all working in Walsall Healthcare Trust (WHT) which is:-

- About facing up to the hard truth when care falls short.
- Putting patients and their loved ones at the heart of care.
- Developing a culture of learning not blame; and of improving services for patients, and not defending the system.
- Creating a culture that listens, faces the truth and learns by making changes for the better.

Our Vision

"It's time to Speak Up"

A truly safe, caring patient focused culture is underpinned by the Trust Values chosen by our staff - **Teamwork, Professionalism, Compassion and Respect.**

We are committed to promoting an open, transparent culture. This culture is underpinned by employees having the confidence to report safety issues knowing that the organization will respond appropriately distinguishing poor care from genuine mistakes. The climate will be one where employees concerns for their safety and the safety of their patients are heard, taken seriously, investigated and acted upon.

Our FTSU Objectives 2020/21

In order to deliver this vision WHT will ensure

- The Executive Team and all managers model the behaviors required to promote an open and positive organizational culture.
- The Executive Team will remove barriers to facilitate a diverse and inclusive approach to speaking up, particularly amongst BAME and LGBT staff members who can sometimes feel more vulnerable.
- The creation of the means to provide advice and listen to staff in relation to concerns they have raised.
- Managers and FTSU Guardian create and implement process to ensure staff receive timely feedback and details of what action has been taken when concerns have been raised.
- Staff know how to access the Trust's speaking up channels and where to go for support and advice on how to raise concerns through them.

Goals

1. Staff feel confident and safe to speak up

2. We have a speaking up culture that is responsive to workers who raise concerns.

3. We have an effective process to share information from across the organisation to identify emerging patient safety issues and cultural hotspots.
4. We share good practice and learning from concerns raised with the Trust Management Board
5. We understand workers' anxieties around speaking up and have support processes in place to address any victimisation of workers that speak up.

Roles and Responsibilities

The Freedom to Speak up Guardians will:

- Support staff to raise concerns, through giving advice, escalating concerns, and signposting employees, whilst maintaining confidentiality
- Develop and deliver communication and engagement programs to increase visibility and awareness of the FTSU service
- Promote local speaking up processes and sources of support and guidance, demonstrating the impact of FTSU in the organization and celebrating speaking up.
- Work with HR and staff side to ensure that speaking up guidance and processes are clear and accessible, reflect best practice, and address and local issues that may hinder the speaking up process.
- Develop and ensure staff are issued with a written guide on speaking up as part of the recruitment process
- Ensure that information and guidance on speaking up is incorporated into the induction programs for all staff.
- Ensure groups of staff and individuals who may find it difficult to speak up are given additional support.
- Taking part in National Guardian office training which may include supporting fellow FTSU Guardians, developing personal networks, peer-to-peer relationships, contributing to wider networking events, and sharing and learning from best practice.

Managers

It is managers who will often hear concerns from members of their team as they are responsible for dealing with concerns raised under the Trust policy. They must ensure that everyone in their departmental service is aware of the policy. This will include permanent and bank employees, agency workers, students, volunteers and contractors.

Furthermore it is the responsibility of managers to offer and provide support to individuals who raise concerns. When hearing the concern they should take steps to prevent victimization and detriment.

Our managers should:

- Take responsibility to create a work environment that promotes civility and mutual respect
- Take the employees' concerns seriously, and thank the staff member for raising the concern.
- Understand the employees may feel uncomfortable raising a concern
- Consider the concerns carefully and undertake the required investigation.
- Seek appropriate advice from their immediate manager and human resources team.
- Take prompt action to resolve the concern or refer it to an appropriate person.
- Keep the employee informed of the process and where appropriate, not breeching confidentiality, feedback to the department the learning and celebrate improvements to patient care
- Monitor and review the situation and inform senior managers.

The Chief Executive/Chair will:

- Be accountable for ensuring the FTSU arrangements meet the needs of workers in the Trust.
- Take responsibility for ensuring the Trust annual report contains information about FTSU.

The Executive Director of People and Culture responsible for speaking up will:

- Oversee the creation of the FTSU strategy and vision
- Deliver the strategy to the board
- Ensure the Organizational Development plan supports the required cultural development.
- Support and develop the FTSU Guardians to meet the demands of their role in terms of time and resources.
- Provide assurance to the Board about the effectiveness of the strategy, policies and procedures in place to support FTSU culture.

The Non-executive Director Lead for FTSU will:

- Provide assurance that systems and processes are put in place to support FTSU and that staff are encouraged and supported to raise concerns.
- Hold the Board to account for implementing the FTSU strategy through appropriate challenge to reflect on cultural responsiveness and genuine focus on learning and improvement.
- Provide assurance that the Board and senior leaders are committed to a 'safe and open values' based culture.
- Oversee speaking up concerns regarding Board members.

Medical Director and Director of Nursing will ensure:

- That the FTSU guardians have the appropriate advice and support on patient safety and safeguarding issues.
- Effective, appropriate and immediate action is taken when potential patient safety issues are highlighted.
- Learning is operationalized within teams and departments

Outcomes, Measures and Impact

Staff and management FTSU modules are included in the mandatory training program to ensure that every employee receives training appropriate to their role. The uptake will be monitored and the data presented to Trust Management Board

An increase in the number of workers reporting the ease at which they are able speak up reflected in WHT

pulse and national surveys

An increase in the numbers of concerns raised via all channels evidenced through data reported to Trust Management Board

Concerns are disclosed by all groups of staff including those with protected characteristics evidenced through data

Increased numbers of staff who report that they would speak up again shown through surveying the experience of each member of staff who raises a concern through the FTSU Guardian route

A reduction in the number of staff who report they have been treated adversely after speaking up demonstrated through post FTSU experiential surveys

All managers undertake training on FTSU and participate in the Trust Leadership program. Take up will be monitored and results fed back to Trust Management Board

Annual staff survey results

Improvements in the percentages for the following staff survey questions:

i) Staff saying that if they are concerned about unsafe clinical practice they would know how to report it
ii) Staff responding positively to the statement "I would feel secure raising concerns about unsafe clinical practice"
iii) Evidence that staff's response to "I am confident that the organization would address my concern" is positive

Walsall Healthcare FTSU staff survey results

A quarterly submission of analytical data to Trust Management Board with the focus being on improving the services we provide for patients. These reports include the FTSU service and team activities, cases seen, themes incurred, and lessons learnt to improve care and service delivery alongside other intelligence whilst maintaining confidentiality.

Trust Management Board and FTSU Guardians will annually review and improve Raising Concerns at Work (Whistleblowing) Policy to include:

- An overview of the cases reported and the themes identified

- Exception reporting if necessary where FTSU raising immediate concerns and actions required.
- Actions taken which show improvement in FTSU culture which also demonstrates any barriers perceived.
- Reporting of lessons learnt to be included in all reporting papers to Board with clear recommendations made.

Monitoring

A FTSU annual report will be presented to the Trust Management Board each year by the FTSU Guardians and the Executive Lead for speaking up which will include:

1. An assessment of the Trusts Raising Concerns at Work (Whistleblowing) Policy
2. An overview of the cases reported and the themes identified
3. Data submitted to the National Guardian Office.
4. Benchmarking data to show how the trust compares with other similar trusts
5. An improvement plan for the next 12 months which will reflect the strategy objectives and any gap analysis of national best practice

MEETING OF THE PUBLIC TRUST BOARD **Thursday 3 September 2020**			
Revalidation Annual Report & Statement of Compliance 2019/20			**AGENDA ITEM: 10.8** **ENC: 18**
Report Author and Job Title:	Mark Read – Medical Revalidation & Job Planning Manager	**Responsible Director:**	Dr Matthew Lewis – Medical Director
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The Annual Report for Revalidation and Statement of Compliance are attached for review by the Board. This has been reviewed and endorsed by the People and Organisational Development Committee on 27th August 2020. Of note is: **Appraisal & Revalidation Performance 1 April 2019- 31 March 2020** • On 19th March 2020, NHS England's Responsible Officer formally requested the suspension of the Appraisal Programme due to COVID19 until further notice; • Limited local Appraisal Programme was reinstated 2nd July 2020; • The GMC have also suspended all revalidation submissions for this appraisal year; • As a result, the NHS England Annual Organisational Audit was not conducted this year; • 98% of connected doctors had a completed appraisal or approved missed appraisal as at the 19th March 2020; • 1% (4) doctors had an unapproved missed appraisal; • 99% (68) of doctors due for revalidation were recommended for revalidation, an improvement from 87% in the previous year; • 1% (1) doctor due to be revalidated were deferred owing to insufficient supporting information, or owing to them being subject to an ongoing process. This figure is an improvement, down from 13% in the previous year; • 0 doctors due for revalidation were recorded as non-engaging doctors. **Key Actions undertaken since 1 April 2019** An increased emphasis on monitoring key quality elements of appraisal, including quality of the appraisal summary, evidence of reflection and the associated Personal Development Plan (PDP) outputs. This has included monitoring and improving Medical Appraiser performance through the Medical Professional Standards Group (PSG): • April 2019 – new Trust Lead Medical Appraiser appointed,		

	Dr. Riaz Bavakunji, Nephrology Consultant. • June 2019 – 17 new Trust Medical Appraisers trained, increasing the total Trust Medical Appraisers to 61; • November 2019 - Appointment of Revalidation Team Resources –the Medical Revalidation & Job Planning Administrator (role was been vacant since May 2018) **Key Actions Planned for 1 April 2020 - 31 March 2021** • Medical Appraisal and Revalidation Policy (yet to be ratified by the Local Negotiating Committee). • Creating a culture focused on reflection and application to clinical performance, robust PDP's that are effective and objectives that are aligned to both Trust, service and individual needs. • The Revalidation Team will be rolling out monthly support sessions via Microsoft Teams for Doctors to attend should they wish, to provide training, support and advice. • MPSG to continue to monitor appraisal compliance; • Complete a programme of refresher training for existing Medical Appraisers in September 2020 (two webinars) • Complete a programme of New Medical Appraisers training in October 2020 (one webinar). • Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development. • Maintain performance - 0 late recommendations to the GMC. • Ensure positive recommendations are confirmed in writing to the doctor; • Invite a Non-executive Director or Lay Member in the monthly Maintaining Professional Standards Group (MPSG) **Risks and Issues** Identified risks include: • New Policy yet to be ratified; • Impact of COVID19 on Trust Appraisal Performance;
Recommendation	The Board is requested to: • Approve the Annual Report for Revalidation • Approve the 'Statement of Compliance' confirming that the organisation, as a designated body, is compliant with the regulations (Section 7) A *Statement of Compliance with the regulations* (Section 7) should be signed by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director and Higher Level Responsible Officer, NHS England Midlands and East by 30 September 2020**.**

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report mitigates BAF Risk S01 - failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm by ensuring consistent processes for revalidation and compliance with the regulations.	
Resource implications	There are no resource implications associated with the paper.	
Legal and Equality and Diversity implications	The Responsible Officer has a statutory obligation to ensure GMC revalidation is embedded and appropriate governance in place. The doctor has an obligation to comply with GMC revalidation or could lose their licence.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☒
	Resources ☒	

A Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published by NHS England in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes was undertaken by NHS England, with the priority redesign of the three annexes below:

1. Annual Organisational Audit (AOA):

The AOA captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included. **See Appendix 1**

2. Board Report:

The Board Report is presented to support Walsall Healthcare NHS Trust (hereafter referred to as the Trust) as a 'designated body' in reviewing progress over time. Whereas the previous version of the Board Report template addressed the Trust's compliance with the responsible officer regulations, the revised version now contains items to help the Trust assess its effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This handbook describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention of this Board Report is to guide the Trust by setting out the key requirements for compliance with regulations and key national guidance. It provides a format to review these requirements, so that the Trust can demonstrate not only basic compliance but continued improvement over time. The Board Report will:

a) help the Trust in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

3. Statement of Compliance:

The Statement Compliance (in Section 7) is now combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The Board of Walsall Healthcare NHS Trust can confirm that:

1. **The Annual Organisational Audit (AOA) for this year has been submitted.**

Date of AOA submission: No AOA was undertaken this year as NHS England's Responsible Officer formally suspended the Appraisal Programme.

Actions from last year: *None.*

Comments: ***Trust Appraisal Compliance***

Figure 1 demonstrates the Trust's overall Appraisal Compliance rate increased from 90% on 31 March 2019 to 98% on 31 March 2020. It should be noted that compliance means either a completed appraisal or an approved missed appraisal due to mitigating circumstances (maternity leave, long term sickness, COVID19).

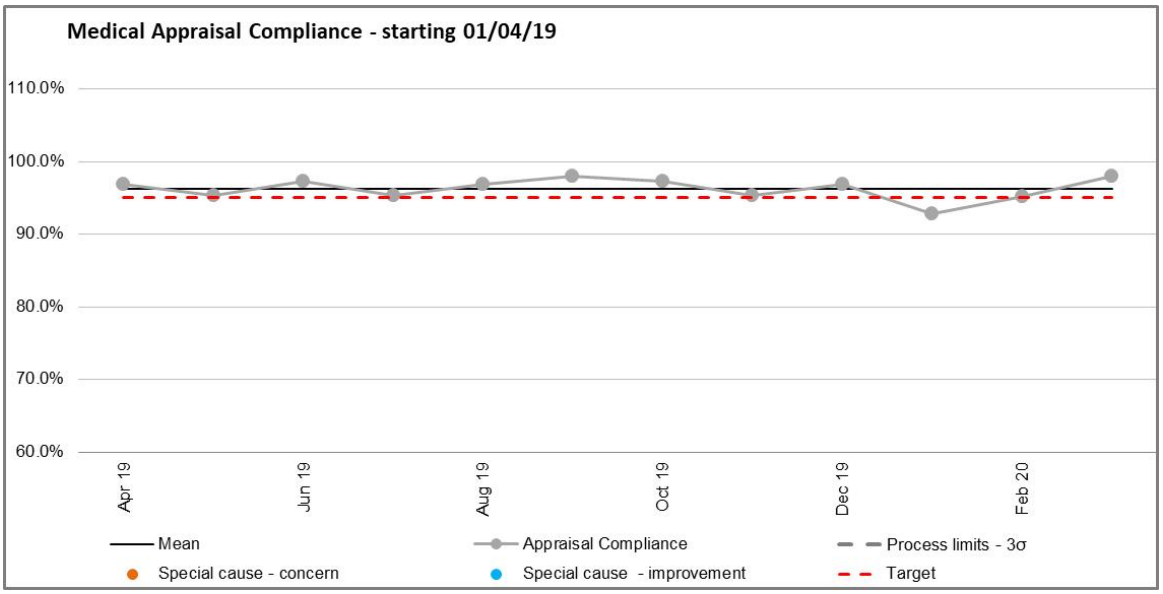


Figure 1- Appraisal Compliance Comparator

Trust Unapproved Missed Appraisals

Figure 2 the Trust had 4 doctors with unapproved missed appraisals, which are being managed and monitored through the monthly Maintaining Professional Standards Group (MPSG) chaired by the Medical Director/Responsible Officer. This group reviews the progress of the appraisal and revalidation programme, discusses concerns and identifies potential non-engagement.

Action for next year: *MPSG to continue to monitor appraisal compliance;*

2. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Dr Matthew Lewis is Medical Director and Responsible Officer.

3. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Yes.

Action from last year: *Complete a programme of refresher training for existing Medical Appraisers in November 2019 and April 2020.*

Comments: the previously long term vacancy of Medical Revalidation and Job Planning Administrator was filled and the post holder commenced in post November 2019.

Action for next year: *Complete a programme of refresher training for existing Medical Appraisers in September 2020 and for New Medical Appraisers in October 2020.*

4. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

Action from last year: *No action.*

Comments: In April 2018, the Trust transitioned to a new system for governing Medical Revalidation and electronic Appraisal for all 259 doctors connected to this designated body. Doctors with a prescribed connection are managed and updated through GMC Connect online, by the Medical Revalidation and Job Planning Manager who has delegated access, on behalf of the Trust's Responsible Officer. The Manager is notified by the Recruitment Team of new starters once an unconditional offer of employment is made to a doctor, to ensure the system is updated in a timely manner.

Action for next year: *No actions identified.*

5. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from last year: *Develop a New Medical Appraisal & Revalidation Policy.*

Comments: The 'Medical Appraisal & Revalidation Policy' is currently being drafted and will be presented at the Medical Advisory Committee (MAC). The existing 'Appraisal Policy for Senior Medical Staff' remains in place. It is anticipated this Policy will be ratified by October 2020.

The Trust also has a Policy in place to manage concerns: 'Disciplinary and Management of Performance Procedure for Medical Staff'. The new 'Maintaining High Professional Standards - Disciplinary and Management of Performance Procedure for Medical Staff' is currently under review by Human Resources and not yet ratified.

Action for next year: *Ratify the Medical Appraisal & Revalidation Policy and a revised Disciplinary and Management of Performance Procedure for Medical Staff.*

6. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from last year: *No action.*

Comments: Last Independent Verification Visit was undertaken by NHS England in 24/11/ 2016;

The Trust appointed a new Medical Appraisal Lead in April 2019 will quality assure a random selection of 60 appraisals each appraisal year and meet all 61 Medical Appraisers on an annual basis to provide peer support and feedback on their performance, using Appraisal Feedback data from doctors and calibrate performance of appraisers. Points of learning and general feedback will be provided to appraisers through bi-monthly Appraiser Support Group Meetings (ASG), facilitated by Lead, to be conducted via Microsoft Teams.

The MPSG also reviews training needs, performance and quality of appraisal and ensures consistency through the Medical Appraisal Lead's feedback data.

Action for next year: *No action.*

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: *None.*

Comments: The Medical Revalidation Team offers 1-2-1 training support for all new starters to the Trust, including Allocate e-Appraisal guidance.

Action for next year: *No action.*

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

   Action from last year: *No action.*

   Comments: Confirmed, information regarding complaints and significant events are all documented within the Complaints and Significant Events Report which is a mandatory element of medical appraisal. This includes a report obtained from other healthcare organisations including private hospitals.

   Action for next year: *No action.*

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

   Action from last year: *Completion of Medical Appraisal Checklist for all connected Doctors.*

   Comments: All 'missed appraisals' have a recorded reason on the Allocate "RO Dashboard", for tracking and monitoring. This includes, 'Approved Missed Appraisals' where the RO has agreed to a postponement (i.e. sickness absence, maternity leave, sabbatical). The RO dashboard is managed and maintained by the Medical Revalidation Manager.

   Where risks or issues are identified or a lack of engagement in the appraisal process through MPSG, there is a procedure in place which includes a meeting with the doctor and Trust Lead Appraiser before the doctors appraisal due date and, if required, the development of an action plan to ensure appraisal completion on time. This has replaced the action from last year.

   Action for next year: *None.*

3. **There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).**

   Action from last year: *Develop New Medical Appraisal & Revalidation Policy.*

   Comments: The 'Medical Appraisal & Revalidation Policy' is currently being drafted and will be presented at the Medical Advisory Committee (MAC). The existing 'Appraisal Policy for Senior Medical Staff' remains in place. It is anticipated this Policy will be ratified by October 2020.

   Action for next year: *Ratify Medical Appraisal & Revalidation Policy (Target Date October 2020).*

4. **The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.**

Action from last year: *Deliver New Medical Appraiser Training.*

Comments: 17 new Medical Appraisers trained in June 2019, increasing the Medical Appraiser cohort to 55. The ratio of appraisers to doctors is now 1: 5, down from 1: 6 in the previous year. New Medical Appraiser Training in scheduled for October 2020 to increase the cohort and improve the ratio.

Action for next year: *Deliver Medical Appraisal Refresher Training.*

5. **Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).**

Action from last year: *Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 101 basis to discuss Appraisal Feedback, performance and development.*

Comments: Medical Appraisal Lead met all 17 newly trained Medical Appraisers on 1-1 basis. Refresher Training will be delivered on September 2020 to existing Medical Appraisers.

All Medical Appraisers are members of the Appraiser Support Group (ASG) which will be chaired by one of the Trust's Lead Appraiser. These meetings will be held bi-monthly via Microsoft Teams. It is a requirement that all Medical Appraisers attend a minimum of 3 ASG meetings per appraisal year. The meetings will cover any issues and concerns to be addressed, the appraiser allocations for the forthcoming year, any training and development needs and Quality Assurance through reviews of anonymised appraisal outputs (to demonstrate good and poor practice) to ensure calibration of practice.

Action for next year: *Lead Appraiser to meet all remaining Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development.*

6. **The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.**

Action from last year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September 2019.*

Comments: The Annual Board Report is presented to the Board each year and provides a quality review framework.

Action for next year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September 2020.*

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 3 – Recommendations to the GMC

1. **Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.**

Action from last year: *A target of 0 late recommendations to the GMC*

Comments:

0 late recommendations occurred in 2019/20.

Since April 2019, the Trust Lead Medical Appraiser supported by the Medical Revalidation Manager, has delegated responsibility for reviewing the Doctors Revalidation Portfolio (typically the last 5 years of Medical Appraisals).

The Medical Revalidation Manager records the decision on GMC Connect and Allocate. Where concerns arise i.e. insufficient supporting information, or where unresolved local/GMC concerns exist, these cases are escalated to the RO to discuss with their GMC Employee Liaison Officer (ELA)

Action for next year: *Target of 0 late recommendations to the GMC.*

2. **Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: *Ensure positive recommendations are confirmed in writing.*

Comments: The GMC have suspended all revalidation submissions for this appraisal year. The Trust Medical Appraisal Lead reviews the doctor's appraisal portfolio once the doctor is 120 days away from their revalidation due date ('under notice'). If there are any likely causes for delay these are considered in advance by the Lead with an appropriate plan put in place with the Doctor, e.g. deferral if necessary.

Action for next year: *No action.*

Section 4 – Medical governance

1. **This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: *No action.*

Comments: Confirmed.

Action for next year: *No action.*

2. **Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: *No action.*

Comments: Confirmed. Trust Teams and systems provide information data as follows: Clinical Audit attendance (Departmental Clinical Audit Lead/Facilitator); Mandatory and in-house Training (ESR), complaints and significant events (Patient Safety/PALS - Safeguard) and e-360 feedback (Revalidation Team); Consultant Appraisal Summary Reports (Health Evaluation Data) to provide Consultants with an overview of their individual performance, Trust specialty performance and National specialty performance.

Current safeguards are in place as well as ongoing discussions between the Medical Director and GMC Employee Liaison Advisor (ELA). When there are concerns regarding conduct or capability, the Trust implements the framework set out in 'Maintaining High Professional Standards in the Modern NHS' (MHPS). This forms the basis of the medical disciplinary Policy. There have also been 7 further medics trained as Case Investigators this year.

Action for next year: *No action.*

3. **There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year: *Arrange 1 NHS Resolution Case Investigator Workshop(s);*

Comments: The Trust facilitated NHS Resolution delivered Case Investigator Training and Case Manager Training (May - July 2019). The Trust now has 20 trained Investigators, and 5 trained Case Managers. To ensure this was delivered in a cost effective manner, the Medical Revalidation manager arranged for a total of 24 external paying delegates to attend across the 3 sessions.

1 further Case Investigator session was due to be arranged, but COVID19 impacted this.

Action for next year: *Arrange 1 further NHS Resolution Case Investigator Workshop.*

4. **The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].**

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

[3]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

Action from last year: Involve a Non-executive Director or Lay Member in MPSG.

Comments: The Trust is currently reviewing the Policy for raising and dealing with concerns. This will follow the 'Maintaining High Professional Standards' framework and NCAS 'Back on Track' framework. All concerns about doctors are managed under the framework of 'MHPS' within the Medical Disciplinary Procedure. All cases that reach the threshold for GMC referral are discussed at a monthly meeting between the Medical Director and the GMC ELA.

Since January 2019, the Trust's Maintaining Professional Standards Group (MPSG) replaced the Revalidation Steering Group (RSG). The number of doctors in remediation and disciplinary processes are reported on and reviewed on a monthly basis at the MPSG. Terms of Reference are in place, and the Group reports directly to the Trust's Quality, Patient Experience and Safety Committee.

Last year's action has been carried over.

Action for next year: *Invite a Non-executive Director or Lay Member in the MPSG.*

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

Action from last year: *No action.*

Comments: The Medical Practice Transfer of Information Form (MPIT) supports the appropriate transfer of information about a doctor's practice to and from the doctor's Responsible Officers (RO). When recruiting, handover information received is forwarded to the Trusts RO. Requests for information received are processed by the Medical Revalidation Manager.

Action for next year: *No action.*

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: *No Action.*

Comments: Confirmed. All Trust Policies are subject to Equality Impact Assessments.

Action for next year: *No Action.*

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. **A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from last year: *No action.*

Comments: Standard Trust Recruitment Policy pre-employment checking process includes references, DBS checks, right to work checks and Occupational Health Assessment for new starters. Also, the Medical Practice Transfer of Information form (MPIT) is requested by the Trust's Recruitment Team once a final offer of employment is confirmed. This applied to all substantive, short-term contract holders. Doctors employed through an Agency are subject to checks by the Agency.

As part of the Recruitment process, candidates are expected to demonstrate that they are up-to-date with their practise and that they have an up-to-date Medical Appraisal. This requirement is incorporated into the local Medical Recruitment procedures.

Action for next year: *No action.*

Section 6 – Summary of comments, and overall conclusion

1. General review of 2019/20

- Appraisal rates have improved with 98% of all doctors eligible for appraisal completing the process. There were 24 doctors exempt from appraisal attributed to long term sickness, maternity leave and the suspension of the appraisal programme due to COVID19. These are all approved reasons for exemption. Reassuringly, there were no recommendations of non-engagement sent in 2019/20.

Appraisal Year	% of doctors with a prescribed connection who have had an appraisal
2015 - 2016	77.3%
2016 - 2017	89.1%
2017 - 2018	97.1%
2018 - 2019	90.2%
2019 - 2020	98.5%

- A continued challenge in 2019/20 was meeting the target set by NHS England of returning completed appraisal documentation within 28 days of the appraisal meeting.

Appraisal Year	% of doctors submitting the completed documentation within 28 days
2018 – 2019	84%
2019 - 2020	87%

- All reasons for delay in appraisal completion are clearly recorded on Allocate. The overwhelming reason cited for delays were workload pressures and appraiser unavailability due to COVID19.

- Following a change to reporting requirements in 2016/17, doctors are now required to have their appraisal by the same 'due date' each year, rather than within a designated quarter. Those that fall beyond 12 months are considered a missed appraisal. The relevant changes in reminders issued through Allocate at 12 weeks, 8 weeks and 4 weeks, and reporting has now been embedded and is working well. There has not been any notable adverse impact on how our appraisal figures are reported externally. The priority for the appraisal team remains ensuring that all doctors have an annual appraisal.

- Doctors who have recently undertaken appraisal but completed it late have been issued with a letter from the MD/RO to remind them of their professional and employee responsibilities and the requirement to undertake appraisal on time next year;

2. Actions still outstanding

- Ratify the Medical Appraisal & Revalidation Policy.

3. Current Issues

- The suspension of the appraisal programme 19th March 2020 was lifted locally by Dr Matthew Lewis on 2nd July 2020, having discussed this matter regionally and with the GMC.
- All doctors have been written (via email) and encouraged to undertake an appraisal discussion focused upon reflection, learning and support given the recent unprecedented challenges faced during the COVID19 pandemic.

4. Completed Actions 2019/20

- An intranet webpage with resources including best practice guides, appraisal training videos and links to further guidance was launched in 2019/20;
- 17 new Appraisers were trained and all have been met with by the Medical Appraisal Lead to discuss their performance and to offer support;

5. New Actions 2020/21

- The Revalidation Team will be rolling out monthly 'drop in sessions' for Doctors to attend that will provide training on the elements as well as technical support and advice;
- MPSG to continue to monitor appraisal compliance;
- Complete a programme of refresher training for existing Medical Appraisers;
- Revise Disciplinary and Management of Performance Procedure for Medical Staff;
- Deliver Medical Appraisal Refresher Training and New Appraiser Training;
- Lead Appraiser to meet all remaining 38 Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development;

- Target of 0 late recommendations to the GMC;
- Ensure positive recommendations are confirmed in writing;
- Arrange 1 further NHS Resolution Case Investigator Workshop;
- Involve a Non-executive Director or Lay Member in the MPSG.

Section 7 – Statement of Compliance:

The Board of Walsall Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Walsall Healthcare NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3rd September 2020			
Performance, Finance & Investment Committee Highlight Report			**AGENDA ITEM: 11.1 ENC: 19**
Report Author and Job Title:	Trish Mills, Trust Secretary	**Responsible Director:**	Mr J Dunn – Chair of PFIC (Non-Executive)
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Performance, Finance & Investment Committee meetings on 29th July and 26th August 2020. The report sets out escalations for the attention of the Trust Board, and key issues discussed and work underway overleaf. Excellent performance on constitutional standards continues both in community and the acute, with two items of particular merit being: 1. Continued improvement against the Emergency Access Standard to achieve 95.4% of patients admitted or discharged within four hours of arrival. July 2020 is therefore the first calendar month in recorded history for Walsall Healthcare NHS Trust to achieve the Emergency Access Standard. Time to Triage also increased to its highest ever position at 74.41%. 2. Medically Stable For Discharge ("MSFD") performance remains strong with a significant decrease in the number of MSFD patients in May, June and July, reflecting the now embedded COVID-19 actions. Length of stay of patients discharged in-month from intermediate care domiciliary pathways reduced marginally in July, however it remains above the local target of 21 days The Board's attentions is drawn to the following escalations: 3. There is a Trust Board Action from the 4th June meeting for an updated on the outcome of STP capital allocation discussions in July. The Trust has provisionally secured £3.7m for critical infrastructure from the recent STP allocation. 4. The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 78.6% and 62 day RTT from Consultant upgrade with performance of 66.7%. As at 14.08.20 Cancer 62 day RTT has deteriorated further to 67.3% for July. 5. 18 week RTT performance in July is 52.5%. There are significant challenges ahead, particularly for the Division of		

	Surgery. MLTC Division has seen an improved position in July, with restoration of outpatients in place. However note that the Trust's national ranking position continues to improve further to 23rd best in the country in June for 18 week RTT. 6. There has been a reduction in nursing capacity in Locality Teams during July and August as staff redeployed during COVID-19 have now returned to their substantive functions. 7. Whilst members reviewed the capital programme (now totalling in excess of £20m). Committee noted this does not mitigate the full backlog estates risk, as such members noted the estates strategy to be a priority. Further discussions will be held on the strategy prior to the next Committee meeting and it will remain on the agenda until such time as the Committee can provide the Board with assurance on the immediate, medium and long-term actions to address the issues. 8. The Trust is seeing 75% of elective activity historically undertaken during this period, with Emergency Department attendances below historic levels by 15%. As expenditure is exceeding historic periods, further reviews of capacity and use of temporary workforce for future periods is to be undertaken. The next meeting of the Committee will take place on 23rd September 2020.	
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to the BAF risk for use of resources.	
Resource implications	The implication is that national funding allocation will not meet the Trusts current financial run rate.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

PERFORMANCE FINANCE AND INVESTMENT COMMITTEE HIGHLIGHT

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee has met twice since the 2nd July Trust Board meeting, with those meetings taking place on 29th July and 26th August 2020. The first half of the July meeting was chaired by Mr John Dunn, Committee Chair and Vice Chair of the Trust Board, with the second half being chaired by Mrs Anne Baines, Non-Executive Director. The meeting was not quorate once Mr Dunn left the meeting, however the items that required quoracy were dealt with whilst he was present. The August meeting was chaired by Mr Dunn and was quorate. The Committee reports each month on escalations for the attention of the Trust Board and key issues from the meeting.

1. Financial Resource and Activity

When the Committee met on 29th July it was not assured as to the underlying run-rate and requested clarity on the position. The August meeting compared levels of expenditure to activity from June 2020 (during Covid 19 response) and June 2019. Costs are c£2m higher in June 2020 than in June 2019. This was driven by a cost inefficiency of c£1.6m nursing capacity that was not utilised, with c£0.3m being caused by a higher unit cost for temporary staff and a potential efficiency loss in the Emergency Department from Covid. The report highlighted levels of elective activity being 75% of that performed historically, with Emergency Department attendances 15% below that experience in the previous financial year. The reporting of activity combined with financial analysis enabled Committee to understand the activity levels and cost, and will monitor the actions to reduce expenditure, including comparative data with other acute providers.

2. Financial report

The committee reviewed financial performance for months 3 and 4 at their July and August meetings respectively. The finance performance report appears on the agenda for this Trust Board meeting, however, the key issues for month 4 for the Board's attention are:

- The Trust achieved a break-even reported position for July 2020, though required top up funding in month from NHSE/I of £3.2m, thus seeking £8.3m year to date to achieve breakeven (April 2020 to July 2020).
- The top up requested in July of £3.2m is significant compared to April to June 2020, largely driven by elective restoration (increased clinical consumable costs) reduction in income by Health Education England (HEE), additional staffing costs linked to doctors hours, Clinical Excellence Award (CEA) and charges relating to historic debt now the detail has been shared on the debt to equity write off.
- The Trust has spent £3.8m on capital YTD (£0.8m in July). This includes expenditure to support COVID-19 for which support received from the NHSI/E regional team (confirmation is awaited from NHSI/E National) and expenditure on the Emergency Department. In addition, the Trust has provisionally secured £3.7m for critical infrastructure from the recent STP allocation and the full capital programme was debated within Committee.
- There remains a risk if anticipated capital allocations are not approved by NHSI/E national teams (COVID or ED) of the Trust breaching its Capital Resource Limit

(spending more on capital than allowed in year) even though the Trust has kept the regional team informed of plans and acted in accordance with guidance received to date. The Committee reviewed the current capital plan for 2020/21 at its meeting in August.

Temporary workforce costs are moving back in line with the Emergency Financial Plan, though the Trust has the opportunity to further reduce expenditure run rates through recruitment, changes to rates of pay and a key focus placed on true levels of capacity required. Nursing costs have exceeded plan, though costs have reduced in line with plan for month 3 and 4. Medical pay is overall on plan, though temporary staffing expenditure has exceeded plan. The Committee is monitoring actions to reduce expenditure.

