Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 1 OCTOBER 2020 AT 12:00 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	Director of People & Culture	Verbal	12.00
2.	Apologies for Absence	Information	Chair	Verbal	12.15
3.	Quorum and Declarations of Interest	Information	Chair	ENC 1	
4.	Minutes of the Board Meeting Held on 3rd September 2020	Approval	Chair	ENC 2	
5.	Matters Arising and Action Sheet	Review	Chair	ENC 3	12.20
6.	Chair's Report	Information	Chair	ENC 4	12.25
7.	Chief Executive's Report	Information and Assurance	Chief Executive	ENC 5	12.30
8.	8.1 Restoration & Recovery Update 8.2 Winter Plan	Information Approval	CEO/ Chief Operating Officer	ENC 6	12.40
9.	COVID-19 Board Assurance Framework	Assurance	Chief Operating Officer	ENC 7	12.55
10.	**PROVIDE SAFE HIGH QUALITY CARE**				
	10.1 Quality, Patient Experience and Safety Committee Highlight Report	Assurance/ Information	Chair of QPES	ENC 8	13.00
	10.2 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 9	13.05
	10.3 Quality Account	Approval	Director of Governance	ENC 10	13.20
11.	**CARE AT HOME**				
	11.1 Walsall Together Partnership Board Highlight Report	Assurance/ Information	Chair of WTPB	ENC 11	13.30
	11.2 Executive Report – Care at Home Appendix 1: Board Assurance Framework Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of Integration	ENC 12	13.35
COMFORT BREAK – 13.45-14.15					
12.	**VALUE OUR COLLEAGUES**				
	12.1 People and Organisational Development Committee Highlight Report	Assurance/ Information	Chair of PODC	ENC 13	14.15
	12.2 Executive Report – Value Our Colleagues Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report	Assurance/ Information	Director of People & Culture	ENC 14	14.20

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
	Appendix 3: Improvement Programme				
	12.3 Safe Staffing Report	Assurance	Interim Director of Nursing	ENC 15	14.40
	12.4 BAME Colleagues Update	Information	Director of People & Culture	ENC 16	14.45
13.	**USE RESOURCES WELL**				
	13.1 Performance, Finance and Investment Committee Highlight Report	Assurance/ Information	Chair of PFIC	ENC 17	14.55
	13.2 Executive Report – Use Resources Well Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of Finance/Chief Operating Officer	ENC 18	15.00
14.	**WORK CLOSELY WITH PARTNERS**				
	Executive Report – Work Closely With Partners Appendix 1: Board Assurance Framework Appendix 2: Improvement Programme	Assurance/ Information	Chief Operating Officer	ENC 19	15.15
	GOVERNANCE AND WELL LED				
15.	Audit Committee Highlight Report	Assurance/ Information	Chair Audit Committee	ENC 20	15.30
16.	Revised BAF Reporting and Governance	Information	Director of Governance	ENC 21	15.40
17.	Governance and Well-Led Improvement Programme Update	Information	Director of Governance	ENC 22	15.50
18.	NHSI undertakings	Approval Assurance	Director of Governance	ENC 23	16.00
CLOSING ITEMS					
19.	Questions from the public				
	Date of next meeting Thursday 5th November 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 – 1st October 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 September 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 3 SEPTEMBER 2020 AT 12:00 p.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
Ms G Augustine	Director of Planning & Improvement
Ms J Wells	Senior Executive Assistant

Members of the Public: 0
Members of Staff: Kuldeep Singh for patient story
Observers: 0

Apologies were received from Mrs T Mills, Trust Secretary

077/20 Patient Story

Mr Kuldeep Singh, Patient Experience Manager, presented the story of Mrs Aileen Ball, as told by her son Neil. Mrs Ball was initially admitted for a procedure in December 2018. She had more than one stay in ITU with a main stay on Ward 11. Concerns were raised by the family that Mrs Ball wasn't being cared for adequately and there was failure to provide fundamental care including ensuring Mrs Ball received adequate nutrition. Family members highlighted that they were not listened to, labelled a difficult family and at times, felt staff were rude. Unfortunately, Mrs Ball later passed away.

Neil Ball has been working with Ms Riley supporting the Care Excellence Programme as he wanted to help with the programmes of work to ensure there was learning from his mother's case..

Ms Riley informed that she spoke to Neil every week and that every element of learning from this case is incorporated into the Care Excellence Programme. Ms Riley added that the Trust was benchmarking against good and outstanding.

There were significant staffing challenges on ward 11 at the time, reporting a high number of vacancies. It was recognised that contributed to care failings . The Trust was working hard to put the right systems in place through the Improvement Programme and the launch of the Perfect Ward App.

Dr Lewis advised that a number of discussions had taken place with the family in response to the concerns raised along with discussions with the teams who looked after Mrs Ball and the shortcomings in care. A number of aspects of care were identified that should have been done better.

The Board shared their disappointment of the lack of care experienced by the family and commended Neil for supporting the Trust to make changes.

078/20 Quorum and Declarations of Interest

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

Ms Oum formally welcomed Glenda Augustine, Director of Planning & Improvement to the Trust.

079/20 Minutes of the Board Meeting held in Public on 2nd July 2020

The Minutes **were approved** as a true reflection of the meeting.

080/20 Matters Arising and Action Sheet

The action log was reviewed by the Board. All actions were complete or not yet due.

081/20 Chair's Report

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 Walks, COVID-19 19 Summit, Long Service event and an update on the 'Pull up a Chair' staff discussions.

082/20 Chief Executive's Report

Mr Beeken described the Strategic Objectives with the delivery, risks and mitigations for them. The delivery of the objectives have been revised and is very much in the context of a recovery and restoration agenda nationally; living with COVID-19 and how the NHS wider care system manages that. The national expectation on living with COVID-19 focused on tackling the health and inequalities in key parts of the country, a safe winter including planning effectively for a potential second wave and the significant diagnostic and elective backlog, setting out the mechanisms organisations are expected to recover.

Mr Beeken cautioned that the national expectations were ambitious and that the Trust may encounter issues with the financial resources and the report laid out the Trust key priorities for the organisation over the coming weeks and months;

- Protecting the most vulnerable in a diverse and deprived Borough.
- Maintaining a safe urgent and emergency care system in winter.
- Reducing urgent, elective and cancer diagnostic and elective backlog.
- Rolling out the People Plan recommended actions.

Discussion took place regarding mitigation if the Trust struggled to deliver and the need for Board involvement in balancing the priorities of colleague wellbeing, infection control, patients waiting for care and financial uncertainty. Mr Beeken advised that efforts will be made to maximise routine elective and to ensure that they are undertaken as efficiently as possible and working with partner organisations, changing the way we work, using up to date evidence regarding vulnerable patients with multidisciplinary teams and accelerating its impact. Resources would be refocused prior to awaiting financial settlement.

ACTION

(a) A further Board Development session regarding Restoration and Recovery would take place prior to 21st September.

083/20 Safe, High Quality Care

Mrs Bradbury presented the Quality, Patient Experience and Safety Committee Report and highlighted the following:

- Acknowledged the huge amount of work being done under the Improvement Programme. The concerns raised were in relation to timelines and resources.
- Pressure ulcers had seen an overall improvement but there had been an increase of pressure ulcers within the community.
- A reduction of falls in hospital was reported.
- There were some concerns about Histopathology, which have now been resolved.
- Friends and Family Test results had dipped.
- The CQC conducted a survey of adult inpatients. An outlier letter was received and any concerns have been included within the Perfect Ward app.
- Safeguarding training showed an increase but there is still work to do to increase level 3 adults and paediatric performance..
- The Royal College of Surgeons were reviewing upper limb and trauma cases and their initial feedback raised concerns regarding documentation. The final report was awaited.
- It was disappointing that the Quality Account hadn't been received but would be reviewed at the next meeting.
- The Medical Examiners, who are independent of the Trust had been asked to submit information to the regional office regarding the number of healthcare workers that had died as a result of COVID-19. The Trust had sadly lost 3 staff members.

Dr Lewis reported that the regional Getting It Right First Time team had reviewed the Trust programme of work during July and rated it as green.

Dr Lewis added a Clinical Lead had been identified for the Medical Devices

Programme. Thrombosis and VTE have seen recent improvements, though it is too early to advise that it is sustained, the Thrombosis Committee has reconvened and a Chair has been appointed from the Royal Wolverhampton NHS Trust.

Dr Lewis presented the Mortality Report, outlining a spike in deaths during March and April which were related to COVID-19. The report described our understanding around COVID-19 related deaths and the process of learning. Three papers were presented to the Quality, Patient Experience and Safety Committed which underpinned this report. The Learning from Deaths paper outlined that the Trust had 225 deaths with a COVID-19 diagnosis. Senior Consultants had conducted a review of the patient notes to check the standard of care and discovered 9 cases were poor and therefore raised through the incident reporting system and will be reviewed under the Trust governance processes.

Co-morbidities were present in 95% of the patient deaths. Frailty was assessed and present in two thirds of the patients upon admission who subsequently died. Documentation concerns were uncovered relating to issues with filing and the admission clerking proforma completion. It is anticipated that the documentation matter would be resolved with the introduction of electronic patient records.

A detailed assessment was also carried out regarding patients admitted to ICU and compared with national audit data. At the point of assessment, the Trust had 88 admissions to ICU, of whom 46 died (52%). It was noted that the number of deaths were higher than the national quoted figure of 40% however the number of the Trust's patients were much smaller than national figures and that Walsall's patient population has a higher rate of co-morbidity, a high number of deprivation and a high number of black, Asian and minority ethnic populations. There was no statistically relevant correlation between risk of death after admission to ICU and gender or ethnicity. The Board noted that consideration needed to be given to the contribution of health inequalities to the high rates of co-morbidity which in turn were linked to higher death rates.

In relation to hospital associated infections and subsequent deaths, the data was analysed up to 7th June and showed that out of 616 positive patients, 104 had either definitely or probably contracted the infection during their hospital stay. Out of the 104 patients, 43 sadly died during their admission. Reductions were observed after a change in practice in a number of areas which reflected a better understanding of controlling infection, an increase in use of PPE, routine testing of admissions, restricting access for visitors, improved levels of mandatory training for hand hygiene and IPC.

Further detailed analysis will be reviewed at the Quality, Patient Experience and Safety Committee.

Mr Hobbs reaffirmed the importance of testing to stratify and stream patients - evidenced through the significant reduction in nosocomial infections once BCPS received sufficient reagents to enable testing of all admissions to hospital from 27th April. Mr Hobbs also addressed the importance of absolute vigilance with our infection prevention and control practice, including segregation of elective patients from emergency patients, as part of our Restoration and Recovery work, and assured the Board that IPC and Microbiology are standing members of the Restoration and Recovery Steering Group so that this vital specialist advice is taken into account for all our decisions.

084/20 Care at Home

The Walsall Together Partnership Board Report was presented by Mrs Baines. There was no meeting of the Partnership Board held in August but to achieve additional assurance, performance aspects were reviewed with the team. Mrs Baines reported that the partnership was developing well, notably the health & equalities and housing aspects.

A meeting has also taken place with the STP, CCG and NHSI about the journey to integrated care partnerships around place, which was very positive. Patient engagement work has started in a variety of care pathways and a specific Service User Group has been established. A 'you said we did' approach will be implemented for clinical staff following their feedback and will be presented to the Partnership Board.

Nursing capacity in locality teams was reducing from the COVID-19 position due to people are returning to their normal duties, therefore reducing the level of cover available. Recruitment of additional staff was required in order to mitigate.

Decision Support Tools has been suspended through COVID-19, however a meeting had been arranged the following week to bring the commissioning groups together under the better care fund to see what opportunities there were not to go back to pre-COVID-19 delays on those elements.

A profile on the role of a paramedic within locality teams will be presented to the People and Organisational Development Committee.

The Freedom To Speak Up Guardians joined and Mr Beeken left the meeting.

085/20 Value our Colleagues

Mr Gayle presented the People and Organisational Development Committee report, reporting significant progress with the quick wins implemented and highlighted through COVID-19 experiences. From July there have been 29 overarching project workstreams of the improvement programme that has been completed. The focus for the coming months is on completing the project ahead of the Board Development sessions planned in October. The committee have reviewed the immediate, short and long term plans to address discrimination which would also be looked at in the Board Development sessions.

Some reductions in sickness had helped to mitigate temporary staffing use, though sickness still remained high and further work was required to get underneath those issues and to support colleagues. Mandatory training was still below target and appraisal compliance was a concern

The Committee escalated to the Board the lack of progress on risk assessments of BAME colleagues between July and August.

<u>People Plan</u>
Ms Griffiths drew attention to the work underway against the requirements of the national People plan. The committee received a report that outlined the journey

the Trust was on and the mapping work very much aligned to the compassionate leaders and the priorities of the national People Plan.

There has been a pattern in the change of sickness which created some challenges. Musculoskeletal is now the second highest cause for absence, with stress, anxiety and depression remaining the highest level of absence.

Gap in assurance were risk assessments and holding people to account. Though there was a higher level of compliance with the completion of risk assessments, the expectation is for 100% compliance. Actions were in place to support and metrics will be reviewed at People, Organisational Development Committee and the Leadership Development was restarting.

The Valuing Colleagues board assurance framework will be reviewed by the committee in September prior to a recommendation to Trust Board.

The Board discussed the examples of good practice and benchmarking for the People Plan. There would be an investment case put forward shortly. Organisational Development resource has been bought in in the short term.

The Board advised that keeping staff was key and achieved, in part, through appraisals and were advised that a new system had been put in place which was colleague led and based upon talent appraisal and ensures that development for next steps is captured.

Workforce and Employment Inequalities

Engagement with and job opportunities for people within the local community was encouraged by the Board.

A number of metrics were in place regarding workforce inequalities but a targeted approach would need to be taken. Whilst 22% of the workforce are black and ethnic minority they are not fairly represented in senior roles. Assurance was sought that the whole executive team are sharing the responsibility for addressing workforce inequality.

Ms Riley opined that a key component is staff experience and shared decision making. The Perfect Ward app included a significant section around staff experience to ensure that staff felt valued, which could be filtered and audited.

Mr Hobbs added that inclusive and compassionate culture within the Trust was an essential prerequisite for delivering outstanding care and if it was not right, would hold back other improvement programme work. Mr Hobbs agreed that the next step was to distinguish and target interventions according to different groups of staff and the useful links with partners are should be utilised.

Safe Staffing

Ms Riley informed that a benchmark would be set during the establishment review and a Quality Impact assessment would also be put in place for every area that held a nursing associate within the budget.

ACTION:

(a) Ms Oum requested that the use of staffing against use of beds and the costs for ease of comparison would be helpful in future reports.

Freedom to Speak Up Annual Report and Strategy

Ms Ferguson, Freedom to Speak Up Guardian, presented the Freedom To Speak Up Annual Report and Strategy for approval and the implementation plan with a view to launching in October. Planning was underway for a joined-up collaborative with the Trust Equality, Diversity and Inclusion Lead and the BAME council for Speak Up Month during October.
Ms Ferguson added that a section regarding detriment due to speaking up to be incorporated into the report as there was a requirement for reporting to the National Guardian Office in the future.

Ms Oum advised that the Board had signed up to the pledge and that there would need to be some refocusing of executive priorities to enable this to be honoured.

Responsible Officer Revalidation and Appraisal Update
Dr Lewis presented the update to approve the statement of compliance. The annual report was in relation to revalidation and appraisal of doctors within the organisation and reported that 98% of connected doctors that had completed appraisals or had an approved missed appraisal as of 19th March.

A number of items lead to an improvement in performance which were highlighted:

- The appointment of the new Trust Lead Medical Appraiser, Dr Riaz Bavakunji.
- Appointed new appraisers
- Trained appraisers
- A Medical Professional Standards Group has been created to monitor compliance and provide support to those struggling to complete them on time. A member of HR would join the group along with the BAME cabinet to ensure the organisation had fair processes and not dealing with any group of doctors adversely.

The Annual Report was approved.

086/20 Use Resources Well

Performance, Finance & Investment Committee
Mr Dunn presented the committee report and highlighted the following:

- The 4 hour target was achieved at over 95%
- Medically stable for discharge has been performing well.
- The committee will complete a deep dive of the Board Assurance Framework at the next meeting
- Activity level and spend was discussed, particularly temporary staffing against bed occupancy.
- Constitutional standards were reviewed.
- Readiness for EPR programme.
- ED new build estate and available money for uplift but need to do further work in relation to the plan mitigations or consequences for backlog maintenance.

- Focus to continue on finances and priorities to ensure the right levels of productivity to improve our capability and matching staffing with clinical need and bed occupancy.

Mr Hobbs advised that the Board Assurance Framework risks had been updated and encompasses a broader risk in terms of HR, financial, physical assets and technology resources. 3 out of the 4 constitutional standards are performing towards the top in the country while cancer standards were in the median, though further elective was restarting over the coming months which would assist with that standard.

Income/Budget Update

The Board reviewed the update which reported an £8m deficit year to date and the Trust had requested additional resources through an £8.3m top up. The funds requested were in line with other Trusts and driven by reduced bed occupancy, COVID-19 streaming, PPE issues and health and wellbeing expenditure. The Trust was awaiting income settlement in October.

Levels of bed occupancy will be scrutinised by the Performance, Finance and Investment Committee. There was time pressure to ensure commitment is delivered within year.

The Board observed that the Trust was currently operating at a level of productivity that is below expectation yet still spending. Benefits were being derived through the improvement programme but having to make a balance between the various priorities faced by the organisation – colleague wellbeing, patient safety, operational performance and the resources available. There was zero tolerance for taking risk with patient safety. Further clarity was sought to address the productivity issues being faced now prior to financial settlement.
Mr Dunn urged a match between activity and deployment of people. A Board Development session was to be scheduled to look at productivity, available resources and the impact upon the bid for money. Scenario testing would also take place to review the effects upon the key priorities and acute waiting lists. The agreed Board risk appetite should also be overlaid to ensure that the Trust is in line with what it is trying to achieve.

087/20 Work Closely with Partners

Mr Hobbs drew attention to the Collaborative Working Executive Group with RWT and Dudley Group that had been reinstated and met twice recently. The invite has been re-extended to Sandwell. Good progress was reported within Dermatology with Dr James Halpern being recruited as Joint Clinical Director over WHT and RWT services.

- Cross site consulting has now commenced.
- Progress in Urology has also been made and will pick up pace following the next workshop between the Trusts scheduled later this month.
- ENT has been formally added to the programme with RWT and Dudley Group delivering joint on call.
- Sessions have begun for the Black Country Imaging network to explore how the Radiology services can work more closely together.
- The Clinical Fellowship programme was being finalised with the

agreement between WHT and RWT.
- The Trust was also undertaking an Options appraisal around the delivery of sterile services with RWT.

The Board cautioned that equality impact assessments were undertaken for all joined up services and asked that engagement with the public and staff took place.

088/20 Governance and Well Led

Audit Committee Report
The Board were informed that Internal Audit Reports were being reviewed the following week and were disappointed that the Quality Account had not been received, noting the deadline of 5th December.

Committee Annual Reports and Terms of Reference
The Audit Committee recommended the approval of revised terms of reference and the annual reports for:
- Quality, Patient Experience and Safety Committee,
- Performance, Finance and Investment Committee
- People and Organisational Development Committee
- Remuneration Committee
- Audit Committee

Improvement Programme Update
Ms Davies presented five areas of focus around board governance, the assurance framework within the organisation, accountability support, integrated governance and strategy and business planning. A gap analysis had been completed against the outcome of the NHSI governance and accountability framework and was unable to give full assurance due to the PIDs not being finalised or approved. The recommendation in the report was to ask the People and Organisational Development Committee on behalf of the Valuing Colleagues workstream to seek assurance that the finalised PIDs contain the recommendations from the NHSI review and that the Board would receive assurance at the next meeting.

Two risks were highlighted:
- The Well Led workstream does not currently have a Programme Manager attached to it which has caused some delay and impacts upon the ability to map interdependencies, however support should be in place from next week which will support the delivery of the programme.
- The Governance Team capacity and capability to deliver on workstream areas. Workshop had been held with the team and outlined the priority projects which were accountability framework, incident framework, risk management, board effectiveness, governance framework and business planning.

Use of Trust Seal
The use of the Trust seal was reviewed by Audit Committee.

089/20 Update on NHSI Undertakings
The update was reviewed by Audit Committee.

090/20 Questions from the Public

No questions.

091/20 Date of Next Meeting

The meeting finished 16:10
The next meeting of the Trust Board held in public will be on Thursday 1st October 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.

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
042/20	04/06/20	BAF & CRR	The BAF will continue to remain on the Board agenda each month until further notice.	Trust Secretary	Monthly	Will remain open action for the agenda for foreseeable future	Open
043/20	04/06/20	Performance Report	PODC at their meeting in June to review remodelling of the workforce to test resilience should there be a second wave, and to include the impact of 'test and trace' on staff availability.	PODC	03/09/2020	Update from 2 July Meeting: To remain open until the impact of track and trace can be determined. Update for 3 September meeting: This will not be determined until October. Update for 1 october meeting: Additional guidance has been received and has been incorporated into restoration and recovery work; a colleague hotline has been established to quickly respond to queries and more active modelling is taking place over the coming weeks. Propose leaving this on the action log as PODC is not fully assured.	Open
059/20	02/07/2020	Care at Home	Journey to ICP status mapping to be presented to the Board in October.	Director of Integration	01/10/2020	Board Development session held on 25th September	Complete
082/20	03/09/2020	Chief Executives Report	A further Board Development session regarding Restoration and Recovery would take place prior to 21st September.	Trust Secretary	01/10/2020	Board Development session held on 16th September	Complete
085/20	03/09/2020	Value our Colleagues	The use of staffing against the use of beds and the costs included within for ease of comparison to be included in future Safe Staffing reports	Director of Nursing	05/11/2020	Not Due Work is ongoing with finance colleagues with the aim to have data available from October	Open

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
088/20	03/09/2020	Governance & Well Led	PODC on behalf of the Valuing Colleagues workstream to seek assurance that the finalised PIDs contain the recommendations from the NHSI review and that the Board would receive assurance at the next meeting.	Director of People & Culture	01/10/2020	See PODC highlight report. In addition, Valuing Colleagues improvement programme includes the co-production/design of the valuing colleagues element of the accountability framework; and a standard operating procedure aroudn the engagement approach detailed in teh NHSI accountability review as a gold standard	Complete
Complete							
Open							
Delayed (1 meeting)							
Overdue (14+ days)							

MEETING OF THE PUBLIC TRUST BOARD - 1st October 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

On 8th September 2020, and in accordance with the Trust's Standing Orders, I took Chair's Action to amend the Emergency Department New Build Full Business Case to reflect increased costs and include the additional anticipated central income capital stream. Attached at Appendix 1 is a file note of that Chair's Action.

2. Provide Safe High Quality Care

Non-executive Directors took part in virtual Board walks this month in the Emergency Department and in Critical Care. They heard of the dedication and pride of the teams and the significant challenges, and opportunities, which COVID-19 presented, together with staff concerns over a second wave.

During my annual leave, the Vice Chair of the Trust Board, John Dunn, facilitated a Board Development Session on Restoration and Recovery which has informed plans before the Trust Board at this meeting. The quality, people and financial impacts were discussed at the September Board Committee meetings to ensure the Trust is prioritising quality, patient safety and staff health and wellbeing.

I continue to participate in regular COVID-19 Updates sessions with executives and non- executive colleagues, and the took part in a series of Midlands Providers' Chairs and Clinical Commissioning Group (CCG) Chairs COVID-19 update call which focus on national and regional priorities arising from the COVID-19 pandemic.

3. Care at Home

The ICP Board Development Session on 25th September provided an opportunity to consider a range of options for strengthening and deepening the Walsall Together partnership as well as reflecting on the benefits already achieved for the local population.

I was pleased to take on the role of chair of Walsall Homeless steering group; an advisory group. I hope the role will contribute to the deepening relationship between housing and health. People experiencing homelessness are an important stakeholder group for the Trust.

4. Value Our Colleagues

The following events/activities relate to this objective:

- I joined colleagues in Paediatrics for a discussion on Actions Speaking Louder than Words in addressing organisational culture.
- The BAME (Black, Asian, Minority Ethnic) Cabinet continues to meet to provide creative thinking and a sounding board in order to accelerate progress on workforce race inequality.

- Our Freedom to Speak Up Guardians have a valuable role to play at the Trust in ensuring colleagues have a conduit through which they can raise concerns. I met with the Freedom to Speak Up Guardians lead for our regular 1:1 catch up and discussed challenges and areas of progress.

5. Work Closely with Partners

There has been a great deal of collaboration work underway, including the establishment of an Acute Collaboration Board sub-group to support progress.

At an STP Collaboration meeting facilitated by Deloitte, Providers' Chairs and CEOs, together with the CCG, committed to work together.

6. Meetings/Events

I attended the first NHS Midlands STaR Board with NHSI to develop thinking around the NHS Reset across the Midlands region.

The Trust's Annual General Meeting will be held on 29th September. This is the first time this meeting has been held virtually and I will provide an update to the Trust Board at this meeting.

APPENDIX 1

WALSALL HEALTHCARE NHS TRUST
EMERGENCY DEPARTMENT BUSINESS CASE
FILE NOTE OF MEETING 8TH SEPTEMBER 2020 AT 2PM

Present:	Mrs D Oum	Trust Chair
	Mr J Dunn	Trust Vice-Chair and Chair of Performance, Finance and Investment Committee)
	Mr S Heer	Chair of Audit Committee
	Mr R Caldicott	Director of Finance and Performance

Purpose of the meeting - Emergency Department (ED) Chairs action for capital cost increase to Full Business Case (FBC)

Introduction

Members received a report clarifying that costs from the Trust appointed construction partner for the Guaranteed Maximum Price (GMP) for construction of an Emergency Department new build had increased by £3m beyond that contained within the Full Business Case (FBC) endorsed at Trust Board. The report referencing the conclusions reached by the Trust Appointed Cost Adviser that the overall costs offered value for money and benchmarked well in comparison to other similar projects of this nature (comparison with developments built pre COVID-19).

The report referred to discussions that had been held with NHSEI in relation to the increased costs, and their expectation the FBC be increased to the current GMP capital value and submitted with an increased central allocation to offset the increase articulated within the FBC, although the allocation of the additional capital award was not agreed at this stage.

Action requested

Chairs action was requested to agree to the Full Business Case endorsed at Trust Board be amended for an increase in capital costs of £3m, with the source of funds to off-set this increase being identified as an additional central capital allocation within the case, though this was not secured at this stage.

Agreement reached

The Members agreed for the case to be amended to reflect the requested amendments and submission made to NHSIE accordingly subject to two conditions;

- Members receive a copy of the Trust commissioned Cost Adviser report to assure value for money
- Members receive an assurance that should funds not be made available centrally, that the Executive support prioritisation of resources from internally generated capital funds over the

three fiscal years of the projects construction, so as to off-set this shortfall (so the project has identified capital resources in full)

A further discussion was held regarding ensuring the Trust was protected from further cost increases should a second phase of COVID-19 occur, though it was noted whilst the Trust is seeking to mitigate this risk through legal counsel, the contract is not signed as of yet and as such this assurance cannot be given at this stage.

Next actions

It was noted the report before members had already been through the Executive and articulated should the additional central capital resources not be received a call against Trust discretionary capital would need to be made (so the second condition was already satisfied). Agreement reached to share the written Cost Adviser report with those present at the meeting upon receipt (estimated by Thursday 10th September).

MEETING OF THE PUBLIC TRUST BOARD 1st October 2020			
Chief Executive's Report			**AGENDA ITEM: 7** **ENC: 5**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	Richard Beeken, Chief Executive Officer
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 is leading and sponsoring, 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, as with last 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. At the time of writing this report, the Board had undertaken a workshop to support the phase 3 recovery plan trajectories for our Trust, which were submitted via the Black Country & West Birmingham system team, on 21st September.		
Recommendation	Members of the Trust Board are asked to: • Note the content of the report • Discuss its contents • Determine whether there needs 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 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'S REPORT – 1ST OCTOBER 2020

1. EXECUTIVE SUMMARY

The recovery and restoration agenda, particularly viewed through the lens of the phase three COVID-19 response communication from Sir Simon Stevens, as with last month, still dominates our thinking and our actions at present. This planning work has been further refined as a result of the national income allocations being confirmed on 12th September, albeit these were allocated to systems and at the time of writing, full and transparent understanding of each Trust's likely income position has not been gained.

The Board discussed last month in public session, the balance that must be struck between the centralised intentions and expectations of national policy and the locally determined priorities which meet the unique needs of our own population. As set out above, that balance now also needs to be triangulated with living within the financial means allocated to us for the remainder of 2020/21. As a Board, we agreed last month that our priorities for the coming period of restoration, recovery and redesign of services will be:

- Protecting the most vulnerable in Walsall, particularly through action we can take to reduce the health inequalities in the borough via the Walsall Together partnership
- 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, through the Valuing Colleagues work stream of our Improvement Programme

I can confirm that our phase 3 elective and diagnostic recovery trajectories, submitted on 21st September as part of the wider system, reflected these priorities, within the context of a financial envelope which we correctly assumed would mirror income received by the Trust during the first 6 months of the year. To that end, we have confirmed that, unless there is a further income injection beyond that confirmed, there will be two areas of phase 3 recovery focus that cannot be achieved in full:

- Overnight elective and daycase elective activity and waiting times recovery will not achieve the levels expected by the national team by October 2020
- Elements of the NHS People Plan, which may lead to an increase in cost base once worked through, may not be implementable in full

Whilst on the face of it, these limitations to our ambition are of concern, we should take comfort from the fact that our investment in the Walsall Together partnership, our winter plan, managing a second wave of COVID-19 admissions and delivering cancer wait expectations, are all within our grasp this financial year. Moreover, our starting

point on elective waiting times is better than most Trusts in the country, so we have a good base from which to plot our incremental recovery in the COVID-19 driven backlogs that our patients are experiencing at present.

2. BOARD ASSURANCE FRAMEWORK

2.1 Safe, High Quality Care

Last month, I set out my intention to continue to ensure that our capacity planning for a safe winter is evidence based, thorough and takes few risks. I also set out that I would 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 continue to chair the Improvement Programme Board to assure myself that this prioritisation continues.

The winter plan is on our agenda for today and is the product of extensive work by our Chief Operating Officer, our Director of Integration, our Finance Director and their operational teams. It clearly and correctly sets out, as I did last month, that sustained or improved performance against the 4 hour emergency access standard is not just an issue of "performance" but is an issue of patient safety and experience. The plan focuses on rolling out best practice in urgent care, backed by the helpful capital funding the Trust has received to help us better manage winter this year, together with prudent contingencies and targeted intensive support on key dates in the festive period. It must be noted by the Board that the capital funding provided is largely for mandated aspects of emergency and urgent care delivery, aimed at eradicating "corridor care", some of which necessarily comes at an increased revenue cost. Our funding envelope for the rest of the financial year adequately provides for the essential resilience within our winter plan.

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-19 has, at times, cruelly exposed in the last six months. As a Board we discussed last month, how this is manifesting itself.

This month, the Trust Chair and I have contributed to challenging the wider STP partnership on how we will practically impact upon this important agenda and how that impact should be measured. At present, the system phase 3 COVID-19 recovery plan does not yet contain specific enough actions on the health inequalities agenda. Future iterations must do so and Danielle Oum is well placed to influence this through her leadership in both the regional and system steering groups on the subject. In the meantime, I would request that the Walsall Together Partnership Board, sets its stall out rapidly on the practical actions it will oversee on reducing health inequalities, in particular but not exclusively, incorporating how the most vulnerable in Walsall will be

supported differentially through multi-agency and locality risk stratification and the Walsall Healthcare investment made in community services this year, of over £1.6 million.

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 and, increasingly on further organisational collaboration and standardisation, we can collectively, as a Black Country system deliver the service resilience on a 7 day per week basis, we require.

The key actions for me as CEO on this agenda set out last month was 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 said that I would 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. Progress made on this is as follows:

- There is strong collaboration evident between Sandwell & West Birmingham Trust and The Royal Wolverhampton Trust on Ophthalmology workforce and service integration, to tackle the significant clinical risk inherent within the COVID-19 driven backlogs in that service across the Black Country
- An agreement has been reached that future iterations and adjustments of our system recovery plan will include an assessment of whether hospital site based segregation, will deliver more benefits in recovery terms, than the current intra-hospital arrangements inherent within the plans
- Correspondence has been received by all 4 Black Country acute hospital Trusts, from NHS England & Improvement, asking us to take forward the production of a case for change on organisational collaboration, which could lead to organisational form change in the future, as a means of accelerating functional, service and workforce integration. I have already begun discussions and planning sessions with STP peers on how that case for change should be developed and our Director of Planning & Improvement and I will work with the Trust Board and our wider organisation on setting out our expectations from this process for our patients, Walsall residents and our staff, ensuring that these are clear in the case for change and considered by all STP partners' Boards in due course. We are targeting considering that case for change by December or January.

2.4 Valuing colleagues

As CEO, last month, I committed to work closely with our Director of People & Culture, to overtly seek out evidence of leadership and team behaviour which is inconsistent with organisational values and tackle it quickly and incisively, with targeted organisation development and HR support. I am pleased to confirm that targeted Organisational Development support has been secured for the five key services/departments of concern. The People & Organisational Development Committee will be receiving a more detailed assurance report on this in this cycle.

The Board will recall agreeing an Organisation Development Strategic Framework in February 2020.

There are three priorities within that framework:

- Leadership, Culture and Organisation Development
- Organisation Effectiveness
- Making Walsall the best place to work

The Organisational Development priorities are contained within the valuing colleagues' work-stream of the improvement programme. The National NHS People Plan requirements are incorporated within these planned actions. In addition, there will be some national leadership development support available early 2021-2022 year.

During the emergency response to COVID-19, plans for leadership and management development, funded through NHS Improvement were not progressed due to the restrictions in place. These plans have been re-instated. The programme provides a 12 month supported development approach which is aligned to improvement and ongoing learning. The key objective of this development is to provide our senior clinical and general management cadre with the skills and confidence to manage resources and take decisions within our new accountability framework. This will release executive directors to manage the strategic and external change environment better, together with improving assurance processes and evidence. Changes to our standing orders and standing financial instructions, to be considered through our well-led/governance work stream of the Improvement Programme, may help underpin that development.

Finally, the impact of the COVID-19 emergency response and its aftermath, on colleague wellbeing has already been and continues to be, significant, and the pace of the requirement to recover services has not allowed colleagues time for reflection. There are structured ways of providing time for reflection through facilitated conversations for teams and the Board should note that our Director of People & Culture is working with Trust Management Board leaders to set out those requirements and structure those conversations, before the peak of winter and a potential second wave of COVID-19 related hospital activity, begins.

2.5 Use resources well

As I pen this report, the Trust is in the throes of going "live" with the roll out of our new electronic patient record system, "Medway". As an indication and reminder of the enormity and importance of this development, I draw the Board's attention to the following:

- We were one of only a handful of Trusts whose Emergency Departments still had a paper patient record. We are no longer in that bracket and the patient safety benefits of this are significant
- We will no longer be relying on paper clinic outcome proformas to capture patient pathway changes in outpatient services. This will be managed, real-time, in the clinic or virtual clinic environment by the clinical staff
- We will have a real time bed state available to us 24 hours per day, enabling the site management team to more safely and efficiently manage patient flow

I would like to put on record my thanks to the EPR (Electronic Patient Record) programme team (including the army of "floor walkers" who have been available 24/7 to manage operational queries and problems quickly), to Daren Fradgley, Director of Integration for his leadership of this agenda, to Matthew Lewis our Medical Director for chairing the programme board and helping us make key decisions and to the 17 "experts by experience" staff from Barnsley Hospital NHS Foundation Trust, who assisted us in person over the go-live weekend. I have thanked their CEO personally for their assistance.

Last month I set out to the Board that one of the key issues I would oversee was the protection and deployment of allocated capital funding for Walsall this financial year. Pressures on the total STP allocation, as a result of developments in other organisations have emerged, but slippage on our own capital programme will be negligible. Our programme and its funding is fully committed. One of the key schemes within our programme is the replacement of our theatre air handling units, which Board colleagues will recall are on the critical backlog maintenance list and have been posing a breakdown risk for some time.

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 - 1st October 2020			
Operational Restoration & Recovery update			**AGENDA ITEM: 8.1** **ENC:6**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer	**Responsible Director:**	Ned Hobbs, Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This paper provides a summary update to the Trust Board on the operational Restoration and Recovery of clinical services impacted by the first surge in Covid-19 admissions to the hospital. It summarises the outputs of two Board Development Sessions, held on the 3rd September and 16th September. <u>Board Development sessions</u> A Trust Board development session on Restoration and Recovery was held on 3rd September 2020 which: • Endorsed recommended clinical prioritisation of services: 1. Urgent, Emergency and Critical Care services in the community and in the hospital. 2. Urgent Elective services including urgent outpatient, urgent diagnostic and urgent surgical/procedural services (e.g. Cancer pathways) 3. Routine Elective services including non-urgent outpatient, non-urgent diagnostic* and non-urgent surgical/procedural services *It is important to be mindful that routinely requested (non-urgent) diagnostics regularly identify serious and urgent pathology, and so there should be heightened vigilance to avoid deferral of diagnostics in patients who do not have a confirmed diagnosis. • Confirmed the Trust had made an assessment of financial resources required to deliver the expectations of the NHSEI phase 3 Covid-19 response letter[1], namely; *A. Accelerating the return to near-normal levels of non-Covid health services, making full use of the capacity available in the 'window of opportunity' between now and winter* *B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable Covid spikes locally and possibly nationally.* *C. Doing the above in a way that takes account of lessons learned during the first Covid peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention."* 1. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/07/Phase-3-letter-July-31-2020.pdf		

	The Trust's financial assessment indicated that the funding required to deliver the Phase 3 expectations would cost £25m more than contract, and £13m more than current (Month 1-5) run rate. Trust Board members concluded it was highly likely this would be deemed unaffordable by the STP. Trust Board members asked for scenarios to be modelled for the potential financial resources to be received against the explicit priorities of: 1. Protect urgent, emergency and critical care services in the hospital and the community. 2. Restore, recover and transform urgent elective services (e.g. Cancer services) as quickly as possible. 3. Improve the wellbeing of our colleagues. 4. Reduce health inequalities for the people we serve. Worst, likely and best case income scenarios were considered for months 7-12 of the financial year, with the likely scenario enabling a financial plan that would cover the necessary allocation for Winter to support Urgent & Emergency Care and Covid resilience. The Winter Plan is presented to Trust Board members for consideration under Agenda Item 8.2. The Board Development session on 16th September supported the Executive's recommendation to submit realistic activity and workforce trajectories to the STP built upon previous draft submissions, noting: a) These to be dependant on confirmation of months 7-12 income allocations at least in line with the likely scenario. b) These fail to deliver NHSEI Phase 3 letter activity expectations in elective care. c) These include some clinical risk associated with delayed elective care. d) The submission of the 5th October 2020 will reflect the actual income settlement (assuming this has been received) and activity and workforce trajectories may require amendment accordingly. A copy of the Trust's Phase 3 STP activity submission is appended.
Recommendation	The Committee is asked to note the contents of this report.
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Covid-19 BAF Risk – this BAF risk has received extensive update between the Chief Operating Officer and Head of Risk Management to bring up to date the risks associated with covid-19 in the context of Restoration and Recovery and of resurgence of covid-19 cases. Use of Resources BAF Risk Risk 25 - Failure to achieve National Referral to Treatment Standards.

Resource implications	Public Trust Board agenda item 8.2 Urgent & Emergency Care and Covid resilience Winter Plan. Interventions within this year's Winter Plan will cost £3.361m plus a further £1.336m of revenue funding to deliver the £4.1m UEC capital schemes that are national priorities. The total cost of this year's Urgent and Emergency Care and Covid resilience Winter Plan is therefore £4.697m which is accounted for in the likely financial modelling scenario for months 7-12.	
Legal and Equality and Diversity implications	The Government has agreed new legislation in relation to Covid-19, reflected in the Trust's Covid-19 Governance Continuity Plan updated and approved at Trust Board on 07/05/20.	
Strategic Objectives	Safe, high quality care ☒	Care at home☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Healthcare NHS

NHS Trust

	RBK	WALSALL HEALTHCARE NHS TRUST	WHT				WHT Forecast							
			Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
		RTT												
RTT Waiting List	E.B.3a	The total number of incomplete RTT pathways at the end of the month	13,952	13,374	12,688	12,598	13,523	13,935	14,130	14,415	14,614	14,788	15,272	16,072
Number of 52+ Week RTT waits	E.B.18	The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period	1	1	8	9	8	12	10	8	8	8	6	6
		Referrals												
Referrals made for a First Outpatient Appointment (General & Acute)	E.M.7a	GP Referrals	840	1,361	2,292		3,106	3,354	3,622	3,912	3,521	3,912	4,225	4,562
	E.M.7b	Other Referrals	1,371	1,771	2,048		2,388	2,579	2,785	3,037	2,737	3,280	3,542	3,825
	E.M.7	**Total Referrals**	**2,211**	**3,132**	**4,340**	**-**	**5,494**	**5,933**	**6,407**	**6,949**	**6,258**	**7,192**	**7,767**	**8,387**
avg 19/20 for reference		GP Referrals 19/20 avg	4,422	4,422	4,422	4,422	4,422	4,422	4,422	4,422	4,422	4,422	4,422	4,422
avg 19/20 for reference		Other Referrals 19/20 avg	4,223	4,223	4,223	4,223	4,223	4,223	4,223	4,223	4,223	4,223	4,223	4,223
avg 19/20 for reference		**Total Referrals 19/20 avg**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**	**8,645**
		Outpatients												
Consultant Led Outpatient Attendances (Specific Acute)	E.M.8c	Consultant-led first outpatient attendances (face-to-face)	2,434	3,499	4,569	4,099	4,122	5,906	6,579	6,579	6,579	6,579	6,579	6,579
		First Outpatient Attendances - Face to Face - of which commissioned by Specialised Commissioning	9	48	54	42	48	53	53	53	53	53	53	53
	E.M.8d	Consultant-led first outpatient attendances (telephone/video)	-	56	372	996	-	-	-	-	-	-	-	-
		First Outpatient Attendances - Telephone/Video - of which commissioned by Specialised Commissioning	-	-	-	-	-	-	-	-	-	-	-	-
	E.M.9c	Consultant-led follow-up outpatient attendances (face-to-face)	5,107	7,649	9,158	7,097	8,042	9,644	10,741	10,771	10,771	10,771	10,771	10,771
		Follow Up Outpatient Attendances - Face to Face - of which commissioned by Specialised Commissioning	319	377	499	548	474	464	464	464	464	464	464	464
	E.M.9d	Consultant-led follow-up outpatient attendances (telephone/video)	-	192	640	2,464	-	-	-	-	-	-	-	-
		Follow Up Outpatient Attendances - Telephone/Video - of which commissioned by Specialised Commissioning	-	-	-	-	-	-	-	-	-	-	-	-
	E.M.8-9	**Total Outpatient Attendances**	**7,541**	**11,396**	**14,739**	**14,656**	**12,164**	**15,550**	**17,320**	**17,350**	**17,350**	**17,350**	**17,350**	**17,350**
		Total Outpatient Attendances - of which commissioned by Specialised Commissioning	**328**	**425**	**553**	**590**	**522**	**517**	**517**	**517**	**517**	**517**	**517**	**517**
		Target %					90%	100%	100%	100%	100%	100%	100%	100%
		Var %					(23%)	(12%)	(2%)	(2%)	(2%)	(2%)	(2%)	(2%)
		Target					15,871	17,634	17,634	17,634	17,634	17,634	17,634	17,634
		Var					(3,707)	(2,084)	(314)	(284)	(284)	(284)	(284)	(284)

Walsall Healthcare NHS

NHS Trust

	RBK	WALSALL HEALTHCARE NHS TRUST	WHT				WHT Forecast							
			Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
		Electives												
Total Elective Spells (Specific Acute)	E.M.10a	Day Case spells	366	510	806	988	902	995	1,025	1,173	1,004	1,295	1,326	1,347
		Day Case spells - of which commissioned by Specialised Commissioning	-	1	4	4	3	3	3	3	3	3	3	3
	E.M.10b	Ordinary spells	48	68	97	158	139	193	235	252	239	276	285	300
		Ordinary spells - of which commissioned by Specialised Commissioning	-	-	-	1	1	1	1	1	1	1	1	1
	E.M.10	**Total Elective spells**	**414**	**578**	**903**	**1,146**	**1,041**	**1,189**	**1,260**	**1,425**	**1,243**	**1,571**	**1,610**	**1,646**
		Total Elective spells - of which commissioned by Specialised Commissioning	**-**	**1**	**4**	**5**	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
		Target %					70%	80%	90%	*90%*	*90%*	*90%*	*90%*	*90%*
		Var %					(28%)	(28%)	(32%)	(23%)	(33%)	(16%)	(14%)	(12%)
		Target					1,449	1,656	1,863	1,863	1,863	1,863	1,863	1,863
		Var					(408)	(467)	(603)	(438)	(620)	(292)	(253)	(217)
		% of 19/20 avg being forecast					**50%**	**58%**	**61%**	**69%**	**60%**	**76%**	**78%**	**80%**
		Non Elective												
Total Non-Elective Spells (Specific Acute)	E.M.11a	0 day length of stay	545	856	1,230	1,372	1,392	1,353	1,425	1,461	1,504	1,617	1,464	1,467
		0 day length of stay - of which commissioned by Specialised Commissioning	-	-	-	-	-	-	-	-	-	-	-	-
	E.M.11c	+1 length of stay - COVID	489	145	46	17	6	55	109	72	36	23	12	2
		+1 length of stay - COVID - of which commissioned by Specialised Commissioning	-	-	-	-	-	-	-	-	-	-	-	-
	E.M.11d	+1 length of stay - Non-COVID	912	1,277	1,557	1,637	1,615	1,516	1,580	1,596	1,633	1,778	1,570	1,562
		+1 length of stay - Non-COVID - of which commissioned by Specialised Commissioning	-	1	1	-	-	-	-	-	-	-	-	-
	E.M.11	**Total Non elective admissions**	**1,946**	**2,278**	**2,833**	**3,026**	**3,013**	**2,924**	**3,115**	**3,129**	**3,173**	**3,418**	**3,046**	**3,031**
		Total Non elective admissions - of which commissioned by Specialised Commissioning	**-**	**1**	**1**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
		A&E												
Type 1-4 A&E Attendances	E.M.12a	Type 1&2 A&E attendances	3,746	4,679	5,522	6,180	6,073	6,166	6,486	6,342	6,696	6,542	6,097	6,097
	E.M.12b	Type 3&4 A&E attendances	1,160	1,636	1,851	2,397	2,504	2,684	2,855	2,644	3,177	2,785	2,564	2,564
	E.M.12	**Total Type 1-4 A&E Attendances**	**4,906**	**6,315**	**7,373**	**8,577**	**8,577**	**8,850**	**9,341**	**8,986**	**9,873**	**9,327**	**8,661**	**8,661**
		Demand and capacity												
General and Acute bed occupancy	E.M.26	Average number of G&A Beds available per day	407	425	431		457	457	485	485	485	485	485	485
		Average number of G&A Beds occupied per day	314	295	308		410	415	445	447	447	447	447	447
		%	77%	69%	71%		90%	91%	92%	92%	92%	92%	92%	92%

Walsall Healthcare NHS

NHS Trust

	RBK	WALSALL HEALTHCARE NHS TRUST	WHT				WHT Forecast							
			Apr-20	May-20	Jun-20	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
		Diagnostic Activity												
Diagnostic Test Activity	E.B.26a	Diagnostic Tests - Magnetic Resonance Imaging	608	609	1,126	1,220	1,570	1,526	1,638	1,602	1,601	1,722	1,595	1,416
	E.B.26b	Diagnostic Tests - Computed Tomography	1,211	1,637	2,031	2,158	2,158	2,128	2,177	2,026	2,099	2,181	1,997	1,823
	E.B.26c	Diagnostic Tests - Non-Obstetric Ultrasound	759	1,207	1,768	2,279	1,804	2,279	2,613	2,499	2,405	2,632	2,488	2,488
	E.B.26d	Diagnostic Tests - Colonoscopy	14	32	68	127	120	138	152	152	152	152	152	152
	E.B.26e	Diagnostic Tests - Flexi Sigmoidoscopy	5	28	26	34	44	68	98	98	98	98	98	98
	E.B.26f	Diagnostic Tests - Gastroscopy	18	49	114	141	155	165	165	165	165	165	165	165
		Target %					80%	90%	100%	100%	100%	100%	100%	100%
		Var %					6%	2%	(1%)	(5%)	(6%)	1%	(6%)	(11%)
		Target					5,520	6,210	6,900	6,900	6,900	6,900	6,900	6,900
		Var					331	94	(57)	(358)	(380)	50	(405)	(758)
		% of 19/20 avg being forecast					**85%**	**91%**	**99%**	**95%**	**94%**	**101%**	**94%**	**89%**
		Cancer												
Urgent cancer referrals	E.B.30	All patients urgently referred with suspected cancer by their GP who received a first outpatient appointment in the given month	345	481	615	790	869	955	1,050	1,155	924	1,155	1,155	1,155
Cancer treatment volumes	E.B.31	Number of patients receiving first definitive treatment following a diagnosis within the month, for all cancers	71	57	51	57	55	60	68	75	85	96	101	98
Number of patients waiting 63 or more days after referral from cancer PTL	E.B.32	Cancer 62 day pathways waiting 63 days or more after an urgent suspected cancer referral at the end of the reporting period	65	115	73	115	45	40	35	30	35	30	25	20
Urgent cancer referrals	E.B.30	19/20 actual	764	888	775	1,045	884	904	1,005	858	780	826	846	854
Cancer treatment volumes	E.B.31	19/20 actual	95	86	89	79	81	79	101	98	90	98	96	79

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Urgent & Emergency Care and Covid Resilience: Winter Plan 2020/21			**AGENDA ITEM: 8.2** **ENC: 6**
Report Author and Job Title:	Ned Hobbs – Chief Operating Officer Kate Salmon – Director of Operations (Medicine & Long Term Conditions)	**Responsible Director:**	Ned Hobbs – Chief Operating Officer
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The winter of 2019/20 was, in the main, a relative success for Walsall Healthcare NHS Trust. At a national level, 4-hour emergency access standard, 12-hour decision to admit trolley waits, and ambulance handovers recorded their worst performance on record. The Trust's national and regional standing on all three key emergency care indicators improved over the course of 2019/20 and in particular during the Winter period. This was, without question, as a result of the diligent winter planning work undertaken by all our Divisions and teams across the organisation. We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This year is likely to be even more challenging for the NHS and Social Care systems due to the Covid-19 pandemic. The potentially toxic scenario of seasonal influenza, norovirus, delayed detection of patients with serious pathology associated with reduced elective and primary care during the pandemic, and a resurgence of Covid itself means that our Winter Plan must have even greater resilience than previous years. In addition, the plan must enable a relentless focus on minimising the risk of nosocomial infection and reflect that this necessitates Covid segregation and streaming within the hospital setting which is acknowledged to make managing patient flow through the Trust more challenging. The 3 central tenets of the plan are as follows: 1. A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than just opening more inpatient beds.		

	2. Following the success of our targeted approach to managing the Festive period last year, the same approach will be adopted for 20/21 (19/12/20-10/01/21). Operational services over the key weekend and bank holiday days will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated. 3. Maximising the £4.1m Department of Health capital investment recently awarded to ensure our emergency care pathways are Covid resilient. This includes increasing Emergency Department (ED)waiting room capacity, creation of additional assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient winter ward capacity through the relocation of the Frail Elderly Service. We know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the recent pan-West Midlands Stat-stress study has highlighted that staff working along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder following the initial peak of Covid-19. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. Interventions within this year will cost £3.361m plus a further £1.336m of revenue funding to deliver the £4.1m urgent and emergency care (UEC) capital schemes. The total cost of this year's Urgent and Emergency Care and Covid resilience Winter Plan is therefore £4.697m. This compares to £2.246m in 2019/20, with the increase reflecting the considerably greater resilience needed to safely manage the combination of usual Winter Pressures and Covid resurgence. The Trust Board development session of 16th September 2020 identified a likely scenario income settlement for months 7-12 that could service a £4.5m Urgent and Emergency Care and Covid resilience Winter Plan. The Winter Plan has been approved at Trust Management Board on 22nd September 2020, approved by Performance, Finance &

	Investment Committee on 23rd September 2020, and endorsed by Quality, Patient Experience and Safety Committee and by People & Organisational Development Committee on 24th September 2020.	
Recommendation	Members of the Trust Board are requested to: Approve the Urgent & Emergency Care and Covid Resilience Winter Plan.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk 208 - Total time spent in ED BAF S01 – Safe, High Quality Care BAF S05 – Use of Resources	
Resource implications	Interventions within this year will cost £3.361m plus a further £1.336m of revenue funding to deliver the £4.1m UEC capital schemes. The total cost of this year's Urgent and Emergency Care and Covid resilience Winter Plan is therefore £4.697m. This compares to £2.246m in 2019/20, with the increase reflecting the considerably greater resilience needed to safely manage the combination of usual Winter Pressures and Covid resurgence. The Trust Board development session of 16th September 2020 identified a likely scenario income settlement for months 7-12 that could service a £4.5m Urgent and Emergency Care and Covid resilience Winter Plan.	
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 ☒	

Walsall Healthcare NHS
NHS Trust

Urgent & Emergency Care and Covid resilience: Winter Plan 2020/21

Active Period
1st November 2020 to
31st March 2021

Version 1

Executive Lead

Ned Hobbs
Chief Operating Officer

Contributing Authors
Kate Salmon, Divisional Director of Operations, Medicine Division

Walsall Healthcare NHS Trust
Trust Headquarters | Moat Road | Walsall | West Midlands | WS2 9PS

Section

1	**Foreword**
2	**Executive Brief**
3	**Purpose of this Document**
4	**Approach to planning for winter 20/21**
5	**Winter plan modelling methodology**
6	**Modelling**
7	**Detailed plans & summary costings**
8	**Urgent & Emergency Care capital allocation**
9	**Risks**
10	**External reporting arrangements**
11	**Appendices**

1.0 Foreword

The winter of 2019/20 was, in the main, a relative success for Walsall Healthcare NHS Trust. At a national level, 4-hour emergency access standard, 12-hour decision to admit trolley waits, and ambulance handovers recorded their worst performance on record. The Trust's national and regional standing on all three key emergency care indicators improved over the course of 2019/20 and in particular during the Winter period. This was, without question, as a result of the diligent winter planning work undertaken by all our Divisions and teams across the organisation.

We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This year is likely to be even more challenging for the NHS and Social Care systems due to the Covid-19 pandemic.

The potentially toxic scenario of seasonal influenza, norovirus, delayed detection of patients with serious pathology associated with reduced elective and primary care during the pandemic, and a resurgence of Covid itself means that our Winter Plan must have even greater resilience than previous years. In addition, the plan must enable a relentless focus on minimising the risk of nosocomial infection and reflect that this necessitates Covid segregation and streaming within the hospital setting which is acknowledged to make managing patient flow through the Trust more challenging.

The 3 central tenets of the plan are as follows:

1. A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than just opening more inpatient hospital beds.

2. Following the success of our targeted approach to managing the Festive period last year, the same approach will be adopted for 20/21 (19/12/20-10/01/21). Operational services over the key weekend and bank holiday days will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

3. Maximising the £4.1m Department of Health capital investment recently awarded to ensure our emergency care pathways are Covid resilient. This includes increasing ED waiting room capacity, creation of additional assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient winter ward capacity through the relocation of the Frail Elderly Service.

Getting this right is really important, and is a whole hospital, whole Trust, and whole health economy responsibility. It is important because if we don't get it right, patients will spend excessive time in the ED and will be at increased risk of contracting covid-19 under our care. We know prolonged duration of stay in the ED for admitted patients is directly associated with an increased mortality rate of approximately 0.75% per hour, and we know that contracting (probable and

definite hospital acquired) covid-19 carries a 40% mortality rate. If any statistics were to re-emphasise the importance of the plans contained within this document, these two do.

We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the recent pan-West Midlands Stat-stress study has highlighted that staff working along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder following the initial peak of Covid-19. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments.

Thank you to all colleagues who played their part in delivering as safe a Winter as possible last year, thank you to all colleagues who have played such an invaluable role in keeping our patients and staff safe during the Covid-19 pandemic, and thank you to all colleagues who have been involved in developing this plan. Just about every specialty or department in the Trust has a role to play to ensure we manage Winter as well and as safely as we can. If we work closely together as a team, and deliver the commitments contained within this document, I am confident we can deliver safe, timely emergency care and a good working experience for our staff.

Ned Hobbs
Chief Operating Officer
Walsall Healthcare Trust

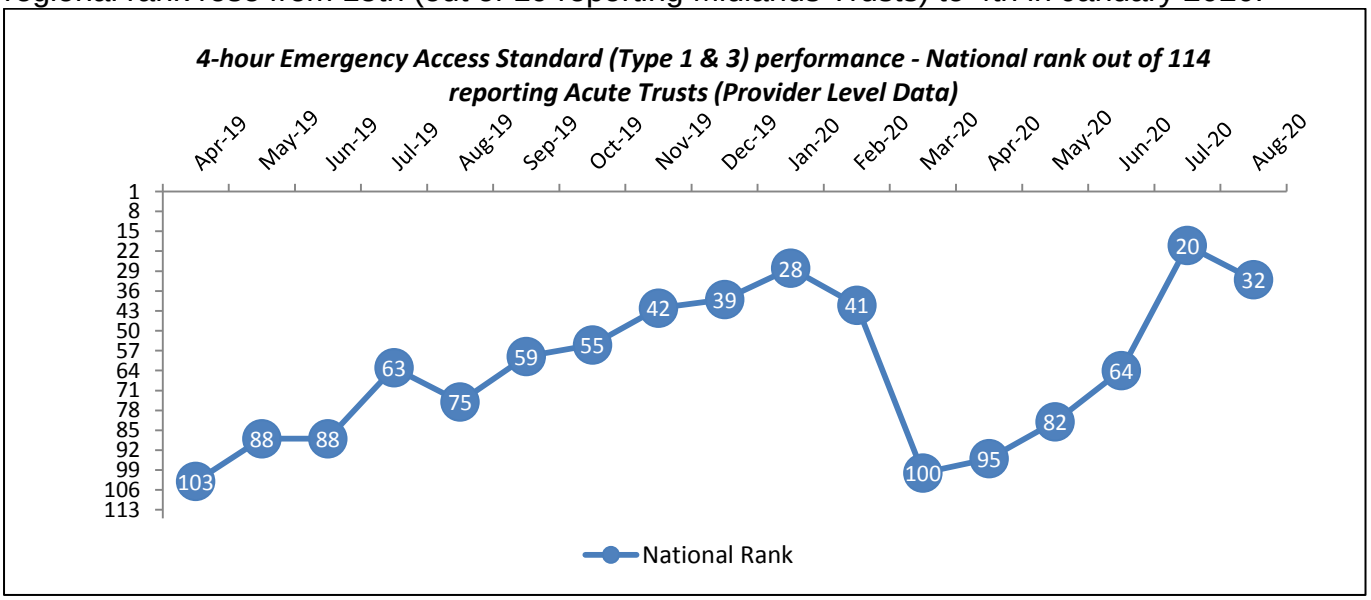
2.0 Executive Brief

Throughout the year we are constantly preparing for and managing variation in demand and anticipated peaks in demand. During the winter period a number of pressures will be prevalent which impact on our ability to manage demand and capacity; indeed with the added challenge of Covid-19 this year may be the most challenging yet:

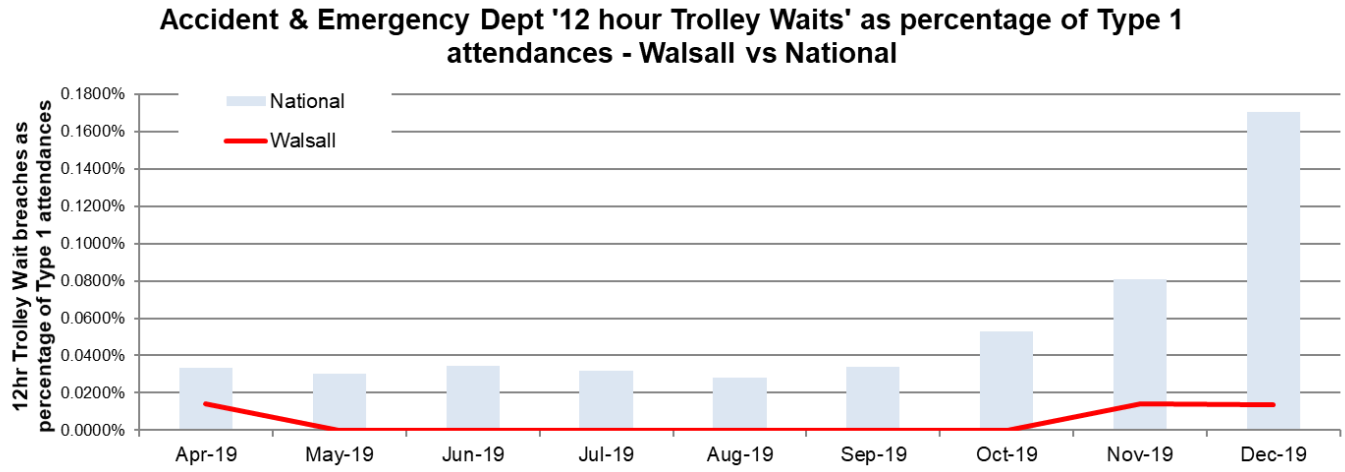
- Impact and effects of the Covid pandemic
- Increased demand for non-elective care
- Higher rate of admissions to hospital
- More acutely unwell patients
- More patients waiting to be discharged from hospital and requiring subsequent care packages to support discharge
- Decreased workforce resilience (festive holidays and sickness absence)
- Requirement to balance the elective restoration programme with management of unplanned care demand
- Need to provide additional health and social care capacity in acute hospital and community settings which will be further challenged due to Covid

We have taken the learning from last year's Winter plan which although not formally reviewed due to onset of the Covid pandemic, a number of important metrics do provide evidence of its relative success.

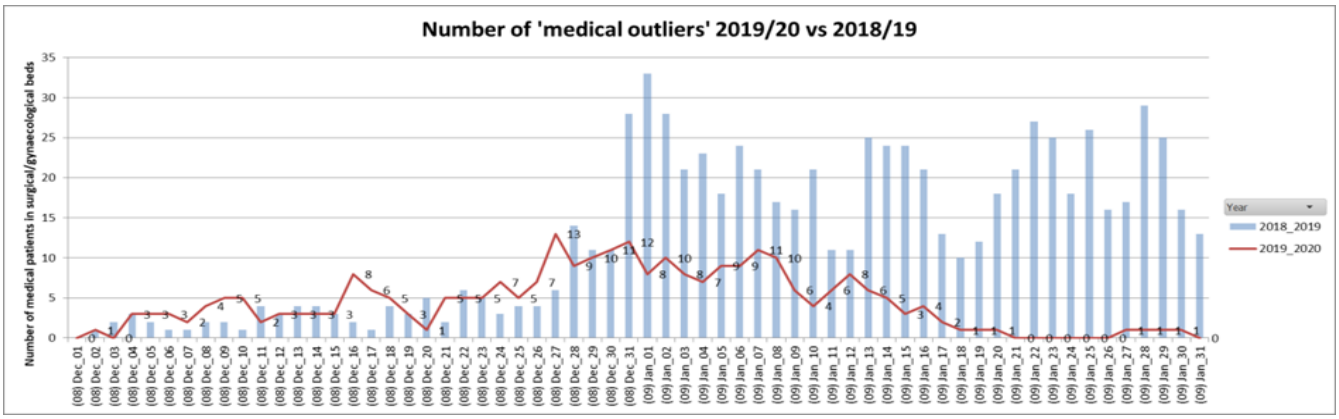
December 2019 was our highest month of Type 1 Emergency Department attendances on record, followed by January 2020 as our 3rd highest month on record. Indeed the rise in demand over the last 2 years has been profound, with a 12% increase in attendances over Q1-Q3 2019/20 compared to just two years prior during Q1-Q3 2017/18. Despite these attendances, the Trust's national ranking for 4-hour emergency access standard performance rose from 103rd (out of 114 reporting Trusts) in April 2019 to 28th in January 2020, and similarly our Midlands (West & East) regional rank rose from 15th (out of 19 reporting Midlands Trusts) to 4th in January 2020.



In addition, as 12-hour trolley wait breaches soared nationally, the Trust avoided a significant increase in patients waiting the most excessive and prolonged period of time from Decision to Admit.



Much of the increased demand and pressure is on the Acute Medical pathway, and thus the above was more impressive in the context of a significant reduction in medical outliers in surgical and gynaecological wards, meaning fewer patients were cared for on wards that are not as used to managing their conditions – an important quality marker.



This plan will build on the winter planning of 2019/20 and demonstrate how the learning from the previous year has translated into a further set of improvements. The plan in this document sets out how health and social care partners in Walsall are preparing for the additional peaks in demand from 1st November 2020 through to 31st March 2021.

The plan, is subject to the following Governance approval process:

- Trust Management Board (22/09/20)
- Performance, Finance & Investment Committee (23/09/20)
- Quality, Patient Experience & Safety Committee (24/09/20)
- People & Organisational Development Committee (24/09/20)
- Public Trust Board (01/10/20)

3.0 Purpose of this document

3.1 The purpose of this Urgent & Emergency Care and Covid resilience Winter plan is to:

- Inform all relevant organisations and individuals of the way in which the system intends to manage Urgent and Emergency demand and provide resilience over the winter 2020/21(01-11-20 to 31-03-21)
- Hold information on the approach taken to building the winter plan

3.2 The plan should be read by:

- Trust Board members
- Divisional Teams of Three
- Matrons
- Clinical Directors in all non-elective specialties
- Senior operational managers in the Trust
- All colleagues who are on an on-call rota.
- Senior operational managers in all system partner organisations
- Infection Control Leads
- Informatics Leads
- Black Country & West Birmingham Urgent & Emergency Care Board

3.3 This document should be read in conjunction with the following documents, plans and arrangements:

- The appendices to this document
- Escalation policy – Full Hospital Protocol (2016)
- Major Incident Plan (May 2019)
- Local business continuity arrangements
- Severe Weather Plan
- Walsall Council Severe Weather Partnership

4.0 Approach to planning for winter 2020/21

4.1 In previous years a formal 'After Action Review' has taken place with a final report presented to a number of committees and to Trust Board; this was not undertaken during 2020 due to the onset of the Covid pandemic disrupting all business as usual processes.

4.2 The Chief Operating Officer's reflections and summary of the Winter plan and effectiveness thereof was written and circulated widely across the Trust however ('Thank You – Winter and Emergency Care' - Appendix).

4.3 Divisions have produced strategic plans following similar principles to the previous winter based on the following:

- A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than just opening more inpatient beds.

- Following the success of our targeted approach to managing the Festive period last year, the same approach will be adopted for 20/21 (19/12/20-10/01/21). Operational services over the key weekend and bank holiday days will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

- Maximising the £4.1m Department of Health capital investment recently awarded to ensure our emergency care pathways are Covid resilient, and to deliver on national urgent and emergency care priorities. This includes increasing ED waiting room capacity, creation of additional assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient winter ward capacity through the relocation of the Frail Elderly Service.

4.4 Planning has also been cognisant of the impact that greater pressures over the Winter period has on our staff. We know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the recent pan-West Midlands Stat-stress study has highlighted that staff working along the emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder following the initial peak of Covid-19. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. The Trust will take the learning from the Covid pandemic to continue to provide access to Psychological support and wellbeing facilities (such as the Haven) to promote the health and wellbeing of our staff over the Winter period.

