Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 3 DECEMBER 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.	Welcome and Apologies for Absence	Information	Chair	Verbal	
2.	Quorum and Declarations of Interest	Information	Chair	Enclosure	12.00
3.	Minutes of the Board Meeting Held on 5th November 2020	Approval	Chair	Enclosure	
4.	Matters Arising and Action Sheet	Review	Chair	Enclosure	
5.	Chair's Report	Information	Chair	Enclosure	12.05
6.	Chief Executive's Report	Information/ Assurance	Chief Executive	Enclosure	12.10
7.	COVID-19 Board Assurance Framework	Assurance	Chief Operating Officer	Enclosure	
8.	Trust Strategic Collaboration	Information	Chief Executive	Enclosure	12.25
9.	Improvement Programme	Approval	Director of Planning and Improvement	Verbal	12.40
	VALUE OUR COLLEAGUES				
10.	People and Organisational Development Committee (PODC) Highlight Report	Assurance/ Information	Chair of PODC	Enclosure	12.50
11.	Executive Report – Value Our Colleagues Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report	Assurance/ Information	Director of People & Culture	Enclosure	12.55
	PROVIDE SAFE HIGH QUALITY CARE				
12.	Quality, Patient Experience and Safety Committee (QPES) Highlight Report (appending the CQC Inspection Report; Infection Prevention and Control Board Assurance Framework; and Mortality Report)	Assurance/ Information	Chair of QPES	Enclosure	13.10
13.	Executive Report – Provide Safe High Quality Care Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report	Assurance/ Information	Medical Director and Director of Nursing	Enclosure	13.15
BREAK: 13.25 TO 13.45					
	USE RESOURCES WELL				
14.	Performance, Finance and Investment Committee (PFIC) Highlight Report	Assurance/ Information	Chair of PFIC	Enclosure	13.45
15.	Executive Report – Use Resources Well Appendix 1: Board Assurance	Assurance/ Information	Director of Finance/Chief	Enclosure	13.50

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
	Framework and Corporate Risk Register Appendix 2: Finance and Operational Performance Report		Operating Officer		
	CARE AT HOME				
16.	Walsall Together Partnership Board (WTPB) Highlight Report	Assurance/ Information	Chair of WTPB	Enclosure	14.05
17.	Executive Report – Care at Home Appendix 1: Board Assurance Framework Appendix 2: Performance Report Appendix 3: ICP Overview	Assurance/ Information	Director of Integration	Enclosure	14.10
	WORK CLOSELY WITH PARTNERS				
18.	Executive Report – Work Closely With Partners Appendix 1: Board Assurance Framework	Assurance/ Information	Chief Operating Officer	Enclosure	14.25
	GOVERNANCE AND WELL-LED				
19.	COVID-19 Evaluation – Lessons Learned	Information	Director of Planning and Improvement	Enclosure	14.45
CLOSING ITEMS					
20.	Any Other Business	Discussion	Chair	Verbal	14.55
21.	Questions from the public				15.00
	Date of next meeting Thursday 4th February 2021				
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Declarations of Interest			**AGENDA ITEM: 2**
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 November 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
		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.

Name	Position held in Trust	Description of Interest
		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
NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 5 NOVEMBER 2020 AT 12:00 P.M. HELD VIRTUALLY VIA TEAMS

Present

Members	
Ms Danielle Oum	Chair of the Board of Directors
Mr John Dunn	Non-Executive Director, Vice Chair Board of Directors
Mr Philip Gayle	Non-Executive Director
Mrs Anne Baines	Non-Executive Director
Mrs Pamela Bradbury	Non-Executive Director
Mr Ben Diamond	Non-Executive Director
Mr Sukhbinder Heer	Non-Executive Director
Mr Richard Beeken	Chief Executive Officer
Dr Matthew Lewis	Medical Director
Ms Ann-Marie Riley	Interim Director of Nursing
Mr Russell Caldicott	Director of Finance and Performance
Mr Ned Hobbs	Chief Operating Officer
In attendance	
Mr Paul Assinder	Associate Non-Executive Director (until 14.30)
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive Officer
Ms Jenna Davies	Director of Governance
Ms Catherine Griffiths	Director of People and Culture
Ms Glenda Augustine	Director of Planning and Improvement
Mrs Trish Mills	Trust Secretary
Members of the Public:	4
Members of Staff:	Joan Dyer for Staff Story
Apologies	
Mrs Sally Rowe	Associate Non-Executive Director
Mr Rajpal Virdee	Associate Non-Executive Director

120/20 **Quorum and Declarations of Interest**

The Chair welcomed members of the public to the meeting and thanked them for taking the time to join. The meeting was quorate and the Chair declared that she had stepped down from the Royal Wolverhampton NHS Trust as Non-Executive Director from 9th October. No other interests were declared.

121/20 **Minutes of the Board Meeting held in Public on 5th November 2020**

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

Page 11 first paragraph, change '….to invest in shortening elective time', to '….to invest in shortening elective waiting time'.

122/20 **Matters Arising and Action Sheet**

The action log was reviewed by the Board and updated with current position statements, with the following noted:

Action 043/20 (test and trace) was closed, noting a workforce planning tool was in place

and used during restoration and recovery planning.

Action 097/20 (a) (acute collaboration communication to staff) was closed as completed.

Action 099/20 (health and wellbeing in Winter Plan) was closed. The addition to the Winter Plan of the health and wellbeing offerings was reviewed by the People and Organisational Development Committee, and other than an amendment related to the purpose of the Haven Room for support rather than rest, the Committee endorsed the addition.

Action 100/20 (nosocomial deaths in wave 1 to be added to COVID-19 BAF) was closed as completed.

Action 102/20 (perfect ward app for MCA/DoLs) was closed as the Quality, Patient Experience and Safety Committee will continue to monitor how the perfect ward app provides more localised ownership of issues and actions for MCA/DoLS.

Action 103/20 (inclusion of health inequalities priority in Quality Account) was closed as completed, with the Board agreeing to the additional priority of "supporting and developing collective responsibility to reduce health inequalities and provide better outcomes for the people of Walsall, through the development of a Population Health and Inequalities Strategy for Walsall".

123/20 **Chair's Report**

The Board received the report from Ms Oum which was taken as read, congratulating Ms Oum on her inclusion in the 50 most influential BAME (Black, Asian and Minority Ethnic) people in health.

124/20 **Chief Executive Officer's Report**

Mr Beeken's report was taken as read, and the Board accepted that the focus at this meeting should shift to the current impact on the Trust that the increase in COVID-19 patients presented. Mr Beeken advised the Board that the second wave of COVID-19 had now exceeded the Trust's planning parameters, which were based on national guidance to prepare for a second wave at 50% of April 2020 COVID-19 admissions. As at 5th November, with England in national lockdown, and the NHS in Level 4 Emergency Preparedness and Resilience Response, the Trust was currently at 75% of April admissions.

Mr Beeken reported the significant impact of this on staffing and the ability to manage elective recovery. On 4th November as part of the existing escalation plan, it was necessary to take down two theatres from routine elective surgery to partly mitigate staffing problems and redirect those colleagues to Critical Care. The increase in COVID-19 patients will have an impact on restoration and recovery, on income from the elective incentive scheme, and on expenditure from the need for temporary staffing. Mr Beeken emphasised the effect of the second wave on the already tired workforce who are also managing significant transformational change, including the Improvement Programme, functional integration and acute hospital collaboration, and our leadership of the integrated care partnership through Walsall Together. **The Board agreed** there will need to be a degree of rationalisation and prioritisation of the Executive Team and the Board to manage this second wave, keep patients safe, and still provide the required level of assurance. An approach to this is will be developed and shared with the Board, which will include a prioritisation of the workstreams under the Improvement Programme that will help to deal with the second wave of COVID-19.

The Chair recognised the significant challenges that the Trust has faced and continues to face over the coming months, and gave thanks to the whole Executive Team, and in particular the Director of Finance and Performance, Chief Operating Officer, and Director

of Integration, for their perseverance with partnership working and performance during restoration and recovery.

Mr Gayle sought assurance on the Trust's readiness for Brexit in January, and Mr Hobbs informed the Board that the emergency preparedness function had an established working group that continue to manage the key risks related to Brexit, including pharmaceutical and general procurement supply chains and the potential impact on clinical services in the new year on those two areas. The Performance, Finance and Investment Committee (PFIC) will receive further details on this at its December meeting.

Mr Dunn queried if the capability and capacity of all the resources across the Strategic Transformation Partnership (STP) were being fully utilised in the COVID-19 response during this second wave, and its impact on other services for the people of the Black Country. Mr Beeken and Ms Oum noted that the STP had discussed the undertaking of a desktop exercise on utilisation of sites for potential improvements in the system, however that has not yet been done. **It was agreed that** a formal request would be made to the STP from the Board that the desktop exercise is now undertaken.

Mr Assinder requested an update on the reconfiguration work on the Electronic Patient Record (EPR) noted in Mr Beeken's report. Mr Fradgley confirmed the work had been completed, and audited by an external team from Barnsley Hospital Foundation Trust.

Action:

(a) Prioritisation of the Improvement Programme workstreams in light of the second wave of COVID-19 will return to the Board
(b) A formal request would be made to the STP from the Trust Board that a desktop exercise is undertaken to ascertain capability and capacity of resources across the STP are being fully utilised in the COVID-19 response

125/20 **COVID-19 Second Wave and Restoration and Recovery**

The Board received Mr Hobbs' report on restoration and recovery and the COVID-19 Board Assurance Framework (BAF) risk. Good progress was noted on restoration and recovery, but the Board agreed that the focus had shifted since the report was written given the acceleration of the second wave and resultant COVID-19 admissions, despite Walsall having been placed in Tier 2 prior to the 5th November national lockdown.

Mr Hobbs reported demands on services increasing beyond levels anticipated, and replicated in other parts of the country. As at 4th November, the hospital had 118 COVID-19 positive inpatients with the Critical Care Unit having 17 patients which is equivalent to 30 patient points against a commissioned service of 18 patient points. As a consequence of the increasing admissions, elective operating theatres have been reduced from 7 theatres to 5, resulting in the cancellation of 14 surgical procedures this week, and 19 next week. Theatre staff have been released to support the Critical Care Unit.

Other planned care activities will be reviewed to ensure resilience of staffing to general inpatient wards, and there will likely be reductions in outpatient clinics and potentially in procedures. Mr Hobbs informed the Board that the impact of the national lockdown on the hospital was likely to be seen after 10 days, with it anticipated to first stabilise admissions and then reduce the number of those requiring hospitalisation.

Mr Fradgley reported that the community slides for restoration and recovery had not been included in the pack but had been presented at the Quality, Patient Experience and Safety Committee (QPES), and would be distributed following the meeting. He noted that the community also planned a second wave of COVID-19 at 50% of the April peak, however the community services are currently stable. Mr Fradgley pointed out there is growing concern, yet unmitigated, for staffing capacity due to the fact that the resources

used in wave 1 - school nurses and health visitors – are not available in wave 2. This may lead to a reconfiguration of services and a knock-on effect to baseline funding. Risk to harm is being monitoring with a return to several command and control meetings in response to growing COVID-19 challenges.

Mr Fradgley brought to the attention of the Board the risk of access to swabbing for staff entering care homes, which is a significant concern shared by the Chair of QPES. A short term mitigation was confirmed through the Black Country Pathology Service (BCPS) who have committed to testing staff for the next four weeks, however the medium and long term risk needs to be mitigated to ensure services to the care homes are not at risk. There is ongoing dialogue with the Council's Public Health Director, BCPS and national testing teams. QPES and Walsall Together Partnership Board will continue to monitor this.

Mr Beeken advised that the Board would receive a report each month on COVID-19 and its impact on the Trust, which will include restoration and recovery from all lenses, including people, quality, finance and operational performance.

Action:

(a) Community restoration and recovery slides not been included in the pack but had been presented at QPES to be distributed.
(b) The Board to receive a report each month on COVID-19 and its impact on the Trust, which will include restoration and recovery from all lenses, including people, quality, finance and operational performance.

126/20 **Staff Story**

The Board heard from Ms Joan Dyer, Head of Nursing for Surgery and Chair of the BAME (Black, Asian and Minority Ethnic) Shared Decision Making Council (the 'Council'). Shared decision making councils are a model of leadership which places staff at the heart of the decision making process, enabling collective ownership to develop and improve patient care, outcomes and staff satisfaction. The Council is one of the first to be established by the Trust under the Pathways to Excellence programme of the Safe, High Quality Care workstream of the Improvement Programme.

Ms Dyer explained that the Council creates a safe space for staff to have conversations about bias and racism in the workplace, and to drive forward organisational change. Whilst the Council has only recently been established, Ms Dyer explained that it had designed a logo, received good engagement through the Daily Dose and the Chief Executive's updates, and trained cultural ambassadors to address cultural bias and discriminatory practices. Future work of the Council includes staff networking forums, coaching and mentoring of BAME colleagues and supporting them in their professional development, access for them to shadowing and interview skills. Involvement from medical colleagues in the Council is also in development.

The Board thanked Ms Dyer for taking on this important role, particularly given our WRES (Workforce Race Equality Standard) data, and the concerns being raised from BAME colleagues through various modalities including the Freedom To Speak Up Guardians and Pull Up a Chair with the Chair.

Both Executive and Non-Executive Directors offered support to the Council and Ms Dyer indicated that the Board's endorsement of their work, and where possible their involvement in initiatives would show staff that there is commitment at Board level. Ms Dyer extended an invitation for members to attend their Council meetings and for the Council to be involved in scrutinising practical actions planned for race equality at the Trust.

Action:

Opportunities for members to stand with colleagues as allies be circulated for them to have the opportunity to support these types of initiatives.

VALUE OUR COLLEAGUES

127/20 **People and Organisational Development Committee Highlight Report**

Mr Gayle, Chair of the People and Organisational Committee (PODC), presented a verbal report on the highlights from their meeting on 3rd November, noting as follows:

- The BAME risk assessments were reviewed and it is commendable that 95% have been undertaken, with 92% for other vulnerable groups, and 88% of risk assessments overall Trust wide completed. A significant sample size of the completed risk assessments was audited, however further work is required to provide assurance on the quality of those assessments and the measures in place as a result. As the risk assessments are ongoing, a review of the fitness for purpose of the risk assessment will also be done, all of which will be reviewed by PODC.
- The addition to the Winter Plan of the health and wellbeing offerings was reviewed by PODC, and other than an amendment related to the purpose of the Haven Room for support rather than rest, the Committee endorsed the addition.
- Th Committee expressed its concerned as to the significant impact the second wave will have on colleague wellbeing, morale and availability of staff.
- Flu vaccination compliance is at 43% as of end of last week, which is comparable to nearby Trusts, but is significantly below where the Trust was this time last year (i.e. 64%). The national expectation is 95% compliance by the end of November. Historically the Trust has had good compliance. Compliance will continue to be reported to PODC and the Committee will review the impact of the interventions planned, including optimising the potential of peer vaccinators, utilising additional Occupational Health resources, supporting staff working remotely and communication and engagement.
- The Improvement Programme for Value Our Colleagues is on track for the development of the Project Initiation Documents (PIDs), noting however that the workstream will look at the projects that require more focus due to the pressures that an increasing number of COVID-19 patients brings to the organisation.
- It was noted that the rate of completion of Performance and Development Reviews (PDRs) is low. The Committee sought assurance on the impact of initiatives to increase compliance at its next meeting.
- The Committee's revised cycle of business was approved

Mr Gayle expressed the concern of the Committee and other Non-Executive colleagues as to a lack of assurance on some key people issues, including the qualitative aspects of the risk assessments, the organisational development interventions for the five departments/services where cultural, attitude and behavioural concerns were raised, and of sickness absence levels. Mr Gayle advised that an assurance focused PODC meeting will be held on these issues in November, and encouraged non-PODC Board members to attend.

128/20 **Executive Report – Value our Colleagues**

Mrs Griffiths presented the Value our Colleagues executive report covering the Board Assurance Framework (BAF) and corporate risks, performance and Improvement

Programme elements of this strategic objective, which had also been discussed at PODC. The report was taken as read given the coverage of priorities by Mr Gayle, with the Chair requesting Ms Griffiths to focus on the flu campaign.

Ms Griffiths agreed that it was disappointing that flu vaccination compliance is not where it was this time last year, but noted that the Occupational Health resources, which played a significant part in the flu campaign in 2019/20, are currently not only running the flu campaign, but also supporting outbreaks of COVID-19 at the Trust. Peer vaccinators are being established, and increased communication and engagement will take place with staff shielding and working from home so they are aware of how they can access the vaccine. Ms Griffiths confirmed that staff shielding and receiving their flu vaccine from their GP will be added to the Trust's database.

129/20 **Safe Staffing Report**

Ms Riley presented the safe staffing report, with the Board noting key elements were also discussed at PODC.

Ms Riley informed the Board that the current staffing issues related to additional capacity required for COVID-19; staff on sick leave due to COVID-19, or going through a period of isolation; support provided for the Electronic Patient Record (EPR) roll-out in the Emergency Department (ED); and resource to support sepsis pathways following the CQC visit in September. Ms Riley noted there was a reduction in bank staff usage from the mid to the end of September and a subsequent increase in agency staff (tier 2 framework agency), and an increase in requests for Thornbury staff (tier 3 off framework higher rate agency).

Ms Riley asked the Board to be mindful that this second wave of COVID-19 brings with it the pressures of managing a recovery programme and not having the additional support of student nurses, medical students and redeployed staff, as was the case in wave 1. The result is that staff are tired and feeling the pressure.

The Board noted that a discussion in private session on bank rates will take place following the public Board meeting, which may assist to alleviate some of the staffing pressures. A longer term solution of availing of international recruitment may also assist and Ms Riley will provide further information in due course.

130/20 **Freedom To Speak Up Quarterly Report – Q1 and Q2 2020/21**

Ms Ferguson and Ms Sterling presented the Freedom To Speak Up Report for Quarters 1 and 2 2020/21, noting that total 82 concerns were raised during that period, with 67 addressed and closed. The concerns that remain open relate to areas receiving organisational development support with respect to culture, attitude and behaviour, and until they are resolved the concerns remain open.

The concerns are primarily themed as:

- Attitude and behaviour
- Policy and procedures (primarily in Quarter 1 due to Personal Protective Equipment during the first wave of COVID-19 and shielding)
- Staffing levels (including redeployment)

The Board was informed that 52.4% of concerns were generated from BAME colleagues, which did not include colleagues of mixed race and Pakistan origin. By division, the largest number of concerns were generated by the Medicine and Long Term Conditions (MLTC) division. Mr Beeken noted that MLTC is the largest division so he would expect higher reporting, and requested that future reports demonstrated the number of concerns

raised per whole time equivalent (WTE) of staff in each division/ethnicity/segmentation of the workforce.

The Board welcomed the data being presented in the new dashboard, which enabled a more analytical view of the issues, and thanked Ms Ferguson and Ms Sterling for the hard work and determination they and Ms Raza have shown in supporting the Trust to increase the number of concerns raised, which provided assurance to the Board that a speaking up culture was being embedded.

Ms Oum sought to understand how concerns coming through the Freedom To Speak Up Guardians are being triangulated with other sources, such as grievances, Staff Side, Pull up a Chair with the Chair etc., and the impact of these issues to the organisation on areas such as sickness absence. Ms Griffiths confirmed this is part of the organisational development programme of the Value Our Colleagues workstream of the Improvement Programme. Ms Oum requested that a watching brief is kept on this action.

Action:

(a) Future reports demonstrated the number of concerns raised per whole time equivalent (WTE) of staff in each division/ethnicity/segmentation of the workforce.

(b) A watching brief is maintained on the triangulation of concerns from the Freedom to Speak Up Guardians and other sources, such as grievances, Staff Side, Pull Up a Chair with the Chair etc., and the impact of these issues on the organisation to areas such as sickness absence.

131/20 **Guardian of Safe Working Quarterly Reports – February to July 2020**

Dr Lewis presented the Guardian of Safe Working Reports for February to July 2020, noting that no exception reports or fines were noted during that period. The report demonstrated that junior doctors felt able to speak up, and he and the Board expressed their thanks to the junior doctors for their professionalism and flexibility to adapt to the demands of hospital during the pandemic.

USE RESOURCES WELL

132/20 **Performance, Finance and Investment Committee Highlight Report**

Mr Dunn, Chair of the Performance, Finance and Investment Committee, presented the highlight report from their meeting on 28th October, noting there was good debate at the meeting, and the reports and their presentation by the Executive's deputies was excellent.

The Committee noted good financial and operational performance, with clear signs of recovery prior to the impact of the second wave very recently. Mr Dunn noted that that recovery and performance will now be adversely affected by the second wave of COVID-19 and the next meeting of the Committee will focus on that impact.

133/20 **Executive Report – Uses Resources Well**

Mr Hobbs and Mr Caldicott presented the Use Resources Well executive report covering the BAF and corporate risks, performance and Improvement Programme elements of this strategic objective, which had also been discussed at PFIC.

Mr Hobbs advised that the Trust entered the second wave of COVID-19 on strong recovery performance, however the need to reduce elective surgery to support Critical Care will impact on elective waiting times and the recovery of elective and day cases.

Mr Hobbs confirmed that all cancer and clinically urgent cases are proceeding.

The issues with transition to the new the EPR in the ED have been resolved and as a result the last two weeks has seen an improvement in the 4 hour access standard.

In light of the second wave of COVID-19, a prioritisation methodology will be applied to the Use Resources Well workstream of the Improvement Programme, and Mr Hobbs noted that may result in some programmes of work being deferred to ensure patient safety.

Dr Lewis confirmed that prioritisation of elective surgery due to the two theatres being closed followed guidance from the Royal College of Surgeons, and is done on the basis of protecting acute admissions, emergency and urgent procedures. Dr Lewis emphasises the clinical teams and the Executive are very conscious of the impact on patients that such prioritisation will have, and the need to support staff that were redeployed to Critical Care. Mr Hobbs added that the Critical Care team developed a training programme after the first wave of COVID-19, and this has been used to maintain training for colleagues to support that unit in any subsequent surges. Staff will also receive supervision and support from senior nursing staff and consultants. The Board expressed their thanks to the Divisional Directors for this preparedness work.

Mr Caldicott confirmed the Trust had reported a break even position to 30th September. The Trust has secured an income allocation through the STP that supports the operational plans approved by the Board, however COVID-19 top-ups will not be available to Trusts for the second half of the year as part of that allocation. The Trust has a capital allocation of £20.6m, having spent £4.5m year to date. PFIC will continue to be appraised of any risk to capital utilisation in the 2020/21 financial year due to COVID-19 related delays. Following the Level 4 Emergency Preparedness and Resilience Response announcement by NHSE, no further information on additional COVID-19 funding had been announced.

Mr Caldicott pointed out that cost pressures that will be evident as part of the second wave of COVID-19, including impact on elective incentive scheme income due to reduced elective theatre capacity, the resources from which are being diverted to the Critical Care Unit. Mr Caldicott has requested clarification from NHSE (NHS England) as to whether there is any flexibility under this scheme due to the Level 4 Emergency Preparedness and Resilience Response, and will update the Board accordingly.

134/20 **Emergency Preparedness, Resilience and Response Annual Assurance 2020/21**

Mr Hobbs presented the 2020/21 Emergency Preparedness, Resilience and Response self-assessment, noting that usual governance requirements had been reduced nationally due to COVID-19 for this year. The self-assessment provided for partial compliance with core standards, with the Board noting that the newly appointed Head of EPRR has developed a strong programme of work across all domains for the next 12 months.

The Board **approved** the 2020/21 Emergency Preparedness, Resilience and Response self-assessment, and noted the programme of work for the following 12 months.

PROVIDE SAFE, HIGH QUALITY CARE

135/20 **Quality, Patient Experience and Safety Committee Highlight Report**

Mrs Bradbury, Chair of the Quality, Patient Experience and Safety Committee (QPES), presented the highlight report from their 29th October meeting, noting as follows:

- The Committee heard a patient story from parents who had their baby at the Primrose Ward during the pandemic. The parents were anxious about coming into

the hospital during the pandemic but said they felt supported and reassured enough to enjoy the birthing experience, with the father being equally involved with the mother and baby.

- The Quality Dashboard continues to be a focus of the Committee, with gaps in metrics being discussed in more detail at the next meeting, as well as engaging with Committee members outside of meetings.
- The Quality Impact Assessment process is an ongoing concern, however the Committee will receive assurance on the process at its December meeting.
- Swabbing of care home staff continues to be a concern.
- The Committee reviewed its priorities for 2020/21 and approved its revised cycle of business.

136/20 **Executive Report – Provide Safe, High Quality Care**

Dr Lewis and Ms Riley presented the Safe, High Quality Care executive report covering the BAF and corporate risks, performance and Improvement Programme elements of this strategic objective, which had also been discussed at QPES.

The BAF for Safe, High Quality Care had been updated in month, and of note is the report from the CQC inspection in September is currently being checked for factual accuracy and will be discussed by QPES in November. Ms Riley noted that the re-inspection from NHSEI of maternity infection control standards may be delayed due to the second wave of COVID-19, however Ms Riley reported confidence that the rating would improve from red to amber, noting that it is not possible to move directly from red to green.

Ms Riley confirmed that there remain gaps in metrics in the Quality Dashboard, and work is underway to ensure timely delivery of data, and to get a better understanding of the drops in performance for dementia screening and Mental Capacity Act assessments, both of which will be discussed at the next QPES meeting.

With respect to the Improvement Programme, Ms Riley informed the Board that the CQC action oversight meetings continue, and a central repository of evidence has been developed to support any regulator visits. The new care excellence strategy is being finalised following consultation. As with other workstreams of the Improvement Programme, a prioritisation methodology will be applied to ensure pressures of dealing with a second wave of COVID-19 are taken into account.

The Board commended the Trust for transitioning to outpatient clinic letters being addressed to the patient, copying in the GP, rather than directly to the GP, noting this is in line with best practice, improves communication with patients and facilitates self-care. This will further transition into a more digital medium which will be more expedient for patients, and cost effective for the Trust.

137/20 **Infection Prevention and Control Annual Report**

Dr Lewis presented the report which had been deferred since May 2020 due to the pressures on the Infection Prevention & Control (IPC) team during the first wave of the COVID-19 pandemic. The report highlighted the activities and performance of the team during 2019/20 and therefore did not include details of the pandemic. It was noted that the Trust had been rated red by NHSI for Infection Prevention and Control since April 2019, however, following further informal reviews the Trust had received positive feedback. A formal review of the current rating had been requested.

Dr Lewis highlighted that the annual plan for 2020/21 had been included and members

were advised that further resources were being recruited to the IPC Team, noting that the lead IPC nurse appointment will be responsible for developing our own staff to the team in the future.

It was acknowledged that assurance on the Infection Prevention and Control annual plan would be received on a quarterly basis by the committee along with monthly exception reports from the Infection Prevention and Control Committee.

The Board **approved** the annual report, and commended the work of the IPC team during the last 12 months.

CARE AT HOME

138/20 **Walsall Together Partnership Board Highlight Report**

Mrs Baines, Chair of the Walsall Together Partnership Board presented the highlight report from their 18th October meeting, noting as follows:

- The impact of the second wave of COVID-19 was apparent in the system, with each partner raising the issue of a tired workforce.
- Partners are developing an approach which links demand on services to the right groups in an integrated way to ensure both physical and mental health issues are addressed simultaneously. The Partnership Board continues to encourage partners to leading on developments, one example of which is the Primary Care Networks and Walsall Housing Group and their work on social prescribing.
- Two new risks have been added to, and are being managed through, the partnership risk register. The first was highlighted to the Trust Board in October and is the lack of access to timely swabbing for care home staff, discussed earlier in the meeting. The second is the lack of available resources to implement new models of care and associated benefits.
- The partnership approach to health inequalities was debated at length. Further work to develop a baseline and to gain community input are taking place. Recent discussions with the local authority and community organisations on the subject and their involvement in the partnership are encouraging.

139/20 **Executive Report – Care at Home**

Mr Fradgley presented the Care at Home executive report covering the BAF and corporate risks, performance and Improvement Programme elements of this strategic objective.

The issues of swabbing of staff entering care homes, and the issue of resources having been dealt with earlier in the meeting, Mr Fradgley assured the Board that the care home intervention teams are in place and offering support, and that outbreaks are currently low.

Mr Fradgley reported that 693 patients discharged from hospital are now overseen by Community Services under the umbrella of the Care Coordination Service and the Rapid Response Team. A process will be rolled-out from 9th November where patients discharged early with oxygen monitoring will be visited three times daily.

The Board was assured that the partnership does not intend stepping back from developing the governance required for Integrated Care Partnership (ICP) status during the second wave of COVID-19. This process and its impact on reduction of health inequalities and improved outcomes for the population of Walsall will continue to be

overseen by the Partnership Board. The partnership will define what it means by health inequalities, and which of those it will address first, in concert with the acute pathways part of the programme.

A pilot for Community Services to deliver First Contact Practitioner Physiotherapy has been successfully completed in one GP practice and discussions to roll out across more practices are in progress. Health visiting and school nurses transferred on 1st October, with some organisational development issues being addressed through interventions that will be discussed further at PODC.

Mr Fradgley reported challenges in getting COVID-19 positive patients back to care homes currently, which impacts on length of stay. Mitigations are actively being pursued, and currently the underlying performance of those medically stable for discharge is good at 2.5 days.

Mr Beeken noted that partnerships take time to evolve to the point where there is a robust accountability embedded on the delivery of its mutual aims, and asked where Walsall Together was on that trajectory. Mrs Baines and Mr Fradgley both responded that the partnership was moving in the right direction, with governance and processes embedding and engagement improving each meeting, however the move to an ICP will be a natural point to move to more robust accountability.

Mr Heer requested that future reports provide detail on what is required from the partnership to obtain ICP status.

Action:

Future Care at Home report to provide detail on what is required from the partnership to obtain ICP status, where it is currently with respect to commitment and investment, and the benefits for the Walsall Healthcare Trust.

WORK CLOSELY WITH PARTNERS

140/20 **Executive Report – Work Closely with Partners**

Mr Hobbs presented the Work Closely with Partners executive report covering the BAF risk and Improvement Programme elements of this strategic objective.

The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals for urology, radiology and dermatology. Mr Hobbs drew the Board's attention to a potential risk to the project management and facilitation resources provided by PA Consulting for the radiology network collaboration project. Any updates on this will be provided to PFIC as this has only recently arisen.

The Board congratulated the teams on the functional collaboration progress and the difference it will make to the quality of services to the local population.

Mr Beeken informed the Board that there had been excellent turnout to an internal clinical senate to discuss the clinical case for change for Trust Collaboration, with overwhelming support from clinical directors, care group managers and matrons.

GOVERNANCE AND WELL LED

141/20 **Audit Committee Highlight Report**

Mr Heer presented the highlight report from the 12th October Audit Committee, which included a bi-annual assurance report from the Chair on the effectiveness of risk management at the Trust.

Mr Heer reported significant progress was being made on the BAF, the corporate risk register and the framework within which it operates. There is some refinement required to the operation of the three lines of defence which is being worked through. The Audit Committee will continue to work with the Chairs of the Board Committees to ensure risks are being looked at in the round and escalated where appropriate. Mr Heer thanked the Director of Governance for the progress made.

Internal Audit is reviewing the priority and timelines of the recommendations in their tracker to ensure there no undue additional pressure during the second wave of COVID-19. Both Internal Audit and External Audit have assured the Audit Committee that they have resources in place to carry out their year-end work to enable the Board to discharge its annual report responsibilities.

Mrs Baines requested that a correlation is made in the BAF between the gaps in controls and/or assurance and the resultant action plan, to ensure each is appropriately addressed.

Action:

All BAF risks to show a correlation between the gaps in controls/assurance and resultant action plans.

142/20 **Governance and Well Led Improvement Programme Update**

The Board received the Governance and Well Led Improvement Programme update and it was taken as read. Ms Oum confirmed that Mr Dunn, Vice Chair, will be the lead Non-Executive Director for this strategic programme of work.

143/20 **Trust Board Cycle of Business**

The Board received and **approved** the revised cycle of business for the Trust Board.

144/20 **Use of Trust Seal**

The Board received the report on use of the Trust seal and noted it for information.

145/20 **Questions from the Public**

One member of the public requested that the Board minimise the use of 'jargon' so that members of the public are more easily able to understand the matters in discussion, and Ms Oum asked members to bear this in mind in future meetings and reports.

The meeting finished at 15.55.

Date of Next Meeting
Thursday 3rd December 2020

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

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Trust Board Chair's Report			**AGENDA ITEM: 5**
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 specific risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	This report sets out the commitment of the Board to equality, diversity and inclusion, and the work the Board has done this month to shape the Equality, Diversity and Inclusion Strategy.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

CHAIR'S REPORT – NOVEMBER 2020

1. On 12th November 2020, and in accordance with the Trust's Standing Orders, I took Chair's Action along with the Chief Executive Officer to approve the COVID-19 governance continuity plan. The plan enables us to focus on supporting the critical delivery of the response to COVID-19. Attached at Appendix A is the approved continuity plan.

2. My focus for this month has been on supporting Executive and Non-Executive colleagues with the inevitable pressures of the second surge of COVID-19 on top of winter pressures and national COVID-19 vaccination logistics. Board and Board Committee agenda and meeting time have accordingly been truncated to enable Executives to focus on operations. I continue to participate in regular COVID-19 update sessions with Executives, as well as regional updates, including the Midlands Providers Chairs and CCG update. I have also met individually with key colleagues, as have Board Committee Chairs, to discuss the response to the second surge, the requirements to roll out COVID-19 vaccinations, and the impact on staff. I am pleased to note the strength of the partnership developed through Walsall Together is proving invaluable in enabling us to support the population we serve through our collective response to the pandemic.

3. In addition to the focus on COVID-19 second surge, my attention, and that of the Chief Executive Officer, Richard Beeken, has also been on trust collaboration, with a number of meetings of the Trust and the Strategic Transformation Partnership (STP) teams taking place. We are working to a very tight timetable to have agreed positions before our Board in December and January, therefore work continues at pace to finalise this.

4. I was delighted to be a part of the interview panel that appointed our Interim Director of Nursing, Ann-Marie Riley, to the substantive post of Director of Nursing this month. Congratulations Ann-Marie and we all look forward to continuing working with you.

5. I have followed up last month's Board development session on Equality, Diversity and Inclusion (EDI) with further discussions to progress the EDI strategy, and I have taken part in a number of inequalities working groups and discussions within the Trust, regionally and nationally. I have contributed to the development of the NHS Confederation EDI Strategy and opened the NHS Confederation's Festival of Learning hosted by the Women Leaders Network. I chaired the Healthwatch England Conference Panel on Health Equity in England and was joined by Professor Michael Marmot who reflected on his review of the same name, and what has happened 10 years on. I also joined a panel discussion at the closing session of the Insight 2020 Festival hosted by the Midlands Decision Support Unit, and spoke on ICS leadership and the behavioural principles needed for tackling health inequalities.

6. I met with the Chairman of the Trust's Disability Advisory Group, Mr Andy Brown, earlier in the month to explore issues of access, involvement and influence for people with disabilities, of particular relevance as the Trust refines its EDI Strategy.

7. I was joined by my fellow Non-Executive Director and Chair of the Health and Wellbeing Group, Ben Diamond, in my Pull up a Chair with the Chair sessions this month. These sessions continue to provide an insight into the issues concerning colleagues at the Trust and I would like to extend my thanks to all who took the time to meet with me. I am continually sharing the themes that arise from these sessions with the wider Board to bring about change in workplace practices to make Walsall the best place to work. The People and Organisational Committee of the Board took time out in its agenda this month to discuss the issues raised in this forum and to understand the importance and urgency of addressing the cultural challenges highlighted.

8. An important part of the role of a Board member, and a Chair in particular, is taking place in discussions to understand the wider system issues, risks and opportunities to ensure they are factored into discussions at Board and Board Committees, particularly as we move towards more collaborative ways of working. During the month of November I attended the NHS Midlands STaR Board and the Black Country Chair's Meeting.

Appendix A to November Chair's Report

GOVERNANCE CONTINUITY COVID 19
12th November to 31st March 2021

1. Situation

In response to increasing coronavirus infections the Government and Parliament have enacted a further set of national COVID-19 measures including the return to its highest level of emergency preparedness, Incident Level 4, from 5 November.

2. Corporate Governance

To support the incident management structures, we have agreed to reduce the decision and governance making processes within the organisation for business as usual and routine business. Revising the structures will enable us to focus on supporting the critical delivery of the response to COVID-19.

2.1 Tier 1 Committees

The Tier 1 Committees will continue to meet throughout a period of increased pressure, however will limit its agenda through its regular agenda setting meeting with the Non-Executive Chair and Executive lead to seeking assurance for immediate/urgent issues or pre-agreed matters of strategic programme progress aligned to their Terms of Reference. As a minimum each Committee will include the following agenda items;

- Risk Management- Each Committee will have a standard agenda item on new and emerging risks, as well as the Board Assurance Framework and Corporate Risk Register
- Covid 19 update- for each Committee a Covid update based on the Committee Terms of Reference will be presented for assurance and escalation of immediate issues or risks
- Improvement Programme- Each Committee will continue to receive progress updates on the overall improvement programme, and where appropriate restoration plans.

Aligned to the national guidance, all Committee and Board Meetings will be conducted virtually via Microsoft teams (Appendix 1). Virtual meetings, subject to quoracy, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

Where it is not possible to convene a meeting via video conference, decision items may be

- circulated to voting members of the body for comment and approval, or:

- taken by Chair's action, in liaison with the Chief Executive and Lead Executive Director for the matter concerned.

In each case, the Trust Secretary will collate responses and ensure that the resulting decision is communicated, and reported to the next formal meeting for information.

As a public body we must transact our Business in accordance with the Public Bodies (Admission to Meetings) Act 1960, which states we must enable members of the public to attend our Public Trust Board. Owing to the national guidance as part of the overall 'social distancing' strategy to protect staff and patients, the public, we are recommending that we publish details of how to join the public meeting online and extend the invite our local Healthwatch and staff side representatives. We will as per standard practice publish the papers of the meeting and ask for written questions in advance of the meeting.

In addition to the formal governance arrangements, we have also put in place informal progresses to ensure Non-Executive s have oversight of the Trusts Covid Response; Weekly NED call, with chairs of acute and hospital tactical command and the chair of strategic command.

In line with National Guidance Non-Executive Directors will be unable to have an onsite presence and therefore to ensure visible leadership and enable our Non-Executive Directors to engage and support staff will continue our virtual Board visit programme for the next 6 months.

2.2 Tier 2 Governance

Further to the above decision we have also agreed to maintain the following operational governance groups, all with an appropriate slimming down of their agendas, to reflect agreed organisational prioritisation:

- **Patient Safety**- To ensure oversight and assurance of the patient safety agenda, safety huddles, the Weekly SI meeting, and the Patient Safety Group will continue to meet, with a reduced agenda.
- **Staff Health and Wellbeing Group;** this group will oversee the support to staff to ensure our staff remains healthy and able to attend work during COVID 19. It will also oversee specific interventions for staff
- **Emergency Department Building group**; This group has been identified as a priority due to decisions which will need to be made to ensure progress in the ED build is not impacted at this stage.
- **Equality, Diversity and Inclusion group**
- **Improvement Programme Board**
- **Divisional and Care Group Boards;** These meetings will continue, as a minimum they will meet monthly, on the following standard agenda items;
    - Patient Safety
    - Quality Assurance (inc metrics)
    - Workforce and ensuring staff wellbeing

- Performance and Financial performance

We have developed a Governance Contingency plan which as the pandemic continues and as national guidance changes it may be necessary to further reduce meetings (Appendix 2). Therefore the contingency plan sets out how decisions could be made in the absence of a quorum if required.

2.3 Financial Decision Making

In order to support incident command structure, we have reviewed our financial governance processes and we are recommending the following changes to our current processes for COVID 19 expenditure;

- Suspension of discretionary spend panel (COVID-19)
- Temporary () changes, to be reviewed for ongoing need monthly, to Standing Financial Instructions to include;
  - Increase in spending limits to the Incident Commander (Executive Director) of the Acute Hospital, and the Incident Commander (Executive Director) of the Community to approve spend aligned to COVID-19 £75,000.
  - Increase in spending limits to the Chief Executive Officer to approve spend aligned to COVID-19 to £150,000

The following financial controls will apply

- All procurement processes, as laid out in SFIs will remain in place.
- Normal consultancy approval and agency reporting requirements
- Incident command will not be authorised to approve Business as usual expenditure or non COVID-19 expenditure
- Recurrent spend or enable the organisation to commit to recurrent spend without following our current SFI processes.
- All expenditure committed within the above revised delegations will (prior to expenditure being committed) be required to detail where costs are to be reduced (or additional income secured) so as to remain within the existing financial plan (run rates) to 31st March 2021, as presented to Board Development sessions and endorsed through the Performance, Finance & Investment Committee.
- The Covid-19 Expenditure Proforma has been amended to require the details of how the financial plan and re-allocation of resource is to be undertaken to maintain financial balance for delivery of the planned outturn for 2020/21.

Financial control and stewardship of public funds will remain critical during our response to COVID-19, and we will need to ensure we are complying with our legal obligations. Therefore through the incident command process will be monitoring all expenditure associated with COVID-19;

- Tactical Command- Senior Financial lead attendance at each meeting to capture all costs/financial impact of each decision

- Strategic Command- Review the COVID financial budget report. Director of Finance to ensure that the financial impact of decisions taken at Strategic level are captured.
- PFIC to receive a monthly COVID Finance report
- Audit Committee will retain oversight of financial governance, specifically relating to procurement, and single source wavers.

In order to provide assurance both to the Board, we will apply the following process to ensure COVID expenditure is appropriate;

- The monthly commitment of resources and schemes enacted then reviewed in a formal report to PFIC
- All schemes endorsed will then be presented monthly within Private Board

Appendix 1 - Managing Meetings attended remotely

1. General
   - Participants using mobile phone to dial in should ensure that once engaged in the meeting their mobiles are turned to 'mute to prevent any unwanted noise, unless it is necessary for emergency reasons.
   - Participants should also ensure they are in a sound free environment for the duration of the meeting.

2. Engaging in the meeting
   - Instructions will be provided to every participant
   - It can be the case that there is a slight delay for all participants to join the call; participants are asked to hold the call until the Chair commences the meeting.

3. Chair to open the meeting
   - The Chair will open the meeting and ask each participant to state their name, and position. This is important for meeting records and to determine whether the meeting is quorate.
   - If the meeting is not quorate at that point, the Chair will:
     a) Ask the Trust Secretary for advice as to any anticipated late attenders; then
     b) Consider delay of up to 10 minutes, then
     c) Dependant on numbers attending, progress with any matters on the agenda that do not require approval.

4. Taking each item on the agenda
   - The Chair will introduce each item, and speaker.
   - No one other than the speaker can contribute until the speaker has concluded.
   - At that point the Chair will ask whether anyone wishes to raise a question.
   - Each participant wishing to raise a question must first state their name. They must not ask any questions until indicated to do so by the Chair.
   - The Chair will then invite each of those participants to raise their query in full; no-one other than the participant raising the question should comment.

- The Chair will respond and /or direct someone to respond

5. Presenting papers and presentations
   - Introduce the paper clearly – be clear at the start what the aim of your paper/presentation
   - Ensure the paper or presentation has page numbers on before circulation
   - Refer to those page numbers clearly as your move through the presentation / paper – so the listeners can follow easily the document and where you are at in it

6. Voting
   - For each item requiring approval:
   - The Chair will read the recommendation
   - He will then ask each participant who is eligible to vote to state their name followed by:
     "Yes": if they approve;
     "No": if they don't approve; or
     "Abstain": if they choose not to vote.
     No other comments are to be made.

   - The Chair will declare the result of the vote.

7. End of meeting
   - The Chair will declare the end of the meeting

8. Video Conferencing – in addition to the above
   - Mute audio but not video otherwise the Chair may think you have left the meeting.
   - Ensure your technology works correctly and that you have the video, audio and papers viewing capabilities you might need.
   - Wear work-appropriate clothing and be in a place with the minimum disturbance.
   - Frame the camera correctly and have the right light – if you sit in front of a brightly lit window, all others will see of you is a silhouette.
   - Look into the camera and reduce any potential distractions.
   - Be courteous – give way or let the Chair invite you to speak by name.
   - Close down properly. Don't forget you might still be seen and heard after the call has finished.

Appendix 2- Governance Continuity Plan- Board and Board Sub Committees

1) The Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees will be temporarily suspended as of xxx, until further notice.

2) During this period, if meetings are to be held, then this will be done through the use of telephone / digital technology.

3) The primary focus of communication with the Board will be the organisation's response to Covid 19, including the safety of patients and the wellbeing of staff.

4) Whilst some effort will be made to continue aspects of 'business as usual' activity, based upon the existing business cycles / forward agenda:

   4a) All matters for approval will be either:
   - Deferred if not urgent or
   - Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
   - Discussed via telephone / digital technology with the decision recorded by Trust Secretary (or nominated representative) or
   - Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

   4b) In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors

5) It is likely that those responsible for preparing assurance papers for Committees and the Board will not be in a position to do so. Therefore:

   5a) All matters for information or assurance will be either:
   - Put on hold until further notice or
   - Circulated via email

6) For ad hoc items agreed by the Executive Directors as requiring a decision by the Board:

   - Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
   - Discussed via telephone / digital technology with the decision recorded by Trust Secretary or
   - Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

   In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors

The Business Cycles will be reviewed and updated by the Trust Secretary, to maintain an accurate record of items considered / approved or deferred

Appendix 3- Email Approval (e-Approval) Protocol

Whilst it is desirable for matters requiring the approval of the Trust Board in private or public session, or of a Board Committee, to be made during a meeting where members have the opportunity to debate the issues, there are circumstances where approval by email may be required. This includes issues of urgency where it may not be appropriate or desirable for Chair's Action to be taken, or where the Trust is operating under emergency preparedness, reliance response (EPRR) and governance. In those circumstances, the following rules must apply:

1. The Chair of the Trust Board or the relevant Committee (hereinafter referred to the 'Chair') must approve the request for e-Approval on the recommendation of the Director of Governance.

2. The Chair will set the timeframe for the e-Approval, and wherever possible this must be no less than two working days.

3. The Trust Secretary will distribute the request for e-Approval to members, setting out the approval required in the body of the email and attaching, where appropriate, any accompanying briefs and materials.

4. Members will be requested to 'reply all' and select the voting buttons to (a) approve (b) reject or (c) request further information. Where the latter is selected, the Trust Secretary shall seek the response to the request from the relevant executive and send the question and response to all members.

5. Once responses have been received from the number of members that equate to a quorum of the Trust Board or the Committee in question (including any reduced EPRR quorum) and the time has lapsed for responses, the Trust Secretary will distribute the result to members.

6. Time for e-Approval may be extended by the Chair if a request for further information is sought.

7. All e-Approvals shall be noted at the next meeting of the Trust Board or Committee and included in the minutes of that meeting.

8. An electronic folder will be retained for each e-Approval email thread by the Trust Secretary.

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Chief Executive's report			**AGENDA ITEM: 6**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	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, made all the more complex by the management and response to the COVID-19 pandemic.		
Recommendation	Members of the Trust Board are asked to: • Note the content of the report • Discuss its contents • Debate whether there need to be any changes to the focus and actions 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 and action 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 – 3rd DECEMBER 2020

1. EXECUTIVE SUMMARY

COVID-19 dominates the landscape this month. The second wave is now very much upon us and the planning parameters on which our operational and financial plans for the second half of the financial year were based, have been significantly exceeded. The planning guidance asked all trusts to plan for COVID-19 activity levels at 50% of the April peak. By the time of writing this report, the trust has reached 85% and although bed occupancy resulting from COVID-19 admissions appears to have stabilised, we nevertheless face significant challenges and risks associated with this, which include;

- chronic staffing shortages resulting from high absence rates, staff exhaustion both physical and mental
- Infection prevention and professional practice compliance challenges in a significant minority of our workforce
- maintaining in this context, a significant elective and diagnostic recovery programme
- segregation and infection control challenges related to the management of separate streams for emergency admissions
- significant pressure on the budget plan for the second half of the financial year as a result of increased unplanned expenditure and the potential loss of elective incentive scheme income
- hot levels of tension and anxiety within the organisation about how both individuals and teams will be able to cope with both the long winter, winter pressures on the 2nd COVID-19 wave
- Logistical challenges associated with short deadline national imperatives such as twice weekly staff testing and COVID-19 mass vaccination planning

Despite these challenges, we maintain our togetherness as a senior team and have a solid escalation plan for winter, backed by clear governance and financial governance frameworks.