3. Electronic Patient Record ("EPR")

Committee members have engaged with the EPR programme team outside of the Committee meetings to gain a deeper understanding of the issues faced in the lead-up to go-live on 19th and 20th September. The overall status of the programme has remained at Amber. The Stakeholder Engagement Plan is a focus but receiving positive feedback. Until budget setting is completed (and the Covid funding confirmed) Finance cannot be moved to Green. In addition, the Covid risk remains, even though the impact on go-live is thought to be diminishing given the lead in time related to any second spike. The virtual training programme has been successfully launched and take-up is a priority focus for the executive over the next three weeks.

4. Effectiveness Review and Terms of Reference

At the 29th July meeting the Committee approved its annual report and revisions to the terms of reference are on the Trust Board agenda for the September meeting. The Committee's revised cycle of business will be reviewed in September.

5. Chair's Action

Chair's action was taken in July for Electronic Patient Record resource contract extension and a 3-year contract with Office 365 under the NHS tenant arrangement. Both actions were reported in full to the Committee.

6. Risk Management

The Committee received a report on the Board Assurance Framework and the Corporate Risk Register relevant to its remit, including a newly added risk related to suboptimal legacy

MEETING OF THE PUBLIC TRUST BOARD 3rd September 2020			
Use of Resources			**AGENDA ITEM: 11.2** **ENC: 20**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance	**Responsible Director:**	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Use of Resources strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Use of Resources and NHS constitutional standards successes and areas for improvement. This report recognises the extraordinary circumstances that the Trust has operated in thus far this financial year, and the altered financial arrangements as a consequence of the national level 4 incident prompted by the Covid-19 pandemic. This report identifies strong operational performance in national rankings for the NHS Constitutional standards. This report identifies the importance of ensuring that the Trust manages within the necessary run rate for the remainder of the financial year, whilst recognising there remains significant uncertainty regarding the level of income the Trust can expect to receive from Month 7 onwards. This report recognises that the Trust will need to carefully calibrate key resourcing requirements for the remainder of the year, including preparing for Winter and a potential resurgence of Covid-19, and restoring and recovering elective services impacted by the first surge.		
Recommendation	Members of the Trust Board are asked to: • Note the extraordinary circumstances that the Trust has operated in thus far this financial year. • Note the financial risk associated with current run rate and future income uncertainty, and the need to evidence Improvement Program efficiency benefits to ensure the Trust		

	exits the current year at the correct run rate trajectory. • Note the actions to report back to PFIC to mitigate this risk.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S06 – Use of Resources to provide positive assurance that there are mitigations in place to manage this risk and the related corporate risks.	
Resource implications	This strategic objective is: *We will deliver optimum value by using our resources efficiently and responsibly* However, there are no requests for approvals with direct resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

USE OF RESOURCES

1. EXECUTIVE SUMMARY

This report recognises the extraordinary circumstances that the Trust has operated in thus far this financial year, and the altered financial arrangements as a consequence of the national level 4 incident prompted by the Covid-19 pandemic. The Trust has occurred significant additional costs associated with Covid-19 (£8.3m YTD) to ensure patients and staff are kept safe.

This report identifies strong operational performance in national rankings for the NHS Constitutional standards. The Trust should be proud of these achievements, which provide evidence that the careful management of available Trust resources is resulting in improved access to care for the patients we serve.

This report identifies the importance of ensuring that the Trust manages within the necessary run rate for the remainder of the financial year, whilst recognising there remains significant uncertainty regarding the level of income the Trust can expect to receive from Month 7 onwards.

This report recognises that the Trust will need to carefully calibrate key resourcing requirements for the remainder of the year, including preparing for Winter and a potential resurgence of Covid-19, and restoring and recovering elective services impacted by the first surge. This will not be straightforward and will need to consider how the Trust best protects the safety of the patients we serve over Winter, restoring access to (and reducing waiting times for) elective care for patients who have experienced significant delays as a result of Covid, and protecting staff wellbeing after one of the most challenging periods in the history of the NHS.

2. BOARD ASSURANCE FRAMEWORK

The Use of Resources Board Assurance Framework (BAF) risk was updated following a joint Executive and Non-Executive Director meeting on 15th July. The risk now reflects the broader resources under the Trust's stewardship, namely financial resources, human resources, physical asset resources (Estate and equipment) and technology resources.

Performance, Finance & Investment Committee have requested further strengthening of the BAF risk to better reflect the digital technology corporate risks, and have requested a review of the Corporate Risk Register under Use of Resources to either consolidate or make interdependencies clearer between:

- Risk 274- Failure to resource backlog maintenance and medical equipment replacement costs results in the organisation being unable to deliver fundamental clinical services and care (Risk Score=20)
- Risk 1005- The Trust has insufficient resources available to ensure the essential maintenance of the Trust's Estate. (Risk Score=16)
- Risk 2054 - Capital and cash availability to support existing infrastructure, equipment (medical and Information technology) service developments and innovation. (Risk Score =16)

Corporate Risk 2188 is a new digital technology risk of suboptimal patient information infrastructure, with the introduction of the new Electronic Patient Record as the primary mitigation.

Key financial risks are articulated within the corporate risk register and inform the Use of Resources section of the Board Assurance Framework, namely;

- Efficient running of the Trust, using every pound wisely in delivery of the financial plan and securing improved run rate performance to ensure financial sustainability in the longer term
- Capital resource availability to service current backlog works requirements and future major capital developments

Trust Board Members are asked to note the uncertain financial planning environment for months 7 – 12 of this financial year, and the risk that this poses to the Trust's ability to plan its resource deployment.

3. PERFORMANCE REPORT

Financial

The Trust entered the 2020/21 financial year having attained planned financial outturn for 2019/20. However, the onset of Covid-19 has resulted in emergency budgets being set by NHSEI and the planning process halted.

The Trust has exceeded the emergency budget allocation set by the centre by £8.3m YTD. However, the financial regime enables Trusts to seek additional income to offset the impact of Covid-19, and the Trust has requested this additional income as a 'top up' of £8.3m to enable reporting of a break-even position as at month 4.

The Trust is currently servicing 75% of historic elective activity levels (with Emergency Department attendances 15% below historic levels in July) whilst costs remain higher than previous years and above the baseline plan, largely driven by temporary workforce costs that exceed historic levels and are higher than contained within the plan. As the Trust seeks to increase elective activity (as per national guidance stipulated in the Phase 3 letter from Sir Simon Stevens and Amanda Pritchard) this will

result in a potential risk to delivery of current performance and or achievement of break-even financial performance (reference BAF & CRR).

Financial run rate modelling to distinguish between costs normally incurred, Covid-19 measures and elective restoration and recovery is to be presented to Performance, Finance & Investment Committee members, with comparison to the levels of income expected (once known). This will need to evidence that delivery of the plan will also enable attainment of break-even financial performance during 2020/21.

The Trust has also received capital allocations in year totalling in excess of £20m, with key risks now centring around the ability to utilise this financing in year. However, this funding is insufficient to offset the backlog maintenance risk the Trust is exposed to and so a full estates strategy has been requested to be provided to PFIC.

Operational

The Trust can be proud to now be delivering upper quartile performance in three of the four main NHS Constitutional Standards.

The Trust has met the 4-hour Emergency Access Standard for the first calendar month on record and was the 20th best performing Trust nationally out of 114 reporting Acute Trusts in July (2020).

The Trust is ahead of it's trajectory to recover the DM01 6-week wait Diagnostic standard following the impact of Covid-19 on elective care earlier this year, and is sustaining its position as the 7th best performing Trust nationally out of 123 reporting Acute Trusts in the most recently published national statistics (June 2020).

The Trust is in line with its trajectory to recover the 18-week Referral To Treatment waiting time standard following the impact of Covid-19 on elective care earlier this year, and has improved to 23rd best performing Trust nationally out of 122 reporting Acute Trusts in the most recently published national statistics (June 2020).

The Trust's Cancer waiting times performance benchmarks reasonably, but with clear opportunity for improvement. Two week wait performance is 59th nationally, 31 day performance is 42nd nationally and 62 day performance is 61st nationally out of 124 reporting acute Trusts in Quarter 1 of 2020/21.

Sustaining emergency access standard performance will be in part dependent on the strength of the Trust's ability to invest in its Winter Plan (including protection against a resurgence of Covid-19 patients), and sustaining elective care recovery following the impact of Covid-19 earlier this year will be intrinsically linked to the financial arrangements for the second half of the financial year which still carry significant uncertainty.

4. IMPROVEMENT PROGRAMME

The Use of Resources improvement programme continues to mature. Operational productivity workstreams associated with restoration and recovery are well developed in Medicine & Long Term Conditions and Surgery. The Capital Programme and it's concurrent impact on medical equipment resources and improvements to the Estate is now defined with far greater clarity, and with the added strength of £3.7m Critical Infrastructure capital and £4.1m Urgent & Emergency Care capital.

The primary risk workstream within the programme is that associated with Estates; including the development of an Estates strategy, the electronic rostering of Facilities staff, and sustainability enhancements to reduce utilities consumption across the Trust. To mitigate this risk a Programme Manager has been engaged specifically for the effective Use of Resources programme, and priority support has been given to the Estates workstream. In addition, external expertise is being commissioned to facilitate the development of the Estates Strategy as a bespoke piece of work, taking into account changes in clinical activity since Covid-19 – particularly greater virtual outpatient consultations, and increases in remote working for non-clinical staff.

The attainment of recurrent financial efficiency improvement through the Use of Resources workstream is key to securing future sustainability of services, ensuring the Trust exits the 2020/21 financial year with a run rate that can be supported by the income earned by the Trust.

5. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Note the contents of the report.
- Note the following actions which will report to PFIC
    i. Full run rate analysis to be provided to PFIC in order to assess the income available to the Trust over the second half of the current financial year, with expenditure analysed by run rate for normal operations, Covid-19 impact, winter and elective restoration. This will provide assurance that the planned levels of expenditure for the current financial year enable attainment of break-even financial performance.
    ii. Temporary workforce costs are exceeding planned levels and historic expenditure. A review of temporary workforce controls is to be undertaken for presentation to PFIC and further reviewed by the Trust's Internal Auditors, reporting findings through to the Audit Committee.
    iii. The delivery of financial efficiencies to improve run rate is key to ensuring future financial sustainability. Quantification of the efficiencies through the Improvement Programme are to be presented to PFIC, so as to assess the level of efficiency that can be delivered, supporting enhanced use of resources and financial sustainability.

iv. Externally commissioned expertise will facilitate the development of a Trust Estates strategy to support coherent stewardship of this key resource.

APPENDICES

1. BAF S06
2. Performance Report (Finance and Constitutional Standards)
3. Improvement Programme update

BAF Risk- S06
Risk Owner; Chief Operating Officer
Date of Review; 20th July 2020

Strategic Objective;

Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly

Risk Appetite;

Risk Appetite; The Trust is prepared to accept a moderate risk appetite on finance where necessary to reduce a negative impact on patient safety, patient experience and clinical effectiveness.

	Impact	Likehood	Score
Initial Risk Rating	**5**	**5**	**25 (Catastrophic)**
Current Risk Rating	**5**	**4**	**20 (Major)**
Target Risk Rating	**5**	**2**	**10 (Moderate**

Current risk rating based on level of risk associated with backlog Estate maintenance, medical equipment, and IT infrastructure capital requirements, in combination with a revenue financial position that has required FRF support and significant uncertainty in the planning environment.

Risk;

The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value.

If resources (financial, human, physical assets, and technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care.

Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving

Rationale for current score

<u>Evidence of risk control</u>

- Achievement of 19/20 financial plan.

<u>Evidence of risk gaps in control</u>

- The Trust experienced run rate risk for the 19/20 financial year that led to needing to re-forecast outturn during the financial year.
- High reliance on temporary workforce
- Lack of credible plan to address backlog maintenance requirements.

Future risks

- Likely move away from PbR towards block contracts.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in 20/21.
- Additional costs associated with safe non-elective and critical care during Covid-19, and planning for a potential second wave.
- Significant impact on elective and non-elective demand during Covid-19, leading to difficulty planning for the future with confidence.

quality of care, and constrains available capital to invest in Estate, Medical Equipment and Technological assets in turn leading to a less productive use of resources.	<u>Evidence of planning uncertainty</u> • The Trust has an Emergency Budget for April 2020 to July 2020, however formal guidance does not yet exist for arrangements for the full 20/21 financial year. • Financial improvement planning and delivery has been impacted by Covid-19.	• Insufficient Capital to enable investments in the Estate, equipment and technology that would in turn support more effective use of resources, and lead time for deployment of capital. • Planning guidance stipulation that receipt of FRF is 50% dependent on delivery of STP financial plan. • Adverse impact of Britain's exit from the European Union on business continuity and the Trust's financial position. • Supply costs are more volatile within the market based on supply and demand associated with Covid-19. • Workforce exhaustion and/or psychological impact from Covid-19 results in higher sickness rates and further reliance on temporary workforce.
Controls • Finance reported monthly via Divisional Performance Reviews and Executive Governance Structures • Performance, Finance & Investment Committee in place to gain assurance • Audit Committee in place to oversee and test the governance/financial controls • CIP Governance processes in place • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation) • Use of Resources workstream identified as part of the Improvement Programme • Revised financial governance in place for COVID-19	**Assurance** • Internal Audit reviews of a number of areas of financial and operational performance • External Audit Assurance of the Annual Accounts • Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • Model Hospital Use of Resources assessments	**Future Opportunities** • Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area. • Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners). • Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home). • Utilisation of national productivity benchmark information (e.g. GIRFT and Model Hospital) to target work through

		the Use of Resources Improvement Programme • Development of major capital upgrades (new Emergency Department) to support improved recruitment of staff. • Harnessing the teamwork and innovation so evident throughout the Covid-19 pandemic to develop service improvements that lead to improved use of resources. • Capitalising on the digital advancement during Covid-19 to harness technology to improve effective use of resources. • Rationalising Estate requirements through increased remote working. • Enhanced leadership capability through Well-led Improvement Programme workstream.
Gaps in Control • Business planning processes require strengthening • Accountability Framework has been approved, however needs review further to the NHSI Governance Review report • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident • Evidencing oversight of the controls in force to monitor and regulate temporary workforce – Implementation of Allocate progressing throughout the Trust (Medical and Nursing) and Internal Audit conducting a full review of controls in	**Gaps in Assurance** • NHSi Governance review highlighted areas of improvement for business process and accountability framework. • External Audit limited due to Covid-19 • NHSI review meetings urgently on hold • Internal Audit core financial controls not completed. • Absence of a financial plan	**Link to Corporate Risk Register** • Risk 208 – Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk score = 12) • Risk 274- Failure to resource backlog maintenance and medical equipment replacement costs results in the organisation being unable to deliver fundamental clinical services and care (Risk Score=20) • Risk 665 - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation. (Risk Score=15) • Risk 1005- The Trust has insufficient

force. • Leadership development needs at Care Group, Divisional and corporate support service levels.		resources available to ensure the essential maintenance of the Trust's Estate. (Risk Score=16) • Risk 1155 - Failure to demonstrate fire stopping certification for all areas of the Trust would breach fire safety regulation, risking public/ patient safety. (Risk Score=16) • Risk 2054 - Capital and cash availability to support existing infrastructure, equipment (medical and Information technology) service developments and innovation. (Risk Score =16) • Risk 2081- Operational expenditure incurred during the current financial year exceeds income allocations, which results in the Trust being unable to deliver a break even financial plan. (Risk Score =16) • Risk 2082-Failure to realise the benefits associated with the outcomes of the improvement programme work-streams, results in the Trust not delivering efficiencies required to attain agreed financial control targets, and deliver financial balance without central support, which therefore impacts on the Trusts ability to deliver financial and clinical sustainability. (Risk Score =16) • Risk 2188 (NEW) - A continued dependency on suboptimal legacy patient information infrastructure, will limit the flow of clinical information, reduce professional confidence and increase administrative burden for healthcare professionals, ultimately impacting on patient care and the ability to transform healthcare services. (Risk Score = 10)

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee – Highlight Page

Executive Lead: Director of Finance: Russell Caldicott / Non-Executive Director Lead and Chair of PFIC Committee: John Dunn

Key Areas of Success

- After significant deterioration in 4-hour Emergency Access standard performance in March, during the rapidly escalating first peak in Covid-19 demand in the Black Country, performance has improved during April, May, June and again in July, with 95.4% of patients being admitted or discharged within 4 hours. This is the first calendar month on record that this Constitutional standard has been met, and is a credit to the Emergency Department team, and to all services in the community and in the hospital who support patients along the emergency care pathway.
- Suspected Cancer 2 Week Wait (all tumour sites) met the constitutional standard for the fourth consecutive month. Although the Breast symptomatic 2 Week Wait (GP referral) standard was not delivered in June, the Trust expects to achieve it in July.
- In July, Diagnostics performance improved to 16.32% from 22.47%. Forecasting shows a continued improvement in the coming months. Despite cessation of most routine 6 Week Wait (DM01) Diagnostics during March and April, and the associated deterioration in waiting times, the Trust's national ranking position continues to perform very well, remaining 7th best in the country in June.
- Despite cessation of routine elective services during March and April, the Trust's 18-week RTT national ranking position continues to improve further to 23rd best in the country in June.
- The Trust submitted draft Annual Financial Statements that detailed achievement of a surplus for 2019/20.
- The Trust has achieved a break-even financial position for of the 2020/21 financial year. However, the Trust required additional funding of £8.3m to attain break-even for months 1-4. Additional funding requirements have increased during the financial year as funding is still required to meet the challenge of Covid 19 but also to support restoration and recovery.

Key Areas of Concern

- 18-week RTT and 6 Week Wait (DM01) Diagnostic performance has deteriorated significantly due to Covid-19 resulting in routine elective work (diagnostics, and elective surgery/procedures) being suspended in March and April. The need to maintain appropriate segregation and Infection Prevention and Control procedures to minimise the risk of in hospital transmission of Covid-19 will mean capacity for routine diagnostics and routine surgery/procedures will remain constrained for some time.
- The Trust is to receive a block allocation of income for the initial six months of 2020/21. If these funds are insufficient for the Trust to breakeven because of Covid 19 expenditure, there is a process to claim further income; the Trust will be using this process to attain break-even. The Trust has revised governance arrangements to manage Covid-19, but must remain vigilant on financial control to ensure appropriate expenditure and therefore receipt of the additional funds requested to maintain breakeven performance.
- The financial regime for the remaining calendar months of 2020/21 is yet to be confirmed, though is expected to reduce the level of income to be received on a monthly basis (further guidance on the income envelope and process for receipt from 1st October 2020 is to be received) this presents a risk at current run rate levels in attainment of break-even for the year (NHSI/E has requested workforce and activity forecasts for the remainder of 20/21 by 21 September 2020).
- Temporary workforce costs remain higher than the baseline period and will be a key focus for ensuring delivery of financial balance moving forwards.
- The Trust is servicing 75% of the elective activity seen last year (Emergency Department attendances 15% below historic levels) whilst costs remain high, as the Trust seeks to increase elective activity (as per national guidance) this will place risk to delivery of current performance and or achievement of break-even financial performance.

Key Actions Taken

- A report on controls for temporary workforce to ensure efficient use of temporary workforce and levels of capacity open is to be provided to members
- Financial run rate modelling to distinguish between costs normally incurred, Covid-19 measures and elective restoration and recovery is to be presented to members, with comparison to the levels of income expected (once known) to evidence delivery of the plan will enable attainment of break-even financial performance during 2020/21

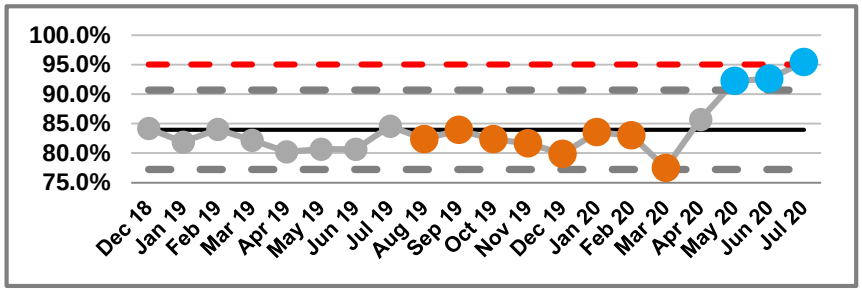
Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

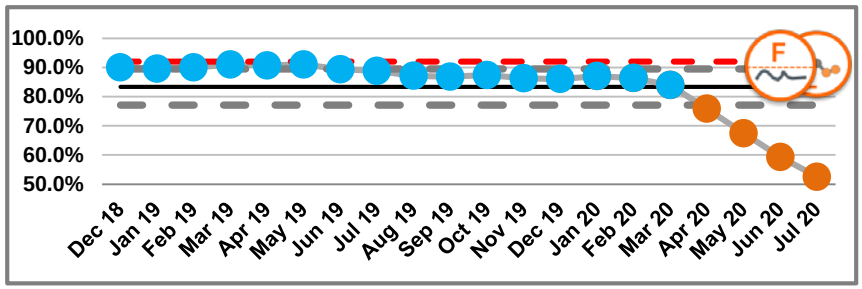
SPC Key

Mean | Process limits - 3σ | High or low point | Special cause - improvement | Special cause - concern | Target | Measure

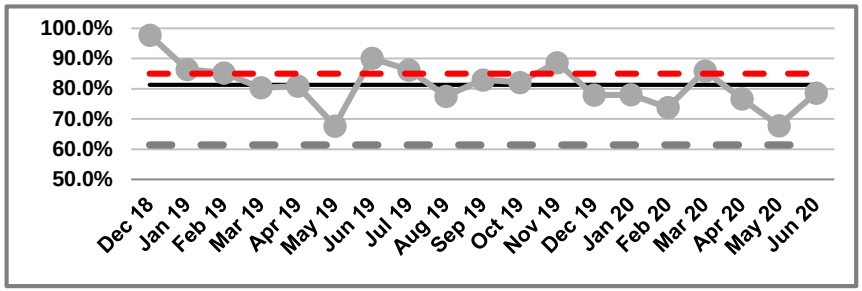
ED - % within 4 hours – Overall (Type 1 & 3)



18 weeks RTT – Incomplete Pathways



Cancer 62 Day RTT



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

Despite attendances increasing again in July, the Trust continued to improve its performance against the Emergency Access Standard to achieve 95.4% in July. July 2020 was the first calendar month in recorded history the Trust has achieved the Standard. This success is is a credit to the Emergency Department team, and to all services in the community and in the hospital who support patients along the emergency care pathway.

RTT

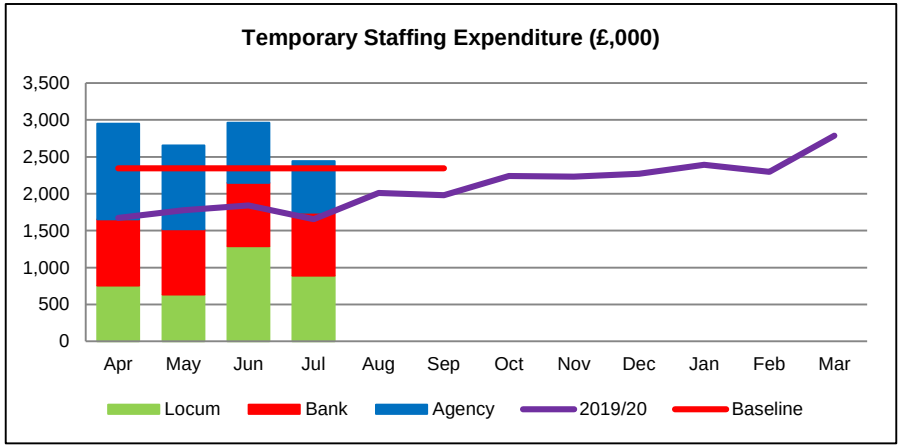
18 week RTT performance in July is 52.5%. MLTC performance has seen an improved position (To 74.6% in July from 69.8% in June). The Surgical specialties continue to deteriorate due to reduced elective inpatient activity and constraints experienced in head and neck services (services reliant on FTF activity to deliver definitive treatment). In July, there were 9 over 52> weeks incomplete breaches, all under division Surgery. Despite the deteriorated performance National ranking continues to improve to a position of 23rd.

Cancer

The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 78.6%. Surgical treatments continue to be carried out by Spire Little Aston using our own surgical Consultants. Chemotherapy continues to be administered. From 17.08.20 the Trust reopened a 4th elective operating theatre to increase capacity on site. However, some patients continue to decline offers of treatment which will impact on performance.

Financial Performance to July 2020 (Month 4)

	Plan YTD July £000s	YTD July Actual £000s	YTD Variance £000s
Income			
Clinical Contract Income	81,760	81,339	**(421)**
Additional Covid Top-up	0	8,264	**8,264**
Other Income (Education&Training)	2,384	2,541	**157**
Other Income (Other)	14,548	11,906	**(2,642)**
Subtotal Income	**98,692**	**104,050**	**5,358**
Pay Expenditure			
Substantive Salaries	(53,812)	(55,360)	**(1,548)**
Temporary Nursing	(4,820)	(5,315)	**(495)**
Temporary Medical	(3,672)	(4,420)	**(748)**
Temporary Other	(876)	(1,276)	**(400)**
Subtotal Pay Expenditure	**(63,180)**	**(66,371)**	**(3,191)**
Non Pay Expenditure			
Drugs	(6,316)	(5,465)	**851**
Clinical Supplies and Services	(6,100)	(4,674)	**1,426**
Non-Clinical Supplies and Services	(5,820)	(5,872)	**(52)**
Other Non Pay	(12,112)	(16,429)	**(4,317)**
Depreciation	(1,976)	(2,209)	**(233)**
Subtotal Non Pay Expenditure	**(32,324)**	**(34,648)**	**(2,324)**
Interest Payable	(3,188)	(3,089)	**99**
Subtotal Finance Costs	**(3,188)**	**(3,089)**	**99**
Total Surplus / (Deficit)	**0**	**(58)**	**(58)**
Donated Asset Adjustment		59	**59**
Adjusted Surplus / (Deficit)	**0**	**1**	**1**



Financial Performance

- The Trust reported a £8.3m (£3.2m in July) overspend versus block and top up funding from NHSIE. Per the guidance the Trust has assumed a further receipt of income totaling £8.3m to cover these overspends and is therefore reporting break-even performance
- The adverse variance of £2.6k on other income is driven largely by new guidelines for Covid-19 resulting in our not being able to charge the CCG for IT, Property Services and other services (£1.3m), the Trust has also lost income on car parking, R&D and accommodation charges (£1m)
- The Trust's substantive pay has increased in July to £14.5m due to the provision made for Clinical Excellence Award's, temporary workforce expenditure (whilst reducing from June to July) remains over baseline plan and historic levels
- Other non pay expenditure is higher, largely due to monthly support costs for the Electronic Patient Record being chargeable this year and costs associated with delays to go live, combined with Covid-19 related costs incurred

Capital

- The Trust has submitted a revised capital plan of £16.5m, though has subsequently received £4.1m for Urgent and Emergency Care (taking the program to £20.6m). Key will be the ability of the Trust to commit and spend the resource during the financial.
- The expenditure to date on capital totals £3.8m

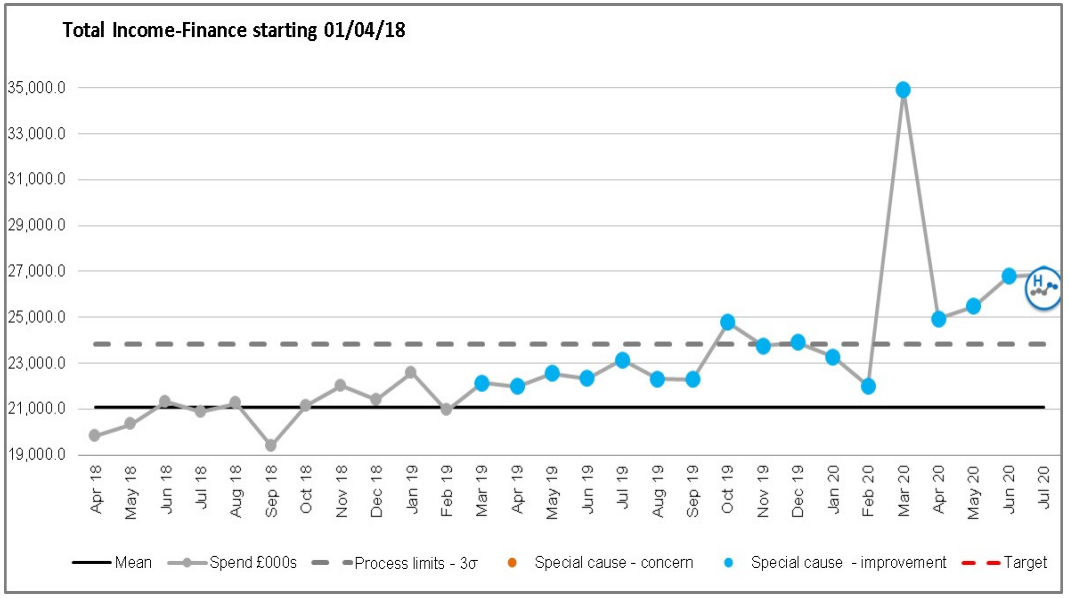
Cash

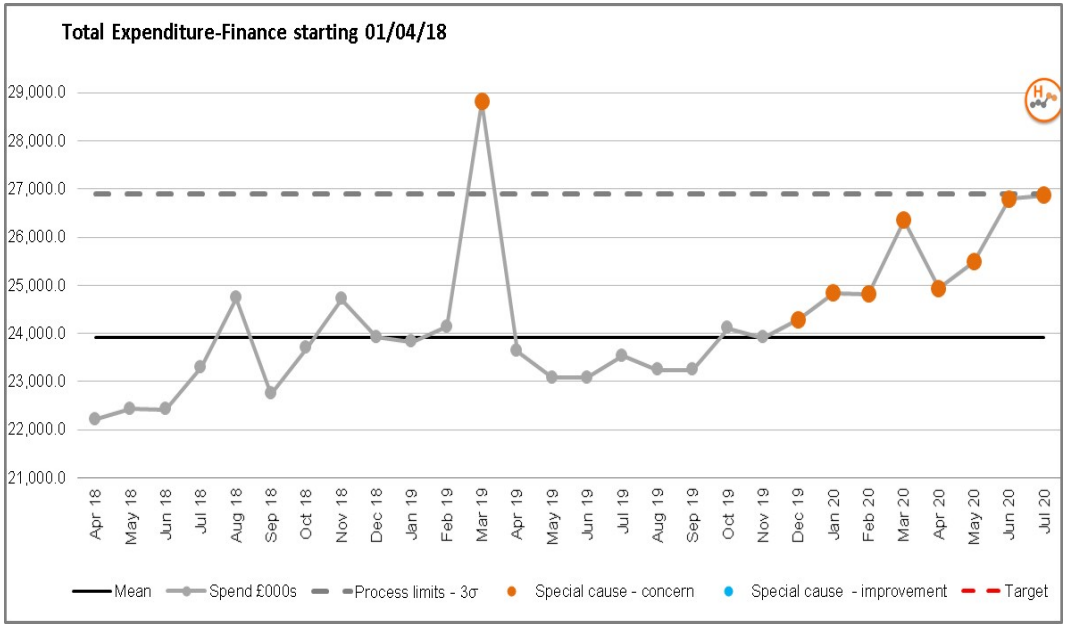
- Actual cash holding was £33.1m due to the contract payment being paid in month (was previously a month in arrears) in accordance with the emergency funding guidance from NHSIE

Efficiency attainment

- The emergency budget planning letter and guidance states there is no efficiency requirement for Months 1-4. However, development of Improvement Programme initiatives is key to ensuring financial sustainability moving forwards, with the outputs of this program to be reviewed by Performance, Finance and Investment Committee.

Income and expenditure run rate charts





Income additional information

- Income has continued to increase year on year, this reflects a level of tariff inflation and growth serviced through the Trust over this period.
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).

Expenditure additional information

- March 2019 the Trust accounted for the ICCU Impairment of £6.2m
- March 2020 costs increased to reflect the Maternity theatre impairment £1m & Covid-19 expenditure
- Throughout April and May 2020 costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base.

Summary

The Trust is reliant on top up funding to deliver break-even performance, with monthly run rate moving from £25m to £27m per calendar month. Costs will need to reduce should the current income envelope not be supported for the later half of the financial year if the Trust is to attain a balanced financial plan.