5.0 **Winter plan modelling methodology**

The following methodology was used to calculate the expected impact/benefits of the planned interventions to produce a winter bed model included in s.6 below:

- Repeated methodology from 19/20 Winter Planning to inform forecast demand (ED attendances and non-elective admissions), accounting for Walsall Together interventions, particularly on admission avoidance.
- Repeated methodology from 19/20 Winter Planning to inform forecast acute hospital bed requirement (daily), accounting for MLTC and Surgery planned improvements in SDEC and inpatient LoS. Assumption that MSFD numbers remain below 50.
- Take account of changed bed configuration i.e. no opportunity for non-elective surgical patients to occupy Wards 20a/20b, reduced opportunity for non-elective surgical patients to occupy ward 23, due to hard elective/non-elective segregation to minimise covid nosocomial transmission risk.
- Map Divisions' phased interventions and phased bed opening plans against base-case scenario (s.5.1).
- Compare with worst case and best case planning scenarios (NHSEI) (s.5.2)

5.1 Detailed demand and capacity modelling has been taken into account using the following as our **base-case scenario**

- Return to 100% pre-Covid ED attendances and non-elective admissions
- Increased acuity of non-elective admissions associated with delayed detection/acting upon serious pathology and/or comorbidity
- Assume prevalence of flu and norovirus consistent with previous Winters
- Assume Covid-19 peak at half April 2020 peak

5.2 Reasonable best-case and worst case scenarios have been taken from the Regional Phase 3 planning letter alongside local interpretation and modelling has assumed the following:

Worst case scenario:

- Winter 2020 demand uplift from 2019 plus a COVID-19 peak equal to April 2020
- Increased acuity of non-elective admissions associated with delayed detection/acting upon serious pathology and/or comorbidity
- Assume prevalence of flu and norovirus consistent with previous Winters

Reasonable best-case Scenario:

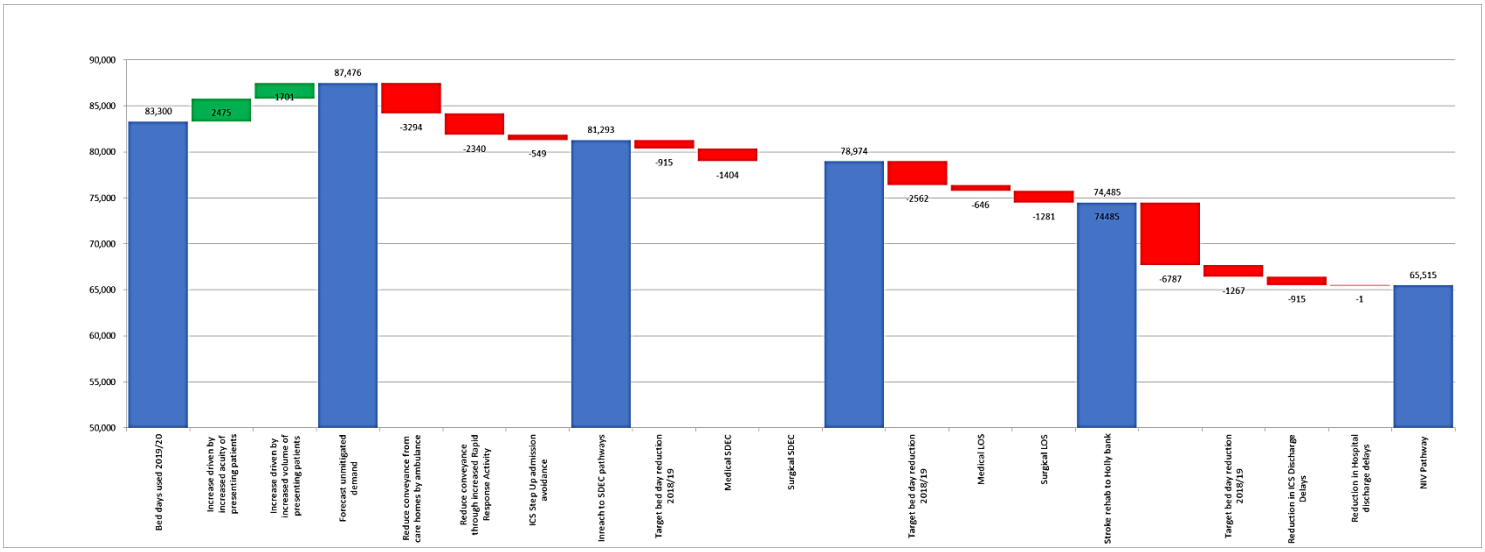
- Winter 2020 demand uplift from 2019 plus assume COVID-19 peak at half April 2020 peak
- No increase in acuity associated with delayed detection of serious pathology
- Reduced prevalence of flu and norovirus due to social distancing and increased IPC awareness in the general population

6.0 Modelling

Calculating the expected impact of planned interventions

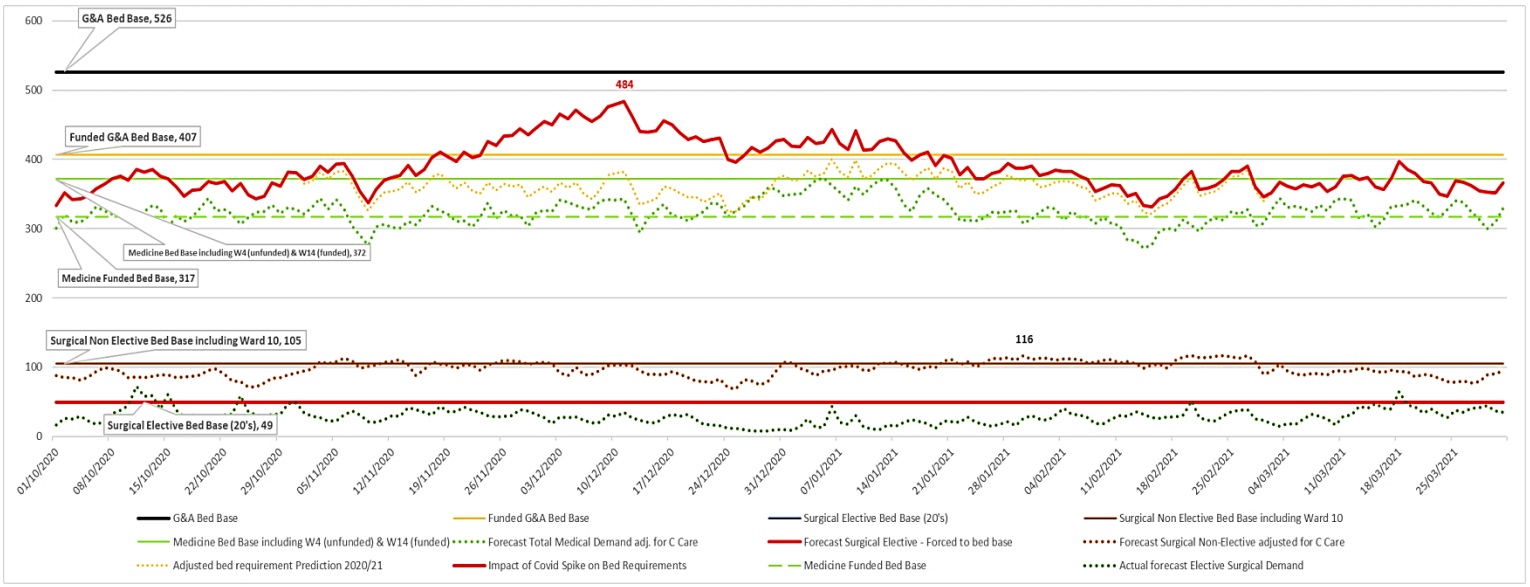
Using the scenarios above in s. 5.1 and s. 5.2 the expected benefit calculations were completed (in a currency of bed day reductions). This benefit was then used to demonstrate the expected impact on demand that each intervention was committing to deliver. This was articulated in a 'waterfall' visualisation which showed historic levels of bed day demand plus forecasted growth minus benefit improvements giving a forecast of annual bed demand for the coming year

'Waterfall' of demand and mitigations for 20/21



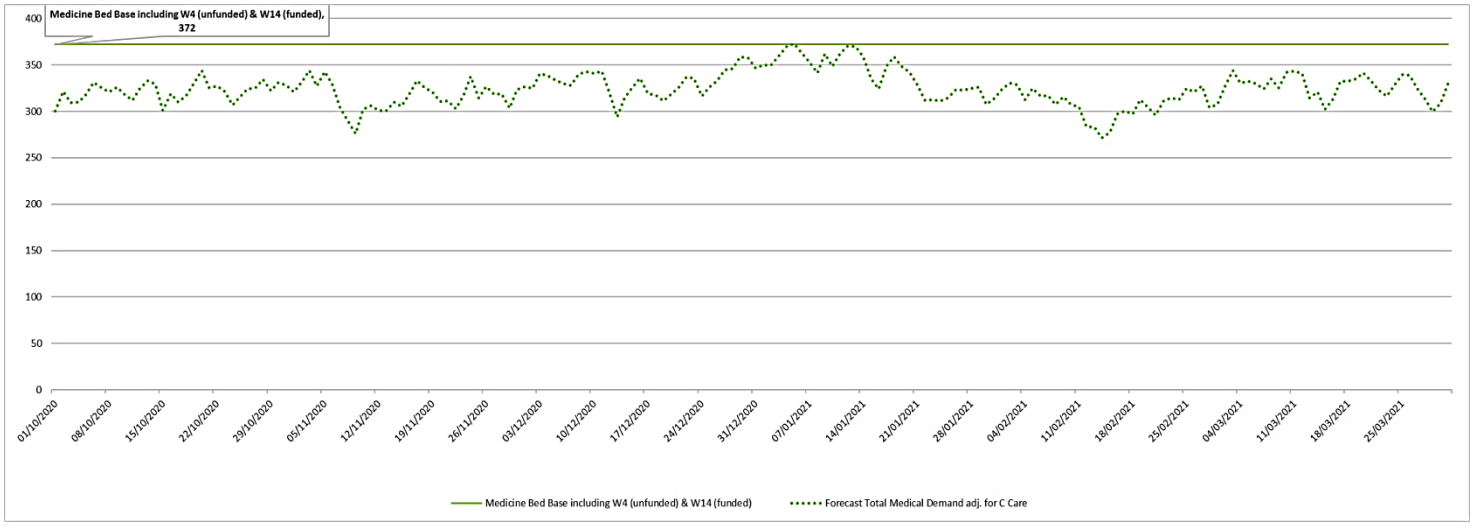
The benefit of these collective actions have created a new forecast for the overall bed demand required to operate safely over the winter period including demand at 50% of April's Covid peak. This has been used this to generate a graphical representation of the way in which bed demand is predicted to increase and fall over the period. In turn this model was 'stress tested' by modelling the expected demand to 1 and 2 standard deviations to replicate the expected pressure if demand increased or planned mitigations failed to deliver the expected benefit. Critically this projection includes the phased realisation of benefits from the improvement work as it moves to full year effect.

Surgical, medical and covid demand (@50% of wave 1)



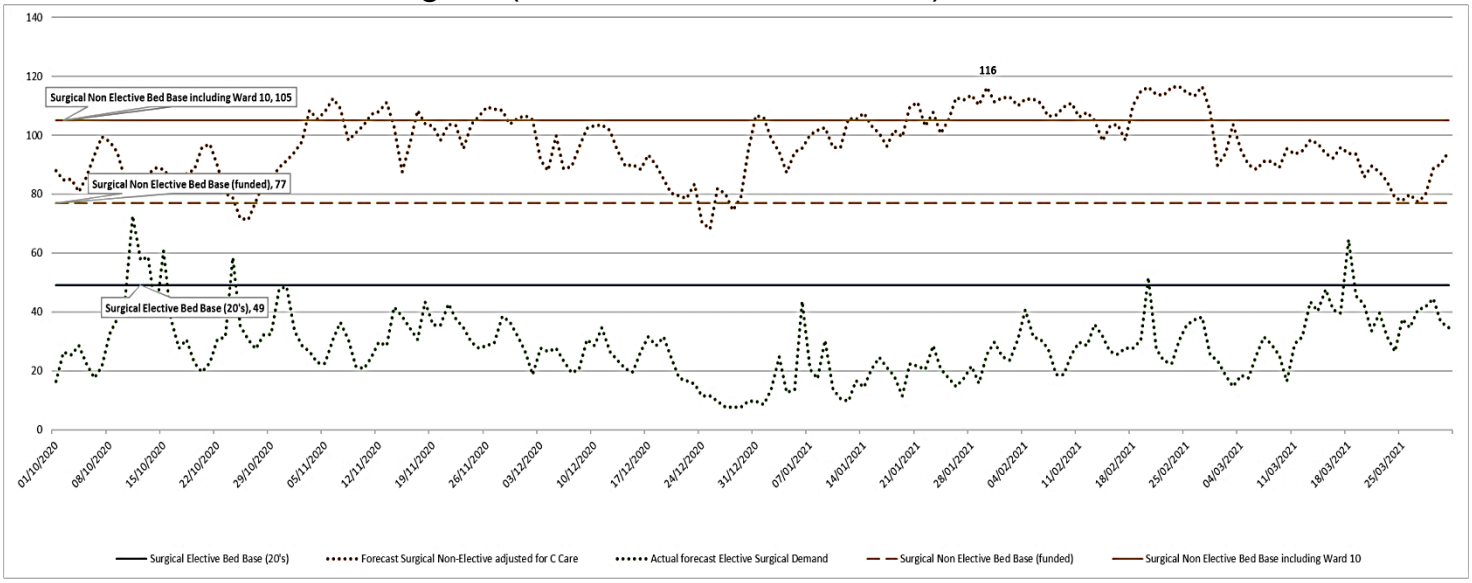
This modelled demand was then used to inform and agree a viable and deliverable operational plan for managing acute bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider opening additional medical and surgical inpatient capacity to safely manage demand.

Forecast Medical demand and medical bed base (funded and unfunded) after mitigations



The bed modelling evidences that both Ward 4 (unfunded) and Ward 14 will both be required to meet anticipated medical bed demand, even after further SDEC and length of stay improvements.

Surgical (elective and non-elective) demand



The model identifies the key risk, based on previous patterns of increased non-elective surgical bed demand over the Festive period of the non-elective surgical bed base being unable to manage demand in January and February, and without access to wards 20a and 20b for non-elective patients. Accordingly, the Surgical Division is adopting considerably stronger Festive Period arrangements (see below) this year to mitigate this risk.

7.0 Detailed plans & summary costings

The following winter initiatives show the planned interventions from each of the Divisions focussing on the strategies as outlined above which aim to reduce inpatient bed demand, increase same day emergency care and reduce length of stay. They typically add resources into existing pathways to strengthen them and/or extend services so that they are available over longer periods (into the evening or at weekends for example). The additional interventions for the festive period ie. 19th December 2020 to 10th January 2021 are also included and are focussed on ensuring the weekends and bank holiday days run as close as possible to a normal week day.

A high level summary of the costs of these interventions is below; please refer to the Appendices which provides the detailed phasings and costings.

7. 1 Summary financial costings

		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	In Year
Winter Plan	MLTC	0	120,795	450,239	428,521	334,276	392,709	**1,726,540**
	Surgery	0	108,195	133,307	64,123	105,878	40,051	**451,554**
	WCCSS	0	97,662	127,516	142,679	105,587	90,587	**564,031**
	Comm	50,271	66,826	79,227	82,895	73,972	58,002	**411,193**
	Estates	0	10,727	44,985	44,985	42,168	42,168	**185,033**
	Corporate	0	0	10,920	11,873	0	0	**22,792**
Winter Plan Subtotal		***50,271***	***404,205***	***846,193***	***775,076***	***661,881***	***623,517***	***3,361,142***
Rev Impact of Capital Case (£4.1m)		0	236,631	401,999	232,307	232,307	232,307	**1,335,551**
Total		**50,271**	**640,836**	**1,248,192**	**1,007,383**	**894,188**	**855,824**	**4,696,693**

	Pay/Non Pay	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	In Year
Winter Plan	Pay	49,771	373,905	793,539	703,422	613,227	589,863	**3,123,726**
	Non Pay	500	30,300	52,654	71,654	48,654	33,654	**237,416**
Winter Plan Subtotal		***50,271***	***404,205***	***846,193***	***775,076***	***661,881***	***623,517***	***3,361,142***
Rev Impact of Capital Case (£4.	Pay	0	89,008	223,104	223,104	223,104	223,104	**981,425**
	Non Pay	0	147,624	178,895	9,203	9,203	9,203	**354,126**
Subtotal UEC CApital		***0***	***236,631***	***401,999***	***232,307***	***232,307***	***232,307***	***1,335,551***
Total		**50,271**	**640,836**	**1,248,192**	**1,007,383**	**894,188**	**855,824**	**4,696,693**

7.2 Division of Medicine

Intervention	Expected benefit
Inpatient Ward Weekend Medical cover	Progressing patient's care plans over the weekend to ensure timely, quality care and increased discharges over the weekend; to improve flow. Sunday ward rounds will be in place over the festive period.
ED Acute Physician	Acute physician working in ED to provide a timely review and confirmation of admission or discharge. Evenings and weekends.
AEC Extended Opening until 22:00	Increasing opportunities for same day emergency care, preventing inappropriate admissions, and decongesting ED at peak times (late afternoon and early evening).
Consultant Orthogeriatrician providing additional ward rounds	Provision of timely review of patients over the festive period to progress patients care plans and providing quality of care.
Inpatient Endoscopy weekends and BHs	To prevent patients waiting longer for their inpatient investigations particularly over the festive period, continuing to provide safe, timely care and freeing up inpatient bed capacity.
Extend FES Cover	Extending weekday hours and providing additional medical and nursing support over the weekend to ensure frail, elderly patients are seen and treated by specialists with the aim of avoiding unnecessary admissions and treated as same day emergencies. Relieving pressure in ED.
Weekend consultant ward rounds supported by Junior doctors	Junior doctors to support Saturday consultant ward rounds to progress patient's management plans and increase discharges. Bolstered further during the festive period with extended ward rounds on Saturday and Sunday
Junior Dr Sunday for EDS and Clerking	Additional doctor to ensure electronic discharge summaries are completed in time to support safe discharges on Sundays providing support to all medical wards. To ensure flow.
Additional ED consultant and middle grade shifts	To strengthen senior decision-making particularly at weekends and evenings/overnight to minimise time from arrival in ED to Doctor/practitioner revie.w
Transfer team in ED	At times of surge and particularly during winter alongside the need to de-congest ED due to Covid segregation; a dedicated transfer team

	supports flow out of ED to free up cubicle capacity.
Extend Rapid Assessment and Treatment service (RATS)	Extended hours to manage times of peak demand and de-congesting ED.
Progress chaser & phlebotomist	Both posts relieve clinical staff ensuring the nursing team are dealing with clinical issues and are providing safe, timely care.
Alcohol Liaison Nurse	The alcohol liaison nurse will case manage patients in ED and assess the appropriateness of patients for ambulatory detox working alongside the community team. This would save hospital bed days, reduce ED attendances and educate staff (providing confidence) as to the available support and pathways in the community rather than admit patients for detox.
Medical winter ward capacity – 34 beds	Additional inpatient winter ward capacity to reduce exit block from ED due to lack of bed capacity. Contributes towards achieving 4 hour EAS standard which is a proxy for safe, timely care; patients should not be in ED any longer than necessary; it is well known it has an adverse impact on patient care. • 28 beds on Ward 14 • 6 beds on Ward 4

7.3 Division of Surgery

Intervention	Expected benefit
Additional trauma capacity – for c. 6 week period with c. 6 additional sessions per week [NB: this is indicative]	No waits for non-elective Trauma surgery >24 hours. Aim to protect ring-fenced elective beds (and thus avoid a period without elective operating), unless additional ward-based staff are required for issues related to Covid-19. [NB: these sessions may come as a replacement of elective sessions for Anaesthetists and Surgeons]
Additional CEPOD capacity – for c. 6 week period with c. 4 additional sessions per week	As above
Ward 10 (28) and Ward 12 (12) bed capacity	Additional non-elective bed capacity within the acute zone of the hospital.
Dedicated nursing flow manager	Senior oversight of bed moves and support to 'pull' surgical patients to SACU and from ED.
Dedicated SACU 24/7	Improvements in same day emergency care, with a view to exceed 50% of emergency surgical hospitalisations discharged same-day.
'Perfect Week'	We will run the 'Perfect Week' for a fortnight over the winter period with a whole Division focus on timely discharge and supporting flow. The operational team will support as ward liaison officers to help resolve issues and only essential meetings will take place.
Emergency Hot Clinics	Continuing to support Hot Clinics across General Surgery and Urology

7.4 Community Division

The following interventions are in addition to the £1.6m investment made in 20/21 in to Walsall Together to sustain healthy communities and address existing health inequalities in the borough. A place-based Winter Plan for the full Walsall Together Partnership will be taken through the Partnership Board for approval, to complement this Walsall Healthcare NHS Trust Winter Plan.

Intervention	Description	Expected benefit
Weekend & Christmas cover	Additional therapy staff to provide support to wards around assessment and discharge	Ensure timely interventions thereby reducing LOS Supports extended 7 day working This was implemented last winter and supported the enhanced Manor response
Hospital Discharge Teams: extended coverage OOH [therapy; planners]	Additional discharge staff to support with discharge of complex patients	See above
Front door discharge nurses	Community nurses working in the assessment & admission areas of the Manor to signpost patients onto community pathways	Ensures community pathways are maximised Patients are discharged before they get referred onto in-patient units by offering care of equal quality at home. (Piloted during Covid.
Enhanced Care Home Team	Support to care homes from community nurses They undertake weekly reviews of residents and will develop advanced care plans for them	This provides clinical oversight of residents in care homes. Ability to detect any changes in condition and intervene early. Provides the opportunity to maintain more people to be cared for in their place of residence and reduce conveyance to hospital Implemented on a bigger scale during Covid – this will now extend to >30 care homes in the Borough
Rapid Response extended hours	Longer working day thereby increasing capacity of the service	c85% of patients treated by Rapid Response are able to stay at home and hospital conveyance is avoided Increasing the number of referrals dealt with will lead to reduced attendances at ED This is a well-established model
Additional capacity within locality teams	More community nurses recruited for locality teams, thereby increasing the number and range of interventions that they are able to make	Additional capacity in the community should lead to more home-based care, greater resilience amongst clients and less referrals to hospital. This is a well-established model

7.5 Division of Women's, Children's and Clinical Support Services

Paeds & Neonates

Initiative	Expected benefit
Increased HDU Capacity (Ward 21)	Based on last year's activity we will be increasing our staffing so we can provide this additional capacity. Benefits for patients as the sooner they received this level of care the better the clinical outcomes and a reduction in the patients LoS.
PAU Split Pathway for Children with direct ED admissions	We have split PAU into two areas and streaming patients through accordingly. Additional Paediatric Consultant and Middle Grade cover will support with same day emergency care for the children and reduce the patients LoS.
Dedicated Elective Activity (Ward 26)	We have secured a separate dedicated standalone Day Case facility for Elective Activity since COVID. This will remain through winter allowing us to continue with children's elective surgery as normal. No reduction in numbers as we have had to do in previous years.

Womens

Initiative	Expected benefit
Independent 24 hour EPAU/GAU to support Emergency Flow to include weekends. Currently only operates Monday to Friday 8am – 8pm	Direct referral from ED which will support patient flow and anticipating increase in patient activity. These include the pathway for women under 40 with lower abdominal pain. This will reduce LOS. Current staffing will require a further 2.88WTE Band 5.
Buzzer system within ANC	Reduce footfall and support visitors within ANC. This will also release pressures on the diabetic clinic footfall.
Navigation point lease	Release pressures with footfall on the acute site for ANC/Postnatal clinics and Gynaecology outpatients Cost - £70k per annum

Clinical Support Services

What are we doing	Description	Expected benefit
Weekend & Christmas cover	• Additional staff to provide support over festive period	Ensure timely interventions thereby reducing LOS This was implemented last winter and supported the enhanced Manor response.
Additional capacity in Imaging	• Additional evening sessions for CT, US • Additional Weekend sessions	• Ensure timely diagnostics thereby reducing LOS • Reducing patient wait
Additional CMU Capacity	• Additional OP capacity - weekends, evenings	• Ensure timely diagnostics thereby reducing LOS • Reducing patient wait

Pharmacy

Initiative	Expected benefit
Move pharmacy resource to support completion of medicines reconciliation at the point of admission	Streamline discharges as there will be fewer drug queries to manage on day of discharge
Pharmacy opening until 7pm over Christmas and New Year period	Support for the higher level of discharges anticipated during the festive period
Set up of dedicated discharge team over the winter period	Will support the timelier discharge of patients and bring forward the time of discharge to earlier in the day (subject to EDS being available)

7.6 Corporate Services

Initiative	Expected benefit
Discharge lounge extended opening hours during December and January.	Discharge lounge has proven to improve flow early in the mornings and into the evenings. It will be open on Sundays and bank holidays during the festive period.
Operations centre will double up on site practitioners on every weekend during December and January.	Additional operational site support provides more robust management of the site, particularly during times of pressure.

8.0 Urgent & Emergency Care capital allocation

The Trust successfully bid for additional capital funding and was awarded £4.1m in early September to ensure our emergency care pathways are Covid secure ie. increasing ED waiting room capacity, creation of assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient winter ward capacity through the relocation of the Frail Elderly Service. Receipt of this capital funding was dependent on evidence of meeting national urgent and emergency care priorities including use of priority admissions unit facilities, increased same day emergency care facilities and increased ED cubicle capacity. The detailed schemes and the associated benefits are outlined below. The funding was awarded on the basis that all schemes must be delivered by 31st December 2020; the design and planning has begun.

Scheme	Expected benefit
Rapid Assessment & Treatment: Portakabin for Rapid Assessment and Treatment area allowing early ambulance handover, requirement of 5 bays to release ambulances (trollied areas). Access to toilets, sinks, power points for monitors, nurses' station. This would provide the option of either increasing ability to RAT or re-provide 4 cubicle spaces within ED thus avoiding 'corridor queuing'.	To ensure early release of ambulance crews, de-congest ED department and avoid 'corridor' queuing. Supports the separation of Covid and non-Covid streams.
Increased Surgical Non-Elective Capacity (SDEC pathway): Additional capacity to be opened within vacant ward 22 area. This area will provide equipment and staffing for 15 additional "Fit to sit" spaces, 8 trolley spaces and 2 assessment rooms.	This will double current surgical non-elective assessment capacity and increase and impact on our ability to meet the SDEC targets. Support de-congestion of ED. Improved pathways for patients.
Priority Admissions Unit: Refurbishment of an existing space on AMU to create a Priority Admissions Unit for up to 5 patients (on trolleys). This will not be an inpatient area.	To reduce the risk of corridor queues in ED and thus the risk of nosocomial spread of Covid. Early transfer of patients from ED, de-congesting ED, improved pathway for patients who are being admitted.
Waiting area: Portakabins to provide additional waiting room capacity requiring seating and toilet facilities.	Two portakabins providing much needed additional waiting room and nurse streaming and triage capacity to assist in Covid and non-Covid separation of streams.
Frail Elderly Care service (SDEC): Refurbishment of an existing space (Clinical Measurements Unit) for the Frail Elderly Care service (currently occupying Ward 14) to ensure Ward 14 is available for use as a 'Winter ward' – 28 beds.	Purpose-designed unit for our Frail elderly service which will ensure the service can continue during the winter period as the ward they are presently occupying will be required for additional bed capacity. Ensures same day emergency care can be provided for our frail, elderly patients.

9.0 Risks

It is recognised that the assumptions within this plan assume the availability of additional staff resource, particularly nursing and medical. Last Winter was evidence of the success of securing such staffing cover, however the impact of Covid-19 on staff may have an impact this Winter. This plan is linked to two risks on the Corporate Risk Register:

Risk Title	Current risk score	Risk description
Risk 208 Failure to achieve 4 hour emergency access standard resulting in patient safety, experience and performance risks.	12	Despite improvement in the Trust's national ranking for EAS performance, there remains a delay in patients being assessed in ED which will result in failure to achieve consistent wait to be seen times, time to treatment which will impact upon failure to achieve 4 hour EAS. This will lead to poor patient experience and risk of adverse clinical outcomes including mortality.
Risk 2093 Risk of staff contracting Covid-19 through the course of their duties in Walsall Healthcare NHS Trust	15	Staff are exposed to infection with Covid-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death.

10.0 External Reporting

Early reporting of data that indicates emerging problems is seen as a key element in the effective management of winter. Trusts are required to use UNIFY2 for reporting local winter pressures. Clarity regarding SITREP contents will follow in due course, current expectations are:

- temporary A&E closures
- A&E diverts
- ambulance handover delays over 30 minutes
- trolley-waits of over 12 hours
- cancelled elective operations
- urgent operations cancelled in the previous 24 hours and those operations cancelled for the second or subsequent time in the previous 24 hours
- availability of critical care, paediatric intensive care and neonatal intensive care beds
- non clinical critical care transfers out of an approved group and within approved critical care transfer group (including paediatric and neonatal)
- bed stock numbers (including escalation, numbers closed, those unavailable due to delayed transfers of care etc.)
- and details of actions being taken if trust has considers that it has experienced serious operational problems

The additional Covid-19 reporting requirements are as follows:

- STP Covid Daily
- National Covid Daily
- Discharge Daily
- Mortuary Weekly
- PPE Weekly
- ICU Consumables Weekly
- Daily Update Submission - to be completed and returned by providers with a declared Covid-19 Outbreak

11.0 Appendices

Winter Plan phased interventions and costings (located in reading room for Trust Board)
Severe Weather Plan

http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/severe-weather-plan---assumptions-and-expectations.docx

Thank you Letter from Ned Hobbs, Chief Operating Officer (located in reading room for Trust Board)

Risk Summary			
BAF Reference and Summary Title:	**BAF 06 COVID - This risk has the potential to impact on all of the Trusts Strategic Objectives.**		
Risk Description:	**The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.**		
Lead Director:	Chief Operating Officer	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title** 2051- Inability to mitigate the impact of Covid-19, results in possible harm and poor patient experience to the people of Walsall. 2066- There is a risk of lack of skilled registered nurses (RN's)/registered midwives (RM's) on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care 2093- Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust 2095- Inability of the NHS supply chain to provide an adequate and on-going supply of PPE to meet the demand to ensure that Walsall Healthcare NHS staff are fully protected during the Covid-19 pandemic. <Add in links to 18-week or 4-hour emergency access standard or cancer waiting time risks> <Add in link to financial sustainability risk>	**Current Risk Score** **20 (Moderate)**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:					• Covid-19 is a novel virus and therefore there is a lack of knowledge and understanding of the disease, how it behaves and the likely trajectory of further resurgence in cases. • The initial wave of Covid-19 has had a profound impact on the services that the Trust provides, both in terms of urgent, emergency and critical care services to manage covid-19 positive patients (in the hospital and the community), and in terms of the reduction in capacity of elective care services. • The initial wave of Covid-19 has had a profound impact on the workforce of the Trust. Almost 1 in 4 Trust staff who have undergone	**Likelihood:**	**2**	31 March 2021
Consequence:						**Consequence:**	**5**	
Risk Level:	**25 (Major)**	**20 (Moderate)**				**Risk Level:**	**10 (Moderate)**	

			a Covid-19 Antibody test have been antibody positive suggesting a significant proportion of the workforce has experienced the disease themselves. Moreover, the challenges of managing the initial wave of the pandemic has had significant psychological impact on staff too. • The Trust is operating in a highly uncertain financial planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19. • The number of Covid-19 positive inpatients has reduced from over 200 at the peak of the initial wave to less than 10 over Summer 2020. • Covid-19 has profoundly exposed existing significant health inequalities in the population the Trust serves. • Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust.		

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	Governance: • Incident Command structure in place incorporating Strategic Command, Hospital Tactical Command, Walsall Together Community Tactical Command and Corporate Tactical Command. • Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. • Specific Covid-19 related SOPs and guidelines	• Individual committees consider specific impact relevant to their portfolio, i.e. Financial matters and Restoration and Recovery of elective services under PFIC; Quality, Safety and Patient experience matters under QPES and Workforce matters including staff wellbeing under P&ODC. • Board Development sessions (x2) on approach to Restoration and Recovery.	• Regional and National Incident Control structure.
Gaps in Control	• National directives and mandates impact on the Trusts ability to make local decisions. • Unable to progress all elements of the improvement programme owning capacity of senior leaders • Comprehensive OD/Culture Improvement plan •		
Assurance:	• Elective waiting times upper quartile for Diagnostics (DM01) and routine elective treatment (18-week Referral to Treatment) •	• Nosocomial Covid-19 infection rate in line with peer-reviewed published evidence • Antibody positive staff rate in line with BCWB peers. • Financial top up requests in line (or lower) as a proportion of turnover than BCWB peers.	• Cancer waiting times in line with national average

Gaps in Assurance	• Lack of assurance of communications within the organisation to ensure staff feel well informed and engaged. • Evidence of higher staff absence rates than BCWB peers during initial wave of Covid-19 • Evidence of slower completion of BAME/vulnerable staff risk assessments than BCWB peers. • Lack of Assurance on sufficient restoration of elective operating theatre capacity to meet expectations of Phase 3 planning letter. • Lack of Assurance that the Trust will have the clinical workforce to deliver services in the event of a second wave. Lack of clarity and certainty regarding levels of income for months 7-12 limit ability to provide assurance on Trust's forecast financial position.

Future Opportunities

- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables
- Opportunity to explore urgent care processes and establishment to deliver increased quality and efficiency of care
- Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough.
- Covid-19 has necessitated closer collaboration with other Acute hospitals which can continue to be built upon.
- Increased profile and appreciation of the NHS within the general public could be harnassed to attract and retain staff National planning guidance for Phase 3 (Recovery & Transformation) creates an expectation that services must not be reintroduced based on historical models
- Identifying and adapting the workforce and professions to create a modern and adaptable workforce

Future Risks

- Potential for resurgence in Covid-19 cases.
- Potential for second wave of Covid-19 cases coinciding with Winter pressures including seasonal Influenza and norovirus, and delayed and advanced (in terms of disease progression) presentation of patients that have not accessed healthcare services in recent months.
- Ongoing pressure on community services associated with patients rehabilitating following Covid-19.
- Delayed and/or prolonged impact of managing the initial wave of the pandemic on staff wellbeing.
- Potential workforce absence in the event of a second wave.
- Limited management and leadership capacity to address core objectives due to the significant demands of managing covid-19 pandemic, and the restoration and recovery of services affected by covid-19.
- More constrained financial operating environment.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.					
2.					
3.					
4.					

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Quality, Patient Experience and Safety Committee Highlight Report			**AGENDA ITEM: 10.1 ENC: 8**
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 24th September 2020. Of note are: - The Quality Account is endorsed for the Trust Board's approval, subject to an additional priority for 2020/21 related to COVID-19. - The Committee reviewed and endorsed the Winter Plan. - The Committee reviewed the clinical model and associated risks with the transfer of palliative care beds from St Giles Hospice to Walsall Healthcare NHS Trust and were assured of the plan and the mitigations. - Assurance of process against the CQC 'must do' and 'should do' actions was requested. This will feed through to the Committee in October following revised governance processes that have been put in place in September. - The Board Assurance Framework (BAF) Risk S01 Safe, High Quality Care was reviewed on the new template, with the Committee noting additional corporate risks related to the BAF risk. - Trust referrals from GPs are expected to gradually increase through the year, however a return to full pre COVID-19 levels is not expected until March 2021. - Outpatient visits, currently at 71%, are expected to return to full levels in the Autumn. - Process and governance for Quality Impact Assessments is being developed and will be reviewed by the Committee at their October meeting.		

	The next meeting of the Committee will take place on 29th October 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 BAF risk S01 for safe high quality care and COVID-19 BAF risk S06.	
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 ☐	

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Safe High Quality Care – Executive Update			**AGENDA ITEM: 10.2** **ENC: 9**
Report Author and Job Title:	Ann-Marie Riley, Interim Director of Nursing Matthew Lewis, Medical Director	**Responsible Director:**	Ann-Marie Riley, Interim Director of Nursing Matthew Lewis, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Safe High Quality Care ("SHQC") 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 Safe High Quality Care improvement programme work-stream and performance against the related strategic objective, successes and areas for improvement.		
Recommendation	1. Note the update to Trust Board on actions taken relating to the Improvement Programme through Quality, Patient Experience & Safety Committee ("QPES") and supporting groups. 2. Note the highlighted updates to BAF risk S01 and related risks: Risk 2051 (Inability to mitigate the impact of Covid-19, results in possible harm and poor patient experience to the people of Walsall); Risk 1986 (Delays in access to Tier 4 in-patient psychiatric care for Children and Young People; Risk 2066 (There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience) 3. Note the relevant updates and assurance in relation to the performance report 4. Note the progress made within the three key elements of the Safe High Quality Care ("SHQC") improvement plan 5. Note the verbal feedback from three external inspections over the last month: • 19 August: Clinical Commissioning Group ("CCG") visit to the Emergency Department ("ED") and Maternity;		

	• 8 and 9 September: Care Quality Commission ("CQC") visiting the Emergency Department and Maternity; • 17 September: NHS Improvement ("NHSI") who were joined by the CCG visiting Maternity, Neonates, Therapies and Emergency Department	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report highlights updates relevant to Board Assurance Framework ("BAF") Risk SO1 and provides assurance or mitigations in place to manage this risk. The related corporate risks are: Risk 2051: Inability to mitigate impact of COVID-19 results in possible harm and poor patient experience to the people of Walsall. The risk ownership has recently transferred to the Chief Operating Officer and is to be reviewed, or closed down, and a new risk developed to reflect current COVID-19 considerations Risk 1986: Delays in access to Tier 4 inpatient psychiatric care for children and young people. This risk is in the process of being closed down and rewritten to reflect the system collaboration required to mitigate this risk Risk 2066: There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience. This risk has been reviewed and the score reduced from 20 to 16	
Resource implications	Current resource implications relate to the delivery of the Safe High Quality Care improvement programme	
Legal and Equality and Diversity implications	Failure to deliver safe, high quality care may result in further breaches of legal requirements under the Health and Social Care Act 2008	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Safe High Quality Care – Executive Update

1. EXECUTIVE SUMMARY

The delivery of safe, high quality care remains a key priority for the Trust.

The key outstanding risks within the BAF for this objective, relate to the delivery of the fundamentals of care more consistently as a Trust in line with best practice; the recovery of diagnostic and elective waiting list backlogs following COVID-19 driven service disruption; the need to improve our approach to patient, carer and public involvement in service redesign and our improvement and strategic work and need to demonstrate how we are identifying and addressing health inequalities across our population.

Significant work is underway in the Safe, High Quality Care improvement programme workstream. The project briefs are complete for the workstream and significant progress has been made to determine project benefits.

We continue to have significant work to do to provide the required assurance that we are on track to deliver the required CQC actions and to ultimately achieve the Trust ambition to be CQC rated 'Outstanding' by 2022.

The Director of Nursing and Medical Director continue work to develop a multi-professional Care Excellence Strategy to drive multi-disciplinary collaboration to support the achievement of care excellence across patient outcomes, patient experience and staff experience; and develop an environment in which clinical excellence will flourish. The final stage of staff consultation taking place this month which will see the development of a shared professional practice model across nursing, midwifery, allied health professionals and medical teams.

The Trust was subject to three external inspections during the last month:

- 19 August: CCG visit to the Emergency Department and Maternity;
- 8 and 9 September: CQC visiting the Emergency Department and Maternity;
- 17 September: NHSI who were joined by the CCG visiting Maternity, Neonates, Therapies and the Emergency Department

A summary of the verbal feedback received is detailed in the report. We are yet to receive written reports from these inspections.

2. BOARD ASSURANCE FRAMEWORK

Our strategic objective is to deliver excellent quality of care as measured by an outstanding CQC rating by 2022. We have reduced the BAF risk score to 16 (in line with the reduction of risk 2066: Lack of registered nurses and midwives, which was our only corporate risk scored at 20) and the Trust continues to have a low risk appetite for compromising quality and safety of patient care.

Key updates on progress over the last month are highlighted below.

2.1 Controls

Faculty of Research and Clinical Education

- Last month we added the Faculty of Research and Clinical Education (FORCE) to our controls, which was established to promote research and professional development in the trust. The team recently submitted a bid to the Clinical Placement Expansion Programme (CPEP) and we are pleased to report that our bid for funding for additional nursing and/or midwifery places has been successful.
- The Clinical Placement Expansion Programme is an expansion fund provided by Health Education England (HEE) and supported by NHS England/Improvement (NHSE/I) to deliver sustainable placement growth in the NHS workforce, in line with the ambitions of the Long-term Plan, throughout the academic year 2020/2021. The funding is for undergraduate placement expansions and will support the growth of education and training across healthcare professions.
- Walsall Healthcare NHS Trust has been awarded £50,000 as part of this expansion to cover the academic year 2020-2021 only and is expected to be used for the sustainability of placements in subsequent years. There are specific contractual expectations with regards to the funding allocation meaning we must provide expansion in line with the numbers specified below:

  Adult Nurses (Students) - 23
  Child Nurses (Students) - 2

Quality Review in place with NHSEI/CQC
We have had three external reviews over the last month –updates from verbal feedback can be seen below.

19 August: CCG visit to Emergency Department and Maternity focus on infection prevention and control practice

- No negative feedback from this visit
- Lots of positive feedback in relation to assurance regarding IPC practice; the friendliness and positivity of staff; staff discussing improvements made and initiatives they had been involved in such as the introduction of Perfect Ward

8 and 9 September: CQC visiting the Emergency Department and Maternity - there were four inspectors each day

- The CQC highlighted that there were no concerns about infection prevention and control (IPC) practice and specifically mentioned how well the Trust had performed in terms of this during COVID-19.
- Positive feedback included Emergency Department (ED) staff had a good knowledge of safeguarding practice and could also demonstrate how they would escalate concerns; ED had good team dynamic- they heard positive feedback from staff about the mix of professions within the department - specifically paramedics. They also highlighted strong team working and the support offered to each other during COVID-

19; the ED safety huddle was praised for demonstrating robust governance, clear divisional ownership and escalation; the CQC noted the Patient and Public engagement in the ED design and build and also noted the new equipment in ED and the positive impact on care.

- For maternity the CQC were positive about Badgernet and the clear and contemporaneous notes; the CQC highlighted evidence of clear governance process and escalations and noted the positive approach to investigations. The CQC gave positive praise for maternity leadership and the general positivity about improvements the team have made. They also noted the strong partnership working through the Local Maternity System (LMS) group.
- Negative feedback included some concerns about poor documentation, gaps and incomplete pathways/processes in ED; concerns raised about an individual patient with mental health issues and their follow up; concerns about potential ED nurse staffing gaps and the impact on flow. The Divisional Director of Nursing is overseeing key actions.
- In Maternity an IV cupboard was open- this had been left open by the pharmacist who was checking stock and was immediately addressed. The CQC also noted that a small number of guidelines were out of date. The Divisional leadership team are overseeing progress to ensure all relevant policies and guidelines are reviewed and are in date.

17 September: NHSI who were joined by the CCG visiting Maternity, Neonates, Therapies and Emergency Department – focus on infection prevention and control practice

- Maternity – good practice noted for Personal Protective Equipment (PPE) and handwashing, praised visibility and completion of cleaning checklist process; noted new waiting room
- Neonatal Unit – visited new unit; no concerns raised
- Therapies – visited staff room, noted social distancing of chairs; noted the number of people who are required to use the space and the attempt to reduce the number of people in the room at any one time by staggering breaks. Minor IPC breaches with out of date food in the fridge; the microwave needed to be cleaned and minor estates works required
- ED – good handwashing noted, no concerns raised regarding IPC practice. One mattress found with sticky tape on it (removed immediately), the reviewer noted that ED was cluttered but this was due to estate limitations rather than practice issues
- Overall staff noted to be friendly and welcoming

2.2 Gaps in Controls update

NHSEI review of Maternity regarding insufficient assurance on infection control standards

- We are in the process of planning the NHSI re-inspection given the positive feedback from previous inspections over the last month. Whilst it is not possible to move from our current RED rating to GREEN in one visit (as there needs to be a period of NHSI oversight to ensure consistency in practice) we are confident that we can improve our rating to AMBER

Out of date clinical Policies, Procedures and Scopes Of Practice:

- We are working closely with governance, and the Well Led workstream, to ensure our policies and procedures are up to date and in line with best practice. All relevant leads have been contacted and we will be monitoring progress closely. The current position can be seen in the table below;

Up to date	131
Due for review in the next 6 months	6
Due for review in the next 3 months	10
Out of date	109
	256

Venous thromboembolism (VTE) performance

- VTE performance continues to improve and the overall compliance for the Trust was 94.15% at the end of August. A Trust clinical lead for VTE has been appointed from Royal Wolverhampton to work across the 2 sites with our team and is due to commence in October. Their role will include chairing the Thrombosis Committee to oversee learning from VTE % responded to within 30 working days

Quality Impact Assessment Process

- A joint piece of work is now underway across the SHQC and Well Led work streams to review the quality impact assessment ("QIA") process.

2.3 Rationale for current score

The following were added to the BAF last month to support the rationale for the current score:

- 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). Updates on completed reviews have been reported to QPES this month.
- As previously reported, initial concerns into audit and data registration were raised by the Royal College of Surgeons. We are still awaiting the final report
- Duty of Candour is below the target performance level. Performance continues to be monitored via the Serious Incident Dashboard and Divisional Performance meetings. The MLTC Division in particular have made some initial impressive progress in month

2.4 Future risks

We are mindful that we need to maintain alignment between SHQC Programme priorities, the broader improvement programme and the activities taking place in Divisions, so the

Divisional plans are aligned and there is clarity on the priorities for years 1-3. The SHQC discussions with Divisional teams would suggest there is further work to do around this.

We also need to ensure that there is regular, clear communication across the organisation so our teams are familiar with, and are engaged with, the improvement programme objectives. The recent appointment to a dedicated communications officer for the Improvement Programme will certainly help, along with further involvement of the Divisional teams in steering group and assurance meetings.

2.5 Future opportunities

We are developing a Quality Assurance Framework which will both prompt when a quality review should be conducted and standardise the approach and reporting of these reviews.

We are also developing a Care Excellence Strategy in collaboration with our teams. This will be a unique strategy supporting multi-professional collaboration to deliver care excellence. The final phase of consultation is underway and will see the development of a shared professional practice model across nursing, midwifery, allied health professionals and medical teams that will underpin the strategy.

2.7 Link to Corporate Risk

Risk 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) This risk has recently transferred from the CEO to the COO is to be reviewed and updated, or closed and a new risk written, depending on the changes required.

Risk 1986 (Delays in access to Tier 4 in-patient psychiatric care for Children and Young People -Risk Score =16) This risk is in the process of being closed and rewritten to reflect the system collaboration required to mitigate this risk.

Risk 2066: (There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience) This risk has been reviewed and the score reduced from 20 to 16 in response to reduced vacancies and maintenance of fill rates.

3. PERFORMANCE REPORT

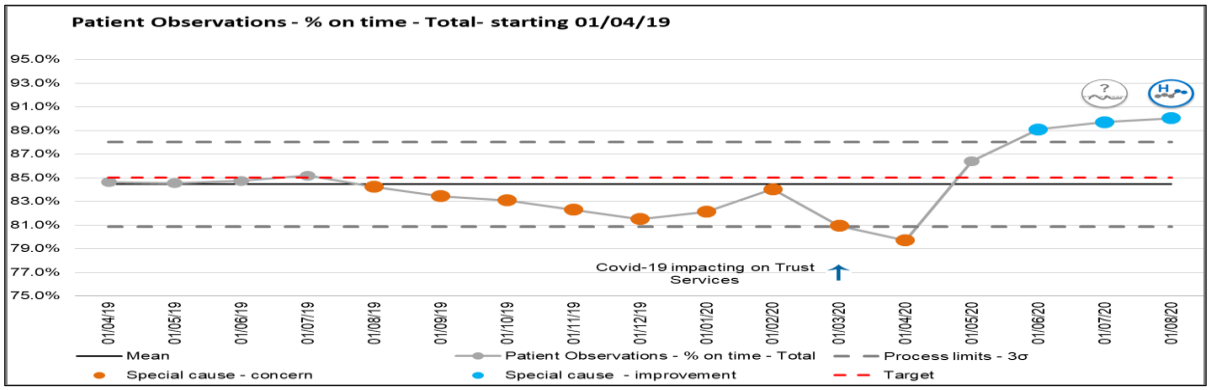
3.1 Clostridium Difficile –number of cases

There were three cases in August. Two cases have had case reviews completed and were deemed avoidable with inappropriate antibiotics as root cause. A multi-professional deep dive will take place to better understand any required practice changes.

3.2 Percentage of observations rechecked within time

The prevalence of late observations has improved again in month to 90.03% in August from 89.70% in July. This remains the best performance since March 2019 (Chart 1). Weekly tracking updates continue to be provided and matrons / seniors sisters have given this more focus and oversight.

Chart 1: % Patient observations completed on time



The deteriorating patient bundle has been approved and it is being trialled on some of the wards. If the tool proves successful then it will be rolled out to other departments with a plan to upload this tool into the Careflow connect software, enabling us to remove the paper tool altogether. A workforce review has completed within the Critical Outreach team to address best ways of working and a training programme has been developed for those on this team. The implementation and training programme for the deteriorating patient bundle is being developed with the Faculty of Research and Clinical Education with the first training being delivered in September.

Within paediatric services PEWS audit show an average compliance of 98%.

Further investigation is continuing to interrogate this data from the maternity Badgernet system so we are able to report performance for Maternity.

3.3 No. of falls resulting in severe injury or death

There were three falls resulting in severe injury in August. All three falls resulted in patients suffering a fractured neck of femur injury (2 patients on Ward 2 and 1 patient on Ward 16). The three serious incidents reported in August are being investigated by the corporate nursing quality team as a cluster investigation. Findings of this investigation will be reported following review by the divisional team of Medicine and Long Term Conditions ("MLTC"), development of a divisional action plan and sign off by the Patient Safety and Serious Incident Group.

3.4 VTE risk assessment

VTE performance continues to improve and the overall compliance for the Trust was 94.15% in August. A Trust clinical lead for VTE has been appointed from Royal Wolverhampton to work across the 2 sites with our team and is due to commence in October. Their role will include chairing the Thrombosis Committee to oversee learning from VTE.

3.5 Midwife to birth ratio

This indicator has reported red for some time. Staffing across maternity services is used flexibly to ensure women receive the expected level of support however there are ongoing staffing pressures caused by absence and vacancies. The new Birthrate+ review and recommendations have now been received by the Trust and will form part of the establishment review which is planned to be completed in September.

3.6 Electronic discharge summaries

The trust has agreed to sign off all electronic discharge summaries within 48 hours of discharge. Currently, we are achieving this target in 89.3% of cases, with an improving trajectory through the financial year. Actions to improve this performance include better data entry through the admit/discharge/transfer (ADT) process, which is anticipated after implementation of Medway. In addition, teams are learning from the positive experiences of the Paediatric ward (currently 95.5%) and reviewing the balance of medical shifts to improve delivery of this standard.

3.7 Dementia Screening

Dementia screening performance dropped slightly from last month to 82.46%. This metric remains an area of focus and the introduction of Medway offers an opportunity to improve digital collation of this data to support timely interventions to increase performance.

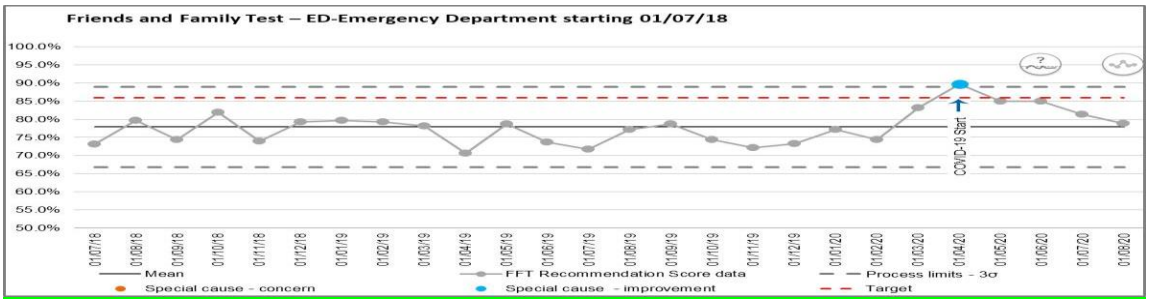
3.8 Complaints response within 30 days

Complaints response timeliness continues to improve and the overall compliance for % responded to within 30 working days was 95.49% in August, surpassing the 80% target for 20/21. The performance for % responded to within 45 working days has also improved in August to 92.86%. This is the best performance for both these metrics since at least September 2019.

3.9 Friends and Family Test (FFT) % recommended

The FFT score % for Inpatients and Outpatients increased from last month however there is still work to do to meet target performance. The Emergency Department's (ED) FFT August score was 79% (-2% from last month) as can be seen in Chart 2. A deep dive will be conducted in the next month to understand how we can improve the experience for patients in ED.

Chart 2: Emergency Department FFT score %



Maternity FFT restarted at end of August so unfortunately we do not have a complete dataset for August.

3.10 Safeguarding Training compliance

The overall performance across Prevent and adult and children safeguarding training has continued to improve however there remains increased focus on ensuring we are working towards meeting the Trust target for the two areas of concern (Adult L3 which is at 66.05 which has increased from 58.83% last month, and Children L3 which remains static at around 82% against a target of 85%).

I am pleased to report that we have now met the Trust target for Children L1 in August with a performance of 95.53**%** against a target of 95%

3.11 MCA/DNAR Performance

Stage 2 MCA assessment performance has dropped and remains a concern. A programme of work is underway which includes MCA/DoLs awareness training and ward champions have been appointed with clear roles assigned. The MCA training is being uploaded as e-learning onto ESR. New consent forms have been developed and implemented with a clear section at the beginning to assess capacity and direct to a stage 2 consent form of capacity is lacking. Posters and a communication campaign are planned for next month to further raise awareness.

4. IMPROVEMENT PROGRAMME

Currently there are an estimated 111 distinct projects with approximately 164 distinct metrics within the SHQC improvement programme with new projects being added each month. Where possible we aim to bench mark our performance against peers with the aim that we continually outperform peers. The benefits realisation work demands analysis against benchmark data across a range of sources including the Model Hospital database and this work has commenced. A suite of SPC charts highlighting our current performance across a range of metrics, and how we benchmark against peers, is under development. There has been progress against each of the three key workstreams within the SHQC programme and

highlights are provided below (see Appendix 3 for the more detailed SHQC improvement programme update).

4.1 CQC action plan

The CQC action plan oversight group is established and we have reviewed every CQC report and required actions from 2015 to 2019. Working closely with the well led workstream we continue to review every piece of evidence to ensure that required actions are delivered and/or sustained. Data is being collated in a single CQC action plan log and an evidence repository has been established.

4.2 Pathway to Excellence

As previously noted, our new Care Excellence Strategy continues to be developed and the work to benchmark our KPI's is still to be concluded.
A core team are scoping policies, procedures, Scopes of Practice related to the SHQC workstream to ensure these are up to date and in line with best practice.

4.3 Care Excellence

Significant progress has been made across a number of projects which can be seen in more detail in Appendix 3. Some key highlights include:

- There continues to be good progress with the cancer pathway action plan. The roles of the Trust Cancer Team have been reviewed and the Trust has committed to a joint Quality Improvement programme with University Hospital Birmingham (UHB) to improve the tertiary referral processes and multi-disciplinary working. A new process for flagging suspected malignancies on imaging has been implemented for in-patients. This aligns with the process for outpatients and will reduce missed and delayed reports. Positive feedback has been received from patients and no new serious incidents have been raised. A more detailed spotlight paper will be presented to QPES in October.
- Getting It Right First Time (GIRFT) – The Trust participated in an STP Respiratory GIRFT workshop in September and will continue to work with partners for a wider solution. This includes improvements in care across the Community whereby the community and MLTC Divisions are working towards ensuring patients receive the best care along the whole pathway. The Trust's significantly improved performance in staff flu vaccination and smoking cessation campaign was highlighted in the STP review.
- Following the reviews of deaths from COVID-19, the Serious Incidents Group have planned root cause investigations as clusters to investigate lessons learnt around the care pathway and hospital infection control.
- A new template has been introduced for speciality groups to focus the lessons learnt and improvements made to reduce avoidable harm in order to provide the Mortality Surveillance Group with assurance of learning. Joint work has been planned within the STP Mortality Leads group to learn from each other. A focus on COVID-19 and coding is planned in October.

- Public consultation concluded for #WalsallFoodFaves and 'what matters to you'. Next steps include reviewing the feedback and impact to our current provision.
- Lessons Learnt group has been established and has a wide membership to include Quality Improvement, governance, legal, patient complaints and Divisional teams as well as communications. The first Trust Learning Newsletter will be completed in October. The group is piloting ideas such as learning walks and learning boards following ward reviews to gain assurance and evidence of learning.
- The terms of reference of the medicine's safety group are being reviewed with a new programme of work to address areas where concerns have been identified.

5. RECOMMENDATIONS

Members of the Trust Board are asked to note the update and progress made relating to the SHQC portfolio.

APPENDICES

Appendix 1: BAF Risk S01/Corporate Risk Register

Appendix 2: Performance Report

Appendix 3: Improvement Programme Update

Risk Summary			
BAF Reference and Summary Title:	**BAF 1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022**		
Risk Description:	**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.**		
Lead Director:	Director of Nursing	**Supported By:**	Medical director
Lead Committee:	Quality, Patient Experience and Safety Committee		
Links to Corporate Risk Register:	**Title** • 208 Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks • 274 Failure to resource backlog maintenance and medical equipment replacement 2062 Failure to fully complete mortuary passport • 2066 Lack of registered nurses and midwives	**Current Risk Score** **16 (High)**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			• 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-19-19 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)	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**4**				**Consequence:**	**5**	
Risk Level:	**High 20**	**High 16**				**Risk Level:**	**Mod 10**	

				• Duty of Candour below target 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 • Risk score has been reduced to 16 in line with the reduction in the staffing risk.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• 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. • Clinical audit programme & monitoring arrangements • Safety Alert process in place • Freedom to speak up process in place • COVID-19-19 SJR have been undertaken for all deaths • GIRFT Meetings reinstated	• 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 • Learning from death framework supporting local mortality review. • Faculty of Research and Clinical Education (FORCE) established to promote research and professional development in the trust • Perfect Ward app allows local oversight of key performance metrics	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of COVID-19-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Quality Review 6 monthly reviews in place with NHSi/CQC
Gaps in Control	• Some policies and clinical guidelines remain out date • VTE performance continues to be below the Trust Target • Deterioration in the Trusts complaints response performance • Mental Capacity Act compliance below the Trusts Standards • Lack of current registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital. • Out of date clinical Policies, Procedures and SOP's • Training performance not meeting set targets • Quality Impact Assessment process is not yet established within the trust		
Assurance:	• Quality Governance process are in place with oversight and escalation process in place throughout the organisation. Escalations are reported to QPES each month. • Ward Review process in place which provides assurance on the quality of care • Improvement programme in place to oversee and monitor improvements associated with	• 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 • Patient priorities for 2021 identified, which will form part of Quality Account objectives	• External Performance review meetings in place with NHSi/CQC/CCG • Monthly Quality meetings with NHSi and CQC • External review undertaken on the SI processes • CQC report (2019) showed improvement and the Trust was rated as 'outstanding' for caring

	the Trust delivery of Safe, and High Quality Care.		
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 • NHSi review insufficient assurance on infection control standards • External audit Assurance relating to the annual quality account has been deferred owing to COVID-19-19 Inconsistent evidence both through quality governance structures and performance reviews, of practice having changed as a result of learning from RCAs		

Future Opportunities

- Improvement programme offers consistency in methodologies and documentation used across transformation programmes
- Care Excellence Programme and Pathway to Excellence Programme offer a structured programme 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
- Development of a Quality Assurance Framework
- Development of Care Excellence strategy

Future Risks

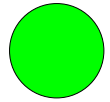
- Resources to deliver the improvement programme.
- Resources to deliver the Care Excellence Programme and Pathway to Excellence Programme
- Potential second wave of COVID-19-19
- Dependence on the success of interdependencies from other work-streams.
- Failure to develop and maintain relationships with 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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Staffing Risk • red flag process being embedded, escalation SOP in development • implementation of Allocate in line with business case, review of KPI's and temporary staff booking reasons • QIA's to be undertaken for every area that has nursing associate role within establishment	Ann-Marie Riley			

	• Establishment review in progress • Self-assessment against NHSI Developing Workforce Safeguards (2018) underway				
2.	Care Excellence • Care Excellence strategy in development • Final phase of consultation to take place in September	Ann-Marie Riley & Mathew Lewis			
3.	Patient Experience • Reviewing TOR for patient experience group • We have developed 12 patient priorities – the action plans for these are underdevelopment	Ann-Marie Riley			

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1986	Delays in access to Tier 4 in-patient psychiatric care for Children and Young People (CYP) and lack of early intervention to prevent escalation to Tier 4 at an earlier stage in the patient pathway.	CYP are waiting on the paediatric ward for a Tier 4 bed to be procured by NHSe/i due to lack of suitbale placements being found in a timely manner. This is an unsatisfactory experience for the CYP, staff managing high risk CYP and other patients / families on the ward as puts the young person, staff and other patients / families at risk of harm.	Charlotte Yale	1 2	• Policy • Policy available for the management of CYP with mental health disorders and self-harm	• Staff are aware of the policy but it is acknowledged that policies offer limited support when dealing with an escalating situation. •	
					• Training • Staff have recived STORM training - mental health assessment training for non-mental health providers	• The unit has trained trainers to deliver Storm risk assessment training (RN's only). All CYP who attend PAU/Ward 21 on the CAMHS pathway recieve a STORM risk assessment upon admission. •	
					• Process • High risk CYP are supervised by a CSW with additional training to provide one to one supervision	• Patients who are deemed to be of high risk recieve adequate supervision. Bank CSW's and Bank Security staff are brought in as needed. This is at cost to the unit and can have a negative impact on the image of the Trust as we have a security guard constantly present outside a patients room. •	
					• Physical Barrier • Anti-ligature safe room available on Ward 21 and PAU	• •	
					• Process • Use of SBAR tool to communicate high risk nature of individual CYP and assess changes in mood on a shift basis. Also allows for an hourly face to face check for CYP not receiving one to one supervision	• SBAR tool embedded in practice and used for all patients. Auditted by Senior Sister for the completion of a local CAMHS database and by the Matron in monthly metrics reviews. •	
					• Process • Escalation by Executive Team to NHSei	• •	

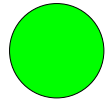
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
18/08/2020	Deputy DoN, Div DoN CYP and D of Governance to identify an appropriate route of escalation.	Matthew Lewis	25/09/2020	30/09/2020
18/08/2020	Interim Div DoN for CYP to discuss with CAMHS commissioner the risk stratification process to ensure that YP who are meeting CAMHS Tier 3 criteria and are deteriorating are known and discussed with a plan to prevent escalation to in-patient crisis	Caroline Whyte	25/09/2020	30/09/2020

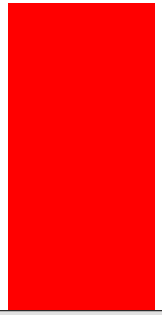
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
18/08/2020	The link with early intervention via the school nursing team to be fully understood in relation to the healthchild programme high impact area of 'Resillince and Emotional Well-Being'		Caroline Whyte			25/11/2020	30/11/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	There is potential for a risk of lack of skilled registered nurses (RN's)/registered midwives (RM's) on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care delivery and excellent patient and staff experience. Staffing any additional capacity that is required puts additional pressure on RN/RM/ staffing demand and there is a risk that these areas cannot be staffed adequately. The current COVID-19 pandemic may put unprecedented pressure on our staffing supply across all grades of nursing and midwifery staff	Lack of skilled registered nurses/midwives on a shift by shift basis leading to: _Poor patient experience leading to increase in complaints, increase in PALS referrals _Increase in episodes of harm, including falls, pressure ulcers, deconditioning, dehydration and malnourishment, loss of continent function; potential increase in incidents/SI's _Increased stress and poor staff morale caused by suboptimal staffing levels _Increased reliance on temporary staffing which has a potential negative impact both financially and to the ward/department skill mix **See Risk Assessment attached for full details**	Caroline Whyte	1 6	• • Development of two staffing hubs manned by the Nursing Team - one for general areas and one for Critical Care. These hubs will oversee the deployment of staff across all Professional Groups. 17/6/20 the staffing hub is no longer required as the staffing position is currently stable. If COVID demand increases then the hub will be reinstated • • Community Teams reviewing and adjusting caseloads as required. Roster sign off reduced to two weeks for the next three months. Use of bank/agency to cover short term gaps. Block booking in place for Critical Care. Deployment of Corporate Nurses at times of high pressure. 17/6/20 - Roster sign off timelines returned to normal, critical care bookings no longer required to previous level as ITU capacity remains stable • • Increased use of Volunteers and Administration roles to complete tasks to free up Registered Nurses to deliver direct patient care. 17/6/20 Volunteer support no longer required to initial levels • • Identification of essential training required to maintain competence and safety (COVID-19). Use of bank/agency staff to support essential training. 17/6/20 - training completed at height of COVID demand -not currently required • • Staff well being policy with additional support identified and put in place to support staff as part of the COVID-19 response.	• Daily reviews of staffing levels by Ward, Monitoring of the number of patient harm incidents reported. Monitoring of the number of complaints, whistle blowing and freedom to speak up concerns raised. • • 6 Monthly review and annual management board sign off of Nursing/Midwifery establishments to ensure appropriate planned staffing levels. Daily review of staffing numbers by ward and moving staff to support areas of short staffing. • • • • Overview of compliance levels at Performance Meetings. Rapid response to falls in levels of essential role based training. • • Monitoring of staff sickness levels and sickness reasons •	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					17/6/20 -Staff support continues, Haven room temporarily moved to Project Wingman area, daily mindfulness sessions will continue • • Early approval by COVID-19 Strategic Command for key decisions that impact on staff and patients deployment of Volunteers supporting the Organisation. Corporate Nursing and Non-Ward based Nursing staff to support areas via Staffing Hub.	• Careful monitoring of leadership in vulnerable areas, •	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
26/03/2020	Review of TNA requirements for the next 12 months and develop case of need for consideration when COVID019 response is no longer required. 17/6/20-review of initial NA modelling and budget changes underway 7 Sept 2020 -establishment review underway, will be completed in Sept and reported to committees in Oct	Ann-Marie Riley	25/10/2020	30/10/2020
26/03/2020	Strategy to be developed to recruit International Nurses who are currently in the UK working as HCA's but need support to register with the NMC as an RN when COVID-19 response is no longer required, 17/6/20 Renewed focus on recruitment opportunities now possible as COVID demand stabilised 14/9/20 -new national funding to be available to support this initiative - awaiting further information	Ann-Marie Riley	25/10/2020	30/10/2020
26/03/2020	Continued proactive recruitment strategy	Ann-Marie Riley	26/03/2021	31/03/2021

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
No.	Sleeping Accommodation Breaches	0	63	83	63	0	0	209	0	0		
No.	HSMR (HED) nationally published in arrears	145.44	145.04	123.03	117				100	110.28		
No.	SHMI (HED) nationally published in arrears	162.5	160.2	113					100	110.73		
Rate	Crude Mortality Rate	5.8	8.07	5.41								
No.	Number of Deaths in Hospital	138	198	95	71	71	74	509		1093		
%	% of patients who achieve their chosen place of death	51.72%	65.28%	59.65%	72.31%	67.27%	71.70%	67.22%		57.63%		
No.	MRSA - No. of Cases	0	0	0	0	0	0	0	0	4		
No.	Clostridium Difficile - No. of cases	5	4	3	3	3	3	16	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	80.94%	79.70%	86.40%	89.09%	89.70%	90.03%		85.00%			
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.83	1.52	0.73	1.24	0.77	0.72					
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.1	0.24	0.48	0.69	0.45	0.86					
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	11	15	7	12	9	9	52		128		
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	3	7	14	20	13	25	79		86		
No.	Falls - Total reported	91	75	68	58	57	60	318		932		

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
Rate	Falls - Rate per 1000 Beddays	5.32	5.63	6.52	4.75	4.66	5.21		6.1			
No.	Falls - No. of falls resulting in severe injury or death	0	0	0	3	0	3	1	0	20		
No.	Falls - Avoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0	0	1	0		1	0	16		
No.	Falls - Unavoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0	0				0		4		
%	VTE Risk Assessment	90.75%	84.24%	91.13%	92.83%	93.67%	94.15%	91.65%	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	5	4	3	16	7	10	40		94		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	1	0	0	0	0	0	0		5		
No.	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	27	16	18	30	24	26	114		287		
No.	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	5	6	6	6	6	10	34		29		
%	% of total incidents resulting in moderate, severe harm or death	2.80%	2.70%	2.83%	3.54%	3.27%	3.46%	3.19%		2.37%		
%	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	15.79%	24.24%	14.04%	13.98%			15.85%	12.00%	14.30%		
No.	No. of reported medication incidents level 3, 4 or 5 (one month in arrears)	0	0	1	2			3	0	4		
Rate	Midwife to Birth Ratio	31.9	32.0	29.6	33.4	32.7	30.8		28			
%	One to One Care in Established Labour	99.13%	100.00%	98.36%	99.10%	99.07%	100.00%	99.28%	100.00%	99.20%		
%	C-Section Rates	29.55%	29.63%	33.94%	30.03%	29.62%	25.42%	29.67%	30.00%	30.16%		
%	Instrumental Delivery	7.99%	6.91%	7.42%	6.48%	6.79%	8.88%	7.28%	10.00%	7.52%		