2. BOARD ASSURANCE FRAMEWORK

2.1 Provide Safe, High Quality Care

Since the last Board meeting, the rapidly changing environment driven by the second wave of the COVID-19 pandemic, has driven some changes we have had to make to the mitigation of this risk and the focus and attention of the executive team. Most notably:

- We have, through the #FromNowOn Programme Board, conducted a prioritisation process and identified a significant number of projects across the work streams, which we have indicated should be deferred. This will allow the executive team to drive forward projects which will have an immediate or immediate post wave 2, impact upon the management of the pandemic locally. Each Board committee will receive the

prioritisation output, so it can be comfortable that the key strategic and operational risks are retaining sufficient attention

- We have used Chair's action, to deploy the COVID-19 wave 2 interim governance arrangements across the Trust. This drives a lighter touch approach to assurance at committee level and retains, importantly, tier 2 governance meetings and processes around both patient safety and clinical effectiveness

In the last two weeks, the Trust has also received and seen published, a focused inspection report from the Care Quality Commission (CQC). The report, details findings, best practice and concerns regarding the fundamentals of care in both our emergency department and maternity services. It has led to a deterioration in the ratings for the Manor Hospital site, in both the well-led and safety domains. Principally, concerns were found regarding:

- Safe staffing levels in the emergency department – not with regards to core establishment but given vacancies and turnover in this intense and difficult working environment
- Lack of assurance that service users (adults or children) with potential sepsis were placed on the correct pathway and given the right care in all cases
- Lack of assurance regarding retrospective safe staffing information in maternity services

All key findings and recommendations are being incorporated into the safe, high quality care workstream of the programme. The Quality, Patient Experience and Safety Committee will take a clear role in assuring the Board on progress with each. External advice and input from NHSI/E governance and informatics experts is being sought, as one of the key learnings from the process has been the linear and efficient production of assurance information, is not always possible within our current systems and processes.

2.2 Care at Home

The strength and reputation of the Walsall Together partnership has come into sharp focus over the last few days, prior to writing this report. Board colleagues will be aware that a great deal of planning and logistics work has got underway with regard to managing the roll out of the COVID-19 vaccines to the Walsall population. Although the first phase of this roll out will be almost certainly managed by primary care colleagues for the most clinically vulnerable, the logistics for vaccinating the rest of the population will be managed by the Walsall Together partnership, with Walsall Healthcare NHS Trust as the lead partner. This will be a hugely significant endeavour and will be one of the most ambitious and difficult programmes most of us will manage in our careers. It will be managed through the multi-agency command structures already established by the partnership during the pandemic led by the Director of Integration with the support from other members of the Trust and partners Executive Teams. The Partnership Board and the Strategic Transformation Partnership (STP) Board will receive regular assurance on progress. The time frame for completion, is between December and April, as it currently stands.

It is also worthy of note that the Community Division have recently launched the national direction of post COVID-19 pathways. These pathways are vital in providing rehabilitation

support to the population in recovering from Covid. The Trust has been commended for being one of the first providers to deploy these services nationwide.

2.3 Working Closely 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.

Since the last Board meeting, the Chairs and Chief Executives of the four STP acute hospital providers, have met to advance the detail in the case for change on deeper organisational collaboration. It is clear that there is not a consensus on the detail of the drivers for change or on the best approach to organisational governance and leadership to accelerate that change. However, there is real common ground on establishing more formally governed and better resourced joint transformational change in the following areas:

- Clinical workforce and clinical service sustainability and safety/effectiveness
- Operational productivity, infrastructure and clinical support services
- Leadership development and talent management

I expect to be able to report on more definitive agreement at our February meeting and provide more detail on its implications for our services and quality standards in the longer term, shortly thereafter.

2.4 Value our Colleagues

As CEO, last month, I set out how, with our Director of People & Culture, we would overtly seek out evidence of individual, leadership and team behaviour which is inconsistent with organisational values and tackle it quickly and incisively, with targeted organisation development and HR support. We also learned that targeted Organisational Development support has been secured for the key services/departments of concern. The People & Organisational Development Committee in November also received a triangulation report from the Trust Chair, helpfully setting out the themes emerging from her “Pull up a chair with the Chair” sessions, which will enable the committee to assure itself that rapid action is being taken culturally, in order that the Trust can mitigate one of its biggest risks, valuing our workforce and investing in them.

During the latter days of November, we have stepped up our ‘flu vaccination programme of our staff and also started the rapid distribution of the lateral flow COVID-19 testing kits for our staff. The lateral flow kits need to be distributed to over 3300 of our staff within a week of 21st November and the ask of our staff is that they test themselves twice per week, with positive results needing to be uploaded to a bespoke web based portal prior to self-isolation. Early results from national pilot sites suggest a positive rate of c 2-4%, which may place

additional pressure on service provision given existing staff absences and general winter related exhaustion.

We were not making satisfactory enough progress on the 'flu vaccination and needed additional leadership and logistics bandwidth to deliver staff testing efficiently, so have committed additional leadership and programme management resources, some diverted from the #FromNowOn programme, to deliver both. The People and Organisational Development Committee will be able to assure itself on progress with both projects.

2.5 Use Resources Well

With the COVID-19 second wave planning parameters being so clearly exceeded, the commitment of both mitigating resources and likely lost income from elective recovery, cause significant concern. While month 7 was a month in which we were able to balance our financial position, month 8 will place us under significantly greater pressure. The commitment of additional resources to rapidly introduce national programmes such as lateral flow testing for staff and mass vaccination, are all being done at risk, under our revised financial governance arrangements. I personally see the need for a separate financial settlement for wave 2 (phase 4) and by the time the Board next meets, this may well have been released.

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.

Public Trust Board 3rd December
Agenda Item 7

Walsall Healthcare NHS
NHS Trust

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:**	All Executive Directors
Lead Committee:			

Links to Corporate Risk Register:	Title	Current Risk Score
	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. 208 – Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk score = 16) 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) 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)	**20 (Major)**

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			• 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 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 had a particularly significant impact on care home residents within the Borough's population. • The initial wave of Covid-19 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, and planning for the 2021/22 financial year. • Covid-19 has exposed existing significant health inequalities in the population the Trust serves. Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust. • 43 probable or definite Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20 • Planning assumptions for a second wave of Covid-19 cases assumed a peak at half the level of the April peak. In November 2020 the Trust exceeded 80% of the April peak in terms of Covid-19 positive bed occupancy. • The Trust has had the 7th highest proportion of its hospital beds occupied by Covid-19 positive patients in the country in early November. • The Trust has consistently had one of the highest Critical Care bed occupancy relative to baseline commissioned capacity across the Midlands region during the second wave.	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:	**20 (Major)**	**20 (Major)**				**Risk Level:**	**10 (Moderate)**	

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	• Walsall borough disproportionately hard hit in second wave again. 7th highest proportion of beds occupied by Covid positive patients in the country, in early November 2020. One of the highest Critical Care bed occupancy levels relative to baseline funded Critical capacity in the Midlands Critical Care Network. • National directives and mandates impact on the Trust's ability to make local decisions. • Ability of the Midlands Critical Care Network to successfully manage demand Critical Care demand across the region. • Unable to progress all elements of the improvement programme owing to capacity of senior leaders. • Comprehensive OD/Culture Improvement plan.		
Assurance:	• IPC Board Assurance Framework	• 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. • Faculty of Research and Clinical Education evaluation of response to first wave	• Cancer waiting times in line with national average • Elective waiting times upper quartile for Diagnostics (DM01) and routine elective treatment (18-week Referral to Treatment) nationally
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.		

Future Opportunities

- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables
- 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 harnessed 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
- Covid-19 Vaccination

Future Risks

- Potential for further resurgence in Covid-19 cases.
- 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.
- Risk of increase of infections/deaths in care homes and/or lack of timely assessments due to decrease in visits in order to protect residents.
- 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.
- Logistical challenges of delivering the Covid-19 Vaccination.

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.	Approval of UEC & Covid resilience Winter Plan	COO	Oct 2020	Complete – approved at Trust Board 01/10/20	
2.	Completion of £4.1m UEC & Covid resilience Estate works to promote segregated pathways	COO	Dec 2020		
3.	Confirmation of M7-M12 Financial income settlement with STP	DoF	Oct 2020	Complete	
4.	Evidence of outcomes of BAME/vulnerable staff risk assessments to be presented to PODC	DoP&C	Nov 2020	Complete	
5.	Re-modelling of impact of second wave on elective activity, waiting time performance and financial position	COO	Dec 2020		

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Black Country and West Birmingham Trust Collaboration - Benefits for Walsall			**AGENDA ITEM: 8.1**
Report Author and Job Title:	Glenda Augustine, Director of Planning & Improvement	**Responsible Director:**	Richard Beeken, Chief Executive Officer
Action Required	Approve ☒ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	A detailed paper on Acute Trust Collaboration was presented to the Private Trust Board in February 2020 and there was a recommendation that a Strategic Outline Case (SOC) for closer collaboration with Acute Hospitals across the Black Country and West Birmingham (BCWB) was developed. The first wave of the COVID-19 pandemic prevented to the commencement of this work. In August 2020 NHS England and Improvement requested that the BCWB increased the pace of Trust collaboration, with a view to the production of a strategic and clinical case for change, working with BCWB Chairs, Chief Executive Officers and key Executive Directors. It is anticipated that a preferred option for collaboration is reviewed and agreed by BCWB Trust Boards in December 2020 with a view to implementation of the agreed plan for Trust Collaboration by April 2021. The purpose of this paper is to provide an overview of the potential benefits that could be realised by Walsall Healthcare NHS Trust following Trust Collaboration. Evidence from The Acute Care Collaboration vanguards has demonstrated some early successes in improving patient access and experience, reducing unwarranted variation, addressing workforce challenges and improving efficiency. These areas are used to underpin the potential benefits outlined and they are clearly aligned to the Trust Strategic objectives: Provide Safe, High Quality Care, deliver Care at Home, Work Closely with Partners, Value our Colleagues and Use Resources Well to ensure that our organisation has good governance and is well-led. The population of Walsall deserve access to the best care available close to where they live. Trust collaboration can significantly improve the quality and range of core and specialist healthcare with sustainable services delivered within local centres of clinical excellence. The future is also exciting for the workforce with increased capacity, learning opportunities, safe and sustainable		

	levels of staffing underpinning the delivery of high quality care.
Recommendation	The Board is requested to **endorse** the potential benefits of BCWB Trust collaboration for the population of Walsall.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The agreed option for Trust collaboration has the potential to mitigate against the following risks by strengthening the quality and range of clinical services offered to the local population, increasing the skills and competence of the workforce, raising staff morale, supporting recruitment and retention, ensuring the optimal use of resources and maximising risk sharing and economies of scale to ensure organisational objectives are met: BAF Risk 1: *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*. Trust collaboration has the potential BAF Risk S03: *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*. BAF Risk S04: *Lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care*. BAF Risk S05: *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*.
Resource implications	There are resource implications associated with Trust collaboration that, whilst not current fully defined, include resources associated with overall governance of the collaboration process which may require the establishment of a Programme Board (and the associated subgroups) to oversee the clinical, workforce, operational, corporate, financial, communication and engagement alongside patient and public involvement elements of the agreed collaborative arrangements to ensure the proposed benefits are maximised across all BCWB Trusts.

<table>
<tr><td>Legal and Equality and Diversity implications</td><td colspan="2">The current NHS statutory framework does not provide any specific mechanisms for NHS provider collaboration and advice will be needed to address any legal barriers that may arise in relation to the chosen option for collaboration. There will need to be consideration of a number of areas such as the legal powers for decision-making, employment and pensions, regulatory issues, information governance, procurement and existing contracts.

There are also equality and diversity implications related to employment and service delivery. An equality impact assessment would be required to assess the agreed option for collaboration to mitigate against equality and diversity risks in relation to employment and service delivery. Trust collaboration is likely to provide greater opportunities for increasing and widening employee participation, talent management, personal and professional development. Shared learning across organisations around patient access and the provision of inclusive services for the population we service will be beneficial.</td></tr>
<tr><td rowspan="3">Strategic Objectives</td><td>Safe, high quality care ☒</td><td>Care at home ☒</td></tr>
<tr><td>Partners ☒</td><td>Value colleagues ☒</td></tr>
<tr><td>Resources ☒</td><td></td></tr>
</table>

Foreword

I had the privilege of joining Walsall Healthcare NHS Trust as Chief Executive in February 2018. I had a clear 100 day plan set out when I started, to undertake my own personal diagnostic on our Trust and report to the Board on both my findings and recommendations. That 100 day report was taken to our Board in June 2018. It set out the following concerns and proposed mitigations:

- A long, incomplete journey on delivering the fundamentals of care in the fields of safety, experience and effectiveness, with no culture of continuous improvement evident and that needing to be grown through investment
- A lack of financial sustainability and little evidence of using best clinical practice, operational productivity or an invest to save culture, to drive financial improvement
- Poor staff survey results demonstrating a culture in parts of the organisation dominated by poor, unsophisticated leadership and upward delegation, requiring significant investment and development
- The Trust had a reputation for being introspective, unstrategic and resistant to partnership working and change
- Our socio-economic backdrop in the borough, meant the services we provide need to be even more responsive and increasingly focused on population health
- Workforce resilience, workforce shortages and diseconomy of scale meant an almost certain inability to deliver on 7 day service standards and achieve sub-specialisation our population deserve

Since this point, I have been unequivocal and consistent in my view that we cannot and should not continue as we are, without significant, rapid and deep organisational collaboration with other NHS Trusts. The population health challenges, workforce shortages and our diseconomy of scale are reasons enough on their own, to collaborate with others and do so formally. More formal organisational alignment will provide the framework and the air cover for our clinical and corporate leaders to collaborate on transformational programmes of change, which will have mutual benefit for our populations. Moreover, the consultation paper issued by NHS England and Improvement on 26th November, setting out how forthcoming legislative change will drive "system by default" working, clearly signals that NHS Trusts must, as a minimum, form such strategic alliances within an Integrated Care System with more statutory powers.

Most of us, including our senior clinical leaders in our Trust, recognise that more formal collaboration across the whole Black Country & West Birmingham STP will drive out the greatest benefits for our populations and our staff, and discussions are still continuing within the partnership about the model and the pace we would follow, to achieve that. We should see any potential alliance with other NHS Trusts in our system that we form, in the context of a clear and unequivocal commitment to the formation of a Trust Group structure across the whole of the Black Country & West Birmingham, as soon as practically possible.

Richard Beeken
Chief Executive Officer – Walsall Healthcare NHS Trust

Black Country and West Birmingham Trust Collaboration:

The Benefits for Walsall Healthcare NHS Trust

1.0 Purpose

This paper presents an outline of the potential benefits that Trust Collaboration across the Black Country and West Birmingham should yield for Walsall Healthcare, focusing on service users and carers, clinical services, care quality, workforce and financial sustainability. It should be noted that this paper is not a business case that provides detailed and specific information on the anticipated returns on investment for the Walsall health economy resulting from Acute Trust Collaboration. The joint Trust transformation programmes, once the options for collaboration have been agreed, will generate the respective business cases with the aligned investments and benefits clearly defined for Board review.

2.0 Background

A detailed paper presenting the rationale for more formal Acute Trust Collaboration was presented at the Private Trust Board in February 2020. The paper provided a summary of the National drivers for collaboration, local challenges and drivers alongside the benefits of collaboration as a brief Walsall Case for Change. One recommendation of this paper was the development of a Strategic Outline Case (SOC) for closer collaboration with Acute Hospitals across the Black Country. The SOC would determine the strengths and weaknesses of the preferred scenarios for future organisational form focusing on improved outcomes for patients, clinical, financial and longer term operational sustainability.

There are a number of national recommendations for closer collaboration between hospitals with the benefits cited as reducing unwarranted variation and improving clinical standards and outcomes, patient safety and financial performance (The Dalton Review 2014, The Carter Review 2016, Next Steps on the Five Year Forward View, 2017, The NHS Plan 2019). These recommendations, alongside the learning that has been gained from other Trust collaboration, would provide the evidence base to inform the development of the SOC.

However, the development of the SOC has been superseded by the NHS England and NHS Improvement request in August 2020 for BCWB Acute Trusts to increase the pace of acute collaboration. A dedicated Acute Collaboration Programme Director has been appointed to facilitate the development of the strategic and clinical case for change, working with BCWB Chairs, Chief Executive Officers and key Executive Directors. It is anticipated that a preferred option for collaboration is reviewed and agreed by BCWB Trust Boards in December 2020 with a view to implementation of the agreed plan for Trust Collaboration by April 2021.

3.0 The Benefits of Trust Collaboration

Acute Care Collaboration (ACC) vanguards (2018) provide some learning on how acute providers can work together to improve care quality, financial efficiency and workforce sustainability. The ACC consists of a collection of 13 acute care providers who were chosen to work together from 2015 to test new ways of collaborative working to improve care quality, workforce sustainability and financial efficiency. However, it is noted that the evidence of measurable benefits and generalizable conclusions arising from ACC is limited and will evolve over time. Nevertheless, the ACC has demonstrated some early successes in improving patient access and experience, reducing unwarranted variation, addressing workforce challenges and improving efficiency.

The evidence of benefits in these areas will be used to underpin the potential benefits for the population Walsall. A headline summary of potential benefits is provided in Table 3 (at the end of this paper), this list is not exhaustive. The benefits are clearly aligned to the Trust Strategic objectives: Provide Safe, High Quality Care, deliver Care at Home, Work Closely with Partners, Value our Colleagues and Use Resources Well to ensure that our organisation has good governance and is well-led. It should be noted that these qualitative and quantitative benefits are interdependent, so there may be some repetition.

3.1 Service Users and Carers

Patients should be able to access local services designed to provide the best safe and high quality of care within a timely manner. Trust collaboration would support service users and carers by improving the patient choice, experience, outcomes and access to local innovative, evidence based care. This would be achieved by the provision of local clinical centres of excellence and increased local sub-specialisation, derived from optimising the cumulative clinical workforce in the delivery of standardised clinical services providing 7 day service resilience. Clinical centres of excellence attract and retain highly skilled staff and opportunities for service users to benefit from and participate in research to improve health outcomes. Access to these services that can be achieved through Trust collaboration would instil service user and carer with confidence in care provision for the local population and establish Walsall as a place where the best care is consistently delivered. There is a citizen story in Table 2 (after the recommendations in this paper) that provides an example of the benefits to service users and carers, clinical services and care quality.

3.2 Clinical Services

The Trust conducted sustainability reviews of 75 clinical services between January 2018 and March 2019. The reviews identified that 42 (56%) services were sustainable i.e. performing at expected level; 27 (36%) services would be sustainable with intervention i.e. a challenge to deliver required quality and safety and an action plan was in place to support achieving required targets; 7 (9%) services had sustainability issues i.e. could not deliver the required levels of quality and safety, no action plan was in place and support was required. The reviews not only identified areas of concern (Urology, Ear, Nose and Throat, Neurology) but also highlighted clinical service areas where Walsall

had the opportunity to lead service delivery, leading best practice across the STP (Dermatology, Community Teams and the Frailty Model). Work was undertaken to review all these clinical services and the plans to refresh the sustainability reviews in Mach 2020 were halted by the COVID-19 pandemic.

There was strong, positive support for Trust collaboration expressed at the Trust Clinical Senate held on 3rd November. The Clinical Senate is a multi-professional forum consisting of Executive Directors, all Clinical and Divisional Directors, Matrons, Divisional Directors of Operations, Professional Heads of Service and Director of Post Graduate Medical Education. The remit of the Clinical Senate is to provide independent, robust strategic clinical advice and leadership to enable the organisation to make the best decisions about healthcare for the local population.

It was evident during discussion at this meeting that Trust collaboration would be welcomed and yield standardisation of clinical best practice, build tertiary level services that would provide key benefits for service users. Tertiary services would also provide key benefits for the workforce providing leadership roles, local accountability and determination to drive the quality of service provision. The desire to deliver local services for local people was evident, providing the best clinical services with the best outcomes for the population we serve. Optimised pathways of care and support services through Trust Collaboration will strengthen service provision and service resilience, enhancing a local and sustainable clinical service offer.

3.3 Care Quality

The Care Quality Commission report for the Trust was published in July 2019 included identification of areas of improvement in fundamental standards of care, mandatory training and levels of safe staffing. Clinical standards are not embedded throughout the organisation which has a subsequent impact on the achievement of high quality clinical outcomes. Trust collaboration would provide a stable, skilled workforce with the strong clinical leadership required to embed Getting it Right First Time recommendations across all four Trusts. Adherence to clinical standards and implementation of evidence based, best practice care would reduce unwarranted variation in the quality of care delivered across the Black County.

The Trust has ongoing challenges in embedding sustainable quality improvement, with clear linkage to the workforce issues listed below. It is difficult for a transient workforce to provide consistent, high quality care which has a negative impact on the service delivered and patient outcomes. A safe and sustainable workforce significantly decreases the current dependence on agency and locum staff, and would deliver consistent quality driven activities at scale. The opportunity to share risk and subsequent risk mitigation, alongside the learning through cross-organisational thematic clinical incident management, was outlined by the Clinical Senate as another benefit of Trust collaboration to improve the quality of care.

3.4 Workforce

There are significant workforce challenges in terms of recruitment and retention that impacts on the Trusts' ability to deliver consistent safe high quality care. The continuous dependency on agency and locum staff is not sustainable long term and affects the continuity of patient care. Workforce

planning across the BCWB would ensure a systematic process for education, training, recruitment, development of a flexible workforce and the management of talent and provision of wider career opportunities. This will include the development of new ways of working and the accompanying new roles to support delivery. These benefits are fully aligned to with the BCWB Sustainability and Transformation Partnership (STP) priority to Make the BCWB the Best Place to Work. This would support the retention of a skilled workforce, support service continuity and reduce the reliance on temporary staff and the associated costs. There is a staff member story Table 2 (after the recommendations in this paper) that provides an example of workforce, clinical services, care quality and service user benefits

3.5 Financial Sustainability

Financial sustainability has been a longstanding challenge for Walsall Healthcare NHS Trust and there is a need to optimise delivery of services to ensure we use our resources, (human, financial, physical assets, estates and technology) efficiently and effectively. Trusts across the BCWB are experiencing similar financial challenges and collaboration offers significant opportunities such as financial risk sharing, standardised and integrated corporate function, shared assets, investment resources, economies of scale in procurement, estates etc. Any future efficiencies arising from more streamlined organisational productivity would be reinvested to enhance the services for the local population of BCWB.

It should be noted that the financial benefits are not a significant driver for collaboration; evidence from other Trust collaborations, and other international examples, indicates that any financial related benefits that result from collaboration may not be realised for at least 5 years.

4.0 The Importance of Place-Based Care

Integrated Care Partnerships (ICPs) are being developed to provide locally integrated, place-based care that will be necessary to support the ambitions for improved health and wellbeing for each local population as well as assist in the demand management of services in each place. The Clinical Senate discussion highlighted that the volume of demand for acute services across the Black Country is overwhelming. ICPs provide the opportunity to reduce avoidable demand and meet this demand more appropriately through robust population health management. This will ensure that health and care services are delivered more proactively, improve prevention and overall health and self-management, where possible.

Walsall Together is recognised within the BCWB as an exemplar Integrated Care Partnership. Trust collaboration will enhance opportunity for shared learning across the BCWB place-based care, with Walsall Together providing best practice guidance. It was clearly stated within Trust collaboration paper presented to the Board that Walsall Together, amongst other key services, is a key exception to BCWB Trust collaboration. The essential need to maintain sovereign, place-based care is agreed by all BCWB Trusts, as there would be no benefit from a separation of acute care provider from the associated Integrated Care Partnership.

5.0 Health Inequalities

There is a long standing challenge across BCWB to address health inequalities within and between population groups and individuals. The gap in life expectancy between the most deprived and least deprived in BCWB, in comparison with Walsall is depicted in Table 1. Whilst Walsall has higher male and female life expectancy overall, in the least deprived groups, male and female life expectancy in the most deprived is lower than the BCWB average. The gap in life expectancy between the most deprived and least deprived groups in Walsall is greater that the Black Country average, indicating a higher level of absolute health inequality.

Table 1: Life expectancy gap between most and least deprived quintiles (2015-17)

Deprivation Quintile	Black Country and West Birmingham		Walsall	
	Male	**Female**	**Male**	**Female**
Most Deprived	74.7	79.4	73.3	78.6
Least Deprived	81.3	84.7	82	85.2
Absolute Gap	-6.6	-5.3	-8.7	-6.6

Source: Public Health England Health Inequalities Dashboard

Public Health England defines health inequalities as, 'systematic, avoidable and unjust difference in health and wellbeing between different groups of people'. The causes of health inequalities are grounded in the socio-economic conditions in which individuals are born, live and work, influencing life choices and opportunities to access preventative, curative and supportive healthcare.

Access to timely health care is critical to the achievement of optimal health outcomes. Trust collaboration can yield a significant benefit by increasing access to high quality evidence based care delivered in a local centre of clinical excellence by a skilled, experienced and stable workforce. It is noted that to maximise the opportunity to address health inequalities through Trust collaboration there needs to be robust population health management, with a prevention agenda, delivered in conjunction with a strong Integrated Care Partnership.

The population of Walsall deserves the best care available, close to where they live and Trust collaboration provides a significant opportunity for us to ensure that local residents can realise the potential benefits that are available through collaborative working. The collective ability offered to tackle health inequalities will enable the innovative application of evidence based approaches at scale, building local expertise to address the wider determinants of health.

6.0 Summary

There are potential, interdependent qualitative and quantitative benefits for Walsall Healthcare NHS Trust that can be realised through a BCWB Trust collaboration. It is acknowledged that whilst the evidence base supporting measurable benefit realisation is emerging from the ACC, key measurable successes have been identified. Trust collaboration across the BCWB presents an opportunity to enhance the breadth and quality of local services provided for the residents of Walsall, ensure a sustainable, skilled workforce and provide assurance of future financial sustainability.

There is also the opportunity to optimise population health management, shift the balance of care provision between acute and community care to consistently address demand and maximise health outcomes with a significant potential to reduce health inequalities overtime.

It should be noted that this paper does not address areas that Walsall will identify as out of scope for the collaboration. Therefore, the Trust Board will be asked to consider non-negotiable services and health care components for inclusion in the agreed, formal group structure separate to this potential benefits paper.

7.0 Recommendation

The Trust Board is asked to **endorse** the potential benefits of Trust Collaboration for the population of Walsall.

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust proposal for Strategic Collaboration			**AGENDA ITEM: 8.2**
Report Author and Job Title:	Glenda Augustine, Director of Planning & Improvement Mike Sharon, Strategic Advisor to RWT Board	**Responsible Director:**	Richard Beeken, Chief Executive Officer
Action Required	Approve ☒ Discuss ☒ Inform ☐ Assure ☐		
Executive Summary	The purpose of this paper is to propose a Strategic Collaboration between Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT), within the wider Black Country and West Birmingham Trust collaboration (BCWB). It is our intention to form a collaborative group across BCWB Trusts. The scale and pace of collaboration across BCWB Trusts is still being discussed. WHT and RWT have the ambition to maximise the opportunities that can be gained for the populations we serve and our workforce through bilateral Strategic Collaboration. This is the first stage in a two-stage process towards multi-lateral collaboration. The proposal also recommends to NHSE/I the appointment of a joint Chair between the two Trusts. Whilst not explicit within the proposal the expectation is that each organisation will retain their Trust Board and Board Committee structures with Executive teams led by a Chief Executive in both Trusts. This paper provides an outline of the high level principles that underpin the collaboration, the desired benefits in the first year and longer term, with an overview of how these benefits will be delivered. The need to develop a brief memorandum of understanding to underpin the collaboration which will outline the sovereign decision-making processes for each Trust will be sought.		
Recommendation	The Board is requested to: a. **Review** and discuss this Strategic Collaboration proposal b. **Approve** the ambition to form a Trust Group/Chain within the broader STP collaboration context. c. **Approve** the immediate commencement of the Strategic Collaboration proposal as a first step towards the ambition to form a Trust Group/Chain within the broader Black Country and West Birmingham collaboration context.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Strategic collaboration with RWT has the potential to mitigate against the following risks by strengthening the quality and range of clinical services offered to the local population, increasing the skills and competence of the workforce, supporting recruitment and retention, ensuring the optimal use of resources and maximising risk sharing and economies of scale to ensure organisational objectives are met: BAF Risk 1: *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*. Trust collaboration has the potential BAF Risk S03: *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*. BAF Risk S04: *Lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care*. BAF Risk S05: *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*.
Resource implications	There are resource implications associated with Strategic collaboration that, whilst not current fully defined, will be informed by the Boards of each organisation.
Legal and Equality and Diversity implications	An equality impact assessment would assess the risk and mitigation against equality and diversity risks in relation to employment and service delivery. Strategic collaboration is likely to provide greater opportunities for increasing and widening employee participation, talent management, personal and professional development. Shared learning across organisations around patient access and the provision of inclusive services for the population we service will be beneficial. There are no immediate legal or governance implications by virtue of the retention of both sovereign organisations and their Boards,

	including Chief Executive roles.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

A proposal for Strategic Collaboration

Chairs' Foreword

Health Inequalities are particularly prevalent in Walsall and Wolverhampton where areas of post-industrial decline, and increasingly ethnically diverse populations combine to create significant issues of poverty, lack of opportunity and poor health. The issues are not uniformly distributed across the boroughs and there is a need for the NHS is to consider how it targets its resources and tailors its services in response.

Addressing health inequalities and workforce inequalities, working closely with local Authority partners in Wolverhampton and Walsall to address the social determinants of health, is mainstream activity. It is core to and not peripheral to the work of the NHS which was stablished to meet the health needs of all communities. The NHS has seen longstanding disparities in access, experience and outcomes as well as experiencing an unsustainable demand for secondary care services by patients who if supported in the community might not have required expensive hospital services.

The NHS Phase 3 Response to COVID-19 Plan required credible plans to address health inequalities and this prioritisation has been underlined by NHSEI Midlands. Both of the Trusts are already working closely with partners in place systems, which include primary secondary and social and mental health care. The disproportionate impact of COVID-19 upon the BAME population and other vulnerable communities have combined with the Black Lives Matter movement to shine a spotlight on longstanding health inequalities.

Leadership capacity, research expertise and innovation are essential to tackling health inequalities and so the Walsall-Wolverhampton collaboration offers a considerable opportunity to improve our response to the health inequalities challenges we face.

We know that there has always been significant unwarranted variation in how healthcare is delivered and in the subsequent outcomes for patients. Our collaborative partnership will underpin our determination to address those variations, deliver evidence based healthcare and deliver the best possible outcomes for the people of Walsall and Wolverhampton.

Danielle Oum

Chair: Walsall Healthcare NHS Trust Trust

Steve Field

Chair: The Royal Wolverhampton NHS

Purpose

The purpose of this paper is to propose a Strategic Collaboration between Walsall Healthcare NHS Trust and the Royal Wolverhampton NHS Trust, within the wider Black Country and West Birmingham (BCWB) acute care collaboration arrangements. The aim of this Strategic Collaboration is to significantly improve the quality of care for the populations we serve, standardise clinical practice and provide a safe, skilled and sustainable workforce.

Background

NHS England and NHS Improvement communication in August 2020 requested BCWB Trusts to increase the pace of acute collaboration following initial informal discussion in January 2020. Through facilitated discussions with BCWB Chairs, Chief Executive Officers and key Executive Directors a broad proposal for Acute Care collaboration across the Black Country is being developed. Our collaborative arrangements will sit within this broader BCWB collaboration when this is agreed but we want to make progress without delay.

The shared view of the Walsall and Wolverhampton Executive teams is that rapid progress can be made to a considerably greater extent by a more formal collaborative approach and that we should proceed with a Trust collaboration initially as two Trusts, to benefit the populations we serve.

Each Trust serves a population that has significant opportunities to improve its health and wellbeing and to reduce significant inequalities in health outcomes if properly supported. The populations share many characteristics and face similar challenges so there is an opportunity for each Trust to learn what has worked in each area.

Our Trusts provide both acute and community services (RWT provides primary care services / WHT provides Social care services through a Section 75 with the Local Authority) which means that each Trust recognises the need to integrate better acute primary and community services with other local partners at the same time as the need to provide some acute services at a larger scale, and to a better, standardised quality. It is recognised that the importance of place is reinforced by retaining a local partner as an anchor for the Integrated Care Partnerships.

Each Trust has some particular strengths to share:

> Walsall Together is recognised within the BCWB as an exemplar Integrated Care Partnership. Trust collaboration will enhance opportunity for shared learning across our place-based care delivery. Walsall is also a fast track digital aspirant pilot site.

RWT are rapidly progressing to leading edge innovation programmes with global partners including Microsoft, Babylon, Teletracking and many others based on a anticipatory digitally driven care model (SCDU)

Both Trusts have an ambition to embed innovation and research into mainstream practice. WHT established a Faculty of Research and Clinical Education (FORCE) in May 2020. RWT hosts the National Institute for Health Research for the West Midlands. Strategic collaboration between our Trusts would help to share expertise, for example in bid writing and data curation to improve recruitment to trials and drive improvements in care. Strengthening the culture of research and professional development across our organisations will support staff and patients to access research, training and development.

The Quality Improvement agenda is also a strong enabling factor for both Trusts; WHT has a Quality Improvement Academy and is Quality Improvement and Service Resdesign training site; RWT has a Continuous Quality Improvement programme.

Strategic Collaboration Ambition

Our ambition, ultimately, is to form a Trust Group across the Black Country. However, given that the Trusts are at different stages in their thinking around the collaboration agenda, the Executive Teams of both The Royal Wolverhampton NHS Trust and Walsall Healthcare Trust are seeking support from the Board to develop a Strategic Collaboration with a joint Chair as soon as practically possible, but at a pace that is mutually agreed. We do not believe that our two Trusts need to set up formal shared governance arrangements in addition to a shared leadership cadre.

As a starting point for shared leadership we are seeking the appointment of a joint Chair for the Trusts and to fill Board vacancies on a potentially shared basis as they arise, commencing with the Non-Executive Director post vacated by the current Walsall Chair.

Given the need for urgent progress on this matter, as impressed on both Trusts by NHS England/ Improvement, together with the potential for significant benefits to be very quickly realised for the communities served by both Trusts, it is proposed that the move to immediate collaboration is approved without the completion of a formal Business Case process. It is the view of the Executive teams in both Trusts that the changes proposed can be brought about without the need for significant investment or other changes that would compel a business case under national guidance, although business cases for individual investment items will be prepared in the usual way.

Principles underpinning our collaboration

The following principles will be adopted to guide our approach and behaviour. We will:

- improve access to safe high quality care for all services users across our footprint
- deliver improved outcomes for all patients - minimising unwarranted variation and reducing inequalities
- ensure Executive management in each "place" with clarity of accountability to minimise the risk of destabilising each Trust
- support and encourage our staff to be the best they possibly can be by providing first class training and research opportunities
- combine our employer and purchasing power to benefit employment opportunities in our local economies as anchor institutions
- minimise bureaucracy, such as additional structures and meetings where feasible
- be sensitive to local needs and differences to ensure the populations we serve are at the heart of our decision making
- establish processes to plan and deliver change across our Trusts

Desired benefits of our approach – year 1

- Maintain and improve performance, outcomes and patient experience in agreed services
- Reductions in unwarranted variation/more standardisation of care
- Improvement in staff recruitment and retention. This will maximise the capacity of our combined workforce, making the best use of skill mix and ensuring that there are opportunities for all staff and a role for everyone in our organisations Significant reduction in agency and bank expenditure is reduced and a shared bank delivered. This will enhance consistent high quality care provided by a stable workforce. Any savings will be reinvested in patient care
- Further collaboration of back office services to generate efficiencies to provide more care
- Standardised quality and corporate governance processes in line with best practice
- Increase the pace at which we are delivering our existing collaborative programmes, and enable us to deliver improvements for population and patients
- Existing Transformation and Organisational Development programmes are harmonised and implementation has commenced to improve the skills and competence of our workforce to attract and retain staff
- Plans accelerated to share innovation e.g. sharing electronic patient record teletracking, Babylon, Sensyne, and population health management systems.

Desired benefits of our approach – long term

Improvements in:

- Demonstrable collaborative working with positive patient outcomes
- Improvement in healthy life expectancy of our local populations and reduction in health inequalities within our local populations
- CQC ratings
- Performance against standards
- Financial performance
- More sustainable clinical services
- Workforce recruitment, retention and development
- Reputation of each Trust
- Standardised evidence based clinical practice embedded into business as usual with consistent upper quartile performance for all clinical services and reductions in unwarranted variation

How we will deliver the desired benefits

We have been working together for many years and we will build on much improved relationships and a track record that has already delivered improvements e.g.

- The creation of the Black Country Pathology service
- A networked urgent cardiac service
- The transfer of acute and hyper acute stroke services from Walsall to Wolverhampton
- The appointment of a Walsall Clinical Director to a shared Dermatology service with a merged service expected in 2021
- Amalgamation of ENT on call services
- A shared strategic educational lead and significantly improved educational governance at Walsall
- Shared Clinical Fellowship programme Board to improve recruitment of medical staff
- Agreement at Trust level on a new Urology pathway

We will work together to review the sustainability of our services and maximise the opportunity to enhance vulnerable services.

To build on this success it is proposed that the following steps are taken:

1. **Extend and strengthen the existing collaborative working group**

A collaborative working group has been in existence for two years (but paused during Covid wave 1) to oversee collaborative service change. This group has selected Executive membership from all four Black Country Trusts. It is proposed to repurpose this group as a Walsall/Wolverhampton only group and have a monthly meeting, jointly chaired by the CEOs and incorporating a wider range of Executives that oversees a collaborative work programme supported by appropriate programme and change management resource from each Trust.

It is assumed that the STP wide service collaboration will be taken forward through the mechanisms proposed in the STP plan when this is developed.

2. **Hold joint Board development sessions**

Each Trust has a Board development programme and a joint programme will be developed so Boards can begin to better understand the issues faced by each Trust and learn from each other

3. **Agree a default position that any new Board vacancies that arise are filled as shared posts**

This may not be an appropriate action for all vacancies but each Trust agrees that this should be the starting assumption

4. **A shared OD programme will be developed that will encompass**

- Shared vision and values
- Equality, Diversity and Inclusion strategy
- Leadership and joint working behaviours
- Workforce resourcing opportunities to include new employment models
- Shared development opportunities e.g. talent management
- Joint approach to embedding cross cutting culture of civility and respect
- Improve workforce/community representation at all levels
- Maximising the use of data to support improved staff and patient experience
- A joint approach to communication and engagement – internal and external
- Sharing best practices widely - ‘best in class’

5. Provide regular reports to each Trust Board to identify progress

A report format that encompasses specific metrics will be developed to allow progress against desired benefits to be monitored.

Conclusion and recommendations

Each Trust has the opportunity to build on and strengthen the collaborative work we have developed so far to improve the health of our populations, to make services more sustainable and higher quality, to attract and retain the best possible workforce and to drive improvements in the health of our populations.

The Trust Board is asked to:

a. **Review** and discuss this Strategic Collaboration proposal

b. **Approve** the ambition to form a Trust Group/Chain within the broader STP collaboration context.

c. **Approve** the immediate commencement of the Strategic Collaboration proposal as a first step towards the ambition to form a Trust Group/Chain within the broader STP collaboration context.

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
People and Organisational Development Committee (PODC) Highlight Report			**AGENDA ITEM:**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Phil Gayle Chair of PODC and 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 26 November 2020. The meeting time and agenda were shortened to allow executives to focus their time on the response to the second wave of COVID-19. Of note are: **COVID-19 Risk Assessments** The Committee was not assured on the quality or impact of the COVID-19 risk assessment process for vulnerable colleagues. To ensure that staff are safe, and feel confident that the measures agreed to protect them have the desired impact, the following actions were agreed to address the assurance gaps: • Risk assessments forms will be changed to reflect the actual risks to staff including those of a socio-economic and demographic nature, rather than purely on a colleague's clinical risk factors; • Assurance that risk assessments are taking place at the right time, including at the point of redeployment; • The expectation is that revised risk assessments will be carried out in a way that leads to appropriate measures to mitigate risk, and a confidence that there will be no detriment or inequity that follows. Managers to be supported to do this; • Process to capture that measures have actually been put in place to protect staff as a result of a risk assessment and a mechanism to provide assurance on that to the Committee; and • Assurance that the colleague experience of the risk assessment is captured. A verbal update on the process elements will be provided at the December meeting with an assurance report in January. **Organisational Development Interventions** • The Committee discussed the short term and long term		

	Organisational Development (OD) interventions underway in areas of the Trust to address bullying and harassment, racist behaviours, discrimination, inequality, ineffective line management, and fear of speaking out. This was triangulated with first hand staff experiences shared with the Trust Chair in 'Pull up a chair with the Chair' sessions. The Committee was assured that the actions planned are those required however not assured that the actions planned were progressing at pace or having enough of an impact. The action agreed included: • Enhanced support and executive sponsorship in areas identified in the Pull up a chair with the Chair' session to ensure staff are aware that action is and will be taken in response to concerns raised; • Assurance on the long-term OD work to address issues; understanding of the process and impact of the shorter OD interventions; and high impact actions that send a message across the Trust that staff are being heard and action is being taken; and • Plan to cascade messaging through the organisation on this issue in a more targeted way The December Committee meeting will receive an update report on the above. Further discussions will take place on sickness absence rates prior to the next meeting, which will take place on 17th December 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 – 3rd December 2020			
VALUING COLLEAGUES – COVID-19 EXECUTIVE UPDATE			**AGENDA ITEM: 11**
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 value our colleagues' strategic objective specific to the emergency response to COVID-19 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 relating to the Board Assurance Framework (BAF). The update has a specific focus on assurance gaps relating to organisation culture and effectiveness of risk assessments. This report provides an update on key actions taken last month relating to the value our colleague's work-stream. The following inform the Trust Board of developments and gaps in assurance: 1. There is a gap in assurance on the resource available for engagement and Equality, Diversity and Inclusion (EDI) strategy implementation in relation to the pace of change required in the organisational culture. In addition the recent investment in Occupational Health and Wellbeing is not likely to be sufficient given the requirements of colleague testing and expanded vaccination programme and the ongoing impact of COVID-19. The investment case to close these gaps has been initiated – some re-prioritisation from existing budgets has been possible. 2. The Trust Board can be assured that additional resource has been identified in month for outbreak control and for the requirements of scoping and delivering colleague testing and the flu and COVID-19 vaccination programme. The investment of resource has been approved through the trust governance process to establish a team to focus on COVID-19 response and in particular outbreak, to recover flu vaccination levels, to plan for COVID-19 vaccination programme and to recover core Occupational Health Services. The flu vaccination percentage is currently 58.36% at 26th November 2020 (compared to 64% at this point last		

	year) 3. The Board Assurance Framework (BAF) risk mitigations in place measure performance against key workforce metrics, these are quantitative metrics. Resourcing is a key metric and this month sickness absence performance has been reviewed in the context of the impact of COVID-19 absence, including self-isolation, has on available workforce. 4. The leadership development planned prior to COVID-19 was planned to re-start in November and complete in May 2021. The planned programme was updated to a virtual offering as part of the restoration and recovery plans, however due to the existing pressures this programme has been deferred to 2021. 5. The work on organisation culture is essential to the emergency response. The organisation culture presents a significant assurance gap. Organisational Development (OD) interventions (short-term impact) took place between August to December. Further assurance is required on the pace, impact and visibility of these interventions. The longer term OD programme of work will need further investment to work with leaders. The OD interventions were 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 supported by the People and Culture directorate. 6. The Trust Board can be assured that a review of the COVID-19 risk assessment approach has been completed, however this demonstrated that there is an assurance gap relating to quality and impact of the COVID-19 risk assessment process for vulnerable colleagues. To close those gaps, the risk assessments forms will be changed to reflect the actual risks to staff including those of a socio-economic and demographic nature, rather than purely on a colleague's clinical risk factors; to provide assurance that risk assessments are taking place at the right time, including at the point of redeployment; process to capture that measures have actually been put in place to protect staff as a result of a risk assessment and assurance that the colleague experience of the risk assessment is captured. 7. The Committee is asked to take positive assurances from the priority exercise on the improvement programme work, which specifically supports the COVID-19 response and the

	recovery beyond.
Recommendation	1. The Trust Board is asked to note the action being taken to close the assurance gaps on the risk assessments and the stratified risk assessment approach. 2. The Trust Board is asked to note that People and Organisational Development Committee reviewed progress on the OD actions for assurance, however the gap in assurance remains in relation to the depth and pace of the actions taken and further controls were identified to improve the organisation culture relating to raising concerns including racism and inequality based on protected characteristics.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk SO5 to provide assurance, or identify gaps in assurance based on 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.
Legal and Equality and Diversity implications	There are significant issues relating to equality arising from matters addressed in the report. The Committee 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 now and in the future must ensure that swift and decisive action is taken to address toxic behaviours and cultures and in particular staff experience in relation to racism in the workplace. In addition to ensure the systems the Trust relies upon can deliver 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 partnership work on developing the trust's place as an anchor employer within the

	community has moved into implementation of some key partnership work including direct recruitment with Walsall Housing Group.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Valuing Colleagues

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 the culture of the organisation is contained within the OD Plan which is delivered through the improvement programme. The approach is multi-faceted and supports the move toward a just and learning culture.

The immediate interventions on OD seek to address the themes and concerns raised through Pull up a Chair, Freedom to Speak Up (FTSU) concerns, Board Walks and Employee Relations case themes. The review of the actions taken to date are included as assurance for the committee, the trust ambition to become outstanding by 2022 will not come to fruition whilst discriminatory practice, bullying and harassment and ineffective people management persists. The EDI strategy will set the ambition and expectation for equality within the trust, the values and behavioural framework sets the expectation for climate within the trust to equip leaders and managers to respond to the system, organisation and cultural challenges (and inequalities) impacting Walsall. The gap in assurance is a significant risk to the Trust's ambition and whilst short term action will have an impact, it is the sustained, consistent leadership at all levels and driving out racism and other discrimination that is required to establish and maintain a healthy organisational culture for Walsall. This will lead to an improved 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 following actions have been taken in month 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-19 and additional resource planned for COVID-19 outbreak work within the month.
- The staff risk assessment process is designed to achieve two outcomes, first that processes are in place for colleagues to work safely during the response to COVID-19 and secondly that colleagues feel safe. There are assurance gaps on both of these outcomes and further action to put controls in place and close the gap were agreed by the People and Organisation Development Committee.
- Staff experience unreasonable treatment based on their race, disability, ethnicity and sexuality, with themes identified through FTSU and Pull up a Chair, the People and OD Committee reviewed this and additional Organisation Development resource deployed, actions taken to date contained within assurance report for committee, however assurance gaps remain and further action is identified to close these gaps.

The following assurance is in place to mitigate the risk:

- Trust Management Board (TMB) has received and commented on update on risk assessment process and a detailed report is presented for the assurance of committee.
- The People and Organisation Development Committee receives monthly updates on arrangements in place to support colleagues through the impact of COVID-19, as part of this the trust has invested in additional Occupational Health and Wellbeing resource, and further resource has been required in month to respond to the requirements of staff testing and preparing for the COVID-19 vaccine. In month the approach to colleague Health and Wellbeing has been updated and communicated.
- There is a recovery plan in place relating to the flu vaccine uptake following gaps in assurance on take up during 2020 compared with previous years, 2018 and 2019. There has been as significant improvement in uptake from 42% reported at last Trust Board to 58.36% at this, albeit the level of compliance at this point last year stood at 64%.

