Bundle Public Trust Board 2 February 2022

0	Agenda 0. Public Board Agenda - 2 Feb 22.docx
1	Chair's Welcome; Apologies and Confirmation of Quorum *Chair to present* *Apologies received:* *Lisa Carroll, Director of Nursing* *Ned Hobbs, Chief Operating Officer*
2	Declarations of interest 2. Public Declarations of Interest February 2022.docx
3	Minutes of the last meeting 3. Public Board Minutes - 02.12.21.docx
4	Matters arising and Action Log Action Log.docx
5	Trust Values and Nolan Principles 5.1 The Seven Principles of Public Life - Nolan Principles.docx 5.2 Vision Values and Objectives v.2.pdf
6	Chair's Report
6.1	Independent review of leadership 6.1 Independent review of Leadership WHT Board cover sheet.docx 6.1 20220131 Walsall Review Progress Letter (002).pdf 6.1 Statment from Chair and CEO.docx
7	Chief Executive's Report *Presented by: Prof. David Loughton* *Action: For information* 7. Chief Executive Officer's Report 2 February 2022.docx
8	Patient Story *https://www.youtube.com/watch?v=UIaHDYSvLoM*
9	Quality, Patient Experience and Safety Committee Report - Verbal Report *Presented by Pam Bradbury* *Action: To Note*
10	Safe High Quality Care Executive Report *Presented by: Caroline Whyte (in attendance)* *Action: To Inform and Assure* 10. Public Trust Board SHQC Executive Report 2nd February 2022.docx 10a. BAF SO 01 - Safe, High Quality Care.pdf
11	Maternity Update *Presented by: Carla Jones-Charles (In Attendance)* *Action: To Inform and Assure* 11. Maternity Update.docx
12	Infection, Prevention and Control (including Board Assurance Framework) *Presented by Amy Wallett (in attendance)* *Action: To Inform and Assure* 12. Public Trust Board IPC BAF update February 2022 (1).docx 12a. Appendix 1 IPC BAF Criterion controls and mitigating actions.docx
13	Mortality Report *Presented by: Dr Simon Harlin (in attendance) & Dr Manjeet Shehmar* *Action: To Inform and Assure* 13. Mortality Report Jan 22 v3.docx
14	Patient Experience Quarter 3 Report

Presented by : Garry Perry
Action: To Inform and Assure

14. Public Trust Board Patient Experince Q3 report 2nd Feb 2022.docx

14a. Appendix 1 Patient Experience Highlight Report.docx

15 Performance, Finance and Investment Committee Report

16 Use Resources Well Executive Report

Presented by: Will Roberts (in attendance)
Action: To Inform and Assure

16. Use Resources Well Executive Report Trust Board Jan 2022v2.docx

16a. New_UseResourcesWell_Presentation_Charts.pptx

16b. BAF SO 05 - Use Resources Well.pdf

17 People and Organisation Development Committee Report

18 Value Our Colleagues Executive Report

Presented by: Catherine Griffiths
Action: To Inform and Assure

18. Valuing Colleagues Executive Update.docx

18a. BAF SO 04b - Organisational Effectiveness.pdf

18b. BAF SO 04a - Leadership Culture & OD.PDF

18c. BAF SO 04c - Making Walsall & BC BPTW.PDF

18e. Workforce Performance Summary - 202112.docx

19.a Nursing and Midwifery Safer Staffing Assurance Framework

Presented by: Gaynor Farmer
Action: To Inform and Assure

19a. Public Trust Board Nursing and Midwifery Safer Staffing Assurance Framework February 2022.docx

19a1. Appendix 1 Nursing and Midwifery safer staffing assurance framework.docx

19a2. Appendix 2 Nursing and Midwifery Assurance Framework NHSEI letter of November 2021.pdf

19.b Workforce Safeguards report

Presented by: Gaynor Farmer
Action: To Inform and Assure

19b. Public Trust Board Workforce Safeguards paper Jan 2022 for February 2022 board.docx

19b1. Appendix 1 Workforce Safeguards completed Trust assessment and action plan.xlsx

20 Vaccination as a Condition Of Deployment (VCOD)

Presented by Catherine Griffiths
Action: To Assure

20. TB Exec Report on Vaccination.docx

21 Walsall Together Partnership Board Report

22 Care at Home Executive Report

Presented by Matthew Dodd
Action: To Inform and Assure

22. Care at Home Report Feb22 v1.docx

22a. CAH App 1 WT Operational Update Jan 22 1.0.pptx

22b. BAF SO 02 - Care at Home.pdf

23 COVID-19 Board Assurance Framework

Presented by: Kevin Bostock
Action: To Assure

23.Trust Board - BAF & CRR Report - 26.01.2022.docx

23. BAF SO 06 - COVID.PDF

24 Charitable Funds Highlight Report

Presented by: Paul Assinder
Action: To Approve, Inform and Assure

24. CF Committee Highlight Report for Jan Board 2022 (2).docx

25 Five Year Strategy Update

Presented by Simon Evans
Action: To Approve

25. V5_ Five Year Strategy Update19Jan22.docx

26 Green Plan

Presented by Simon Evans
Action: To Approve

26. Green Plan - Walsall Healthcare NHS Trust Boad Paper Front Sheet.docx

26. Walsall NHS Trust Green Plan_Final (007) 20.01.22.pdf

27 Improvement Programme Update

Presented by Simon Evans
Action: To Approve

27. Improvement Programme Update Report Feb 2022 Board v2.docx

28 Any Other Business

29 Questions from the Public

30 Date and Time of Next Meeting

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD

Held in public on Wednesday 2nd February 2022 from 09.30am to 13.00pm
Meeting held virtually via Microsoft Teams

AGENDA

#	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Inform	Steve Field	Verbal	09.30
2.	Declarations of interest	Inform	Steve Field	Enclosure	
3.	Minutes of last meeting	Approve	Steve Field	Enclosure	
4.	Matters arising and action log	Review	Steve Field	Enclosure	09.35
5.	Trust Values and Nolan Principles	Inform	Steve Field	Enclosure	09.40
6. 6.1	Chair's Report Independent review of leadership	Inform	Steve Field John Dunn	Verbal	09.45
7.	Chief Executive's Report	Inform	David Loughton	Enclosure	09.50
STORY					
8.	Patient Story	Discuss	Introduced by Lisa Carroll	Verbal	09.55
PROVIDE SAFE, HIGH QUALITY CARE					
9.	Quality, Patient Experience and Safety Committee Report	Assure Inform	Pamela Bradbury	Verbal	10.10
10.	Safe High Quality Care Executive Report (including Board Assurance Framework and performance)	Assure Inform	Manjeet Shehmar Ann-Marie Cannaby Lisa Carroll Caroline Whyte	Enclosure	10.20
11.	Maternity Update	Assure Inform	Carla Jones-Charles	Enclosure	10.25
12.	Infection, Prevention and Control (including Board Assurance Framework)	Assure Inform	Lisa Carroll Amy Wallett	Enclosure	10.35
13.	Mortality Report	Assure	Manjeet Shehmar	Enclosure	10.45
14.	Patient Experience Quarter 3 Report	Approval Assure	Lisa Carroll Gary Perry	Enclosure	10.55
USE RESOURCES WELL					
15.	Performance, Finance and Investment Committee Report	Assure Inform	John Dunn	Verbal	11.05
16.	Use Resources Well Executive Report (including Board Assurance Framework and performance)	Assure Inform	Ned Hobbs Russell Caldicott	Enclosure	11.15
11.20– 11.30 COMFORT BREAK					
VALUE OUR COLLEAGUES					
17.	People and Organisational Development Committee Report	Assure Inform	Junior Hemans	Verbal	11.30
18.	Value Our Colleagues Executive Report (including Board Assurance Framework and	Assure Inform	Catherine Griffiths	Enclosure	11.40

#	Agenda Item	Purpose	Lead	Format	Time
	performance)				
19.	Nursing and midwifery safer staffing assurance framework Workforce Safeguards report	Assure	Ann-Marie Cannaby Lisa Carroll Caroline Whyte	Enclosure	11.45
20.	Vaccination as a Condition Of Deployment (VCOD)	Assure	Catherine Griffiths	Enclosure	11.50
CARE AT HOME					
21.	Walsall Together Partnership Board Report	Assure Inform	John Dunn	Verbal	12.00
22.	Care at Home Executive Report (including Board Assurance Framework and performance)	Assure Inform	Matthew Dodd	Enclosure	12.05
GOVERNANCE AND WELL LED					
23.	COVID-19 Board Assurance Framework	Assure	Ned Hobbs	Enclosure	12.20
24.	Charitable Funds Highlight Report	Assure	Paul Assinder	Enclosure	12.25
STRATEGIC AND PARTNERSHIP WORKING					
25.	Five Year Strategy Update	Assure	Simon Evans	Enclosure	12.45
26.	Green Plan	Approve	Simon Evans	Enclosure	12.50
27.	Improvement Programme Update	Assure	Simon Evans	Enclosure	12.55
CLOSING ITEMS					
28.	Any other business	Discuss	Steve Field	Verbal	13.00
29.	Questions from the Public	Discuss	Steve Field	Verbal	
DATE AND TIME OF NEXT MEETING					
Thursday 6th April 2022 at 09.30am					
EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC					
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).					

Lead Presenters

Name of Lead	Position of Lead
Prof Steve Field	Chair of Trust Board
Mr John Dunn	Vice Chair of Trust Board; Chair of Performance, Finance and Investment Committee
Mrs Pamela Bradbury	Non-Executive Director; Chair of Quality, Patient Experience and Safety Committee
Mr Junior Hemans	Non-Executive Director; Chair of People and Organisational Development Committee
Mrs Mary Martin	Non-Executive Director; Chair of Audit Committee
Mr Paul Assinder	Non-Executive Director; Chair of Charitable Funds Committee

Name of Lead	Position of Lead
Prof David Loughton	Interim Chief Executive Officer
Prof Ann-Marie Cannaby	Chief Nursing Officer/ Interim Deputy Chief Executive Officer
Dr Manjeet Shehmar	Medical Director
Mr Russell Caldicott	Director of Finance and Performance
Ms Catherine Griffiths	Director of People and Culture
Mr Ned Hobbs	Chief Operating Officer
Mrs Glenda Augustine	Director of Planning and Improvement
Ms Lisa Carroll	Director of Nursing
Mrs Carla Jones-Charles	Divisional Director of Midwifery, Gynaecology & Sexual Health
Mr Simon Evans	Acting Chief Strategy Officer
Mr Matthew Dodd	Acting Director of Integration
Mr Mike Sharon	Strategic Advisor to the Trust Board
Mr Kevin Stringer	Interim IT Director and SIRO
Mr Keith Wilshere	Interim Company Secretary

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Declarations of Interest			**AGENDA ITEM: 2**
Report Author and Job Title:	Keith Wilshere Interim Trust Secretary	**Responsible Director:**	Steve Field, Trust Board 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 February 2022

Name	Position held in Trust	Description of Interest
Professor Steve Field	Chair	Chair: Royal Wolverhampton NHS Trust
		Director: EJC Associates
		Trustee for Charity: Pathway Healthcare for Homeless People
		Trustee: Nishkam Healthcare Trust Birmingham
		Honorary Professor: University of Warwick
		Honorary Professor: University of Birmingham
Mr John Dunn	Vice Chair Non-executive Director	Non-Executive Director, Royal Wolverhampton NHS Trust
Ms Pamela Bradbury	Non-executive Director	STP Workforce Bureau (Vaccination Programme)
		Partner, Dr George Solomon is a Non-Executive Director at Dudley Integrated Health and Care Trust
Mr Junior Hemans	Non-executive Director	Non-executive Director - Royal Wolverhampton NHS Trust
		Visiting Lecturer – University of Wolverhampton
		Director – Libran Enterprises (2011) Ltd
		Chair/Director - Wolverhampton African Caribbean Resource Centre
		Chair - Tuntum Housing Association (Nottingham)
		Company Secretary – The Kairos Experience Ltd.
		Member – Labour Party
		Mentor – Prince's Trust
		Spouse is a therapist at Royal Wolverhampton NHS Trust
Ms Mary Martin	Non-executive Director	Royal Wolverhampton NHS Trust - Non-Executive Director
		Trustee/Director, Non-Executive Member of the Board for the charity - Midlands Art Centre
		LTDTrustee/Director, Non-Executive - B:Music
		Director - Friday Bridge Management Company Ltd
		Non-Executive Director/Trustee - Extracare Charitable Trust (stood down 21 June 21)
Professor	Non-executive Director	Member - Birmingham and Solihull Workforce

Name	Position held in Trust	Description of Interest
Louise Toner		Action Board and Education Reform Workforce Group
		Associate Dean Faculty of Health, Education and Life, Birmingham City University
		Visiting Professor/Advisory Board Member, Lovely Professional University India
		Chair – Education Focus Group, Birmingham Commonwealth Associated
		Member – Royal College of Nursing – UK
		Member – Greater Birmingham Chamber of Commerce Commonwealth Group
		Teaching Fellow – Higher Education Academy
Mr Paul Assinder	Associate 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 Rajpal Virdee	Associate Non-executive Director	Lay Member, Employment Tribunal Birmingham
		Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021)
Mrs Sally Rowe	Associate Non-Executive	Executive Director Children's Services - Walsall MBC
		Trustee of the Association of Directors of Children's Services
Professor David Loughton	Interim Chief Executive	Chief Executive – Royal Wolverhampton NHS Trust
		Health policy advisor to the Labour and Conservative Parties
		Member – Dementia Health and Care Champion Group
		Member of Advisory Board – National Institute for Health Research
		Chair – West Midlands Cancer Alliance
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive	Chief Nurse – Royal Wolverhampton NHS Trust
		Director – Ann-Marie Cannaby Limited

Name	Position held in Trust	Description of Interest
		Visiting Professor – Staffordshire University
		Honorary Fellow – La Trobe University, Victoria, Australia
		Teaching Fellow – Higher Education Academy
		Member – Royal College of Nursing
		Visiting Professor – Birmingham City University
		Principal Clinical Advisor – British Telecom
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
		Director of Plan 4 E-Health
Dr Manjeet Shehmar	Medical Director	Company Director Association of Early Pregnancies Units UK
		Executive Member Association of Early Pregnancy Units UK
		Private Practice Health Harmonie ceased August 2021
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chartered 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
Mrs Lisa Carroll	Director of Nursing	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research
		Spouse - RCPCH Assistant Officer for exams
		Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group
		Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)
		Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM

Name	Position held in Trust	Description of Interest
		Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar
Ms Glenda Augustine	Director of Performance & Improvement	No interests to declare
Mr Mike Sharon	Interim Strategic Advisor to the Board	Strategic Advisor to the Trust Board - RWT
		Member of the Liberal Democrat Party
		Wife works as an independent trainer, coach and counsellor. Some of this work is for local NHS bodies (excluding RWT) Wife had undertaken work for Walsall Healthcare NHS Trust as a self-employed trainer.
Mr Matthew Dodd	Director of Transformation Walsall Together	Wife working as a Physiotherapy Assistant at Birmingham Community Health Care
Mr Kevin Bostock	Director of Assurance	Sole director of a limited company Libra Healthcare Management Limited trading as Governance, Risk, Compliance Solutions

RECOMMENDATIONS

The Board is asked to note the report

MEETING OF THE PUBLIC TRUST BOARD
HELD ON THURSDAY, 2ND DECEMBER 2021 AT 10.00AM
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Prof. S Field CBE	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director; Vice Chair, Board of Directors
Mrs P Bradbury	Non-Executive Director
Mr J Hemans	Non-Executive Director
Ms M Martin	Non-Executive Director
Prof. L Toner	Non-Executive Director
Mr P Assinder	Associate Non-Executive Director
Mr R Virdee	Associate Non-Executive Director
Prof. D Loughton CBE	Interim Chief Executive
Ms L Carroll	Director of Nursing
Mr R Caldicott	Director of Finance and Performance
Miss C Griffiths	Director of People and Culture
Mr N Hobbs	Chief Operating Officer
Dr M Shehmar	Acting Medical Director
Mr K Bostock	Director of Assurance

In attendance

Mr M Dodd	Director of Transformation, Walsall Together
Ms C Jones-Charles	Deputy Divisional Director of Midwifery, Gynaecology and Sexual Health
Mr M Sharon	Strategic Advisor to the Board
Mr K Stringer	Chief Financial Officer - RWT
Mr K Wilshere	Interim Company Secretary
Mrs J Wilson	Staff Side Representative
Ms R Crossey	Head of Business Development and Planning
Mr A Rice	Patient Relations & Patient Experience
Mr C Lemord	UNISON representative
Mrs D Ohai	Divisional Director of Operations – Womens, Childrens and Clinical Support Services
Ms Carol Dawes	Administrative Support Officer

Apologies

Mrs G Augustine	Director of Planning and Improvement
Mrs S Rowe	Non-Executive Director
Prof. A-M Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Mr S Evans	Interim Chief Strategy Officer

200/21	**Welcome, Apologies and Confirmation of Quorum**
	Prof. Field welcomed everyone to the meeting and apologies were noted.
201/21	**Declarations of Interest**
	Prof. Field confirmed that there were no further interests declared in addition to those published.
202/21	**Minutes of Last Meeting**
	Prof. Field confirmed that the minutes of the meeting held on 4 November 2021 were read and approved as an accurate record. **Resolved: The minutes of the last meeting be received and approved.**
203/21	**Matters Arising and Action Log**
	Prof. Field received the action log and updates were noted.
204/21	**Trust Values and Nolan Principles**
	Prof. Field brought the attention of the Board to the seven principles of public life, the Nolan Principles, and the Trust Values.

205/21	**Chair's Report**
	Prof. Field presented his report, highlighting that interviews had taken place for new Non-Executive Directors and the panel had been impressed with the number and quality of applications received from local and national areas and decisions to offer had been agreed. Prof. Field advised that appraisals for the current Non Executive Directors had also been held. **Resolved: The Chair's Report be received and noted.**
206/21	**Chief Executive's Report**
	Prof. Loughton presented his report and highlighted that a great deal of his time had been spent lobbying nationally for better rates of pay for domiciliary care. He said that the flow through the hospital was of concern and teams were working hard to get as many patients home ahead of the festive break. Prof. Loughton advised that the hospital had been working with West Midlands Ambulance Service (WMAS) to have a number of beds empty by Christmas Eve in preparation for the busy New Year period. Prof. Loughton advised that he and Prof. Field had hosted a visit from Senior Executives of the Department of Health and Social Care (DHSC) and also provided a briefing session for all MPs of Wolverhampton, Walsall, Cannock and South Staffordshire. Prof. Field added that the meeting with MPs was excellent and supportive and during the visit of the Secretary of State and his team to Wolverhampton, the work in the primary care and Walsall Together had been positively received. Ms Martin referenced the recent national briefing by Ms Amanda Pritchard, NHS CEO and asked whether there was anything the Board needed to know about her approach. Prof. Loughton said there would be no fundamental change and that they need to continue to work with local government and deliver the best service possible under difficult circumstances. . Mr Assinder said Ms Pritchard referred to virtual wards and asked if this was being promoted as a concept locally. Mr Dodd confirmed that part of the fundamental principle in the community was around managing people virtually via the Care Navigation Centre and that this was being undertaken virtually and monitored safely and remotely and a team would be sent in if needed. Mr Dodd said that as this had been successful through COVID and during winter they had been looking to expanding it to other services. Mr Dodd reported that the ICS had received £100k to support the development of virtual monitoring for paediatrics and children's services were picking up the approach to manage more children in the community. Dr Shehmar reported that WMAS had attended a recent ICS quality meeting to present the work undertaken at Walsall and had asked other providers to visit Walsall as an exemplar. Prof. Loughton highlighted that acutely ill patients were not being discharged at the rate of the patients arriving. Prof. Field said that they need to promote the vaccination programme to patients including pregnant women. Mr Dunn asked if they were providing the right amount of public communications to illustrate and recognise the work being done within Walsall Together in order to reduce flow into the hospital and the borough council providing good packages of care. Prof. Loughton reiterated the focus must be on the rate of pay in domiciliary care as this was a national issue. Ms Evans advised they were working on case studies to promote Walsall Together and the services provided in the community and sharing internally what services can be accessed. Mr Assinder asked if there was an alternative for RSV and Mr Dodd said the Primary Care Networks (PCNs) had identified a hub for GPs to have face to face contact with children to relieve the pressure on primary care and working with childrens services. **Resolved: the Chief Executive's Report be received and noted.**
STAFF STORY	

207/21	**Re-introduction of the volunteers**
	Ms Carroll introduced the report and welcomed Mr Andrew Rice, Patient Relations & Patient Experience Lead. Mr Rice shared an inspirational video showing a number of volunteers expressing their reasons for joining the Trust and some of the difficulties they encountered over the last year, due to COVID restrictions, in carrying out their usual activities and highlighted the importance of patient experience within the Trust. He reported a number of volunteers had taken a break during this time but were now being welcomed back into the organisation. Mr Virdee thanked Mr Rice for bringing this positive report to the attention of the Board and was pleased to see people who had received care in the hospital wanting to give something back into the organisation. He asked what the mix of volunteers was from different communities and Mr Rice advised this data could be provided and that volunteering was accessible to all in the community. Prof. Field asked for the data to be shared with Board members. Mr Sharon questioned whether using volunteers in the community settings had been considered as part of Walsall Together and Mr Rice confirmed two staff had been funded to train at Manor Farm and their roles would focus on recovery and supporting staff wellbeing and morale. Mr Rice said that roles were limited due to not having visitors within the hospital however, they have in excess of 200 volunteers at Walsall and that a cadet's programme for younger volunteers was also being put in place. Mr Sharon suggested he speak to Mr Dodd on this aspect within the community. Mr Rice advised the volunteers had been nominated for the Unsung Hero award in the forthcoming Staff Awards and highlighted the tremendous commitment of the volunteers. **Resolved: the report on the Re-introduction of the volunteers be received and noted.** **Action: It was agreed that Mr Rice would share the data on ethnic mix of volunteers with Board Members.** Mr Rice left the meeting at 10:45.
PROVIDE SAFE, HIGH QUALITY CARE	
208/21	**Quality, Patient Experience and Safety Committee Report**
	Mrs Bradbury, Chair of the Quality, Patient Experience & Safety Committee (QPES), presented the Chairs report from the meeting held on 25 November 2021, highlighting that the Committee had received the staff video by the volunteers and asked that a visit with the volunteers be included should boardwalks recommence in the Trust. Mrs Bradbury presented the QPES report which was taken as read. Referring to the serious incidents, Prof. Field said that they must not get to a position where these were not being regularly reviewed. **Resolved: The report from the Chair of the Quality, Patient Experience and Safety Committee be received and noted.**
209/21	**Safe High Quality Care Executive Report**
	Dr Shehmar presented the Safe High-Quality Care Executive report that included the relevant Board Assurance Framework (BAF) risk and the performance dashboard which was taken as read. Ms Martin referenced the BAF Qtr 2 risk level assessed at 25 and the target to bring this down to 10, noting the work already undertaken and asked what assurance there was that key issues were addressed and where the risk level would be at month end. Ms Carroll said historically this was the highest BAF risk for Mental Health Tier 4 and that access work had been undertaken to lower risk from 25 to 20. Dr Shehmar confirmed that the work undertaken on Mental Health had reduced the risk but this had not been updated as yet as staff recruited for other actions were not yet in post. However, Dr Shehmar said that she was confident the risk score would reduce further. Ms Carroll advised there were other

	risks within the BAF being worked through. Prof. Field asked that the next meeting receive more detailed assessments on the other risks and more time to debate issues in the Board. Mrs Bradbury advised her committee highlight report would be amended to focus on the BAF risks. Dr Shehmar said the BAF risks needed to be reviewed and retitled to be realistic on what could be achieved and updated to identify where they could be reduced. Mr Dunn said the report contained a lot of information but he wanted assurance on what was being done, the key issues, the top three priorities to be concerned about, the actions and completion date and resources in place to achieve it. Prof. Field agreed to use the next Trust Board to receive the detail for assurance. Mr Virdee referenced the never events and was pleased to note an external review was being undertaken. **Resolved: The Safe High-Quality Care Executive report be received and noted. Action: Dr Shehmar and Ms Carroll to provide further assurance on the key issues, work being undertaken and the top three priorities with actions and completion dates and resources to be received at the next Trust Board.**
210/21	**Maternity Update**
	Mrs Jones-Charles presented the report and highlighted the ongoing work on the action plan and the national constraints on recruitment of midwives. Referencing the Ockenden report, Mrs Jones-Charles advised that in June 2021, the Organisation had been required to submit evidence of compliance and confirmed that this had been done. A preliminary report had since been received, some of which they had challenged and they were now 97% compliant and working with partners regionally on perinatal surveillance to ensure the right methods were in place across the region. Prof. Field congratulated Mrs Jones-Charles on a good and clear report. Ms Toner said it was a good outcome and asked what standards were not achieved. Mrs Jones-Charles advised that it was the perinatal networks run by the ICS development and the external maternal networks involved in a regional wide network. Prof. Loughton advised he had been working with Mrs Jones-Charles on a plan to relocate the Midwifery Led Unit (MLU) into the main hospital site and highlighted the difficulties in obtaining materials for capital schemes. Dr Shehmar stated that the networks were out of their control but there were actions from serious incidents asking whether processes were in place for agreed pathways and whether these were implemented and embedded. Mrs Jones-Charles confirmed the audit on the networks was completed and that this provides assurance to the patients on those pathways and would continue to be audited. Mr Assinder referenced the birthing chart on the number of births annually and queried the clinical viability and the future sizing of units both clinically and in terms of sustainability. Prof. Loughton confirmed there would always be a maternity unit in Walsall and Wolverhampton and he would see this as one service on two sites coming together to alleviate the pressure. Mr Hobbs reported an incremental increase in the number of births since 2017/18 which had taken place in the backdrop of birth rates nationally decreasing and that this was an endorsement of women and families wanting to have care at the Hospital. He said that the chart shows decreasing vacancy rates highlighting the successful recruitment programme and a good indication to providing and attracting staff to the service.

	Mrs Bradbury sought clarification on the maternity capacity for safe births and Mrs Jones-Charles responded that staffing models would be moved depending on how they staff the service and the number of vacancies. **Resolved: The Maternity Update be received and noted.**
USE RESOURCES WELL	
211/21	**Performance, Finance and Investment Committee Report**
	Mr Dunn, Chair of the Performance, Finance, and Investment Committee (PFIC) presented the Chair's Report from the meeting held on 24 November 2021. Mr Dunn highlighted that the meeting had focused on the worst case scenario of a deficit position, the risks to delivery of H2 plan, the progress of the nurse recruitment to reduce the reliance on agency staff, the efficiency programme and plans in key risk areas. He said that performance and the Restoration plan were on track. Mr Dunn noted the review of security arrangements within the mortuary and said there was clear assurance that this was of an adequate state. **Resolved: The Chair's Report from the Performance, Finance, and Investment Committee Chair be received and noted.**
212/21	**Use Resources Well Executive Report**
	Mr Hobbs referenced the comments of Prof. Loughton around the ambulance challenges and the 4 hour access/ambulatory standards, during the most challenging period of greatest pressure late December early January. Mr Hobbs reported that whilst performance was holding up, pressure remained as patients were spending longer in hospital. Mitigations were in place following early approval of the winter plan. Mr Hobbs referenced the comments in Mrs Bradbury's report concerning non-obstetric ultra sound and added that the mitigations had been provided with additional capacity and a third provider, two sonographers recruited and a locum radiologist appointed medium term and short term plans. Mr Hobbs highlighted there was pressure on the breast service due to unforeseen sickness absences and isolation however, support for the service was being provided by the Royal Wolverhampton NHS Trust. Mr Caldicott reported on the October performance and the delivery of H1 advising that there had been some one-off expenditure resulting in the run rate being slightly below plan. He said that the two key risks were the need to get assurance around the efficiency schemes, some of which were income focussed, and for the recruitment programme to reduce temporary work and agency spend. Mr Caldicott reported that the risk Profile was around £5m and he had flagged £2.7m of contingent risk with the Sustainability Transformation Partnership (STP).and said that the STP would have £12m of contingency fund which would be accessible to the Trust. Mr Caldicott said that there was a fully resourced capital programme and advised that the supply issues highlighted by Prof. Loughton and the programme was being reviewed in light of these issues. Ms Martin referenced the capital programme and the gaps in assurance around the backlog maintenance programme and sought assurance on the size of the backlog and how long it would take to address it. Mr Hobbs advised that the latest estimates of the backlog reported to PFIC ranged between £28m and £37m and quotations being provided. He said that work was being prioritised for the internal capital and externally sourced capital on the highest risk areas (including refurbishment of operating theatres and air handling unit). Mr Hobbs reported that the score on the Corporate Risk Register would not reduce until next calendar year when the theatre refurbishment was complete and he

	agreed to share the details with Ms Martin offline. Mr Hemans noted the mortuary review had been undertaken following a significant case reported in the media and asked whether any areas of concern or risk beyond that case were considered. Mr Hobbs said a specific review had been undertaken of mortuary security arrangements in relation to the case mentioned and further enhancements were being made to strengthen those arrangements. Mr Hemans said no further widespread review had been undertaken and that whilst security had not recently been reviewed he would be happy to take that as an action for it to be considered more broadly. Mrs Bradbury said one of the primary risks to achieving H2 was around cessation of agency staff and recruitment of international nurses and asked whether there was a financial contingency as a number of nurses recruited were now pregnant. Ms Carroll said the number was low and Prof. Loughton advised that Royal Wolverhampton NHS Trust were building a contingency for this. Prof. Loughton referenced the backlog maintenance programme highlighting that there was some old estate on the site that required attention. Mr Assinder said as the COVID period of funding was ending and they would be reverting back into NHS funding, it would be helpful for Board Members to have a clearer view of efficiency programmes and pipeline of opportunity. **Resolved: The Use Resources Well Executive Report be received and noted.** **The Trust Board convened for a short break from 11.45am to 11.55am.**
VALUE OUR COLLEAGUES	
213/21	**People and Organisational Development Committee Report**
	Mr Hemans, Chair of the People and Organisational Development Committee presented the Chair's report of the Committee meeting held on 25 November 2021 and this was taken as read. **Resolved: The highlight report from the Chair of the People and Organisational Development Committee be received and noted.**
214/21	**Value Our Colleagues Executive Report**
	Ms Griffiths presented the report which was taken as read. She highlighted the issues raised in employment of domiciliary care and said conversations were ongoing as part of People Board discussions to ensure they have a real living wage and advised that the Trust was already accredited as a Real Living Wage employer. Miss Griffiths introduced Mrs Ohai who attended to present the WCCSS division presentation to highlight the division's commitment to people. Mrs Ohai reported that on the Divisional Away Day, it had been recognised how staff were feeling and they were therefore opening their doors to having one to one conversations with team members and opening up the away days so all care groups have away days, time to plan. Ms Ohai said that they had started a talent forum to look at the diverse workforce and looking at workforce development and apprenticeships. She said they were encouraging teams to look at things in a different way and escalate anything they were not able to manage. Mrs Bradbury asked what care and support was being provided to the international nurses that were now pregnant. Ms Carroll confirmed nurses were being supported by GPs and antenatal care was being provided and the next step would be the financial support needed. Mrs Bradbury noted the reduction in concerns raised via the Freedom to Speak Up (FTSU) Guardians, and said that the verbal report the Committee received had not reflected that

	and asked what was being done to triangulate that. Mrs Ohai confirmed that work had been undertaken with the FTSU Guardians to encourage staff in the Division to speak up and that arrangements were in place for the FTSU Guardian to join their quarterly meetings to share feedback on areas of concern and how to improve. Mr Virdee noted the level of Personal Development Review (PDR) compliance was particularly low in corporate areas, which was due to not recording on Electronic Staff Record (ESR) when completed. He also noted long term sickness was a concern and queried if any financial implications were being reported to the Performance, Finance and Investment Committee (PFIC). He asked when the Committee would receive divisional presentations on how they were implementing the Equality, Diversity and Inclusion (EDI) strategy. Ms Griffiths responded confirming there were data compliance issues with PDRs but highlighted the Board agreement that the important aspect was that appraisals took place in a way that it was a more detailed quality experience and advised the recovery period would be March 2022. Ms Griffiths advised that reviews on long term sickness were received by the Committee and the divisional performance reviews and that increases in musculoskeletal (MSK) issues were being seen. However, Ms Griffiths said that she was confident absences were being dealt with proactively by the divisions and that other long term sickness issues related to stress, anxiety and depression had appropriate support mechanisms in place to support staff back to work. In response to the EDI question Miss Griffiths said divisional reviews would be received by the Committee and at the next meeting they would look at the actions on EDI strategy to assess whether outcomes had been met and identify any gaps in assurance. Dr Shehmar said that they were people were wanting to work at the Organisation because of the culture and that was something to be proud of and highlighted that Health Education England had reported that some doctors did not know how to raise concerns and asked whether a focussed piece of work was therefore required around this topic. Dr Shehmar questioned whether the learning from the CQC report in midwifery could be shared with other areas. Mrs Ohai advised the midwifery staff had been offered one to one's with all staff which had been taken up and supported by Care Groups and Human Resources. Ms Martin asked whether the Committee had looked at the need for mandatory vaccinations by the end of financial year and if there was a programme of roll out to staff to provide them the opportunity to get the assurance they need around having the vaccine. Miss Griffiths confirmed discussion had taken place and the data and compliance levels were being looking at using the health and wellbeing guidance to ensure staff were supported. Mr Dunn noted the increased response rate to the staff survey and congratulated the team. Prof. Field echoed Mr Dunn's congratulations. Ms Toner reported all students and healthcare professionals were also required to have vaccinations according to the guidance which may have a knock on affect with the workforce in the future. **Resolved: The Value Our Colleagues Executive Report be received and noted.**
215/21	**Safe Staffing Report and Establishment Review**
	Ms Carroll presented the Safe Staffing report which was taken as read and highlighted the Registered Nurse (RN) /Midwife vacancy rate was reducing and the impact of the international nurse recruitment was starting to take effect. Ms Carroll reported that twelve trainee Nurse Associates were expected to qualify in December and in total there were 38 trainers going through the next stages of development, and 15 student nurses who had placements last year had been allocated positions to commence in the Trust as Newly Qualified Nurses in January/February 2022. Ms Carroll said that agency usage had reduced and the revised inpatient theatre

	establishments were being introduced into ward budget lines in November 2021 and recruitment was underway. Mrs Bradbury said that she was pleased to note the reduction in the vacancy gaps in all areas but noted the WCCSS division had increased month on month over the past six months and wanted to understand if they were looking to fill that area first with international nurses. Ms Carroll advised that the challenges in midwifery and paediatrics were included in the numbers and focus was on these areas. Mr Hobbs noted the improvement in the overall registered nurse and midwifery vacancy rate and asked if it was possible to include the equivalent SPC charts for the clinical support workers given their vital role they provide in providing good quality care and Ms Carroll said she was happy to do that. **Resolved: The Safe Staffing Report be received and noted.**
CARE AT HOME	
216/21	**Walsall Together Partnership Board Report**
	Prof. Field congratulated Mrs Rowe on the Office for Standards in Education, Children's Services and Skills (OfSted) rating of Good for the Council for Children's Services, stating that this was excellent news and he was delighted for Mrs Rowe and the team on the achievement. Mr Dunn presented the Chair's report of the Walsall Together Partnership Board from the Committee meeting held on 17 November 2021. The report was taken as read and Mr Dunn highlighted that the relationships between the team and the Council were working well together on the packages of care being created. Mr Dunn congratulated the Walsall Together team on their ideas to reduce visits and the focus to ensure improve the flow through the acute hospital and said it was heartening to see this in operation. **Resolved: The Chair of Walsall Together Partnership Board be received and noted.**
217/21	**Care at Home Executive Report**
	Mr Dodd reported that the community service performance in October was better in terms of hours delivered, hospital avoidance and was medically stable for discharge against an environment that was increasingly volatile. Mr Dodd said that within the partnership there was an obligation to work collectively to ensure partners were not destabilised in the process. Mr Dodd advised that the independent sector had concerns about vaccinations and had been working with partners to send mobile teams out to do vaccinations in care agencies and care homes to support them. He said that they had been looking at a recruitment strategy that supports the independent sector in recruiting and growing the skills among its workforce. Mr Dodd reported that they have 130 clinical support workers and have been looking at how to better support them. Mr Dodd said that another approach against mitigation in preventing admission and attendance, was working jointly with West Midlands Ambulance Service on a falls service which was having an impact and reducing attendances to hospital. He said undertaking streaming, working from care homes, pathways around respiratory and acute respiratory infections, as well as taking the GP calls to the hospital for referring people from January, was an exciting aspect in trying to deflect that and manage it within the community setting. Mr Dodd advised that in November, Sam Sherrington Head of Community Nursing had visited the community services which had been a positive experience and had been proud to share their work. Mr Hemans said he had attended an event in Wolverhampton on youth unemployment which was a major issue and asked whether this was been looked at in Walsall with the

	partners and how they could play their part to create opportunities. Mr Dodd advised that this was being monitored by the senior management group for community services. He explained that a recruitment process was in place with Walsall Housing Group, finding roles on apprenticeship schemes and then using that approach with the care agencies to develop them and get a pipeline workforce in development. **Resolved: The Care at Home Executive Report be received and noted.**
WORK CLOSELY WITH PARTNERS	
218/21	**Acute Provider Programme Board Update**
	Mr Hobbs presented a combined report taken as read. **Resolved: The Acute Provider Programme Board Update be received and noted.**
GOVERNANCE AND WELL LED	
219/21	**Audit Committee Highlight Report**
	Mrs Martin presented the report which was taken as read and highlighted the Audit Committee Terms of Reference which were presented for approval. **Resolved: The Audit Committee Highlight report be received and the Audit Committee Terms of Reference approved.**
220/21	**COVID-19 Board Assurance Framework**
	Mr Hobbs said the COVID BAF quarterly update was due this month and he would include information on the new variant. Mr Hobbs advised that this would be presented to the Board at the next meeting. **Resolved: The COVID-19 Board Assurance Framework be received and noted.**
STRATEGIC AND PARTNERSHIP WORKING	
221/21	**Progress on Partnership Working**
	Mr Sharon presented the report outlining the journey to date, to improve the collaboration between Walsall Healthcare Trust and the Royal Wolverhampton Trust during 2021. Mr Sharon highlighted the senior management roles shared, clinical and nursing service developments and other collaborative functions shared between both organisations. Mr Assinder congratulated Mr Sharon and Mr Wilshere on the clear set of papers and in terms of setting objectives in the collaboration. He said that research and teaching had been under played around the anchor organisation influence on the economic stimulus in the local community and asked if Mr Sharon could review this further. Mr Sharon agreed they had been under played and that they need to set metrics on the wider economic impact. Mrs Bradbury sought clarification on the staff passport into the Black Country. She asked if rotational posts had been considered. She also referred to slide eleven in the report and asked that it include patient outcomes. Prof. Field agreed that should be talking about people and not just about patients. **Resolved: he Progress on Partnership Working report be received and noted.**
222/21	**Proposal regarding Partnership Development**
	Mr Sharon presented the report and explained the creation of a Provider Group Model between the Wolverhampton and Walsall Trusts and outlined the proposals of how to make them more effective and streamlined; these included changing frequency of board meetings to bi-monthly, sub-committee structure would continue and the setting up Committees in Common between both organisations. He said the Provider Group Model could be modified to include further trusts if required. Prof. Field confirmed the same paper would be presented at the Wolverhampton Board the following week and thanked everyone involved for their contribution and said that he fully supported the Committees in Common approach. Prof. Field added that the new Non-Executive Directors being appointed would also have input in the process. **Resolved: the Proposal regarding Partnership Development report be received and approved.**

CLOSING ITEMS	
223/21	**Any Other Business**
	Prof. Field noted that no other business was raised. Open link for the public at the next meeting.
224/21	**Questions from Public**
	Prof. Field confirmed that the next meeting was to take place on Thursday 3rd February 2022.
225/21	**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. **Resolved: That the resolution be approved.** **The meeting concluded at 11:57.**

Walsall Healthcare NHS
NHS Trust

31 January 2022 12:37

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 02/12/2021 8 Story				
114.	Re-introduction of the volunteers	Carroll, Lisa	01/02/2022	Completed
	Explanation action item It was agreed that Mr Rice would share the data on ethnic mix of volunteers with Board members.			
	Explanation Emailed Trust Board members on Monday 31st January 2022			
Public Trust Board 02/12/2021 10 Safe High Quality Care Executive Report				
110.	Safe High Quality Care Executive Report	Carroll, Lisa Shehmar, Manjeet	01/02/2022	Pending
	Explanation action item Dr Shehmar and Ms Carroll to provide further assurance on the key issues, work to be undertaken and the top three priorities with actions and completion dates and resources to be received by the next Trust Board.			
	Explanation Shehmar, Manjeet Assurance around AMU and Medicines Management provided in SHQC report.			

The Seven Principles of Public Life
‘Nolan principles’

The Seven Principles of Public Life (also known as the Nolan Principles) apply to anyone who works as a public office-holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the Civil Service, local government, the police, courts and probation services, non-departmental public bodies (NDPBs), and in the health, education, social and care services. All public office-holders are both servants of the public and stewards of public resources. The principles also apply to all those in other sectors delivering public services.