Cash Flow Statement & Statement of Financial Position (M4)

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending July 2020	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	3,030
Depreciation and Amortisation	2,209
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	10,791
Increase/(Decrease) in Trade and Other Payables	17,001
Increase/(Decrease) in Stock	(36)
Interest Paid	(2,784)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	30,211
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(5,011)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(5,011)**
Net Cash Inflow/(Outflow) before Financing	25,200
Cash Flows from Financing Activities	(1,197)
Net Increase/(Decrease) in Cash	**24,003**
Cash at the Beginning of the Year 2020/21	9,056
Cash at the End of the July	33,059

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending July 2020	Balance as at 31/03/20	Balance as at 31/07/20	Year to date Movement
	'£000	'£000	'£000
Total Non-Current Assets	**144,866**	**146,570**	**1,704**
Current Assets			
Receivables & pre-payments less than one Year	39,001	28,114	(10,887)
Cash (Citi and Other)	9,056	33,059	24,003
Inventories	2,620	2,656	36
Total Current Assets	50,677	63,829	13,152
Current Liabilities			
NHS & Trade Payables less than one year	(25,955)	(17,775)	8,180
Other Liabilities	(1,480)	(25,771)	(24,291)
Borrowings less than one year	(134,693)	(133,307)	1,386
Provisions less than one year	(437)	(437)	-
Total Current Liabilities	(162,565)	(177,290)	(14,725)
Net Current Assets less Liabilities	**(111,888)**	**(113,461)**	**(1,573)**
Non-current liabilities			
Borrowings greater than one year	(116,013)	(116,013)	-
Total Assets less Total Liabilities	(83,035)	(82,904)	131
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	68,300	68,489	189
Revaluation	14,832	14,832	-
Income and Expenditure	(166,167)	(166,167)	-
In Year Income & Expenditure	-	(58)	(58)
Total TAXPAYERS' EQUITY	(83,035)	(82,904)	131

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
%	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	83.00%	77.49%	85.73%	92.21%	92.62%	95.43%	92.17%	95.00%	81.77%	F	
%	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	66.13%	64.06%	63.33%	70.46%	75.04%	75.60%	71.43%	100.00%	62.10%	F	
No.	Ambulance Handover - No. of Handovers completed over 60mins	14	30	0	0	1	0	1	0	312	F	
%	Cancer - 2 week GP referral to 1st outpatient appointment	85.82%	95.78%	94.20%	95.84%	93.17%	93.16%	93.90%	93.00%	84.07%	?	L
%	Cancer - 62 day referral to treatment of all cancers	73.81%	85.90%	76.67%	67.80%	78.57%	67.39%	73.00%	85.00%	80.93%	P	H
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	86.35%	83.93%	75.82%	67.41%	59.32%	52.50%				F	L
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	0	1	1	8	9	19	0	0	?	
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	0.39%	2.43%	39.09%	36.99%	22.47%	16.32%	24.91%	1.00%	1.63%	?	
No.	No. of Open Contract Performance Notices	9	9	9	9	9	9		0		F	
CARE AT HOME												
%	ED Reattenders within 7 days	7.26%	7.55%	8.61%	8.84%	7.82%	8.45%	8.40%	7.00%	7.60%	?	
RESOURCES												
%	Outpatient DNA Rate (Hospital and Community)	9.51%	11.56%	11.33%	5.28%	5.11%	6.76%	6.75%	8.00%	10.44%	F	
%	Theatre Utilisation - Touch Time Utilisation (%)	85.88%	74.71%	36.47%	58.08%	47.06%	62.98%	54.76%	75.00%	85.42%	?	
%	Delayed transfers of care (one month in arrears)	3.95%	3.71%	2.54%	2.82%	2.23%		2.53%	2.50%	3.68%	?	
No.	Average Number of Medically Fit Patients (Mon&Thurs)	84	73	53	36	37	39					
No.	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	8.00	9.00	5.00	4.00	4.00	3.00					
£	Surplus or Deficit (year to date) (000's)	-7	-333	0	0	0						

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
£	Variance from plan (year to date) (000's)	-7	-613	0	0	0						
£	CIP Plan (YTD) (000s)	8900	8500									
£	CIP Delivery (YTD) (000s)	7500	8500									
£	Temporary Workforce Plan (YTD) (000s)	18600	20300	2300	4700	7000						
£	Temporary Workforce Delivery (YTD) (000s)	22400	25200	2900	5600	8600						
£	Capital Spend Plan (YTD) (000s)	6500	8200									
£	Capital Spend Delivery (YTD) (000s)	5300	11500		1300	3000						

Effective use of Resources Development and Mobilisation Status

Exec Leads: Ned Hobbs
WHT Improvement Leads: Malcolm Roper Moore / Jane Hayman

#FromNowOn
NHS
Walsall Healthcare NHS Trust

Caring for Walsall together

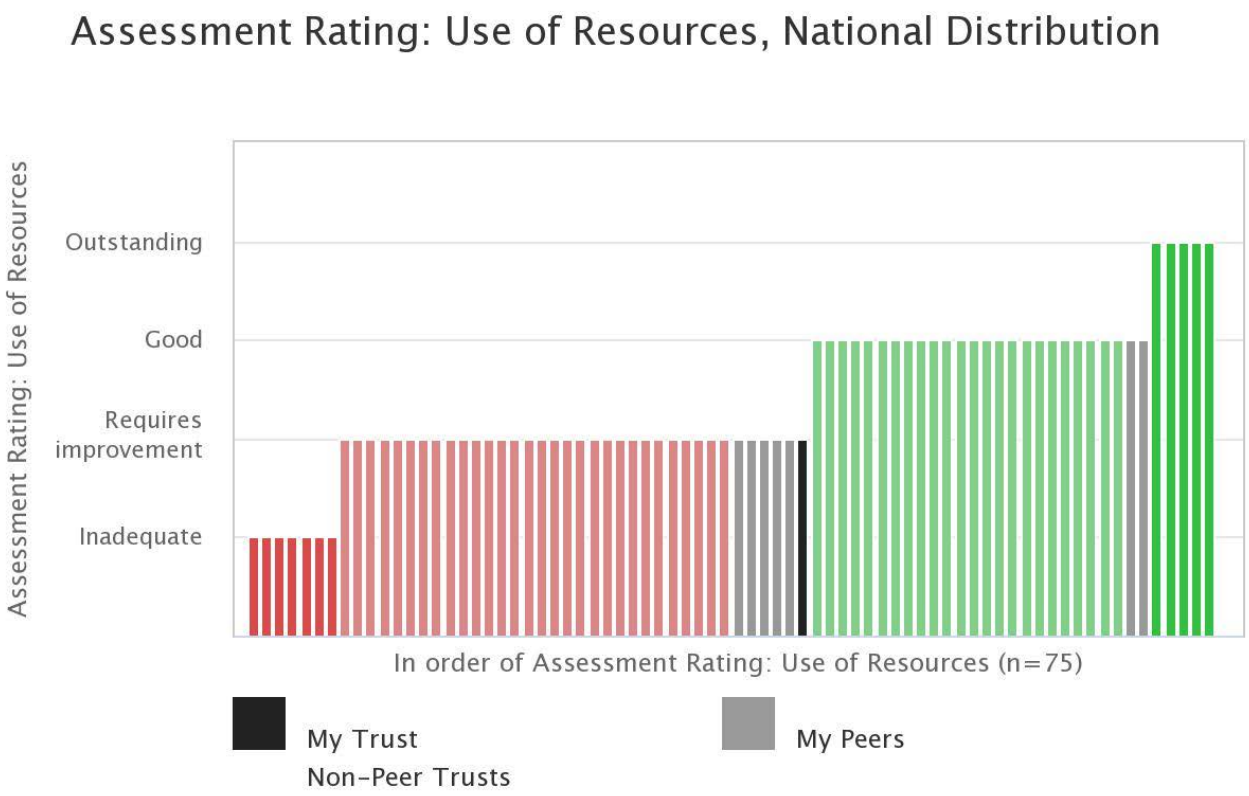
Safe, high quality care
Care at home
Partners
Value colleagues
Resources
Respect
Compassion
Professionalism
Teamwork

Defining our view of Outstanding

We lay out below our view of 'Outstanding' in relation the scope of this workstream:

- **Estates and Facilities:** delivering high quality, efficient estates and facilities services enabling our organisation to achieve its objectives and to continuously improve its performance
- **Operational Productivity (Clinical):** reducing clinical variation to deliver improved clinical outcomes, productivity and financial efficiencies
- **Resource Management:** ensuring that utilisation of our staff (our most crucial resource) is planned and deployed in the most efficient and effective way
- **Wider Carter efficiencies:** driving the adoption of Service Line Reporting & Management to identify and address unwarranted spend and spend variation to ensure optimal use of the NHS pound.
- **Digital Transformation:** the Digital workstream aims to deliver simple, secure, interconnected systems and tools that save time and effort, improving our ability to deliver excellent patient care in the most efficient and effective way.

Current Model Hospital Position (July 2020)



NHS Improvement's assessment looks at how efficiently the trust manages things like:

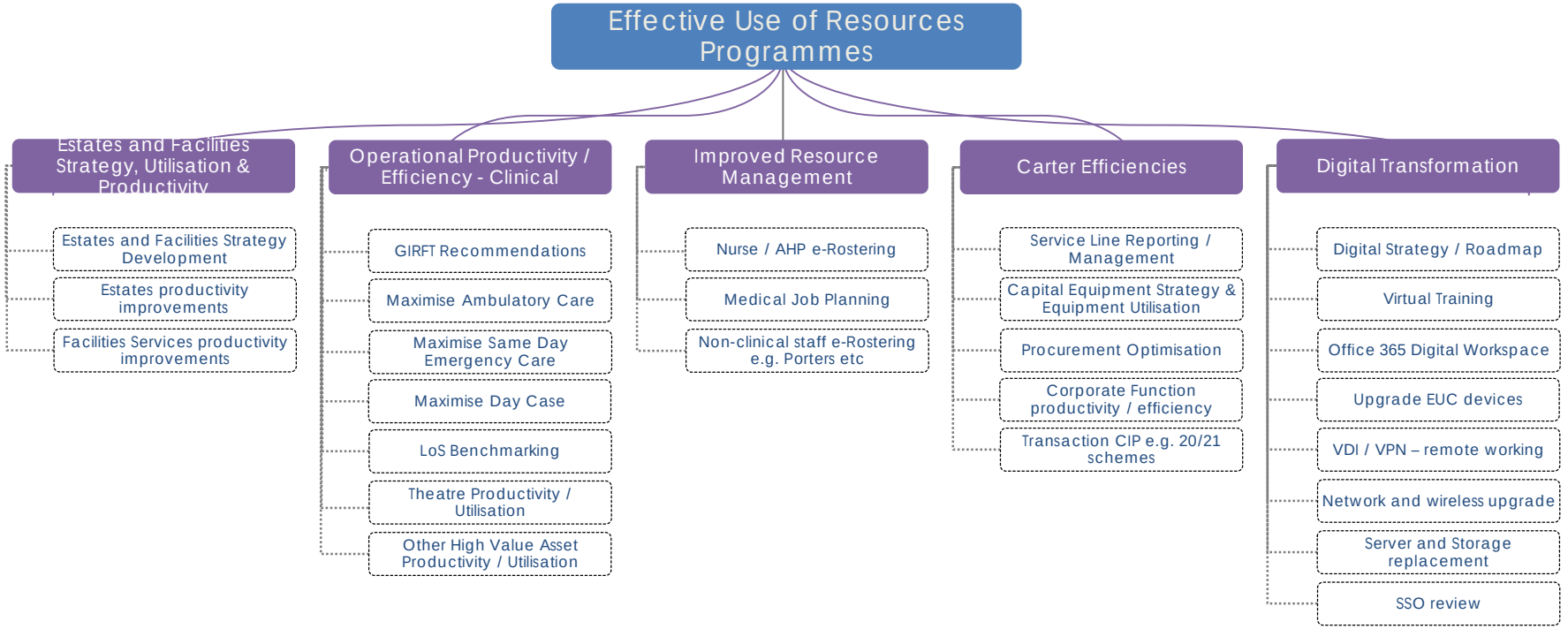
- workforce
- estates and facilities
- technology
- how it buys goods and services
- Finances

Hence the portfolio proposed forming the structure of this workstream

For further details: https://improvement.nhs.uk/resources/use-resources-assessment-framework/

Work Breakdown Structure

The following diagram represents the full current scope of work proposed for delivery through this workstream:



Note: Outpatients Transformation being delivered through the Care at Home workstream due to WT links

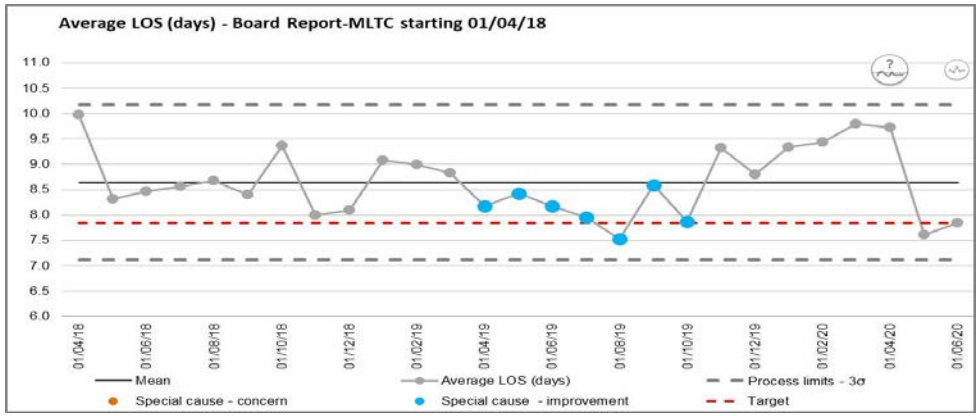
Effective use of Resources - Estates – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Jane Longden	**Core Team:**	.TBC
Progress to date:	• Progressing engagement of external support to develop Estates and Facilities strategy • MyPorter portering deployment system introduced. • Strategy for remote working considered by Space Utilisation Group and Executive team – to be formalised in conjunction with the Valuing Colleagues workstream	**To be completed:**	• Conclude engagement of external resource and develop PID for work proposed
Dependencies:	Any estates strategy being produced will need to assess impacts of: • Trust decisions on long term strategy for remote working • Medium to Long Term service reconfiguration post-Covid (both internal to WHT and wider BC collaboration) • Dependency with Resource Management i.e. staff rostering	**Risks / Issues / Support Required:**	• **Risk:** Post-Covid effects on Estates strategy not fully quantifiable at this point • **Issue:** Team continue to be stretched supporting Phase 2 and Phase 3 Restoration and Recovery Plan implementation, limiting capacity to support this work • **Support Required:** External support on Strategy development, and Programme Manager for Facilities and Sustainability workstream
Overall Status:	Red	**IP Board Comments:**	• Securing expertise for development of Estates Strategy is essential. • Prioritise newly appointed Programme Manager for eUoR towards the Estates workstream.

Effective use of Resources – MLTC – Operational Productivity update – August 20 IP Board / PFIC

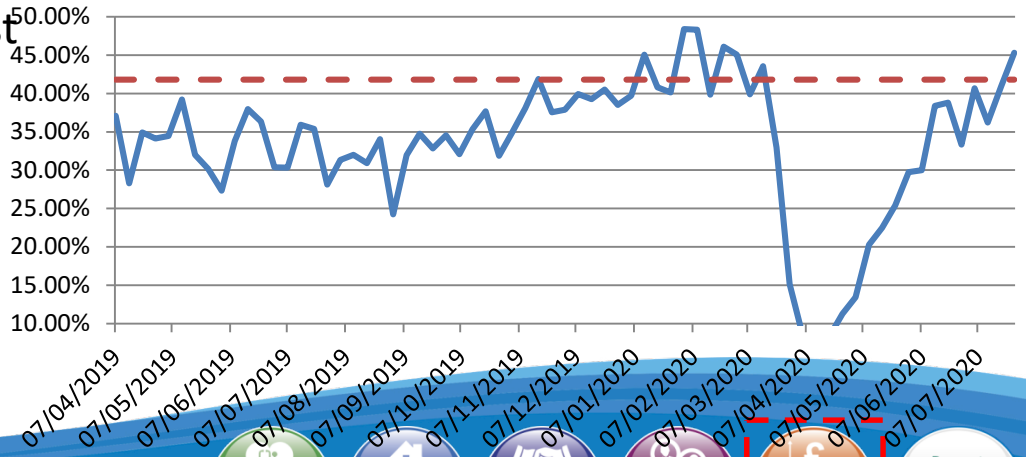
Lead(s):	Kate Salmon, Dr Nuhu Usman	**Core Team:**	Rob Ankcorn, Care Group Managers
Progress to date:	• Financial modelling based on LoS and SDEC improvements calculated. (£1.2m) • ToT meeting with Dr Abdalla and QI Academy on 17th July to establish two more Improvement Huddles on Wards 1 & 2. There are expected gains to LoS. • Weekly LoS and Discharges report has been requested to P&I that accounts for transfers to MFFD Ward. This will allow the Division to proactively manage LoS by ward. • Neurology hot clinics have been set up to help support SDEC. • Dermatology have specified a hot clinic pathway.	**To be completed:**	• Consolidate medical wards to use staff more efficiently. • Implement new Hot Clinic capacity in Gastroenterology and Dermatology. • Deep dive into First Seizure in Known Epileptic and Diabetes non SDEC patients. • Business Case for Neurology CNS
Dependencies:	• Performance and Information (for the further refining of reports) • Human Resources (for the recruitment into AEC post business case)	**Risks / Issues / Support Required:**	• **Risk:** Diverting clinic capacity from elective to SDEC makes reducing elective waiting times more difficult. • **Issue:** Non • **Support Required:** None
Overall Status:	Green	**IP Board Comments:**	• MLTC and Adult Community Division to work with P&I to clearly delineate LoS gains associated with acute hospital pathway improvements, and LoS gains associated with reduced MSFD.

Effective use of Resources – MLTC – Operational Productivity update – August 20 IP Board / PFIC



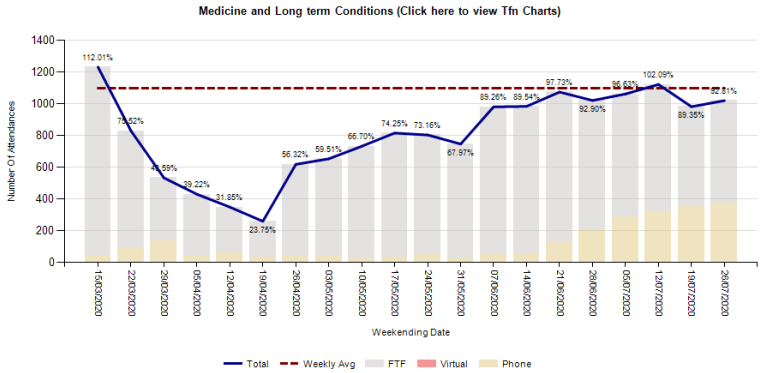
- The Division has met the LoS target of 7.8 days for the last 2 months.
- In January the MLTC Division had 20 patients over 50 days and 4 over 100 days.
- In July (29th) the MLTC Division has only 1 patient over 50 days.

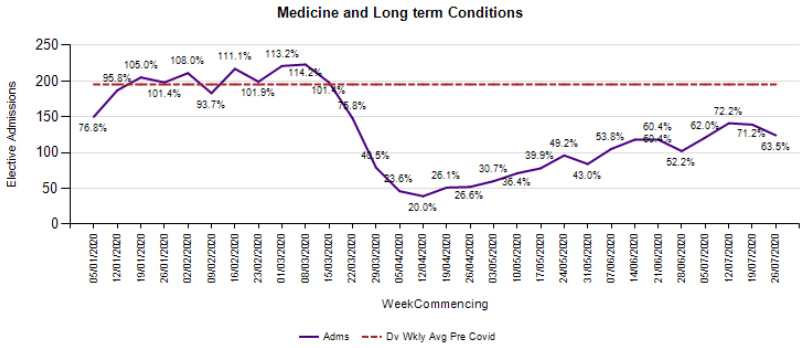
- Week Ending 26th July marks the first week the SDEC target of 41.8% has been met since Covid restoration.
- The SDEC Improvement Group is guiding the work stream around completing this.



Effective use of Resources – MLTC – Operational Productivity update – August 20 IP Board / PFIC

- The MLTC Division has restored the most Outpatient and Procedures in Walsall Healthcare NHS.





Effective use of Resources – MLTC – 20/21 CIP update – August 20 IP Board

Lead(s):	Rabeena Narwain, Sarah Haywood	**Core Team:**	Stephen Murray, Tracy Crutchley, Anna Harding
Progress to date:	A review of all the CIP plans approved during Gateway sessions for 2020/21 has been conducted by the divisional team to ascertain their financial delivery. Summary of the review outlined below: - £188,248 worth of CIP plans will deliver - £289,023 worth of CIP plans have the potential to deliver and dependant on continuous operational efficiency i.e. 2nd wave of COVID-19 could have an adverse effect. - £354,729 worth of CIP plans are rated as RED mainly because of their dependency on the terms of new contract with CCG	**To be completed:**	• The division is currently working on 14 improvement plans which have the potential to deliver over £1.2 mil of financial savings (most of which is attributed to SDEC and LoS programs) • The plans have been shared with the DBA and are being assessed for potential financial efficiency.
Dependencies:	• Workforce planning • Partnership working with Modality • STP funding approval	**Risks / Issues / Support Required:**	• **Risk:** .2nd surge of COVID-19 • **Issue:** .none • **Support Required:** .none
Overall Status:	Amber	**IP Board Comments:**	

Effective use of Resources – Surgery – Operational Productivity update – August 20 IP Board / PFIC

Lead(s):	[Insert Core Team Lead for this work]	**Core Team:**	[Insert additional team members]
Progress to date:	• Daycase procedures identified as area of focus to maximise day case rates • Continued monitoring of impact of 2nd Registrar on SACU, via SDEC charts • Top common emergency pathways identified, developed and signed off by CD • 4th all day elective theatre commenced • Areas of opportunity identified to support SDEC • Actions to support reduced LOS for #NOF pts and emergency colorectal pts commenced	**To be completed:**	• High level programme plan developed • 14 improvement projects to date • 14 project briefs completed, of which:- • 11 project implementation plans in development • 3 projects implemented
Dependencies:	• Community Services to support LOS reduction, particularly T&O in terms of physiotherapy input post discharge, links into Care at Home Workstream	**Risks / Issues / Support Required:**	• **Risk:** .Delays would be incurred if there was a 2nd covid surge • **Issue:** Limited capacity within Divisional Management Team to drive projects at the required pace. • **Support Required:** .None. PMO support consistent and sufficient.
Overall Status:	Green	**IP Board Comments:**	• Recognise that Divisional Leadership team is newly forming, with commencement of substantive Director Of Operations Aug 2020.

Effective use of Resources – Surgery – Operational Productivity update – August 20 IP Board / PFIC

- **Maximising Day Cases**
  - Clinical Lead has commenced workshops with Clinical Directors, Clinical Leads. Areas of opportunity have been presented following benchmarking exercise. Procedures have been identified across the majority of specialties (ENT, GS, T&O, Urology)
  - Changes in breast pathway from 29.6.20, to support early discharge, will be audited during August to monitor patient outcomes, to ensure expected benefits in terms of reduced overnight stays are realised.

- **Same Day Emergency Care**
  - Weekly monitoring via SDEC charts, on impact of 2nd Registrar allocated to SACU along with the provision of an additional assessment room to support timely triage/assessment and treatment plan.
  - Top common emergency pathways (Biliary colic, R Upper Quadrant Pain, RIF Pain, LIF Pain, Abscess, Obstructive Jaundice +/- Sepsis), implemented from July 20.
  - Ambulatory Care Directory review complete for surgical conditions. SDEC/LOS targets identified, potential to improve this further with support from J&J. Care Group Managers to undertake patient level audit for 5 conditions with greatest opportunity to determine reasons for not achieving same day discharge.
  - Further work is required to quantify benefits associated with SDEC.

Effective use of Resources – Surgery – Operational Productivity update – August 20 IP Board / PFIC

- **Theatre Productivity/Utilisation**
  - Elective theatre sessions increased to 3 all day session (Mon-Fri) from 20th July, with an increase to a 4th all day list planned for w/c 17.8.20. The table below outlines the current theatre list sessions per week compared to pre-covid levels:-

Elective - Theatre Activity Covid vs Pre-Covid		
Site	Period	Average sessions per week
Walsall	Pre-Covid	75
Walsall	Covid	38
LAH	Covid	12
Pelsall Village	Covid	4

  - We are currently utilising 50% of theatres compared to pre-covid levels. This will increase to approx. 65% on introduction of a 4th theatre list per day during August. Plans for 5th, 6th and 7th elective operating theatres by October 2020.
  - To further improve productivity, LA vascular cases will be undertaken in an OPD setting.
  - Currently exploring potential to relocate LA injections out of theatre for Pain, T&O and General Surgery

- **Minimising inpatient LOS**
  - T&O workshop 29.6.20 to support reduced LOS for #NOF pts with additional community and acute therapies support. Set of actions agreed (acute and community divisions represented). Pilot from 1st August.
  - Discussions with Elderly Care Consultant to provide support to elderly laparotomy patients to support reduced LOS resulting in better patient outcomes. Resource requirements identified and sourced from existing medical budgets. Implementation date tbc.

Effective use of Resources – Surgery – 20/21 CIP update – August 20 IP Board / PFIC

Lead(s):	Will Roberts, Director of Operations	**Core Team:**	[Insert additional team members]
Progress to date:	• £1.3m shortfall against pre-Covid £2.64m target. Schemes identified £1.35m. • Re-modelling of J&J Care Advantage Package benefits commenced, to align to reduced activity as a result of Covid 19. • Weekly Divisional Improvement meetings set up from w/c 31.8, to include senior management team representation to drive/monitor existing schemes and develop new schemes to mitigate shortfall.	**To be completed:**	• Quantify savings following remodelling of J&J Care Advantage Package • Review current run rate
Dependencies:	• .	**Risks / Issues / Support Required:**	• **Risk:** will not deliver full £2.6m target Aug-Mar21 • **Issue:** . • **Support Required:** .PMO/Finance to support identification of potential schemes, particularly in Procurement domain.
Overall Status:	Amber	**IP Board Comments:**	

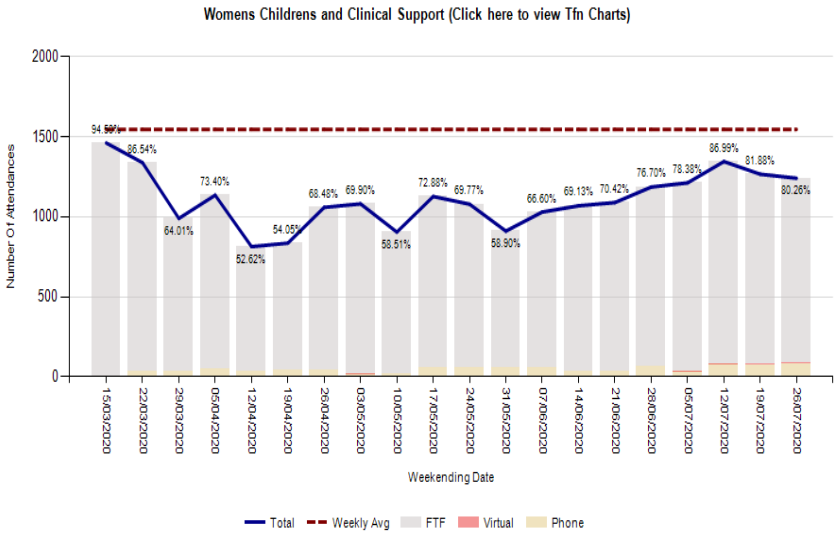
Effective use of Resources – WCCSS – Operational Productivity update – August 20 IP Board

Lead(s):	Louise Holland, Delreita Ohai	**Core Team:**	
Progress to date:	• Elective Inpatient activity has increased from 45% to 63% during July • Elective paediatric capacity recovered in full. • Outpatient capacity has increased from 70% to 82% of pre-covid levels in July. • CMU recovery plans developed, service delivering ahead of plan. • Divisional RTT for July was 77%. • MRI & CT back to capacity and backlog cleared. • External bank developed to support clearance of Ultrasound backlog. • DM01 at 7th best in country for June 2020.	**To be completed:**	• Develop Core Team • Agree and prioritise divisional plans • PIDs in process • Quantify benefits of first phase plans • Case to be submitted to increase capacity using internal & external bank. • Implement Advice & Guidance
Dependencies:	• Access to Community locations • Human Resources to support workforce challenges moving forward. • Close working Cross-Divisionally • Closer working with Walsall Together	**Risks / Issues / Support Required:**	• **Risk:** Theatre capacity to support recovery of Gynae inpatient capacity. Continued access to additional OP rooms for CMU. • Continued funding to support clearance of backlog and increases in demand. • **Issue:** None • **Support Required:** to be confirmed
Overall Status:	amber	**IP Board Comments:**	

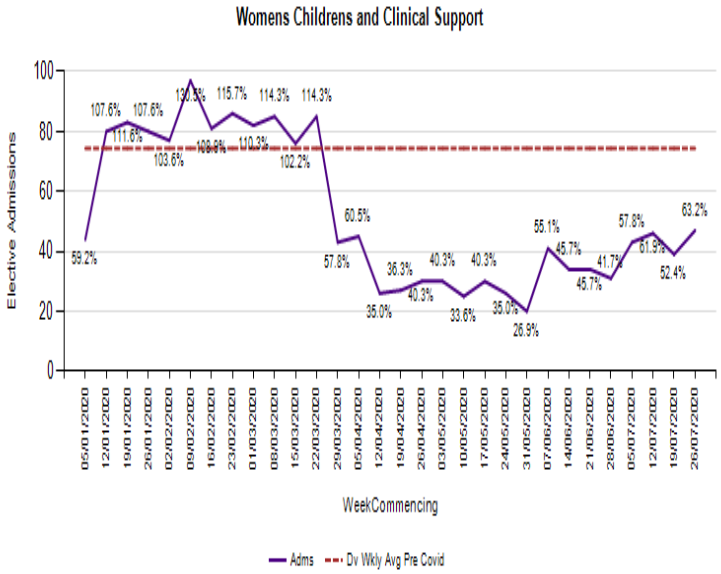
Effective use of Resources – WCCSS – Operational Productivity update – August 20 IP Board

There has been significant improvement in capacity across both inpatient and outpatients, however this has levelled off more recently for outpatients.

Outpatient Capacity

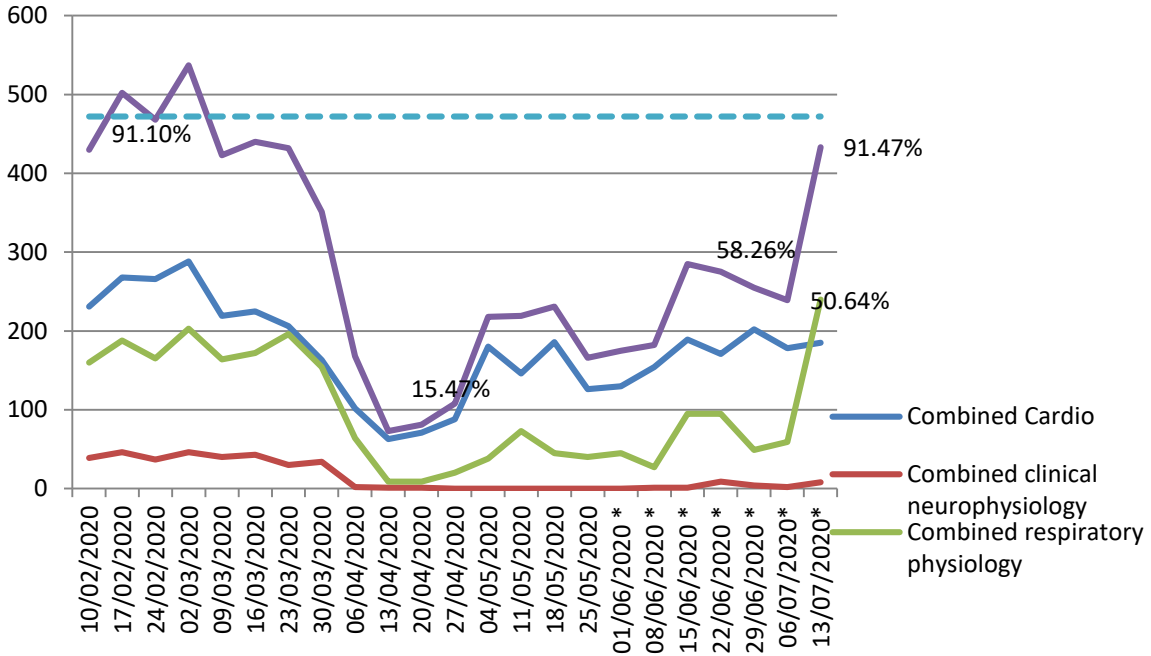


Procedural Capacity



Effective Use of Resources- WCCSS Operational Productivity Update – August 20

CMU Outpatient Activity Restoration



Activity week on week:
Pre – Covid19
During Covid19
Post – Covid19

* Indicates Data tracked from CRIS ('Go Live date 01/06/2020)

Effective use of Resources – WCCSS – Operational Productivity update – August 20 IP Board

Minimising inpatient LOS

Divisional Care groups/Services were tasked with focussing on options to reduce LOS proposed projects include:

Paediatrics

- Paediatric Elective pre-op – Project group established working with Theatres.

Maternity

- Implementation of outpatient Induction of labour of low risk pregnancies – This is the to provide Dilapan in the OPD setting for the low risk woman for IOL which will reduce LOS by 1 day per case.
- Actim Prom for patients who have SROM but no liquor – Actim Prom could be provided which would reduce the need for admission (reduction of 1 day).
- Placental immune growth factor (PIGF) test – Reduction in the need for admission for Query Pre-eclampsia with an average LOS of 2-3 days

Gynaecology:

- Use of Intrauterine Manipulator within Gynaecology surgery: reduce the need to perform Laparotomy surgery as majority of the manipulator will support with Laparoscopy surgery for out of hours emergencies such as Ectopics, Ovarian cysts etc. Reduction of LOS by 1 day.

Effective use of Resources – WCCSS – Operational Productivity update – August 20 IP Board

Theatre Productivity/Utilisation: Gynaecology: this chart includes Little, Aston, WHT and TOPs activity

- Theatre activity in June was 4 sessions per week compared to 10 pre-covid. From 6th July this increased to 6 sessions and from 20th July capacity increased further to 8 sessions.
- Due to PPE guidance consultants are now required to undertake a full day session which will only include 3 cases maximum (6 cases per session pre-covid)
- Each week there will be a slight fluctuation in activity for TOPs admissions as they are not guaranteed per week and in session has been reduced capacity from 7 to capacity of 5 due to donning and doffing for PPE and IPC re theatres.
- The Division continue to work closely with Theatres to review utilisation of theatres.