The following gaps in assurance remain:

- The private Trust Board colleague experience, FTSU Guardians, Board Walks, Pull up a Chair, NHS Staff Survey, Workforce Race Equality Standard 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 the Board that this is controlled

and sufficient steps taken to eliminate. The assurance that can be provided is that resource has been deployed, action planned and taken during the period to December 2020 and where a longer term intervention is required e.g: MLTC this has been defined.

- There is a gap in the assurance on the impact of risk assessment process and updated assurance process was considered by the People and Organisation Development Committee and further action and controls identified.
- There is a gap in the assurance on whether sufficient resource is available to respond to the requirements of staff testing, vaccination programmes and support on resourcing in light of sickness absence rates, although additional resource has been put in place, these may not be sufficient to respond to planned changes to the vaccination programme.

3. PERFORMANCE REPORT

The workforce metrics performance element of this report takes a standard set of quantitative metrics and tracks performance over time. Resourcing is the significant risk currently due to the impact of COVID-19 on workforce health and wellbeing and consequently absence rates.

4. RECOMMENDATIONS

- The Trust Board is asked to note the action being taken to close the assurance gaps on the risk assessments and the stratified risk assessment approach.

- The Trust Board is asked to note that People and Organisational Development Committee reviewed progress on the OD actions for assurance, however the gap in assurance remains in relation to the depth and pace of the actions taken and further controls were identified to improve the organisation culture relating to raising concerns including racism and inequality based on protected characteristics.

APPENDICES

Appendix 1a - BAF SO5

Appendix 1b - Corporate Risk Register

Appendix 2 - Performance Report – Workforce Metrics

Walsall Healthcare NHS
NHS Trust

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:	PEOPLE AND ORGANISATIONAL DEVELOPMENT 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	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:						**Risk Level:**	**8**	

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. • Internal staff mental health awareness champions identified. • Restorative 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. • PODC approved measures to monitor progress against Trust Board Pledge in place. • STP funding achieved to support training and implementation of restorative just and learning culture. • F2SU strategy agreed at PODC and in place. • Accredited RCN training programme for 60 Cultural Ambassadors has been implemented to support recruitment and selection processes. • Additional HR/OD support in place for 2020 Q3 to support work areas with complex people needs and poor staff experience.	• Quarterly deep dive of key workforce metrics by CCG. • BCWB STP People Plan in development to support implementation of National NHS People Plan. • Midlands NHSE&I monitoring of individual COVID-19 risk assessment performance. • STP and regional NHSE&I monitoring of Trust performance regarding uptake of staff flu programme. • WRES and WDES outcomes monitored at national and regional NHSE&I level.

<table>
<tr><td>Gaps in Control</td><td colspan="3">• 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
• 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.</td></tr>
<tr><td>Assurance:</td><td>• 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.
• Audit of Individual COVID-19 Risk Assessments undertaken to understand risk levels and outcomes of measures implemented to protect staff.</td><td>• 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.
• Board development sessions to support co-design and approval of EDI strategy completed in October 2020.
• Staff Inclusion Network established in May and meetings taking place with Network leads across the protected characteristics</td><td>• 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 2020-21, paused due to Covid response. Revised implementation plan agreed at TMB to commence Q1 2021.
• NHSi partner for Retention programme – the 90 day plan is complete, impact on retention rate to be reviewed Q2 1920
• EDI WRES/WDES metrics and other EDI metrics developed for inclusion within the organisation's accountability framework</td></tr>
<tr><td>Gaps in Assurance</td><td colspan="3">• 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.</td></tr>
<tr><td colspan="4">Future Opportunities</td></tr>
<tr><td colspan="4">• Capitalise on external resource/expertise to establish evidence based best practice</td></tr>
</table>

- 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	Progress Report	BRAG
1.	Draft Health & Wellbeing Strategy & Engage and Consult Key stakeholders	Catherine Griffiths	March 2021	• Focus and rapid development and implementation of HWB interventions to support staff working through COVID-19. • Contines development of HWB conversations and developing process and skill set to support individual HWB plan conversations. •	
2.	Develop and Implement a leadership Development Programme	Catherine Griffiths	March 2021	• Updates shared at Execs and TMB in October 2020 • FMLD programme recommissioned following COVID-19 pause – commence Q1 2021. • Growth Mindset Leadership Development Programme commissioned – due to be implemented from November 2020.	
3.	Launch EIA Policy and Form	Catherine Griffiths	October 2020	• New forms and Policy to be cascaded 12th October . Board and Executive paper EIA prompt sheet developed and uploaded on to Trust Corporate Communications Intranet web pages alongside Corporate communication templates • EIA learning package with EIA Video developed- due to be launched with Policy on 12th October 2020	
4.	Review and relaunch equality impact assessment	Catherine	March 2021	• Options currently being explored to develop an online version of	

	processes	Griffiths		the EIA proforma via Cloud 2 intranet project and the functionality of share point.	
5.	Agree Valuing Colleagues Improvement Programme Benefits	Catherine Griffiths	November 2020	• Set of qualitative and quantitative benefit measures considered at Improvement Board workshop 02 October 2020.	
6.	Finalise and approve Equality, Diversity and Inclusion Strategy	Catherine Griffiths	January 2021	• Colleague and community engagement and consultation completed in September 2020. • EDIC and Staff Inclusion Network BAME Decision Making Counsel engagement completed. • Board Development sessions on the 5 & 19 October 2020 completed. • Strategy to be received by PODC in December ahead of Trust Board consideration in January 2021.	
8.	Provide assurance regarding outcomes of individual COVID-19 Risk Assessments	Catherine Griffiths	October 2020 Action completed	• Detailed audit commissioned between 12-23 October 2020. Initial analysis to be reported to October PODC.	

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	

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*
12/11/2020	Paper being developed to identify needs in accordance with agreed strategic ambitions. Joint temporary post with F2SU team currently being advertised.	Sabrina Richards		29/11/2020	04/12/2020
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

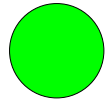
Walsall Healthcare Risk Register

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.	Catherine Griffiths	15	• 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	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/11/2020	Joint piece of work currently underway with finance to cleanse subjective codes to help align finance and ESR records.	Clair Bond		26/12/2020	31/12/2020
01/01/2021	This action will follow the joint work currently being undertake by the ESR and Finance team to cleanse subjective records which drive finance reporting.	Clair Bond		26/03/2021	31/03/2021
01/09/2020	Specific work package within the valuing Colleagues Improvement Programme.	Marsha Belle		25/11/2020	30/11/2020
09/10/2020	Meeting with senior divisional representatives to discuss concerns and co-design action plan. Meeting planned for 09 October 2020.	Clair Bond	**Closed**	25/10/2020	30/10/2020
01/08/2020	Audit of hierarchies and work structures undertaken to ensure staff are correctly identified in the appropriate department with the correct manager.	Marsha Belle	**Closed**	25/09/2020	30/09/2020
01/09/2020	weekly exception report produced by ESR team and shared with L&D team to ensure information is updated manually to reconcile information.	Sebastian Smith-Cox	**Closed**	08/11/2020	13/11/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
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	• 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)	
					• BAF Control 05 • - Working across the system across the STP with HEE partners to define local, collaborative, system and national workforce supply solutions.	• Workforce Plan is reviewed and agreed by TMB and PODC • Workforce STP agenda via STP people board Collaboration with Walsall Together Partnership Board.	
					• Process • Valuing Colleagues Improvement Programme involves a number of work 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.	• Improvement Programme Board People and Organisational Development Committee. • 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	

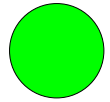
Walsall Healthcare Risk Register

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*
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
01/04/2020	The 'New Roles Group' is being reviewed to support the development of new roes, skills and career pathways.	Clair Bond	26/12/2020	31/12/2020
12/10/2020	Enhancing the career progression for non Doctors in Training and supporting career development will increase the ability of WHT to attract and retain talent.	Clair Bond	25/11/2020	30/11/2020

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	

Walsall Healthcare Risk Register

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	Workforce to reflect assurance with regards to completion of risk assessments for 'at risk' staff internally and externally.	Catherine Griffiths	26/12/2020	31/12/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
05/10/2020		Audit of individual risk assessments to be completed y the end of October.	Catherine Griffiths		**Closed**	25/10/2020	30/10/2020	
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		**Closed**	25/11/2020	30/11/2020	
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		**Closed**	25/11/2020	30/11/2020	
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		**Closed**	01/11/2020	06/11/2020	
27/09/2020		SOP developed and agreed at Tactical. Resources to provide facility for staff testing working around the hours of the patient testing facility are being identified.	Michala Dytor		**Closed**	01/11/2020	06/11/2020	

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*
14/10/2020	Review Trained resource and scope availability of Trained testers with managers to establish a monthly rota.	Jenna Davies		06/12/2020	11/12/2020
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
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
01/09/2020	Provide Fit 2 Fit training via external provider to staff particularly in high use areas.		**Closed**	25/09/2020	30/09/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
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			**Closed**	18/10/2020	23/10/2020

Public Trust Board – 3rd December
Agenda item 11, Appendix 2

Walsall Healthcare NHS
NHS Trust

October 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 Lead

Contents

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Quality, Patient Experience and Safety Committee (QPES) Highlight Report			**AGENDA ITEM: 12**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mrs Pamela Bradbury – Chair of QPES (Non-Executive Director).
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Quality and Patient Safety Committee meeting on 26 November 2020. The meeting time and agenda were shortened to allow executives to focus their time on the response to the second wave of COVID-19. Of note are: • The Committee acknowledged the work which the teams have done both in the community and acute settings during difficult and unprecedented pressures due to second wave of COVID-19. Of note was the increased rate of dementia screening and reduced number of patients who are medically stable for discharge. • The report from the Care Quality Commission (CQC) following their inspection on 8th and 9th September is attached at Appendix 1. QPES reviewed the report and have sought further assurance on the actions to address both the must do and should do items in that report, as well as historical actions. These will be reviewed monthly by the Committee, with any exceptions or issues reported to Board thereafter. • The Committee reviewed the Infection Prevention and Control Board Assurance Framework (IPC BAF), which is attached at Appendix 2. The IPC BAF is updated periodically and reviewed through the Committee. As an update to the IPC BAF, the committee received verbal assurance on areas such as laundry bagging; patients placed in COVID-19 streams in error; appropriate fitting and usage of FFP3 masks, increased protection on trauma and orthopaedic wards with additional screening where adequate distancing was difficult and also reinforcement of messaging to staff regarding social distancing particularly in communal areas. Further mitigations in place were discussed and those related to health and safety will be discussed further in the People and Organisational Development Committee in December.		

	• The Committee has requested further assurance at next meeting in December in specific areas to include: falls due to an significant increase in falls in September with 2 reported as serious incidents which are subject to review, and children's safeguarding training. Quarterly data for 'sepsis - % of patients screened who received antibiotics within one hour' was not available to the Committee. As it was not assured on these items, further detail will be sought for the next meeting. • The Mortality Report was presented to the Committee and is at Appendix 3. By way of update, the Medical Director noted that on 26th November COVID-19 related deaths were at 332 and are dominating the mortality focus currently. Thematic reviews of areas of concern are being undertaken by the Mortality Surveillance Group, details of which will come to the Committee in future meetings. The next meeting of the Committee will take place on 17th December 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 ☐	

Manor Hospital

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West Midlands
WS2 9PS
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Date of inspection visit: 8 and 9 Sept 2020
Date of publication: This is auto-populated when the report is published

Ratings

Overall rating for this hospital	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Overall summary of services at Manor Hospital

Requires improvement 

Walsall Healthcare NHS Trust provides acute hospital and community health services for people living in Walsall and the surrounding areas. The trust serves a population of around 270,000. Acute hospital services are provided from one site, Walsall Manor Hospital. Walsall Manor Hospital has 429 acute beds. There is a separate midwifery-led birthing unit (this is currently not operating but due to open in October 2020), and the trust's palliative care centre in Goscote is their base for a wide range of palliative care and end of life services.

Facts and data about the trust:

- Total number of inpatient beds – 429 as at September 2020
- Total number of outpatient appointments between April 2019 and March 2020 – 518,051
- 3,594 whole time equivalent staff as at April 2020
- A and E attendances from April 2019 to March 2020: 83.537 attendances
- Number of deliveries from January 2019 to December 2019: 3,438

We carried out a short notice announced focused inspection of the emergency department and maternity service at Manor Hospital on the 8 and 9 September 2020, in response to concerns around safety and governance. At the time of our inspection the department was operating under COVID-19 infection, prevention and control measures.

During this inspection we inspected using our focused inspection methodology. We did not cover all key lines of enquiry. For the emergency department we looked at the safe and well domains and aspects of the responsive domain. For maternity services we looked at the safe and well led domains and aspects of the effective domain.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of a regulation and issued a requirement notice or acted under our enforcement powers. in these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the ratings for well led (in urgent and emergency care and maternity services), and therefore the overall ratings went down. We rated these areas as requires improvement. Please refer to the 'areas for improvement' section for more details.

Our key findings were:

Urgent and Emergency Care

- The service provided mandatory training in key skills but completion levels for staff in the department were low.
- The service controlled infection risk well.
- The documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.
- The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff did not keep detailed records of patients' care and treatment.

Summary of findings

- The service managed patient safety incidents well.
- People could access the service when they needed it and received the right care promptly.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.
- Leaders and teams did not always manage performance effectively. They did not always identify and escalate relevant risks and issues and identify actions to reduce their impact.
- Systems for sharing of information with external bodies were not always effective.
- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Maternity Services

- The service provided mandatory training in key skills to all staff and made sure everyone completed it
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service mostly had suitable premises and equipment.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service had enough nursing and medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service mostly collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However , systems for monitoring the provision of staffing were not robust.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Summary of findings

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

We found areas for improvement including breaches of legal requirements that the trust must put right. These can be found in the 'Areas for improvement' section of this report.

Heidi Smoult (Deputy Chief Inspector Midlands)

Urgent and emergency services

Requires improvement 

Summary of this service

Walsall Healthcare NHS Trust has a purpose built emergency department (ED) that is part of the Manor Hospital. As a result of the COVID-19 pandemic the department had been split into two separate assessment streams for patients, those with potential or confirmed COVID-19 and those without any COVID-19 concerns.

For the COVID-19 stream there was an ambulance triage room, a four bedded resus area which included a dedicated paediatric bed, eight cubicles for the treatment of patients.

For the non-COVID-19 stream there were two triage rooms, a resuscitation area with two beds, one which could be used for paediatrics, five high dependency beds and seven cubicles. There was also an ambulance triage area for up to six trolleys. In the paediatric department there was a triage room, one treatment room for suspected COVID-19/non-infectious children and a separate treatment and triage room for potential COVID-19/infectious patients. There is an urgent care centre that is located on the same site and that shares an entrance and reception area with the ED, this is managed by a different provider and was not inspected.

From July 2019 to July 2020, there were 82,372 attendances at the trust's urgent and emergency care services. This included adults (65,862) and children (16,510 patients) attendances for both majors and minors treatment.

We visited the ED as part of our unannounced focussed inspection on 8 and 9 September 2020. We spoke with 15 members of staff across a range of roles and looked at 22 sets of patient records.

During the last inspection in March 2019 we rated urgent and emergency services as good overall with effective, caring, responsive and well led rated good and safe rated requires improvement. We told the trust they must improve mandatory and safeguarding training compliance for all urgent and emergency care staff. (Regulation 18). We also told the trust that they should improve waiting target compliance levels for triage and treatment in the urgent and emergency for all patients and they should consider replacing old or missing equipment in the urgent and emergency department.

Is the service safe?

Requires improvement 

Our rating of safe remained the same, we rated it as requires improvement because:

The service provided mandatory training in key skills but completion levels for staff in the department were low.

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.

The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff did not keep detailed records of patients' care and treatment**.**

Urgent and emergency services

Is the service responsive?

Good 

Our rating of response remained the same. We rated it as good because:

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line or better than national standards.

Is the service well-led?

Requires improvement 

Our rating of well-led went down one, we rated it as requires improvement because:

Leaders and teams did not always manage performance effectively. They did not always identify and escalated relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events.

Systems for sharing of information with external bodies were not always effective. Senior leaders in the department demonstrated they had a limited understanding of performance across the department

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service provided mandatory training in key skills but completion levels for staff in the department were low.

During our previous inspection in March 2019 we told the provider they must improve their mandatory training compliance rates.

Staff received mandatory training in; conflict resolution; fire safety; annual fire local arrangements; equality, diversity and human rights; information governance and data security; health, safety and welfare; load handling; patient handling; IPC; safeguarding children and adults and prevent. The mandatory training topics were based on the core skills training framework that the trust had adopted in January 2020.

During this inspection we found that not all staff working in the department kept up to date with mandatory training. The trust set a mandatory training target of 95%.

Across all of the courses nursing staff had an average completion rate of 68% and nursing support staff had an average completion rate of 65%. The mandatory training target was only met by nursing support staff on the prevent level 3 course.

Career grade doctors had an average completion rate of 61%, consultants had an average completion rate of 68% and training grade doctors had an average completion rate of 42% for August 2020 across all of the mandatory training topics.

Managers monitored mandatory training and alerted staff when they needed to update their training. During the inspection staff told us that completion rates of mandatory training had dropped due to the pandemic. We were also told that all of the mandatory training modules had been converted to online courses to aid staff in accessing these courses.

The trust had recently appointed two new practice development nurses for the department. Part of their role was to ensure that staff in the department had completed their mandatory training.

All medical staff working in the department had up to date Advanced Life Support (ALS) and European Paediatric Advanced Life Support (EPALS) training apart from two who were booked onto these courses.

All nurses had ALS training apart from one who was booked to attend training in November 2020. All eligible nurses had completed their European Paediatric Advanced Life Support training.

Between March to August 2020 there were 12% of day shifts without a member of staff with EPALS training and 8% of night shifts. The trust reviewed all incidents submitted on shifts where there was no EPALS cover. There was a total of one sub-optimal staffing incident submitted but this has been reviewed this did not caused any patient harm. Following the inspection we raised this as an area of concern to the trust. They told us that all junior doctors and specialist registrars had completed EPALS and APLS so suitably trained staff were available. They also reviewed shifts from the 28 March to 26 August 2020 and found that there was always a doctor or advanced care practitioner on shift where the paediatric nurse did not have the qualifications.

The trust did not have formal sepsis training for substantive medical or nursing staff. All rotational junior doctors who worked in the emergency department had sepsis training as part of their induction. Half of the paediatric nursing team received sepsis training as part of their annual clinical update and the remaining half were booked onto training within October and November 2020. Following the inspection, we raised sepsis management with the trust as an area of concern and the trust told us they were formulating a plan for sepsis training in the department, however we were not provided with a completion date for this.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it, although training rates were not always met. The trust had plans in place to improve completion of safeguarding level 3 training.

Staff received training specific for their role on how to recognise and report abuse. The trust set a target of 95% for completion of safeguarding training. During the last inspection in March 2019 we told the provider it must improve its safeguarding training completion rates.

The current completion rates for nursing staff were:

- safeguarding children level 2- 94%
- safeguarding children level 3- 59%
- safeguarding adults level 3- 50%
- prevent level 3- 75% .

The completion rates for medical staff were:

- safeguarding children level 3- 51%
- safeguarding adults level 3- 37%
- prevent level 3- 55%.

The completion rates for nursing support staff were:

- safeguarding children level 2- 77%,
- safeguarding adults level 1- 100%,
- safeguarding adults level 2- 83%,
- prevent level 1 and 2- 83%
- prevent level 3- 100%.

During the last inspection in March 2019 we told the provider it must improve its safeguarding training completion rates. Following the inspection we raised the lack of staff who had received safeguarding training as an area of concern. The trust provided us with assurance that all staff requiring level three training would be booked onto the next available courses by November 2020.

The safeguarding team had strengthened their presence within the department since our last inspection. The team did daily walk arounds where staff could ask questions or for advice. The team had also delivered a number of different smaller training sessions in the department over the summer for different safeguarding topics to refresh staffs understanding. This was structured training with different topics delivered over a six-week period, this included topics such as child sexual exploitation and county lines training. Staff reported that this was useful and helped them to be conscious of safeguarding concerns.

The department had a lead consultant and lead nurse for safeguarding within the department, this was in line with the royal college of paediatrics and child health (RCPCH) Standards for children in emergency care settings standard 28.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were supported by a trust wide children's and adults safeguarding policy this was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 29. The safeguarding team had recently reviewed the safeguarding procedures and flow charts to make them easier for staff to understand. During the inspection we saw these displayed in the department and staff told us that they helped to strengthen the process and to make it clearer. At the time of our inspection the team were in the process of reviewing and updating the safeguarding adults policy. Staff within the department reported they were confident to report safeguarding concerns. Staff within the department were aware that when treating adults, they assessed the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents. Staff were also aware of arrangements in place to support women or children with, or at risk of Female Genital Mutilation (FGM).

The safeguarding team within the hospital had introduced safeguarding supervision. This was an hour long session that everyone within the department was required to attend at least once every six months. This was introduced to upskill staff and to give them more confidence. Staff were able to go and discuss recent cases.

The department had a pathway for staff to follow to assess the risk of physical abuse in children presenting with an injury. This had recently been strengthened and staff we spoke with were aware of the process to follow.

The department had access to the Child Protection Information Sharing System in place, this system was searched for every child who presented to the department to see if there was any information staff needed to be aware of. This was in was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 36.

Urgent and emergency services

All staff in the emergency department had access to safeguarding advice 24 hours a day from a paediatrician with safeguarding expertise. Staff within the department also had access 24 hours a day to a paediatric sexual assault service if they needed to make a referral or for advice. This was in was in line with the royal college of paediatrics and child health (RCPCH)standards for children in emergency care settings standard 30.

The trust had systems in place to identify children and young people who attended frequently. If a child or young person had attended more than three times in the previous year then they would be reviewed by the paediatric liaison nurse. When children visited the department their last three admissions were printed onto their records by reception staff so that staff reviewing the children could see their recent history. The trust also shared information with other trusts to help protect children who may visit multiple local hospitals. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 32.

Staff told us the primary care team, including GP and health visitor/school nurse and named social worker, were informed of each attendance. This would be completed by the paediatric liaison nurse. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 33.

The department had a standard operating procedure for when a paediatric patient either left or absconded from a department unexpectedly prior to discharge or when they did not attend for planned follow up. This included advice for staff on what to do in such event and contained contact numbers of the local safeguarding team if required. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 37.

If a child left the department unexpectedly prior to discharge then a safeguarding referral would automatically be made. This would be reviewed by the paediatric liaison nurse who would notify the relevant parties.

Staff told us that children identified as being high risk of potential safeguarding concerns were reviewed by a senior (ST4+) paediatrician or paediatric emergency medicine consultant. They would be referred to the paediatric unit in order for this to take place. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 38.

At the beginning of September 92% of staff working in the emergency department had an up to date DBS recorded.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The urgent and emergency care department was visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed ward cleaning taking place and saw standard operating procedures about cleaning were available. ‘I am Clean’ stickers were used to indicate when equipment was ready for re-use. During the inspection we looked at cleaning records which showed that staff signed to record daily checks and cleaning had been completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to plentiful supplies of PPE. During the inspection we observed staff wearing the correct PPE for the area that they were working in. We saw staff consistently discarded PPE such as gloves and aprons after each patient contact and wash their hands before putting on fresh disposable PPE.

Hand cleansing gel was available at points throughout the departments for use by staff, patients and relatives and staff were ‘bare below the elbow’ to allow effective hand washing. We observed staff washing their hands between patients in line with the five moments of hand hygiene. Sinks were equipped with liquid soap, paper towels and a pedal bin to reduce cross infection. Hand gel and masks were available for patients in the entrance to the department in line with current government guidelines.

Urgent and emergency services

Patients were identified at streaming if they had a potential COVID-19 infection. There were two pathways through the urgent and emergency department dependent on their risk level (discussed further in environment and equipment). This helped to minimise the risk to patients of contracting COVID-19 within the department.

The service generally performed well for cleanliness. The department completed monthly infection prevention control audits. This looked at the environment, sharps, PPE, equipment, linen, waste and hand hygiene. Scores for the three months prior to our inspection were; July 89%, August 74%, September 87%.

The trust had an external audit completed in relation to their infection control measures around COVID-19 on 18 September 2020. This found the department to be compliant with national standards and did not require any follow up actions from the trust.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The adult and children's emergency departments were located together, ensuring equal access to all services, but were separated from each other. Patients self-presenting booked themselves in at reception. They were streamed by a nurse from the urgent treatment centre which was not run by the trust but was co-located. At this point patients would either be streamed to the paediatric waiting area, or the COVID-19 waiting area or non-COVID-19 waiting area. The paediatric waiting area was split from the main waiting area by a glass wall, this obscured some of the view of the main waiting area but both waiting areas were visible to each other. In the main department waiting area there were screens to separate the potential COVID-19 patients from the non-COVID-19 patients.

The department had been split into two separate streams for patients, those with potential or confirmed COVID-19 and those without any COVID-19 concerns. For the COVID-19 stream there was an ambulance triage room, a four bedded resus area which included a dedicated paediatric bed, eight cubicles for the treatment of patients. For the non- COVID-19 stream there were two triage rooms. A resuscitation area with two beds, one which could be used for paediatrics. Five high dependency beds and seven cubicles. There was also an ambulance triage area for up to six trolleys. In the paediatric department there was a triage room, one treatment room for non- COVID-19 /non-infectious children and a separate treatment and triage room for potential COVID-19 /infectious patients.

The paediatric area was small for the number of children they saw. Staff reported how they mitigated the risk by quickly triaging patients to the paediatric wards where required. They also reported how medical staff would review patients quickly in the department to reduce the amount of time they spent in the department. The paediatric waiting room had information boards, secure entry, CCTV, a TV screen and hand sanitisers. There was also a board that introduced the staff to the patients.

Staff carried out daily safety checks of specialist equipment. Regularly checked and fully equipped adult resuscitation trolleys were available in the main resuscitation area and in the non-COVID-19 resuscitation area. A fully equipped resuscitation area with all sizes of equipment was available for children and checked regularly in the COVID-19 resuscitation area and in the paediatric department. However, during the inspection, we spoke to staff in the non-COVID-19 resuscitation area who were not aware of where to find the paediatric resuscitation equipment for that area. We raised this as an area of concern with the trust during our inspection and they informed us they had spoken to staff and told them where the resuscitation equipment could be found. Sepsis trolleys were available throughout the department, this contained medicines and equipment needed to start treatment for sepsis to aid the quick treatment.

Staff carried out daily safety checks of specialist equipment. Staff working in the department reported that they had good access to equipment. During the COVID-19 outbreak the department was able to order new equipment such as heart rate monitors to ensure all bed spaces had access to one to reduce the risk of cross infection. Engineers were available to check and repair equipment where necessary. The checking of medical equipment was undertaken on a

daily basis and equipment we checked was serviced within date and marked clean for use. We checked equipment within the paediatric treatment area, this included an electrocardiogram (ECG) machine and a blood pressure monitoring machine which were both in date and due to be re-serviced in May 2021 and January 2021 respectively. The department had removed all toys from the waiting area to reduce the risk of cross-infection from COVID-19.

Staff disposed of clinical waste safely. There were effective systems and processes in place for the segregation and management of clinical and non-clinical waste. Sharps bins were readily available for staff to use.

The trust had a quiet room in the emergency department where patients could wait to have mental health assessments. It met national best practice in relation to the design and features of mental health assessment rooms: seating was sturdy and could seat four people, there was an alarm on the wall for staff to use in an emergency, there were no ligature points and two doors. The trust did not have a risk assessment for the use of the quiet room in ED. At the time of our inspection the trust was in the process of developing a psychiatric decision unit, which was going to be a room in the neighbouring urgent care centre where patients aged 16 plus could wait for a mental health assessment to be completed, this would be staffed by the trusts staff.

The trust had a ligature risk assessment for the department which identified risks in the department and how staff should manage those risks, for example, by not having high risk patients in certain cubicles.

Future building plans had been signed off and work was due to commence on a large new building to house the existing emergency department. The plans showed a large increase in floor space, an improved layout for all the areas, together with larger and wider corridors, more storage and dedicated rooms for those with additional needs. It was planned that the building work would be completed by August 2022.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, documentation of sepsis screening/management was not robust and required further scrutiny to ensure the safety of patients.

Systems were in place for assessing all patients arriving in the emergency department to determine how quickly they should be reviewed. This included a clear streaming/triage process including a separate triage protocol for paediatric patients. Streaming criteria were in place for staff to determine which patients could be signposted to the co-located primary care centre. The department had a flagging system that could be used by the streaming nurse to prioritise certain patients who required a prioritised triage, this included chest pains and patients with learning disabilities whose conditions may deteriorate if they were left in the waiting area. Staff told us that whilst this may mean that certain patients had to wait longer than the target of 15 minutes for triage it helped ensure that patients were kept safe.

Experienced nurses were on duty on each shift to triage patients who self-presented in the department. Reception staff were able to quickly alert the triage nurses on duty if a patient deteriorated. Children were triaged by either a children's nurse or a nurse who had received additional training in emergency care of the sick child.

The department had an escalation policy for when the triage time exceeded 15 minutes. This included routes for escalation and what staff should do to keep the children in the department safe. During the inspection we spoke with staff who were aware of this policy and what they would need to do if the triage time exceeded 15 minutes. This was in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings standard 18.

The trust conducted audits into triage times. The last paediatric audit was completed in June 2020 and looked at 10 patient records. This showed 72% were triaged within 15 minutes, 68% had a pain score completed, 88% had safeguarding risks assessed, 72% had their first set of observations within 15 minutes, 74% had PEWS completed and 96% were discharged within four hours.

Urgent and emergency services

A live electronic feed from the local ambulance trust informed the emergency department on the arrival times of ambulances due into the department. If a seriously ill patient was being transported to the hospital they were advised prior to their arrival and could prepare in a timely way. Patients brought in by ambulance were handed over to hospital staff either in resuscitation or one of the two ambulance handover areas dependent on COVID-19 risk and how sick they were.

The trust had improved its performance on the percentage of ambulance journeys with a turnaround time of over 30 minutes. This had gone from an average of 7% January to March 2020 to an average of 1% for June to August 2020.

The NHS deems ambulance handovers delayed by more than 60 minutes as unacceptable breaches. The trust had dramatically reduced the number of breaches from 28 in January 2020, 14 in February and 30 in March to one in June, zero in July and five in August.

In the paediatric emergency department nurses in charge were either paediatric trained or adult nurses who had undertaken in-house additional training to care for children.

National Early Warning Scores (NEWS) and Paediatric Early Warning Scores (PEWS) were used throughout the emergency department to assess the deteriorating patient, particularly with regard to sepsis. NEWS uses six physiological measurements: respiratory rate; oxygen saturation; temperature; systolic blood pressure; heart rate and level of consciousness. Each scores 0–3 and individual scores are added together for an overall score. An additional two points are added if the patient is receiving oxygen therapy. The total possible score ranges from 0 to 20. The higher the score the greater the clinical risk. Higher scores indicate the need for escalation, medical review and possible clinical intervention and more intensive monitoring. PEWS scores also use six core parameters they are; respiratory rate and effort, oxygen requirements, heart rate, level of consciousness and clinician/family concern. The trust had a PEWS policy and an adult deteriorating patient escalation policy. During the inspection we looked at 11 sets of patient records, three of the adult patient records had either no NEWS completed, or no NEWS calculated.

The trust conducted monthly PEWS audits, this looked into whether the correct charts had been used, if observations had been completed and scored correctly and if required had repeated observations been completed. These audits had stopped during the peak of COVID-19 but the department had scored 100% for June, July and August 2020.

We were concerned about the way sepsis was managed in the department. During the inspection we looked at four sets of paediatric records where sepsis screening should have taken place and the pathway followed, four of which showed that the sepsis pathway had not been followed. We also looked at four sets of adult records which did not have sepsis scores/bundles completed where this would have been appropriate. Following the inspection we also looked at incidents that the department had recorded for the previous year. There were 18 reported which related to sepsis. The main themes from these incidents were delays in treatment and escalation. Eleven of these were reported as being no harm, six low harm and one moderate harm in which the patient ended up in the intensive care unit following a 151 minute delay in receiving antibiotics.

The trust completed sepsis audits as part of their monthly audit schedule, for August 2020 they had a 95% compliance rate, June they had a 96% compliance rate and May an 84% compliance rate. The trust sent their last adult emergency department sepsis screening audit from April 2020. Patients who had COVID-19 were not included within the audit. There were 33 patients who were flagged as being appropriate for sepsis screening of these 31 were screened. Four who required antibiotics were not given them within one hour.

The trust had a sepsis 2018 to 2020 flowchart document that contained recognition and assessment, immediate management, antibiotics to give further investigations and discharge and follow up.

Urgent and emergency services

However, during the inspection all staff we spoke with were aware of the 'Sepsis Six' and the importance of recognising sepsis in patients admitted to the department. 'Sepsis Six' are immediate interventions that increase survival from sepsis. There is strong evidence the prompt delivery of basic aspects of care detailed in the Sepsis Six care bundle prevents much more extensive damage and has been associated with significant mortality reductions when applied within the first hour.

Following the inspection, we raised sepsis management to the trust as an area of serious concern. Following discussions with ourselves and an external support organisation the trust submitted an action plan on sepsis. This included having an additional nurse in the department for the next four weeks to oversee sepsis management, escalation channels for patients with queried sepsis, improved communication around sepsis and audits to be completed to see how sepsis had been managed.

Comprehensive processes were in place for staff to follow in the event of a sudden unexpected death of a baby or child in the department. There was a pack available in the resuscitation area which explained the process, key contact details, forms that were required and blood taking equipment.

The service had 24-hour access to mental health liaison and specialist mental health support. A liaison psychiatric team staffed by mental health trained nurses, from a neighbouring mental health trust, was available to the emergency department 24 hours a day to support patients admitted with mental health problems and the staff caring for them. Any children who required a mental health assessment were admitted to the paediatric ward where they would be assessed the same day by the child and adolescent mental health (CAMHS) team. For the assessment to take place the same day a referral needed to be made by 6pm or they would be assessed the next day. In the adult department the trust had a suicidal intent assessment screening tool, this was for staff to use to asses is patients had suicidal intentions and to guide them on making a referral to the mental health team.

During the inspection we reviewed a patient record where a patient with mental health needs who was sectioned under the Mental Health Act 1983 absconded from the department. The patient records did not show where the patient was or if they were safe. This was raised on day one of the inspection and following the inspection the trust informed us that the patient was receiving appropriate care. Without us raising this patient as a concern the trust would not have been aware of what happened to this patient. The trust did have a policy for patients who had absconded. This was for staff to follow once it had been identified that a patient had gone missing from a ward area, emergency department and other areas but did not include information on what to do if a patient was detained under the Mental Health Act 1983. The trust had a separate deprivation of liberty policy.

The trust had a policy for the management of children and young people presenting to an acute service as a result of self-harm or identified mental health behaviours. This included responsibilities of different areas in the hospital and what to do in certain situations (such as if a child absconded). If a child was assessed to be at risk of suicide or self-harm, then they would be treated in the emergency department until they were medically stable then they would be transferred to the paediatric unit whilst they awaited a mental health assessment. If a child in the paediatric emergency department required extra observation, then staff from the paediatric unit who had been trained in mental health and observations would support the child in the emergency department. Staff told us that children would never be restrained in the department.

The trust did not have any procedures or policies around safe rapid tranquilisation. This could mean that staff do not have a process to follow if rapid tranquilisation if used on a patient which could result in the patient not being kept safe.

CCTV was in use in the waiting areas and corridors of the department, this was monitored 24 hours a day by the security team. Staff told us that if they were required the security team were responsive.

The trust had a policy on COVID-19 management in the emergency department, this guided staff on triage, risk factors, investigations to do, treatments and discharge. During the inspection we saw that staff followed the policy and patients were streamed, triaged and treated dependent on their risk levels.

Urgent and emergency services

The trust had protocols in place to transfer children who required intensive care to a neighbouring hospital. From August 2019 to July 2020 there had been no incidences where a child had been transferred from the emergency department to an intensive care unit.

Prior to our inspection we received some information that staff had been using family members to translate in the department which is against best practice guidelines. During the inspection staff told us they had access to an over the phone translation service. We also saw signs in the department in local common different languages.

Nurse staffing

The service did not have enough nursing staff and support staff to keep patients safe from avoidable harm and to provide the right care and treatment.

During the inspection staff reported that their main concern/risk area for the department was shortages of staff. During the inspection whilst looking at records we saw records where shortages of staff resulted in patients being put at potential risk of harm. For example, on one patient record it was recorded that triage was late due to lack of resources. We also saw two incidents where different areas of the department had to shut due to a shortage of staff, this included the cold (non- COVID19) area being shut and patients having to use the hot (COVID-19) area and one where the rapid ambulance assessment area was shut meaning patients had to be triaged elsewhere in the department.

During a review of rotas, we found shortages in the shifts filled to be in the registered nursing shifts from 10:00-21:00 (mid-shift) and 14:00-00:00 (twilight shift). From the 13 July to 06 September 2020 there were 28 out of a total 167 mid-shifts that were not filled by registered nursing staff and 41 out of 202 twilight shifts not filled. From 07 September there appeared to be improvements in staffing in the department with ten registered nursing shifts not covered across all shift times.

The service had high vacancy rates. From April 2020 to July 2020 the department had an average vacancy rate of 15.5 whole time equivalent (WTE) for registered nursing staff.

The service had high turnover rates. From April 2020 to July 2020 the trust had an average turnover rate of 20% of their total workforce.

The service had average sickness rates. From June to August the emergency department had an average sickness rate of 4.5% for their qualified nursing workforce.

The service had high rates of bank and agency nurses. From April to August 2020, 40% of total requested hours were filled by agency staff. From April to August 2020 21% of shifts were not filled by either trust, bank or agency staffing. Managers in the department told us that they tried to get agency staff who had worked in the department before and so were aware of how the department was ran.

Royal College of Paediatrics and Child Health (RCPCH) standards state that every emergency department treating children must be staffed with two registered children's nurses. From March to August 2020 there were 43 shifts that did not have two registered children's nurses on shift. The trust also told us that there had not been any moderate harm incidents over the last six months in relation to not having two children's registered nurses on each shift. The trust mitigated the risk of not having two children's nurses by having one paediatric nurse and one nurse with paediatric competencies. From 16 June to the end of September the department had 17 shifts (8% of all shifts) where the department did not have one trained paediatric nurse and one nurse with paediatric competencies which could put children at risk of being treated by a nurse who was not competent or a delay in treatment.

From March to August 2020 there were 46 incidents reported by the emergency department about sub-optimal staffing, 32 of these were reported in August 2020. Following the inspection the trust told us that all staffing incidents had been reviewed following the increase in incidents in August 2020 and found no incidents that caused any level of patient harm

and no delay in time to treat due to suboptimal staffing. However, during the inspection we reviewed one patient record and saw their triage was delayed and this was documented in the records as being related to a shortage of staffing. We also reviewed the summary of the incidents reported and these described delays in treatment for patients and increased risk of cross infection, for example having two patients in one cubicle.

Following the inspection the trust told us they have put in extra support in the department. We were told that the divisional Director of Nursing and Matron were meeting with Band 7 nurses each week for one hour to discuss any support they may require and review the staffing. They also planned to visit the emergency department on a daily basis to support the band 7 nurse in charge. They also told us that they had clear escalations in regard to staffing in place this included; lead consultant and nurse in charge have safety huddles at start of each shift (am), midday review and a late shift review. Patients in the department are reviewed and issues with flow and staffing are highlighted with clear actions to take. The trust also identified that they were working to ensure that there were two paediatric nurses on every shift and that staff were aware of escalation when this was not the case. They told us they also planned to audit the rotas.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction .

The department aimed to have 20 medical staff working in the department in the week and 12 at the weekend. The trust reported an average fill rate for medical staffing from 01 April 2020 to 07 October 2020 overall as 104%. In this time period there were 24 shifts where there was one medical staff short and seven where there were two, other shifts were overstaffed reflecting the above 100 % fill rates overall. From the 10 August to 07 October there was only one shift that was missing one member of medical staff and this was due to sickness.

The service had high vacancy rates for medical staff. From April to July 2020 the emergency department had an average whole-time equivalent vacancy rate for medical staff of 18.

From June to August 2020 there was no medical staff sickness reported.

The service had high turnover rates for medical staff. From June to August 2020 the emergency department reported a 13.6% of the whole time equivalent staffing turnover rate.

The trust was unable to give us a percentage breakdown of the number of shifts filled by bank and agency medical staffing. However, they could tell us that in August 2020, 50% of required shifts were filled by either bank staff or agency staff.

The department was working to address sustainability amongst the medical workforce. They had a number of locum consultants who had joined the trust to gain experience to complete their training. The aim was that once they had completed their training, they would remain at the trust in a consultant position.

The department met the Royal College of Paediatrics and Child Health (RCPCH) standard of a dedicated paediatric emergency medicine consultant with session time allocated to paediatrics emergency department. The service had a part time consultant who had set hours spent in the department and was exploring ways that this could be increased.

Records

Staff did not keep detailed records of patients' care and treatment.

During our inspection we found some gaps in patient records. For four paediatric patients out of the 11 records we looked at showed that the sepsis pathway was not followed correctly. Out of the 11 adult patient records we looked at;

three patients either had no national early warning score (NEWS) completed or no NEWS calculated; three patients did not have sepsis scores/bundles completed where this would have been appropriate; two patients did not have falls paperwork completed; two patients did not have venous thromboembolism (VTE) assessments completed; one patient had no observations recorded and one patient did not have a pressure ulcer assessment completed.

The trust conducted their own internal documentation audits. For the adult department they scored 72% in May, 88% in June and 96% in August 2020. For the paediatric area they scored 90% in June, 96% in July and 94% in August 2020.

During the feedback session to the trust they told us that they were aware of the gaps in the records and had action plans to address this. Following the inspection we requested these action plans. The main action in these action plans was the implementation of the electronic patient record system. The trust also had plans as part of the action plan to complete record audits to ensure they were an acceptable standard.

The trust was due to introduce an electronic patient record in the month following our inspection. Staff were optimistic that this would lead to improvements in the quality and completeness of the patient records.

When patients transferred to a new team, there were no delays in staff accessing their records. When patients were admitted to a ward or handed over to another care provider, staff undertaking and receiving the handover were required by the trust to complete a handover section found on the department's paper record for the patient. This included the patient's diagnosis, treatment plan, any safeguarding concerns and outstanding treatments. This ensured patients were not put at risk on transfer because of lack of information.

If a child or adult had previously attended the department then their records would contain details of the patient's mental health, learning disability, autism or dementia care needs alongside their physical health needs.

Discharge summaries were sent to the child's GP and other relevant healthcare professionals usually within a week of their attendance to the emergency department. This is not in line with the royal college of paediatrics and child health (RCPCH) standards for children in emergency care settings 25 which states that discharge summaries should be send within 24 hours of their attendance.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

During the inspection staff told us that the management of controlled drugs within the emergency department had the worst performance in the hospital demonstrated by its internal audit results. There had been an incident in the department where a controlled drug went missing, despite there being an internal investigation it was not established what happened. Since June 2020 there has been a pharmacist into the emergency department full time to help improve the performance within the department. The pharmacist had conducted a review of controlled drugs management, this review showed that performance had improved since the introduction of the pharmacist into the department.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. During the inspection we were told that the medicine cabinet (an electronic lockable storage unit) that was previously used to store medications had broken in August 2020 and there had been a business case for a replacement had been submitted and it was expected they would have the new machine by January 2020. The medicines were still being stored in the medi365 but the machine was unlocked, the room the medicines were in was locked and only accessible to authorised staff.

In the resuscitation trolleys we saw appropriate emergency medicines were available. There were also appropriate medicines for the treatment of sepsis contained within the sepsis trolleys.

The trust had guidelines for staff to follow for the withdrawal of alcohol, they had plans to create guidelines for the withdrawal of illegal substances.

Urgent and emergency services

The department had 53 medication incidents in the last 12 months. This was six near misses, 39 no harm, seven low harm and one moderate harm. The moderate harm incident related to a patient who had diabetes and when they were admitted the ward were unable to find any documentation of blood glucose or ketones on any of the patient records.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Incidents were reported using the trusts online incident reporting system. Staff we spoke with were aware of how to report incidents and felt confident to do so. Incidents that occurred in the department were investigated by senior nursing staff and were all reviewed by the clinical director.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents and safety learning were discussed at regular weekly safety huddles. These huddles were well attended by all grades of staff, and a register was taken so that management could ascertain who had attended. During the inspection we attended one of these meetings where new incidents were discussed, and actions were chased on previously discussed incidents. There were examples where clear learning processes had been influenced and implemented following these meetings. Staff told us that incidents and learning were also discussed during handover meetings.

The trust also had monthly morbidity and mortality meetings which were attended by staff at division level. These were cancelled due to COVID-19 but recommenced in August 2020. The trust did not provide us with minutes from these. During the pandemic morbidity and mortality meetings were held at trust level but there were not any cases discussed from the emergency department at these sessions. Staff told us the learning from these meetings was shared by emails to staff who did not attend.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Following the inspection we reviewed an incident investigation. The investigations looked at root causes, any contributing factors, staff involvement and support, lessons to be learnt, examples of good practice, unrelated practice issues and action plans. They also demonstrated that duty of candour had been undertaken, through verbal telephone conversations followed up by letters.

During the inspection we were told about an incident that involved some controlled drugs going missing from the emergency department. The investigation into this incident found that incident reporting processes had not been followed fully, processes to ratify policies had not been followed so there was confusion around the policy in use at the time, confusion on staffing rotas not identifying staff members fully and poor record keeping. The trust identified an action plan which included target dates and owners for the actions, and this included keeping a pharmacist in the department to oversee medicines management until March 2021.

During the inspection there was an incident where there was a potential outbreak of COVID-19 amongst some of the reception staff in the emergency department. We saw how the trust managed this incident by stopping all non-essential visitors to the department and undertaking extra cleaning. The trust also held incident meetings where the outbreak was discussed as well as any actions that needed to take place. Following the inspection, it was highlighted that outbreaks had affected staff in three separate areas; the emergency department, therapies and the breast screening department. The trust also reported this as a serious incident internally and were conducting an investigation.

Never Events

The service had no never events in the department.

Urgent and emergency services

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From September 2019 to August 2020 there were no never events reported for urgent and emergency care.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incident (SI) in urgent and emergency care which met the reporting criteria set by NHS England from September 2019 to August 2020. The serious incidents were categorised as a fall with harm and a missed diagnosis.

The trust also reported all clinical incidents. From September 2019 to September 2020 there were 702 clinical incidents reported. 69 of these were near misses, 406 no harm, 198 low harm, 21 moderate harm, three were severe and five related to deaths. In the six months prior to our inspection there had been one child death, this was investigated, and an action plan compiled.

Safety thermometer

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety Thermometer Data has not been submitted over the last three months. This is because all data collection for the classic safety thermometer ceased in March 2020. The trust had not collected any safety thermometer equivalent data in the previous six months to our inspection due to the pandemic

Is the service responsive?

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line or better than national standards.

The trust had worked to improve the accessibility and flow of the department during the pandemic. The trust were performing better than the England average for all but one of the measures we looked at.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. Patients at the trust waited on average six minutes from arrival to treatment for June 2020, less than the England average of seven minutes. *(Source: NHS Digital - A&E quality indicators)*

Managers and staff worked to make sure patients did not stay longer than they needed to. The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. The trust had worked hard to improve its performance on this measure and had increased the percentage of patients admitted under the four hour wait target from 55% in January and February 2020 to 86% in Jun and 91% in July 2020.

Urgent and emergency services

The departments median total time in the emergency department for admitted patients was 175 minutes, less than the England average of 214 minutes. The median total time in the emergency department for non-admitted patients was 114 minutes, less than the England average of 124 minutes, for June 2020.