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

Our **Vision, Objectives & Values**

Walsall Healthcare NHS Trust is guided by five strategic objectives which combine to form the overall 'vision' for the organisation.

Complementing this are our 'values', a set of individual behaviours that we wish to project amongst our workforce in order to deliver effective care for all.

Our Vision: **Caring for Walsall together**

"Caring for Walsall together" reflects our ambition for safe integrated care, delivered in partnership with social care, mental health, public health and associated charitable and community organisations.

Our Objectives: **Underpinning the vision**

The organisation has five strategic objectives which underpin our vision of 'Caring for Walsall together', and they are to:

Provide Safe, high-quality care;
We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.

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

Work Closely with Partners;
We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.

Value our Colleagues;
We will be an inclusive organisation which lives our organisational values without exception.

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

Walsall Healthcare NHS
NHS Trust

Our Values: **Upholding what's important to us as a Trust**

Our values, coupled with individual behaviours, represent what we wish to project in our working environments.

Respect	**We are open, transparent and honest, and treat everyone with dignity and respect.** • I appreciate others and treat them courteously with regard for their wishes, beliefs and rights. • I understand my behaviour has an impact on people and strive to ensure that my contact with them is positive. • I embrace and promote equality and fairness. I value diversity and understand and accept our differences. I am mindful of others in all that I do.
Compassion	**We value people and behave in a caring, supportive and considerate way.** • I treat everyone with compassion. I take time to understand people's needs, putting them at the heart of my actions. • I actively listen so I can empathise with others and include them in decisions that affect them. • I recognise that people are different and I take time to truly understand the needs of others. • I am welcoming, polite and friendly to all.
Professionalism	**We are proud of what we do and are motivated to make improvements, develop and grow.** • I take ownership and have a 'can-do' attitude. I take pride in what I do and strive for the highest standards. • I don't blame others. I seek feedback and learn from mistakes to make changes to help me achieve excellence in everything I do. • I act safely and empower myself and others to provide high quality, effective patient-centred services.
Teamwork	**We understand that to achieve the best outcomes we must work in partnership with others.** • I value all people as individuals, recognising that everyone has a part to play and can make a difference. • I use my skills and experience effectively to bring out the best in everyone else. • I work in partnership with people across all communities and organisations.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Independent review of Leadership			**AGENDA ITEM: 6.1**
Report Author and Job Title:	NHSE/I	**Responsible Director:**	Not applicable
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This letter sets out the findings of an independent report into the Leadership of the Trust and subsequent follow up actions and conclusions. The action set out in Recommendation 1 of the report is included as Annex D.		
Recommendation	Members of the Trust Board are asked to note this paper		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline.	This letter recognises significant progress in tackling key issues		
Resource implications	Not applicable		
Legal and Equality and Diversity implications	None identified		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

31 January 2022

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

E: jeff.worrall1@nhs.net
W: www.england.nhs.uk and
www.improvement.nhs.uk

Steve Field
Chair
David Loughton
Interim CEO
Walsall Healthcare NHS Trust

Dear Steve and David

Re: Walsall Healthcare NHS Trust – external review recommendations progress meeting

Thank you for meeting with us on 25 January 2022. This letter provides an overview of the discussion, the progress made to date against the external review recommendations and the agreed next steps. Please could you bring this letter to the attention of your board.

Context

As you know an independent review was commissioned by NHS England and NHS Improvement – Midlands (NHSEI) at Walsall Healthcare NHS Trust (the trust). We commissioned Dr Kathy McLean OBE to conduct this review in June 2021 and a final report and recommendations was received in September 2021.

This review was commissioned following receipt of serious allegations about your behaviours, and examined the allegations raised directly with NHSEI and through the trust's internal processes.

In making the recommendations, the wider context and best interests of patients and employees as well as those directly impacted by the allegations addressed in the review was considered. Given this, it was concluded that an initial focus on reconciliation was, on balance, the best approach.

Over recent months we have been closely monitoring progress, including through oversight meetings to understand progress made against each recommendation. A full update against these recommendations is at Annex A.

Triangulation Meetings

As discussed and agreed at the meeting held with you on 16 December 2021, NHSEI met with a number of Board members (Executive / Non Executive) to assess whether progress has been made over the last few months.

The collective themes identified from these meetings were as follows:

- There was a real sense that the way in which the interim CEO entered the organisation was not managed well and this unsettled some people at the trust.
- There was an acknowledgement that this was a difficult period for the Chair / interim CEO as well as trust colleagues.
- There has been significant change in the trust board membership and this has eased the initial tensions.
- There is a strong feeling that a good team is being developed and people are feeling supported. Non executives are feeling supported by the Chair and there was recognition that the interim CEO has supported individuals across the senior team.
- There was a consensus that the Board and executive team are working together more effectively, with recent conversations feeling more inclusive.
- Challenge at the Board is reasonable and fair and there is no restriction on difficult conversations. People referenced that they are encouraged to speak up.
- The Chair and principally, the interim CEO, are providing clarity on the organisation's key priorities and areas of focus.
- The contribution of the Chair and interim CEO within the wider Walsall system is acknowledged and welcomed by wider stakeholders.
- There was a strong view that improvements have already been made i.e on substantive nursing recruitment and staff survey response rate, with robust plans to make further improvements.
- The collaborative work between the trust and The Royal Wolverhampton Trust (RWT) was acknowledged as being positive and supportive and it was highlighted that this is not a one sided relationship. There are examples where RWT are learning from the trust, in particular, Walsall Together was referenced.
- Stability is now needed for the organisation and it is important that the team continues to grow together.

Further you were able to provide some further evidence of improved morale within the trust with a significant increase (to 70%) in the number of medical trainees who now recommend the trust as a place to train.

As part of the triangulation discussions, the interim CEO was also keen for NHSEI to meet with the leader and CEO of Walsall Council.

System lessons learned review

A number of the issues identified by the Chair / interim CEO upon commencement were recognised by Black Country and West Birmingham (BCWB) CCG and had been included on the CCG's risk register.

The CCG has had a follow up conversation with the trust in relation to the:

- issues that were identified,
- how these were responded to,

- any learning and;
- feedback mechanisms

A paper will go to a future BCWB System Quality Oversight Committee to outline the issues, the lessons and to support system learning. In particular it was noted and agreed that:

- the impact of a 'financial special measures' type regime on quality was an important area of learning; and
- the importance of the governance infrastructure, particularly clinical governance and accountability. The trust has now produced a governance report on this issue, which has been shared with the CCG.

There was acknowledgement that wider learning is needed, and one of the recommendations from the external review is to do just this. Therefore, NHSEI will use this system review and any specific learning in terms of the regulatory and improvement regime within NHS Midlands through our own regional governance processes.

Next Steps

An action log from the meeting is at Annex B.

Future Review Meetings

Given the progress that has been made against the report recommendations (Annex A) and the outcomes of the triangulation meetings, we proposed that future oversight meetings be stood down.

The triangulation meetings have provided a positive view of the trust's leadership team and the progress made. Colleagues were candid about where the trust was, where it is now and the confidence for the future.

It is important that there is wider learning for the system and this will be taken through SQOC.

Report Publication

We agreed that NHSEI would work with the trust to discuss and agree the arrangements for the publication of the report via the Board meeting. Post meeting note: the report is attached at Annex C to facilitate sharing of the report alongside this letter.

Tenure

We discussed the position in respect of your respective tenures and confirmed we would support extensions, particularly in the context of the improvements made and need for certainty for yourselves, the board and the organisation. We will pick these matters up separately given the separate decision-making processes required.

If you have any questions in relation to the matters set out in this letter, please contact me or Rebecca Farmer.

Yours sincerely

Jeff Worrall
Senior Leadership Advisor
NHS England and NHS Improvement

Cc: John Dunn, Senior Independent Non Executive Director, Walsall
Dale Bywater, Regional Director - Midlands, NHSEI
Mark Axcell, Interim CEO Designate of Black Country Integrated Care System
Rebecca Farmer, Director of Strategic Transformation, West Midlands, NHSEI

Annex A

Progress against the Walsall External Review Recommendations

Recommendation	Update
Recommendation one: *Joint Chair and interim CEO should reflect on and acknowledge the impact of their behaviour on some members of the Board and other leaders at Walsall Healthcare NHS Trust. Once acknowledged an apology should be offered to the Board members and others who have been affected*	• An apology was issued to the Walsall Board members by the Chair. • As agreed, NHSEI (Midlands) also issued the apology to those individuals who had raised concerns directly with NHSEI.
Recommendation two: *Joint Chair and interim CEO should continue to spend time with individual Board members and to repair and restore professional relationships where these have broken down. It may be helpful for these conversations to include a facilitator.*	• Board meetings are now more effective and you have received positive feedback from Board members. • From a clinicial perspective positive feedback has been received from wards regarding the recruitment of 260 nurses and consultants are feeling listened to. • Recent Non Executive Director and Medical recruitment processes have demonstrated that people want to work at WHT, referencing leadership and being part of a success programme as influencing factors. • Recent NHSEI (Midlands) meetings with individual Executive / Non Executive Board members identified improved relationships.
Recommendation three: *Joint Chair and interim CEO should continue to co-create, with Board members, a Board development programme to build an effective unitary Board.*	• Board development programme previously in place which was externally facilitated. • 1:1 meetings held with Board members • Two positive development sessions have been held with the trust's Non Executive Directors. • There have also been a number of Board development sessions with the Royal Wolverhampton (RWT) Board. • The Board development programme will be accelerated as the move to a group model progresses, with externally facilitated development sessions being diarised as part of the newly agreed governance arrangements. Included in the development programme will be: o Inductions for the newly appointed Non Executive Directors who are due to commence in February 2022 o Group sessions o Committees in Common • Considerable work in relation to race and diversity has been undertaken and the recent Non Executive Director recruitment process has increased the diversity of the Board. • Recent NHSEI (Midlands) meetings with individual Executive / Non Executive Board members identified improved relationships.

Recommendation four: *The joint Chair should ensure that the relationship between the joint Chair and interim CEO is one in which the joint Chair is able to hold the interim CEO to account*	• The most recent Board meetings have been effective, collegiate and with constructive challenge. • All appraisals have recently been completed and the feedback received during these has been positive. • There are weekly meetings between the Chair and interim CEO and after each Board meeting where there is review and reflection on how effective they have been, including the level of challenge.
Recommendation five: *To ensure that Executive Directors who have been personally impacted by leadership changes are provided with individual support to ensure that they are able to take the appropriate next steps in their careers.*	• NHSEI have signposted colleagues to David Sissling (NHSEI Midlands Senior Leadership Advisor) and to NHSEI HR colleagues. These details were included in the review outcome letters to all board members and also those who raised issues directly with us. • Support being provided where colleagues have requested.
Recommendation six: *NHSEI should consider how they can better support the collaboration and take learning from this into any future similar collaborations.*	• NHSEI (Midlands) has been in discussion with the NHSEI national provider development team who lead on the development of the provider collaborative guidance and who are currently developing a best practice toolkit. The need to include the importance of getting it right from the outset has been referenced. • In addition, NHSEI (Midlands) will be taking an update report to the Regional Support Group regarding any further lessons that can be learned as a region.
Recommendation seven: *NHSEI should oversee and monitor implementation of the recommendations*	• Monthly review progress meetings commenced in December between NHSEI, the trust's Chair and Interim CEO and the ICS BCWB ICS Interim CEO Designate

Annex B

Actions from the Walsall External Review Progress Meeting – 25 January 2022

Action	Lead	Timescale
NHSEI to meet with the leader and CEO of Walsall Council.	Jeff Worrall	February 22
A paper will go to a future BCWB System Quality Oversight Committee to ensure there is system learning.	Mark Axcell	February 22
NHSEI to take any learning through its governance processes to ensure wider regional learning	Rebecca Farmer	March 22 – following report on learning going to SQOC.
NHSEI to work with WHT regarding the publication of the external report	Rebecca Farmer	January 22
NHSEI to progress Chair tenure extension	Rebecca Farmer	February 22

Annex C

Independent Review into allegations about the Interim Leadership at Walsall Healthcare NHS Trust

Reviewer: Dr Kathy McLean OBE

September 2021

Scope

To consider allegations raised with NHS England and Improvement (NHSEI), and through the Walsall Healthcare NHS Trust's Freedom to Speak Up and whistle-blowing processes, of:

- poor and inappropriate behaviour by the interim CEO from April onwards
- complicity with, and a failure to address, this poor conduct by the joint Chair of the trust.

To take account of the current context of the strategic collaboration and the requirement for urgent improvements to be made within Walsall Healthcare NHS Trust in response to CQC findings, the 2020 staff survey, and weaknesses in quality governance.

Assessment based on correspondence and interviews

Correspondence received by NHSEI from those who raised concerns was shared with me to assist in conducting a series of interviews with Board members and senior leaders at Walsall Healthcare NHS Trust. Several additional documents were provided by interviewees which have added helpful information which assisted me when reaching my conclusions. I reviewed the video of the first Team Brief conducted by the Interim CEO in April and a letter received by NHSEI from a local MP who raised concerns about what they were hearing.

Twenty-one people were interviewed, six in joint posts with Royal Wolverhampton NHS Trust thirteen based solely at Walsall Healthcare NHS Trust and two others

Examples and quotes have been used where these have been triangulated by several interviewees or said in Public Board meetings. I have not set out to detail each event in a chronological order, but to create an overall picture of the reported behaviour since leadership changes took place in March 2021.

This has allowed me to form a view about the allegations outlined in the scope.

Background and Strategic Direction for Walsall Healthcare NHS Trust

Over many years discussions have taken place about the potential for closer collaboration between NHS Trusts in the Black Country and West Birmingham. Listening to Board members there was a remarkable consistency in their understanding of, and expectations about, the strategic intent. Without exception everyone interviewed was in no doubt that collaboration between Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust was the correct direction of travel. This was expected to take the form of a chain or group but not a formal merger, a couple of people referred to a time when they believed merger may take place, but this was not the general understanding. It was well articulated that originally four trusts would be involved across the system but latterly The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust agreed to collaborate, as The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust had other areas for immediate focus.

It was expected that there would be a joint Chair and joint CEO but separate management teams with maintenance of sovereignty of the two organisations. Some referenced a 'Committee in Common', but everyone I interviewed was clear that the two organisations would maintain their own sovereignty.

There was recognition of potential benefits for Walsall Healthcare NHS Trust of working more closely with The Royal Wolverhampton NHS Trust, but the benefits could be mutual. It was suggested that 'the door was open' to and the conditions set for collaboration to be progressed. When the previous Chair at Walsall Healthcare NHS Trust took up a new Chair role at another NHS Trust it was recognised that there was an opportunity to advance the collaboration more quickly.

Recent Context

In common with most trusts Walsall Healthcare NHS Trust had focused on managing the consequences of the pandemic for the previous 12-15 months but emerged from the second peak of Covid-19 cases with better waiting times than many other trusts. The organisation was reported as having been stretched by the pandemic, expanding bed numbers significantly, including critical care. The trust leadership had also focused on developing 'Walsall Together' (integration at a local level), which was generally felt to have made good progress.

Over the previous few years there had been several changes at executive level and many of the members of the Executive Director team were in their

first Executive posts. In February 2021 the substantive Chief Executive Officer was seconded to Sandwell and West Birmingham NHS Trust, the Chair had moved to a new role and the Medical Director and Chief Nursing Officer had left or were leaving to take up new roles at a larger organisation.

The Trust had exited Special Measures (Quality) on 25th July 2019 with a rating of 'requires improvement' overall and 'outstanding' for caring, However, more recently there were a range of documented quality concerns, including those noted at a CQC inspection of the division of medicine, which led to CQC issuing a section 29a Warning notice (Health and Social Care Act 2008) on 31/03/2021, highlighting a range of issues. CQC issued their report rating Medicine at the Manor Hospital as Inadequate on 19th May 2021. A visit by Health Education England reported to the Trust on 9th April, described concerns about the support to trainees and their low rate of recommending the trust for training. The 2020 NHS Staff survey identified the trust to be in the lowest ten trusts in England overall with only 52% of those who completed it recommending the trust as a place to work and only 53% recommending it as a place to receive treatment. The Clinical Commissioning Group had highlighted concerns about the effectiveness of clinical governance, with the management of Serious Incidents and safeguarding specifically highlighted.

Timeline of material events

30/11/2020 Email from the CEOs of The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust to staff setting out the intent to work more closely in collaboration

03/12/2020 Paper by Chairs of Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust to Board of Walsall Healthcare NHS Trust proposing a strategic collaboration and a joint Chair

08/01/2021 Approval for the appointment of Steve Field as joint Chair for The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust from 01/03/2021- 31/02/2022

26/01/2021 Announcement that Richard Beeken would become the interim CEO at Sandwell and West Birmingham NHS Trust from 08/02/2021

27/01/2021 Approval for Junior Hemans (Non-Executive Director (NED) at The Royal Wolverhampton NHS Trust) to Walsall Healthcare NHS Trust Board for one year

21/01/2021 It was agreed that Daren Fradgley should provide short term cover for the CEO role at Walsall Healthcare NHS Trust, commenced 08/02/2021

28/02/2021 Approval for John Dunn (NED at Walsall Healthcare NHS Trust) to join The Royal Wolverhampton NHS Trust Board for one year

01/03/2021 Steve Field commenced as Chair at Walsall Healthcare NHS Trust

30/03/2021 Steve Field contacted NHSEI to request that the appointment of David Loughton as joint CEO should be expedited. A request was made in writing by the region that a conversation should take place first

12/03/2021 it was approved that Mary Martin (NED at The Royal Wolverhampton NHS Trust) should be appointed as NED at Walsall Healthcare NHS Trust and then Audit Chair (for six months)

w/c 05/04/2021 Rem Com meeting to appoint David Loughton as interim CEO until 31/07/2021 (NB: Date on the paper is 21/01/2021)

David Loughton commenced in post w/c 12th April 2021

16/04/2021 Letter from Dale Bywater supporting the appointment of David Loughton as interim CEO until 31/07/2021

Early April 2021 Increasing number of allegations were raised nationally and regionally about behaviour of joint Chair and interim CEO

Values against which to judge behaviour

The NHS has a strong history of developing values to guide behaviour. I have set out below three sets, two national and one co-created with employees at Walsall Healthcare NHS Trust. I have considered these when reaching my conclusions.

NHS Values as set out in the NHS Constitution

- **working together for patients**. Patients come first in everything we do
- **respect and dignity**. We value every person – whether patient, their families or carers, or staff – as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits
- **commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness, and patient experience right every time
- **compassion**. We ensure that compassion is central to the care we provide and respond with humanity and kindness to each person's pain, distress, anxiety or need
- **improving lives**. We strive to improve health and wellbeing and people's experiences of the NHS
- **everyone counts**.

The NHS People Plan includes a 'People Promise':

We are **compassionate** and **inclusive;** We are **recognised** and **rewarded;** We each have a **voice that counts;** We are **safe** and **healthy;** We are always **learning**

Walsall Healthcare NHS Trust Values

The Trust has four values: Respect; Compassion; Professionalism; Teamwork

Summary of findings

Joint Chair

NHSEI approved the appointment of a joint chair between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust in January 2021 and Steve Field (Chair at Royal Wolverhampton NHS Trust) commenced in post at Walsall Healthcare NHS Trust on 1st March 2021 for nine months.

Dale Bywater (Regional Director) wrote to Steve Field at the beginning of February agreeing his appointment as joint Chair of The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust including this sentence:

'The handling of further changes needs to be carefully managed and requires ongoing collaboration and engagement with key individuals on the Walsall Healthcare NHS Trust Board, as well as careful handling and communications across and within both organisations'

- Initial experience of the joint Chair was reported as predominantly positive by Walsall Healthcare NHS Trust Board members
- Early meetings between the joint Chair and Executive and Non-Executive Directors were welcomed
- Visits to clinical and other areas of the Trust were seen as evidence of energy and a real effort to get to know the trust with some comments about the benefits of 'fresh eyes'
- In the first few weeks the joint Chair was felt to be communicative and engaging
- Some interviewees expressed concern that prior to the Trust receiving a Section 29a warning notice the joint Chair appeared to be in regular contact with CQC (joint Chair agreed with this) and seemed to be aware of the regulatory notice ahead of the acting CEO (this prior knowledge was denied by the Chair).

- Concerns were expressed by several Walsall Healthcare NHS Trust Board members that the joint Chair exaggerated the quality issues at Walsall Healthcare NHS Trust. At The Royal Wolverhampton NHS Trust Board meeting in public in the w/c 5th April the Chair was reported by several people to have said, 'If I knew what I know now I would not have taken the job' and that he 'was ashamed to call himself Chair of Walsall'.
- It was reported that at a Remuneration Committee meeting at Walsall Healthcare NHS Trust to consider the appointment of the interim CEO the Joint Chair described the trust as being 'in a desperate state' with the 'need to move quickly'
- Several interviewees reported that they witnessed a change in behaviour of the joint Chair once the interim CEO arrived at Walsall Healthcare NHS Trust
- Some described feeling unsupported by the joint Chair when the interim CEO did not appear to be listening or had seemed brusque or direct and some suggested that the Chair was 'managed' by the interim CEO
- It was reported by some interviewees that opportunities for NEDs and Executives to speak to the joint Chair were not always available
- It was perceived (several examples were provided) when the joint Chair did not appear to recognise or intervene when behaviours were not in line with Trust values
- Some interviewees felt that there were individual Board members who were not respected by the joint Chair
- There was an event described by several interviewees when a Memorial Garden was to be opened in a ceremony, but key Board members were late as the Board overran. At the next meeting the joint Chair apologised for allowing the Board to overrun, but the distress caused to a number of employees was not felt to be adequately recognised

Behaviour of the Joint Interim CEO

The Remuneration Committee at Walsall Healthcare NHS Trust unanimously approved the appointment of David Loughton as interim CEO on 09/04/2021and he commenced in post at the beginning of the week of 12th April 2021.

- The interim CEO is very experienced. He shared several documents which referred to his positive leadership and achievements, although in one document (a well led review commissioned by The Royal Wolverhampton NHS Trust in 2021) there was a comment that his 'style of fast pace and high expectations may not suit everyone'

- It was noted by some Board members that the Interim CEO was demonstrably focused on patient safety, his values in this regard were commended
- The interim CEO moved quickly to resolve estates and nurse staffing issues; these changes were reported to have been appreciated by frontline staff
- The style exhibited by the interim CEO was perceived by most interviewees at Walsall Healthcare NHS Trust as being very different from the previous permanent CEO, more direct with a focus on rapid decision making in contrast to an inclusive but slower pace experienced over recent years at Walsall Healthcare NHS Trust
- Some people were reported to have been 'chuffed to bits' as 'pace has never been a strength'
- Most interviewees described that the interim CEO was 'straight talking' or 'plain speaking' but at times this was perceived to have stepped beyond respectful communication, this opinion included some of those serving in joint posts at The Royal Wolverhampton and Walsall Healthcare NHS Trust
- A perspective was offered by some joint Board members, that those who have worked with him as their CEO over years are very loyal and are used to the approach, though they too noted that it was a very direct style
- Several Board members described examples of Board meetings where open debate was felt to be stifled. The interim CEO was not perceived to welcome questioning of his views or decisions. This was described as a greater issue for some members of the Board than others
- Several people recounted that they had heard the interim CEO speak in negative ways about both Executives and NEDs at Walsall Healthcare NHS Trust, for example referring to them as 'useless' on more than one occasion
- Executives at Walsall Healthcare NHS Trust did not feel supported through the change process, with some describing impacts on their health and wellbeing
- The interim CEO was perceived by some to ignore the positive departments or services at Walsall Healthcare NHS Trust as balance for the areas requiring improvement
- Conversation and discussion in Board and Executive meetings was reported to be reduced with a perception this was due to fear of being criticised by the interim CEO
- Undermining was a word used by several interviewees in relation to the CEO with examples given where he used denigrating words about

Board members in settings where those being managed by them were present
- Several interviewees reported that both the joint Chair and interim CEO made references to the Trust being 'similar to Mid Staffs', this was felt to be unhelpful

General Communication

There were several examples where communication was not felt to be optimal in supporting the changes:

- Individual Executive Directors did not have a one-to-one discussion ahead of any announcements which could potentially affect them personally, or receive communication as an Executive team ahead of significant changes
- An email from the interim CEO to the organisation, announcing his appointment, (09:49) arrived ahead of one from the joint Chair (10:05). This was not the sequence expected. A letter and other documents from many years ago, referring to merger, were attached to the interim CEOs email. This information was viewed negatively by members of the Walsall Healthcare NHS Trust Board, as merger had not been agreed in the papers considered by the Board in December 2020 when they had formally approved the strategy of closer collaboration
- The first Team Brief presented to the organisation by the interim CEO via video, was highlighted as a concern by several people. One called it a 'car crash'. References to merger and no job losses were described as particularly insensitive.

Governance Processes

A perceived disregard for governance processes by both the joint Chair and interim CEO was an allegation which I heard from many interviewees

- When the substantive CEO at Walsall Healthcare NHS Trust was seconded to Sandwell and West Birmingham the Deputy CEO agreed to become the acting CEO. This was endorsed by the joint Chair and agreed at the Walsall Healthcare NHS Trust Remuneration Committee
- On 24th March a paper, outlining steps to increase the pace of collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, including a change in some of the Executive roles, was shared with the Acting CEO at Walsall Healthcare NHS Trust. This paper included, for example, a proposal that there should be a joint interim CEO, a new Deputy CEO and the Chief Operating Officer should cease (temporarily) to be a voting member of

the Board. It also set out plans for members of a support team from The Royal Wolverhampton NHS Trust to be appointed. It appears there was a miscommunication about the status of this paper and what was expected, the author (at The Royal Wolverhampton NHS Trust) was said to be shocked and had no intention of causing distress. This set-in train a series of attempts to re-write the paper.

- The interim CEO appointment was unanimously agreed at the Walsall Healthcare NHS Trust Remuneration Committee, but some NEDs felt they were not offered any options. For example. there was no paper presented which summarised what the potential options could be, just a Curriculum Vitae for the potential Interim CEO attached. One NED said they stated that they were supportive, but their support was conditional on subsequent behaviours being in line with the Trust values
- Because of the way the changes were introduced several interviewees felt that the Acting CEO/Deputy CEO (Walsall Healthcare NHS Trust) was not treated respectfully
- Several examples were cited where previous processes were no longer followed. There were multiple references by interviewees to Executive and Board meetings where the resources for estates appeared to be agreed in the absence of any funding stream. Several accounts of an exchange between the interim CEO and the Director of Finance at a Board meeting were recounted including words used by the interim CEO 'didn't you listen to me? I told you I had sorted the money'.
- It was acknowledged that there was a pressing requirement to improve the estate and at a private Board meeting, NEDs were reported to have said 'if you can get the money, fabulous'. An expectation was expressed by the interim CEO that NHSEI would have to provide the money
- A focus on pace of delivery was appreciated by several interviewees but the way this was executed was felt by some to be to the detriment of engagement and relationships
- It was reported that clinical and other front-line staff were happy with changes which improved their environment and increased staff numbers

Support Team from The Royal Wolverhampton NHS Trust

- The appointment of a support team and process for their arrival was a concern to many interviewees, with allegations of a lack of transparency and due process
- However, there were multiple positive comments made about the support team once they commenced work
- Some said they 'enjoy working with them' and felt they had been a helpful resource

- The diagnostic undertaken and reported by the support team was accepted as helpful but interpreted as overly critical of Walsall Healthcare NHS Trust, failing to identify the positives. However, my review of the slides presented does not wholly support this. The diagnostic does highlight positive examples of good quality at Walsall Healthcare NHS Trust

Impact on Individuals

I have summarised the key points from the conversations I had with interviewees, but this does not convey the depth of feeling or impact that the behaviours displayed by the interim CEO and joint Chair had on individuals. There was a consistency of message from interviewees which was at times hard to hear. In the narratives I heard there was a consistent lack of compassion or respect for people.

Conclusions

I have spoken with and listened to most of the Board members at Walsall Healthcare NHS Trust and several other people who had relevant views or have been part of the recent changes. I would like to thank all these people for their time and for being open and frank about their experiences which in many cases cannot have been easy.

In the months leading up to the leadership changes the strategic aims for Walsall Healthcare NHS Trust were developed and discussed. It was clear there was remarkable agreement amongst the Board members about the ambition to collaborate with other trusts in the system. This coherence of vision should have been a great asset when creating the environment for change. I believe the conditions were in place for a smooth change of leadership to support greater collaboration and increase capacity, with subsequent benefits for the delivery of safe services and wider benefits for patients.

Leadership changes can, understandably, represent a period of anxiety for those affected but this can be minimised if changes are made in line with appropriate values and processes. Whilst I conclude that the joint Chair and interim CEO were motivated to act in the best interests of patients, I was saddened by much of what I heard.

Without doubt there were quality and cultural issues at Walsall Healthcare NHS Trust (evidenced by external inspections and the NHS Staff Survey), which needed to be addressed urgently, but time could have been taken to

engage Board members and other senior leaders in a compassionate way, leading to an effective increase in capacity and leadership.

The key allegations, raised by a range of people who spoke up, related to the behaviour of the interim CEO and the joint Chair as set out in the scope of the review:

- poor and inappropriate behaviour by the interim CEO from April onwards
- complicity with, and a failure to address, this poor conduct by the joint Chair of the trust.

I have concluded that the interim CEO brings pace and clarity of direction, with a focus on patient safety and quality. However, the manner of some of his interactions with senior colleagues falls short of those expected when considered against the NHS values, those set out in the People Promise and the values agreed by Walsall Healthcare NHS Trust. Consequently, there is a risk that people will not speak up, undermining good governance, and some individuals have described a negative impact on their health and wellbeing. These views should be balanced by those from colleagues who serve jointly on Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust Boards, where they have worked with the CEO for a longer period and have become used to a pacier style. Individuals spoke of loyalty to the CEO from the people who work with him at The Royal Wolverhampton NHS Trust. I also heard that frontline staff were positive and welcomed the pace of improvements as a result of the leadership by the interim CEO.

If there had been more consideration and understanding of the significant differences in prevailing style in The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust, I believe leadership actions and tone could have been modified to ensure that changes were made in a compassionate way. Compassion is a value common to the three value sets I outlined above.

A well led review at The Royal Wolverhampton NHS Trust, published in June 2021 highlighted that the pace and style of the interim CEO might not suit everyone. This warning, preceded by a another in a similar well led review in 2016, which suggested he should consider the impact he has on those around him could, if heeded, have helped him modify his approach.

Communication of the arrival of the interim CEO at Walsall Healthcare NHS Trust was clumsy, there appeared to be no plan but a series of mistimed emails with attachments referring to talks about merger many years ago. References to ‘merger’ in trust wide meetings was unhelpful, this had not been agreed by Board members.

There were several examples where individual Directors were personally impacted by changes or felt undermined, but there was no evidence that an appropriate discussion had taken place to ensure they had a chance to consider how they could be impacted. This was disrespectful and may have longer term implications for some individuals.

The joint Chair made a positive start in March 2021, but this impression changed over time. There were concerns expressed that the relationship between the joint Chair and interim CEO was not one whereby the CEO was being held to account. From the interviews I have conducted I conclude that the joint Chair did little to intervene or moderate the style of the interim CEO, leaving Board colleagues feeling exposed and undermined. Whilst I do not believe the joint Chair could change the fundamental style and behaviour of the interim CEO; he could have ensured that both NEDs and Executives were supported and facilitated to make their points when they were ignored or dismissed in meetings.

The Regional Director had specifically requested the joint Chair to note that *'The handling of further changes needs to be carefully managed and requires ongoing collaboration and engagement with key individuals on the Walsall Board, as well as careful handling and communications across and within both organisations'*

The joint Chair could have been more helpful in guiding and coaching the interim CEO to make changes in a compassionate way, supporting Directors who were feeling vulnerable, when a change in pace was required.

I heard that the joint Chair may not always have made himself available to talk with NEDs or communicate with Executives when asked. The opportunity to hear and take concerns seriously was missed, this could have been a significant factor in supporting the changes.

In summary I have concluded that the interim CEO, whilst motivated by the safety and care of patients has behaved poorly and inappropriately and that the joint Chair has been complicit with and failed to address this behaviour.

Recommendations

Collaboration between The Royal Wolverhampton and Walsall Healthcare NHS Trust has been agreed as the best way to improve quality, culture, and sustainability for Walsall Healthcare NHS Trust. When framing my recommendations, I have considered the wider context and best interests of patients and employees as well as those directly impacted by the allegations addressed in this review. I believe that an initial focus on reconciliation is on balance the best approach. This will require insight, reflection, and an agreement to change. These recommendations will need to be fully implemented, to have the potential to assist recovery from recent events and help the leadership focus on the improvements necessary at Walsall Healthcare NHS Trust.

1. **Recommendation one**

Joint Chair and interim CEO should reflect on and acknowledge the impact of their behaviour on some members of the Board and other leaders at Walsall Healthcare NHS Trust. Once acknowledged an apology should be offered to the Board members and others who have been affected.

Responsibility: Chair and interim CEO

2. **Recommendation two**

Joint Chair and interim CEO should continue to spend time with individual Board members and to repair and restore professional relationships where these have broken down. It may be helpful for these conversations to include a facilitator.

Responsibility: Chair and interim CEO

3. **Recommendation three**

Joint Chair and interim CEO should continue to co-create, with Board members, a Board development programme to build an effective unitary Board.

Responsibility: Chair

4. **Recommendation four**

The joint Chair should ensure that the relationship between the joint Chair and interim CEO is one in which the joint Chair is able to hold the interim CEO to account

Responsibility: Chair

5. **Recommendation five**

To ensure that Executive Directors who have been personally impacted by leadership changes are provided with individual support to ensure that they are able to take the appropriate next steps in their careers.

Responsibility: NHSEI

6. **Recommendation six**

NHSEI should consider how they can better support the collaboration and take learning from this into any future similar collaborations.

Responsibility: NHSEI

7. **Recommendation seven**

NHSEI should oversee and monitor implementation of the recommendations

Responsibility: NHSEI

Appendix

Brief Biography of reviewer (Dr Kathy Mclean)

Currently Chair of University Hospitals Derby and Burton NHS FT, Chair Designate Nottingham and Nottinghamshire Integrated Care Board, Non-Executive Barts Health NHs Trust

Previously Executive Medical Director and Chief Operating Officer NHS Improvement

Clinical transitions Director NHS Commissioning Board

Executive Medical Director NHS East Midlands

Executive Medical Director Derbyshire Hospitals NHS FT

MBChB, FRCP OBE

We are both driven by a passion to ensure the highest possible standards of care for the people we serve. That means providing patients with the safest possible care, delivered to the highest professional standards, in suitable surroundings, with the necessary equipment and delivered with compassion.

It also means we must attract and retain the best possible staff that we can and create an environment that supports this.

Since our arrival at WHT we have looked for the good and outstanding practice to celebrate but we have also had confirmation of concerns raised by external reports and discovered new concerns that impact on the safety of patients, and the compassion with which patients and staff are treated. Numerous staff have raised concerns with us and welcomed the fact that we are taking action.

We have been impatient to see the improvements, especially for patients, and sometimes we have felt that our concerns have not been listened to, accepted or acted upon or that a need for swift change has been recognised.

We are aware we have put pressure on senior leaders to make improvements and accept the need for change to improve care and staff engagement. In wanting to make improvements quickly, to reduce the risk of causing harm to our patients or staff leaving we accept that we have not always got things right in terms of process and we have used direct and directive language to inject a sense of pace. We are sorry if this has caused offence or been construed as a lack of compassion or respect. Our aim is to create a cohesive team and an effective organisation and we will reflect on how we can achieve this while continuing to strive for the very best care for the people of Walsall, which they deserve.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Interim Chief Executive Officer's Report			**AGENDA ITEM: 7**
Report Author and Job Title:	Prof David Loughton, Interim Chief Executive Officer	**Responsible Director:**	Prof David Loughton, Interim Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	Assurance relating to the appropriate activity of the Chief Executive Officer.		
Advise	The paper includes details of key activities undertaken since the last Trust Board meeting.		
Alert	None in this report.		
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	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

IINTERIM CHIEF EXECUTIVE OFFICER'S REPORT

1.0	**Review**
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	**Consultants**
	There has been eight Consultant Appointments since I last reported: **Cardiology** Dr Nadia Sunni **Radiology** Dr Hayder Hamadah Al-Assam Dr Francesco Carbonetti Dr Soumya Tangudu **Occupational Health and Well Being** Dr Grace Radford **Orthodonist** Dr Ourvinder Chawla **Peadiatrician** Dr Noha Nagui Attia Mohamed Elshimy **General Anaesthetist** Dr Manish Mittal
3.0	**Policies and Strategies**
	• There are no policy and strategy updates this month.
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since Monday 3 August 2020 I have participated in weekly calls with the Black Country and West Birmingham Strategic Transformation Partnership (STP) on the co-ordination of a collective Birmingham and the Black Country restoration and

	recovery plan and COVID-19 regional update • Since Tuesday 21 December 2021 I have participated in the virtual STP Gold Command daily meetings • 22 November 2021 - participated in the virtual STP Acute Collaboration Programme Board and participated in the Clinical Research Network (CRN) – Chairs Partnership virtual meeting and joined Professor Gatrad OBE, Deputy Lord Lieutenant to Her Majesty's Lord Lieutenant and former Consultant Paediatrician's retirement dinner • 23 November 2021 – participated in the virtual Staff Inclusion Network event and chaired the virtual Trust Management Committee (TMC) • 30 November 2021 – undertook a site visit of maternity services • 1 December 2021 – participated in the virtual Birmingham and Black Country Local Medical School Liaison Committee • 8 December 2021 – participated in a Joint Board Development session – The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) and presented the annual Staff Awards • 9 December 2021 – undertook a hospital site visit to maternity, surgical and medical services and chaired a Senior Managers Briefing • 15 December 2021 – participated in a virtual Regional Cancer Board meeting • 16 December 2021 – chaired the Joint Negotiating Committee (JNC) and participated in the virtual STP Acute Collaboration Provider Programme Board • 17 December 2021 – held a virtually briefing meeting with Wendy Morton MP and Eddie Hughes MP and participated in the virtual NHS Improvement/ England – Regional Roadshow • 29 December 2021 – participated in the NHS England – System response to Omicron virtual event • 7 January 2022 – participated in virtual Walsall Council-led Incident Management Team meeting • 10 January 2022 – participated in the virtual Black Country Integrated Care Board (ICB) Non- Executive Director (NED) interviews • 11 January 2022 – chaired the virtual West Midlands Cancer Alliance Board • 12 January 2022 – participated in the virtual Walsall Proud Partnership meeting • 13 January 2022 - participated in virtual Walsall Council-led Incident Management Team meeting • 14 January 2022 – participated in the virtual Institute of Health and Social Care Management (IHSCM) Executive Advisory Committee • 19 January 2022 – participated in the virtual NHS England System Leadership event
5.0	**Board Matters**
	Dr Manjeet Shehmar was appointed as Chief Medical Officer.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Safe High-Quality Care Oversight Report – December 2021 data			**AGENDA ITEM: 10**
Report Author and Job Title:	Lisa Carroll Director of Nursing and Caroline Whyte Deputy Director of Nursing	**Responsible Director:**	Manjeet Shehmar Medical Director Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• 151 overseas nurses have arrived in the Trust. 121 of those are now successfully registered with the NMC. • Falls per 1000 bed days was 3.84 and remains significantly below the national average of 6.63 as recognised as the Royal College Physicians. • The prevalence of timely observations is 85.69% and consistently is remaining above trust target.		
Advise	• VTE compliance is 91.01%. Divisional teams are now reporting on their performance and plans to Patient Safety Group (PSG). • The Trust internal target for Clostridium difficile 2021/22 is set at 29 and cases are below the trajectory. 3 cases were identified in December 2021 with early review identifying appropriate use of antibiotics • The Mental Capacity Act Audit shows that 52.08% of patients who lacked capacity had a stage 2 assessment undertaken, this is a decrease in performance from the 70% in November 2021. • The Trust has added risk 2737 around non adherence to the Medicines Management Policy in response to lack of assurance from audits.		
Alert	• Significant pressures continue to occur in the paediatric department regarding young people waiting for Tier 4 placements. • There has been a significant increase in off framework agency use during December 2022. This is primarily due to increased staff absence as a result of the Omicron variant of COVID-19 and staff having to self-isolate.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF IPC BAF Corporate risk 2066; Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels Corporate risk 2439: External inadequate paediatric mental health and		

	social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'	
Resource implications	None	
Legal and/or Equality and Diversity implications	No negative impact	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

Provide Safe High-Quality Care – Executive Update

1. Executive Summary

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

The associated Board Assurance Framework (BAF) and corporate risks have been reviewed and updated as required. Where there are gaps in control and assurance these are detailed in the monthly report to the Quality, Patient Safety and Experience Committee and actions taken and in progress are explained.