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	Induction of Labour	38.81%	39.73%	38.27%	39.01%	43.95%	43.48%	40.93%		39.09%		
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.25%	12.94%	15.61%	14.81%	14.62%		14.57%	10.00%	11.50%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours	83.52%	89.77%	88.65%	90.10%	88.73%	87.82%	88.94%	100.00%	84.59%		
%	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards) (one month in arrears)	53.06%	33.33%	98.31%	62.69%	87.04%	82.46%	77.91%	90.00%	69.32%		
%	Compliance with MCA 2 Stage Tracking	26.67%	73.91%	64.44%	75.00%	36.84%		63.55%	100.00%	62.61%		
%	Complaints - % responded to within 30 working days	37.93%	27.59%	20.00%	53.85%	77.78%	92.86%	50.56%	80.00%	43.45%		
%	Complaints - % responded to within 45 working days	51.72%	27.59%	40.00%	69.23%	77.78%	92.86%	56.18%		59.82%		
No.	No. of Open Complaints	69	55	43	39	42	43					
No.	No. of Closed Complaints	15	8	6	9	23	15	61		211		
No.	Longest Wait for an Open Complaint	398	414	431	139	143	117					
No.	Clinical Claims (New claims received by Organisation)	14	14	5	14	6	7	46		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	9.05%	8.88%	7.95%	7.42%	6.89%		7.78%		9.71%		
%	Friends and Family Test - Inpatient (% Recommended)	95%		89%	89%	87%	88%		96%			
%	Friends and Family Test - Outpatient (% Recommended)	92%		88%	88%	88%	92%		96%			
%	Friends and Family Test - ED (% Recommended)	83%		85%	85%	81%	79%		85%			
%	Friends and Family Test - Community (% Recommended)	98%					63%		97%			

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

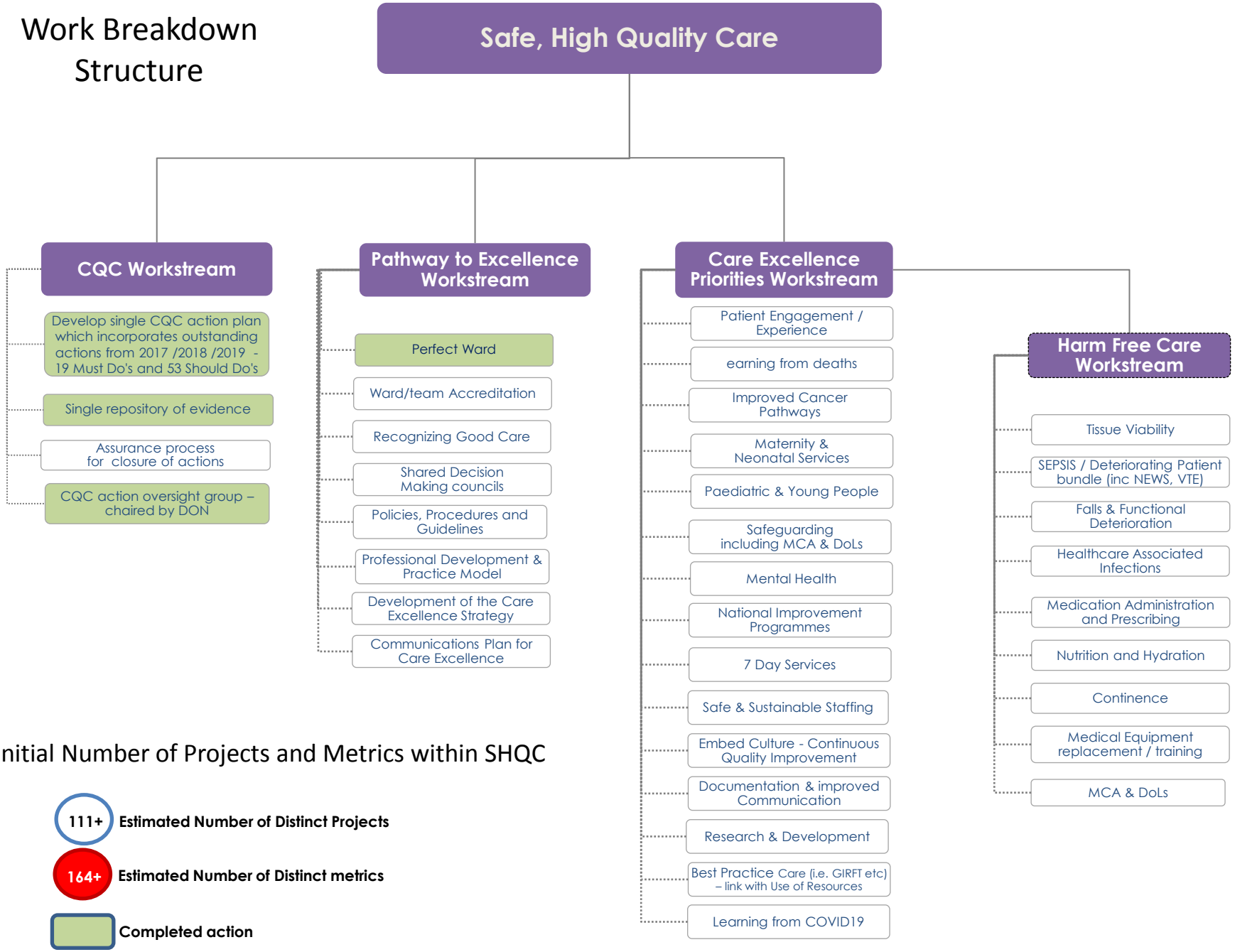
		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	Friends and Family Test - Maternity - Antenatal (% Recommended)	100%					100%		95%			
%	Friends and Family Test - Maternity - Birth (% Recommended)	98%					94%		96%			
%	Friends and Family Test - Maternity - Postnatal (% Recommended)	100%					86%		92%			
%	Friends and Family Test - Maternity - Postnatal Community (% Recommended)	97%							97%			
%	PREVENT Training - Level 1 & 2 Compliance	90.73%	90.65%	90.70%	90.64%	92.12%	92.91%		85.00%			
%	PREVENT Training - Level 3 Compliance	79.24%	79.97%	80.82%	82.68%	85.44%	86.79%		85.00%			
%	Adult Safeguarding Training - Level 1 Compliance	96.46%	95.47%	96.55%	95.07%	96.34%	96.26%		95.00%			
%	Adult Safeguarding Training - Level 2 Compliance	84.31%	84.14%	86.38%	88.94%	91.22%	93.01%		85.00%			
%	Adult Safeguarding Training - Level 3 Compliance	58.50%	58.30%	56.77%	55.96%	58.83%	66.01%		85.00%			
%	Children's Safeguarding Training - Level 1 Compliance	87.73%	86.46%	88.42%	89.81%	92.27%	95.53%		95.00%			
%	Children's Safeguarding Training - Level 2 Compliance	86.35%	86.43%	86.94%	86.54%	88.44%	90.60%		85.00%			
%	Children's Safeguarding Training - Level 3 Compliance	81.29%	78.97%	78.89%	79.46%	82.18%	82.00%		85.00%			

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
RESOURCES												
No.	Total Deliveries	335	297	277	323	314	299	1510	3739	3661		

Work Breakdown Structure



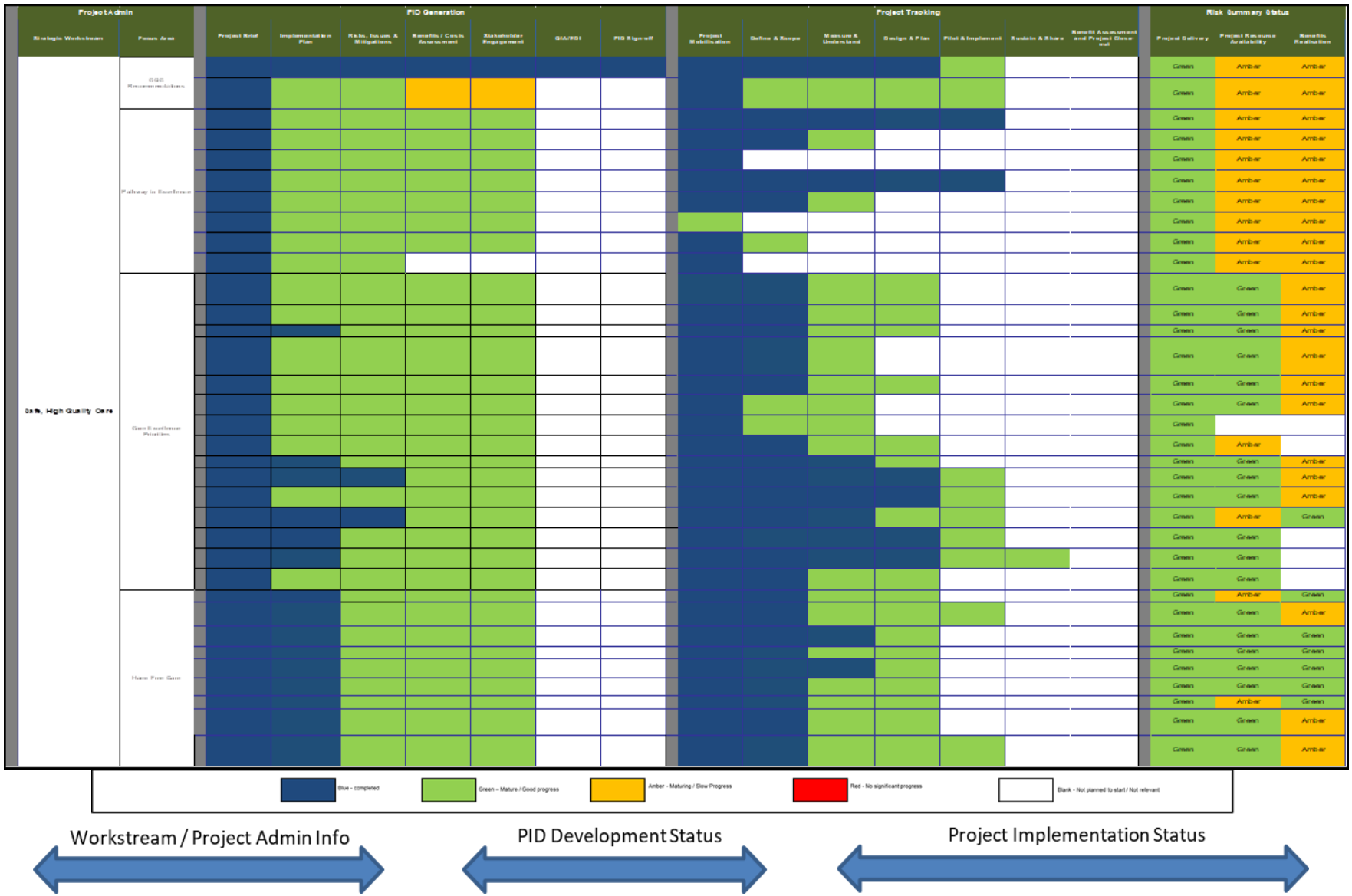
Initial Number of Projects and Metrics within SHQC

111+ **Estimated Number of Distinct Projects**

164+ **Estimated Number of Distinct metrics**

Completed action

Safe High Quality Care workstream development update: September 2020 IPBoard



Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	COVID-19 2nd wave	A	
	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	
	Medicine safety – external review of older people rules for assessment of care 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

MEETING OF THE PUBLIC TRUST BOARD - 1st October 2020			
Quality Account 19/20			**AGENDA ITEM: 10.3** **ENC: 10**
Report Author and Job Title:	Alan Lakin Head of Financial Governance	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Executive Summary	The Trust Quality Account is attached and sets out to the public a report on the quality of services delivered by the Trust. The Trust is normally required to complete an annual Quality Account. This is typically attached to the Trust's Annual Report for submission to NHSE/I by the end of May. The Quality Account is also required to be uploaded to the NHS website by the end of June each year. The process for preparing the annual Quality Account this year has been impacted on by the COVID-19 pandemic. As such the national guidance received outlined that the Trust was not subject to the normal requirement of needing to have an external audit opinion on the Quality Account this year, and the ultimate deadline of end of June was moved until December 2020. The Trust's Quality Account has been shared, as per normal process, with key local stakeholders. Given the circumstances, not all stakeholders have been able to provide comments for the Trust. The CCG will be providing comments to the Trust however at the time of writing this has not been received by the Trust. The Quality Account Priorities have been reviewed by the Quality, Patient Experience, and Safety Committee.		
Recommendation	Members of the Trust Board are asked to approve the Quality Account		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The Quality outlines the key Quality Priorities for 2020/21 which align to the BAF Risk S01 - The Trust fails to deliver excellence in care outcomes, and/or patient/public experience which impacts on the Trusts ability to deliver services which are safe and meet the needs of our local population		
Resource implications	There are no resource implications associated with this paper.		

Legal and Equality and Diversity implications	Equality and Diversity implications have been outlined in the 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 Healthcare NHS
NHS Trust

Quality Account
2019/20

Caring for Walsall together

CONTENTS

Page number

Part 1: A statement on quality from the Chief Executive

Part 2: Priorities for improvement and statements of assurance from the board

1 Review of 2019/20 Quality Priorities

1.1 Reduce the number of inpatient falls and falls with harm.

1.2 Reduce the number of category 2 pressure ulcers across the Trust and aim to eliminate category 3 and 4.

1.3 At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST.

1.4 Continue to implement extended working in a number of areas through new service delivery models.

1.5 Learning from deaths – recruitment of medical examiner.

1.6 Reduce harm from sepsis: increase the number of patients screened, and give antibiotics within an hour of a patient being diagnosed with sepsis.

1.7 Safe and effective discharge and improving our patients' experience of getting home.

1.8 Improve communication with patients through the provision of a 'Values Based Customer Care Programme'.

2 Priorities for improvement 2020/21

3 Statements of assurance from the board

3.1 Review of Services

3.2 Participation in Clinical Research

3.3 Participation in Clinical Audit

3.4 CQUIN

3.5 Information on registration with the Care Quality Commission (CQC)

3.6 Information Governance Toolkit attainment levels

3.7 Clinical Coding

3.8 Information on the quality of data

3.9 A consolidated annual report on rota gaps

3.10 Learning from Deaths

Part 3: Review of other quality performance

1 Quality Improvement Academy

2 Duty of Candour

3 Patient Care Improvement Plan (PCIP)

4 Number of Never Events

5 Number of serious incidents

6 Learning from complaints

7 National Patient Safety Alerts
8 Learning from excellence
9 Patient Safety Walkabout visits
10 Mortality Review Process
11 Implementation of priority clinical standards for 7 day services
12 Focus on Patient Experience
13 NHS Staff Survey
14 Freedom to Speak Up

Part 4: Statements from our stakeholders

- Healthwatch
- Walsall Social Care Scrutiny and Overview Committee
- Walsall CCG
- Independent Auditor's Assurance Report to the Directors of Walsall Healthcare NHS Trust on the Annual Quality Account

Appendices

Appendix 1 Summary of findings CQC report
Appendix 2 Mandatory indicators
Appendix 3 Statement of director's responsibilities in respect of the quality account
Appendix 4 Glossary

We have tried to make this document as straightforward and reader-friendly as possible. A glossary of terms used throughout the document can be found on pages 68-69.

Part 1: A statement on quality from the Chief Executive

I am pleased to present Walsall Healthcare NHS Trust's Quality Account 2019/20. This document is an honest reflection of our performance, challenges and achievements during 2019/20 and describes the quality improvement priorities for 20/21.

We started this year enjoying the moment of coming out of special measures, after three years of work which concentrated on the fundamentals of care, staffing safety, patient safety culture, staff engagement and leadership improvements. With enthusiasm the Trust commenced work to look "beyond special measures" as and engage the organisation in the development of our improvement programme – the vehicle for delivering our strategic objectives and our aim of achieving outstanding rated services by 2022. We launched our improvement programme with an engagement event on this with our top 100 leaders, system partners and patient representatives in June.

The Trust's vision is to "Care for Walsall together" to reflect our aims of reducing health inequalities in our diverse and deprived borough. We will deliver this in partnership with social care, mental health, public health and associated charitable and community organisations, through our role as host provider of the Walsall Together partnership. In 2019 the Trust and statutory organisations in the borough, approved the Walsall Together Business case. That case signals a radical shift in where we will invest in the future – out of hospital care, population health management and a move away from acute hospital locus.

The Trusts maternity services have continued to improve and received an improved rating of 'good' during the latest inspection. The trust's new £5.6m Neonatal Unit at Walsall Manor Hospital opened in November 2019. The unit houses a purpose-built Intensive Therapy Unit and High Dependency Unit and a new obstetric theatre has also been created. Walsall's Midwifery-Led Unit (MLU) re-opened for intrapartum care on 6 January 2020. The MLU also continues to offer supportive antenatal, postnatal and perinatal mental health clinics.

I have been delighted that Walsall Healthcare has continued to climb both the national and regional performance league tables for delivery of the 4-hour emergency access standard. This standard remains the best proxy indicator of safety and experience for urgent, non-elective care. Our national ranking for the 4-hour emergency access standard rose from 108th (out of 132 trusts) in April 2019 to 53rd in February 2020, (out of 118 trusts, the number has reduced due to a number of trusts scoping the new national ED measures and not submitting the 4-hour data). Our Midlands regional ranking rose from 15th (out of 21 Midland trusts) to 9th (out of 29 Trusts) in February 2020. March 2020 saw deterioration in ED 4-hour performance in the early phases of the Covid-19 pandemic.

The Trust has responded well, in large part, to the COVID challenge from a quality and safety perspective. By virtue of being the borough with the highest COVID incidence rate per 100,000 population and because the Black Country system had the highest incidence rate nationally, we were tested fairly early on with regard to the correct admission pathways and effective cohorting and segregation.

Our response to the Covid-19 pandemic and the restoration and recovery of services remains a key focus for this Trust through 2020/21, along with tackling health inequalities and making Walsall an exceptional place to work. I fully recognise the immense pressure colleagues have been under for a prolonged period of time. The wellbeing and welfare of patients, carers and colleagues is a priority for me and the Trust.

An important part of the Quality Account is looking forward to the year ahead. We are pleased to include our new Quality Improvement Priorities for 2020/21, informed by the priorities within our improvement programme, which will support our endeavours to provide excellent and high-quality healthcare for our patients.

Best Wishes

Richard Beeken
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the board

1 Review of 2019/20 Quality Priorities

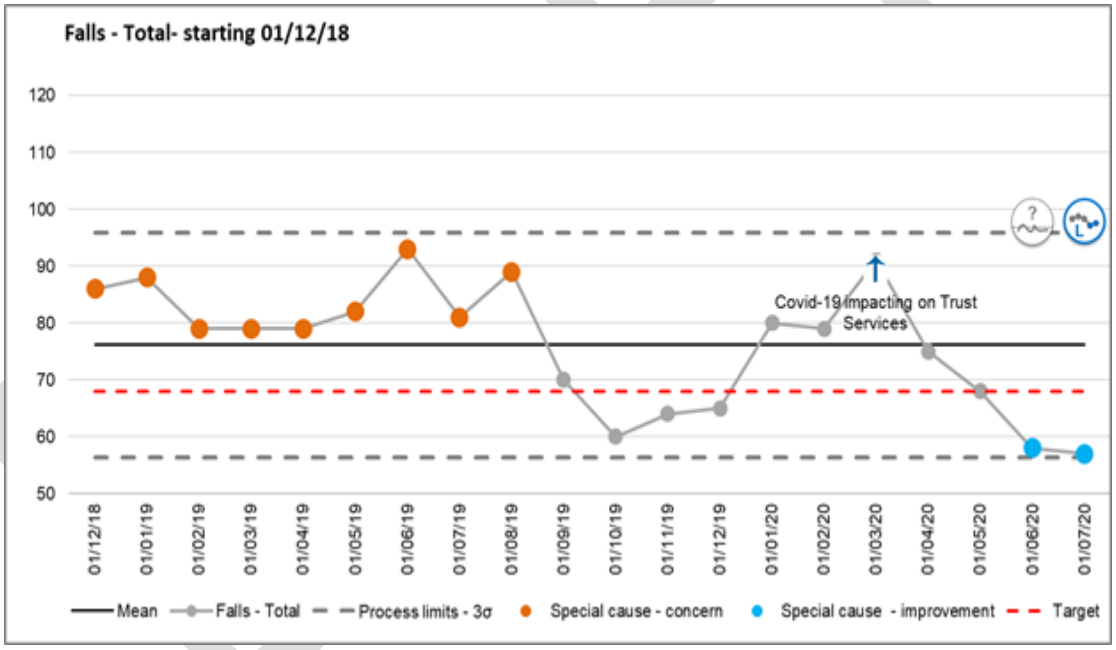
The Trust made a commitment to the following quality improvement priorities for 2019/20.

1.1 Reduce the number of inpatient falls and falls with harm

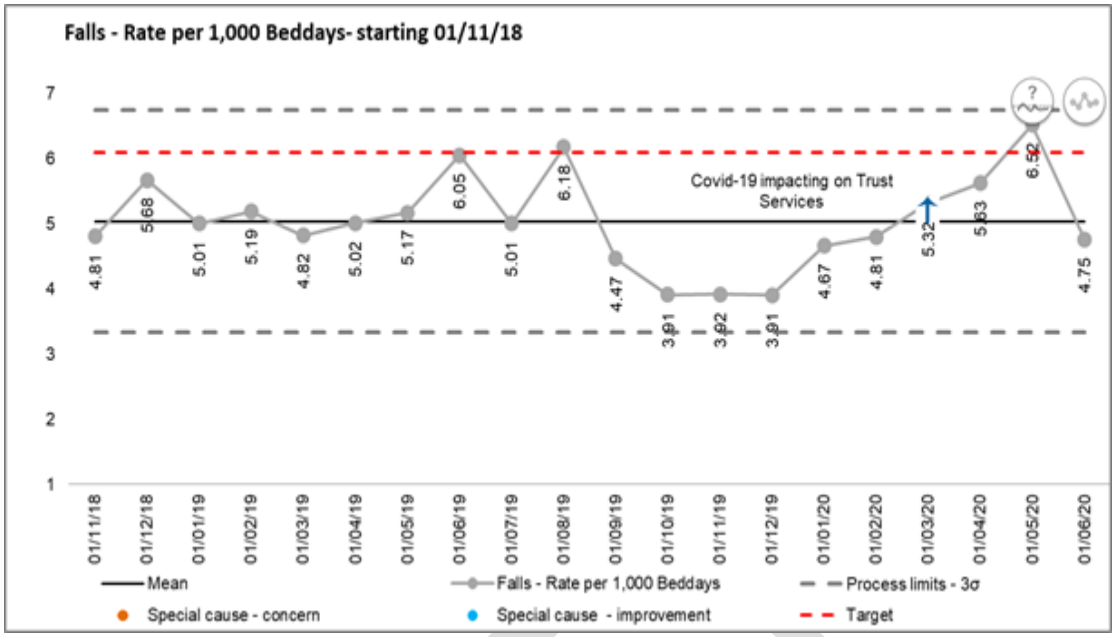
We have seen an overall reduction in falls since 2017

The number of falls overall for 2017 /18 was reported as 1026; by 2019-2020 the overall number of falls was 933 which represent a reduction of approximately 9% over the two year period. This is slightly short of the NHSi proposed reduction of 10% as identified by the NHSi Falls collaborative.

The trust has seen a gradual reduction in the average number of falls per month over the period from 85.5 for 2017 /18 to 77.75 for 2019 to 2020.



The RCP guidelines for falls per 1000 OBD suggest a performance of 6.6 to be the national average. The trust target has been determined as 6.1 in line with regional peers. Since November 2018 the trust has seen 2 rises above this point, August 2019 to 6.18 and May 2020 to 6.52, the latter being a peak during COVID 19 escalation.



1.2 Reduce the number of category 2 pressure ulcers across the Trust and aim to eliminate category 3 and 4.

The Tissue Viability Team launched the skin bundle in April 2019; a pressure ulcer prevention document and since the commencement of this we have seen a reduction in pressure ulcers.

The skin bundle document was added to the Matrons audit for monitoring.

The tissue viability team provide training sessions on pressure ulcer prevention, wound management and back to basics throughout the year with bitesize training to support AMU and Ward 1 to support those teams improve practice.

For these wards we are also produced a pocket guide which has the category of pressure ulcers, difference between pressure and moisture, equipment selection guide and dressing selection chart.

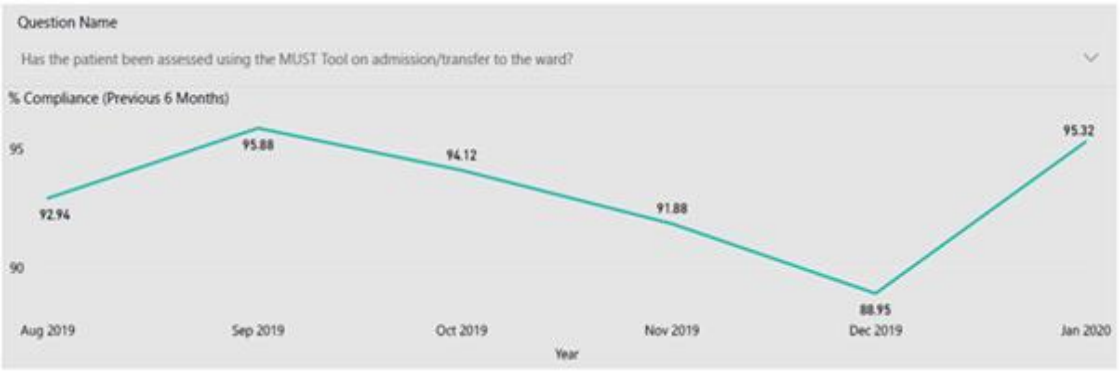
Each November the team actively take part in Stop the Pressure which is national campaign to raise awareness of prevention of pressure ulcers. Last November the tissue viability team walked the hospital as pressure hero's highlighting the importance of pressure ulcer prevention, the importance use of skin bundle document and categorisation of pressure ulcers.

We continue to monitor pressure ulcer trends via RCAs as this helps us identify area of learning.

A wound assessment chart was launched in December 2019 and work continues to instil the wards the need for assessment and reassessment of wounds.

1.3 At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST

Maintaining adequate hydration and nutrition for those in our care remains a high priority and completion of a nutritional assessment ensures we are able to plan safe, evidence based and effective plan of care. Ongoing focus and training on this aspect of care has continued over the last year and will remain a priority for 20/21



1.4 Continue to implement extended working in a number of areas through new service delivery models

Current Provision - Critical Care

The Trust now has a 24/7 Critical Care Response Team (CCRT) service, comprising of three band 7's (1 is covering half Follow-up clinic) plus 4 band 6 nurses. ICU rotates all band 6's into CCRT for their development. Prior to rotation all band 6 nurses would have to pass Advanced Life Support and the Trust are looking at sending staff on Health assessment courses. At present there are 3 staff on the Advances Clinical Practitioner programme, at the end of their study (end of year) they would all be Non-Medical Prescriber. All staff that complete health Assessment course are able to apply to complete NMP course. Additionally, there is also 1 whole time Practice Development Nurse.

As a result of Covid 19, the Trust has been able to temporary increase follow-up clinic nurse to full time and 1 extra Practice Development Nurse is in place to support nursing staff across the Trust.

Planned Provision (included in STP capacity spreadsheet) – Critical Care
Planned introduction of 24/7 Advanced Critical Care Practitioner (ACCP) within critical care. The ACCP role is a way of working which crosses professional boundaries. ACCPs are currently developed from experienced nurses, physiotherapists, paramedics or other related health care professionals. In the future it is envisaged that ACCPs may also be drawn from other emerging healthcare roles.

Current Provision - Non Elective Services (Wards 9, 11, 12)

1 Advanced Care Practitioner Trauma and Orthopaedics.

Planned Provision (included in STP capacity spreadsheet) - Non Elective Services (Wards 9, 11, 12)

Addition of three Advanced Care Practitioner's (ACP) to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon- Sun.

Theatres
3 staff are trained in surgical first assistance and 1 SCP in place.

1.5 Learning from deaths – recruitment of medical examiner

A lead medical examiner has been appointed and we have completed the recruitment of 3 medical examiners (ME) to support the system-wide approach to learning from deaths and supporting bereaved relatives and carers. As part of the implementation process, the trust will move to align data collection with the dataset mandated by the National Quality Board (NQB). The ME undertakes proportionate scrutiny of all non-coronial deaths. Any issues or concerns identified in care, system or process or any learning points are identified and managed through the learning from death governance processes.

1.6 Reduce harm from sepsis: increase the number of patients screened, and give antibiotics within an hour of a patient being diagnosed with sepsis.

A professional lead for Quality has been appointed to the corporate nursing team whose role will be to support and contribute to the national deteriorating patient strategy. Responsibilities will include the implementation of the NHSi guidelines, collaborative working with the regional networks, implementation of national CQUINS relating to the deteriorating patient monitoring and analysing performance and facilitating the development of action plans to address areas of underperformance. This relates specifically to the national indicator for administration of antibiotics and the CQUIN relating to unexpected transfers to critical care monitoring identification, escalation and response. The professional lead will facilitate education and training for the nursing teams working collaboratively with medical teams and ensure effective policies and procedures and developed and embedded to support in the reduction of harm and death relating to undetected or untreated deterioration in patients.

1.7 Safe and effective discharge and improving our patients' experience of getting home.

Audits from discharge lounge
With the implementation of the outpatient parenteral antibiotic therapy (OPAT) policy, there is greater involvement of antimicrobial team to increase the quality of OPAT discharges, but encourage oral switch where possible.

Weekly antimicrobial team and OPAT team MDT help to keep patients safe at home. The OPAT team have developed a 'cellulitis referral service' and 'ward review service' where they regularly attend wards to prompt discharge via the OPAT route.

The Trust has introduced a service for 24-hour infusion pumps at home, which allows patients with complex antimicrobial needs to be cared for in their own home, receiving either flucloxacillin or piperacillin-tazobactam.

Furthermore, the antimicrobial team has conducted a weekly induction programme for 4-hours of training for new entry FY1s to enhance their understanding of antimicrobial use and stewardship and increased pharmacy education so they can confidently conduct antimicrobial review.

1.8 Improve communication with patients through the provision of a 'Values Based Customer Care Programme'

Background

During 2017, a number of staff were involved in the co-design of a customer care approach which had been identified as a priority within the Patient Experience Strategy. The Trust also pledged to initiate welcome improvements at reception desks and identified Customer Care as one of its Quality Commitment pledges. A 'Putting Patients First' workshop was held and consultation and support was gained from an exemplar in the field of Customer Care via the John Lewis Partnership. This resulted in the development of the 'Hand in Hand' customer care approach and a train the trainer session being developed with a number of staff and teams engaged in trialling the approach within their areas:

- Patient Relations and Experience,
- Atrium Reception,
- Clinical Measurement Unit,
- Access Call Centre, and
- East Locality District Nurses.

Feedback following the training session was extremely positive and a number of workplace improvements followed including clerical officer uniforms, de-cluttering and welcome signs at reception desks. Taking the customer care programme forward was delayed due to the on-set of the new Trust values as it was felt that these should be integral to any new offer. Now the values have been launched the programme has been amended to reflect these, upholding respect, compassion, teamwork and professionalism as a values based approach in delivering Customer Care to colleagues, patients and partners.

Developing The Approach

John Lewis Partnership

The approach focuses on understanding people and being capable of empathy. When people are busy at work, we can often lose sight of the simplicity of a positive human interaction - something that is at the core of the John Lewis approach. Brilliant basics - are simple factors that can make or

break a service interaction (10 top things such as being smartly dressed, smiley, heads up and ready to help). These are the total basics and are introduced to all John Lewis staff on their induction as they are critical to setting the foundational standards of the service environment they to operate in.

There are common similarities with the John Lewis approach and that expected of us in the Healthcare setting. The John Lewis approach encourages co-ownership encouraging the involvement of colleagues in understanding their service environment and setting the standards against which they are going to operate.

Applying the approach to Walsall

The 'Putting Patients First' workshop discussed what 'Outstanding' would look like and what were the barriers to delivering this. It was agreed that simple positive human interactions often made the most difference and they were not resource intensive either.

As a result five Customer Care Commitments were developed which were to be applied to individuals and their teams. It would be up to each area to demonstrate how they would apply these and what positive actions they would take to ensure improvements were made. This was called 'Hand in Hand' as it was essential that the commitments applied to everyone from staff to our patients. However, since the launch of the Trust values the offer was amended to reflect these as the initial commitments are reflected in the behaviour framework. In doing so, the behaviour framework is the success criteria in which to assess how Trust staff are 'upholding the values' to enhance both the colleague and patient experience.

Values Based Customer Care

The programme: 'Delivering exceptional customer care – that upholds the values we are signed up to'

- The team nominate a staff member to complete the Train the trainer session, (3 Hours duration). They become the named '**Values Envoy'** responsible for taking the training back, delivering a team talk and completing the Customer Care Toolkit including an initial assessment of where they are on their customer care journey.
- The '**Values Envoy'** are allocated a '**Values Sponsor'**
- The sponsor support the envoy in developing their identified actions into reality and in the grading of whether a team are delivering Bronze, Silver or Gold customer care – these will be termed the '**Values Mark'** and determined on the level of consistency of practice using the behaviour framework as success criteria. The sponsor will work with teams to upskill and move them onto Gold – and beyond.
- The aim is to have a sustainable programme of improvement which can be linked to the Friends and Family Test, Staff and Pulse survey measures as a guide as to whether the programme is having an

impact. However, we should not initially over complicate matters and produce unrealistic targets – small steps – 1% improvements across the board!

- The '**Values Mark'** – beyond brilliance! We should recognise exemplar activity and share this – if a team is graded as Gold then they should commit to one of two things:
    1) On board another team and act as '**sponsor'** to their '**envoy'**
    2) Support a team not yet there in moving them on through the levels of values mark in a 'coaching' capacity.

This programme is designed to empower staff and teams to deliver and own standards of customer care applicable to them, as described above the initial 'Hand in Hand' pilot has been amended to reflect the Trust values so we have a consistent approach from Induction and beyond – the golden thread being the values of Respect, Compassion, Teamwork and Professionalism. The Trust Induction Customer Care session has also been revised to reflect the Trust values as the preferred approach as to what is expected.

<u>Progress</u>

- ✓ 12 teams piloted the Values Based Programme since April 2019 – Podiatry, Informatics, General Office, Antenatal, Trust HQ PA's, West 1 Community Nursing, ED Reception, Community Midwives, RTT and Re-design, Imaging, Dietetics, Adult Community Nursing,
- ✓ 3 Values Sponsor's assigned
- ✓ Team location visits undertaken, Bentley, Blakenall, General Office, ED reception, Trust HQ
- ✓ Action plan's completed – these are under review.

Examples of changes made:

General Office	• Privacy sign in place in waiting area • Instruction leaflet for car parking passes • Ownership for issues raised • Use of voicemail in busier periods to allow face to face customers priority • New deceased database has been implemented to electronically store deceased information in one place making the process of obtaining Medical Certificate of Cause of Death more efficient • Supporting others - demonstrating compassion, empathy, and alternatives • Values team assessment undertaken
Podiatry	• Values team assessment undertaken and team discussion held • Listen to FFT feedback at team meetings • Changed way people can book appointments to prevent call delays • Information leaflets provided in different languages • Telephone etiquette in place • Information signs and roll up banners in place at community

	venues • De-clutter environment at Brace Street, privacy area at Anchor Meadow • Stakeholder survey in place
Adult Community	• Embracing change through Walsall Together collaborative • Locality Based working and administrative support re-structure • Total mobile roll out made it easier to record care and provide feedback to patients • Looking at self-service kiosk integration of information with GP surgeries • 'My name is' principles reinforced
Trust HQ PA staff	• Team discussion held including values focussed assessment • Monthly team huddles initiated • Feel delivering a 'silver' level of customer care • Share and support concerns more openly to support each other to maintain professionalism • Recognition/thank you cards issued

In addition the values based customer care sessions are delivered to all new staff at Trust induction, the session includes two case studies of a patient and staff experience and a discussion thereof applying the values to the impact.

Next steps
The programme requires dedicated resource to enable pace and reach of wider staff groups. Initial gradings are to be shared with teams once sponsors have completed their 1-2-1 assessments with teams.

2 Priorities for improvement 2020/21

Harm free Care

We will focus improvement and delivery of care excellence on the following aspects of harm free care:

- Tissue Viability
- Falls and Deconditioning
- Nutrition and Hydration
- Mouth Care
- Deteriorating patient and sepsis
- Healthcare associated infections
- Improve learning from Medication Errors
- Continence
- VTE

We will review our metrics to ensure we focus on delivery of outcome measures that directly impact on care outcomes; for example measuring VTE risk assessments to number of those at risk, who were subsequently prescribed appropriate dose of treatment and that treatment was administered will have the optimal impact on harm reduction.

The areas indicated in harm free care will be measured against peer group benchmarks (whilst keeping a view on the best) and we will strive to be the above the mean of our peer group in majority of quarters. Where there are no external benchmarks we will use internal benchmarks to determine the mean state. We have also invested in the Perfect ward app to support data collection and understanding of 'where we are' and demonstrate real time quality improvement in clinical care indicators.

3.Patient Priorities

Patient experience is an essential part of understanding whether we are delivering safe, effective and personalised care. We are committed to learning from the experience of those using our services and have developed a set of 12 patient priorities based on patient and public feedback that will support development of detailed plans to support the organisation to improve in the identified areas during 2020/21.

Learning from deaths

The Trust aims to be in the top quartile for the peer group in preventing avoidable deaths. Priorities have been set through a thematic review of lessons learnt from the Learning from Deaths Programme in the last year to meet this aim and include:

1. Improvements in pathway for patients with fractured neck of femur.
2. Early detection and escalation of deterioration through the use of NEWS2 and appropriate escalation and standardised clinical management.
3. Improvement in cancer pathways to reduce delay and clinical variation in order to support best outcomes.
4. Improved end of life care to support end of life discussions and planning including DNAR/MCA.
5. Improved prevention, diagnosis and treatment of hospital acquired pneumonia and adoption and spread of effective, evidence-based practice - chronic obstructive pulmonary disease discharge care bundle.
6. Implementation of Emergency Department safety checklist to reduce mortality from long waits in ED.

Learning from Covid

We recognise the need to learn from our experience:

1. Updating pathways based on our audits and new research
2. Participation in research nationally
3. Sharing best practice through Fast Learning groups and Grand Rounds
4. Maintaining national best practice with regards to Personal Protective Equipment
5. Ensuring Personal Protective Equipment available at all relevant areas
6. Carrying out risk assessments in clinical and non-clinical areas

Improving cancer pathways

Through a focus on lung cancer and colorectal pathways through 2020/21 we will introduce new ways of working to support the implementation of 28-day fast diagnosis target. We will streamline cancer referral pathways both internally and with external partners, ensure every patient has the best possible standard of care based on National best evidence by setting and implementation of MDT standards. For patients who have a delay in the cancer pathway, we will implement a robust mechanism to review all 104 day breeches.

3 Statements of assurance from the board

3.1 Review of Services

During 2019/20 Walsall Healthcare NHS Trust provided and/ or sub-contracted 136 NHS services.

The income generated by the NHS services in 2019/20 represents 100 per cent of the total income generated from the provision of NHS services by the Walsall Healthcare NHS Trust for 2019/20.

3.2 Participation in Clinical Research

Research & Development (R&D) refers to innovative activities undertaken by the NHS, corporations (Pharmaceutical) or governments in developing new services or products, or improving existing services or products. From an NHS perspective research can be either Commercial (clinical trials) or Non-commercial (academic). Having a balanced portfolio is important for Walsall Healthcare NHS Trust as it offers patients the opportunity to be involved in a variation of research studies.

The R&D department has been amalgamated with the Professional Development unit in 2020 and launched the new Faculty of Research and Clinical Education (FORCE). FORCE supports the trust to ensure that evidence based care is central to all clinical work and that there is growth of research across the Trust. For the growth, delivery and performance of research to continue there is a need to nurture and increase the infrastructure of the FORCE team and to change the culture of research activity to ensure that research is everyone's business and a core part of all clinical roles within the trust.

The number of recruits to NIHR Portfolio Studies in the year (2019/20), as a percentage of agreed targets for Walsall Healthcare NHS Trust was 66% [Target was 703; the number recruited 465.]

Table 1 below outlines the number of studies open, in set-up, suspended, missing information closed and total numbers of studies (2019/20).

Walsall Healthcare NHS Trust Recruitment Data Table 1

Walsall Healthcare NHS Trust	
Number of Open Studies	9
Number of Studies in set-up	5
Number of Studies in Suspension	1
Number of Closed Studies*	16
Number of Studies recruiting on CPMS and missing on EDGE	0
Total	31
Total Number of Studies with Complete and Accurate Data	31
% of Studies with Complete and Accurate Data	100%
Number of Studies with Missing Data	0
Number of Studies with Data Discrepancies	0

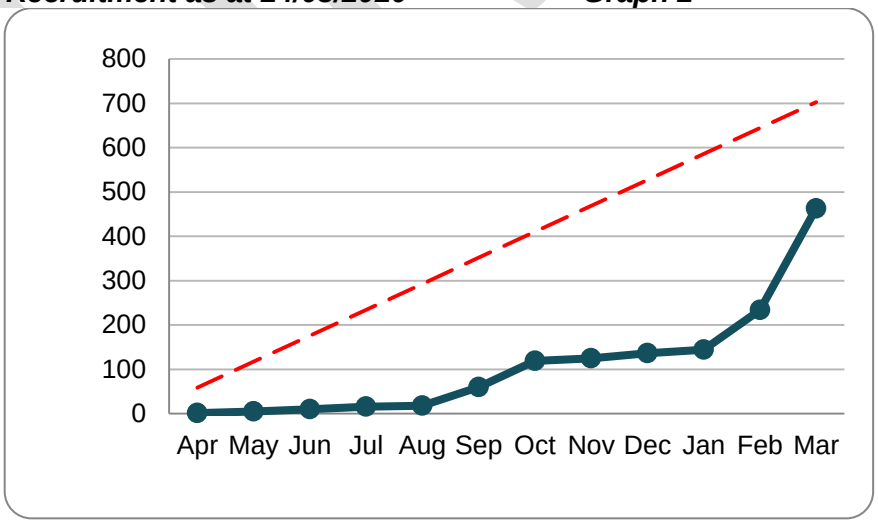
Overview of Studies at Walsall Healthcare NHS Trust

The Trust has a good record in recruiting to time and target on commercial trials, previous performance from 2014-2019 of the 9 studies which participated in research 7 trials hit their target. 2 studies excelled in recruitment the areas being Dermatology and Infection (HIV). In 2019 Walsall Healthcare NHS Trust closed 16 non-commercial studies all studies hit their target and closed green (RAG rated). No commercial studies closed in 2019. There is a need for the Trust to open more studies and have a balance portfolio (commercial and non-commercial).

Research recruitment from 2014-2020 (February) ***Graph 1***

Graph 1 gives an overall of performance since 2014 to present time; the graph shows a steady increase in recruitment and performance overall to end of year 2019. 2019/20 was a challenging year for the team and many changes took place in staffing and process which impacted on the team's ability to recruit into studies. Covid 19 hit in the last month resulting in all non-Covid Studies being suspended and recruitment halted prematurely. It has taken some time to rebuild but the team is now in a good position to see the number of recruits increase again for the year 2020/21. The FORCE team are committed to improving the quality of care offered to patients though research.

Recruitment as at 24/03/2020 ***Graph 2***



Moving forward

In 2020/21 the FORCE team will be focussing primarily on Covid 19 Studies and in particular vaccine studies will be introduced in the autumn. We also need to review and restart our non-Covid studies and increase the number of studies undertaken across the Trust. The department will need to scope potential areas where there is growth for research in relation to population need; this will support stability within the department. The Trust needs to grow its commercial research portfolio however we are anticipated some challenges to this in 2020/21 due to slow recovery in industry from Covid. This will impact on our ability to generate income which could be used to further develop the department.

Detailed below are some of the improvements Team FORCE has identified as key for 2020/21:

- Embedding research into core work for clinical staff.
- Approval and embedding of Research and Clinical Education strategy to give clear direction and accountability.
- Re-energising and stabilising governance framework through effective R&D committee.
- Introduction of a sub committee to review appropriateness of re-opening non-Covid studies.
- Training-Programme for developing research skills developed with Professional Development colleagues and the CRN to ensure availability of professional development for staff. PI masterclasses run for senior staff to take on more research studies.
- Digital transformation of Research processes, Innovation funding gained for virtual assistant project, Edge to be embedded into core process and data recording and Redcap installed for researchers to use.
- Performance Monitoring – Undertaken weekly to identify any missing data or discrepancies in information.

3.3 Participation in Clinical Audit

During 2019/20, there were a number of national clinical audits programmes and national confidential enquiries covering NHS services that Walsall Healthcare provides.

During that period Walsall Healthcare participated in 100% of the national clinical audits programmes and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that Walsall Healthcare was eligible to participate in during 2019/20 are below.

National Audit Title (n=65)	Trust Participation (48)	% of the No of cases Submitted	Actions / Comments
Serious Hazards of Transfusion (SHOT)	✓	Data submission in progress	Data Submission in progress not due to complete till July 2020

National Asthma and COPD Audit Programme (NACAP) – COPD	✓	Data submission in progress	On-going data submission not due to complete till May 2020. Action plan in progress for 2018/19 outcomes.
National Asthma and COPD Audit Programme (NACAP) - Asthma	✓	Data submission in progress	On-going data submission not due to complete till May 2020
National Asthma and COPD Audit Programme (NACAP) - Pulmonary Rehabilitation	✓	Opens March 2019	Data submissions ongoing till March 2020
National Diabetes Adult - Inpatient Audit	✓	Data submitted	Data collected and submitted 27/09/2019 - Await copy of report
National Diabetes Adult - Foot Care Audit	✓	Data submission in progress	On-going data submission
National Diabetes Adult – Pregnancy	✓	Data submission in progress	On-going data submission
National Diabetes Adult – Harms in England	✓	Data submission in progress	On-going data submission. Report expected May 2020
National Diabetes Adult – Core	✓	Data submission in progress	On-going data submission
National Paediatric Diabetes Audit	✓	Data submission in progress	On-going data submission
National Lung Cancer Audit (NLCA)	✓	100%	Data submitted await report
NCEPOD – In Hospital Management of Out of Hospital Cardiac Arrests	✓	Data submission in progress	Data submitted await report
Mental Health – CEM	✓	100%	Data submitted await report.
Assessing Cognitive Impairment in Older People – CEM	✓	100%	Data submitted await report.
Care of Children in ED - CEM	✓	100%	Data submitted await report
Major Trauma Audit - TARN	✓	100%	Data for the period submitted - On-going data submission await the report
NCEPOD –Acute Bowel Obstruction	✓	66%	Action ongoing to implement NCEPOD recommendations

National Audit of Heart Failure	✓	Data Submission in progress	On-going data submission
National Audit of Cardiac Rehabilitation	✓	Data Submission in progress	On-going data submission
NCEPOD – Dysphagia in Parkinson's Disease	✓	Data Submission in progress	On-going data submission
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	Data Submission in progress	On-going data submission
Cardiac Rhythm Management	✓	100%	On-going data submission
National Oesophago-Gastric Cancer	✓	100%	Data Submitted await report
UK IBD Registry	✓	100%	Data collection ongoing – deadline April 2020
NCEPOD – Long Term Ventilation in Children	X	N/A	Not undertaken at the Trust
Sentinel Stroke National Audit – Community	✓	100%	Data submissions ongoing
Adult Cardiac Surgery	X	N/A	Not undertaken at the Trust
Coronary Angioplasty / National Audit of Percutaneous Coronary Interventions (PCI)	X	N/A	Submitted as part of New Cross data
BAUS Urology Audits - Nephrectomy audit	✓	Data submission in progress	On-going data submission
National Prostate Cancer Audit	✓	Data submission in progress	On-going data submission
Case Mix Programme (CMP) - ICNARC	✓	100%	On-going data submission
National Audit Of Breast Cancer in Older People	✓	On-going data submission	Awaiting the report
National Bariatric Surgery Registry	✓	100%	On-going data submission
National Bowel Cancer Audit	✓	100%	Data submission ongoing final data submission April 2020
National Emergency Laparotomy Audit	✓	99%	Total number of cases 213. Total Meeting NELA criteria 130. 129 cases submitted

Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	✓	Data Submission in progress	Falls data – Ongoing data submission
Elective Surgery (National PROMs Programme)	✓	Data Submission in progress	On-going data submission
National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis	✓	Data submission in progress	Data submission on-going
National Ophthalmology Audit	X	N/A	Not applicable patients treated at New Cross
National Vascular Registry	X	N/A	Not undertaken at the Trust
BAUS Cystectomy	X	N/A	Not undertaken at the Trust
BAUS Radical Prostatectomy Audit	X	N/A	Not undertaken at the Trust
MBRACE-UK	✓	100%	On-going data submission
National Maternity and Perinatal Audit (NMPA)	✓	100%	On-going data submission
National Comparative Audit of Blood Transfusion - Fresh Frozen Plasma	✓	100%	Awaiting the report
National audit of Seizures and Epilepsies in Children and Young People	✓	Data Submission in progress	On-going data submission
NCEPOD - Cancer in Children, Teens and Young Adults	X	N/A	Not undertaken at the Trust
National Neonatal Audit Programme	✓	Data submission in progress	On-going data submission
Paediatric Intensive Care	X	N/A	Not undertaken at the Trust
Learning Disability Mortality Review Programme	✓	100%	On-going data submission
Surgical Site Infection Surveillance Service	✓	100%	On-going data submission
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	100%	On-going data submission
Reducing the impact of Serious Infections	✓	100%	On-going data submission
NCEPOD - Pulmonary Embolism	✓	100%	Awaiting the report
National Cardiac Arrest Audit (NCAA)	✓	Data submission in progress	On-going data submission

National Audit of Anxiety and Depression	X	N/A	Not undertaken at the Trust
Prescribing Observatory for Mental Health	X	N/A	Not undertaken at the Trust
UK Cystic Fibrosis Registry	X	N/A	Not undertaken at the Trust
BAUS Urology Audit – Female Stress Urinary incontinence (SUI)	X	N/A	Not undertaken at the Trust
BAUS Urology Audit – Percutaneous Nephrolithotomy (PCNL)	X	N/A	Not undertaken at the Trust
Child Health Clinical Outcome Review	✓	Data Submission in progress	Ongoing data submissions
National Clinical Audit of Psychosis	X	N/A	Not undertaken at the Trust
National Congenital Heart Disease (CHD)	X	N/A	Not undertaken at the Trust
National Joint Registry (NJR)	✓	Data Submission in progress	Ongoing data submission
Neurosurgical National Audit Programme	X	N/A	Not undertaken at the Trust

The number of local clinical audits reviewed by Walsall Healthcare NHS Trust was 106 during the period of 2019/20. Reports from these audits are presented at multi-speciality meetings where recommendations and actions are derived to improve the care delivered. Some examples are detailed below:

Title	Outcome	Action
Prolonged Jaundice Audit	The audit identified there was potential to over screen babies when jaundice was not fully visible.	To develop a SOP to support to enable first line testing to occur and help to streamline screening thus reducing potentially unnecessary testing.
Post Take Ward Round Standards – Re Audit	Poor documentation was identified during the original review. The re-audit demonstrated that overall improvements had been achieved however further work was necessary to the proforma once fully embedded.	To continue with the proforma that acts as a prompt for investigations, to support patient safety and patient flow. To continue the audit as a Quality improvement project in the next financial year.
30 day mortality post endoscopy	All endoscopies were done for an appropriate indication. Rockall score not done in	Information sessions to be scheduled to ensure all staff understand the importance of

	15% of the patients	documenting the Rockall Score
Effective Theatre Utilisation during Summer Holidays	The review identified theatre utilisation was reduced during the summer weeks and was suboptimal (<90%)	A trial period of theatre utilisation is to be undertaken during the Easter holidays 2020 with the aim of improving theatre productivity.
Oxygen prescription audit Trust Wide	The audit identified low compliance to the standards	An action plan was derived that constitutes a trail pharmacist on a ward as a pilot to review the prescriptions daily. Investigation underway to identify feasibility of changing the Drug charts to place oxygen in the prescribed medicines section to act as a prompt reminder.
Overdose of insulin due to incorrect abbreviations	The audit identified good practice however the clinical guidance on the intranet were outdated	Action was taken to ensure the out of date guidance was removed and replace with the UpToDate guidance. Regular audits by pharmacy to continue
Mis selection of high strength midazolam	The audit identified an out of date policy was on the intranet. High strength doses were found in areas with no evidence of a risk assessment in the ward areas.	Pharmacy acted on the outcome and removed all high strength dosages from areas. The policy is in the process of review. All areas reminded about the risk assessments that need to be completed in line with National guidance. All antidotes to be checked in areas that carry high strength doses. Spot audit to be conducted.
NatSSIPs LocSSIPs	The audit identified compliance across the Trust was improving but still failed to meet National recommendations	An action plan is in place to drive compliance and improvements through standardisation and target forms for the areas of use. Regular walk about to raise awareness and act as prompts. An Observation audit is to be targeted in the new financial year to supplement the notes review. Established monthly submission checks to give ownership to the areas of use.
Resources to support safer bowel care for patient at risk of autonomic dysreflexia	Good compliance was noted against the national standards apart from attendance at the training programme.	An action plan to improve compliance is in development.

Valproate	Poor documentation around the use and reviews were identified.	An action plan is to be developed to review current practices and adopt /accept National guidance.

3.4 CQUIN

A proportion of the Trust's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services.

This income related to quality improvement is part of the Commissioning for Quality and Innovation payment framework, and formed part of agreements with local Clinical Commissioning Groups, NHS England and the Local Authority. The financial value attached through the framework to delivery of the agreed improvement goals in 2019/20 was 1.25% of the value of all healthcare services commissioned through the respective contracts. This equated to just above £2.2 million for the Trust in 2019/20.

There were 5 CQUIN schemes for 2019/20. This includes 3 National (CCG) schemes, 1 NHS England Specialised Commissioning scheme and 1 NHS England Dental scheme.

3.5 Information on registration with the Care Quality Commission (CQC)

Walsall Healthcare NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "registered without conditions"

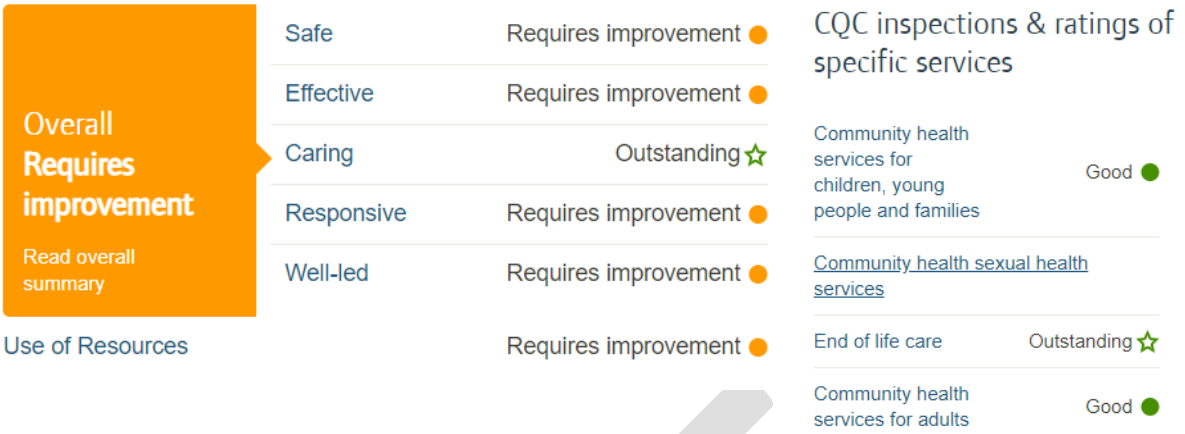
The Trust received an unannounced focus inspection of its maternity services on the 5, 6 and 12 June. The purpose of the inspection was to determine if the maternity services at Walsall Healthcare NHS Trust had made the improvements highlighted following the 2017 inspection and if the requirements of the warning notice had been met.

The CQC also carried out a comprehensive inspection of the Trust's:

- medicine and critical care services on 4 – 6 February 2019,
- urgent and emergency care, surgery and maternity services on 11 – 13 February 2019,
- Community Sexual Health Services on 25 and 26 February 2019 and
- Well Led requirements was undertaken on 19-21 March 2019.

In addition, NHS Improvement (NHSI) conducted the Use of Resources inspection on the 8 February 2019.

The final Quality Report detailing the inspection findings was published on 25 July 2019 with the results shown below:-



Ratings for the Combined Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019
Community	Requires improvement Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019
Overall trust	Requires improvement Jul 2019	Requires improvement Jul 2019	Outstanding Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

Ratings for Manor Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019	Good ↑ Jul 2019
Medical care (including older people's care)	Requires improvement →← Jul 2019	Requires improvement ↓ Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Good →← Jul 2019	Requires improvement ↓ Jul 2019
Surgery	Requires improvement →← Jul 2019	Requires improvement →← Jul 2019	Requires improvement ↓ Jul 2019	Good →← Jul 2019	Requires improvement ↓ Jul 2019	Requires improvement →← Jul 2019
Critical care	Good →← Jul 2019	Requires improvement →← Jul 2019	Good →← Jul 2019	Requires improvement →← Jul 2019	Requires improvement →← Jul 2019	Requires improvement →← Jul 2019
Maternity	Requires improvement →← Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good ↑ Jul 2019	Good →← Jul 2019
Services for children and young people	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
End of life care	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Outpatients and Diagnostic Imaging	Good Dec 2017	N/A	Good Dec 2017	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017
Overall*	Requires improvement Jul 2019	Requires improvement Jul 2019	Good Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019	Requires improvement Jul 2019

Ratings for Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Good Dec 2017
Community health services for children and young people	Requires improvement Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017	Good Dec 2017
Community end of life care	Good Dec 2017	Good Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017	Outstanding Dec 2017
Community health sexual health services	Requires improvement Jul 2019	Outstanding Jul 2019	Outstanding Jul 2019	Good Jul 2019	Good Jul 2019	Good Jul 2019
Overall*	Requires improvement Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019	Outstanding Jul 2019	Good Jul 2019

The Trust was subject to 5 enforcement notices as follows:-

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 12 HSCA (RA) Regulations 2014 Safe care
- Regulation 11 HSCA (RA) Regulation 2014 Need for consent
- Regulation 5 (Registration) Regulation 2009 Registered manager condition

In response to the report, the Trust has continued to manage the must and should actions via the Patient Care Improvement Plan (PCIP) along with the requirement notices issued. The work and progress has been reported to the Quality, Patient Experience and Safety Committee and Trust Board.

3.6 Information Governance Toolkit attainment levels

Walsall Healthcare NHS Trust is a recognised and registered Data Controller with the Information Commissioners Data Protection Register and has current Data Protection registration.

All organisations that have access to NHS patient data and systems must use the Data Security and Protection Toolkit (DSPT) to provide assurance on their practice.

The assessment enables organisations to measure their performance against the National Data Guardian's (NDG) 10 data security standards, compliance with legislation and central guidance to assess whether personal information is handled appropriately, and protected from unauthorised access, loss, damage and destruction.

The Trust has completed the DSPT for 2019/20 evidencing the requirements and providing assurance in relation to 115 of 116 mandatory assertions. The Trust was unable to demonstrate the required target of 95% of all staff being

appropriately trained in data security awareness. Walsall Healthcare NHS Trust's Information Governance Assessment for 2019/20 is therefore 'standards not fully met – (plan agreed)'.

The Trust continues to monitor its Information Governance mandatory training compliance, and through audit scrutinises records quality, storage and retention. Our Information Governance improvement plan for 2019/20 was overseen by our Information Governance Steering Group, chaired by our Director of Governance and attended by the Trust's Caldicott Guardian and Senior Information Risk Owner.

The Trusts' toolkit is shared with the Care Quality Commission (CQC), NHS England and Improvement, and provides important evidence for the key line of enquiry on Information in the CQC well-led inspection.

3.7 Clinical Coding

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

The audit used the Clinical Coding Audit Methodology v13.0 from the Clinical Classifications Service (CCS) at NHS Digital. The auditors are approved by the CCS and follow the Clinical Coding Auditor Code of Conduct Version 10.0.

The audit of 202 Finished Consultant Episodes (FCEs) was commissioned by the Head of Clinical Coding at the Trust. The audit sample of 202 episodes for this report was drawn from activity between April and June 2019 in two areas; General Medicine and Dermatology. The audit took place 11-12th February 2020.

Results

The overall coding inaccuracy rate of 2.6 per cent is much lower than the national 6.5 per cent average error rate as identified in the latest available national Payment by Results Report for 2014/15.

The accuracy of the coded clinical data has increased in every area since the 2018/19 audit was undertaken. The accuracy of the diagnosis coding has improved so that now only 2.6 per cent of diagnosis codes are inaccurate in any way. Excluding the non-coder errors, related mainly to documentation availability, the overall error rate is just 1.6 per cent.

Area	Level of attainment - Mandatory	Trust Percentage - Correct
Primary Diagnosis	>=90.0%	* 92.1%
Secondary Diagnosis	>=80.0%	98.4%
Primary Procedure	>=90.0%	97.2%
Secondary Procedure	>=80.0%	96.9%

* Excluding the Non-Coder Errors, the accuracy of the primary diagnosis is 98.0%

3.8 Information on the quality of data

Walsall Healthcare NHS Trust can confirm that it submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) for national reporting purposes.

April 2019 to March 2020

The percentage of records in the submitted data which included a valid NHS number was:

- admitted patient care = 99.54%
- outpatient care = 99.94%
- accident and emergency care = 99.48%

The percentage of records in the submitted data which included a valid General Medical Practice Code was:

- admitted patient care = 100.00%
- outpatient care = 100.00%
- accident and emergency care = 100.00%

Good quality information underpins the delivery of effective patient care and is essential to understanding where improvements need to be made.

3.9 A consolidated annual report on rota gaps

A Programme Lead for medical workforce was appointed in July 2019. Since then, the Trust has successfully implemented a new job planning and WLI policy, undertaken Trust wide job planning and is in the process of implementing the remaining units within a software management system to help utilise medical staff to reduce rota gaps and developed a more sustainable workforce programme. The Trust has also gained approval to work in partnership with RWT's Clinical fellowship programme that will work alongside our MTI recruitment programme in the appointment and development new doctors. The Trust has also approved the recruitment of workforce into ambulatory emergency care pathways in line with its strategy for Walsall Together.

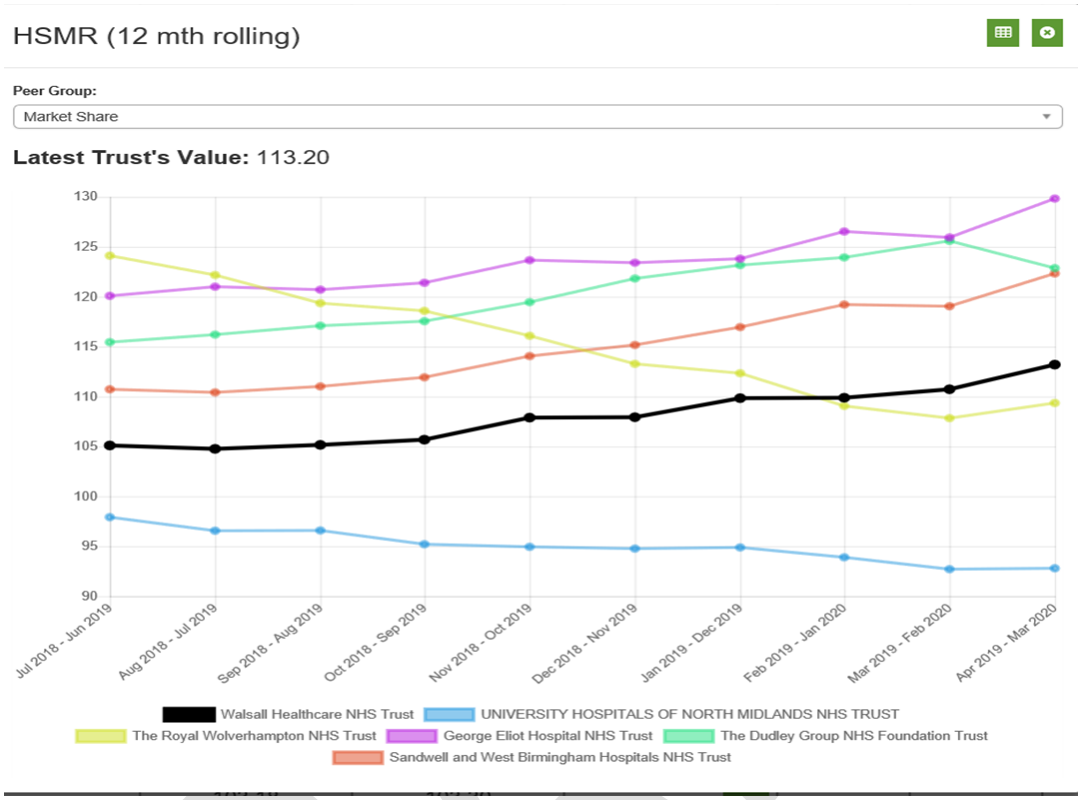
In 2020/21, the Trust will continue to develop new roles, implement the SAS charter and continue partnership working with MTI schemes, particularly for difficult to recruit into specialities.

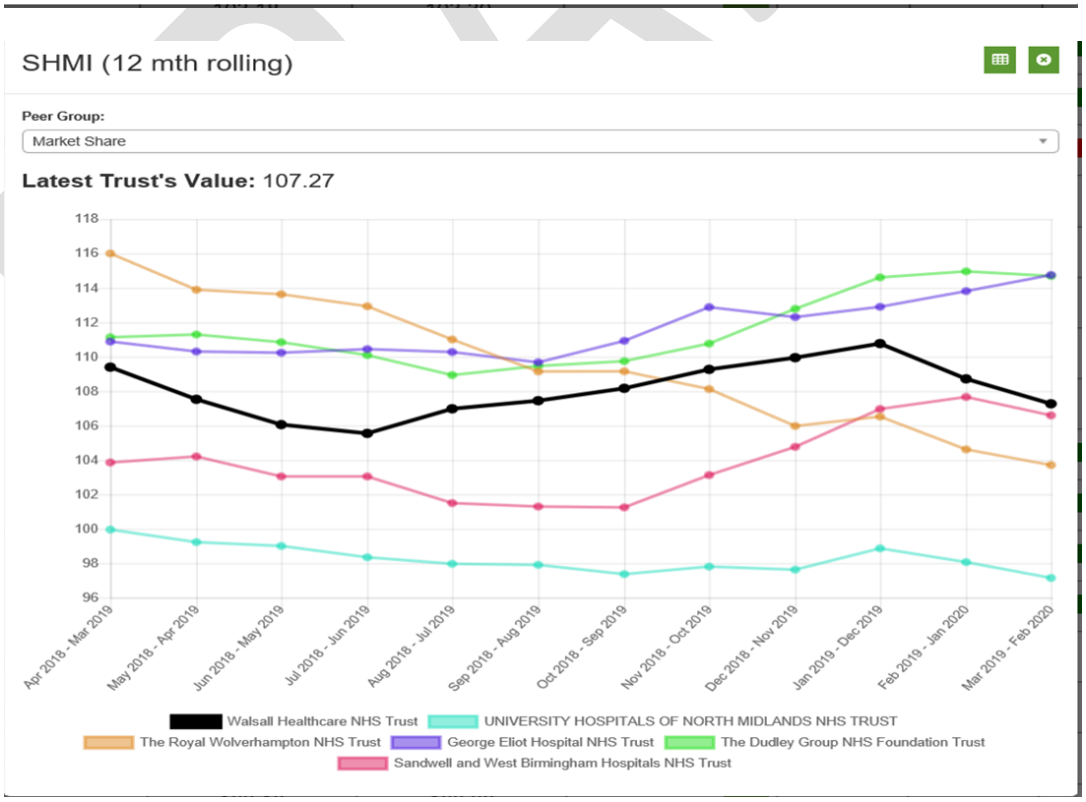
3.10 Learning from Deaths

During the reporting period April 2019-March 2020, 1066 patients died as in-patients of Walsall Healthcare NHS Trust or within 30 days of discharge.

The Trust uses two key national benchmarks as the primary indicator for mortality, for comparison against regional peers: Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index, (SHMI). Data is provided by NHS Digital and hosted by Healthcare Evaluation Data (HED), and shows

the trust is in a comparable or improved overall position relative to regional peers.