Maximising Daycases

- Vaginal hysterectomy and laparascopic hysterectomy as day case – looking at other trusts currently performing this for peer review. Potential to reduce LOS by 1 day

Effective use of Resources – WCCSS – #FromNowOn – August 20 IP Board

- Increased working in the Community: CSS Phlebotomy based at Hollybank House, Gynae working with Health Harmony
- Use of technology to develop efficiency of our services: Use of electronic handover board in deliver suite, development of home working / reporting for Consultant Radiologists, development of CMU CRIS / ICE system for requesting / reporting
- Pathway development: Advice and guidance referral pathway for Clinical Haematology, reduction in inappropriate Imaging referrals from GP's / MSK pathway, further improve turnaround times for inpatient imaging with target of 12 hours referral to report.
- New ways of working: NIPE triangles implemented, resulting in zero incidents of baby's not having NIPE check undertaken at the appropriate time.
- Improved comms with GPs: Imaging letter outlining guidelines for referral of patients for Phase 3
- Service Improvement days across care groups; Paeds held 08.06.20
- Development of Pharmacy service in the DTC
- Imaging Reduction in DNA rates – develop choose and book for appropriate modalities

Effective use of Resources – Resource Mgmt – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Charlotte Hill / Gaynor Farmer	**Core Team:**	Divisions / Care Groups / Functions
Progress to date:	• **Medical Job Planning –** original Job Planning exercise completed in February 20 • **Nurse / AHP e-Rostering –** Allocate roll out halted mid March – 75% complete (29/44). Support received for Covid related spend (£44k) to renew RosterPro licence. • **Non-clinical staff e-Rostering e.g. Porters etc –** Corporate Senior Nurse has liaised with Estates and Facilities team to review options, inclusion with Allocate is not advised (expensive) without reviewing potential of other products available.	**To be completed:**	• **Medical Job Planning –** groups are reviewing and updating job plans currently, with the intention to sign and lock them all down by 14/8, enabling the subsequent rebuild of Allocate • **Nurse / AHP e-Rostering –** Reassess Allocate benefits case. Training recommences September 2020 on a 10-month basis to ensure we are not using RosterPro by end Aug 2021. • **Non-clinical staff e-Rostering e.g. Porters etc –** Erika Blunt and Gaynor Farmer have seen a demonstration of capability of Microsoft Teams offering. Erika is happy to proceed with a trial of this- no costs associated.
Dependencies:	• STP Bank Collaboration Programme • Job Planning Actions to be picked up as part of Phase 3 Recovery Planning with Divisions • Functionality of Microsoft Teams software to support facilities is to be evaluated fully with practical application being tested by the facilities team.	**Risks / Issues / Support Required:**	• **Risk:** Original Allocate Rostering Benefits Case unlikely to be realised – reassessment required - still not identified PMO support for this task. • **Support Required:** PMO support required for benefits realization from Allocate
Overall Status:	Green	**IP Board Comments:**	

Effective use of Resources - Carter – Workstream Development update – August 20 IP Board / PFIC

Dan Mortiboys	**Core Team:**	TBC
Significant progress on key actions within this element of workstream despite the effect of Covid: • **Procurement –** It is anticipated that a decision will be made whether to work with the BCA or UHNM in the first week of August and is with CEO. A revised procurement plan for 20/21 will be finalised by 14 August. Plans for 21/22 are underway but will be heavily influenced by choice of procurement partner. A 1st draft is aimed for by 25 September. There is a current effort to drive down the number of waivers. The concern is that opportunities are being missed by improper process. • **20/21 CIP –** There remains uncertainty on national funding arrangements at the time of writing and this would impact the approach to CIP. The procurement plan for 20/21 will include levels of some tactical level CIP. An £80k savings on mobile phones is already planned. The focus will be different this year as lower levels of activity reduce the total quantum of savings attainable in year. • **SLR / SLM –** A template has been designed to present information in which will be more user friendly based on feedback. This will now be rolled out. The vacancy within the team is to be recruited which will increase capacity to work on SLR (from 1 WTE to 2 WTE, 100% increase). This will accelerate the pace of development • **Corporate Function –** Information has been generated comparing back office functions to Model Hospital data. This identified worthwhile opportunities. However, the data is going to be presented to each Executive lead first to ensure there is acceptance before this is presented elsewhere. We are trialling with the Director of Finance. Meetings will be arranged with Directors of Governance, HE and Integration (IT).	**To be completed:**	• **Procurement –** A decision on future partnerships will be made by CEO early August. • **Procurement –** A plan for 20/21 will be finalised by 14 August and 1st draft on 21/22 by 25 September (while a partner is determined). • **Corporate Function –** Analysis of back office will be shared with Execs before presentation elsewhere • **20/21 CIP** - PMO department to continue to develop savings opportunities where possible and rebrand. • **SLR/SLM** - Rollout of SLR/SLM/PLICS data
Dependencies: • National/Corporate decisions on CIP delivery in 20/21 beyond current 4 month freeze • Uncertainty on National funding arrangements for 20/21 and 21/22 • Maturity of other workstreams to remove reliance in traditional non-recurrent CIP • Decision of procurement partner and potential TUPE or SLA development • Accuracy of model hospital data • Availability of key stakeholders	**Risks / Issues / Support Required:**	• **Risk**: Unknown funding agenda from 1 September and potential drain on resource • **Risk:** Unknown national CIP agenda • **Issue:** Resource to deliver costing remains an issue but should be resolved through recruitment
Amber	**IP Board Comments:**	• Capital Plan on TMB agenda for 25/8/20.

Effective use of Resources – Medical Equipment – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Michael Koushi	**Core Team:**	TBC
Progress to date:	• No progress on capital equipment strategy to date beyond the purchase of additional equipment as part of the Trusts Covid Response • Original intent was around wider capital replacement programme development and introduction of a new asset management solution to improve equipment lifecycle management and asset monitoring and utilisation	**To be completed:**	• Trust to confirm Equipment Replacement position in order to move this aspect of programme forward
Dependencies:	• Walsall Together Digital Strategy • Service model changes from Safe, High Quality Care and Clinical Operational Productivity element of EUoR	**Risks / Issues / Support Required:**	• **Risk:** Resource availability and capital programme funds • **Issue:** none • **Support Required:** Corporate strategy to be agreed on Medical Equipment replacement programme
Overall Status:	Red	**IP Board Comments:**	• Capital plan (including Medical Equipment) on TMB agenda 25/8/20

Effective use of Resources - Digital – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Digital Portfolio Heads	**Core Team:**	Digital Team + TBC
Progress to date:	• Engaged with NHS X and D to secure national discounts for O365 licences to sustain use post COVID pandemic. • PID development in progress, benefits requires more work • New project plan for hardware upgrades and rollout of EUC being created • Windows 10 rollout program to recommence, deadline extended to Dec 2020 by NHS D • Mandatory training utilising O365 now in progress • New VPN solution Fotingate in place, still a few remaining staff to be migrated from old Cisco solution • Ownership of network and telephony infrastructure transferred to Digital Services in April • Project plan for replacement of Switches and Telephony being created for sharing with Div Boards etc	**To be completed:**	• WHT Digital Strategy to be signed off internally, priority matrix completed to be ratified • Further actions tbc dependent on the strategy above • Network, Telephony and Wifi infrastructure replacement Project plan being created • SAN migration almost completed • Server migration started, Server OS upgrades to be scheduled • Setup of Digital Transformation board to support prioritisation and accountability • Closer links to ToT meetings and Div boards to discuss Digital Services items – First Div board WCSS attended • DAP funding now approved – Priorities agreed, project plans to be created
Dependencies:	• Walsall Together Digital Strategy • Service model changes from Safe, High Quality Care and Operational Productivity element of EUoR • Service changes due to OP re-design or Elective Recovery requirements	**Risks / Issues / Support Required:**	• **Risk:** Post Covid and wider Transformation proposals will have an effect on timing of the digital programme • DAP funding now approved DAP – require release of budget • Recurrent capital funding for device lifecyling • Competing resource requirements for programme and operational duties • Timeliness of the information provided to us • **Issue:** none • **Support Required:** Organisational prioritization
Overall Status:	Green	**IP Board Comments:**	

Robust Infrastructure

- Managed service and move to Cloud technology reducing cost of ownership, increased expertise and resilience
- Meeting users needs with technology platform
- Role based access to systems and technology
- Changes the way staff interact with patients and technology.
- Role based technology (tablet & hand-held) for each role
- Single sign-on
- Responds to user requirements of being mobile and responsive.

Digital Programme

Robust Infrastructure

Implementation

Investigation / Initiation / Future

Closure

Improvement

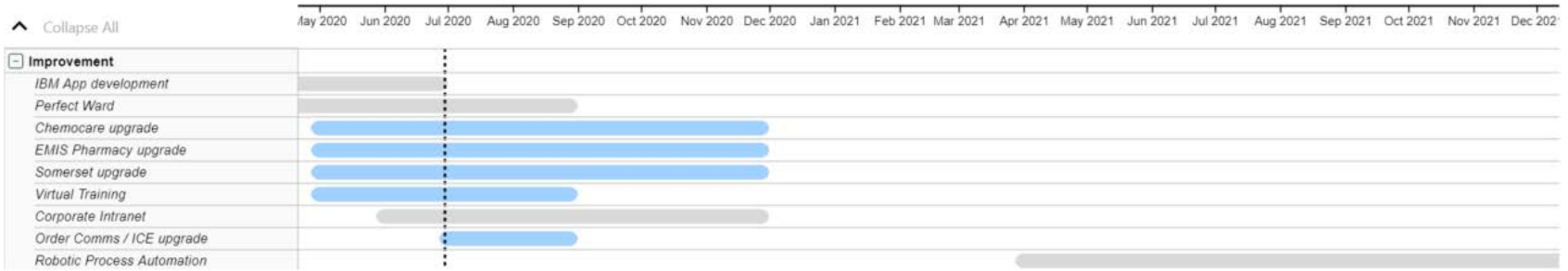
- Upgrading and enhancing existing business processes and systems
  - Clinical Teams App (IBM App development)
  - Pharmacy (EMIS Ascribe upgrade)
  - Chemotherapy (Chemocare upgrade)
  - Cancer Services (Somerset upgrade)
  - Order Comms (ICE upgrade)
  - New Corporate Intranet
  - Data Quality and Business Process Improvement through Robotic Process Automation
  - Perfect Ward
  - Move to Virtual Training from Classroom based model

Electronic Document Management & Transfer of Care

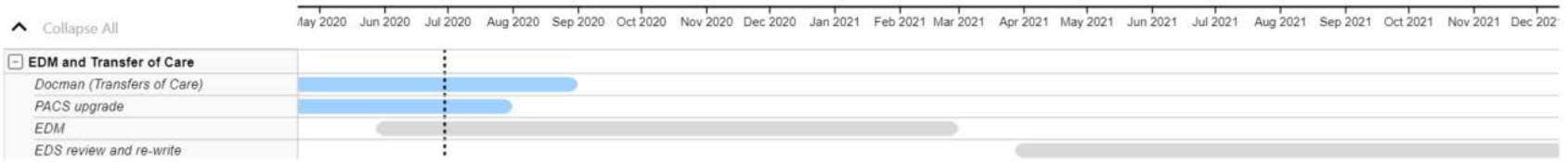
- Enterprise advanced Order Communications and Results
- More to a consolidated and integrated imaging sharing across the trust and partners (including PACS upgrade)
- Electronic Document Repository and Scanning Capacities across the trust
  - Loose leaf filling scanned
  - External correspondence scanned
  - Health records digitised
- Transfer of Care capability to message information between organisations and partners (including APIs and FHIR standards)

Digital Programme

Improvement



EDM and Transfer of Care



Implementation

Investigation / Initiation / Future

Closure

Patient Flow

- Manage site live anywhere
- Improve patient flow and reduce the reliability on telephones and spreadsheets.
- Provide real-time bed management and simple and intuitive data entry for Admissions, Discharges and Transfers (ADT).
- Introduction of Self Check-in Kiosks
- Puts patients in control of their data.
- Patient and equipment tracking
- Patient Portal for self-service appt booking / cancellation and digital correspondence

System-wide Integration (Walsall Together/ICP)

- **Shared Care Record -** The shared care record combines data from our local systems to create a single care record. An entry-level system might allow primary care and acute clinicians to view each other's records, while a full shared care record combines records from multiple types of organisation and across care settings within a designated community. This is linked to the Walsall Together partnership and Black Country Shared Care Record programme.

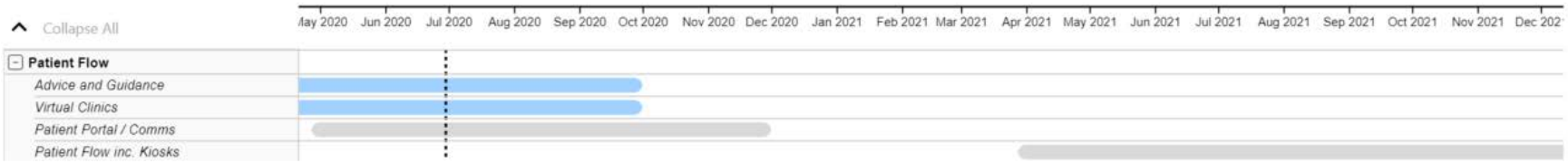
- **Care Planning** - Integrates the collection and update of community-wide assessment, event-driven alerting, task management, referral, secure instant messaging, workflow and care planning applications – to deliver integrated, patient-centric care. Patient registers can be created using risk stratification or manual assignment. Early visibility via End of Life Pathway.

- **Population Health Management** - The population health BI allows for the analysis of aggregated detailed patient data gathered from across a care community, using risk stratification and other tools. That enables data and decision to aid new services, pathways, ways of working and the Walsall Together Programme.

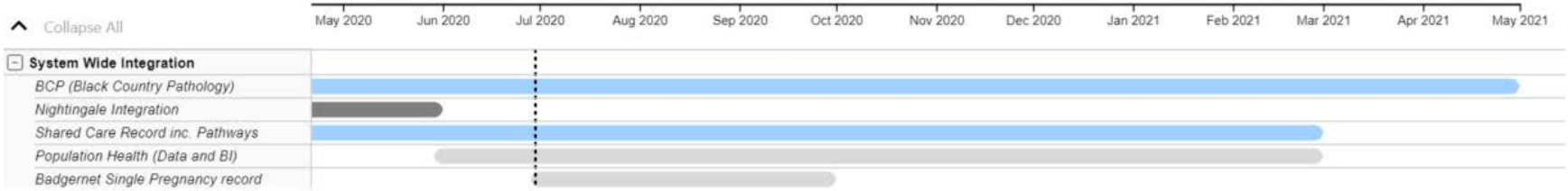
- **Patient Access and Engagement -** Provide foundations of future development - patients are engaged in their own health through the Patient Portal and signposted directory of services. They can self-monitor using wearables and telehealth devices (funded case by case) and interact directly with clinicians in real-time to improve the management of their condition.

Digital Programme

Patient Flow



System Wide Integration



Implementation

Investigation / Initiation / Future

Closure

MEETING OF THE PUBLIC TRUST BOARD 3rd September 2020			
Working with Partners			**AGENDA ITEM: 12.1** **ENC: 21**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Dr Matthew Lewis, Medical Director	**Responsible Director:**	Ned Hobbs, Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Working with Partners Strategic Objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. The Collaborative Working and Integration Executive Group Meeting (CWIEG) between Royal Wolverhampton Hospital NHS Trust (RWT), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT) has now been reinstated and has met on 30th June and 11th August since reinstatement. An invitation to Sandwell & West Birmingham NHS Trust has been re-extended. The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals. This report highlights progress in Dermatology, Urology, ENT and Radiology services.		
Recommendation	Members of the Trust Board are asked to note the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S04 Working with Partners to provide positive assurance the mitigations in place to manage this risk and the related corporate risks There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce		
Resource implications	There are no resource implications associated with this report.		

Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☐	

WORKING WITH PARTNERS

1. EXECUTIVE SUMMARY

Covid-19 affected the ability of the Trust to formally oversee and programme manage integration between Acute Hospital services. However, Covid-19 has necessitated significant collaboration between Trusts on many matters including mutual aid for Personal Protective Equipment, standardisation of policies in relation to the workforce, and shared learning to deal with a novel virus pandemic.

In many ways, therefore, collaboration between Black Country Trusts is stronger as a result of the experience of the last six months. There is a clear appetite to use this opportunity to build upon those foundations and progress functional service integration where there is a clear opportunity to improve care for the patients we serve and/or to improve the working lives of our staff.

This report highlights the reinstatement of Executive Director-led governance arrangements through the Collaborative Working and Integration Executive Group (CWIEG) and functional service progress, particularly in Dermatology, Urology, ENT and Radiology.

The Working with Partners Programme has also reviewed (in line with Public Trust Board action 060/20) the scale of activity currently leaving the Black Country, and a benefits assessment of previous service integrations. The output of this review will be reported to Performance, Finance & Investment Committee through the Working with Partners Improvement Programme update in September.

2. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework risk recognises the risk, previously shared with Trust Board that Covid-19 affected the pace with which functional collaboration with Acute Hospital partners in the Black Country could progress. The Collaborative Working and Integration Executive Group Meeting (CWIEG) between Royal Wolverhampton Hospital NHS Trust (RWT), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT) has now been reinstated and has met on 30th June and 11th August since reinstatement. An invitation to Sandwell & West Birmingham NHS Trust (SWBH) has been re-extended.

CWIEG has reflected on the lessons learnt through collaboration during Covid-19 and has considered the impact of both the fist surge of Covid-19 and the restoration and recovery of elective services impacted by Covid-19 to inform priorities across the Black Country.

3. IMPROVEMENT PROGRAMME

The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals overseen through CWIEG to support improved patient care, and improved working lives for our people. Key highlights to draw out for the Board's attention are as follows:

Dermatology

Strong progress has been made by the Dermatology teams from RWT and WHT who have:

- Appointed a joint Clinical Director (Dr James Halpern, Walsall Healthcare NHS Trust) to lead both services
- Identified 8 priority integration workstreams, and defined Task and Finish Groups for each.
- Established a Joint Steering Group to oversee the work of the Task and Finish Groups, with the first meeting having taken place on 19th August 2020.
- Agreed cross-site Consultant working which will commence in September 2020.
- Developed a draft Business Case proposal for Black Country Mohs surgery service to be delivered from New Cross site through collaboration with both RWT and DGFT.

Urology

The important workstream of Urology has been reinstated as follows:

- Joint RWT/WHT meeting held 17/7/20 to reinstate workstream
- New Programme Manager (RWT) commenced July 2020 to lead integration programme coordination
- Next WHT/DGT/RWT workshop scheduled 22/9/20
- Cross-site elective operating has re-commenced following Covid-19 Elective operating suspension
- Newly commenced Divisional Director of Operations (Surgery) to review programme plan and assess level of management resource needed to progress this important work at appropriate pace.

ENT

ENT has been formally added to the programme and collaborative work has progressed at pace as a result of challenges during the Covid-19 period. WHT ENT Consultants and Middle Grades have integrated with the DGFT/RWT on-call rota to form a Black Country ENT emergency on-call service, following University Hospitals Birmingham withdrawing from the previous joint on-call arrangements at the onset of Covid-19.

Phase Two of the developments are to consider the optimal Black Country Head & Neck cancer pathways.

Radiology

Radiology has been formally added to the programme and collaborative work between WHT/RWT/DGFT has begun with the support and facilitation of PA Consulting. The initial workshop took place on 30th July 2020. Attendees supported the formation of a Black Country Imaging network ahead of future mandated national policy that is likely to result in a pan-West Midlands Imaging Network was the right decision as it will provide service resilience considering existing operational pressures and especially in light of COVID.

The group agreed 4 initial high priority areas they wish to focus on to impact service delivery now and to act as key enablers for the future:

1. Community hubs and cancer screening – in line with the development of regional Rapid Diagnostic Centres, how best to maximise the contribution of such hubs
2. Workforce – service resilience, numbers and skill mix. Vision to create a shared Black Country Diagnostic Academy in conjunction with HEE and a sponsoring University with annual committed funds allocated to training & development of clinicians and AHPs
3. Assets – location, usage, and leveraged procurement opportunities. A shared PACS (and ideally Radiology Information System) strategy should be agreed to identify the path to a shared system
4. Demand and Capacity insights – implementation of shared dashboard, utilising standardised measurements and agreed KPIs (i.e. turnaround times by patient type, DNA rates, average and maximum reporting times)

The follow up workshop is scheduled for 11/9/20, and SWBH will be invited.

Clinical Fellowship Programme

Agreement has been reached between WHT and RWT to collaborate with the established RWT Clinical Fellowship Programme. A Service Level Agreement is being formulated between the two Trusts, and recruitment is being harmonised to fellowship posts.

Sterile Services

The Trust are working with RWT to conduct an options appraisal to inform whether or not collaboration on the provision of Sterile Services would be beneficial.

Bariatric Services

At the request of CWIEG, further work is needed to develop an integrated Weight Management service proposal, as opposed to simply a Bariatric Surgery proposal.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

APPENDICES

1. BAF SO4
2. Improvement Programme update

BAF Risk- S04
Risk Owner; Medical Director
Date of Review; 24th June 2020

Strategic Objective

Work with Partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System

Risk Appetite

Risk Appetite: The Board is prepared to accept a high risk appetite on the development of integrated pathways across partner organisations to deliver quality and sustainability. It has a moderate risk appetite on development of technology driven improvements and on sustainability to deliver the Trust vision.

	Impact	Likelihood	Score
Initial Risk Rating	**4**	**4**	**16 (Major)**
Current Risk Rating	**4**	**3**	**12 (Moderate)**
Target Risk Rating	**4**	**2**	**8 (Low)**

Risk

Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.

Rationale for current score

This risk has been reduced to moderate due to the advancement of a number of key work streams.

- Black Country Pathology Service (BCPS)
- Executive group established across provider organisations to review opportunities for collaboration
- Transfer of WHT payroll service to RWT
- Advanced discussions re: dermatology and urology
- Initial discussions re: bariatric services
- STP Clinical Leadership Group continue to drive Clinical Strategy

Owing to the Covid-19 pandemic the Acute Hospital collaboration group is currently on hold.

Future risks

- Conflicting priorities and leadership capacity to deliver required changes
- Ineffective STP level governance
- Lack of national guidance in relation to organisational form
- Lack of engagement/involvement with the wider public
- Acute Hospital Collaboration may not progress at the anticipated pace owing to COVID-19
- Disrupted relationships with neighbouring trusts due to altered visions of the form and pace of future collaboration

Controls

- Black Country ansd West Birmingham STP plan and governance processes in place

Assurance

- All Acute Collaboration partners have initially approved development of a business case

Future Opportunities

- Strengthen collaboration with RWT, Dudley and Sandwell & West Birmingham

• Sustainability review process completed • Regular oversight through the Board and its sub committees • Improvement Programme to progress clinical pathway redesign with partner organisations	• Progress overseen nationally and locally • System Review Meetings providing assurance to regulators on progress	• Consolidate other services, including back office functions • Collaborate with partner organisations outside the Black Country, including community and third party organisations • Promote Walsall as an STP hub for selected, well-established services • Develop links with local community • COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign
Gaps in Control • Lack of co-alignment by our organisation and neighbouring trusts • Lack of shared processes and objectives with Partner Organisations • No transparent implementation plan in relation to service integration	**Gaps in Assurance** • Clinical strategy is still emerging • CCG currently in a state of transition • Additional pressures with Covid-19 have delayed acute collaboration	**Link to Corporate Risk Register** • There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce

Working with Partners
Development and Mobilisation Status

Exec Leads: Ned Hobbs
WHT Improvement Leads: Malcolm Roper Moore / Jane Hayman

Working with Partners - Dermatology – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Kate Salmon, Divisional Director of Operations Dr James Halpern, Clinical lead Dermatology, WHT	**Core Team:**	Sarah Haywood, Care Group Manager
Progress to date:	• Clinical Leads and representatives for the 8 Task & Finish Groups have all been agreed (good representation from both Trusts). • Task & Finish Groups have been meeting during July to agree objectives, outputs and timescales. • Dr James Halpern appointed as Joint Clinical Director for both services. • RWT identified a Project Manager who has been supporting the Task and Finish groups. • Band 7 x 2 WTE posts have been advertised at WHT and RWT	**To be completed:**	• PID to be finalised once Task & Finish groups have all met and agreed objectives/ timescales. • Joint Steering Group meeting arranged for 19/08 to receive progress reports from each of the Task & Finish groups • To further discussions regarding Matron support across both Trusts • Review Consultant requirements at RWT and ?advertise • Cross site working should begin from September
Dependencies:	• Collaborative Working and Integration Executive Group • RWT on-going commitment to the project	**Risks / Issues / Support Required:**	• **Risk:** Change in Management arrangements at RWT could slow progress. • **Issue:** None • **Support Required:** None
Overall Status:	Green	**IP Board Comments:**	• Very encouraging progress from this workstream.

Working with Partners - Urology – Workstream Development update – August 20 IP Board / PFIC

Lead(s):	Kim Skelding	**Core Team:**	.TBC
Progress to date:	• New Programme Manager commenced July (Wolverhampton), to lead phased programme of works. • Meeting held 17.7.20 Walsall/Wolverhampton Management to review progress to date and agree next steps. • Meeting scheduled for 5.8.20 to present Emergency pathway demand and capacity data • Proposed date for next workshop 22.9.20. Wolverhampton to host with representation from Walsall, Wolverhampton, Dudley and ? SWBH	**To be completed:**	• Over-arching programme plan to be developed to support individual projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work) by Programme Manager. • Capacity and Demand modelling of elective procedures
Dependencies:		**Risks / Issues / Support Required:**	• **Risk:** .2nd Covid surge will delay progression • **Issue:** IT interfacing between sites • **Support Required:** .N/A
Overall Status:	Green	**IP Board Comments:**	• New Director of Operations for Surgery to assess whether there is sufficient management resource allocated to progress this workstream at an appropriate speed.

Working with Partners - Urology – Workstream Development update – August 20 IP Board / PFIC

- New Programme Manager (Jane McKiernan) allocated to programme July 20. Over arching programme plan under development to support individual projects for two phases:-

    1. Emergency work – joint working arrangement with Walsall and Wolverhampton
    2. Elective/Cancer work – collaborative working across Walsall, Wolverhampton and Dudley. This may extend to SWBH who have made tentative enquiries to the Programme Manager regarding the potential involvement.

- Joint (Walsall/Wolverhampton) Management meeting held 17.7.20 to review progress to date and agree next steps. These include detail required to support capacity/demand requirements for both emergency and elective admissions, sharing GIRFT reports inc recommendations to incorporate into the programme of works, review of Model Hospital data and agree provisional date for next workshop to support progression of phase two project.

- Meeting scheduled for 5.8.20 to present Emergency pathway demand and capacity data . Representatives from Clinical and Management Teams (Walsall and Wolverhampton) will be in attendance.

- Proposed date for next workshop 22.9.20. Wolverhampton to host with representation from Walsall, Wolverhampton, Dudley and SWBH

Working with Partners – Surgery – Workstream Development update – August 20 IP Board / PFIC

- New Collaboration Proposal:
  - ENT collaborative working with Wolverhampton and Dudley
    - Phase one being the incorporation of Walsall Cons/MG onto the existing Wolves/Dudley weekend on call rota (due to commence on 7th August 2020)
    - Phase two being the plan around H&N cancer work and repatriation from UHB.

Working with Partners – Collaborative Bank / Clinical Fellows – Workstream update – August 20 IP Board / PFIC

Lead(s):	Gaynor Farmer / Charlotte Hill	**Core Team:**	.TBC
Progress to date:	• **Collaborative bank -** Financial appraisal now complete (WHC finance colleague contribution).Briefing given to PODC in July. Mission - Agency Avoidance/ Reduction, economy of scale across STP sharing Bank staff as a resource. • **Clinical Fellows –** 1st steering group meeting held agreeing development of MoU and SLA to move this work forward. MoU drafted by WHT.	**To be completed:**	• **Collaborative bank -** Applying final updates to proposal which will go to STP People Board (Sept) • **Clinical Fellows –** Issue approved MoU to RWT and progress SLA development and approval ahead of utilising the CF programme to address critical gaps in medic cover
Dependencies:	• STP Bank Collaboration Programme	**Risks / Issues / Support Required:**	• **Risk:** Nursing staff not transient enough to avoid agency • **Support Required:** none this month
Overall Status:	Green	**IP Board Comments:**	

Working with Partners – Imaging Network – Workstream Development update – August 20 IP Board

Lead(s):	Delreita Ohai / Alan Deacon	**Core Team:**	.TBC
Progress to date:	• Divisional meeting re-scheduled with PA Consulting on took place on 30th July and involved clinical and operational stakeholders from 3 of the 4 Black Country acute organisations (The Royal Wolverhampton NHS Trust, The Dudley Group NHS Foundation Trust and Walsall Healthcare NHS Trust) as well as representation from the STP. Meeting reviewed the Department of Health networking document published November 2019 and scoped possible areas where collaboration may be of benefit: (1) Staffing / Reporting (2) Reporting infrastructure (PACS) (3) Training (4) Procurement (5) Home Working (6) Recruitment / Retention (7) Capacity (8) Workflow (9) Best Practice • Further meetings to be scheduled in the coming weeks to establish work streams and agree priorities. • Internal communication with service staff to discuss potential scope of work • Network already in place for interventional radiology	**To be completed:**	• Regional Core Team to be established. • Networking workstreams to be developed • PID development
Dependencies:	• PACS replacement • New equipment implementation • Staffing	**Risks / Issues / Support Required:**	• **Risk:** Project Affordability. WHT may be a smaller party in a much bigger collaboration. • **Issue:** . • **Support Required:** Project Support.
Overall Status:	Amber	**IP Board Comments:**	

Working with Partners
Programme Board / Committee Update
August 2020

Exec Lead: Ned Hobbs

WHT Improvement Lead: Jane Hayman

Caring for Walsall together

Working with Partners – Workstream Development update – August 20 IP Board / PFIC

	Project Admin							PID Generation							Project Tracking							Risk Summary Status		
	Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Enagement	QIA/EDI	PID Sign-off	Project Mobilisation	Define & Scope	Measure & Understand	Design & Plan	Pilot & Implement	Sustain & Share	Benefit Assessment and Project Close-out	Project Delivery	Project Resource Availability	Benefits Realisation
	PW 1	Partnership Working	Functional Collaboration	Dermatology	Kate Salmon	MLTC	Sarah Haywood															Green	Green	Green
	PW2			Urology	Kim Skeling	Surgery	Julie Earl															Green	Green	Green
	PW3			Collaborative Nurse Bank	Gaynor Farmer	Corporate	Gaynor Farmer															Green	Green	Amber
	PW4			Medical MTI	Charlotte Hill	Corporate	Charlotte Hill															Green	Green	Green
	PW5			Imaging Network	Delreita Ohai	WCCSS	Alan Deacon															Green	Green	
	PW10																							

Project Progress Key: Blue - completed; Green – Mature / Good progress; Amber - Maturing / Slow Progress; Red - No significant progress; Blank - Not planned to start / Not relevant

Workstream / Project Admin Info

PID Development Status

Project Implementation Status

MEETING OF THE PUBLIC TRUST BOARD - Thursday 3rd September 2020			
Audit Committee Highlight Report			**AGENDA ITEM: 13**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mr S Heer Chair of Audit Committee
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Audit Committee meeting 28th August 2020. The report sets out escalations for the attention of the Trust Board, and key issues discussed and work underway. 1. The Annual Reports and revised terms of reference for the Audit Committee were reviewed, together with the Annual Reports and revised terms of reference for the Quality, Patient Experience and Safety Committee, People and Organisational Development Committee, Performance, Finance and Investment Committee, and the Nominations and Remuneration Committee. These are commended to the Trust Board for approval. 2. A revised Board Assurance Framework ("BAF") template was approved by the Committee to be rolled out for all BAF risks in the coming meetings. 3. The internal audit reviews, annual plan and recommendation tracker were not reviewed in this meeting due to unavoidable absences, however an extraordinary meeting will be held in September with a sole focus on internal audit. 4. The Quality Account was scheduled for review at this meeting, however it was not presented due to internal delays and late stakeholder input. Whilst the deadline for completion of the Quality Account was extended nationally to 5th December, the Committee expressed its disappointed that it was unable to review the Quality Account. The next meeting of the Audit Committee will be on 12th October 2020.		
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.		
Does this report mitigate risk included in	Audit Committee is essential to Trust Board managing risk across the organisation.		

the BAF or Trust Risk Registers? please outline		
Resource implications	Poor internal control and/or management of risk would almost certainly result in financial loss.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

AUDIT COMMITTEE HIGHLIGHT REPORT

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee met 28th August 2020. The meeting was chaired by Mr Sukhbinder Heer, Committee Chair and Non-Executive Member of the Trust Board and was quorate. The Committee had been due to meet on 27th July, however due to quoracy issues was postponed to 19th August. Whilst the 19th August meeting was quorate, it was further postponed to 28th August due to unavoidable issues relating to executive representation of which the Trust Chair and Committee Chair were appraised of.

The Committee reports each month on escalations for the attention of the Trust Board and key issues from the meeting.

1. Effectiveness Review and Terms of Reference

In addition to the review of the annual reports and terms of reference for committees of the Board, the Audit Committee reviewed its own effectiveness at this meeting, setting the following priorities:

- Embed Risk Management systems and processes across the organisation, and focus on ensuring that the Board Assurance Framework and Corporate Risk Register are linked will be carried in to the 2020/21 work programme

- Review the organisation's cyber risk management and the appropriateness of its risk management strategies will be strengthened going forward.

The Chair of the Walsall Together Partnership Board was added to the membership of the Committee. The revised cycle of business will be approved at the October meeting.

2. Risk Management

A revised BAF template was reviewed and approved by the Committee. The template includes a dashboard, heat map, historical movement detail for risk scores, and action plans for each BAF risk. The inclusion of the three lines of defence will aid the Committee is ensuring appropriate spread of

assurance and controls. This template will be rolled out to Committees and the Board for the next meetings for each BAF risk.

The risk management group, which will report to the Committee, will now be chaired by the Chief Executive and have executive and divisional director representation. This is a welcomed step to ensure robustness of reporting and oversight.

3. Single Tender Actions

The Committee reviewed single tender actions with a value exceeding £50,000 that have not been subject to competitive tender in accordance with the Trust's Standing Orders, Scheme of Delegation and Standing Financial Instructions. There were no issues to escalate to the Board. The Committee had detailed discussion on the procurement process generally, and suggested some changes to the way in which the schedules are presented to provide stronger assurance to the Committee.

4. Counter Fraud

Two referrals of fraud have been received by local counter fraud since 1 April 2020, both of which have been closed with no fraud found. Five counter fraud investigations are ongoing.