Projects within the Safe, High Quality Care Improvement Programme have continued to progress and some of the key highlights are:

- VTE compliance for December 2021 was 91.01% compared to 90.56% for November 2021. Divisional teams are reporting on their performance and plans to Patient Safety Group (PSG).
- The prevalence of timely observations is 85.69% and is consistently remaining above trust target.
- Falls per 1000 bed days was 3.84 in December 2021 (3.53% November 2021) and remains significantly below the national average of 6.63 as recognised as the Royal College Physicians.
- The Trust internal target for Clostridium difficile 2021/22 is agreed as 29. 3 cases were identified in December 2021 with early review identifying appropriate use of antibiotics.
- Mental Capacity Act Audit shows that 52.08% of patients who lacked capacity had a stage 2 assessment undertaken in December 2021, this is a decrease from 70.00% in November 2021.
- Significant pressures continue to occur within the paediatric department regarding young people waiting for Tier 4 placements.
- The AMU Improvement Assurance Board has been established chaired by the Director of Nursing and Chief Medical Officer to oversee and report assurance to QPES on quality and safety issues highlighted in the acute medical pathways.

2. CQC Inspections

Maternity Services

The CQC report following the unannounced inspection of maternity services was published on the 1st October 2021. The division have developed an action plan and progress is being made against the actions. An oversight group is in place to monitor progress against the actions and improvement made.

A corporate action plan is in place to ensure that those actions outside of divisions control and requiring a Trust wide approach to change are led by an Executive Director. Progress against these actions is through TMC to board.

3. Links to corporate risk register

Following a review of the risks held on the corporate risk register a number have been added to the Safe High Quality Care report as they are aligned to the focus of this report.

208 - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks (Risk Score 15).
1937 - Risk of harm to staff from AGP (e.g. COVID-19) as a result of matching capacity for Fit Testing for two masks (Risk score 10)
2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15).
2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).
2325 – Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score 16).
2430 – Risk of harm to children due to fragmented record storage (Risk Score 20).
2439 - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' (Risk Score 20).
2475 - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services (Risk Score 20).
2512 – Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes Best Practice Tariff Standards (Risk Score 16).
2540 - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems (Risk Score 12).
2581 – Internal risk for patients awaiting Tier 4 hospital admission (Risk Score 20).
2587 - Not having sufficient staffing levels available to support the release for fit testing in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19) (Risk Score 9).
2601 - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6 (Risk Score 20).
2654 - Risk of patient harm from significant delay in management of serious incidents (Risk score 20)
2663 - Lack of support to new Trust nursing staff, including but not limited to International Nurses (Risk score 9).
2664 - Patient Safety and Training Issues in Medicine / ED (Risk Score 20).
2737 - Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy

4. Performance Report

4.1 Falls

The number of falls inpatient falls recorded for December 2021 is reported as 62, a slight increase from the 54 reported in November 2021. Work continues on the falls strategy aligned with the 'Key Performance Indicators' in the Safe High Quality Care Improvement Programme (SHQC).

4.2 Tissue Viability

The tissue viability data has not been validated at the time of writing the report and will be presented in the next report to board..

4.3 Venous Thromboembolism (VTE)

VTE compliance for December 2021 was 91.01% compared to 90.56% for November 2021., compliance rates remain steady but below the 95% target for compliance.
Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants. Divisional teams are reporting on their performance and plans for improvement to Patient Safety Group

4.4 104-day harm

There were 6 patients identified in November 2021, 4 x urology (harm reviews awaited) 1 x head & neck, the harm review has been completed and the outcome is awaited 1 x colorectal (no harm).

4.5 Sepsis

The Trust is aware of issues relating to the accuracy of sepsis reporting where results from manual audits differ from system generated results. Work with System C has shown user issues with de-escalation of patients which are exacerbated by non-friendly user interfaces on E-Sepsis. System C and the digital team are addressing these. Manual audits continue to provide assurance.

The Trusts sepsis team commence in post on the 24th January 2022

4.6 Clostridium *difficile*

The Trust target for 2021/22 is 29 cases; the national targets have been set at 33 cases. There were 3 reported cases in December 2021. On review of these cases the antibiotic use was deemed appropriate and these were unavoidable. To date the Trust has reported 22 cases for the year 2021/2022.

4.7 Percentage of observations undertaken within timeframe

The prevalence of timely observations has increased slightly to 85.69% in December 2021 from 85.21% in November 2021 but remains above the Trust target of 85% for the tenth month running

4.8 Mental Capacity Assessment

Audit for December 2021 shows that 52.08% of patients who lacked capacity had a stage 2 assessment undertaken; this is a decrease from 70.00% in November 2021. Discussion with patient's relatives or attorney has decreased slightly to 53.01% (November 56.63%) of cases audited

4.9 Safeguarding, Prevent, DoLs, MCA and Dementia Awareness Training

Safeguarding Adult and Childrens levels 1 and 2 training remain above trust target. Level 3 training remains under target for both adults and children. The Safeguarding Committee is monitoring divisions progress to achieving compliance.

4.10 Controlled drugs and adherence to Medicines Management

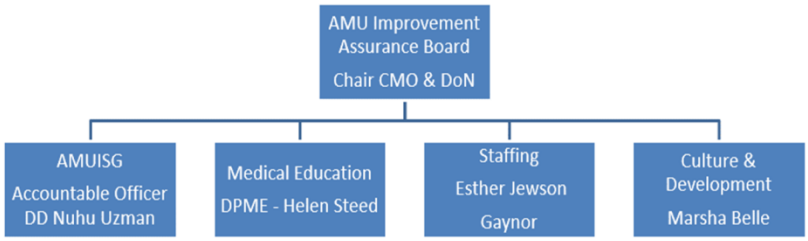
In quarter 4, October to December 2021 has been completed-see attached spreadsheet. A total of 46 wards/departments have had CD audits completed in Quarter 4; 4 wards do not stock CDs and were therefore not included in the dataset. There were 25 anomalies raised on Audits but only 16 incidents reported due to non-compliance with CD audit results. The trend as regards the most common non-compliances described in previous CD audit reports continues to be reported. The results have been added to the medicines management risk 2737 on the risk register. A new Governance advisor has been appointed to pharmacy who has worked with the Divisions to file Divisional risks and agree plans to address the issues. Divisions will be reporting their audit performance monthly to PSG. A case is being developed for safer storage units for medications.

5. External reviews

A Health Education England Review of training in acute and general medicine has highlighted patient safety concerns for transfer from the emergency department to the acute medical unit and prioritization of patients in the acute medical unit.

Immediate actions were taken at the time and these were reported to board in December 2022. A detailed action plan is in place for AMU and an operational group oversees the implementation of this. The project group report monthly to an assurance meeting chaired by the Chief Medical Officer and Director of Nursing with the following governance structure, ensuring close working with medical education, workforce and culture:

AMU Improvement plan Governance Structure



Updates from the assurance group will be included in the SHQC report monthly. There has been a restructure in the leadership across AMU and acute medicine, a staffing review has taken place to establish the workforce needed to provide a resilient service. Temporary medical posts are being converted to substantive which will ensure job plans which include teaching of junior doctors. All consultants have now agreed to undertake teaching and have had the appropriate training. New junior doctor rotas are now in place to ensure senior cover; this rota works when they are fully staffed. The Division is working with recruitment, the clinical fellowship scheme and medical staffing to recruit to rotas in a resilient manner. Support has also been secured in the consultant structure from a consultant from RWT working in the WHCT AMU.

Clear agreement has been gained and signed up to regarding the Trust values and behaviors expected within the team and any concerns are being addressed via support from the People and Workforce Directorate and through the appropriate professional standards structures.

Approval was gained from HEE in December to redeploy junior doctors to address Covid pressures during January. The Trust was able to reduce the impact of this redeployment to HEE doctors by adding clinical fellows to the medical rotas. The Chief Medical Officer has set up listening sessions with the junior doctors to understand Covid pressures, these are attended by other executive including the Director of People and Workforce and the Chief Executive.

End of Report

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 01 - 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/Medical Director.
Lead Committee:	Quality, Patient Experience & Safety Committee.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **208** - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks. (Risk Score = 16). • **2066** - Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). • **2245** - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level. (Risk Score = 20). • **2325** - Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes. (Risk Score = 16). • **2430** - Risk of harm to children due to fragmented record storage. (Risk Score = 20). • **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Risk Score = 20). • **2475** - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services. (Risk Score = 25). • **2512** - Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes Best Practice Tariff Standards. (Risk Score = 16). • **2540** - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems. (Risk Score = 9). • **2581** - Internal risk for patients awaiting Tier 4 hospital admission. (Risk Score = 15). • **2587** - Not having sufficient staffing levels available to support the release for fit testing in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19). (Risk Score = 20). • **2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6. (Risk Score = 20). • **2654** - Risk of patient harm from significant delay in management of serious incidents. (Risk Score = 20). • **2663** - Lack of support to new Trust nursing staff, including but not limited to International Nurses. (Risk Score = 9). • **2664** - Patient Safety and Training Issues in Medicine / ED. (Risk Score = 20). • **1937** - Risk of harm to staff from AGP (e.g. COVID-19) as a result of matching capacity for Fit Testing of two masks. (Risk score = 10).	**Likelihood = 5 Consequence = 5 = 25 High ↔** Forecasted Risk Score Movement for Q4: **Likelihood = 5 Consequence = 5 = 25 High ↔**

Risk Appetite

Status:	Averse	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 9																									

Risk Scoring								
Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3	5	5		• Risk score increased in line with worst case scenario SHQC risk, Mental Health Act (ID 2475) with a risk score of 25. • The Trust's Quality Strategy is evolving to address the emerging priorities from reviews of systems, process and services. • A review of the process for ensuring lessons learnt from incidents and patient feedback is embedded in practice is under way. • CQC action plans requiring corporate action/leadership assigned to an executive Director with oversight at Trust Board. Divisional action plans overseen through divisional performance reviews and Patient Safety Group • The Trust is an early adopter site for the new patient complaint standards and will be rolling these out with additional support from the national team over the coming months. • A number of clinical guidelines policies and procedures are out of date. The Trust has a clear plan for reviewing and updating these. • Potential to breach statutory requirements under the Mental Health Act due to inconsistent knowledge and application of Trust Policy. • CCG and LA assured that safeguarding systems are embedded. This is supported by spot checks and quality assurance visits to test staff knowledge and increase in incidents reported • Substantive staffing levels are below those agreed in establishment reviews to deliver safe, high quality care resulting in high usage of temporary staff. • Failure to report accurate Sepsis data Nationally, resulting in non-compliance and increased risk of delivering suboptimal sepsis care/treatment.	Likelihood:	2	31 December 2021
Consequence:	5	5	5			Consequence:	5	
Risk Level:	**15 High**	**25 High**	**25 High**			Risk Level:	**10 Moderate**	

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Clinical audit programme & monitoring. Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels. • Central staffing hub co-ordinating nurse staffing numbers in line with acuity and activity arrangements with staff re-deployed across clinical units and divisions as required to maintain safe staffing levels • Daily safety huddle in midwifery to ensure safe staffing and make decisions on re-deployment of staff across the service • Safety Alert process in place and assured through QPES. • Perfect Ward app allows local oversight of key performance metrics. • Freedom to speak up process in place, reporting to the People and organisational development committee. • Covid-19 SJR undertaken for all deaths process of assurance for lessons learnt developed. RCAs underway • CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital. • CQC action plans requiring corporate action/leadership assigned to an executive Director with oversight at Trust Board. Divisional action plans overseen through divisional performance reviews and Patient Safety Group • Improvement programme in place to	• Patient Experience group in place. • 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. • Weekly fit testing data uploaded to ESR and reported through Corporate Tactical • MLU service paused and staff re-deployed to acute Trust • Trust supporting system wide international midwifery recruitment • External visits from HEE in place	• CQC Inspection Programme. • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM). • External Performance review meetings in place with NHSEI/CQC/CCG.

	oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality Care. • Support to safeguarding team in place from RWT • Business case under development to ensure a safeguarding team that is fit for purpose • Safeguarding Committee meetings increased to monthly • International Registered Nurse recruitment underway with 200 recruits expected by the end of 2021 • RPE Procedure developed providing guidance on the rationale for use of RPE and managers responsibilities under COSHH Regulations Force 8 SOP in place • Train the tester training completed • Multiple types of FFP3 masks available • Ten Practice Education Facilitators recruited • Manual audit in place to monitor compliance with Sepsis 6 • Medical education group and education and training steering group established		
Gaps in Controls:	• Performance targets not being met for all activities, including complaints, Mental Capacity Act compliance and VTE assessments. • Out of date clinical policies, guidelines and procedures. • Training performance not meeting set targets. • Quality Impact Assessment process requires embedding within the trust. • Sepsis audit frequency and performance. • CQC rating of 'Requires Improvement' in 2019; Medicine rated as 'Inadequate' in May 2021 report. • NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required. • Dementia screening performance. • Failure to demonstrate compliance with terms of the Mental Health Act. • Reputational Impact on the trust regarding Doctors in Training placements. Potential for withdrawal of Doctors in Training placements by Health Education England. And financial reduction of Health Education income.		
Assurance:	• Process in place through ward, business unit and divisional reviews and sub-committees of QPES to	• Patient priorities for 2021 identified which aim to improve patient experience. Assurance of impact via patient feedback.	• NHSI and CCG reviews of IPC practice in ED and Maternity have not highlighted any immediate concerns.

	confirm and challenge and gain assurance with overarching report and assurance at QPES. • International recruitment continues. As of end September 2021 94 nurses commenced in post and 45 have completed their OSCE and have registered or an in the process of registering with the NMC	• Learning Matters Newsletter published monthly • Fortnightly assurance meeting with CQC and CQRM meeting with CCG.	• 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 Assurance:	• Some CQC 'MUST' and 'SHOULD' do actions remain outstanding. • Inconsistent evidence, both through quality governance structures and performance reviews, of practice having changed as a result of learning from adverse events. • 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. • Lack of robust strategic approach to ensuring effective patient/public engagement and involvement. • Lack of clinical engagement and leadership oversight of the Quality Governance agenda. • Lack of assurance regarding dementia screening data collection process. • Lack of assurance internally and externally regarding staff ability to recognise, report and escalate safeguarding concerns • Lack of assurance from electronic data reporting on management of Sepsis and Sepsis 6 compliance		

Future Opportunities

- Improvement Programme offers a structured programme to achieve excellence in care outcomes, patient/public experience, and staff experience.
- Implementation of new technologies as a clinical or diagnostic aid (such as electronic patient records, e-prescribing & patient tracking; artificial intelligence; telemedicine).
- Development of Prevention Strategy.
- National Patient Safety Strategy will give an improved framework for the Trust to work.
- Well Led work stream working on quality governance structures and patient safety.
- Leadership Development programme to address and mitigate gaps within clinical leadership.
- Development of sepsis module within Medway
- Re-design of SI process

Future Risks

- Ongoing impact of Covid-19 plus additional significant time pressured programmes of work such as COVID vaccination, staff testing, etc. Communications across the organisation to share programme objectives.
- Performance targets not being met for all activities, including Mental Capacity Act and VTE.
- Sepsis audit frequency and performance.
- NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Define action plan for addressing lack of assurance around provision of services in line with requirements of Mental Health Act	Medical Director	~~01/10/2021~~ 01/12/2021	Risk included on corporate risk register in May 2021. Action plan in place. 14/07/2021 - Business case in development to ensure	

				adequate resource to Mental Health team. To be presented to PFIC July 2021.If approved recruitment will take approx. 3 months. Due date re-aligned tor reflect this process 03.11.2021 Business case approved by Trust board and posts currently being recruited to.	
2.	Develop a Clinical Audit Strategy and Policy	Director of Governance	~~01/08/2021~~ 31/01/2022	To be reviewed on completion revised governance structure and commencement in post of Deputy DoN with quality portfolio	
3.	Oversight of progress to address out of date policies and procedures will be strengthened via the Clinical Effectiveness Group which be reflected in the revised terms of reference	Medical Director	01/04/2021	**Complete** - Terms of reference agreed through Clinical	
4.	NHSI re-inspection of cleanliness and IPC practice in maternity services	Director of Nursing	~~31/10/2021~~ 31/01/2022	NHSE/I IPC inspection is booked for 22.06.2021. Report expected end of w/c 12.07.2021. Feedback on the day very positive with no significant concerns. Review undertaken and report received 15.09.2021 - Action plan in place and monitored through IPC committee 03.11.2021 Matron master classes undertaken by NHSE/I. Re inspection expected Jan 2022	
5.	Further develop processes to provide assurance that lessons learnt from adverse events	Medical Director/ Director of Nursing	31/10/2021	Scoping of new ward performance boards continues.	
6.	Development of Patient Engagement and Involvement Strategy	Patient Experience Lead / Lead for Patient Involvement	~~30/09/2021~~ 31/12/2021	03.11.2021 Deputy DoN with portfolio for Patent Voice will lead this work from 08.11.2021	
7.	Review of dementia screening data collection process. Initial deep dive completed. Scoping of improvement options commence April 2021	Director of Nursing	~~30/09/2021~~ 31/01/2022	Scoping of improvement options complete; documentation options still under consideration. Collaboration with RWT to review resources, share best practice and where possible align documentation and process. 14.07.2021 - Monthly audit in place and demonstrates improved compliance with dementia screening. Work is underway to review documentation across WHT and RWT to align. Due date re-aligned to reflect this work 03.11.2021 Alignment between WHT and RWT to be progressed by Deputy DoN with quality portfolio	
8.	Develop Maternity Services BAF	Interim Director of Nursing	30/12/2021	Ongoing review.	

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Maternity Update			**AGENDA ITEM: 11**
Report Author and Job Title:	Carla Jones-Charles Director Of Midwifery	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒		
Assure	• 1:1 care in labour has been maintained at 100% • Triage audit demonstrates that 93% of women were seen within 15 minutes of arrival • Women reported feeling safe in Triage.		
Advise	• Caesarean section rates have declined in December. • There were no new maternity Serious incidents (Sis)		
Alert	• Staff absence remained a challenge in December due to sickness and Covid related absences.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care 2066 Lack of registered nurses and midwives		
Resource implications	There are no resource implications associated with this report.		
Legal and/or 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 ☐		

Divisional Director of Midwifery Report

1.0 PURPOSE OF REPORT

The purpose of the report is to provide a monthly update to assure the board in relation to:

- Midwifery staffing review
- Activity within the maternity unit
- Triage update
- Maternity Serious Incidents (SIs)

2.0 BACKGROUND

This report will update the on-going position on the key elements above by exception.

2.1 MIDWIFERY STAFFING

The current Trust uplift is 21%, this is to account for annual leave, sickness and training. The table below is a breakdown of absence for December 21.

Unavailability by Grade Type Category (Percentage of Contracted Hours)

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Women's Services (Are)	Delivery Suite - Nursing	Registered	13.5%	4.8%	1.6%	14.1%	0.5%	2.7%	37.3%
		Unregistered	7.4%	1.8%		11.7%	0.9%		21.8%

The sickness rate on delivery suite was reported at 14.1% and the service continues to work with staff to support their return to work ensuring support via occupational health where appropriate.

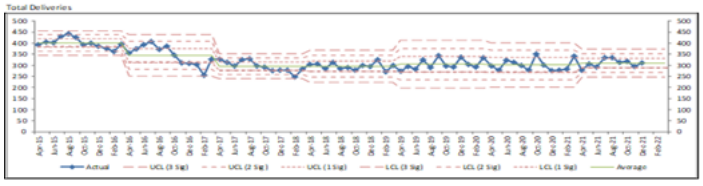
3.0 Activity within the Maternity Unit

Table 1 highlights the monthly activity within the Maternity Unit: the total number of births per month. Graph 1 is the SPC chart for deliveries and graph 2 is the SPC chart for caesarean sections. Maternal ethnicity data is outlined in table 2 and 3.

Table 1: Activity Aug 20 – Aug 21

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb 21	Mar 21	Apr-21	May 21	Jun 21	Jul 21	Aug 21	Sept 21	Oct 21	Nov-21
Births	279	351	301	276	279	285	342	279	307	293	334	337	322	317	294

Graph 1



Graph 2

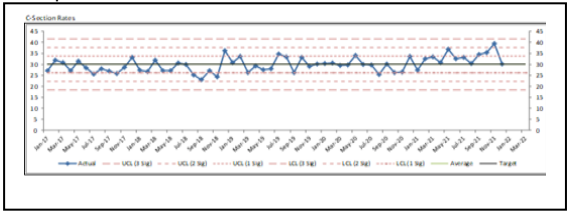


Table 2

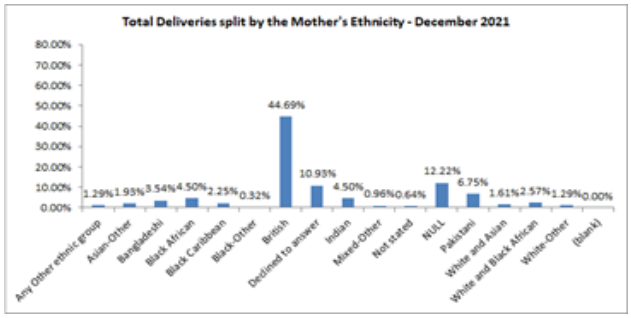
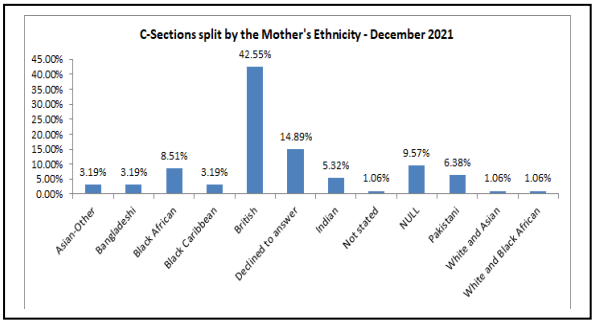


Table 3

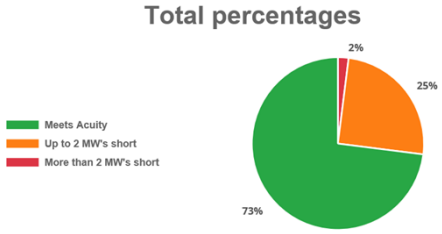


3.1 Acuity

Acuity is monitored 6 times a day on the delivery suite and is used to assess staffing needs. The national recommendation is to maintain an average acuity of 85%. Acuity over the month of December was 73% however 1:1 care in labour was maintained at 100%.

Graph 3
The target is to average acuity of 85% or above.

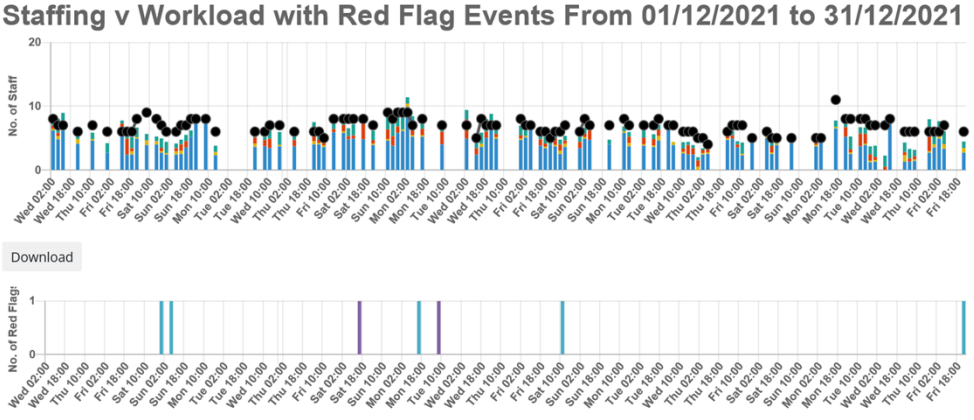
Acuity data

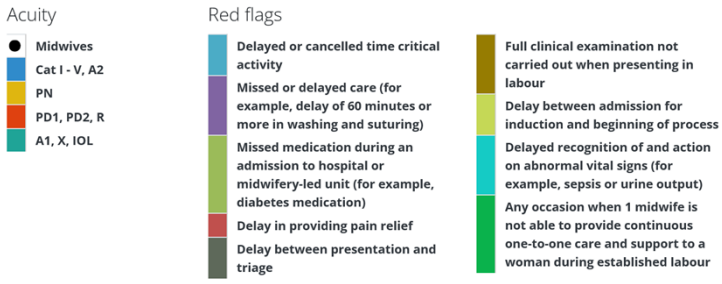


The acuity was 73% green for November, 25% amber and 2% red. 1:1 care was maintained by redeploying staff as required.

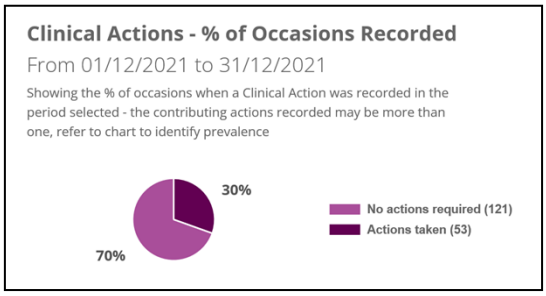
Graph 4 illustrates some of the staffing vs workload as well as red flag events which consisted mainly in induction of labour. There were no reported adverse outcomes related to red flag events. Graph 5 outlines actions taken at times of high acuity.

Graph 4





Graph 5



Number & % of Clinical Actions Taken
From 01/12/2021 to 31/12/2021

CA1	Decline in utero transfer	0	0%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL as per trust guidelines	3	6%
CA4	Delay /cancel planned procedures e.g.ECV,Cervical suture	0	0%
CA5	Delay in transfer of cases to theatre e.g. perineal repair, MROP	0	0%
CA6	Delay El. LSCS >24hrs	0	0%
CA7	Delay in continuing IOL as per Trust guideline	50	94%

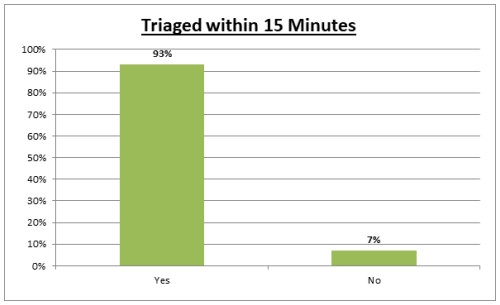
4.0 Triage update

The service launched a new triage process in November to improve the early risk assessment and treatment of women according to need. It involves a process of prioritising the order in which patients receive medical attention on arrival to the Triage Department, guiding treatment according to clinical need. A concurrent audit has been conducted to provide assurance as well as providing data, looking for areas of improvement and change.

Findings

The audit found that 93% of women were seen within 15 minutes of arrival (graph 3). 11% of women did not have a Rag status recorded, see graph 6, graph 7 outlines the Rag status of women attending and graph 8 compares ethnicity of women using triage.

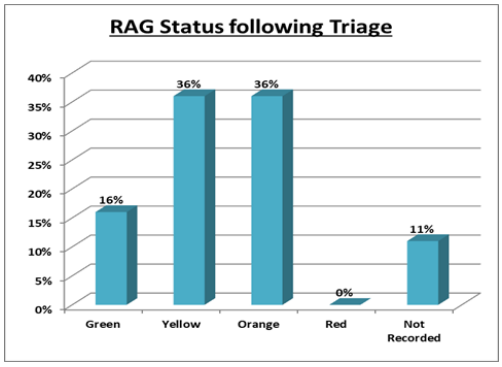
Graph 6



Of the 4 women that were not triaged within 15 minutes:

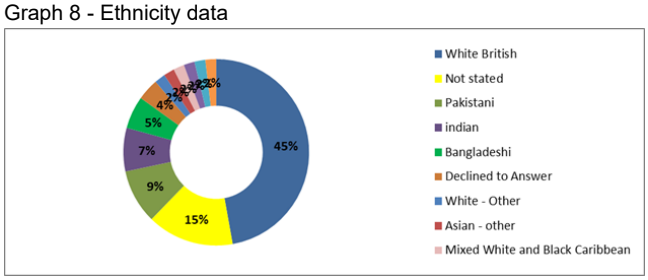
- 1 was triaged within 18 minutes - Triaged Amber with no adverse effects
- 1 was triaged within 30 minutes – Triaged Amber with no adverse effects.
- 1 was triaged within 21 minutes however only attended for a scan review.
- 1 was triaged within 45 minutes – Triaged Yellow. Same Midwife triaged and assessed which delayed care.

Graph 7



The service will continue to monitor the data and improvements. 11% of data not recorded have been reviewed to ensure women had the appropriate care.

Graph 8 - Ethnicity data



Analysis:

- Good practice:
  - ✓ 93% of women triaged within 15 minutes
  - ✓ Overall good compliance with initial RAG status.
  - ✓ Verbal feedback received from Midwives confirming they feel more confident and supported within Triage. A systematic approach to the assessment of women.

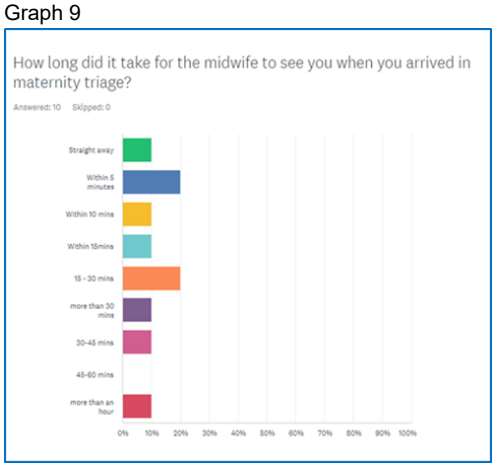
- Areas for action:
  - Monitor compliance of documentation of time of triage
  - Supporting staff to ensure correct categorisation of RAG status.
  - Audit Doctors review and initiate action plan based on findings.

Triage Patient feedback

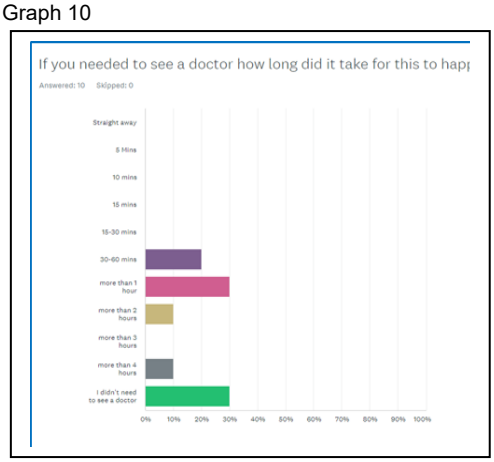
A sample of women were contacted via text (48 women were contacted) and invited to take part in a survey to provide feedback from their recent visit to the triage

department since the implementation of the new triage system. 10 women responded to the survey.
All the women who responded reported feeling safe in triage and 8 women reported feeling cared for.

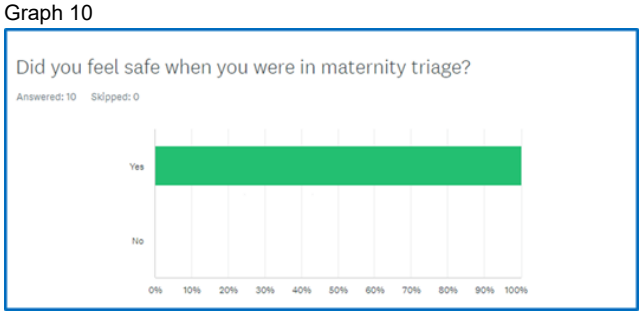
Graph 9



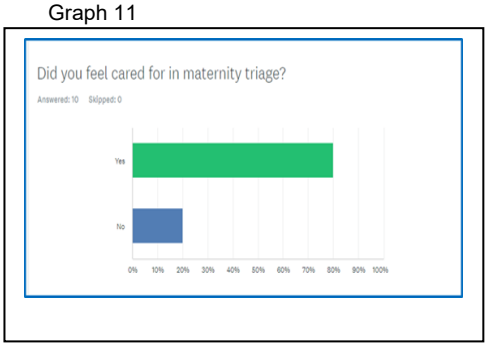
Graph 10



Graph 10



Graph 11



The service will continue to seek the views of women using the triage service as it seeks to embed the new process. There has been an action plan developed by the Deputy Director of Midwifery in response to the initial survey.

5.0 Maternity Serious Incidents (SI's).

There were no new maternity SI recorded by the service.
There was one completed (HSIB) Health service Investigation Branch report returned to the service. There were no safety concerns identified.

6.0 RECOMMENDATIONS

Members of the Board are asked to review and note the contents of this report.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Infection Prevention and Control BAF Update			**AGENDA ITEM: 12**
Report Author and Job Title:	Amy Wallett Head of Infection Prevention and Control	**Responsible Director:**	Lisa Carroll, Director of Infection Prevention and Control and Director of Nursing.
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	The IPC Board Assurance Framework has been updated to capture progress against the required actions IPC audits are embedded in practice with a programme of work planned throughout the year		
Advise	NHSE/I undertook a planned IPC inspection in December 2021. This was following a red rating in July 2021. The feedback was very positive and we were given verbal confirmation on the day that the Trust would no longer be rated as red. The Trust is yet to receive the final report.		
Alert	The old estate continues to pose some IPC challenges. Four wards in the old estate have been refurbished with four more planned for Spring 2022.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	IPC BAF		
Resource implications	There are no resource implications		
Legal and/or 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 ☐		

Summary of Current IPC BAF Position

The full IPC BAF can be found in appendix 1

Infection Prevention Board Assurance Framework: Summary							
Action/ Page	Required action	Risk Score				Change in level of risk	Comments
		Q1 2021/22	Q2	Q3	Q4 current position		
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 services users.	12	12	12	12	→	Recent changes to National guidance and adaptation of local policy. Further assurances needed on embedding new respiratory pathways prior to change in risk score.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	20	20	12	8	↓	Multiple actions in place during quarter three to support improvements in overall cleanliness of the environment and ongoing refurbishments. NHSEI external review December 2021 demonstrated significant improvements in cleanliness.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	6	6	4	4	→	Consistent improvements demonstrated in all aspects of AMS in reports submitted to IPCC. Assured of ongoing actions
4	Provide suitable accurate information on infections to services users, their visitors and any person concerned with providing further support or nursing/medical care, in a timely fashion	3	3	3	6	↑	Recent risks identified while there has been an increase in community cases of COVID-19; visitors who have not met criteria for compassionate visiting have accessed Trust premises at different access points and groups clustered in the hospital café.
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	6	6	6	8	↑	Increased outbreaks during winter; regular themes including patient mask wearing for patients who can tolerate masks during an increase in community prevalence. Patient information actions required to support improvements.
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	3	6	3	6	↑	Asymptomatic staff testing with LAMP showing low submissions. Recent pathology demands leading to a change in asymtpomatic staff testing requirements. Recent outbreaks included asymptomatic positive staff members who were not previously submitting LAMP specimens.
7	Provide or secure adequate isolation facilities	20	20	20*	20	→	Purchase for 9 Bioquell isolation pods. Company have since changed lead times for installation set back to March 2022.
8	Secure adequate access to laboratory support as appropriate	15	12	12	12	→	Recent delayed turn around times for COVID-19 testing due to lab pressures. Rapid testing for other respiratory pathogens now in place but Norovirus testing not available on site, continuing delayed bay closures.
9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections	6	6	6	6	→	Recent external inspection observed improvements in IPC standards.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	6	6	8	8	→	Robust systems implemented by COVID-19 team to support safe return to work for staff. Further assurance required on fit testing provisions for

Details of gaps in control/assurance captured in BAF

Screening for infections and alert organisms

Since February 2021 in line with national guidance the Trust implemented a policy of COVID-19 screening on the day of admission, day 3, day 5 and then every 7 days until discharge.

In October 2021, a new COVID-19 screening document was implemented by the IPCT to inpatient settings, prompting review of patients wearing masks and includes all screening standards throughout a patient stay. This has demonstrated improvements overall in screening and reflected in recent bay closures, where no further transmission has occurred due to prompt identification of asymptomatic positive patients. A review of the COVID-19 screening dashboard during December 2021 has shown since implementation of the screening document, there is vast

improvement in Day 3 and 5 screening in comparison to pre-implementation of the record. IPC divisional reports shared at Infection Prevention and Control Committee also now share their screening improvement work and regular monitoring of this standard.

MRSA admission screening compliance continues to improve but not achieving the standard of 95%. Targeted work is underway with AMU, who have registered a Qi project specifically on improving MRSA admission screening processes.

Norovirus testing

Rapid testing for Norovirus will not be available on Walsall Manor Hospital site this winter but will be processed through Black Country Pathology Service (BCPS). Previous turnaround time with onsite testing was two hours, supporting prompt infection prevention management within the area affected and a better outcome for hospital capacity. BCPS have provided their process of specimens for rapid testing, which confirms a result on the same day but cannot achieve the same rapid turnover of results. BCPS are working with IPC for testing on site in the future.

Infection Prevention in the healthcare environment

The old estate and current poor condition of many of the wards has resulted in a number of department environment audits not achieving >90% compliance score. An action plan has been undertaken during quarter two and three following the NHS England and Improvement IPC visit in June 2021. A revisit by NHSE/I took place on the 14th December 2021 with confirmation on the day that the Trust had demonstrated significant improvement and the red rating would be removed. The Trust is awaiting the written report from the visit. Senior Sisters and Matrons in the Trust have been undertaking NHSE/I masterclasses in infection prevention and joining the Lead from NHSE/I for ward walk arounds. There has been a lot of positive feedback regarding progress made in leading IPC in the healthcare environment.

The environmental control group commenced in August 2021 which is providing a mechanism for colleagues to discuss standards of cleanliness and improving the healthcare environment. Papers from these meetings are shared in the estates and facilities report to Infection Prevention and Control Committee.

The limited availability of side rooms in the Trust can lead to an inability to isolate all patients who require isolation in a timely manner. Funding has been approved to install nine Bioquell isolation pods at the Manor hospital site to improve available isolation facilities. Two pods will be installed on Wards 1, 2, 3 and 4 and one pod will be installed on AMU. The trust was informed that the lead time for this was 12 weeks from October 2021. The Director of Nursing was informed in late December 2021 that that this is not the case and the Trust should not have been advised of this. The expected installation date is March 2022.

Older parts of the Manor Hospital estate does not have sufficient mechanical ventilation to support frequent air changes within the inpatient setting as a control in preventing patient to patient transmission of COVID-19. These areas currently have air disinfector units in place to improve air quality; IPC monitor the use of these in clinical areas to ensure they are switched on at all times. In November 2021, labels were placed on the units to encourage being on at all times and window posters are being displayed to promote natural ventilation in the environment. The Trust has implemented CO2 monitoring in January 2022 for clinical areas to provide assurance on ventilation and these are currently being monitored by the IPC team.

Staff members undertaking LAMP testing

To continue routine testing and identification of asymptomatic staff members with COVID-19, the Black Country Pathology Service facilitate LAMP testing. BCPS wrote to the Trust in December 2021 requesting cessation of LAMP testing and a move to twice weekly lateral flow due to capacity challenges within the laboratory. In line with RWT the Trust will be moving to twice weekly lateral flow testing from the 24th January 2022, with LAMP no longer available from the 13th February 2022.

Twice weekly lateral flow testing is in line with national guidance and staff will upload results to a Trust platform. The Trust will submit weekly compliance data to the national system.

Performance: Infection Prevention and Control Targets

In August 2021, the Trust received a paper from NHS England and NHS Improvement, confirming target data for health care associated infections at Walsall Healthcare. In addition to *C.difficile,* gram-negative bacteraemias have been included for the first time.

Targets for 2021/22:

MRSA: Continues to be 0 cases as a National target. The Trust experienced an MRSA bacteraemia in May and July 2021 resulting in multiple actions as part of the annual programme. Good progress has been observed in standards of aseptic technique and hand hygiene standards across all staff groups. More work is being undertaken to improve standards of indwelling device monitoring in collaboration with Royal Wolverhampton NHS Trust.

C.difficile: Target 33. Currently at 22 *C.difficile* toxin cases at WHT. Educational support has been undertaken on C.diff from the IPC team since wave 2 of COVID-19 to ensure appropriate IPC measures were in place for other infections. This work included rapid identification of symptoms and testing, which demonstrates improvement in cases during the year. Antimicrobial stewardship reports shared at IPCC also demonstrate consistent improvements, which could be influencing overall rates.

E.coli: Target 64. Currently at 15 cases at WHT. This low case rate may be associated with multiple work streams across the Trust, including prevention of urinary tract infections via the continence steering group and antimicrobial stewardship.

Pseudomonas: Target 7. Currently at 1 case. The Trust have a monthly Water Safety Group meeting, which includes proactive water sampling and controls put in place to prevent environmental burden of Pseudomonas. The IPC team regularly update Trust staff on their role in water safety, including in November 2021 with a newsletter on the subject.

Klebsiella species: Target 18. Currently at 15 cases. A significant increase occurred during August 2021 with 5 cases; this was thoroughly reviewed by the consultant microbiologist who determined different types and cases within different time and space. This appeared to be an anomaly but may have been reflective of seasonality of the infections caused by this organism.

The new targets are now being captured in infection monthly reports for committee. The Trust were recently praised by NHSEI for our current HCAI rates and IPC tools designed and adopted by WHT IPCT have been shared in National forums to share best practice in November 2021.

Outbreaks

Ward 16 closed on 14th October due identification of 3 HCAI COVID positive cases; the ward reopened on 3rd November. Total of 9 HCAI COVID identified during the outbreak, no positive staff.

Ward 1 was closed on 30th October following 2 cases meeting HCAI COVID-19 criteria. Full isolation period was completed with no further patient or staff cases.