The only measure that was worse than the England average was the median time between arrival time and time to be seen for treatment which was 50 minutes compared to England average of 40 minutes in June 2020.

The trust had worked to reduce the percentage of patients waiting in the department for more than six hours. This had gone from 15% in January 2020 to 4% in June, 2% in July and 4% in August.

The trust had also improved its performance on the percentage of admissions from the emergency department waiting 4-12 hours from decision to admit to admission. This had gone from 10% in February and March 2020 to less than 1% in July and 2% in August.

The number of patients leaving the service before being seen for treatments was low. In June 2020 2% of patients left the department without being seen, which was equal to the England average. Unplanned reattendances to the department within seven days was 8% at Walsall compared to the England average of 9%, in June 2020.

During the inspection we reviewed an incident where, due to a shortage of staff the ambulatory assessment area was closed. This resulted in patients being cared for in the corridor, also known as boarding. Following the inspection we asked the trust for their policy on this to see how patients would be managed safely in this area and they responded to say that boarding does not happen within the hospital.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The department was overseen by a clinical director and matron. At the time of our inspection there was an acting matron due to the previous matron leaving. Every member of staff we spoke with felt senior managers, including doctors, were approachable and felt well supported in their roles. Staff were supported to attend leadership courses to develop if they were new in leadership roles.

Within the trust the different departments and wards were split into divisions, the emergency department fell under the medical care division. This enabled a flow of information easily between the division due to the joint meetings that took place.

The trust had recently appointed a mental health lead nurse within the department, at the time of our inspection they had not yet started their new role.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Urgent and emergency services

The trusts vision is: caring for Walsall together. The trust aimed for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations. During the inspection senior staff we spoke with told us about how they worked in partnership with others and how they planned to strengthen this going forward. For example, the trusts safeguarding team had done a lot of work with the local authority to improve how they work together with the aim to improve patient safety.

The trust was also part of the Walsall Together programme that brought multi-disciplinary services such as mental health, social care and GP services together with the emergency department. This aimed to improve working relations and to provide a better service for those in the Walsall area.

The trusts values were; respect, compassion, professionalism and teamwork. These were displayed around the trust on displays for staff and visitors to see. During the inspection we saw staff display these values and staff spoke frequently about how well staff in the department worked as a team.

The trust was due to commence work on the new building to house a larger emergency department. This designed to meet the increasing demands on the department, ensure the environment was suitable for all and to increase productivity in the department. The trust held monthly meetings to discuss progress with key stakeholders. It was hoped that this new department would be finished by August 2022. To bridge the gap between the new building being completed and the current lack of space in the department the trust had funding approved for three temporary portacabins to increase the capacity of different areas within the department, for example the waiting area.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service generally had an open culture where patients, their families and staff could raise concerns without fear.

There was a strong and palpable culture of teamwork within the emergency department and providing good quality care for patients. Staff we spoke with told us the team working in the department had been essential in supporting them through the recent pandemic.

We observed staff working well together and helping each other in an open, friendly but professional manner. Different disciplines worked alongside each other and showed respect for each other's opinions. Staff told us that everyone across the hospital worked together to enable them to provide a better service to patients.

If staff failed to perform in their job role, processes were in place to support them although staff were placed on performance management if this was necessary.

However, an incident investigation into missing controlled drugs found concerns around culture within the department. The report contributed an element of poor management of controlled drugs to the culture within emergency department around clinical challenge. This subsequently left staff unsupported during their practice to facilitate a safe environment.

Staff we spoke with told us that they were able and encouraged to report incidents. However one staff member raised that they felt that others might not be confident to report incidents due to comments from more senior staff in the department.

There were innovative approaches to help ease staffing issues, since the last inspection the department had employed four paramedics to help with the initial triage and treatment of patients. Advanced care practitioners and training nurse associates were also embedded in the department with staff reporting how well the variety in the team worked.

Staff reported that they were happy to raise concerns and were aware of the trusts freedom to speak up guardian.

There were appropriate arrangements to keep staff and others safe. There were CCTV cameras in the department which was monitored 24 hours a day by the security team. If there was an incident then staff told us the security team were responsive and would visit the department.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were regular governance meetings in both the trust and the emergency department. For example, each day there were departmental huddles daily which covered different topics. There were weekly divisional safety huddle meetings. These discussed complaints, incidents, duty of candour and serious incidents. There were separate weekly divisional serious incident meetings that discussed investigations, inquests and learning. There were monthly adult and paediatric working group committees to discuss changes to policies and procedures. There was also a weekly department meeting to discuss incidents and an email was sent to all staff highlighting any themes/ concerns with the incidents each week.

The trust held monthly governance meetings with partners involved in the rapid response team. Meetings covered a variety of topics such as performance, referrals to the team, how long the team see the referrals, caseloads, risks, educational needs, new pathways, nominations for awards, operational needs of the team, infection control updates.

Individual staff we spoke with were aware of their role and responsibility, what they were accountable for and to whom.

The sepsis lead was the departments clinical director, they were supported by a team of sepsis leads who worked in the department and linked in with other sepsis leads across the hospital.

Managing risks, issues and performance

Leaders and teams did not always manage performance effectively. They did not always identify and escalated relevant risks and issues and identify actions to reduce their impact. However, they had plans to cope with unexpected events.

The trust did not always have effective performance processes in place and this had been evidenced throughout the COVID-19 pandemic. Through this period the department had paused a lot of its routine governance activities, such as audits. This meant that the senior leaders within the trust did not have a full oversight of performance within the department and therefore the safety of patients. When we raised the issues with the trust following our inspection leaders within the trust were initially unable to provide us with any assurance of how they would ensure patients were kept safe.

The department and trust did not effectively manage risks within the emergency department. Risks we found during the inspection were not always identified by staff working in the trust. When risks were identified by the trust there were gaps in the actions taken by the trust to improve performance and patient safety. For example we found that patient record completion was poor during the inspection. When we fed this back to the trust they told us that they had plans in place to improve this but when we requested these plans the main action was the implementation of a new system not how staff completion of the records would be improved.

The department had a risk register. It contained 16 risks. Nine of the risks or their associated action plans were highlighted as requiring a review. The risks with the highest ratings were; insufficient floor size of the department; failure to complete clinical documentation; ability of the paediatric service to meet the professional standards set and the lack of ability to ensure social distancing in the waiting area. The risk register contained information on the risk, controls, assurance and action plans with action owners listed. This risk register fed into the emergency department care group risk register. This risk register contained 13 risks, risks with the highest risk ratings contained on this risk register included; failure to meet national targets, inadequate data completeness, nurse staffing, reliance on locum doctors and insufficient space. This risk register was discussed at monthly care group performance meetings.

Urgent and emergency services

Arrangements were in place to respond to emergencies and major incidents. Comprehensive major incident and business continuity plans had been made detailing actions to be taken by different grades of staff.

The service participated in a number of audits in relation to mental health. These included, the number of patients presenting with a mental health concern, whether risk assessments of suicide had been completed and whether there were any safeguarding concerns. The service also contributed data to a number of national clinical audits which had sections for mental health data.

The trust conducted yearly nursing and medical appraisals. The completion rate for nursing staff at the time of our inspection was 44%, the department had a plan to complete appraisals by November 2020 for nursing staff. Medical staff had a completion rate of 97%.

Managing information

Systems for sharing of information with external bodies were not always effective. Senior leaders in the department demonstrated they had a limited understanding of performance across the department. The information systems were integrated and secure.

Systems for sharing of information with external bodies were not always effective. We conducted this inspection as we were unable to get assurance from the trust about some concerns that had been shared with the CQC. During the inspection the trust were slow to respond to our requests for information following our inspection visit, we requested information from the trust numerous times and had to use our powers as set out in Section 64 of the Health and Social Care Act 2008. Section 64 gives the Care Quality Commission the legal power to require certain persons to provide it with information, documents, records (including personal and medical records) or other items that the Commission considers it necessary or expedient to have for the purposes of its regulatory functions. Following the final request for information the trust shared that they recognised that they needed to ensure their data and evidence was as live and visible as possible. The trust acknowledged that data quality was a concern for them. They had two new developments to support improvements going forward; the electronic patient record system and an electronic audit tool.

Senior leaders in the department demonstrated they had a limited understanding of performance across the department. Following the inspection we requested audits form the trust, we were told these had stopped due to the COVID-19 pandemic and therefore staff had limited knowledge of performance during this period. Following our conversations with the trust they told us they planned to improve the oversight of key quality metrics by conducting a review of all key quality metrics across the organisation to identify any gaps.

Staff had access to information they needed to carry out their roles effectively, with policies and procedures available on the trust's intranet. The department used both paper and electronic records for reviewing and documenting patient care. The trust had plans to introduce an electronic patient record system in the month following our inspection. This had been communicated with staff who were excited for the new system to begin.

During our inspection we did not see any occasion when patient records with confidential information were left unattended. Patient records were kept securely at all times.

The trust used an electronic incident reporting system. During the inspection we reviewed incidents using this system, we saw an incident that had been reported that was in relation to conduct of a member of staff. This was not an appropriate incident to have on the system to protect the confidentiality of this member of staff. We raised this with the trust during our inspection and they informed us that they had removed it off the incident reporting system and the matter was being managed through their human resources processes.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Urgent and emergency services

People who use services, those close to them and their representatives had been actively engaged and involved in decision-making for the planned new department. The trust had held focus groups to gather ideas and feedback on the new department.

Staff had also been actively engaged with the design of the new department and had attended focus groups to feed back their ideas. Staff we spoke with during the inspection spoke highly of their involvement in the new design.

The trust conducted the friends and family survey through text messages and over the phone. They had received 4,786 survey responses from September 2019 to August 2020 which included during the COVID-19 pandemic, giving an average positive score of 78.4%. Staff attitude, clinical treatment and waiting times were the top positive comment themes while staff attitude, waiting times and environment were most commented negative themes. Before the COVID-19 pandemic the trust had held weekly patient experience huddles, this involved the patient experience team playing sound bites of patient feedback to the staff in the department followed by discussions. Staff we spoke with during the inspection had said how invaluable this was to hear about the patients views first hand.

The department also had a "Star of the month" this was rewarded to a staff member for giving outstanding patient experience. Nominations were made by staff members and patient feedback was used for special mentions.

The trust had met with three patients and their families in the last 12 months following complaints.

The department held adult and paediatric steering group meetings. These were well attended by staff from the department and were used to formulate and review all standard operating procedures and policies. This gave staff the opportunity to be involved and to ensure they were relevant for the service.

Previously the department had monthly emergency department newsletters. This had stopped due to the COVID-19 outbreak and had not recommenced at the time of our inspection.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. The trusts focus for learning and continuous improvement lay with the new building plans.

The trusts main focus of continuous improvement and innovation lay with the new department plans and designs. Regular meetings were being held to discuss progress and to gain new ideas with a variety of stakeholders. The trust had also put plans in place to increase the capacity within the current department to help to make sure it could meet the current demand until the new build was ready.

The trust had started work on ensuring lessons were learnt across the organisation. The department was actively involved in the trust's improvement plan in which there was a 'lessons learnt' task and finish group. This commenced in August 2020 and aimed to ensure lessons from each division and care groups are shared across the organisation.

The department had also implemented regular huddles for learning. There was representation at the divisional governance sub group meeting where learning and improvement was shared. The department also met with the governance team weekly to discuss incidents. From this the clinical director of the department circulated an email to all staff highlighting any themes or areas of concerns.

The trust had also recruited to new roles; emergency care assistant practitioners and assistant care practitioners to supports rapid assessment. During the inspection we saw these roles were embedded within the department.

Areas for improvement

Action the provider must take to improve

Urgent and emergency services

The trust must ensure:

The provider must ensure they support staff to participate in mandatory training (regulation 18 (2)(a)).

The provider must ensure that staff are continued to be supported to complete their safeguarding training. (regulation 18(2)(a)).

The provider must ensure that risk assessments are completed for patients within the department, particularly in relation to sepsis management (regulation 12 (2)(b))

The provider must ensure they have processes in place to enable staff to safely care for patients detained under the mental health act (regulation 17 (2)(b)).

The provider must ensure they deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs (regulation 18(1).

The provider must ensure they maintain accurate, complete and contemporaneous records in respect of each service user (regulation 17 (2)(c))

The provider must ensure they evaluate and improve their practice in respect of processing information required by external bodies (regulation 17 (2)(a)).

Action the provider should take to improve

The trust should ensure:

The provider should ensure there are procedures and processes around restraint and rapid tranquilisation to make sure people are protected. (regulation 17 (2)(b)).

Maternity

Requires improvement 

Summary of this service

The service has 62 maternity beds across two sites:

The Manor Hospital has 49 maternity beds, these are located within two wards and a delivery suite.

There is a consultant led delivery suite with nine rooms plus an enhanced maternity care room and an obstetric theatre, a fetal assessment unit, a triage area, induction of labour suite, outpatient antenatal clinic, antenatal/postnatal ward and a community-based midwifery service.

Elective Caesarean sections are currently performed in the elective theatres in main theatres and a Delivery Suite Theatre was opened in January 2020. There is a four-bedded transitional care unit on one of the wards.

The Freestanding Midwifery Led Unit (MLU) has three maternity beds. This was closed during our inspection so wasn't visited however has since reopened. Some community outpatient clinics took place at the MLU.

This inspection was a focussed inspection of maternity services on 8 and 9 September 2020.

We spoke to 22 staff and reviewed four prescription charts and five patient records.

We last inspected maternity services at Walsall Healthcare NHS Trust in 19 March 2019.

We rated safe as requires improvement and effective, responsive, caring and well-led as good. The overall rating for the service was good.

A range of data was requested from the service as part of this inspection.

Is the service safe?

Requires improvement 

Our rating of safe remained the same. We rated it as requires improvement because:

The service mostly controlled infection risk well.

The service mostly had suitable premises and equipment and mostly looked after them well.

Is the service effective?

Good 

Our rating of effective remained the same. We rated it as good because:

The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines were up to date.

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Maternity

Is the service well-led?

Requires improvement 

Our rating of well led went down one, we rated it as requires improvement because:

The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Detailed findings from this inspection

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made all staff completed it.

The service dashboard identified a target of 90% for completion of mandatory training.

As of August 2020, overall compliance with midwifery mandatory training was 94% with 89% of staff having completed midwifery clinical update training.

Between February and July 2020 compliance in the ante natal clinic ranged from 81 to 87%. Community midwife compliance ranged from 85% to 87%, obstetrics and gynaecology consultant compliance ranged from 84% to 91% and obstetrics and gynaecology non consultant compliance ranged from 56% to 77%. Compliance on Ward 24 and 25 ranged from 75% to 85% and compliance on Ward 27 (delivery) ranged from 80% to 86%.

Maternity specific training covered infant feeding, perinatal mental health, ante-natal screening, K2 (Perinatal Training Programme) an interactive, online, e-learning tool, offering certification for fetal monitoring and maternity crisis management, GAP (Growth assessment Protocol) and smoking cessation. Staff accessed this training through an e learning platform.

Compliance with cardiotocography CTG training in maternity services was at 92% at the end of August 2020. This was against a trust target of compliance of 90%. cardiotocography (CTG) is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor (EFM)

However, the antenatal and fetal assessment unit compliance was at 78% and midwife led unit at 67% (although this unit was currently closed). No action plans were provided to us. Following our inspection, the trust told us that the midwife led unit related to one member of staff. The antenatal clinic also related to one member of staff. The compliance rates were negatively affected as these were small teams with one member of staff out of date in each area.

Staff had completed training on how to reduce preventable harm for mothers and their babies. As of the end of August 2020, compliance with PROMPT (Practical Obstetric Multi-Professional Training) in maternity services was 92% against a trust target of 90%.

Staff took part in skills and drills sessions to gain and maintain the relevant skills staff required to manage a range of obstetric emergencies such as new-born basic life support, breech delivery (a breech birth occurs when a baby is born bottom first instead of headfirst), shoulder dystocia (where the infant's shoulder is obstructing labour and manipulation is required)"),

Maternity

The service had a specialist continuing professional development midwife who was the lead for training and development. Their role was to support, maintain, improve and broaden staff member's knowledge and skills and develop the professional and personal qualities required in their professional lives

Staff completed their mandatory training through face-to-face sessions and online courses. Midwives and medical staff attended an update study day each year.

Managers had systems in place to monitor and address staff compliance with mandatory sent staff reminder emails in advance to inform them their training was expiring. Managers could take disciplinary action if required.

This meant staff received effective training in safety systems, processes and practices.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff were 83% compliant with level 3 safeguarding adults and children training. All staff we spoke with had the knowledge and skills to confidently deal with safeguarding issues.

Clinical staff were required to complete level 3 in adult safeguarding with non-clinical staff completing level 2 in adult safeguarding. This covered the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom, Prevent (level 3) and the Mental Capacity Act 2005 (MCA). The MCA is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. Managers told us all staff would be compliant by November 2020 at the latest. Prevent is about safeguarding people and communities from the threat of terrorism.

Effective arrangements were in place to safeguard women from a range of risks including female genital mutilation, diabetes and epilepsy. Effective systems were in place to address areas such as child protection, asylum seekers, travellers and migrants, safeguarding unborn babies and baby abductions.

Staff could access and receive advice and support regarding safeguarding issues. For example, staff said they could contact the service wide safeguarding leads for support.

Managers identified the service were not following national guidance in relation to Safeguarding Supervision 'Working together to Safeguard Children 2015'. As a result, community midwives were unable to receive quarterly supervision around their caseload to provide shared support and learning around complex cases. Due to staffing shortages and a reduced capacity for trained supervisors there has been a significant delay in completing supervision posing a risk to patients and staff.

Managers had put action plans in place to address this such as transferring the safeguarding lead midwife into the division to provide greater access and a quarterly report had been developed to monitor all safeguarding compliance.

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well.

Staff kept themselves, equipment and the premises clean. They did not always fully use control measures to prevent the spread of infection.

Although all the wards and areas we visited, were visibly clean, managers had identified issues with staff compliance with infection prevention control procedures (IPC) on the inpatient wards on the risk register. Managers had an action plan in place to address this area of risk.

For example, poor infection and prevention control standards were identified on the risk register for two areas within maternity. Audits were completed and results collated on a maternity dashboard. These showed full compliance with hand hygiene audits, 91% compliance with housekeeping audits and 86% (below expected level) for clinical audits for August 2020. Action plans had been developed to address areas of non-compliance. For example, local weekly and monthly audits were being undertaken to review the IPC standards.

Information provided by the trust identified a monthly review of infection control was undertaken and was assessed in June 2020 as clinical 84% and housekeeping 86%, July 2020 both clinical and housekeeping scored 80%, August 2020 clinical 91% and housekeeping 85%, this showed improvement on standards.

One risk register for a ward recorded a risk of infection from venous infusion phlebitis assessments (VIP) not being appropriately correctly being assessed, this was rated red and had been a risk since November 2018. Action plans were in place to address this area such as monitoring compliance monthly on the maternity metrics board VIP scoring to be undertaken three time daily for women and neonates with intravenous cannula in situ and review of compliance weekly, with monthly collation by the ward manager and matron. The trust did not provide us with these audit results. Peripheral venous catheter-associated phlebitis is caused by inflammation to the vein at a cannula access site. It can have a mechanical, chemical or infectious cause. Good practice when inserting a cannula, including appropriate choice of device and site, can help to prevent phlebitis.

Managers told us a CCG inspection in August 2020 showed full compliance and engagement of staff with IPC practices within the service.

Staff complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the sharps bins were dated and were not filled more than halfway.

The service adapted practices within the unit to protect patients and staff from the Covid-19 infection during the pandemic. The service enforced a two-metre social distance in the hospital and staff were asking women to attend appointments and scans alone. The sonography rooms were small and to maintain a safe social distance woman were required to attend alone. Partners were required to wait outside in the car park to ensure the antenatal clinic waiting room was also kept as clear and as safe as possible. The unit allowed one birthing partner during active labour. Staff continually monitored and reviewed these arrangements and would update our website and social media if anything changes.

Infection prevention control was audited monthly through the Midwifery Assurance System standards Tool. The tool allowed staff to self-assess whether they are meeting operational service delivery meets national standards, guidance and regulatory requirements.

We reviewed the audit results for ward 24, 25 and 27 for June, July and August 2020. In July 2020, ward 24 achieved full compliance and ward 25 achieved 91% compliance. Ward 27 achieved 84% which was below the expected standard. Areas covered included whether there was enough alcohol hand gel available at point of care and whether the 'I am clean' stickers had been appropriately used. Where staff had not fully complied with infection control standards managers immediately rectified the issue. For example, where the managers found a dirty bedpan, they cleaned it immediately.

Uniform audits looked at area such as 'are the staff bare below the elbow (no rings, bracelets etc) and 'are all staff wearing correct footwear?". Ward 24, 25 and 27 achieved full compliance for the month of June 2020. This supported what we observed.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Maternity

The midwifery-led unit (MLU) is a short-stay birthing centre which is a relaxed environment close to the hospital with midwives and clinical support workers always on shift. At the time of our inspection the MLU was closed for deliveries, however it has since fully reopened.

Resuscitation trolleys and defibrillators were accessible to all staff in line with Resuscitation (UK) guidance.

The environmental standards ensured that women were made as comfortable and relaxed as possible throughout labour. The delivery suite offered eight functional delivery rooms, and all facilities (other than the birthing pool) could be made available for use at the time of our inspection.

The environment and housekeeping audit for delivery suite between June and August 2020 identified between 84% and 85% overall compliance. The audit identified actions undertaken such as purchase of new waste bins and replacement of sealant around sink when mould was visible.

A room was also available for women who required enhanced care in relation to their pregnancy and birth. There were two emergency theatres with round the clock access and one planned elective theatre located in the main theatre suite providing for planned C-sections two days per week. This was increased as necessary depending on demand.

A range of birthing aids were available on the delivery suite including a birthing cube (complete with a foam mattress that allows freedom of positioning in labour), birthing pool, a specialised pole with slings/support to enable women support in labour and beanbags to aid positioning and comfort in labour

The service had systems for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste.

Maternity leaders ensured the environment was comfortable for women and visitors and staff. For example, a new, improved maternity triage waiting area for mums-to-be had been created at Walsall Manor Hospital. The previous triage waiting area was situated in a corridor by the entrance doors into maternity services and women had described it as “too hot, with no windows and nowhere to really sit properly”.

The new and improved environment provided a more comfortable area for women to wait for review and assessment. This also made it easier to ensure social distancing could be maintained during the pandemic too.

Maternity care facilities were designed in keeping with the DH guidance. For example, the obstetric theatre and neonatal unit were located closely to the delivery suite.

Housekeeping was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements.

We reviewed the audit results for ward 24, 25 and 27 for June, July and August 2020. Areas covered included ‘are all high and low surfaces are free from dust?’ and ‘are chairs are free from splashes, soil, film, dust fingerprints and spillages?’. For June 2020, Ward 24 and 25 achieved 90% compliance. Ward 27 achieved 86% which was below the expected standard. Managers immediately rectified areas of non-compliance. For example, when a small amount of mould around the sinks in two rooms, the job was promptly reported for completion, at the next audit this had been resolved.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff secured and check controlled drugs in line with current national guidance and legislation. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. For example, two registered midwives completed the required daily checks, and all medication was in date and matched the controlled drugs register on each ward. This was in line with the Misuse of Drugs legislation.

Managers monitored medicines monthly through the matron's audit, quarterly through the pharmacy audit. This was in addition to the routine pharmacy monitoring. Compliance was escalated through the maternity inpatient forum and Nursing and Midwifery Advisory Forum through monthly metrics. Compliance for July 2020 was 93%.

Information provided by the trust for the delivery suite identified between June and August 2020 medicines audits identified between 84% and 95% compliance. The compliance was monitored monthly. The matron completed an escalation sheet which included actions for non-compliance.

Medicines were generally stored securely. However, we found an intravenous fluid (IV) cupboard was left open. Staff immediately addressed this.

Staff recorded room temperatures and escalated room temperatures that were out of range. This was in line with their policy and guidelines.

Staff had systems in place to ensure they were alerted to patients with allergies. Patients wore red wristbands detailing any allergies.

The service promoted self-care for patients. Staff could offer patients lockers for safe storage of their medications.

Ward drug storage was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Areas audited included 'are all medicines stored securely and appropriately are drug cupboards locked?' and 'are fridge temperature checked daily for the last 7 days?'. Ward 24, 25 and 27 achieved full compliance in this area for June 2020.

The controlled drug audit looked at areas such 'are keys to CD cupboard held by a registered Midwife?' and 'are keys kept separate from other drug keys?'. Ward 24 achieved full compliance and ward 25 and 27 achieved 89% and 87% respectively. This was below the expected standard; no action plans were provided to us.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed five sets of patients records. Staff had accurately recorded the patient's choices and risk assessments and care plans were clear and up to date and signed and timed by staff.

Staff in the unit used an online portal and electronic application (app) that allowed women to access their maternity records over the internet through their PC, tablet device or mobile phone. The information that women viewed was generated in real-time from the hospital-based maternity system, using details entered by the midwife or other health professionals involved in their care. Benefits of this system included Information could be shared with women directly from the maternity system, records could be easily updated at each maternity visit or appointment, Midwives did not have to double enter data onto paper handheld notes and only those with the correct login details were able to access the notes.

Managers completed documentation audits monthly as part of the monthly metrics. Results were discussed with the deputy chief nurse. This was fed in through the nursing and midwifery advisory forum on a monthly basis. Amber and red areas were fed back to individual members of staff and fed back through Matrons assurance meetings. Information provided by the trust identified there was a monthly review called 'Maternity Assurance Standards Systems'. The assurance included the review of ten mothers and babies' records. August 2020 compliance was 95%. This was monitored on an ongoing monthly basis.

Documentation also formed part of the forward audit cycle which was undertaken annually. The overall result for this was 87% (August 2019 – October 2019). Managers produced action pans to address areas of non compliance. For example, amber and red areas were fed back to individual members of staff and fed back through matrons assurance meetings.

Whether staff stored patient case notes appropriately and not left on work surfaces/desks was audited monthly through the Midwifery Assurance System Standards Tool. The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Ward 24, 25 and 27 achieved full compliance in this area for June 2020. This supported what we found during our inspection.

Staff ensured patients received continuity of care in the community. Staff sent discharge and care plan information to GPs upon the patients discharge from the maternity services.

Assessing and Responding to patient risk

Staff completed and updated risk assessments for each patient.

They kept clear records and asked for support when necessary.

Staff had accurately recorded the patient's choices and risk assessments and care plans were clear and up to date and signed and timed by staff in all the five records we reviewed.

Staff had the knowledge and skills to assess and respond to patients with suspected or confirmed sepsis. The services' sepsis pathway was in line with current guidance. The service had a nationally recognised sepsis screening tool. Medical and midwifery staff conducted sepsis training during their annual training day and skills and drills training. However, the guidelines for bacterial sepsis in pregnancy and the puerperium had exceeded its review date on June 2020. Following our inspection the trust told us that all non-essential meetings were cancelled between April 2020 and June 2020 due to COVID-19. This included the guidelines group. Therefore, they did not have the opportunity to review the guidelines during this period of time.

Midwives took a holistic approach to their patients and acknowledged and addressed the physiological, psychological, sociological, developmental and cultural needs of the patient. Risk assessments at booking included a social and medical assessment and referral if needed as well as consideration for mental health needs.

Patients could seek advice and treatment immediately in an urgent or emergency. Midwives ran a triage unit and could make referrals to appropriate medical professionals and others if they detected deviations from the norm.

Staff ensured high risk antenatal patients received appropriate levels of care. An antenatal lead consultant and manager triaged referrals and referred patients to the appropriate pathways.

Staff had the opportunity to share key information in a systematic and safe way. Effective handovers took place. For example, midwives, consultants, junior doctors and clinical support workers attended the daily board round. Staff held summary discussions of the patient journey and what was required that day for it to progress using the SBAR technique. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that can be used to facilitate prompt and appropriate communication.

Staff identified and responded appropriately to changing risks to women in the unit. For example, staff were clear about the process of dealing with a patient whose condition had deteriorated. The procedure for escalation depended on the level of the problem but varied from seeking advice from managers or facilitating immediate admission to the acute department at the trust. Staff told us they could seek support from senior staff in these situations.

Maternity

Midwives and support workers monitored vital signs for new-borns and mothers as clinically required and took time-appropriate action to prevent avoidable deterioration in a patient. Staff used the Maternal Early Warning System (MEWS) with the aim to reduce maternal morbidity and mortality and improve clinical outcomes. Managers completed audits to check whether staff had complied with these requirements.

Compliance audits with MEWS for August 2019 to October 2019 was 100% completion, this was an annual audit. The audit showed that 70% reached the required standard and 30% were suboptimal, no action plan was provided. Audits confirmed that the MEWS was documented in the record of key data staff recorded during labour.

Managers reported that consideration would be given to adding these audits to the perfect ward audits. Perfect Ward is a smartphone application for healthcare audits and assists nursing teams to monitor the quality of care. The app aims to save staff 'admin' time to give more time to patients. It also enables access to real time information.

Staff involved in surgical procedures followed a surgical safety checklist (World Health Organisation (WHO) surgical safety ('Five Steps to Safer Surgery'). Managers reviewed 10 sets of notes in maternity theatres monthly identifying full compliance with the use of the WHO checklist. Between January and July 2020, audits showed full staff compliance with the WHO checklists, these were retrospective audits of patient notes.

However, on the risk register it was identified to historic never events, it was identified that instances of poor communication and inconsistent approaches to the NaTSSiP for swab and needle counts presented a potential for incidents of women with devices in situ on ward 27. The National Safety Standards for Invasive Procedures (NatSSIPs) aim to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur. Managers put action points in place. For example, managers were to undertake monthly spot checks in the compliance in the completion of the swab and needle checks tabs for all birth events. The aim was for staff to achieve 90% by September 2020 for all births.

Staff followed processes to assess and put the women who needed antenatal and postpartum thromboprophylaxis on the correct pathway of care. Thromboprophylaxis is a mechanical method used to treat venous thromboembolism (VTE). Venous thromboembolism (VTE) refers to a blood clot that starts in a vein. The maternity dashboard showed maternity triage compliance ranged from 97% to 98%, ward 24 showed full compliance in every month apart from July (94%), ward 25 showed 93% to 100% compliance and Ward 27 (delivery) showed 90 to 97% compliance. The national target was 95%

Safety huddles took place four times a day. These were short multidisciplinary briefings designed to give healthcare staff, clinical and non-clinical opportunities to understand what is going on with each patient and anticipate future risks to improve patient safety and care.

As part of the Midwifery Assurance System Standards Tool. Managers audited whether the Neonatal Reus had been checked daily for last 7 days and whether the Crash trolley had been checked daily for the previous months (yes 100%)

The tool allowed staff to self-assess whether their operational service delivery met national standards, guidance and regulatory requirements. Areas audited included

Staffing

The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

The maternity inpatient service had a significant shortfall in registered midwives to support the delivery of care. Managers identified staffing issues due to an increased rate of maternity leave (25.1%) and staff shielding due to COVID-19 procedures.

Maternity

We reviewed staffing levels for ward 24 and 25 from June to September 2020. The fill rates for registered midwives during the day ranged from 63% to 65% and for clinical support workers day fill rates ranged from 67% to 132%. The fill rate for registered midwives during the night shifts ranged from 73% to 103% and for clinical support workers from 59% to 100%.

There was a high level of maternity leave within the maternity team, currently totalling 25% of registered midwives across all inpatient areas. This included staff absence due to annual leave and time off for mandatory training.

Following our inspection the trust told us that the maternity service monitored staffing through a daily staffing huddle three times a day. The trust said high acuity may not result in the movement of staff but may result in a temporary pause of non-urgent activity. This was recorded on the acuity tool. Actions taken during these periods were recorded on the acuity notes and could be reviewed to evidence actions taken. For example, staff moved to support other areas, on-call staff called into the main maternity unit, any escalation to the manager on-call and delays in non-urgent procedures until it is was safe to proceed. However, these actions were not actively collated to gain an overview. The trust said they were looking at implementing a process so the unit could evidence the deployed staff in future.

The maternity unit Is planning to implement the acuity tool onto the postnatal area so that it can more directly support the acuity in that area.

Following the inspection, the trust told us that bed occupancy was a maximum of 62.90% during the period in question. The roster demand was not reduced when occupancy was reduced and so even if staffing were aligned to patient need there was still a reported reduced percentage fill rate.

Leaders showed an understanding of the impact of staffing levels and deployment practices and safety of care for mothers and babies. Managers identified the midwifery team having to undertake non-clinical duties due to an inability to provide 24/7 administrative support to the delivery suite as a risk on the risk register. The inability to provide twenty-four-hour ward clerk cover on delivery suite affected admissions, discharges, transfers, coding and fire safety as unaware at times of who is admitted through the electronic patient record system. Clinical Staff were required to undertake non-clinical duties in the absence of administrative support. This resulted in delays in uploading of admissions to the IT systems.

Following our inspection the trust told us there were currently 2.7 whole time equivalent (WTE) clerical staff for the ward and 3.85 WTE for delivery suite in post. The divisional directory of midwifery had recently reviewed the clerical model for the delivery suite. Using the existing budget the care group had generated round the clock cover for the delivery suite.

Additionally the care group was undertaking a ward clerk review. Following consultation with existing ward clerks the aim was to change the current provision of ward clerks and included the revision of working patterns to provide appropriate service provision.

Managers had put action plans and controls in place to address this risk. For example, a workforce and budget review was being undertaken.

It was recorded on the risk register that a shortage of sonographers could potentially lead to limited availability of scans that were required under the saving babies lives bundle. This meant there may have been an increase to the risk of not identifying babies who were small for gestational age. Following our inspection the trust told us they were mitigating this risk as the ANC met regularly with the scanning team to identify any gaps in relation to demand and put on additional lists through bank staff when required. A business case was being developed to support additional scanning capacity including midwifery sonographers

The national target to midwife to birth ratio was set nationally at 1:28. The trust achieved between 1:28 and 1:33 between February and August 2020.The trust did not meet the recommended midwife to birth ratio for six of the seven months between February and August 2020: March 2020 (1:31.9), April (1:32), May (1:29.6), June (1:33.4), July (1:32.7),

August (1:30.8). It was identified in the most recent board papers (October 2020) that "This indicator has reported red for some time. Staffing across maternity services were used flexibly to ensure women receive the expected level of support however there were ongoing staffing pressures caused by absence and vacancies. Following our inspection the trust told us staffing pressures were also impacted by high maternity leave and that the maternity unit had a live advert out to address this area of risk.

The new Birthrate+ review and recommendations have now been received by the trust and was to form part of the establishment review which is planned to be completed in September (2020)".Birthrate plus is a tool for midwives to assess their "real time" workload in the delivery suite arising from the numbers of women needing care, and their condition on admission and during the processes of labour and delivery

The percentage of episodes appropriately staffed on labour ward as per four-hour acuity tool, ranged from 74% to 94% between March and August 2020. The trust target was 85%, this was not met on three of the months audited. The percentages showed most were near to 85% although not always meeting the target.

Critically ill women were cared for during birth. There was always at least one enhanced maternal care midwife trained midwife on duty between February and July 2020.

Women classified as being at higher obstetric or fetal risk and who may require more specialist care and input during their labour and birth were appropriately cared for. The weekly number of hours of obstetric consultant cover on the labour ward was 114 hours in every month from February to August 2020. This exceeded the national target of 98 hours.

The weekly hours of anaesthetic consultant cover on the labour ward reached the national target of 50 hours in every month from February to August 2020. This helped to ensure women received pain relief and anaesthetic choices for their labour and birth and emergencies.

The percentage of women receiving one to one care in established labour ranged from 98% to 100% from February and August 2020. The national target was 100%. This reduced the likelihood of problems for her and her baby.

The vacancy rate ranged from 25% to 42%. However, some of these figures appeared high due to a proportionally low number of staff working in some areas. For example, the vacancy rate for community midwives was two whole time equivalents WTE which had now been recruited to. There were no vacancies on delivery suite. Action plans were in place. For example, in August to September 2020 the MLU was being supported by two secondments and these positions were out to advert. The vacancy represented 2.0 whole time equivalents. Between June and August 2020, the MLU was closed. Staff were deployed as needed. Ten vacancies were kept open due to the planned closure of Foxglove ward and related to a reduction in birth numbers; this however did not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. Morning staffing review huddles where staff were relocated to areas of need and the escalation policy was followed. Actions put in place included to complete a review of non-urgent activity and to identify opportunities to undertake new ways of working to support care delivery.

Incidents

The service managed patient safety incidents well.

Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Since our previous inspection in 2019, the service reported no incidents which were classified as never events for maternity.

Maternity

Staff understood their responsibilities to raise concerns and to record safety incidents, concerns and near misses.

Arrangements were in place to review and investigate incidents. All relevant staff, services, partner organisations and people who used services were involved in reviews and investigations. For example, incident reports made by staff were allocated to their line manager and the governance team had oversight of all incident's reports within the service. Managers reviewed all incident reports every Monday routinely. Every Tuesday an assurance working huddle was held to review all incidents, a working multi disciplinary team meeting took place every Wednesday where staff reviewed incidents that happened within the maternity unit and every Thursday a serious incident (SI) meeting was held where new SI follow ups were discussed. Lead investigators allocated by the group were always external to the maternity department.

An incident grading system was in place. If the incident was graded as level 3 or above the governance team automatically offered support. Staff defined the risk(s) in terms of the adverse consequence(s) that might arise from the risk.

Managers shared learning from lessons to make sure that action was taken to improve safety. Sharing of learning was shared across a variety of channels such as though a poster called 'incidents at a glance' and weekly safety alerts which highlighted incident themes and learning from incidents, by feeding back at handovers, huddles and team meetings and through a risk newsletter.

There had been one maternal death in the past 12 months, this was currently being investigated. Initial findings and learning had been shared with staff.

Data on incidents were presented in the form of a SPC chart, by cause, group, serious incidents, Healthcare Safety Investigation Branch cases, and concise investigations being carried out. The HSIB maternity investigation programme is part of a national action plan to make maternity care safer. Actions from incidents and updates, duty of candour monitoring was discussed. The SPC chart is known as a Statistical Process Control (SPC) chart and plots data like a run chart every week so you can see whether you are improving, if the situation is deteriorating, whether your system is likely to be capable to meet the standard, and also whether the process is reliable or variable.

A risk and incident midwife had been employed since July 2019. They reported to the divisional quality governance advisor who was also a midwife. Serious incidents (SI) were investigated by a multi-disciplinary team. Following a possible SI a tabletop discussion took place. All levels of staff were invited including junior staff. Where moderate harm or above was identified a 72-hour rapid review was carried out.

Systems were in place to ensure all incidents were graded correctly in accordance with the level of harm. For example, the risk and incident midwife reviewed all incidents every morning. This meant they could assess and carry out initial scoping if they did not agree with the rating.

We attended the divisional safety huddle meeting. All incidents level 3 of harm and above were discussed and themes were identified. Staff followed Duty of candour requirements correctly. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Staff followed the trust's duty of candour policy which set out how they would meet the legal requirements as well as promoting a culture within the organisation that encouraged candour, openness and honesty. The process was set out so that staff were supported to inform patients and their families and carers about where staff were investigating the

care they had 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 was a duty of candour guidance pack as an appendix to the policy which offered staff useful information on all the above aspects of the process.

The patient safety teams also supported staff with the process and continued to provide bespoke individual training to colleagues where identified. The trust used a series of information leaflets, targeted towards specific patient groups (including maternity). Staff handed these to patients and families at the time verbal conversations were held. This provided information about the process which would be followed and key contact details to enable engagement throughout the following weeks. The leaflet also enabled the trust to comply with the regulation to provide in writing a summary of what was verbally discussed. The trust monitored the compliance with the application of the statutory duty of candour requirements through an electronic safeguard system, with regular assurance and monitoring of this through divisional quality governance structures and escalation to the patient safety Group.

During a governance meeting we observed staff discussing whether duty of candour had been followed up in writing for a shoulder dystocia incident. It was added to the action log that staff would follow this up in writing opportunities for shared learning were discussed

Staff also used the incident reporting system to learn from excellence (LFE). The LFE system, aimed to provide a means of identifying and capturing learning from peer-reported excellence or positive actions. For example, there were two reported within May 2020. these concerned a consultant's safe care and high-quality delivery during a maternal cardiac arrest and positive patient experience following excellent midwifery support.

The service supported a systematic approach to the review of the loss of a fetus, neonate deaths and care complications. This helped to improve patient care and provide professional learning. The meetings gave ownership to clinical teams and offer a direct opportunity to improve care delivery in a timely manner.

Managers had processes in place to review patient deaths to ensure these did not occur due to unsafe clinical practices. The service held monthly multidisciplinary perinatal mortality and morbidity meetings, which fed into service improvement. Meetings were held locally at care group level. Any concerns were escalated through the divisional quality board. The unit was reviewing all still births for the last 18 months and had invited an external advisor to provide additional assurance.

The trust reported serious incidents relating to intrapartum still birth, early neonatal death and severe brain injury diagnosed in the first seven days of life to the Healthcare Safety Investigation Branch (HSIB). HSIB is an external investigation bureau that reviews specific maternity cases against a set criterion. Managers produced action plans to address safety recommendations made by the HSIB.

To date there were ten cases that had been referred to HSIB for consideration for their investigation. Four of these cases had been rejected by HSIB and returned to the trust to instigate further as they did not fulfil their criteria for investigation. Five of these cases were or had completed their review with HSIB. Out of these cases four were returned to the trust for factual accuracy and the final report subsequently returned to commence any actions set against recommendations. One case remained with the family for factual accuracy. Therefore, one case was currently outstanding to be completed and returned from HSIB.

Acceptance or rejection of cases to HSIB was set against a strict criteria, therefore if there was any question as to whether a case should be referred there was immediate liaison with a designated team member within HSIB to determine this.

Regardless if a case was accepted or rejected by HSIB the care group had set a standard of 72 hours to complete a rapid review of the case; this ensured that any initial learning or actions could be undertaken without delay. This has been actioned within the care group as the intention of HSIB was to return completed case reviews within a six-month period, however this timeframe had been exceeded on several occasions.

All actions noted were recorded as per routine against the relevant incident number on the trust 'safeguard' electronic system to monitor outcome and completion of actions.

Factual accuracy of a draft report returned from HSIB was checked by a designated team within the care group to ensure that the report was accurate.

Once the final report was returned to the trust the governance team within the care group along with consultant oversight determined appropriate actions against recommendations and these were duly set against the incident number on the electronic safeguard system and monitored for completion through relevant internal governance meetings.

An increase in in uterine deaths (IUD) was highlighted in the maternity governance meeting. The trust was undertaking an in depth review of all IUD cases which they would share when complete. We requested this from the trust, but the report was not yet completed. Following our inspection the trust told us the review commenced on the 23 September, 2020 and that the report would not be ready until January 2021.

Safety Thermometer

The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Safety Thermometer Data has not been submitted over the last three months. This is because all data collection for the adapted maternity safety thermometer ceased in March 2020. The trust had not collected any safety thermometer equivalent data in the previous six months to our inspection due to the pandemic.

Is the service effective?

Evidence based practice

The service provided care and treatment based on national guidance and evidence of its effectiveness, however not all guidelines were up to date.

The service had consultant oversight and a designated clinical guidelines lead. They held regular multi disciplinary meetings to discuss guidelines, updates and reviews. Escalation sheets were provided to maternity governance group to ensure oversight of guidelines.

Managers checked to make sure staff followed guidance. For example, policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and professional bodies.

We found five of the clinical guidelines had not been updated in a timely manner. It was recorded on the risk register that many clinical guidelines and standard operating procedures were out of date. Maternity leaders were aware of this. Guidelines were monitored through the governance system. Managers had produced a guideline escalation sheet. As of July 2020, five percent of the guidelines were out of date, 8% were amber rag rated and 87% were compliant. This showed that all out-date actions were being appropriately monitored and actioned.

Staff followed evidence-based practice. For example, staff followed procedures for reducing smoking in pregnancy, women with a multiple pregnancy received additional care, staff offered women with diabetes additional or different

care to reduce associated risks and staff carried out tests so that only those women who needed prophylaxis (preventative treatments) received it, preventing unnecessary treatments. Staff offered women a choice of birth settings, antenatal care was easily and readily accessible to all pregnant women and women were supported to access antenatal care by 10 weeks. Staff treated women with respect and dignity and involved them in decisions about their own care.

Staff followed Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE-UK) (2015) guidelines. For example, staff offered all women with risk factors for gestational diabetes a tests and midwives and obstetricians emphasised the importance of fetal movements to women during antenatal appointments. We saw leaflets 'feeling your baby move is a sign they are well' detailing what to do if women were worried about their baby's movements.

Staff were working towards offering patients an evidence-based bereavement pathway to improve the overall quality and consistency of bereavement care for parents and families.

Patient Outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.

Staff collected information about the outcome of women's care and treatment and routinely monitored this. A maternity dashboard was based on RCOG guidance, staff used the National Perinatal mortality Review Tool to review and report perinatal deaths to the required standard.

The total count of women receiving a C-section between February and July 2020 ranged from 30% to 34%. The total count of women receiving a C-section between February and July averaged at 31%. The local target was 30%. The progress was monitored weekly to show any changes, improvement or deterioration.

The number of women receiving caesarean delivery after labour had started, as well as the quite rare 'very urgently' needed Caesareans before labour (such as perhaps, after heavy vaginal bleeding), are all called 'emergency LSCS' or Category 1 or Category 2 Caesareans. The locally set target was 18%. Between February and August 2020 the trust ranged from 14.7% - 22%, for five out of six months this was worse than the local target.

The percentage of women receiving a lower (uterine) segment Caesarean section (LSCS) is the most commonly used type of Caesarean section. Most commonly to deliver the baby a transverse incision is made in the lower uterine segment above the attachment of the urinary bladder to the uterus ranged from 8% to 13%. The locally set target was 12%.

The number of vaginal delivered between February and July 2020 ranged from 58% to 64%. The national target was set at 57%.

Instrumental delivery (percentage of ventuouse and forceps) between February and July 2020 ranged from 6 to 8%. The national average was 13%.

The percentage of women who initiated breast feeding within 48 hours of birth (one month in arrears) ranged from 64% to 70% between February and July 2020. The target set by commissioners and nationally reported data was 66%.

The percentage of women receiving an induction of labour from February to July 2020 ranged from 38% to 44%. The national average was 29%.

The target for still births and set by MBRRACE was 3.7% per 1000. Between February 2020 and July 2020, the maternity department rates varied from 4.5% to 4.9% per 1000. The trust had action plans in place to address this risk. For example, we saw leaflets advising women what to do if they were worried about their babies' movements.

Staff also provided the women with externally produced accredited midwife-led pregnancy health information for parents-to-be. The organisation funded research into the causes of pregnancy loss.

Maternity

The target set by MBRRACE for extended perinatal mortality rate per 1000 births was 4.6% per 1000. Between February and July 2020, the maternity department rates varied between 6% and 7% per 1000.

The national average for term admissions as a percentage of registerable births (ATAIN project) was 6%. The maternity department reported between 3% and 4% between February and July 2020.

The national target for the number of shoulder dystocia's at two. The trust reported between zero and two from February to July 2020.

The percentage of episodes appropriately staffed on labour ward as per four hour acuity tool ranged between 74 and 94 % between February and May 2020. The target was 85%. No data was supplied for June and July 2020 on the maternity dashboard.

The target for one to one care in established labour ranged between 98% to 100% compliance between February and July 2020. The nationally set target was 100%.

The service had audited CTG assessment between July and September 2020, it identified between 90% and 92% compliance and for the 'fresh eyes' assessment for the same timeframe between 95% and 100% compliance.

Staff were committed to reducing the number of stillbirths, new-born and women deaths. The service took part in the 2017 MBRRACE (Maternal Newborn and Infant clinical outcome review programme (MBRRACE UK Audit) and their stabilised and risk adjusted extender perinatal mortality rate (per 1,000 births) was 4.6, the rate recorded for the unit ranged from 6 to 7 per 1000 between February and July 2020. The Stillbirth and perinatal mortality rate on the dashboard was a crude rate which tended to be slightly higher than the adjusted and stabilised rate produced by MBRRACE report.