One of the areas that local counter fraud is looking at is temporary staffing – particularly in relation to recruitment checks carried out on agency staff. Further discussion will take place with internal audit to ensure any reviews carried out are triangulated with, and complimentary to, other work in this area to provide the Committee with more than one source of assurance. Cyber risk and the procurement process are also areas of focus for local counter fraud. The Committee requested that their reports include evidence of where lessons learned have been applied in the organisation and where systems have been strengthened as a result of the work of counter fraud.

5. External Audit

External audit presented their annual audit letter and commended the finance team on the quality of the financial statement, and that was echoed by the Committee, noting the assurance this provides over the Trust's financial management. The main focus for 2020/21 will be revenue recognition and the valuation of land and buildings.

MEETING OF THE TRUST BOARD – 3 September 2020			
Board Committee Effectiveness Reviews			**AGENDA ITEM: 14** **ENC: 23**
Report Author and Job Title:	Trish Mills – Trust Secretary	**Responsible Director:**	Jenna Davies- Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	Trust Boards are responsible for all aspects of performance and governance of the organisation. Boards are expected to conduct their business effectively and in so doing build patient, public and stakeholder confidence that high quality and sustainable care is being provided. The Board's role is to set strategy, lead the organisation and oversee high level performance and to be accountable to stakeholders in an open and effective manner. In order gain assurance and to ensure appropriate time is dedicated to the delivery of our core objectives, the Board has established seven Board Committees: • Audit Committee • Quality, Patient Experience and Safety Committee • Performance, Finance and Investment Committee • People and Organisational Development Committee • Remuneration Committee • Walsall Together Partnership Board • Charitable Funds Committee (A legal requirement for the Trust's charity) Both through the Well led framework and the code of governance for the NHS it is recommended that effectiveness reviews are undertaken annually. Such periodic reflection improves efficiency, identifying areas of good practice, and areas where there may be gaps or areas of focus. This can lead to changes to the Terms of Reference and cycles of business to ensure Committees have before them the right information to make the decisions that are so important to provide quality of care to the population of Walsall. Due to COVID-19 the effectiveness reviews took place in June and July 2020. The reviews led to some changes to Terms of Reference and cycles of business, and a priority focus for the		

	Committees for 2020/21. The annual reports and Terms of Reference which are attached have been reviewed by each Committee and the Audit Committee. The Charitable Funds Committee and Walsall Together Partnership Board have not met since the review to approve the revised Terms of Reference and annual report, but will do so in September.	
Recommendation	The Trust Board is requested to note the outcome of the effectiveness reviews and approve changes to membership and to the Terms of Reference for: • Audit Committee • Quality, Patient Experience and Safety Committee • Performance, Finance and Investment Committee • People and Organisational Development Committee • Nominations and Remuneration Committee	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The Paper provides assurance that robust structures are in place to support the Trust Board in delivering its Strategic Objectives.	
Resource implications	None	
Legal and Equality and Diversity implications	Failure to implement robust governance structures within the organisation impacts on the Trusts CQC registration and NHSi licence requirements	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

BOARD COMMITTEE EFFECTIVENESS REVIEWS 2019/20

1. PURPOSE OF REPORT

The Audit Committee has delegated authority from the Board to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the organisation's activities (both clinical and non-clinical) that supports achievement of the Trust's objectives. On 28th August, the Audit Committee reviewed the annual reports and revisions to Terms of Reference for the Audit Committee; Quality, Patient Experience and Safety Committee; Performance, Finance and Investment Committee; People and Organisational Development Committee; and Remuneration Committee.

2. BACKGROUND

Trust Boards are responsible for all aspects of performance and governance of the organisation. Boards are expected to conduct their business effectively and in so doing build patient, public and stakeholder confidence that high quality and sustainable care is being provided. The Board's role is to set strategy, lead the organisation and oversee high level performance and to be accountable to stakeholders in an open and effective manner. In order gain assurance and to ensure appropriate time is dedicated to the delivery of our core objectives, the Board has established seven Board Committees:

- Audit Committee
- Quality, Patient Experience and Safety Committee
- Performance, Finance and Investment Committee
- People and Organisational Development Committee
- Remuneration Committee
- Walsall Together Partnership Board
- Charitable Funds Committee (A legal requirement for the Trust's charity)

As the factors underpinning effective governance can change, for example as people leave or organisations restructure, regular reviews can ensure governance remains fit for purpose should be undertaken. Both through the well led framework and the code of governance for the NHS it is recommended that effectiveness reviews are undertaken annually.

3. METHODOLGY

Reviews of the effectiveness of the Committees were undertaken in June by the Chair of each Committee meeting with the Executive Lead, Director of Governance and Trust Secretary. This review considered the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. The performance of the Committees with respect to their Terms of Reference was conducted, the results of which are included in each annual report, and a prospective look was taken on any changes required, which are reflected in the Terms of Reference comparison documents. The Audit Committee completed a self-assessment which sought feedback as to whether the five good practice principles as laid out in the HM Treasury's Audit and Risk Assurance Committee Handbook have been followed for the 2019/20 year.

The Performance, Finance and Investment Committee, Quality, Patient Experience and Safety Committee, and People and Organisational Development Committees met in July and Nominations and Remuneration Committee in August, and considered their annual reports, 2020/21 priorities and revisions to their Terms of Reference, and approved them for Audit Committee's review.

The Charitable Funds Committee will meet on 17th September, and Walsall Together Partnership Board on 23rd September to review their annual reports and Terms of Reference revisions.

4. KEY FINDINGS

The annual reports for each Committee are included in this report, as are the amendments to the Terms of Reference by way of a comparison document. Changes to the way Committees report to the Board will be introduced to ensure they are providing assurance to the Board on the delivery of the objectives, risks and issues within their remit.

A brief analysis of the actions identified for each of the committees is detailed below.

4.1 Quality, Patient Experience and Safety Committee

The Committee met ten times in 2019/20, providing appropriate scrutiny and challenge. No changes in membership are proposed and the committee was quorate at each meeting. NHSI attended the October 2019 meeting, noting the meeting kept to time, with the Chair being inclusive in approach, managing discussion well, allowing all to engage in the discussion, and summarising key points and items for escalation. Areas for improvement have been taken into account both for the Committee's effectiveness and with respect to individual reports.

Amendments have been made to Terms of Reference to reflect maturity and provide clarity on development, delivery and monitoring of strategic objectives in the areas of safe, high quality care; patient experience; and patient safety. The People and Organisational Development Committee will receive the clinical staffing report showing right staff, right skills, right place and time, as well as clinical workforce establishment, with this Committee receiving staffing reports where it impacts on patient care. This may be driven by an increase in harm data which will triangulate staffing issues that may have contributed to that harm, as well as acuity, patient outcomes and clinical judgment.

Specific duties have been added with regard to infection control, and more specificity included on the duty to engage patients.

The focus of the committee for 2020/21 includes:

- The development and finalisation of the project initiation documents for the Safe, High Quality Care workstream;
- Scrutiny of the Board Assurance Framework and actions to mitigate and manage risks (both strategic and corporate);
- Initiatives and outcomes on the engagement and involvement of patients and the public
- A review of the Terms of Reference and reporting requirements for each group reporting to the Committee

4.2 Performance, Finance and Investment Committee

The Committee met twelve times in 2019/20, with three meetings being cancelled and three extraordinary meetings being held. Eleven out of the twelve meetings were quorate. NHSEI, in their Accountability and Governance Report noted the Committee provided an appropriate forum for support and challenge on financial performance. A change in membership is proposed to include the Director of Planning and Improvement.

Amendments have been made to the Committee's Terms of Reference, the majority of which serve to provide clarity. Specific duties have been added with respect to review of budgetary policies, and the requirement to review the Health and Safety Policy has been transferred to the People and Organisational Development Committee.

The focus of the committee for 2020/21 includes:

- Efficiency delivery, through active monitoring of the Use of Resources output from within the Improvement Programme, so as to ensure the wider program of work delivers financial benefits aligned to targeted efficiency delivery in year
- Scrutiny of the board assurance framework and actions to mitigate and manage risks (both strategic and corporate);
- Trust income modelling to ensure the funding architecture for the NHS delivers sufficient resources to enable a sustainable service model in the immediate and medium term.
- Attainment of agreed performance metrics, Emergency Department 4 hour performance and Elective Recovery post Coronavirus and Walsall Together initiatives key examples
- Estates and Facilities Strategy- including oversight of the Trust's capital programme, space utilisation, oversight of the PFI contract and major capital developments (Emergency Department Capital Scheme)

4.3 People and Organisational Development Committee

No changes in membership are proposed, however attendance of non-members will be agenda driven in 2020/21 to ensure strategic discussions are prioritised. The Committee met twelve times in 2019/20, providing appropriate scrutiny and challenge. The Committee was quorate at eleven out of twelve of their meetings.

Amendments have been made to the Committee's Terms of Reference, the majority of which reflect maturity, i.e. the committee having established a baseline for process and now moving to oversight, and to provide clarity. Specific duties have been added with regard to sources of assurance that demonstrate the Board's Pledge; approval of workforce KPIs in addition to monitoring; review of the Health and Safety Policy and other key policies within its remit; review of external reports for issues within its remit.

The focus of the committee for 2020/21 is to ensure the:

- Development and finalisation of the project initiation documents for the Valuing Colleagues workstream;
- Review at a greater depth the board assurance framework and actions to mitigate and manage risks (both strategic and corporate);

- Development of the equality, diversity and inclusion strategy;
- Development of the health and wellbeing strategy.

4.4 Nominations and Remuneration Committee

All members of the Trust Board are in attendance at the Committee, therefore no change in membership is proposed. The Committee met five times in 2019/20 and was quorate at each meeting.

During the review it was identified that there were areas which had not been discussed by the Committee during 2019/20, and it was agreed that the revised cycle of business following approval of the amended terms of reference would ensure the relevant matters were appropriately timetabled for the Committee.
I
The changes to the Terms of Reference align with the Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The commitment of the Committee at the last review to include a nominations role focussing on succession planning, skill mix and high cost appointments has been included in the proposed revisions, as has succession planning and skill mix of the Non-Executive and Executive Directors. An explicit duty regarding severance packages has been added.

The focus of the committee for 2020/21 includes:

- Ensuring all requirements of the fit and proper person regulations are adhered to;
- Review succession planning for the Executive Directors and members of the Trust Board.

5. Recommendation

The Trust Board is requested to note the outcome of the effectiveness reviews and approve changes to membership and to the Terms of Reference for:

- Audit Committee
- Quality, Patient Experience and Safety Committee
- Performance, Finance and Investment Committee
- People and Organisational Development Committee
- Nominations and Remuneration Committee

6. Next Steps

The next steps are as follows:

1. The annual reports and amended Terms of Reference for the Charitable Funds Committee and Walsall Together Partnership will reviewed by the Chair of the Audit Committee following their meetings in August and September and endorsed to the Board for approval on 1st October 2020.
2. Cycles of business for all Committees will be revised and approved by the Committees in September.
3. Terms of Reference documents will be updated in accordance with comparison documents and distributed to the Committees.

ANNUAL REPORT ON COMMITTEE EFFECTIVENESS 2019/20
AUDIT COMMITTEE

1. INTRODUCTION

This report sets out the work of the Audit Committee during 2019/20 and the Committee's priorities for 2020/21.

The Committee met eight times in 2019/20, and provided highlight reports to the Trust Board for consideration on a monthly basis.

2. MEMBERSHIP OF THE COMMITTEE

The Terms of Reference provide that the members the chairs of the Quality, Patient Experience and Safety Committee; People and Organisational Development Committee; and Performance, Finance and Investment Committee, and one other NED of who has recent relevant financial experience who will chair the Committee.

The Chair of the Walsall Together Partnership Board has been added to the membership for 2020/21.

The Committee is expected to meet at least 5 times per year, and members are expected to attend 75% of meetings, and a named deputy may attend where a member is unable to be present. The Committee held 8 meetings in 2019/20, with extraordinary meetings on 25th april and 28th June. Attendance through the 2019/20 year was as follows:

Position	Name	% Attendance	No. of Eligible Meetings[1]	Attendance
Non-Executive Director and Chair	Sukhbinder Heer	87%	8	7/8
Chair, People and Organisational Development Committee	Phillip Gayle	75%	8	6/8
Chair, Performance, Finance and Investment Committee	John Dunn	75%	8	6/8
Chair Quality, Patient Experience and Safety Committee	Anne Baines (April, May, June and July meetings)	33%	6	2/6
Chair Quality, Patient Experience and Safety Committee	Pam Bradbury (as chair of QPES for the December 2019 and January 2020 meetings)	0%	2	0/2

The Committee requires two non-executive directors to be quorate, and the Committee satisfied quorum at each meeting other than the extraordinary meeting on 25th April 2019, which was also attended by the Trust Board Chair. All four members of the Committee were in attendance at the

[1] Including extraordinary meetings

same time at only one meeting in 2019/20. Mrs Bradbury was unavailable for meetings in 2020/19 due to prior commitments that the Committee was aware of ahead of meetings, however will be able to attend meetings from September 2020.

3. REVIEW OF EFFECTIVENESS

A review of the effectiveness of the Committee was undertaken in June by the Chair of the Committee, the Director of Finance and Performance, who is the lead executive for the Committee, Director of Governance, and Trust Secretary. This review considered the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. These will be reflected in the cycle of business.

The Committee members and attendees also completed a self-assessment which sought their feedback as to whether the five good practice principles as laid out in the HM Treasury's Audit and Risk Assurance Committee Handbook have been followed for the 2019/20 year, namely:

Principle 1: Membership, independence, objectivity and understanding

The Audit Committee remains independent and objective; in addition, each member has a good understanding of the objectives and priorities of the organisation and of their role as an Audit Committee member.

The Committee is comprised of the Chairs of the Performance, Finance and Investment Committee, the Quality, Patient Experience and Safety Committee and the People and Organisational Development Committee. The Chair of the Committee is a Non-Executive Director of the board with recent relevant financial experience. All members of the Committee satisfy the fit and proper requirements. The Committee is attended by the Chief Executive Officer and the Director of Finance, as well as the Head of Internal Audit and the External Auditor.

Members and attendees in their self-assessment felt the Committee was performing effectively with respect to this principle. The Committee will ensure that executives are in attendance where an internal audit reviews concludes anything other than significant assurance.

Principle 2: Skills

The Audit Committee has an appropriate skills mix to allow it to carry out its overall function. Members and attendees in their self-assessment felt the Committee was performing effectively with respect to this principle; however a more structured programme of induction will be introduced as well as a board development session on internal and external audit.

Principle 3: The role of the Audit Committee

The Audit Committee supports the Board and Accounting Officer by reviewing the comprehensiveness and reliability of assurances on governance, risk management, the control environment and the integrity of financial statements and the annual report.

Members and attendees in their self-assessment felt the Committee was performing effectively with respect to this principle, with the Chair ensuring the agenda reflects the breadth of work and priorities for the Committee, however the Committee recognised that it could have been more robust in its

review of the procedures and alternative sources of assurance whilst the Board Assurance Framework was developed. Notwithstanding this, Internal Audit carried out a review of the Board Assurance Framework which provides assurance on the management of risk during the period when the Board Assurance Framework was being developed, with that review acknowledging that snapshots of the Board Assurance Framework were reviewed by the board committees in the year. The annual governance statement also highlights the approach to risk during this period, which has also been reviewed by external audit.

Principle 4: Scope of work

The scope of the Audit Committee work is defined in its Terms of Reference, and encompasses all the assurance needs of the Board and Accounting Officer. Within this, the Audit Committee has particular engagement with the work of internal audit, risk management, the external auditor, and financial management and reporting issues. Members and attendees in their self-assessment felt the Committee was performing effectively with respect to this principle, however further developing their oversight of key strategic risks and the overall control environment by a focus on the Board Assurance Framework is recognised as an important priority for the Committee.

The Committee Terms of Reference are approved by the Board and internal and external auditors regularly attend meetings of the Committee, with members challenging the work of both internal and external auditors to ensure they are comfortable with the information presented to them.

Anti-fraud and corruption arrangements are reviewed at each meeting. The assurances received on the organisation's cyber risk management and the appropriateness of its risk management strategies will be strengthened going forward.

Principle 5: Communication and reporting

The Audit Committee ensures that it has effective communication with all key stakeholders, for example, the Board, Head of Internal Audit, the External Auditor, Director of Governance and other relevant assurance providers. The Committee provides a highlight report to the Trust Board following each meeting, and endorses the annual report and audited accounts annually for presentation to the Trust Board.

The Committee meets privately with the internal and external Auditors at least once per year, and this is moving to more regular meetings in the 2020/21 year. The Chair of the Audit Committee meets with both the Director of Governance and the Director of Finance on a regular basis.

The Chairs of the Board Committees for assurance on quality, people, performance and finance are members of the Audit Committee and bring to bear the experience of the issues within the remit of their committees to each meeting, cross-cutting issues where necessary.

Following each Committee meeting an agenda planning discussion takes place which is led by the Chair of the Committee to ensure the agenda is reflective of the cycle and is agile enough to deal with urgent or key issues.

In addition to the above, the Committee met on 19th August and considered its duties for its core areas and how it has discharged them, as set out below:

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
Core Area: Governance, Risk Management and Internal Control The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. In particular, the Committee will review the adequacy and effectiveness of:		
1.1. All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors	Review of Progress for Annual Filings April 2019 External Audit Report May 19 Head of Internal Audit Opinion May 19 Internal Audit Annual Report May 19 Provider Licence June 19 Quality Account June 19	Review/Assurance Approval Approval Approval Approval Approval
1.2. The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.		
1.3. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications;	Suspension/Breaches of Standing Orders, Scheme of Delegation & SFI's Oct 19	Review
1.4. The policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority.	Escalation Policy between Counter Fraud, Trust and Chair of Committee Dec 19	Review
2. **Core Area: Risk Management** The Committee will seek assurances from the Executive Risk Management group to guide its work to ensure that there are systems and processes in place to minimise risks to patients through the application of a comprehensive risk management system. This will include without limitation the following specific tasks:		
2.1. Reviewing the process to ensure an effective Risk Management Strategy is in place to deliver compliance with statutory responsibilities and considering the strategy prior to its presentation to the Board of Directors for approval.		
2.2. Overseeing the management of risks and related risk treatments considered by the Committees which report to it (including sub groups and aligned Board Committees) as detailed within	Committee Administration April 19 QPES, PFIC PODC Committee Administration July 19 QPES, PFIC PODC Committee Administration Oct 19	Assurance Assurance Assurance

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
these terms of reference. Where appropriate, the Committee will add issues of concern raised by other committees to the Trust risk register.	QPES, PFIC, PODC	
2.3. Reviewing the high level risks on the Trust risk register (risks with a score of 16 or more), specifically considering the impact of these high scoring risks on the Board Assurance Framework.	Board Assurance Framework Internal Audit Report July 19	Assurance
2.4. Ensuring that all risks are escalated in line with the Trust's Risk Management Strategy. Receiving assurance, through exception-based reporting, that areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place.	Horizon Scanning - Dec 19	Assurance
2.5. Advising the Board of Directors on any significant issues regarding quality, risk or compliance issues.	Highlight reports to Trust Board	Assurance
3. **Core Area: Internal Audit** The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards 2013 and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:		
3.1. Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal		
3.2. Review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework	Internal Audit Plan 2019/20 June 19 Internal Audit Plan & Implementation July 19	Approve Approve
3.3. Consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources	Internal audit recommendations tracker report April 2019; December 2019; January 2020 Data security and protection toolkit report April 2019 Core financial controls report April 2019 and December 2019 ESR Data quality Dec 19 DSPT final report for issue Dec 19	Information

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
3.4. Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation	Internal audit progress reports April 2019; July 2019; October 2019; January 2020 Revised Internal Audit Report & Timelines Dec 19 Revised Internal Audit Tracker of Recommendations Dec 19	Review Review
3.5. Monitoring the effectiveness of internal audit and carrying out an annual review.	Workplan & Timelines for 2019/20 capacity, delivery & escalation Dec 19 Escalation Policy between Internal Audit, Trust & Chair of Committee Dec 19	Review Review
4. **Core Area : External Audit** The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:		
4.1. Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit, including the formation of an Audit Appointment Panel as set out in the Local Audit and Accountability Act 2014	External audit fee	Approve
4.2. discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy	External audit plan and fee	Approve
4.3. discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;	External Audit Update December 2019 and January 2020	Information/Assurance
4.4. reviewing all external audit reports, including the report to those charged with governance	External Audit Progress Reports Oct 19	Review
4.5. Agreement of the annual audit letter before submission to the Board		
4.6. Any work undertaken outside the annual audit plan, together with the appropriateness of management responses		

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
5. **Core Area:** Other **Assurance Functions** The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.		
5.1. These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).	KPMG Financial Review June 19	Assurance
5.2. In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Safety Committee and the Performance, Finance and Investment Committee.	Business case for recruitment of ED pediatric nurses from PFIC April and June 2019 Committee effectiveness reviews for QPES, PFIC, PODC, Charitable Funds and Nominations and Remuneration Committee June 2019	Information/Assurance Information/Assurance Information/Assurance Information/Assurance Approval
6. **Core Area: Clinical Audit Function**		
6.1. In reviewing the work of the Quality, Patient Experience & Safety Committee around clinical risk management, the Audit and Risk Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and issues around clinical risk management.		
6.2. The Audit and Risk Committee will review the Clinical Audit Strategy and Plan each year and monitor through the Quality, Patient Experience and Safety Committee		
7. Core Area: 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.	Counter Fraud Progress Report & work plan April 19; October 2019 Revised Counter Fraud Report & Timelines Dec 19 Workplan & Timelines for 2019/20 capacity, delivery information & escalation Dec 19 Counter Fraud Recommendation Tracker Jan 20	Review/Approval Review Review Review Review

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
8. **Core Area:** Whistleblowing		
To review the adequacy of the Trust's arrangements (whistleblowing arrangements) by which Trust staff and other individuals where relevant, may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety or other matters or any other matters of concern. The Committee shall receive its assurance that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action through the Non-Executive Freedom to Speak up champion.	Freedom to Speak Up Report April 2019	Information/Assurance
9. **Core Area: Management**		
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit).	Management responses and actions for internal and external audits – regularly reported Town Wharf Property Sale Review	Assurance Assurance
10. **Core Area: Financial Reporting**		
10.1. The Audit and Risk Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.	Audited accounts and ISA260 review Review losses and special payment April 2019; July 2019; October 2019; December 2019 Report on single tender actions April 2019; July 2019; October 2019	Review / Endorse Approve Information
10.2. The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided	Non-substantive workforce expenditure report April and June	Information
10.3. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on: - the wording in the Annual	Review progress for filing of Annual Accounts April 2019 Charitable Funds Annual Report	Review

Duties (from TORs v.5.0)	Outputs for 2019/20	Purpose
Governance Statement and other disclosures relevant to the Terms of Reference of the Committee; - changes in, and compliance with, accounting policies, practices and estimation techniques; - unadjusted mis-statements in the financial statements; - significant judgements in preparation of the financial statements; - significant adjustments resulting from the audit; - Letters of representation; - Qualitative aspects of financial reporting	& Accounts	

The above illustrates the effectiveness of the Committee, holding regular meetings with appropriate membership, providing appropriate scrutiny and challenge, and assurance to the Board.

4. REVIEW OF TERMS OF REFERENCE

In order to identify efficiencies in reporting and to ensure that the Committee was exercising the appropriate degree of strategic oversight, a deep dive review of the Terms of Reference took place when the Chair met with the lead and others in June.

The changes serve to provide clarity and are attached for the Board's approval.

5. 2020/21 WORK PROGRAMME

The focus for the Committee for 2019/20 to embed Risk Management systems and processes across the organisation, and focus on ensuring that the Board Assurance Framework and Corporate Risk Register are linked will be carried in to the 2020/21 work programme. Extensive risk workshops, together with revised reporting to committees and the Board, and internal audit reviews on the Board Assurance Framework and Risk Management have provided a robust foundation for that work in 2020/21.

A review of the governance arrangements for Walsall Together which was earmarked for 2019/20 has begun, having been delayed in the last quarter due to COVID-19.

The Committee will also review the organisation's cyber risk management and the appropriateness of its risk management strategies will be strengthened going forward.

Walsall Healthcare NHS
NHS Trust

REVISIONS TO AUDIT COMMITTEE TERMS OF REFERENCE

Current (version 3.0)	Proposed revisions July 2020
1. CONSTITUTION 1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Audit and Risk Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.	Change Refer to the Committee as the Audit Committee
2. PURPOSE 2.1 The purpose of the Audit and Risk Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports achievement of the organisation's objectives. 2.2 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 cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or independent advice and to see the attendance of outsiders with relevant experience	No change

Current (version 3.0)	Proposed revisions July 2020
and expertise if it considers necessary.	
3. MEMBERSHIP 3.1 The Committee shall consist of the Chair of the People Organisational Committee, Chair of the Quality, Patient Experience and Safety Committee and Chair of the Performance, Finance & Investment Committee plus one other NED of whom has recent, relevant financial experience, who will Chair the Committee.	Change Membership to include the Chair of the Walsall Together Partnership Board
4. ATTENDEES 4.1 The Director of Finance and Performance, and the Director of Governance, shall normally attend meetings. 4.2 Representatives of the external auditor and internal audit will attend. The Committee will meet in private with the internal and external audit representatives at least once a year. 4.3 Only members of the audit committee have the right to attend meetings, but the Chief Executive shall generally be invited to attend routine meetings of the audit committee. 4.4 The Chair may be invited to attend meetings of the audit committee as required. 4.3 Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.	No change 4.3 Other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director and where an internal audit review provides anything other than significant assurance.
5. ATTENDANCE 5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year.	No change

Current (version 3.0)	Proposed revisions July 2020
6. QUORUM 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors present.	No change
7. FREQUENCY OF MEETINGS 7.1 The Committee will meet five times a year additional meetings may be arranged as required.	No change
8. CHANGES TO TERMS OF REFERENCE 8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.	No change
	Addition **ESTABLISHMENT OF SUB GROUPS** The Committee may establish sub-groups and/or sub-committees, which may include members of the Committee, to support its work. These may be enduring or time limited. The terms of reference of such sub-groups and/or sub-committees will be approved by this Committee and will be reviewed at least annually. The Committee may delegate work to the sub-groups and/or sub-committee in accordance with the agreed terms of reference. The Chair of each sub-groups and/or sub-committees will provide a Chairs report to the Committee on a frequency agreed with the Committee.
9. **ADMINISTRATIVE ARRANGEMENTS** 9.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Governance. The Committee shall be supported administratively by the Director of Governance and the Executive PA who's duties in this	No change

Current (version 3.0)	Proposed revisions July 2020
respect will include: • Agreement of agenda with Chair and attendees and collation of papers • Taking the minutes • Keeping a record of matters arising and issues to be carried forward • Advising the committee on pertinent issues / areas • Enabling the development and training of Committee members 9.2 All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee	
10. ANNUAL CYCLE OF BUSINESS 10.1 The Committee will develop an annual cycle of business for approval by the Committee meeting at its first meeting of the financial year. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.	No change
11. REPORTING TO THE TRUST BOARD 11.1 The Chair of the Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the quality and safety issues, key risks identified and key levels of assurance given.	No change
12. STATUS OF THE MEETING 12.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee and lead Executive.	No change

Current (version 3.0)	Proposed revisions July 2020
13. MONITORING 13.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided. This will include reporting at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness of risk and governance systems are integrated and embedded in the organisation, the appropriateness of evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the quality accounts.	Slight change to clarify second paragraph The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided. This will include reporting at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework and risk management processes; that governance systems are integrated and embedded in the organisation; the appropriateness of evidence compiled to demonstrate fitness to register with the CQC; and the robustness of the processes behind the quality accounts.
14. PERFORMANCE EVALUATION 14.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.	No change
15. REVIEW 15.1 The terms of reference of the audit committee shall be reviewed by the Board at least annually.	No change
16. DUTIES	**16. DUTIES**
16.1 Governance, Risk Management and Internal Control The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's	No change

Current (version 3.0)	Proposed revisions July 2020
objectives. In particular, the Committee will review the adequacy and effectiveness of:	
• all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors;	No change
• the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;	
• the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certifications;	No change
• the policies and procedures for all work related to counter fraud and security as required by NHS Counter Fraud Authority .	No change
	Add The Committee will review the proposed changes to, the standing orders, standing financial instructions and the scheme of delegation prior to approval by the Trust Board.
In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching	

Current (version 3.0)	Proposed revisions July 2020
systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.	
16.2 Risk Management The Committee will seek assurances from the Executive Risk Management group to guide its work to ensure that there are systems and processes in place to minimise risks to patients through the application of a comprehensive risk management system. This will include without limitation the following specific tasks:	No change
• Reviewing the process to ensure an effective Risk Management Strategy is in place to deliver compliance with statutory responsibilities and considering the strategy prior to its presentation to the Board of Directors for approval.	Change – combined with fourth bullet point below: Review the risk management strategy, policy and procedure for effective risk management, monitor compliance with statutory responsibilities and ensure risks are appropriately escalated.
• Overseeing the management of risks and related risk treatments considered by the Committees which report to it (including sub groups and aligned Board Committees) as detailed within these terms of reference. Where appropriate, the Committee will add issues of concern raised by other committees to the Trust risk register.	No change
• Reviewing the high level risks on the Trust risk register (risks with a score of 16 or more), specifically considering the impact of these high scoring risks on the Board Assurance Framework.	Change: Review the Board Assurance Framework (BAF) and the high level risks on the Corporate Risk Register (risks with a score of 16 or more), specifically considering the impact of the high level risks on the BAF
• Ensuring that all risks are escalated in line with the Trust's Risk Management Strategy. Receiving assurance, through exception-based reporting, that areas of risk within the Trust are regularly monitored and that effective disaster recovery plans are in place.	Change – combine compliance with strategy to first bullet point above; leave business continuity as a stand-alone item • Review the business continuity strategy and policy for endorsement to the Trust Board; and monitor compliance

Current (version 3.0)	Proposed revisions July 2020
• Advising the Board of Directors on any significant issues regarding quality, risk or compliance issues.	No change
	Add: Review the organisation's cyber risk management and appropriateness of the risk mitigation strategies.
16.3 Internal Audit The Committee shall ensure that there is an effective internal audit function that meets the *Public Sector Internal Audit Standards 2013* and provides appropriate independent assurance to the Committee, Accountable Officer and Board of Directors. This will be achieved by:	No change
• consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal	No change
• review and approval of the internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework	No change
• consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources	No change
• ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation	No change
• monitoring the effectiveness of internal audit and carrying out an annual review.	No change
16.4 External Audit	

Current (version 3.0)	Proposed revisions July 2020
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:	
• consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit, including the formation of an Audit Appointment Panel as set out in the Local Audit and Accountability Act 2014	No change
• discussion and agreement with the external auditor, before the audit commences, on the nature and scope of the audit as set out in the annual plan and ensuring coordination, as appropriate, with other external auditors in the local health economy	No change
• discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;	No change
• reviewing all external audit reports, including the report to those charged with governance	No change
• Agreement of the annual audit letter before submission to the Board	No change
• Any work undertaken outside the annual audit plan, together with the appropriateness of management responses	No change
16.5 Other Assurance Functions The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.	No change

Current (version 3.0)	Proposed revisions July 2020
These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.). In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work. In particular this will include the Quality and Safety Committee and the Performance, Finance and Investment Committee.	
16.5.1 Clinical Audit Function In reviewing the work of the Quality, Patient Experience & Safety Committee around clinical risk management, the Audit and Risk Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function and issues around clinical risk management. The Audit and Risk Committee will review the Clinical Audit Strategy and Plan each year and monitor through the Quality, Patient Experience and Safety Committee	No change
16.5.2 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.	No change

Current (version 3.0)	Proposed revisions July 2020
16.5.3 Whistleblowing To review the adequacy of the Trust's arrangements (whistleblowing arrangements) by which Trust staff and other individuals where relevant, may raise, in confidence, concerns about possible improprieties in matters of: financial reporting and control; clinical quality; patient safety or other matters or any other matters of concern. The Committee shall receive its assurance that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action through the Non-Executive Freedom to Speak up champion.	No change
16.5.4 Management The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation (e.g. clinical audit).	No change
16.5.5 Financial Reporting The Audit and Risk Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance. The Committee should also ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject	No change

Current (version 3.0)	Proposed revisions July 2020
to review as to completeness and accuracy of the information provided. The Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors, focusing particularly on: • the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee • changes in, and compliance with, accounting policies, practices and estimation techniques • unadjusted mis-statements in the financial statements • significant judgements in preparation of the financial statements • significant adjustments resulting from the audit • Letters of representation • Qualitative aspects of financial reporting	

ANNUAL REPORT ON COMMITTEE EFFECTIVENESS 2019/20
QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE

1. INTRODUCTION

This report sets out the work of the Quality Patient Experience and Safety Committee during 2019/20 and the Committee's priorities for 2020/21.

The Committee met ten times in 2019/20, and provided highlight reports to the Trust Board for consideration on a monthly basis.

2. MEMBERSHIP OF THE COMMITTEE

The Terms of Reference provide that members are:

- 3 Non-Executive Directors
- Medical Director
- Director of Nursing
- Chief Operating Officer
- Director of Governance
- Director of Integration and Deputy CEO – added during the year

Regular attendees include:
- Rajpal Virdee (Associate NED)
- Chief Executive (Richard Beeken)
- Trust Secretary (Trish Mills)
- Committee Secretary (Sophie Edwards)

No change is proposed to the membership for 2020/21.

Members are expected to attend 75% of meetings, and a named deputy may attend where a member is unable to be present. Attendance through the 2019/20 year was as follows[1]:

Position (NED/ED)	Name	% Attendance	No. of Eligible Meetings	Attendance
Non-Executive Director (Chair)	Pam Bradbury	90%	10	9/10
Non-Executive Director	Phil Gayle	90%	10	9/10
Non-Executive Director	Ben Diamond	100%	5	5/5
Medical Director	Matthew Lewis	80%	10	8/10
Interim Director of Nursing	Ann-Marie Riley	100%	1	1/1
Chief Operating Officer	Ned Hobbs	66.67%	9	6/9
Director of Governance	Jenna Davies	80%	10	8/10
Associate Non-Executive Director	Rajpal Virdee	60%	5	3/5
Left Committee during 2019/20 Year				
Director of Nursing	Karen Dunderdale	77.8%	9	7/9
Non-Executive Director	Anne Baines	50%	4	2/4
Associate Non-Executive Director	Liz England	0%	2	0/2
Chief Operating Officer	Mags Barnaby	100%	1	1/1

[1] Attendance for Executive Directors includes a formal named deputy

The Chair of the Trust Board attended the August 2019 meeting. NHSI attended one meeting in October 2019.