Hollybank Rehabilitation Centre closed on 30th December. Total of 4 HCAI COVID-19 patients and 9 positive staff members identified as part of asymptomatic staff screening. Re-opened on 14th January 2022.

Ward 14 closed on 9th December due to confirmed Norovirus. A total of 5 patient cases and 0 staff members,

Ward 15 closed on 6th December due to incidental findings of RSV in discharge patient screening on 3 patients. Total of 5 patient cases, all asymptomatic. Ward fully reopened on 12th December.

No other outbreaks to report for quarter three. When outbreaks do occur, outbreak meetings are undertaken as part of the management process with involvement from Walsall Council, CCG, UKHSA and NHSEI. The IPCT have received very positive feedback on the assurance presentation template they have developed for outbreak

management and this is now being shared regionally as an example of good practice.

Infection Prevention and Control Audit Programme: Quarter Three Progress

The table below shows the audit plan for 2021/22. In addition to this, the Infection Prevention and Control Team will undertake audits based on incidents or obtaining assurances on updated infection prevention guidance/policy.

Audit	Location	Plan	Related Compliance Criterion	Related Strategic Theme	Progress
Full ward audit	All inpatient wards	To be completed by August 2021	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	Completed
Community audits	Community clinics and units	To be completed by October 2021	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	Completed
Full departmental audits	Acute site departments	To be completed January 2022	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	To be completed January 22
Ward kitchens	Inpatient wards	To be completed by March 2022	1,2,9	Infection Prevention in the Environment, Hand Hygiene	March 2022
Support services cupboards	Inpatient wards	To be completed by March 2022	1,2,9	Infection Prevention in the Environment, Hand Hygiene	March 2022
Hand hygiene	Acute site	Quarterly: June 2021 September 2021 December 2021 March 2022	6,9	Hand Hygiene, Invasive Devices	Quarter Three completed.
Compliance to wearing	Acute site	Quarterly: June 2021	6,9,10	Hand Hygiene, Invasive	Quarter Three

Audit	Location	Plan	Related Compliance Criterion	Related Strategic Theme	Progress
personal protective equipment (PPE)		September 2021 December 2021 March 2022		Devices	completed.

IPC Annual Report and Annual Programme of Work

Progress against the Annual Programme of Work will be overseen by the IPC Committee.

In addition to the set programme of work, the team deliver a "focus of the month" which includes distributing newsletters and providing specific education around the focus directly to colleagues within clinical areas.

Focus for October: Infection Prevention week- "My role, everyone's responsibility", Bell for Clinell

Focus for November: Water Safety

Focus for December: Norovirus preparedness

Infection prevention activity can be found via the Trust infection prevention Twitter page: @IPCWalsall

Collaborative working with RWT

The Head of Infection Prevention and Control at WHT is currently undertaking regular meetings with the IPC leads at RWT to standardise approaches to infection prevention across the Trusts, including plans to align policies, educational programmes and processes to manage infections.

End of Report.

Walsall Healthcare NHS Trust

IPC BAF Criterion controls and mitigating actions – January 2022

Infection Prevention Board Assurance Framework: Summary

Action/ Page	Required action	Risk Score Q1 2021/22	Q2	Q3	Q4 current position	Change in level of risk	Comments
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 services users.	12	12	12	12	→	Recent changes to National guidance and adaptation of local policy. Further assurances needed on embedding new respiratory pathways prior to change in risk score.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	20	20	12	8	↓	Multiple actions in place during quarter three to support improvements in overall cleanliness of the environment and ongoing refurbishments. NHSEI external review December 2021 demonstrated significant improvements in cleanliness.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	6	6	4	4	→	Consistent improvements demonstrated in all aspects of AMS in reports submitted to IPCC. Assured of ongoing actions
4	Provide suitable accurate information on infections to services users, their visitors and any person concerned with providing further support or nursing/medical care, in a timely fashion	3	3	3	6	↑	Recent risks identified while there has been an increase in community cases of COVID-19; visitors who have not met criteria for compassionate visiting have accessed Trust premises at different access points and groups clustered in the hospital café.
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	6	6	6	8	↑	Increased outbreaks during winter; regular themes including patient mask wearing for patients who can tolerate masks during an increase in community prevalence. Patient information actions required to support improvements.
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	3	6	3	6	↑	Asymptomatic staff testing with LAMP showing low submissions. Recent pathology demands leading to a change in asymtpomatic staff testing requirements. Recent outbreaks included asymptomatic positive staff members who were not previously submitting LAMP specimens.
7	Provide or secure adequate isolation facilities	20	20	20*	20	→	Purchase for 9 Bioquell isolation pods. Company have since changed lead times for installation set back to March 2022.
8	Secure adequate access to laboratory support as appropriate	15	12	12	12	→	Recent delayed turn around times for COVID-19 testing due to lab pressures. Rapid testing for other respiratory pathogens now in place but Norovirus testing not available on site, continuing delayed bay closures.
9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections	6	6	6	6	→	Recent external inspection observed improvements in IPC standards.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	6	6	8	8	→	Robust systems implemented by COVID-19 team to support safe return to work for staff. Further assurance required on fit testing provisions for

Criterion detail with controls and mitigation

1. Systems 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 their environment and other users may pose to them			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
A respiratory season/winter plan is in place: that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services, to enable appropriate segregation of cases depending on the pathogen. Plan for and manage increasing case numbers where they occur. A multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.	Trust IPC guidance including all triaging processes for respiratory viruses in emergency and elective pathways.	Audit required for assurance in adherence to triage and flows of patients in the emergency pathway following implementation of pathway approved December 2021.	Audit planned by IPCT Feb 2022 to report back to Infection Prevention and Control Committee
	Review of pathways and Trust Winter Plan via Trust Tactical command, Strategic Command, Tactical action log and slides.	Assured	
	Abbot ID in place in ED, SAU and Paediatrics for point of care testing	Assured	
	Surge plans and isolation requirements within the winter plan consulted with IPCT and shared at Trust Tactical Command	Assured	
	Exercise PATTON led by EPRR and supported by IPCT and microbiology to determine plans and streams for increasing numbers	Assured	
Health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Trust workplace guidance reviewed weekly at Corporate Command and shared via central Trust Communications	Assured	

	Maximum occupancy signage in place across Trust staff area settings.	Recent IPC reviews indicate not displayed in all applicable areas	Feedback shared at December 2021 IPCC for divisions to action
Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. o applied in order and include elimination; substitution, engineering, administration and PPE/RPE. o communicated to staff.	Trust respiratory guidance flow incorporates hierarchy of controls to enable decision making on level of PPE required, with supporting appendices including the Trust ventilation policy. PPE group minutes.	Updated Trust risk assessment required to support rationale for decision making on level of PPE required. Regular monitoring of CO2 required via purchased CO2 monitors across the Trust to support risk assessment.	Health and Safety to support Trust risk assessment in relation to latest guidance. Estates team have purchased 100 Co2 monitors for distribution across site and to incorporate in audits. PPE group commenced January 2022.
Safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. Risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents. If an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	All IPC risk assessments/SOPs are approved via the Infection Prevention and Control Committee. Urgent items following National guidance may be approved at Tactical command with DIPC sign off.	Assured	
If the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	N/A- National guidance followed.		

Ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	All COVID-19 cases, C.difficile and other alert organisms are reviewed by the Infection Prevention and Control Nurses (details accessible on ICNet). The review includes monitoring transfer of patients to determine appropriate move for the patients clinical/infectious status/vulnerability.	Assured	
The Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Daily report to DoN and MD and update daily to Exec team. Twice weekly Trust Tactical command in place.	Assured	
There are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Divisional reports presented at IPCC with executive chair (DoN/DIPC) check and challenge. IPC report to Quality, Patient Experience and Safety Meeting and Public Trust Board. Evidence in meeting minutes.	Assured	

Resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). The application of IPC practices within this guidance is monitored, eg: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination.	Audits undertaken across all departments as detailed in the Trust IPC annual programme of work with focus on hand hygiene practice, decontamination and all principles of PPE. Audits are shared at time of being undertaken, reports shared with divisional leads, divisional quality meeting and final feedback at IPCC. Responsive audits undertaken following a confirmed infection at request of DIPC/Deputy DIPC/Lead IPCN/Microbiologist.	Assured	
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board. • the Trust Board has oversight of ongoing outbreaks and action plans.	Quarterly presentation of the IPC BAF report presented to Public Trust Board. Monthly updates to IPCC with escalation to QPES. Monthly review of supporting evidence, assessment of risk and actions required	Assured	
The Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Procurement provides weekly update on PPE supply. Trust has supply of 4 types of FFP3. PPE group established.	Assured	

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
The Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Trust Plan in place and ratings have been agreed by Trust DIPC. All reports and updates shared monthly at IPCC.	Cleanliness audit data not easily accessible for ward/department leaders.	Facilities working with Perfect ward to review how cleanliness audits can be captured in this format.
The organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	Process in place to log jobs/requests. Space Utilisation Health and Safety risk assessments completed. Previous patient areas that have been repurposed as staff facilities to allow distancing measures are clearly signposted with maximum occupancy signage displayed. Evidence of request process via minutes from Space Utilisation Request Group.	Assured	
Cleaning standards and frequencies are monitored in clinical and nonclinical areas with actions in place to resolve issues in maintaining a clean environment.	Cleanliness audits in accordance with the NHS cleaning standards. Reports reviewed by Environmental Control with escalations to IPCC. Audit system in place to record results and actions.	Assured	

Increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Process in place to record and monitor increased frequency in cleaning as required	Assured	
Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.	Chlorine solution and detergent combined solution standard on all wards. Audits capture dilution to 1,000ppm as standard.	Assured	
If an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.	N/A		
Manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	The trust follows manufacturers' recommendations and is information is included in training packages.	Assured	
A minimum of twice daily cleaning of: patient isolation rooms; cohort areas; Donning & doffing areas; 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails;o where there may be higher environmental contamination rates, including: toilets/commodes particularly if patients have diarrhoea.	Trust standards documented and available for staff. Areas of potential higher risk are escalated by IPCT and action taken on the same day.	Assured	
A terminal/deep clean of inpatient rooms is carried out: following resolutions of symptoms and removal of precautions; when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Detailed in Trust cleaning matrix. Evidence of completion in capacity records and submissions from housekeeping team to evidence completion of Violet and Red cleans.	Assured	
Reusable non-invasive care equipment is decontaminated: between each use; after blood and/or body fluid contamination at regular predefined intervals as part of an equipment cleaning protocol, before inspection, servicing, or repair equipment. Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	Each department has a daily cleaning schedule detailing equipment used between patients. This is monitored in IPC audits/ Matrons audits	Assured	

As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. The assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.	Ventilation assessment incorporated into Trust policy (which is embedded as an appendix in respiratory SOP to support risk assessment for flow/ PPE decisions).	Not all Trust premises have mechanical ventilation with sufficient air changes (e.g. Hollybank centre, West Wing wards)	Air disinfector units and natural ventilation records in place to mitigate mechanical ventilation controls in these settings. Introduction of CO2 monitors in clinical areas
A systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	Ventilation assessment incorporated into Trust policy (which is embedded as an appendix in respiratory SOP to support risk assessment for flow/ PPE decisions).	Assured	
Where possible air is diluted by natural ventilation by opening windows and doors where appropriate	"Take Care, Refresh your Air" window clings/posters on windows to promote natural ventilation where possible. Clinical areas have records to demonstrate window opening for 10 minutes per hour.	Assured	
Where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.	Air disinfector units in place for wards/departments with insufficient mechanical air changes. Approval for use via Trust Tactical command and spot check audits for use undertaken by IPCT.	Assured	Implementation of CO2 monitoring
When considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	Screens in place in reception/ waiting areas with Estates team review prior to installation. Responsibility for cleaning with department and incorporated in cleaning schedule.	Assured	

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Arrangements for antimicrobial stewardship are maintained	Trust antibiotic guidelines in place and audited monthly. Reports to IPCC. Campaign materials shared with divisions reflecting National messaging	Assured	
Previous antimicrobial history is considered	Microguide in place to support decisions. Recording of drug allergy status included in monthly audit reports.	Assured	
The use of antimicrobials is managed and monitored: to reduce inappropriate prescribing; to ensure patients with infections are treated promptly with correct antibiotic.	Monthly report to IPCC demonstrates good compliance	Assured	
Mandatory reporting requirements are adhered to, and boards continue to maintain oversight.	Monthly report to IPCC demonstrates good compliance	Assured	
Risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	SOPs in place to identify triggered alert organisms- new cases or readmissions; clinical teams are notified and reviews undertaken by IPCT. Alert tags on Fusion to identify previous Multi Drug Resistant Organism history	Assured	

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 (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors. National guidance on visiting patients in a care setting is implemented.	Compassionate visiting policy in place and information shared on public internet page and social media platforms. Visiting guidance is reviewed weekly at Trust Tactical command with community case rate as per visiting SOP. Additional compassionate visiting guidance provided to clinical areas to support decisions.	Visitors have been accessing acute site via different access points when welcome hub advise visiting cannot take place. Patients found to meet groups of relatives in hospital café.	
Restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	SOP includes COVID cohort areas and areas with outbreaks for restricted visiting.	Restricted/compassionate visiting in operation in all areas currently.	
There is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Pull up banners and posters to prompt patients to wear face masks.	On checks, patient information posters not on display in all areas to promote their role in IPC.	Collaborative meeting between RWT and WHT IPC, Patient experience, communications to develop patent information resources for standardisation across all sites. IPCT providing updated patient information resources for each bed space.
If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	All visitors provided with information) to guide on PPE which are readily available on entrance to Trust buildings and in all departments		

Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitors are triaged via the Welcome Hub at pint of arranging a visit to confirm if any symptoms and this is rechecked when they arrive on site and an information leaflet provided. Guidance in this respect is regularly reviewed and updated as appropriate. Visitors requested to take a lateral flow test prior to visiting and tests are available on site	Assured	

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 (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.		Recent checks found outdated resources.	IPCT to undertake review of all access points to Trust premises for patients and remove old signage. Communications team to support with updated banners/signage as standard display to all clinical settings.
Infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.	Recorded in patients' medical notes/handover documents. Alerts on Fusion. Bed Bureau have live access to isolation requirements of patients on ICNet, which are reviewed daily by the IPCT.	Assured	
Staff are aware of agreed template for screening questions to ask.	Incorporated in respiratory guidance flow for all emergency and elective patients.	Assurance audit needed to determine latest compliance in completion of screening questions	Audit planned by IPCT January 2022.

Screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	Captured within elective pathway procedure. Screening questions completed on initial presentation to ED, decision to admit any patient leads to undertaking Abbot ID rapid test for COVID-19 to determine status and correct stream as per Trust procedure.	Assured	
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. Triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Clear separation in ED for respiratory pathways vs non-respiratory pathways including within waiting area, majors and separated resus departments.	Assured	
There is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	MRSA screening compliance improved for emergency pathways. CPE screening criteria embedded within the Trust. Reviewed daily by IPCT. COVID-19 inpatient screening process improving.	Overall improvements in COVID-19 screening compliance but still gaps identified when reviewing overall compliance.	Divisions to share ongoing actions to improve screening compliance and monitor at Infection Prevention and Control Committee.

Patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Educational sessions provided to staff on patients wearing face masks. Patient information resources and mask wearing prompt on patient screening record.	Good compliance observed in COVID cohort ward for patients wearing masks but limited assurance within emergency medicine of patients wearing masks/ risk assessments being completed to demonstrate if patient can tolerate wearing face masks.	Feedback shared with divisions for actions and collaborative work taking place to support patients in IPC.
Patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. Patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. Patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly.	Single cubicles within ED that are sealed off when respiratory infection suspected. Separated resus areas for respiratory vs non respiratory infection suspected. Patients who develop respiratory infections during their stay are prioritised for isolation pending result and bay area is closed in the event of a positive result.	Assured	
Patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	ICNet isolation report includes patients who require protective isolation. Isolation signs in place to reflect that the patient is in protective infection. IPCT audits monitor compliance with display of isolation signage.	Assured	

Where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.	Incorporated in Trust respiratory process for elective procedures.	Assured	
Face masks/coverings are worn by staff and patients in all health and care facilities.	COVID-19 assurance audits monitor compliance with mask wearing in staff and patients. Provisions of surgical mask stock is well maintained at each access point to Trust premises.	Masks are not always worn by patients	As per previous action point for patient information action
Where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.	No changes have been made to inpatient distancing to enable 2m distancing in respiratory pathways. Ward 29 and modular blocks have been selected for cohort facilities due to sufficient distancing that can be achieved and mechanical ventilation systems. Cohort areas are within Trust winter plan and included on IPCT daily closure update. COVID assurance audits observe good compliance with patient furniture placement to support distancing measures when a patient is sat out of bed.	Assured	

Patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	Distancing measures are in place for patients across all Trust settings. Non-respiratory pathways have a minimum 1m distancing and minimum 2m for respiratory (incorporated in IPC Trust procedure). Visiting SOP incorporates distancing measures and is observed in practice during audits. Staff distancing is incorporated in Workplace guidance procedure and audited regularly by IPCT.	Some workplace environments (ward settings) make it difficult for staff to achieve distancing measures.	Refurbishment plans in Spring 2022 have provided multiple separated work stations to support staff distancing measures.
Patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	As per respiratory pathway.	Assured	

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 (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Appropriate infection prevention education is provided for staff, patients, and visitors.	All staff receive mandatory training via ESR accounts. ESR records demonstrate compliance at departmental level/ staff group level. The IPC annual programme of work includes a focus of the month which consists of an educational package- newsletters that are distributed to clinical areas and IPCT deliver bespoke education in a responsive basis (e.g. C.diff audit cycle support). Patient education leaflets are provided on different infections if applicable during their care. All visitors are provided with an information leaflet on their arrival to the hospital site to demonstrate the measures required to prevent transmission of infection.	Standardised patient information on prevention of COVID-19 is not visible in all locations. Patient information leaflets could be more accessible via Trust intranet page for Trust staff to print easily to provide to patients. Need confirmation that all visitors are provided with information on access to other settings e.g. Hollybank and Palliative Care Centre	Collaborative work for patient information underway. Work with communications to update intranet page for simple accessibility to key IPC resources. Community Division to confirm information provided to visitors within community bed bases.

Training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	PPE principles incorporated in mandatory training package at the Trust for all new starters. Fit test training added as a competency on ESR for easy booking to a training session. IPC audits review PPE principles to confirm that fit tested members of staff have an appropriate fit of an FFP3 respirator.	**Assured**	
All staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, nonintact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	PPE standards and respiratory guidance demonstrates that gloves only required when potential exposure to body fluids. This is audited in IPC COVID assurance reviews and quarterly PPE audits, which have demonstrated improvements throughout the year in appropriate glove use. Audit reports shared at IPCC	Assured	
The use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Only paper towel dispensers available in each clinical area at a hand wash basin. Recent change of dispenser to prevent staff accessing the side of the dispenser and avoid contamination of hands.	Assured	
Staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	Audit completed as part of IPC COVID assurance reviews. Signage for different locations to demonstrate maximum occupancy.	Overall improvements observed but challenges in West Wing areas which has a more crowded environment	Work stations incorporated in Spring refurbishment plans to prevent crowding in work place.

Staff understand the requirements for uniform laundering where this is not provided for onsite.	Captured within uniform policy. Ward audits monitor uniform standards.	Recent concerns at NMAAF meeting regarding staff not changing out of uniform at work.	Communications shared with all Trust colleagues to reiterate principles of the uniform policy.
All staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.	SOP on staff isolation and Staff guidance document shared with all Trust staff. COVID-19 team log demonstrates all calls from staff who have contacted with isolation requirements that meet rapid testing criteria.	Assured	
To monitor compliance and reporting for asymptomatic staff testing	Trust signed up to LAMP testing for weekly asymptomatic testing of staff.	Difficulties in accessing performance data for submissions at departmental level to support managers actions. From December 2021, pathology demands have led to a request to Trust executives to step down LAMP and for staff to undertake twice weekly LFTs instead to enable pathology services to focus on patient testing.	Actions to follow up request to ensure staff have sufficient supply to LFT testing. Trust platform for reporting of results to be launched w/c 24th January 2022
There is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	WHT Microbiologists, IPCN and EPRR lead attend Health Protection Walsall weekly updates for in depth review of local surveilance data. This is incorporated into twice weekly Tactical meetings presentation slides. COVID figures are reported daily by IPCT and daily closures/COVID stream	Assured	

Positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	HCAI COVID-19 cases are incident reported by IPCT and assigned to division. IPCT undertake HCAI COVID initial review which is embedded on incident. Cases meeting outbreak definition have an SI reported and trigger outbreak investigation process, including external outbreak meetings chaired by DIPC/Deputy DIPC	Assured	

7. Provide or secure adequate isolation facilities			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
That clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.	Captured in other compliance criterion review.	A more standardised approach to patient information required (as cited in criterion 6)	Collaborative work for patient information underway.

Separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.	Outpatient clinics and community clinics have well spaced waiting areas and follow elective flow respiratory pathway to ensure segregation. Patients within elective care that demonstrate respiratory risk are risk assessed to determine if appointment can be delayed until resolved to meet elimination within hierarchy of controls.	Assured	
Patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.	Patients who cannot be deferred are segregated to a different wait area/clinical room to minimise risk. All patients in elective pathway are asked to wear masks and this is well adhered to during IPC walk arounds/audits.	Assured	

Patients are appropriately placed ie, infectious patients in isolation or cohorts.	Evidence of this is captured in ICNET isolation reports and cohort plans submitted daily via distribution list.	Challenges in isolating all patients who require isolation for infection reasons	Captured in action log- mitigating risk via risk assessments from IPCT daily to support prioritisation of isolation/cohorts and action underway for 9 isolation pods to be installed on site.
Ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Incorporated in COVID assurance reviews on distancing in bed spacing. Any changes in layout of clinical areas are consulted with IPCT for review. Amendments are finalised via Tactical command	Assured	
Standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Incorporated in Trust respiratory pathway process citing standard IPC precautions. Monitored through IPC assurance checklists/matrons audits.	Assured	
The principles of SICPs and TBPs continued to be applied when caring for the deceased	Policy supporting managing deceased patients in place.	No recent assurance/audit capturing staff understanding of precautions required when caring for deceased patients.	IPC review to check understanding of registered nurses and support workers on what principles apply when managing a deceased patient.

8. Secure adequate access to laboratory support as appropriate			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Testing is undertaken by competent and trained individuals.	Trained colleagues from BCPS. Resources on how to correctly undertake a respiratory swab provided. Department staff where Abbot ID in place have been trained in use of devices including requesting sample, obtaining and processing via the machines and inputting data in line with IG requirements.	Assured	

Patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance	Point of care testing available for COVID-19, Influenza and RSV (Abbot ID). Rapid in house PCR tests can be conducted on site when new clinical suspicion of respiratory infection or urgent clinical move to determine status.	Assured	
Staff testing protocols are in place	Trust SOP and workplace guidance for staff in place	Assured	
There is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	Reports submitted weekly demonstrating turnaround times.	Recent lab pressures have prolonged turnaround time, having an impact on increased contact time when incidental positives have been identified.	

Screening for other potential infections takes place.	Incorporated in respiratory guidance flow charts to consider other respiratory infections to screen for. MRSA screening policy, CPE screening policy, VRE screening policy. IPCC IPCT review wards Monday-Friday and update ICNet reports to monitor compliance with VRE/CPE screening and sending stool samples.Compliance reporting through	Assured	
That all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	Look back on patient cases demonstrate good compliance to initial admission screens for all patients regardless of presenting complaint.	Recent Influenza A case on Day 5 of admission; patient presented with respiratory symptoms, COVID-19 ruled out and admitted into a non-respiratory pathway.	Learning shared with the division and respiratory flow is being further circulated and to Trust staff and education planned by IPCT.

That those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	IPCN reviews of positive case and confirms symptom onset associated with sample date.	Assured	
That all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.	Dashboard available to review overall compliance to screening on day 3, 5, 12 and weekly for long stay admissions.	Improvements required in day 3 and 5 particularly in departments across the Trust. Most consistent risk factor in HCAI COVID-19 reviews are missed opportunities for screening within first week of admission.	Multiple actions underway to improve overall screening compliance. Improvements observed but not yet reached a standard for suitable assurance.
That sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	Determined by outbreak management team chaired by DIPC/Deputy DIPC. Any bay closure/Ward closure will screen contacts every 48 hours determined during outbreak reviews.	Assured	

That those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Undertaken and captured in discharge letter to care provider. Rapid testing is regularly utilised and authorised to enable this process promptly.	Assured	
Those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	Incorporated in discharge plan/letter to the care setting. Liaison between IPCTs and local health protection team to enable safe discharges to other care settings. IPCT communicate to IPCTs in other care providers where transfers have taken place. Documentation of this captured on ICNet.	Assured	

There is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	SOP in place to support this process. IPCT meet with surgery Team of Three on a weekly basis who report back on ongoing process. Assurance provided at Tactical command.	Assured	

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 (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
The application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPCT annual programme of work audit plan incorporates a preventative monitoring programme for IPC practice across all areas in the Trust and all staff attending the area. Departmental audit plan embedded led by Matrons. Reports to IPCC and divisional quality meetings.	Assured	

Staff are supported in adhering to all IPC policies, including those for other alert organisms.	Policy updates are cascaded to teams from IPCT programme of work/focus of the month, newsletters and guidance at a glance. All policies available on Trust intranet. Posters for key guidance such as PPE available in clinical areas	Assured	
Safe spaces for staff break areas/changing facilities are provided.	Assurance audits find well-spaced staff break areas that are compliant with guidance.	Changing facilities are limited on site and impact on staff getting changed at work.	Refurbishment plans include additional changing facilities.
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Outbreak policy in place and accessible on Trust intranet	Update review required as part of collaborative work with RWT IPCT	Collaboration plan involves policy reviews/alignment.
All clinical waste and linen/laundry related to confirmed or suspected COVID19 cases is handled, stored and managed in accordance with current national guidance.	Segregation of linen and waste is reviewed during IPC reviews within the clinical area.	Waste hold areas on West Wing corridor are very small and impact on ability to segregate streams.	Works being undertaken for a clean mattress central store on site. This will free the current mattress holds adjacent to wards to be used as a waste or used linen segregation area.
PPE stock is appropriately stored and accessible to staff who require it	Clean store areas have appropriate supply of PPE for the clinical area. IPCT undertake checks during ward reviews.	Assured	

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key Lines of Enquiry (KLOE)	**Evidence**	**Gaps in Control or Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Records of advice sought recorded in COVID-19 team logs and OH department records	Assured	
Bank, agency, and locum staff follow the same deployment advice as permanent staff.	Bank, agency and locum staff are inducted into the area in which they are working and are required to adhere to Trust policies and follow Trust guideline	Assured	
Staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)	Trust follows national guidance. SOP and flow chart approved at tactical command to enable prompt return to work for staff members who meet the criteria.	Assured	

Staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	Included in mandatory training and recorded on ESR.	Assured	
A fit testing programme is in place for those who may need to wear respiratory protection.	Accredited fit test trainer and cascade trainers within the Trust to support fit test compliance. FIT testing available daily through a combination of booked sessions and FIT testers visiting wards and departments to provide testing in the clinical area. Compliance report to PPE group	Not all staff are FIT tested for two masks as per Health and Safety Guidance	Health and safety team increasing availability of session s and training an additional FIT tester
Where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: lead on the implementation of systems to monitor for illness and absence; facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce; lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19; encourage staff vaccine uptake.	COVID-19 team undertake reviews when a breach occurs. Occupational health risk assess and signpost to antiviral prophylaxis in the event of a potential BBV exposure. OH lead the Influenza Vaccination programme. Vaccination centre provides staff COVID-19 and Influenza vaccinations. OH monthly report to IPCC	Assured	
Staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	Guidance is standardised for IPC precautions regardless of vaccination status. Audit programme in place an no concerns or variance in practice identified		

A risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19; A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; that advice is available to all health and social care staff, including specific advice to those at risk from complications; Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff; A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	Staff risk assessment document in place and embedded in practice. Occupational Health referral is available to support anyone at high risk or with particular concerns	Assured	
Vaccination and testing policies are in place as advised by occupational health/public health.	Vaccination and testing policies for infection in place as per National guidance (Green Book)	Assured	
Staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.	Fit test trainers for the Trust are fit to fit accredited. Fit test training records available and shared fortnightly to Trust PPE group.	Not all staff are FIT tested for two masks as per Health and Safety Guidance	Health and safety team increasing availability of session s and training an additional FIT tester
Staff who carry out fit test training are trained and competent to do so.	Core fit test trainers are accredited. Fit testers in the Trust have been trained by accredited facilitator.	Assured	

All staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.	Fit test training records demonstrate compliance against the FFP3 masks available on site.	Not all staff are FIT tested for two masks as per Health and Safety Guidance	Health and safety team increasing availability of session s and training an additional FIT tester
All staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	Demonstrated compliance to two masks in fit testing report	Improvements needed in fit testing compliance to two masks	Raised at Trust PPE group. Requested that booking system demonstrates for two masks.
A record of the fit test and result is given to and kept by the trainee and centrally within the organisation.	Recorded centrally on Trust system	Record of the fit test result not shared with the trainee.	Fit test passport format shared with the Fit testing team to embed into fit testing process to provide to the trainee.
Those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.	Recorded centrally on Trust system, staff member advised.	Record of the fit test result not shared with the trainee.	Fit test passport format shared with the Fit testing team to embed into fit testing process to provide to the trainee.
That where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Reusable respirators available across Trust premises for individuals who have not had a successful fit test	Respirator hood SOP requires updating and circulation	Trust PPE Group to oversee update of policy
Members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.	Captured within staff risk assessments.	Assured	
A documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	Recorded in individual staff risk assessment and referrals where appropriate made to OH.	Assured	

Boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.	Central record of fit mask compliance held by Health and Safety team with dedicated lead for FIT testing. Compliance reported to the Risk Management Committee with escalation to Trust board.	Assured	
Consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Incorporated into SOPs and staffing arrangements for the Trust. In the event of outbreaks/mixed ward environments- staff are segregated to particular areas to prevent transmission.	Assured	
Health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.	Risk assessments in place with documented mitigating actions. Monitored through COVID-19 assurance reviews and health and safety reviews.	Assured	
Staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing.	Sickness absence monitored and circulated weekly and managers are advised on Wellbeing conversations. Staff who are self-isolating can access the Covid line for support. The Trust has access to rapid COVID testing for staff identified as for contacts due on shift within 24 hours. Staff not due on at work in the next 24 hours access Pillar two testing in line with national guidance.	Assured	

Staff who test positive have adequate information and support to aid their recovery and return to work.	COVID-19 team provide advice to positive staff members and information via the staff isolation SOP on safe return to work processes. Manager training covers wellbeing conversations for returnees and full HWB resource available to all staff and managers	Assured	

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Hospital Mortality Report (Quarter 3, 2021/22)			**AGENDA ITEM: 13**
Report Author and Job Title:	Dr Simon Harlin Acting Deputy Medical Director	**Responsible Director:**	Dr Manjeet Shehmar Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• Learning from deaths is part of the SHQC Improvement Programme, with learning monitored via the Mortality Surveillance Group • This paper summaries the learning and improvements as a result of the learning from deaths programme		
Advise	• The Trust SHMI for August 2021 is 104 and HSMR for September is 115 • In the last quarter, there have been 425 deaths at the Trust. In Q3, 26 SJR's have been completed. Care has been assessed as level 3a or below in 3 of these cases.		
Alert	• Year to date; as assessed by SJR level 1 reviews, 0.5% of deaths were definitely avoidable, 1.6% strong evidence of avoidability, 8.2% were probably avoidable (more than 50/50), 24.6% probably not avoidable (less than 50/50), 55.7% probably not avoidable and 9.3% of deaths slight evidence or definitely not avoidable • There have been a total of 794 Covid positive deaths in the hospital (07.01.22)		
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 CCG		
Resource implications	Recruitment to additional posts to support the expansion of the Medical Examiner programme to community		
Legal and/or 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 ☒		

Introduction

This report details:

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

1. PERFORMANCE

National Benchmarks

The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index (SHMI). Table 1 shows the Trust SHMI and HSMR. The appendices at the end of this report show SPC charts and benchmarks of mortality metrics.

Table 1: Trust mortality 2020-21

	HSMR	SHMI	Crude Mortality Rate
Sep-20	110.59	115.00	3.55
Oct-20	120.75	115.17	3.88
Nov-20	138.80	132.13	3.23
Dec-20	122.47	105.69	3.86
Jan-21	150.41	127.59	4.66
Feb-21	133.48	100.20	3.83
Mar-21	104.37	103.62	3.16
Apr-21	80.84	87.28	2.21
May-21	113.24	115.23	2.97
Jun-21	116.43	117.56	2.67
Jul-21	121.45	124.40	2.87
Aug-21	123.12	104.61	2.90
Sep-21	115.00		2.51

KEY AREAS FOR ATTENTION

Covid-19 Deaths Dashboard

There have been a total of 794 Covid positive deaths in the hospital (to 07/01/22). Covid deaths are scrutinised by the medical examiners and escalated at SJRs in line with the Learning from Deaths Policy. Any Covid deaths associated with a hospital acquired infection are reported with an incident via Safeguard.

Non Covid excess death rate

There have been 294 non Covid related deaths in Q3 2021 as compared to 241 in Q1 2021. This is likely to reflect the more varied clinical presentations now being admitted as compared to the same time period last year.

MEDICAL EXAMINER UPDATE

Extending Medical Examiner scrutiny to non-acute settings

As reported in October, during 2021/22, the services provided by medical examiner offices will start to be extended beyond acute trusts to provide independent scrutiny of all non-coronial deaths, wherever they occur. Implementation of this next phase will happen incrementally, to allow time for capacity and processes to be put in place.

The Trust's Lead Medical Examiner has been meeting with the LMC to discuss the process for review of deaths with local GP representatives to move towards implementation of the service.

The recruitment process has commenced with the successful appointment of an additional Medical Examiner Officer. There is a requirement for a further MEO and the vacancy will be put back out to advert in January 2022. Recruitment for Medical Examiners was not successful and this will also be readvertised in January 2022. The Lead Medical Examiner is discussing the posts at meetings with LMC to encourage GPs to apply and become part of the process.

The Medical Examiner team continue their efforts to meet with Primary Care Networks and are seeking involvement from GPs to run a pilot prior to statutory implementation.

Accommodation

The refurbishment completed in December 2021 and the medical examiner team are expected to move into the new offices mid January 2022 following sign off of the work and furnishing of the offices.

The accommodation comprises of an open plan office which under current restrictions, has space for 6 members of the team. A separate side office has been allocated to the bereavement team and two other offices will accommodate medical examiners and clinicians completing death certificates.

This will provide the space for the team to provide an improved, more cohesive, service and will accommodate the additional staff needed for the introduction of community services.

LEARNING FROM DEATHS

Process for reviewing deaths in hospital

A number of reviews as referenced in the NQB guidelines as a minimal requirement undergo formal structured judgment review (SJR):

- All deaths where a bereaved family, carer or staff have raised a concern
- Patient deaths of those with a learning disability
- Patient deaths of those with a mental illness
- Unexpected deaths, such as following an elective procedure
- Particular groups where an alarm has been raised for example via HSMR, SHMI or CQC
- Deaths where learning will inform the providers quality improvement work
- All maternal deaths
- All child deaths, over 16 years of age
- All perinatal and still birth deaths.

Learning from deaths performance

The Trust has four medical examiners, two are anaesthetists and one is a microbiologist. Despite clinical pressures requiring these doctors to contribute to clinical care for Covid, the team have been able to maintain performance in scrutinising deaths with between 95-100% of deaths reviewed.

Figure 3: Learning from deaths (LfD) performance.

Completed SJR Review (AUG-DEC)	**35**
Number of Notes Delivered(AUG-DEC)	**42**
Total SJR Required (AUG-DEC)	**76**
SJR Outstanding (AUG-DEC)	**41**
Returned from Backlog(March-July)	**14**

The LfD Administrator continues to follow up SJRs and sends a monthly update to Mortality Leads advising them of outstanding SJRs in their specialty. A new reporting system is being developed which will have a RAG rating showing SJRs that are due, late or over 1 month late. This report can then be downloaded and sent to specialities regularly and enable us to easily recognise outstanding SJRs. Performance is reported to and monitored by the Mortality Surveillance Group

The administrator has attended care group meetings to provide training and updates and will continue to do so.

National Learning from Deaths Dashboard

- The Trust has adopted reporting via the National Learning from Deaths Dashboard (https://view.officeapps.live.com/op/view.aspx?src=https://www.england.nhs.uk/w

p-content/uploads/2017/03/nqb-learning-from-deathsdashboard.xlsm). In the last quarter, there have been 425 deaths at the Trust. In Q3, 26 SJRs have been completed. Care has been assessed as level 3a or below in 3 of these cases (table 3).

- Year to date; as assessed by SJR level 1 reviews, 0.5% of deaths were definitely avoidable, 0.9% strong evidence of avoidability, 8.2% were probably avoidable (more than 50/50), 24.6% probably not avoidable (less than 50/50), 55.7% probably not avoidable and 9.3% of deaths slight evidence or definitely not avoidable (table 4)

Table 3: National Dashboard Learning from Deaths Performance

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)					
Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3a)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
147	152	2	16	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
425	310	26	213	3	22
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1016	1649	244	543	25	45

Figure 4: Trend of Learning from Deaths Performance 2019-2021

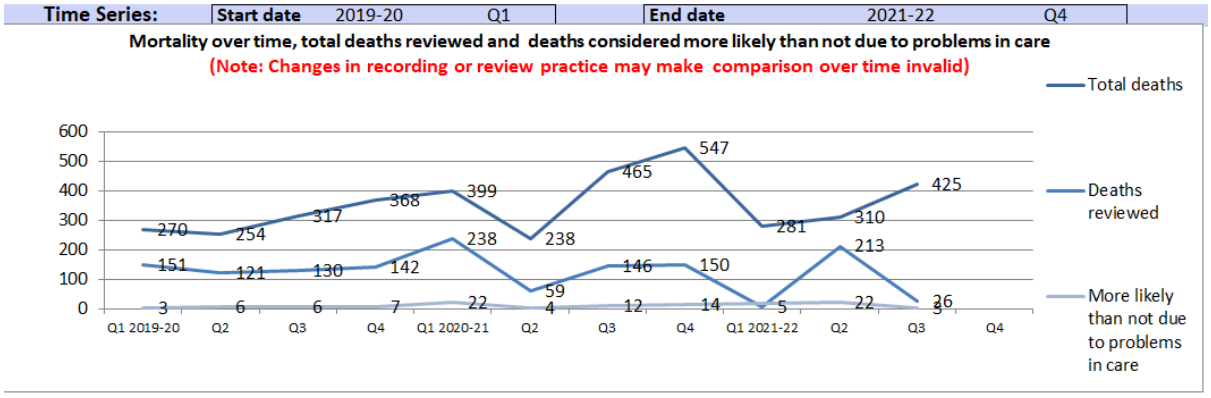


Table 4:

Total Deaths Reviewed, categorised by SJR Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3a Probably avoidable (more than 50:50)		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	1.0%	This Quarter (QTD)	1	3.8%
This Year (YTD)	1	0.5%	This Year (YTD)	4	1.6%	This Year (YTD)	20	8.2%

Score 3b Probably not avoidable (less than 50/50)			Score 4 Probably not avoidable			Score 5 Slight evidence or definitely not avoidable		
This Month	2	100.00%	This Month	4	200.0%	This Month	0	0.0%
This Quarter (QTD)	9	23.4%	This Quarter (QTD)	13	50.0%	This Quarter (QTD)	1	3.8%
This Year (YTD)	60	24.6%	This Year (YTD)	136	55.7%	This Year (YTD)	23	9.4%

Deaths of patients with a learning disability

There were 7 deaths of patients with learning disability in Q3 2021 (table 5). These deaths are reviewed as part of the LeDer review process.

Table 5: Deaths of patients with a learning disability

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable by RCP SJR score <=3a	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	3	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	2	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
12	14	5	14	0	0

Figure 5: Alerts and notifications

The following Trust alerts have been received from the National HED database.

INDICATOR NAME	PERIOD	VALUE
Hospital Standardised Mortality Ratio (HSMR) - 27 - Cancer of ovary	November 2020 - October 2021	496.23
Hospital Standardised Mortality Ratio (HSMR) - 29 - Cancer of prostate	November 2020 - October 2021	341.04
Hospital Standardised Mortality Ratio (HSMR) - 153 - Gastrointestinal hemorrhage	November 2020 - October 2021	214.12
Hospital Standardised Mortality Ratio (HSMR) - 13 - Cancer of stomach	November 2020 - October 2021	337.46
Hospital Standardised Mortality Ratio (HSMR) - 19 - Cancer of bronchus; lung	November 2020 - October 2021	180.32
Hospital Standardised Mortality Ratio (HSMR) - 42 - Secondary malignancies	November 2020 - October 2021	300.02

A deep dive into new alerts relating to cancer of bronchus and cancer of stomach have been requested, patient level data has been provided to the service to assist investigation. There is a technical issue with the HED database and patient level details are currently not available for the other alerts. This should be rectified by the end of January and details will be forwarded to relevant specialties to carry out deep dives.