SHMI V LOCAL COMPARATORS (REGIONAL)

In line with National Quality Board (NQB) guidance the trust updated its Learning from Deaths (LfD) Policy in 2017 to include the Learning Disabilities Mortality Review (LeDeR) process and in 2019 to include a clear internal governance structure to link for Trust wide learning in line with Safeguard. In addition, the Structured Judgment Review (SJR) process was embedded in practice in 2017/18 to identify patients for review using a defined set of triggers derived from NQB guidelines. In total, 658 deaths were flagged for review in this way.

Trust Overview	April – March 2020
Number of Deaths	**1066**
Number Scrutinised by ME	**51**
Number Appropriate for Review (Adult Inpts)	**658**

In 2019/20, 475 (81% of flagged records) patient records were reviewed. In each case an assessment was made by the reviewing clinician of the overall quality of patient care. Assessment of quality of patient care is completed using a standardised mortality screening tool. The results for 2019/20 are as follows:

Score (2019/2020)							
1	**2**	**3a**	**3b**	**3**	**4**	**5**	**LD**
1	8	10	84	8	294	83	10

Trust-wide, mortality review and return rates have been recognised as an area for improvement. Audits show that of the notes available, 75% of reviews had been completed. Remedial actions were agreed further through the Mortality Surveillance Group and Medical Advisory Committee, and Divisional leads expected to provide oversight.

The trust uses a variety of mechanisms and forums to learn from patient deaths, celebrate good practice and to communicate findings to clinical and nursing teams. These include:

- Mortality Surveillance Group
- Resuscitation Group
- Divisional Safety huddles
- Care Group Meetings and Divisional Quality Boards
- The 'Daily Dose' e-mailed to all staff on a daily basis

Some of the learning, service developments and changes in practice identified from reviews in 2019/20 included:

- Working with Walsall CCG to develop and embed a Designated Doctor of Death role and Child Death Overview Panel, to improve the child death review process.
- Fractured neck of femur deaths: A quality service improvement project which has streamlined the pathway leading to faster access to theatre for operating, more consultant involvement and joint orthogeriatrics

pathways of care including post-operative delirium assessment, physiotherapy assessment on the first day after surgery and reduction of acute kidney injury. Further improvements are on-going including benchmarking and learning from other Trusts.

- Speech and Language Therapy (SALT): To improve pneumonia-related ill health and mortality, SALT have put an action plan in place to embed improved oral care trust-wide and to support safer nutrition.

Part 3: Review of other quality performance

1 Quality Improvement Academy

QI Academy & QSIR Programmes

At the start of February 2020, the QI Academy completed its second year of delivering training, building on the sound foundations developed through its first year in 2018 and now using the QSIR Programmes. During 2019/20 the accredited QSIR trainers delivered 12 open sessions of the one day QSIR Fundamentals programme and three sessions for specific staff groups including; the Palliative Care Team leaders, regional library managers and delegates on the Band 2 – 6 Development Programme. Delegates on the Senior Nursing Development Programme were encouraged to participate in the QSIR Fundamentals programme to support their delivery of a QI project, which was an essential part of their overall programme. A total of 179 members of staff undertook this QSIR Fundamentals programme during 2019/20.

The QSIR trainers also delivered 5 cohorts of the 5 day QSIR Practitioner course, through which 87 members of staff completed their training and 20 members of staff need to finish one or two days to complete and are scheduled to do that during 2020/21.

The Trust currently retained has 5 Accredited QSIR trainers having lost 2 but recruited and accredited 2 others. Retaining trainers and developing more is an ongoing priority for the QI Academy. To address this there are an additional 6 colleagues undertaking the training that, once accredited, should be able to deliver training through 2020/21.

The plans for delivering 5 fully subscribed cohorts during 2020 have been finalised and submitted to the Advancing Change and Transformation Academy who accredit the QSIR Programmes. There is also a plan to deliver a further 5 cohorts through 2021. Achieving these plans would give approximately 10% of the Trusts staff as having completed the 5 day programme by December 2021.

One of the key elements of delivering QI changes is Leading Quality Improvement and the QI Academy is developing a programme for those managers who will lead and support colleagues to deliver QI Changes locally.

QI Sessions within Induction Programmes

The QI Session continues to be an essential part of the trust's Induction programme and the slide set has been refreshed to cover the three key QI tools and approaches which the Trust has undertaken;

- Model for Improvement,
- Measurement for Improvement and
- NHS Sustainability model.

All new starters joining the trust undertake this session.

The QI faculty have strengthened the approach for induction for incoming Doctors about their understanding of what Quality Improvement is, how it differs from clinical audits and how their colleagues have been involved and they could become involved in on-going QI projects or identify new ones in their specific areas. There was also a session for junior doctors as part of their Induction training.

Ad hoc QI training

Ad hoc QI Training has been delivered to teams from the Pharmacy department, Chemotherapy Daycase, Adult and Children Safeguarding team, Anaesthetics team and A&E staff. These have used the QSIR Fundamentals as the basis for their training. More is planned for 2020/21 including a session for regional anaesthetics and intensive care staff, which has been supported by the West Midlands deanery for study leave.

In the summer of 2019, the QI Academy delivered 4 awareness raising sessions for Healthcare Systems Engineering. Over these 4 workshops, 47 members of trust staff had their understanding of what causes delays and capacity challenges through clinics challenged and then supported to design a system that delivered a scenario that had improved safety, effective flow, improved quality and productivity. Two colleagues have started the Health Care Systems Engineering programme to develop in-house practitioners and are working on projects in Antenatal and Trauma and Orthopaedics.

QI Awards and QI Conference

The first QI Awards evening was held in July 2019 where medical colleagues were able to submit abstracts on QI Projects that they had undertaken with a view to being invited to either deliver an aural presentation or submit a poster. There were 32 posters and 5 presentations on the evening. Plans for the 2020 QI Awards session are currently being developed and it will be open to all colleagues from across the Trust and its partner organisations.

There was one QI Conference during 2019/20 held in November 2019 where colleagues who had undertaken the 5 day QSIR Practitioner programme were able to present on their QI changes. Also within that day was a break out session where the National Analytics team from NHS England and Improvement delivered a session on measurement for improvement and their "Plot the Dots" session.

Human Factors

The trust was commissioned to deliver a limited number of sessions on Human Factors through 2019/20 which were delivered and planning for a larger programme for 2020/21 are being developed and have been supported with external funding.

QI Strategy

The Trust has revised its original QI Strategy setting out its continued approach to build capacity, capability and confidence in the application of the QI tools, methodology and approach, which it will continue to promote over the next few years.

New for 2020/21

As well as the aspects mentioned above for continued embedding of QI within the organisation, the introduction of Improvement Huddle Boards is just being initiated and will be progressed through 2020/21. These are a combination of the Improvement Boards that both Western Sussex NHS Foundation Trust and Birmingham Women's and Children's NHS Foundation Trust are using for local improvements within services, departments and wards, and a story board that explains what the aims and drivers for the service are.

The QI Academy is developing a programme for supporting those colleagues who undertook the QSIR Practitioner Programme to become QI Coaches and for them to support their colleagues across the trust.

2 Duty of Candour

Walsall Healthcare NHS Trust has a clear policy which sets out how we meet the legal requirements as well as promoting a culture within the organisation that encourages candour, openness and honesty. The process is set out so that staff are supported to inform patients and their families and carers about where we are investigating the care we have provided to identify areas where this could be improved, provide reasonable support to them and to understand the necessity for providing truthful information and above all provide an apology to those affected.

There is a Duty of Candour guidance pack as an appendix to the policy which gives staff useful information on all of the above aspects of the process. The Patient Safety teams also support staff with the process and continue to provide bespoke individual training to colleagues where identified. The Trust uses a series of information leaflets in use, targeted towards specific patient groups (adult inpatients, paediatrics, maternity) which is given to patients and families at the time verbal conversations are held to provide useful information about the process which will be followed and key contact details to enable engagement throughout the following weeks. The leaflet also enables the Trust to comply with the regulation to provide in writing a summary of what was verbally discussed.

The Trust monitors the compliance with the application of the statutory duty of candour requirements through the Ulysses Safeguard system, with regular assurance and monitoring of this through divisional quality governance

structures and escalation to the Patient Safety Group. During the Trusts CQC inspection in 2019, they noted that consistent application of the duty of candour process, particularly ensuring patients and / or their families and carers have the opportunity to meet with representatives of the Trust, was an area for the Trust to seek to improve; this has been a component of the Trusts PCIP action plan to ensure this recommendation is acted upon and implemented fully in all areas.

3 Patient Care Improvement Plan (PCIP)

The Trust has continued to use the PCIP however it is the intension of the Trust, as it builds its overall Trust Improvement Programme, to incorporate the Patient Care Improvement Plan enabling a more systematic, trust wide approach. To enable this, the PCIP has since been "Themed" to allow for easier alignment to the overarching Improvement Programme also enabling improved aggregation to the Trust Improvement KPI's. This will also further improve the Divisions ability to work collectively across Division and with our Partners enabling a Project Delivery approach to be adapted which can be support by the QI Academy. This will also improve the Governance of the PCIP by incorporating it into a Trust Wide Programme Governance Framework.

4 Number of Never Events

A never event is defined as a serious, largely preventable, patient safety incident that should not occur if the available preventative measures have been implemented.

During 2019/20 there has been 1 Never Event reported by Walsall Healthcare NHS Trust, which related to a retained foreign object post procedure which was identified to have occurred in 2017; this incident was investigated via the Trust local serious incident investigation process, based upon National best practice, with lessons shared widely with action to prevent recurrence monitored.

5 Number of serious incidents

During 19/20, the STEiS system shows the Trust reported 94 serious incidents compared to 143 in 2018/19, the main categories were 21 incidents of Treatment delays meeting SI criteria, 21 slips trips and falls meeting SI criteria and 19 HCAI infection control serious incidents.

The key learning messages from SIs are cascaded via a number of sources including weekly Divisional Safety Huddles, local ward, departmental and other local based initiatives where available, 'Incidents at a glance' one page summaries describing the incident, lessons learnt, and Monthly Lessons learned bulletin.

6 Learning from complaints

The Patient Relations team provides access to the department via a designated email address, telephone, the Trust website, and via the receipt of written correspondence - the team also offers face to face contact via the department

from 09:00 hours to 16:00 hours Monday – Friday. There is also an answer machine for out of hours.

Patient Relations is at times perceived to be just about 'complaints' when in fact our work and the support we provide is much broader. Everyone is welcome to contact the department whether they are a patient, relative, carer or member of staff, and a friendly, professional welcome is given to all. We have access to a wide range of information to help where we can and during the day we respond to many requests for information and advice and signpost all who access our service in the right direction. Our remit is 'if we don't know, we will find out who does'. The team also continues to attend the ward and clinic areas as and when we are required.

We provide support to Trust staff enabling them to respond to concerns and complaints in a positive manner. For example; helping to resolve concerns as and when they happen; providing information to the patient with respect to internal processes, i.e. being involved in Multi-Disciplinary Team Meetings (MDT) and arranging attendance and guidance.

The Patient Relations team also provides pastoral support and family liaison support to the complainant through the complaints process. The team continues to work closely with the Divisions to respond in a proactive manner to concerns received within the Trust. This entails immediate involvement of the Divisions as well as contacting nursing staff, clinicians and administration staff in any particular area, to liaise and respond to concerns in real time. By providing the link between staff, patient, relative or carer and offering the support to everyone involved leads to a greater degree of satisfaction for all concerned and embeds a culture where learning and feedback is valued.

The team continues to encourage the empowering of staff to work with us proactively to resolve concerns at source. The team provides support to staff, patients, carers and their relatives through difficult times without always having to engage in the formal complaints process. In the past year we produced a guide to assist staff in informal resolution of concerns in addition to a separate guide to aid effective resolution of complaint meetings. We are always appreciative of the support we receive from staff from all areas and levels as this provides us with the confidence that we work as one team, successful in the building of firm relationships with our colleagues.

We work closely with the Patient Safety, and Adult and Children's Safeguarding Leads, and attend the weekly divisional safety huddles providing information on complaints and concerns received each week, as well as providing the more positive aspects of information received. These meetings assist in the triangulation of incidents, claims and complaints discussed on an individual basis to enable a more in depth discussion to assist with the decision making of how they are to be taken forward. These can include complaints that are also reflected in a Serious Untoward Incident, complaints received from MPs, and where specialist advice is required. This ensures prompt decision making regarding the progression of these complaints and, where appropriate,

instigation of investigations through the Root Cause Analysis process or independent reports from clinical and nursing experts externally.

The Department also works with the legal and claims team to liaise with relatives who have any outstanding concerns following an inquest and acting on communication/instruction from the Coroner. Working with the office of the Parliamentary Health Service Ombudsman (PHSO), we have built positive links with case workers; providing the necessary information and advice for a speedy and thorough resolution to their investigations. This enabled us to take an active role in the forthcoming national standardisation of Complaints and the development of an accredited training programme.

Advocacy links are maintained via ICAS (Independent Complaints Advocacy Service) and Healthwatch to ensure that the complainant is signposted to independent advice and direction to an advocate that is right for them when this is required. As such our relationship with Healthwatch Walsall has grown and we have worked alongside Healthwatch to provide information and resolution to concerns or questions when raised.

We have seen a reduction of the number of contacts responding to both the complaint satisfaction survey and equality monitoring survey. This will need to improve and a variety of options will be utilised in order to further capture this valuable information.

Our priorities for 2020/2021 include:

Piloting a complaint investigation 'support hub' with the division of Medicine. If successful we will roll this out across Divisions.

1) Develop an e-learning module with certification to replace the Trust complaints update which is out of date.
2) Introduce virtual meetings for patients/families rather than meeting face to face following COVID -19 adjustments.
3) Improving the collection of Equality data, the team will also be scoping using the envoy messaging service to obtain feedback on the service.

2019-2020 Activity

During 2019/2020 a total of 4,176 contacts were received by the Patient Relations Team which is an increase of 399 contacts from the previous year. This figure includes a total of 359 written complaints (KO14a) about care addressed in letters to the Chief Executive. Of these 344 were written complaints, 6 were letters received via Members of Parliament (MP letter) and there were 9 informal to formal converted complaints. The total figure represents an overall increase of 13 complaints compared to the previous year 2018/2019. Throughout this report 'K041a' written complaints are referred to as 'complaints' and these are managed through the Trust's complaints process and reported quarterly to the HSCIC (Health and Social Care Information Centre).

Complaints

This section details written complaints received during 2019/20.

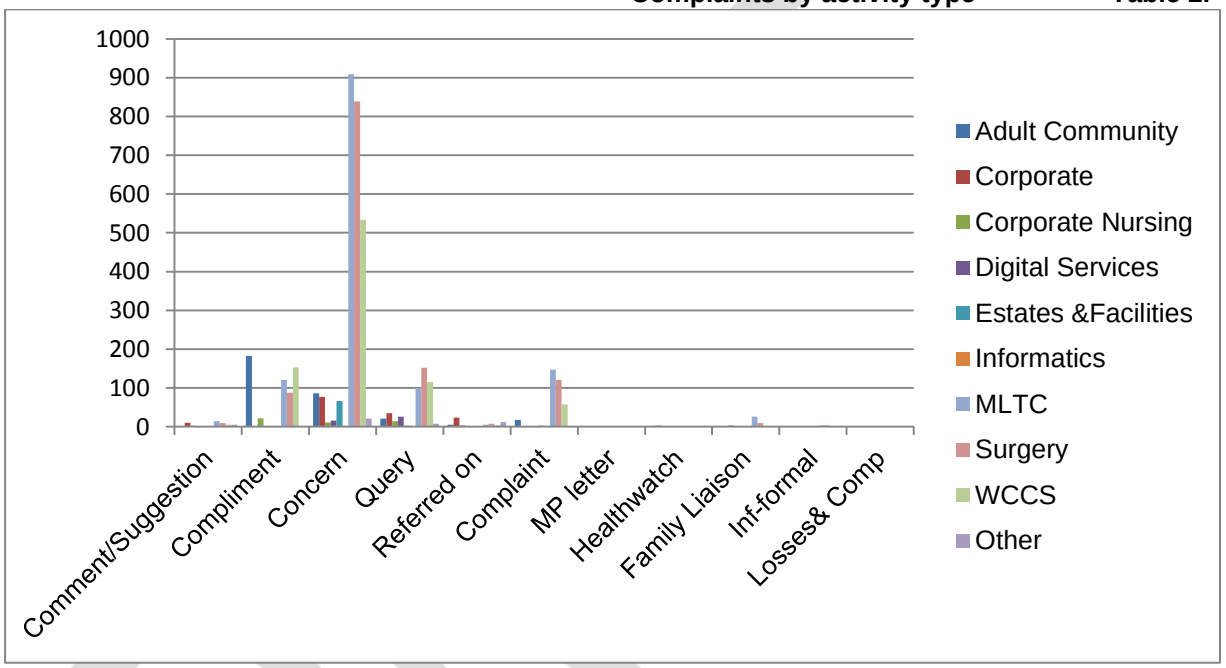
Complaints by Division

- **There has been an overall increase of 13 complaints compared to the previous year 2019/2020.**

The Divisions of Medicine and Long Term Conditions (MLTC) and Surgery generated the greatest number of complaints, accounting for 77% of all complaints received.

MLTC (152 complaints), Surgery (127), Women's Children's and Clinical Support Services (WCCS-60). Corporate functions, Urgent Care, Estates and Facilities and Adult Community account for the remainder.

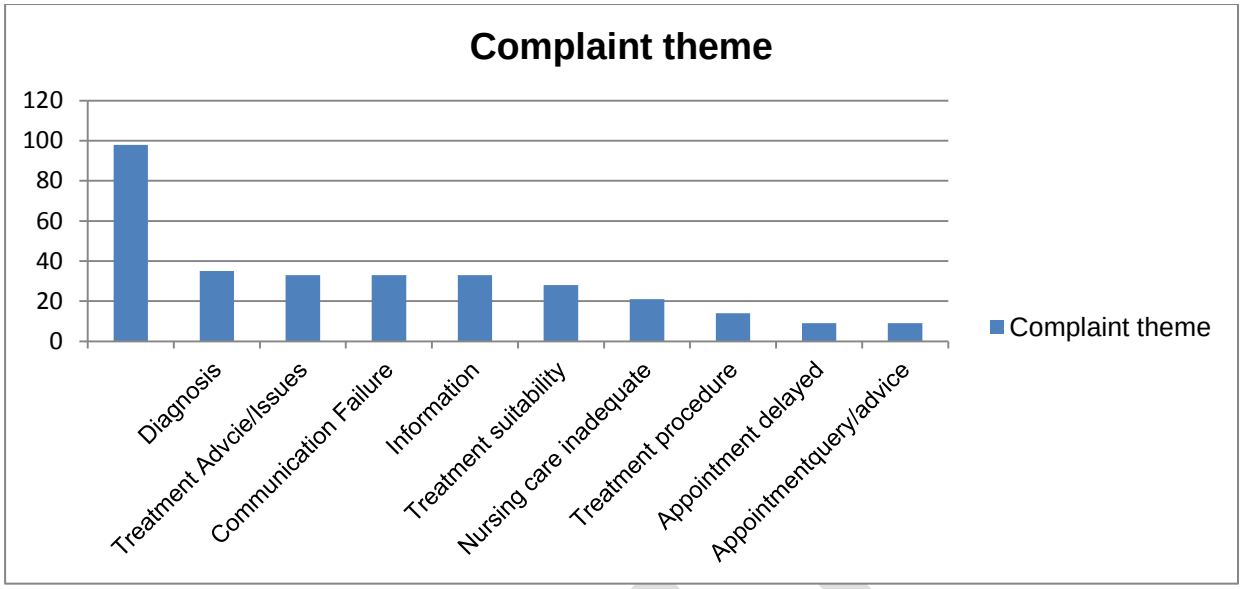
Complaints by activity type **Table 2.**



Complaints by category type

During 2019/2020, there were 409 complaint types by category with the main theme emerging from formal complaints being treatment care and supervision. This accounted for 24% of all complaint categories, 98 complaints fell within this domain. The top 10 category types from all complaints are highlighted in the table below.

Complaints by category **Table 3.**



Complaints via patient activity (10,000 spells) 2019/2020

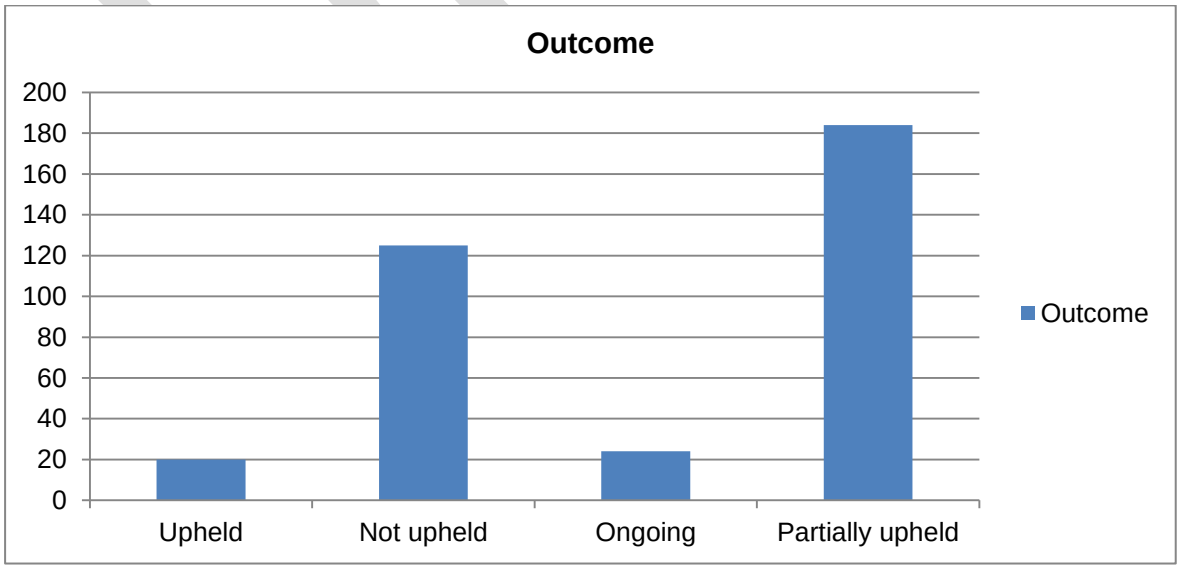
The number of complaints versus patient activity was 9%. This is calculated as the number of complaints divided by-elective, non-elective and emergency patients (40,942) and multiplied by 1000.

Complaints by outcome

At the time of completing this report, the total number of complaints resolved was 334.

20 complaints were upheld with 126 not upheld and 186 partially upheld. 21 complaints are ongoing with 4 withdrawn.

Complaints by outcome **Table 4.**

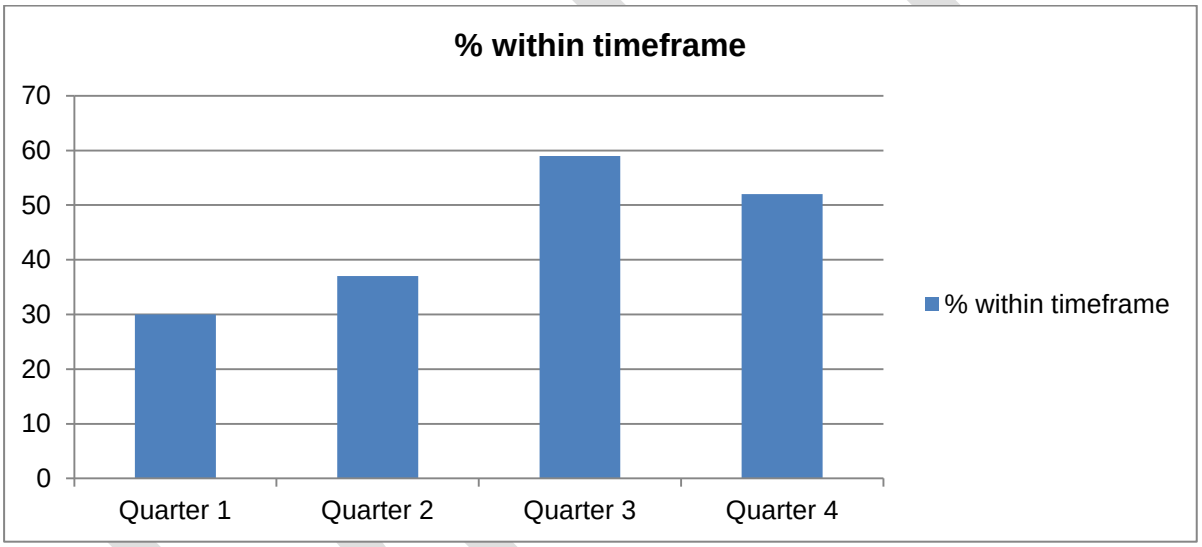


Response times

The 2009 Complaint Regulations removed the 25 working day target to provide greater flexibility with the intention for minor complaints to be resolved much quicker whilst accepting that longer timescales will be needed for the most complex/severe. The Trust target is 80% of all complaints to be completed within 30 working days. 45% of written complaints were completed within 30 working days for 2019/2020.

During the year there was a change in the approach used to record complaints completed within timeframe, from timescales agreed with the complainant (which the regulations allow) to one which focused directly on number of days to complete. The difference in recording highlighted that in the main the organisation was not meeting the local target of completion within 30 working days for 80% of all complaints. Actions have been undertaken to address this in year with a reduction in the backlog of complaints and a clear escalation process where support is required.

Complaints timeframe **Table 5**

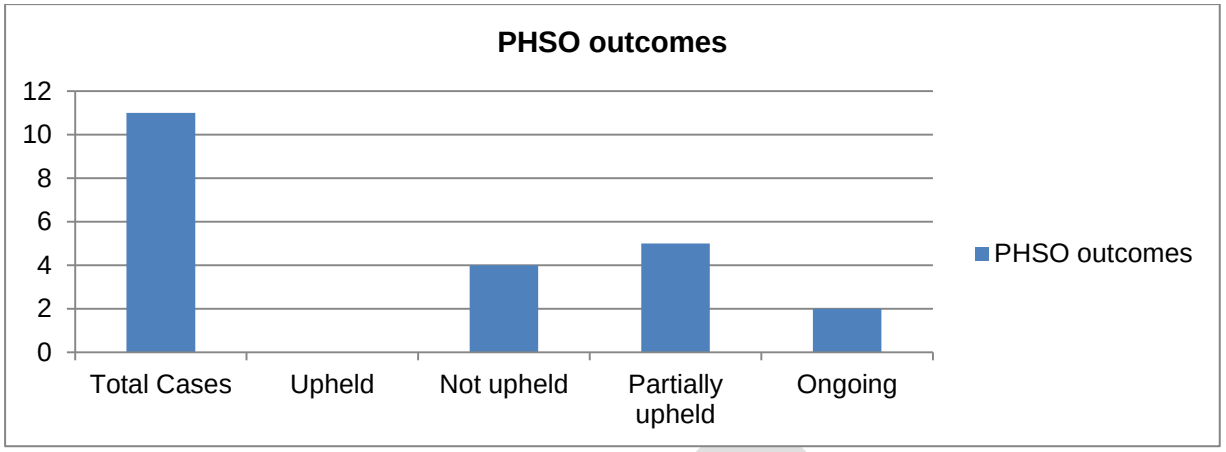


Supportive action is in place to manage caseloads and provide ongoing support for the divisions. This has included a deep dive of all cases identifying complaints that can be responded to via available records, and some support via re-deployed nursing staff – one each from Surgery and Medicine who have coordinated, led and investigated a number of additional complaints. Patient Relations team staff have also acted as coordinators in order to 'template' complaints where investigation statements have been received. In addition complaints requiring escalation i.e. potential serious incidents, safeguarding, mortality/subject judgement reviews are also facilitated.

Parliamentary and Health Service Ombudsman (PHSO) Cases

In 2019/20, a total of 11 cases were accepted via the PHSO for investigation. This equates to 3% of all complaints received. There are nil cases open from the previous year 2018/2019. 9 were cases completed during this year with 2 ongoing.

PHSO Cases and outcome **Table 6**



Themes emerging include:

- Concerns highlighted with regard to clinical care assessment and treatment,
- poor communication,
- inadequate pain management and
- poor nursing care.

Outcome from PHSO cases closed & lessons learned from complaints closed

Action plans are submitted within a timeframe set by the PHSO and evidence is included of compliance. Lessons learned from complaints closed are recorded and disseminated.

Concerns

There were a total of 3,395 concerns received during 2019/2020 an increase of 507 concerns from the previous year (2,888).

This figure includes concerns (2,834), comments, suggestions and queries and referred on (553), Losses and Compensation 3, Health watch referrals 2, other PALS 3. MLTC equated for 33% (1,133) of the total activity, with Surgery 32% (1,074) and WCCSS 20% (685).

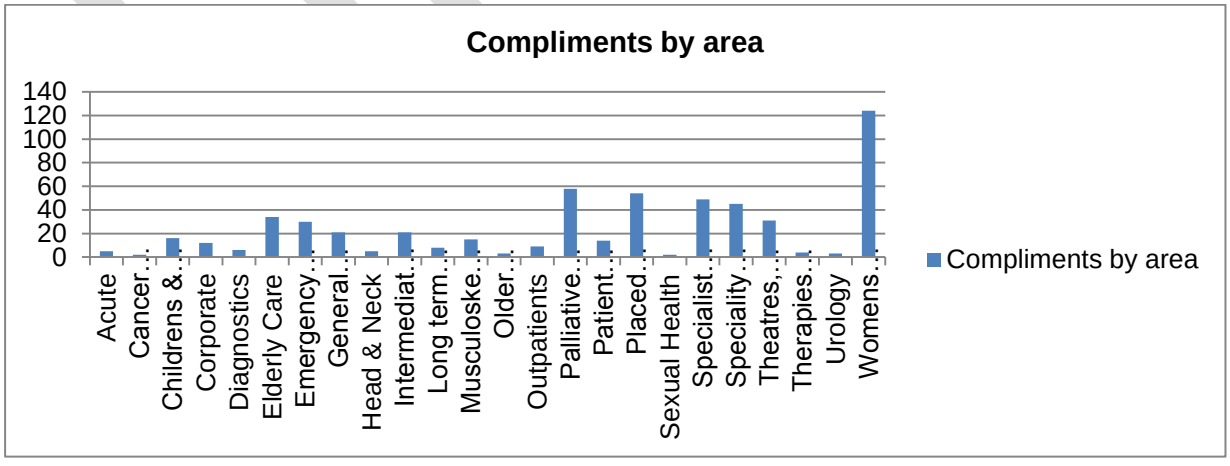
Concerns by category and type **Table 7**

The main themes identified via the number of concerns raised are clinical care, assessment and treatment (925) 27%, Appointments (910) 26% and patient access issues (appointment linked) (348), 10%.

Compliments

439 compliments were received by the Trust. Women's Services (124), Placed based teams (54), Palliative Care (50) and Specialist Services (49) accounted for the majority of compliments recorded – 64%.

Compliments **Table 8**



☺ *Please thank the staff for community nursing South team - the staff were professional, treated my dad with kindness and respect in what is and remains a very difficult time for you all*

☺ Karen is a true asset to the health in pregnancy team and I only wish I was eligible to access her services longer

☺ Ward 7 – 'From me to you, and all you do, I send this card to say thank you – to all doctors and nurses at Walsall Manor Hospital especially Ward 7 for all you have done for me'

☺ Ward 15 – 'Every person on this ward gives 100% of their profession and care, my hospital stay could not have been made any easier and a massive thank you from me and my family'

☺ West 2 Community Nurses – 'Thank you so much for all you have done for me and continue to do for me – it is very much appreciated'

☺ Accident & Emergency – 'The nurse who looked after me was very professional and caring she gave us information that was factual but in a way that did not make it too distressing, she also ensure I was comfortable and is a credit to the profession'

Complaint Satisfaction Questionnaire

Our feedback survey is based on the 'I' statements outlined in the Parliamentary Health Service user-led vision. Answers are requested using a scale of 0-5 with 0 as completely disagree and 5 completely agree. Feedback received is outlined as follows based on 10% return rate (38 responses):

- Making a complaint was straight forward : 87%
- I knew I had the right to complain: 97%
- I knew that my care would not be compromised by making a complaint: 82%
- The staff who spoke to me regarding my complaint were polite and helpful: 87%
- My complaint was acknowledged within 3 working days: 85%
- I was informed about the complaints process: 90%
- I was informed of any delays and updated on the progress: 90%
- I received a resolution in a time period that was relevant to my particular case and complaint: 73%
- I am happy with my overall response time to my complaint: 74%
- I feel the Trust has taken my comments on board and have made changes to improve the things that I was unhappy with: 79%
- I would complain again if I felt the need to: 87%

Equality Monitoring

An equality monitoring form is in place and is issued at the point of acknowledgement with 5% (18) returned in 2019/2020. Key highlights:

- 33% of service users who responded to our survey where White British, the remaining 11% where British Asian, 5% Bangladeshi, Black British and White Irish, Romany Gypsy/Traveller and Afghan.
- 88% of all service users who responded to our survey where age 51 plus (51-60, 61-70, 71-80 and 81 and over. Only 12% where under 30.
- 50% of service users stated their religion was Christianity, 11% Islam, and 17% did not wish to say, or had no belief.
- 39% of responses were received from females, 33% men and 11% did not wish to state.
- 62% of patients who responded were heterosexual, 11% Homosexual Male, 5% did not wish to state.
- Relationship status was varied, with the highest response being married (40%) 16% Living with a partner, single 17%.
- Of those who responded NIL were pregnant at the time of making a complaint with no respondent stating they had recently given birth.
- 73% of respondents would consider themselves not to have a disability. 16% stated they had a disability namely physical impairment, long term illness and a mental health need.

7 National Patient Safety Alerts

The Department of Health and its agencies have systems in place to receive reports of adverse incidents and to issue Alert Notices and other guidance where appropriate. These alerts provide the opportunity for Trusts to identify deficiencies in their systems and to correct them by learning lessons from identified risks. All NHS bodies have a duty to promptly report adverse incidents and take prompt action on receipt of Alert Notices.

For the period 1 April 2019 to 31 March 2020 the Trust has been issued with a total of 9 Patient Safety Alerts (PSA) from the Central Alerting System. Two of these alerts have been completed in line with the stipulated completion periods. 5 remain ongoing with work in progress no delays are anticipated for completion within the timescales. There are 3 outstanding alerts that have breached the implementation date and work is progressing to close these in line with the recommendations.

8 Learning from Excellence

If we can learn when things go wrong, shouldn't we be able to learn when things go right?

This is the premise behind Learning from Excellence (LfE). Inspired by initiatives in local Trusts (notably Birmingham Children's Hospital) and now gaining national recognition, we have adapted our incident reporting system as a means to capture "Excellence Nominations". Staff can quickly enter the details of an individual or team who have excelled.

During 2019/20, there were 244 Excellence nominations made:

- 30 in Adult Community,

- 56 in Medicine and Long Term Conditions,
- 53 in surgery and
- 97 in Women's Children's and Clinical Support services.
- The remaining nominations were spread across the corporate services including Estates and Facilities.

9 Patient Safety Walkabout visits

Walsall CCG visits the Trust routinely to assess standards of care in clinical services and support the Trust to achieve continuous improvement across all services. As in all patient safety walkabout visits, where initial feedback is provided to the visited areas. Once the formal report is received from the CCG it is disseminated to the appropriate areas and divisions.

The reports are reviewed and where any issues have been identified then actions are agreed within the Divisions to address the issues. Patient safety walkabout visit reports are discussed at divisional meetings and at a Trust Committee level via the Quality Patient Experience and Safety Committee.

Healthwatch Walsall is included as a key member of the Ward Review team who undertake unannounced visits to each ward at least annually to assess the ward against the five key domains of the CQC framework. Repeat visits are undertaken where standards fall short or where a ward requires a level of support to achieve improvement. The Ward Review report is seen by the Quality Patient Experience and Safety Committee every six months.

All members of the Trust Board are invited to take part in walkabout visits each month across the Hospital divisions and Community services using this as an opportunity to seek and provide feedback to the range of areas visited.

10 Mortality Review Process

The Trust Mortality Policy has been reviewed and revised to link the Learning from Deaths Policy with the Trust Safeguard Governance Process. Reviews are consultant-led and follow the Structured Judgment Review (SJR) process. Lessons learnt and areas of good practice are discussed first within Care Groups then at the Mortality Surveillance Group. A serious incident investigation is conducted for cases where the SJR identified sub-standard care with dissemination of lessons learnt via the monthly mortality report.

The Trust Mortality Surveillance Group is chaired by the Medical Director and reports to the Quality, Patient Experience and Safety Committee. There is representation from Walsall CCG and the group reviews the mortality dashboard, peer benchmarks, HSMR, crude mortality rate and other indicators monthly. The group decides monthly where trends require investigation, and allocates ownership as necessary.

11 Implementation of priority clinical standards for 7 day services

We will continue to implement extended working in a number of areas through new service delivery models. It has been determined that there are four priority clinical standards of the suite of ten that are considered to have the greatest impact on the quality of care patients receive, these are:

- Time to first consultant review
- Availability of diagnostics
- Consultant led interventions
- On-going consultant review.

Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.

This standard was not met by the Trust at the last submission (Autumn 2019), however as part of a trust-wide medical workforce programme (MWP) of work the clinical teams are engaged in 4 key focus groups overseen by a formal programme board. The objectives of the MWP is to undertake a full workforce review to ensure effective utilisation of resources, understand the workforce requirements of each specialty to sustain services. A particular focus will be to provide 7 day medical workforce resources.

Standard 5: the availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales: is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients. The Trust met this standard with the exception of MRI. Patients requiring MRI within this time frame would not be managed at the trust and would be redirected to a MTC as per network agreements.

Standard 6: timely 24-hour access 7 days a week to nine consultant- directed interventions. The Trust achieved this standard via a combination of inhouse and off site arrangements.

Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

Cardiology and acute medicine are meeting this standard by delivering a consultant-led ward round. A business case to support further medical speciality ward rounds on Sunday has been developed. Women's and Children's services have met this standard.

T&O have introduced Consultant ward rounds over the weekend and weekend cover with Consultants onsite from 9.00 am to 9.00 pm and 9.00 pm to 8.30 am non-resident.

Non Elective Services - Trauma and Orthopaedics are planning the addition of x3 ACP's to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon- Sun.

12 Focus on Patient Experience

Undertake the NHSI Patient Experience Improvement Framework self-assessment and develop actions following self-assessment to ensure compliance against the framework is achieved

- Undertake the self-assessment with clinical groups using the NHSI Patient Experience Improvement Framework.
- To identify 3 key elements from the self-assessment and develop action plans for implementation.

Improve patient, carer and service user involvement in co-designing service improvements including ED & UCC New Build, OP, Cancer Services and Catering.

- Adopt new virtual ways of interacting with wider audiences in an inclusive way.
- Develop Patient Panels with specific services to improve services for patients and families.

Review and refresh the Patient Experience & Involvement Strategy.

- Working in collaboration with staff, patients, carers and wider community with wide consultation.

Develop a Patient Partnership Counsel to ensure the Trust works collaboratively with patients, service users and carers to deliver the Patient Experience & Involvement Strategy.

Develop a structured programme to learn from our 'Hear2Care' Patient Experience Stories.

- Facilitating improvement initiatives with Divisions, Care Groups and front line staff.

Customer Care

Making Customer Care 'Everyone's Business'.

We will produce a customer care guide for staff that underpins the values of the organisation. The aim of the guide is to develop a set of core and supporting standards to ensure that every patient or visitor of our Trust receives an outstanding service which reflects excellence in care.

The Trust has previously piloted a 'Values Based Customer Care Programme' and it is intended that this is re-launched and rolled out as quickly as possible subject to resources.

Values Based Customer Care

The pilot programme will be reviewed prior to roll-out with the intention of empowering staff and teams to deliver and own standards of customer care applicable to them, using the staff guide as a reflection of the Trust values and expectations. The Trust Induction Customer Care session has already been revised to reflect the Trust values and is the preferred approach to engaging staff at the on-set of appointment.

Measures:

- Reduction in number of complaints and concerns
- Increase in satisfaction via the in-patient survey
- FFT local measures to reflect WHNHST as place of choice

13 NHS Staff Survey

The 2019 NHS Staff Survey benchmark report for Walsall Healthcare NHS Trust contains the results of the 2019 NHS Staff Survey. This year the results of the survey have been collated into eleven themes (see below) with team working as a new category. The results are presented in the context of the best, average and worst results for similar organisations, for Walsall Healthcare NHS Trust the benchmark group is Acute and Community Trusts.

1. The response rate for the Trust was 31% against 46% for the national average for the benchmark group. Completed questionnaires 1,299, 2019 response rate 31%.

2. The benchmark report shows a statistically significant lower score for equality, diversity & inclusion between 2018 and 2019.

3. The benchmark report shows a statistically significant lower score for immediate managers between 2018 and 2019.

4. The benchmark report shows no significant change on the remaining nine of eleven themes between 2018 and 2019.

5. The benchmark report shows stability on nine of the eleven themes detailed below between 2018 and 2019.

The themes are as follows:

- Equality, diversity & inclusion – decline
- Health & wellbeing – stable
- Immediate managers – decline
- Morale – stable
- Quality of appraisals - stable
- Quality of care - stable
- Safe environment - Bullying & harassment - stable
- Safe environment - Violence - stable
- Safety culture – stable
- Staff engagement – stable
- Team working - new

14 Freedom to Speak Up

Sir Robert Francis' review of whistleblowing in the NHS, 'Freedom to Speak Up' (FTSU), was published in February 2015.

'Freedom to Speak Up 'concluded that the NHS does not consistently listen or act on concerns raised by whistle-blowers and that some individuals have suffered detriment as a result of raising concerns. The review set out a number of principles for NHS organisations to adopt in order to ensure that NHS staff are encouraged and supported to share concerns. The report established the Freedom to Speak Up Guardian role as a way of encouraging and supporting speaking up. All NHS Trusts and NHS Foundation Trusts were required by the NHS contract (2016/17) to nominate a Freedom to Speak Up Guardian.

The Trust has three established Freedom to Speak Up Guardians, all of whom are clinicians and between them work with the Trust Board to develop a culture within the Trust where openness, transparency and speaking up is encouraged and recognised as a way of supporting patient safety and care. The Trust Guardians report to the Chief Executive Officer, have an established Non-executive Board Director lead and an Executive Board Director sponsor to help them develop the approach within the Trust. Effective speaking up arrangements are important to help to protect patients and improve the experience of NHS workers. The Care Quality Commission (CQC) assessed the Trust's speaking up culture during its well-led inspection during March 2019. The speaking up agenda goes some way towards enabling the trust to meet key priorities of improving patient safety and developing the culture of the organisation.

During the period April 2019 to January 2020 a total of 80 concerns were raised to Trust Guardians, indicating that staff are confident to use internal routes to speak up for help and support to ensure action is taken. Of the concerns raised, 55% related to quality and safety, 10% to patient experience and 9% on policy, process and procedure. The Trust has an area in its Safeguard incident reporting system for FTSU concerns and receiving feedback on actions taken, which includes the ability to report anonymously.

The Freedom to Speak Up Guardians and Trust Board reviewed the approach to speaking up within the Trust in order to learn from experience and develop an action plan to improve the service provided, and during 2019 and 2020 has been working on developing practice and learning from best practice with the support of NHS Improvement.

Part 4: Statements from our stakeholders

Walsall CCG

NHS Walsall Clinical Commissioning Group is pleased to have had the opportunity to review the draft Quality Account 2019/2020 for the Walsall Healthcare NHS Trust and considers that this Quality Account is a true reflection of the work undertaken.

The CCG wishes to acknowledge the hard work and commitment to improvement in quality and CQC rating. We would like to congratulate the Trust on their CQC 'Care' rating of 'Outstanding' in July 2019, progress with the Care for Walsall Together Strategy and the improvements seen in Maternity Services.

The CCG acknowledges the Trust's achievements against Quality Standards during 2019/20 and welcomes the Trust's achievements related to National Core Quality Indicators including reducing the prevalence of falls and grade 3 and 4 category pressure ulcers, Friends and Family Test feedback, complaints feedback and ensuring that all standards applicable to mortality reviews and learning from deaths have been met.

The CCG notes the progress made against the Trust's Priorities for Improvement for 2019/20 including; the appointment of a Professional Lead for Quality, Care Excellence Strategy, Quality Improvement Academy and the Values Based Programme with reference to the John Lewis approach.

The CCG supports and welcomes the Priorities for Improvement for 2020/21 including; a 10 percent reduction in the prevalence of falls, the introduction of the Complaints Investigation Support Hub and the focus of the FORCE team on further COVID-19 studies and vaccine studies.

The CCG recognises however that there areas needing further work including; Serious Incident management, compliance with Mandatory Training requirements, specifically Safeguarding Level 3, Cancer Harm Reviews, and the sustainability of full health economy checks and reviews via MASH management.

We recognise the Trust's commitment to working closely with commissioners and the public to ensure the ongoing delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Appendix 1 – Summary of findings - CQC report

The Trust was inspected in February 2019, and the following core services were visited

Between 4 and 6 February 2019, CQC inspected the core services of critical care and medicine.

Between 11 and 13 February 2019 CQC inspected urgent and emergency care, surgery and maternity.

Between 25 and 26 February 2019 CQC inspected community sexual health services.

The CQC carried out the well led review from 19 March to 21 March 2019.

The CQC report was published in July 2019 during their inspection saw a number of areas of improvement and outstanding practice, and gave the Trust a rating of requires improvement, and recommended the Trust be removed from special measures.

The CQC found areas of outstanding practice across the Trust, however also highlighted areas for improvement including seven breaches of legal requirement, and also found 59 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of its services

Areas of improvement that the Trust must improve:

Ensure compliance with the requirements of the fit and proper person's regulation. (Regulation5).

Ensure the effectiveness of governance arrangements and the board is consistently informed of and sited on risks. (Regulation17).

Must improve mandatory and safeguarding training compliance for all urgent and emergency care staff. (Regulation 18).

The trust must ensure all staff have regard for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2010 when assessing patients and delivering care, including ensuring mental capacity assessments are detailed, compliant with legislation and best practice, and is undertaken in away and at a time that recognises patient's abilities.(Regulation11).

The medical service must have systems in place to maintain safe staffing ratios and skill mix on medical wards. (Regulation18).

Ensure staffing levels on surgical wards are safe and reduce the risk of patient harm. This includes reviewing, monitoring and recording patient acuity (Regulation18: Staffing).

The trust must ensure the care and treatment provided to patients is safe.

This includes keeping up to date patient care records, adherence to infection prevention and control practices and systems and processes which prevent never events (Regulation12: Safe care and treatment).

Critical Care Must ensure the staffing cover provided by the critical care outreach team complies with required standards.

The trust should take to improve:

Urgent and Emergency Care should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients.

Should consider replacing old or missing equipment in the urgent and emergency department.

The medicine service should ensure that all intravenous fluids are always securely stored in locked cupboards.

The medicine service should monitor mandatory training and safeguarding rates to ensure that the trust targets are met.

The medicine service should use audits to monitor and improve the quality of the service.

The trust should ensure all staff are given an appropriate handover when starting or covering shifts.

Thetrustshouldensureanystoreroomwheremedicationisstoredislockedanddoorsareclosed.

The trust should ensure all surgical staff comply with the World Health Organisation checklist and the five steps to safer surgery.

The trust should ensure medical and nursing staff are compliant with all mandatory training.

The trust should ensure all patients receive care which protects their privacy and dignity.

The trust should consider that all incidents are reported promptly.

The trust should consider monitoring the performance in relation to sepsis management.

The Trust should consider recording all risks on the relevant risk registers and are understood and mitigated appropriately.

The trust should consider improving the process of collecting, analysing, managing and using data in relation to the surgical assessment unit and surgical sterilisation unit to support and improve performance.

Consider improving mandatory training compliance levels for medical staff to comply with trust targets.

Consider improving ways to monitor and drive improvement for non-compliance with infection prevention and control practices.

Consider updating all critical care policies to ensure they are up to date.

Consider providing information to patients and those close to the in different languages.

Consider giving patients the option to use patient diaries.

Consider Reporting Data for All quality indicators to the Intensive Care National Audit and Research Centre (ICNARC).

Consider auditing the performance of the critical care service against the Guidelines for the Provision of the Intensive Care Services (GPICS) standards to assess areas of compliance and non-compliance.

Consider exploring the range of pathway options for patients requiring discharge from the critical care unit to expedite discharge.

Consider supporting a patient forum group for the service to enable patients and their relatives to provide feedback and views on any aspect of their experience during their care and treatment.

The maternity service should ensure all staff are fully compliant with infection prevention control procedures.

The maternity service should ensure all inpatient staff have enough basic equipment such as fetal monitoring machines and thermometers to carry out their roles effectively.

Ensure all surgeons attend all crucial stages of the surgical safety checklist.

The maternity service should ensure complaints are investigated and closed in line with their complaints policy.

Ensure the maternity risk register is kept up to date.

The maternity service should ensure they always follow best practice when prescribing, giving, recording and storing medicines.

The maternity service should ensure it closes all complaints in the timeframe set out in the service wide complaints policy.

The maternity service should encourage managers to utilise the mechanisms in place to manage risk.

Should ensure car parking at the sexual health satellite clinic is controlled in a way that does not present a safety risk to occupants of the clinician emergency evacuation.

Should review health and safety monitoring and practices to reduce the risk of injury, abuse and violence to staff for community sexual health staff.

Should improve monitoring of appointment cancellations for community sexual health to address trends.

Should review arrangements for trust-level and senior management communication with community sexual health.

Staff to ensure they feel supported and have access to managers during periods of change and high levels of pressure.

Should address the negative views held by staff of the working culture and vision and strategy of the trust.

For the overall trust:

The trust should ensure there are appropriate processes in place to investigate and learn from patient deaths.

The trust should ensure that duty of candour processes are followed and that families have the opportunity to meet with representatives of the trust where there has been harm.

The trust should ensure that there are suitable processes in place for patients detained under the Mental Health Act 1983 that ensure detentions are legal and their rights are protected.

The trust should ensure that there are networks in place to support and promote staff equality and diversity.

Appendix 2 – Mandatory indicators

NHS Outcomes Framework Domain 1

Title	Indicator	2018/19		2019/20		National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Summary Hospital Mortality Indicator (SHMI)	a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period;	Apr-18	121.88	Apr-19	97.89	1.00 (100)	Latest position – Jul 20 Issue (Mar 19 – Feb 20) <u>Highest Performing Trust</u> – University College London Hospitals NHS Foundation Trust (0.68) <u>Lowest Performing Trust</u> – The Rotherham NHS Foundation Trust (1.19)
		May-18	119.98	May-19	100.07		
		Jun-18	117.74	Jun-19	109.21		
		Jul-18	91.9	Jul-19	110.40		
		Aug-18	108.33	Aug-19	113.09		
		Sep-18	113.39	Sep-19	120.68		
		Oct-18	105.13	Oct-19	117.14		
		Nov-18	100.53	Nov-19	107.11		
		Dec-18	103.26	Dec-19	109.39		
		Jan-19	118.39	Jan-20	96.35		
		Feb-19	113.36	Feb-20	94.71		
		Mar-19	121.62	Mar-20	NA		

	b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	April 2018 to March 2019 = 31%	Latest Position (March 2019 to February 2020) = 29%	Latest Position (March 2019 to February 2020) = 37%	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		The data reported represents the trusts performance against the national benchmarks. The data represents deaths occurring across primary and secondary care. Variances in performance represent the health demographics of the population, seasonal trends in keeping with the national picture. The trust has not reported any CUSUM alerts for this period.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:		See section 2.4		

NHS Outcomes Framework Domain 3

Title	Indicator PROMs case mix-adjusted scores	TRUST 2018/19 Adjusted average health gain		TRUST 2019/20 (Apr to Sept) Adjusted average health gain		National Average 2018/19 Adjusted average health gain		Upper and Lower 95% control limit for the Trust Health Gain
Patient Recorded Outcome Measures **(PROMS)**	(i) groin hernia surgery	No longer measured		No longer measured		N/A		N/A
	(ii) varicose vein surgery	No longer measured		No longer measured		N/A		N/A
	(iii) hip replacement surgery	EQ5D	0.411	EQ5D	0.50	EQ5D	0.50	N/A
		EQVAS	13.338	EQVAS	13.929	EQVAS	13.8	
		OHS	19.434	OHS	24	OHS	22	
	(iv) knee replacement surgery	EQ5D	0.281	EQ5D	0.54	EQ5D	0.3	N/A
		EQVAS	2.557	EQVAS	11.810	EQVAS	7.5	
		OKS	15.778	OKS	20.35	OKS	17	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	Oxford Hip Score (OHS) is a validated tool for the measurement of pain and function related to hips before and after replacement surgery. The lower the score the worst outcome perceived by the patient. (Worst pain and function 0 – 48 Best pain and function. It also affected by the overall health state of the patient and as the general population in Walsall has high levels of deprivation this is reflected in the EQ5D measurement.						
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	• New Patient Information Booklets that include up-to-date information regarding why PROMs is collected and why it is important to the patient and the Trust. • Joint School recommenced November 2017 and subsequently capacity was increased from March 2019 to ensure availability						

		for patients to attend. Joint School presentation mirrors the Patient Information Booklet regarding PROMs participation; in addition the MSK data clerk attends and supports to assist improved submission rates. • Pre-operative Assessment Clinics are collecting, monitoring and both the HIP & Knee Booklets to the performance Department for entry onto the database. A second opportunity is made available to capture any missed data at Joint school. • We communicate with the National Proms team to discuss ways of improving PROMs participation rates, including attending their regional events. Information Leaflets in different languages are available via the PROMS Website and link given to the Pre-operative Services. • We attend the Yearly National PROMS summit to learn from other Trust Experience. • Future audits looking at PROMS and variations of outcomes are planned for 20/21.

<table>
<tr><th>Title</th><th>Indicator</th><th colspan="3">2018/19</th><th colspan="3">2019/20 (April 2019 to August 2019)</th><th>National Average</th><th>Highest and lowest NHS Trust and FT scores for the reporting period</th></tr>
<tr><td rowspan="14">Readmission rates</td><td rowspan="14">The percentage of patients aged
(i) 0 to 15; and
(ii) 16 or over,
Re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of</td><td></td><td>0 to 15</td><td>>=16</td><td></td><td>0 to 15</td><td>>=16</td><td rowspan="14">N/A</td><td rowspan="14">N/A</td></tr>
<tr><td>Apr-18</td><td>8.26%</td><td>11.61%</td><td>Apr-19</td><td>9.84%</td><td>11.57%</td></tr>
<tr><td>May-18</td><td>8.52%</td><td>11.34%</td><td>May-19</td><td>8.64%</td><td>12.71%</td></tr>
<tr><td>Jun-18</td><td>9.56%</td><td>10.29%</td><td>Jun-19</td><td>9.62%</td><td>12.36%</td></tr>
<tr><td>Jul-18</td><td>6.20%</td><td>10.56%</td><td>Jul-19</td><td>8.35%</td><td>11.97%</td></tr>
<tr><td>Aug-18</td><td>6.52%</td><td>11.23%</td><td>Aug-19</td><td>9.79%</td><td>13.15%</td></tr>
<tr><td>Sep-18</td><td>8.05%</td><td>11.17%</td><td>Sep-19</td><td>9.29%</td><td>11.61%</td></tr>
<tr><td>Oct-18</td><td>7.40%</td><td>11.75%</td><td>Oct-19</td><td>10.10%</td><td>11.20%</td></tr>
<tr><td>Nov-18</td><td>8.81%</td><td>10.84%</td><td>Nov-19</td><td>10.41%</td><td>11.92%</td></tr>
<tr><td>Dec-18</td><td>6.95%</td><td>11.55%</td><td>Dec-19</td><td>9.04%</td><td>11.67%</td></tr>
<tr><td>Jan-19</td><td>9.36%</td><td>10.85%</td><td>Jan-20</td><td>12.87%</td><td>11.76%</td></tr>
<tr><td>Feb-19</td><td>12.41%</td><td>10.60%</td><td>Feb-20</td><td>10.94%</td><td>10.33%</td></tr>
<tr><td>Mar-19</td><td>11.33%</td><td>11.74%</td><td>Mar-20</td><td>N/A</td><td>N/A</td></tr>
<tr><td colspan="4">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="5">The figures provided above are taken from HED and based off the number of spells per month and the number of emergency readmissions within 28 days</td></tr>
<tr><td colspan="4">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="5">- In depth analysis is to be undertaken during the coming months to review emergency readmissions to establish trends and identify patients with high number of admissions.
- The community services review all frequent admissions known to their caseloads and have demonstrated a reduction in admissions over the past year. Following a revised methodology to determine the performance for readmissions a robust piece of work will be undertaken in Month 6 to analyse trends and determine strands of work to be undertaken to review causation for key cohorts of patients.
- In line with this, work will be developed to link the work currently being done in the community around frequent admissions to those who are readmitting within 30 days to aid a better understanding of why these patients are frequently being admitted.</td></tr>
</table>

NHS Outcomes Framework Domain 4

Title	Indicator	2017 (these results relate to 2016 results which were received in 2017)	2018 (these results relate to 2017 results which were received in 2018)	2019 (these results relate to 2018 results which were received in 2019 – these results are embargoed until 20.6.2019 & do not include national benchmarking)	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Patient Survey – Responsiveness to patient's needs	The trust's responsiveness to the personal needs of its patients during the reporting period	Q32: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.6/10** Q35: Did you find someone on the hospital staff to talk to about your worries and fears? **5.1/10** Q37: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q57: Did a member of staff	Q34: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.8/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **4.9/10** Q39: Were you given enough privacy when discussing your condition or treatment? **8.2/10** Q58: Did a member of staff	Q34: Were you involved as much as you wanted to be in decisions about your care & treatment? **6.9/10** Q37: Did you find someone on the hospital staff to talk to about your worries and fears? **5.2/10** Q39: Were you given enough privacy when discussing your condition or treatment? **8.3/10** Q58: Did a member of staff tell you	Trust score about the same as national score Trust score about the same as national score Trust score about the same as national score Trust score about the	N/A

		tell you about medication side effects to watch for when you went home? **3.9/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **6.9/10**	tell you about medication side effects to watch for when you went home? **4.0/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	about medication side effects to watch for when you went home? **4.3/10** Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? **7.3/10**	same as national score Trust score about the same as national score	
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:			The Trust follows the National Survey programme for implementing the CQC surveys. The data collated is processed by National Survey Co-ordination Centre and published by CQC via their public website.		
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:			• The Friends & Family Test (FFT) provides additional insight into the views and experiences of the patients that use our services. Teams use this information in huddles, team meetings, discussions with the Patient Experience Team. Positive feedback is promoted through a weekly social media post. This boosts morale of staff. Positive feedback is also posted on the Trust Website. • Local Surveys are also used with Teams to build on FFT and national survey feedback to gain a wider understanding of the patient		

			experience and identify where improvements can be made or best practice celebrated. • Patient, Carer and Staff experience stories are shared at every Trust Board and Quality, Patient Experience and Safety Committee meetings as well as other staff and team meetings. The stories shared are either patients, carers and staff attending in person or a video/audio is played.

Title	Indicator	2018/19	2019/20	National Average	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Staff recommending the trust as a provider of care	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	49.3%	48.8%	71% (2019/2020 for Combined Acute & Community Trusts)	N/A
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	The data provided is from question 21d in the National NHS Staff Surveys 2018 and 2019 respectively. Slightly lower than the previous year. Surprising again this year as this did not reflect the much better results of the Staff FFT for the same question during Q2 prior to the National Staff Survey, published by NHS England 22/11/2019.			
	Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:	The questionnaire was sent to all colleagues and 1299 responded, equating to a 31% response rate, a decrease of 9% on the previous year. This was lower than the national average response rate of 46% for all combined acute and community trusts in England. Since the survey has taken place analysis of the results at Organisational and Divisional Level work has taken place. Agreement of priority areas for action and focus over 2020/21 - Equality, Diversity and Inclusion, Line Managers and reducing Bullying & Harassment. Divisional Boards will review local results and discuss actions they will undertake within the division across the three areas of focus. A Divisional staff experience improvement plan will be presented at Divisional Performance Boards. Updates will be provided to the People and Organisational Committee outlining progress.			

<table>
<tr><th>Title</th><th>Indicator</th><th>2018/19</th><th>2019/20</th><th>National Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="3">Patients who would recommend the Trust to their family or friends</td><td></td><td>
<table>
<tr><td>March 2019 - % Rec</td><td></td></tr>
<tr><td>Inpatients</td><td>95%</td></tr>
<tr><td>ED</td><td>78%</td></tr>
<tr><td>Outpatients</td><td>92%</td></tr>
<tr><td>Community</td><td>97%</td></tr>
<tr><td>Antenatal</td><td>100%</td></tr>
<tr><td>Birth</td><td>94%</td></tr>
<tr><td>Postnatal Ward</td><td>92%</td></tr>
<tr><td>Postnatal Comm</td><td>100%</td></tr>
</table>
</td><td>
<table>
<tr><td>January 2020 - % Rec</td><td></td></tr>
<tr><td>Inpatients</td><td>96%</td></tr>
<tr><td>ED</td><td>77%</td></tr>
<tr><td>Outpatients</td><td>91%</td></tr>
<tr><td>Community</td><td>97%</td></tr>
<tr><td>Antenatal</td><td>94%</td></tr>
<tr><td>Birth</td><td>100%</td></tr>
<tr><td>Postnatal Ward</td><td>100%</td></tr>
<tr><td>Postnatal Comm</td><td>99%</td></tr>
</table>
</td><td>
<table>
<tr><td>December 2019 - % Rec</td><td></td></tr>
<tr><td>Inpatients</td><td>96%</td></tr>
<tr><td>ED</td><td>85%</td></tr>
<tr><td>Outpatients</td><td>94%</td></tr>
<tr><td>Community</td><td>95%</td></tr>
<tr><td>Antenatal</td><td>95%</td></tr>
<tr><td>Birth</td><td>97%</td></tr>
<tr><td>Postnatal Ward</td><td>95%</td></tr>
<tr><td>Postnatal Comm</td><td>98%</td></tr>
</table>
</td><td>N/A</td></tr>
<tr><td>Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="3">The Trust follows The nationally mandated process for implementing The FFT programme.
- Data collated is submitted monthly to NHS England via UNIFY2 submissions
- FFT results are published NHS England on their public websites</td></tr>
<tr><td>Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="3">• All wards and departments display their FFT results on a weekly basis for patients, visitors and staff members.
• An IPad pilot on four wards was successful in increasing accessibility and involvement of patients with feedback activity on the inpatient wards.
• Awareness of the Quiet Protocol was promoted across the Trust in response to feedback relating to reducing noise at night, full protocol implementation is scheduled for quarter 1 of this year.
• Volunteer support has been increased across the wards and A&E to assist with activities like mealtimes, patient visiting, dementia tea parties and waiting area support.
• The Trust has joined the National Always Events® Programme which aims to optimise positive patient experience and improved outcomes for every patient every time.
• Observe & Act Tool was piloted which paves the way for using lay members to identify and co-produce service improvements.</td></tr>
</table>

NHS Outcomes Framework Domain 5

<table>
<tr><th>Title</th><th>Indicator</th><th colspan="2">2018/19</th><th colspan="2">2019/20</th><th>England Average</th><th>Highest and lowest NHS Trust and Foundation Trust scores for the reporting period</th></tr>
<tr><td rowspan="4">Venous thromboembolism risk assessments</td><td rowspan="2">The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period</td><td>Apr-18</td><td>96.34%</td><td>Apr-19</td><td>91.01%</td><td rowspan="2">Latest national position – Quarter 3 2019/2020 = 95.33% (excluding Independent Providers)</td><td rowspan="2">Latest position – Quarter 3 2019/2020

<u>Highest Performing Trust</u> – Salisbury NHS Foundation Trust (99.67%)

<u>Lowest Performing Trust</u> – Blackpool Teaching Hospital NHS Foundation Trust (74.07%)</td></tr>
<tr><td>May-18</td><td>96.28%</td><td>May-19</td><td>92.02%</td></tr>
<tr><td>Jun-18</td><td>96.50%</td><td>Jun-19</td><td>92.29%</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Jul-18</td><td>95.57%</td><td>Jul-19</td><td>93.20%</td></tr>
<tr><td rowspan="2"></td><td>Aug-18</td><td>95.08%</td><td>Aug-19</td><td>93.83%</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Sep-18</td><td>94.38%</td><td>Sep-19</td><td>93.42%</td></tr>
<tr><td rowspan="2"></td><td>Oct-18</td><td>94.63%</td><td>Oct-19</td><td>92.06%</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Nov-18</td><td>95.11%</td><td>Nov-19</td><td>92.26%</td></tr>
<tr><td rowspan="2"></td><td>Dec-18</td><td>94.67%</td><td>Dec-19</td><td>88.87%</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Jan-19</td><td>95.00%</td><td>Jan-20</td><td>92.61%</td></tr>
<tr><td rowspan="2"></td><td>Feb-19</td><td>93.61%</td><td>Feb-20</td><td>94.04%</td><td rowspan="2"></td><td rowspan="2"></td></tr>
<tr><td>Mar-19</td><td>91.94%</td><td>Mar-20</td><td>90.75%</td></tr>
<tr><td></td><td colspan="3">Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:</td><td colspan="4">This data is reflective of the trust performance for VTE assessment of all appropriate admissions as determined by the use of a robust methodology for determining the performance developed and embedded since March 2017.
• The improved performance represents the use of a single electronic data sources for adult and maternity services and strategies supported by senior clinical and nursing team members to embed a revised system and process.</td></tr>
<tr><td></td><td colspan="3">Walsall Healthcare NHS Trust has taken the following actions to improve this number, and so the quality of its services, by:</td><td colspan="4">• See section 2.3 for a description of the actions taken</td></tr>
</table>

Title	Indicator	2018/19	2019/20	National Average (2017/2018)	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
C. difficile infection	The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	12.18	21.23	13.7	Not available
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:		- The Trust has a process in place for collating data on C Difficile cases - data collated internally and submitted monthly to Public Health England		
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate, and so the quality of its services, by:		For 2019/20 WHT trajectory was no more than 26 cases. This is an increase on the trajectory from 2018/19 but this is due to changes in the criteria used for assignment of cases. For 2019/20 a case will be classified as an acute case if the stool sample is taken the day of admission, plus 1 day; whereas in 2018/19 it was day of admission plus 2 days. In addition a new criteria has been added this year which means any patient who has been in WHT in the last 4 weeks will also count as a WHT case. Please refer to section 2.6		
	Data source		Combined monthly snapshot in line with KH03 definition		

Title	Indicator	2018/19 (April – Sep 2018)	2019/20 (April – Sep 2019) The latest data available	National Average (April – Sep 2019) The latest data available	Highest and lowest NHS Trust and Foundation Trust scores for the reporting period
Incidents	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period,	5,628 incidents reported and equating to 74.5 incidents per 1,000 bed days	5,993 incidents reported and equating to 78.5 incidents per 1,000 bed days	6,276 incidents reported and equating to 50 incidents per 1,000 bed days	21,685 incidents reported by University Hospitals Birmingham NHS Foundation Trust and equating to 48.0 incidents per 1,000 bed days. Whittington Health NHS Trust reported 1,392 incidents which equates to 27.8 incidents per 1,000 bed days.
	the number and percentage of such patient safety incidents that resulted in severe harm or death	18 0.3%	32 0.6%	19.4 0.3%	95 incidents (0.5%) – University Hospitals Birmingham NHS Foundation Trust 0 incidents (0.0%) – Airedale NHS Foundation Trust
	Walsall Healthcare NHS Trust considers that this data is as described for the following reasons:	• The data is provided by the National Reporting and Learning System (NRLS)			
	Walsall Healthcare NHS Trust has taken the following actions to improve this rate (for incident reporting) and number (of incidents that result in severe harm or death) and so the quality of its services, by	• Continuing to promote incident reporting through patient safety workshops and by providing feedback to staff on incidents reported and action taken as a result. This is reflective in the increased number of incidents reported per 1,000 bed days compared to the previous Quality Account			

Appendix 3: Statement of director's responsibilities in respect of the Quality Account

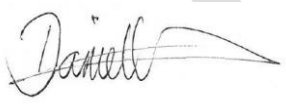
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the trust's performance over the reporting period
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Account has been prepared in accordance with any Department of Health guidance

The directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board,



Danielle Oum
Chair

Richard Beeken
Chief Executive

Appendix 4 Glossary

For those readers who are not familiar with some of the terminology used in this document, the table below offers some explanation of abbreviations that have been used:

Abbreviation	Description
A&E	Accident and Emergency (see ED)
C. difficile	Clostridium difficile
CCG	Care Commissioning Group
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
DNAR	Do not attempt resuscitation
DSPT	Data Security and Protection Toolkit
ED	Emergency Department (see A&E)
FFT	Friends and Family Text
GP	General Practitioner
HED	Healthcare Evaluation Data
HRG	Health Resource Group - a grouping consisting of patient events that have been judged to consume a similar level of resource.
HSMR	The Dr Foster Hospital Standardised Mortality Ratio
ICNARC	Intensive Care National Audit and Research Centre
IDDSI	International Dysphagia Diet Standardisation Initiative
ITU	Intensive Therapy Unit
LeDeR	Learning Disabilities Mortality Review
LfD	Learning from Deaths
LfE	Learning from Excellence
LiA	Listening into Action
MAC	Medical Advisory Committee
MCA	Mental Capacity Act 2005
MMC	Medicines Management Committee
MCCD	Medical Certificate Of Cause Of Death
MRI	Magnetic Resonance Imaging - a technique to take a cross sectional image of a patient
MRSA	Meticillin Resistant Staphylococcus Aureus
MRSA BSI	Meticillin Resistant Staphylococcus Aureus Blood Stream Infections
MTI	Medical Training Initiative
MUST	Malnutrition Universal Screening Tool
NDG	National Data Guardian
NEWS2	National Early Warning Score. This is the latest version which advocates a system to standardise the assessment and response to acute illness.