The Committee was quorate at each meeting in 2019/20.

3. REVIEW OF EFFECTIVENESS

A review of the effectiveness of the Committee was undertaken in June by the Chair of the Committee, Medical Director, Interim Director of Nursing, Director of Governance, Trust Secretary and Committee Secretary. This review considered the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. These will be reflected in the cycle of business.

Following each Committee meeting an agenda planning discussion takes place which is led by the Chair of the Committee to ensure the agenda is reflective of the cycle and is agile enough to deal with urgent or current emerging key issues.

Changes to the way the Committee reports to the Board will be introduced to ensure that the Committee is providing assurance on the delivery of the Safe, High Quality Care Workstream and highlighting risks and issues related to its remit.

NHSI observed the October 2019 meeting, noting the meeting kept to time, with the Chair being inclusive in approach, managing discussion well, allowing all to engage in the discussion, and summarising key points and items for escalation. They observed good interaction and discussion, with contributions and suggestions made by both Executive and Non-Executive Directors. As far as the Committee's effectiveness is concerned, there was room for improvement identified on the ownership of actions in the action log, review of the matters coming forward in the cycle of business and consistency in the executive summaries in reports. There were also improvements proposed, which were subsequently implemented, to clinical harm reporting, patient care improvement plan, mortality report, and infection, prevention and control reports. The report recommended that consideration is given to what actions needed to be taken to achieve outstanding in each of the reports received and to critically apply this to the level of discussion, and this principle will be included in agenda setting meetings and commissioning of papers for the Committee.

The Committee met on 30th July and considered the duties it has for oversight of safe and high quality care; patient experience; and patient safety under its Terms of Reference, which are as follows:

Duties	Outputs for 2019/20	Purpose (approval/ assurance)
1. CORE AREA – Safe and High Quality Care		
1.1. The Committee will receive professional staffing reviews relating to clinical; nursing; and midwifery functions (and associated professions) and review the impact of staffing on patient care.	Monthly safe nurse staffing report received Nursing E-Rostering System Project Update	Assurance
1.2. The Committee will satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This	Compliance with safeguarding training received monthly in the performance and quality report Learning Disability Strategy	Assurance Approval

Duties	Outputs for 2019/20	Purpose (approval/ assurance)
includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.	Exception reports from Safeguarding Committee Updates on compliance with terms of Mental Capacity Act 2005	Information Assurance
1.3. To oversee the development and implementation of the Trust's Quality Strategy and the agreement of annual quality objectives and the link to strategic objectives.	Quality Account received which outlines quality priorities for the Trust	Assurance
1.4. To consider the monthly Quality & Safety Reporting as part of the Integrated Performance report and Annual Quality Account prior to submission to the Trust Board and publication of the Annual Quality Account.	Performance and Quality report received on a monthly basis Quality Account received in June 2019 for approval prior to submission to the Board	Assurance Approval
1.5. To agree key quality and safety performance indicators and utilise these as appropriate to assess Trust performance and delivery of services against the Trust's vision and values to improve quality.	Performance and Quality report received on a monthly basis	Assurance
1.6. Promote clinical leadership and engagement in the development and delivery of the organisation's overall improvement strategy and programme	Quality Improvement Updates Patient Care Improvement Plan updates Improvement Programme updates	Assurance Assurance Assurance
1.7. To consider the outcomes of relevant local and national audits, reports (e.g. dementia, appraisals) and other sources of evaluation (e.g. Patient Reported Outcome Measures (PROMS)) and recommend appropriate action to further improve quality and/or monitor the development and implementation of appropriate action plans.	Learning from Excellence, incidents and themes monthly report Internal audit report on mortality reviews Evaluation of method and outcomes associated with the Winter Plan Internal Audit report on Controlled Drugs National Audit of Care at End of Life Medical Revalidation Annual Organisational Audit Clinical Audit & Effectiveness report	Assurance Assurance Assurance Assurance Assurance Assurance Assurance
1.8. To agree the Annual Clinical Audit Programme. To agree the Annual Clinical Audit Report prior to submission to the Trust Board and Audit, Risk Management Group for information.	Clinical audit plan updates received in the clinical audit and effectiveness report	Assurance
2. **CORE AREA – Patient Experience**		
2.1. To facilitate shared learning across the organisation in respect of required improvements to the quality of the patient experience.	Quarterly patient experience report Patient stories	Assurance Assurance
2.2. To consider the findings from the national	Maternity Inpatient Survey Results 2018	Assurance

Duties	Outputs for 2019/20	Purpose (approval/ assurance)
patients surveys and monitor the development and implementation of appropriate action plans. To consider themes/trends and learning from complaints, Serious Incidents, claims and concerns and consider how this information might be used as part of the wider Trust approach to improving the patient experience. To consider the findings from Ombudsman's' reports and monitor the development and implementation of appropriate action plans.	Adult Inpatient Survey National Cancer Survey Results Comparison & action plan Urgent and Emergency Care Survey 2018 Children and Young People's Patient Experience Survey Results Learning from Excellence, incidents and themes reports Annual Complaints Report Quarterly Complaints Report	Assurance Assurance Assurance Assurance Assurance Assurance Assurance
2.3. The Committee will receive periodic detailed reports on the activity of the PALs service; Patient Experience Surveys and Stories; Complaints; Serious Incidents; Ombudsman findings; Litigation; and seek assurance on the lessons learned and implemented.	As above	As above
2.4. To receive the following quarterly/ad-hoc reports: -Quarterly Ward Assurance Reports -Quarterly Director Visit Reports -Reports from Healthwatch 'Enter & View' Visits -Quality: Clinical Effectiveness	Patient Stories Healthwatch 'Enter & View' Visits included in Patient Experience Report Clinical audit & effectiveness report	Assurance Assurance Assurance
3. **CORE AREA – Patient Safety**		
3.1. A mortality update highlight report will be received by the committee and be a standing agenda item for the Medical Director	Monthly mortality report received	Assurance
3.2. It will promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to learn adverse clinical incidents, complaints and litigation.	Learning from Excellence, Incidents and Themes Report Complaints reports	Assurance Assurance
3.3. The Committee will satisfy itself that examples of good practice are disseminated within the Trust, ensuring that the investigation of incidents has been adequately scrutinised and that there is evidence that learning is identified and disseminated across the Trust.	Learning from Excellence, Incidents and Themes Report	Assurance
3.4. It will also satisfy itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.	Learning from Excellence, Incidents and Themes Report Patient Care Improvement Plan updates CQC Response - Mortality Review Deep Dive	Assurance Assurance Assurance

Duties	Outputs for 2019/20	Purpose (approval/ assurance)
	Patient Safety Alert, CAS, NatSSIP's Report	Assurance
	Updates on CQC reports from inspection	Assurance
	External review action plan for IPC following NHSI letter	Assurance
	Compliance with Mental Capacity Act 2005	Assurance
4. **CORE AREA : Use of Resources**		
4.1. The Committee will scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS Improvement, Care Quality Commission, NHS England, the NHS Resolution, the Royal Colleges and other professional and national bodies.	Reduction of Readmission Rates	Assurance
	Outpatient Follow Up Back Log	Assurance
	CQUIN report	Assurance
	Mortality Report & Outcomes Associated with GIRFT Programme	Assurance
	CIP Quality Impact Assessments and Post Implementation Review Reports	Assurance
	Emergency Care Medical Workforce Business Case	Approval
	Ambulatory Emergency Care Business Case	Approval
5. **Board Assurance Framework and Corporate Risk Register**		
5.1. To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks	Corporate Risk Register and Board Assurance Framework Updates	Assurance
	Deep dive into Risk regarding management of children and young people who have mental health problems	Assurance
5.2. To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive	Corporate Risk Register and Board Assurance Framework Updates	Assurance
	Deep dive into Risk regarding management of children and young people who have mental health problems	Assurance

The above illustrates the effectiveness of the Committee, holding regular meetings with appropriate membership, providing appropriate scrutiny and challenge, and assurance to the Board in its aim for 2019/20 to drive safe, high quality care across all services and to deliver the wider Quality Improvement Agenda.

4. SUB-GROUPS

The Committee has the following groups established for reporting purposes:

- Safeguarding Committee
- Nursing Midwifery & AHP Advisory Forum

- Medical Advisory Group
- Medicines Management group
- Patient Safety group
- Patient Experience group
- Clinical Effectiveness group
- Infection Prevention and Control group
- Deteriorating Patient Group

A review of the Terms of Reference and reporting requirements for each group will be undertaken in the 2020/21 year.

5. REVIEW OF TERMS OF REFERENCE

In order to identify efficiencies in reporting and to ensure that the Committee was exercising the appropriate degree of strategic oversight, a deep dive review of the Terms of Reference took place when the Chair met with the lead and others in June. The various initiatives under the improvement programme, bringing together as they do the key duties of the Committee of setting the strategy and holding the executive to account, have enabled a more strategic focus to the duties in the Terms of Reference.

Some duties have required minor changes to wording to reflect maturity. The People and Organisational Development Committee will receive the clinical staffing report showing right staff, right skills, right place and time, as well as clinical workforce establishment, with this Committee receiving staffing reports only where it impacts on patient care. This may be driven by an increase in harm data which will triangulate staffing issues that may have contributed to that harm, as well as acuity, patient outcomes and clinical judgment.

Specific duties have been added with regard to infection control, and more specificity added on the duty to engage patients.

The revised Terms of Reference are attached for the Board's approval.

6. 2020/21 WORK PROGRAMME

The focus of the committee for 2020/21 includes:

- The development and finalisation of the PIDs for the Safe, High Quality Care workstream;
- Scrutiny of the Board Assurance Framework and actions to mitigate and manage risks (both strategic and corporate);
- Initiatives and outcomes on the engagement and involvement of patients and the public
- A review of the Terms of Reference and reporting requirements for each group reporting to the Committee

Walsall Healthcare NHS
NHS Trust

REVISIONS TO QUALITY, PATIENT EXPERIENCE AND SAFETY COMMITTEE TERMS OF REFERENCE

Current (version 3.0)	Proposed revisions July 2020
1. CONSTITUTION 1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Quality & Safety Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.	No change
1. PURPOSE 2.1 To enable Board to obtain assurance that high standards of care are provided by the Trust and in particular that adequate and appropriate governance structures process and controls are in place throughout the Trust to promote safety and excellence in patient care • Identify, prioritise and manage risk arising from clinical care • Ensure the effective and efficient use of resources through evidence based clinical practice 2.2 The Committee shall review the establishment and maintenance of an effective system of quality governance, and internal control, across the organisation's activities that support the achievement of the Trust's objectives and that ensure that all statutory elements of clinical	**2. PURPOSE** Change The purpose of the Committee is: • Provide assurance to the Board that high standards of care are provided by the Trust and governance structures, process and controls are in place to deliver high quality care, patient safety, and positive patient experience; • Scrutiny of the outcomes of these systems and processes in relation to quality; • Provide direction regarding the delivery of the Trust's quality improvement priorities and strategic objectives in respect of quality of care.

Current (version 3.0)	Proposed revisions July 2020
governance are adhered to.	• Provide oversight of, and seek assurance on, statutory and regulatory compliance.
2. MEMBERSHIP 3.1 The Committee will comprise: • Three Non-Executive Directors • Director of Nursing • Chief Operating Officer • Medical Director • Director of Governance	**3. MEMBERSHIP** Include Director of Integration in membership
3. ATTENDEES 4.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda.	**4. ATTENDEES** No change, however include Director of Planning and Improvement to meetings in attendance.
4. ATTENDANCE 5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy must be identified for core members of the Committee and must attend when a member is unable to be present. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.	**5. ATTENDANCE** Change It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy may attend when a member is unable to be present. **Note:** Moved "A named deputy will count towards quorum" to the Quorum section. Removed "and members or their named deputy should ensure 100% attendance" as we have already set the expectation of 75% as a

Current (version 3.0)	Proposed revisions July 2020
	minimum.
6. QUORUM 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present, one of which must be the Director of Nursing or Executive Medical Director.	**6. QUORUM** Change The Committee has no decision making authority unless there are 2 Non-Executive Directors, which for the avoidance of doubt shall include Associate Non-Executive Directors, and 2 Executive Directors present, one of which must be the Director of Nursing or Medical Director. A named deputy will count towards quorum **Note:** Added in clarity around Associate Non-Executive Directors for quorum.
7. FREQUENCY OF MEETINGS 7.1 The Committee will meet on a monthly basis.	**7. FREQUENCY OF MEETINGS** Change The Committee will meet on a monthly basis or as otherwise agreed. **Note**: Added in 'or as otherwise agreed'.
8. CHANGES TO TERMS OF REFERENCE 8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.	**8. CHANGES TO TERMS OF REFERENCE** No Change.
9 ESTABLISHMENT OF SUB GROUPS 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and subcommittee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or subcommittee in accordance with the agreed terms of reference. The Chair of each sub group and or subcommittee will be expected to provide a Chairs report to the	**9. ESTABLISHMENT OF SUB GROUPS** Change 9.1 The Committee may establish sub-groups and/or sub-committees, which may include members of the Committee, to support its work. These may be enduring or time limited. The terms of reference of such sub-groups and/or sub-committees will be approved by this Committee and will be reviewed at least annually. The Committee may delegate work to the sub-groups and/or sub-committee in

Current (version 3.0)	Proposed revisions July 2020
Committee and review its effectiveness on an annual basis.	accordance with the agreed terms of reference. The Chair of each sub-groups and/or sub-committees will provide a Chairs report to the Committee on a frequency agreed with the Committee. **Note:** Slight change to reflect Committee members do not have to be part of the sub-groups/committees
10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 The Chair of the Committee will agree the agenda for each meeting with the Trust Secretary and the lead Director. The Committee shall be supported administratively by Executive PA whose duties in this respect will include: • Agreement of agenda with Chair and attendees and collation of papers • Taking the minutes • Keeping a record of matters arising and issues to be carried forward • Advising the committee on pertinent issues / areas • Enabling the development and training of Committee members All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.	10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 No change. 10.2 Change: All papers presented to the Committee must be prefaced by a summary of key issues and clear recommendations developed by the executive lead, which sets out what is required of the Committee.
11. ANNUAL CYCLE OF BUSINESS 11.1 The Committee will develop an annual cycle of business for approval by the Trust board meeting at its first meeting of the financial year. The	**11. ANNUAL CYCLE OF BUSINESS** No change.

Current (version 3.0)	Proposed revisions July 2020
Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.	
12. REPORTING TO THE TRUST BOARD 12.1 The Chair of the Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the quality and safety issues, key risks identified and key levels of assurance given.	**12. REPORTING TO THE TRUST BOARD** No change
13. STATUS OF THE MEETING 13.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee and Executive Lead.	**13. STATUS OF THE MEETING** No change
14. MONITORING 14.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided.	**14. MONITORING** No change
15. PERFORMANCE EVALUATION 15.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.	**15. PERFORMANCE EVALUATION** No Change
16. REVIEW 16.1 The terms of reference of the audit committee shall be reviewed by the	**16. REVIEW** Change

Current (version 3.0)	Proposed revisions July 2020
Board at least annually.	The terms of reference of the committee shall be reviewed by the Board at least annually
17. DUTIES	**17. DUTIES**
SAFE AND HIGH QUALITY CARE	**SAFE AND HIGH QUALITY CARE**
• The Committee will receive professional staffing reviews relating to clinical; nursing; and midwifery functions (and associated professions) and review the impact of staffing on patient care.	Change: See 17.3 below. **Note:** PODC to receive safe staffing reports and establishment reviews, with QPES receiving staffing reports where it impacts on patient care. This may be driven by an increase in harm data which will triangulate staffing issues that may have contributed to that harm, as well as acuity, patient outcomes and clinical judgment. Note the way the assurance is received on this will be detailed in the cycle of business.
• The Committee will satisfy itself that Safeguarding Children and Vulnerable Adults is at the heart of everything we do, ensuring that the Trust meets all of its obligations in respect of safeguarding at all times. This includes satisfying itself that all staff have training to the standard and frequency required. It will also satisfy itself that the Trust captures the learning from nationally published reports and that the learning is embedded in the practices, policies and procedures of the Trust.	17.4 Change: Be assured that the Trust is meeting its obligations with respect to safeguarding of children and vulnerable adults, and that learning from reports and incidents is embedded in the Trusts practices, policies and procedures.
• To oversee the development and implementation of the Trust's Quality Strategy and the agreement of annual quality objectives and the link to strategic objectives.	Change: Make this duty no. 1, 2 and 3 and amend wording to simplify 17.1 Review and recommend to the Board the Trust's quality strategy and monitor its implementation. 17.2 Review and recommend to the Board the Trust's annual quality account and quality improvement priorities for the coming year, monitoring progress against these priorities and their impact on patient safety. 17.3 The Committee will review the impacts of staffing issues on patient

Current (version 3.0)	Proposed revisions July 2020
	care from a multi-professional lens and consider the quality impacts of any service changes and financial efficiency plans.
• To consider the monthly Quality & Safety Reporting as part of the Integrated Performance report and Annual Quality Account prior to submission to the Trust Board and publication of the Annual Quality Account.	Remove. Reflected in 17.2
• To agree key quality and safety performance indicators and utilise these as appropriate to assess Trust performance and delivery of services against the Trust's vision and values to improve quality.	Remove. Reflected in 17.2
• Promote clinical leadership and engagement in the development and delivery of the organisation's overall improvement strategy and programme	Remove as not a specific duty
• To consider the outcomes of relevant local and national audits, reports (e.g. dementia, appraisals) and other sources of evaluation (e.g. Patient Reported Outcome Measures (PROMS)) and recommend appropriate action to further improve quality and/or monitor the development and implementation of appropriate action plans.	Change: 17.6 To consider local and national audits, reports and other sources of evaluation and the recommended action plans to improve quality; and monitor the development and implementation of appropriate action plans
• To agree the Annual Clinical Audit Programme. To agree the Annual Clinical Audit Report prior to submission to the Trust Board and Audit, Risk Management Group for information.	Change: 17.5 To approve the annual clinical audit plan
	Additions: 17.7 Approve the Infection Prevention and Control annual plan and monitor its implementation.

Current (version 3.0)	Proposed revisions July 2020
	17.8 Review the Infection Prevention and Control Annual Report prior to its presentation to the Trust Board. 17.9 Approve the research governance framework and oversee its implementation.
PATIENT EXPERIENCE	**PATIENT EXPERIENCE**
• To facilitate shared learning across the organisation in respect of required improvements to the quality of the patient experience.	Change 17.10 Approve a patient experience/engagement plan and monitor its implementation. 17.11 Receive regular reports on the trust's effectiveness in engaging patients across the range of its services and communities. **Note:** Cycle of business for this item to include: • Information from family and friends survey; complaints; PALs; litigation; serious incidents; healthwatch enter and view reports; Caldicott reports; Board walks visits reports; ombudsman – draw together the themes and what the learnings are from that i.e. the 'so what'. • Patient-led involvement and experience group; will look at themes and the 'so what'. • Patient stories/staff stories for triangulation of the above.
• To consider the findings from the national patients surveys and monitor the development and implementation of appropriate action plans. To consider themes/trends and learning from complaints, Serious Incidents, claims and concerns and consider how this information might be used as part of the wider Trust approach to improving the patient experience. To consider the findings from Ombudsman's' reports and monitor the development and implementation of appropriate action plans.	Change: combine with 17.11

Current (version 3.0)	Proposed revisions July 2020
• The Committee will receive periodic detailed reports on the activity of the PALs service; Patient Experience Surveys and Stories; Complaints; Serious Incidents; Ombudsman findings; Litigation; and seek assurance on the lessons learned and implemented.	Change: combine with 17.11
• To receive the following quarterly/ad-hoc reports: o Quarterly Ward Assurance Reports o Quarterly Director Visit Reports o Reports from Healthwatch 'Enter & View' Visits o Quality: Clinical Effectiveness	Change: combine with 17.11
PAITENT SAFETY	**PATIENT SAFETY**
• A mortality update highlight report will be received by the committee and be a standing agenda item for the Medical Director.	Remove this as a duty – it should be in the cycle as a quarterly report and by exception outside of that cycle.
• It will promote a culture of open and honest reporting of any situation that may threaten the quality of patient care and oversee the process within the Trust to ensure that appropriate action is taken in response to learn adverse clinical incidents, complaints and litigation.	Change: 17.12 Gain assurance that the Trust has systems and processes in place to support the delivery of an open & honest reporting and continuous learning culture. 17.13 Oversee improvements and changes applied as a result of reviews of mortality, clinical incidents, complaints, litigation, external regulator reports etc., and its impact on minimising patient harm and maximising patient experience. **Note**: Cycle to include mortality reports; patient safety information; complaints; dissemination of information through the Trust etc; learning from incidents report; – likely to be best 'packaged' in the newly established

Current (version 3.0)	Proposed revisions July 2020
	operational quality committee/group. To include a quarterly mortality report as part of Board's statutory requirement.
• The Committee will satisfy itself that examples of good practice are disseminated within the Trust, ensuring that the investigation of incidents has been adequately scrutinised and that there is evidence that learning is identified and disseminated across the Trust.	Combined with 17.13
• It will also satisfy itself that the appropriate actions in respect of Patient Safety and Governance have been taken following recommendations by any relevant external body. This includes monitoring the Trust's compliance with the Care Quality Commission registration requirements and any reports resulting from visits.	Combined with 17.13
17.4 USE OF RESOURCES	**USE OF RESOURCES**
• The Committee will scrutinise the effective and efficient use of resources through evidence based clinical practice and assure itself that there is an appropriate process in place to monitor and promote compliance across the Trust with all standards and guidelines issued by the regulators, NHS Improvement, Care Quality Commission, NHS England, the NHS Resolution, the Royal Colleges and other professional and national bodies.	Move compliance to 'other assurance'
BOARD ASSURANCE FRAMEWORK AND COPORATE RISK REGISTER	**BOARD ASSURANCE FRAMEWORK AND COPORATE RISK REGISTER**

Current (version 3.0)	Proposed revisions July 2020
• To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks.	Change: 17.14 Review the Board Assurance Framework ("BAF") for risks within the Safe High Quality Care strategic Objective on a frequency set out in the Risk Management Policy
• To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.	Change: 17.15 Be assured that there are plans in place to address gaps in controls and gaps in assurance, and have oversight of such plans
17.6 OTHER ASSURANCE FUNCTIONS	**17.6 OTHER ASSURANCE FUNCTIONS**
• Receive assurance that recommendations from audits relation to workforce and development are being progressed and any risks associated with these are being managed.	Change: 17.16 Review audits conducted on areas within the remit of this committee and quarterly updates on progress against recommendations
	Move from above 17.17 Ensure compliance across the Trust with all standards and guidelines issued by the regulators, including but not limited to NHSEI, Care Quality Commission, NHS Resolution, the Royal Colleges and other professional and national bodies
• Board Committees are encouraged to utilise the breadth of the Board Committee structure to escalate items to other Board Committees for action. As an example, the Finance, Performance and Investment Committee may escalate an item regarding cost improvement proposals to the Quality, Patient Experience and Safety Committee to further explore and provide assurance on quality impact issues involved.	17.18 No change

Current (version 3.0)	Proposed revisions July 2020
Therefore the Committee with the appropriate expertise is being utilised to provide assurance to another Committee. Actions that are referred to other Board Committees will be recorded by both the escalating Committee and the receiving Committee. .	
• The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.	17.19 No change

Walsall Healthcare NHS
NHS Trust

ANNUAL REPORT ON COMMITTEE EFFECTIVENESS 2019/20
PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

1. INTRODUCTION

This report sets out the work of the Performance, Finance and Investment Committee during 2019/20 and the Committee's priorities for 2020/21.

The Committee met twelve times in 2019/20. Three meetings were cancelled (28th August 2019; 18th December 2019; and 29th January 2020), however three extraordinary meetings were scheduled on 8th August 2019; 8th January 2020; and 12th February 2020.

The Committee provided highlight reports to the Trust Board for consideration on a monthly basis.

2. MEMBERSHIP OF THE COMMITTEE

The current Terms of Reference provide that the members are:

- 3 Non-Executive Directors, one of whom is the Chair.
- Director of Finance and Performance
- Chief Operating Officer
- Director of Integration and Deputy CEO
- Director of Governance

There is a change proposed to membership of the Committee, to take effect from the date of approval of the revised Terms of Reference. The change is to include the Director of Planning and Improvement as a member of the Committee. It is proposed that either the Medical Director, or the Deputy Medical Director is in attendance at each meeting, in addition to any other attendees required for matters on the agenda.

Members are expected to attend 75% of meetings, and a named deputy may attend where a member is unable to be present. Attendance through the 2019/20 year was as follows:

Position (NED/ED)	Name	% Attendance	No. of Eligible Meetings[1]	Attendance
Non-Executive Director	John Dunn Chair	100%	12	12/12
Non-Executive Director	Anne Baines (joined in November)	100%	5	5/5
Non-Executive Director	Sukhbinder Heer	75%	12	9/12
Associate Non-Executive Director	Paul Assinder (joined in November)	80%	5	4/5
Executive Director of Performance & Finance	Russell Caldicott	92%	12	11/12

[1] Includes Extraordinary Meetings

Chief Operating Officer	Ned Hobbs (and previously M Barnaby)	92%	12	11/12
Executive Director of Integration	Daren Fradgley	67%	12	8/12
Executive Director of Governance	Jenna Davies	67%	12	8/12
Non-Executive Director	Alan Yates (Left in August)	75%	4	3/4

The Committee was quorate at each meeting other than the 30th October meeting. The Trust Board Chair attended the 26th June 2019, 27th November 2019, and 25th March 2020 scheduled meetings, and the 8th August 2019, 8th January 2020, and 12th February 2020 extraordinary meetings.

3. REVIEW OF EFFECTIVENESS

A review of the effectiveness of the Committee was undertaken in June by the Chair of the Committee, the Director of Finance and Performance who is the lead executive for the Committee, Director of Governance, and Trust Secretary. This review considered the Committee's effectiveness, the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. These will be reflected in the cycle of business.

Following each Committee meeting an agenda planning discussion takes place which is led by the Chair of the Committee to ensure the agenda is reflective of the cycle and is agile enough to deal with urgent or key issues.

Changes to the way the Committee reports to the Board will be introduced to ensure that the Committee is providing assurance on the delivery of the Effective Use of Resources and the Working with Partners workstreams of the Improvement Programme, and highlighting risks and issues related to its remit.

The Committee met on 29th July and considered its duties for the core areas of improving service efficiency and productivity; resource management; digital strategy; and estates strategy and how it has discharged them, as set out below:

Duties (from TORs v.3.1)	Outputs for 2019/20	Purpose (Approval/Assurance)
1. Core Area: Improving service efficiency and productivity		
1.1. Business Case Investments and Evaluation - ensuring that these support the delivery of the Trust's corporate objectives and strategic direction	• Clinical Waste Contractor – Award of Contract • Allocate Business Case • Mammography Equipment Replacement Business Case • Theatre Monitors Business Case • EPR Implementation Director Business Case • Contract award for upgrade Server, Storage and Backup Infrastructure	Approval Approval Approval Approval Approval Approval

Duties (from TORs v.3.1)	Outputs for 2019/20	Purpose (Approval/Assurance)
	• Trust Secretary Business Case • Switchboard Replacement Business Case • PACS replacement Business Case • Sensyne Business Case • Total Mobile Contract Extension • Priority developments (health and well-being; Walsall Together; Ambulatory emergency care; Emergency Department; Ward 14 and Ward 29:	Approval Approval Approval Approval Approval Discussion
1.2. To receive and scrutinise post implementation reviews on business case and capital investment schemes		Information
1.3. To oversee implementation of the annual plan, monitoring and reviewing progress against plan, taking decisions to recover areas of underperformance, providing assurance to the Board and escalating as required	Use of Resources report and response	Information
1.4. To oversee the implementation of national transformation plans within divisions, including GIRFT, HED, Model Hospital, and Carter. This will include cost improvement and other productivity improvement programmes	• Agency staff updates • 2018/19 Nursing sickness absence outturn and 2019/20 projections • Meridian Commission Report • Maternity cost reduction plan • Patient Length of Stay reduction plan • Theatres and Outpatients Productivity financial forecast and underpinning plan • Annual nursing establishment review	Information Information Discussion Information Information Information Information
1.5. Setting and Monitoring key performance, financial, activity and workforce plans over the short, medium and long term. This will include annual targets (including revenue and capital budgets) for approval by the Trust Board on an annual basis prior to the start of each financial year.	• Constitutional standards reviewed monthly • Monthly finance performance reports • Report on stranded patients and medically fit for discharge • Performance and Quality exception report • Update on urgent care centre • Plan for recovery of theatre activity • Breast Service Referrals • Winter Plan reviews	Assurance Assurance Information Information Information Information Information Information

Duties (from TORs v.3.1)	Outputs for 2019/20	Purpose (Approval/Assurance)
	• Medicine bed occupancy • Elective productivity • Nursing temporary workforce	Information Information Information
2. Core Area: Resource Management		
2.1. To consider the Trust's medium and long term financial strategy, in relation to both revenue and capital	• Financial Plan 2020/21 • Financial forecast and run rate update • Clinical Income – STP • COVID-19 expenditure	Assurance Information Discussion Information
2.2. To consider the target level of Cost Improvement Programme (CIP) and actions to ensure that CIP targets are achieved without compromising on quality and to ensure that proposed financial initiatives are rated according to their potential impact on quality	Cost improvement programme updates	Assurance
2.3. To agree budget setting principles on an annual basis	Planning guidance	
2.4. To receive and consider major Trust Investment Plans and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's Strategic Direction and Annual Plan. To review and approve or make a recommendation to the Board on recurring or non-recurring revenue schemes that will result in costs that over twenty four months in line with the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation	Emergency Department OBC Update Emergency Department Selection of Contractor	Approval Discussion/Approval
2.5. To approve and keep under review, on behalf of the Trust Board, the Trust's Procurement Strategy and related policy. To review and approve or make a recommendation to the Board on all schemes for investment and capital programme schemes	This was due to be reviewed in March 2020 but was postponed due to COVID-19	
3. Core Area: Digital Strategy		
3.1. To monitor the implementation of the IT/Systems Strategy	EPR Deep Dive Digital Aspirant Funding	Discussion Information

Duties (from TORs v.3.1)	Outputs for 2019/20	Purpose (Approval/Assurance)
3.2. Review project plans and monitor implementation of major ICT and Information/Reporting Projects	EPR/Digital Board updates	Assurance
3.3. Monitor the delivery of benefits from ICT and Information/Reporting implementations		
3.4. Oversee the development and implementation of the Data Quality Strategy		
3.5. To receive regular reports in relation to Information Governance and GDPR	Information Governance Steering Group update	Information
4. Core Area : Estates Strategy		
4.1. To approve and monitor the implementation of the Trusts Estates Strategy	Estates backlog maintenance and upgrading of estates Estates backlog maintenance prioritisation and funding	Discussion Approval
4.2. Monitor and receive reports on Major Capital investment projects		
4.3. To receive regular reports on the Private Investment Initiatives		
4.4. To receive regular reports on the implementation of the Health and Safety Policy		
Board Assurance Framework and Corporate Risk Register		
4.5. To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks	PFIC Committee Effectiveness and Terms of Reference	Approval
4.6. To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive		

The Committee has operated effectively during the 2019/20 year, providing the required assurance to the Trust Board with a focus on delivery of strategy and improvements in performance. It has provided the appropriate level of scrutiny, support and challenge and worked with the executive members of the Committee to ensure clarity of reporting and purpose. NHSEI, in their Accountability and Governance Report noted the Committee provides an appropriate forum for support and challenge from the board around financial performance.

The work set out above illustrates that that Committee met its aim for 2019/20 to drive the Trust's Financial Improvement plan, evidenced in attainment of the 2019/20 financial plan and all financial metrics, improved length of stay and reduced medically stable lists and improved levels of productivity in certain specialities. This included active in year monitoring and reporting of all performance, highlighting key drivers of risk to delivery and mitigations adopted through to Trust Board.

Whilst the Committee reported on the estates backlog maintenance to the Board, and had detailed oversight of the Emergency Department business cases, there is more work to be done in 2020/21 to ensure the appropriate estates and facilities strategy is in place. Similarly with the priority on digital transformation, the EPR programme was a focus for the Committee with a deep dive review and regular updates on implementation. The data quality strategy has been carried over as a priority for 2020/21, as has the introduction of mechanisms to ensure the Committee looks at post implementation reviews from business cases.

4. REVIEW OF TERMS OF REFERENCE

In order to identify efficiencies in reporting and to ensure that the Committee was exercising the appropriate degree of strategic oversight, a deep dive review of the Terms of Reference took place when the Chair met with the lead and others in June. The various initiatives under the improvement programme, bringing together as they do the key duties of the Committee of setting the strategy and holding the executive to account, have enabled a more strategic focus to the duties in the Terms of Reference.

The majority of the changes serve to provide clarity. Specific duties have been added with regard review of budgetary policies, and the requirement to review the Health and Safety Policy has been transferred to the People and Organisational Development Committee.

The revised Terms of Reference are attached for the Board's approval.

5. 2020/21 WORK PROGRAMME

The review of the Committee identified future areas of priority for the agenda throughout 2020/21 to focus on delivery of the wider use of resources, specifically around the following areas:

- Scrutiny of the board assurance framework and actions to mitigate and manage risks (both strategic and corporate);
- Trust income modelling to ensure the funding architecture for the NHS delivers sufficient resources to enable a sustainable service model in the immediate and medium term.
- Attainment of agreed performance metrics, Emergency Department 4 hour performance and Elective Recovery post Coronavirus and Walsall Together initiatives key examples
- Efficiency delivery, through active monitoring of the Use of Resources output from within the Improvement Programme, so as to ensure the wider program of work delivers financial benefits aligned to targeted efficiency delivery in year
- Estates and Facilities Strategy- including oversight of the Trust's capital programme, space utilisation, oversight of the PFI contract and major capital developments (Emergency Department Capital Scheme)

- Digital Transformation- Including oversight of the EPR programme, NHS digital toolkit, and the development of a data quality strategy.