Specialties have been asked to report at the next Mortality Surveillance Group with the results of the deep dive.

LEARNING FROM MORTALITY SURVEILLANCE GROUP

The Mortality Surveillance Group meets monthly to focus on the learning shared and implemented from the deaths within the speciality care groups. Each thematic focus group reports to the MSG quarterly.

Learning from Structured Judgments Reviews

Examples of learning from mortality reviews in the last quarter include:

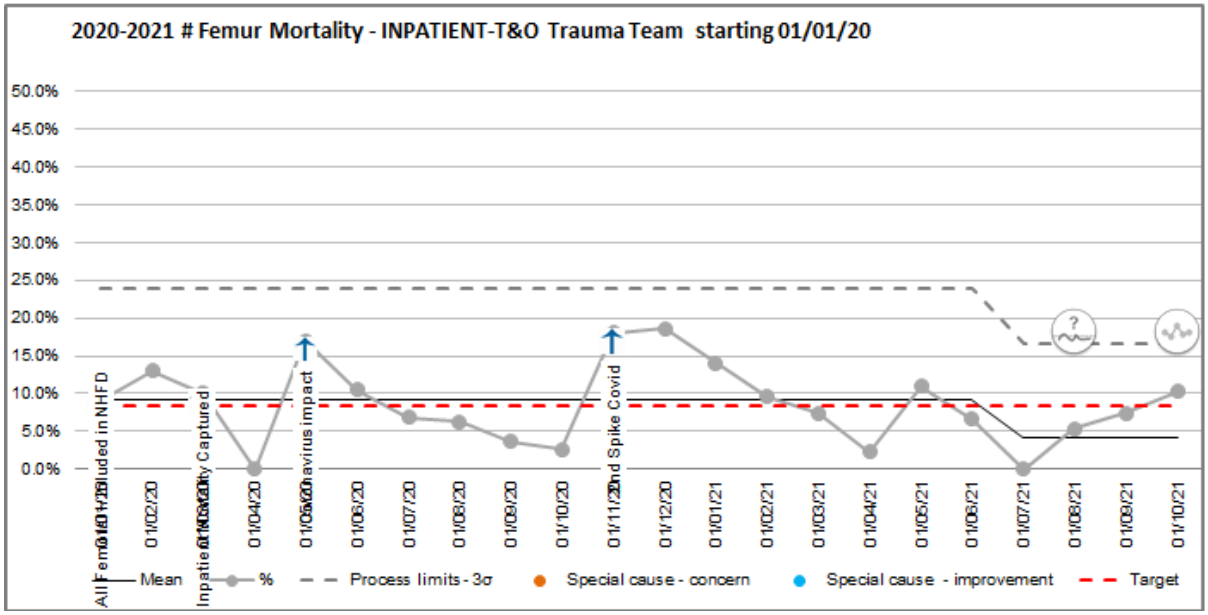
- Improvements to the fracture of femur pathways with Physiotherapy Plan to include a Band 7 and weekend cover
- Introduction of Suspected Community Acquired Pneumonia Pathway
- Pleural care improvement programme

QUARTERLY UPDATES FROM SHQC LEARNING FROM DEATHS THEMES

Fractured neck of femur

Monthly mortality from fractured neck of femur is tracked through MSG. For quarter 3, mortality rates remain stable (although the numbers have increased slightly, the SPC chart shows there is no cause for concern). However, the group will continue to monitor until there is a sustained reduction. Monthly Mortality - 2 deaths in September 7.4% and 1 death in October 2.8%.

Figure 4: Mortality from fractured neck of femur



National Cardiac Arrest Audit

The Resuscitation Officer reported on the NCAA (national clinical audit of in-hospital cardiac arrests in the UK and Ireland - a joint initiative between the Resuscitation Council (UK) and ICNARC).

The aims of the audit are to:

- improve patient outcomes;
- decrease incidence of avoidable cardiac arrests;
- decrease incidence of inappropriate resuscitation; and
- promote adoption and compliance with evidence-based practice.

The following actions are in place to improve reporting and management of cardiac arrests:

- ReSPECT-
  - Improve access to, and awareness of, training to improve confidence amongst staff, training has already commenced and is ongoing
  - Early conversations with patients to take place, if not already done in primary care setting. This will be in conjunction with the palliative care team (see comments below). This will prevent inappropriate resuscitation attempts.
- Data capture now includes cardiac arrest survivors

Pleural Care Improvement Programme

The Trust provides specialist management for the complete spectrum of pleural disease.

Geographical and population factors, such as occupational asbestos exposure, 17.6% smoking prevalence and 8% within the most deprived areas in England (PHE

Fingertips), result in an above average incidence of asbestos-related disease, malignant effusions and pleural infection.

Aims of the project: **For the Patient**; reduced time to diagnosis and definitive treatment; a hospital contact, with expert knowledge, for support and reassurance; and increased flexibility of care with minimised hospital attendances, admissions and LOS: **For the hospital;** improved patient flow, reduced admissions and LOS; Patients proactively pulled from the front door; early supported discharge; introduction of the tPA-DNase protocol in pleural infection: **For nursing staff;** develop new skills and autonomy leading to improved satisfaction and staff retention.

To achieve these aims, the following steps have been taken. The ambulatory pleural clinic started in 2020 with a pleural coordinator recruited at the start of 2020. A Pleural nurse was recruited and started in post in December 2021. The team is currently undergoing QIP training and pleural training completed in November 2021. The pleural lead consultant post is currently out to advert.

Pleural SOPs are being reviewed and rewritten where necessary.

Learning Disability

The learning disability team identified a number of areas for improvement, for example:

There needs to be a robust flagging and support system for patients with LD admitted to Walsall Manor Hospital, notification to LD nurses

- There needs to be evidence of more joined up approaches to inpatient and outpatient care so that patients with LD are not further disadvantaged by hospital admissions
- Hospital discharge planning needs to evidence that safety and wellbeing as well as holistic care needs have been weighed up adequately to prevent deterioration and readmission; this is particularly traumatic for people with LD whose experience of hospital may already be one associated with fear.
- Re-ablement therapy services must be able to evidence appropriate mitigations to support skill and mobility recovery in patients when face to face therapy may not be possible
- Standard of documentation / record keeping/ escalation of incidences
- Consideration of reasonable adjustments to enable care to be delivered- MCA application, Visiting (a communication should be issued to all wards and departments to remind them that reasonable adjustments should be made to enable people to be supported by family members or paid carers if necessary regardless of restrictions on general visiting)

In order to achieve these improvements the team will work towards better engagement with the intermediate care services group. An action plan will be monitored both externally and internally. To ensure standards are upheld, the team will carry out case note audits and work with the patient experience team. As part of

the improvement, redacted copies of LeDeR reviews will be sent to Trust mortality leads to ensure learning is shared.

Palliative Care

To understand palliative care in the Trust, a review of 8 colorectal deaths where palliative care was not involved was undertaken. 4 patients died on ITU after appropriate efforts to save their lives, 2 died on surgical wards after prolonged post-operative stays and 2 died on medical wards having presented with metastatic disease

This identified that if a patient is 'sick enough to die' then the treating team should consider whether continuing active treatment is the right thing to do and ask what good might it cause and/or what harm might it cause?

If a patient is dying, then this needs to be included in the notes. Even if a patient is dying they have needs, options and choices. By not discussing the situation these choices are denied.

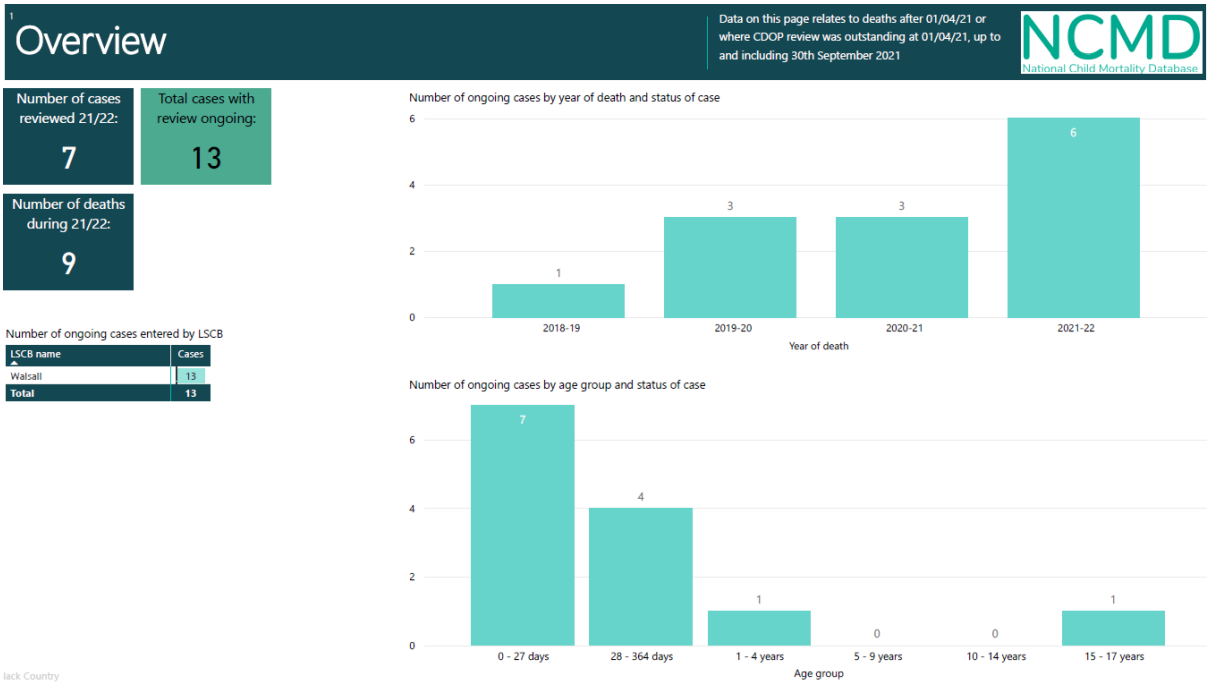
In order to improve palliative care, specialties need to ensure they involve the palliative care team as soon as it is recognised a patient is dying and DNAR completed early in treatment.

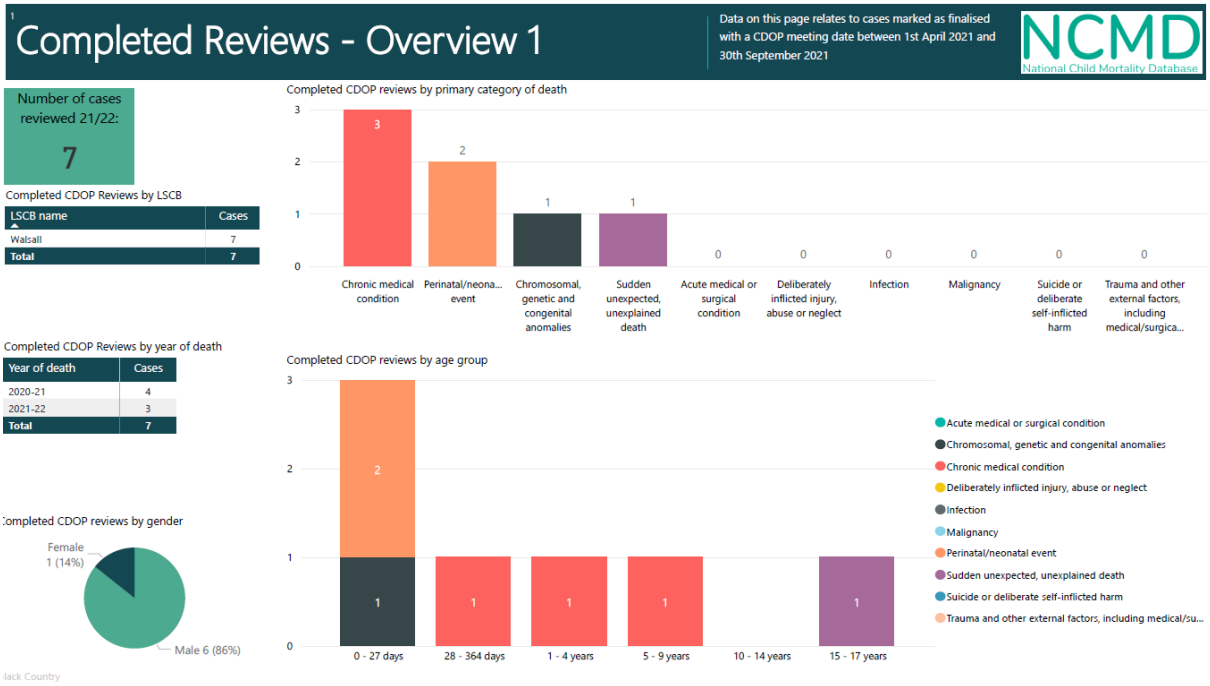
The palliative team have been asked to ensure staff are aware of the outcome of the review and to provide training if necessary. The team will report back to the Mortality Surveillance Group with an update and assurance that the above is now in place.

QUARTERLY REPORTS

Child deaths report

The trust reviews child deaths through the Black Country Child Deaths programme (CDOP).





As at November 2021 there were 13 child death reviews outstanding

- 3 are awaiting police investigations
- 1 are awaiting coroners inquests
- 1 awaiting SI completion
- 4 awaiting PMRT from elsewhere
- 2 awaiting PMRT from here
- 2 ongoing

Recommendation:
When a child/young person dies on an adult ward/ Intensive Care Unit.

- Notification of the child death should go to the child health system, GP, local CDR partners and CDOP office and the designated doctor for child deaths. The Designated Doctor for Child Deaths should ensure that the adult Morbidity & Mortality meeting completes a standardised Analysis Form for the purposes of the relevant CDOP with any other notes.

The recommendation will be followed up by the Mortality Lead and assurance reported to the Mortality Surveillance Group.

Perinatal mortality report

In Q3 2021, 8 cases were eligible for review by the National Perinatal Mortality Review Tool as shown in table 6 below

Table 6:

For Information – Ongoing Reviews (information as of 12.11.21)

Reporting Period	Deaths eligible for review by PMRT	No Reported to Coroner	PMRT Reviews commenced within 2 months (standard = 95%)	No of deaths reviewed by MDT (at PNMM) within 4 months)	No PNMM draft reports within 4 months (standard = 50%)	PMRT validated report within 6 months (standard = 50%)	No of parents involved in review (standard = 95%)	No of SI/RCA/ Concise/ HSIB	No of complaints
Q3 2021	8	0	8 (100%)	8 (100%)	8 (100%)	8(100 %)	8	2	0

* Reports have been finalised pending final post mortem repots, placental cytogenetic reports and placental histology reports.

Lessons:

- The PMRT enables the review team to identify contributory factors (task/ organisational / staff / patient), to any issues found during the review and to develop action points to address any issues with care.
- Points identified as part of the initial MDT review and the monthly Perinatal Mortality and Morbidity Meeting can be incorporated into lessons learnt where relevant.

Assurance

- All elements of Saving Babies Lives Care Bundle have been implemented achieving SNSR safety action 6 for 2021.
- All eligible cases are referred to HSIB with a low lack of family agreement rate. There have been no repeat themes reported by HSIB for the Trust this quarter.
- All cases are reviewed through PMRT with external obstetrician and neonatologist input.
  There is an improvement project within antenatal clinic to improve access to preterm prevention clinic and review clinical templates and job plan for consultants

Top 5 themes for improvement

	Issue	Aim	Method	Results
1	CTG Interpretation	To provide refresher training to clinicians undertaking CTG monitoring	1:1 Training led by the CTG Lead Midwife & Continuing development Midwife	1:1 Refresher training rolled out and workbook provided. Guides to CTG interpretation put up in all clinical areas
2	Risk Assessments on Admission & Intrapartum	Ensure Risk assessments are being completed on Admission and In the Intrapartum Period.	Email to be distributed to all clinicians – reminder to complete Risk Assessments. Risk Assessment s to be made mandatory in Badgernet.	- Email sent to all clinicians working on delivery suite to remind them the important of completing Risk assessments on admission and in the intrapartum period and that this is a mandatory field. - Working with Digital Lead Midwife to make Antenatal & Intrapartum Risk Assessments a mandatory field in Badernet. - This is already on the Bereavement checklists to remind staff - To be audited on a monthly basis via PMRT by the SPMW Bereavement.
3	Maternity Triage	To improve the safety of women attending maternity triage and amend the staffing model.	To implement BSOTS (Birmingham Symptom Specific Obstetric Triage System)	- BSOTS Implemented 08/11.2021 - Core staff members have received training - Training is being rolled out to other Midwives via Microsoft teams and also badger net training (IT)

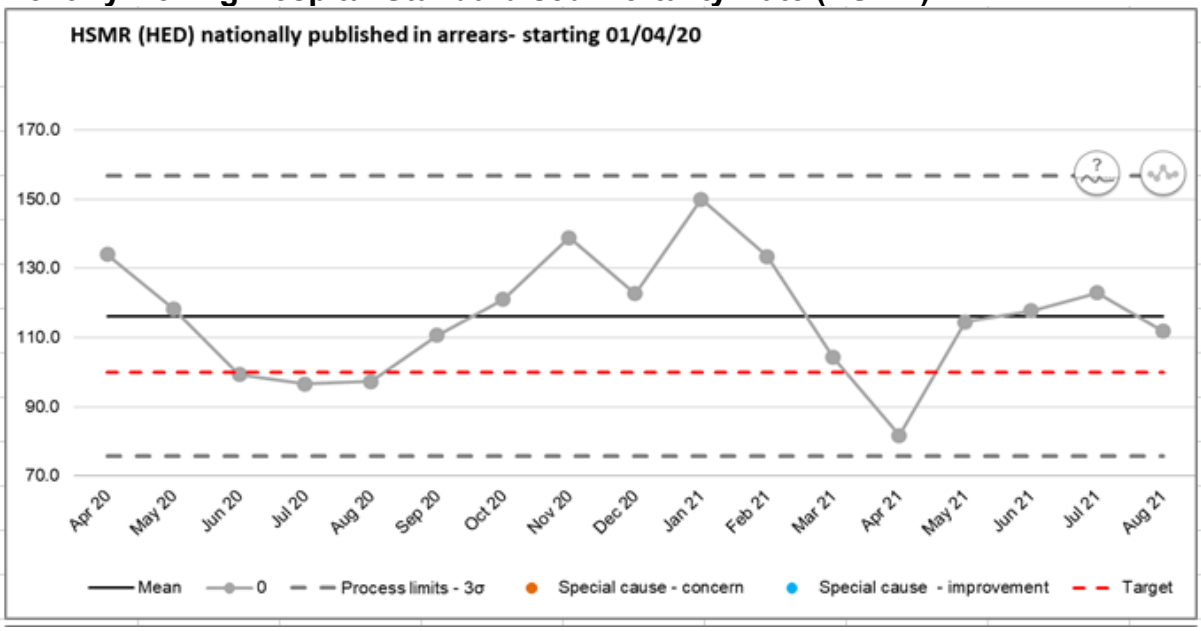
Top 5 themes of sharing good practice

	Issue	Aim	Method	Results
1	Maternity Triage	To improve the safety of women attending maternity triage and amend the staffing model.	To implement BSOTS (Birmingham Symptom Specific Obstetric Triage System)	- BSOTS Implemented 08/11.2021 - Core staff members have received training - Training is being rolled out to other Midwives via Microsoft teams and also badger net training (IT)
2	Involving Parents in the Perinatal Review Process	Provide parents with written information about the Perinatal review process	Create & introduce a leaflet into bereavement services	- Leaflet created and implemented *This is a recommendation from the National PMRT Repot 2020

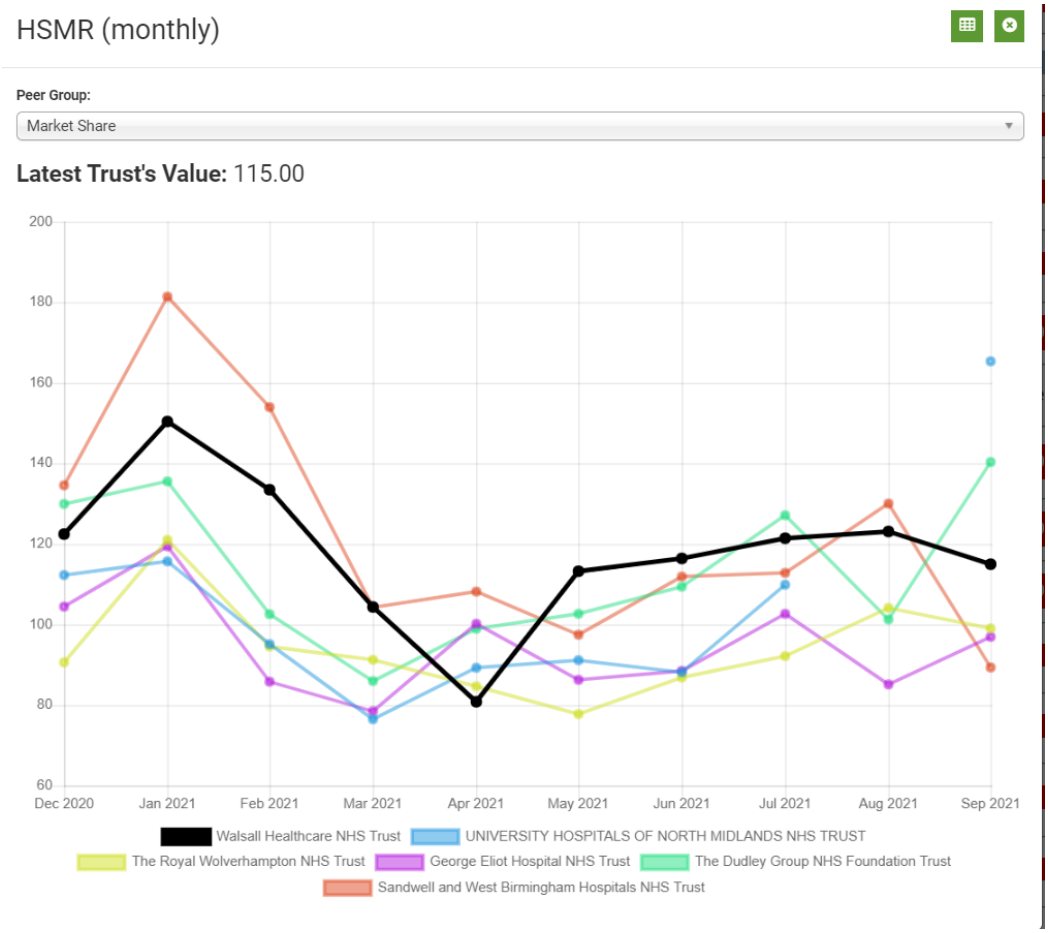
END OF REPORT

Appendices

Monthly Rolling Hospital Standardised Mortality Rate (HSMR)

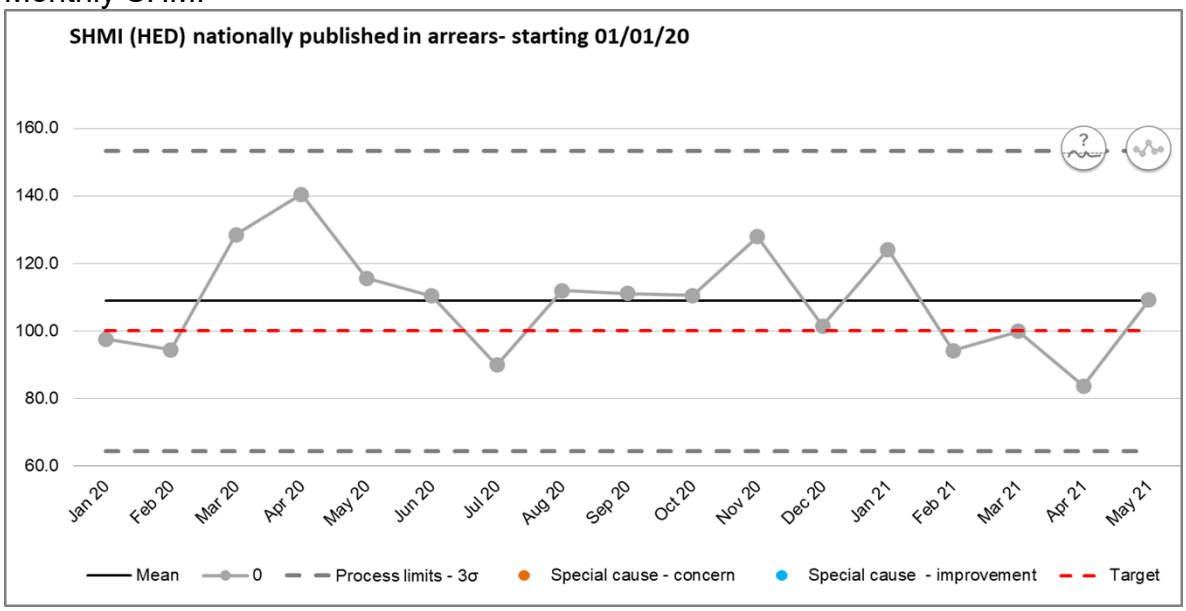


Market Benchmark HSMR



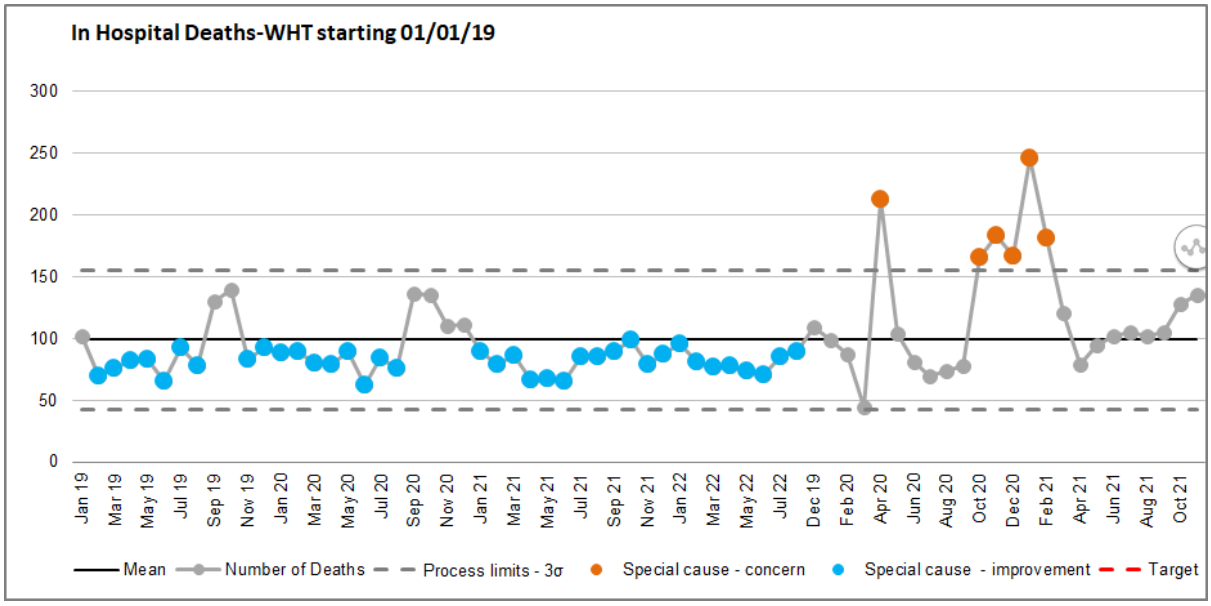
Standardised Hospital Mortality Index (SHMI)

Monthly SHMI

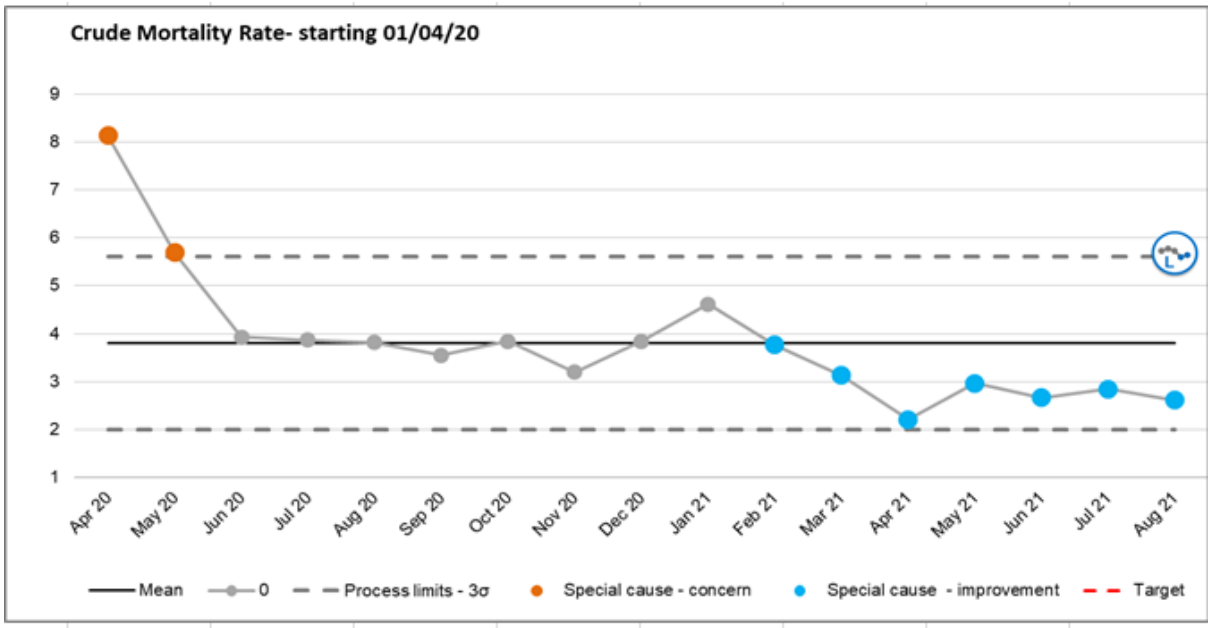


Market Benchmark SHMI

In Hospital Deaths



Crude Mortality June 2020 – June 2021 (deaths per 1000)


Crude Mortality Rate- starting 01/04/20
9
8
7
6
5
4
3
2
1
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Mean
0
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Glossary of Terms

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

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 2nd February 2022**			
Patient Relations and Experience Quarter 3 Report – Oct-Dec 2021			**AGENDA ITEM: 14**
Report Author and Job Title:	Garry Perry Associate Director Patient Relations and Experience	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	The Trust average compliance rate (response timeframes) for Quarter 3 was 93%. This is an increase of 24% when compared to the previous quarter, which was 69%.		
Advise	The Friends and Family Test hierarchy is being amended to better effect near time action to real time feedback. Members of the Patient Experience team have been assigned as support to areas where data collection is a problem.		
Alert	No issue of risk/concern this quarter		
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/or 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 ☐		

Patient Relations and Experience Quarter 3 Report (Oct-December 2021)

1. PURPOSE OF REPORT

To provide activity data for the Patient Relations and Experience Team including Complaints, Concerns, Compliments and the Friends and Family Test (FFT) for quarter 3, 2021/2022. The report also provides detail on learning taken and a summary of enhanced activity to support a positive Patient Experience.

The Patient Experience Highlight Report can be found in appendix 1.

2. BACKGROUND

A report on patient and carer experiences is presented to the Quality Patient Experience and Safety Sub-Committee quarterly and the Board of Directors as part of the series of quality reports. This report focuses on patient and carer experiences and how people are involved in shaping service developments. Feedback identifies themes for improvement and learning arising from outcomes.

3. DETAILS

The Trust received a total of 6919 feedback contacts throughout quarter 3. This figure includes 5763 friends and family test responses and 1156 contacts through Patient Relations received as Complaints (96), Concerns (713), Queries (165),Comments/Suggestions (52).130 Compliments were also received. The division of Medicine accounts for 35% of all contacts, 32% Surgery, 14% Women's, Children's and Clinical Support Services and 8% Community.

The Trust average compliance rate (response timeframes) for Quarter 3 was 93%. This is an increase of 24% when compared to the previous quarter, which was 69%.

The top 3 trends for complaints and concerns relate to clinical care, assessment and treatment, appointments and access with the majority of these contacts being in regard to call handling issues.

The Friends and Family Test (FFT) has shown improvement in recommendation scores for Outpatients (month on month comparison increasing from 89-91%, 1% above local Trusts), the Emergency Department 76-80% and an improvement of 4% over the last quarter – this is 9% above the STP, and 2% above national averages and 10% above local comparable data.

Antenatal has demonstrated a 6% increase on quarter 2 – slightly above STP average and although still below national averages is 11% above local comparable data.

Post-natal community FFT has an overall recommended score of 67% which is an increase of 37% on quarter 2 although below local, STP and National averages.

Community services score is 95% - a 1% increase on quarter 2 but above both the STP, National and local averages. FFT recommended scores for in-patients was 85% a 1% decrease on quarter 2, birth 82% a 5% decrease and 79% and a 7% decrease for postnatal ward. Themes mirrored I both positive and negative themes include attitude, implementation of care, communication and environment.

Learning from feedback and the changes made is shared with team and widely across the Trust. Details of improvements in care delivery following patient feedback and lessons learnt from complaints are included in the quarterly Learning Matters bulletin.
.
The team continually strive to develop and innovate and in the last quarter have initiated food surveys, mystery shopping feedback and analysis, and overseen the supportive visiting process which to date has delivered 2323 parcels to patients, 1397 video calls and 653 compassionate visits.

Our newly formed Patient Involvement Partners (PIP's) have met and will support teams as they seek to shape, change and improve services. PIP's will become active members of the Patient Experience Group and will also support the implementation and development of actions arising from National Surveys.

In the last quarter 1955 volunteer hours were recorded with three volunteers contributing a total of 671 hours between them. These hours are the equivalent of 261 full time working days and based on AFC Band 2 hours - £18,000.

In November the team were awarded £25,000 from the NHSE Voluntary Services Fund. The Trust has partnered with Manor Farm Community Association who have provided involvement and support in developing new volunteer roles and overseeing the transfer of the former Wingman Lounge to the new Manor Staff Well-being Lounge which opened in January 2022.

End of report

Caring for Walsall together

Safe, high quality care

Care at home

Partners

Value colleagues

Resources

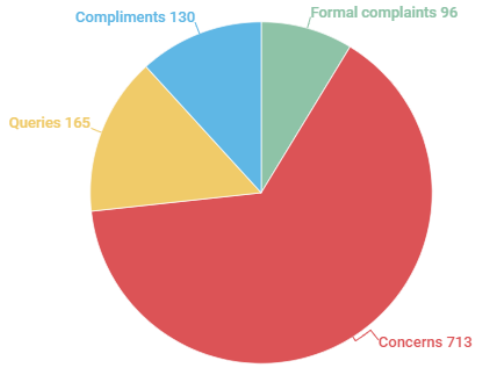
Respect
Compassion
Professionalism
Teamwork

Walsall Healthcare NHS Trust

Quarter 3 Patient Relations Report October 2021 – September 2021

1.0 Summary of concerns received

96 Formal complaints were received across all divisions in Quarter 3, with 713 concerns and 165 queries raised. The Trust received 130 compliments. These, along with family liaison, comments/suggestions and other contacts give a total of 1156 contacts received.



2.0 Timeframe compliance

The Trust average compliance rate for Quarter 3 was 93%. This is an increase of 24% when compared to the previous quarter, which was 69%.

3.0 Complaints Trends (Top 3)

The highest number of contacts received was in relation to Clinical Care / Assessment / Treatment with 273 contacts being received, which is an increase of 44 when compared to the previous quarter. Of the 273 contacts received, 192 were logged as treatment advice/ issues and 26 were logged as treatment/care/supervision – inadequate. The highest departmental trend was the Emergency Department with 21 contacts received.

The second highest number of contacts received was in relation to appointments, with 245 being received. This is an increase of 37 when compared with the previous quarter. Of the 245 contacts received, 132 were logged as appointment query/advice and 60 were logged as appointment - cancelled. The highest departmental trend was Trauma & Orthopaedics with 38 contacts received.

Access contacts were the third highest number of contacts received with 159 contacts received. This is an increase of 95 contacts when compared with the previous quarter. 133 of these contacts were logged as call handling issues. AMU received the highest amount of contacts with 25, followed by Ward 14 with 16.

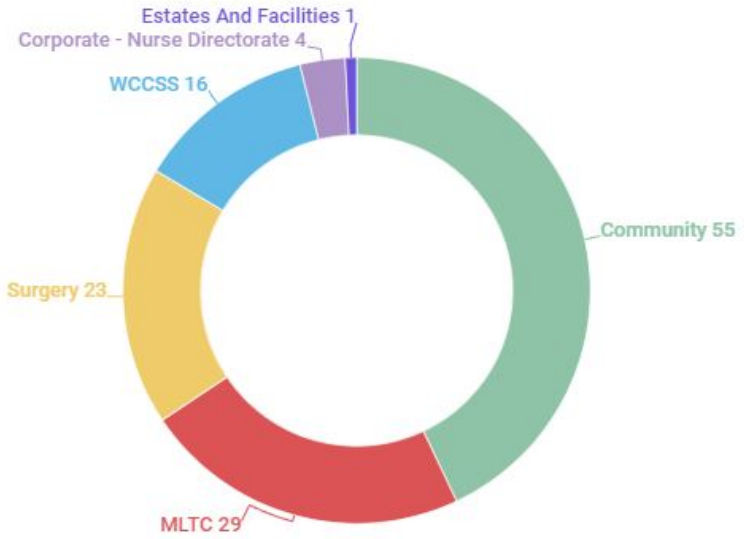
Quarter 3 Patient Relations Report October 2021 – September 2021

1.1 Highlights

128 Compliments were received in Quarter 3. Some examples of the compliments are reflected below:

Surgery

Patient complimented staff member in audiology and said how helpful and professional she was. She certainly went the extra mile to sort her hearing aids out and was very thorough in her actions. Patient said she is a credit to the department and she would like to thank her for her help



Community

Dear cannock stroke team

A huge thank you to you all. The past 5 weeks have been fabulous and i will be sad to say goodbye. You are not only amazing of what you do, but each of you are amazing people. It was a pleasure to work alongside you.

I will carry you all in my heart as I continue my physio journey and will pop by to say hello whenever I can with chocolate in tow

MLTC

I attended the A&E department via ambulance on the evening of Tues 28th Sept with stomach pain and vomiting. I wish to express my thanks for the service i received. The Nurses were professional, caring and attentive. The doctor was thorough and having carried out an examination, sat and explained possible causes and action needed. whilst waiting to be seen I was struck by the friendly atmosphere of the staff who were working hard but remained cheerful. They were attentive and caring towards other patients, checking on them regularly. I would like to express my thanks to the staff as i'm sure they do not get the credit that they deserve. Thank you.

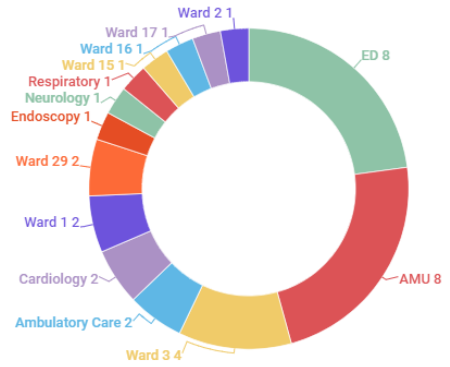
WCCSS

I just wanted to say how grateful I am for the EPAU department, I'm currently 19 weeks pregnant and been a regular visitor (since 7 weeks) due to hypremesis, the staff cannot do enough to put you at ease. I'd especially like to thank S & E they have both been fantastic. Absolutely amazing team, what the NHS should be proud of.

Quarter 3 Patient Relations Report October 2021 – September 2021

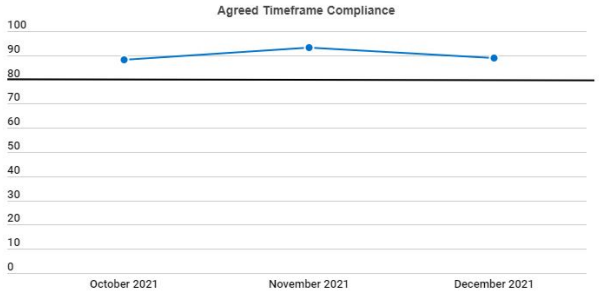
2.0 Complaint breakdown by division

Medicine & Long Term Conditions



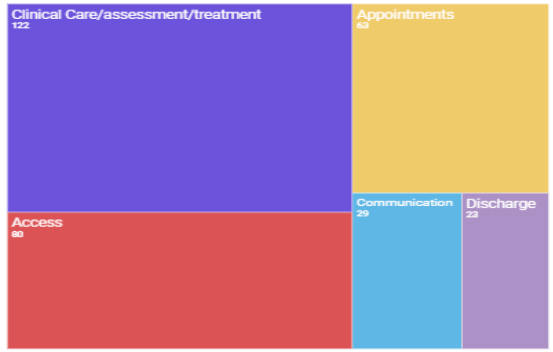
Summary of Concerns Received

35 Formal complaints were received for MLTC in Quarter 3. There were a total of 304 concerns and 32 queries received. 29 compliments were received for the division. These contacts, along with family liaison, comments/suggestions and other contacts give a total of 406 contacts received for the division.