Abbreviation	Description
NFA	No Fixed Abode
NIHR	National Institute for Health Research
NNU	Neonatal Unit
NQB	National Quality Board
NRLS	National Reporting and Learning System
OPAT	Outpatient parenteral antibiotic therapy
OPD	Outpatient Department
PALS	Patient Advice & Liaison Service
PE	Pulmonary embolism – a blood clot in the lung
PEG	Passionate for Engagement Group
PGD	Patient Group Directives - Who can supply and or administer specific medicines to patients without a doctor under a PGD and which medicines can be administered
PHSO	Parliamentary and Health Service Ombudsman
QSIR	Quality, service improvement and redesign
R&D	Research and development
RCP	Royal College of Physicians
SAS doctor	Includes staff grade, associate specialist and specialty doctors* with at least four years of postgraduate training, two of which are in a relevant specialty. SAS doctors are a diverse group with a wide range of skills, experience and specialties
SALT	Speech and Language Therapy
SHMI	Standardised Hospital Mortality Indicator – this looks at the relative risk of death of all patients managed by the Trust and includes the period up to 30 after discharge.
SI	Serious Incidents
SJR	Structured Judgment Review
SOP	Standard Operating Procedure
SPECT	Single-photon emission computed tomography – a technique to take a cross sectional image of a patient
TC	Transitional Care (between the Neonatal Unit and the post-natal ward)
TMB	Trust Management Board
VTE	Venous Thromboembolism
WHO	World Health Organisation
WMAHSN	West Midlands Academic Health Science Network
WMAS	West Midlands Ambulance Service
WMQRS	West Midlands Quality Review Service

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Walsall Together Partnership Board Highlight Report			**AGENDA ITEM: 11.1** **ENC: 11**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Anne Baines - Non Executive Director.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The report provides the key messages from the Walsall Together Partnership Board meeting on 23rd September 2020. The key points for the attention of the Board are: - The Director of Public Health, Walsall Council provided a COVID-19 updated, giving credit to regulatory services, community teams and ongoing community support for the fact there has not been large outbreaks in the community. - An enhanced care homes support delivery model was approved which demonstrates the additional benefit that the Walsall Together Alliance can bring to transforming community based services. The approach taken to care homes during COVID-19 by Walsall Together was recently cited as good practice in the national Social Care Taskforce Report. - There are growing concerns about the requirement for staff going into homes to have weekly COVID-19 swabbing, since Community Services are unable to access the swabs to implement this. It raises concerns about the viability of the commissioned strategy to support care homes over the winter, and will be added to the risk register. - Significant pressures are being placed on mental health services, with unprecedented numbers presenting to accident and emergency. Discussions will continue on how the partnership can assist the mental health partnership to address this.		
Recommendation	Members of the Board are asked to note the report.		
Risk in the BAF or Trust Risk Register	This report aligns to the BAF risks for Care at Home (S02) and COVID-19 (S07)		
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 23rd September 2020, with the meeting Chaired by Mrs Anne Baines, Committee Chair and Non-Executive Member of the Walsall Healthcare Trust Board.

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

1. Patient Story/User Update

Walsall Housing Group highlighting the integrated work that is being undertaken as part of their Social Prescribing model, which is aimed at reducing social isolation and improving the physical and mental health of their customers.

A user story presented to the Partnership Board illustrated the use of the "what matters to me" approach under the Social Prescribing model, with the focus being placed on the customer, with bespoke actions put in place for their particular needs. The Partnership Board heard of a range of actions introduced for one individual that included help with communication tools to contact family, do online shopping and socialise; assistance with utility providers; referrals for home adaptations; fire safety checks; and a pendant alarm. The Partnership Board commended the work of the Walsall Housing Group and recognised the significant improvements this brought to their customers with relatively small investment.

2. Operational Update

Key performance indicators were reviewed for partners noting:

- Referrals to the care coordination service remain higher than at the start of the year
- This work is being absorbed by the Rapid Response Team with increased support provided by the Locality Teams
- The numbers of patients at Walsall Manor Hospital who are medically stable remain at a significantly reduced level
- The Decision Support Tool process has been resumed but the backlog clearance for people predominantly in care homes will take >4 months
- In care homes, resident numbers have started to increase slowly and deaths have returned to normal levels

There are concerns about the requirement for staff going into homes to have weekly COVID-19 swabbing, since Community Services are unable to access the swabs to implement this. It raises concerns about the viability of the commissioned strategy to support care homes over the winter. This has been added to the risk register as one of the primary risks.

Partner restoration and recovery activities were discussed, noting the increase in demand for both primary care and mental health services.

3. Programme Update

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. The following exceptions are reported:

- Approval of the Tier 0 – Resilient Communities – Plan is overdue; an updated position will be provided following a workshop with key stakeholders to be arranged for as soon as possible in September or early October;
- The above delay is impacting on the Grant Funding Programme within Resilient Communities and this is currently showing as a delayed start;
- The integration of primary and community mental health services is delayed; Black Country Healthcare have paused their transformation initiatives during COVID-19.

The Partnership Board received an overview of health inequalities in the context of the partnership and how deliverables in the plan are prioritised according to their importance in delivering integrated care and reducing health inequalities. These priorities include the deployment of the population health module, creating a living directory for community and voluntary services and ensuring there is a robust, single model for social prescribing in Walsall. It was agreed that the focus on health inequalities needed to be more prominent and run as the golden thread through everything the partnership does. There is currently an analysis underway of population health needs which will inform the population health strategy in this regard.

4. Winter Plan and Flu Arrangements

A winter planning sub-group has been established to synthesise what planning is to be delivered and how it is to be resourced. Current focus is on hospital discharge services and the social care COVID-19 winter response plan.

5. Walsall Palliative Care Services

The addition of the 12 beds at Goscote was recognised as an opportunity to enhance the partnership's end of life pathways, and partners are working closely with Compton CCG to strengthen integration in this regard.

6. Enhanced Support in Care Homes

The Partnership Board approved an approach to a system-wide and integrated overall delivery model for enhanced support to care homes in Walsall, commending the primary, community and care home integration in the model.

The delivery model draws upon lessons learned from the COVID-19 response to date and aims to establish the programme of enhanced support for care homes as a formal programme as part of the Walsall Together Partnership. This includes a consolidation of the current support arrangements to reduce duplication and to make more effective use of the overall level of resources by improving the extent of co-ordinated and multi-disciplinary working.

There was support in principle from the CCG on the funding aspects of the model which are currently covered by COVID-19 funding, and the Partnership Board noted that this would be the subject of internal governance to commit to additional resources.

7. Walsall Together Branding

The Partnership Board were pleased to approve the new branding for Walsall Together, the logo of which is set out below:

Walsall Together

8. Risk Register

The Partnership Board operates within the governance arrangements of Walsall Healthcare Trust as Host Provider. Each organisation retains its statutory responsibilities and accountability for risk management, as outlined in the Alliance Agreement. Partner organisations were requested to share sections of their corporate/strategic risk registers that are pertinent to the partnership in order that the Partnership Board can offer support with mitigation and also be informed of any individual organisation risk that may have implications for the partnership.

There are 7 risks identified with current risk scores range from 8 to 16. Those rated at 16 (major) are (a) the availability of funding to deliver the full transformation; and (b) the size and complexity of the local population health challenges.

The risk related to swabbing capacity and availability will be added to the risk register.

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Care at Home Executive Report			**AGENDA ITEM: 11.2** **ENC: 12**
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. BAF Risk – SO1 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		
Resource implications	The transfer of hospice services is covered within this report and has been debated and approved at all Board Committees and the Private Trust Board. This transfer does not present any additional final pressure to the Trust as this is fully funded by the CCG but involves the movement of our recruitment to an additional 40 posts into the community division. The risks and mitigations associated with this have been fully debated and assured through the Board Committees.		
Legal and Equality and Diversity implications	The issue of health inequalities is rightly receiving growing prominence in all forums across Walsall Together. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare. There are multiple workstreams that have given focus to this issue within the forward look programme and the WTP Board has formally requested a paper is presented to the October meeting that pulls all of these strands of work into a		

	single assurance paper. It will then be reported to members at the November Trust Board meeting.	
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
OCTOBER 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 have dropped slightly during August to approximately 600; this remains within the expected levels of demand and is significantly higher than at the start of the year. This reduction in activity was expected as new contacts in community always reduce slightly in August due to families taking annual leave. The service was able to deal with over 50% through either advice and guidance or through disposition to Locality Teams. As a result, the levels of demand on the Rapid Response service is lower than expected and this presents an opportunity to expand the capacity offered to West Midlands Ambulance Service (WMAS). The work in this area is one of the biggest contributors to the reduction of complex and chronic condition patients presenting at our emergency department. This is one of the biggest building blocks now in place ready for winter and allows the community teams to flex capacity across teams and manage flow in a way that ensures delivery of care closer to home. The progress to date in this area has only been possible due to the additional support developed and deployed during wave one of COVID-19 and underpinned by the Investment Case made by the Trust Board in July.

The work to develop and deploy an integrated front door on the Manor site is now in the final stages. A location has been secured on the hospital sites in the interim on ward 14 moving during the peak of pressures to the current CMU location which is about to be refurbished. This initiative will be the first phase of the admission avoidance work led collaboratively by the frailty team and the intermediate care service. As reported last month, the integrated care pathways that underpin this service have now been mapped and the final staffing model is being coordinated. This brand new approach will enhance the current frailty team and provide direct access to intermediate care and support pathways that will divert patients away from complex admission and back to locality teams with a wrapper of support and care.

Medically Stable for Discharge (MSFD) performance remains strong with a significant and sustained decrease in the number of patients since in May, confirming the now embedded COVID-19 actions. The Trust maintains a positive position with 36 patients on the list during August. There has been a slight increase in length of stay for these patients, which will need to be monitored over the next month and in the context of the re-start of Decision Support Tools (referenced further in section 3). There has been a

challenge in this area during September due to some short-term staff pressures but these are now under control and performance at the time of writing is returning to reported levels.

Further progress has been made to develop the live data feed that was reported in last month's paper with data received from the voluntary sector. An initial meeting has taken place with data and insights leads from across the Walsall Together partnership, the Black Country Sustainability & Transformation Partnership (STP) and the Commissioning Support Unit (CSU) as a first step in bringing together a virtual intelligence team. Alongside this, we are working with Walsall Housing Group to recruit a Head of Intelligence that will coordinate and provide leadership to this virtual team, which will focus on providing place-based population health insight to drive prioritisation of resources in order to address health inequalities. It will inform an overall Population Health Management Strategy, that is jointly owned by Walsall Together and Primary Care Networks (PCNs) and that will embed a single, robust approach to tackling health inequalities. The work will be focused on public health data to directly address the inequalities in each local area. To compliment this each locality team will have a local information picture that show areas of concern and progress required for the population they serve.

The transfer of palliative care services at Goscote will go live on 1st October. This has been discussed in all of the Board Committees and the required assurance has been given to Board members. The handover plan, recruitment and our ability to open the service on time is testament to the substantial work undertaken by the operational teams, ensuring we can continue to deliver bed-based end of life services in Walsall. Additionally, I am pleased to report that funds available through the transfer of this service have been invested into support for the community division with the full support of the CCG.

Our bed-based stroke and neurological rehabilitation teams have now been based at Holly Bank House for 6 months. Significant work has been undertaken to continually develop the facility to delivery safe, high quality care for our patients and we are now close to being able to confirm the facility as an official substantive site within the Trust's estate. From a digital perspective, the site is now part of the bed base and vital pack is now live. The lease with Walsall Council has been agreed by both parties and has now been handed to the respective solicitors to conclude the legal process. The long-term financial model is in the latter stages of internal approvals and is expected to be presented through the executive and the Performance, Finance and Investment Committee during October.

Within the Improvement Programme, the outpatients workstream continues to make excellent progress. Following on from MSK services in July, the Cardiology Referral Assessment Service (RAS) is now live. Cardiology Consultants had a demonstration of the RAS process by NHS Digital and felt that this would be of benefit to streamline patient journey and ensure that all patients receive the right care at the right time. The service developed the process and went to pilot on the 13 August 2020; the process

was subsequently shared and agreed at the clinical task and finish group. In the initial 3 weeks of operation, there were 51 referrals received of which:

- 6 received a telephone consultation;
- 8 went on to face-to-face consultation;
- 7 were discharged back to the care of their GP; and
- 30 were referred directly for testing.

Gastroenterology and Podiatry are the next specialities on the list for RAS implementation.

We now recognise that we are entering a complex phase in the development of the outpatient's programme beyond the initial COVID-19 response. As a result, we are organising a series of workshops by Care Group to bring together the strategic intentions across acute and community services. This will inform the delivery plan for Walsall Together for the remainder of the 2020/21 financial year and beyond and also inform the direction of travel within the context of any future Integrated Care Provider contract. This work will bring primary care partners and patients closer to this transformation to ensure that all parties are on the journey.

There are a number of emerging risks relating to Care Homes as we move towards a potential second wave of COVID. However, the partnership continues to monitor these closely and offer support to the sector that will be retained through any future wave and beyond. Indeed, the swift and integrated response provided to Care Homes through the initial outbreak has received recognition from the CQC and national Task Force Report (Adult Social Care) as best practice.

The potential second wave of COVID-19 is expected to coincide with the usual winter pressures and a robust and pertinent Winter Plan is being developed in response. A key element of this will be a system wide vaccination strategy and a coordinated view of capacity across all providers.

The transformation element of Walsall Together is on track to deliver in 2020-21 in line with the approved Programme Plan:

- Discussions have now taken place with the operational teams and external training provider to restart the Strengths Based Practice (SBP) training programme that was paused at the start of COVID-19. We know that the training will be undertaken in a virtual environment and the details are currently being worked through to plan these sessions in the context of the ongoing COVID-19 pressures and the anticipated winter pressures, ensuring we can maintain service delivery.
- Good progress continues to be made across Tiers 3 (ICS) and 4 (Acute flow) with the respective project groups for ICS and the Integrated Front Door meeting on a regular basis. To secure engagement from the acute side of operations, the governance has been aligned to the Trust's Improvement Programme Care at Home workstream; assurance reporting will be undertaken through this route in addition to the Walsall Together governance process.

- Recruitment to the additional posts that form part of the WHT investment in community services continues. A detailed report in respect of which posts have been recruited to and the activity actuals for September will be reported next month, noting the impact of the change in case mix as referred to throughout this report. There is some early impact of the investment evident across certain services such as Care Coordination that has already been able to expand capacity, as reported above.
- The Family Safeguarding Model has now gone live in Walsall. Recognition needs to be given to the core teams across multiple partner organisations that have enabled this to happen in the context of COVID-19 and the challenges faced with operationalising what is a delivery model predicated on increased contact with families needing to be delivered within social distancing parameters and a significantly reduced workforce. This brings adult and children's teams together from both health and care into a family Multi-disciplinary Team (MDT) approach
- All system partners are engaging in discussions to develop a single social prescribing model for Walsall that aligns existing providers into a single pathway with clear links from Primary Care and complex MDTs into the broad range of support and services available across our voluntary and community sector, including housing.
- The Integrated Shared Care Record will be ready for the first stage of implementation in October. Data feeds from Medway, Fusion and Mosaic (Walsall Council) will be added to the primary care data over the coming weeks. The shared care record will be available to support the complex MDT meetings between community services and primary care in the first instance before being rolled out across the wider health and care economy. The phase of development will focus on getting the relevant data feeds from mental health partners. This major step forward has been possible due to the migration onto Medway in September.
- The Communications Lead for Walsall Together has significantly improved the internal and external communications associated with the partnership. However, much of the focus has understandably been on supporting the operational response to COVID since the post holder joined the team in February 2020. As we start to think about restoration and recovery, a formal Communications Strategy has been drafted and shared with key stakeholders across the partnership. The Strategy will be presented for approval by the Senior Management Team and Walsall Together Partnership Board during October.

3. AREAS OF CONCERN

The case mix and demand profile for community services continues to change. A work programme is starting which looks at maximising opportunities to promote self-care (this will further reduce the number of 'green' cases) and enable the service to focus on patients with more complex care needs ('amber' and 'red' cases). As reported last

month, there are still shortfalls in nursing capacity in Locality Teams; however, these are at a lower rate than pre COVID-19.

The number of new referrals into Locality Teams has continued the downward trend that we have seen throughout COVID-19 and is reflected in the following overall trends seen across community services:

- Increased referrals from acutely unwell patients;
- Reduced referrals for post-procedural care;
- Change in case mix of those with long term conditions already on the case load now requiring more complex nursing care.

The change in acuity and subsequent impact on activity levels was anticipated and reported to the Performance, Finance and Investment Committee within the approved benefits profile for the WHT investment case. We are now seeing the result of the changing demand as the teams are seeing a higher acuity and are therefore making fewer, longer calls with patients. A significant amount of low complexity, high volume activity has been reduced and it is planned for this to continue post COVID-19. For example, where possible, patients and relatives have been taught to give their own injections. These trends have instigated a review of skill mix across community services. In response the teams have thoroughly mapped the hours that they have available and as a result have reduced the amount of cancelled appointments and provided more clinical facing time to the population with the same workforce.

In adult social care, the level of referrals is increasing as we enter the 'reset' phase. It needs to be noted the safeguarding in care settings, complexity of needs, carers stress and self-neglect are a significant feature of the work that teams are dealing with. The pressure remains for supporting those who are demonstrating complex behaviour.

As reported last month, Decision Support Tools (DSTs) were suspended at national level during COVID-19. As of 11th September, there were 72 people in community beds awaiting a DST. This is a further increase on the 61 people reported last month and remains significantly higher than the pre COVID-19 levels (5-10 waiting). The DST process has now resumed, and it is anticipated that the backlog will take in excess of 4 months to clear. To mitigate the increased pressure on discharge capacity, a post is being converted within community services at risk to support this function and discussions with commissioners continue to focus on how we can retain key elements of the COVID-19 processes that could further mitigate this risk. A monitoring group has now been set up in this area and risk is being managed on a daily basis.

There is also a concern about the continued ability of staff to access care homes to undertake DSTs. Public Health England (PHE) guidance indicates that all staff going into homes should have weekly COVID-19 swabs to ensure they are clear, but Community Services are unable to access swabs in sufficient numbers to implement this. Reduced access to care homes is a broader significant risk in terms of the ability of the health and care system to review residents and provide early clinical

interventions. This may impact on the work of the Enhanced Care Home Team. This is under dynamic review and is critically important as we move into a potential wave 2.

This also reflects a broader emerging risk regarding the access to swabbing for care homes, which the Senior Management Team has now formally escalated to the Walsall Together Partnership Board. We are current experiencing an increased demand for testing in care homes and an increase in the number of positive cases in both residents and staff (currently in 4 homes). Vacancy levels in Care Homes remain significant, there are national issues with the supply of kits and increasing delays in the return of results. However, deaths currently remain within normal levels and Public Health are continuing to monitor and respond to confirmed/suspected cases and outbreaks.

The estates issues that were reported as a risk over the last few months are now being resolved with the Trust taking access to clinic rooms at Pelsall Village and several other sites in smaller volume. In conjunction with the CCG, community blood clinics have opened to release the pressure on primary care and further work is being investigated to see what other services can be moved into the community areas before winter and a second wave.

As the new patient flows from the legacy of COVID-19 wave one begin to become clear, new referrals into diabetes teams have been highlighted as a concern. Typically 70 new referrals per month are seen and this has fallen away to below 10 per month. Whilst progress has been made on pathways in this area, they are not sufficient to cause such a swing in activity. This is being explored as a Walsall Together clinical risk given these referrals originate from GPs.

4. KEY PRIORITIES

The partnership is giving particular focus to the operational preparedness for a potential second wave over and above the usual winter pressures. The promotion of self-care, as reported earlier in this paper, is a key element of the winter plan.

Beyond the immediate operational pressures, the partnership is in discussions with commissioners about the future of the falls service and we are preparing for the formal transfer of School Nursing and Health Visiting into the Community Services division in October.

Discussions across the system regarding the move to a more formal Integrated Care Partnership continue. At the time of writing, we are awaiting the WHT Board Development Session to explore the options and any associated risks to the organisation in order that our own Board can make an informed decision on the preferred direction of travel. Irrespective of the outcome of any decisions regarding a formal contractual change, the Walsall Together partnership continues to mature and as a system we acknowledge the collective responsibility to reduce health inequalities and provide better outcomes for the people of Walsall. In response, the Walsall Together Partnership Board is rightly demanding an improved level of integration in

respect of assurance reporting and WHT has, as Host Provider, instigated an internal audit of the governance associated with the partnership. Over the coming months, a full review of the governance, risk and legal frameworks will be undertaken to ensure they are fit-for-purpose. The Walsall Together Partnership Board has approved the creation of a formal risk register that includes risks to delivery of the transformation and to the strategic objectives of the partnership. Partners have also committed to sharing sections of their respective corporate risk registers where risks are pertinent to the wider partnership. Work is underway to ensure any process is aligned to the WHT Risk Management Framework (as Host Provider) and to ensure the appropriate governance is in place to allow the Walsall Together Partnership Board to collectively manage any further identified risks, including those risks to operational services in scope.

5. CONTROLS AND ASSURANCE

The Walsall Together Partnership Board continues to meet monthly and is well attended. As reported above, there has been an increased focus on the governance associated with risk and assurance to ensure that an integrated position is reported to Walsall Together Partnership Board.

The Walsall Together Senior Management Team continues to meet 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. Early discussions have taken place to review the membership and purpose of the Group to ensure it can better support the partnership's approach to tackling health inequalities and the development of a Population Health Management Strategy.

Further discussions have taken place to improve the alignment of governance and reporting mechanisms between the Walsall Together programme and the Care at Home workstream in the Improvement Programme. Several Walsall Together projects have been identified for increased oversight and assurance via the Improvement Programme. These are projects where the accountability for delivery needs to sit at least jointly with a division other than Community Services, for example, the Integrated Front Door. The full list of projects will be discussed at the next Care at Home Core Team Meeting to confirm how the assurance on delivery will be monitored.

6. RECOMMENDATIONS

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

Risk Summary			
BAF Reference and Summary Title:	**BAF SO2 - Care at Home – We will host the integration of Walsall together partners addressing health inequalities and delivering care closer to home.**		
Risk Description:	**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.**		
Lead Director:	Director of Integration	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title**		**Current Risk Score**
	• 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		**12 (Moderate)**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	**3**	**3**			• 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	**Likelihood:**	**2**	31 March 2021
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**12**	**12**				**Risk Level:**	**Mod 10**	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Executive Director recruited • Non-Executive Director appointed	• 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 • Business case approved by Partners	
Gaps in Control	• Lack of investment across the health economy impacts on the delivery of the Partnership – notwithstanding the recent investment from the Trust • Commissioner contracts to be aligned to Walsall Together • Data needs further aligning to project a common information picture		
Assurance:	• Risk management now underway at a locality level. • Divisional quality board now starting to look at the integrated team response.	• Walsall Together included on Internal Audit Programme • Walsall Together Committee in place overseeing assurance of the partnership • STP oversight of 'PLACE' based model	• NHSi support of Walsall Together
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		

Future Opportunities

- Further development of the Governance around risk sharing
- 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
- QC action oversight group

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Agree a joint business plan for Walsall Together and PCNs that describes how the enhanced and additional roles within the PCN contract will integrate with community services	Daren Fradgley	Dec 20		
2.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations	Daren Fradgley	Dec 20		
3.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital workstream)	Daren Fradgley	Mar 21		
4.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure	Jenna Davies	Mar 21		

Summary

Restoration, Reset and Recovery

- Community Services are delivering more hours of care than before COVID-19 even though referrals into the service have reduced
- Activity for the Care Coordination Centre has increased and this is being dealt with by better signposting and clinical advice as well as use of Rapid Response
- There is a focus within Community Services on Reset rather than solely Restoration

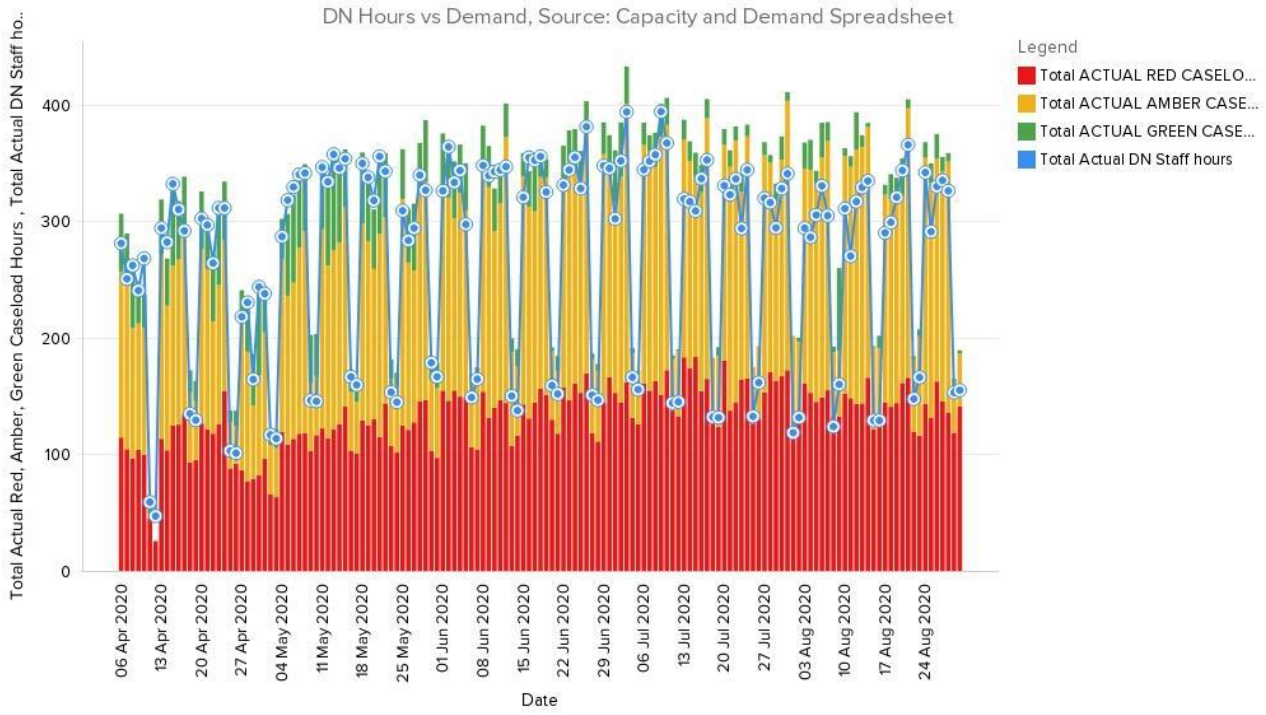
Palliative Care

- There is a clinical model that will provide safe high quality care from 1st October
- Further work will be undertaken post-transfer to develop a model of care encompassing specialist in-patient and domiciliary care with greater focus on Advanced Nursing roles

Community Work Streams

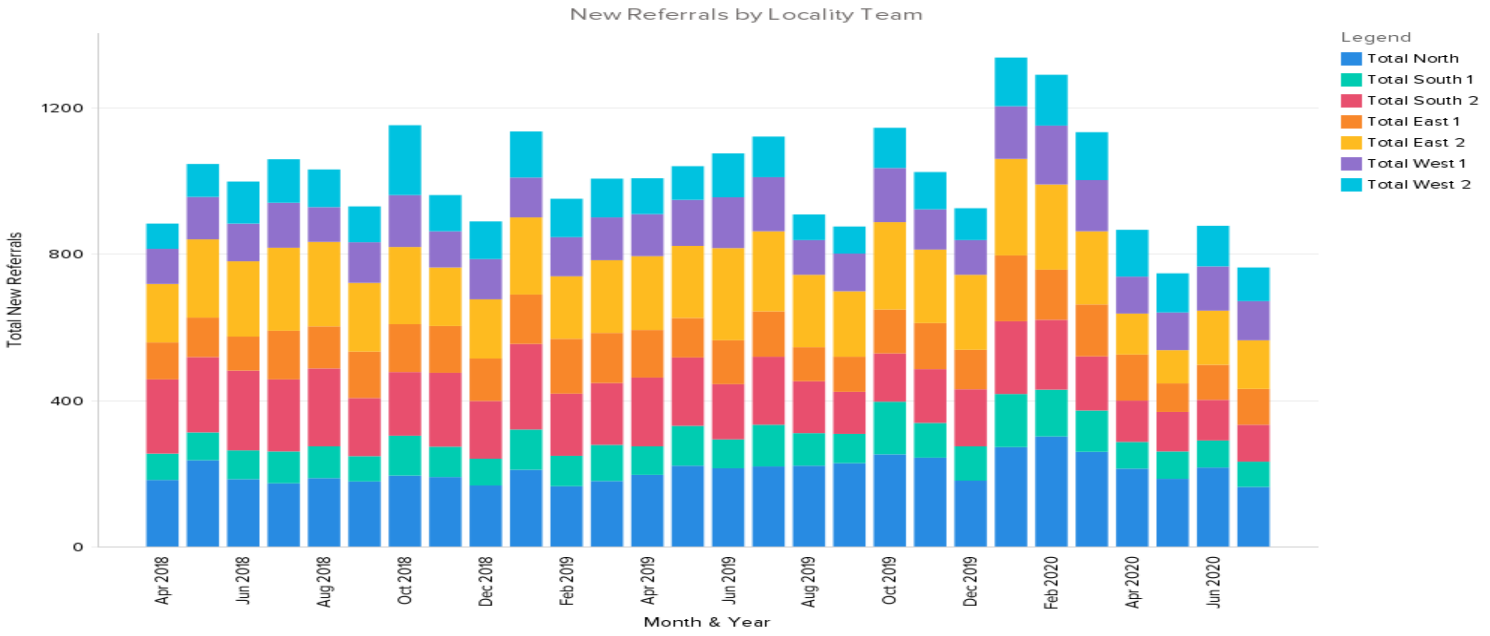
RAG scoring of capacity and demand enables better targeting of limited resources

- The chart shows that the case mix / demand profile for community services is changing with more amber-rated patients and fewer green rated ones
- There are still shortfalls in capacity however these are at a lower rate than pre-COVID-19
- A work programme is starting, which looks at maximising opportunities to promote self-care and enable the service to focus on patients with more complex care needs



Community Work Streams

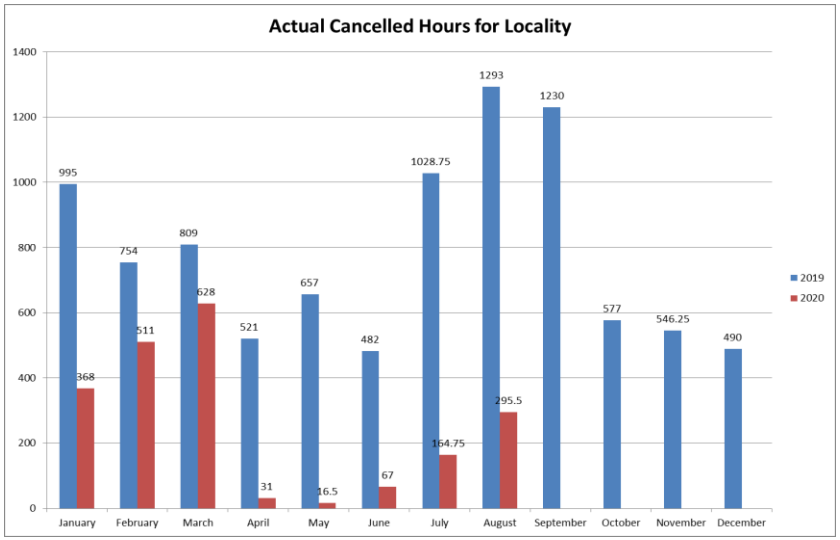
Referrals into Locality Teams have reduced

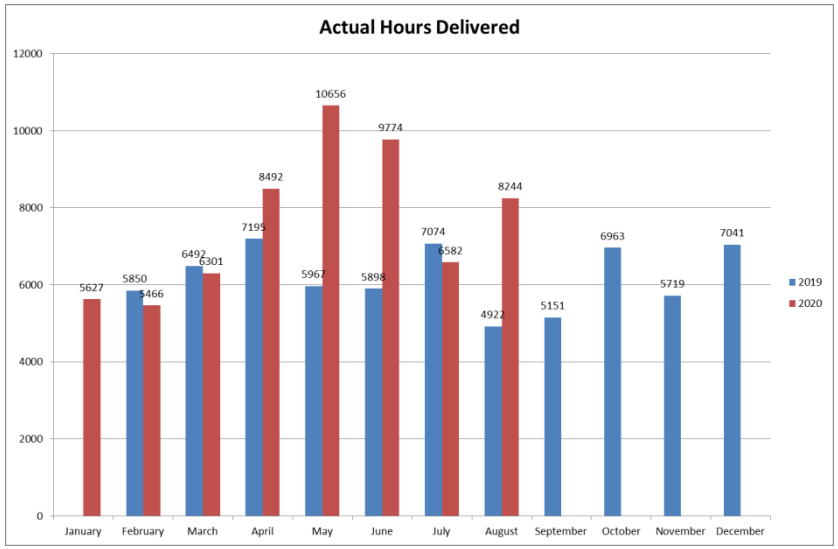


- The number of new referrals remains lower than usual and in part this reflects the reduction in hospital-based elective activity that would have generated demand (e.g. wound care)

Cancellations & Service Hours delivered

Community Services are cancelling fewer patients whilst delivering more hours of care overall





The reduction in cancelled hours has been due to better management of workload in terms of staff allocation. In addition, extra staff were available for general community work as specialist community activity was curtailed during COVID-19 Phase 1.

This support reduced during July and August and although cancellations increased, they were not at the same level as the previous year

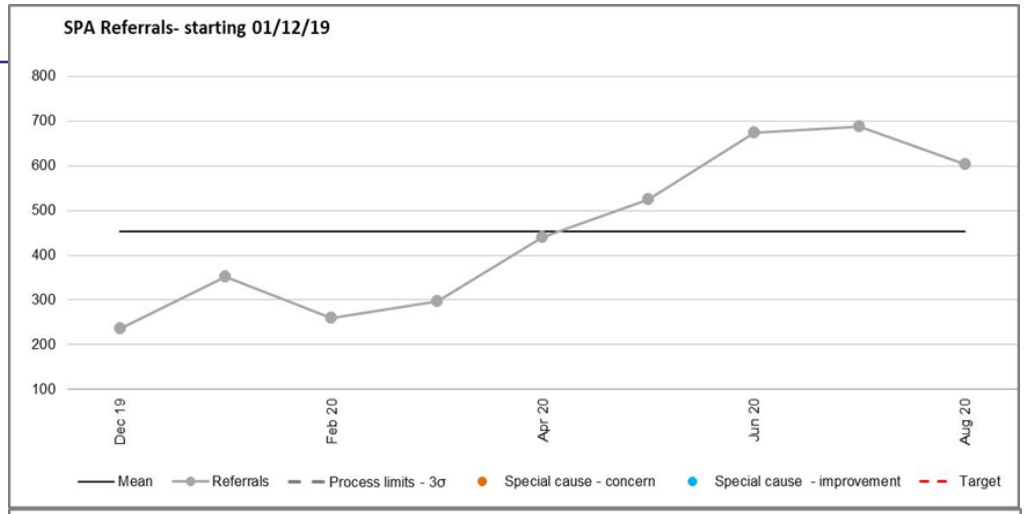
Despite the reduction in new referrals, the volume of hours available for service delivery has increased. That the number of contacts has not increased significantly, serves to reinforce the understanding that there has been a shift in demand profile with more complex care being delivered

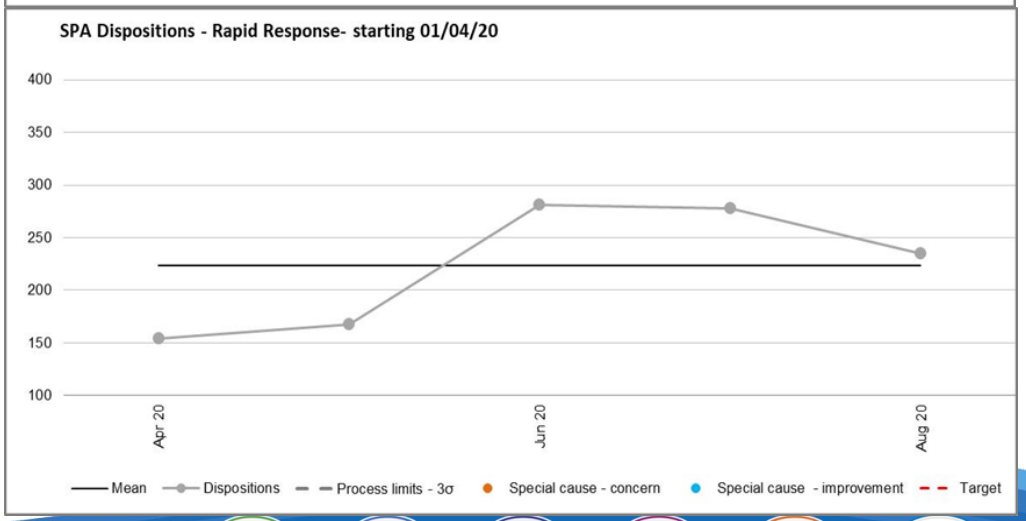
Care Coordination Service

New referrals to Locality Teams may be reducing, but they are increasing for acutely unwell patients

The number of referrals for Care Coordination Centre remains higher than at the start of the year. These have been mainly from GPs.

The Centre is able to deal with over 50% of these through advice & guidance and use of Locality teams, indicating that the function has become more than a mechanism to streamline referrals into Rapid Response



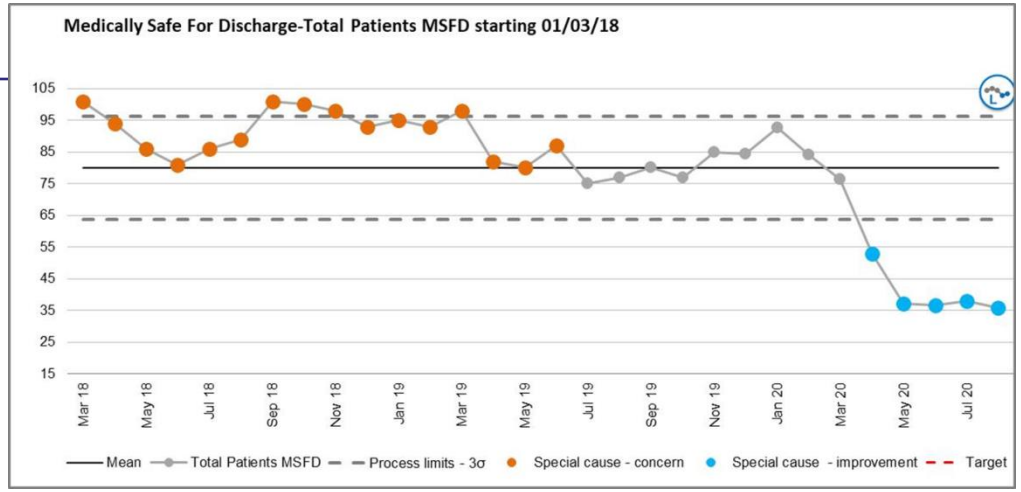


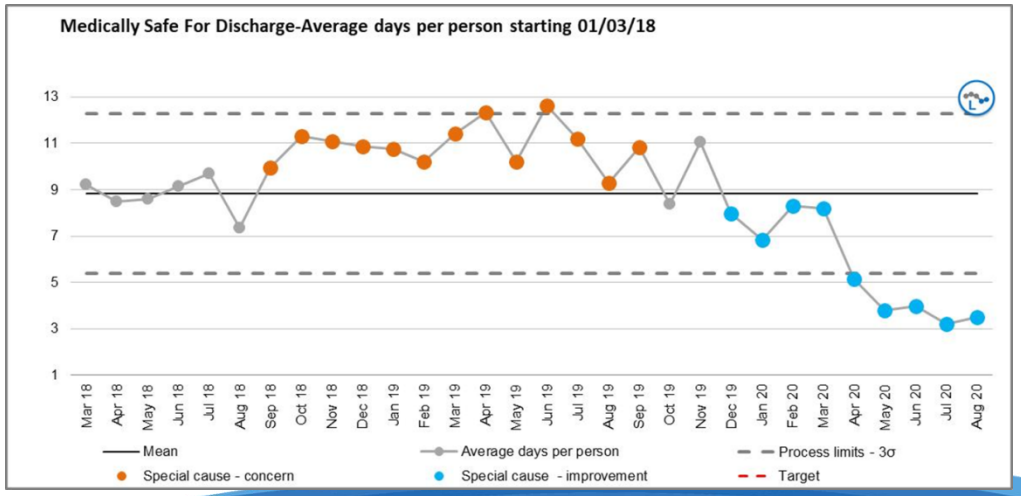
Medically Stable for Discharge (MSFD)

The reduction in numbers and LOS of MSFD patients equates to over 2 wards' worth of beds for the acute sector

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 and June, which reflects the now embedded COVID-19 actions that are aimed at reducing both numbers and length of stay.

The suspension of Decision Support Tools (DSTs) during Phase 1 of COVID-19 meant that Discharge Nursing resource was able to be directed to support the wards with discharge paperwork. With DSTs resumed from the start of September, this has been removed so a post is being converted within Community Services at risk to support this function, in order to keep the numbers of MSFD patients as low as possible.





3rd Phase of COVID Response – Return to Elective Activity

Restoration or Reset? Going back to previous models of care delivery may not be the best thing for patients

Capacity versus demand: demand has dropped in many areas due to COVID [e.g. GP referrals into Diabetes have gone from average 70/month to <10 per month so services are able to meet demand via less clinic activity

Switch to virtual/telephone clinics: Many people are not prepared to come to clinics and prefer telephone reviews, particularly for chronic conditions such as COPD where they are extremely vulnerable and were in the shielding category

Switch to home visiting: When people actually require a face to face contact, some specialities have switched to home visits [e.g. Respiratory]

Merging of the work within Localities: the staff and caseload for chronic conditions were merged into locality teams - the patients were put into the daily RAG rating process and were seen by a member of the locality team if they required clinical review

Redundant models of care: COVID has highlighted the ability of people to self-care if they are adequately supported and has questioned the role of some specialist intervention within community services

Speciality	Commissioned Monthly Benchmark	Projected contacts August restoration	Projected % restoration	Projected contacts September restoration	Projected % restoration
Podiatry	2035	1208	58%	1568	75%
Wound Care	652	652	100%	652	100%
Diabetes	424	400	94%	450	100+%
Respiratory	265	326	100%	352	100+%
Continence	166	50	30%	75	45%
Falls	121	52	73%	64	90%
Osteoperosis	68	276	100%	276	100%

Restoration or Reset?

Where is the assurance and what is the strategy?

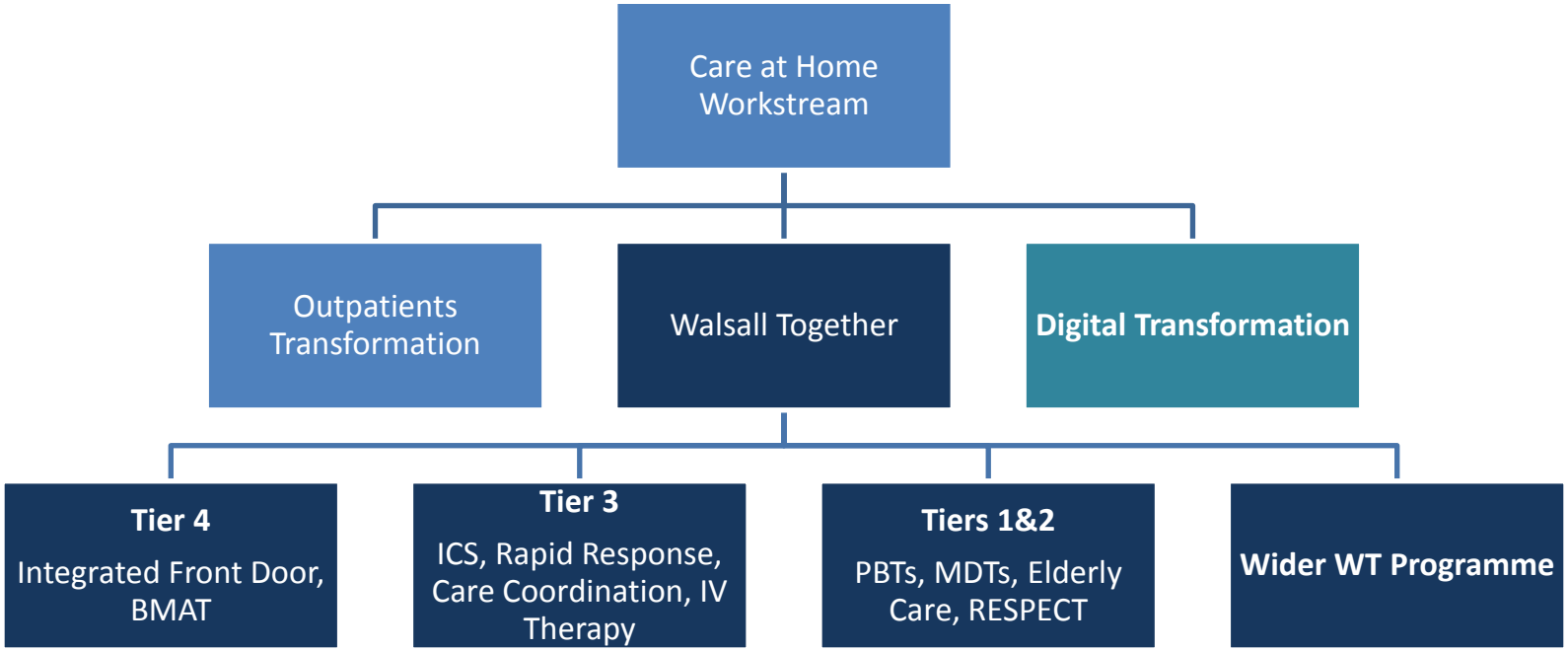
Assurance:

- As part of the work around self care, Community Services is to undertake a review of people whose management moved into self-care, which is how the de facto model of care for many Long Term Conditions (LTCs) emerged. This will be in 2 phases:
  1) Review of case-notes of a sample of patients who were moved to self care to identify outcomes and their views
  2) Service development work with staff around the role of self care in the management of the following conditions: Insulin administration; pressure area checks; wound care; patient handover to identify people for self care and to ensure adequate monitoring

Review of Service model:

- Again, learning from lessons during COVID, Community Services is now reviewing its model / philosophy of care.
- It is moving to greater emphasis on self care and empowering people in a strengths-based management model for their long term conditions, rather than delivery of a deficit-based model of care which may disempower residents of Walsall
- There is a move to creation of a model with more generic nurses skilled in dealing with a range of conditions linked to frailty and feeding into specialist nursing and multi-disciplinary team (MDT) support, rather than specialist teams working on a single condition (on people with multi-pathology) and in silos

Care at Home Workstream Structure



Care at Home Workstream Development update: September 20 IP Board / Walsall Together Committee

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
CaH 1	Care at Home	Outpatient Transformation (One PID has been completed for these areas)	Advice and Guidance rollout	Keith Dibble / Jane Hayman	Cross Division	Jane Hayman				Drafted									TBC	TBC	Amber	Amber	Amber
CaH 2			Virtual technology roll out	Keith Dibble / Jane Hayman	Cross Division					Drafted						N/A			TBC	TBC	Red	Red	Amber
CaH 3			Referral Assessment Service	Keith Dibble / Jane Hayman	Cross Division	Jane Hayman				Drafted									TBC	TBC	Amber	Red	Amber
CaH 4			Implement Modality outpatient clinics	Keith Dibble / Jane Hayman	MLTC & Surgery	Modality Partnership				Drafted						N/A		TBC	TBC	TBC	Amber	Amber	Amber
CaH 5		Others - tbc by WT PMO																					
CaH 6																							

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

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	**Risks required from Walsall Together**	**TBC**	**TBC**
	Resource supporting the OPD transformation has been from IT, these staff have been diverted back into EPR as roll out of system gets closer	R	Engaged some resource from NHSD to support roll out of A&G and RAS, which is part time (2.5 days per week) for 7 weeks
	Resource for funding the Modality partnership / activity is not agreed	R	Update requested from Executive team
	There is insufficient capacity in community estates to enable the roll out of Community Outpatients clinics with partners in each of the localities	A	It may be that a community hub can be developed at a vacant GP practice setting at Pelsall Village. Community services are currently embarking on the capacity required for services going forward
Issues	**Issues required from Walsall Together**	**TBC**	**TBC**
	SOP developed that makes clear the mechanism for capturing face 2 face (F2F) telephone and telemedicine activity, however < 15% have been identified to date. This puts contract setting for 2021/22 at risk	A	When EPR goes live mode of consultation is a mandatory field and will therefore be collected appropriately

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
People and Organisational Development Committee Highlight Report			**AGENDA ITEM: 12.1 ENC: 13**
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 24th September 2020. Of note are: - The Board Assurance Framework (BAF) Risk S04 – Culture - was reviewed on the new template, with the Committee noting the additional controls introduced, and the actions both in the BAF and the improvement programme, to manage the risks. - The Committee reviewed and endorsed the Winter Plan. - The Trust is one of only twenty nationally to have been chosen by the Project Wingman Foundation charity to continue the Project Wingman Lounge for staff at Trust. - The Committee reviewed feedback and recommendations from staff as to what 'valuing colleagues' means to them and how a culture of this might be evidenced in terms of measurements. Metrics developed will form part of the Trust's accountability framework, and the Committee will have an opportunity to review these in more detail in coming meetings. This work supports the recommendations made in the NHSI governance and accountability review, and the Committee were assured that the recommendations from this review were incorporated into the valuing colleagues improvement programme. - The Committee has requested a process be developed that will provide a mechanism to assure the Committee, and the Trust Board, that workplace practices have changed where appropriate for BAME colleagues as a result of risk assessments. Currently that information is not centrally held, however there is progress on this with Trust Management Board and Directorates. The next meeting of the Committee will take place on 29th October		

	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 S04 – 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 ☐	

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Valuing Colleagues – Executive Update			**AGENDA ITEM: 12.2** **ENC: 14**
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 ☒		
Executive Summary	This report provides an overview of the risks to delivery for 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, this report highlights successes and identifies gaps and areas for improvement. This report provides an update on actions taken last month relating to the valuing colleagues work-stream of the improvement programme. The following points seek to inform the Trust Board of progress, identify where assurance can be taken and where required to seek approval for actions proposed. 1. The investment case for People and Culture has been initiated to align resource to improvement priorities. The investment case follows the actions taken through the People and Organisational Development Committee (PODC) and supporting groups. 2. The Trust Board can be assured that the resource plan for Occupational Health and Wellbeing has now been put in place with significant additional resourcing; this has been contained within existing budgets. This will afford greater resilience for existing and emerging services such as contact tracing for outbreak control and will support SEQOHS (Safe Effective Quality Occupational Health Service) accreditation plans as well as the broader work on the Health and Wellbeing Strategy. 3. The Board Assurance Framework (BAF) risk mitigations in place measure performance against key workforce metrics,		

	these are quantitative metrics. The Accountability Framework adds in qualitative workforce metrics measuring colleague experience, which have been co-designed following wide engagement with trust colleagues. These qualitative metrics will be considered at each division's monthly executive performance reviews and the overall measures at the People and Organisation Development Committee with any matters of concern escalated to Trust Board. 4. The Trust Board can be assured that the leadership development planned prior to COVID 19, will re-start in November and complete in May 2021. The planned programme has been updated to a virtual offering as part of the restoration and recovery plans. The People and Organisation Development Committee received an update on the detailed proposal and delivery schedule for the Faculty of Medical Leadership and Management's (FMLM) leadership and management development programme along with the 'Walsall Manager' development framework. 5. The Trust Board are asked to note that the People and Organisation Development Committee received a verbal update on Human Resources/Organisational Development interventions planned in response to colleague experience, freedom to speak up concerns relating to organisation culture. The teams of three in the divisions are leading this work and a detailed assurance report will be presented to the Committee in December. 6. The Trust Board can be assured that compliance levels on the risk assessments have improved in month to 95% BAME risk assessment and 85% risk assessment all. The People and Organisation Development Committee received an update 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 this month. The Trust Management Board members are in the process of reviewing the quality and outcomes of risk assessments and effectiveness of the adjustments made. 7. Trust Board are asked receive positive assurance arising from the improvement programme work, which includes significant progress on defining the benefits and benchmarking and to note gaps in assurance and plans to address these gaps.

Recommendation	Members of the Trust Board are asked to note the report and in particular take assurance on the re-start on the Leadership and Talent work which is designed to support leaders to lead and manage for performance improvement and in doing so improve patient experience through achieving the outcomes and benefits contained within the valuing colleagues' element of the improvement programmed. In addition members of the Trust Board are asked to note that progress on the Organisational Development (OD) actions scheduled and feedback for colleagues raising concerns including racism and inequality based on protected characteristic are being reviewed on a monthly basis by the People and Organisation Development Committee and who will receive a detailed assurance report in December.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk SO4 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 People and Organisation Development Committee, Performance Finance and Investment Committee and Quality Patient Experience and Safety Committee before further recommendation to Trust Board. The FMLM leadership and management development programme has been funded from NHSi business case and special measures funding. The 'Walsall Manager' and Growth Mindset programme has been funded from existing budgets.
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. The leadership and management development programmes both focus on equality outcomes and developing skills and understanding of an inclusive leadership approach, whilst leading for performance improvement in a compassionate framework that supports a just and learning culture.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Valuing Colleagues – Executive Update

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 poor and discriminatory practice which run counter to the trust values and which are normalised in some areas.

Without decisive action to tackle poor and discriminatory practice and behaviours, including racism, 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.

The focus on developing leaders and managers to role model the behaviours and values of the trust is a critical lever to change the direction of travel and to appreciate and build on good practice, learn from it and embed it elsewhere. In this regard, the work that was paused during the emergency response to COVID 19 has been reset as part of restoration and recovery.

The Faculty of Medical Leadership and Management (FMLM) programme provides a 12 month supported development approach which is aligned to improvement and ongoing learning with complementary professional development on developing a growth mind-set, which supports the move towards a just and learning culture. This is one key strand of the restoration and recovery for workforce.

The impact of the Covid-19 emergency response and its aftermath on colleague wellbeing is significant and the pace of the requirement to recover services has not allowed colleagues time for reflection. The People and Organisation Development Committee considered structured ways of providing time for reflection through facilitated conversations for teams and the Trust Management Board are progressing this. This is a significant requirement and dependency for the restoration and recovery work as well as the resilience of services generally.

The leadership and management approach seeks to equip leaders and managers to respond to the system, organisation and cultural challenges (and inequalities) impacting Walsall such as:

1. Responding to fatigue and distress evident and supporting teams to work with this to support colleagues at team and individual level.

2. Developing compassionate and inclusive leadership approaches and resilience within the trust in line with the Trust values and Trust Board pledge

3. Developing career pathways to support retention and having transparent and equal access to opportunities to progress.

4. Enhancing the leadership approach towards the trust becoming an anchor employer and embedding approaches to talent management and succession planning in an equal, transparent and effective way.

5. Leading the local solution to the national challenge of persistent bullying and harassment within the NHS by developing the skills of leaders and managers to lead inclusively and with compassion.

6. Eliminating differential and unfavourable experience reported by colleagues through the staff survey and other forums and improving staff experience and organisational culture.

7. Leading for improvement within a just and learning environment.

The aim of this leadership development work is to provide a leadership and talent management framework which provides clear accountability for leaders at all levels to lead for improvement. In doing so this will contribute to improving the staff rating for Walsall as a place to work and a place to be treated to reach the target of being top decile within the national NHS staff survey by 2022.

2. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) Risk S05 provides that lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care. The BAF is attached at Appendix 1. The Board noted that the Assurance Framework current risk score was been increased in August from 16 to 20 [major risk], the following actions have been taken to mitigate the risks are as follows:

- Significant additional Occupational Health and Wellbeing resource secured and operational to support the workforce during a potential second wave of COVID. The resource will seek to mitigate the risk of significant impact on the physical and psychological health of individuals and workforce availability by completing referrals swiftly, increasing the number of support interventions available and supporting leaders to prioritise wellbeing within their teams.

- Data and information from staff engagement events have identified the existence of unhealthy climates in several areas/departments across the Trust where colleagues have shared stories of unreasonable treatment based on their race, disability, ethnicity and sexuality. Significant additional Organisation Development resource is engaged within the trust working alongside the teams of three to ensure this is tackled effectively and then to support the development of high performing teams leading for improvement.

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: 95 % BAME colleagues; 87% other vulnerable groups and 85% whole workforce.

- The short OD interventions have been initiated to complete by end November although some action will be complete before that point. The People and Organisation Development Committee receive an update on the plan at each meeting and will receive a detailed assurance report in December. Some longer term OD interventions that will require investment decisions relating to the valuing colleagues work-stream will be contained within an investment case.

- The leadership and talent management approach is in place and the leadership development programme through FMLM will re-start in November, the trust strategy framework for Leadership and Talent Management will be presented to the People and Organisation Development Committee for assurance at their November meeting.

The following assurance is in place to mitigate the risk:

- Trust Management Board (TMB) has received the approach to leadership and management development and the programme has been designed to incorporate equality outcomes, building an inclusive leadership approach and a framework for compassionate leadership within a just and learning culture.

- PODC receive monthly updates regarding to assure robust arrangements in place to support colleagues through the impact of COVID, as part of this the trust has invested in additional Occupational Health and Wellbeing resource, this is in place.
- 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 shared decision making approach supports greater colleague empowerment.

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. The detailed assurance report will be presented to the People and Organisation Development Committee in December.

- There are themes emerging relating to equality of experience and treatment relating to disability, age, sexuality, religion – the OD work with the teams of three will mitigate this risk and close the gap in assurance, this detailed assurance report will be presented to the People and Organisation Development Committee in December.

- There is a gap in the risk assessment completion and the work on the quality of the assessments and impact is not complete, the cycle of continuous assessment is not yet fully established.

3. PERFORMANCE REPORT

The workforce metrics performance element of this report takes a standard set of quantitative metrics and tracks performance over time. The workforce performance report is attached at Appendix 2. 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 reviews recovery plans at each meeting and escalates gaps in assurance to Trust Board.

<u>Qualitative Metrics – the Valuing Colleagues element of the Accountability Framework</u>

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 the People and Organisational Development Committee 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 valuing colleagues element of the accountability framework has been updated following a series of workforce engagement events and now provides measures of colleague experience through the lens of valuing colleagues. The framework will be deployed to complement the quantitative workforce metrics. This control mechanism is a vital way of ensuring colleague

experience and colleague voice is acknowledged and to gain assurance 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 freedom to speak up concerns raised, Employee Relations 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 qualitative metrics will be part of the performance review meetings with a template for reporting from all divisions.

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

The valuing colleagues work-stream of the improvement programme is on schedule, the focus during September has been defining the benefits and completing the metrics and measurements for 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. Please see Appendix 3.

5. RECOMMENDATIONS

- Members of the Trust Board are asked to note the report and in particular take assurance on the re-start on the Leadership and Talent work which is designed to support leaders to lead and manage for performance improvement and in doing so improve patient experience through achieving the outcomes and benefits contained within the valuing colleagues' element of the improvement programmed.

- In addition members of the Trust Board are asked to note that progress on the Organisational Development (OD) actions scheduled and feedback for colleagues raising concerns including racism and inequality based on protected characteristic are being reviewed on a monthly basis by the People and Organisation Development Committee and who will receive a detailed assurance report in December.

APPENDICES

Appendix 1: BAF Risk S04/Corporate Risk Register

Appendix 2: Performance Report – workforce metrics

Appendix 3: Improvement Programme Update

Risk Summary			
BAF Reference and Summary Title:	**BAF 04 - Value our Colleagues - We will be an inclusive organisation which lives our organisational values at all times**		
Risk Description:	**Lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care**		
Lead Director:	Director of People and Culture	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title** • **2072 -** Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency. • **707 -** Relates to a Failure to comply with equality, diversity and inclusion standards. • **2093 -** Staff are exposed to infection with COVID-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death • **2095 -** The demand for 'Personal Protective Equipment' (PPE) has contributed to a national shortage of proper and effective PPE, resulting in delays in obtaining from supply chain, with the potential to impact on our ability to maintain key critical services and protect staff against COVID-19.	**Current Risk Score** **20 (Major)**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			• Staff recommending Walsall as a place to work is below all England average [bottom quartile Q2 2019-2020] • Staff recommending Walsall as a place to be treated is below all England average [bottom quartile Q2 2019-2020] • Staff engagement score in NHS staff survey is below peer comparators • NHS staff survey indicates a lack of inclusive culture with differential staff experience in bullying, harassment, violence, career progression and promotion • NHS staff survey indicates a lack of open culture (speaking up)	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:						**Risk Level:**	**8**	

				below peer comparators • The model hospital data indicates bottom quartile performance on workforce indicators such as sickness absence and use of resources • Historical WRES data indicates a lack of progress to tackle barriers to inclusion. • 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 staff have shared stories of unreasonable treatment based on their race, disability, ethnicity and sexuality.		

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Values launched and evaluated across the Trust • Staff engagement and communication approach in place • Policy on zero tolerance to violence in place • Behaviour Framework implemented and evidence of practicing behaviours in action to be reviewed within the IPDR process • Values based appraisal process in place which incorporates Talent Management and the ability to track access to career progression and promotion • Increased engagement through engagements and EDI champions • Health and Wellbeing approach based on holistic offering to staff being developed • Just Culture work initiated and ER	• Head of Talent, Resourcing and Inclusion appointed to lead the approach • Analysis against actions required from NHS People Plan against actions progressed under the Valuing Colleagues Improvement Programme has been reviewed by PODC.	

	casework triaged for opportunities for early resolution. • Staff in at risk groups have been identified and managed appropriately according Wellbeing Review and Stratified Risk Assessments. • Set of measures have been identified to monitor progress against workforce inequalities and employment inequality in Walsall.		
Gaps in Control	• Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Approaches and resources may be insufficiently robust or at scale to achieve meaningful change • Current Policy framework not fit for purpose – legacy policies are not aligned to the approach • Further support required to develop FTSU approach and embed within the leadership approach • Leadership development programme is in its infancy • Management competency framework is not yet available, impact and evaluation not complete • Resourcing not yet stable – workforce metrics still demonstrate adverse trends • EDI targets at organisational and divisional level have not been developed.		
Assurance:	• 21 • Engaging with the wider Trust and TMB on co-designing an Organisation Development Plan – work packages and delivery through the improvement programme • 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. •	• People and OD committee of the Board in place to seek assurance, through the cycle of business and review of workforce metric trends. • EDI group led by a Non-Executive director in place to review approach to EDI and delivery of metrics in the EDI strategy framework and Equality Impact Assessment. • PODC receive monthly updates regarding to assure robust arrangements in place to support colleagues through the impact of COVID. • BAME cabinet provides strategic Board focus on EDI.	• NHSi working with the Trust to develop the FTSU approach and to develop a strategic framework by Q2 for FTSU by 2020-2021 • NHS Leadership Academy working with the Trust on developing leadership capacity and capability, the delivery was scheduled for Q1 1920-21, paused due to Covid response • NHSi partner for Retention programme – the 90 day plan is complete, impact on retention rate to be reviewed Q2 1920-
Gaps in Assurance	• All elements of the Trust Board pledge, bullying harassment, discrimination and listening to the voice of staff. • Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Evidence based approach to positive action interventions not yet in place to support EDI objective • Evaluation of zero tolerance to violence not yet evaluated.		

	• NHS staff survey results do not evidence an improvement in staff reporting of an inclusive and open culture • The indicators for staff recommending the Trust as a place to work or a place to be treated have failed to improve significantly. • The staff engagement score has worsened indicating lower levels of staff morale and role satisfaction. • NHSE/I Governance and Accountability review highlighted areas of improvement associated with culture and leadership • No internal audit assurance gained in year • Line managers are required to ensure all staff have received an opportunity to undertake a wellbeing review risk assessment. Not all staff are recorded to have participated in the process. • Benefits of the Valuing Colleagues Programme to be agreed. • An audit against ESR data is being undertake to provide assurance regarding workforce and learning data quality.

Future Opportunities

- Capitalise on external resource/expertise to establish evidence based best practice
- Closer working with through the STP/LWAB
- Collaborative working with other Trusts to creatively address resourcing matters
- New roles and scenario based workforce planning for full resourcing and consequent impact on staff morale
- To work collaboratively on a Black Country Health and Wellbeing approach to make Walsall and the Black Country the best place to work
- To develop a more structured and inclusive approach to widening participation
- To develop the Trust's profile as an employer of choice by having clear pathways for career development.
- To become an anchor employer within Walsall attracting talent as a result of our EDI approach and strategy.
- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Board EDI development sessions scheduled for October 2020.
- Divisional Board Accountability Framework to monitor on Divisional EDI targets

Future Risks

- A culture of speaking up is not embedded and the organisational culture does not support the development of FTSU
- The capability and capacity of leaders does not support the development of a Just Culture approach in practice
- Recruitment and retention activity does not result in improved performance, meeting targets for vacancy, turnover, absence and the trust remains below peer comparators within the STP.
- Potential second wave of COVID impacting on the physical and psychological health of individuals and workforce availability.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Draft Health & Wellbeing Strategy & Engage and Consult Key stakeholders	Catherine Griffiths	October 2020		

2.	Develop and Implement a leadership Development Programme	Catherine Griffiths	March 2021		
3.	Launch EIA Policy and Form	Catherine Griffiths	October 2020		
4.	Review and relaunch equality impact assessment processes	Catherine Griffiths	March 2021		

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
707	Failure to comply with equality, diversity and inclusion standards for services leads to poor experience for patients causing increased complaints, impact on patient and staff experience and potential regulatory action	A gap analysis of the Trust arrangements regarding equality, diversity and inclusion highlighted significant gaps in provision, monitoring and reporting. The risk to the organisation is: - Users of the services will have a poor/inequitable experience - Staff could receive inequitable treatment and opportunity - The Trust fails to meet its statutory obligations under the Race Equality Act and other legislation Equality Diversity and Inclusion - failure to promote, develop and support a culture which values equality, diversity and inclusion with the risk of adverse impact on patient experience and staff experience and the potential for the trust values to not be the lived experience of staff working within the Trust and patients being treated within the Trust. The risk	Sabrina Richards	1 6	• • There is an EDI Strategy which has been developed and is published on the Trust intranet (effective until 2022). • Policy • HR policies in place to ensure consistent, open and transparent processes and procedures • Policy • Staff Survey results improvement	• EDI group chaired by a Non Executive Established EDI improvement workstream of the Improvement programme established • WRES 2019 analysis report Staff Survey Results • PODC reviews approach to EDI and monitors key performance indicators EDI group established WRES action plan developed •WRES Single oversight framework staff survey results • PODC overseeing Staff survey action plan People and Culture Workstream of the improvement programme EDI lead appointed EDI NED Champion in post FTSU champions in place FTSU NED in post •WRES Staff Survey Single oversight framework	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		that differential staff experience impacts adversely on staff engagement and involvement in improvement. The risk of the Trust not being able to attract and retain talent for the current and future workforce and in particular the ability to attract and retain a diverse workforce, inclusive and representative of the community it serves across all job groups and at all levels within the Trust. The risk that organisational controls are not sufficient to meet the Trust's Public Sector Equality Duty requirements, NHS Provider Contract requirements and the legal provisions of the Equality Act potentially resulting in discrimination on grounds of sex, age, sexual orientation, race, religion or belief, disability, marriage or civil partnership, gender reassignment or due to pregnancy.					