The Committee review highlighted areas that would enhance effectiveness being:

- The establishment of two sub groups, one to focus on the estates strategy and report more regularly on estate and a second to drive the digital transformation agenda

- All business cases to be subject to and specify when post implementation reviews are to be undertaken throughout the financial year (this element included as an item within the cycle of business)

Walsall Healthcare NHS
NHS Trust

REVISIONS TO PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE TERMS OF REFERENCE JULY 2020

Current (version 3.0)	Proposed revisions July 2020
1. CONSTITUTION 1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Performance, Finance and Investment (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.	**1. CONSTITUTION** No change
2. PURPOSE a. The purpose of the Committee is to provide assurance to the Trust Board on that; • The Trusts Digital Strategy is being delivered successfully • The Trust is improving service efficiency and productivity to better than national average performance in delivery of patient centred, high quality and safe care. • To ensure we are effective in the utilisation of the resources at our disposal to support provision of effective, productive and cost-efficient care, ensuring every pound is spent wisely. • The Trusts Estates Strategy is fit for purpose • Putting the interests of patients at the heart of what the organisation does.	**2. PURPOSE** Change – additional first bullet point: • There are plans in place to deliver the Trust's strategic objectives of Effective Use of Resources and Working With Partners, and the committee is monitoring the delivery and risks associated with those objectives

Current (version 3.0)	Proposed revisions July 2020
• Gaining Assurance and Challenging relevant Executive Leads on financial controls and the reliability of the data. • Review, approve and evaluate business case investments and requests for capital expenditure within the powers delegated by the Trust Board.	
3. MEMBERSHIP 3.1 The Committee will comprise: • Three Non-Executive Directors (one of whom is the Chair of the Committee) • Director of Finance & Performance • Chief Operating Officer • Walsall Together Director • Director of Governance	**3. MEMBERSHIP** Change The Committee membership will also include the Director of Planning and Improvement. Changed the title of Walsall Together Director to Director of Integration/Deputy
4. ATTENDEES 4.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda.	**4. ATTENDEES** Change The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda. The Medical Director or Deputy Medical Director will be in attendance at Committee meetings.
5. ATTENDANCE 5.1 It is expected that each member attends a minimum of 75% of meetings	**5. ATTENDANCE** Change:

Current (version 3.0)	Proposed revisions July 2020
and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance	It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy may attend when a member is unable to be present. **Note:** Moved "A named deputy will count towards quorum" to the Quorum section. Removed "and members or their named deputy should ensure 100% attendance" as we have already set the expectation of 75% as a minimum.
6. QUORUM 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present.	**6. QUORUM** Change: The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present. A named deputy will count towards quorum.
7. FREQUENCY OF MEETINGS 7.1 The Committee will meet monthly.	**7. FREQUENCY OF MEETINGS** Change: The Committee will meet on a monthly basis or as otherwise agreed. **Note**: Added in 'or as otherwise agreed'.
8. CHANGES TO TERMS OF REFERENCE 8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.	**8. CHANGES TO TERMS OF REFERENCE** No Change.
9 ESTABLISHMENT OF SUB GROUPS 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be	**9. ESTABLISHMENT OF SUB GROUPS** Change: 9.1 The Committee may establish sub-groups and/or sub-committees,

Current (version 3.0)	Proposed revisions July 2020
approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference. The Chair of each sub group and or sub committee will be expected to provide a Chairs report to the Performance, Finance and Investment Committee. 9.2 The Committee has established two sub groups; • Estates Sub Group • Information Technology Sub Group	which may include members of the Committee, to support its work. These may be enduring or time limited. The terms of reference of such sub-groups and/or sub-committees will be approved by this Committee and will be reviewed at least annually. The Committee may delegate work to the sub-groups and/or sub-committee in accordance with the agreed terms of reference. The Chair of each sub-groups and/or sub-committees will provide a Chairs report to the Committee on a frequency agreed with the Committee. **Note:** Slight change to reflect Committee members do not have to be part of the sub-groups/committees Removed reference to specific sub-groups from TORs. They can be reported via the annual report.
10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Finance & Performance and Chief Operating Officer. The Committee shall be supported administratively by the Executive PA whose duties in this respect will include: • Agreement of agenda with Chair and attendees and collation of papers • Taking the minutes • Keeping a record of matters arising and issues to be carried forward • Advising the committee on pertinent issues / areas • Enabling the development and training of Committee members 10.2 All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.	10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 No change. 10.2 Change: All papers presented to the Committee must be prefaced by a summary of key issues and clear recommendations developed by the executive lead, which sets out what is required of the Committee.

Current (version 3.0)	Proposed revisions July 2020
11. ANNUAL CYCLE OF BUSINESS 11.1 The Committee will develop an annual cycle of business for approval by the Trust Board meeting at its first meeting of the financial year. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.	**11. ANNUAL CYCLE OF BUSINESS** No change.
12. REPORTING TO THE TRUST BOARD 12.1 The Chair of the Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the quality and safety issues, key risks identified and key levels of assurance given.	**12. REPORTING TO THE TRUST BOARD** No Change The Chair of the Committee will provide a monthly report to the Trust Board outlining key actions taken with regard to issues in its remit, key risks identified and key levels of assurance received.
13. MONITORING 13.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided.	**14. MONITORING** No change.
14. PERFORMANCE EVALUATION 14.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.	**15. PERFORMANCE EVALUATION** No Change
15. REVIEW 15.1 The terms of reference of the audit committee shall be reviewed by the Board at least annually.	**16. REVIEW** No change
16. DUTIES	**16. DUTIES**

Current (version 3.0)	Proposed revisions July 2020
16.1 Improving service efficiency and productivity	**Improving service efficiency and productivity**
• Business Case Investments and Evaluation - ensuring that these support the delivery of the Trust's corporate objectives and strategic direction.	Change • Review business cases for alignment with Trust's delivery of corporate objectives and strategic direction • Approve business cases and/or endorse for Board approval in line with Standing Orders and Standing Financial Instructions
• To receive and scrutinise post implementation reviews on business case and capital investment schemes.	No change
• To oversee implementation of the annual plan, monitoring and reviewing progress against plan, taking decisions to recover areas of underperformance, providing assurance to the Board and escalating as required.	No change
• To oversee the implementation of national transformation plans within divisions, including GIRFT, HED, Model Hospital, and Carter. This will include cost improvement and other productivity improvement programmes	No change
• Setting and Monitoring key performance, financial, activity and workforce plans over the short, medium and long term. This will include annual targets (including revenue and capital budgets) for approval by the Trust Board on an annual basis prior to the start of each financial year.	No Change
16.2 Resource Management	**Resource Management**

Current (version 3.0)	Proposed revisions July 2020
• To consider the Trust's medium and long term financial strategy, in relation to both revenue and capital.	No change
• To consider the target level of Cost Improvement Programme (CIP) and actions to ensure that CIP targets are achieved without compromising on quality and to ensure that proposed financial initiatives are rated according to their potential impact on quality.	Change To consider the targeted levels of efficiencies in year, ensuring quality impact assessments have been undertaken, and appropriately rated and assessed; with performance against targeted efficiencies monitored and reported through the Effective Use of Resources workstream.
• To agree budget setting principles on an annual basis.	No change Add in To approve the Trust's budgetary controls policy and review changes to Standing Financial Instructions before approval at Audit Committee
• To receive and consider major Trust Investment Plans and maintain an oversight of the Trust's investments, ensuring compliance with the Trust's Strategic Direction and Annual Plan. To review and approve or make a recommendation to the Board on recurring or non-recurring revenue schemes that will result in costs that over twenty four months in line with the Standing Orders, Standing Financial Instructions, Scheme of Reservation and Delegation.	No Change
• To approve and keep under review, on behalf of the Trust Board, the Trust's Procurement Strategy and related policy. To review and approve or make a recommendation to the Board on all schemes for investment and capital programme schemes	Change 16.12 To approve the Trust's Procurement Strategy and related policy.
16.3 Digital Strategy	**Change** **Digital and Information**

Current (version 3.0)	Proposed revisions July 2020
• To monitor the implementation of the IT/Systems Strategy	Change To review the digital strategy for approval by the Board, and monitor its implementation
• Review project plans and monitor implementation of major ICT and Information/Reporting Projects	No Change
• Monitor the delivery of benefits from ICT and Information/Reporting implementations.	No Change
• Oversee the development and implementation of the Data Quality Strategy	Change Oversee the development and implementation of the Data Quality Strategy; seek assurance that the underpinning systems and processes for data collection and management are robust and provide relevant, timely and accurate information to support the operational management of the organisation.
• To receive regular reports in relation to Information Governance and GDPR	No change
16.4 Estates Strategy	**Change** **Estates**
• To approve and monitor the implementation of the Trusts Estates Strategy	No Change
• Monitor and receive reports on Major Capital investment projects	No Change
• To receive regular reports on the Private Investment Initiatives	Change To receive bi-annual reports on the Private Finance Initiative referencing in

Current (version 3.0)	Proposed revisions July 2020
	year contractual performance and in-year risks
• To receive regular reports on the implementation of the Health and Safety Policy	Remove – duty sits with PODC
	Add Oversight and assurance to the Board on the delivery to plan of the Emergency Department new build
16.5 Board Assurance Framework and Corporate Risk Register	**Board Assurance Framework and Corporate Risk Register**
• To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks.	Change Review the Board Assurance Framework ("BAF") for risks within the Effective Use of Resources and Working With Partners strategic Objectives on a frequency set out in the Risk Management Policy
• To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.	Change Be assured that there are plans in place to address gaps in controls and gaps in assurance, and have oversight of such plans
	Add **OTHER ASSURANCE FUNCTIONS**
	Add Review audits conducted on areas within the remit of this committee and

Current (version 3.0)	Proposed revisions July 2020
	quarterly updates on progress against recommendations
	Add Ensure compliance across the Trust with all standards and guidelines issued by the regulators, including but not limited to NHSEI, Care Quality Commission, NHS Resolution, the Royal Colleges and other professional and national bodies
	Add Board Committees are encouraged to utilise the breadth of the Board Committee structure to escalate items to other Board Committees for action. As an example, the Finance, Performance and Investment Committee may escalate an item regarding cost improvement proposals to the Quality, Patient Experience and Safety Committee to further explore and provide assurance on quality impact issues involved. Therefore the Committee with the appropriate expertise is being utilised to provide assurance to another Committee. Actions that are referred to other Board Committees will be recorded by both the escalating Committee and the receiving Committee.
	Add The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.

ANNUAL REPORT ON COMMITTEE EFFECTIVENESS 2019/20
PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

1. INTRODUCTION

This report sets out the work of the People and Organisational Development Committee during 2019/20 and the Committee's priorities for 2020/21.

The Committee met twelve times in 2019/20, and provided highlight reports to the Trust Board for consideration on a monthly basis.

2. MEMBERSHIP OF THE COMMITTEE

The Terms of Reference provide that the members are:

- 3 Non-Executive Directors, one of whom is the Chair.
- Director of People and Culture
- Director of Nursing
- Director of Integration and Deputy CEO
- Director of Governance

There is no change proposed to membership for 2020/21.

Members are expected to attend 75% of meetings, and a named deputy may attend where a member is unable to be present. Attendance through the 2019/20 year was as follows:

Position (NED/ED)	Name	% Attendance	No. of Eligible Meetings	Attendance
Non-Executive Director	Philip Gayle	100%	12	12/12
Non-Executive Director	Pam Bradbury	100%	11	11/11
Non-Executive Director	Ben Diamond	100%	1	1/1
Non-Executive Director	Rajpal Virdee	66%	3	2/3
Executive Director of People and Culture	Catherine Griffiths	92%	12	11/12
Executive Director of Nursing	Ann-Marie Riley	100%	1	1/1
Executive Director of Integration and Deputy CEO	Daren Fradgley	42%	12	5/12
Executive Director of Governance	Jenna Davies	58%	12	7/12
Left Committee during 2019/20 Year				
Executive Director of Nursing	Karen Dunderdale	50%	10	5/10

The Committee was quorate at each meeting other than the February meeting. The Trust Board Chair attended the March 2020 meeting, and the Audit Committee Chair attended the April 2019 meeting. Anne Baines, Non-Executive Director, attended the April 2019 meeting.

In addition to the committee members, the Freedom to Speak Up Guardians and Staff Side Leads also attend the meetings, as does the Talent, Inclusion and Resourcing Lead; Occupational Health Consultant; Deputy Director of People and Culture; and Workforce Lead. The Committee is serviced by Becky Edwards, Executive Assistant.

3. REVIEW OF EFFECTIVENESS

A review of the effectiveness of the Committee was undertaken in June by the Chair of the Committee, the Director of People and Culture who is the lead executive for the Committee, Director of Governance, and Trust Secretary. This review considered the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. These will be reflected in the cycle of business.

Following each Committee meeting an agenda planning discussion takes place which is led by the Chair of the Committee to ensure the agenda is reflective of the cycle and is agile enough to deal with urgent or key issues.

Changes to the way the Committee reports to the Board will be introduced to ensure that the Committee is providing assurance on the delivery of the Valuing Colleagues workstream of the Improvement Programme, and highlighting risks and issues related to its remit.

The Committee met on 30th July and considered its duties for the core areas of leadership, culture and organisational development; workforce sustainability and redesign; effective human resources processes; and equality and diversity, and how it has discharged them, as set out below:

Duties (from TORs v.3.0)	**Outputs for 2019/20**	**Purpose** **(Approval/ Assurance/Information)**
1. **Core Area: Leadership, Culture and Organisational Development**		
1.1. Oversee the initial development and subsequent delivery of the Trust's People and OD Strategies and plans ensuring that they are consistent with the Board's overall strategic direction and with any requirements/guidance set externally. **//**Consider organisational development implications and advise on the development of plans required to deliver the change in culture, leadership, service improvement and processes required by the Trust.	NHS leadership academy diagnostic; Quality Improvement Academy Progress Reports Learning and development strategy Review of just culture and learning from excellence	Information Information Information Review
1.2. Receive assurance that the Trust has in place structures, systems and processes for effective people management including strong leadership and transparent lines of	Findings from exit reviews considered in May Update on Trust Retention Workstream – Valuing Colleagues Improvement	Assurance Discussion

Duties (from TORs v.3.0)	Outputs for 2019/20	Purpose (Approval/ Assurance/Information)
accountability.	programme	
1.3. Receive and consider National Staff Survey results and PULSE survey results for the Trust and advice on improvement actions. Oversee the implementation and effectiveness of improvement plans on colleague experience and engagement. Where necessary bring recommendations to the attention of the Board on key people and OD issues affecting those working within the Trust. .	National Staff Survey and action plan Update on Trust Health and Wellbeing Workstream – Valuing colleagues Improvement Programme Health and Wellbeing Performance Report Delivery against health and wellbeing CQUIN Occupational health/health and wellbeing and mental health and wellbeing update for COVID-19 in March	Discussion Discussion Review Assurance
1.4. Receive assurance regarding the Trusts compliance with equal pay legislation, principally through an annual Equality Pay Audit.	Gender Pay Gap Review	
1.5. The Trust is monitoring staff engagement and experience, and delivering its plans to achieve a highly motivated and engaged workforce to enhance the quality of patient care	2019 annual plan on equality for workforce Staff survey action plan	Information
1.6. Review progress of leadership, talent management and succession planning processes	Talent Management Strategy Pilot Process Coaching and Mentoring Update	Discussion Information
1.7. Receive assurance on the implementation of the Values and Behaviour Framework, ensure an evaluation of the effectiveness of implementation has been undertaken	Exit Interviews	Assurance
1.8. The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.	Winter Plan – Evaluation and outcomes	
2. **Core Area: Workforce Sustainability and Redesign**		
2.1. Receive assurance that people are appropriately selected, trained supported and responsive to the needs **of** the service, ensuring that professional standards and registration/revalidation requirements are maintained	Freedom to Speak Up Guardians Reports Guardian of Same Working Annual Report and updates Report on mandatory Training Compliance performance Walsall Together update Staffing implications of COVID-19 in March	Approval/assurance Approval/assurance Discussion Information Discussion

Duties (from TORs v.3.0)	Outputs for 2019/20	Purpose (Approval/ Assurance/Information)
2.2. Receive, challenge and approve Trust workforce plans annually. This includes a specific responsibility to seek assurance regarding 'fitness for purpose' for the workforce and its future sustainability.	Workforce plans Internal staff transfer SOP Proposal for Medical Workforce Programme and update Nursing Strategy and Nursing Strategy Implications Evaluation and method and outcomes of winter plan Impact of Lifetime Allowance on Medical Workforce Progress report on minimising agency use Safer Staffing Reports Organisational Development Plan Library Annual Report Time owing balance management Emergency Care Medical Workforce and Ambulatory Emergency Care business case Kark review on fit and proper person test	Approval/Assurance Approval Information Discussion Review Discussion Discussion Assurance/Information Information Information Review Information
2.3. Arrangements are in place for the effective training and education of the workforce in all professions and disciplines. Review progress on plans and actions to improve mandatory training compliance / performance (exception only)	Monthly Workforce Performance Data & Metrics Report on national ESR Issues on Recording training	Review Assurance
2.4. Review progress on the implementation of clinical establishment reviews, rotas and e rostering	Medical and nursing rostering Review of action plan to address NHSI visit regarding staffing establishment setting process Annual establishment review E-rostering – health roster policy	Assurance Assurance Approval Discussion
2.5. Review the appraisal system to ensure that the appraisal delivered is of high quality, undertaking an evaluation of the effectiveness of the system.	Reviews on HR and OD progress Update on Talent Management and appraisals	Information
3. **Core Area: Effective Human Resource Processes**		
3.1. Receive assurance that the Trust's people policies and procedures are in accordance with legislation, NHS guidelines and requirements and are operating within the Trust's overall assurance framework.	Human Resources Policy Framework Updates	Assurance
3.2. Receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce.	Annual flu report and update	Assurance
3.3. Receive assurance and oversight of the employee relations position		

Duties (from TORs v.3.0)	Outputs for 2019/20	Purpose (Approval/ Assurance/Information)
between the Trust and its recognised unions and joint working across the partnership over the year.		
4. **Core Area : Equality and Diversity**		
4.1. The Committee will receive annual reports on progress of delivery of the Trust Equality objectives and an annual assessment of overall performance in relation to Equality outcomes. The Committee will also advise the Trust Board on setting of Trust Equality objectives a report demonstrating compliance with the Public Sector Equality Duty.	EDS2 and WRES Updates Equality Diversity and Inclusion Strategy Review of opportunities and enablers for attracting a diverse workforce	Assurance Discussion
4.2. The Trust is delivering its ambition and legal obligations in relation to the Equality, Diversity and Inclusion opportunity of the workforce	Annual Equalities report Equality Impact assessment for ED establishment Review	Information Information
5. **Core Area : Board Assurance Framework and Corporate Risk Register**		
5.1. To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks.	Workforce risks/Board Assurance Framework reviews	Assurance
5.2. To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.		
6. **Core Area : Other Assurance Functions**		
6.1. Receive assurance that recommendations from audits relation to workforce and development are being progressed and any risks associated with these are being managed.	Not applicable	
6.2. Board Committees are encouraged to utilise the breadth of the Board Committee structure to escalate items to other Board Committees for action. As an example, the Finance, Performance and Investment Committee may escalate an item regarding cost improvement proposals to the Quality, Patient Experience and Safety Committee to further explore and provide assurance on quality impact issues involved. Therefore the Committee with the appropriate expertise is being utilised to provide assurance to another Committee. Actions that are referred to other Board Committees will be recorded by both the escalating Committee and the		

Duties (from TORs v.3.0)	Outputs for 2019/20	Purpose (Approval/ Assurance/Information)
receiving Committee. .		
6.3. The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.		

The above illustrates the effectiveness of the Committee, holding regular meetings with appropriate membership, providing appropriate scrutiny and challenge, and assurance to the Board in its aim for 2019/20 to continue to drive the improvements within the HR function.

The workforce elements of the improvement programme and the frameworks to design and deliver the required transformation to be the employer of choice were a focus for 2019/20, with the organisational development framework scrutinised by the Committee and presented to the Board in February 2020. Training and education in place to support the workforce demands was also a priority and the Committee received assurance on compliance to mandatory training, and discussed the issues related to this at a local and national level.

4. SUB-GROUPS

The Committee has the following groups established for reporting purposes:

- Health and Safety Group
- Equality, Diversity and Inclusion Group
- Health and Wellbeing Steering Group
- Education, Training and Learning Steering Group
- Joint Negotiating Consultative Committee
- Local Negotiating Committee
-

A review of the Terms of Reference and reporting requirements for each group will be undertaken in the 2020/21 year.

5. REVIEW OF TERMS OF REFERENCE

In order to identify efficiencies in reporting and to ensure that the Committee was exercising the appropriate degree of strategic oversight, a deep dive review of the Terms of Reference took place when the Chair met with the lead and others in June. The various initiatives under the improvement programme, bringing together as they do the key duties of the Committee of setting the strategy and holding the executive to account, have enabled a more strategic focus to the duties in the Terms of Reference.

The majority of the changes reflect maturity and serve to provide clarity. Specific duties have been added with regard to sources of assurance that demonstrate the Board's Pledge; approval of workforce KPIs in addition to monitoring; review of the Health and Safety Policy and other key policies within its remit; review of external reports for issues within its remit.

The revised Terms of Reference are attached for the Board's approval.

6. 2020/21 WORK PROGRAMME

The focus of the committee for 2020/21 is to ensure the:

- Development and finalisation of the PIDs for the Valuing Colleagues workstream;
- Review at a greater depth the board assurance framework and actions to mitigate and manage risks (both strategic and corporate);
- Development of the equality, diversity and inclusion strategy;
- Development of the health and wellbeing strategy.

Walsall Healthcare NHS
NHS Trust

REVISIONS TO PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE TERMS OF REFERENCE - JULY 2020

Current (version 3.0)	Proposed revisions July 2020
1. CONSTITUTION 1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the People and OD Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.	No Change
1. PURPOSE 2.1 The purpose of the Committee is to provide assurance to the Trust Board on • 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 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	**2. PURPOSE** No Change

Current (version 3.0)	Proposed revisions July 2020
2. MEMBERSHIP 3.1 Membership shall be appointed by the Board and comprise of: • One Non-executive Director (Chair) • Two other Non-executive Director • Director of People & Culture • Director of Nursing • Director of Strategy & Improvement • Director of Governance	**3. MEMBERSHIP** No change other than to change the title of the Director of Strategy and Improvement.
3. ATTENDEES 4.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda.	**4. ATTENDEES** No change
4. ATTENDANCE 5.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy will count towards quorum and members or their named deputy should ensure 100% attendance.	Change **5. ATTENDANCE** It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year. A named deputy may attend when a member is unable to be present. **Note:** Moved "A named deputy will count towards quorum" to the Quorum section. Removed "and members or their named deputy should ensure 100% attendance" as we have already set the expectation of 75% as a minimum.
6. QUORUM 6.1 The Committee has no decision making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present.	Change **6. QUORUM**

Current (version 3.0)	Proposed revisions July 2020
	The Committee has no decision making authority unless there are 2 Non-Executive Directors, which for the avoidance of doubt shall include Associate Non-Executive Directors, and 2 Executive Directors present. A named deputy will count towards quorum **Note:** Added in clarity around Associate Non-Executive Directors for quorum.
7. FREQUENCY OF MEETINGS 7.1 The Committee will meet on a monthly basis.	Change **7. FREQUENCY OF MEETINGS** The Committee will meet on a monthly basis or as otherwise agreed. **Note**: Added in 'or as otherwise agreed'.
8. CHANGES TO TERMS OF REFERENCE 8.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.	Change **8. CHANGES TO TERMS OF REFERENCE** No Change.
9 ESTABLISHMENT OF SUB GROUPS 9.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference. The Chair of each sub group and or sub committee will be expected to provide a Chairs report to the Committee.	Change **9. ESTABLISHMENT OF SUB GROUPS** 9.1 The Committee may establish sub-groups and/or sub-committees, which may include members of the Committee, to support its work. These may be enduring or time limited. The terms of reference of such sub-groups and/or sub-committees will be approved by this Committee and will be reviewed at least annually. The Committee may delegate work to the sub-groups and/or sub-committee in accordance with the agreed terms of reference. The Chair of each sub-groups and/or sub-committees will provide a Chairs report to the Committee on a frequency agreed with the Committee.

Current (version 3.0)	Proposed revisions July 2020
	Note: Slight change to reflect Committee members do not have to be part of the sub-groups/committees
10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 The Chair of the Committee will agree the agenda for each meeting with the Executive Lead. The Committee shall be supported administratively by the Executive PA whose duties in this respect will include: • Agreement of agenda with Chair and attendees and collation of papers • Taking the minutes • Keeping a record of matters arising and issues to be carried forward • Advising the committee on pertinent issues / areas • Enabling the development and training of Committee members **10.2** All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.	10. **ADMINISTRATIVE ARRANGEMENTS** 10.1 No change. Change 10.2 All papers presented to the Committee must be prefaced by a summary of key issues and clear recommendations developed by the executive lead, which sets out what is required of the Committee.
11. ANNUAL CYCLE OF BUSINESS 11.1 The Committee will develop an annual cycle of business for approval by the Committee at its first meeting of the financial year. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.	**11. ANNUAL CYCLE OF BUSINESS** No change.
12. REPORTING TO THE TRUST BOARD 12.1 The Chair of the Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the quality and safety issues, key risks identified and key levels of assurance	No change

Current (version 3.0)	Proposed revisions July 2020
given.	
13. STATUS OF THE MEETING 13.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee and Executive Lead.	**13. STATUS OF THE MEETING** No change
14. MONITORING 14.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided.	**14. MONITORING** No change
15. PERFORMANCE EVALUATION 15.1 As part of the Board's annual performance review process, the Committee shall review its collective performance.	**15. PERFORMANCE EVALUATION** No change
16. REVIEW 16.1 The terms of reference of the audit committee shall be reviewed by the Board at least annually.	Change **16. REVIEW** 16.1 The terms of reference of the committee shall be reviewed by the Board at least annually.
17. DUTIES	**17. DUTIES**
17.1 LEADERSHIP, CULTURE AND ORGANSATIONAL DEVELOPMENT	**17.1 LEADERSHIP, CULTURE AND ORGANSATIONAL DEVELOPMENT**
• Oversee the initial development and subsequent delivery of the Trust's People and OD Strategies and plans ensuring that they are consistent with the Board's overall strategic direction and with any requirements/guidance set externally. Consider organisational development implications and advise on the development of plans required to deliver the change in culture, leadership, service improvement and processes required by the Trust.	Change 17.1.1 Review and approve the programmes of work to deliver the Valuing Colleagues strategic objective, ensuring they are consistent with the Board's overall strategic direction and with any requirements/guidance set externally, and that they will deliver the required changes in culture, leadership, service improvement and processes required by the Trust.

Current (version 3.0)	Proposed revisions July 2020
	17.1.2 Be assured that the programmes of work approved in 17.1.1 are delivered through the improvement programme or any other agreed means of delivery. **Note**: The OD framework is the basis of the programmes of work under the Valuing Colleagues workstream. 17.1.1 would include review and approval of EDI; FTSU; education & training; health & wellbeing approaches, or endorsement.
• Receive assurance that the Trust has in place structures, systems and processes for effective people management including strong leadership and transparent lines of accountability.	17.1.3 No change **Note:** The process of how the Committee receives assurance here will be the work that Valuing Colleagues is doing with the accountability framework to ensure there is strong leadership and transparent lines of accountability. The mechanics of how this assurance will be provided is to be developed – possibly through a highlight or exception report from the performance meetings to flag where further assurance is to be sought. The Governance and well-led workstream will look at this in the assurance and performance programmes.
• Receive and consider National Staff Survey results and PULSE survey results for the Trust and advice on improvement actions. Oversee the implementation and effectiveness of improvement plans on colleague experience and engagement. Where necessary bring recommendations to the attention of the Board on key people and OD issues affecting those working within the Trust.	Change Combined this and fifth bullet point below. Removed "*Where necessary bring recommendations to the attention of the Board on key people and OD issues affecting those working within the Trust"*, as this will happen by way of a committee highlight report in any event. 17.1.4 Monitor staff engagement and experience, and the plans to achieve a highly motivated and engaged workforce to enhance the quality of patient care. 17.1.5 Receive assurance from staff surveys as to levels of engagement and experience.
• Receive assurance regarding the Trusts compliance with equal pay	17.1.6 Ensure the Trust is compliant with equal pay legislation and conducts an annual equal pay audit

Current (version 3.0)	Proposed revisions July 2020
legislation, principally through an annual Equality Pay Audit.	
• The Trust is monitoring staff engagement and experience, and delivering its plans to achieve a highly motivated and engaged workforce to enhance the quality of patient care	Remove – combined with 17.1.4 and 17.1.5 above.
• Review progress of leadership, talent management and succession planning processes.	Change 17.1.7 Review progress of leadership, talent management and succession planning outcomes and impact **Note:** Reflective of the work maturing from one of oversight of processes to that of outcomes and impact.
• Receive assurance on the implementation of the Values and Behaviour Framework, ensure an evaluation of the effectiveness of implementation has been undertaken	Change 17.1.8 Review the Values and Behaviour Framework, and ensure an evaluation of effectiveness of implementation has been undertaken.
	Proposed addition: Seek out sources of assurance that demonstrate the Trust Board's compliance to its pledge to *"demonstrate through our actions that we listen and support people. We will ensure the organisation treats people equally, fairly and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you"* and report to the Board bi-annually.
• The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.	17.1.9 No change
17.2 WORKFORCE SUSTAINABILITY AND REDESIGN	**17.2 WORKFORCE SUSTAINABILITY AND REDESIGN**
	Proposed addition: 17.2.1 Approve workforce KPIs annually.

Current (version 3.0)	Proposed revisions July 2020
	17.2.2 Oversight on performance of workforce KPIs, ensure agreed targets are met and plans are progressing to address performance issues
• Receive assurance that people are appropriately selected, trained supported and responsive to the needs of the service, ensuring that professional standards and registration/revalidation requirements are maintained	Change 17.2.3 Be assured that people are appropriately selected, trained supported and responsive to the needs of the service. 17.2.4 Be assured that professional standards and registration/revalidation requirements are maintained.
• Receive, challenge and approve Trust workforce plans annually. This includes a specific responsibility to seek assurance regarding 'fitness for purpose' for the workforce and its future sustainability.	Change 17.2.5 Review and approve the Trust's workforce model annually, and ensure it is fit for purpose for the workforce and its future sustainability. 17.2.6 Review the workforce plan annually, and be assured that it is fit for purpose and aligns to the workforce model.
• Arrangements are in place for the effective training and education of the workforce in all professions and disciplines. Review progress on plans and actions to improve mandatory training compliance / performance (exception only)	Change 17.2.7 Ensure arrangements are in place for the effective training and education of the workforce in all professions and disciplines. 17.2.8 Review outcomes of training and education by faculty. **Note**: Specific reference to improving mandatory training compliance is removed. If it is one of the workforce KPIs and is falling behind, the committee will oversee plans to improve it as it would with other KPIs.
• Review progress on the implementation of clinical establishment reviews, rotas and e rostering	17.2.9 No change
• Review the appraisal system to ensure that the appraisal delivered is of high quality, undertaking an evaluation of the effectiveness of the system.	17.2.10 No change

Current (version 3.0)	Proposed revisions July 2020
17.3 EFFECTIVE HUMAN RESOURCE PROCESSES	**17.3 EFFECTIVE HUMAN RESOURCE PROCESSES**
• Receive assurance that the Trust's people policies and procedures are in accordance with legislation, NHS guidelines and requirements and are operating within the Trust's overall assurance framework.	Change 17.3.1 Review any changes to the Health and Safety Policy. 17.3.2 Review any policies that relate to the core duties of the committee. 17.3.3 Ensure the Trust's people and organisational development policies and procedures are current, based on best practice, and compliant with relevant legislation and guidelines.
• Receive reports and action plans on the requirements of new and emerging guidance from regulators and external agencies that relate to workforce.	17.3.4 No change
• Receive assurance and oversight of the employee relations position between the Trust and its recognised unions and joint working across the partnership over the year.	Change 17.3.5 Review any agreements between the Trust and its recognised unions and be assured that such agreements are operating in accordance with those agreements.
17.4 EQUALITY AND DIVERSITY	**17.4 EQUALITY AND DIVERSITY**
• The Committee will receive annual reports on progress of delivery of the Trust Equality objectives and an annual assessment of overall performance in relation to Equality outcomes. The Committee will also advise the Trust Board on setting of Trust Equality objectives a report demonstrating compliance with the Public Sector Equality Duty.	Change 7.4.1 Review the Trust's annual Equality, Diversity and Inclusion objectives for approval by the Board 17.4.2 Be assured that the objectives are being delivered 17.4.3 Receive an annual assessment of the overall performance and impact of the objectives and compliance with the Public Sector Equality Duty.
• The Trust is delivering its ambition and legal obligations in relation to the Equality, Diversity and Inclusion opportunity of the workforce	Remove. Incorporated above by way of approval of the objectives and oversight on delivery above.
17.5 BOARD ASSURANCE FRAMEWORK AND COPORATE RISK REGISTER	**17.5 BOARD ASSURANCE FRAMEWORK AND COPORATE RISK REGISTER**
• To review the status of the top-level strategic risks owned by the	Change

Current (version 3.0)	Proposed revisions July 2020
Committee by reviewing the actions being taken to mitigate risks.	17.5.1 Review the Board Assurance Framework ("BAF") for risks within the Valuing Colleagues strategic Objective on a frequency set out in the Risk Management Policy
• To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.	17.5.2 Be assured that there are plans in place to address gaps in controls and gaps in assurance, and oversight of such plans
17.6 OTHER ASSURANCE FUNCTIONS	**17.6 OTHER ASSURANCE FUNCTIONS**
• Receive assurance that recommendations from audits relation to workforce and development are being progressed and any risks associated with these are being managed.	Change 17.6.1 Review audits conducted on areas within the remit of this committee and quarterly updates on progress against recommendations
• Board Committees are encouraged to utilise the breadth of the Board Committee structure to escalate items to other Board Committees for action. As an example, the Finance, Performance and Investment Committee may escalate an item regarding cost improvement proposals to the Quality, Patient Experience and Safety Committee to further explore and provide assurance on quality impact issues involved. Therefore the Committee with the appropriate expertise is being utilised to provide assurance to another Committee. Actions that are referred to other Board Committees will be recorded by both the escalating Committee and the receiving Committee.	17.6.2 No change
• The Committee will also consider matters referred to it by other committees and groups across the Trust provided they are within the Committee's remit.	Remove. This is set out at 17.1.9 above
	Proposed addition: Receive external assurance reports from CQC and other regulatory/statutory bodies in relation to the workforce agenda and ensure management responses/action plans are robust, and oversee such action plans.