The service had undertaken National Neonatal Audit Project (NNAP) between 2018 and 2020 to help to improve neonatal services and improve outcomes for babies dependant on maternity care for those mothers who may deliver premature babies. Information provided identified the administration of steroids and magnesium sulphate. was 100% for both in 2020 (national average 90.8% and 82.9%) Improvement was identified for presence of parents 74% during the ward round compared to a national average of 83.7%. An action plan to identify improvement was identified. Managers identified they were doing very well in a few areas but needed to work on areas such as breast feeding. Action plans had been put in place to address areas of non-compliance.

All maternity patients received safe care in the appropriate setting always. As of October 2020, the service reported no active maternity outliers.

Staff complied with procedures relating to the screening elements undertaken as part of the head-to-toe examination of the baby. The NIPE (new-born and infant physical examination) programme screens new-born babies within 72 hours of birth, and then once again between six and eight weeks for conditions relating to their heart and hips. We reviewed the NIPE compliance audit data provided to the joint Antenatal and New-born screening board meeting with NHS England and Public Health England on 09/09/2020. This audited the new-born and infant physical examination – coverage (new-born). The proportion of babies eligible for the new-born clinical physical examination who were tested within 72 hours of birth ranged from 97 to 99% compliance. the minimum target was set at no less than 95% and the target was 99.5%. Twenty-four babies did not receive their screening within 72 hours of their birth. However, eight of those babies were transfers in from other trusts after the 72-hour timeframe had elapsed. Fifteen of the babies were resident on the neonatal unit and deemed too unwell to be screened due to being ventilated. The remaining baby was resident on the postnatal ward and had their screening at seventy-four hours of age. The reason for the delay was unknown.There was no harm to this baby; the baby was under the care of the paediatricians jointly with the maternity team.

Maternity

Is the service well-led?

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

The maternity service was part of the Women's, Children's and Clinical Support Services (WCCSS) division. The interim Divisional Director of Midwifery, Gynaecology & Sexual Health and the Clinical Director led the service.

Effective leadership structures provided direction and support to staff across all areas of the unit. A Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health led the service. Two community leads oversaw the four community midwifery teams.

All community and inpatient staff we spoke with said the Divisional Director of Midwifery, Gynaecology & Sexual Health, Clinical Director and matrons and area leads were visible and approachable. Staff felt leaders appreciated the day-to-day pressures they experienced. They felt supported to develop in their roles.

The labour ward had a rota of experienced senior midwives as labour shift coordinators to ensure managerial cover in line with safer childbirth guidelines. The unit had a consultant obstetrician as a clinical lead, a matron and a labour ward manager.

Leaders understood the challenges to quality and sustainability the unit faced. For example, the midwifery-led Unit had been closed and was due to re-opens for births on 5 October 2020.

Staff told us leaders were visible and approachable. They had a presence in the work area and staff felt they could approach them and discuss any issues or concerns.

Vision and strategy for this service

The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

A five-year strategy was embedded. The service took coordinated action to address the challenges faced by its population in terms of maternal and infant health and planned to create a single Black Country maternity plan that inter-related with Birmingham and Solihull where necessary.

Staff worked with stakeholders to ensure the region had improved maternity services and outcomes based on the Better Births guidance. Service leaders had close links with maternity units and commissioners in the Black County region, this was called Local Maternity Systems (LMSs).

Staff told us felt engaged with the strategy for the service. The strategy was aligned to local plans in the wider health and social care economy and the services were planned to meet the ends of the local population. The service was committed to listening to women, their families and healthcare professionals to ensure everyone worked together to contribute, review and be involved in how services were designed and delivered as part of the local maternity system.

Key messages were shared with staff through a series of listening events. These events gave staff an opportunity to discuss what was needed within local maternity services to feel supported and listened to. It also showed that having personalised care plans and ensuring that women and their families were involved in decision making was key to ensuring they felt at the centre of their care.

Culture

Maternity

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Staff felt supported, respected and valued and felt positive and proud to work in the unit. One member of staff described governance as very much empowering and a learning culture"

Staff felt wanted and involved in service development. For example, staff were involved in initiatives such as the introduction of the ''perfect ward' system. This was a system of being able to record and share audits and checks in real time with colleagues.

Mechanisms were in place to provide all staff with the development they needed. Staff said they received high quality appraisal and career development conversations with managers.

Working relationships were positive all staff groups including midwives, doctors and consultants were positive. For example, staff said they felt comfortable challenging consultants if need be.

Staff felt the unit promoted a no blame culture. The culture encouraged staff to be open and honest at all levels such as with women using the service.

Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Effective structures, processes and systems of accountability to promote good quality services**.** Governance meetings supported the escalation of information upwards and the cascading of information from the management team to front-line staff. The service now had a specialist governance consultant

All levels of governance and management functioned effectively and interacted with each other appropriately. The divisional director of midwifery, Gynaecology and Sexual Health maintained appropriate oversight of governance in the maternity division. They attended the range of governance meetings including care group governance meetings and divisional quality meetings. These were well attended by staff from many disciplines, including obstetricians, anaesthetists and midwifery staff.

The divisional director could escalate to the trust management board and the trust board had oversight of performance within the maternity division.

Staff at all levels were clear about their roles and understood what they were accountable for and to whom. There were clear managerial lines of accountability. Registered practitioners were also registered with and accountable to regulatory bodies in terms of standards of practice and patient care. For example, midwives were professionally accountable to the Nursing and Midwifery Council (NMC).

Management of risk, issues and performance

The service mostly had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Comprehensive assurance systems were in place. We reviewed a variety of governance meeting minutes. Performance issues were appropriately escalated through clear structures and processes.

Leaders kept an overarching risk register for the maternity service. Individual departmental risk registers were also provided. The overarching risk register included 29 risks and three red risks.

The unit held regular 'risk confirm and challenge' meetings to review risk register at all levels (care group, divisional and corporate). These were discussed at the divisional quality meetings as well as the corporate risk register meetings.

Managers identified risks and these were updated regularly. Audit trails were in place to ensure that risks and issues were identified, mitigated and ultimately closed and that all actions and steps were captured.

Reviews were not always timely to ensure actions were being taken, however this may have been due to the impact of the COVID–19 epidemic.

The service had winter plans in place and managers could follow escalation procedures to keep women safe if they were up to full capacity and couldn't accept any more patients. This meant the service took potential risks into account when planning services such as the winter season and unexpected fluctuations in demand.

Leaders considered factors such as the impact on quality when making changes to the service. For example, Walsall's Midwifery Led-Unit (MLU) was set to re-open for births. This would offer women greater birth choices maternity leaders were liaising with stakeholders to ensure the re-opening of MLU did not compromise patient's safety.

Information management

The service mostly collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. However systems for monitoring the provision of staffing were not robust.

Managers demonstrated a holistic understanding of performance which looked at people's views with information on quality, operations and finance. Managers had a framework to oversee the quality and safety of patient care. They reported a range of service performance measures and discussed quality and sustainability in all governance meetings.

Arrangements ensured availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Staff followed the General Data Protection Regulation (GDPR).

A risk was recorded on the risk register regarding the reliability of information and data from the electronic systems used. The trust was working with the provider of the systems to resolve this.

Safety was monitored using information from a range of sources including performance against safety goals. For example, staff used a maternity dashboard. This enabled maternity clinical teams to view data collected from providers in England and regularly compare their own clinical outcomes to identify areas for quality improvement.

Leaders identified a lack of assurance around the reliability of some data systems as a risk on the risk register. As a result managers were unable to assure themselves that data which was captured and being reported on the dashboard was accurate. High quality data was important to the service as it could lead to improvements in patient care and patient safety. It also plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services. Following our inspection the trust told us this risk related specifically to breastfeeding and smoking figures. The trust told us they gained additional assurance through manual monthly audits which were carried out by the breastfeeding lead midwife and saving babies lives midwife. This was fed into the dashboard.

Although managers had systems in place to ensure safer staffing across the service such as staffing meetings and escalation processes, control measures such as redeploying midwives and using bank staff were not reflected in the fill rates reported. This meant the trust did not have an accurate picture of staffing numbers across maternity services. The trust told us they were looking at implementing a process so the service could evidence the actual numbers of staff on each shift which included deployed and bank staff.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.

Maternity

People's views and experiences were gathered and acted upon to shape and improve services and culture. The patient experience Friends and Family Test (FFT) records the percentage of patients who said they would recommend the antenatal services. This was 99% in February 2020 and 100% in March 2020. The percentage of patients who said they would recommend giving birth at the unit was 100% and 98% respectively, for the post-natal ward it was 93% and 100% and the post-natal community was 99% and 97 %.the target was 95%. No figures were available for April to July 2020 due to the COVID-19 pandemic.

FFT results were presented and discussed at board level. FFT results were also included as part of the maternity dashboard so staff were aware of them.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture of the unit. The service continued to hold listening into action (LiA) events. This was a forum to engage and empower staff to make improvements that would improve the care they gave to their patients. Staff told us about the listening into action events. The purpose of LiA was to listen to staff and support them to make the changes, removing any barriers so they could take the lead and contribute to the success of their trust.

Positive and collaborative relationships were maintained with external partners. The local maternity system helped build a shared understanding of the challenges within the system and the needs of the relevant population and to deliver services to meet those needs.

Learning, continuous improvement and innovation

Maternity and Neonatal services at Walsall Healthcare NHS Trust were successful in the first stage of their ambition to achieve full Baby Friendly Initiative accreditation.

The Unicef UK (United Nations Children's Fund) Baby Friendly Initiative (BFI) is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the UK, the initiative works with health professionals to ensure that mothers and babies receive high-quality support to enable successful breastfeeding.

Walsall Healthcare was awarded its Certificate of Commitment that recognised that a healthcare facility was dedicated to implementing recognised best practice standards last year. Maternity and Neonatal Stage 1 BFI Accreditation was achieved in July.

Areas for improvement

Action the provider must take to improve

The trust must ensure:

The trust must put in place systems or processes to effectively assess and monitor the provision of staffing within the maternity service. (regulation 17 (1)(2)(a)(b)).

Our inspection team

CQC team

The team that inspected the service comprised of a CQC inspection manager, two CQC inspectors, two specialist professional advisors with experience in urgent and emergency care and maternity services. The inspection was overseen by Fiona Allinson, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

Walsall Healthcare NHS
NHS Trust

Infection Prevention and Control Board Assurance Framework – 11/11/20

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure guidance is current and adhered to	Infection prevention and control policies are current and up to date with current national guidance. The Infection Prevention and Control Committee has continued to meet throughout the pandemic and reports to QPES. Policies and SOPs are available on the intranet	St Giles staff recently joined the Trust and have worked to different policies and procedures	WHT policies and procedures being implemented
	Staff receive reminders of guidance through Daily Dose and Team Brief and assurance visits from IPC and Matrons to clinical areas.Daily tactical meetings are held in community and acute for the management and control of Covid-19 attended by all divisions including IPCT to share: - changes in national guidance, - safety alerts - CMO guidance All decisions from Tactical are fed back to the Divisional teams. Daily reporting to regional and national	Recent update regarding returning travellers from Denmark	Discussed at tactical, SOP produced and ED staff made aware

	teams		
Risks are reflected in risk registers and the Board Assurance Framework where appropriate	Changes in Guidance and risks are escalated through Board papers via Strategic Command via Tactical Command by MD, DON or COO. Reports are received through ICC which reports through QPES to the Board. Covid -19 is on WHT Risk Register and reviewed by the Board, Risk 2093 and 2095.		
Robust IPC risk assessment processes and practices are in place for Covid -19 and non Covid-19 infections and pathogens	Microbiologist and IPCT are in daily contact with Covid-19 wards and available to community teams 7 days per week. Hand hygiene, device, IPC Assurance and PPE audits have been undertaken during the pandemic providing assurance to the ICC, QPES and Board. All normal non-Covid-19 work undertaken by IPC and Microbiology has continued despite the increased workload: • C.diff ward rounds. • Alert organism work including all screening. • RCAs and Serious Incident reports and reviews. • Outbreak control. • Audits, Policies and SOP development and reviews. • Infection Control Committee continued monthly. • NHSI Assurance visits continued by	Streaming of patients. Evidence of Healthcare acquired covid infections occurring in non-covid and covid streams. PPE audits demonstrated poor compliance. Full sets of papers required for ICC. IPC overwhelmed by number of SIs related to Covid 19	A review of streaming SOPs and ED triage form being reviewed. Increased the uptake of mandatory IPC level 2 training on line and hand hygiene training added to the IPC training portfolio. Shortened versions of papers written. Serious incident reviews in to HCAI Covid 19 deaths from first wave have been allocated to investigating officers within the Trust

	the Interim Director of Nursing and Head of IPC. Increasing requirements for the Trust COVID-19 data and daily sit-reps provided to EPRR through the IPCT. Community teams hold daily MDT meetings to RAG rate clients on their lists	Daily situation reports delivered by IPC to EPRR	Additional admin support required at the weekend would help to cover this.
There is access to IPC and Microbiology services 24/7	Microbiology lab continues to work to identify all serious (non- COVD-19) infections and alert organisms. Microbiologist input into clinical management of infectious/ microbial disease. Microbiologists provide 24/7 access to advice on all related management issues and for direction on antimicrobial prescribing. Reduction in laboratory tests for certain microbiology specimens communicated to all clinicians by Microbiologist. IPCT team available Monday to Friday 8.30 – 4.30 on site and 8.30 – 4.30 on-call at weekends	Risk assessment – reduction of some routine tests in laboratory to free up time for COVID-19 testing. Reduced service to allow staff some time to have rest periods	Clinicians made aware that these can be undertaken after discussion with microbiology if deemed essential to patient care. Business case approved and new staff members are currently being appointed.
EPRR are fully engaged with Covid-19 management	Reflection of Tactical command after first wave undertaken to identify good practice and lessons learned Exercise Muirfield undertaken to test planning assumptions prior to winter		

	Trust Covid-19 contingency plan produced October 20, which pulled together lessons learned from above exercises and put in place arrangements for next 6 – 12 months. Reviewed November 20 Review of Incident Control Centre arrangements. Recommendations to strengthen team to make it more robust and to be a single point of contact for the Trust Coordination of outbreak meetings EPRR acting as interface between tactical and outbreak control team Weekend planning has increased IPC input	Formal debrief of outbreak outstanding	Lessons learned during each outbreak incorporated into management of subsequent outbreaks
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
• Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.	Record of areas receiving deep cleaning Staff at low and medium risk have been redeployed to low risk areas CEV staff shielding	High numbers of cleaning team absent from work A&E and delivery requesting 24/7 support, but no funding or staff to allow this Back log of new staff awaiting OHD assessment. Staff under restricted duties are awaiting review by OHD.	Actively recruiting. 60 agency staff being used at present. Currently working up proposal for additional rapid response/deep clean team OHD aware

• Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	Trust Policies cross referenced and meet the National Cleaning Guidance requirements, with the addition of HPV decontamination where this is possible. 1 new HPV machine and 1 UV light machine purchased by Trust now on site. Deep cleaning team available 11 -8pm only. Night shift consists of 3 staff for the whole acute site up until 5am.	Deep clean team consists of 3-4 staff. No budget for consumables. Delays in cleaning lead to delays in patient flow through hospital	Staff undertaking training on the use of the machines. 16 staff will have completed training week beginning 23/11/20
• Increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Frequency of cleaning has been assessed in conjunction with Facilities and IPCT.	Increasing requests for cleaning putting additional stress on poorly staffed teams. HK working tireless to fill vacancies or staff shortages.	Estates to agree with IPC where areas of low risk are cleaned less frequently to allow resources to be diverted to areas of greater need
• Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	Laundry policy is in place and assessed as meeting the National guidance. Monitored during IPCN daily visits.	Some areas have been non-compliant recently where linen hasn't been bagged appropriately.	AH discussed with Matrons and furthers communications relayed.
• Single use items are used where possible and according to Single Use Policy	Single use items used in line with WHT policy.		
• Reusable equipment is appropriately decontaminated in line with local and PHE and other national policy	Reusable equipment is cleaned in line with Trust and National Policy. Spot checks take place by Matrons and IPC during daily visits. Shortened IPC assurance audits have taken place during the COVID-19 pandemic as part of the NHSEI Action Plan.		

	NHSEI action plan shared across divisions for learning. Community teams advised on the decontamination of equipment in line with national and Trust policy.		
• Clear desk policy	All staff are reminded of the need to declutter work areas and to clean the areas down before and after their shift (and during) using Clinell wipes. Particularly important in office spaces and hot desking where key boards, mouse and telephones are likely to be contaminated.	Staff outbreaks of covid 19 in office space and shared areas.	Areas reassessed for being covid secure. Social distancing, maximum people in a room at any onetime advertised on the door, use of face masks, care taken if sharing a car to work, staggering breaks.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	Monthly snap shot audits and antimicrobial report to medicines Management Committee and ICC Antimicrobial formulary updated August 2020 and available on Trust intranet and micro-guide. Microbiologist service for referral of difficult cases and advice on antimicrobial deployment. Community teams review antibiotic prescribing for patients and refer to senior staff where there are ocncerns	There has been an increase in the number of Cdiff cases identified in the Trust and the numbers will exceed the objective for this year	A working group has been formed and is reviewing each case and identifying additional measures that can be put in place to prevent further cases of the infection. This group reports to the IPCC
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Systems and processes are in place to ensure: • implementation of national guidance on visiting patients in a care setting	The no visiting policy in the Trust remains in place; with the exception of EOL care and special circumstances following discussion with Matron/Ward Sister. This also applies to Holly Bank House and St Giles. PPE and HH advice given to attending relatives by the ward team prior to arriving. Outpatients advised to attend alone, follow hand hygiene and mask usage and social distancing measures in place.		
• Clear signage and restrictions in place for areas in which suspected or confirmed COVID-19 patients are placed	Entrances to hospital have hand cleansing and mask stations Not all community premises are owned / sole use by the Trust hence there is a requirement to work with the landlords of each unit to determine signage and access/egress routes.	Signage in reviewed by new matron A&E inadequate	New signage on order
• information and guidance on COVID-19 is available on all Trust websites with easy read versions	Patient and staff information is available on the Trust website. Translated versions are also available in the commonly used languages in the area. Reviewed by PALS and Comms teams when new guidance available.		New patient information leaflets being printed and placed on intranet – will be available by 20/11/20
• District nurses risk assess patients own homes at beginning of visit to ensure no unnecessary increased exposure to covid	DNs contact family by phone following their visit, with patients permission, to provide advice and support and refer them to national guidance as required	.	

infection			
• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Infection status is recorded within the internal and external Trust transfer documentation. Where there is an issue of a patient being refused by an acute or care home provider then there are mechanisms to deal with the problem. As a Trust we use the standard documentation for patients discharged to home or to a care home. EDS communication of status to GPs and other community HCWs with access to 'Fusion'. All patients being discharged to a care home will have a Covid-19 result within the 48 hours prior to discharge		Designated care homes in Walsall have been approved by Walsall Health Protecttion team to admit Covid-19 positive patients from hospital
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • front door areas have appropriate triaging	SOP's are available for patients arriving into the Trust through all routes: • ED • AMU and SAU • Gynae • Paeds • Maternity • Planned admissions These have been updated as National	Potential for overcrowding in A&	A&E in receipt of portacabins to help with appropriate streaming of patients From 23/12/20 patients will book A&E appointment via 111 first (999 calls will continue as usual)

arrangements in place to cohort patients with possible or confirmed Covid-19 symptoms to minimise the risk of cross-infection	advice has changed and assurance given through Tactical Command. A&E triage also include identification of clinical extremely vulnerable patients who require shielding. Site Coordination lead on the appropriate transfer of patients, liaising with IPC/Microbiologist as appropriate. Community staff aim to promote social distancing during home visits	Difficult within large households in community	Advice and education given before and during each community visit. Limiting the number of people within the one room and adhering to social distancing guidance.
• All inpatients are tested for Covid-19 on admission	PCR testing of for all Covid requirements now established on PANTHER platform at WHT microbiology dept. Rapid GeneXpert PCR testing established at WHT laboratory for use when a result is required urgently	Test kits are rationed	Requests for rapid tests must be approved by IPCT or Microbiology
• patients that test negative for Covid-19 but display or go on to develop symptoms of Covid-19 are segregated and promptly re-tested.	Patients who test negative now receive a follow up test at day 5 and every 7th day following admission until discharge as per national policy. Those patients who subsequently test positive are moved to an appropriate stream or side room within 2 hours as per Trust policy. Incident raised if this does not happen in a timely manner.	Concerns raised by clinicians that some patients may have been placed in covid-19 stream in error	Investigation being carried out by IPCT as a matter of urgency.
• Clear signage for different flows of patients through the hospital	Blue, red and purple routes through hospital		
• patients that attend for routine	All patients are reminded not to attend for	Some systems have been	Monitored through the

appointments who display symptoms of Covid-19 are managed appropriately	routine appointments if they are showing signs of Covid-19 infection. Patients receive a text reminder of actions to take. Protocol and SOPs in place. Posters advising patients what to do when booking in and standard questions for staff to ask all patients. OPD have socially distanced waiting rooms and all patients are requested to wear a mask if tolerated. Robust triage, action plans and SOP's in place within community to support appointments.	slower in ensuring changes in the letters are made.	Surgical Division and discrepancies escalated to Tactical Command if unable to rectify.
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that all staff within the Trust are aware of their responsibilities to prevent infection	Daily Dose, poster and pull ups around hospital remind staff of need to wear a face mask, gel their hands and maintain social distancing WHT has actively followed National guidance throughout wave one and two. 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. Contractors written to by Procurement		

	regarding PPE provision and use. June 2020. Following recommended precautions.		
• all staff (clinical and non- clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe	IPC, PPE and HH covered in training for staff moving areas. Redeployed staff from other organisations received face to face mandatory training. Staff training records are uploaded onto ESR. PPE regional submission and national submission daily and PPE daily meeting.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	1:1 and team training Posters and videos for Donning and Doffing provided to all clinical and community areas and through Daily Dose. PPE visual audits are carried out daily during IPC visits.	Daily assurance visits for staff compliance with PPE, Hand hygiene, social distancing and mask wearing undertaken by IPCT show lapses	Feed back to Nurse in charge of ward area at time of visit. Escalated to matron and Div DON. Empower Nurse in charge to challenge non-compliant behaviour in all staff on ward including senior medics
• staff required to wear FFP3 reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	National Guidance followed - Cascade training provided by manufacturer undertaken by individuals within each division. Log developed and kept with each hood. Instruction manuals printed and delivered with each Hood to the clinical area. Sufficient hoods are now available within the organisation for those staff who failed the Fit test but perform AGPs		

• a record of staff training is maintained	Video and posters provided to staff Donning and Doffing PPE. IPCN attended ED and Ward 29 and the POD for the initial testing to support staff with Don and Doff of PPE. Ward staff maintain these records and logged in IPCT. Mandatory training for IPC level 2 and hand hygiene has been prioritised. Current uptake is IPC 81.4% and HH 84% Hood cascade training delivered by external company in the use and care of these. Logged on ESR. **FFP3 Fit Testing** FFP3 Masks are only required when caring for patients receiving Aerosol Generating Procedures (AGP) and in ICU / ED resuscitation areas, not routine care. Staff undertaking AGP require Fit Mask Testing every 3 years. FFP3 Fit Mask testing/checking has continued throughout the outbreak and records kept on ESR.	Staff wearing FFP3 masks even when not undertaking AGPs Staff wearing FFP3 masks that they have not been fit tested for	Compassionately challenged Reminder going to all staff that they must be fit tested for each brand of FFP3 mask that is available. Efforts made to ensure same brand goes to same area each week.
• staff understand the requirements for uniform laundering as this is not provided for on site	Uniform Policy is in place with laundry instructions, specific sections have also been shared regularly on Daily Dose.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to	Flow of patients defined in SOPs which are		

ensure: • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	updated when change of guidance or plan. Managed by Ops centre and raised to IPCT/Microbiologist as required. Side room IPCT monitor side room list daily and closed bays. Clear Covid-19 streams and non-Covid-19 streams as numbers increase All patients in Holly Bank and St Giles Hospice are nursed in single rooms and new admissions are kept isolated for 14 days. Universal precautions applied.		
• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Clear designated wards / areas across the organisation agreed at Tactical Command. National IPC guidance is followed for all cohort areas. IPT confirm that the areas are suitable for the co-hort of patients, then agreed at divisional level and Tactical Command. Review of inpatient 2m distancing by Div DON for each area and IPCT to ensure patients are separated appropriately reported to Tactical Command. SOP in place for social distancing for outpatient departments and hotspot area's. The Trust has 1 negative pressure room in ICU. First suspected patient placed in this room.	Orthopaedics may be difficult depending on the side of surgery. .	Awaiting delivery of Quick screens to provide barrier between patients where 2m distancing difficult •

• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Patients with resistant/alert organisms are managed according to local IPC, evidenced through ongoing patient reviews and audit. Monitored/ alerted through ICNET. Site Coordination Team responsible for the placement of patients, incident raised if this happens. RCAs/ outbreak meetings continue for other specified alert organisms. Microbiologist advice on management of highly resistant organisms always available.		
• Access to side rooms for isolation	Limited numbers of side rooms available in the Trust	Inability to isolate infectious patients and increased risk of spread of infection in Trust	SOP to help prioritise sideroom usage developed Business case to purchase 9 PODS to increase isolation capability in draft Nightingale Birmingham may be opening at the end of November which may alleviate some of the pressures
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: Access to laboratory support	Pathology services transferring to Royal Wolverhampton Hospital 6/12/20, although phasing in will commence 17/11/20 • Repertoire of services to remain the same • Access to extended operating hours	Potential for delay in results from RWT	Microbiologist monitor turnaround times for specimens within the Lab.

•	and 24 hour Covid-19 lab • WHT samples couriered hourly • Onsite rapid testing for flu and Covid-19 to continue at WHT Screening for other infections takes place, evidenced in ICNET.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms	National guidance followed and the Trust discharge documentation is in line with this. All standard IPC Policies up to date and in place as per Hygiene Code. During COVID-19; C.diff, IPC, Hand hygiene and PPE audits have continued to take place. Assurance walks have been undertaken by the Director of Nursing and Head of IPC. IPT visit all COVID-19 wards daily, with most other areas on a daily basis. To advise and assure practices are being undertaken correctly.	Staff not following policy on occasions.	Compassionately challenge and educate staff. Hand hygiene training delivered to all areas of the Trust and include in mandatory training Escalation through divisions and professional leads. Escalation to ICC, QPES as appropriate.
• any changes to the PHE national guidance on PPE are quickly	Any national changes to PPE guidance are immediately printed and taken to clinical	Staff not always following advice and guidance through	Compassionately challenge and educate staff. While

identified and effectively communicated to staff	areas where a member of the IPCT go through the changes. This is followed up by distribution to all staff and communication through Daily Dose. Identified for community teams through daily huddle and community tactical. Information then shared across the division.	their personal beliefs.	attempting to understand the reason for non-compliance. Escalation through divisions and ICC.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Clinically extremely vulnerable staff including staff greater than 28 weeks pregnant have been advised to shield during this second wave. Staff in high or medium risk have completed risk assessments and have been advised on correct PPE etc and will continue to work whether from home or onsite. Community staff undergone further assessments during second wave. Advice shared in Daily Dose 6/11/20 Managers of staff who are able to work from home must complete on-site working application. Risk assessment in place to support vulnerable staff with underlying health conditions, to include BAME staff.		

• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms.	National guidance on the symptoms of Covid-19 has been shared with all staff and on Daily dose, regularly updated and available through the intranet. Posters across the Trust. Covid HOTLINE now available for staff to contact		
• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Havens continue with psychological support for all staff. Wingman Project continues	Staff working whilst symptomatic	All staff are questioned before start their shift to confirm that they feel well enough to do so.
• staff that test positive have adequate information and support to aid their recovery and return to work.	OH record of staff follow-up contacts COVID-19 testing procedure available		
• PPE stock is appropriately stored and accessible to staff who require it	System in process for ensuring all areas have the appropriate PPE and monitored daily. Managers all aware of how to obtain further supplies if usage increased. Top–up team check stock levels every morning and replenish appropriately. Daily exception reporting covering PPE stock completed daily across community. Base stock kept within community to use as and when required.		
Environmental risk assessment of social distancing undertaken in all non clinical areas	Health and safety have records of all assessments	Staff not socially distancing has led to outbreaks which have impacted on patient	Some areas have been re assessed. Notice on door which indicates maximum

		services	number of people allowed in the room. Reduced occupancy, staggered breaks etc. Further message to be issued to staff on weekly brief 12/11/20
Community staff entering care homes will be screened weekly in line with national guidance from week beginning	Plans in place to facilitate this		

Walsall Healthcare NHS
NHS Trust

MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE Thursday 26th November 2020			
Hospital Mortality Report			**AGENDA ITEM: 12**
Report Author and Job Title:	Dr Manjeet Shehmar Deputy Medical Director	**Responsible Director:**	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This is the quarterly review of mortality in the trust, generated through the Mortality Surveillance Group. The committee is asked to note the following key items: • Monthly Standard Hospital Mortality Index (July 2020) = 87.39; monthly Hospital Standard Mortality Rate (August 2020) = 104.39 • Deaths due to COVID-19 have risen to 290 (at 15/11/20) • Continued review of deaths through care groups, with lessons learnt presented by specialties to Mortality Surveillance Group • Focussed work on fractured neck of femur has been associated with sustained reduction in trauma unit length of stay • Walsall's response to the annual Sustainability and Transformation Partnership report for deaths in people with learning disabilities (LeDeR) is detailed in this report • Deteriorating bundle tool has been created and is currently being trialled in the Emergency Department. Sepsis modules for Medway are due to introduced in December to facilitate recording, interpreting and auditing sepsis criteria		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register • Systems and processes for the identification and learning from issues in care have been identified as ineffective by the Clinical Commissioning Group		
Resource implications	Procurement of the Cross Origin Resource Sharing (CORS) Learning from Deaths Information Management System		
Legal and Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. • National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

HOSPITAL MORTALITY

This report details:

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

1. PERFORMANCE

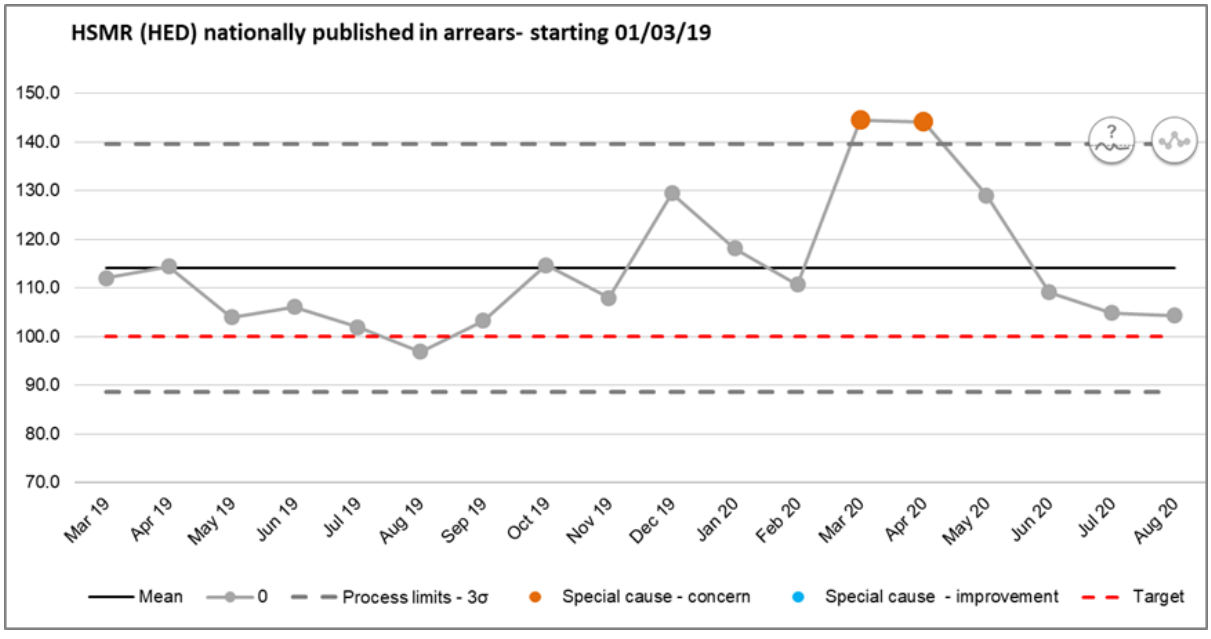
1.1 National Benchmarks

The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index (SHMI). Delays in reporting SHMI are due to data issues with NHS Digital and Hospital Evaluation Data.

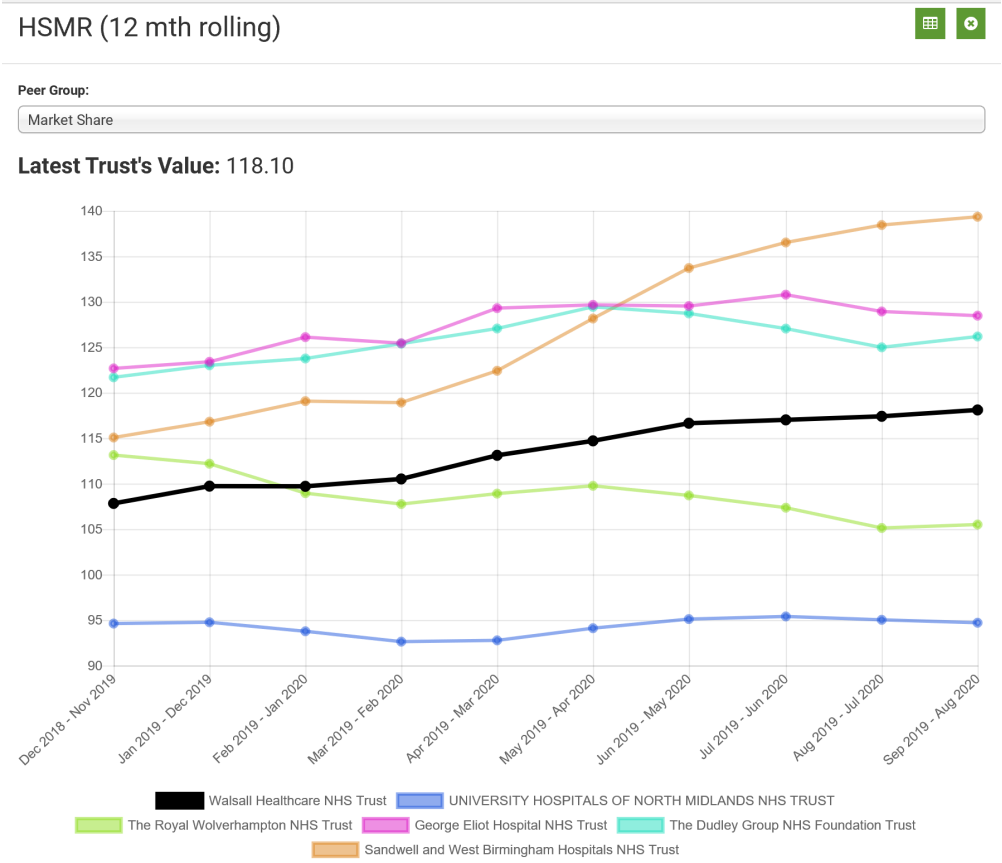
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20
HSMR	91.00	108.20	109.40	117.91	101.52	112.03	114.41	103.98	106.15	101.94	96.89	103.33	114.70	107.94	129.47	118.16	110.72	144.51	144.15	129.03	109.10	104.86	104.39
SHMI	105.10	100.50	102.30	116.96	111.86	119.82	97.48	99.57	108.71	107.23	109.82	117.52	113.30	104.20	107.31	99.10	95.93	132.69	144.39	119.25	109.91	87.39	
Crude Mortality Rate	3.60	4.00	4.50	4.70	4.00	4.20	4.60	4.00	3.50	3.20	3.08	3.23	3.71	3.91	4.89	4.22	3.95	5.80	8.08	5.67	3.90	3.85	3.80

1.2 Hospital Standard Mortality Rate (HSMR)

Monthly HSMR

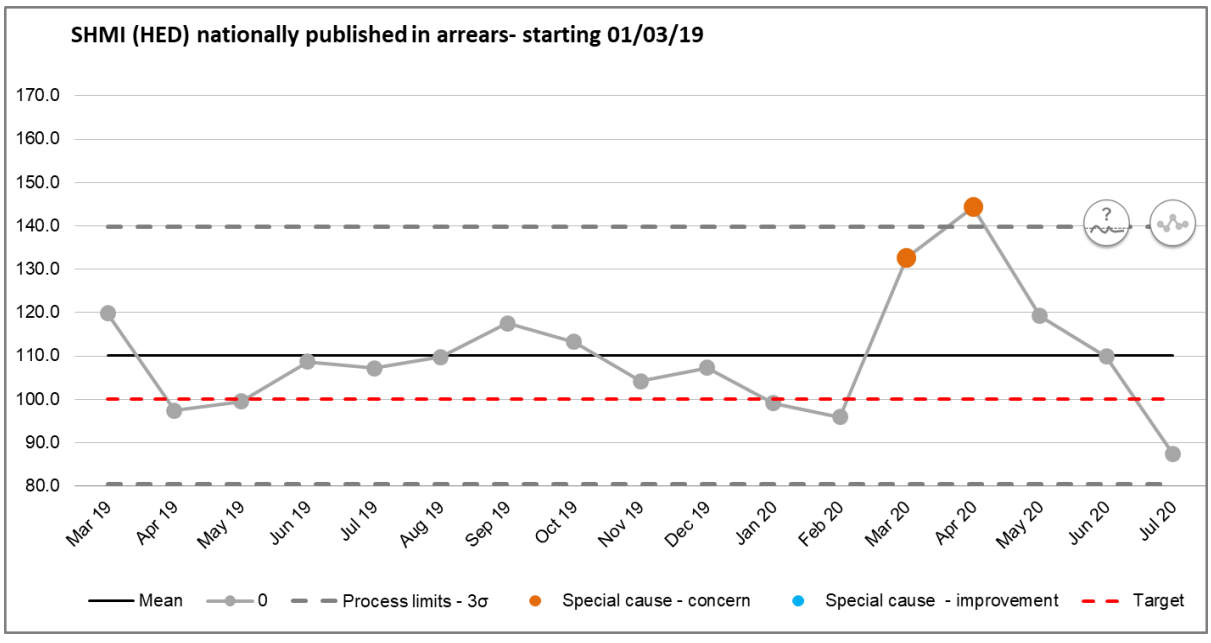


12 Month rolling HSMR STP benchmark (Walsall = black line)

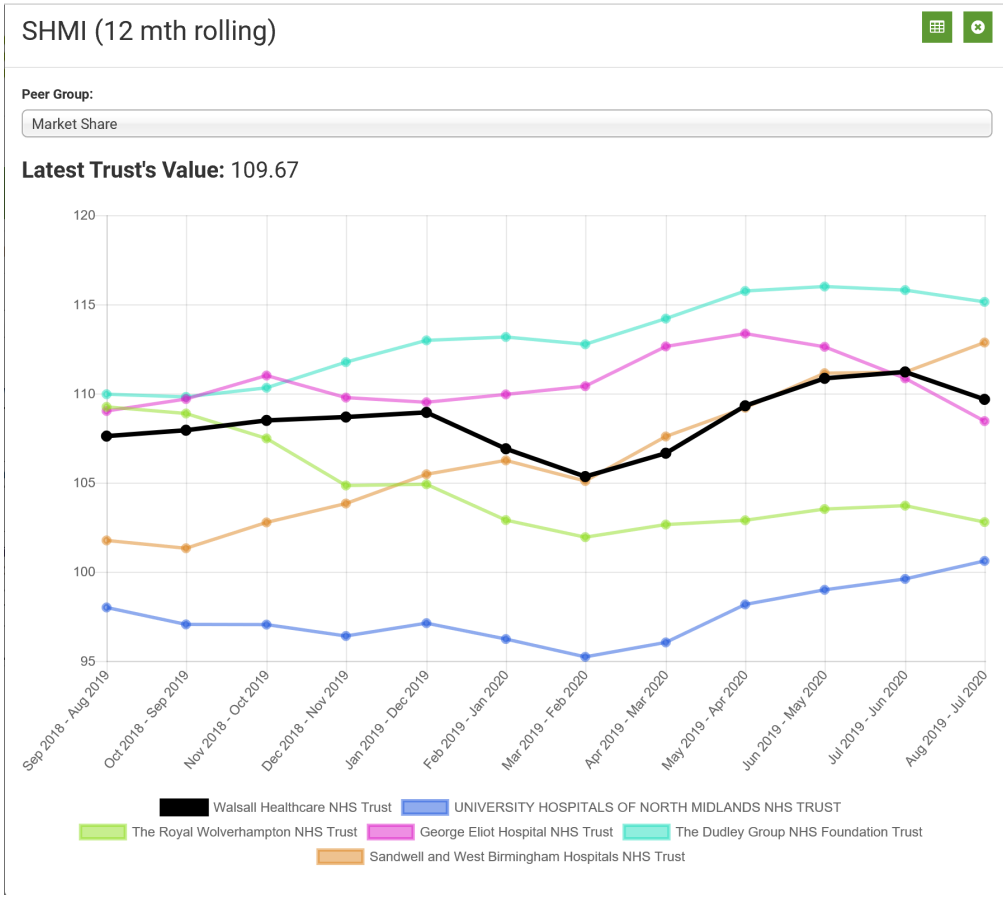


1.3 Standard Hospital Mortality Index (SHMI)

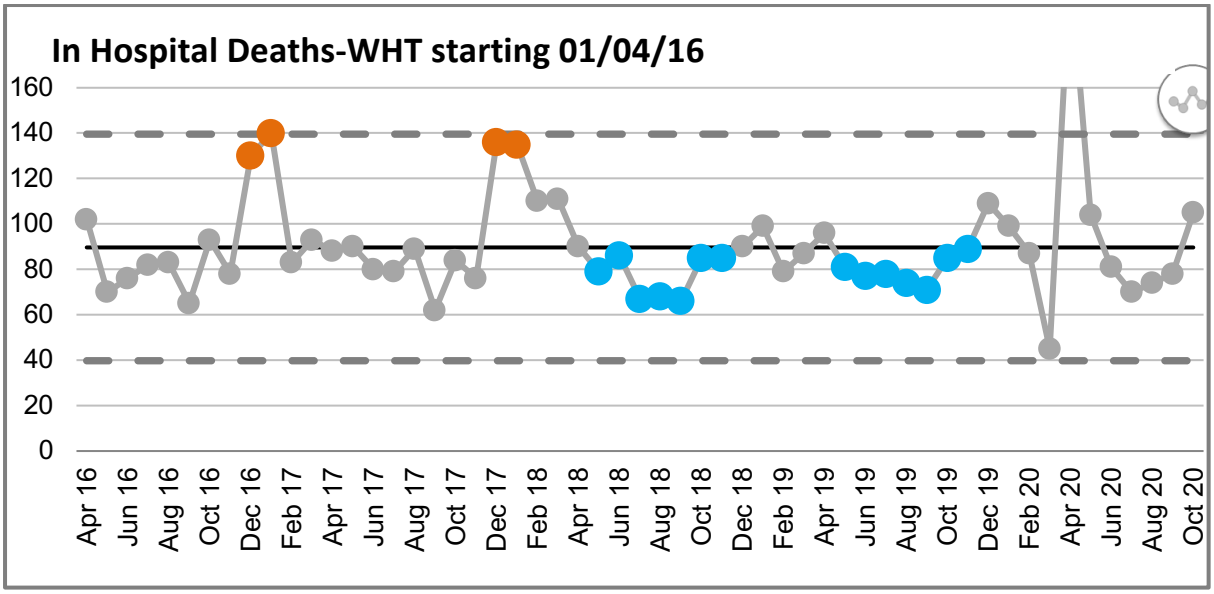
Monthly SHMI



12 Month rolling SHMI STP Benchmark (Walsall = black line)

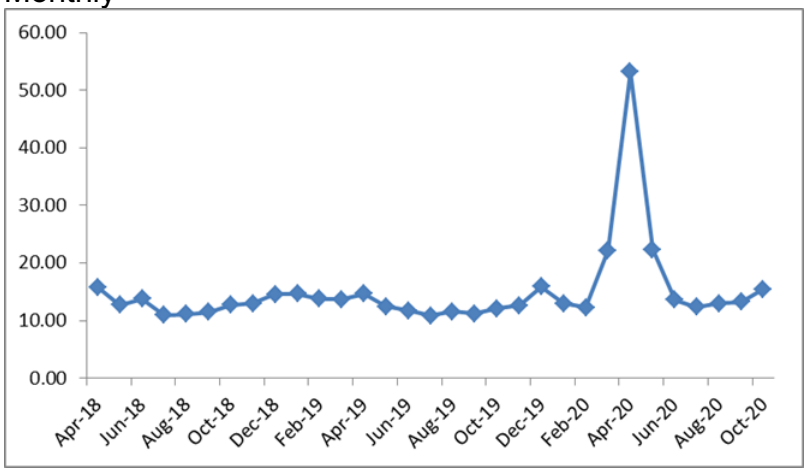


1.4 In hospital deaths 2016 – 2020

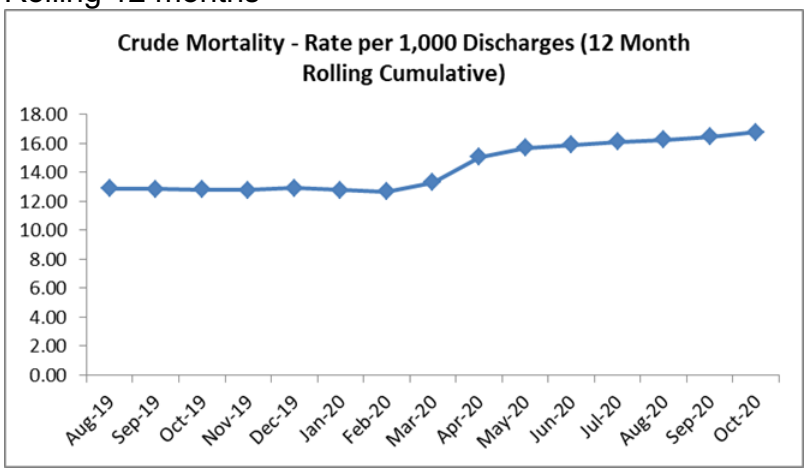


1.5 Crude Mortality 2015 – 2020 (deaths per 1000)

Monthly



Rolling 12 months



Walsall Healthcare NHS
NHS Trust

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	Current Risk Score
	• 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 • 2066 Lack of registered nurses and midwives (this risk has increased to 20 from 16) • 2260 Lack of a whole system approach across health and social care for the management of Children and Young People (CYP) in mental health or behavioural crisis.	**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 • Outstanding CQC Must and Should Do actions from 2019 inspection and new actions from 2020 inspection in Maternity and the Emergency Department • Gaps in the number and quality of clinical guidance, 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 • Failure to deliver 7 Day Services to provide uniform levels of care throughout	Likelihood:	2	31 March 2021
Consequence:	5	4				Consequence:	5	
Risk Level:	High 20	High 20				Risk Level:	Mod 10	

		the week • Failure to demonstrate that the trust is identifying and addressing inequalities in health • Delays in cancer diagnosis and treatment pathways • Increased staffing pressures, and impact on staff resilience, caused by increased requirement in ITU, COVID pathway management, sickness absence and outbreak management	