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
02/03/2020	Explore options to pilot the Recruiting for Difference (RfD) initiative in specific hot spot area and report on pilot outcomes to determine whether this initiative should be implemented in the trust.	Sabrina	Richards	26/12/2020	31/12/2020
31/03/2020	To carry out a detailed analysis of hotspot areas across the trust where White staff are more likely to be appointed than BME staff and provide a report to PODC. This will enable targeted work to be completed within the divisions with specific targets linked to the staff survey indicators and WRES/WDES indicators.	Sabrina	Richards	**Closed** 26/07/2020	31/07/2020
31/03/2020	Review and revise the current recruitment and selection policy and processes and communicate changes across the organisation. Safeguards will be put in place to ensure consistent, open and transparent processes and procedures.	Sabrina	Richards	**Closed** 26/07/2020	31/07/2020
31/03/2020	-The development of a revised recruitment and selection training package to be delivered as a webinar. All recruiting managers will be required to attend. The revised package will incorporate learning about the WRES and WDES and the importance of being an inclusive recruiter. This training will be available from mid-May until the end of the year	Sabrina	Richards	**Closed** 26/07/2020	31/07/2020
02/03/2020	To develop a set of equality diversity and inclusion targets for inclusion within divisional directorate accountability reviews. The targets will be linked to staff survey indicators for harassment bullying and abuse and WRES/WDES workforce indicators.	Sabrina	Richards	**Closed** 26/07/2020	31/07/2020

Walsall Healthcare Risk Register

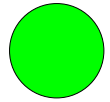
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1390	Inaccuracies within ESR does not allow correct training figures to be supplied to the division which is a risk to reported data that the Division appears incompliant with mandatory training.	ESR is not updated timely with training records. ESR has wrong mandatory requirement attached to wrong people. Managers cannot be assured that their teams have completed the required training to deliver a safe high quality service. System does not currently interface robustly with Allocate (Doctors system) and record basic competencies.	Jenna Davies	1 5	• Process • ESR operations Policy & Plan • Process • Individual managers emailing and reviewing data with ESR when inaccuracies are identified. • Process • Competence and data matching completed during January 2020. Alignment to core skills framework and process agreed at TMB in February 2020	• • • • • TMB • CQC	
2072	Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency.	National planning decisions have impacted the supply of healthcare staff in particular doctors in training and theatre staff and therefore our ability to recruit is reduced .This can drive reliance on temporary staffing arrangements which may impact on quality and financial controls and the fundamentals of care	Clair Bond	1 6	• Process • A values based appraisal process which incorporates Talent Management and the ability to track access to Career progression should assist in retaining the staff already employed • BAF Control 05 • - Working across the system across the STP with HEE partners to define local, collaborative, system and national workforce supply solutions. • Process • Valuing Colleagues Improvement Programme involves a number of work	• Valuing Colleagues Improvement Board and PODC. Training and development sessions to support managers. Coaching techniques to support conversations. F2SU approach and feedback. • WRES and WDES performance. 2020 National Staff Survey (results due Feb 2021) • Workforce Plan is reviewed and agreed by TMB and PODC • Workforce STP agenda via STP people board Collaboration with Walsall Together Partnership Board. • Improvement Programme Board People and Organisational Development Committee.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					packages which seek to improve staff experience, amplify Walsall as an anchor employer and enhance our ability to attract, recruit, retain and develop the workforce.	• NHS People Plan - STP People Plan WRES / WDES data	
					• Training • Improvement in education and training offer intended to expand apprenticeship offer, identify and develop new roles on a local and system wider level, and improve the ability to transfer competencies and skills between NHS employers.	• •	
					• Policy • Improve workforce flexibility and availability by harnessing opportunity of agile working within the Trust, standardising job roles / descriptions and supporting the case to align bank processes internally and across the STP system.	• Agile working task and finish group established. • BCWB STP People Board	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
31/03/2021	Workforce Policy Framework to be aligned to the Valuing Colleagues Improvement Programme	Clair Bond	26/03/2021	31/03/2021
01/04/2020	Participation in STP task and finish group to scope business case and benefits for establishing collaborative nurse and midwifery bank.	Clair Bond	26/03/2021	31/03/2021
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond	26/03/2021	31/03/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2093	Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust	Staff are exposed to infection with COVID-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death. Mitigations include national measures to control the outbreak, training for staff in IPC/hand hygiene, provision of appropriate PPE in workplace settings.	Matthew Lewis	20	• Training • Systems and processes are in place to ensure designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • Physical Barrier • All staff providing patient care in Covid Area have access to the right PPE appropriate for the clinical situation	• During the outbreak wards have gradually been converted to COVID-19 specialist areas, clinical staff have been supported by National Guidance, SOPs, Education by IPT, Matrons and Div DONs. Use of existing policies. PPE training and education has continued through the outbreak in line with the National guidelines including the don and doff of PPE with posters provided to all clinical areas along with links on the Intranet and Daily Dose communications. Staff letters have been sent reminding them of need to be re tested when different masks are received by the Trust. WHT has actively followed National Guidance throughout outbreak guidance from Royal Colleges reviewed and escalated to Strategic command where there is conflicting advice. PHE PPE guidance followed, posters are issued to each clinical area by IPN when a change is made and posted on Daily Dose daily communication. Trust Policies meet the National Cleaning Guidance requirements, with the addition of HPV decontamination where possible. • • Where specific shortages are reported, a risk assessment is undertaken through Tactical Command Mitigations are put into place. Tactical command and strategic command in place Regular PPE Audit undertaken • No External Assurance available	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Policy • COVID 19 Incident category set up to enable staff to raise concerns relating to Covid-19 and PPE	• Weekly SI meeting in place, with weekly oversight of all incidents raised in relation to COVID-19 Incidents relating to PPE - discussed with staff member at the time, ensure have updated information /poster/policy. Line manager informed if persistent issues or particular team issues. • non available external assurance currently available review commissioned	
					• Process • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Covid-19 health and wellbeing group in place and reviewing approach to physical and psychological wellbeing is supported Additional 24/7 mental health support has been deployed Additional occupational health support Health and Wellbeing booklet has been sent out via email and paper copy to all staff in the organisation,. Oversight of Covid-19 health and wellbeing through POD • No external assurance is available at the time	
					• Process • Risk assessment in place to support vulnerable staff with underlying health conditions, to include BAME staff	• Oversight via Corporate Command Oversight via strategic command Oversight via POD EDI group support the development and roll out of BAME risk assessment • No external Assurance available at this time	
					• Policy • There have been a number of staff test positive for COVID and there is evidence that in one department, cases are linked and are formally regarded as an outbreak.	• OH support to track, trace and test. IFC and H&S support to audit areas for compliance with social distancing, PPE and IFC measures. Hand Hygiene and IFC M&S training Colleague COVID Hotline implemented • PHE and NHSE/I support in place to manage and monitor outbreak.	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
15/07/2020	Every line manager to undertake a stratified risk assessment of at risk/ vulnerable/ BAME groups and returns/ compliance collated by HR.	Catherine Griffiths	11/10/2020	16/10/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
15/07/2020		Workforce to reflect assurance with regards to completion of risk assessments for 'at risk' staff internally and externally.	Catherine Griffiths			25/09/2020	30/09/2020
15/07/2020		Assessment to be undertaken to determine reasonable adjustments have been put in place to mitigate risk to any staff members identified as being at high risk/ vulnerable.	Catherine Griffiths			11/10/2020	16/10/2020
07/09/2020		Outbreak meeting in place to respond and manage the outbreak. Assurance sought by Trust, PHE and NHSEI that appropriate actions are in place in response.	Matthew Lewis			25/09/2020	30/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2095	The demand for 'Personal Protective Equipment' (PPE) has contributed to a national shortage of proper and effective PPE, resulting in delays in obtaining from supply chain impacting on our ability to maintain key critical services and protect staff against COVID-19.	Inabilty of the NHS supply chain to provide an adequate and on-going supply of PPE to meet the demand to ensure that Walsall Healthcare NHS staff are fully protected during the Covid-19 pandemic.	Caroline Whyte	1 6	• Process • Daily PPE meeting with clincial , procurement and distribution staff to review levels and report into tactical command. • Process • Frequent communication via comms route to ensure staff re aware of PHE gudiance in relaiton to correct PPE. • Process • PPE figures fed into tactical comand daily with daily burn rates and usage figures discussed. • Process • External review to be undertaken to provide a diagnostic and assurance around protecting staff in the workplace, whilst delivering care to Covid Patients	• PPE numbers have been reported to QPES in May 2020 • PPE stock levels monitored daily via SIT rep process • Incident Command process in place which oversees the Trusts response to change in national PPE guidance • Infection Prevention and Control framework presented to QPES • PPE stock levels have remained consistent and sufficient for the organisation • • Review has been agreed via strategic command •	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/09/2020	Provide Fit 2 Fit training via external provider to staff particularly in high use areas.			25/09/2020	30/09/2020
15/05/2020	Daily sitrep of PPE figures into tactical command for oversight and assurance	Gillian Farr		26/12/2020	31/12/2020
15/05/2020	Ensure mutual aid proposal agreed at tactcial command.	Caroline Whyte		26/12/2020	31/12/2020
11/08/2020	Draft a proposal to secure monies to recruit an RPE lead to provide training in all areas of RPE including cascade of FIT Testing	Jenna Davies		17/09/2020	22/09/2020
14/04/2020	A Paper to be presented to Strategic Command outlining approach to Fit Mask testing	Jenna Davies	**Closed**	25/04/2020	30/04/2020
01/05/2020	relevant staff received a letter outlining the FP3 mask trained on and whether they are compliant	Matthew Lewis	**Closed**	04/05/2020	09/05/2020
21/05/2020	IPC Board Assurance Framework to be completed which includes elements of PPE and Health and Safety	Jenna Davies	**Closed**	26/07/2020	31/07/2020
30/06/2020	Source reusable half face masks specifically for high use areas.	Gillian Farr	**Closed**	26/08/2020	31/08/2020
30/06/2020	Procure 2x Portacount meters to facilitate quantitative Fit testing.	Gillian Farr	**Closed**	19/08/2020	24/08/2020

Walsall Healthcare NHS
NHS Trust

August 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

Page 2 – Workforce Performance Summary

Page 3 – SPC Summary Dashboards

Page 7 – Workforce Metrics

Page 10 – Trust Analysis & Performance Drivers

Page 11 – Appendix

Workforce Performance Summary

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

Appraisal Compliance

- The release of guidance from NHS England & Improvement has provided clarity on the flexible approach for the appraisal of medical colleagues.
- Advice that Trusts should aim “to begin reinstating appraisals by 1 October, with a view to resuming normal levels of activity by 1 April next year” will be assessed internally; with interests of patient safety and colleague development/well-being taken into account.

Sickness Absence

- The impact of supporting colleagues who need to shield themselves, combined with the increased adoption of remote working arrangements, is reflected in a 3 year low for long-term absence (2.96%).
- Colleagues with long-term conditions, who may have previously suffered frequent sickness absence, are likely to be shielding; with advances in I.T. support and working models making the management of long-term illness whilst also contributing to service delivery a more attainable option.

Mandatory Training Compliance

- The Learning & Development Team have been engaging directly with colleagues via email/Microsoft Teams; clarifying training requirements and resolving any individual barriers to compliance.
- The use of virtual courses for safeguarding competencies has been scaled up; with the feedback from larger audiences positive. This model of training delivery will be explored for other mandatory courses, providing improved economies of scales of compliance improvement.

SPC Summary Dashboard - Retention (24 Months)

*Exclusions Apply – See Appendix A	August 2020 Outturn	Numerator: FTE (24 Months+ Service)*	Denominator: June 2019 FTE*	Will We Meet The Target? (85%)	Is Performance Stable?	Analysis Page
WH Trust	**82.7%**	2637.23	3188.13	**No**	Yes	8
Adult Community	**139.7%**	412.97	295.58	**Yes**	**Getting Better**	-
Estates & Facilities	**83.9%**	215.33	256.77	**Yes**	**Getting Worse**	-
MLTC	**71.0%**	472.81	665.85	**No**	**Getting Worse**	-
Surgery	**84.5%**	545.30	645.59	Sometimes	**Getting Worse**	-
WCCSS	**67.1%**	619.66	923.51	**No**	**Getting Worse**	-
Chief Executive Directorate	**50.0%**	4.00	8.00	**No**	**Getting Better**	-
Finance Directorate	**78.0%**	63.12	80.89	Sometimes	**Getting Worse**	-
Governance Directorate	**66.4%**	21.47	32.31	**No**	**Getting Worse**	-
Informatics Directorate	**94.6%**	101.70	107.54	Sometimes	**Getting Better**	-
Medical Directorate	**42.3%**	6.19	14.63	Sometimes	**Getting Worse**	-
Nurse Directorate	**106.5%**	75.88	71.22	**Yes**	Yes	-
Operations Directorate	**201.1%**	24.13	12.00	**Yes**	**Getting Better**	-
People & Culture Directorate	**98.0%**	62.95	64.24	Sometimes	**Getting Better**	-
Transformation & Strategy	**117.3%**	11.73	10.00	Sometimes	**Getting Better**	-

SPC Summary Dashboard – Sickness Absence

	August 2020 Outturn	Numerator: FTE Days Lost During August 2020	Denominator: FTE Days Available During August 2020	Will We Meet The Target? (4.5%)	Is Performance Stable?	Analysis Page
WH Trust	**4.2%**	4777.50	113196.41	Sometimes	**Getting Better**	8
Adult Community	**3.7%**	621.67	16927.36	Sometimes	Yes	-
Estates & Facilities	**10.2%**	798.37	7835.87	**No**	**Getting Worse**	-
MLTC	**3.7%**	830.20	22514.84	Sometimes	**Getting Better**	-
Surgery	**4.7%**	1061.85	22834.58	**No**	**Getting Better**	-
WCCSS	**4.0%**	1095.88	27250.98	Sometimes	**Getting Better**	-
Chief Executive Directorate	**0.0%**	0.00	308.00	**Yes**	Yes	-
Finance Directorate	**1.7%**	42.80	2483.86	Sometimes	Yes	-
Governance Directorate	**0.0%**	0.00	851.47	Sometimes	**Getting Better**	-
Informatics Directorate	**1.2%**	46.25	3975.72	Sometimes	Yes	-
Medical Directorate	**7.9%**	60.00	758.87	Sometimes	Yes	-
Nurse Directorate	**3.7%**	112.00	3057.20	Sometimes	Yes	-
Operations Directorate	**8.8%**	83.63	947.74	Sometimes	Yes	-
People & Culture Directorate	**0.9%**	62.95	2845.59	Sometimes	**Getting Better**	-
Transformation & Strategy	**0.0%**	0.00	604.33	Sometimes	**Getting Better**	-

SPC Summary Dashboard – Mandatory Training Compliance

Walsall Healthcare NHS Trust

	August 2020 Outturn	Numerator: Competencies Completed	Denominator: Competencies Required	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**86.5%**	37764	43666	**No**	Yes	8
Adult Community	**96.3%**	6665	6920	Sometimes	**Getting Better**	-
Estates & Facilities	**89.2%**	3168	3550	**No**	**Getting Better**	-
MLTC	**79.1%**	6443	8149	**No**	Yes	-
Surgery	**81.4%**	6966	8558	**No**	**Getting Worse**	-
WCCSS	**89.1%**	9800	10994	Sometimes	**Getting Worse**	-
Chief Executive Directorate	**75.8%**	69	91	**No**	**Getting Better**	-
Finance Directorate	**94.0%**	761	810	Sometimes	**Getting Better**	-
Governance Directorate	**89.2%**	255	286	Sometimes	Yes	-
Informatics Directorate	**94.5%**	1370	1450	Sometimes	Yes	-
Medical Directorate	**93.8%**	150	160	Sometimes	**Getting Better**	-
Nurse Directorate	**92.7%**	1085	1170	Sometimes	**Getting Better**	-
Operations Directorate	**82.2%**	290	353	Sometimes	Yes	-
People & Culture Directorate	**90.1%**	869	965	Sometimes	Yes	-
Transformation & Strategy	**94.3%**	198	210	Sometimes	Yes	-

SPC Summary Dashboard – Annual Appraisal Compliance

Walsall Healthcare NHS Trust

*Exclusions Apply – See Appendix A	August 2020 Outturn	Numerator: Appraisals Completed*	Denominator: No. Colleagues Eligible For Appraisal*	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**76.7%**	2534	3303	**No**	**Getting Worse**	8
Adult Community	**92.2%**	483	524	Sometimes	Yes	-
Estates & Facilities	**72.2%**	239	331	Sometimes	**Getting Worse**	-
MLTC	**69.0%**	389	564	**No**	Yes	-
Surgery	**68.6%**	446	650	**No**	**Getting Worse**	-
WCCSS	**88.4%**	700	792	Sometimes	**Getting Worse**	-
Chief Executive Directorate	**66.7%**	4	6	Sometimes	Yes	-
Finance Directorate	**60.6%**	43	71	**No**	**Getting Worse**	-
Governance Directorate	**34.8%**	8	23	**No**	**Getting Worse**	-
Informatics Directorate	**66.7%**	86	129	**No**	Yes	-
Medical Directorate	**80.0%**	8	10	Sometimes	Yes	-
Nurse Directorate	**61.8%**	55	89	**No**	**Getting Worse**	-
Operations Directorate	**59.3%**	16	27	**No**	Yes	-
People & Culture Directorate	**76.7%**	56	73	Sometimes	Yes	-
Transformation & Strategy	**7.1%**	1	14	**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	3658.38	-	-	-	-	-	-	-	59.74
Substantive Staff FTE (Ex. Rotational Drs)	3513.84		3526.82	3537.75	3583.09	3596.23	3580.58	-	-	-	-	-	-	-	66.74
Substantive Staff Headcount	4238		4246	4275	4302	4321	4306	-	-	-	-	-	-	-	68
Bank Staff Only Headcount	919		967	995	1012	988	1007	-	-	-	-	-	-	-	88
% Staff from a BME Background	28.09%		28.12%	28.24%	28.03%	28.19%	28.37%	-	-	-	-	-	-	-	0.27%

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	121.68	-	-	-	-	-	-	-	-0.09
Additional Clinical Services	619.10		615.85	616.39	623.22	625.37	626.99	-	-	-	-	-	-	-	7.89
Administrative and Clerical	807.03		804.47	806.79	819.07	825.11	829.16	-	-	-	-	-	-	-	22.13
Allied Health Professionals	221.43		222.60	221.93	225.53	228.17	228.17	-	-	-	-	-	-	-	6.74
Estates and Ancillary	252.47		250.75	250.13	250.23	250.06	249.21	-	-	-	-	-	-	-	-3.26
Healthcare Scientists	45.22		45.52	43.93	42.93	43.62	43.22	-	-	-	-	-	-	-	-2.00
Medical and Dental	363.71		364.51	360.34	358.94	356.24	358.69	-	-	-	-	-	-	-	-5.02
Nursing and Midwifery Registered	1159.93		1155.45	1145.99	1145.11	1146.82	1145.04	-	-	-	-	-	-	-	-14.89
Students	8.00		30.53	54.36	82.16	81.36	56.23	-	-	-	-	-	-	-	48.23

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	-15.64	-	-	-	-	-	-	-	-
Starters WTE	482.66		57.27	27.53	46.49	28.69	98.00	-	-	-	-	-	-	-	257.97
Leavers WTE	547.19		21.69	26.12	16.15	25.15	132.65	-	-	-	-	-	-	-	221.77
TUPE in WTE	0.00		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	-	-	-	-	-	-	-	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%	7.37%	-	-	-	-	-	-	-	8.89%
Add Prof Scientific and Technic	16.74%	10%	15.66%	17.56%	18.54%	18.73%	18.35%	-	-	-	-	-	-	-	17.77%
Additional Clinical Services	9.66%	10%	8.85%	9.64%	10.53%	8.98%	8.40%	-	-	-	-	-	-	-	9.28%
Administrative and Clerical	10.24%	10%	10.34%	9.80%	5.52%	3.35%	4.95%	-	-	-	-	-	-	-	6.79%
Allied Health Professionals	17.41%	10%	14.63%	13.52%	13.72%	12.48%	11.05%	-	-	-	-	-	-	-	13.08%
Estates and Ancillary	7.73%	10%	6.96%	6.91%	5.84%	5.87%	3.98%	-	-	-	-	-	-	-	5.91%
Healthcare Scientists	5.56%	10%	6.60%	7.50%	2.14%	4.55%	4.67%	-	-	-	-	-	-	-	5.09%
Medical and Dental	6.30%	10%	5.28%	5.66%	6.32%	6.96%	5.82%	-	-	-	-	-	-	-	6.01%
Nursing and Midwifery Registered	12.06%	10%	10.77%	11.40%	10.15%	8.07%	7.64%	-	-	-	-	-	-	-	9.61%

Workforce Metrics

Walsall Healthcare NHS
NHS Trust

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%	91.05%	-	-	-	-	-	-	-	90.56%
Retention Rate (24 Months)	81.96%	85%	82.14%	82.09%	82.39%	82.79%	82.72%	-	-	-	-	-	-	-	82.43%
Retention Rate (5 Years)	60.58%		63.13%	62.75%	63.56%	63.47%	63.39%	-	-	-	-	-	-	-	63.26%

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%	74.12%	-	-	-	-	-	-	-	72.47%
Additional Clinical Services	78.39%		80.55%	81.19%	80.49%	80.61%	81.02%	-	-	-	-	-	-	-	80.77%
Administrative and Clerical	86.84%		89.61%	88.88%	89.97%	90.54%	90.68%	-	-	-	-	-	-	-	89.93%
Allied Health Professionals	72.46%		76.26%	74.60%	75.52%	76.39%	74.81%	-	-	-	-	-	-	-	75.51%
Estates and Ancillary	90.41%		87.80%	88.02%	88.84%	89.44%	85.84%	-	-	-	-	-	-	-	87.99%
Healthcare Scientists	81.50%		75.37%	75.37%	73.55%	78.96%	76.45%	-	-	-	-	-	-	-	75.94%
Medical and Dental	85.04%		84.24%	84.07%	85.08%	85.72%	85.08%	-	-	-	-	-	-	-	84.84%
Nursing and Midwifery Registered	80.09%		78.92%	79.22%	79.16%	79.44%	79.95%	-	-	-	-	-	-	-	79.34%

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%	4.22%	-	-	-	-	-	-	-	5.55%
% Sickness Absence (Rolling 12 Months)	5.61%	4.50%	5.83%	5.82%	5.75%	5.63%	5.52%	-	-	-	-	-	-	-	5.71%
FTE Days Lost	73437		8986	6733	5405	4861	4777	-	-	-	-	-	-	-	6152
% Short Term Sickness	30.27%		28.21%	22.98%	26.72%	28.53%	29.84%	-	-	-	-	-	-	-	27.26%
% Long Term Sickness	69.73%		71.79%	77.02%	73.28%	71.47%	70.16%	-	-	-	-	-	-	-	72.74%
Estimated Cost of Sickness £	£6,433,476		£835,103	£564,120	£446,924	£404,236	£390,296	-	-	-	-	-	-	-	£528,136

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	1336.4	-	-	-	-	-	-	-	13.68%
Back Problems	436.4		438.7	610.6	602.4	580.6	702.9	-	-	-	-	-	-	-	34.50%
Other musculoskeletal problems	590.2		670.6	586.7	524.8	404.7	426.9	-	-	-	-	-	-	-	-11.44%

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%	86.48%	-	-	-	-	-	-	-	84.08%
Appraisal	80.27%	90.00%	75.05%	72.85%	71.68%	73.53%	76.72%	-	-	-	-	-	-	-	73.97%

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

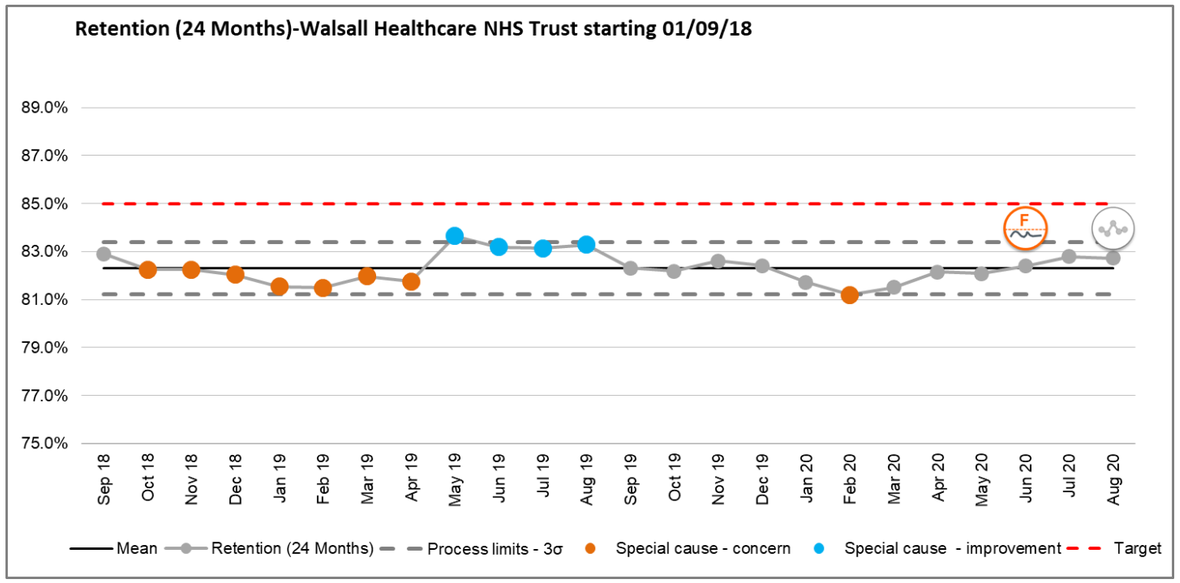
Bank Spend (£000's)	2019/20	Target	2020/21												YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Bank Spend	**£15,073**		£1,653	£1,524	£2,143	£1,744	-	-	-	-	-	-	-	-	£7,065
Nursing and Midwifery Registered	£4,267		£448	£441	£439	£459	-	-	-	-	-	-	-	-	£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	-	-	-	-	-	-	-	-

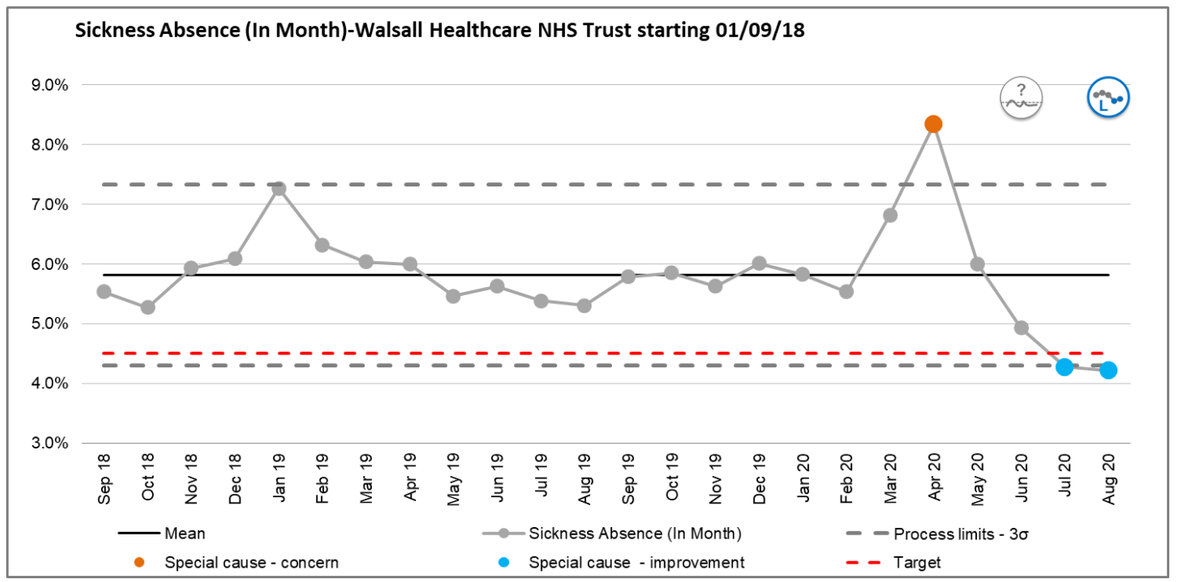
Trust Analysis & Performance Drivers

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

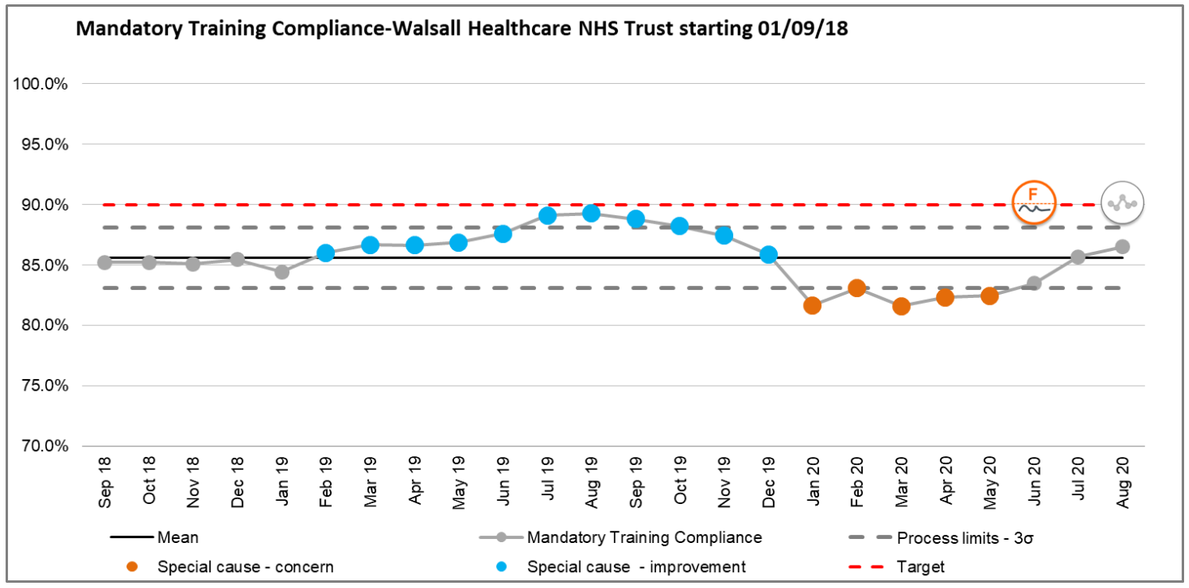
Walsall Healthcare NHS Trust



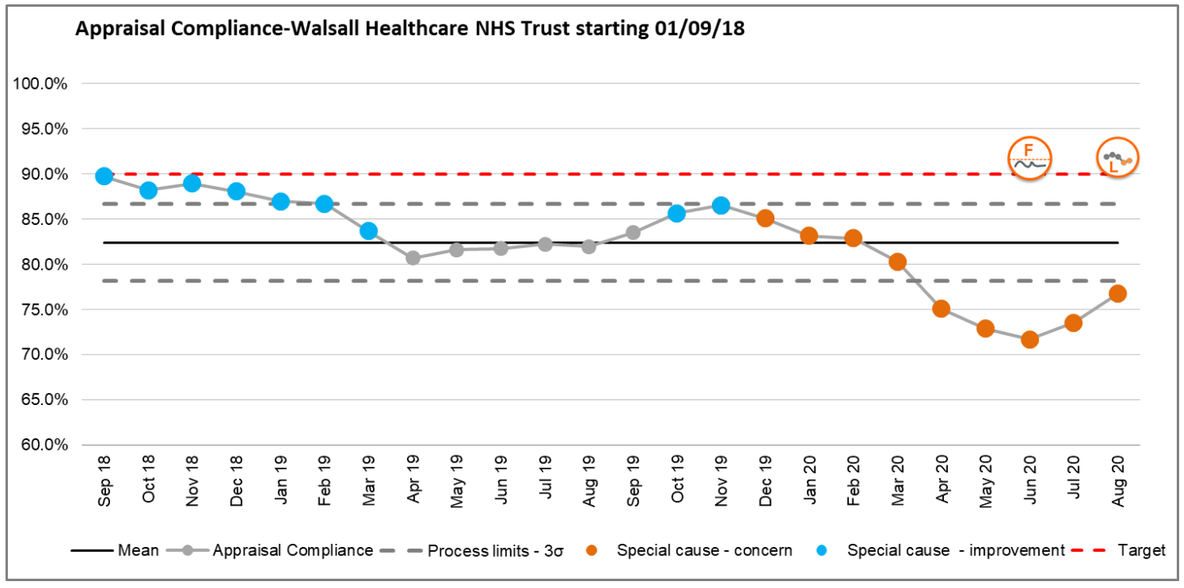
- Retention rates remain stable around an 82% average.
- High Retention = Admin/Estates/Medical | Low Retention = Scientific



- Absence levels are beginning to stabilise below 4.5%.
- Lowest recorded long-term absence levels, at 2.96%, since Sep-17.



- 5th successive month of improvement, with compliance now at 86.5%.
- All competencies show progression towards the target trajectory.



- Sustained month on month improvement in PDR compliance.
- Compliance remains is lowest amongst Admin & Clerical Colleagues.

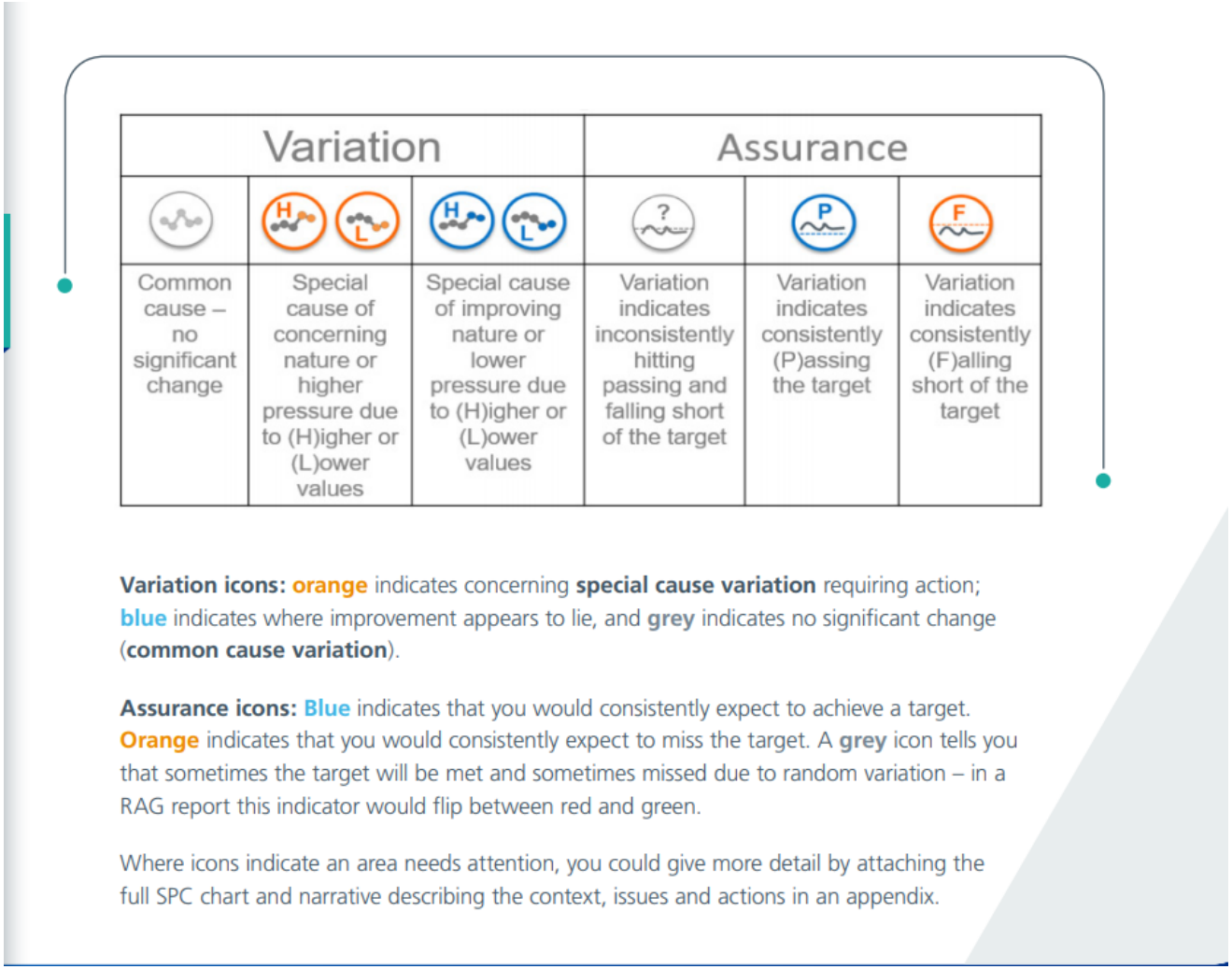
Appendix A - Supplementary Comments

- 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 B - Using the SPC Charts



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: orange indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

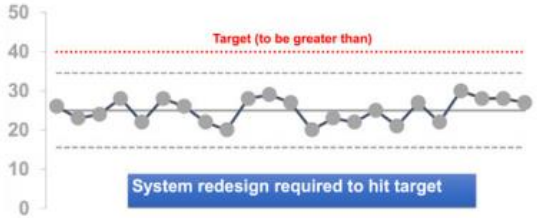
Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

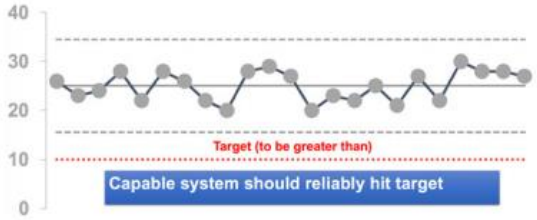
Appendix B - Using the SPC Charts

The position of a target line in relation to the process limits will inform you if your indicator can hit a target or threshold consistently, by random chance, or not at all.

If your target line is in between the process limits be cautious about reacting to success (green) and failure (red) when natural variation may be causing the target to be passed or failed. Remember that approximately 99% of data points should fall within the process limits. These graphs will help guide your action:

Improvement Analysts **Alex and Thomas,** discuss the presence of target lines in statistical process control (SPC) charts for assurance.





Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

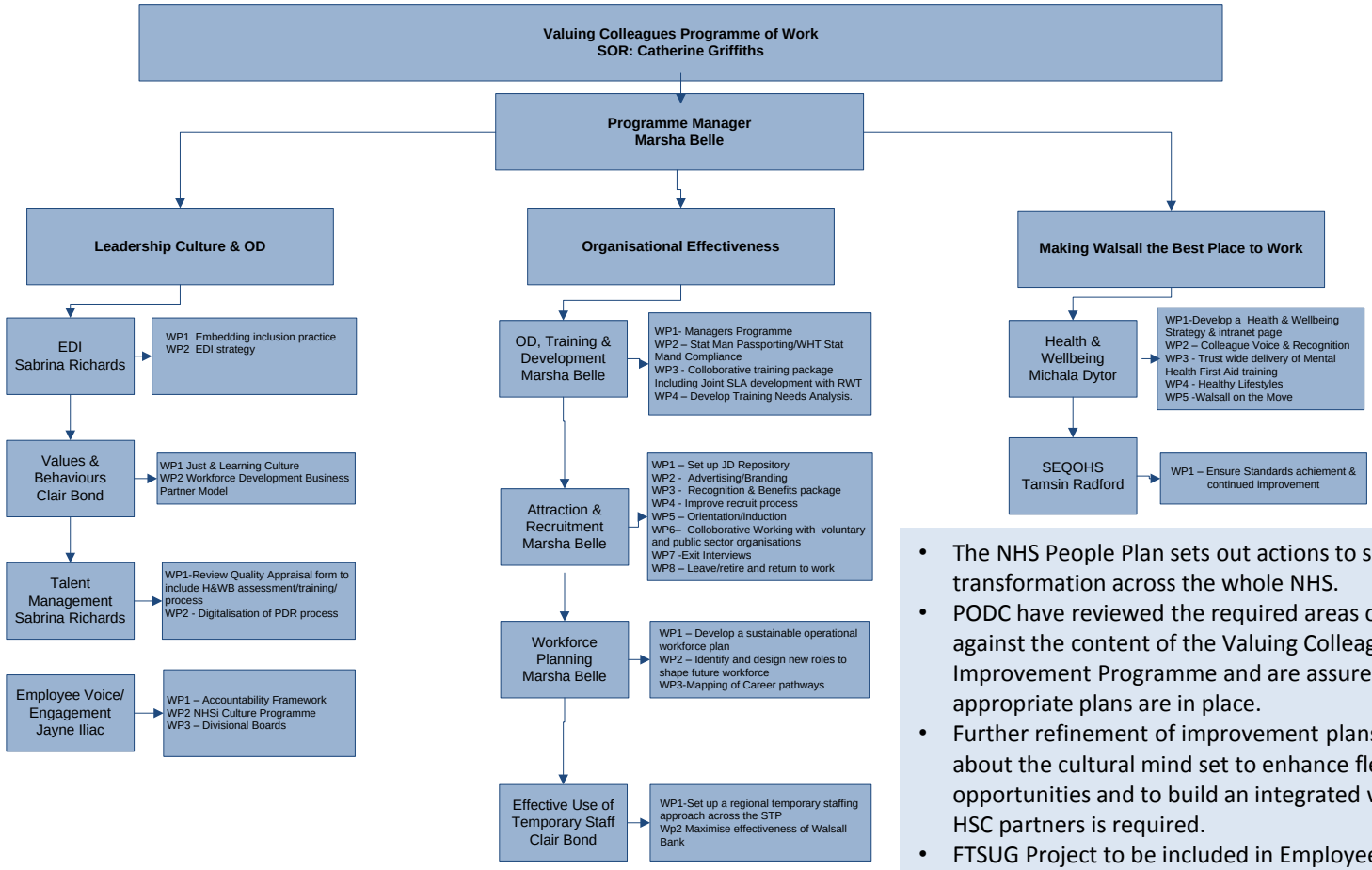
Appendix C - HR KPI RAG Rating Scales

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 %	>5%	4.5% - 5%	<=4.5%
Turnover	>11%	10% - 11%	<=10%

Appendix D - Training & Appraisal Exclusion Lists

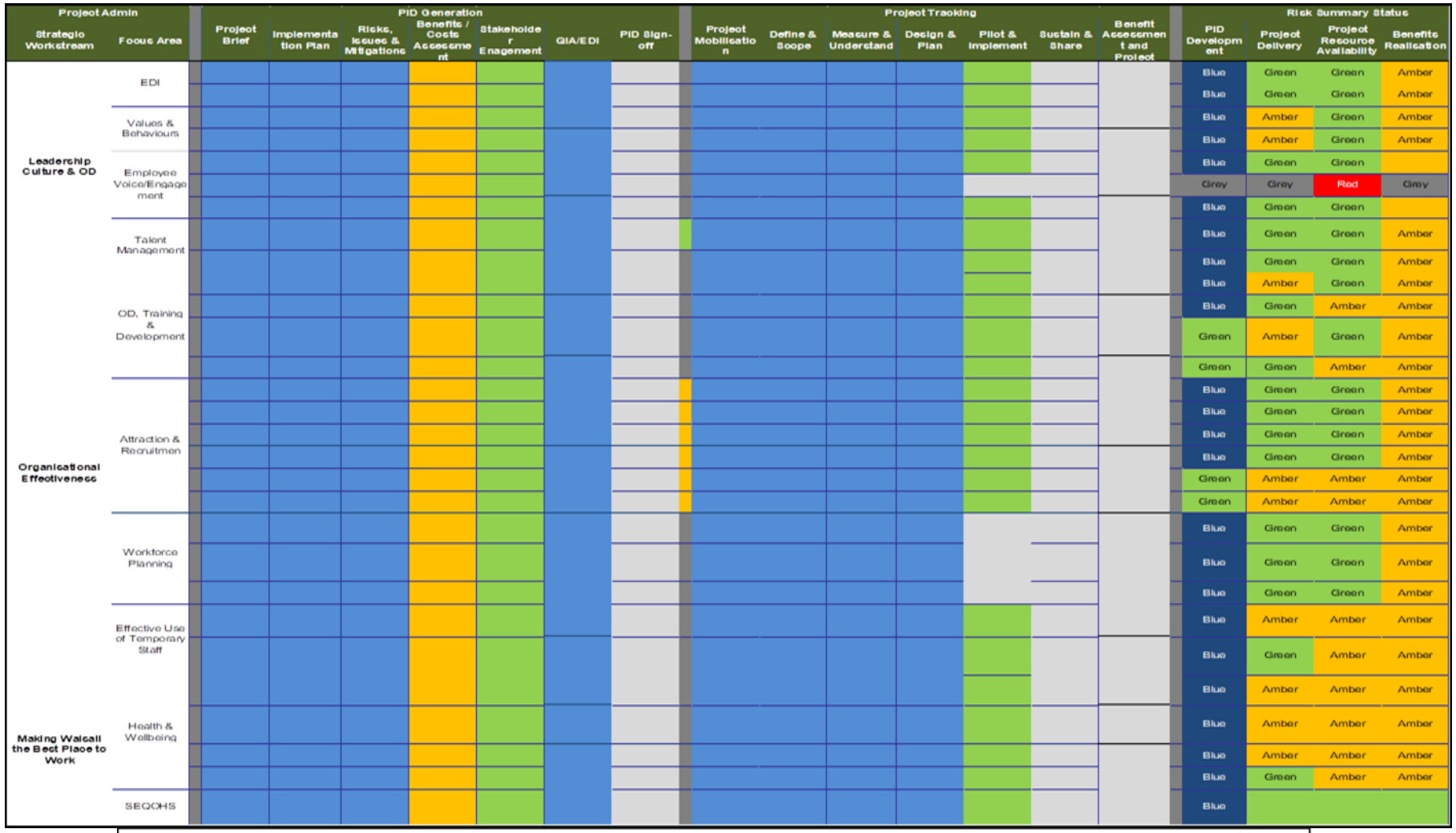
Training	Annual Appraisal
• Bank Staff* • Rotational Doctors (FY1s/FY2s)* • Students* • Anyone on Career Break* • Anyone on External Secondment* • Anyone on Suspension* • Anyone on Maternity Leave*** • Anyone Long-Term Sick***	• Bank Staff* • Rotational Doctors (FY1s/FY2s)* • Students* • Anyone on Career 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



- The NHS People Plan sets out actions to support transformation across the whole NHS.
- PODC have reviewed the required areas of action against the content of the Valuing Colleagues Improvement Programme and are assured that appropriate plans are in place.
- Further refinement of improvement plans to bring about the cultural mind set to enhance flexible working opportunities and to build an integrated workforce with HSC partners is required.
- FTSUG Project to be included in Employee Voice & Recognition Work Package

Valuing Colleagues workstream development update: September 2020 IPBoard



Workstream / Project Admin Info

PID Development Status

Project Implementation Status

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	As a result of COVID organisational recovery and potential Wave 2 of the COVID pandemic it could impact on overall delivery of this programme of work and associated benefits		Reporting progress and escalating slippages through Governance Framework
	There is insufficient Comms and Engagement capacity to involve wider internal stakeholders in the design and delivery of work packages		Comms and engagement has been secured for 3 days per week for an initial period of 5 months covering 6 core areas. We are proactively working with them to develop a Comms and Engagement Strategy.
Issues	Capacity of team to deliver programme of work in line with BAU requirements whilst responding to requirements of COVID recovery		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. Specific HR / OD support has been commissioned to support teams with complex needs.
	H&WB Hub temporarily moved to MLCC which is not appropriate due to availability of access for staff and growing demand for conference rooms		Decision still outstanding to house H&WB Hub as if a resolution is not agreed then this is having a detrimental impact on benefits realisation of this project
Dependencies	Safe High Quality Care, Pathway to excellence programme of work		Joint work shop required to define workforce model / employment model –and design principles (org and team levels) to be established
	Well Led Programme of Work		Joint working to define clear aims and objectives to deliver Accountability Framework and business partner models

MEETING OF THE BOARD – 1st October 2020			
Safe Staffing Report			**AGENDA ITEM: 12.3** **ENC: 15**
Report Author and Job Title:	Caroline Whyte Interim Deputy Director of Nursing	**Responsible Director:**	Ann-Marie Riley Interim Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	Registered Nurse (RN) vacancy rate is currently 7.57%. 23 student nurses are expected to convert to substantive posts during September and October. The ward establishment review process is taking place throughout September and will be reported through the Committee structures in October The overall Nursing and Midwifery fill rate was 99.45% in August and was an increase of 3.4% since July. Bank utilisation has increased in Nursing and strategies to continue with a Tier 2 reduction are in place. NHS Improvement (NHSI) agency cap breaches have continued to remain within control Reporting of Red Flag incidents is reported via the Safeguard system on Allocate. Areas who have reported Red Flags are noted in the report		
Recommendation	The Committee is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF S01: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022 Corporate Risk 2066: There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience		
Resource implications	COVID-19 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-19-19 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 ☒		

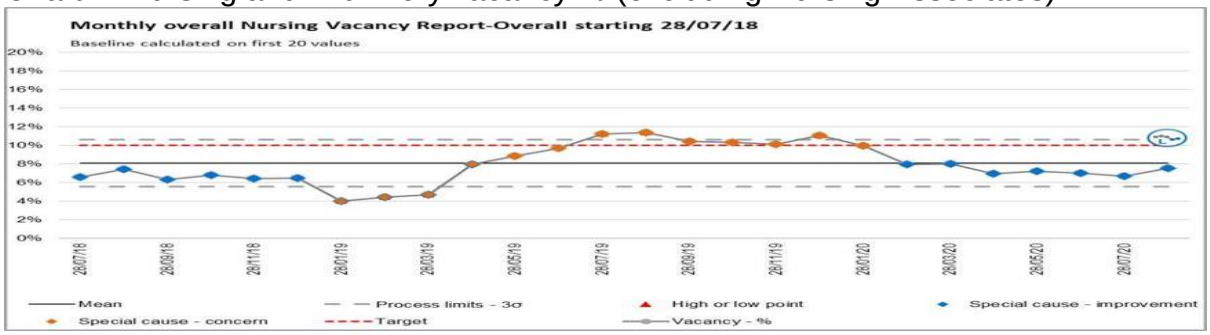
Safe Staffing Update

1: Vacancy Position

The registered nurse (RN) vacancy rate for August is 7.57% which equates to 89.65 whole time equivalent (wte) nurses (Chart 1). 23 nursing students are expected to join the Trust in September and October 2020 as RN's, pending Examination Board sittings.

The Central Recruitment Team are planning to commence a Task and Finish Group to commence work related to the Nursing and Midwifery recruitment strategy to ensure that it is aligned to support operational changes and service re-design to ensure the safest staffing levels possible are achieved whilst COVID-19-19 challenges remain.

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



We have a total of 59.32wte Nursing Associate (NA) posts within establishments. As noted in previous papers the numbers of NA trained, or available externally for recruitment, outstrips demand.

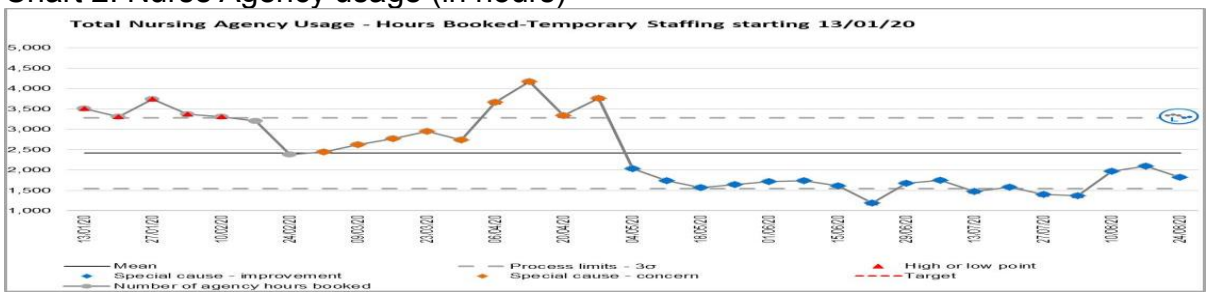
The vacancy position for NA's remains at 76% with 15.18 WTE NA's in post. The vacant gaps for these positions are predominantly filled with bank or agency Band 5 nurses. This leads to an additional £6.31/hr (potential >£10k/wk) cost pressure for every shift backfilled with a bank B5 RN (obviously the backfill cost increases if agency RNs are used to backfill NA shifts).

Nursing Establishment reviews are scheduled during September and we will review the NA position during those meetings.

2: Temporary Staffing Analysis of Hours Used

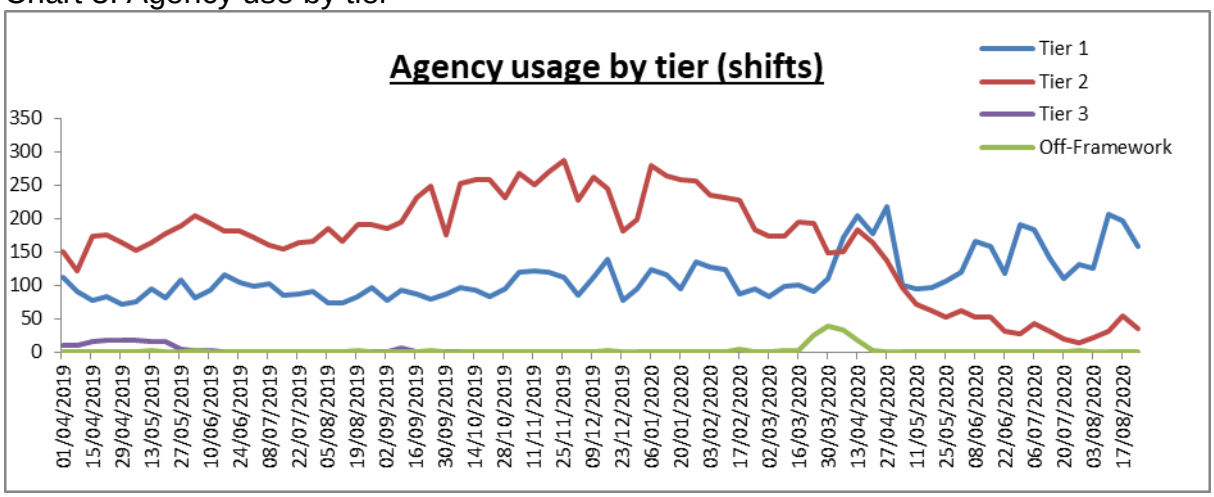
Nurse agency use fluctuated during August, with the final week in August seeing 1830 hrs used (see Chart 2).

Chart 2: Nurse Agency usage (in hours)



Both Tier 1 and Tier 2 use showed some variation during August with the final week showing a reduction in both. Tier 2 use remains low at 144 shifts for August and this is in line with our activities to avoid Tier 2 use (see Chart 3). The majority of Tier 2 use is within our ED department who currently have an additional demand due to COVID-19-19 streams within the department.

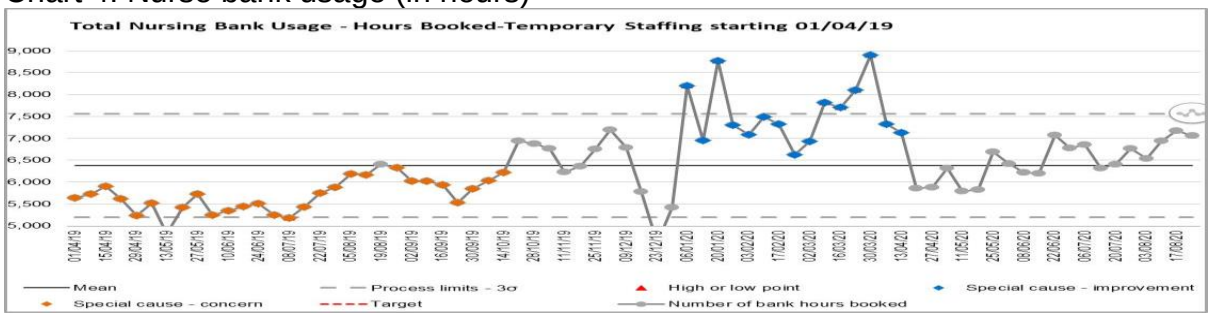
Chart 3: Agency use by tier



Matrons also ensure that in the twice daily staffing meetings we seek opportunities to redeploy personnel where this is safe to do so. In August, before consideration of escalation to Agency Tier 2, Matrons redeployed 281 hours of substantive RN and 342 hours of Clinical Support Worker (CSW) from reviews during staffing approval meetings.

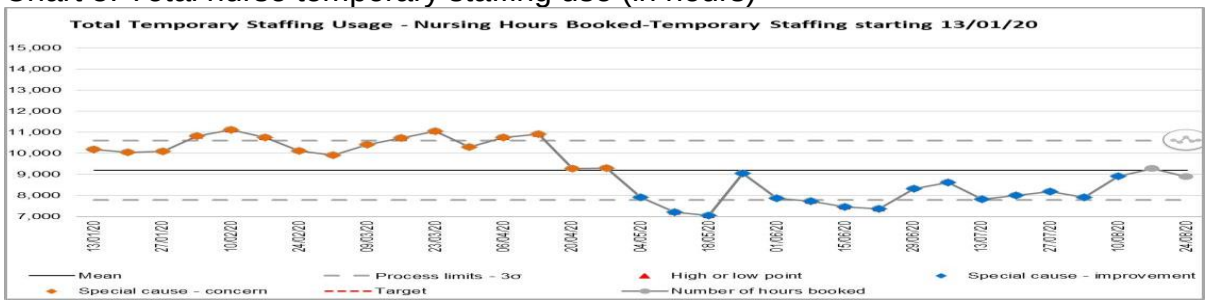
Bank shift utilisation (see Chart 4) has continued to increase during August and some of this can be attributed to lower levels of staff absence and therefore more staff available to work. COVID-19-19 Bank pay rates will have contributed to this positive effect also. Bank staff also have an enhanced level of shift visibility through the Allocate HealthRoster suite.

Chart 4: Nurse bank usage (in hours)



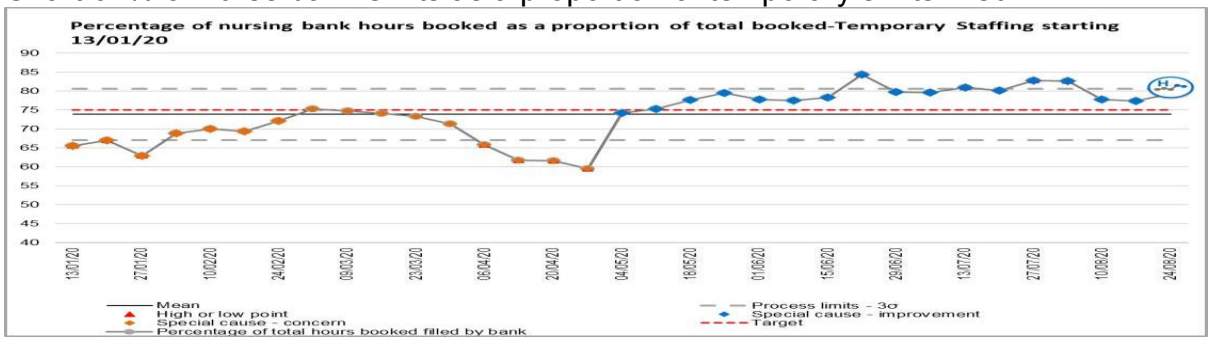
Overall temporary staffing (see Chart 5) use in nursing is remaining within control limits and is less than pre COVID-19. Reasons for this are substantive staff redeployments and increased empty beds across a number of wards.

Chart 5: Total nurse temporary staffing use (in hours)



Bank as a proportion of our temporary staffing use has remained higher than normal during August (see Chart 6). Bank staff pay rates were increased by £3 per hour during the COVID-19-19 period and contributes significantly to overall spend. 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.

Chart 6: % of nurse bank shifts as a proportion of temporary shifts filled



NHSI Agency Cap Breaches (see Chart 7) have continued to be reported weekly to NHSI. There was 34.5 hours of Off Framework use in August for Intensive Care Unit (ICU) support and in a correction to last months' report this is compared to 40.5 hours used in July, all for ICU. The number of cap breach shifts has remained within control. We had 144 Cap Breaches within August 2020 and for the same period in 2019 we had 899. The avoidance of Tier 2 is contributing to this improvement (See Chart 8).

Chart 7: Agency cap performance

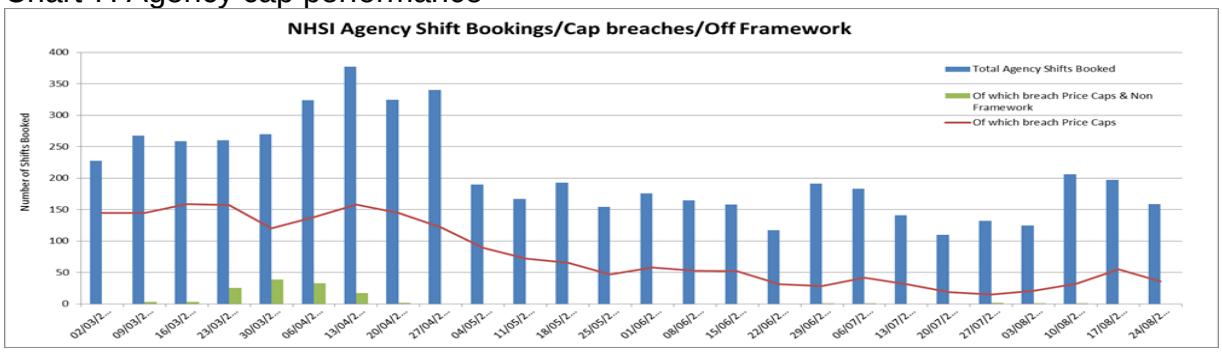
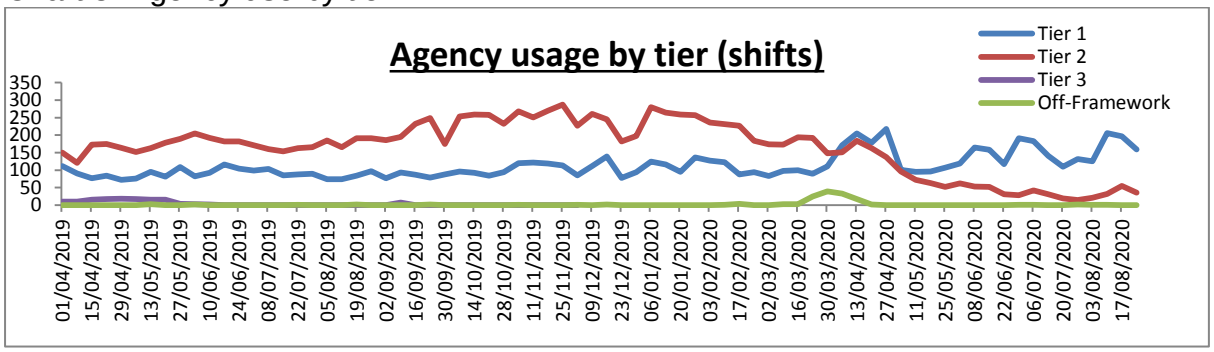


Chart 8: Agency use by tier

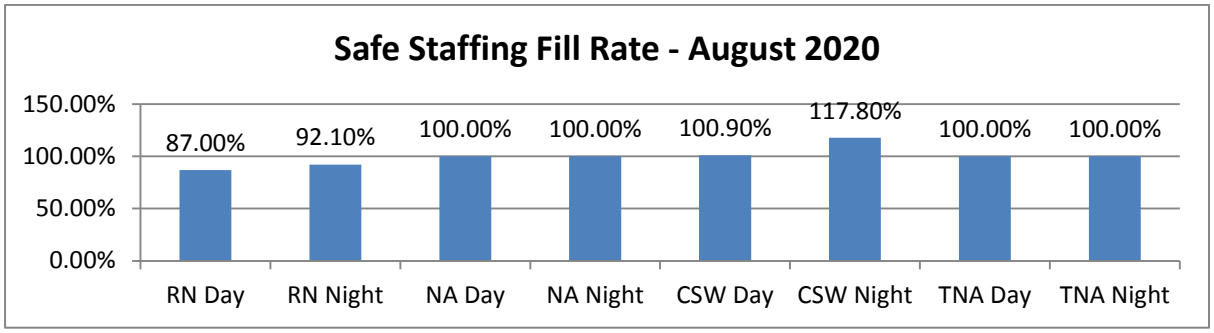


3: Staffing Fill Rates

Lowest fill rate was seen in the day RN at 87% (see Chart 8) this is a slight reduction on last month. The overall nursing and midwifery fill rate was 99.45% in August and was an increase of 3.4% since July. 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 varied in June between 66% to 100% with mean in-patient occupancy of 81%. This calculation is based on adult in-patient wards, excluding paediatric and maternity, who do not use agency for temporary staffing. Wards 20a and 20b were also excluded due to the nature of their current operation of arrivals, day-case, non-COVID-19 in-patients and High Dependency Unit (HDU). Further work is taking place within the division to understand the changes in bed base and staffing numbers.

Redeployed staff 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 have their costs reclaimed via COVID-19-19 central funds.

Chart 8: Ward areas fill rates



4: Staff sickness and temporary staffing cover

RN sickness absence has reduced during August (Chart 9) and is at the lowest level since September 2018; CSW sickness absence (Chart 10) has also reduced and is improved compared to the same period last year.

Chart 9: Sickness Absence RN (ESR data)

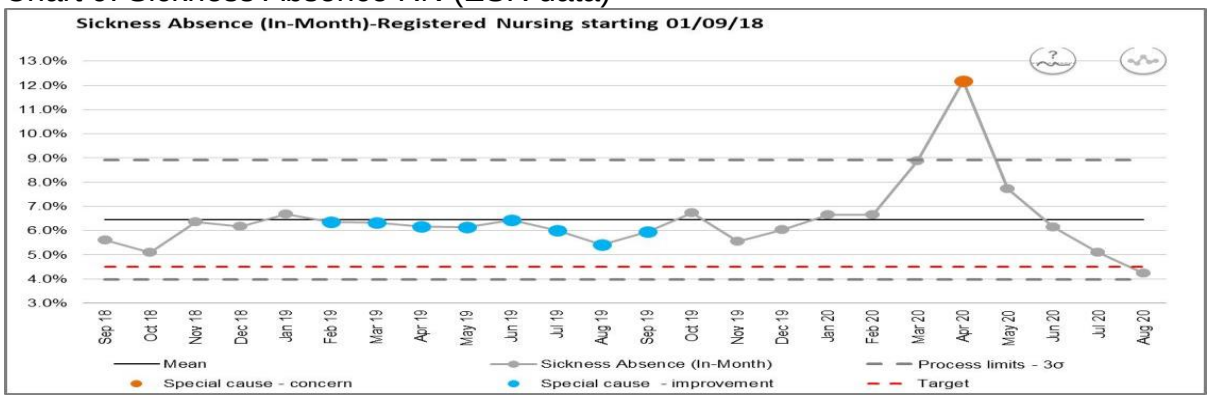
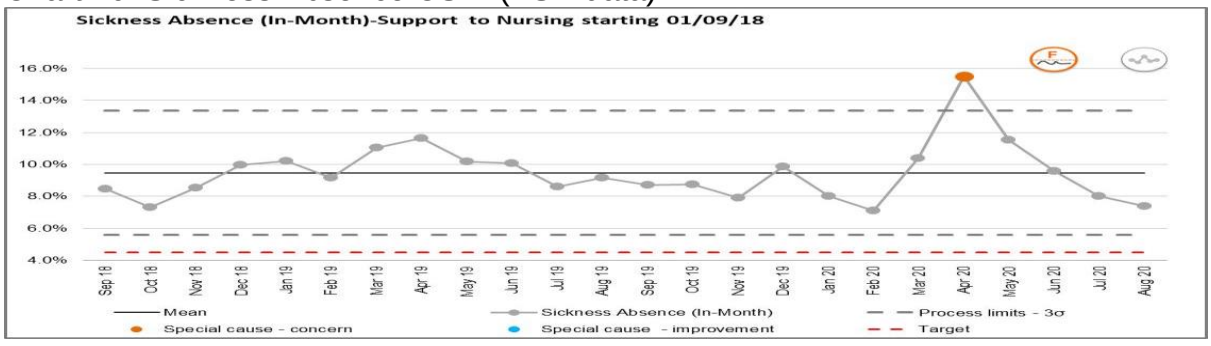


Chart 10: Sickness Absence CSW (ESR data)



In the Eroster systems we have the recorded numbers of COVID-19 Related 'other leave' which areas will backfill using the sickness reason for Temporary Staffing (Table 1).