Divisional Compliance

The divisions average response rate compliance for Quarter 3 was 90%. This is a 42% increase when compared to the previous quarter (48%).



Top trends at a glance

The highest number of contacts received were in relation to Clinical Care / Assessment / Treatment with 122 contacts being received. Of the 122 contacts received, 21 were in relation to the care provided in the ED, with 20 received for AMU. The second highest trend were logged as Access Issues with 80 contacts received, 75 were in relation to call handing issues, with AMU being the highest departmental trend with 25 contacts.

Learning Matters

A concern was raised regarding the level of care a patient received on AMU and Ward 7. During the investigation it was identified that communication was poor in relation medication on discharge. The family stated that they were contacted to attend the ward to collect the patient's medication, however on arrival there was no recollection from staff regarding this conversation. This led to the patient leaving Ward 7 without her medication, albeit at the request of the family. It was agreed as part of our formal complaint response that the complaint handler would review the process around patient's being discharged without medication, and it is now process that patients do not leave the ward without their TTO's

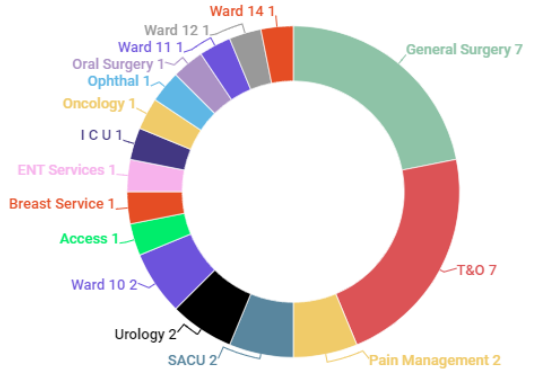
Walsall Healthcare NHS Trust

Quarter 3 Patient Relations Report October 2021 – September 2021

Surgery

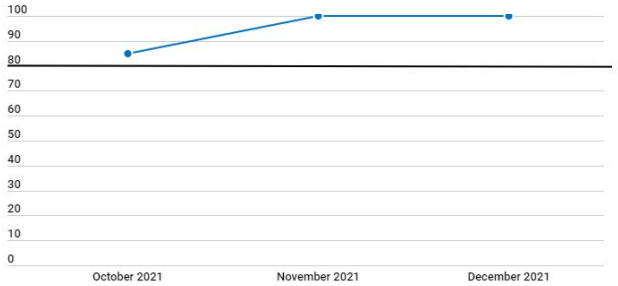
Summary of Concerns Received

32 Formal complaints were received for Surgery in Quarter 3. There were a total of 265 concerns and 45 queries received. 23 compliments were received for the division. These contacts, along with family liaison, comments/suggestions and other contacts give a total of 372 contacts received for the division.



Divisional Compliance

The divisions average response rate compliance for Quarter 3 was 95%. This is a 20% increase when compared to the previous quarter (75%).



Top trends at a glance

The highest number of contacts received were in relation to Appointments with 125 contacts being received. Of the 125 contacts received, 26 were in relation to ENT and 25 in relation to Trauma & Orthopaedics. 68 contacts received were in relation to Appointment – query/advice and 35 contacts were in relation to cancelled appointments.

Learning Matters

A concern was raised regarding conflicting information being provided by the medical team. The patient was also discharged without medication and a follow- up appointment. When the patient was followed up by a consultant he was informed he required an operation and the brace that had been fitted in the Emergency Department was fitted incorrectly. The patient eventually had the procedure and now has radial nerve palsy to his right hand. Following the investigation, it was agreed that the T&O department would ensure all medical staff are trained in how to apply a humeral brace to prevent any further occurrence in the future. It was also agreed that the team would set up a Virtual Fracture Clinic to ensure patients are seen by the right consultant, at the right time and in the right place.

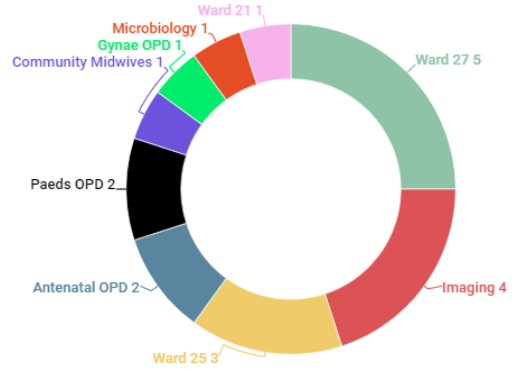
Walsall Healthcare NHS
NHS Trust

Quarter 3 Patient Relations Report October 2021 – September 2021

Womens, Childrens & Clinical Support Services

Summary of Concerns Received

20 Formal complaints were received for WCCSS in Quarter 3. There were a total of 95 concerns and 24 queries received. 16 compliments were received for the division. These contacts, along with family liaison, comments/suggestions and other contacts give a total of 158 contacts received for the division.

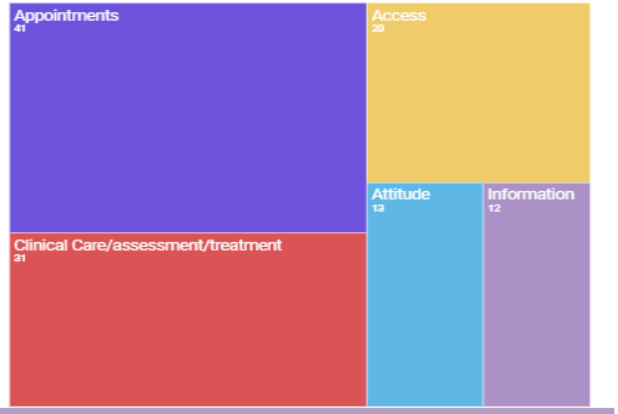


Divisional Compliance

The divisions average response rate compliance for Quarter 3 was 100%. WCCSS has maintained a 100% compliance rate for 12 consecutive months.

Top trends at a glance

The highest number of contacts received were in relation to Appointments with 41 contacts being received. Of the 41 contacts received, 17 were in relation to imaging appointment queries. 28 contacts were logged as appointment queries overall with the majority of contacts relating to cancelled appointments / chasing appointments.



Learning Matters

A concern was raised in relation to the delivery of the patient's baby. The complainant felt she was forced into a sweep and her requests were not honoured. Ultimately, this led to the patient feeling pressured into decisions she did not wish to make. Following the investigation, it was agreed that the team would review how information is relayed, as well as conducting a review of the informed consent policy. A face to face debrief took place with the family and she was invited to the Maternity Voice partnership to support the improvement of our services going forward. The team also agreed to explore a birth trauma clinic alongside the HIPS team mental health midwife and service user.

Walsall Healthcare NHS Trust

Quarter 3 Patient Relations Report October 2021 – September 2021

Summary of Concerns Received

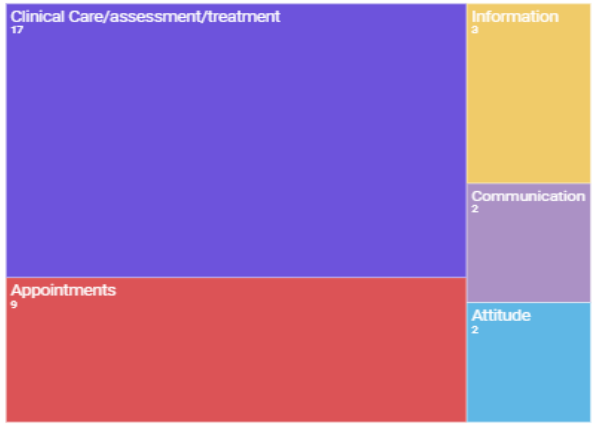
4 Formal complaints were received for Community division in Quarter 3. There were a total of 25 concerns and 7 queries received. 55 compliments were received for the division in Quarter 3. These contacts, along with family liaison, comments / suggestions and other contacts total of 92 contacts received for the division.

Divisional Compliance

Community Division had no formal complaint responses due out in Quarter 3.

Top trends at a glance

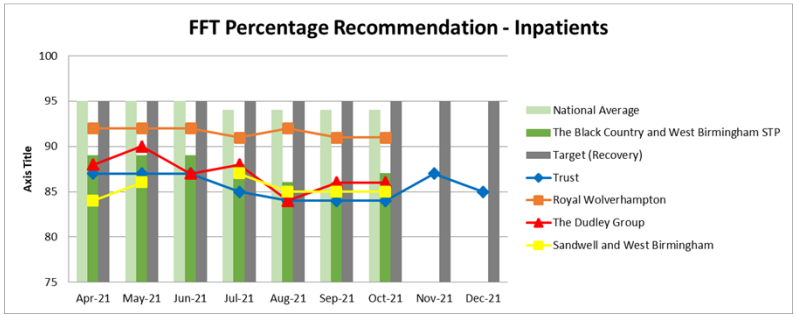
The highest number of contacts received were in relation to Clinical care / Assessment / Treatment with 17 contacts being received. Of the 17 contacts received, 3 were in relation to the Saddler Vaccination Hub. Of the 3 contacts received, 2 reference a query regarding vaccination eligibility/timeframe. The second highest number of contacts were in relation to appointments with 9 contacts being received. Of the 9 contacts received in relation to appointments, 3 were relating to Adult Physiotherapy.



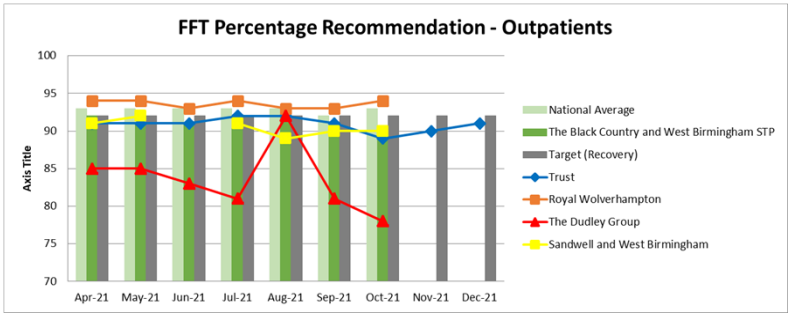
Learning Matters

Concerns were raised regarding the poor attitude of a member of the Health Visiting Team. Concerns were also raised regarding the complainant's baby's head being recorded incorrectly. Following the investigation into the concerns raised, the team agreed to conduct a review of processes for recording visit information in the absence of a patient's red book. It was also agreed that the member of staff involved would undergo additional training in relation to infant feeding advice and customer care. The final action was that the complaint would be anonymised and shared with the service team for educational purposes.

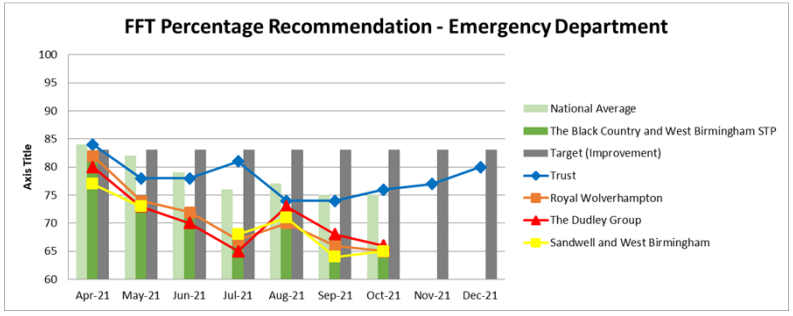
National, regional and comparable Trust data is as reported on the FFT NHS website and delayed by 2-3 months due to FFT reporting time lag.



5.1 Inpatients. The average inpatients FFT recommendation for Q3 was 85%. This is a 1% decrease on Q2. This score is based on 2952 responses, a response rate of 19.5% and a reduction of 1.7% on Q2. Response methods used include mobile SMS, IVM and tablet. Compared to Q2 STP and national FFT scores, the Trust is 2% below the STP and 9% below the national average. Compared to RWT, SWB and TDG, which together average a score of 88% over Q2, the Trust is 3% below when compared to Q3 Trust data. The top 3 positive themes were staff attitude, implementation of care and environment. This is also mirrored in the negative themes. The themes were the same in Q2.



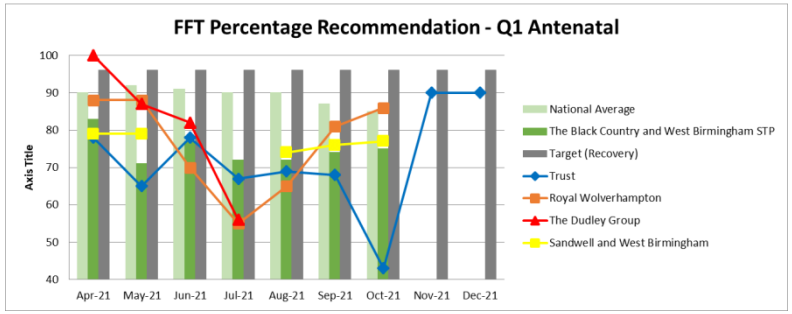
5.2 Outpatients. The average outpatients FFT recommendation for Q3 was 90%. This is a 2% decrease on Q2, however, has shown improvement month on month increasing from 89% to 91%. This score is based on 5405 responses, a response rate of 14.8% and a decrease of 0.7% on Q2. Response methods include mobile SMS, IVM and tablet. Compared to the Q2 STP and national FFT scores, the Trust is 1% below the STP and 3% below the national average. Compared to SWB, TDG and RWH, which together average a score of 89% over Q2, the Trust is 1% above when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, implementation of care and environment. The top 3 negative themes were staff attitude, environment and communication. The themes were the same in Q2.



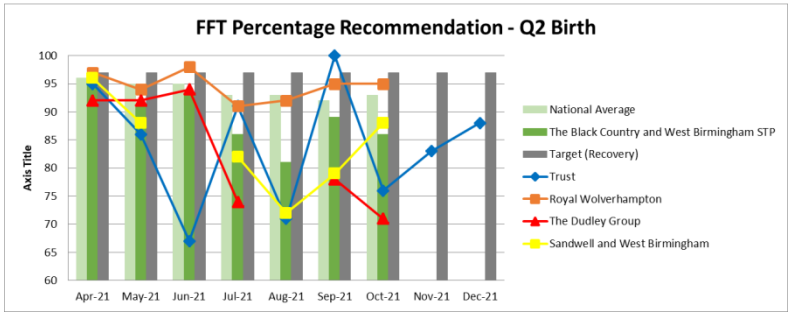
5.3 Emergency Department. The average emergency department FFT recommendation score for Q3 was 78%. This score has shown improvement over the quarter from 76% in October to 80% in December,

an improvement of 4% over the quarter and an average improvement of 2% on Q2. This score is based on 1343 responses, a response rate of 14.6% and a decrease of 0.6% on Q2. Response methods include mobile SMS and IVM. Compared to the Q2 STP and national FFT scores, the Trust is 9% above the STP and 2% above the national averages. Compared to SWB, TDG and RWH, which together average a score of 68% over Q2, the Trust is 10% above when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, clinical treatment and waiting time. The top 3 negative themes are waiting time, staff attitude and communication.

5.4 Maternity Services

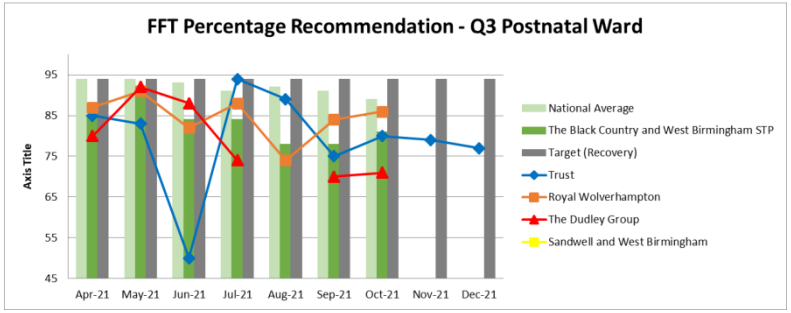


The average **antenatal** FFT recommendation score for Q3 was 74%. This is a 6% increase on Q2. This score is based on 41 responses, a response rate of 4.4% and a decrease of 1.2% on Q2. Response method used is mobile SMS. Compared to Q2 STP and National FFT scores, the Trust is 1% above the STP and 15% below the national averages. Compared to SWB, TDG and RWH, which together average a score of 63% over Q2, the Trust is 11% above when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, implementation of care and communication. The top 3 negative themes were staff attitude, patient mood/feeling and environment.

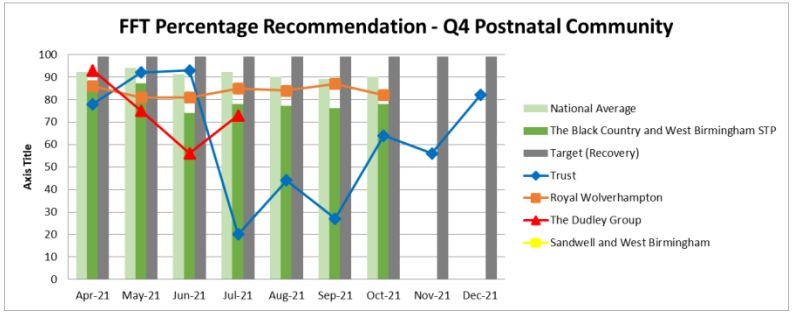


The average **birth** FFT recommendation score for Q3 was 82%. This is a 5% decrease on Q2 average. The Q2 score has shown month on month increase from 76% to 88%. This score is based on 84 responses, a

response rate of 12.4%. The total number of responses has reminded similar to Q2; however has shown a reduction in the response rate of 0.8%. Response method used is mobile SMS. Compared to Q2 STP and national FFT scores, the Trust is 3% below the STP and 11% below the national averages. Compared to SWB, TDG and RWH, which together average a score of 83% over Q2, the Trust is 1% below when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, implementation of care and patient mood/feeling. The top 3 negative themes were staff attitude, patient mood/feeling and communication.

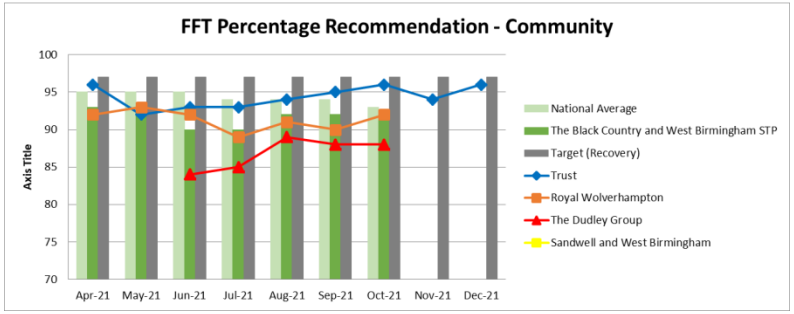


The average **postnatal ward** FFT recommendation score for Q2 was 79%, this is a 7% decrease on Q2. This score is based on 50 responses, a response rate of 7.3% and a reduction of 1.1%. Response method used is mobile SMS. Compared to Q2 STP and national FFT scores, the Trust is 1% below the STP and 12% below the national averages. Compared to SWB, TDG and RWH, which together average a score of 78% over Q2, the Trust is 1% above when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, implementation of care and environment. The top 3 negative themes were communication, environment and patient mood/feeling.



The average **postnatal community** FFT recommendation score for Q2 was 67%. This is an increase of 37% on Q2. The score has fluctuated over the period between 56% and 82%. This score is based on 44

responses, a response rate of 5.8% and an increase of 1.3% on Q2. Response methods used are mobile SMS and IVM. Compared to Q2 STP and national FFT scores, the Trust is 13% below the STP and 24% below the national averages. Compared to TDG and RWH (no data reported for SWB), which together average a score of 78% over Q2, the Trust is 11% below when compared to Q3 Trust data. The top 3 positive themes were staff attitude, patient mood/feeling and communication. The top 3 negative themes were implementation of care, communication and staff attitude.

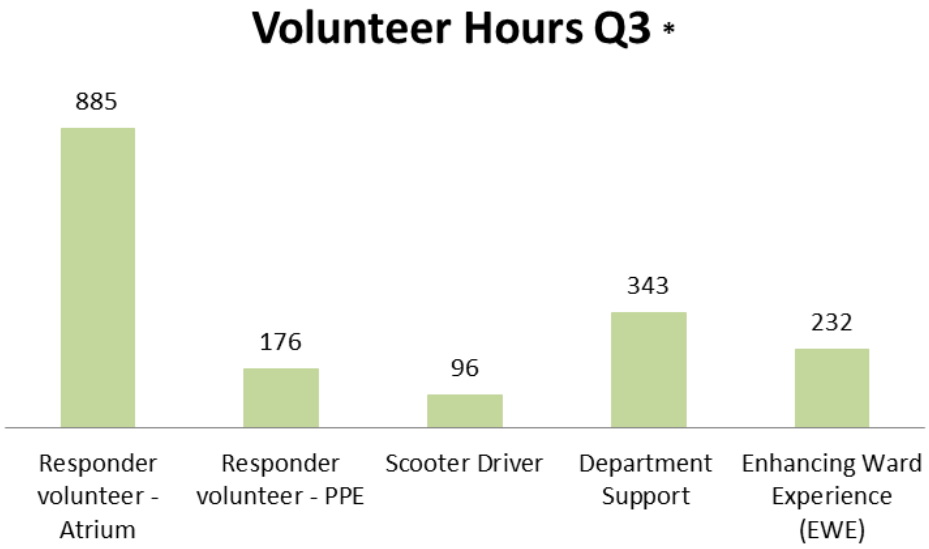


5.5 Community Services. The average community FFT recommendation score for Q3 was 95%, a 1% increase on Q2 score. This score is based on 1249 responses, a response rate of 7% and a decrease of 2%. Compared to Q2 STP and national FFT data the Trust is 4% above the STP, and 1% above the national averages. Compared to TDG and RWH (no data reported for SWB), which together average a score of 89% over Q2, the Trust is 6% above when compared to Q3 Trust data. The top 3 Positive themes were staff attitude, implementation of care and patient mood/feeling, this is mirrored in the top 3 negative themes and is the same as Q2.

6. Voluntary Services

Total hours recorded	1955hrs
Hours recorded (1st)	245hrs
Hours recorded (2nd)	224hrs
Hours recorded (3rd)	202hrs

Full time working days equivalent	261 Days
Staff cost equivalent (Based on AfC B2)	£18,000



*Key areas, not all volunteer roles

The Manor Lounge

Staff wellbeing lounge opened in partnership with Project Wingman and Manor Farm CA

Located near Ward 29

Supported by the voluntary services fund 2021

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Use Resources Well Executive Report			**AGENDA ITEM: 16**
Report Author and Job Title:	William Roberts, Acting 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. This report recognises the financial arrangements within which the Trust is operating during the 2021/22 financial year, a result of the impact of the COVID-19 pandemic. The Trust delivered a surplus for Horizon 1 – H1 (April to September 2021) of £0.01m following receipt of £0.95m from the Sustainability and Transformation Partnership (STP) from the risk share agreement (a result of increased attendance and ambulance conveyances contributing to high levels of temporary workforce). The Trust also negotiated in H1 receipt of STP capital slippage, the resources sufficient to mitigate the risk to overspends contained within the capital programme, financing the essential ward refurbishment works commenced in year. The report then focuses upon Horizon 2 (H2) October 2021 to March 2022. Expenditure run rate plans developed and owned by Operational teams, to include provision for both investments (Nursing establishment an example) and winter initiatives as endorsed by Board colleagues. The primary risks to delivery of H2 Operational plans within resource envelopes centred upon (a) Securing an income settlement that would offset projected run rate costs (b) Agency cessation aligns to Nurse Investment business case (c) delivery of efficiencies at 1.6% of H1 (d) additional costs exposure over winter The H2 financial plan (October 2021 to March 2022) was endorsed		

	through Executive, Trust Management Committee, Performance, Finance and Investment Committee (PFIC) and Trust Board. The Trust secured an appropriate income settlement and Urgent and Emergency Care demands remain below planned levels. As such, the Trust has attained a small surplus of £0.283m to 31st December 2021. Should demand continue at these levels it is expected the Trust will attain a small surplus, delivering plan at close of the financial year. The STP also forecasting break-even. The report then focuses upon 2022/23 planning (1st April 2022 to 31st March 2023) key risks to financial sustainability centring upon income settlement, delivery of efficiencies and cessation of agency use from during April 2022. The STP has confirmed resource allocations for the 2022/23 financial year that include a 1.1% efficiency ask and reduction of Covid-19 designated funding by 57% (c£80m for the STP) provider allocations are yet to be determined. The Operational teams have been working on development of the expenditure baseline (normalised) exit run rate for March 2022 for when we enter 2022/23. March 2022 planned expenditure totalling c£29m, c£26.2m as a normalised expenditure position. NHSEI has released initial planning guidance, though this moves submission deadlines from February 2022 to April 2022 for 2022/23 plans. Further guidance is expected in relation to submission deadlines. The report identifies continued strong operational performance. Emergency care performance has been maintained as strong relative to the rest of the NHS. The Trust continues to deliver the best Ambulance Handover times (<30 minutes) in the West Midlands, and has now been within the Top 3 performing organisations for 12 consecutive months; performance was almost 10% points better than the second best performing Trust in the West Midlands. This has been achieved despite supporting 99 ambulances intelligently conveyed – from neighbouring Emergency Departments due to excessive ambulance handover times - in December 2021. Whilst pressure on emergency care has remained high, type 1 attendances were down 3% in December 2021 when compared with December 2019, possible owing to public anxiety

	and restraint association with the Omicron variant. The Trust performed at 76.53% in December 2021 for the 4-hour Emergency Access Standard, a slight deterioration from performance in November 2021 of 77.12%. Performance remains strong relative to peers, ranking 26th nationally amongst 111 reporting Acute Trusts. National performance for December 2021 set records for the lowest ever performance, with 61.2% of patients meeting the 4-our Emergency Access Standard. Challenges associated with increased numbers of Medically Stable For Discharge patients remain as a result of challenges in the domiciliary care market. The Trust responded to guidance received from NHSEI to reduce the number of patients declared as medically stable for discharge with the hospital. The request for a 30% reduction by 24th December 2021 was surpassed with a record low number of patients achieved. The report highlights the stable Trust performance against the 18-week Referral To Treatment waiting time standard. The Trust is maintaining performance against trajectory. The number of patients waiting in excess of 52-weeks has deteriorated slightly with the Trust slipping from 5th to 6th he in the lowest proportion of its elective waiting list waiting over 52-weeks in the (combined West and East) Midlands. In December 2021, the Trust's for 62-day Cancer performance declined to 70.5%, from above 80% throughout both October and November 2021. The Trust remains amongst the best performing Trusts in the Midlands, ranking 4th of 22 Acute Trusts. Following a period of statistically significant improvement in waiting times for patients referred by their GP on 2 week wait suspected cancer and breast symptomatic pathways, waiting times became challenged. Mutual aid with RWT continues and waiting times have now reduced to 22 days. Timely care for patients with cancer is vital given the clear evidence that clinical outcomes (including survival rates) correlate with the stage of the cancer disease on diagnosis, and thus detecting and treating cancer early directly improves patient outcomes. The report notes that the Trust is providing mutual aid to The Royal Wolverhampton NHS Trust for long waiting patients needing Urology surgery and to a number of neighbouring Trusts for

	intelligently conveyed ambulances away from Emergency Departments with prolonged Ambulance Handover times. The report also notes that the Trust is receiving mutual aid from The Royal Wolverhampton NHS Trust for 2 week wait breast symptomatic pathways.
Recommendation and key items of note	Members of the Trust Board are asked to note the contents of this report, key messages, and the next steps: • Trust has attained a small surplus of £0.3m to 31st December 2021, the STP also delivering a small surplus and forecasting attainment of financial plans for 2021/22 (to 31st March 2022) • 2022/23 Plan submission has been deferred from February 2022 to April 2022, further guidance awaited. Plans will be presented to members for endorsement at the next meeting of the Board • STP 2022/23 income allocations are known (to include a 1.1% efficiency and 57% reduction in Covid-19 funding) with provider income allocations yet to be confirmed • The review of Covid-19 measures, cessation of agency and delivering the efficiency programme remains key for 2022/23 sustainability • STP capital has been agreed, the capital programme now including the ward infrastructure works for 2021/22, plans for 2022/23 exceeding current funding streams
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* - Financial impacts are as described within the recommendations section.
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. The published literature evidence base for differential access to secondary care services by protected characteristic groups of the community is less well developed. However, there is clear evidence that young children and older adults are higher users of services, there is some evidence that patients who need interpreters (as a proxy for nationality and therefore a likely correlation with race) are higher users of healthcare services. And in defined patient cohorts there is evidence of inequality in use of healthcare services; for example end of life cancer patients were more likely to attend ED multiple times if they were men, younger, Asian or Black. In summary, further research is needed to make stronger statements, but there is published evidence of inequity in consumption of secondary care services against the protected characteristics of age, gender and race.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

WALSALL HEALTHCARE NHS TRUST - TRUST BOARD

USE RESOURCES WELL

AUTHOR – ACTING CHIEF OPERATING OFFICER & DIRECTOR OF FINANCE

1. 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 financial circumstances that the Trust is now operating in during the new 2021/22 financial year.

It updates Board members on attainment of a surplus of £0.01m to September 2021 of the financial year (month 6 of 2021/22). The Trust was forecasting at month 5 reporting a trading deficit of £0.95m that has been mitigated through securing additional income from the Sustainability and Transformation Partnership (STP) and therefore has attained financial plans for H1 (Horizon 1 to September 2021). This representing the continued achievement of a surplus and financial plan (as has been the case for the previous two financial years).

The report also confirms key performance against financial plans for Horizon 1 (H1 - April to September 2021) of the 2021/22 financial year and performance for Horizon 2 (H2 – October 2021 to March 2022).

The primary risks to delivery of H2 Operational plans within resource envelopes centred upon:

(a) Securing an income settlement that would offset projected run rate costs
(b) Agency cessation aligns to Nurse Investment business case
(c) Delivery of efficiencies at 1.6% of H1
(d) Potential additional costs exposure over winter

The H2 financial plan (October 2021 to March 2022) was endorsed through Executive, Trust Management Committee, Performance, Finance and Investment Committee (PFIC) and Trust Board.

The Trust attained a small surplus of £0.283m to 31st December 2021. This reflects mitigation of risks from securing an appropriate income settlement and Urgent and Emergency Care demands and this expenditure being below planned levels.

The Trust is forecasting delivery of financial plans to 31st March 2022 and attainment of break-even duty for the 2022/23 financial year (attaining a small surplus). The STP also forecasting break-even (should demand continue at these levels)

The report identifies continued strong operational performance following the extreme pressure experienced during the third wave of the Covid-19 pandemic in early 2021. It highlights good constitutional standard performance in the DM01 6 week wait diagnostic standard and relative performance in emergency care with the Trust's ambulance handover times (within 30mins).

However, the report notes the significant and persistent pressures on Urgent & Emergency Care services with 4-hour EAS performance and ambulance handover performance the worst on record nationally.

The report highlights the Trust's stable 18-week Referral To Treatment waiting time standard performance, and Trust's GP referred 62-day Referral to Treatment Cancer waiting time performance is now significantly better than the West Midlands and national average.

2. BOARD ASSURANCE FRAMEWORK

The Use Resources Well Board Assurance Framework (BAF) risk has been further updated to include:

- Confirmation of break-even for H1, following receipt of £950k STP risk share income associated with significant mutual aid for patients conveyed by ambulance from outside the Walsall borough to Walsall Manor ED due to prolonged ambulance handover times at neighbouring Trusts.
- Confirmation that H2 Planning Guidance was issued on 30th September 2021, and the Trust submitted a plan that attains a small surplus in year
- **The Trust has attained a surplus of £0.283m to 31st December 2021 and is forecasting delivery of financial plan at 31st March 2022 (subject to demands for urgent and emergency care remaining at current levels)**

Key financial risks are as 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
    - Modelling trajectories for temporary workforce (cessation of agency)
    - Identification of efficiencies to service the plan and enable re-investment into services
- Capital resource availability to service current Estate backlog works requirements and future major capital developments

The Chief Operating Officer and Director of Finance review the risk score monthly. The review noting risks articulated centring upon the 2022/23 financial year having a reduction of Covid funds for the STP (57% reduction) uncertain demand for urgent and emergency care combined with a need to attain efficiencies of 1.1% to offset reduced income but also enable investment in services.

The conclusion of the review was for the risk to remain as reported, owing to the significant uncertainties regarding income and the level of efficiencies that need to be generated to offset income reductions and service investments.

3. PERFORMANCE REPORT

3.1.1 Financial Performance - background

The Trust entered the 2020/21 financial year having attained planned financial outturn for 2019/20. However, the onset of COVID-19 resulted in emergency budgets being set by NHSEI and the normal planning process halted. However, the Trust attained a £0.14m surplus for the 2020/21 financial year.

The 2021/22 financial planning was also affected by the pandemic, and has been divided into two periods, Horizon 1 (H1) covering April to September 2021 and Horizon 2 (H2) covering October to March 2022. This section of the report will update members on H1, H2 and 2022/23 revenue and then capital & cash.

3.1.2 Revenue position – Horizon 1 (April 2021 to September 2021)

Income allocations were confirmed for H1 (April to September 2021) and the Trust endorsed a plan for income and expenditure for this period 2021/22. This H1 plan supported by Executive and Trust Management Board, and recommended for adoption by Performance, Finance, & Investment Committee, was endorsed at Private Board.

The Trust achieved a surplus at month 6 of 2021/22's financial plan of £0.01m. The Trust was forecasting a trading deficit against the H1 overall plan of £0.95m at

month 5. However, the Trust secured further income from the Sustainability and Transformation Partnership to offset this forecast deficit.

3.1.3 Revenue position Horizon 2 (H2 – October 2021 to March 2022)

Income allocations were confirmed at expected levels contained within the plans put before and endorsed by Trust Board.

The Operational teams developed robust run rate models for the 2021/22 financial year, the plans and finances owned by the teams, with further expenditure on winter plans and for investments (Nursing an example) within services then overlayed within the modelling to identify the expenditure for the financial year.

The Operational Plans have been modelled with resultant overall run rates presented to the Executive, Trust Management Committee and Performance Finance and Investment Committee. However, the modelling identifies risks associated with:

(a) Agency cessation aligning to the Nurse Investment business case
(b) Delivery of efficiencies at 1.6% of Horizon 1 (previously targeting 3%)
(c) Cost exposure over winter (mitigation being the winter plan and H1 risk share)

The Executive, Trust Management Committee, PFIC and Trust Board received and endorsed the financial plans for H2. The draft plan then presented to members of the Performance, Finance and Investment Committee, the plan identifying delivery of break-even performance for the financial year.

As noted, the Trust secured an appropriate income settlement and Urgent and Emergency Care demands remain below planned levels. As such, **the Trust has attained a small surplus of £0.283m to 31st December 2021.** Should demand continue at these levels it is expected the Trust will attain a small surplus, delivering plan at close of the financial year. The Trust remains within a risk share (so no member in surplus whilst another is in deficit) with the STP forecasting attainment of a small surplus.

3.1.4 Revenue financial modelling to 2022/23

Income allocations are expected to further reduce as the Government seeks to revise expenditure commitments post Covid-19. The STP has confirmed resource allocations for the 2022/23 financial year that include a 1.1% efficiency ask and reduction of Covid-19 designated funding by 57% (c£80m for the STP). Provider allocations are yet to be determined.

This is expected to place further pressure on expenditure budgets. The key risks to financial sustainability centring upon

(a) income settlement
(b) review of Covid-19 expenditure commitments
(c) delivery of efficiencies
(d) cessation of agency use

The Operational teams have been working on development of the expenditure baseline (normalised) exit run rate for March 2022 for when we enter 2022/23. March 2022 planned expenditure totalling c£29m, c£26.2m as a normalised expenditure position.

NHSEI has released initial planning guidance, though this moves submission deadlines from February 2022 to April 2022 for 2022/23 plans. Further guidance is expected in relation to submission deadlines.

3.1.5 Capital and cash

Capital expenditure in the 2021/22 financial year places focus upon investment within critical infrastructure works, Digital and Medical Equipment, with the most significant scheme being the Emergency Department New build (it is an impressive addition to the estate of the Trust).

The capital programme for 2021/22 is fully resourced, the Trust successful in securing an increase from the initial capital allocation to support essential ward refurbishments from the STP overall allocation. The Trust is concluding the signing of the memorandum of association with the regulator in relation to securing funds transfer for the Emergency Department works in year.

In regard to the 2022/23 financial year, the Trust has schemes that significantly exceed initial resource allocations and a paper will be presented for review and endorsement of the programme as part of the planning process.

The Trust has substantial cash holdings (c£41m) at the close of H1 (September 2021).

Operational

Emergency Care:

The Trust continues to deliver the best Ambulance Handover times (<30 minutes) in the West Midlands, and has now been within the Top 3 performing organisations for 12 consecutive months; performance was almost 10% points better than the second best performing Trust in the West Midlands. This has been achieved despite supporting 99 ambulances intelligently conveyed in December 2021. Type 1 attendances were down 3% in December 2021 when compared with December 2019, possible owing to public anxiety and restraint association with the Omicron variant.

4-hour Emergency Access Standard performance in December 2021 had 76.53% of patients admitted or discharged within 4 hours of arrival to ED. Whilst the Trust was ranked 26th nationally out of 111 reporting Trusts, the urgent and emergency care pathway up and down the country remains under unprecedented strain. Whilst this is a slight deterioration from performance in November 2021 of 77.12%, performance remains strong relative to peers, ranking 26th nationally amongst 111 reporting Acute Trusts. National performance for December 2021 set records for the lowest ever performance, with 61.2% of patients meeting the 4-our Emergency Access Standard.

The Trust's Winter Plan has been crucial in mitigating the risk of timely emergency treatment given the clear association between prolonged duration of stay within ED and both increased mortality for admitted patients, and worse patient experience. Furthermore, the Trust responded to guidance received from NHSEI to reduce the number of patients declared as medically stable for discharge with the hospital. The request for a 30% reduction by 24th December 2021 was surpassed with a record low number of patients met.

Elective Care:

Despite challenges in the sonography service, the Trust's 6 Week Wait (DM01) Diagnostics performance remains strong and is 18th best (November 2021 reporting), out of 122 reporting general acute Trusts. Temporary staff absence within the ultrasound service during August, September and October (sickness, and self-isolation) has meant that performance has deteriorated as a result and will now take until the end of December, at least, to recover. The recovery effort is on track, with 275 patients waiting in excess of 6 weeks for a non-obstetric ultrasound, compared to a peak in December 2021 in excess of 800 patients.

Despite cessation of routine elective services during March and April 2020, and reduced elective operating capacity again from November 2020 to March 2021 over the second and third waves of the pandemic, the Trust's 18-week RTT performance remains stable with 64.1% - against a trajectory of 63.8% - of patients waiting under 18 weeks at the end of October 2021, and is 59th nationally (out of 122 reporting Trusts) for November 2021 performance. The Trust's 52-week waiting time performance has deteriorated from 5th to 6th best in the Midlands (out of 20 Trusts), with an increase of 76 patients from October 2021, now standing at 704 patients waiting in excess of 52-weeks as at the end of November 2021. The Trust has received underwriting of ERF funding to support additional elective Orthopaedic capacity with the specific objective in reduction in 52-week breach patients. Providing timely routine elective care is important given many patients will be suffering pain, discomfort and loss of independence whilst awaiting treatment and the clear evidence that patient outcomes can be adversely affected by excessive waiting times for treatment.

In December 2021, the Trust's for 62-day Cancer performance declined to 70.5%, from above 80% throughout both October and November 2021. The Trust remains amongst the best performing Trusts in the Midlands, ranking 4th of 22 Acute Trusts. Following a period of statistically significant improvement in waiting times for patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways, waiting times became challenged. Mutual aid with RWT continues and waiting times have now reduced to 22 days. Timely care for patients with cancer is vital given the clear evidence that clinical outcomes (including survival rates) correlate with the stage of the cancer disease on diagnosis, and thus detecting and treating cancer early directly improves patient outcomes.

4. IMPROVEMENT PROGRAMME

The Operational Productivity improvements forming a key tenet of the Use Resources Well improvement programme are now being evidenced through the Trust's improved relative performance against key Model Hospital operational productivity metrics, including. Performance, Finance & Investment Committee at its September meeting received assurance on the following operational productivity improvements:

- Cost per Weighted Activity Unit (19/20) now below peer and national median (Q2 2021/22 - Model Hospital)
- Day case rates for British Association of Day Case Surgery better than peer and national medians (Q3 2021/22 – Model Hospital), and productivity opportunity for British Associated of Day Case Surgery procedures is within the upper quartile (M8 2021/22)
- Theatre productivity – as measured by touch time utilisation – is within the upper quartile (Q3 2021/22 – Model Hospital)
- Average Length of Stay for elective admissions rolling 6 months below peer median (Q1 2021/22 – Model Hospital)
- Average Length of Stay for emergency admissions rolling 6 months below peer and national median (Q1 2021/22 – Model Hospital)

The H2 Financial plan has set a cash-releasing financial improvement target of 1.6% for the Trust. Divisions are consolidating local plans against their constituent targets and efficiency meetings are included within the monthly reporting cycle with Operational teams.