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. • Central staffing hub co-ordinates nurse staffing numbers in line with acuity and activity • Clinical audit programme & monitoring arrangements • Safety Alert process in place • Freedom to speak up process in place • Covid-19 SJR undertaken for all deaths • GIRFT Meetings reinstated • Thrombosis committee reinstated • Agreement and plan to implement the electronic sepsis bundle for adults and children. • Process of assurance for lessons learnt being developed • CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital.	• 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 NHSEI/CQC
Gaps in Control	• Clinical audit monitoring arrangements to be reviewed and strengthened • VTE performance continues to be below the Trust Target • Deterioration in the Trust's complaints response performance • Mental Capacity Act compliance below the Trusts Standards • Out of date clinical Policies, Procedures and SOP's • Training performance not meeting set targets		

	• Mandatory training below acceptable levels of completion • Quality Impact Assessment process is not yet established within the trust • Preventing future deaths notice for VTE • Sepsis audit frequency and performance • New Electronic Patient Record not yet functioning at full capacity		
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 the Trust delivery of Safe, and High Quality Care • Signed SLA with Mental Health Trust to support the organisation to meet the requirements of our CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital.	• 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 NHSEI/CQC/CCG • Monthly Quality meetings with NHSEI and CQC • External review undertaken on the SI processes • CQC report (2019) showed improvement and the Trust was rated as 'outstanding' for caring • NHSI and CCG reviews of IPC practice in ED and Maternity have not highlighted any immediate concerns.
Gaps in Assurance	• Outstanding CQC 'MUST' and 'SHOULD' do actions remain outstanding • Trust CQC rating requires improvement • Quality Concerns raised to CQC • A number of national audits outcomes remain below national average • NHSEI review insufficient assurance on infection control standards resulting in RED rating • 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 • Gaps in assurance noted from the recent CQC inspection including management of sepsis and robust audit data; gaps in ability to have two paediatric nurses rostered each shift in paediatric ED • Complaints highlighting failure to deliver consistently high standards of care, poor patient experience • CQC inpatient survey 2019 results • Lack of assurance regarding equality, diversity and inclusion and actions to reduced inequalities • Lack of evidence of risk assessments and quality impact assessments relating to staffing contingency planning and/or activity changes		

Future Opportunities

- Improvement programme offers consistency in methodologies and documentation used across transformation programmes
- Care 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

Future Risks					
• Resources to deliver the improvement programme. • Resources to deliver the Care Excellence Programme and Pathway to Excellence Programme • Impact of second wave of Covid-19 plus additional significant time pressured programmes of work such as COVID vaccination, staff testing etc • 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 • Self-assessment against NHSI Developing Workforce Safeguards (2018) underway	Ann-Marie Riley	30.11.2020	The establishment review has concluded. Outputs from that and the Birthrate plus recommendations will be presented in November 2020 Self-assessment against NHSI Developing Workforce Safeguards Guidance completed reported to QPES in October 2020	
2.	Care Excellence • Care Excellence strategy in development • Final phase of consultation to take place in September	Ann-Marie Riley & Matthew Lewis	01/04/21	The Professional Practice Model was chosen by staff. The draft strategy has been reviewed and just requires some elements adding to highlight community partnership working.	
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 & Matthew Lewis	1/12/20	Secured patient partnership support for the Patient Experience Group. Family Liaison extended to support families through complaint process when needed (action a result of learning from a previous complex complaint.	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
193	Consultant Radiology capacity is significantly below the required numbers to meet current KPIs within its current numbers if organisational funding support for the continued use of outsourcing were to end. Many staff report high numbers of cases in top quartile in benchmarking national data which is currently being assessed to identify if this is a significant risk factor to patient care.	From April 2019, national standard of 28 diagnostic cancer pathway (Imaging component 1 week turnaround) has been in place for cancer targets but these are not sustainably deliverable under current workforce and equipment capacity. Reduced effectivness of the diagnostic aspect of the of the patient pathway will lead to reduced effectiveness of the whole trust to meet national standards e.g. cancer, 18 week and AE. This would lead to low performance ratings with improvement notices and possible national media coverage. Length of stay will also be increased. Complaints from consultants and clinical teams due to reports being unavailable and potential for wasted outpatient appointments as a	Louise Holland	1 5	• • • • Inpatient and urgent examinations are prioritised for reporting • • Radiologists are contacted on an adhoc basis to reivew cases which need urgent review • • Clinical team respond to requests to expedite individual cases • • A&E referrals are prioritised • • WLI reporting sessions underway with Divisional and Trust agreement to maintain these at 2 week maximum from examination to report • • Consultant radiologists have increased clinical PAs for a 12 month period • • Out of hours radiologist on call duties have been outsourced to a private provider and equivalent PAs reinvested into 7 day working for Consultant Radiologist team • Natural Barrier • Approval of business case for radiology capacity	• • • • • • • • • • • • • • • • • •	

Walsall Healthcare Risk Register

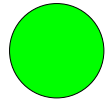
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		result. This may result in low staff morale and breeches of 18 week targets Low staff morale affecting all members of the imaging team, associated with not being able to provide a high quality service and concern for the implications of this. In addition, high levels of stress as staff are placed under pressure by colleagues to respond to requests to expedite the reports. Risk of adverse publicity due to individual patients informing the press of negative experience or failure to meet national targets attracting media attention. This may result in local media coverage with short term reduction in public confidence. Risk of mis-diagnosis by radiologists due to increased speed of reporting to accommodate					

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		demand, associated with failure to review all images fully due to speed of reporting and/or interruptions to clinical reporting sessions. This has the potential to lead to patient formal complaints and litigation claims between £10,000 and £100,000 There are specific service impacts on MSK, Head and Neck (thyroids), Cardiac CT, CT Colon and AKI Ultrasound.					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/09/2020	Business case to be developed to secure funding for recruitment of Consultant Radiologists.	Harinder Rai	29/11/2020	04/12/2020

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	20	• • 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 20/10/20 - staffing hub for nursing reinstated	• 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. •	
					• • 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	• 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. •	
					• • 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	• Overview of compliance levels at Performance Meetings. Rapid response to falls in levels of essential role based training. •	
					• • Staff well being policy with additional	• 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
					support identified and put in place to support staff as part of the COVID-19 response. 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	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 20/09/20 - Response from NHSI received and funding available made clear. Very tight turnaround for further information to support progression of the bid which is being worked through by Kelly Geffen.	Ann-Marie Riley		26/12/2020	31/12/2020
26/03/2020	Continued proactive recruitment strategy	Ann-Marie Riley		26/03/2021	31/03/2021
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly.	Caroline Whyte		26/12/2020	31/12/2020
13/11/2020	Deputy DoN to meet with HR to agree temorary mandatory training schedule	Caroline Whyte		15/11/2020	20/11/2020
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 27 Oct - establishment review meetings delayed slightly due to CQC inspection/COVID -now complete. Recommendations to be presented in Nov	Ann-Marie Riley	**Closed**	25/11/2020	30/11/2020

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
No.	HSMR (HED) nationally published in arrears	129.03	109.1	104.86	104.39				100	110.28		
No.	SHMI (HED) nationally published in arrears	119.25	109.91	87.39					100	110.73		
No.	MRSA - No. of Cases	0	0	0	0	0	0	0	0	4		
No.	Clostridium Difficile - No. of cases	3	3	3	3	2	5	23	26	36		
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.73	1.24	0.9	0.72	0.49	0.85					
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.48	0.69	0.45	0.86	0.24	0.24					
Rate	Falls - Rate per 1000 Beddays	6.52	4.75	4.66	5.21	3.26	4.67		6.1			
No.	Falls - No. of falls resulting in severe injury or death	0	3	0	3	1	2	1.285714	0	20		
%	VTE Risk Assessment	91.13%	92.83%	93.67%	94.15%	89.51%	91.24%	91.24%	95.00%	92.22%		
No.	National Never Events	0	0	0	0	0	0	0	0	1		
Rate	Midwife to Birth Ratio	29.6	33.4	32.7	30.8	28.5	37.3		28			
%	C-Section Rates	33.94%	30.03%	29.62%	25.42%	30.11%	26.21%	29.16%	30.00%	30.16%		
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	15.61%	14.81%	14.62%	15.53%	13.64%		14.55%	10.00%	11.50%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours	88.65%	90.10%	88.73%	87.82%	84.98%	86.65%	87.87%	100.00%	84.59%		
%	Compliance with MCA 2 Stage Tracking	64.44%	75.00%	36.84%	85.71%	46.67%	52.38%	61.33%	100.00%	62.61%		
%	Friends and Family Test - Inpatient (% Recommended)	89%	89%	87%	88%	88%	92%		96%			
%	PREVENT Training - Level 1 & 2 Compliance	90.70%	90.64%	92.12%	92.91%	93.34%	89.85%		85.00%			

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	PREVENT Training - Level 3 Compliance	80.82%	82.68%	85.44%	86.79%	86.74%	87.69%		85.00%			
%	Adult Safeguarding Training - Level 1 Compliance	96.55%	95.07%	96.34%	96.26%	97.18%	96.44%		95.00%			
%	Adult Safeguarding Training - Level 2 Compliance	86.38%	88.94%	91.22%	93.01%	93.50%	94.77%		85.00%			
%	Adult Safeguarding Training - Level 3 Compliance	56.77%	55.96%	58.83%	66.01%	67.33%	69.26%		85.00%			
%	Children's Safeguarding Training - Level 1 Compliance	88.42%	89.81%	92.27%	95.53%	96.43%	88.51%		95.00%			
%	Children's Safeguarding Training - Level 2 Compliance	86.94%	86.54%	88.44%	90.60%	89.94%	90.60%		85.00%			
%	Children's Safeguarding Training - Level 3 Compliance	78.89%	79.46%	82.18%	82.00%	81.06%	83.61%		85.00%			

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Performance, Finance & Investment Committee (PFIC) Highlight Report			**AGENDA ITEM: 14**
Report Author and Job Title:	Trish Mills, Trust Secretary	**Responsible Director:**	Mr John 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 meeting on 26 November 2020. The meeting time and agenda were shortened to allow executives to focus their time on the response to the second wave of COVID-19. Of note are: - The Committee commended the Executive for the effective mobilisation of plans for the second wave of COVID-19. - The Committee was informed of Chairs action taken between meetings in accordance with standing orders, which included approval of Infection Prevention and Control resources, and an increase to the Bank Rate to February 2021. - The Trust has attained a small surplus of £73k to 31st October 2020, an improvement over the planned surplus of £48k. However, the Trust is forecasting increased expenditure that will result in the Trust moving into a planned deficit for November 2020 (the plan a £3.8m deficit at 31st March 2021). The members noted the risk associated with income reductions associated with non-attainment of historic elective activity, the reported position containing no provision for this potential loss of income. Escalation and discussions are continuing with the regulator to seek clarification of the income risk. - There was good progress on the restoration and recovery plan prior to the second wave of COVID-19, with elective and day case activity being restored to 92% of pre COVID-19 norms in October; and 18 week referral to treatment time and 6-week wait diagnostics performance strong relative to other trusts. However, given that the number of patients with COVID-19 in the second wave is significantly higher than predicted in Walsall, the Trust has had to reduce routine elective surgery to release staff to support Critical Care. Due to this, together with the enhanced COVID-19 services that the Trust will be delivering over the coming months, the next meeting of the Committee will		

	look at the full month quantitative and financial impact on services under the restoration and recovery plan. - Good performance on constitutional standards continues both in community and the acute, however the Emergency Department has seen deterioration in the 4 hour access standard. As predicted, the familiarisation process for staff on the newly introduced Electronic Patient Record was a significant contributory factor. The Committee commended the teams for excellent performance during difficult times to reduce the number of patients at the Walsall Manor Hospital who are medically stable for discharge. - Prioritisation of the Improvement Programme in light of the second wave of COVID-19 was discussed, and further work was requested on the impact of projects prioritised and paused was requested. - The Committee discussed the submission of the Full Business Case (FBC) and separate request for enabling works funding approval submissions to NHSEI. The Trust needing to secure approvals to resource the enabling works to 31st March 2021 and approval for the FBC to enable the full contract to be awarded. The timeframes for completion of the construction works are crucial to meet expected patient flow/demand, and a further Board discussion on the risks will be held regarding capital prioritisation of internally generated and held resources. The next meeting of the Committee will take place on 16th December 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 – 3rd December 2020			
Use Resources Well Executive Report			**AGENDA ITEM: 15**
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 Resources Well 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 Resources Well 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 allocation for the remainder of financial year 2020/21, on financial performance for Month 7 of this financial year, and on remaining items of uncertainty / risks (revenue and capital). This report identifies continued strong operational performance in national rankings for the elective NHS Constitutional standards. It also shares with Board members the impact of adjustment to the new Electronic Patient Record in the Emergency Department and the significant impact on Emergency Access Standard performance as a result. It describes the extent to which Walsall has been disproportionately hard hit again in the second wave of COVID-19, and the consequential impact on elective care restoration and recovery.		
Recommendation	Members of the Trust Board are asked to note the contents of this report, and the next steps: i. Re-forecasting elective restoration and recovery plans in the context of a second wave of COVID-19 that has far exceeded the original planning parameters. ii. Assessment of the quantified impact of the necessity to prioritise Improvement Programme workstreams, including the deferral of some schemes. iii. Securing NHSEI agreement to proceed with enabling works associated with the Emergency Department development		

	iv. Confirmation from NHSEI of the income risk associated with non-attainment of historic (non-urgent) elective performance	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report addresses BAF Risk S05 – Use Resources Well 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* October Public Trust Board approved the Trust's Urgent and Emergency Care and COVID-19 resilience Winter Plan, at a cost of £4.697m which is accounted for in the likely financial modelling scenario for months 7-12. The return to a level 4 national incident due to the scale of the second wave of Covid-19 has not yet resulted in further resources being allocated to the Trust.	
Legal and Equality and Diversity implications	There is clear evidence that greater deprivation is associated with a higher likelihood of utilising Emergency Department services, meaning longer Emergency Access Standard waiting times will disproportionately affect the more deprived parts of the community we serve. Whilst not as strongly correlated as emergency care, there is also evidence that socioeconomic factors impact the likelihood of requiring secondary care elective services and the stage of disease presentation at the point of referral. Consequently, the Restoration and Recovery of elective services, and the reduction of waiting times for elective services must be seen through the lens of preventing further exacerbation of existing health inequalities too.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

USE RESOURCES WELL

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 initial national level 4 incident prompted by the COVID-19 pandemic, and the return to this status as a result of the scale of the second wave. The Trust has incurred significant additional costs associated with COVID-19 (during the period in which a top up could be requested, £13.8m was received in order to attain break-even) to ensure patients and staff are kept safe.

This report identifies continued strong operational performance in national rankings for the elective NHS Constitutional standards. This provides evidence that the careful management of available Trust resources is resulting in improved access to care for the patients we serve relative to other NHS organisations, particularly measured against the 18-week Referral to Treatment standard, and the 6-week wait Diagnostic (DM01) standard.

This report summarises the impact of the adjustment to the new Electronic Patient Record in the Emergency Department (ED), and the consequent adverse impact on Emergency Access Standard performance.

This report identifies the financial performance to month 7 from the confirmed income settlement for months 7-12 of this financial year, and the remaining uncertainties/risks regarding the financial settlement and work progressing to secure approval for works associated with the Emergency Department development.

This report also highlights to the Board the clear risk that the nationally set assumptions in relation to COVID-19 positive hospitalisations, which were used to underpin the Trust's Urgent & Emergency Care and COVID-19 Resilience Winter Plan have been materially exceeded. Namely, the assumption of a 2nd COVID-19 peak being at 50% of the April peak has been significantly exceeded, with the Trust surpassing 80% of the April peak in early November.

2. BOARD ASSURANCE FRAMEWORK

The Use Resources Well Board Assurance Framework (BAF) risk has been further updated to reflect the COVID-19 2nd wave exceeding planning parameters, the significant uncertainty to the 21/22 financial planning arrangements and the uncertainty associated with the potential impact of the Elective Incentive Scheme in 20/21.

The primary strategic risk affecting this month's cycle of BAF updates is the clear evidence that the second wave of COVID-19 has materially exceeded 50% of the April peak, and thus materially exceeded the base case planning assumptions. As of 10th November 2020, the Trust had 157 COVID-19 positive inpatients, representing 83.5% of April's peak. In mid-November the Trust had the 7th highest proportion of its hospital beds occupied by COVID-19 positive inpatients in the country, and the Trust has consistently had one of the highest Critical Care bed occupancies in the Midlands, relative to baseline commissioned establishment, during the second wave. The second wave of COVID-19, at this scale, will adversely affect the Trust's restoration and recovery plan, and will pose financial risks due to the need to care for more acutely unwell and critically unwell inpatients than forecast.

Key financial risks are articulated within the corporate risk register and inform the Use Resources Well 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
- Securing the income block allocation in full, with no reduction based on non-attainment of historic non-urgent elective activity.
- 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 normal planning process halted.

The Trust attained a break-even financial position for the initial six months of the financial year (attaining break-even through requesting additional funds of £13.8m for the period as a top up. From month 7 onwards, the Trust no longer receives retrospective top up income to offset costs, instead the Trust has negotiated an income settlement for the remainder of the financial year. As at Month 7 the Trust is performing slightly better than the financial plan with a surplus of £0.073m versus a plan of £0.048m, with the income settlement off-setting costs incurred.

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), which has been met through the income settlement.

Whilst this plan delivers key elements prioritised by Board, it does not deliver historic levels of elective activity. Resulting, in a key risk to the plan remains the uncertainty over the financial consequences of non-delivery of historic elective activity (for which NHSEI can reduce income allocations at a Strategic Transformation Partnership (STP) level through the Elective Incentive Scheme).

The Trust has secured income for the latter half of the financial year in the likely income scenario and run rate modelling. The STP as a whole is working to a deficit plan of £27.1m with the Trust having a £3.8m deficit in year. The deficit for the Trust is driven by omissions contained within NHSEI's income allocation methodology (the overall deficit of the STP a consequence of these income allocation shortfalls).

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. The Trust held discussions with NHSEI regarding a further allocation of £2m to support Critical Care but unfortunately received no award. The Trust has now received a £200k allocation for Endoscopy.

Securing efficiencies from the Improvement Programme to ensure the Trust exit run rate aligns to available income for 2021/22 is key to securing a balanced financial model for clinical care.

The Trust has submitted a request for funding to support the new Emergency Department and Acute Medicine development enabling works (as requested by NHSEI) and in addition has submitted the Full Business Case (FBC) for the development. Approval to the enabling works and the FBC will be critical to keeping the development to programmed completion timeframes.

<u>Operational</u>

Elective Care:

The Trust continues to deliver strong performance in DM01 (6 week wait diagnostics) and 18-week Referral to Treatment (RTT) NHS Constitutional Standards.

The Trust is in line with 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 currently the 17th best performing Trust nationally out of 123 reporting Acute Trusts in the most recently published national statistics (September 2020). Reported performance has improved further in October with the proportion of patients waiting over 6 weeks reducing to 12.35%. There is a risk to November's performance as a result of staff absence in Clinical Measurement Unit services causing more patients to wait over 6-weeks.

The Trust is now ahead of its trajectory to recover the 18-week RTT waiting time standard following the impact of COVID-19 on elective care earlier this year. The Trust's 18-week RTT national ranking position has improved to 22nd best in the country in September out of 121 reporting Trusts, and October has shown the third consecutive month of improvement since the first wave of the pandemic, with performance improving further to 74.03% waiting less than 18 weeks. The extent of the second wave of the pandemic has meant that routine elective surgery has needed to be reduced during November, to release Theatres and Anaesthetics staff to support Critical Care. This will adversely impact on 18-week performance in coming months.

The Trust's Cancer waiting times performance benchmarks reasonably, but with clear opportunity for improvement. 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 commenced on 30th September 2020.

Emergency Care:

As reported last month, the Trust implemented the first phase of its new Electronic Patient Record (EPR) on the weekend of 19th/20th September. This included the Emergency Department (ED) moving from a paper-based clinical record to an electronic clinical record for the first time. Both EPR and ED teams have worked very hard to make the transition, and the new EPR is well-received within ED. However, it has resulted in a significantly longer cycle time for ED's own part of the patient pathway. October was the first full month post go-live and so monthly reported Emergency Access Standard performance deteriorated further, as predicted. There is clear evidence in November of improved time from arrival to triage in ED, improved time from arrival to being seen by a doctor/practitioner in ED, and of improvement in Emergency Access Standard performance as a result. The ED Improvement Programme that has delivered these post go-live improvements will continue to run until we are assured that Emergency Access Standard performance is materially recovering.

4. IMPROVEMENT PROGRAMME

The Use Resources Well component of the Improvement Programme has needed to be re-prioritised in light of the scale of the second wave of COVID-19. The details of this are covered under Agenda Item 9: Improvement Programme.

The attainment of recurrent financial efficiency improvement through the Use Resources Well 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. Re-forecasting elective restoration and recovery plans in the context of a second wave of COVID-19 that has far exceeded the original planning parameters.
ii. Assessment of the quantified impact of the necessity to prioritise Improvement Programme workstreams, including the deferral of some schemes.
iii. Securing NHSEI agreement to proceed with enabling works associated with the Emergency Department development
iv. Confirmation from NHSEI of the income risk associated with non-attainment of historic (non-urgent) elective performance

APPENDICES

1(a). Board Assurance Framework Risk S05
1(b). Corporate Risk Register
2(a). Performance Report (Finance and Constitutional Standards)
2(b). Performance Dashboard

Public Trust Board 3rd December
Agenda Item 15, Appendix 1a

Walsall Healthcare NHS
NHS Trust

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:**	Director of Finance
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 = 16) •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**			Evidence of risk control • Achievement of 19/20 financial plan. Evidence of risk gaps in control • The Trust experienced run rate risk for the 19/20 financial year that led to needing to re-forecast outturn during the financial year. • High reliance on temporary workforce • Lack of credible plan to address backlog maintenance requirements. Evidence of planning uncertainty • The Trust has an Emergency Budget for April 2020 to September 2020, and only received confirmation of October 2020 to March 2021 income levels in October 2020. • Financial improvement planning and delivery has been impacted by Covid-19. • Significant uncertainty associated with 2021/22 financial arrangements.	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:	**20 (Major)**	**20 (Major)**				**Risk Level:**	**10 (Moderate)**	

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 • Board Development session for the Improvement Programme with identified 3-year targeted financial benefits.	• 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	• Externally benchmarked Financial performance data.
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, with leadership development programme deferred due to Covid-19 second wave. • Covid-19 second wave significantly exceeds planning parameter assumptions. • Application of the Elective Incentive Scheme in systems that have experienced significantly greater Covid-19 second wave pressures than others.		

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. • Late confirmation of a confirmed Month 7 -12 20/21 financial plan		

Future Opportunities

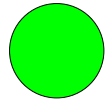
- Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area.
- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with 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

- Covid-19 second wave significantly exceeds planning parameter assumptions, leading to increased costs delivering safe emergency and critical care.
- 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.
- 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 2 Progress Report**	**BRAG**
2.	Review and update Accountability Framework further to the NHSI Governance Review report.	R. Caldicott	Oct 2020		
3.	Financial regime post 31st September 2020 to be approved by Board in October 2020- Russell Caldicott	R. Caldicott	Oct 2020	Financial regime only confirmed in late October.	
4.	All work-streams to have Improvement programme benefits defined.	G. Augustine	Oct 2020	**Complete – Presented to Trust Board Development Session on 1st October 2020**	
5.	Development of 2021/22 Financial plan	R. Caldicott	March 2021		

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 6	• 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 had delivered performance over 95% on 5-seperate weeks over June, July and August 2020. Ambulance handover times were being achieved (within 30-mins) Time to triage were being achieved (within 15 mins) Since implementation of the Medway electronic patient record system in Sept 2020, there has been significant deterioration in performance against the access standard, ambulance handover and time to triage associated with the transition to the Medway system. • Monthly reporting to NHSi System review meeting oversight via regulator and CCG	
					• Process • Operational demand management policies & procedures in place. Escalation policy in place to manage overcrowding in ED.	• Trust's performance has dropped due to increasing numbers in the department and introduction of Medway. • NHSE/I & ECIST 'Critical Friend' visit to be arranged during October/early November.	
					• 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.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						• 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 £4.1m capital funding will provide additional portcabins to reduce over-crowding within the waiting room, and a further 9 cubicle spaces for ED. Work to be completed 18/12/20.	
					• Process • Substantive staff are in place to provide safe and high quality care and use our resources well	• A rolling program of Nurse recruitment with interviews held 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 approved at Trust Board in June 2020 and will address the royal college guidance. New ED Matron appointed in October Interviewed for RGN Posts in November and offered: 4 x Band 6, 1 x Band 5 and 8 CSW's. Band 7 advert currently advertised. • Safe staffing report published monthly on website Staffing levels are overseen via system review meeting Agency meeting review with NHSi	
					• Process • Process agreed with WMAS 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 • NHSE/I have introduced an escalation policy and COO must report any delays >60mins within 24 hours along with actions to address delays.	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					•	•	
					• 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	•	
					• Physical Barrier • 4.7 million revenue funding for the Trusts urgent and emergency care Covid-19 resilient winter-plan approved by the Board in October 2020	• Increased capacity in community services to reduce hospital admissions and reduce length of stay. In addition, to reduce hospital admission, increased emergency surgical, paediatric, diagnostic and support service capacity to minimise delays for patients needing admission to hospital. •	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
14/06/2020	Creation of a psychiatric decision unit for the mental health teams to assess patients away from ED and to provide a calm environment.	Kate Salmon	25/09/2020	30/09/2020
11/10/2020	Deputy Director of Operations for MLTC will spend up to 8 weeks working on a Rapid improvement plan for ED. Meetings are being held three times/week to work through all of the issues and identify solutions.	Kate Salmon	06/12/2020	11/12/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
274	Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care.	Failure to identify, purchase and replace sufficient medical equipment has the potential to harm patients and impact staff negatively.	Michael Koushi	1 6	• Process • Allocation of circa £1.5 million from NHSEi, Covid funds and additional critical care funds to support the Trust capital equipment programme in 2020.	• Regular review at Medical Devices Group Regular Risk reviews in place Divisional representation on the Capital Controls Group to support allocation of medical equipment. • Internal audit and Annual Report Regional Group for Medical Equipment	
					• 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
20/10/2020	To identify a budget so equipment can be funded based on risk.	Jane Longden	22/11/2020	27/11/2020

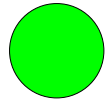
Walsall Healthcare Risk Register

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	15	• • Organisation IT related Disaster Recovery/BC plans. IG and Data protection compliance.	• New EPRR Manager now in post • Data security Toolkit rating	
					• Process • Penetration testing undertaken annually through internal audit which identifies necessary digital safety actions required.	• Action plan developed following penetration testing and monitored via digital services governance meeting. •	
					• Physical Barrier • All vulnerable systems Sandboxed.	• 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.	
					• • Windows IOS upgrade pgoramme	• •	
					• Physical Barrier • Cyber Next generation measures put in place	• 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*
15/07/2020	OS upgrade programme to Windows to be undertaken.	Daren Fradgley		26/12/2020	31/12/2020
30/06/2020	Risk raised from Divisional to Corporate	Andrew Griggs	**Closed**	25/06/2020	30/06/2020
03/09/2020	Cyber Security Desktop scenario exercise planned for Sept 3rd 2020	Andrew Griggs	**Closed**	25/09/2020	30/09/2020

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 grading of high risks to low risks has a material effect on the Estate as high risk failures will obviously increase the effect to operational practices compared to significant, moderate or low risks.This risk 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	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. HIGH RISK	• 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
		- £5500. The segregation of risks into these categories dictates the priority works on site that need to be addressed. £3.8 million capital has recently been received by the Trust and designated for "Critical Infrastructure Risk" - some minor Covid capital funding has been received also.			• 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 and HSDU infrastructure requires resplacing due to the age and condition is past its life expectancy. The initial survey costs are around £1.8 million with £900k of that being high risk.	• 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. HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK	• Ensure that the equipment is being maintained. • Skanska maintaining equipment and doing monthly ppms	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • Medical Air & Vacuum Plant HIGH RISK	• Ensure the maintenance of the equipment as per the HTM and monthly PPMs. • Ensure monthly ppms and maintenance done through Hard FM and Estates Services Group.	
					• Process • Control Panel Units HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK	• 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	

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 • Nurse call and bed head services HIGH RISK	• 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 HIGH RISK	• 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 HIGH RISK Cost Circ £4 million.	• 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 HIGH RISK	• 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. HIGH RISK	• 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 HIGH RISK	• 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.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • Pump sets HIGH RISK	• 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 • Water Treatment Plants HIGH RISK	• 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 HIGH RISK	• 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 • Building Management System HIGH RISK	• 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 HIGH RISK	• 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.	
					• Physical Barrier • The replacement of £1.8 million of HSDU plant that is past is end of life date.	• The plant is monitored from HSDU to EBME and through the Estates team each month. Any issues are referred to our external contractors. • Skanska maintain the plant to HTM	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						and do monthly ppms as do EBME in respect of quality testing	
					• Physical Barrier • Steam Distribution and Condensate systems MEDIUM RISKS	• Lifecycle plan reviewed by Trust through ESG and Hard FM • PPMs conducted by Skanska	
					• Physical Barrier • Steam Generators - Medium Risk	• Hard FM and Estates Services Group being informed in respect of issues and risk. • Skanska do monthly checks through ppms and also report back in Hard FM and ESG.	
					• Physical Barrier • Water Treatment plant - additional works Medium Risk	• Hard FM and ESG report back on a monthly basis to Trust. • PPMs carried out and any remedial works undertaken and reported if any major issues.	
					• Physical Barrier • Cold Water Storage Tanks Medium Risk	• Trust reviews with PFI partners on a monthly basis. • PPMS done monthly and reported back in Hard FM or ESG with any remedial works that need doing.	
					• Physical Barrier • Low Voltage Power Outlets Medium Risk	• Trust receives any updates by exception about kit and liaises with Hard FM provider. • Hard FM provider does ppms and reports back through Hard FM	
					• Physical Barrier • Windows per Module Medium Risk	• Trust to raise windows and draft issues with PFI contractor and identify minor works. • PFI contractors to provide assurance through ppm checks of remedial works in the interim period.	
					• Physical Barrier • Floor Coverings Medium Risk	• Flooring issues identified by Trust and relayed to PFI partners with a view to either conducting remedial works or replacement. • Reported through Hard FM	
					• Physical Barrier • Capital Funding to proceed with high risk issues outlined in Risk 1005.	• Funding of £3.8 million and £4.1 million has been received by the Trust and is being prioritised. This will be reviewed as part of the Trust's current lifecycle plan which is being agreed at present with Skanska &	

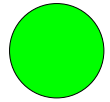
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					PCo. • The monies will be used for backlog maintenance and Theatres have been identified in the first instance.		

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
05/11/2018	All areas to have business continuity plans	Mark Hart	21/02/2021	26/02/2021
01/04/2019	Located the summary of the latest update to PFIC.	Ned Hobbs	26/03/2021	31/03/2021

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.	

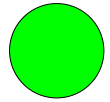
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Physical Barrier • Retained Estate Fire Compartmentation. Works stopped due to Covid have been recommenced now for over a month and will take 26 weeks to complete.	• Trust has received confirmation of full programme of works and updated through monthly meetings. The works have now recommenced and will be reviewed on a monthly basis. • PFI partners updating trust through Hard FM meetings and ESG.	
					• Physical Barrier • Retained Estate Fire Compartmentation	• •	

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	26/03/2021	31/03/2021
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
20/10/2020	To be completed in a 26-week period now all areas identified. Covid may cause some delays in respect of access.	Colin Plant	26/03/2021	31/03/2021
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	26/03/2021	31/03/2021
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	26/03/2021	31/03/2021

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 Financial arrangements altered/set by NHSE/I	• 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. Financial arrangements set by NHSE/I have been complied with. The Trust has declared breakeven months 1-6	
					• • 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	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					•	• Appropriately qualified staff • Draft reporting from NHSE/I	
					• NHSI/E have been asked by Trust Board to do a review on Finance and PMO functions. The draft outcomes of this report support the performance of these areas. There is strong control in this area		
					•	• 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	
					• Robust financial management arrangements are in place across the organisation		
						• 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		25/04/2021	30/04/2021
15/05/2020	Ongoing development of financial reporting to highlight key issues	Russell Caldicott	**Closed**	26/03/2021	31/03/2021
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	**Closed**	26/10/2020	31/10/2020

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. Financial arrangements altered/set by NHSE/I	• 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 Financial arrangements set by NHSE/I have been complied with. The Trust has declared breakeven months 1-6	
					• 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 •	

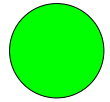
Walsall Healthcare Risk Register

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*
17/05/2020	A process to be established to ensure alignment between the operational planning process and the improvement programme	Glenda Augustine		25/11/2020	30/11/2020
15/05/2020	Delivery of activity including key groups	Glenda Augustine		25/11/2020	30/11/2020
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		13/12/2020	18/12/2020
17/05/2020	PIDS to be developed and approved which outline Financial Benefit	Glenda Augustine		25/11/2020	30/11/2020
17/05/2020	benefits realisation process to be developed including ongoing tracking and closure process	Glenda Augustine		26/12/2020	31/12/2020
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	2	• 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

- Despite cessation of most routine 6 Week Wait (DM01) Diagnostics during March and April, and the associated deterioration in waiting times, the Trust's performance has continued to improve in October and the Trust's national ranking position continues to remain strong, at 17th best in the country in September out of 123 reporting Trusts. Self-isolation of staff within the Clinical Measurement Unit services during November will temporarily impact recovery further recovery of the DM01 standard.
- Despite cessation of routine elective services during March and April, the Trust's 18-week RTT national ranking position has further improved to 22nd best in the country in September out of 121 reporting Trusts. October has shown the third consecutive month of improvement since the pandemic, with performance improving further to 74.03% ahead of the trajectory.
- The Trust attained a break-even financial position for the initial six months of the financial year (attaining break-even through requesting additional funds of £13.8m for the period as a top up. The Trust no longer receives retrospective top up income to offset costs, instead the Trust has negotiated an income settlement for the remainder of the financial year. As at Month 7 the Trust is performing slightly better than the financial plan with a surplus of £0.073m versus a plan of £0.048m, income settlement off-setting costs incurred.
- The Trust has secured capital resources for Critical Infrastructure Risk (£3.7m) which enables replacement of the end of life theatre air handling units and in addition has secured further capital funding to support Urgent and Emergency Care of £4.1m (with the works set to complete by 18th December 2020).

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 Concern

- As reported last month, the Trust implemented the first phase of its new Electronic Patient Record on the weekend of 19th/20th September. This included the Emergency Department (ED) moving from a paper-based clinical record to an electronic clinical record for the first time. Both EPR and ED teams have worked very hard to make the transition, and the new EPR is well-received within ED. However, it has resulted in a significantly longer cycle time for ED's own part of the patient pathway. October was the first full month post go-live and so monthly reported EAS performance deteriorated further, as predicted. There is clear evidence in November of improved time from arrival to triage in ED, improved time from arrival to being seen by a doctor/practitioner in ED, and early signs of improvement in Emergency Access Standard performance as a result. The ED Improvement Programme that has delivered these post go-live improvements will continue to run until we are assured that Emergency Access Standard performance is materially recovering.
- The second surge of COVID-19 over Autumn 2020 has exceeded planning parameters of only being at half the level of April's surge. Consequently, the Trust has needed to reduce routine elective surgery during November and reduce targeted outpatient clinics as well, to release staff to safely cover non-elective inpatient wards and critical care. This will impact 18-weeks RTT performance (and to a lesser extent) Cancer performance against previously set trajectories, and the Trust will continue to have 52-week breaches awaiting routine surgical treatment whilst there is insufficient operating theatre capacity to undertake both routine and urgent operations. The Trust had 14 52-week breaches in October.
- In September, The Trust did not achieve 5 of the national constitutional cancer metrics; 2WW GP & Breast Symptomatic with a performance of 86.6% and 72.7% respectively, 31 day wait for first treatment & subsequent surgery was not achieved, with a performance of 92.4% & 90% respectively and 62 day RTT with a performance of 67.8%. Newly instituted weekly PTL meetings are in place.
- The Trust will continue to receive income as a 'block' for the remainder of the 2020/21 financial year (to include fixed income allocations for COVID-19). Should costs exceed the negotiated block income the Trust will move away from the planned deficit of £3.8m for the year, no longer having the capacity to claim additional funds. Temporary workforce costs remain higher than the baseline period and will be a key focus for ensuring delivery of financial balance moving forward.
- The STP has elective activity targets for the remaining months of the financial year (based on a percentage of historic performance). If the STP does not achieve these targets there could be a reduction to the income the Trust is to receive (a reduction in the block). The Trust has seen increased Urgent and Emergency Care demands from the second wave of COVID-19 that has displaced elective (non-urgent) activity. There is no provision made in the financial performance to month 7 for a reduction in income for non-attainment of historic non-urgent elective activity and as such this remains a risk if the income is reduced.
- The Trust has submitted a request for funding to support the Emergency Department development enabling works (as requested by the regulator) and in addition has submitted the Full Business Case (FBC) for the development, approval to the enabling and then FBC will be critical to keeping the development to programmed completion timeframes.
- Securing efficiencies from the Improvement Programme to ensure the Trust exit run rate aligns to available income for 2021/22 is key to securing a balanced financial model for clinical care.

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 Actions Taken

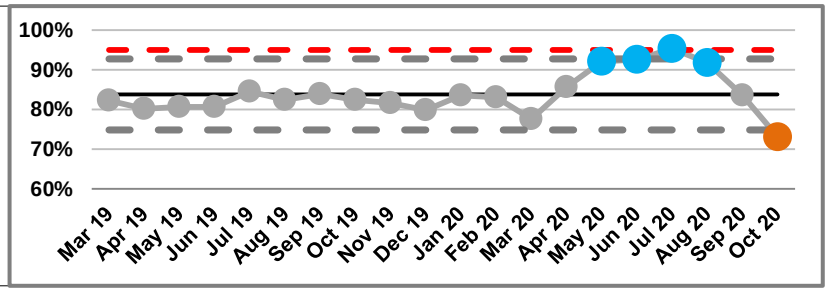
- The STP has provided funding that covers the Trust 'most likely' scenario for months 7-12 and formed a risk share arrangement, costs below income projections for the month of October 2020.
- The Trust has requested from NHSEI clarification of the risk associated with the 'Elective Incentive Scheme' and potential for income to be reduced owing to performance being below historic (non-urgent) elective activity, so as to clarify the methodology and evaluate fully the risk to delivery of the financial plan.
- The Trust has escalated with the regulator the urgent need for approval and allocation of resource to support the Emergency Department capital development.
- Financial modelling has taken place to analyse year on year temporary staffing costs and a review of temporary workforce controls is to be undertaken by the Trust Internal Auditors.
- Improvement Programme financial efficiencies to be presented to Performance, Finance and Investment Committee in January 2021.

Performance, Finance and Investment Committee

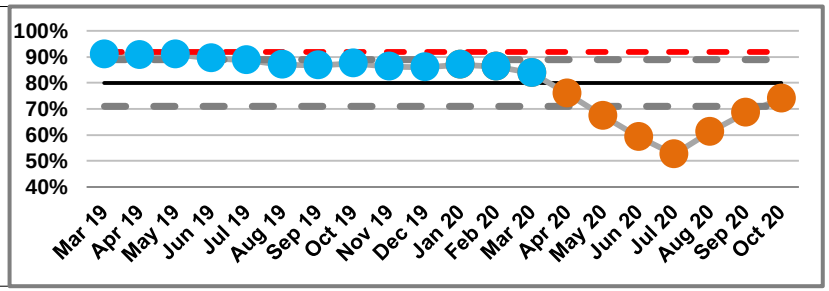
SPC Key

Mean
Process limits - 3σ
Special cause - improvement
Measure
Special cause - concern
Target

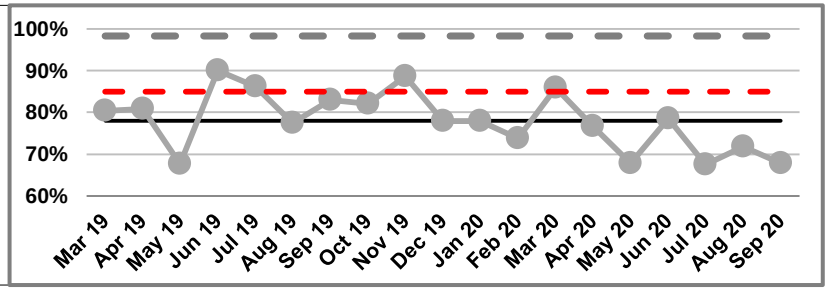
ED - % within 4 hours – Overall (Type 1 & 3)



18 weeks RTT – Incomplete Pathways



Cancer 62 Day RTT



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

EAS achieved 73% of patients admitted or discharged within four hours of arrival. This is the first full month of post Go-Live EPR impact and is the lowest EAS performance for over 2 years. The causes of this further decrease in performance remain the same three. Firstly, the implementation of Medway has had a significant effect on processing speed within the department – increasing cycle time by approximately one third. Actions taken jointly by the department and EPR are reducing this but there remains a decline in speed. Secondly, nurse staffing has been severely challenged during the COVID-19 'second surge'. Finally, hospital flow has been adversely affected by increasing inpatient bed occupancy due to increasing COVID-19 cases, ward closures due to outbreaks, and transfers happening too late in the day.

RTT (18 weeks Referral to Treatment)

Patients waiting greater than 18 weeks reduced during October for the third consecutive month. The surgical specialities benefitted from the reopening of further elective theatres and this increased the number of admitted pathways > 18 weeks being completed (731, which is the best performance since Feb 20). Pathways continue to increase post Medway implementation. There is a requirement for improved data quality and tracking by the teams. BAU activities have been impacted by the need to settle into the new EPR. There is a planned launch of a new Data Quality Referral to Treatment report suite during November to support Care Groups which takes a targeted approach based on a recent best-practice pilot led by the North of England Commissioning Support Unit.

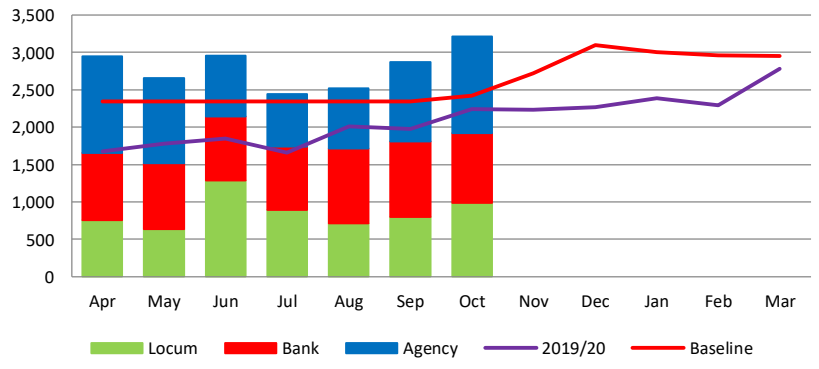
Cancer

The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 67.8%. Actions to recover standard: Trust increased the amount of operating theatres, with a clear theatre rota to protect capacity for cancer within the COVID 19 surge plan. Services continue to access Little Aston to support restoration and prioritise cancer cases. FIT testing continues for patients on the colorectal pathway, a revised administrative process implemented during October to manage patient compliance and support improved tracking. Additional cystoscopy lists in place, with a plan to secure locum support for Urology. Plan to secure Oncoplasty Fellow to support short fall in breast capacity.

Financial Performance to October 2020 (Month 7)

	YTD Oct Plan £000s	YTD Oct Actual £000s	YTD Variance £000s
Income			
Clinical Contract Income	148,533	147,625	**(907)**
Additional Covid Top-up	0	13,678	**13,678**
Other Income (Education&Training)	4,105	4,373	**267**
Other Income (Other)	22,283	18,189	**(4,094)**
Subtotal Income	**174,921**	**183,865**	**8,944**
Pay Expenditure			
Substantive Salaries	(94,816)	(96,921)	**(2,105)**
Temporary Nursing	(8,605)	(9,016)	**(411)**
Temporary Medical	(6,799)	(7,997)	**(1,199)**
Temporary Other	(1,688)	(2,604)	**(915)**
Subtotal Pay Expenditure	**(111,908)**	**(116,538)**	**(4,630)**
Non Pay Expenditure			
Drugs	(10,938)	(9,727)	**1,211**
Clinical Supplies and Services	(10,480)	(8,769)	**1,711**
Non-Clinical Supplies and Services	(9,850)	(10,428)	**(578)**
Other Non Pay	(22,558)	(29,015)	**(6,457)**
Depreciation	(3,571)	(3,968)	**(397)**
Subtotal Non Pay Expenditure	**(57,397)**	**(61,906)**	**(4,510)**
Interest Payable	(5,583)	(5,452)	**130**
Subtotal Finance Costs	**(5,583)**	**(5,452)**	**130**
Total Surplus / (Deficit)	**34**	**(31)**	**(66)**
Donated Asset Adjustment	15	104	**89**
Adjusted Surplus / (Deficit)	**49**	**72**	**23**

Temporary Staffing Expenditure (£,000)



Financial Performance

- The Trust has achieved 'breakeven' for months 1-6 of the 2020/21 financial year through requesting income to off-set costs retrospectively. However, the second half of the year will see a different funding regime and the Trust now receiving block funding that includes an estimation of funds for COVID-19, the retrospective 'top up' for COVID-19 funding removed.
- The Operational Divisions and support functions have produced a Trust run rate plan for the remainder of the 2020/21 financial year, set to deliver; Urgent and Emergency care and COVID-19 resilience, Elective recovery and restoration and maintain measures endorsed for health and well-being and already committed investment in Walsall Together. The Trust has developed a balanced financial plan on this basis.
- The Trust forecasted a surplus of £0.049m in month for October 2020, with the actual performance being slightly better at £0.073m. However, this performance does not account for any income loss from non-achievement of historic elective (non-urgent) activity levels (which remains a risk to delivery of the plan)
- The adverse variance on other income is driven largely by guidelines for COVID-19 resulting in our not being able to charge the CCG for IT, Property Services and other services (£3.3m), the Trust has also lost income on car parking, R&D and accommodation charges (£0.7m) in the first 6 months of the year.
- Temporary workforce expenditure remains over baseline plan and historic levels being driven by increased vacancies, COVID related absence and increased staffing levels.
- Other non pay expenditure is higher, largely due to monthly support costs for the Electronic Patient Record being chargeable this year and costs associated with delays to go live, combined with COVID-19 related costs incurred

Capital

- The Trust has submitted a revised capital plan of £16.5m, though has subsequently received £4.1m for Urgent and Emergency Care (taking the program to £20.6m). Key will be the ability of the Trust to commit and spend the resource during the financial, the expenditure to date on capital totals £5.4m

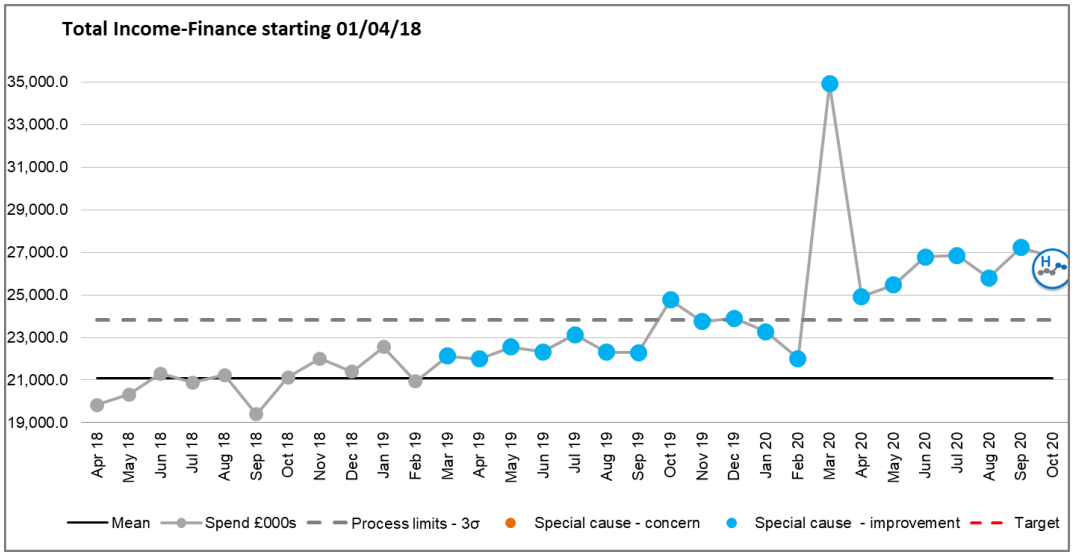
Cash

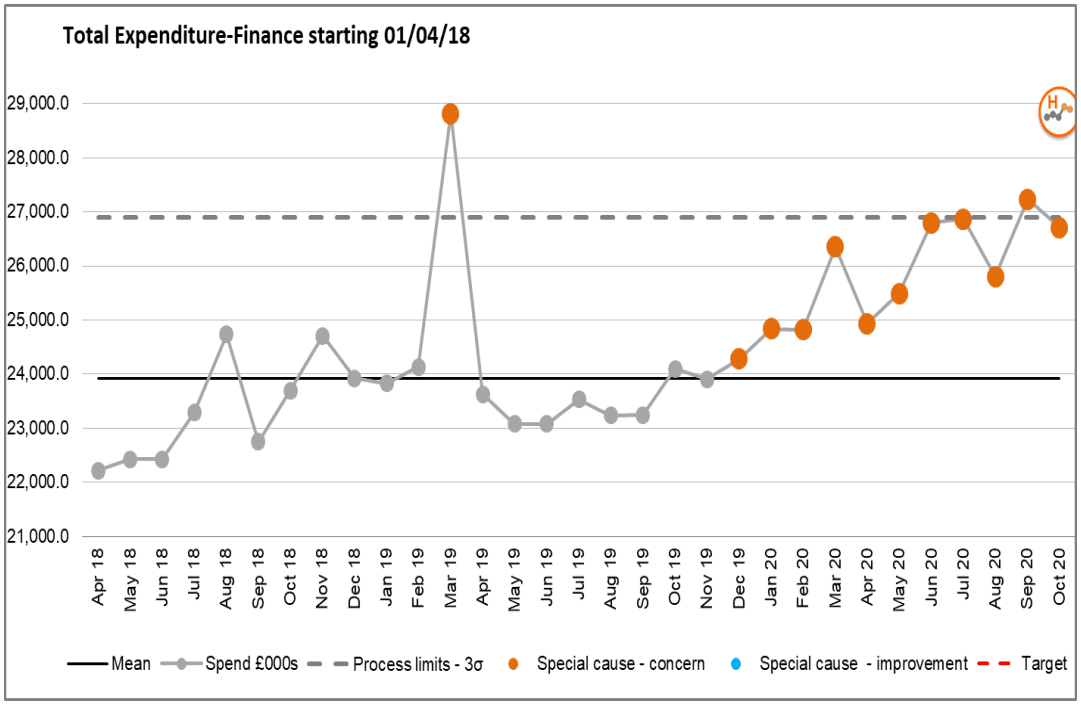
- Actual cash holding was £40m due to the contract payment being paid a month in advance in accordance with the emergency funding guidance from NHSIE. If the Trust is requested to repay this cash allocation the cash holding will reduce accordingly.