Table 1: Eroster Systems COVID-19 related absence levels

Staff Type	COVID-19 Related Absence Hours (Eroster)
RN	553
CSW	448

Table 2 highlights the maternity/paternity absence in comparison to identified backfill for this reason.

Table 2: Comparison of Maternity/Paternity absence against Temporary Staffing

Staff Type	Maternity/Paternity Absence hrs	Temporary Staffing Hours Cover for maternity/paternity related absence
RN	3910	1008 (-2902 hours variance)
CSW	2340	443 (-1897 hours variance)

Temporary staffing bookings for additional capacity was used for the following areas:

Ward with increase	RN increase (24 hrly)	CSW increase (24 hrly)	Total in month increased requirement (hrs)
Ward 14	23 hrs	0	RN=552 hrs
Ward 12	0 (reduction of 11.5)	11.5	CSW=345
Ward 10 gaps			RN=549 hrs CSW=203 hrs
ED Covid streams	46 hrs		RN=1426 hrs
TOTAL REQUIRED FOR MONTH			**RN= 2527 hrs CSW=548 hrs**

- Ward 14 (open until 24 Aug)
- Ward 12 staffing levels remained at COVID-19-19 levels during August
- Staff required in Ward 10 ,after all redeployments from Wards 20a and 20b, gaps in staffing were covered with temporary staffing
- ED COVID-19-19 streams has required an additional 46 hours of RN per day (1xTriage/1x Resus 24 hours per day)

5: Red Flags and areas under review

5.1 Red Flags

Nursing areas have use of the Safecare system which can report Red Flags events, i.e. alerts which warn when nurses in charge must act immediately to ensure they have enough staff to meet the needs of patients. Use of the Safecare system commenced in June 2020 and this system records shift by shift information of Red Flags being reported at ward level.

The Red Flags determined by the National Institute of Clinical Excellence (NICE 2014) are:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as:
  - Pain: asking patients to describe their level of pain level using the local pain assessment tool.
  - Personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.
  - Placement: making sure that the items a patient needs are within easy reach.
  - Positioning: making sure that the patient is comfortable and the risk of pressure ulcers is assessed and minimised.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a Red Flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift (which is the loss of more than 25% of the required registered nurse time).
- Less than 2 registered nurses present on a ward during any shift.

Note: other Red Flag events may be agreed locally.

In August we saw an increase in use of the system across ward areas, though this shows an increase in Red Flags, however we are still in the embedding stage of the change process. There were 70 Red Flags recorded in August (Chart 3). We continue to see that the majority of Red Flags are recorded on weekdays (79%). The majority of Red Flags (68%) were recorded for the reason of 1:1 care. There were 3 Red Flags for delay in recording Vital Signs In August, this is a decrease compared to July. Details of the areas reporting Red Flags and the rationale can be seen in Table 4.

Chart 3: Red Flags

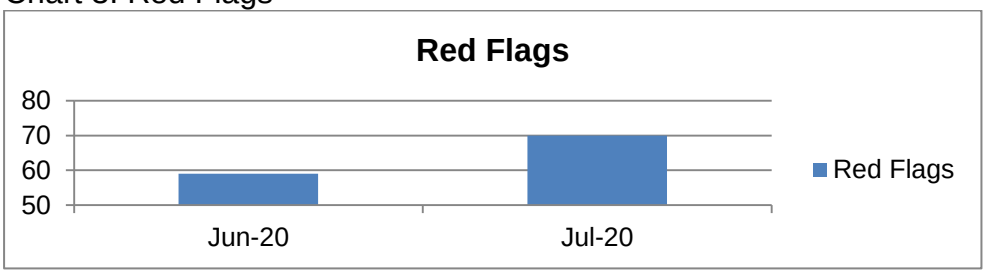


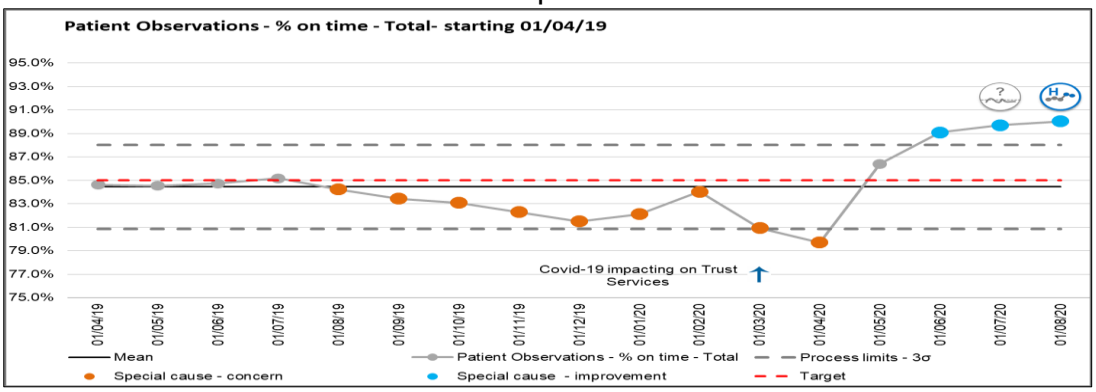
Table 4: Wards declaring red flags:

Ward	1:1	Increase in acuity	Delay in personal care	Delay in observations	Delay in medication	Shortfall of more than 8hrs or 25% of RN time
2	3		1			
3	14	2				
5/6	1				2	2
7				3		
9	5					
11	6	1				2
12	5					1
15	11	1	2			1
16	2	1				1
17	3					
29	2					1

As processes are still being embedded we don't currently have accurate data regarding which shifts had the Red Flags mitigated with additional support, but this will be reported once we have more accurate information.

Although we are starting to see areas report Red Flags for delays in conducting observations, the prevalence of late observations for adult patients overall has improved again in month to 90.03% in August from 89.70% in July. This remains the best performance since March 2019 (Chart 11).

Chart 11: % Patient observations completed on time



Within paediatric services Paediatric Early Warning Score (PEWS) audit show an average compliance of 98%.

5.2 Areas under review

Wards 2 and 16 have seen the most severe harm incidents over recent months (falls with harm) and Ward 16 has the worst performance for timeliness of observations in the Trust. Both wards are rated as amber via the current paper based quality metric review but
remained areas of concern. The following immediate actions were undertaken:

- Both Wards underwent a full review of harm free care using the new Perfect Ward App by the corporate nursing team.
- Unannounced Ward reviews took place using the CQC domains.
- All staff in both ward areas had a 1 to 1 conversation with the matron for the area, where responsibilities and accountability were discussed.

Ward 2 was rated as inadequate overall but was good for caring and well-led (Table 5). A second review will take place in three months.

Table 5: Ward 2 rating

Domain	Overall Scoring
Safe	
Effective	
Caring	
Responsive	
Well-led	

Ward 16 was rated as requires improvement in all domains (Table 6). A second review will take place in six months.

Table 6: Ward 16 rating

Domain	Overall Scoring
Safe	
Effective	
Caring	
Responsive	
Well-led	

Both ward areas have produced action plans that will be monitored via divisional governance routes.

6: Community Temporary Staffing Spend

The most recent update for Community temporary staffing spend in July saw an increase to £35,000 as they were still managing COVID-19-19 related care. Finance information has not been updated to include community spend for August (Finance Weekly Tracker). RN/RM Community total absence (Electronic Staff Record data) was 9265 hours in August and for CSW there was 2453 hours of absence which have both increased since July, see Table 9. The Division do not use Agency.

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

- June £28,000
- May £22,000
- April £21,000
- March £1.4,000

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.

7: Allied Healthcare Professionals Update

Work has continued to gather the Allied Healthcare Professional information for vacancies in month. Currently there is not a single route of oversight that gathers this data 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, these areas use a paper timesheet process for any Bank worked. Information gathered so far from service leads is shown in Table 10 and shows a total gap of 24.8 WTE.

Table 10: Allied Health Professionals Vacancy (WTE)

	Band 5 Vacancy (WTE)	**Band 6 Vacancy (WTE)**	**Band 7 Vacancy (WTE)**	**Band 8+ Vacancy (WTE)**
Physiotherapy	0.4	7.61	(0.52)	0
OT acute	0.4	1.69	0	0
Dietetics	0	(1.0) funded by paeds business case	0	0
Podiatry	0	0	(1.6)	0
SLT	(2.84)	(0.11)	(1.09)	(0.28)
Orthoptics	0	0.04	0.04	0
ODP's	3.96	1.22	0	0
Radiography	5.0	0.2	1.49	1.0
Audiology	0	0	0	0
CMU Neuro	0	0	0	0
Clinical Psychology	0	0	0	0.2
Specialist complimentary therapy	0	0	0	0
Sonography	N/A	N/A	1.57	0
Bereavement services	0	0	0	0
TOTAL GAP	**9.76 WTE**	**10.76 WTE**	**3.1 WTE**	**1.2 WTE**

(Bracketed number is over established)

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Addressing workforce and social inequality.			**AGENDA ITEM: 12.4** **ENC: 16**
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. The People and Culture Directorate have continued to seek assurance on the levels of risk assessment that have been completed and this continues to be managed by clinical divisions and corporate directorates. This important work remains an area of high focus for managers and leaders. Assurance that the process is undertaken meaningfully and dynamically across the organisation is provided from Divisional Boards through the divisional performance review process. At the time of writing this report (21 September 2020) 94% of BAME colleagues and 85% of all colleagues had received a risk assessment and 87% of colleagues with known risk factors (race, ethnicity, age and gender). Conversely this means that there are approximately 500 colleagues recorded as not having received a risk assessment, 53 of whom are from a Black, Asian and Ethnic Minority background. The baseline against which progress is measured is 'living data' and is updated frequently to reflect new starters and leavers. As a result there are colleagues who have recently returned to work, for instance from maternity leave, career breaks and long term sickness who require a risk assessment to be completed. To understand the experience of colleagues when undertaking the risk assessment and the types of changes that have been made as a result of the process, a survey has been developed for any colleague who has undertaken a risk assessment with their line		

	manager to complete. A high level summary of the feedback from the survey is provided within the main report. Understanding this in greater depth, particularly given the national increase in COVID-19 numbers and the number of cases experienced by staff is vital. A framework to provide further insight and assurance focusing on the impact of the risk assessments (keeping our staff safe) will be presented to PODC in October.	
Recommendation	The Board are asked to note the contents of this report in particular the continued focus to capture the measures put in place following with the completion of individual 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 S04; "*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-19 individual risk assessment; update report.

September 2020

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 provided in August 2020

- Updated position - number of risk assessments completed.
- The committee received early analysis of feedback received from a survey that has been released to understand staff experience of the risk assessment process and gain an insight into the measures put in place to safeguard colleagues.
- A high level comparison of how the Trust's performance has compared nationally

This months report will cover the following areas:

- Updated position – number of risk assessments completed. *An updated position will be reported to the Board verbally.*
- Overview of measures implements and changes to workplace actions.
- A review of the Trusts progress between June and September 2020.
- A discussion of key lessons / reflections

The Board are asked to note the contents of the report. The People and Culture Directorate have continued to seek assurance on the levels of risk assessment that have been completed and this continues to be managed by clinical divisions and corporate directorates.

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NHS Trust

Progress

The data provided is accurate as of the 21 September 2020. A verbal update will be provided at the Board meeting.

- 95% of colleagues from a Black, Asian and Ethnic Minority background (BAME).
- 85% of all colleagues had received a risk assessment.
- 87% of staff groups identified with a risk factor (BAME, White over 60 and all men).

The Board are reminded of the following points:

- The data is live and therefore takes into account new starters and leavers, and staff who are not available due to LTS, maternity leave etc.

- That from the 1 September 2020, Wellbeing Reviews and Risk Assessments were recorded on ESR as a competency against individual records.

Division	Risk Assessments Completed	
	BAME %	Overall %
***All**	**94.86%**	**84.92%**
Adult Community	96.15%	93.83%
Chief Executive Directorate	100.00%	94.44%
Directorate of Strategy	100.00%	70.00%
Estates and Facilities	97.22%	93.35%
Finance Directorate	95.00%	98.70%
Governance Directorate	100.00%	100.00%
Informatics Directorate	100.00%	90.71%
Medical Directorate	66.67%	28.00%
MLTC	96.31%	63.85%
Nurse Directorate	66.67%	57.55%
Operations Directorate	100.00%	29.63%
People & Culture Directorate	100.00%	91.21%
Surgery	95.73%	94.90%
WCCSS	93.02%	87.79%

Walsall Healthcare NHS
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Tracking our progress

This page provides an overview of the Trusts progress against national and local targets set in relation to the completion of risk assessments for staff.

The initial 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 failed to achieve the local and national target, reporting as at 30 July 2020 with 87% of risk assessments being completed for BAME colleagues and 57% for all colleagues.

In August NHSE/I extended the deadline for all staff to have received a risk assessment by the 2 September 2020. The Trusts performance submitted in accordance with NHSI/E reporting requirements is set out in box (a) and a comparative of our position regionally and nationally is provided within table (a)

Box (a) By 2 September 2020 the Trust reported the following position nationally:-

- 92% of BAME colleagues
- 75% of staff groups identified with a risk factor (BAME, White over 60 and all men).
- 74% of all colleagues had received a risk assessment.

Table (a)	Midlands Average	National Average
% BAME Assessed	98%	96%
% At Risk Assessed	95%	91%
% All Staff Assessed	88%	77%

Walsall Healthcare NHS
NHS Trust

Comparing our progress

On the Boards behalf, PODC have monitored progress against local and national performance requirements since June 2020. In August the committee sought to understand how the number of risk assessments completed within the Trust compared to performance of other Trusts across the Midlands. A detailed overview of the key actions taken to support the achievement of the requirements is provided in appendix 1 and a summary of the Trusts reported progress is detailed in appendix 2.

Board colleagues will recognise that the Trust made a decision to proactively protect the wellbeing of colleagues from a Black, Asian and Ethnic Minority in May 2020 before NHSE/I mandated the process on the 24 June 2020.

Each Trust has taken an individual approach to the process in the absence of a standardised approach and methodology. For example:

- Black Country Healthcare NHS Foundation Trust have achieved 100% compliance rate by directing the process via the Equality and Diversity lead.

- Sandwell and West Birmingham NHS Trust asked individuals to complete a risk assessment and email it to the OH Team. Each RA was reviewed by OH and contact was made with managers to clarify actions required.

At a recent Trust Management Board meeting, trust leaders confirmed their commitment to retaining the responsibility and accountability of undertaking risk assessments with line managers applying the principle ‘know your staff’ in action.

Walsall Healthcare NHS
NHS Trust

Measures taken

Throughout August and September, 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 and the measures taken to safeguard them at work.

At the time of writing this report only a small sample of completed questionnaires had been received. A summary of key feedback is provided below and an overview of the survey is outlined in Appendix 3.

- 47% of respondents advised that the risk assessment process had left them feeling safer at work. Where this was not the most common feedback related to staff failing to follow IFC guidance,
- 69% of respondents advised that the risk assessment process had left them feeling that their line manager took a genuine interest in their health and wellbeing.
- A number of free text comments were received relating to a lack of management training and understanding on how to apply and undertake the risk assessment.
- 43% of respondents fed back that adjustments were not required in response to their individual needs.
- Where adjustments were required these ranged from working remotely (27%) and not working in areas where COVID-19 patients could be treated (17%).
- 11% of respondents have been redeployed and a small proportion of respondents advised that they had moved offices. Feedback relating to redeployment included; “details of redeployment were very poorly explained”

Walsall Healthcare NHS
NHS Trust

Redeployment: Case Study

Through the completion of Wellbeing Reviews and Risk Assessments, the Surgical Division encountered challenges arranging to meet with colleagues as many had been redeployed to other areas due to the reduction in elective work. This prompted the division the want to seek to understand the impact that staff redeployed to other areas in response to COVID had felt.

The division were able to identify that 12 members of staff had resigned their positions as a direct response to their experience of not being able to work in their usual role / area of work due to COVID-19. Fortunately all of these staff have chosen to remain at Walsall Healthcare NHS Trust and to change the focus of their career.

Through this process the division were able to understand that a number of colleagues were particularly distressed following their redeployment to ITU over the COVID period. The ITU team have developed a support programme which involves debriefing these colleagues and supporting them to spend time on ITU during the recovery phase to help them to re-position the unit outside of COVID and support the individuals to grow their confidence and continue to develop ITU competencies should redeployment to the area be required in the future.

Conclusion

It is of concern that there remain colleagues working within the Trust who have not been able to access a Wellbeing Review and Stratified Risk Assessment, especially in light of the rise in cases and concerns regarding infection rates in the Black Country.

In August PODC were assured that managers would be held to account where risk assessments remain outstanding. This is being managed by the clinical divisions and corporate directorate leadership teams.

The detail and outcomes of risk assessments undertaken have not been collected on a central basis and this therefore limits the extent to which data relating to the proportion of specific measures implemented to protect colleagues, for example redeployment can be reported. PODC have recommended that this is explored directly with leadership teams within divisional performance reviews.

The Corporate Risk relating to the risk of COVID-19 on the workforce has been increased from 16 to 20 based on the recent outbreak involving contact between colleagues and the changing national picture. It is therefore important to ensure that risk assessments remain dynamic.

Walsall Healthcare NHS
NHS Trust

Appendix 1: Timeline

- 6 May 2020: Letter to Colleagues from BAME backgrounds outlining commitment to understand their COVID concerns and protect them at work.
- 06 May 2020: Wellbeing Review Template distributed
- 18 May 2020: Supporting resources launched for managers.
- 29 May 2019: Stratified Risk Assessment supported by STP/PHE & OH advice agreed.
- 4 June 2020: Risk Reduction Framework and Stratified Risk Assessment supporting resources released.
- 09 June 2020: Letter to all managers from Director of People and Culture clarifying that colleagues at increased risk should be prioritised for completion by mid June and that all other colleagues to receive a risk assessment by mid July.
- 7 July 2020:
    - Extraordinary TMB held to discuss how managers can be supported to undertake responsibility.
    - NHSI/E requested 100% risk assessment of at-risk staff group by the end of July 2020.
- 18 August 2020:
    - Provision of individual risk assessment template to support completion levels
    - Email to each Divisional Leadership Team to highlight RA position and need for management accountability.

- Monthly review at TMB, PODC and Divisional Performance Reviews.

Walsall Healthcare NHS
NHS Trust

Appendix 2: Summary of reported progress.

This page provides an overview of the Trusts reported position against national and local targets set in relation to the completion of risk assessments for staff. A detailed overview of the key actions taken to support the achievement of the requirements is provided in appendix 1.

(a) 30th June 2020:

- 43% of all BAME colleagues recorded as having received a risk assessment. *

(b) 30 July 2020

- 87% of BAME colleagues
- 57% of all colleagues had received a risk assessment. *

(c) By the 19 August 2020

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

(d) By 2 September 2020 the Trust reported the following position nationally:-

- 92% of BAME colleagues
- 74% of all colleagues had received a risk assessment.
- 75% of staff groups identified with a risk factor (BAME, White over 60 and all men).

(d) By 21 September 2020 the locally reported positon was

- 95% of BAME colleagues
- 85% of all colleagues had received a risk assessment.
- 87% of staff groups identified with a risk factor (BAME, White over 60 and all men).

** At this stage, the data parameters for determining 'at risk factors' had not been clarified by NHSI/E and were not reported.*

Appendix 3

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 - 1st October 2020			
Performance, Finance & Investment Committee Highlight Report			**AGENDA ITEM: 13.1 ENC: 17**
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 23rd September 2020. The report sets out escalations for the attention of the Trust Board, key issues discussed and work underway.
	- The Winter Plan, which is on the Trust Board agenda for this meeting, was endorsed by the Committee and is recommended to the Trust Board for approval.
	- The Committee commended the EPR (Electronic Patient Record) team for the delivery and execution of the Medway roll-out over the weekend of 19th/20th September.
	- Good progress was acknowledged on the Board Assurance Framework for the Use of Resources and Working With Partners strategic risks, as well as the Corporate Risk Register. To address gaps in controls and risk score rationale, an update on the backlog maintenance issue will return to the Committee in November.
	- The Trust achieved a break-even reported position for August 2020.
	- Further assurance was sought on temporary staff expenditure, however the Interim Director of Nursing provided assurance on the controls in place for temporary staff use and enhancements to those controls.
	- Excellent performance on constitutional standards continues both in community and the acute, with items of particular merit being:
	  - Gains continue to hold for medically stable for discharge and length of stay;
	  - Improvements in care navigation through care coordination that will have impact on admissions during winter;		

	- The Trust has now delivered four consecutive months of performance over 90% for 4-hour Emergency Access, with the s national ranking at 32nd out of 114 reporting Trusts in the country. - Suspected Cancer 2 Week Wait (all tumour sites) met the constitutional standard for the fifth consecutive month and Breast Symptomatic 2 Week Wait also met the standard in July. - National ranking for 6 Week Wait (DM01) Diagnostics position continues to improve further, up to 5th best in the country in July out of 123 reporting Trusts. - 18-week RTT national ranking position remains strong at 32nd best in the country in July out of 121 reporting Trusts, and August has shown the first signs of improvement since the pandemic, with performance improving to 61.1%. - The Committee approved the expenditure of the palliative care overheads for the Walsall Hospice. - The Committee approved the use of Interserve Construction Limited, the Trust's P22 partner, to undertake urgent estate works following the recent award of additional capital moneys for Urgent and Emergency Care, and Critical Infrastructure funding. The next meeting of the Committee will take place on 28rd 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 the BAF or Trust Risk Registers?	This report aligns to the BAF risk for use of resources and working with partners, and associated corporate risks.	
Resource implications	The resource implications are set out in this highlight 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 ☒	

MEETING OF THE PUBLIC TRUST BOARD – 1st OCTOBER 2020			
Use of Resources – Executive Update			**AGENDA ITEM: 13.2** **ENC: 18**
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. It updates Board members on the likely financial settlement for Months 7-12 of this financial year. This report identifies continued strong operational performance in national rankings for the NHS Constitutional standards, and risks to emergency access standard and elective waiting time performance standards ahead. This report identifies the work undertaken and debated through Board Development sessions on 3rd September and 16th September to model a likely financial scenario for the second half of the financial year, and that provision to support the Winter Plan (agenda item 8.2 Public Board) is secured through that scenario.		
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 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* Public Trust Board agenda item 8.2 Urgent & Emergency Care and Covid resilience Winter Plan. Interventions within this year's Winter Plan will cost £3.361m plus a further £1.336m of revenue funding to deliver the £4.1m UEC capital schemes that are national priorities. The total cost of this year's Urgent and Emergency Care and Covid resilience Winter Plan is therefore £4.697m which is accounted for in the likely financial modelling scenario for months 7-12.	
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 – Executive Update

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 incurred significant additional costs associated with Covid-19 (£10.4m YTD) to ensure patients and staff are kept safe.

This report identifies continued 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 work undertaken and debated through Board Development sessions on 3rd September and 16th September to model a likely financial scenario for the second half of the financial year, and that financial provision to support the Winter Plan (agenda item 8.2 Public Board) is secured through that scenario.

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 requested further strengthening of the BAF risk to better reflect the digital technology corporate risks, and a review of the Corporate Risk Register (CRR) to avoid duplication. To avoid duplication, corporate risk 2054 has been archived with relevant contents transferred to corporate risks 274 (medical equipment), 1005 (Backlog maintenance of the Estate) and 2188 (IT legacy infrastructure).

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

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 £10.4m 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 £10.4m to enable reporting of a break-even position as at month 5.

The Trust is currently servicing 75% of historic elective activity levels (with Emergency Department attendances in August 94.2% of August 2019 attendance levels) whilst costs remain higher than previous years and above the baseline plan, largely driven by temporary workforce costs (associated with segregated Covid pathways) that exceed historic levels. 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).

An Operational plan has been developed through the Restoration and Recovery work and financial modelling completed, with the modelling identifying a likely income scenario and run rate modelling for the remainder of the financial year (presented through Board Development and received by the Performance, Finance and Investment Committee).

Whilst this plan delivers key elements prioritised within the Board setting within an income envelope that is likely to be available, it does not deliver historic levels of elective performance. The key risk to the plan remains the uncertainty over levels of income for months 7-12 and clarification of the income settlement, to include determining the financial consequences of non-delivery of historic elective activity (for which NHSEI will reduce income allocations). Confirming the income settlement will be key to being able to deliver operational plans and financial balance in the latter half of the financial year.

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 the Performance, Finance and Investment Committee. It is also of note the Trust is in discussion with NHSEI to receive a further £2m allocation to support Critical Care and is awaiting confirmation to proceed from the regulator.

Operational

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

The Trust has delivered 4-hour Emergency Access Standard for four consecutive calendar months and was the 32nd best performing Trust nationally out of 114 reporting Acute Trusts in August 2020.

The Trust is ahead of its trajectory to recover the DM01 6-week wait Diagnostic standard following the impact of Covid-19 on elective care earlier this year, and is now the 5th best performing Trust nationally out of 123 reporting Acute Trusts in the most recently published national statistics (July 2020).

The Trust is now ahead of 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 is 32nd best performing Trust nationally out of 122 reporting Acute Trusts in the most recently published national statistics (July 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. A newly constituted weekly Cancer Waiting Times PTL and Performance meeting has been instituted by the newly in post Director of Operations for Surgery and commences on 30th September 2020.

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). The Trust's Urgent & Emergency Care and Covid resilience Winter Plan is presented for consideration by Trust Board under Agenda Item 8.2. The Winter Plan has been approved at Trust Management Board on 22nd September 2020, approved by Performance, Finance & Investment Committee on 23rd September 2020, and endorsed by Quality, Patient Experience and Safety Committee and by People & Organisational Development Committee on 24th September 2020. Board members should note that Emergency Access Standard performance is likely to deteriorate in the month of September, associated with worsened performance in the week immediately following EPR (Electronic Patient Record) Go-live whilst the new system was embedded.

In the likely scenario financial model for months 7-12, there are insufficient resources to enable differential investment in elective services to accelerate reduction in the number of patients waiting, and length of time that patients are waiting, for treatment. This in turn means the elective activity targets set in Sir Simon Stevens and Amanda Pritchard's Phase 3 letter are unlikely to be met unless the income settlement exceeds that which the Trust has modelled as it's likely scenario.

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 its 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, £4.1m Urgent & Emergency Care capital, and (subject to final confirmation) £2m Critical Care capital.

Significant work has been undertaken to assess and quantify the benefits associated with all Improvement Programme workstreams in recent weeks, and these are being presented at the Improvement Programme Board Development Session on 1st October.

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;
  i. Confirmation of the expected income settlement for months 7 to 12 aligning to the income profiled within the likely operational model presented to Board development session on 16th September 2020 and received by Performance, Finance and Investment Committee on 23rd September 2020. 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 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 the Board Development session on 1st October 2020, so as to assess the level of efficiency that can be delivered, supporting enhanced use of resources and financial and clinical sustainability.
  iv. Externally commissioned expertise will facilitate the development of a Trust Estates strategy to support coherent stewardship of this key resource.

APPENDICES

Appendix 1 - BAF S05

Appendix 2 - Performance Report (Finance and Constitutional Standards)

Appendix 3 - Improvement Programme update

Risk Summary			
BAF Reference and Summary Title:	**BAF 05 Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly**		
Risk Description:	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 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.		
Lead Director:	Chief Operating Officer	**Supported By:**	
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title** •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 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 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	**Current Risk Score** **20 (Major)**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	**4**	**4**			<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	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:	**20 (Major)**	**20 (Major)**				**Risk Level:**	**10 (Moderate)**	

				• Lack of credible plan to address backlog maintenance requirements. <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.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Finance reported monthly via Divisional Performance Reviews and Executive Governance Structures • CIP Governance processes in place • Revised financial governance in place for COVID-19	• Performance, Finance & Investment Committee in place to gain assurance • Audit Committee in place to oversee and test the governance/financial controls • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation) • Use of Resources work-stream identified as part of the Improvement Programme	
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 force. • Leadership development needs at Care Group, Divisional and corporate support service levels.		
Assurance:	• Model Hospital Use of Resources assessments	• Internal Audit reviews of a number of areas of financial and operational performance	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts
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		

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.

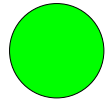
Future Risks

- 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.
- 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.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Develop divisional plans to address dips in activity and agree a forecast model to minimize the impact of annual leave on activity.	N. Hobbs/ K Salmon	Oct 2020		
2.	Review and update Accountability Framework further to the NHSI Governance Review report.	N. Hobbs	Oct 2020		
3.	Financial regime post 31st July 2020 to be approved by Board in October 2020- Russell Caldicott	R. Caldicott	Oct 2020		
4.	All work-streams to have Improvement programme benefits defined -	G. Augustine	Oct 2020		

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
208	Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks Linked to Divisional Risk - MLTC 157	Despite improvement in the Trust's national ranking for Emergency Access Standard performance, there remains a delay in patients being assessed in the ED department which will result in failure to achieve consistent wait to be seen (WTBS), (time to treatment performance) which will impact upon failure to achieve the 4 hour Emergency Access Standard which will lead to poor patient experience and risk of adverse clinical outcomes including mortality	Kate Salmon	1 2	• Process • A governance process is in place to monitor performance throughout the organisation	• Monthly reports to Performance Finance & Investment Committee (and Quality & Safety for Patient Care Improvement plan progress) Emergency & Urgent Care Task force in place, monitors actions Daily escalation processes in place through Division to Executives where necessary • A&E delivery Board overseeing system response	
					• Policy • Board approval of EAS improvement Trajectory to meet 95% agreed by Board	• Assured and overseen via divisional governance and performance reviews The Trust has delivered performance over 95% on 5-seperate weeks over June, July and August 2020. Ambulance handover times are being achieved (within 30-mins) Time to triage are being achieved (within 15 mins) • Monthly reporting to NHSi System review meeting oversight via regulator and CCG	
					• Process • operational demand management policies & procedures in place	• Trust is currently meeting the 4 hour target • NHSI 2 day deep dive	
					• Physical Barrier • Insufficient ED cubicle capacity to enable effective and timely assessment of patients in ED, increasing WTBS.	• Revised process are in place to deliver care Increased staffing is required to ensure line of sight Increased staffing is required owing to cohorting of Covid Patients ED & Acute Medicine New build business case approved through internal processes 4.1 million capital funding for additional UEC capacity. • ED & Acute Medicine New business case approved through internal processes ED & Acute Medicine New OBC approval ED & Acute Medicine New procurement through the national P22 framework	
					• Process • Substantive staff are in place to	• a rolling program of Nurse recruitment with interviews held	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					provide safe and high quality care and use our resources well	on a monthly basis Staffing vacancies reviewed regularly via governance structure Nurse staffing reviewed daily Safe staffing report presented to People and OD Committee and Board Nursing and quality paper to QPES ED Medical workforce business case has approved at Trust Board in June 2020 and will address the royal college guidance.	
						• Safe staffing report published monthly on website Staffing levels are overseen via system review meeting Agency meeting review with NHSi	
					• Process • Robust process are in place to meet ambulance handover standards	• Handover Policy with the Ambulance service in place Ambulance handover key metrics is monitored at care group, Divisional, performance reviews, PFIC and Board Revised process in place owing to covid, which has improved performance	
					•	•	
					• 12 hour breach policy in place	•	
					•	•	
					• PFIC review of performance on a monthly basis	•	
					•	•	
					• Monthly A&E operational group in place providing assurance to the system	•	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
14/06/2020	Creation of a psychiatric decision unit for assessment of patients for psychiatric assessment	Kate Salmon		25/09/2020	30/09/2020
12/06/2020	Revised pathway for access to imaging to reduce waiting	Kate Salmon	**Closed**	27/08/2020	01/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
274	EBME require sufficient resources to be made available for the purchase of medical equipment as the equipment within the Trust is depreciating faster than the current capital programme allocation.	The failure to replace medical equipment may have a long-term effect on patient flow and patient safety.	Michael Koushi	1 6	• Process • Fully resourced Equipment replacement programme in place	• The Medical Devices Group will be monitoring the needs of the Divisions and can then report to QPES. This will be done through equipment lists which will then be RAG rated and set out with the associated costs. • EBME are in the process of pursuing an ISO accrediation so they can be audited externally on an annual basis.	
					• Process • Life cycle program for the next 5 years in place	• Risk reviews process in place prioritise funds with clinical leaders The EBME department is undertaking ward visits to identify any medical equipment due for a service; this process assists with mitigating the risk of wards not logging a service request in a timely manner • Internal Audit report	
					•	•	
					•	•	
					•	•	
					•	•	

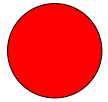
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
02/09/2019	Medical Devices Group to risk assess, document and recommend to the Board the required capital for medical devices replacement. Papers to be sent through TMB monthly to confirmed the high risk equipment due for replacement with the associated costings.	Michael Koushi		25/10/2020	30/10/2020
30/09/2019	Ensure Terms of Reference of the Medical Devices Group references responsibility for the medical devices. This needs approving and documented.	Michael Koushi		25/10/2020	30/10/2020
31/10/2019	Establish whether ESR or other HR process such as PDR can be used to record and monitor medical device training	Michael Koushi	**Closed**	11/07/2020	16/07/2020
02/09/2019	Identify equipment owners within Wards/Departments.	Michael Koushi	**Closed**	26/03/2020	31/03/2020
02/09/2019	Ensure T34 syringe training compliance is reported to the medical devices group	Michael Koushi	**Closed**	26/03/2020	31/03/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
02/09/2019	Produce options paper/ Business case for requested EQUIPAM Database		Michael Koushi			**Closed**	25/09/2020	30/09/2020
02/09/2019	Review cost/benefit of ISO.		Michael Koushi			**Closed**	25/09/2020	30/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
665	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	Risk of a deliberate/intentional attack/hack on any part of the IT services and systems within the NHS or partner organisations from an external or internal source which could include infecting computers/networks/ systems with a lethal virus or malware resulting in disrupting to NHS services and NHS care provision.	Andrew Griggs	1 5	• • Organisation IT related Disaster Recovery/BC plans. IG and Data protection compliance. • Process • Penetration testing undertaken annually through internal audit which identifies necessary digital safety actions required. • Physical Barrier • All vulnerable systems Sandboxed. • • Windows IOS upgrade pgoramme • Physical Barrier • Cyber Next generation measures put in place	• Recruitment of EPRR Manager • Data security Toolkit rating • Action plan developed following penetration testing and monitored via digital services governance meeting. • • Windows 7 term cut off from network to avoid prospect of viral attack. • Sandbox is a security mechanism for separating running programs, usually in an effort to mitigate system failures or software vulnerabilities from spreading. • • • Cyber next generation firewall was put in place early in 2020. • A next-generation firewall is a part of the third generation of firewall technology, combining a traditional firewall with other network device filtering functions, such as an application firewall using in-line deep packet inspection, an intrusion prevention system.	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
03/09/2020	Cyber Security Desktop scenario exercise planned for Sept 3rd 2020	Andrew Griggs		25/09/2020	30/09/2020
15/07/2020	IOS upgrade programme to Windows to be undertaken.	Daren Fradgley		28/10/2020	02/11/2020
30/06/2020	Risk raised from Divisional to Corporate	Andrew Griggs	**Closed**	25/06/2020	30/06/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1005	Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks.	The failure to invest adequate capital annually to reduce the backlog maintenance, critical infrastructure and mechanical/engineering risks may result in the trust not being able to utilise the facilities such as theatres, imaging etc. The risk is that this would affect patient safety considerably if critical areas were 'out of use'. This risk is a national risk to many NHS Trusts and the risks are as detailed in previously submitted from Nov 19 - July 20 PFIC papers and accrues to £26.25 million. Full list attached to SAFEGUARD. High Risk - £20.4m, Significant £5.2, Moderate, £546k, Low - £5500 £3.8 million capital has recently been received by the Trust and designated for "Critical Infrastructure Risk"	Jane Longden	1 6	• Process • Investment needed to be made in ICU & HDU refurbishment to combine the departments.	• This building was completed and handed over on 1 December 2018 with an investment made of circa £11 million. •	
					• Process • New Maternity Theatre required combined with the expansion of NNU.	• The maternity and NNU expansion completed in September 19 which has increased NNU capability and a contingency theatre has now reduced to the risks in respect of patient safety. • HTM Accredited building - validated by external maintenance contractors and theatre audited annually for statutory compliance.	
					• Process • The current ED Department is no longer fit for purpose following its current size and design originating from the mid-1980s	• The Outline Business Case (OBC) has been signed off and the Full Business Case (FBC) is due to be signed off by December 2020. The ground works for car parking are due to commence around 12 October subject to approval. • NHSI has signed off the OBC and will be reviewing the FBC thereafter following its submission.	
					• Process • Investment required for the Mortuary Body Stores as the refrigerated units are past their end of life condition.	• Funding acquired in 2018-19 and a programme of works agreed with on-site PFI contractor, Skanska Facility Services. • ProjectCO and Skanska detailing specification of works, risk assessments and programme timetable.	
					• Process • Medical Air Plant/Entonox plant to be replaced in Maternity.	• A programme of works has been drawn up, funding acquired and a timetable set out. • The works were completed in 2019 and are now fully operational, maintained and HTM compliant.	
					• Process • The plate heat exchangers relating to the control of the domestic hot water supply in maternity need replacing	• The programme of works, design and costs all agreed and works to commence in 2018. • Skanska & PCO are undertaking works which will be statutory compliant with HTMs and current legislation.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • Car Park barriers and payment machines on Car Park B are past the 10-year end of life date and need replacing.	• The tender process was concluded in 2019 with the installation of the new equipment in September 2019. • The equipment is being maintained by an external company on an annual basis with all lifecycle of parts included.	
					• Process • HSDU Hotwell requires resplacing due to the age and condition is past its life expectancy	• The specification, design and costs have been outlined to Skanska who now have to develop a programme of works. This provides further resilience for our Sterilisation Department. • PCO & Skanska	
					• Process • The upgrade of Block 4 is required to ensure that staff have a good working environment and will allow other office moves to be initiated.	• Trust Estates have requested - the programme of works has been sent to Skanska to outline scope of works, final specification and the timeline relating to these works • PCO/Skanska undertaking the works to HTM and statutory standards.	
					• Process • Replacement of the Maternity chillers	• a scope of works has been drawn up by the Trust and instructed on-site PFI partners. • PCo/Skanska have provided costs and timetable to complete the works following discussions with departments.	
					• Process • Replacement Theatre AHUs for Theatres 1,2 & 3 (shared AHU), 5 & 6 required as the equipment is past its life expectancy - maintenance is ongoing.	• The Trust monitors through the Estates Services Group and the monthly HARD FM meeting. • The control in place is that there is ongoing maintenance at present and that there continues to be monthly PPMs to ensure that the equipment is performing to statutory and HTM requirements. Funding agreed.	
					• Process • Heating and Pipe Distribution Systems - £1.86 m	• Ensure the maintenance of the equipment as per the HTM and monthly PPMs. • Ensure the maintenance of the equipment as per the HTM and monthly PPMs.	
					• Process • Steam Generators	• Ensure that the equipment is being maintained. • Skanska maintaining equipment and doing monthly ppms	
					• Process • Medical Air & Vacuum Plant	• Ensure the maintenance of the equipment as per the HTM and monthly	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						PPMs. • Ensure monthly ppms and maintenance done through Hard FM and Estates Services Group.	
					• Process • Control Panel Units	• Ensure monthly ppms and maintenance done and monitored through monthly Hard FM. • Skanska to maintain to HTM and statutory standards.	
					• Process • Cold Water Storage tanks	• Ensure monthly ppms are done through Hard FM and Estates Services Group • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Fire Alarm installation per system	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • High & Low Voltage switchgear	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Low Voltage power outlets	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Lighting	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Emergency Lighting	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						• Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Nurse call and bed head services	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Heat Recovery installations	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • External & internal fire doors	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Food Storage Cold Rooms	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Split Air Con Units.	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Pressurisation units	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Pump sets	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Water Treatment Plants	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Medical Gases	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • BMS System	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • UPS Systems	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	
					• Process • Macerators/washers	• Trust to ensure that the monthly ppms are undertaken and kit maintained through Hard FM and Estates Services Group. • Skanska to undertake monthly ppms to statutory and HTM standards.	

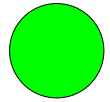
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
10/08/2020	A review of the 20/21 lifecycle plan and risk assessed items is being undertaken by WHT and PCO/Skanska to produce a priority list of critical infrastructure that needs maintaining.	Colin Plant	26/03/2021	31/03/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
05/11/2018	All areas to have business continuity plans				Mark Hart	25/10/2020	30/10/2020
01/04/2019	Located the summary of the latest update to PFIC.				Ned Hobbs	25/09/2020	30/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1155	Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation.	There is a lack of assurance in the form of fire stopping certification to identify the integrity of the fire compartments in the Retained Estate and the remedial works undertaken. A failure to identify the key areas through surveys and complete the remedial works may result in a breach of fire safety regulations and risk to patients, staff and public safety	Colin Plant	1 6	• Process • Fire stopping sub group created to develop this risk assessment and requirements for survey works	• Minutes from meeting •	
					• Process • Phase 1. West Wing (WW) Level 1 and 2 main Spine corridor (protective access and egress to wards). Data collection not on Fire Tronic portal (this was developed during Phase 2). Fire doors and dampers excluded	• report on Firetronic •	
					• Process • -Phase 2.WW Wards 5, 6, 7, 9, 10, 11, 12, 14, 15, 16 and 17. Remedials took place within the central access/egress corridor and the Central joint central wall between wards. All data is on Fire Tronic and drawing with remedial specific reference numbers and photos are on the portal (the WHT Fire Officer (RD) has access to the data). Fire doors and dampers excluded	• •	
					• Process • Phase 3.WW and Maternity Plant Rooms and Risers. Remedials took place in Blocks 58, 60, 61 and 62. All data is on Fire Tronic and drawing with remedial specific reference numbers and photos are on the portal. Not including fire doors and dampers	• •	
					• Process • Phase 4. (Work completed). The following works were completed: o A&E. Remedials carried out during October 2015. All data is on Fire Tronic and drawing with remedial specific reference numbers and photos are on the portal. o Imaging. Remedials carried out during October 2015. All data is on Fire Tronic and drawing with remedial specific reference numbers and photos are on the portal. Not including fire doors or dampers	• •	
					• Process • Maternity roof void survey by Rockwool and report to identify issues	• •	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • Fire stopping remedials included in all small works from Skanska and records held on firetronic	• •	
					• Process • Annual fire door ppm as part of schedule 14 works of contract	• •	
					• Process • Trust Fire Risk Assessments all include caveat that unable to verify fire stopping	• •	
					• Process • Skanska Firetronic database now available to access by Trust Estates Team and Fire Officer to review prior to risk assessments or when have queries	• •	
					• Process • Phase 4a. (Stopped part way through Project). Works planned to be carried out in WW Theatres was started however: later stopped when remedial works could not be carried out without the initial installer (Rockwool) agreeing the proposed reinstatement of stopping arrangements. Rockwool subsequently wrote a report which identified significant issues that prevented out Specialist completing the planned stopping works. A Rockwool report was produced and this was forwarded to the WHT Director of Estates and Facilities Directorate where FS were awaiting a meeting to facilitate a plan for Theatres in general.	•	
					• • Fire and structural survey being undertaken and baseline survey will be produced. Action plan to be developed	• •	
					• Process • Colin Plant CEO chairs fire stopping meeting	• Fire Group mins attached • External company performing remedial works through Skanska and will give statutory accreditation after the works have been completed.	

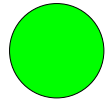
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
16/07/2020	Formulate an action plan with Skanska further to the fire survey of the Retained Estate areas, to review and address the issues with particular emphasis on key fire-resisting construction and escape routes	Paul Richardson	26/09/2020	01/10/2020
15/07/2020	Review and update the existing Fire strategy and risk assessments taking account of the fire survey results.	Colin Plant	28/10/2020	02/11/2020
14/04/2020	Revised timetable needs to be agreed with Skanska and then the associated costs agreed. The current timetable for the works ceased on 14 April due to Covid 19.	Colin Plant	26/09/2020	01/10/2020
01/07/2020	A joint appointment is to be agreed with PCO to review both new build and the retained estate fire stopping compliance and current position.	Russell Caldicott	26/09/2020	01/10/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	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.	Dan Mortiboys	1 6	• Process • Financial governance and reporting throughout the organisation	• PFIC review the financial performance with Executive on at least a monthly basis. • NHSI receive monthly reports from the Trust. NHSI raise key issues with Trust executives STP Finance receive monthly updates from the Trust and comment as appropriate NHSI governance and Accountability review noted the good level of challenge and oversight of the PFIC Committee	
					• • Through the Trusts Accountability Framework divisions and corporate Areas are held accountable for financial delivery.	• The Accountability Framework has been approved by the Trust Board and there is evidence it is in operation. Processes are all developed and continue to be developed • NHSi Governance and Accountability Framework	
					• Process • Covid Governance process approved by the Board	• There is a weekly report to Executive and PFIC on the expenditure Forms are in place, which must be submitted to the relevant incident command for approval Strategic Command oversight of expenditure Finance team oversee the adequacy of the controls, and ensuring the governance process has been followed • NHSI receive regular reports on expenditure and re-imburse as appropriate.	
					• • Standing Financial Instructions (SFI) are in place across the Trust	• Breaches reported to Audit Committee IT systems are set up to support the SFIs Director of Governance ensuring legislative compliance of SFIs • Internal Audit and External Audit will do specific pieces of assurance work in this area and more general pieces that reference SFI. Counter fraud in place	
					• • NHSI/E have been asked by Trust Board to do a review on Finance and PMO functions. The draft outcomes	• Appropriately qualified staff • Draft reporting from NHSE/I	

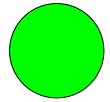
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					of this report support the performance of these areas. There is strong control in this area		
					• Robust financial management arrangements are in place across the organisation	• SFIs are in place Budgetary Control and Virement Policy in place Training for budget holders Financial Business Partners support budget holders Financial reporting process are in place	
						• Positive External Audit opinion Positive internal audit opinion on financial control audit	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
15/05/2020	Finance will provide training to budget managers to improve financial literacy. In addition finance will undergo further training to continually professionally develop. This will be subject to Covid 19 pressures Finance will arrange training and development	Dan Mortiboys		26/03/2021	31/03/2021
15/05/2020	SFI require improvement and will picked via Improvement Programme	Jenna Davies		25/09/2020	30/09/2020
15/05/2020	Ongoing changes to NHSI/E Covid 19 finance regulations and reporting requirements. Continue to work with colleagues across the NHS to ensure Walsall implements best practice and meets all regulations	Russell Caldicott		26/10/2020	31/10/2020
15/05/2020	Ongoing development of financial reporting to highlight key issues	Russell Caldicott	**Closed**	26/03/2021	31/03/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Future Financial Sustainability	Failure to realise the benefits associated with the outcomes of the improvement programme workstreams, 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.	Dan Mortiboys	1 6	• Process • Financial Planning Process in place aligned to National Guidance.	• Trust wide operational planning process in place which incorporates improvement operational planning aligned to the national operational planning and contracting guidance Plans are agreed throughout the Trusts Governance Process. Final Approval of the plan via the Trust Board. • CCG and STP sign off of the financial plan NHSi sign off regionally and nationally of the financial plan	
					• Policy • PMO function in place to ensure standardisation of good project management process and reporting is in place.	• Improvement programme governance in place for workstream oversight. SRO and Programme manager overseeing programme delivery • Internal Audit have given significant assurance on the current PMO function. NHSI have reviewed the PMO function and the financial elements	
					• • Overall Programme and Workstreams PIDs in place	• Improvement programme in place to oversee the implementation of the Trust's Improvement Plan Programme plan approved by the Board Workstream PIDs approved by relevant Committees • NHSI/E are in attendance at the Improvement Board and can provide support and challenge as appropriate Internal Audit review of Improvement programme	
					• Process • Benefits realisation process in place	• PIDs including benefits realisation approved through Governance structure PFIC TOR include duties relating to benefits realisation Improvement programme Board in place which includes a duty •	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
17/05/2020		A process to be established to ensure alignment between the operational planning process and the improvement programme	Glenda Augustine			26/10/2020	31/10/2020
15/05/2020		Delivery of activity including key groups	Glenda Augustine			26/08/2020	31/08/2020
17/05/2020		establish a robust governance process in place to ensure financial improvement oversight via DoF, Performance Reviews, improvement board with Assurance gained at PFIC	Glenda Augustine			26/08/2020	31/08/2020
17/05/2020		PIDS to be developed and approved which outline Financial Benefit	Glenda Augustine			26/08/2020	31/08/2020
17/05/2020		benefits realisation process to be developed including ongoing tracking and closure process	Glenda Augustine			26/08/2020	31/08/2020
15/05/2020		Recruitment is ongoing and temporary staff is in place	Richard Beeken		**Closed**	25/09/2020	30/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2188	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.	Prevent integration of our clinical systems Delayed/ lack/ loss of access to necessary clinical information - reliance on paper based systems Inefficient use of administrative resource/ duplication and multisystem use. Laboured/ ineffectual reporting Potential data quality issues Prevent the Trust delivering its strategic objective in terms of being outstanding by 2222	Keith Dibble	1 0	• Natural Barrier • Lorenzo (workaround) processes in place to ensure data quality is effectively managed including: Data Quality Team Systems owners to mitigate errors. Configuration team in place to scrutinised requested changes. • Process • Detailed implementation plan in place regarding the EPR programme to bring in Medway, including revised timescales to go live in September 2020. Progress and risks addressed and monitored at the EPR Programme Board on a monthly basis. • Physical Barrier • The trust has put in a number of requests for capital to support the Covid response.	• • • Regular scrutiny of implementation plan including timescales, milestones, risks and actions at Programme Board. • •	

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

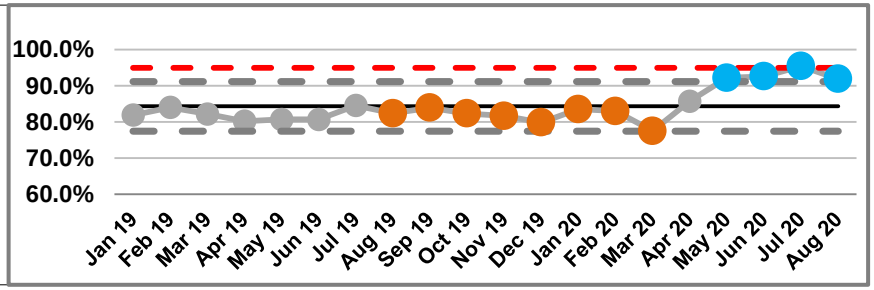
- **Key Areas of Success**
- After significant deterioration in 4-hour Emergency Access standard performance in March, during the rapidly escalating first peak in Covid-19 demand in the Black Country, the Trust has now delivered four consecutive months of performance over 90% - a credit to the Emergency Department team, and to all services in the community and in the hospital who support patients along the emergency care pathway. The Trust's national ranking remains strong at 32nd out of 114 reporting Trusts in the country.
- Suspected Cancer 2 Week Wait (all tumour sites) met the constitutional standard for the fifth consecutive month and Breast Symptomatic 2 Week Wait also met the standard in July.
- 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 improve further, up to 5th best in the country in July out of 123 reporting Trusts.
- Despite cessation of routine elective services during March and April, the Trust's 18-week RTT national ranking position remains strong at 32nd best in the country in July out of 121 reporting Trusts, and August has shown the first signs of improvement since the pandemic, with performance improving to 61.1%.
- The Trust has achieved a break-even financial position so far for 2020/21 financial year. However, the Trust required additional funding of £10.5m to attain break-even for months 1-5. August request for additional funds was c£2.2m which is in broadly in line with the Months 1-5 average of c£2.1m
- The Trust has secured additional capital to support emergency care (£4.1m), critical infrastructure (£3.8m) and is seeking to secure additional funding for Critical Care capacity (£2.0m)
- **Key Areas of Concern**
- Emergency Department attendances continue to rise with August's Type 1 attendances up to 94.2% of pre-Covid levels. To sustain safe, timely emergency care in the face of Winter pressures and Covid resurgence, it will be essential for the Trust to invest strongly in the 2020/21 Winter Plan.
- 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 is constrained for some time.
- The Trust will receive income as a 'block' for months 7-12 of the 2020/21 financial year. In addition the Trust will receive fixed allocations for Covid 19 and growth. If allocations are insufficient the Trust will need to reduce expenditure and will no longer have the capacity to claim additional funds.
- The STP will have elective activity targets for the remaining months of the financial year. It is implied if the STP does not achieve these targets there could be financial 'penalties'. While the calculation is yet to be confirmed, there is risk for the Trust if targets are not achieved.
- Temporary workforce costs remain higher than the baseline period and will be a key focus for ensuring delivery of financial balance moving forward.
- The Trust is servicing 75% of the elective activity seen last year (August's Emergency Department Type 1 attendances up to 94.2% of pre-Covid 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**
- Significant operational planning and financial modelling has taken place to gain assurance on a best, worst and most likely scenarios for months 7-12, so as to ensure the operational plans for the second half of the year (months 7 to 12) is affordable and can maximise performance.
- Temporary workforce staffing costs have been reviewed and the financial plans (referred to in the above bullet) include the outputs of analysis of year on year review of costs.
- Key reviews continue in regards to the Improvement Program and outputs moving forwards

Performance, Finance and Investment Committee

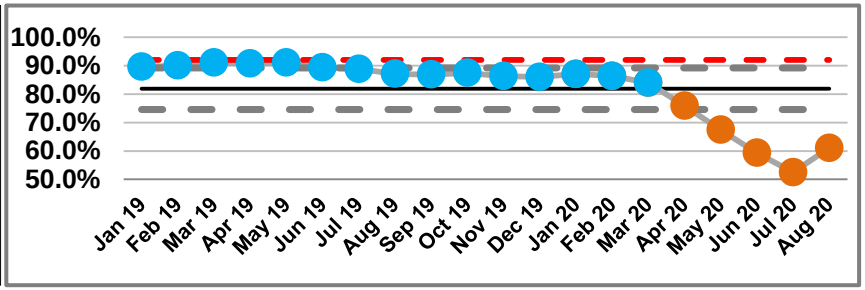
SPC Key

Mean
Process limits - 3σ
Special cause - improvement
Measure
Special cause - concern
Target

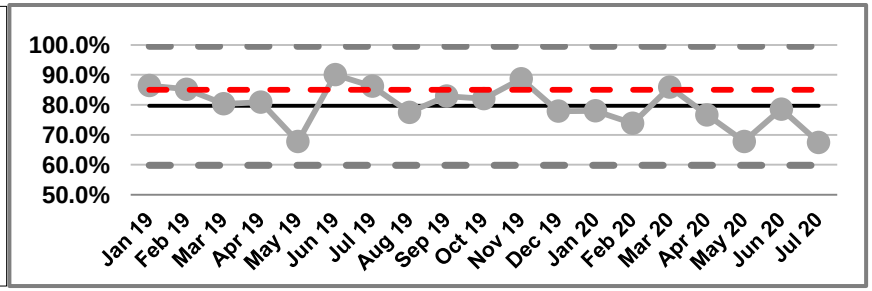
ED - % within 4 hours – Overall (Type 1 & 3)



18 weeks RTT – Incomplete Pathways



Cancer 62 Day RTT



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

In August Type 1 ED attendances increased by 2.9% from July to 6359. Despite attendances increasing, the Trust maintained performance within the redrawn process limits. EAS achieved 91.9% of patients admitted or discharged within four hours of arrival. The fact that EAS is almost 10% higher than the same month last year whilst attendances were 94% further demonstrates the increased resilience of ED and hospital flow.

RTT

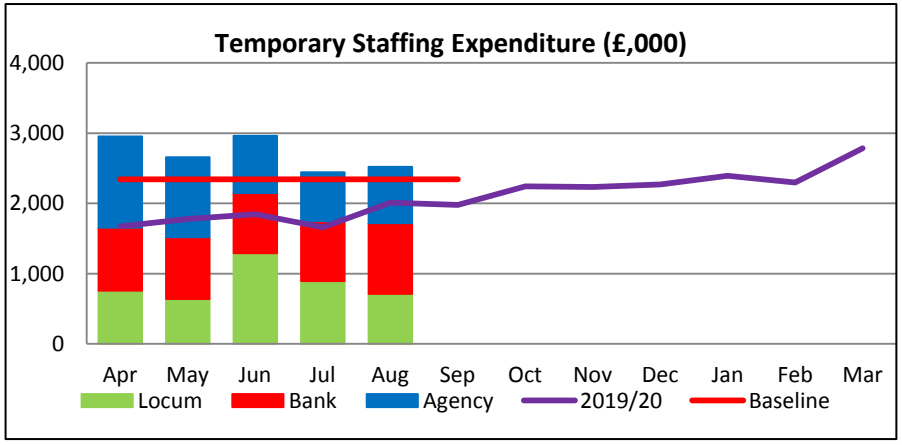
18 week RTT performance in August is 61.06%. This partly reflects reduced referrals during April/May. It is anticipated that additional routine surgical patients will be accommodated with the increase in theatre lists following the 5th, 6th and 7th elective theatres re-opening on the Manor site by October 2020, but the risk of 52 week breaches will remain. There were 8 52-week breaches in August, all under Surgery division.

Cancer

The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 67.4%. However the Trust did achieve the 62 day consultant upgrade with a performance of 85.2%. Surgical treatments continue to be carried out by Spire Little Aston using our own surgical Consultants. Chemotherapy continues to be administered. From October there is a plan to increase the number of operating theatres to 7 to increase operating capacity on site. However, some patients continue to decline offers of treatment which will impact on performance.

Financial Performance to August 2020 (Month 5)

	Plan YTD Aug £000s	YTD Aug Actual £000s	YTD Variance £000s
Income			
Clinical Contract Income	102,200	101,542	(658)
Additional Covid Top-up	0	10,423	10,423
Other Income (Education&Training)	2,980	2,996	16
Other Income (Other)	18,185	14,893	(3,292)
Subtotal Income	**123,365**	**129,853**	**6,488**
Pay Expenditure			
Substantive Salaries	(67,265)	(69,118)	(1,853)
Temporary Nursing	(6,025)	(6,458)	(433)
Temporary Medical	(4,590)	(5,401)	(811)
Temporary Other	(1,095)	(1,671)	(576)
Subtotal Pay Expenditure	**(78,975)**	**(82,648)**	**(3,673)**
Non Pay Expenditure			
Drugs	(7,895)	(6,927)	968
Clinical Supplies and Services	(7,625)	(5,949)	1,676
Non-Clinical Supplies and Services	(7,275)	(7,146)	129
Other Non Pay	(15,140)	(20,621)	(5,481)
Depreciation	(2,470)	(2,775)	(305)
Subtotal Non Pay Expenditure	**(40,405)**	**(43,418)**	**(3,013)**
Interest Payable	(3,985)	(3,861)	124
Subtotal Finance Costs	**(3,985)**	**(3,861)**	**124**
Total Surplus / (Deficit)	**0**	**(73)**	**(73)**
Donated Asset Adjustment		74	74
Adjusted Surplus / (Deficit)	**0**	**1**	**1**



Financial Performance

- The Trust reported a £10.4m overspend versus block and top up funding from NHSIE. Per the guidance the Trust has assumed a further receipt of income totaling £10.4m to cover these overspends and is therefore reporting break-even performance
- The adverse variance of £3.3k 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 (£2.4m), the Trust has also lost income on car parking, R&D and accommodation charges (£0.9m)
- The Trust's substantive pay has reduced in August to £13.7m due to the provision made for Clinical Excellence Award's (in July), temporary workforce expenditure remains over baseline plan and historic levels
- Other non pay expenditure is higher, largely due to Covid-19 costs, an example being monthly support costs for the Electronic Patient Record being chargeable this year and costs associated with delays to go live.

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 £4.3m

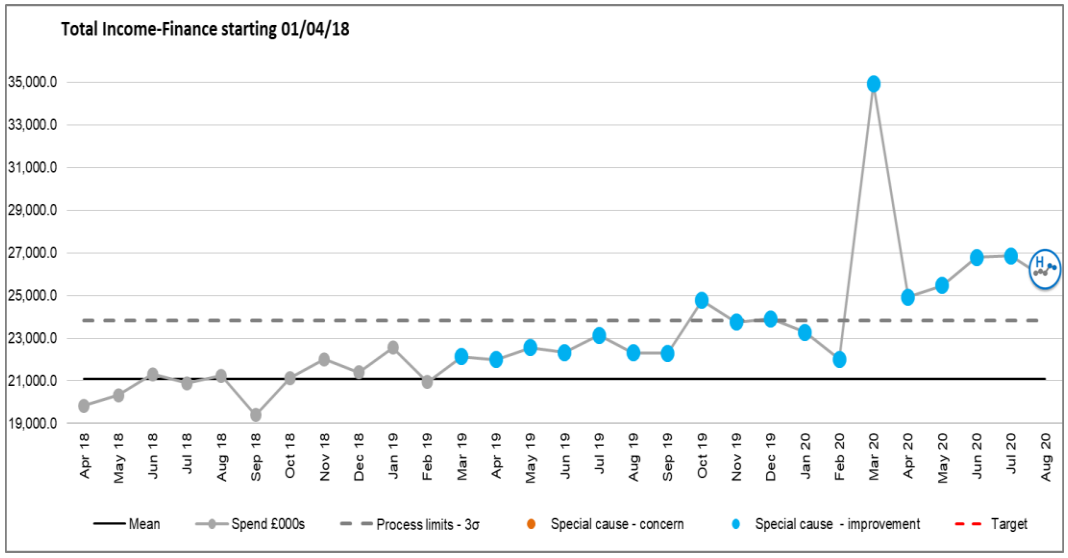
Cash

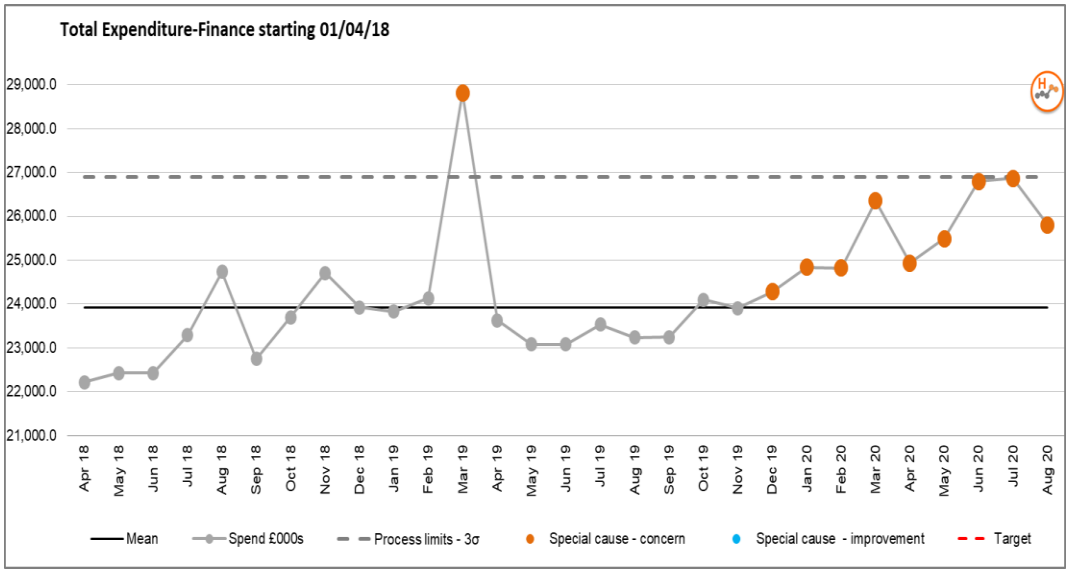
- Actual cash holding was £35.3m due to the contract payment being paid in month (was previously a month in arrears) in accordance with the emergency funding guidance from NHSIE

Efficiency attainment

- The emergency budget planning letter and guidance states there is no efficiency requirement for Months 1-5. 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, noting a reduction in expenditure in August due to the non recurrent nature of these.

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 (M5)

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending August 2020	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	3,787
Depreciation and Amortisation	2,775
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	10,634
Increase/(Decrease) in Trade and Other Payables	19,519
Increase/(Decrease) in Stock	(10)
Interest Paid	(3,480)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	**33,225**
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(5,476)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(5,476)**
Net Cash Inflow/(Outflow) before Financing	**27,749**
Cash Flows from Financing Activities	(1,544)
Net Increase/(Decrease) in Cash	**26,205**
Cash at the Beginning of the Year 2020/21	9,056
Cash at the End of the August	**35,261**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending August 2020	Balance as at 31/03/20	Balance as at 31/08/20	Year to date Movement
	'£000	'£000	'£000
Total Non-Current Assets	**144,866**	**146,437**	**1,571**
Current Assets			
Receivables & pre-payments less than one Year	39,001	28,271	(10,730)
Cash (Citi and Other)	9,056	35,261	26,205
Inventories	2,620	2,630	10
Total Current Assets	**50,677**	**66,162**	**15,485**
Current Liabilities			
NHS & Trade Payables less than one year	(25,955)	(19,780)	6,175
Other Liabilities	(1,480)	(26,895)	(25,415)
Borrowings less than one year	(134,693)	(132,393)	2,300
Provisions less than one year	(437)	(437)	-
Total Current Liabilities	**(162,565)**	**(179,505)**	**(16,940)**
Net Current Assets less Liabilities	**(111,888)**	**(113,343)**	**(1,455)**
Non-current liabilities			
Borrowings greater than one year	(116,013)	(116,013)	-
Total Assets less Total Liabilities	**(83,035)**	**(82,919)**	**116**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	68,300	68,489	189
Revaluation	14,832	14,832	-
Income and Expenditure	(166,167)	(166,166)	1
In Year Income & Expenditure	-	(74)	(74)
Total TAXPAYERS' EQUITY	**(83,035)**	**(82,919)**	**116**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

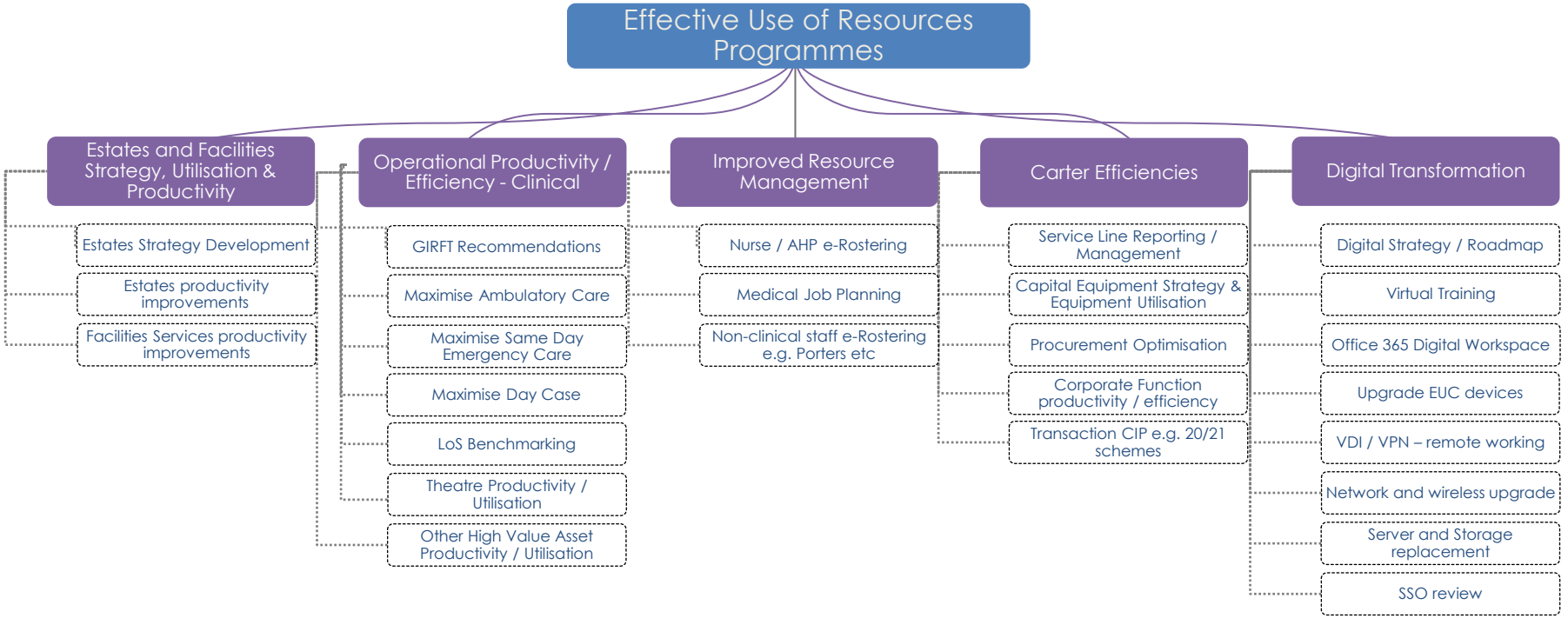
		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
%	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	77.49%	85.73%	92.21%	92.62%	95.43%	91.88%	92.09%	95.00%	81.77%	F	H
%	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	64.06%	63.33%	70.46%	75.04%	75.60%	73.25%	71.84%	100.00%	62.10%	F	H
No.	Ambulance Handover - No. of Handovers completed over 60mins	30	0	0	1	0	5	6	0	312	?	
%	Cancer - 2 week GP referral to 1st outpatient appointment	95.78%	94.20%	95.84%	93.17%	93.00%	91.26%	93.27%	93.00%	84.07%	?	
%	Cancer - 62 day referral to treatment of all cancers	85.90%	76.67%	67.80%	78.57%	67.44%	65.67%	71.43%	85.00%	80.93%	?	
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	83.93%	75.82%	67.41%	59.32%	52.50%	61.06%				F	L
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	0	1	1	8	9	8	27	0	0	?	H
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	2.43%	39.09%	36.99%	22.47%	16.32%	18.24%	23.18%	1.00%	1.63%	?	H
No.	No. of Open Contract Performance Notices	9	9	9	9	9	9		0		F	L
CARE AT HOME												
%	ED Reattenders within 7 days	7.55%	8.61%	8.84%	7.82%	8.45%	8.78%	8.49%	7.00%	7.60%	?	
RESOURCES												
%	Outpatient DNA Rate (Hospital and Community)	11.56%	11.33%	5.28%	5.11%	6.76%	10.25%	7.51%	8.00%	10.44%	?	
%	Theatre Utilisation - Touch Time Utilisation (%)	74.71%	36.47%	58.08%	47.06%	62.98%	67.50%	59.48%	75.00%	85.42%	?	L
%	Delayed transfers of care (one month in arrears)	3.71%	2.54%	2.82%	2.23%	2.57%		2.54%	2.50%	3.68%	?	L
No.	Average Number of Medically Fit Patients (Mon&Thurs)	73	53	36	37	39	35					L
No.	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	9.00	5.00	4.00	4.00	3.00	3.00					L

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
£	Surplus or Deficit (year to date) (000's)	-333	0	0	0	0	0					
£	Variance from plan (year to date) (000's)	-613	0	0	0	0	0					
£	CIP Plan (YTD) (000s)	8500										
£	CIP Delivery (YTD) (000s)	8500										
£	Temporary Workforce Plan (YTD) (000s)	20300	2300	4700	7000	9400	11700					
£	Temporary Workforce Delivery (YTD) (000s)	25200	2900	5600	8600	11000	13500					
£	Capital Spend Plan (YTD) (000s)	8200										
£	Capital Spend Delivery (YTD) (000s)	11500		1300	3000	3800	4300					

Use of Resources Workstream



Note: Outpatients Transformation being delivered through the Care at Home workstream due to WT links

Effective Use of Resources workstream development update: September 2020 IPBoard

Project Admin		PID Generation							Project Tracking							Risk Summary Status		
Strategic Workstream	Focus Area	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Engagement	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
Effective Use of Resources	Estates & Facilities																Amber	
																	Amber	
																	Amber	
	Operational Productivity - Clinical															Green	Amber	Green
																Green	Amber	Green
																Amber	Amber	Green
	Improved Resource Management															Green	Green	Red
																Green	Green	Amber
																Green	Green	Green
	Carter Efficiencies																Amber	
																Amber	Green	
																Amber	Green	
																Amber	Amber	
																Amber	Green	Red
																Amber	Green	Red
																Amber	Green	Red
	Digitally Enabled Transformation																	

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

Key Risks, Issues & Dependencies

	Description	RAG	Board escalation / assurance comments
Risk	Provision of sufficient capital each year to deliver proposed projects. This is particularly a risk for Estates and Facilities Productivity improvement projects.	A	The development of a three year capital investment strategy to ensure delivery of each project is supported effectively.
Risk	A second wave of Covid 19 diverts attention away from the Improvement Programme onto solely operational management activities.	A	
Issue	There are a number of competing processes being used across the Improvement Programme which have had the tendency to introduce confusion.	A	Activity to streamline a number of processes and documents being used is underway, to ensure clarity across all Effective Use of Resources activities.
Dependency	Interdependencies with other Improvement Programme workstreams.	A	Work is underway to ensure work across all workstreams is complementary and furthers the delivery of the whole Improvement Programme.