ANNUAL REPORT ON COMMITTEE EFFECTIVENESS 2019/20
NOMINATION AND REMUNERATION COMMITTEE

1. INTRODUCTION

This report sets out the work of the Nomination and Remuneration Committee during 2019/20 and the Committee's priorities for 2020/21.

The Committee met five times in 2019/20.

2. MEMBERSHIP OF THE COMMITTEE

The Terms of Reference provide that members are the Non-Executive Directors of the Trust Board. No change is proposed to the membership for 2020/21.

Members are expected to attend 75% of meetings. Attendance through the 2019/20 year was as follows:

Position	Name	% Attendance	No. of Eligible Meetings	Attendance
Non-Executive Director (Chair)	Danielle Oum	100%	5	5/5
Non-Executive Director	John Dunn	80%	5	4/5
Non-Executive Director	Phillip Gayle	80%	5	4/5
Non-Executive Director	Sukhbinder Heer	100	5	5/5
Non-Executive Director	Anne Baines	60%	5	3/5
Non-Executive Director (from Nov)	Pam Bradbury	50%	2	1/2
Non-Executive Director (from Nov)	Ben Diamond	100%	2	2/2

The Associate Non-Executive Directors are in attendance at meetings, and the Chief Executive, Director of People and Culture, and Director of Governance attend at the invitation of the Chair.

The Committee was quorate at each meeting in 2019/20.

3. REVIEW OF EFFECTIVENESS

A review of the effectiveness of the Committee was undertaken in June by the Chair of the Committee, the Director of Governance, and the Trust Secretary. This review considered the suitability of the Terms of Reference and the content and structure of various reports the Committee reviews on a regular basis, providing guidance on streamlining reporting and requirements for assurance. These will be reflected in the cycle of business.

The Committee met on 17th August and considered the discharge of its duties for the 2019/20 year as follows:

Duties	Outputs for 2019/20	Purpose (approval/ assurance)
1. To determine pay and reward strategy for Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board) including bonus payments and eligibility criteria	Executive Pay Review – March 2020 Executive Team Portfolio and Structure – March 2020	Information Information
2. To determine the remuneration and terms / conditions of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board)	Pay review for senior and VSM – November 2019 and December 2019	Approval
3. To ensure fair reward for individual contribution to the organisation and having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate	Implementation of remuneration for Chairs and Non-Executive Directors – December 2019	Information
4. To receive a report from the Trust Chair on the annual performance of the Chief Executive and to give comment before the Chief Executive's annual appraisal is completed		
5. To receive a report from the Chief Executive on the annual performance of the Executive Directors (voting and non-voting members of the Trust Board) and to give comment before their annual appraisals are completed		
6. To consider any remuneration issues of significance to the Trust that do not comply with Trust or national pay / terms and conditions	Redundancy Payments – Health Visiting Service – June 2019 Redundancy Payments – HR – June 2019 Redundancy Payment – August 2019 Impact of pensions tax August 2019, November 2019 and March 2020 Living Wage Accreditation – November 2019	Approval Approval Approval Information Discussion Approval
7. To receive and consider any matters relating to the test for Fit and Proper Person (FPPT) for Trust Directors and employees within the scope of the test, where a decision of the Committee is required.		

During the review it was identified that there were areas which had not been discussed by the Committee during 2019/20, and it was agreed that the revised cycle of business following approval of the amended terms of reference would ensure the relevant matters were appropriately timetabled for the Committee.

8. REVIEW OF TERMS OF REFERENCE

In order to identify efficiencies in reporting and to ensure that the Committee is exercising the appropriate degree of oversight, a review of the Terms of Reference took place when the Chair met with the Director of Governance and Trust Secretary in June.

The changes to the Terms of Reference align with the Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The commitment of the Committee at the last review to include a nominations role focussing on succession planning, skill mix and high cost appointments has been included in the proposed revisions, as has succession planning and skill mix of the Non-Executive and Executive Directors. An explicit duty regarding severance packages has been added.

The revised Terms of Reference are attached for the Board's approval.

9. 2020/21 WORK PROGRAMME

During 2020/21 the Committee will ensure all requirements of the fit and proper person regulations are adhered to; review the succession planning for the Executive Directors and members of the Trust Board; and maintain oversight of the performance of the Chief Executive and Executive Directors by reviewing their appraisals in August 2020.

Walsall Healthcare NHS
NHS Trust

REVISIONS TO NOMINATIONS AND REMUNERATION COMMITTEE TERMS OF REFERENCE

Current (version 3.0)	Proposed revisions July 2020
1. CONSTITUTION 1.1 The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Nominations and Remuneration Committee (The Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.	No Change
2. PURPOSE 2.1 The purpose of the Committee is to determine, on behalf of the Trust board, the remuneration and terms of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board).	Change The purpose of the Committee is to: 2.1 Determine, on behalf of the Trust board, the remuneration and terms of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board); the setting of remuneration and conditions of service for other employees; and approval of severance packages. 2.2 Review the annual objectives of the Chief Executive and Executive Directors and ensure there is appropriate succession planning in place. 2.3 Recommend the appointment of the Chief Executive and, with the latter, the appointment, discipline and dismissal of Executive Directors

Current (version 3.0)	Proposed revisions July 2020
	2.3 Review the structure, size, composition, diversity and succession plans for the Trust Board. 16.14 Ensure compliance with Fit and Proper Persons regulation.
3. MEMBERSHIP 3.1. Membership shall be all Non-Executive Directors of the Trust Board.	No Change
4. ATTENDEES 5.1 Associate Non-Executive Directors are in attendance at the meeting. 5.2 The Chief Executive, Director of OD & HR and Director of Governance will attend the Committee at the invitation of the Chairman but will not be involved in decision making regarding their own (in the case of the Chief Executive) remuneration.	**5. ATTENDEES** 5.1 No change 5.2 Change: The Chief Executive, Director of People and Culture, and Director of Governance will attend the Committee at the invitation of the Chair but will not be involved in decision making regarding their own remuneration. The Trust Secretary shall be in attendance and minute the meeting.
5. ATTENDANCE 6.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year.	No change
7. QUORUM 6.1 The Committee has no decision making authority unless 60% of the members are present.	No change
8. FREQUENCY OF MEETINGS 8.1 The Committee will meet as required throughout the year, but at least twice to review performance of the Chief Executive and Executive Directors (voting	**8. FREQUENCY OF MEETINGS** 8.1 Change: The Committee will meet at least twice per year

Current (version 3.0)	Proposed revisions July 2020
and non-voting members of the Trust Board). 8.2 Meetings will be expected to last no more than 2 ½ hours routinely.	8.3 Remove
9. CHANGES TO TERMS OF REFERENCE 9.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.	No change
10 ESTABLISHMENT OF SUB GROUPS 10.1 The Committee may establish sub groups and / or sub committees made up wholly or partly of members of the Committee to support its work. The terms of reference of such sub group and sub committee will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group and or sub committee in accordance with the agreed terms of reference.	**10. ESTABLISHMENT OF SUB GROUPS** No change
11. ADMINISTRATIVE ARRANGEMENTS 11.1 The Chair of the Committee will agree the agenda for each meeting with the Director of Governance. The Committee shall be supported administratively by the Director of Governance and the Executive PA who's duties in this respect will include: • Agreement of agenda with Chair and attendees and collation of papers • Taking the minutes • Keeping a record of matters arising and issues to be carried forward • Advising the committee on pertinent issues / areas	11.1 No change 11.2 Change: All papers presented to the Committee must be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee

Current (version 3.0)	Proposed revisions July 2020
• Enabling the development and training of Committee members 11.2 All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee	
12. ANNUAL CYCLE OF BUSINESS 12.1 The Committee will develop an annual cycle of business for approval by the Trust Board meeting at its first meeting of the financial year. The Committee work plans informs the standing agenda items as described within the terms of reference, to ensure that all regulatory and legislative items are adequately reviewed and acted upon.	No change
13. REPORTING TO THE TRUST BOARD 13.1 The Chair of the Committee will provide a highlight report monthly to the Trust Board outlining key actions taken with regard to the issues, key risks identified and key levels of assurance given.	**13. REPORTING TO THE TRUST BOARD** Change by removing 'monthly' to 'following each meeting'
14. STATUS OF THE MEETING 14.1 All Committees of the Trust Board will meet in private. Matters discussed at the meeting should not be communicated outside the meeting without prior approval of the Chair of the Committee.	No change
15. MONITORING 15.1 The Committee will provide the Trust Board with an Annual Report setting out the issues that have been considered by the Committee and details of assurance provided.	No change
16. DUTIES	**16. DUTIES**

Current (version 3.0)	Proposed revisions July 2020
	Change **Add Heading: REMUNERATION**
16.1 To determine pay and reward strategy for Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board) including bonus payments and eligibility criteria	Change 16.1 Advise the Board as to the appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and senior employees including all aspects of salary (including any performance-related elements/bonuses) and provisions for other benefits, including pensions and cars to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff 16.2 In the case where a new or uplifted salary is at or above £150,000pa, external approval may also be required in accordance with any guidance in place at the time. (The current threshold is benchmarked against the Prime Ministers salary, set by NHS Improvement requiring their external approval) 16.3 Consider appropriate benchmarking data when considering the overall market positioning of Chief Executive and Executive Director remuneration packages.
16.2 To determine the remuneration and terms / conditions of service for the Chief Executive and other Executive Directors (voting and non-voting members of the Trust Board)	Remove as merged above.
16.3 To ensure fair reward for individual contribution to the organisation and having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate	Remove as merged above.
16.4 To receive a report from the Trust Chair on the annual performance of	Change

Current (version 3.0)	Proposed revisions July 2020
the Chief Executive and to give comment before the Chief Executive's annual appraisal is completed	16.4 The Committee will receive a report from the Chair of the Trust Board on the annual objectives of the Chief Executive.
16.5 To receive a report from the Chief Executive on the annual performance of the Executive Directors (voting and non-voting members of the Trust Board) and to give comment before their annual appraisals are completed	Change 16.5 The Committee will receive a report from the Chief Executive on the annual objectives of the individual executive directors.
16.6 To consider any remuneration issues of significance to the Trust that do not comply with Trust or national pay / terms and conditions	Change 16.6 To consider remuneration issues of significance to the workforce, or that do not comply with the national pay policy terms and conditions.
	Add 16.7 Endorse for approval by the Board, proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by this Committee. 16.8 Ensure that the policies of the Trust Board on remuneration and terms of service are applied consistently. 16.9 To approve severance packages as follows: o All severance packages, regardless of value for Chief Executive and Executive Directors; o All non-contractual severance packages, regardless of value, for all staff; and o Severance packages of over £100,000 for all staff

Current (version 3.0)	Proposed revisions July 2020
16.7 To receive and consider any matters relating to the test for Fit and Proper Person (FPPT) for Trust Directors and employees within the scope of the test, where a decision of the Committee is required.	Moved to 16.12 below
	Add Section: APPOINTMENTS Add: 16.10 Recommend to the Trust Board the appointment of the Chief Executive (noting that NHSI has the ultimate responsibility to appoint) and, with the latter, the appointment, discipline and dismissal of Executive Directors. 16.11 Where urgency requires it, the Chair may take Chair's action in respect of duty 16.10, reporting the recommendations to the Committee by email and fully at the next meeting.
	Add: 16.11 Provide assurance to the Board that there is appropriate succession planning in place for executive directors. 16.12 Ensure there is appropriate governance in place for high cost interim appointments 16.13 Review annually the structure, size, composition, diversity and succession plans for the Trust Board 16.14 Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation. 16.14 Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.

MEETING OF THE PUBLIC TRUST BOARD 3rd September 2020			
Well Led Improvement update			**AGENDA ITEM: 15**
Report Author and Job Title:	Jenna Davies Director of Governance	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The overall aim of the well Led improvement workstream is to improve the Trusts leadership, governance and assurance structures using the CQC Well Led Key Lines of Enquiry (KLOE). This workstream was added to the improvement in April 2020. The SRO for the workstream is the Director of Governance, supported by the Director of Finance and the Director of Planning and Improvement. The workstream incorporates the recommendations from several internal and external reviews including • CQC Inspection July 2019 • Outcome report and recommendations from Governance and Accountability review conducted by Deloitte in January-March 2018 • Internal Audit reports specifically Board Assurance Framework and Risk Management. The Well led improvement workstream has 5 underpinning focus areas; • Board Governance- Led by Trust Secretary • Assurance- Led by Interim Assurance lead • Accountability and Support- Led by Director of Finance, and Performance • Integrated Governance- Led by Interim Deputy Director of Governance • Strategy and Business Planning- Led by the Director of Planning and improvement. The Core team meeting has been established on a monthly basis reporting to the improvement board. In addition, a weekly meeting has been established to ensure that the workstream is progressing at the required pace. The key deliverables to date; • Board Effectiveness project underway, and annual effectiveness review as completed with the outputs reported to the Committees and the Board through August and September.		

	• Risk Management project is underway with a review of risk appetite statements, revised governance and reporting process presented to Audit Committee. • Incident reporting project has commenced which is focused on the delivery of a revised framework for addressing the new national expectations, as well strengthening the learning from all adverse events (complaints, mortality etc.) There are risks to the delivery of the workstream which are detailed within the paper. The highest rated across the whole workstream relates to resource, both in terms of project management support and capacity within the governance team and wider workforce to deliver the projects. Several conversations have taken place at both at Executive and Programme level about identifying resource to support well led, as the programme does not have a dedicated programme manager which has impacted the development of comprehensive PIDs. A workstream has been held to review the 20/21 projects and reprioritise based on capacity, the projects which will be prioritised are; • Accountability framework • Incident framework and learning from adverse events • Risk Management • Board Effectiveness • Governance Framework • Business planning project	
Recommendation	Members of the Trust Board are asked to note the report and the risks to the delivery of the workstream	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Well led workstream is fundamental in terms of Risk Management and improvements of risk management systems and processes. The delivery of actions contained within the workstream will create a stronger control environment within the Trust.	
Resource implications	There is a risk outlined in the paper in relation to resource to deliver the programme, however any additional resource requirements would be requested via business case and appropriate approval processes.	
Legal and Equality and Diversity implications	Boards have a duty to demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing Safe and High-Quality care. Robust governance processes and open, transparent leadership should give staff at all levels confidence about their capability to maintain and continuously improve services.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒

	Partners ☒	Value colleagues ☒
	Resources ☒	

Well led Improvement Programme Update

1. PURPOSE OF REPORT

The Purpose of this report is to provide the Board with an overview of the Well led workstream, and progress to date. This report also outlines risks to delivery of the workstream.

2. BACKGROUND

The Trust has the aim to achieve an 'outstanding' rating by 2022. In order to achieve this, aim the Trust has established a comprehensive improvement programme as the vehicle to deliver and oversee the required improvements. The Improvement programme has 6 workstreams, 5 which links to our overall strategic objectives, and a workstream was added in April 2020 around 'Well Led'.

3. WELL LED WORKSTREAM

The overall aim of the well Led improvement workstream is to improve the Trusts leadership, governance and assurance structures using the CQC Well Led Key Lines of Enquiry (KLOE). This workstream was added to the improvement in April 2020. The SRO for the workstream is the Director of Governance, supported by the Director of Finance and the Director of Planning and Improvement.

The workstream incorporates the recommendations from several internal and external reviews which including;

- Outcome report and recommendations from Governance and Accountability review conducted by NHSi
- CQC recommendation 2019
- Internal Audit reports

3.1 NHSI Governance and Accountability review

In October 2019 the Chairman and Chief Executive, requested NHSi completed a Governance and Accountability review which was presented to the Trust Board in May 2020, the Board asked for assurance that the recommendations from the review have been reflected within the individual workstreams of the improvement programme.

A mapping exercise has been completed of the 49 recommendations contained within the report and aligning them with the projects contained within the improvement programme;

- Board Governance Project has 1 recommendation aligned to the overall governance framework of the Trust, SFI, standing orders and the scheme of delegation and ensuring cultural alignment

- Assurance workstream has 5 recommendations which all relate to the risk management project.
- Accountability and Planning workstream has 9 recommendations aligned. These can be themed into three areas. The first theme relates to the accountability framework and ensuring cultural alignment. The second theme relates to the business partnering approach within the Trust. The third area relates to business processes and benefits realisation processes.
- Integrated Governance workstream has 5 recommendations which relate to the effectiveness of the Trust Governance process at divisional and care group level.
- Strategy and Planning workstream has 18 recommendations which relate to the Project Management office and specifically the support at divisional level and the Business planning processes.
- Leadership Culture and Organisational Development has 6 recommendations around leadership development and engagement.
- Organisational Effectiveness has 5 recommendations which relate to recruitment processes and improving HR policies to align to cultural changes.

At this time, we cannot give full assurance that the actions have been included in individual PIDs and the recommendation is that the Committees of the Board to gain assurance through the review of the Project Initiation document of each project that the individual actions have been reflected within each project and also gain assurance moving forward that the recommendations are being addressed.

4. WORKSTREAM UPDATE

4.1 Board Governance Workstream

The Project Initiation document has been completed and presented to the Well Led core team. This project includes three workstreams Governance framework, Board Effectiveness, and statutory and regulatory compliance.

The Effectiveness project is making good progress with the effectiveness reviews completed and Terms of reference revisions proposed for all committees. The Annual reports and amended terms of reference have been reviewed by Performance, Finance, and Investment Committee, People Organisational Development Committee and Quality Patient Experience and Safety Committee.

4.2 Assurance Workstream

The Project Initiation document has been completed and presented to the Well Led core team. This project includes 8 workstreams. The high-level project initiation documents for each of the 8 workstreams have been completed and interdependencies have been mapped. However further work is required on the benefits realisation, a workshop has been arranged early in September to further develop the benefits.

The Risk Management project sits within this workstream and is currently on track with delivery. A number of key actions have already been completed including;

- The formation of an executive lead risk management group, chaired by the Chief Executive which will report to the Audit Committee on a bi-annual (six monthly) basis on the effectiveness of the systems and processes the group has established relating to risk management, any significant weaknesses or failings that have been identified and the conclusions of any testing carried out by internal and/or external auditors and/or other consultants
- A revised BAF and CRR which has been presented on a monthly basis to the Committees and the Board.
- A confirm and challenge framework has been developed which aims to bring consistency of approach at each tier of the Trust's review and scrutiny of risks within the Trust.
- Progress continues to be made on the development of revised risk appetite statements, and throughout August, Members of the Committees are meeting with the Director of Governance together with an external consultant to refine the statements before being presented to the Board.

4.3 Accountability & Support

The Project Initiation document has been completed and presented to the Well Led core team. This project includes 5 workstreams including accountability framework, business partnering model, business process, integrated performance reporting, and procurement process.

The Accountability framework is a priority workstream, and this has an interdependency with the valuing colleagues workstream associated with the people metrics contained with the framework. The action plan associated with the delivery of the accountability framework has been mapped against the findings contained within the NHSi governance and accountability review.

4.4 Integrated Governance

The Project Initiation document is under development, however a high level PID has been presented to the Well Led core team. Further work is currently underway supported by the SRO for the overall programme. This project includes 8 workstreams. Three of the projects have commenced;

- Adverse events framework, this project is aligning all the adverse events processes within the Trust as well incorporating changes at a national level, owing to the changes to the national incident framework.
- IG / Data Security, this project is underway linked to the national Data Security and Protection Toolkit
- SafeGuard Project, this project focuses on the Trust governance system safeguard. The Safeguard system is used for our risk, incident, and duty of candour processes. The current system was implanted in 2017, on feedback from staff the current system requires further work to ensure I supports staff and leaders within the Trust to manage their risks, and incidents. The system is also being expended to enable us to manage litigation and complaints which will enable us to link all adverse events and centralise in one place all records associated.

4.5 Strategy & Business Planning

The Strategy and Business Planning workstream Project Initiation has been developed at a high level. This workstream is led by the Director of Planning and Improvement. We agreed as part of the improvement board that this workstream would deliver a high level PID, and outline actions until September to enable the recently appointed Director of Planning and Improvement can review the workstream and agree the Project Initiation document. Progress has been made in the following areas;

- Corporate Objectives; the corporate objectives have been updated and are now aligned with our BAF
- Business Planning; Business planning process is being socialised with divisions, and we have commenced alignment of business plans and efficiency improvement plans onto “plan on a page”

5. WORKSTREAM RISKS AND ISSUES

There are a number of risks associated with the delivery of the workstream, which have been reported via the core team and the higher rated risks have been reported to the overall Improvement Board.

The red rated risks for the workstream;

- The Lack of an identified project manager has impacted on the overall delivery of the programme, specifically this has impacted on the development of the overall project initiation documents, and mapping of the interdependencies across the improvement programme. This has been discussed at the Improvement programme Board, and an interim support has been identified and will commence in September.
- There is a lack of capacity within the governance team to support the delivery of the well led workstream. This not only impacts on the delivery of the well led workstream but also impacts on the team’s ability to engage and be involved in interdependent workstreams across the whole improvement programme. A workshop was held with the governance team to review the improvement programme, and specifically the well led workstream to agree prioritisation of projects for the 2020/21 year. The projects which will be prioritised are;
    - Accountability framework
    - Incident framework and learning from adverse events
    - Risk Management
    - Board Effectiveness
    - Governance Framework
    - Board to Ward operational governance- Phase 1
    - Business planning project

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
Use of Trust Seal			**AGENDA ITEM: 15 ENC: 24**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	In accordance with the Trust's Standing Orders the Seal of the Trust is affixed to a document that has been authorised by a resolution of the Board or of a Committee of the Board, or where the Board has delegated its powers[1]. Use of the Trust Seal is reported at least quarterly, with the report containing details of the seal number, the description of the document and date of sealing[2]. The following have been noted in the Register of Sealings: 1. Transaction number 160 dated 12th March 2019 for land sale, Town Wharf. The document was witnessed by Richard Beeken and Jenna Davies. 2. Transaction number 161 dated 14th March 2020 for P22 FA Template A: Major Project Works PFI. The document was witnessed by Richard Beeken and Russell Caldicott. 3. Transaction number 162 dated 1st May 2020 for Deed of Variation – Project Agreement – Network and Comms. The document was witnessed by Richard Beeken and Russell Caldicott.		
Recommendation	The Committee is asked to note the use of the Trust Seal, the details of which have been reviewed by the Audit Committee at their meeting on 28th August.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		

[1] Standing Order 8.2
[2] Standing Order 8.3

Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd September 2020			
NHSI – Review of Undertakings			**AGENDA ITEM: 16 ENC: 25**
Report Author and Job Title:	Trish Mills – Trust Secretary	**Responsible Director:**	Jenna Davies, Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	NHS Improvement accepted enforcement undertakings from the Trust on 19 December 2017 in relation to quality, operational performance and financial issues after the Trust was placed into special measures for quality. In July 2019, the Trust exited special measures and NHS England and NHS Improvement accordingly issued a compliance certificate in respect of paragraph 1 (Quality), 4 (Buddy trust and other partnerships) and 5 (Leadership and governance) of the December 2017 undertakings. Revised undertakings were signed in October 2019 (attached at Appendix 1) as NHS England and NHS Improvement continued to have concerns about the Trust's finances and operational performance in relation to sustained performance against the A&E 4-hour and diagnostics targets. These undertakings committed the Trust Board to demonstrating that there are clear plans which lead to improvements in performance on key priorities which the Board has already identified NHSI will review progress against the undertakings in October 2020, with such review informing future undertakings. Progress against the Undertakings will be reported to the Trust Board on 1st October 2020 and thereafter to NHSI.		
Recommendation	The Trust Board is requested to note the timelines for the progress review which will be reported to the Trust Board on 1st October.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This paper relates to BAF S01 (safe, high quality care) with respect to quality improvement and CQC action plans; BAF S06 (use resources well) with respect to financial and operational performance		
Resource implications	There are no resource implications associated with this paper		
Legal, Equality and Diversity	This report relates to issues which affect the Trust's license and compliance certificate issued by NHSEI in July 2019.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☒		

ENFORCEMENT UNDERTAKINGS

NHS TRUST:

Walsall Healthcare NHS Trust ("the Trust")
Moat Road,
Walsall,
West Midlands,
WS2 9PS

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS England and NHS Improvement under or by virtue of the National Health Service Act 2006 and the TDA Directions, NHS England and NHS Improvement has decided to accept undertakings from the Trust.

BACKGROUND:

NHS Improvement accepted enforcement undertakings from the Trust on 19 December 2017 in relation to Quality, Operational performance and Financial issues after the Trust was placed into special measures for quality.

In July 2019, the Trust exited special measures and NHS England and NHS Improvement accordingly issued a compliance certificate in respect of paragraph 1 (Quality), 4 (Buddy trust and other partnerships) and 5 (Leadership and governance) of the December 2017 undertakings.

Although the Trust made some progress against the remaining parts of the December 2017 undertakings, NHS England and NHS Improvement continues to have concerns about the Trust's finances and its operational performance in relation to sustained performance against the A&E 4-hour and diagnostics targets.

NHS England and NHS Improvement is now taking regulatory action in the form of these updated undertakings which replace and supersede the outstanding December 2017 undertakings.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS England and NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TDA Directions;

"NHS England and NHS Improvement" means the National Health Service Trust Development Authority;

"TDA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

The Trust is an NHS trust all or most of whose hospitals, facilities and establishment are situated in England.

2. Issues and need for action

NHS England and NHS Improvement has reasonable grounds to suspect that the Trust has provided and is providing health services for the purposes of the health service in England while failing to comply with the following conditions of the Licence FT4(5)(a) to (g), and FT4(6)(a)to (f).

In particular:

Quality Improvement

2.1. The Trust was placed into Special Measures in February 2016 following its comprehensive CQC inspection in September 2015 where the Trust was rated 'Inadequate' overall.

2.2. The Trust exited Special Measures in July 2019 following a further announced core services and well-led inspection in February and March 2019. The Trust was rated overall as 'Requires Improvement.' The CQC's report of 25 July 2019 sets out the outstanding concerns on the Trust's performance on quality issues.

2.3. A requirement of the Trust exiting Special Measures is that there is a comprehensive exit support plan in place which addresses the outstanding CQC areas of concern.

Financial issues

2.4. The Trust has reported a 2018/19 draft year-end deficit, before Provider Sustainability Fund (PSF) of £29.702m, which is £14.237m worse than planned. The year-end variance to plan is due to failure to control nursing and medical workforce pressures and some delays in outpatient productivity schemes. In particular, medical locum expenditure has not reduced as planned and ward nursing has overspent due to above plan fill rates, unfunded night posts and poor rota grip and control leading to high unpaid leave and sickness. The 2018/19 financial performance is a deterioration on the 2017/18 outturn deficit of £24.801m.

2.5. The Trust has submitted a control total compliant financial plan for 2019/20 which will deliver a deficit of £18.380m pre-PSF. The Trust remains in enhanced financial oversight led by the NHS England and NHS Improvement sub-regional finance team.

Operational performance

2.6. An urgent care system improvement plan has been developed and ECIST support has been provided, however there are ongoing challenges to deliver against the 4-hour emergency care standard and the improvement trajectory.

2.7. The impact of financial decisions made at the end of 2018/19 resulted in deterioration in the performance against the diagnostic standard.

2.8. During quarter 1 of 2019/20, the Trust saw deterioration against the 2-week wait, 2-week breast and 62-day cancer standards as a consequence of the diagnostic challenges.

3. Failures and need for action

These failings by the Trust demonstrate a failure of governance arrangements including, in particular:

3.1. Failure to establish and effectively implement systems or processes:

3.1.1. to ensure compliance with the Trust's duty to operate efficiently, economically and effectively;
3.1.2. for timely and effective scrutiny and oversight by the Board of the Trust's operations;
3.1.3. to ensure compliance with healthcare standards binding on the Trust.

3.2. Need for action:

NHS England and NHS Improvement believes that the action which the Trust has undertaken to take pursuant to these undertakings, is action required to secure that the governance failures in question do not continue or recur.

UNDERTAKINGS

NHS England and NHS Improvement has agreed to accept and the Trust has agreed to give the following undertakings.

4. Quality Improvement (post Special Measures)

4.1 The Trust will work with NHS England and NHS Improvement to ensure that the post Special Measures exit support plan as agreed with NHS England and NHS Improvement is fully implemented within 12 months of the date of these undertakings.

4.2 The Trust will provide progress updates against the exit support plan as part of the NHS England and NHS Improvement regular oversight arrangements.

4.3 The Trust should continue to develop and take all reasonable steps to implement Quality Improvement Plans to address the concerns identified in, but not limited to, CQC reports. The Trust will provide progress updates on the progress with their

plans, advising NHS England and NHS Improvement of any matters that materially affect their ability to deliver the plans within agreed timelines.

4.4 The Trust will ensure that it has sufficient capacity at both executive and other levels of management to enable delivery of quality improvements, and ensure that these measures do not compromise its overall financial position.

5. Finance Performance

2019/20 Performance

5.1. The Licensee will ensure that robust financial plans are in place to:
- 5.1.1. deliver the 2019/20 control total and planned CIPs; and
- 5.1.2. minimise the revenue cash support requirement.

5.2. The Licensee will take all reasonable steps to ensure that 2019/20 CIP plan, as set out in plans submitted to NHS England and NHS Improvement in May 2019, are fully delivered with full assessment being completed on the impact of schemes on quality and the Licensee's underlying financial position.

5.3. The Licensee will comply with planning guidance issued by NHS England and NHS Improvement in January 2019 and June 2019 related to receipt of the financial recovery fund in 2019/20. The Licensee will have in place financial recovery plans as part of the five-year system level strategic plans by December 2019. These plans will demonstrate recurrent financial improvement as measured by I&E run-rate and planned financial outturn, and which return the Licensee to sustainable financial balance.

5.4. The Licensee will develop a long-term financial model (LTFM) to achieve a sustainable financial position that aligns with the Black Country and West Birmingham Sustainability and Transformation Plan (the STP); the Licensee's strategic direction and the STP strategic and financial context. The Licensee will work constructively with STP partners to develop a long-term plan in line with guidance issued by NHS England and NHS Improvement in June 2019. The Licensee will agree the long-term plan with system leads and partners by mid-November 2019 and publish the plan in December 2019.

Governance

5.5. The Trust should ensure that appropriate governance arrangements are in place to deliver both the submitted 2019/20 plan and the medium-term financial strategy. These structures will be reviewed and approved by the NHS England and NHS Improvement regional team.

6. Operational Performance

6.1 The Trust will take all reasonable steps to recover operational performance to meet national standards in relation to the 4 hour Urgent and Emergency care standard and the diagnostic standard, including but not limited to those set out in paragraphs 6.2 to 6.4, below.

6.2 The Trust will ensure that there are robust improvement plans in place to meet the requirements of paragraph 6.1, which has been agreed with NHS England and NHS Improvement.

6.3 The improvement plans will, in particular:

6.3.1 include the actions required to meet the requirements of paragraph 6.1, with appropriate timescales, key performance indicators and resourcing;
6.3.2 describe the key risks to meeting the requirements of paragraph 6.1 and mitigating actions being taken;
6.3.3 be based on realistic assumptions;
6.3.4 reflect collaborative working with key system partners and other stakeholders;
6.3.5 set out the key performance indicators which the Trust will use to measure progress.

6.4 The Trust will keep the improvement plans and their delivery under review and provide appropriate assurance to its Board regarding progress towards meeting the requirements of paragraph 6.1, such assurance to be provided to NHS England and NHS Improvement on request. Where matters are identified which materially affect the Trust's ability to meet the requirements of paragraph 6.1, whether identified by the Trust or another party, the Trust will notify NHS England and NHS Improvement as soon as practicable and update and resubmit the performance plan within a timeframe to be agreed with NHS England and NHS Improvement.

7. Programme management

7.1 The Trust will develop and implement or where appropriate, strengthen, Trust-wide governance and programme management processes to manage and deliver sustained performance covered by these enforcement undertakings. Such programme management and governance arrangements must enable the board to:

7.1.1 obtain clear oversight over the process in delivering these undertakings;
7.1.2 obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
7.1.3 hold individuals to account for the delivery of the undertakings.

7.2 In the event that successful delivery of the financial and operational improvement plans do not result in corresponding sustained improvements, the Trust will consult with NHS England and NHS Improvement and other stakeholders on alternative course of actions.

8. Access

8.1. The Trust will provide to NHS England and NHS Improvement direct access to its advisors, programme leads and the Trust's board members as needed in relation to the matters covered by these undertakings.

9. Meetings and reports

9.1. In addition to the action in paragraph 4.2 (reporting in relation to the special measures exit plan) the Trust will:

9.1.1 attend meetings or, if NHS England and NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England and NHS Improvement; and

9.1.2 provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.

Any failure to comply with the above undertakings may result in the NHS England and NHS Improvement taking further formal action. This could include giving directions to the Trust under section 8 of the National Health Service Act 2006.

THE TRUST

Richard Beeken
Chief Executive

4th October 2019

NHS ENGLAND AND NHS IMPROVEMENT

Signed (Acting Director of Strategic Transformation (West Midlands) and member of the Midlands Regional Support Group)

Dated 8/10/2019