Efficiency attainment

- The emergency budget planning letter and guidance states there was no efficiency requirement for Months 1-6. 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 and directly impacting on exit run rate and sustainability.

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).
- From October there will no longer be retrospective top up 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. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend.

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. The actual income secured for the remainder of the financial year resulting in attainment of a balanced position in October 2020.

Cash Flow Statement & Statement of Financial Position (M7)

Walsall Healthcare NHS
NHS Trust

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending October 2020	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	5,421
Depreciation and Amortisation	3,968
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	19,134
Increase/(Decrease) in Trade and Other Payables	16,501
Increase/(Decrease) in Stock	8
Interest Paid	(4,781)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	**40,251**
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(7,078)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(7,078)**
Net Cash Inflow/(Outflow) before Financing	**33,173**
Cash Flows from Financing Activities	(2,237)
Net Increase/(Decrease) in Cash	**30,936**
Cash at the Beginning of the Year 2020/21	9,056
Cash at the End of the October	**39,992**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending October 2020	Balance as at 31/03/20	Balance as at 31/10/20	Year to date Movement
	'£000	**'£000**	**'£000**
Total Non-Current Assets	**144,866**	**145,844**	**978**
Current Assets			
Receivables & pre-payments less than one Year	39,001	20,362	(18,639)
Cash (Citi and Other)	9,056	39,992	30,936
Inventories	2,620	2,613	(7)
Total Current Assets	**50,677**	**62,967**	**12,290**
Current Liabilities			
NHS & Trade Payables less than one year	(25,955)	(20,906)	5,049
Other Liabilities	(1,480)	(22,631)	(21,151)
Borrowings less than one year	(134,693)	(1,733)	132,960
Provisions less than one year	(437)	(437)	-
Total Current Liabilities	**(162,565)**	**(45,707)**	**116,858**
Net Current Assets less Liabilities	**(111,888)**	**17,260**	**129,148**
Non-current liabilities			
Borrowings greater than one year	(116,013)	(116,013)	-
Total Assets less Total Liabilities	**(83,035)**	**47,091**	**130,126**
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	68,300	198,455	130,155
Revaluation	14,832	14,832	-
Income and Expenditure	(166,167)	(166,165)	2
In Year Income & Expenditure	-	(31)	(31)
Total TAXPAYERS' EQUITY	**(83,035)**	**47,091**	**130,126**

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-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)	92.21%	92.62%	95.43%	91.88%	83.50%	73.00%	87.59%	95.00%	81.77%		
%	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	74.72%	78.86%	80.29%	79.35%	58.23%	57.04%	71.07%	100.00%	62.37%		
No.	Ambulance Handover - No. of Handovers completed over 60mins	0	1	0	5	20	66	92	0	312		
%	Cancer - 2 week GP referral to 1st outpatient appointment	95.84%	93.17%	93.00%	92.06%	86.57%	85.45%	90.73%	93.00%	84.07%		
%	Cancer - 62 day referral to treatment of all cancers	67.80%	78.57%	67.44%	71.83%	67.78%	64.36%	70.16%	85.00%	80.93%		
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	67.41%	59.32%	52.50%	61.06%	68.66%	74.03%					
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	8	9	8	14	14	55	0	0		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	36.99%	22.47%	16.32%	18.24%	14.70%	12.35%	19.97%	1.00%	1.63%		
No.	No. of Open Contract Performance Notices	9	9	9	9	9	9		0			
CARE AT HOME												
%	ED Reattenders within 7 days	8.84%	7.82%	8.45%	8.78%	6.63%	7.60%	8.05%	7.00%	7.60%		
RESOURCES												
%	Outpatient DNA Rate (Hospital and Community)	5.28%	5.11%	6.76%	10.25%	11.42%	12.93%	9.09%	8.00%	10.44%		
%	Theatre Utilisation - Touch Time Utilisation (%)	58.08%	47.06%	62.98%	67.50%	43.61%	66.17%	56.63%	75.00%	85.42%		
%	Delayed transfers of care (one month in arrears)	2.82%	2.23%	2.57%				2.54%	2.50%	3.68%		
No.	Average Number of Medically Fit Patients (Mon&Thurs)	36	37	39	35	46	48					
No.	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	4.00	4.00	3.00	3.00	4.00	5.00					
£	Surplus or Deficit (year to date) (000's)	0	0	0	0	0	72					

Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
£	Variance from plan (year to date) (000's)	0	0	0	0	0	23					
£	CIP Plan (YTD) (000s)											
£	CIP Delivery (YTD) (000s)											
£	Temporary Workforce Plan (YTD) (000s)	4700	7000	9400	11700	14100	17100					
£	Temporary Workforce Delivery (YTD) (000s)	5600	8600	11000	13500	16300	19600					
£	Capital Spend Plan (YTD) (000s)											
£	Capital Spend Delivery (YTD) (000s)	1300	3000	3800	4300	4500	5400					

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Walsall Together Partnership Board Highlight Report			**AGENDA ITEM: 16**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mrs Anne Baines – Chair and Non-Executive Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The report provides the key messages from the Walsall Together Partnership Board (Partnership Board) meeting on 18th November 2020. The meeting time and agenda were shortened to allow partners to focus their time on the response to the second wave of COVID-19. Key points for the attention of the Trust Board are: - Support was provided by partners to a Walsall Together approach to the COVID-19 vaccination programme. A sub-group of the partnership has been formed to work through the modelling and delivery of the programme. A verbal update will be provided to Trust Board on progress. - Three new risks have been added to, and are being managed through, the partnership risk register. They, and the existing risks, continue to represent the golden thread of all the identified risks, i.e. the ability to identify funding and resources to effectively and efficiently deliver the ambitious scale of transformation identified in the original business case, within a very challenged population. - The Partnership Board approved the Project Initiation Documents for maternity transformation plan continuity of carer, and first contact physiotherapy. A communications and engagement plan was also approved. - The Partnership Board approved revisions to its Terms of Reference, which will come to the Trust Board for approval once they have been reviewed by the Audit Committee.		
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 (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 in this paper, however the developing approach to health inequalities is noted.	
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 18th November, with the meeting Chaired by Mrs Anne Baines, Committee Chair and Non-Executive Member of the Walsall Healthcare Trust Board. The meeting was quorate, with all partner organisations represented.

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

1. Operational and Winter Updates

The Partnership Board were informed that services are resilient at the moment; however the second wave of COVID-19 was starting to look similar to that of the first wave. The difference being that staff are exhausted and the increasing pressure on staff is impacting, understandably, on their enthusiasm in the second wave. The Board resolved to focus on staff health and wellbeing through future operational updates in addition to assurance on the safe delivery of services.

Key performance indicators were reviewed for partners noting:

- Referrals to the care coordination centre remain high. The centre will become a standalone service from 9th November offering 7 days a week service. The centre is able to deal with referrals using services other than rapid response, which has meant rapid response has been able to maintain service provision for the current demand.
- Community nursing is providing more hours of care and cancelling less hours of care than pre COVID-19. Audits of patients where care was reduced or transferred to self-care are being undertaken. The service is reviewing all patients on the case load for pressure care checks.
- Locality team referrals remain lower than usual; in part reflecting the reduction in hospital based elective activity.
- Adult social care reported a decrease in safeguarding concerns, and the number of new referrals is higher than last month for locality teams, including increase in referrals to the intermediate care service.
- The numbers of patients at Walsall Manor Hospital who are medically stable remain at a reduced level, however the average length of stay is beginning to rise, with the key reason being the ability to discharge COVID-19 positive patients to care homes.
- The reactivation of Decision Support Tools is progressing well within the Intermediate Care Service and Locality Teams.

- Concerns continue about the requirement for staff going into care homes to have weekly COVID-19 swabbing, however a resolution has been found to address this.

- Care homes are seeing increased incidence of positive staff and residents, as well as increases in staff required to isolate. Deaths remain at normal levels and there are no increases in COVID-19 related deaths currently. A meeting is scheduled to discuss the winter response to Care Homes from the Enhanced Team as there are increasing pressures in this part of the system.

- One Walsall is continuing to promote its development tool and training programme, secure funding for voluntary groups (with £176,000 being secured since lockdown), and progress their plans for a place-based volunteer centre.

- Walsall Housing Group's Resilient Communities work included distribution of hampers and fuel vouchers for the community. Their employment and training programme sees unemployed customers gaining employment with Walsall Manor Hospital using an intermediate labour market approach.

- There continues to be significant pressure on Mental Health inpatient beds due to both demand and COVID-19. Inpatient care delivery is being remodelled to improve capacity and continuity, and partners were encouraged to utilise the early help available as part of the IAPTs (Improving Access to Psychological Therapies) service.

- Primary care capacity is reviewed weekly with trigger points in place, with a focus on the safe management of suspected and confirmed COVID cases in primary care.

2. Programme Update

The overall status of the transformation programme is amber. Whilst the majority of milestones on the Plan are now on track following a re-profiling agreed at last month's Partnership Board meeting, there are significant risks to delivery of the programme due to operational pressures and resourcing constraints in the Programme Office.

The following were approved:

(a) Maternity Transformation Plan - Continuity of Carer Project Initiation Document (PID)

The programme provides continuity of carer during the antenatal, intrapartum and postnatal period for all Women who access maternity services within Walsall as per the directive from the Better Births 5 year forward view, in order to improve maternal and perinatal outcomes for Women, babies and their families.

(b) First Contact Practitioner Physiotherapy PID
Partnership with Primary Care Networks to provide a physiotherapy-based First Contact Practitioner service within each network to assess, manage and treat patients with musculoskeletal complaints

(c) Communications and engagement strategy which outlines plans to support the partnership's population health approach and commitment to working together with our citizens and communities to promote equality and reduce inequalities by focusing on the wider determinants health.

3. Integrated Care Provider (ICP) Roadmap

The Board received the pathway to ICP status, indicating the key tasks to be undertaken between now and April 2021. Each workstream will provide details on delivery to that programme given the current pressures and context of the second wave. This will be reviewed in more detail in the December meeting.

4. Risk Register

Three risks have been added to the risk register, and together with those already existing, represents the golden thread that runs through the register which is the ability to identify funding and resources to effectively and efficiently deliver the ambitious scale of transformation identified in the original business case, within a very challenged population. The new risks are:

- Ability to promote and encourage commitment to the Alliance Principles and Alliance Objectives amongst all Alliance Participants may result in an inability to achieve the Alliance aims;
- Inability to identify recurrent funding for several diabetes services may result in poor outcomes for the population and increased usage and expenditure of secondary care services;
- Lack of a robust process and systems for data collection within Walsall Healthcare Trust community services may lead to poor data quality and an inability to take assurance on either operational performance or delivery of the transformation.

There are increasing pressures across the operational and transformational teams as a result of COVID-19 and Winter. Resource is being prioritised according to those initiatives that will have the greatest positive impact in this context.

Partners were encouraged to add risks to the risk register so that they could be supported in their management and mitigation.

5. Terms of Reference

Minor amendments were made to the Terms of Reference of the Committee. These included the addition of Healthwatch as a member; and the addition of the duty to 'provide direction on the options for pursuing ICP or comparable status'.

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Care at Home Executive Report			**AGENDA ITEM: 17**
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 report includes: • Operational performance for Walsall Healthcare services in scope for the Walsall Together partnership, including Adult Social Care, provided via the Section 75; • The most recent Board Assurance Framework (BAF) risk for Care at Home, updated to reflect known pressures across the system as a result of COVID-19; • An overview of what is required from the partnership to obtain Integrated Care Provider (ICP) status. <u>Performance, Assurance and Risk</u> The incident response command and control structure for Walsall Together has been reinstated in response to COVID-19 service pressures across the system around demand, staffing and care capacity. This has impacted on the delivery of the transformation programme and is reflected in updates to the BAF. **However, the full extent of impact of the COVID-19 vaccination programme and associated risks to Programme from diverted time and effort by the Partnership is not yet known. This will be reviewed continually over the coming weeks and reflected in the BAF.** The pattern of demand and delivery within Community Services remains in place with lower referrals, more hours of service delivery and a more complex caseload. The Care Coordination Centre (CCC) formally detached from Rapid Response on 9th November, providing increased capacity for call handling and receipt of urgent referrals. The Safe at Home Service, launched on 17th November, is supporting domiciliary pulse oximetry for patients who would otherwise have remained as inpatients at Walsall Manor Hospital. The numbers of patients at Walsall Manor Hospital who are medically stable remain at a reduced level. The work to clear the backlog of Decision Support Tools is progressing well within the Intermediate Care Service and locality teams		

	Concerns about the requirement for staff going into care homes to have weekly COVID-19 swabbing have been addressed on an interim basis. Community Services have now been allocated 150 swabs each week for staff. It is anticipated that the national swabbing scheme will supersede this approach in the next few weeks. Work to transition the existing Walsall Together partnership to a formal ICP contract has mobilised across multiple workstreams. In the context of growing pressures across the system, each workstream is in the process of confirming the specific deliverables required to operate in shadow form from 1st April versus what is required in advance of the formal contract variation. NHSE/I have requested that the Walsall Together Partnership Board undertakes a self-assessment in accordance with the NHSE/I transaction guidance by 8th January 2021. This will be the main focus of the partnership over the coming 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	BAF Risk SO1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022 BAF Risk- S03 Failure to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities.	
Resource implications	There are no new resources implications associated with this report.	
Legal and Equality and Diversity implications	The issue of health inequalities continues to receive 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.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☒
	Partners ☐	Value colleagues ☐
	Resources ☐	

Appendix 1 – Care at Home BAF

Appendix 2 – Operational Performance Report

Appendix 3 – ICP Overview

Walsall Healthcare NHS
NHS Trust

Risk Summary			
BAF Reference and Summary Title:	**BAF SO2 - Care at Home – We will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall together.**		
Risk Description:	**Failure to work with partners and communities to understand population health and inequalities, integrate place based services and deliver them through a whole population approach would result in a continuation of poor health and wellbeing and widening of health inequalities.**		
Lead Director:	Director of Integration	**Supported By:**	
Lead Committee:	Walsall Together Partnership Board		
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 and the size and complexity of the population health challenges • Minimal programme risks relating to Community Services provision escalated 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 bring the logs together • Risks associated with creating an ICP contract will be considered through a formal due diligence process, supported by NHSE/I	**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 stakeholder 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 seen before and during Covid 19 continue through Phase 2 ? • Virtual clinics and community outpatients progressing at a quicker pace now	**Likelihood:**	**2**	31 March 2021
Consequence:	**4**	**4**				**Consequence:**	**4**	
Risk Level:	**12**	**12**				**Risk Level:**	**Mod 10**	

	Covid response in place • Partnership approach agreed for mortality reviews with care homes		

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 • Partnership Board/Groups and meetings in place Business Case developed PMO/Project in place and reporting	• 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 • Monthly report to Board and partner organisations	Enactment of section 75 in terms of Monitoring meeting External assessment – CQC/Audit STP Scrutiny Health and Wellbeing Board Reporting Scrutiny Committee
Gaps in Control	• No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust • Commissioner contracts not yet aligned to Walsall Together • Data needs further aligning to project a common information picture • Effective engagement with community in development with local groups • Organisational development for wider integrated working not yet outlined or agreed		
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 • Reporting to Board and Partners • Oversight on service change from other committees	• NHSE/I support of Walsall Together • STP support
Gaps in Assurance	• Internal Audit not complete • 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
- Insufficient 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 across partners
- 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
- Programme Resource – Capacity to deliver the WT programme will become more difficult as the same resource will be required to support the delivery of COVID-19 workstreams, e.g. mass swabbing, flu vaccination programme, Covid-19 vaccination programme, outbreak management and the covid-19 management Service (CMS)

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

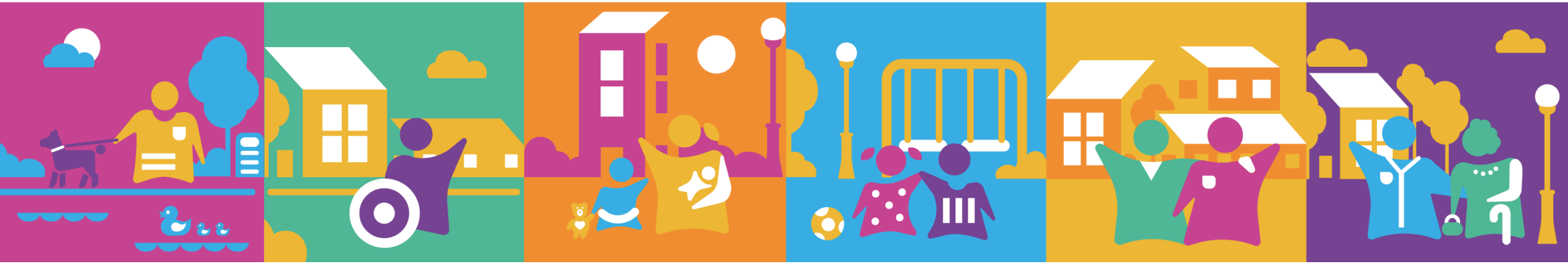
No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Agree a joint business plan for Walsall Together and PCNs that describes how the enhanced and additional roles within the PCN contract will integrate with community services	Daren Fradgley	Dec 20	A formal business plan will be delayed as a result of Primary Care being required to divert time and effort to the COVID vaccination programme. Work continues in regard to establishing formal relationship between community services and primary care to deliver additional roles, starting with First Contact Practitioners for physiotherapy	
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	This work has been subsumed into the ICP transition programme and the refreshed strategic case will form part of the due diligence process, supported by NHSE/I. The initial self-assessment is due in January. Work across the Resilient Communities workstream continues, as does work to develop a Health & Inequalities Strategy	
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. This should include an outline governance structure that shows the links to other WHT committees and acknowledge the transition to holding a formal ICP contract.	Jenna Davies	Mar 21		
5.	Agree a Communications & Engagement Strategy for Walsall, aligning work across all partner organisations, that clearly articulates the ambition for addressing health inequalities and how we will achieve coproduction with our citizens and communities	Daren Fradgley	Dec 20	Approved at Walsall Together Partnership Board in November 20	

6.	Prepare for implementation of a formal ICP contract under a Lead Provider model with WHT as Lead Provider. This will include confirmation of all services in scope and a clear rationale for the change in the context of improving outcomes for the population.	Daren Fradgley	April 21		

Walsall Together

Walsall Healthcare Care at Home Performance Report

Daren Fradgley
Director of Integration / Deputy CEO



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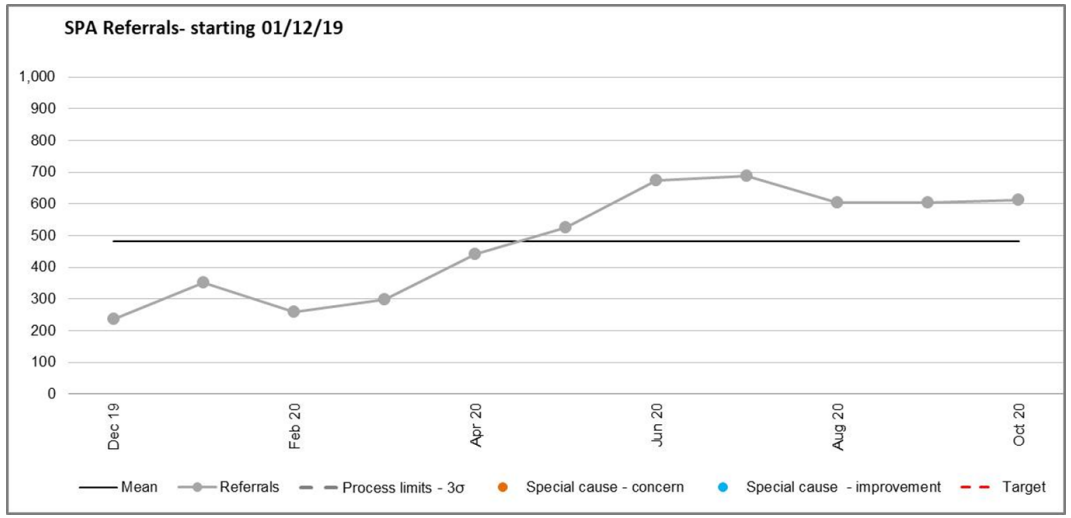
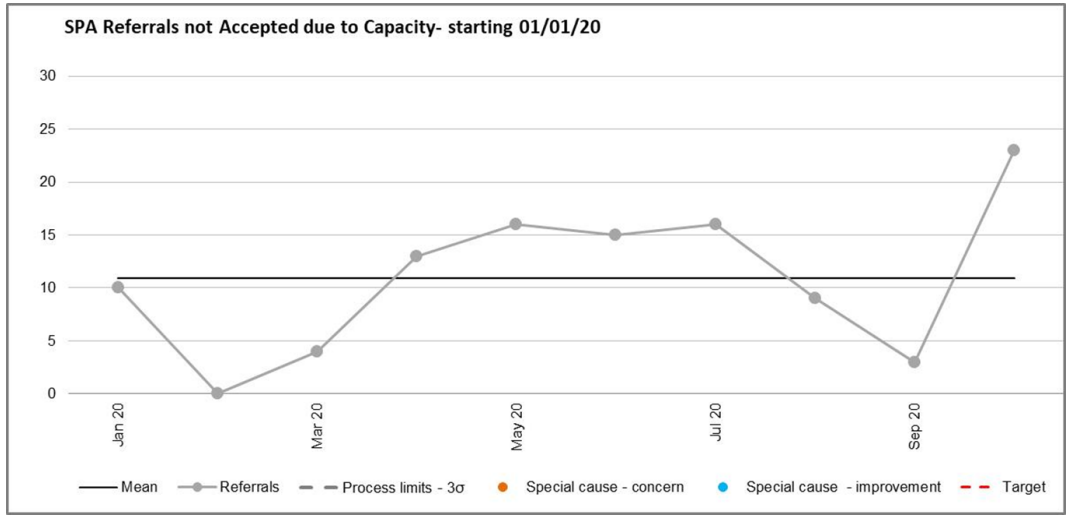
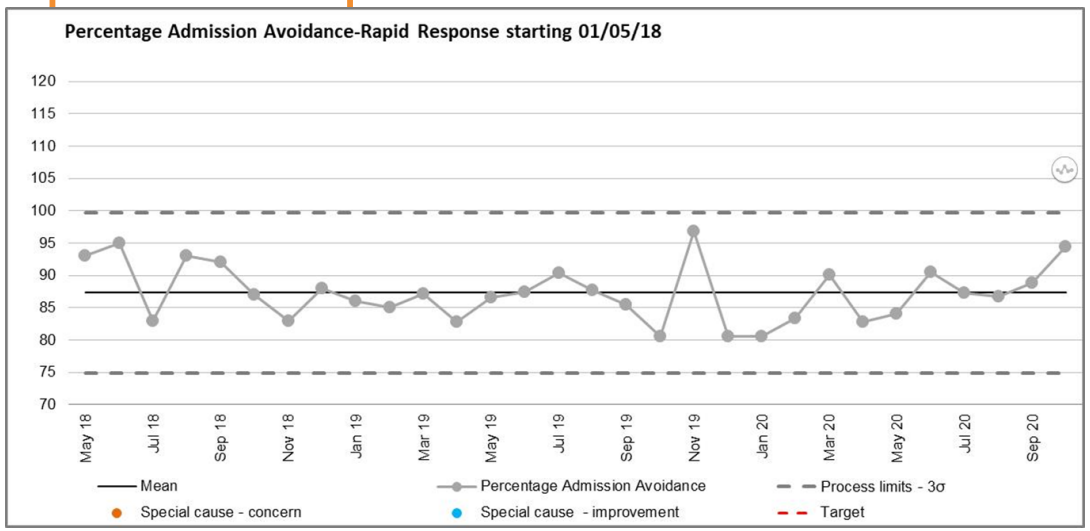
Care Coordination Service

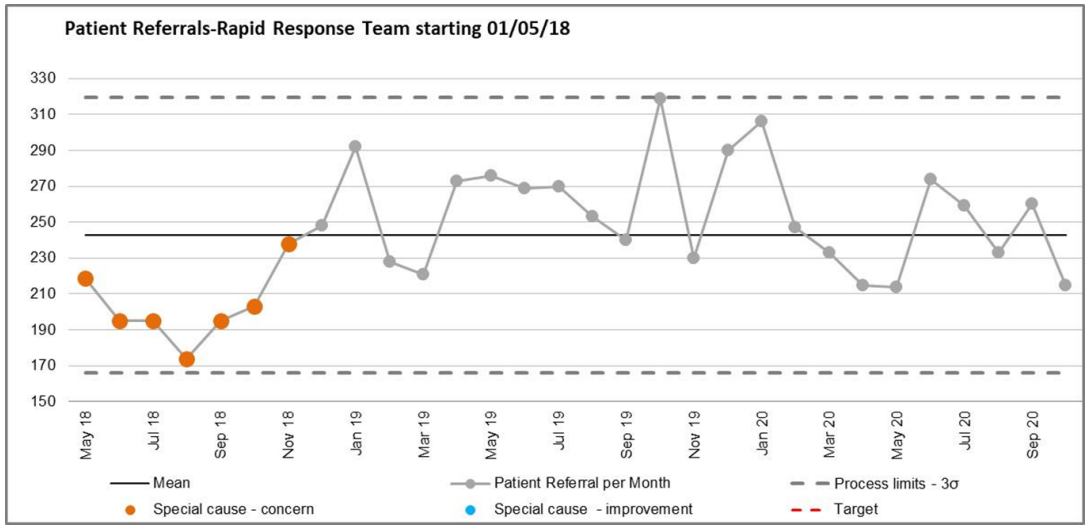




- The number of referrals for the Care Coordination Centre (CCC) remains higher than at the start of the year. These have been mainly from GPs and the utilisation by West Midlands Ambulance Service (WMAS) is lower than predicted. WMAS report higher utilisation by their staff of similar services in other areas, so the South Staffs service has been contacted and a review meeting has been arranged.
- The Centre will shortly become a standalone service from 9th November. Initially the service will deliver 8:00am to 6:00pm, 7 days per week and will also seek to provide a telephone monitoring service for a cohort of long COVID-19 patients. The CCC will continue to recruit to support additional hours.

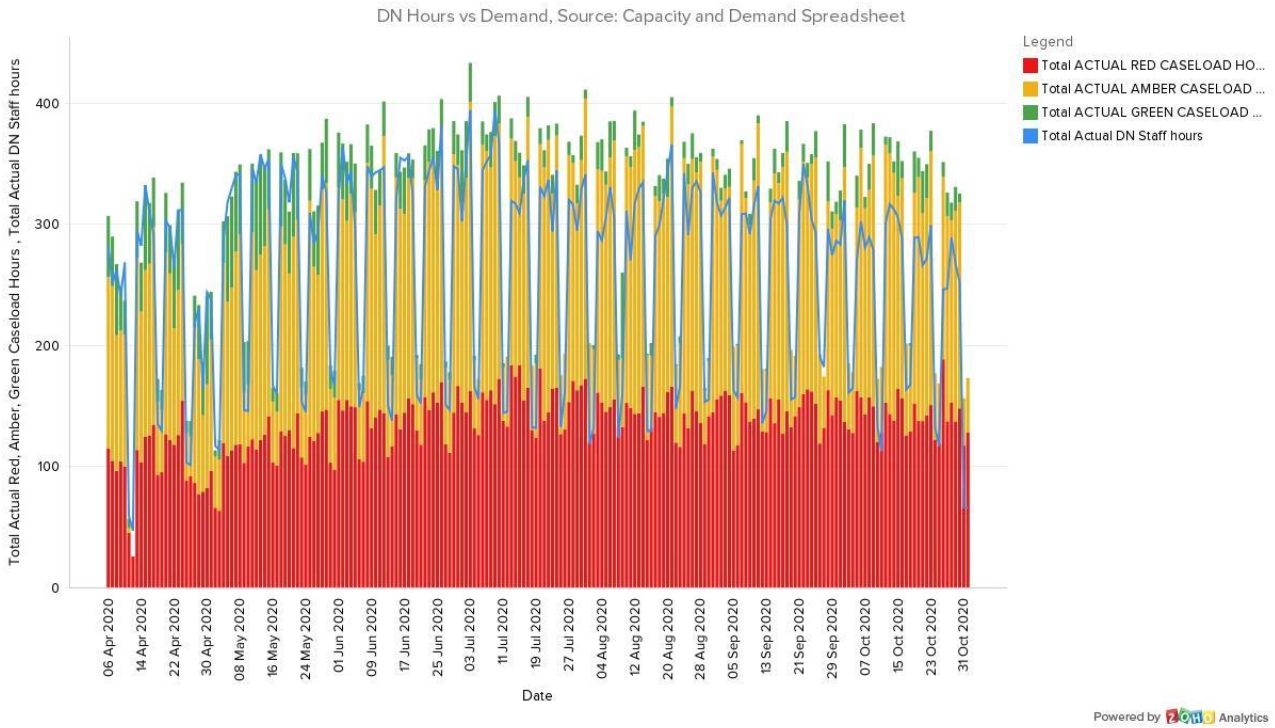
Rapid Response





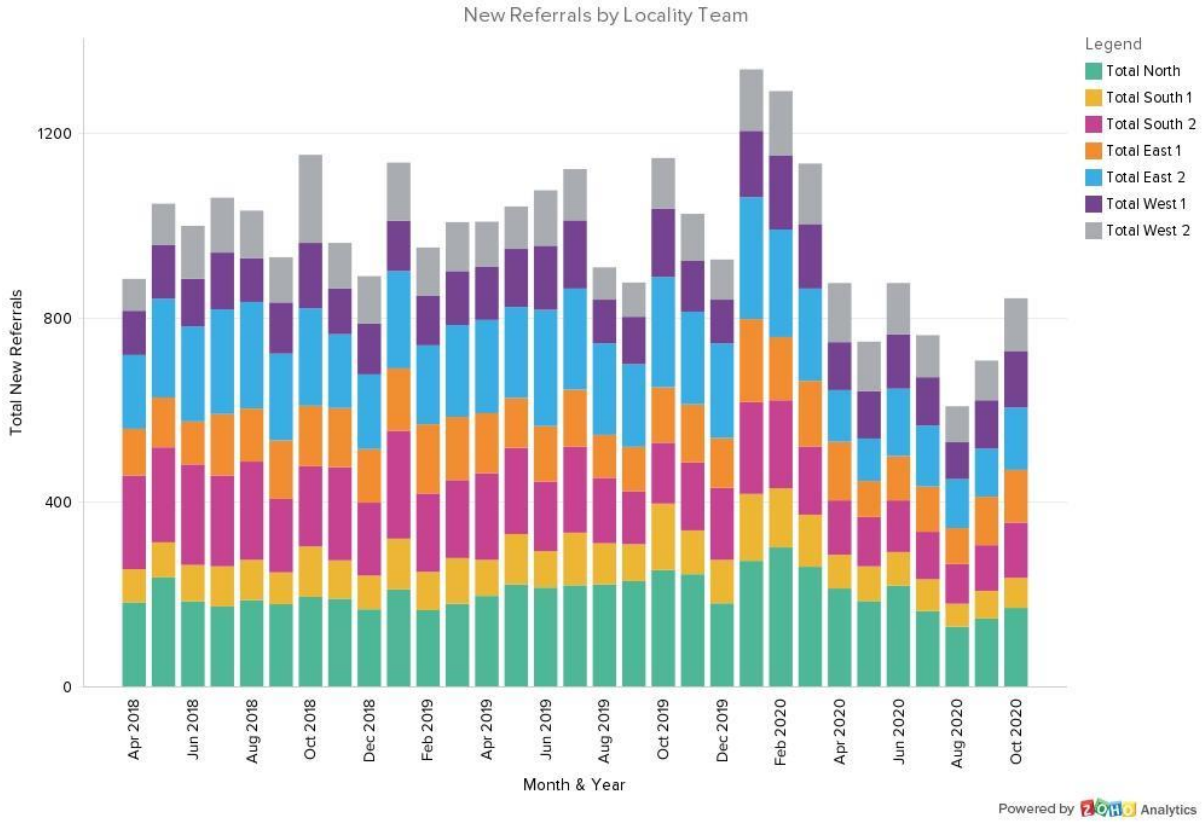
- This chart shows the activity for Rapid Response over a longer time frame. The aim was to have at least 300 new referrals into Rapid Response per month. The Care Coordination / SPA function is receiving levels of referrals as planned but it appears that the triage function is able to deal with them using other resources available within the community rather than via Rapid Response.
- This has provided the service with the ability to maintain service provision for the current demand with minimal disruption in the face of ad hoc staffing interruptions linked to COVID-19 self-isolation requirements and requests to provide COVID-19 swabbing for localised incidence.

Community Nursing Capacity and Demand



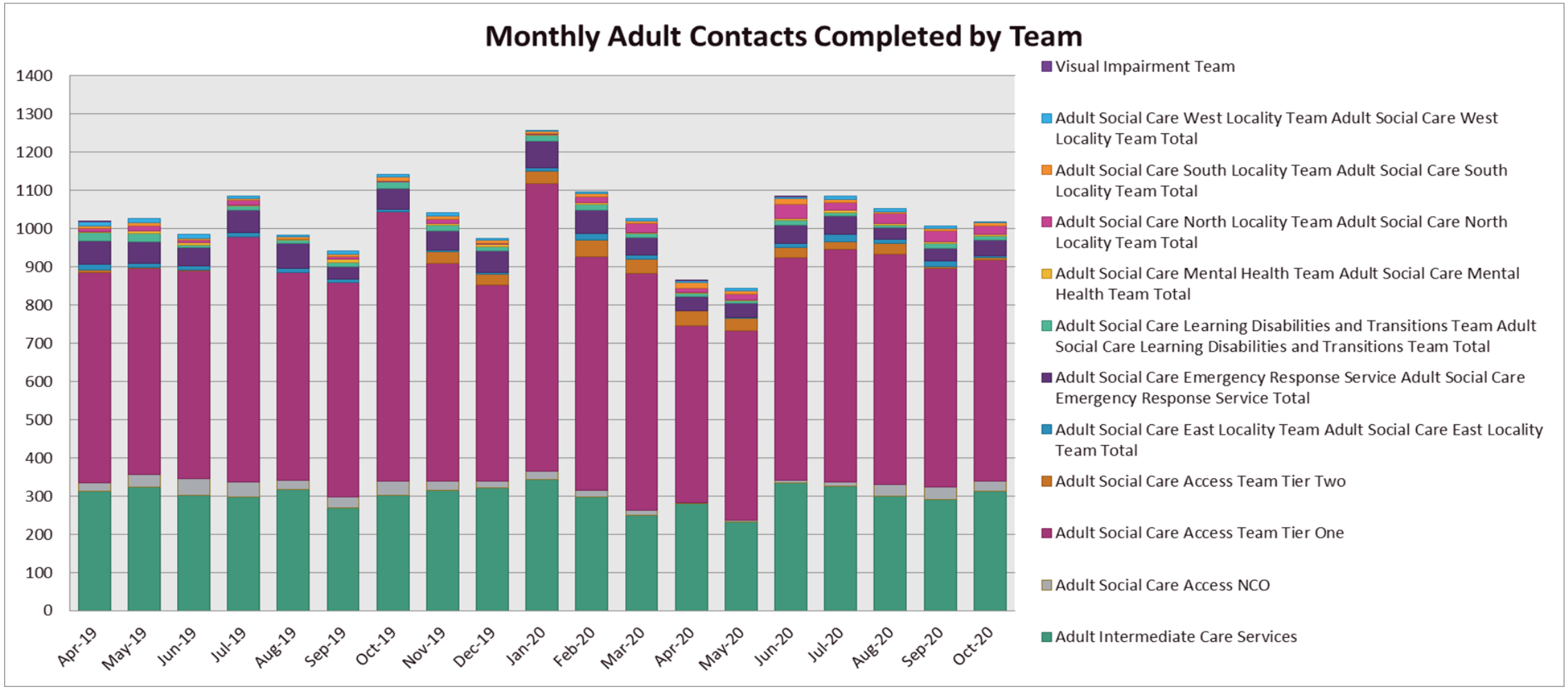
- The service is providing more hours of care and cancelling less hours of care than pre-COVID
- The caseload risk rating system is being reviewed to ensure that all patients who need to be seen are receiving timely care
- Audits of patients where care was reduced or transferred to self-care are being undertaken to seek for any clinical harm which may have arisen. This in turn will inform the RAG system
- Already the service is reviewing all 1,200 patients on the case load for pressure care checks with revised pathways for onward referral and care following the learning from COVID Wave 1

Locality Teams New Referrals

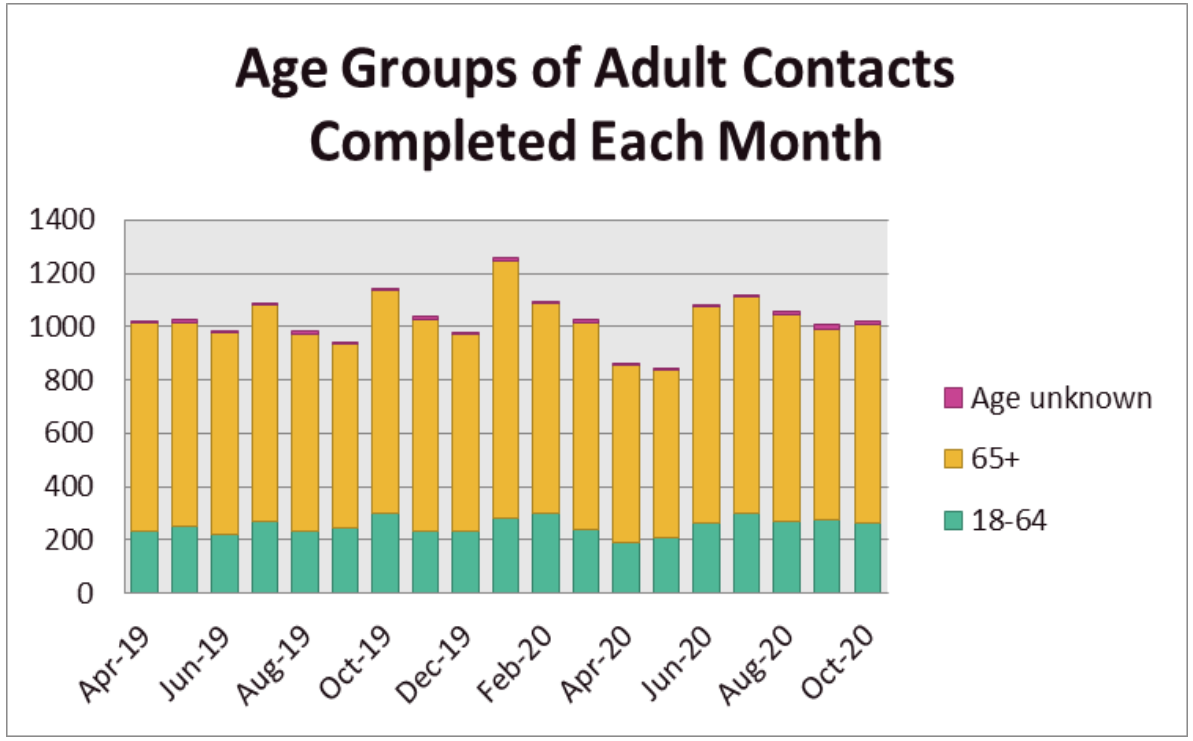


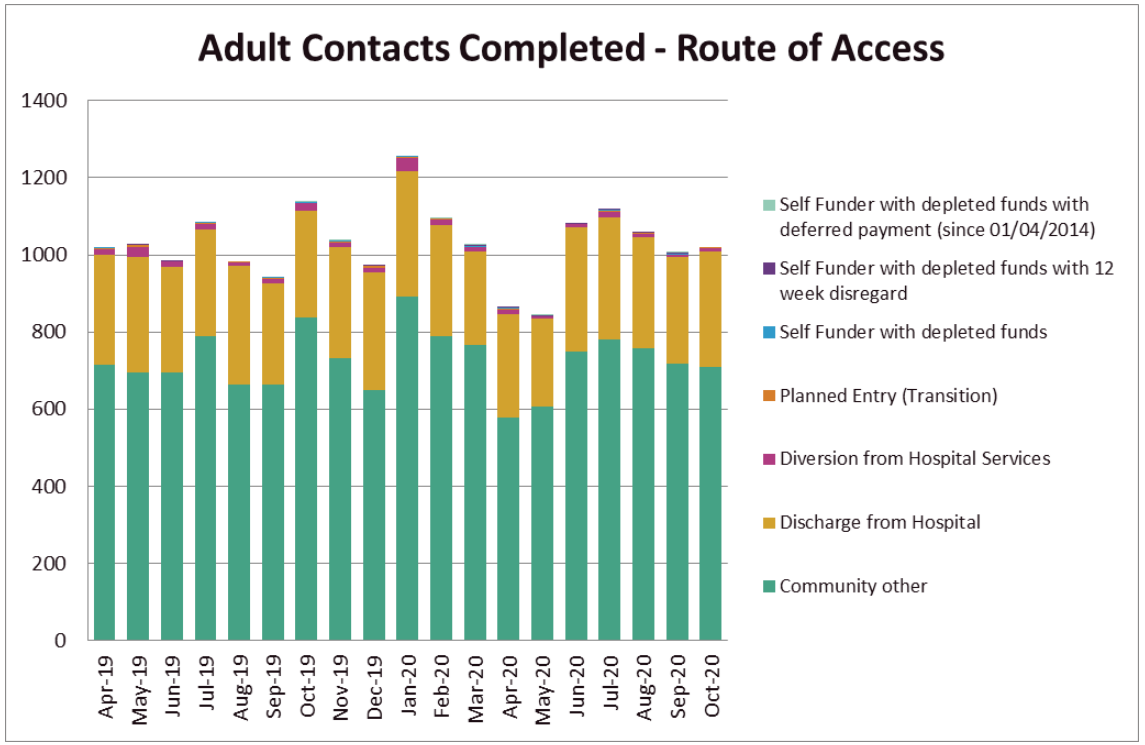
- The number of new referrals remains lower than usual and in part this reflects the reduction in hospital-based elective activity that would have generated demand (e.g. wound care).
- The trend remains post-COVID of the service delivering more hours of care, cancelling fewer hours of care but not increasing the number of contacts significantly as the complexity and care needs have changed. Teams report care requires more interventions from qualified rather than unqualified staff while nursing and therapy staff report having to spend more time contacting family members to update on care or seek information as they may not be visiting as frequently.

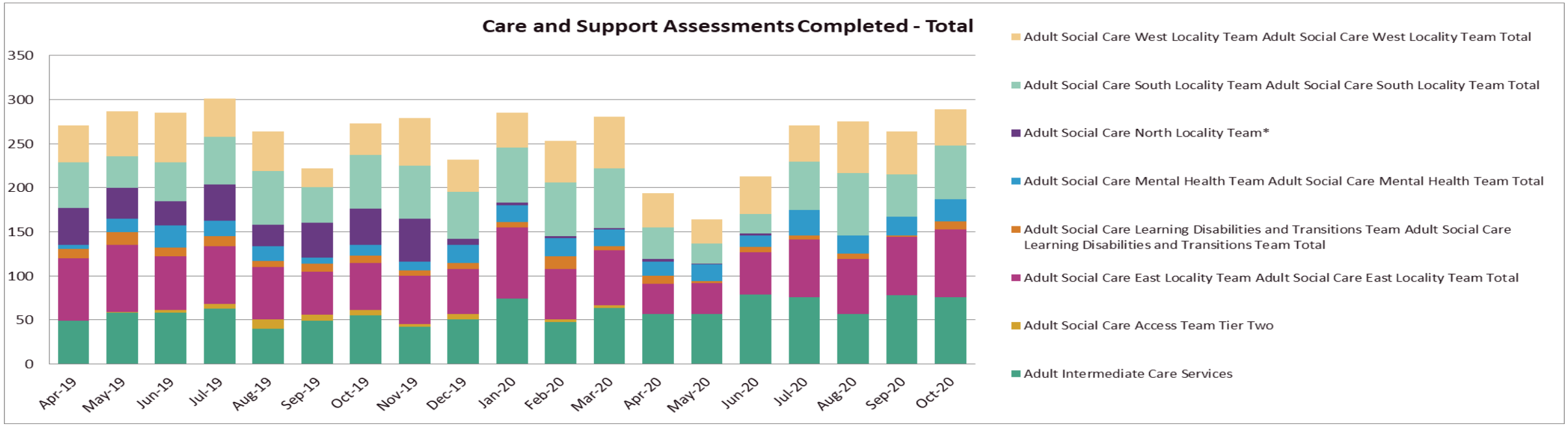
Adult Social Care

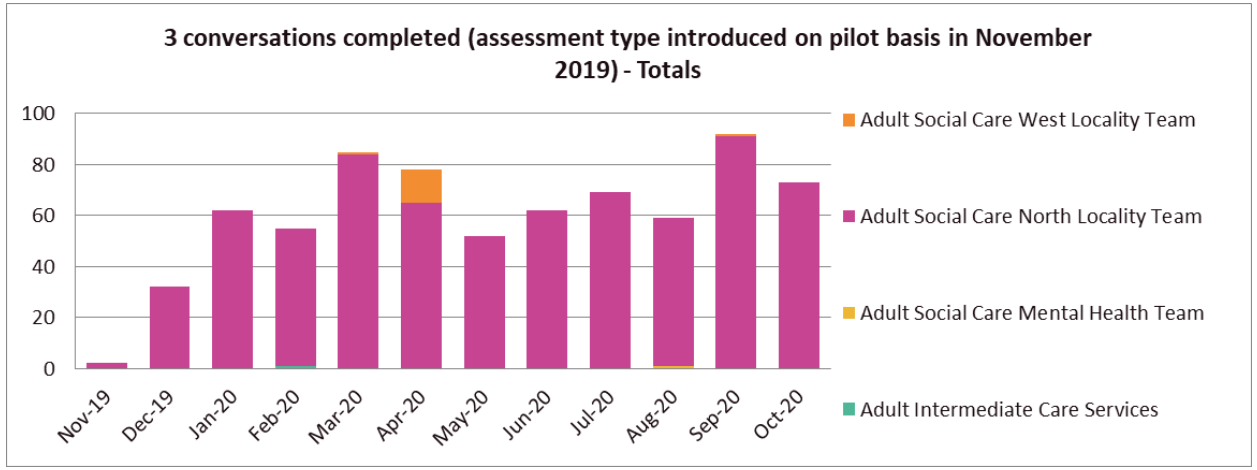


Adult Social Care









Completed Care and Support assessments have increased in addition to completing our statutory Safeguarding enquiries and Reviews.