However, Performance, Finance & Investment Committee could not yet take assurance that the schemes would all be delivered to meet the 1.6% requirement in year (though Urgent & Emergency care demand being below plan has seen reductions in expenditure accordingly) members recognised that there was inherent risk to the delivery of this financial improvement, with a 1.1% further efficiency ask for 2022/23.

5. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report, key messages, and the next steps:

- **Trust has attained a small surplus of £0.3m to 31st December 2021, the STP also delivering a small surplus and forecasting attainment of financial plans for 2021/22 (to 31st March 2022)**
- 2022/23 Plan submission has been deferred from February 2022 to April 2022, further guidance awaited. Plans will be presented to members for endorsement at the next meeting of the Board
- STP 2022/23 income allocations are known (to include a 1.1% efficiency and 57% reduction in Covid-19 funding) with provider income allocations yet to be confirmed
- The review of Covid-19 measures, cessation of agency and delivering the efficiency programme remains key for 2022/23 sustainability
- STP capital has been agreed, the capital programme now including the ward infrastructure works for 2021/22, plans for 2022/23 exceeding current funding streams

APPENDICES

1. Board Assurance Framework Risk S05
2. Performance Report (Finance and Constitutional Standards)

Walsall Healthcare NHS
NHS Trust

Use Resources well

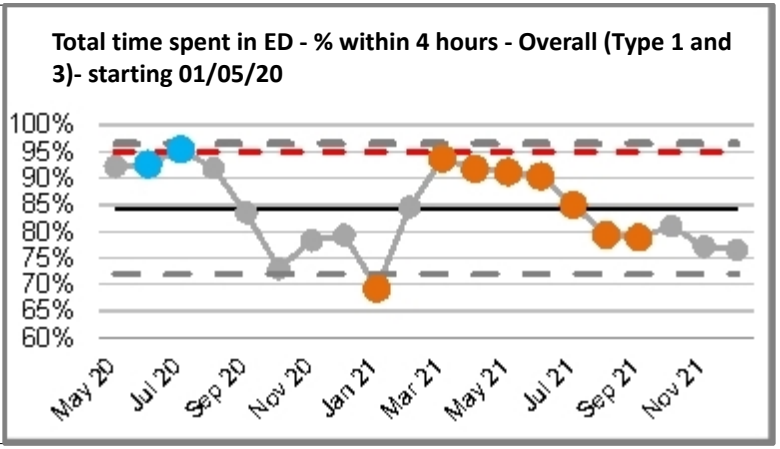
Caring for Walsall together

Use Resources Well - Performance

SPC Key

Mean
Process limits - 3σ
Special cause - improvement
Measure
Special cause - concern
Target

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

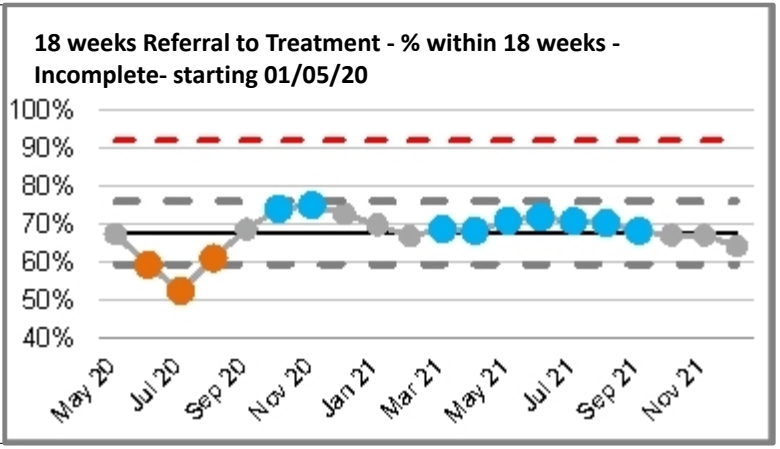


Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

The Trust performed at 76.53% in December 2021 for the 4-hour Emergency Access Standard, a slight deterioration from performance in November 2021 of 77.12%. Performance remains strong relative to peers, ranking 26th nationally amongst 111 reporting Acute Trusts. National performance for December 2021 set records for the lowest ever performance, with 61.2% of patients meeting the 4 hour Emergency Access Standard.

18 weeks RTT – Incomplete Pathways



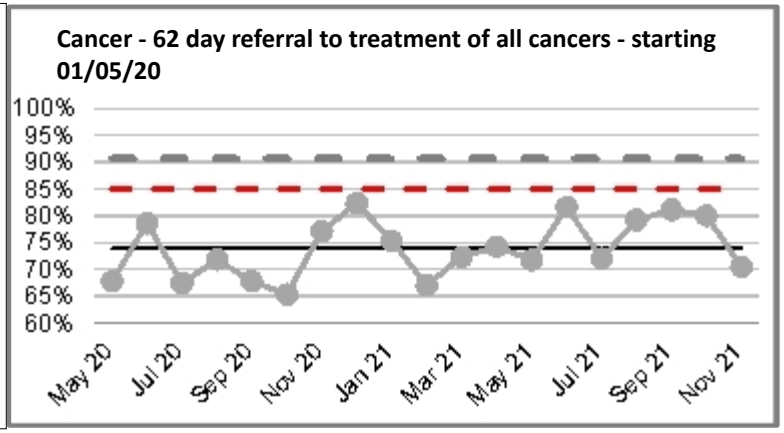
RTT (18 weeks Referral to Treatment)

The chart highlights the stable Trust performance against the 18-week Referral To Treatment waiting time standard. The Trust is maintaining performance against trajectory. The number of patients waiting in excess of 52-weeks has deteriorated slightly with the Trust slipping from 5th to 6th in the lowest proportion of its elective waiting list waiting over 52-weeks in the (combined West and East) Midlands.

Use Resources Well - Performance

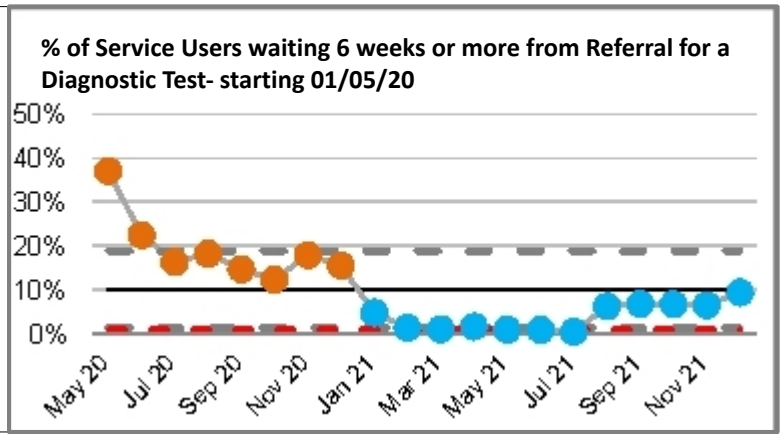
Mean
Process limits - 3σ
Special cause - improvement
Measure
Special cause - concern
Target

Cancer 62 Day RTT



Cancer
In December 2021, the Trust's for 62-day Cancer performance declined to 70.5%, from above 80% throughout both October and November 2021. The Trust remains amongst the best performing Trusts in the Midlands, ranking 4th of 20 Acute Trusts. Following a period of statistically significant improvement in waiting times for patients referred by their GP on 2 week wait suspected cancer and breast symptomatic pathways, waiting times became challenged. Mutual aid with RWT continues and waiting times have now reduced to 22 days. Timely care for patients with cancer is vital given the clear evidence that clinical outcomes (including survival rates) correlate with the stage of the cancer disease on diagnosis, and thus detecting and treating cancer early directly improves patient outcomes.

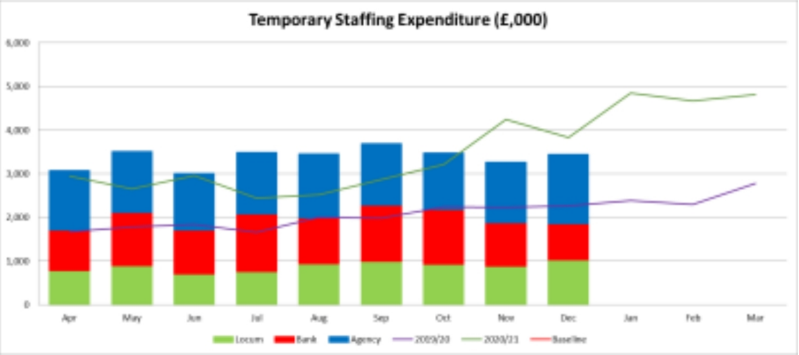
Diagnostic waiting times (DM01)



Diagnostic waiting times & activity (DM01)
Despite challenges in the sonography service, the Trust's 6 Week Wait (DM01) Diagnostics performance remains strong and is 18th best (November 2021 reporting), out of 122 reporting general acute Trusts. Temporary staff absence within the ultrasound service during August, September and October (sickness, and self-isolation) has meant that performance has deteriorated as a result and will now take until the end of December, at least, to recover. The recovery effort is on track, with 275 patients waiting in excess of 6 weeks for a non-obstetric ultrasound, compared to a peak in December 2021 in excess of 800 patients.

Financial Performance to December 2021 (Month 9)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	243,581	252,130	**8,549**
Other Income (Education&Training)	6,351	6,318	**(33)**
Other Income (Other)	4,692	6,432	**1,739**
Subtotal Income	**254,625**	**264,880**	**10,254**
Pay Expenditure			
Substantive Salaries	(132,499)	(134,916)	**(2,417)**
Temporary Nursing	(12,045)	(14,297)	**(2,252)**
Temporary Medical	(11,945)	(10,707)	**1,238**
Temporary Other	(3,893)	(3,678)	**216**
Vaccination Programme	(4,981)	(2,267)	**2,714**
Subtotal Pay Expenditure	**(165,364)**	**(165,865)**	**(501)**
Non Pay Expenditure			
Drugs	(13,353)	(15,270)	**(1,917)**
Clinical Supplies and Services	(12,638)	(14,018)	**(1,380)**
Non-Clinical Supplies and Services	(12,077)	(13,655)	**(1,577)**
Other Non Pay	(37,571)	(41,543)	**(3,973)**
Vaccination Programme	(159)	(489)	**(330)**
Depreciation	(6,385)	(6,364)	**21**
Subtotal Non Pay Expenditure	**(82,182)**	**(91,339)**	**(9,157)**
Interest Payable	(7,114)	(7,044)	**70**
Subtotal Finance Costs	**(7,114)**	**(7,044)**	**70**
Total Surplus / (Deficit)	**(34)**	**632**	**666**
Donated Asset Adjustment	169	(349)	**(518)**
Adjusted Surplus / (Deficit)	**135**	**283**	**149**



Financial Performance

- The Trust has determined an operational plan for the period October to March of 2022 (Horizon 2 of the 2021/22 financial year) that has enabled the Board to endorse a financial plan for this period.
- The Trust has a surplus at the end of December 2021 of £0.283m, an improvement to plan of £0.149m largely due to reduction in planned urgent and emergency care demand and reduced expenditure accordingly.
- The Trust continues to see high levels of temporary staffing spend particularly in areas of increased activity, the main driver being temporary nurse staffing as a result of increased activity in ED, ICU and Maternity. However, overall temporary workforce costs remain below the level seen in the same period last year.
- The Trust has included an Elective Recovery Fund receipt of £2.3m for activity undertaken during the April to September 2021 period (Horizon 1). Whilst this income improves performance against plan, costs are provided for within expenditure that negates this benefit in the current month (as directed by NHSEI and undertaken within the STP).
- The STP risk share agreement endorsed in Horizon 1 of the 2021/22 financial year is to continue into the second half of the financial year (Horizon 2)
- Excluding ERF, Non Pay was above forecast due to High Cost Drugs and Devices usage and purchase of healthcare which has been offset by increased income.

Capital

- The approved programme for the year totals in excess of £31m, with the major developments being the New Emergency Department which is currently progressing at pace and is expected to open in October of 2022, full refurbishment of a number of theatres and upgrades to ward environments that are now completed.
- Capital expenditure totals £14.337m for the financial year to date. The Trust securing a further allocation from the STP of £1.8m to support the ward refurbishment programme.

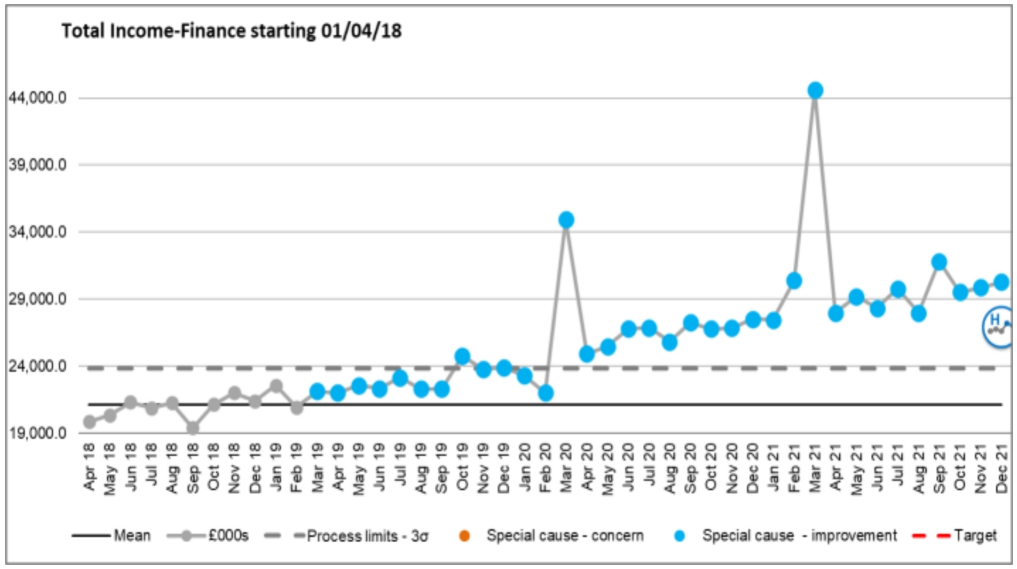
Cash

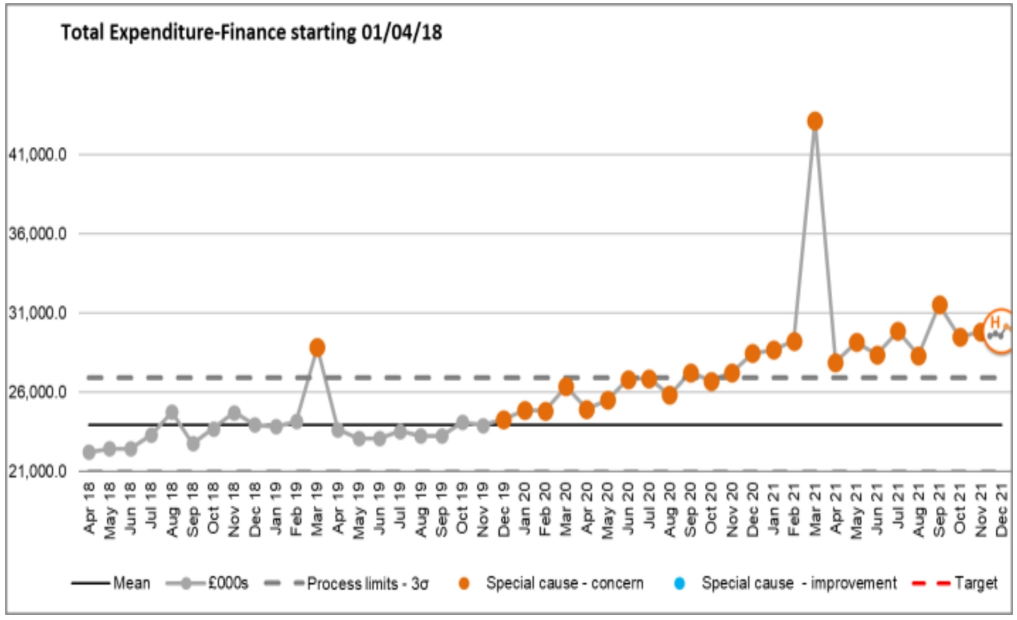
- The Trust has a positive cash holding of £40.3m as at 31st December 2021

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.
- The financial sustainability for the second half of the year requires attainment of a 1.6% efficiency and moving into 2022/23 it is envisaged further savings will be required to maintain financial sustainability of services. Delivery of this savings ask is a key risk to the Trust.

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, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

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
- 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 and increased further in Q4 20/21 driven by the additional pressures of a second wave of COVID activity.
- March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income.
- In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m

Cash Flow Statement & Statement of Financial Position

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending December 2021	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	7,958
Depreciation and Amortisation	6,364
Donated Assets Received credited to revenue but non-cash	(608)
(Increase)/Decrease in Trade and Other Receivables	(4,462)
Increase/(Decrease) in Trade and Other Payables	12,863
Increase/(Decrease) in Stock	(296)
Increase/(Decrease) in Provisions	0
Interest Paid	(6,180)
Dividend Paid	(282)
Net Cash Inflow/(Outflow) from Operating Activities	**15,357**
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(15,522)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(15,522)**
Net Cash Inflow/(Outflow) before Financing	**(165)**
Cash Flows from Financing Activities	(3,043)
Net Increase/(Decrease) in Cash	**(3,208)**
Cash at the Beginning of the Year 2021/22	43,532
Cash at the End of the December	**40,324**

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending December 2021	Balance as at 31/03/21	Balance as at 31/12/21	Year to date Movement
	'£000	'£000	'£000
Non-Current Assets			
Property, plant & Equipment	161,995	171,407	9,412
Intangible Fixed Assets	6,417	5,587	(830)
Receivables greater than one year	561	283	(278)
Total Non-Current Assets	**168,973**	**177,277**	**8,304**
Current Assets			
Receivables & pre-payments less than one Year	11,075	15,815	4,740
Cash (Citi and Other)	43,532	40,324	(3,208)
Inventories	2,951	3,247	296
Total Current Assets	57,558	59,386	1,828
Current Liabilities			
NHS & Trade Payables less than one year	(35,179)	(42,126)	(6,947)
Other Liabilities	(284)	(5,881)	(5,597)
Borrowings less than one year	(4,058)	(4,058)	-
Provisions less than one year	(96)	(96)	-
Total Current Liabilities	(39,617)	(52,161)	(12,544)
Net Current Assets less Liabilities	**17,941**	**7,225**	**(10,716)**
Non-current liabilities			
Borrowings greater than one year	(111,956)	(108,912)	3,044
Total Assets less Total Liabilities	74,958	75,590	632
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	215,632	215,632	-
Revaluation	24,307	24,307	-
Income and Expenditure	(164,981)	(164,981)	-
In Year Income & Expenditure	-	632	632
Total TAXPAYERS' EQUITY	74,958	75,590	632

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 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 & 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, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & Investment Committee.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **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). • **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). • **1005** - Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks. (Risk Score = 15). • **1155** - Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation (Risk Score = 8). • **2081** - Delivery Operational Financial Plan. (Risk Score = 16). • **2082** - Future Financial Sustainability. (Risk Score = 9). • **2398** - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12).	**Likelihood = 3** **Consequence = 5** **= 15 High** ↔ Forecasted Risk Score Movement for Q4: **Likelihood = 2** **Consequence = 5** **= 10** ↓

Risk Appetite

Operational Status:	Balanced	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 14	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 16																									
Financial Status:	Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	<10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	<11																									
Compliance Status:	Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	<9	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	<11																									

Risk Scoring							
Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):	Target Date:
Likelihood:	3	3	3		Evidence of risk control • Achievement of 19/20 and 20/21 financial plans. • Achievement of 21/22 H1 financial plan. • On financial plan for 21/22 H2 as at Month 8. • Adherence to revised financial arrangements during 20/21 as a result of the Covid-19 pandemic, despite significant planning uncertainty • Strong operational performance measured through constitutional standards, and associated operational performance metrics. • Development of draft 5-year capital programme • Majority of allied Corporate Risks associated with Use Resources Well mitigated to scores of 16 or less. • Improved Cost per WAU, and operational productivity indicators (Model Hospital) 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 remains, whilst international nurse recruitment is delivered. • West Midlands Ambulance Service Intelligent Conveyancing protocol resulting in significant out of Walsall borough ambulances conveyed to the Trust, forecast to equate to circa £1.5m of ED attendance and non-elective admission activity during 21/22. • Formal Month 5 submission to NHSEI Midlands/ICS re-forecasted to a £952k adverse variance to H1 plan, subsequently revised to break-even following confirmation of additional income through the STP risk-share agreement, in recognition of the additional ambulance activity received on behalf of BCWB Trusts. H1 financial plan ultimately delivered. • Increasing general risk in the UEC system due to high demand on EDs, and compromised domiciliary care market resulting in excessively high hospital bed occupancy. • Risk of Omicron variant Covid wave, particularly	Likelihood:	2	31 March 2022
Consequence:	5	5	5			Consequence:	5	
Risk Level:	**15 High**	**15 High**	**15 High**			Risk Level:	**10 Moderate**	

					resulting in increased staff absence, and in turn higher reliance on temporary workforce. • Lack of credible capital plan to fully address backlog maintenance requirements, despite 5-year Capital Programme in place. <u>Evidence of planning uncertainty</u> • Normal national financial planning cycle for 21/22 financial year was postponed due to the Covid-19 pandemic • H2 (Q3 and Q4) 21/22 Planning guidance issued on 30th September 2021. • 22/23 financial planning guidance issued 24/12/21 by NHSEI.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Financial position reported monthly via Care Groups, Divisions, Divisional Performance Reviews and Executive Governance Structures. • Revised financial governance in place for COVID-19 through the Trust's Governance Continuity Plan. • 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 Resources Well work stream of the Improvement Programme has Governance infrastructure in place. • Establishment of Financial Efficiency Group to oversee cash-releasing Financial Efficiency improvements.	• Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital.
Gaps in Controls:	• Business planning processes require strengthening. • Accountability Framework has been approved however needs to mature and be embedded. • Leadership development needs at Care Group, Divisional and corporate support service levels, with completion of Faculty of Medical Leadership and Management leadership development programme delayed due to Covid-19 second wave. • Covid-19 second and third waves significantly exceeded planning parameter assumptions.		
Assurance:	• Model Hospital Use of Resources assessments. • Proportion of acute surgical patients managed without overnight hospital stay has risen from less than 30% to over 50%. • Number of patients managed through the Integrated Assessment Unit's Frailty service without overnight hospital stay has increased by over 50%.	• Internal Audit reviews of a number of areas of financial and operational performance • Covid-19 'top-up' resource in line with peers as a percentage of turnover • Top 20 in the country out of 122 general acute reporting Trusts for the 10th consecutive month (Oct 2021) for 6 week wait Diagnostic (DM01) performance • Top 40 in the country (out of 113 reporting general acute Trusts) (Nov 2021) for the 9th consecutive month for 4-hour Emergency Access	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts • Cost per WAU (19/20) now below peer and national median (Model Hospital) • Productivity Opportunity for British Association of Daycase Surgery procedures second lowest quartile (Sep 2021 – Model

	• Inpatient Length of Stay in MLTC (excluding 0-day LoS) has reduced from over 9 days to less than 8 days on average. • Number of Medically Stable for Discharge inpatients sustained at lowest level on record through 20/21 (although rising since June 2021). • Delivery of 2020/21 Financial plan, representing the second consecutive year of meeting financial plan, followed by delivery of H1 2021/22 financial plan.	Standard, and Top3 in the West Midlands out of 14 reporting Trusts for Ambulance handover <30 mins for the 13th consecutive month, 9 of which have been top performing Trust in the region. • 61st best in the country out of 122 reporting Trusts (Oct 2021) for 18-week RTT performance and 6th lowest proportion of elective waiting list waiting over 52 weeks in the Midlands (out of 20 reporting Midlands Trusts) • 62-day Cancer performance (Oct 2021) 21st out of 122 reporting general acute Trusts nationally, with 80% of our patients treated within 62 days of GP referral.	Hospital). • Average LoS for elective admissions rolling 6 months in line with peer and national median (Sep 2021 – Model Hospital) • Average LoS for emergency admissions rolling 6 months below peer and national median (Sep 2021 – Model Hospital) • Average late starts and average early finishes in Operating Theatres better than peer and national median (Sep 2021 – Model Hospital), and upper quartile performance. • Medical specialties Same Day Emergency Care rates for ambulatory emergency care conditions rated second best in the country by the AEC Network.
Gaps in Assurance:	• NHSi Governance review highlighted areas of improvement for business process and accountability framework. • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident. Time lag on updating of some Model Hospital metrics means there is a delay in receiving some independent assurance of improved financial and operational productivity metrics. • External Audit limited due to Covid-19. • NHS Digital Templar Execs external review (Cyber Operational Readiness Support) has identified improvements required for the Trust's Cyber Security.		

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.
- International Nurse Recruitment with RWT to significantly decrease reliance on temporary workforce.
- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners), and following catchment area changes for non-elective care when Midland Metropolitan Hospital opens in 2023, and Sandwell ED closes.
- Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home).
- Improved Equality, Diversity and Inclusion in the Trust to harness the skills of the whole workforce and leadership development programme for Care Group and Divisional leaders to enhance capability (Valuing Colleagues).
- 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 (e.g. 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 work stream.

Future Risks

- Covid-19 second and third waves have significantly exceeded planning parameter assumptions, leading to increased costs delivering emergency and critical care, and reduced leadership time dedicated to long time resource planning during the height of the pandemic. Risk of a 4th wave associated with Omicron variant in Winter 2021/22.
- Likely move away from PbR towards block contracts and the associated paradigm shift for elective care in particular.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in 20/21, and 21/22.

- Additional costs associated with safe non-elective and critical care during Covid-19.
- Significant changes to elective and non-elective demand during Covid-19 and in 21/22 in emergency care in particular 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 significant lead time for deployment of capital.
- Impact of Covid-19 on the wider economy and supply chain markets may destabilise some costs of goods/services upon which the Trust relies.
- Workforce exhaustion and/or psychological impact from Covid-19 may result in higher sickness rates and/or colleagues deciding to leave the healthcare professions, and thus further reliance on temporary workforce.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Review and update Accountability Framework further to the NHSI Governance Review report.	R. Caldicott	Oct 2020	**Complete** Revisions to assessment, content and agenda in conjunction with the Divisional Directors, Trust Management Board, Executive and the Improvement Programme Board have been enacted and work on development of key metrics is progressing. However, a key element of the review centres upon wider Trust consultation to gain ownership of the framework and metrics used for assessment. This has been difficult to progress in light of the pandemic which results in the current rating of amber. Target completion June 2021.	
2.	Financial regime post 31st September 2020 to be approved by Board in October 2020 - Russell Caldicott	R. Caldicott	Oct 2020	**Complete**	
3.	All work-streams to have Improvement programme benefits defined.	G. Augustine	Oct 2020	**Complete** - Presented to Trust Board Development Session on 1st October 2020.	
4.	Development of 2021/22 Financial plan	R. Caldicott	~~March 2021~~ Nov 2021	**Complete** H1 21/22 financial plan approved at Board. H2 plan to be received at extraordinary PFIC 20/10/21.	
5.	Development of 2022/23 Financial plan	R. Caldicott	March 2022	**In Progress** Receipt of 22/23 Planning Guidance 24/12/21	

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Valuing Colleagues – Executive Update			**AGENDA ITEM: 18**
Report Author and Job Title:	Catherine Griffiths, Director of People and Culture	**Responsible Director:**	Catherine Griffiths, Director of People and Culture
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	Trust Board are asked to note positive assurances on a number of workforce metrics – at appendix two and note the plans to address gaps in assurance, for attendance levels in particular. The Trust Board can be assured that the leadership development work through the Faculty of Medical Leadership and Management's (FMLM) leadership is complete, there is a leadership development offer drawing from best practice at the Royal Wolverhampton NHS Trust this is led by the Director of Education and Training, the management development programme is in place		
Advise	The attendance levels have worsened over the last month, impacting workforce availability and creating pressures for those at work, although rates are now showing reduction on the peak. The absence rate is 9.92%, a decrease on peak rate of 10.87%. Within this 1.52% is directly attributable to COVID-19 and self-isolation requirements. The underlying absence rate 8.40% is due to increases in long-term absence (LTS), a focused approach to reducing LTS is in place with a strong focus on health and wellbeing CHATs and a proactive approach to LTS management.		
Alert	The Trust Board are asked to note that implementation of the Infinity system to record Lateral Flow Device (LFD) results in real time went live week commencing 31st January 2022 and the trust now shares the same system and reporting that is in place at the Royal Wolverhampton NHS Trust. The system provides management information reports on workforce availability, to support workforce deployment and the LFD reporting will replace the LAMP testing approach by end March 2022. The legislative requirement for mandatory vaccine as a condition of deployment (VCOD) went into statute on 6th January 2022, and comes into effect on 1st April 2022. The preparation for this is in place and the Trust Board can be assured the due diligence on the data and interface with the National Immunisation system is complete and will continue. The supporting data privacy arrangement is in place, and the divisions and leaders are receiving frequent update reports on the workforce numbers that remain unvaccinated. There is a strong and proactive health and wellbeing approach being taken to support our unvaccinated workforce with uptake, including reviewing adjustments. The Equality Diversity and Inclusion group has reviewed the local Equality Impact Assessment (EIA).		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The Board Assurance Framework (BAF) risk mitigations in place measure performance against key workforce metrics. These are found at appendix one. The scheduled improvement work is complete and the BAF and Corporate Risks are being re-assessed to provide clarity on the remaining assurance gaps. These will be presented to the People and OD Committee in April 2022 for approval. The work on Civility and improving organisation culture by equipping leaders with the skills to lead this remains priority.	
Resource implications	The resource implications have been met from base budgets. The improvement program and OD approach will require investment beyond the base budget in order to achieve the milestones and progress envisaged by 2022. The investment case will be considered through trust governance including People and Organisation Development Committee, Performance Finance and Investment Committee and Quality Patient Experience and Safety Committee before further recommendation to Trust Board. The FMLM leadership and management development programme has been funded from NHSi business case and special measures funding. The 'Walsall Manager' and Growth Mindset programme has been funded from existing budgets.	
Legal and/or Equality and Diversity implications	There are significant issues relating to equality arising from matters addressed in the report. The Trust Board has been presented with the evidence base for differential staff experience based on ethnicity, disability, age, sexuality, gender, religion and other protected characteristics. This goes to the heart of both the Trust Board pledge and the Trust values and supporting behaviours.	
Strategic Objectives	Safe, high-quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Valuing Colleagues – Executive Update

1. EXECUTIVE SUMMARY

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

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

The focus has been on resourcing to enhanced establishments and this work is beginning to have impact across the trust.

2. BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework (BAF) Risk S05 provides that lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care. The BAF is attached at appendix one. The Board are asked to note that the Assurance Framework is currently being reviewed and updated to identity the remaining assurance gaps.

3. PERFORMANCE REPORT

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

The emergency response to COVID 19 had a negative impact on compliance for a number of the workforce metrics, PODC reviews recovery plans at each meeting and escalates gaps in assurance to Trust Board. The Board are asked to note that the recovery plan for appraisal uptake is scheduled to complete in June 2022, by which time compliance with target will be evident.

4. IMPROVEMENT PROGRAMME

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

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

The programmed work within the valuing colleagues work-stream of the improvement programme is complete. The workforce risks are being reviewed and the updated BAF will be received at People and Organisation Development Committee in April 2022.

5. RECOMMENDATIONS

- Members of the Trust Board are asked to note the report and note the update on resourcing and the plans for bringing workforce metrics to compliance with targets.

APPENDICES

1. BAF SO5
2. Performance Report – Workforce Metrics

Latest Board/Committee/Group - 16/12/2021
Version V8.02

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • SO 04b - Organisational Effectiveness.
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
Lead Committee:	People & Organisational Development Committee

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **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. (Risk Score = 16, Consequence 4 x Likelihood 4).	**Likelihood = 4 Consequence = 4 = 16 High ↔** Forecasted Risk Score Movement for Q4: **Likelihood = 4 Consequence = 4 = 16 High ↔**

Risk Appetite

Status:	Averse	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 9																									

Risk Scoring

Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	4	4	4		*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.*	Likelihood:	2	31 March 2022
Consequence:	5	4	4			Consequence:	4	
Risk Level:	**20 High**	**16 High**	**16 High**		Evidence of risk gaps in control. • Staff recommending Walsall as a place to work is below all England average. • Staff recommending Walsall as a place to be treated is below all England average. • Employee Engagement Index of 6.7 below sector average of 7.0. • High reliance on temporary workforce. • Apprenticeship levy underutilised.	Risk Level:	**8**	

					• High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%. • As of 31 March 2021 there were 98 FTE registered nurse vacancies. • 48 vacancies within band 2 positions in Estates & Facilities (E&F) to be filled during Q1 campaign planned for June. <u>Evidence of risk control – Q3 (Oct, Nov, Dec 21)</u> • First submission of Trust operational workforce planning 2022-2023 presented to October PODC. • Armed Forces Covenant Bronze Certificate achieved. Plan developed to achieve Silver Status by Q1 22/23. • Interim Head of Medical Staffing appointed until 31 March 2022 to provide expert strategic and operational leadership to improve the functioning of the service. • Registered Nurse (RN) /Midwife vacancy rate for December 2021 is XXX, this is less than the previous Q2 (6% end of September 21) • 140 overseas nurses have arrived in the Trust. 103 of those have completed their OSCE. A further 7 are due to arrive in December and 24 in January 2022. • Apprenticeship Levy			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Participating in STP Acute Collaboration to enable movement of staff via MOU and identify vacancy hotspots. • ESR data cleanse work stream supported by Informatics Team in place to accurately reflect organisational hierarchies. • International nurse recruitment programme in place supported by Regional NHSIE and RWT Clinical Fellowship Scheme. • Partnership with Walsall Housing Group, Job Centre and local higher education providers to fill all clinical support worker, housekeeping and porter vacancies by end of October 2021.	• People and Organisational Development Committee in place to gain assurance. • Education and Steering Group in place and reports through to PODC for assurance. • Use of temporary staffing and ambition to eliminate agency staff by end of December monitored via PFIC and QPES for assurance.	• ICS 2021/22 priorities and operational plan. • Annual Internal audit of financial controls and payroll. • Annual ESR Data Quality Audit carried out by ESR. • Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Participant of STP collaborate bank proposal. • Leading STP BCWB Workforce Supply Group and member of STP Workforce Flexibility working groups. • Improved outcomes from annual NHS Staff

	• Community division reviewing therapy services to understand demands and AHP capacity to deliver ensure effective use of resources and support recruitment to existing and new roles in accordance with service pathways. • Implemented Step Into Health programme which connects Trusts with the Armed Forces community, by offering an access route into employment and career development opportunities. • Anchor Employer model in place with WHG • Collaboration with Health Education England to pilot new role of Medical Support Worker.		Survey which match sector average scores • Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital. • STP Acute collaboration focus to enable movement of staff across the system and work in partnership to address recruitment hotspots.
Gaps in Controls:	• There is a requirement to procure a Learning Management System (LMS) as a platform to manage content and completion of e-learning. • There is insufficient assurance that medical rota's (excluding senior medics) are compliant with contractual requirements. • ESR data cleanse improvement project has slipped from 31 March 21 to 31 July 21. • Apprenticeship levy underutilised. • High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%.[March 2021] • As of 31 March 2021 there were 98 FTE registered nurse vacancies. • 48 vacancies within band 2 positions in Estates & Facilities (E&F) to be filled during Q1 campaign planned for June.		
Assurance:	• Model Hospital Use of Resources assessments. • Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. • Staff recommending Trust as a place to work has increased from 47.8% [20190 to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • Average 2-year retention rate across the Trust of 82.4%. • Time to hire 55 days - 2nd quartile of Model Hospital data • Clinical Support Worker (CSW) vacancies reduced to 0 as of 31 Mach 2021. • 21/98 nurse vacancies filled by 10 May 2021.	• Implementation of Anchor Institute Recruitment Campaign • Associate Director of AHP appointed and commenced in role [May 2020].	• Work with education organisations and Health education England. • NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.
Gaps in Assurance:	• There is a lack of workforce planning capability across leaders within the Trust. • Lack of ability to meet local and national professional clinical staffing models / guidelines. • There is a lack of clarity regarding roles and responsibilities relating to the appointment, onboarding and deployment of medical staff.		

Future Opportunities

- Following growth in the number and variety of apprenticeships support colleagues to recognise and access apprenticeships as an opportunity to develop in current or alternative roles.
- Collaborative recruitment campaigns with STP partners to attract candidates outside of the Black Country for hard to fill roles to reduce competition for same pool of staff within the system.

Future Risks

- Impact of Covid-19 restrictions on international travel which may delay the planned start date of newly recruited international nurses.
- Workforce exhaustion and/or psychological impact from Covid-19 may impact on the ability of managers to practice compassionate and inclusive leadership.
- Uncertainty regarding senior leadership arrangements of the Trust may impact on ability to; attract, recruit and retain required skills and talent to the organisation.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Ongoing recruitment and on boarding of international nurses via Clinical Fellowship Programme	Catherine Griffiths	31/12/2021	Ongoing: 140 overseas nurses have arrived in the Trust. 103 of those have completed their OSCE. A further 7 are due to arrive in December and 24 in January 2022.	
2	NHSEI sponsored ICS work stream to develop Anchor Institute network across Walsall involving healthcare, local government and voluntary a partners.	Catherine Griffiths	31/03/2022	Lead appointed - hosted by Walsall.	
3	Formal TNA requirements informed by IPDR process to be collated to inform L&D funds and distribution.	Catherine Griffiths	31/01/2022	PDR process updated to support data capture - July 2021.	
4	Establish control review to clarify position of CSW vacancies between financial ledger, ESR	Catherine Griffiths	~~31/12/2021~~ 31/01/2022	Draft reports developed, currently be refined between stakeholders.	
5	Governance process to enact procurement of Learning Management System to be completed	Catherine Griffith	~~31/12/2021~~ 31/01/2022	MM system to align with RWT system – single waiver process for Exec approval	
6	Medical Staffing Improvement Plan accepted by CMO and DP&C to be shared with clinical leaders and other key stakeholders to identify priorities and engage stakeholders in improvement activity.	Catherine Griffiths	31/07/2022	Additional resources agreed (within budget for 2021/22). Improvement methodology agreed and to be shared with Execs and Senior Medics in January 2022.	
7	Report detailing all risks and issues relating to the medical staffing function to be provided to PODC	Catherine Griffiths	31/12/2021	**Complete:** Diagnostic report presented to CMO and DP&C by Interim Head of Medical Staffing (30 December). Proposal agreed and updates to be provided to Executive Committee and Medical Workforce Group.	
8	Completion of Operational Workforce Planning 2022-2023	Catherine Griffiths	31/10/2021	**Complete**. First draft completed and reviewed by PODC.	
9	Official Launch of formal partnership with Walsall Housing Group to support local people into healthcare careers to be completed.	Catherine Griffiths	~~31/08/2021~~ 31/10/2021	**Complete.** Manager's briefings to be completed and post appointed to provide pastoral support for new healthcare workers.	
10	Update report to PODC re Anchor Institute and employment models to include overview of system work streams to be presented in August 2021.	Catherine Griffiths	31/08/2021	**Complete**.	
11	Work with Acute Provider Collaboration to identify hard to recruit roles and staff groups.	Catherine Griffiths	30/09/2021	**Completed** - WHCT paper re recruitment hotspots.	

12	Identify opportunities to work collaboratively across RWT and WHCT to support recruitment and retention of people	Catherine Griffiths	31/10/2021	**Complete** - Ongoing. Joint paper developed - oversight provided by Joint HR Working Group. Next meeting arranged for 29 November 2021.	
13	Consideration of case to align WLI rates between Walsall and RWT	Catherine Griffiths	31/08/2021	**Complete** - Acute Collaborative paper outlining options to be considered by Executive Team.	
14	Scoping of collaborative bank model between RWT and WHCT	Catherine Griffiths	31/08/2021	**Complete** - Outline paper to identify opportunity and what would be required to formalise collaborative approach due for joint HRD consideration. Progress towards Acute collaborative bank continues. Outline paper completed and submitted.	