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Working with Partners – Executive Update			**AGENDA ITEM: 14** **ENC: 19**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer	**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. CWIEF has not met in September. The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals. This report highlights particular progress in Urology and Radiology services over the last month.		
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 S03 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 – Executive Update

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. There is also growing evidence of collaborative working in the context of Restoration & Recovery of services following the initial peak of COVID -19 within the Black Country.

The Board Assurance Framework risk has been extensively reviewed and materially re-written. It was received and endorsed by Performance, Finance & Investment Committee in September 2020.

This report highlights functional service integration progress in the last month, particularly in Urology 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 was reported to Performance, Finance & Investment Committee through the Working with Partners Improvement Programme update in September 2020.

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, The Dudley Group NHS Foundation Trust and Walsall Healthcare NHS Trust 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.

The BAF risk was reviewed in detail by the Chief Operating Officer, Medical Director and Director of Governance. The risk has been brought up to date to reflect the evidence of successful partnership working, the demonstrable progress in functional

service integration in further specialties now, but also the risk that the pace of partnership integration work may be impeded by limited leadership capacity and by the lack of formal integration at organisational levels between Trusts.

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 from the last month, to draw out for the Board's attention are as follows:

Urology

The important workstream of Urology has been reinstated and held its first network workshop since COVID-19 on 22nd September 2020. The session reviewed a Urology Cancer Network presentation, Clinical Nurse Specialist collaboration, delivery of 7-day service standards, and provision of sub-specialist female urology services for which the Black Country is under-served and for which Walsall has expressed interest in being the lead provider for.

The pan-Midlands Urology Network Oversight Group are supportive of establishing a formal Urology Network across the Black Country including Royal Wolverhampton, Walsall Healthcare, Dudley Group and Sandwell & West Birmingham Trusts. The Network aims to reduce unwarranted variation in both outcomes and access to effective treatment, whilst standardising best practice regarding early intervention and diagnosis. The Trust continues to recognise that a joint approach to on-call and cover of emergency Urological admissions with Wolverhampton would be beneficial.

Work continues to define and confirm future arrangements for both cancer and benign elective services and emergency urology services. It was agreed that any formal changes made would target commencement on 01 April 2021.

Radiology

Radiology has been formally added to the programme and collaborative work between Walsall Healthcare, Royal Wolverhampton and Dudley Group has begun with the support and facilitation of PA Consulting. The second Imaging network workshop took place on 11th September 2020. Key topics and outputs from the workshop included:

Community Diagnostics Hubs:
The draft national blueprint was shared with the group with an agreement of the need to co-locate Community Diagnostic Hubs with Rapid Diagnostic Centres. There was agreement between the Trusts of the need to lead this within the NHS, rather than be led by independent sector providers.

Workforce - service resilience, numbers and skill mix:
There was recognition of the lack of a consistent approach or plans in place for Imaging services people strategy. There was consensus that "if not now, then when?" – current circumstances provide an opportunity to objectively transform existing workforce models utilising the imaging network and Covid as a catalyst.

Assets - location, usage, and leveraged procurement opportunities:
There was agreement that it is desirable and ultimately aspirational for all networked Trusts to be on a shared Picture Archiving and Communication System (PACS) and Radiology Information System (RIS) although there are some limitations due to the existing PFIs. Two out of the three Trusts have managed equipment contracts; therefore any potential leverage for group purchasing would be focussed on additional purchasing of scanners over and above existing levels within the network.

Demand, capacity & performance insights:
Significant demand and capacity modelling and forecast activity projections have been undertaken for Diagnostic services, including Radiology, as part of the response to Sir Simon Stevens and Amanda Pritchard's Phase 3 letter. Further work in this area is paused pending feedback from NHSE/I on the Phase 3 Restoration and Recovery plan submission.

Dermatology

Progress continues in the Dermatology workstream, supported by the joint Clinical Directorship of Dr James Halpern. The Dermatology Partnership Steering Group has not met in September, but its next meeting is scheduled for Monday 5th October 2020.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

APPENDICES

Appendix 1 - BAF SO3

Appendix 2 - Improvement Programme update

Risk Summary			
BAF Reference and Summary Title:	**BAF S03 Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System**		
Risk Description:	**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.**		
Lead Director:	Medical Director	**Supported By:**	Chief Operating Officer & Executive Director for Planning and Improvement
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title** • 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		**Current Risk Score** **12 (Moderate)**

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**			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 collaboration in dermatology including appointment of joint clinical director Advanced discussions in Urology including cross site working • Integrated ENT on-call rota in place • Initial discussions re: bariatric services and radiology • STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy • Advanced discussions taking place with RWT to create a shared Clinical Fellowship Programme. Despite progress, integration plans are not yet fully implemented	**Likelihood:**	31 March 2021
Consequence:	**4**	**4**				**Consequence:**	
Risk Level:	**12**	**12**				**Risk Level:**	**2 (low)**

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Collaborative working and integration executive group in place • Sustainability review process completed • Regular oversight through the Board and its sub committees • Improvement Programme to progress clinical pathway redesign with partner organisations		• Third line of control NHSE/I regulatory oversight • Black Country and West Birmingham STP plan and governance processes in place
Gaps in Control	• Lack of co-alignment by our organisation and neighbouring trusts • Lack of formal integration at Trust level • Mandated arrangements by regional networks		
Assurance:	• Track record of functional integration of clinical services including hyper acute stroke, vascular surgery, cardiology, rheumatology, ophthalmology, neurology, oncology, black country pathology service and OMFS	• Demonstrable evidence of functional integration in ENT, Urology and Dermatology • Three out of the four Acute Collaboration partners have committed to collaborative working. • Audit Committee has oversight of partnership working within its terms of reference. • System Review Meetings providing assurance to regulators on progress	• Progress overseen nationally and locally
Gaps in Assurance	• Clinical strategy is still emerging • CCG currently in a state of transition • Additional pressures with Covid-19 have delayed acute collaboration • Sandwell and West Birmingham NHS Trust has not yet committed to formal collaborative working. • Limited independent assessment of integrated services or collaborative working arrangements		

Future Opportunities

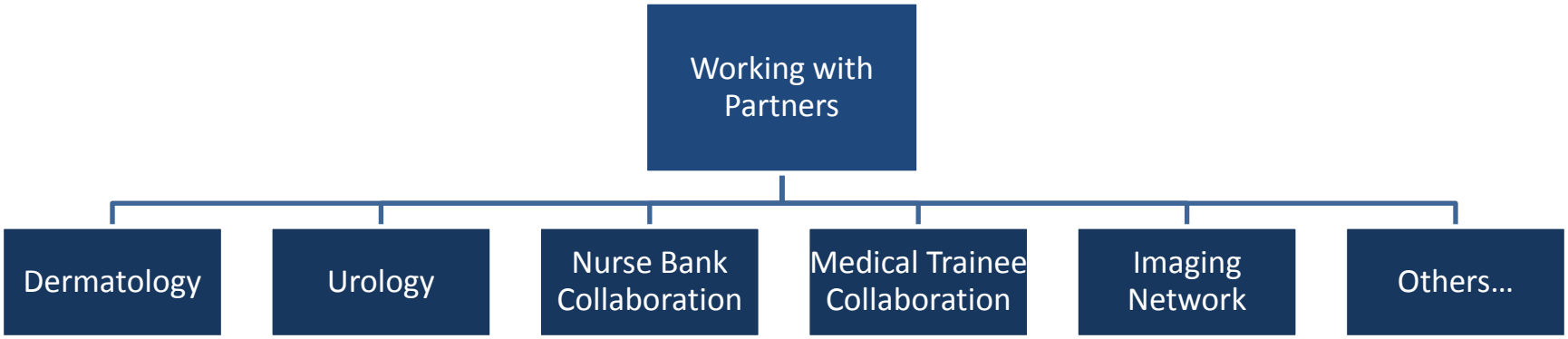
- Strengthen formal collaboration with Sandwell & West Birmingham
- Consolidate other services, including back office functions
- Collaborate with partner organisations outside the Black Country, including community and third party organisations
- Promote Walsall as an STP hub for selected, well-established services
- Collaborative working during COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign

Future Risks

- Conflicting priorities and leadership capacity to deliver required changes
- STP level governance does not have statutory powers
- Lack of engagement/involvement with the wider public
- Acute Hospital Collaboration may not progress at the anticipated pace if a resurgence of COVID-19 coincides with a challenging winter.
- Disrupted relationships with neighbouring trusts due to altered visions of the form and pace of future collaboration

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020		
2.	Develop over-arching programme plan to support individual projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work).	Programme Manager	Dec 2020		
3.	Incorporate restoration work/plans and risk into the winter plan.	N. Hobbs			
4.					

Working with Partners Workstream Structure



Working with Partners: Workstream Development update September 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 Hil	Corporate	Charlotte Hil															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

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	For Dermatology and Urology projects there is a risk that the on-going Covid pandemic will delay progress	R	Significant progress on Dermatology has been made utilising Teams meetings and regular monthly meetings have now been established for Urology. Covid and winter plans to be put in place to mitigate impact on service provision
	Dermatology – Lack of clinical engagement on both sites	A	Clinical Director appointed to work across both Trusts
	Nurse Bank - Nursing staff not transient enough to avoid agency	A	No support required
	Imaging Network - Project Affordability. WHT may be a smaller party in a much bigger collaboration.	A	Project support required
Issues	IT Interface between the Walsall and Wolverhampton sites	A	Under discussion
	Decommissioning of General Dermatology services at RWT has resulted in a reduction in budget. As a consequence service is potentially over established	R	Over establishment will need to be addressed through redeployment or vacancies, however there is potential for PUVA and Biologic clinics to be sub-contracted back to RWT which will mean it will be necessary to retain staffing levels.
Dependencies	• STP Bank Collaboration Programme • PACS replacement • New equipment implementation		

MEETING OF THE PUBLIC TRUST BOARD - 1st October 2020			
Audit Committee Highlight Report			**AGENDA ITEM: 15** **ENC: 20**
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 16th September 2020. The focus of this meeting was entirely on internal audit, as the internal auditors were unable to attend the August meeting. The report sets out escalations for the attention of the Trust Board, and key issues discussed and work underway: 1. The internal audit plan was approved, however a contingency plan will be developed to deliver the internal audit plan should a further lockdown prevent the required level of access to staff on site. 2. Internal Audit will conduct a review of the COVID-19 expenditure governance process. 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 the BAF or Trust Risk Registers? please outline	Audit Committee is essential to Trust Board managing risk across the organisation.		
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 ☒		

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Board Assurance Framework			**AGENDA ITEM: 16** **ENC: 21**
Report Author and Job Title:	Jenna Davies Director of Governance Simone Smith Head of Health and Safety	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The Board Assurance Framework (BAF) provides a structure and process that enables a focus for the Board on the key risks which might compromise the achievement of the organisation's Strategic Objectives. The BAF maps out the key controls which are in place to support delivery of those objectives and to mitigate risk and provide a framework of assurance which the Board can draw upon when considering the effectiveness of those controls. These controls and assurances have been set out in line with the '3 lines of defence' model (appendix 1), aiding the identification of areas of weakness. The 'Strategic Risk Heat Map' at section 4 of this document is drawn from the content of the BAF and aims to illustrate at a high level the degree of risk exposure associated with the Strategic Objectives Each BAF risk has been reviewed and updated in month as part of the regular process through exec lead review, the Executive Risk Management Group and the lead board committee. key updates have been highlighted below BAFS03 – 'Work with Partners' has a current risk score of 12 (moderate). Rationale for the current score has been reviewed and further narrative added to provide clarity. Risk ownership remains with the Medical Director supported by the Chief Operating Officer & Executive Director for Planning and Improvement. Additional control and assurance measures have been included to reflect the track record of functional integration of clinical services and Audit Committee oversight partnership working within its terms of reference. BAFS04- The BAF has been reviewed and updated to include further controls and assurance. An analysis against actions required from the NHS People Plan against actions progressed under the Valuing Colleagues Improvement Programme has been		

	completed and has been reflected within the BAF risk. It should be noted that significant work has been undertaken to improve the format and function of BAF, and we are continuing to progress the Risk Management improvement project.	
Recommendation	The Board is asked to note the BAF and the relevant updates	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Risk implications are outlined within the document	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	The BAF and indeed elements of the attached risks form part of our registration and licence requirements to both NHSi and CQC, which may result in regulatory or legal action under the Health and Social Care Act.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Healthcare NHS Trust

BOARD ASSURANCE FRAMEWORK

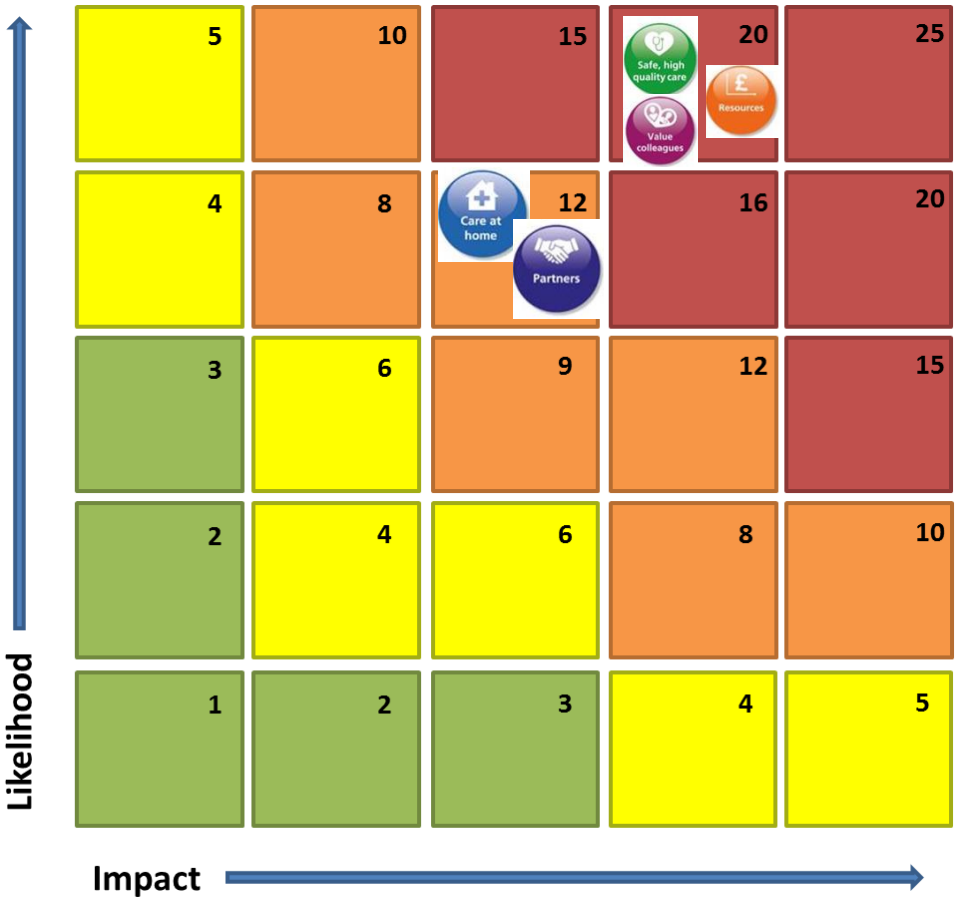
1. Index and Summary Board Assurance Framework as at Quarter 2 2020/21

Ref / Page	Summary Risk Title	Strategic Objectives Under Threat	3 Lines of Defence					Change in Current Risk Score				
			1st Line of Defence		2nd Line of Defence		3rd Line of Defence	Q1	Q2	Q3	Q4	Change
			Controls	Assurances	Controls	Assurances						
BAF 1 Page 6	BAF SO1: Safe, High Quality Care	Safe, high quality care	✓	✓	✓	✓	✓	20	20			
BAF 2 Page 9	BAF SO2 - Care at Home	Care at home	✓	✓	✓	✓		12	12			
BAF 3 Page 11	BAF S03 Working with partners	Partners	✓	✓	✓	✓	✓	12	12			
BAF 4 Page 13	BAF 04 - Value our Colleagues	Value colleagues	✓	✓	✓	✓		16	20			✓
BAF 5 Page 15	BAF 05 Use Resources Well	Resources	✓	✓	✓	✓	✓	20	20			
BAF 6 Page 17	BAF 06 COVID	Safe, high quality care; Care at home; Partners; Value colleagues; Resources	✓	✓	✓	✓	✓	20	20			

Safe, high quality care	Care at home	Partners	Value colleagues	Resources
SO1 - Safe, high quality care	SO3 - Deliver care at home	SO4 -Work with Partners	SO5 - Value our Colleagues:	SO6 - Use Resources Well

BAF Action Plans – Key to Progress Ratings		
B	Complete / Business as Usual	Completed: Improvement / action delivered with sustainability assured.
GA / GB	On Track	Improvement on trajectory either: A. On track – not yet completed *or* B. On track – not yet started
A	Problematic	Delivery remains feasible, issues / risks require additional intervention to deliver the required improvement e.g. Milestones breached.
R	Delayed	Off track / trajectory – milestone / timescales breached. Recovery plan required.

2. Strategic Risk Heat Map



Review of Impact on our Strategic Objectives

The maps shown above aim to illustrate where the risks set out within the BAF impact upon the achievement of our Strategic Objectives.

3. Board Assurance Framework 2020/21

Risk Summary			
BAF Reference and Summary Title:	**BAF 1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022**		
Risk Description:	**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.**		
Lead Director:	Director of Nursing	**Supported By:**	Medical director
Lead Committee:	Quality, Patient Experience and Safety Committee		
Links to Corporate Risk Register:	**Title** • 208 Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks • 274 Failure to resource backlog maintenance and medical equipment replacement 2062 Failure to fully complete mortuary passport • 2066 Lack of registered nurses and midwives	**Current Risk Score**	**16 (High)**

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			• 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 performance level	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**4**				**Consequence:**	**5**	
Risk Level:	**High 20**	**High 16**				**Risk Level:**	**Mod 10**	

				• 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 • Risk score has been reduced to 16 in line with the reduction in the staffing risk.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• 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. • 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 • GIRFT Meetings reinstated	• 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 • Learning from death framework supporting local mortality review. • Faculty of Research and Clinical Education (FORCE) established to promote research and professional development in the trust • Perfect Ward app allows local oversight of key performance metrics	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Quality Review 6 monthly reviews in place with NHSi/CQC
Gaps in Control	• Some policies and clinical guidelines remain out date • VTE performance continues to be below the Trust Target • Deterioration in the Trusts complaints response performance • Mental Capacity Act compliance below the Trusts Standards • Lack of current registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital. • Out of date clinical Policies, Procedures and SOP's • Training performance not meeting set targets • Quality Impact Assessment process is not yet established within the trust		
Assurance:	• Quality Governance process is in place with oversight and escalation process in place throughout the organisation. Escalations are reported to QPES each month. • Ward Review process in place which provides assurance on the quality of care • Improvement programme in place to oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality	• 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 • Patient priorities for 2021 identified, which will form part of Quality Account objectives	• External Performance review meetings in place with NHSi/CQC/CCG • Monthly Quality meetings with NHSi and CQC • External review undertaken on the SI processes • CQC report (2019) showed improvement and the Trust was rated as 'outstanding' for caring

	Care.		
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 • NHSi 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 RCAs		

Future Opportunities

- Improvement programme offers consistency in methodologies and documentation used across transformation programmes
- Care Excellence Programme and Pathway to Excellence Programme offer a structured programme 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
- Development of a Quality Assurance Framework
- Development of Care Excellence strategy

Future Risks

- Resources to deliver the improvement programme.
- Resources to deliver the Care Excellence Programme and Pathway to Excellence Programme
- Potential second wave of Covid-19
- Dependence on the success of interdependencies from other work-streams.
- 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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Staffing Risk • red flag process being embedded, escalation SOP in development • implementation of Allocate in line with business case, review of KPI's and temporary staff booking reasons • QIA's to be undertaken for every area that has nursing associate role within establishment • Establishment review in progress	Ann-Marie Riley			

	• Self-assessment against NHSI Developing Workforce Safeguards (2018) underway				
2.	Care Excellence • Care Excellence strategy in development • Final phase of consultation to take place in September	Ann-Marie Riley & Mathew Lewis			
3.	Patient Experience • Reviewing TOR for patient experience group • We have developed 12 patient priorities – the action plans for these are underdevelopment	Ann-Marie Riley			

Risk Summary			
BAF Reference and Summary Title:	**BAF SO2 - Care at Home – We will host the integration of Walsall together partners addressing health inequalities and delivering care closer to home.**		
Risk Description:	**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.**		
Lead Director:	Director of Integration	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title** • 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	**Current Risk Score** **12 (Moderate)**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**3**	**3**			• 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	**Likelihood:**	**2**	31 March 2021
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**12**	**12**				**Risk Level:**	**Mod 10**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Executive Director recruited • Non-Executive Director appointed	• 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 • Business case approved by Partners	
Gaps in Control	• Lack of investment across the health economy impacts on the delivery of the Partnership – notwithstanding the recent investment from the Trust • Commissioner contracts to be aligned to Walsall Together • Data needs further aligning to project a common information picture		
Assurance:	• Risk management now underway at a locality level. • Divisional quality board now starting to look at the integrated team response.	• Walsall Together included on Internal Audit Programme • Walsall Together Committee in place overseeing assurance of the partnership • STP oversight of 'PLACE' based model	• NHSi support of Walsall Together
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		

Future Opportunities

- Further development of the Governance around risk sharing
- 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
- QC action oversight group

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

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Agree a joint business plan for Walsall Together and PCNs that describes how the enhanced and additional roles within the PCN contract will integrate with community services	Daren Fradgley	Dec 20		
2.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations	Daren Fradgley	Dec 20		
3.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital workstream)	Daren Fradgley	Mar 21		
4.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure	Jenna Davies	Mar 21		

Risk Summary			
BAF Reference and Summary Title:	**BAF S03 Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System**		
Risk Description:	**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.**		
Lead Director:	Medical Director	**Supported By:**	Chief Operating Officer & Executive Director for Planning and Improvement
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title** • 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		**Current Risk Score** **12 (Moderate)**

Risk Scoring							
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**	**Target Date**
Likelihood:	**3**	**3**			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 collaboration in dermatology including appointment of joint clinical director Advanced discussions in Urology including cross site working • Integrated ENT on-call rota in place • Initial discussions re: bariatric services and radiology • STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy • Advanced discussions taking place with RWT to create a shared Clinical Fellowship Programme. Despite progress, integration plans are not yet fully implemented	**Likelihood:**	31 March 2021
Consequence:	**4**	**4**				**Consequence:**	
Risk Level:	**12**	**12**				**Risk Level:**	**2 (low)**

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Collaborative working and integration executive group in place • Sustainability review process completed • Regular oversight through the Board and its sub committees • Improvement Programme to progress clinical pathway redesign with partner organisations		• Third line of control NHSE/I regulatory oversight • Black Country and West Birmingham STP plan and governance processes in place
Gaps in Control	• Lack of co-alignment by our organisation and neighbouring trusts • Lack of formal integration at Trust level • Mandated arrangements by regional networks		
Assurance:	• Track record of functional integration of clinical services including hyper acute stroke, vascular surgery, cardiology, rheumatology, ophthalmology, neurology, oncology, black country pathology service and OMFS	• Demonstrable evidence of functional integration in ENT, Urology and Dermatology • Three out of the four Acute Collaboration partners have committed to collaborative working. • Audit Committee has oversight of partnership working within its terms of reference. • System Review Meetings providing assurance to regulators on progress	• Progress overseen nationally and locally
Gaps in Assurance	• Clinical strategy is still emerging • CCG currently in a state of transition • Additional pressures with Covid-19 have delayed acute collaboration • Sandwell and West Birmingham NHS Trust has not yet committed to formal collaborative working. • Limited independent assessment of integrated services or collaborative working arrangements		

Future Opportunities

- Strengthen formal collaboration with Sandwell & West Birmingham
- 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
- Collaborative working during COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign

Future Risks

- Conflicting priorities and leadership capacity to deliver required changes
- STP level governance does not have statutory powers
- Lack of engagement/involvement with the wider public
- Acute Hospital Collaboration may not progress at the anticipated pace if a resurgence of COVID-19 coincides with a challenging winter.

- Disrupted relationships with neighbouring trusts due to altered visions of the form and pace of future collaboration

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020		
2.	Develop over-arching programme plan to support individual projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work).	Programme Manager	Dec 2020		
3.	Incorporate restoration work/plans and risk into the winter plan.	N. Hobbs	Oct 2020		

Risk Summary			
BAF Reference and Summary Title:	**BAF 04 - Value our Colleagues - We will be an inclusive organisation which lives our organisational values at all times**		
Risk Description:	**Lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care**		
Lead Director:	Director of People and Culture	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title** • **2072 -** Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency. • **707 -** Relates to a Failure to comply with equality, diversity and inclusion standards. • **2093 -** Staff are exposed to infection with COVID-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death • **2095 -** The demand for 'Personal Protective Equipment' (PPE) has contributed to a national shortage of proper and effective PPE, resulting in delays in obtaining from supply chain, with the potential to impact on our ability to maintain key critical services and protect staff against COVID-19.	**Current Risk Score** **20 (Major)**	

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			• Staff recommending Walsall as a place to work is below all England average [bottom quartile Q2 2019-2020] • Staff recommending Walsall as a place to be treated is below all England average [bottom quartile Q2 2019-2020] • Staff engagement score in NHS staff survey is below peer comparators • NHS staff survey indicates a lack of inclusive culture with differential staff experience in bullying, harassment, violence, career progression and promotion • NHS staff survey indicates a lack of open culture (speaking up) below peer comparators • The model hospital data indicates bottom quartile performance on workforce indicators such as sickness absence and use of resources • Historical WRES data indicates a lack of progress to tackle barriers to inclusion. • Data and information shared via staff feedback mechanisms evaluating	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:						**Risk Level:**	**8**	

				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 staff have shared stories of unreasonable treatment based on their race, disability, ethnicity and sexuality.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Values launched and evaluated across the Trust • Staff engagement and communication approach in place • Policy on zero tolerance to violence in place • Behaviour Framework implemented and evidence of practicing behaviours in action to be reviewed within the IPDR process • Values based appraisal process in place which incorporates Talent Management and the ability to track access to career progression and promotion • Increased engagement through engagements and EDI champions • Health and Wellbeing approach based on holistic offering to staff being developed • Just Culture work initiated and ER casework triaged for opportunities for early resolution. • Staff in at risk groups have been identified and managed appropriately according Wellbeing Review and Stratified Risk Assessments. • Set of measures have been identified to monitor progress against workforce inequalities and employment inequality in Walsall.	• Head of Talent, Resourcing and Inclusion appointed to lead the approach • Analysis against actions required from NHS People Plan against actions progressed under the Valuing Colleagues Improvement Programme has been reviewed by PODC.	
Gaps in Control	• Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Approaches and resources may be insufficiently robust or at scale to achieve meaningful change • Current Policy framework not fit for purpose – legacy policies are not aligned to the approach • Further support required to develop FTSU approach and embed within the leadership approach • Leadership development programme is in its infancy		

	• Management competency framework is not yet available, impact and evaluation not complete • Resourcing not yet stable – workforce metrics still demonstrate adverse trends • EDI targets at organisational and divisional level have not been developed.		
Assurance:	• 21 • Engaging with the wider Trust and TMB on co-designing an Organisation Development Plan – work packages and delivery through the improvement programme • 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. •	• People and OD committee of the Board in place to seek assurance, through the cycle of business and review of workforce metric trends. • EDI group led by a Non-Executive director in place to review approach to EDI and delivery of metrics in the EDI strategy framework and Equality Impact Assessment. • PODC receive monthly updates regarding to assure robust arrangements in place to support colleagues through the impact of COVID. • BAME cabinet provides strategic Board focus on EDI.	• NHSi working with the Trust to develop the FTSU approach and to develop a strategic framework by Q2 for FTSU by 2020-2021 • NHS Leadership Academy working with the Trust on developing leadership capacity and capability, the delivery was scheduled for Q1 1920-21, paused due to Covid response • NHSi partner for Retention programme – the 90 day plan is complete, impact on retention rate to be reviewed Q2 1920-
Gaps in Assurance	• All elements of the Trust Board pledge, bullying harassment, discrimination and listening to the voice of staff. • Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Evidence based approach to positive action interventions not yet in place to support EDI objective • Evaluation of zero tolerance to violence not yet evaluated. • NHS staff survey results do not evidence an improvement in staff reporting of an inclusive and open culture • The indicators for staff recommending the Trust as a place to work or a place to be treated have failed to improve significantly. • The staff engagement score has worsened indicating lower levels of staff morale and role satisfaction. • NHSE/I Governance and Accountability review highlighted areas of improvement associated with culture and leadership • No internal audit assurance gained in year • Line managers are required to ensure all staff have received an opportunity to undertake a wellbeing review risk assessment. Not all staff are recorded to have participated in the process. • Benefits of the Valuing Colleagues Programme to be agreed. • An audit against ESR data is being undertake to provide assurance regarding workforce and learning data quality.		

Future Opportunities

- Capitalise on external resource/expertise to establish evidence based best practice
- Closer working with through the STP/LWAB
- Collaborative working with other Trusts to creatively address resourcing matters
- New roles and scenario based workforce planning for full resourcing and consequent impact on staff morale
- To work collaboratively on a Black Country Health and Wellbeing approach to make Walsall and the Black Country the best place to work
- To develop a more structured and inclusive approach to widening participation
- To develop the Trust's profile as an employer of choice by having clear pathways for career development.
- To become an anchor employer within Walsall attracting talent as a result of our EDI approach and strategy.

- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Board EDI development sessions scheduled for October 2020.
- Divisional Board Accountability Framework to monitor on Divisional EDI targets

Future Risks

- A culture of speaking up is not embedded and the organisational culture does not support the development of FTSU
- The capability and capacity of leaders does not support the development of a Just Culture approach in practice
- Recruitment and retention activity does not result in improved performance, meeting targets for vacancy, turnover, absence and the trust remains below peer comparators within the STP.
- Potential second wave of COVID impacting on the physical and psychological health of individuals and workforce availability.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Draft Health & Wellbeing Strategy & Engage and Consult Key stakeholders	Catherine Griffiths	October 2020		
2.	Develop and Implement a leadership Development Programme	Catherine Griffiths	March 2021		
3.	Launch EIA Policy and Form	Catherine Griffiths	October 2020		
4.	Review and relaunch equality impact assessment processes	Catherine Griffiths	March 2021		

Risk Summary			
BAF Reference and Summary Title:	**BAF 05 Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly**		
Risk Description:	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 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.		
Lead Director:	Chief Operating Officer	**Supported By:**	
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title**		**Current Risk Score**
	•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 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 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		**20 (Major)**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4			<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	**Likelihood:**	2	31 March 2021
Consequence:	5	5				**Consequence:**	5	
Risk Level:	**20 (Major)**	**20 (Major)**				**Risk Level:**	**10 (Moderate)**	

				to needing to re-forecast outturn during the financial year. • High reliance on temporary workforce • Lack of credible plan to address backlog maintenance requirements. <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.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Finance reported monthly via Divisional Performance Reviews and Executive Governance Structures • CIP Governance processes in place • Revised financial governance in place for COVID-19	• Performance, Finance & Investment Committee in place to gain assurance • Audit Committee in place to oversee and test the governance/financial controls • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation) • Use of Resources work-stream identified as part of the Improvement Programme	
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 force. • Leadership development needs at Care Group, Divisional and corporate support service levels.		
Assurance:	• Model Hospital Use of Resources assessments	• Internal Audit reviews of a number of areas of financial and operational performance	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts
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

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.

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.
- 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.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Develop divisional plans to address dips in activity and agree a forecast model to minimize the impact of annual leave on activity.	N. Hobbs/ K Salmon	Oct 2020		
2.	Review and update Accountability Framework further to the NHSI Governance Review report.	N. Hobbs	Oct 2020		
3.	Financial regime post 31st July 2020 to be approved by Board in October 2020- Russell Caldicott	R. Caldicott	Oct 2020		

4.	All work-streams to have Improvement programme benefits defined -	G. Augustine	Oct 2020		

Risk Summary			
BAF Reference and Summary Title:	**BAF 06 COVID - This risk has the potential to impact on all of the Trusts Strategic Objectives.**		
Risk Description:	**The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.**		
Lead Director:	Chief Operating Officer	**Supported By:**	
Lead Committee:			
Links to Corporate Risk Register:	**Title** 2051- Inability to mitigate the impact of Covid-19, results in possible harm and poor patient experience to the people of Walsall. 2066- There is a risk of lack of skilled registered nurses (RN's)/registered midwives (RM's) on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care 2093- Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust 2095- Inability of the NHS supply chain to provide an adequate and on-going supply of PPE to meet the demand to ensure that Walsall Healthcare NHS staff are fully protected during the Covid-19 pandemic. <Add in links to 18-week or 4-hour emergency access standard or cancer waiting time risks> <Add in link to financial sustainability risk>	**Current Risk Score** **20 (Moderate)**	

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:					• Covid-19 is a novel virus and therefore there is a lack of knowledge and understanding of the disease, how it behaves and the likely trajectory of further resurgence in cases. • The initial wave of Covid-19 has had a profound impact on the services that the Trust provides, both in terms of urgent, emergency and critical care services to manage covid-19 positive patients (in the hospital and the community), and in terms of the reduction in capacity of elective care services.	**Likelihood:**	**2**	31 March 2021
Consequence:						**Consequence:**	**5**	
Risk Level:	**25 (Major)**	**20 (Moderate)**				**Risk Level:**	**10 (Moderate)**	

			• The initial wave of Covid-19 has had a profound impact on the workforce of the Trust. Almost 1 in 4 Trust staff who have undergone a Covid-19 Antibody test have been antibody positive suggesting a significant proportion of the workforce has experienced the disease themselves. Moreover, the challenges of managing the initial wave of the pandemic has had significant psychological impact on staff too. • The Trust is operating in a highly uncertain financial planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19. • The number of Covid-19 positive inpatients has reduced from over 200 at the peak of the initial wave to less than 10 over Summer 2020. • Covid-19 has profoundly exposed existing significant health inequalities in the population the Trust serves. • Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust.		

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	Governance: • Incident Command structure in place incorporating Strategic Command, Hospital Tactical Command, Walsall Together Community Tactical Command and Corporate Tactical Command. • Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. • Specific Covid-19 related SOPs and guidelines	• Individual committees consider specific impact relevant to their portfolio, i.e. Financial matters and Restoration and Recovery of elective services under PFIC; Quality, Safety and Patient experience matters under QPES and Workforce matters including staff wellbeing under P&ODC. • Board Development sessions (x2) on approach to Restoration and Recovery.	• Regional and National Incident Control structure.
Gaps in Control	• National directives and mandates impact on the Trusts ability to make local decisions. • Unable to progress all elements of the improvement programme owning capacity of senior leaders • Comprehensive OD/Culture Improvement plan •		
Assurance:	• Elective waiting times upper quartile for Diagnostics (DM01) and routine elective treatment (18-week Referral to Treatment)	• Nosocomial Covid-19 infection rate in line with peer-reviewed published evidence • Antibody positive staff rate in line with BCWB peers.	• Cancer waiting times in line with national average

	•	• Financial top up requests in line (or lower) as a proportion of turnover than BCWB peers.	
Gaps in Assurance	• Lack of assurance of communications within the organisation to ensure staff feel well informed and engaged. • Evidence of higher staff absence rates than BCWB peers during initial wave of Covid-19 • Evidence of slower completion of BAME/vulnerable staff risk assessments than BCWB peers. • Lack of Assurance on sufficient restoration of elective operating theatre capacity to meet expectations of Phase 3 planning letter. • Lack of Assurance that the Trust will have the clinical workforce to deliver services in the event of a second wave. Lack of clarity and certainty regarding levels of income for months 7-12 limit ability to provide assurance on Trust's forecast financial position.		

Future Opportunities

- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables
- Opportunity to explore urgent care processes and establishment to deliver increased quality and efficiency of care
- Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough.
- Covid-19 has necessitated closer collaboration with other Acute hospitals which can continue to be built upon.
- Increased profile and appreciation of the NHS within the general public could be harnassed to attract and retain staff National planning guidance for Phase 3 (Recovery & Transformation) creates an expectation that services must not be reintroduced based on historical models
- Identifying and adapting the workforce and professions to create a modern and adaptable workforce

Future Risks

- Potential for resurgence in Covid-19 cases.
- Potential for second wave of Covid-19 cases coinciding with Winter pressures including seasonal Influenza and norovirus, and delayed and advanced (in terms of disease progression) presentation of patients that have not accessed healthcare services in recent months.
- Ongoing pressure on community services associated with patients rehabilitating following Covid-19.
- Delayed and/or prolonged impact of managing the initial wave of the pandemic on staff wellbeing.
- Potential workforce absence in the event of a second wave.
- Limited management and leadership capacity to address core objectives due to the significant demands of managing covid-19 pandemic, and the restoration and recovery of services affected by covid-19.
- More constrained financial operating environment.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.					
2.					
3.					
4.					

Three Lines of Defence Model – TO BE AGREED

Audit Committee

Senior Management

1st Line of Defence

Functions that own and manage risk – i.e. front line staff.

- Operational Management
- Internal Controls
- Managerial and supervisory controls
- **Preventative controls** – controls designed to limit or reduce impact should a risk materialise
- Effectiveness determined by overall control environment and culture
- Awareness of controls must be established and maintained by management and staff

Nature of Assurance:

- Comes direct from those responsible for delivering specific objectives or operation;
- provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved
- may lack independence and objectivity, but its value is that it comes from those who know the business, culture and day to day challenges

2nd Line of Defence

Functions and personnel that oversee risk

- Risk Management Processes
- Compliance, including compliance with laws and regulations
- Contract management arrangements
- Financial control monitoring financial risks and reporting
- Quality
- IT
- Other control departments

Core purpose to ensure that the first line of defence is properly designed and operating as intended.

- **Directive:** designed to ensure a particular objective is achieved
- **Detective:** designed to identify particular occasions when undesirable outcomes have been realised
- Key aspects of maintaining policies and produces and ensuring staff receive training in relation to first line of defence.

Nature of Assurance:
This assurance provides valuable management insight into how well work is being carried out in line with set expectations and policy or regulatory considerations.

It will be distinct from and more objective than first line assurance.

3rd Line of Defence

Function that provide independent assurance

- Internal Audit
- External Audit
- Local Counter Fraud Services (LCFS)
- Care Quality Commission
- Regulators – NHSI/E
- Other external assurance providers (i.e. external accreditation / inspections)

Nature of Assurance:

- Independent of the first line and second lines of defence.
- Internal audit operates to professional and ethical standards in carrying out its work, independent of the management line and associated responsibilities.
- External Audit operates similarly and reports mainly to Parliament.

The Three Lines of Defence model provides a simple and effective way to enhance communications on risk management and control by clarifying essential roles and duties.

To ensure the effectiveness of the risk management framework, the board and senior management need to be able to rely on adequate line functions – including monitoring and assurance functions – within the organisation.

As illustrated here, the Three Lines of Defence model provides a means of explaining the relationship between these functions and as a guide to how responsibilities should be divided:

- the first line of defence – functions that own and manage risk
- the second line of defence – functions that oversee or specialise in risk management, compliance
- the third line of defence – functions that provide independent assurance

From Quarter 2 2019/20, the Three Lines of Defence Model was incorporated into the BAF against each Strategic Risk. Whilst this is expected to evolve further, it provides an alternative 'lens' for Board and Committee members to consider – particularly around identifying areas of potential weakness.

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
Well Led Improvement update			**AGENDA ITEM: 17** **ENC: 22**
Report Author and Job Title:	Dave Dingwall Programme Lead	**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 Trust's leadership, governance and assurance structures using the CQC Well Led Key Lines of Enquiry (KLOE). This workstream was added to the improvement programme in April 2020. The Senior Responsible Officer for the workstream is the Director of Governance, supported by the Director of Finance and the Director of Planning and Improvement. Since the last update to the Board further project management support has been identified and will commence work on the project from 28th September. The Integrated Governance workstream is currently off track in both development of the Project Initiation Document development and Implementation. A rectification plan has been agreed with a full day workshop due to take place on 30th September. Additional resource has been requested to support the delivery of this project over the coming months to ensure it is delivering at the required pace. The Accountability and Support workstream is currently rated as red as the Project Initiation Document requires development. This has been escalated though the programme board, and a rectification plan is in place.		
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 link 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 Senior Responsible Officer 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 recommendations 2019
- Internal Audit reports

3.1 NHSI Governance and Accountability Review

In October 2019 the Chair and Chief Executive requested NHSi complete 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 Project Implementation Documents and the recommendation is that the Committees of the Board gain assurance through the review of the Project Initiation Documents 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 all Board Committees with the exception of the Walsall Together Partnership Board.

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 Board Assurance Framework and Corporate Risk Register 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 Project Initiation Document has been presented to the Well Led core team. Further work is currently underway supported by the Senior Responsible Officer 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 Document 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 Project Initiation Document, and outline actions until September to enable the recently appointed Director of Planning and Improvement to 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”

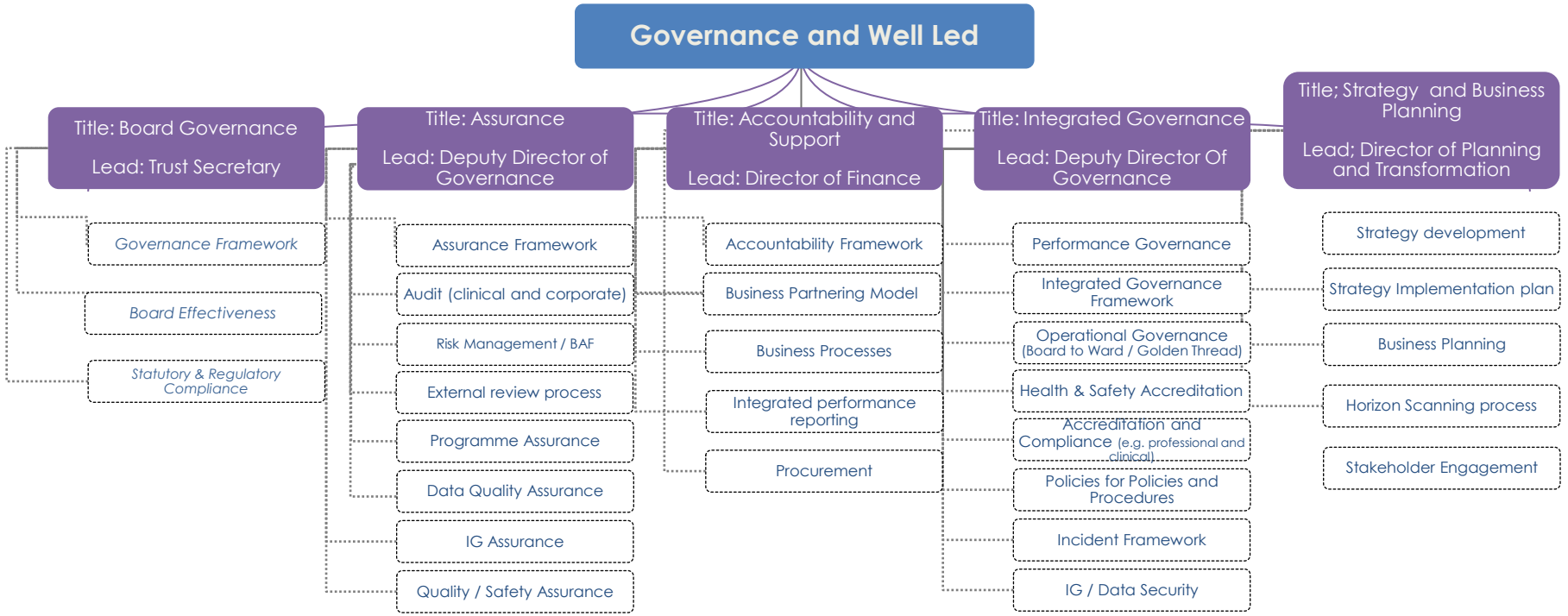
5. WORKSTREAM RISKS AND ISSUES

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.

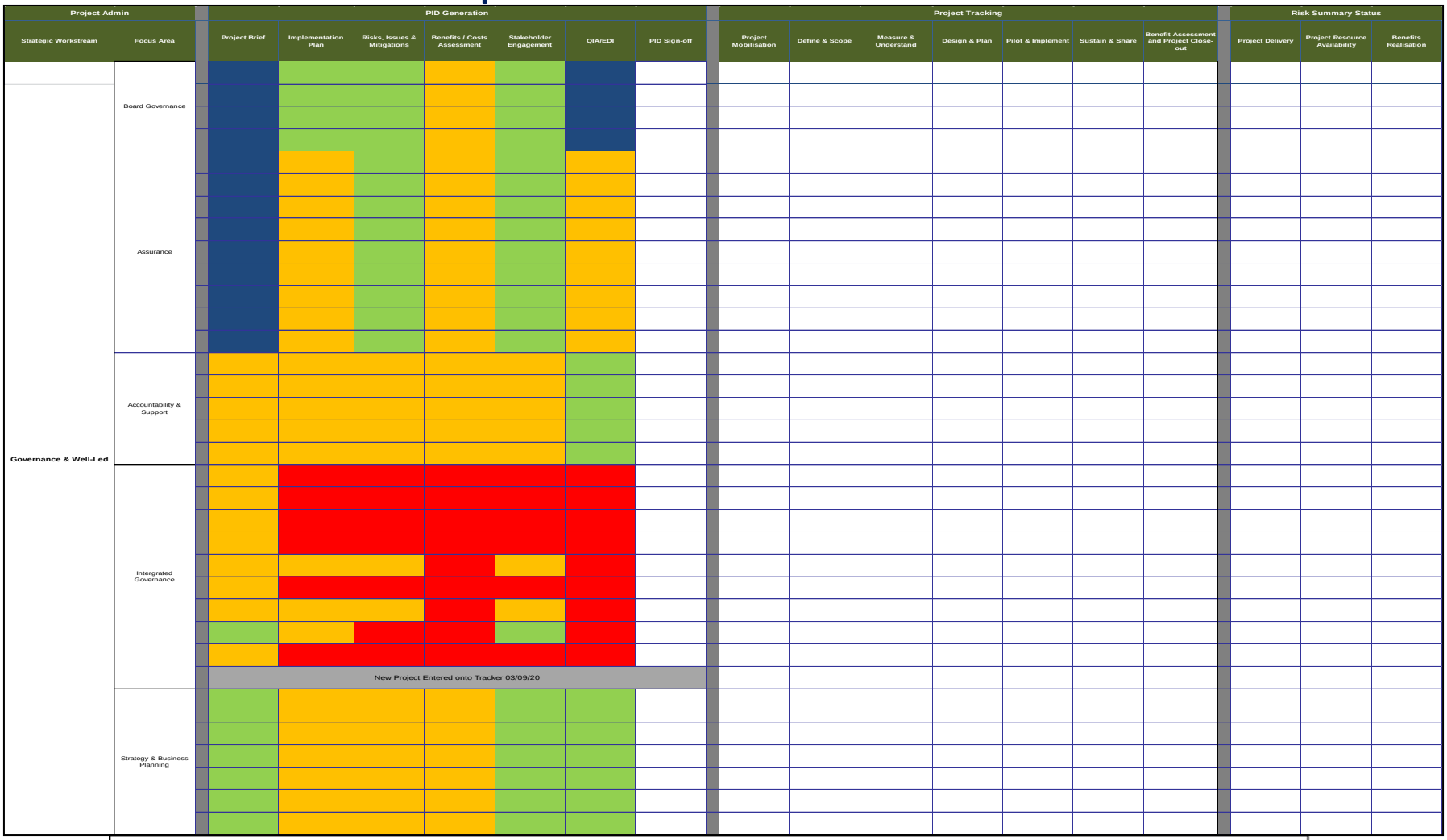
The red rated risks for the workstream;

- 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

Workstream Breakdown



Governance & Well Led update : September 2020 IP Board



Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	Insufficient engagement of colleagues in workstream or solution development	A	Comms and Engagement resource required at Programme level
	Improvement work streams are not fully integrated with the strategic and annual planning and business processes	A	Processes to be updated to ensure integration
Issues	Identification of sources of compliance information	A	
	No confirmed resource available to develop revised assurance framework or to be the day to day lead on the Accountability & Support workstream	R	Jenna / Dave / Russ to discuss
	Core and project team capacity constraints leading to delays in PID development / finalisation	R	
Dependencies	Interdependencies between all aspects of the Governance and Well Led workstream to be fully identified and managed	A	Internal team session held to progress
	Safe, High, Quality Care (SHQC) and Valuing Colleagues	A	Cross-workstream dependency workshop held and actions confirmed

MEETING OF THE PUBLIC TRUST BOARD – 1st October 2020			
NHSI – Review of Undertakings			**AGENDA ITEM: 18 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	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 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. Attached at Appendix 1 is the Trust's progress against the Undertakings. This update, together with evidence to substantiate it, will be provided to NHSI, and may inform revised Undertakings.		
Recommendation	The Trust Board is requested to approve the submission to NHSI as the Trust's progress against its Undertakings.		
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 ☒		

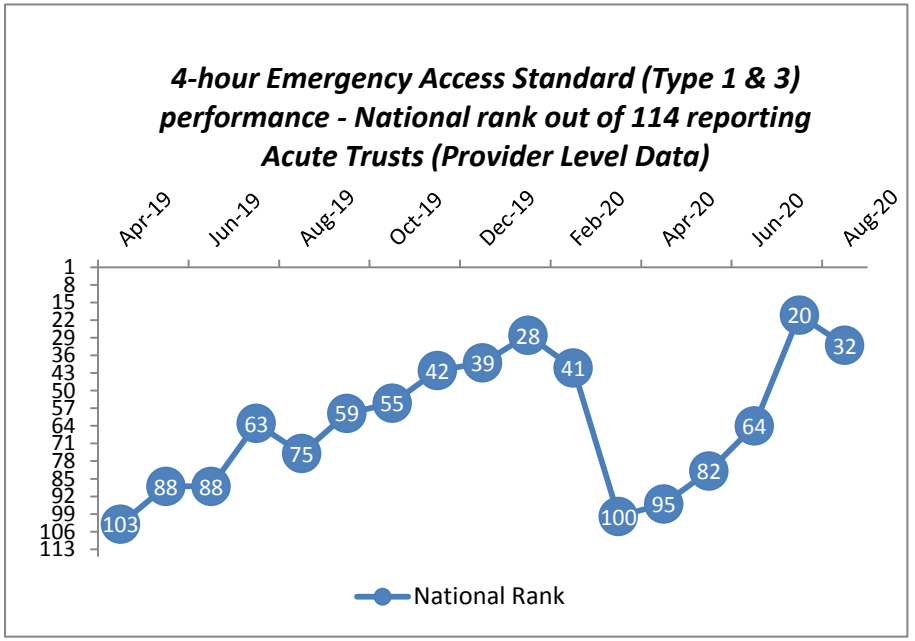
Walsall Healthcare NHS Trust Review of Undertakings

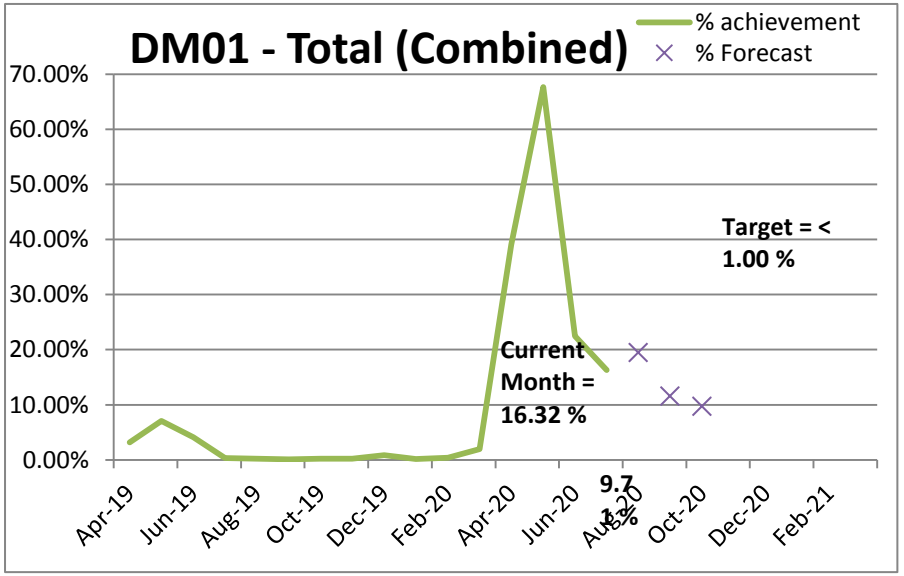
Appendix 1

#	Undertaking detail	Evidence	Status
1. Quality Improvement			
1.1	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.	The Special Measures support plan is in place and has been agreed. The plan has been monitored through the Executive team. There are a number of areas which remain 'in progress', generally around the Board, Executive and triumvirate development. Executive development is in place and ongoing; Board development is planned with discussions taking place currently with potential facilitators, and triumvirate development commencing in October.	In progress
1.2	The Trust will provide progress updates against the exit support plan as part of the NHS England and NHS Improvement regular oversight arrangements.	Regular updates have been provided to NHS England and Improvement at the regular oversight meetings. Regular meetings are also in place between the Assistant Director of Strategic Transformation and the Trusts Director of Governance to oversee progress	In progress
1.3	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.	The Trust has initiated a Trust wide improvement programme which includes all aspects of improvement across the Trust. The Improvement programme also includes the recommendations of the CQC reports and other external visits. NHSIs Assistant Director of Strategic Transformation is a member of the improvement board. The Trust has recently revised its governance/accountability approach to overseeing the CQC recommendations, with the Director of Nursing chairing a confirm and challenge meetings with the divisional teams of three The Director of Governance, and the Director of Nursing meet with CQC on a biweekly basis to provide updates on Quality Improvement.	Completed
1.4	The Trust will ensure that it has sufficient capacity at both executive and other levels of management	The Trust has expanded its executive capacity by recruiting a Director of Planning and Improvement, which enables a clear separation	Completed

#	Undertaking detail	Evidence	Status
	to enable delivery of quality improvements, and ensure that these measures do not compromise its overall financial position.	between delivery of the improvement and oversight/assurance. The Chief Executive Officer is the SRO for the programme and chairs the improvement programme. The Trust has strengthened its project management capacity, analytics, and senior management capacity in order to deliver the required improvements. There are clear processes and governance in place for escalation of capacity through the improvement programme.	
2. Finance performance			
2.1	The Licensee will ensure that robust financial plans are in place to:	Trust Board reviewed and endorsed the financial plan for 2019/20, recommended for adoption by Performance, Finance and Investment Committee and adopted by full Trust Board *(see papers to PFIC & Trust Board on financial plan – minutes endorsing plan)*	Complete
2.1.1	deliver the 2019/20 control total and planned CIPs; and	The Trust attained the 2019/20 financial plan, though it is of note the Trust financial position was monitored throughout and a revised forecast submitted in December 2019, though costs associated with Emergency Care activity above block allocations were remitted back to the Trust (following negotiation) and the forecast adverse position to plan reversed. *(See attached the Trust re-forecast report to Board December 2020 and final March 2020 financial report on outturn and minutes)*	Complete
2.1.2	minimise the revenue cash support requirement	As above, Trust attained financial plan	Complete
2.2	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.	The Trust attained the Cost Improvement Programme targeted for 2019/20, with all schemes receiving Quality Impact Assessments. However, the Trust was reliant on income generation and elements of non-recurrent delivery. (NHSEI review of PMO function and report on performance to PFIC in March and April 2020)	Complete
2.3	The Licensee will comply with planning guidance issued by NHS England and NHS Improvement in	Trust complied with and received in full central Financial Recovery Fund and Provider Sustainability Funds.	Complete

#	Undertaking detail	Evidence	Status
	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.	Trust had documented financial plans to deliver within the metrics articulated by the three-year review and control totals issued by NHSEI in relation to 2021/22 and beyond (though reliant on receipt of Long-Term Plan funding) (Trust Board financial plan submission and minutes endorsing the plan)	
2.4	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.	Financial submissions endorsed through wider STP work, with provider organisations and commissioners of healthcare submitting system wide plans for the 2021/22 financial year, though note the system submission was not in accordance with issued control targets (other providers unable to attain targeted outturns). Plans were not published as a consequence of the shortfall and then Covid-19 impact. (Trust Board report on Financial outturn / plan over three fiscal years)	Complete, though adversely affected by Covid-19
Governance			
2.5	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.	Structures and governance were in force, plan was attained and break-even achieved by the Trust. NHSEI have reviewed the PMO function and the report is referenced for information. The Trust is in transition from a traditional PMO function to an Improvement Programme approach, delivery will be key to attainment of financial strategy in the medium term.	Complete
3. Operational Performance			
3.1	The Trust will take all reasonable steps to recover operational performance to meet national	**Emergency Access Standard**	In progress

#	Undertaking detail	Evidence	Status
	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 3.2 to 3.4, below.	Despite attendances increasing, the Trust continued to improve its performance against the Emergency Access Standard to achieve 95.4% of patients admitted or discharged within four hours of arrival. July 2020 was the first calendar month in recorded history Walsall Healthcare NHS Trust has achieved the Emergency Access Standard.  **Diagnostics** With increasing demand for Imaging and diagnostic services the Trust has continued to build on its performance in terms of the DM01 metric. The below table highlights the diagnostic performance both prior to and throughout the COVID-19 pandemic and inclusive of forecasted recovery position for the next 3 months.	

#	Undertaking detail	Evidence	Status
		 Pre-COVID the Trust was able to consistently maintain compliance with the DM01 standard and post-COVID is aiming to return to this through the restoration and recovery planning and performance of the contributing modalities.	
3.2	The Trust will ensure that there are robust improvement plans in place to meet the requirements of paragraph 3.1, which has been agreed with NHS England and NHS Improvement.	**Emergency Access Standard** The MLTC Division has established an Emergency Access review meeting to ensure good oversight and governance over our EAS performance. The current actions include: 1. Ensure a consultant attends breach analysis once per week. 2. Host a training day to improve the performance and	Complete

#	Undertaking detail	Evidence	Status
		standardisation of the progress chasers. 3. Complete works on the Psychiatric Decisions Unit. 4. Confirm a plan for measuring See & Treat triage. **Diagnostics** The Diagnostics services have reinstated the EAPG meeting with local users and commissioners which takes place on a monthly basis. This is where local service users hold services accountable for performance against local and national standards. Before and continuing through COVID-19 the Diagnostic services have continued to hold and attend the monthly oversight committee for the BCPS. Diagnostics have continued to hold patient safety, quality and performance meetings during the COVID pandemic at both service and Divisional level. DM01 has been discussed and monitored through these fora. In addition, DM01 performance has been monitored through post-COVID weekly Restoration & Recovery meetings and through the Constitutional Standards report produced monthly.	
3.3	Governance Arrangements; 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;	The Trust requested a governance and accountability review be undertaken by NHSi. The review did not identify any material failures of governance, however identified areas of improvement and made some specific recommendations which have been aligned to the relevant area of the improvement programme. The Trust has in place an Internal Audit programme and External Audit programme, the outcomes of both are reflected within the Trust's	In progress

#	Undertaking detail	Evidence	Status
	3.1.2 for timely & 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	Annual Governance Statement. The Trust has made improvements to internal control systems during the financial year 2019/20, however we acknowledge a there are still weaknesses that require improvement including risk management, staff survey results and our Workforce Race Equality Standards. All of these areas have improvement rectification plans within our overall improvement programme. As part of the Trust's provider licence the Trust is required to make a self-declaration against a number of the licence specific conditions. The Director of Governance undertook an audit of compliance which was presented to the Board in June, and the Board confirmed its compliance with both FT4 and G6.	
3.3.1	include the actions required to meet the requirements of paragraph 3.1, with appropriate timescales, key performance indicators and resourcing;	Monthly performance review established with Community Services & Executive team to look at KPIs and service delivery / risks Community Services & Walsall Together report on activity and delivery impacting on WHT through to Trust Board sub-committees [e.g. QPES, PFIC]	
3.3.2	describe the key risks to meeting the requirements of paragraph 3.1 and mitigating actions being taken;	***Risk:*** Limited infrastructure within Community Services to support this level of monitoring & reporting ***Mitigation:*** Additional infrastructure requirements for Community Services have been presented to the Executive team – this is being reviewed	
3.3.3	be based on realistic assumptions;	The dynamic of the performance reviews is to establish & confirm the nature of any assumptions with those responsible for operational delivery	
3.3.4	reflect collaborative working with key system partners and other stakeholders;	Walsall Together delivery & oversight runs concurrently with Trust internal governance systems. The former is a multi-agency body working in partnership to improve health and social well-being across the borough of Walsall	
3.3.5	set out the key performance indicators which the Trust will use to measure progress.	KPIs have been developed as part of the performance review process, and our contained within the Accountability Framework. Community	Completed

#	Undertaking detail	Evidence	Status
		services is working with the organisation to produce a suite of reports that are more meaningful to its daily operations but which can be aggregated to provide assurance at macro-level Via the improvement programme the Trust is reviewing its current accountability framework in line with the recommendations from NHSi, and also reviewing the alignment with the annual planning process.	
3.4	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 3.1, 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 3.1, 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.	The Trust has made improvements to internal control systems during the financial year 2019/20. This included the launch of revised accountability framework and governance structure. The Trust improved its reporting lines to ensure the board were signed on all aspects of performance across Quality, Workforce, Operational performance and finance. There is a mechanism in place via the Director of Governance and the Director of Finance to ensure where matters materially affect the Trusts licence conditions these are immediately notified to NHSI	Completed
4. Programme Management			
4.1	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:	A Finance Programme Management Office (PMO) was established during 2018 at the Trust. This has significantly enhanced capacity to provide support to the CIP and consequently has improved governance, monitoring and reporting arrangements within the Trust. During 2019/20 internal audit reviewed the Finance PMO and noted the following '*The overall governance arrangements, including the reporting of CIP delivery, risks and mitigations are considered robust. There are clear reporting lines and escalation channels and there has been a strong focus on CIP delivery in the year.'* This report received significant assurance.	Completed

#	Undertaking detail	Evidence	Status
		Moving forward during 20/21 we are now establishing a Trust wide PMO linked to the improvement programme in line with recommendations from NHSi. We have recruited a Director of Planning and Improvement who will lead to new Project Management office and implement revised governance arrangements and ensure benefits of the improvement programme are tracked.	
4.1.1	obtain clear oversight over the process in delivering these undertakings;	The monitoring of the progress against the undertakings is regularly reviewed at an Executive level and performance against the key KPIs is monitored via the relevant Committee within the Trust.	Completed
4.1.2	obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and	The Trusts undertakings are linked to the performance reports which are submitted to the Board and the Board Committees. Any risks associated with non-achievement are captured via our risk register and reported to the Board via Board Committees	Completed
4.1.3	hold individuals to account for the delivery of the undertakings.	The Trust during 2019/20 approved a revised accountability framework. Divisions are held to account via performance reviews, and based on there performance are then rated for support requirements.	Completed
4.2	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.	The Trust attained financial and operational plans during the 2019/20 financial year, with the 2020/21 financial and operational plans aligned to the control target offer (pre covid-19 impact) so alternative course of action was not pursued. However, the Trust is in dialogue on formation of a group with Black Country Sustainability and Transformation Providers and sees this as strengthening financial and operational delivery. *(Board papers on Group formation and April PFIC & Board papers on financial and operational performance)*	Completed
5. Access			
5.1	The Trust will provide to NHS England and NHS Improvement direct access to its advisors, programme leads and the Trust's board members	There is a mechanism in place via the Director of Governance for NHSi to request access to any of its advisors.	Completed

#	Undertaking detail	Evidence	Status
	as needed in relation to the matters covered by these undertakings.	NHSi have the details and are able to directly contact the Trusts internal and external audit advisors.	
6. Meetings and reports			
6.1	In addition to the action in paragraph 1.2 (reporting in relation to the special measures exit plan) the Trust will:	The Trust throughout 19/20 attended all meeting as required by NHSi and engaged with the performance review meetings, and the system review meetings. Executive Directors also meet on a regular basis with their counterparts at NHSi. The Chair, the Chief Executive, the Director of Integration and the Director of Governance have regular one to one meetings with the Assistant Director of Strategic Transformation. There is a mechanism in place via the Director of Governance for NHSi to request and receive any information, including of reports from the Trust.	Completed
6.1.1	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		
6.1.2	provide such reports in relation to the matters covered by these undertakings as NHS Improvement may require.		