Adult Social Care

- There has been a decrease of safeguarding concerns progressing to a S42 enquiry from 40.64% in September 2020 to 30.37% in October 2020, with the current year average standing at 31.32%.
- Current data for Q3 identifies that for October 2020, ASC have received 214 safeguarding concerns and concluded 214 for the same month.

Walsall Adult Social Care Safeguarding Concerns

Reporting period: 01/10/2020 31/10/2020

214
Total concluded concerns

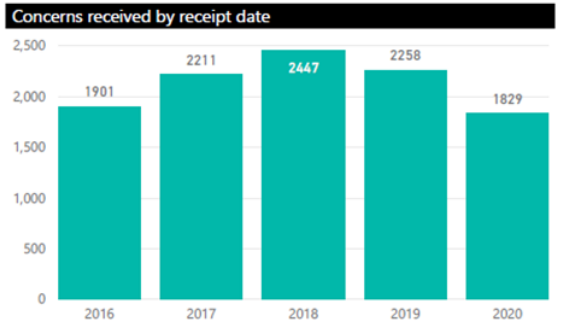
30.37
% Concerns progressed to S42 enquiry

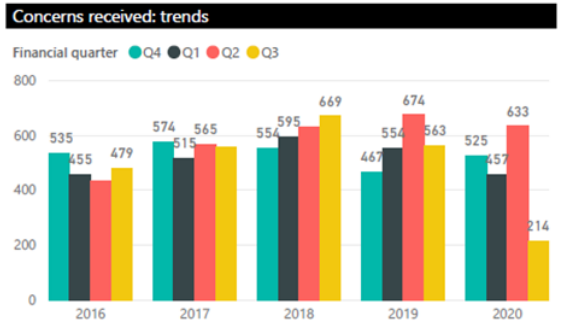
Concluded concern outcomes

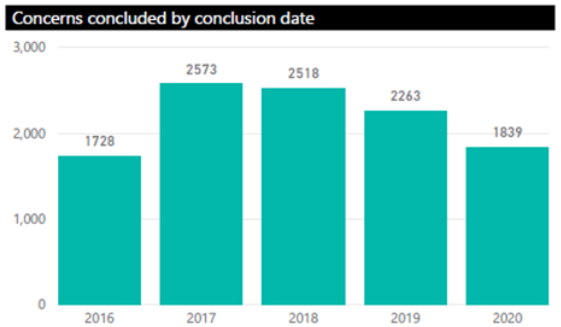
65
S42 enquiry

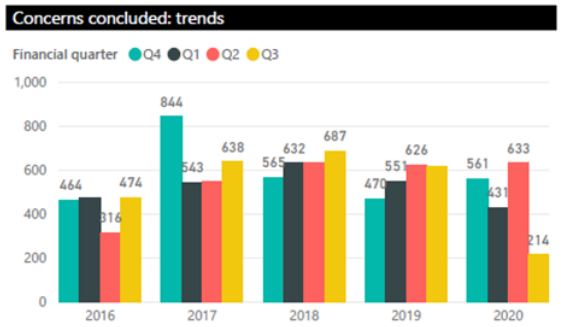
3
Non-S42 enquiry

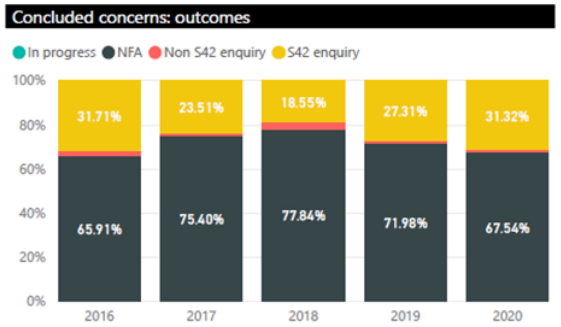
146
No further action











Data extracted: 01/11/2020

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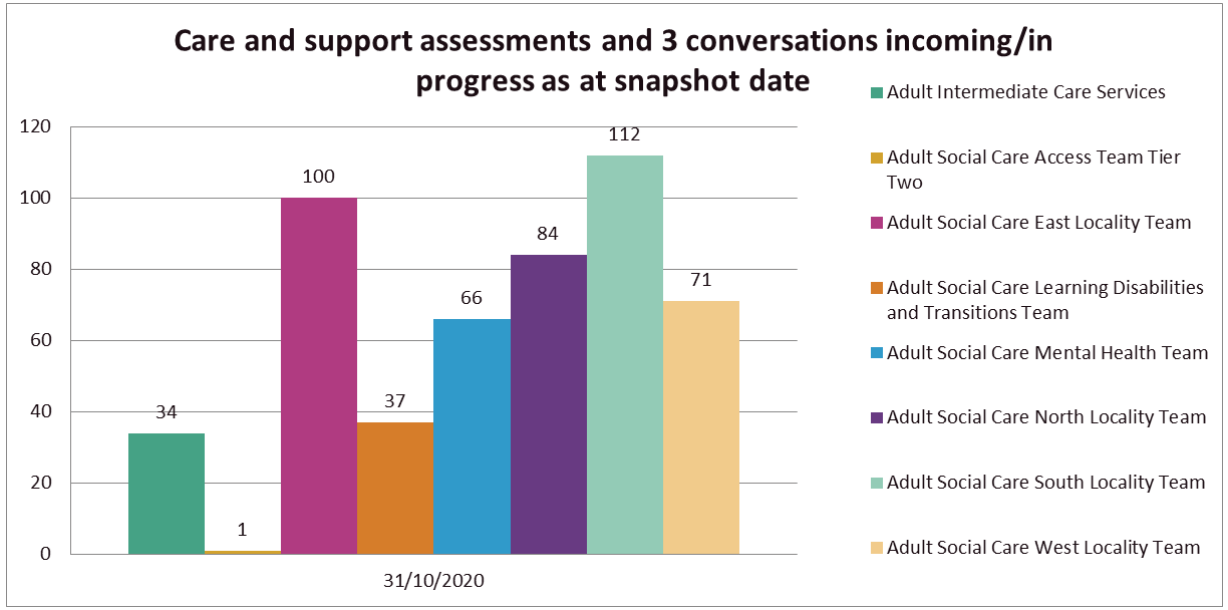
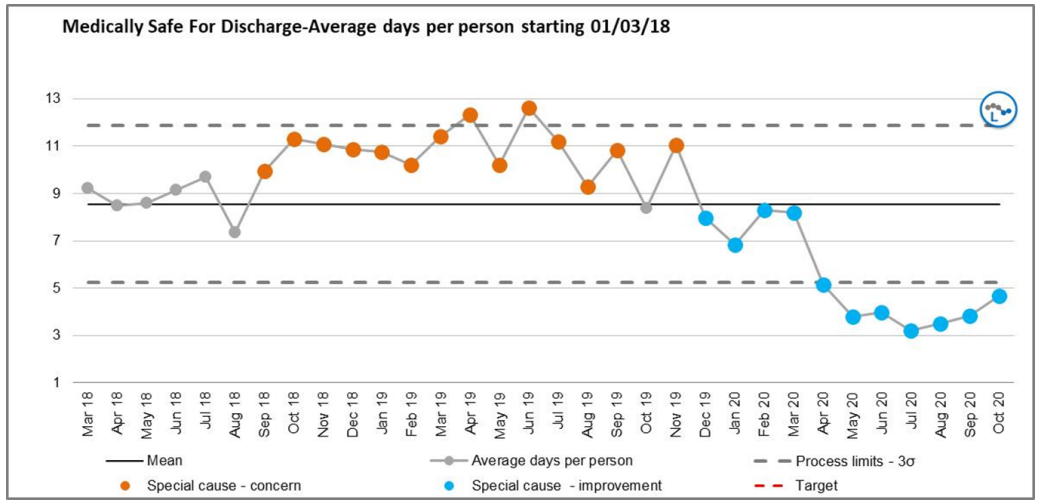
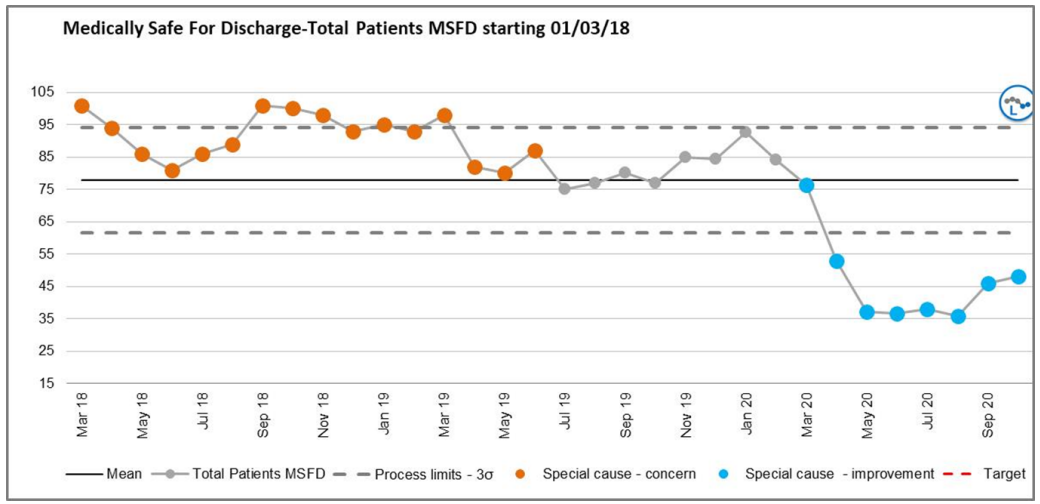
Adult Social Care



The number of new referrals is slightly higher than last month for our locality teams including an increase in referrals to the Intermediate Care Service.

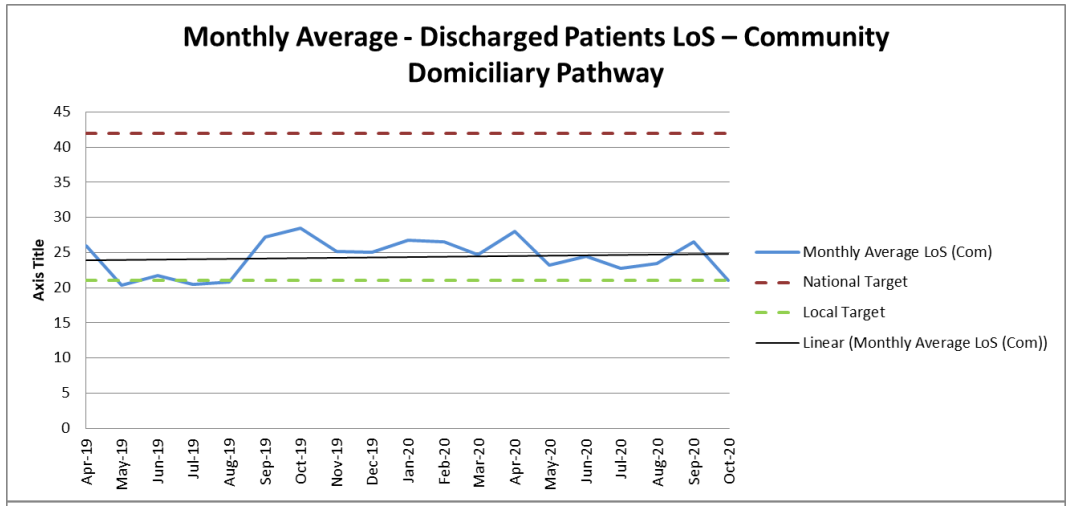
Medically Stable for Discharge (MSFD)

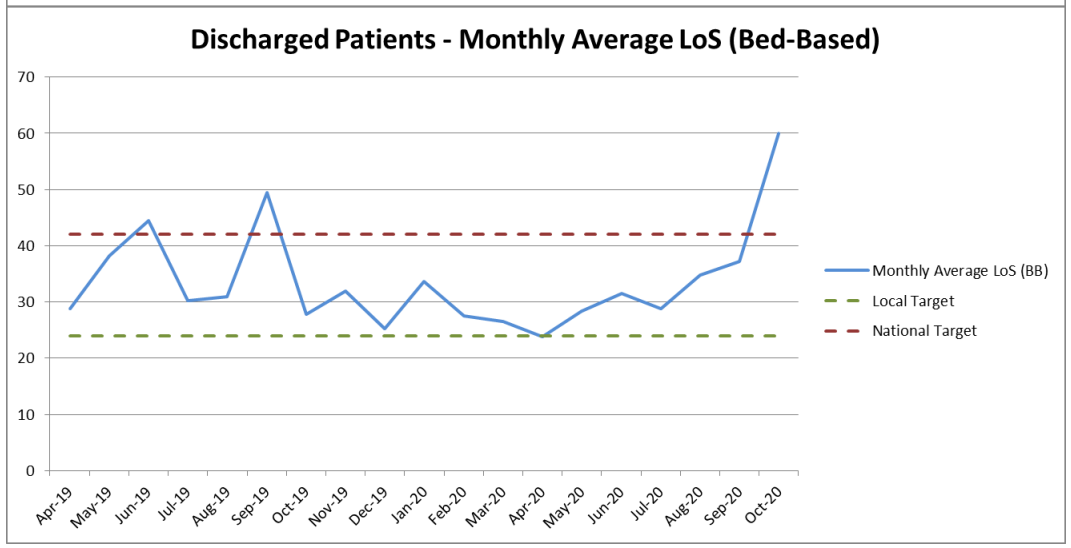




- COVID actions that are aimed at reducing both numbers and length of stay remain standard practice. The average length of stay on the MSFD list is beginning to rise however.
- The key reason for delay is focused on moving some patients who may be COVID positive into care homes. The affects both residents of Walsall and other boroughs. A list of homes within Walsall that are prepared to accept COVID positive patients has been circulated, however even these homes are then declining referrals. The majority of the patients have complex needs. A contingency plan is required, and this may have to focus on opening additional beds at Holly Bank House or using the Birmingham Nightingale facility

Domiciliary and Bed-Based Pathways





- The key factor is the number of patients on a Decision Support Tool (DST) pathway in beds. There were 55 patients on DST pathways on 06/11/20, which is composed of the historic backlog plus new placements. This is a 20% reduction from the cohort of 70 patients earlier in October.
- Of these 55, 22 have DSTs booked, 2 have been completed and now require panel/social care review and 5 are out of area.
- Swabbing: Community Services has been unable to comply with the guidance on weekly swabbing of staff going into homes, due to a lack of supply for the swabs within the healthcare system. It appears that a resolution may have been found to enable significant numbers of staff to be swabbed
- The arrangements for operational overview of care homes that existed during COVID Wave 1 have been stepped up and multi-agency support is being put into care homes once again.

Care Homes Update

- Increasing incidence of positive staff and residents as well as increases in staff required to isolate;
- Deaths remain at normal levels and no increases in COVID-19 related deaths currently;
- Public Health responding to issues as required;
- Resident numbers remain static and significant capacity remains – ongoing question about future viability of some providers;

- Meeting scheduled to discuss winter response to Care Homes from Enhanced Team due to increasing pressures.

Care Homes Update

As per 06/11/2020:

- 1301 residents
- 418 vacancies
- 7 homes with positive cases
- 19 closed to admissions
- 37 open to admissions

Fatality data from 01/04/20 to date

Provider	Covid-19 -Confirmed or suspected Deaths	Non Covid 19 related since 1st of April 2020	Overall deaths since 1st of April 2020.
1	0	60	60
2	6	43	49
3	6	16	22
4	17	4	21
5	8	9	17
6	7	10	17
7	13	3	16
8	2	12	14
9	8	4	12
10	7	5	12

Walsall Together
Collaborating for happier communities

Walsall Integrated Care Provider Contract
Briefing Note to Walsall Healthcare Trust Board
November 2020

1. Introduction

This report provides an overview of the requirements to obtain Integrated Care Provider (ICP) status in Walsall, with Walsall Healthcare NHS Trust as the Lead Provider.

2. Background

Following approval of the Business Case by statutory partner governing bodies in 2019, the contractual structure of the partnership was virtually integrated under an Alliance Agreement. Contractual accountability lines have since continued to be bilateral between commissioners and providers as in 2018/19.

As per the business case, the commercial model from April 2019 to March 2021 was intended as a transitionary period to allow for the development of the necessary governance, payment and contracting environment in which an integrated care operating model can be designed and implemented. The direction of travel inferred in these documents was to develop more formal contractual arrangements through which to plan, manage and deliver integrated care and reduce health inequalities as the alliance matures. This formal contractual arrangement will take the form of an ICP contract, delivering integrated provision of NHS services (including Walsall Healthcare and approved elements Black Country Healthcare, CCG provider services) elements of primary care services with agreed partners and uniquely to Walsall, integration with Social Care and Public Health through the existing Section 75 agreement.

3. Assurance Process and Due Diligence

There will be a phased approach to implementation of the ICP contract, recognising the ongoing system challenges as a result of COVID-19 and the significant amount of work required to achieve the new contract. There is an expectation that the ICP contract will operate in shadow form from 1st April 2021, with a view to full implementation during the 2021/22 financial year, subject to national, regional and local dependency factors. The legislation for this to take place is delayed due to Covid 19 but is expected in early 2021.

NHSEI has now confirmed the expected assurance process, in accordance with the NHSEI transaction guidance, and associated timescales. A self-assessment will need to be presented to NHSEI on 8th January 21 and as such, it is proposed that the Walsall Together Board will receive a draft of this self-assessment at its December meeting before being presented for approval at this Board on 7th January 21.

The transaction guidance requires the presentation of a strategic case for development of a formal ICP contract, specifically in the context of what the Walsall Together partnership has achieved to date. The core components include:

- How the ICP will improve care for patients, ensuring choice is maintained;
- How the ICP will demonstrate material improvement in performance;
- How the ICP could alter the risk profile of Walsall Healthcare and other affected organisations;
- An evaluation of strategic options to proceed, assessed against alignment to the original business case and potential benefits;
- An overview of existing operational, quality, cultural and financial arrangements and why the ICP is the preferred option for improving these.

Oversight of this work is provided by the Walsall Healthcare Director of Governance. Most of the work for this has already taken place in the form of the original Walsall Together Business Case.

It is not anticipated that the transaction guidance will be triggered given the majority of the provision is already established within the partnership.

4. ICP Transition

A Core Team has been established with representation across all partner organisations, except for PCN colleagues, which is being managed via a separate workstream in order to minimise the number of meetings requiring clinical representation. It is anticipated that the ICP will strengthen the support for the PCN's through closer collaborative working. Primary Care core contracts will not be in scope as agreed previously with the Walsall Together Partnership. Several of the workstreams have mobilised with Executive-level sponsorship and dedicated lead roles. Wider representation across all partners is currently being sought. Project support and oversight is provided jointly by the Walsall Together Programme Office (WTPO) and Walsall CCG to ensure both the commissioner and provider requirements are met.

The following Boards and Committees have been identified to receive formal reporting from the Core Team:

- Walsall Together Partnership Board (routine updates);
- Walsall Place Commissioning Board (routine updates);
- Health and Well Being Board (Health & Inequalities Strategy);
- Statutory Partner Governing Bodies (approvals/final decision making).

The is in addition to the board development programme that is already underway and has already held two sessions this year on ICP and Health Inequalities.

The table below provides an overview of 10 workstreams that have been established. Each workstream is tasked with confirming the detailed scope, with clarity on the specific deliverables required a) in advance of 1st April and b) to be delivered in 2021/22. Key risks are also being identified.

Workstream	Key Deliverables	Progress/Next Steps
Finance and Contracting	Contracts and service schedules for the ICP contract (note that usual contract planning and negotiation will take place in parallel with clear interdependencies)	A detailed review and clarification of in-scope services is now in progress with support from information colleagues to confirm specific service lines.
Corporate Governance	Due diligence processes Refresh of governance, legal and risk frameworks	Self-assessment in accordance with transaction guidance to be completed during December; transition plan for revised governance, legal and risk management frameworks to be implemented between Jan-Mar 21.
Population Health Management	Health & Inequalities Strategy Population health management approach including population health needs assessment and deployment of the supporting digital infrastructure	Discussions are in progress with the STP Healthier Futures Academy to agree how best to deliver the Health & Inequalities Strategy in the current climate (following the postponement of the WTP Board Development session originally scheduled for November)
Workforce and Organisational Development	People Plan for Walsall	Detailed scope is in progress. This will include the role of WHT as an anchor institution and deployment of the NHS People Plan locally.
PCN Integration	PCN Integration Agreement	Agreement in principle that the Integration Agreement will be developed during 2021/22, recognising the significant resource challenges currently faced by primary care in delivering the COVID vaccination programme.
Citizen and Communities Engagement	Communications & Engagement Strategy (approved at WTP Board in November)	Agreement in principle across system partners to implement a new model of engagement for Walsall that builds on work to date and meets the different needs of each organisation. Resource is available from the CCG to coordinate this work; a system-wide workshop is being arranged.
Clinical	Mobilisation of services in	Core work of the WTPO and

Operating Model	scope including Operating Plan for Population Health approach	Senor Management Team (meetings weekly)
Personalised Care	TBC	Scope to be confirmed
Quality and Outcomes	Outcomes Framework and local quality standards for inclusion in the contract	Workstream has mobilised, regular meetings agreed, first draft for review at CPLG in Dec
Communications	Communications Plan for transition period	Plan to be approved at Nov Core Team meeting

5. Recommendations

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

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
Work Closely With Partners			**AGENDA ITEM: 18**
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 Work Closely 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 been reinstated and has met on 30th June, 11th August and 13th October since reinstatement. Sandwell and West Birmingham NHS Trust (SWBH) are now also members. Due to the level of pressure on the BCWB system associated with the second wave of COVID-19 the CWIEG meeting scheduled for 24th November was cancelled. The Work Closely with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals. This report gives a brief update on functional integration, in the absence of a formal CWIEG meeting to report from.		
Recommendation	Members of the Trust Board are asked to note the contents of this report. Members of the Trust Board are asked to approve the proposed Diagnostic Imaging Network configuration that places the Trust within Diagnostic Imaging Network 'Midlands 1 - The Black Country' alongside The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Sandwell & West Birmingham NHS Trust.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S04 Working with Partners to provide positive assurance the mitigations in place to manage this risk and the related corporate risks		

	There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☐	

Work Closely with Partners – Executive Report

1. EXECUTIVE SUMMARY

COVID-19 affected the ability of the Trust to formally oversee and manage the programme of 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, approaches to restoration and recovery planning, and shared learning to deal with a novel virus pandemic, and management of the second wave of COVID-19.

As a result, collaboration between Black Country Trusts is stronger due to the experience of this year. There is a clear appetite to use this opportunity to build upon those foundations and progress functional service integration where there is an 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, and through the management of second wave COVID-19 pressures.

2. BOARD ASSURANCE FRAMEWORK

The BAF risk recognises the risk, previously shared with Trust Board that COVID-19 affected the pace with which functional collaboration with Acute Hospital partners in the Black Country could progress. The Collaborative Working and Integration Executive Group Meeting (CWIEG) between Royal Wolverhampton Hospital NHS Trust (RWT), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT) has now been reinstated and has met on 30th June, 11th August and 13th October since reinstatement. The BAF now recognises the risk that the second wave of COVID-19 is likely to further delay some elements of functional integration between services.

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, by the lack of formal integration at organisational levels between Trusts, and by the second wave of COVID-19.

3. IMPROVEMENT PROGRAMME

The Work Closely 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. Abbreviated updates, in the absence of a formal CWIEG meeting this month are drawn out for the Board's attention as follows:

Urology

A joint Chief Operating Officers and Medical Directors meeting is scheduled for 27th November between WHT and RWT Directors to consider opportunities to accelerate the integration of Urology services.

Radiology

Correspondence has been received by the STP on 16th November 2020, from Jeff Worrall (COVID-19 Strategic Incident Director & Director of Performance and Improvement – Midlands, NHS England and NHS Improvement). The correspondence requests STPs (and constituent Trusts) to confirm that they approve the proposed Imaging Network configuration across the Midlands. Walsall Healthcare NHS Trust would be networked within Diagnostic Imaging Network 'Midlands 1 - The Black Country' alongside The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Sandwell & West Birmingham NHS Trust. This aligns completely with the embryonic work already undertaken through facilitation from PA Consulting to develop a Black Country Imaging Network, and thus it is recommended that the Board approve the proposed Network configuration.

Dermatology

Progress continues in the Dermatology workstream, supported by the joint Clinical Directorship of Dr James Halpern. Workstream groups continue to meet regularly and the project team meet weekly. An overarching programme plan with milestones, risks and benefits has been completed and is monitored by the project team and steering group.

Work continues to identify and develop a cross-site Matron post. A new Clinical Nurse Specialist commenced at WHT in November 2020 and will lead the nurse-led patch test and photochemotherapy (PUVA) service.

The draft business case for Microscopically Controlled (Mohs) Surgery is progressing with costings for necessary Estates work on the RWT site being finalised. The case is aiming to be presented at the Dermatology Partnership Steering Group meeting in December, and then subsequently at CWIEG in either December or January.

Demand & Capacity work is being undertaken on both sites and is due for presentation at the Dermatology Partnership Steering Group meeting in December to inform medium term service planning.

Clinical Fellowship Programme

The Clinical Fellowship joint working Service Level Agreement between WHT and RWT has been approved, and the Memorandum of Understanding (MOU) has also been approved. The MOU includes a revised recruitment process and responsibilities of each Trust. The first Clinical Fellow interviews are scheduled for Acute Medicine, with six candidates invited to interview on 30th November 2020 as part of the programme.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

Members of the Trust Board are asked to approve the proposed Diagnostic Imaging Network configuration that places the Trust within Diagnostic Imaging Network 'Midlands 1 - The Black Country' alongside The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust and Sandwell & West Birmingham NHS Trust.

APPENDICES

1. BAF SO3

Walsall Healthcare NHS
NHS Trust

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:	Chief Operating Officer	**Supported By:**	Medical Director & 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. • Executive group established across provider organisations to review opportunities for collaboration • Success of Black Country Pathology Service (BCPS) • 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 • Shared Clinical Fellowship Programme agreed with RWT, and recruitment	Likelihood:	2	31 March 2021
Consequence:	4	4				Consequence:	2	
Risk Level:	12	12				Risk Level:	4 (low)	

				process well under way with interviews diarised for appointment panels. • Despite progress, integration plans are not yet fully implemented	

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 recent functional integration in ENT, Urology and Dermatology • Emerging commitment from Acute Collaboration partners to more formalised 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, and extent to which second wave exceeds planning assumptions is likely to result in further delays. • Limited independent assessment of integrated services or collaborative working arrangements • Embryonic independent evidence-base for successful collaborations to assess progress against.		

Future Opportunities

- Consolidate other services, including back office functions
- Collaborate with partner organisations outside the Black Country Acute Trusts, 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		
4.	Assess resource requirement to support Imaging Network programme	G Augustine & N Hobbs	Dec 2020		

MEETING OF THE PUBLIC TRUST BOARD – 3rd December 2020			
COVID-19 Summary Evaluation Report – Post First Wave			**AGENDA ITEM: 19**
Report Author and Job Title:	Glenda Augustine, Director of Planning & Improvement	**Responsible Director:**	Jenna Davies Glenda Augustine, Director of Planning & Improvement Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The purpose of this paper is to provide a summary of the staff and patient voice following the first wave of COVID-19. An overview of the organisational lessons learned and the subsequent request for the beneficial changes implemented during the pandemic response to continue 'From Now On', will be presented. The paper has been informed by the detailed internal COVID-19 evaluation conducted between May and August 2020 and the reported findings of the Board Walk visits to services and the Executive Directors COVID-19 experience visits between July and October 2020. The aim of the evaluation, Board Walks and Executive Directors experience visits was to capture the personal staff and patient experiences. There was also the opportunity to consider the changes made to respond to the pandemic and the factors that fuelled innovation that occurred. It is acknowledged that there were a number of beneficial and there is a commitment to ensure that 'From Now On', these changes are embedded into business as usual. The was close align between the findings of the evaluation and the Board Walks and Executive Director visits with common themes arising that enabled consolidation of the lesson learned and the 'From Now On' beneficial changes. The key aim of this work was to provide organisational learning and support for the workforce and advanced preparation for a potential second wave of COVID-19. However, the Trust is now in the midst of the Second Wave of the Covid-19 pandemic. A summary evaluation that only provides a reflection on actions and experience following the first wave will not provide a comprehensive evaluation of staff and patient experience, lessons learned and sustained changes implemented based on the findings from the internal evaluation, surveys, Board Walks and Executive Directors Covid-19 experience visits. This paper,		

	therefore, highlight the key findings from the internal evaluation, service and department visits, and the associated lessons learned and 'from now on requests' in the following themed areas: communication, staff experience in terms of emotional health and wellbeing, redeployment, community service and risk assessments, patient experience and finally leadership. The internal evaluation of staff and patient experiences, alongside the Board Walk and Executive experience visits has provided a breadth of intelligence to inform the ongoing organisational response to the Covid-19 pandemic. The lessons learned and the 'From Now On' requests from staff are not exhaustive as this a brief summary of rich qualitative data collected through research and staff and patient engagement. Whilst the responses received are not generalisable, they provide the staff and patient voice and the lived experience of Covid-19 to enable the development of an organisational response to meet expressed needs.
Recommendation	The Trust Board is requested to note the essential requirement for an additional evaluation of the Trust response to the management of the COVID-19 pandemic post second wave that will enable: • Understanding of the impact that COVID-19 has had on the health and wellbeing of staff • Comparison of staff and patient experience following the second wave to assess application of lessons learned from the first wave • Identification of additional lessons learned and changes that are/are not beneficial • Review of the continued application of the 'From Now On' benefits
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The following risk is held on the BAF; "*Lack of an Inclusive and open culture impacts on staff morale, staff engagement and patient care*". The COVID pandemic has highlighted the impact of health and social inequalities and the measures taken by the Trust provide an opportunity to further understand this impact for colleagues at Walsall Healthcare NHS Trust enabling the development of actions/interventions to improve inclusivity. CRR 2093: *Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust*. The risk assessments seek to understand if adjustments to roles or additional measures in the working environment to protect the health, safety and wellbeing of staff.

Resource implications	There are internal human resource implications associated with a post COVID-19 wave two evaluation. The initial evaluation was completed by medical students, supervised by Dr Marie Lewis (Faculty of Research and Clinical Education Walsall) and Dr Hesham Abdalla (Quality Improvement Clinical Lead, Walsall). A discussion with be required with this team to discuss the resource required to conduct a second evaluation.	
Legal and Equality and Diversity implications	COVID-19 poses a serious and continuing risk to the health of employees, service users and the wider community and is having a disproportionate impact on individuals from black, Asian and minority ethnic (BAME) communities. There are legal, health and safety implications of the risks COVID-19 poses to equality, diversity and inclusion which 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 **The Coronavirus Legislation** for England, Wales, Scotland and Northern Ireland, continues to be developed to protect public health as new evidence emerges and as the public health crisis continues. The Equality and Diversity issues highlighted in the detailed report on the internal COVID-19 evaluation that was presented to People and Organisational Development Culture, alongside a separate update on risk assessments, at the committee meeting held on 3rd November.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

COVID-19 Summary Evaluation Report – Post First Wave November 2020

1.0 Purpose

The aim of this paper is to provide a summary of the staff and patient voice, organisational lessons learned and the subsequent request for the continued implementation of the beneficial changes 'From Now On', following the first wave of COVID-19. The paper has been informed by the internal COVID-19 evaluation, the Board Walk visits to services and the Executive Directors COVID-19 experience visits.

2.0 Background

The Trust commissioned an internal evaluation to assess the personal, lived experiences of staff and patients at Walsall Healthcare NHS Trust during this the first wave of COVID-19 pandemic. The evaluation was conducted between May and August 2020 focussing on changes made, both beneficial and non-beneficial, the factors which fuelled innovation and what changes remain as the new normal. The evaluation was completed by five medical students, supervised by Dr Marie Lewis (Faculty of Research and Clinical Education Walsall) and Dr Hesham Abdalla (Quality Improvement Clinical Lead, Walsall). Four detailed reports were produced providing comprehensive detail of the evaluation findings. Individual reports have been presented at the following committees: People, Organisational Development and Culture, Quality, Patient Experience and Performance, Finance and Investment. Collective reports were presented to Executive Directors, Trust Management Board and Trust Board. The COVID-19 summit held on 27th July 2020 alongside a number of surveys, focus groups and individual sessions informed the findings of the evaluation.

Board Walks and Executive Directors COVID-19 experience visits between July and October 2020 consisted of virtual or personal visits services and departments. The aim of these visits were aligned to the internal evaluation, with a focus to review staff experiences, identify what could have made the experience better and to capture positive experiences that should be retained 'From Now On'. The lessons learned and the 'From Now On' results would provide valuable intelligence to support preparation for, and insight into coping with a potential second wave of COVID-19.

However, the Trust is now in the midst of the Second Wave of the COVID-19 pandemic. A summary evaluation that only provides a reflection on actions and experience following the first wave will not provide a comprehensive evaluation of staff and patient experience, lessons learned and sustained changes implemented based on the findings from the internal evaluation, surveys, Board Walks and Executive Directors COVID-19 experience visits. This paper will, therefore, highlight the key findings from the internal evaluation, service and department visits, outlining the lessons learned and 'From Now On' requests to date. It should be noted that as the responses outlined are not generalizable to the whole organisation as they are a reflection of the sample of individuals who participated in the evaluation, responded to the surveys and engaged with the Trust Board members during the Board Walks and Executive experience visits.

3.0 Summary Evaluation/Experience Visits Findings

There were common themes identified from the internal evaluation and the Board Walks/Executive visits namely, communication; staff experience in terms of emotional health and wellbeing, redeployment, community service, risk assessment; patients; leadership. T A brief summary of these themes, with the associated lessons learned and 'From Now On' recommendations where available, is summarised in this section.

3.1 Communication

At the beginning of the COVID-19 pandemic, there were concerns about the timeliness of communication received, conflicting and ambiguous advice and guidance, impacting on application and adherence. There was the awareness that this was a global pandemic caused by a novel virus with a dependence on research and Government guidance to inform local action. The live, weekly digital format for the Chief Executive Team Briefs was deemed a beneficial initiative which was pivotal in supporting and guiding staff during the COVID-19 response. The opportunity for opened dialogue between the leaders of the organisation and the wider workforce was highly valued. The constant updates on changes via the Daily dose provided timely information on the current local situation, relevant guidelines and campaigns which was very well received. However, the inability to access certain Trust methods of communication at home (Emails, Daily dose, Chief Executive Team Brief) left staff feeling forgotten, isolated and abandoned.

The use of Microsoft Teams was welcomed as a medium to maintain communication, connectivity, and productivity whilst supporting the need for social distancing. This required a rapid roll-out digital/information technology with the initial inherent problems associated with internet access at home, timely receipt of equipment licence permissions, training and increasing the confidence and competence of the workforce in virtual communication. The chat function, raise hands function and the ability to record meetings helped to address the concerns raised regarding inclusivity. There were challenges for some staff without internet access at home. Overall, virtual meetings were a positive aspect of the COVID-19 response, with the request that it should be part of the new normal.

Lessons learned:

- the need for rapid assimilation of new information on COVID-19 and the developing treatments
- the crucial role that research plays in healthcare to support the provision of evidenced based care
- the importance of clear, timely and well communicated evidence-based advice and guidance for staff to support adaption to rapidly changing circumstances
- the need for regular communication via a variety of channels with an opportunity for staff to interact enhances morale and adherence to guidance

'From Now On'

- continuation of the live Chief Executive team brief as it provided the most clarity, was more engaging and informative and removed the need for staff to rely on line managers to cascade the information

- maintain and enhance the functionality of Microsoft Teams to support home working
- make email accounts easily accessible outside of the Trust setting, allowing users to access their accounts at a convenient time and stay updated.

3.2 Staff experience – Emotional health and Wellbeing

The lack of preparedness and available, adequate Personal Protective Equipment (PPE) at the beginning of the COVID-19 pandemic had a significant impact on staff emotional health and wellbeing. There was a significant culture of fear, fear of the unknown and fear for their personal health and wellbeing. Staff felt that they were at risk by caring for COVID-19 patients, creating anxieties about coming to work, resulting in some absences. The emotional pressure of coping with unprecedented numbers of deaths in a short period of time and providing support for dying patients and their families during the tight visiting restrictions had a significant impact on staff. Some staff found it difficult to dissociate from work-related events at home, which had a negative impact on their personal life. Staff cared for colleagues who died from COVID-19, had personal COVID-19 related bereavements and still continued to care for others within a COVID-19 environment.

There have been many positive changes to the support available for staff mental health and wellbeing throughout this crisis. The change to visiting restrictions relieved some pressures, staff supported each other and many wellbeing services were introduced to support staff. The 'Haven' and 'Project Wingman' made staff feel valued as any are still fearful so services are required to continue to meet evolving needs of the workforce.

The emotional health and wellbeing of staff was also impacted by working from home. A positive work-life balance was reported by some, whilst others struggled with the imposed isolation, guilt related to the need to shield and balancing childcare responsibilities whilst trying to maintain productivity.

Overall the COVID-19 Board Walks and Executive experience visits prior to the second pandemic wave indicate a number of service areas are treating the admission of patients with COVID-19 as 'business as usual'. They know what to do, the treatment required and are aware of the signs of rapid deterioration. The change in the cohort at the beginning of the second wave was noted, with staff used to caring for elderly patients rapidly adapting to caring for younger adults.

Lessons learned:

- ensure sufficient PPE availability and guidance to allow staff to feel safe to deliver high quality care to patients
- recognition that ongoing support will be needed to meet staff health and wellbeing for a significant period of time
- the unintended impact of restricted visiting on staff mental health and wellbeing
- a flexible approach to home working required to meet individual and service need

'From Now On'

- ensure there is consistent and continuous mental wellbeing services being offered to staff, to support staff in making a recovery over time and reduce any feelings of loneliness
- raise awareness and support for home working as an option across the organisation

3.3 Staff experience - redeployment

The redeployment of staff to support the COVID-19 response provided positive and negative experiences often related to the processes and support underpinning redeployment. Active

contribution in areas needing additional resources whether personally or virtually maintained staff morale and involvement. This was particularly noted in high risk/shielding clinical staff who were redeployed to non-clinical roles.

Negative experiences of redeployment resulted from disorganised processes, poor skills matching and utilisation, ineffective communication of the rationale for redeployment and lack of training and guidance in the new roles. There also the issue of constantly moving between different wards with the perceived inability to discuss the impact on mental health and wellbeing with frequently changing new colleagues. Inequity in relation to workloads, who was asked to move to different services area was an issue raised across all groups in the evaluation and communication in the Board Walks/Executive visits.

A key to improving redeployment in the future includes the use of a skills audit to place staff and a timely consistent rota. The uncertain nature of COVID-19 and the rapidly changing demand in various areas will need was staff to be flexible to these changes.

Lessons Learned

- the use of a skills audit will provide a robust process for successful redeployment, matching workforce skill set to resource need
- a buddy scheme, pairing redeployed staff with a member of staff in the new area, would reduce anxiety, promote socialisation and rapid adaption to new role
- the need for a consistent approach to temporary redeployment to avoid the disproportionate requirement for specific staff to constantly change working environment

'From Now On'

- provide mentorship for staff temporarily redeployed to a new area to provide a supportive environment, just as mentorship and support would be provided for new starters

3.4 Staff experience - Community

The rapid discharge of patients and movements of services from the acute setting to the community alongside increased admission avoidance had a significant impact on the workload of community staff. Although there were some improved working relationships between individuals and departments, there was a feeling of 'community neglect'. Lack of involvement in decision making, information received too late, unhelpful information provided based on acute care that could not be translated to a community setting. Tailored communication was needed to avoid confusion and support seamless transition of care.

Support was provided for care homes, teaching staff to provide basic nursing care such as dressing changes to minimise community staff attendance to homes and reducing the risk of virus

transmission. Another positive change noted by community staff was the help provided from Infection Prevention and Control to community settings. The community staff were able to build knowledge and confidence for self-management and adapt to the ever-increasing workloads during the COVID-19 response. Staff stated that they feel better prepared for a second wave of COVID-19.

Lessons learned:

- there is a need to support community infrastructures to ensure seamless patient pathways and to provide timely resources for community to ensure staff feel valued and supported to deliver care closer to home
- Tailor communication to suit setting to ensure staff fully informed

'From Now On'

- enhance the links between acute and community settings to enhance transition
- upskilling care homes to meet the basic nursing needs of residents

3.5 Staff experience – Risk Assessment

The internal evaluation focus groups and service/department visits indicated that staff felt there was a lack of clarity around the risk assessments in general and the duty of care of the organisation towards the BAME members of staff. Staff from a white background felt ignored and that their needs were not important, whilst BAME staff perceived that they were treated differently by their line manager compared to colleagues from a white background. There were also concerns raised about non-completion of risk assessments, implementation of the findings and subsequent reassessment.

Lessons learned:

- ensure clear communication of the rationale for risk assessments and the equitable action required to protect the workforce at greatest risk
- provide a robust process for promoting and monitoring completion of risk assessments and implementation of the identified actions

3.6 Patient Experience and safety

The pandemic had an impact on the length of hospital stay with rapid early discharge, increasing the shift to community care and some delayed discharges whilst awaiting packages of care. The unintended consequence of early discharges was deterioration in the patients' conditions and subsequent readmission. Patients were distressed and felt isolated being in hospital, with communication with their families restricted to telephone calls with access to virtual calls implemented later during the pandemic. Better communication between acute and community settings would have improved delayed discharges and it was suggested that medication could have been prescribed by General Practitioners. Some delayed transfers were related to care homes refusing to admit patients who were COVID-19 positive.

Patient experiences during the COVID-19 response were both positive and negative. Whilst staff professionalism was praised, the lack of empathy displayed by some staff was raised as a concern. The need to live and display the Trust values is inherent in the delivery of all care and interactions. Clear communication, providing information to support decision making and ensuring the patient understands the condition and the care being provided would enhance patient experience. This was

evident in the quality of care provided to patients at end of life with effective planning of care and treatment pathways to improve patient care and support provide during restricted visiting.

Patient safety was enhanced by staff e-rostering which provided more effective working and e-handover, increasing the efficiency and patient safety during the night shift handover. Redeployment increased the out of hours resource at night with more doctors on the wards improving the availability of prompt support and guidance.

Lessons learned:

- review of early discharge decisions to include assessment of the potential risk of deterioration warranting readmission
- the need to support care homes with the management of infection control prior to patient discharge
- reinforcement of staff behaviour and values required via line manager communications and personal development review
- the enabling nature of digital technology in enhancing patient safety

'From Now On'

- maintain the high standard of care achieved for patients at the end of life
- support all staff to adhere to the staff values and beliefs
- maintain e-rostering and e-handover.
- Maintaining the number of doctors on wards past 17:00, at least above two

3.7 Leadership support

Visible leadership across the organisational hierarchy was crucial to the maintenance of staff morale. Many praised the increased visibility of managers and executives, especially in wards. Rapid decision-making closer to the point of care and empowerment of staff to be actively involved in those decisions was high valued. It was recognised that it is hard to provide guidance when dealing with a novel virus with limited global information. Nevertheless, staff felt supported by the Executive Team to make sensible decisions, weighing up the risks and benefits. The shifting from a top-down to a bottom-up culture ensured rapid decision making, testing and adoption of improvement ideas at the front line and will be essential for us to move forward as an innovative organisation. Increased autonomy and freedom to make required changes at pace led to more beneficial patient outcomes. This was supported by centralised finances that reduced the discussion between teams about funding new initiatives.

However, the flattening of the hierarchy of decision-making can result in patients not receiving the best care, so refinement of bottom-up decision making is required to eliminate any chances of breaches to patient care.

There was a clear inequality of recognition across Trust departments and the public with the focus directed almost entirely to clinical areas, such the intensive care unit (ICU), with other support areas feeling unrecognized and unappreciated. Staff working remotely had similar feelings, describing a lack of visibility from their managers and almost no communication. The need to share concerns with managers outside of a formal 'listening programme' was expressed. During the initial stages of the pandemic some staff working remotely felt bullied by managers to work onsite due to staff shortages;

however, this behaviour appears to have improved over time. It was noted that senior managers were under increasing pressure and also need ongoing support.

Some conflict arose when the initial guidelines set by the Trust and enforced by management were questioned by staff, especially the guidelines surrounding PPE, in particular the wearing of masks and the types of masks available by department.
Guidelines that were perceived as unsuitable and unsafe were criticised heavily by staff, using their knowledge to challenge adherence, whilst other staff felt forced to adhere to them. This affected the staff negatively, leading to decreased trust within leadership. Team brief was effective in addressing these initial concerns and the apparent constant changes in Government guidance. The Executive experience visits also provided an opportunity to demystify confusion through supportive leadership and reinforce the latest guidance.

Lessons learned:

- the importance of visible leadership in instilling staff confidence and morale
- the value of rapid decision-making closer to the point of care
- robust governance is required to ensure point of care decision making process does not negatively impact on patient safety and the quality of care
- the need for equitable recognition of the organisational response to the pandemic
- staff working remotely need more regular contact with their managers
- a branded “listening programme” is not always needed, just genuine listening by managers and responding to what is heard
- support required for senior managers who were less likely to access health and wellbeing support

‘From Now On’

- an increase in the inclusivity during decision making where possible, as it enabled increased autonomy, motivated staff and was a key factor to the Trust’s performance during the pandemic
- leadership discussing the best course of action with colleagues
- leaders being visible to promote areas of change as this boosts staff morale and adherence to the changes

Conclusion

The internal evaluation of staff and patient experiences, alongside the Board Walk and Executive experience visits has provided a breadth of intelligence to inform the ongoing organisational response to the COVID-19 pandemic. The lessons learned and the ‘From Now On’ requests from staff are not exhaustive as this a brief summary of rich qualitative data collected through research and staff and patient engagement. Whilst the responses received are not generalisable, they provide the staff and patient voice and the lived experience of COVID-19 to enable the development of an organisational response to meet the expressed needs.

4 Recommendation

The Trust Board is asked to note the essential requirement for an additional evaluation of the Trust response to the management of the COVID-19 pandemic post second wave that will enable:

- Understanding of the impact that COVID-19 has had on the health and wellbeing of staff
- Comparison of staff and patient experience following the second wave to assess application of lessons learned from the first wave
- Identification of additional lessons learned and changes that are/are not beneficial
- Review of the continued application of the 'From Now On' benefits