Latest Board/Committee/Group - 16/12/2021
Version V8.02

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04a - Leadership Culture & Organisational Development.	
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	
Lead Committee:	People & Organisational Development Committee	
Links to Corporate Risk Register:	Title: • **2489** - Poor colleague experience in the workplace. (Risk Score = 16, Consequence 4 x Likelihood 4).	Current Risk Score Movement: **Likelihood = 4 Consequence = 4 = 16 High ↔** Forecasted Risk Score Movement for Q4: **Likelihood = 4 Consequence = 4 = 16 High ↔**

Risk Appetite

Status:	Averse	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 9																									

Risk Scoring

Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	4	4	4		*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.* <u>Evidence of risk gaps in control.</u> • Staff recommending Walsall as a place to work is below all England average. • Staff recommending Walsall as a place to be treated is below all England average. • Employee Engagement Index of 6.7 below sector average of 7.0 • Bullying and Harassment Index of 7.6 below	Likelihood:	2	31 March 2022
Consequence:	5	4	4			Consequence:	4	
Risk Level:	**20 High**	**16 High**	**16 High**			Risk Level:	**8**	

					sector average of 8.1. • EDI Index of 8.7 below sector average of 9.1. • Safety culture index of 6.3 below sector average of 6.8 • WRES indicator 2; recruitment 1.40 [2021] – best performing organisations 1.0 or below. • IPDR rates remain consistently below 90% Trust KPI <u>Progress towards risk control – Q3 (Oct, Nov, Dec)</u> • Managers Framework Launched in Oct 21. • Leadership Development via FMLD for Clinical division and care group leadership teams secured for further 12 months (to commence end of Q4). • Trust 2021 NHS National Staff Survey achieved 53% response rate. Early 'face value' results indicate the following:- - Positive increase in response to NSS question *'My Trust acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or ageLack of senior managers representing ethnic minority and disability'.* From 49% in 2020 to 51% in 2021. • EDI analysis as at 30 December 2021 indicates increase in BAME staff represented in B7 and above roles to 30% (compared to 19% in April 2021). • HR Policy Framework proposed to JNCC. 15 HR Policies reviewed as fit for purpose and renewed. • October F2SU month informed review of policy. Draft available and due for consultation and ratification by end of Q4. • 3 places secured for ICS Transforming Organisational Cultures through Restorative Just & Learning Culture secured for operational managers. • Ally-ship programme jointly attended for WHCT and RWT HR teams.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Cycle of local Pulse Survey implemented • Participation in NHS National Staff Survey	• People and Organisational Development Committee in place to gain assurance.	• Assessment of activities in line with requirements of National NHS People Plan

	• Equality, Diversity and Inclusion Strategy co-designed through consultation agreed at Board May 2021. • Freedom to Speak-Up (F2SU) Strategy in place and service improvement programme embedded within Value Our Colleagues Improvement Programme. • Trust Board Pledge in place to eliminate workplace inequality, detriment, discrimination and bully & harassment. • Divisional cultural heat maps reflecting F2SU, Employee Relations activity (via dashboards) and local staff experience pulse survey produced for Divisional Boards to inform insight into local colleague experience. • Employee Engagement and Experience Oversight Group implemented to engage senior leaders across all divisions to address issues which have a detrimental impact on experience at work. • In depth Restorative Just and Learning Culture (RJLC) training secured for 30 leaders across Trust.	• Implementation of delivery plan overseen by Equality, Diversity & Inclusion Group (reviewed monthly) and monitored by People and Organisational Committee (PODC) (reviewed quarterly). • Quarterly report to PODC and Trust Board. • Annual update against strategy received by PODC. • Progress against F2SU improvement programme monitored by PODC and Improvement Board. • PODC monitors progress against agreed metrics for Trust Board Pledge and provides assurance to the Board. • Monthly monitoring of Employee Engagement and Experience Oversight Group progress and actions via PODC. • Comparative performance against organisational workforce and culture indictors available via Model Hospital. • Joint Race Code action plan with RWT in place.	and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Improvement of Workforce Equality and Workforce Disability Standards Performance (WRES / WDES). • Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital.
Gaps in Controls:	• Limited capability and capacity to provide depth and breadth of leadership development for leaders / people managers across the Trust. • Workforce policies require review and update. • Management competency framework is not yet available, impact and evaluation not complete • RJLC and Civility and Respect leadership modules to be developed.		
Assurance:	• Divisional and organisational performance monitored by Accountability Framework. • Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. • Staff recommending Trust as a place to work has increased from 47.8% [20190 to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • WRES indicator 2; recruitment improved from 2.73 [2019] to 1.52 [2020] to 1.40 [2021] • WRES indicator 3; disciplinary improved from 2.04 [2019] to 0.65 [2020] to 0.12	• NHSIE support to develop F2SU service and achieve improvements identified within programme. • NHSIE culture programme	• NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.

	[2021]. • WRES indicator 4; access to non-mandatory training and CPD improved from 1.34 in 2020 to 0.91 in 2021. • Faculty of Leadership and Management Development programme has commenced Divisional Leadership and Care Group Management Teams. • Increased BAME representation in B7 and above roles from 18.81% to 30% as at 30 December 2021.		
Gaps in Assurance:	• Trust 2020 National Staff Survey results score below sector average for 9/10 indicators. • From the early 2021 NSS results 51% of staff feel like the Trust acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or ageLack of senior managers representing ethnic minority and disability. This is an increase from 49% in NSS 2020, however is still below the average for the sector. • Only 55.8% of BME colleagues believe that we provide equal opportunity for career progression and promotion compared to 81.8% of White colleagues. From a BME perspective the experience has worsened for the second consecutive year decreasing further from 63.2% in 2019. • The number of staff reporting that they have experienced discrimination at wok from their manager / team leader or other colleague has increased to 11.4% and is 4.2% higher than in 2018. • Insufficient representation of managers from an ethnic minority background across the Trust [19.17% against a target of 28%]. • Only 2.46 staff have formally declared and recorded a disability		

Future Opportunities

- Enhanced leadership capability through strategic alliance with RWT and collaborative working with BCWB STP.
- Closer collaboration with RWT and across BCWB STP to increase capability and capacity to provide leadership and management development.

Future Risks

- Workforce exhaustion and/or psychological impact from Covid-19 may impact on the ability of managers to practice compassionate and inclusive leadership.
- Uncertainty regarding senior leadership arrangements of the Trust may impact on extent to which colleagues feel psychologically safe in their role/work.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Restorative Just and Learning Cultural Programme to be implemented for operational managers.	Catherine Griffiths	~~31/10/2021~~ 30/11/2021	Supplier identified. Course content to be developed and agreed by 30 September 2021. This has now been completed and dates for next cohorts are being arranged. Meeting set for 19 November to agree dates for training with provider. 3 x places secured on ICS training.	
2.	Senior Leadership Team to complete succession and talent mapping	Catherine Griffiths	31/10/2021	Templates and guidance circulated.	
3.	As a result from Freedom to Speak up Month review and update Raising Concerns Policy and F2SU strategy for 2022/23 working in collaboration with RWT	Catherine Griffiths	~~31/12/2021~~ 31/03/2022	Updated policy in draft form. To be consulted via internal stakeholders in January 2022 with aim to approve by end of Q4.	

4.	Launch Management Framework and Leadership Development opportunities	Catherine Griffiths	30/11/2021	**Complete**: SLA for leadership development provision with RWT in place. Final sign off for Management Framework to be agreed.	
5.	Establish collaborative working between RWT and WHCT staff inclusion networks	Catherine Griffiths	30/11/2021	**Complete**: EDI leads at RWT and WHCT are developing collaborative working plan. This will be overseen by the HR Collaborative Working Group.	
6.	Internal Audit re Effectiveness of National Staff Survey preparation to be completed.	Catherine Griffiths	30/11/2021	**Complete**: Draft audit complete. Due for finalisation and presentation to Audit committee in November 21.	
7	Review of leadership offer / options / opportunities across Walsall Healthcare NHS Trust and RWT.	Catherine Griffiths	30/09/2021	**Complete.** Review process agreed between RWT and WHCT leads. Outcome to be reported to future PODC.	
8	Divisional Leadership Teams to be supported to strengthen accountability towards improving the EDI agenda across their services.	Catherine Griffiths	30/09/2021	**Completed** - Divisional Talent Forums scheduled.	
9	Staff Engagement and Experience Oversight Group to produce menu of best practice from Divisional feedback re response to NSS and Pulse Survey	Catherine Griffiths	~~31/07/2021~~ 31/08/2021	**Completed**.	
10	Review of self-assessment / progress against NHS People Plan to be received by PODC in August 2021	Catherine Griffiths	31/08/2021	**Completed** - Presented to PODC in August 2021.	
11	WRES and WDES national data submission	Catherine Griffiths	31/07/2021	**Completed**.	

Latest Board/Committee/Group - 16/12/2021
Version V8.02

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04c - Making Walsall (and the Black Country) the Best Place to Work.
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
Lead Committee:	People & Organisational Development Committee

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **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 (Risk Score = 16, Consequence 4 x Likelihood 4). • **2093** - Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust (Risk Score = 12, Consequence 3 x Likelihood 4). • **1937 -** Risk of failure to protect staff from harmful substances (e.g. COVID-19) as a result of matching capacity for FIT mask testing and supply of PPE (Risk Score 10, Consequence 5 x Likelihood 2) • **2774** – Risk of some staff who work in front line roles and have face to face contact with service users who have not received both doses of the COVID-19 vaccine and therefore in line with the new statutory regulations with effect from 1 April 2022, will not be able to continue in their role. (Risk Score 20, Consequence 5 x Likelihood 5)	**Likelihood = 4** **Consequence = 4** **= 16 High ↔** Forecasted Risk Score Movement for Q4: **Likelihood = 4** **Consequence = 4** **= 16 High ↔**

Risk Appetite

Status:	Averse	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 9																									

Risk Scoring

Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	4	4	4		*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.* <u>Evidence of risk gaps in control.</u> • Staff recommending Walsall as a place to work is below all England average. • Staff recommending Walsall as a place to be treated is below all England average. • Employee Engagement Index of 6.7 below	Likelihood:	2	31 March 2022
Consequence:	5	4	4			Consequence:	5	
Risk Level:	**20 High**	**16 High**	**16 High**			Risk Level:	**10**	

					sector average of 7.0. • Lack of SEQOHS accreditation. • Sickness absence levels were 5.3% excluding Covid-19 related absence against target of 4.5% [30 June 2021]. • Lack of recurrent HWB funding to support ambitious and innovative HWB interventions. <u>Evidence of risk control Q3; Oct, Nov, Dec 2021</u> • Establishment of workforce dashboard report for managers re staff vaccination. As at 31 December 2021: - 91% staff received 1st Covid-19 vaccine - 88% staff received 2nd Covid-19 Vaccine - 71% staff that are eligible have received the Covid-19 booster. - 49% of available substantive staff have accessed the flu vaccine • ICS, local (WHCT specific) and collaborative (WHCT & RWT) project plan to manage risk of Mandatory Covid-19 vaccines in place. • Auto registration of all staff for LAMP testing complete. As at 17/12/21 32% compliance across the Trust. • Process in place via Corporate Command to continually review & update IFC / Workforce guidance produced for staff and managers re COVID-19 measures. • Agreement to fund further fit mask super trainer (train the trainer) to enable targeted local delivery. • Trust acceptance on Cohort 1 of the National NHSEI Flex for the Future cultural programme. • Implementation of Health & Wellbeing Strategy Group to improve governance of HWB interventions. • Completion of Self- Assessment against NHS Employers Health and Wellbeing Framework (HWBF) released in Nov 2021. • Initial (face value) raw NSS 2021 data identifies above average response to question m*y immediate manager take a positive interest in my health and well-being* – [67% compared to average of 66%].			

					• SEQOSH accreditation project plan remains on track for end of Q4. • Task & Finish group including senior Trust leaders in place to work through Mandatory Covid-19 vaccination implications. Action Plan developed at local and ICS level.		

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Schwartz rounds have been implemented in accordance with Point of Care Foundation license. • Internal Mental First Aider network established, accredited training complete and network contact details and support available to staff promoted. • Detailed project improvement programme plans for; *Health & Wellbeing Strategy*, *Achieving SEQOSH accreditation* and *Enhancing Flexible Working*. • Calendar of Black Country career events in place to attract and recruit to health and social care employment opportunities (NHS, Social Care and Voluntary Sector) • Development of system workforce metric. • Digital passport (improving education and training and mobility of workforce) • Anchor employer • Implementation of BMA Facilities and Fatigue Charter.	• People and Organisational Development Committee in place to gain assurance. • Monthly Schwartz Round Steering Group established to plan, prepare and debrief agreed rounds. • Colleague Health and Wellbeing group continues to meet and address feedback / act on ideas to enhance wellbeing in the workplace. • Trust Health and Wellbeing meets monthly to progress HWB activity and reports through to PODC. • Value Our Colleagues Improvement Programme has Governance infrastructure in place. • 2021 Pulse Survey completed.	• Achievement of SEQOHS accreditation and rolling improvement plan in Occupational Health • Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital. • Leading STP (BCWB) Workforce Supply Programme Delivery Group. • Members of STP (BCWB) Work • Leadership & Culture • Workforce flexibility & consistency (improving workforce capacity) • Education & Training • Workforce Support (HWB) • Health Education England QA process re-experience of Doctors in Post Graduate Training.
Gaps in Controls:	• More colleagues require training to apply the CHATS Framework when undertaking HWB conversations • Working towards gifting apprenticeship levy with social care partners / providers. • Development of Black Country Employer Brand. • Development of system health and social care roles to support system workforce gaps.		
Assurance:	• Increase in occupational health resources secured. • Divisional and organisational performance monitored by Accountability Framework. • Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. • Staff recommending Trust as a place to	• Health and Wellbeing Guardian appointed at Trust Board	• Quarterly deep dive of key workforce metrics by CCG. • NHSIE central and regional team oversight of progress against NHS People Plan. • Development of ICS Workforce Metric • SEQOHS Accreditation.

	work has increased from 47.8% [20190 to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • % of colleagues confirming manager takes interest in wellbeing has increased from 65% to 69% in 2020 NSS. • Stage 3 hearings re ill health capability have reduced. • Opportunities for flexible working patterns increased from 50.9% to 54.6 % in 2020 NSS. • Funding for Covid / infection risk team agreed until March 2022.		
Gaps in Assurance:	• Further validation of staff flu vaccination and Covid booster records required to provide assurance sufficient uptake. • LAMP testing capacity decommissioned from March 2022. • Approx. 500 staff remain unvaccinated from Covid-19 • Lack of recurrent HWB budget. • Trust 2020 National Staff Survey results score below sector average for 9/10 indicators. • Approved Health and Wellbeing Strategy • Not all colleagues are recorded as having completed an individual Covid-19 Risk Assessment. [as at 31 December 2021 85% recorded]. • Currently lack ability to consistently achieve and sickness absence levels of 4.5% or below. • Junior Doctor national training programme feedback.		

Future Opportunities

- Potential to rely upon complete Covid-19 vaccination of staff to reduce individual Covid-19 risk assessments to enable more staff to return to full roles in a Covid-19 secure way.
- Once SEQOHS accreditation achieved - potential to enhance service and develop commercial OH service across Walsall Partner.
- Closer collaboration with RWT and across BCWB STP to increase capability and capacity to enhance health and wellbeing of NHS and HSC staff.
- Formation of an evidence HWB strategy with closer working of OH / HWB teams on track to start Q2.

Future Risks

- Workforce exhaustion and/or psychological impact from Covid-19, flu and the general pressure on all NHS services may impact on the ability of managers to practice compassionate and inclusive leadership.
- Impact of managing further Covid-19 outbreaks via the occupational health team would reduce ability of OH to use specialist skills to support colleagues to remain at / return to work and in enabling clearance for new staff, and supporting the recovery from the reduced morale and increased health demands caused by the pandemic including Long Covid.
- Uncertainty regarding senior leadership arrangements of the Trust may impact on extent to which colleagues feel psychologically safe in their role/work.

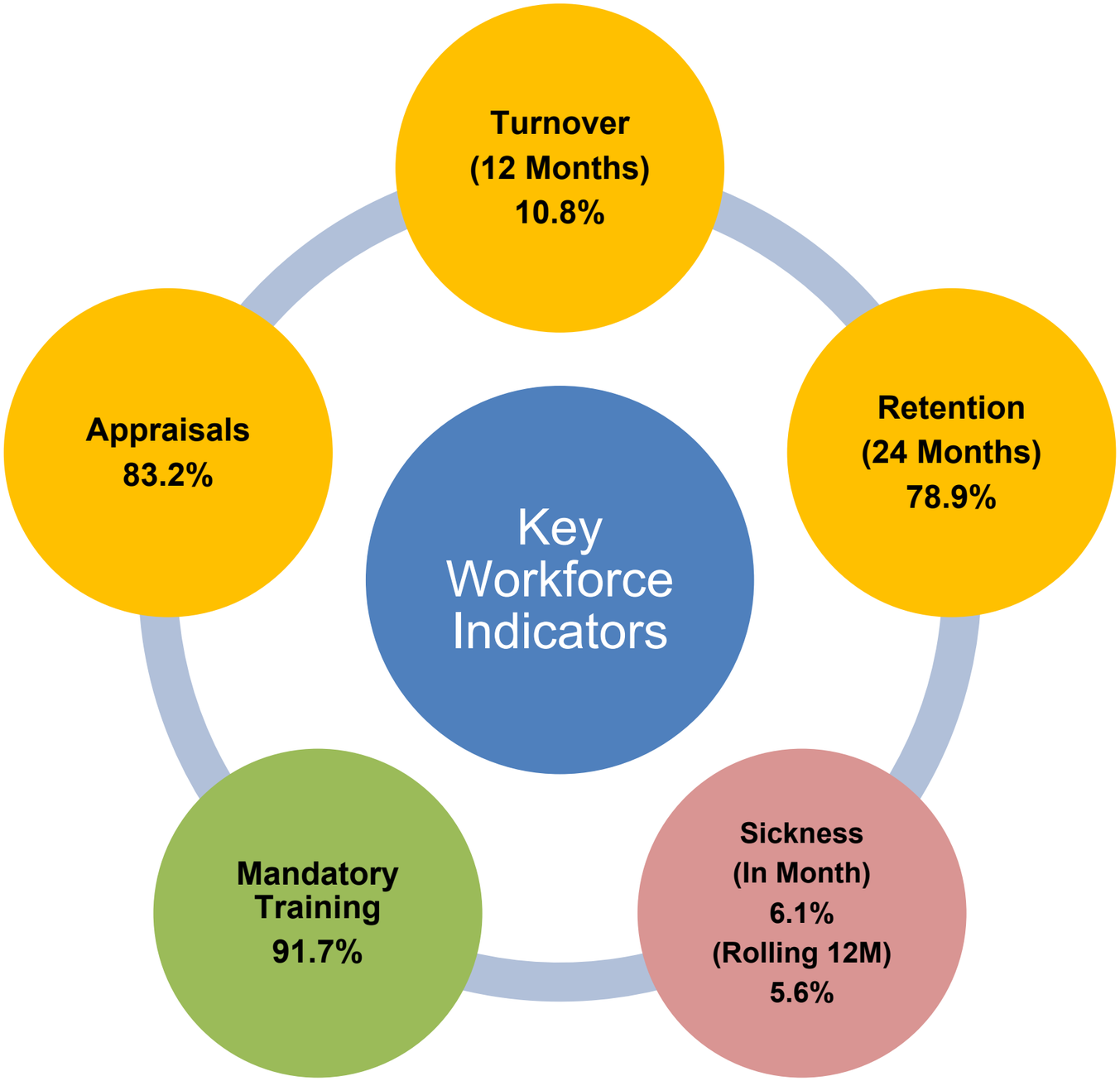
Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	HWB Stake Holder event to take place to identify areas of focus and priority for 22/23.	Catherine Griffiths	31/01/2022	Event booked to take place 10 January 2022. Outcomes to be reported to HWN Strategy Group in	

				February 2022.	
2.	Develop evidenced based Health and Wellbeing Strategy	Catherine Griffiths	~~31/12/2021~~ 31/03/2022	New project lead, milestones now on track. Self-assessment against national framework completed and presented to HWB Strategy Group 04.01.2022.	
3.	Business Case for 22/23 HWB funding to complement HWB strategy and support ambitious and innovative interventions.	Catherine Griffiths	31/03/2022	Update to HWB Strategy Group on 6 December 2021	
4.	Achieve Occupational Health accreditation	Catherine Griffiths	31/03/2022	All milestones ahead or on track. Reviewed at HWB Strategy Group 04.01.22	
5	Update interim Home Working Procedure and develop into flexible working strategy for the Trust.	Kevin Bostock	~~30/11/2021~~ 31/03/2022	Under review at Corporate Tactical. Guidance issued in relation to national updates. Strategy to be informed following feedback from agile working questionnaire distributed in November 2021.	
6	Execute local and ICS action plan to mitigate risks and take relevant actions to meet statutory obligation for staff employed to undertake regulated activities to have received both doses of a recognised Covid-19 vaccine.	Catherine Griffiths	01/04/2022	Local Task and Finish Group established. Staff in scope identified. Comms plan in place. ICS collaborative approach being taken.	
7	Complete Fit Mask trainer the trainer to increase expert resource and enable targeted, local delivery	Lisa Carroll	31/12/2021	**Complete**: Individual accredited to provide training.	
8	Substantively recruit to Occupational Health Consultant	Catherine Griffiths	~~31/10/2021~~ 30/11/2021	**Complete**: Recruitment paperwork in place. Interview took place 13 September 2021 - conditional offer made. Process to be finalised via RC rep on AAC panel 22.11.21.	
9	Complete gap analysis on Health and Wellbeing offer – for completion by end August 2021- to shape HWB strategy	Catherine Griffiths	31/08/2021	**Complete:** Document now supporting completion of National HWB Framework.	
10	Deep dive review of sickness absence at divisional level	Catherine Griffiths	17/09/2021	**Complete** - Workforce data and narrative from HR Advisory team shared with Divisions for Sept/Oct DPR	
11	Rapid roll out of Health and Wellbeing Conversation's via CHAT framework following successful pilot	Catherine Griffiths	30/09/2021	**Complete:** Regular training sessions available and training / HWB conversation resources printed and distributed. Intranet site updated and comparison of framework to national training completed.	
12	Implement regular Fit Mask Testing data reports	Catherine Griffiths	31/10/2021	**Complete:** Action Plan completed by compliance group (HSE, L&D, IFC) and reflected in risk 1937.	
13	Formally bring OH and HWB services together as one team.	Catherine Griffiths	30/09/2021	**Complete**.	
14	Data validation re Flu Uptake and Covid vaccinations to be completed.	Catherine Griffiths	30/11/2021	**Complete**: Plan agreed via weekly flu meeting and corporate command. Dashboard in place and weekly WFI report produced for management information.	
15	All staff to be auto-registered for LAMP testing	Catherine Griffiths	30/11/2021	**Complete:** Process rolled out in November 2021.	
16	Assurance paper to PODC re measures in place to protect staff from exposure to IFC risks	Catherine Griffiths	30/11/2021	**Complete:** CRR 2093 updated	

Walsall Healthcare NHS
NHS Trust

Workforce Performance Summary – December 2021



What Does The Data Tell Us?					
Will We Meet The Target?			Is Performance Stable?		
?	P	F		H L	H L
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

	Target	Will We Meet The Target?	Is Performance Stable?
Sickness Absence	4.5%	Sometimes	**Getting Worse**
Mandatory Training Compliance	90%	Sometimes	**Getting Better**
Appraisal Compliance	90%	**No**	Yes
Turnover (12 Months)	10%	Sometimes	Yes
Retention (24 Months)	85%	**No**	**Getting Worse**

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Nursing and Midwifery Safer Staffing Assurance Framework			**AGENDA ITEM: 19**
Report Author and Job Title:	Gaynor Farmer Corporate Senior Nurse for Workforce	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	On the 12th November NHSE/I released the document "Winter 2021 preparedness: Nursing and midwifery safer staffing" This paper provides the board with information on the existing controls and actions being taken to ensure safe staffing levels are maintained across the Trust		
Advise	• The Trust has robust systems in place for detecting and responding to staff absence. • The Trust has utilised the corporate nursing team and nurse specialists to support staffing rotas and ward managers and matrons have been working clinically at all times during December 2021 and January 2022.		
Alert	• The Trust has been under pressure during December 2021 and January 2022 due to increased nursing and midwifery staff absence as a result of an increased prevalence of COVID-19. • There has been an increased requirement for staff to be re-deployed during this time to mitigate risk and ensure safe staffing across the Trust. • The Trust has at no point been unable to provide at least 2 registered nurses on every shift but there have been shifts where staff have been unable to provide the standard of clinical care they would wish to deliver. • The requirement to utilise the corporate nursing team , ward managers and matrons to maintain safe staffing levels results in elements of the roles of these staff not being delivered during this time.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).		
Resource implications	The risk assessment details how staff have been re-deployed to maintain safe staffing levels Staff absence and the inability of the bank and on framework agencies to fill shifts has resulted in an increased use of off framework agency during December 2021		

Legal and/or 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 ☒	

Nursing and Midwifery Safer Staffing Assurance Framework

1. Background

On the 12th November 2021 NHSE/I released the document Winter 2021 preparedness: Nursing and midwifery safer staffing.:

This document states that Trust board members are collectively responsible for workforce planning, practice and safeguard and must ensure that actions taken focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

The Director of Nursing has completed a detailed risk assessment in accordance with the national guidance and this can be found in appendix 1.

A copy of the NHSE/I document published on the 12th November 2021 can be found in appendix 2.

2. Expectations of Trust Boards

The document clearly lays out the expectations of the Director of Nursing and Trust Boards and these are summarised below:

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.
- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.
- Executive Directors of Nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.
- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive Director of Nursing and countersigned by the Medical Director as joint quality lead.
- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.

Decision making and escalation

- Even during challenging times, executive Directors of Nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.
- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive Director of Nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.
- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.
- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.
- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.
- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.
- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.
- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.
- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.
- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.
- The Nursing and Midwifery Council (NMC) and the four Chief Nursing Officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.
- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.
- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.
- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. The CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.
- Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

3. Trust Risk Assessment

The Trust has completed a detailed risk assessment in line with the nationally recommended assurance framework for nursing and midwifery safer staffing document.

The detailed risk assessment can be found in appendix 1.

The Trust currently has controls in place to mitigate risk and has identified some areas where further action is required.

- Supporting staff to complete competencies to enable them to confidently work in different clinical areas/specialities
- Continued recruitment to establishment, including overseas recruitment
- Recognition that there is a continued reliance upon agency Registered Nurses until overseas nurses are all registered with NMC and during periods of increased staff absence due to COVID-19
- A central storage area for QIA and Risk Assessment for staffing to be identified
- Eroster Reviews to be embedded in Divisional routine
- Transfer of Care Policy and Incident Management Policy to be updated and ratified
- Temporary Staffing Policy to be written and ratified
- Ensure workforce vacancy information is made available on a weekly basis to divisions and DoN
- Finalise the Integrated Quality and Performance Report template and reporting to board

Walsall Healthcare NHS
NHS Trust

Assurance framework – nursing and midwifery staffing

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
1.	Staffing Escalation /Surge and Super Surge Plans						
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB	Critical Care reservist training ongoing to prepare for staff to be redeployed into the department. This includes ward and Theatre staff and support nurses from other clinical areas. CFN's within ICU are completing ICU competencies and perform at varying levels of the ICU nurse role. Winter Support Rota with volunteers from Corporate and Specialist Nursing established. Staff are deployed to the areas in most need. Phlebotomy support role in place in ED. Corporate PMO support for clerical/admin duties in place. Medical Students FY3/4/5 are being recruited onto bank to enable them to	Positive: Nursing and ODP staff members on reservist list (outside of ICU nominal role). Positive: Risk assessment completed for corporate nursing teams to support wards with rostered shifts. Negative: Risk of staffing gaps leading to inability to deliver safe, high quality care if the identified and redeployed volunteers are absent Negative: Agency usage, including off framework use, remains high with agencies not able to fill all shift requirements	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)	Enlisted redeployment may be required to maintain safe staffing and delivery of safe, high quality care if there are insufficient volunteers. Supporting staff to complete competencies to enable them to confidently work in different clinical areas/specialities Continued recruitment to establishment, including overseas recruitment Staffing hub to routinely expand forecast to 7 days forward view	Nil at present	Staffing Hub Twice Daily Meetings with escalations to Director of Nursing Divisional Directors of Nursing in Divisional ToT meetings Daily Senior Team Safe Staffing Meetings Safe staffing report to QPES and PODC

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		support ward areas with patient care tasks. Military support for general duties in place Central Staffing Hub established with twice daily staffing meetings and review of 72 hour forecast of staffing Elective surgery reduced to support staffing Overseas nurse recruitment: 153 in post; 121 on the NMC register					
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Each Division has completed a staffing escalation plan based on reduction of 75%/50% Staffing. Previous experiences have been considered.	Divisions have risk assessments in place for areas that are included in Winter Plans	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).	None	None	Staffing Hub Twice Daily Meetings with escalations to Director of Nursing Divisional Directors of Nursing in Divisional ToT meetings Daily Senior Team Safe Staffing Meetings Plans shared at Tactical Command

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)			
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Each Division has completed a staffing escalation plan based on reduction of 75%/50% Staffing and shared this with divisional team members Plans have been shared at Tactical and Corporate command and medical cell which includes staff side representatives	Divisions have risk assessments in place for areas that are included in Winter Plans	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)	Updated plans to be shared at JNCC and LNC	None	Staffing Hub Twice Daily Meetings with escalations to Director of Nursing Implementation of plans authorised through Tactical and Strategic Command Incident reports monitored on a daily basis with review at SI group and Patient Safety Group
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles	QIA process in place. There may be times	Completed QIA for winter pressure wards for 2021/22	Corporate risk 2066 – Risk of avoidable harm to patients due	Area for central logging of completed QIAs to be identified	None	Staffing Hub Twice Daily Meetings with escalations to Director

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
	(including base staffing levels) and this is signed off by the CN/MD	when these will happen dynamically and be recorded as changes enacted	completed and held by Divisions	to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)			of Nursing Implementation of plans authorised through Tactical and Strategic Command
2. Operational Delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily	Safecare Patient Acuity data captured twice daily. Safe Care and Staffing System, provides real-time staffing and patient acuity information. A review is undertaken at the Staffing Hub meetings twice daily where Matrons review acuity	Red Flag process in place since June 2020 to support staff to raise concerns relating to patient safety and near miss issues. Matron reviews the red flag incidents and places in mitigation within SafeCare system. On Call Manager	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed	Implementation of Eroster Reviews to ensure effective roster management.	None	Staffing Hub Twice Daily Meetings with escalations to Director of Nursing Directorate/Divisional Staffing Meetings

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		and Red Flag information alongside staffing and make decisions on staff movement to maintain safe staffing levels	responsible for management of staffing outside of hours.	establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)			
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.	Staffing Hub meetings are in place twice daily to identify and escalate risks to DoN via SITREP report. Staff re-deployment recorded on daily sit-rep Deployment of staff from other areas centrally logged and held by Workforce team. Out of hours senior nurses have access to central log to record deployment/re-deployment out of hours	Positive- Twice daily review of forecast of next 4 days Negative- limited to 4 days forecast	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit.	Staffing hub to routinely expand forecast to 7 days forward view	None	Staffing Hub Twice Daily Meetings with escalations to Director of Nursing Implementation of deployment plans authorised through and overseen by Tactical and Strategic Command

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				There are shortages across several staff groups.(Risk score 16)			
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.	SBAR communication tool in use Red flag system on safecare to identify immediate skills and care gaps Safecare red flags reviewed at least twice daily during Trust wide staffing meeting. Transfer of Care Policy in place Incident Reporting via Safeguard Incident Management System	Positive-Policy provides guidance on the safe handover of patient care needs and the responsibility of the nurse in charge of the receiving area.	Corporate risk 2664 - Patient Safety and Training Issues in Medicine / ED (Risk Score 20).	Transfer Policy currently being updated	None	Divisional Directors of Nursing in Divisional ToT meetings Daily review of incidents reported. Director of Nursing Safe Staffing report to PODC and QPEs details red flags and mitigations. Escalations from divisions to Patient Safety Group
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	SBAR communication tool in use Red flag system on safecare to identify immediate skills and care gaps Safecare red flags reviewed at least twice daily during Trust wide staffing meeting. Transfer of Care Policy in place	Positive-Policy provides guidance on the safe handover of patient care needs and the responsibility of the nurse in charge of the receiving area.	Corporate risk 2664 - Patient Safety and Training Issues in Medicine / ED (Risk Score 20).	Transfer Policy currently being updated	None	Divisional Directors of Nursing in Divisional ToT meetings Daily review of incidents reported. Director of Nursing Safe Staffing report to PODC and QPEs details red flags and mitigations. Escalations from divisions to Patient Safety Group

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		Incident Reporting via Safeguard Incident Management System					
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	There is a Trust Local Induction that is to be used for when new Agency or Bank staff are working in department areas	Positive: document is in existence and is available to all department areas Negative: lack of assurance of completion by ward areas	2663 - Lack of support to new Trust nursing staff, including but not limited to International Nurses (Risk score 9).	Implement monitoring of Nurse Induction completion via Nurse Bank Temporary Staffing policy to be ratified	None	Report to Information Governance Group
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.	Raising Concerns policy in place Letter to all staff on 23rd December 2021 from DoN, CMO, COO and staff side Freedom to Speak Up Capacity Meeting Red flag system on safecare to identify immediate skills and care gaps Safecare red flags reviewed at least twice daily during Trust wide staffing meeting. Incident Reporting via Safeguard Incident Management System	Positive- Senior nurse and matron onsite rota 7 days per week. Onsite senior nurse are available out of hours to support staff with concerns raised.	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated	None	None	Director of Nursing Safe Staffing report to PODC and QPEs details red flags and mitigations. Incident reports monitored on a daily basis with review at SI group and Patient Safety Group Freedom to Speak Up Guardian report

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)			
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.	Twice Daily Staffing meeting. Review of Safecare (with recorded redeployments and mitigations of any Red Flags or raised Risks/concerns) Freedom to Speak Up Guardians available to staff Incident Reporting via Safeguard Incident Management System	Positive: evidence within Safecare and Staffing Hub SITREP	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)	None	None	Three times a week Senior Nurse Huddle to identify on site issues Head of Workforce monthly Red Flag report to NMAAF Director of Nursing Safe Staffing report to PODC and QPES details red flags and mitigations. Freedom to Speak Up Guardian report
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing.	Intranet Homepage with Health and Wellbeing Support for	Monthly report to PODC includes Health and well being offer	Corporate risk 2489 -A significant loss of workforce diversity,	Train more PNA/PMAs to support staff in the workplace	None	Ongoing People and

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
	The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.	staff to refer to. Staff Self Care and Wellbeing booklet available- including help lines Occupational Health Support available Links to NHS England and NHSi for psychological support with links to wellbeing apps BAME specific advice Trust has Mental Health First Aiders Wingman Lounge for staff 'time out' Chaplaincy support Manor Farm lounge with rest areas and free drinks and snacks Corporate command led by Director of People and OD with agenda item focussing on health and well being of staff Access to external psychological support for staff through HR	Staff feedback through drop in sessions and staff surveys	talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work (reduction in effort above and beyond contractual requirements), lack of opportunity to develop and progress, not feeling safe due to unacceptable behaviours such as racism, bullying and harassment, workforce fatigue and not valued for the incredible job that they do and therefore not recommending the trust as a place to work or a place to be treated.			Organisational Development Committee.

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		Executive team site presence walking Trust and speaking to staff A staff experience and engagement group established Freedom to speak up service in place					
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self-Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.	Occupational Health and Human Resources hold data relating to unavailability which includes self-isolation, shielding as well as coded sickness. Safecare Patient Acuity data captured twice daily. Safe Care and Staffing System, provides real-time staffing and patient acuity information. A review is undertaken at the Staffing Hub meetings twice daily where Matrons review acuity and Red Flag information alongside staffing and make decisions on staff movement to maintain safe staffing levels	Positive: evidence within Safecare and Staffing Hub SITREP Monthly safe staffing and workforce reports to PODC	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages	Long term non-c0vid related sickness data to be provided to DoN to ensure oversight of long term sickness management within non-medical clinical workforce. Monthly confirm and challenge meetings with Div DoNs and Matrons to be instigated	None	Monthly safe staffing report and Workforce reports to People and Organizational Development Committee (PODC)

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				across several staff groups.(Risk score 16)			
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.	Indicatively post arrest and peri arrest debriefs are provided for and an individual is identified to provide this debrief. Time to talk sessions in place to enable staff to raise concerns Divisional Governance Advisors aligned within each division to support incident management process Daily safety huddles on every ward Weekly divisional safety huddles in place Governance and Risk Management Framework in place and available on the intranet Incident Reporting and Management Policy in place and available on the intranet Risk Management	Positive-Incidents are reported the Trusts incident management system- SafeGuard. Daily review of incidents at care group and divisional level with all incidents of moderate harm or above reviewed daily be member of executive team. Divisional Safety huddles occur weekly reviewing all incidents moderate and above for learning. Monthly Patient Safety Group Weekly Serious Incident committee Negative- Incident Reporting and Management Policy is out of date –currently being reviewed	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)	Incident Reporting and Management Policy currently being updated	None	Monthly report Quality and Patient Experience Committee

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		Policy and Strategy in place and available on the intranet Weekly Serious Incident Group in place Monthly Patient Safety Group in place Health and well-being established sessions and access to psychologists					
3.	Governance via EPRR route (when/if required)						
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Tactical and Strategic Command to provide the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	Weekly Corporate Tactical group in place to review staff related concerns – all decisions and escalations documented A Health and Wellbeing Group is in place Staffing Hub is in place to support staffing decisions with all re-deployment documented Weekend plans and Business Continuity Management Policy in place	Staffing escalations are managed through staffing hub meetings and are escalated to Tactical and Strategic command if required Weekend plans and Business Continuity Management Policy in place	Corporate risk 2489 -A significant loss of workforce diversity, talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work . Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15).	Consider increased utilisation of national support packages to resolve tactical and strategic staffing issues.	None	EPRR Team monitoring and reporting to Tactical and Strategic command

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16			
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (strategic and tactical command)	Staffing Hub takes place twice daily reviewing site staffing and re-deploying staff as required to maintain safe staffing levels. All staffing decisions are documented on the staffing SITREP 4 day forward view of staffing embedded in staffing hub process Escalation to Tactical and Strategic	Positive- escalations and SITREP report embedded in practice with oversight and escalation to the DoN and senior colleagues	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20).	Staffing hub to routinely expand forecast to 7 days forward view	None	Three times a week Senior Nurse Huddle to identify on site issues Head of Workforce monthly Red Flag report to NMAAF Director of Nursing Safe Staffing report to PODC and QPES details red flags and mitigations.

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
		command if required		Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)			
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	The Trust submits SITREP reports as required to the regional and national teams. DoN, COO and CMO attend required resilience forums and escalate through regional leads as required. Weekend plans and Business Continuity Management Policy in place	Positive: Business Continuity Management Policy defines levels of responsibilities including CCG/NHSEI and Trust reliance upon services from other organisations	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated	None	None	EPRR Team escalation reports and oversight at Tactical and Strategic Command

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)			
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	Workforce Intelligence able to provide a spectrum of staffing data. Staffing rotas available in Allocate Healthroster system providing real time staffing data within acute Trust SafeCare and Red Flag is in use across all wards to identify areas of concern and document mitigation	Limited data is available for informing and reporting on staffing risks- work arounds are enacted but some manual Community/ AHP/ non clinical rotas are not included on Allocate System Limited absence and vacancy data in the required granularity	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.(Risk score 16)	Absence and vacancy reports to be provided to divisions and DoN on a weekly basis	None	Head of Workforce monthly Red Flag report to NMAAF Director of Nursing Safe Staffing report to PODC and QPES details red flags and mitigations.
4.	Board oversight and Assurance (BAU structures)						
4.1	The quality committee (or other relevant designated board committee)	The Safe High Quality Care Report to QPES	Mandatory Monthly Reporting	Corporate risk 2066 – Risk of avoidable	Work currently underway to develop	None	Monthly Safe High Quality Care Report to

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
	receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks.	provides data on the clinical quality of care and staffing information. PODC receives a monthly safe staffing report		harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)	nurse quality indicators and dashboard to enable ease of visibility of links to quality and staffing. Going forward this will be included in reports to QPES and PODC		QPES Monthly Safe Staffing Report to PODC DoN report to Trust Board
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	DoN Report is triangulated data from the staffing report, incidents nurse sensitive indicator metrics.	Mandatory Monthly Reporting	Corporate risk 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 15). Corporate risk 2245 - Risk of suboptimal care and potential harm to patients from available midwives being below agreed	Work currently underway to further develop nurse quality indicators and dashboard to enable ease of visibility of links to quality and staffing. Going forward this will be included in reports to QPES and PODC	None	Monthly Safe High Quality Care Report to QPES Monthly DoN report to TMC DoN report to Trust Board

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
				establishment level (Risk Score 20). Corporate risk 2372 – community services - The appropriate workforce and skill mix required to deliver the business case model may not be available. (Risk score 16)			
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.	Monthly workforce intelligence report to PODC Integrated performance dashboard drafted and shared with Trust Board	Mandatory Monthly Reporting Trust Accountability Framework reports are not adapted to Covid		IQPR to be finalised with monthly reporting to Trust Board	None	Monthly Workforce Intelligence to PODC IQPR report to Trust Board
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.	Monthly DoN report for Quality and Workforce is reported to TMC and Board Safe High Quality Care Report to QPES	Monthly DoN report for Quality and Workforce is reported to TMC and Board	BAF SO01 –Safe High Quality Care	Work currently underway to further develop nurse quality indicators and dashboard to enable ease of visibility of links to quality and staffing. Going forward this will be included in reports to QPES and PODC	None	Monthly Safe High Quality Care Report to QPES Monthly DoN report to TMC DoN report to Trust Board
4.5	The quality committee is assured that the decision making via the Incident management structures (strategic and tactical) minimises any potential exposure of patients to harm than may	EPRR Arrangements: Staffing discussed and acted upon at both strategic and tactical command levels.	Weekend plans and Business Continuity Management Policy in place	BAF SO01 –Safe High Quality Care	None	None	EPRR Team escalation reports and oversight at Tactical and Strategic Command

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
	occur delivering care through staffing in extremis.	Strategic command review process and escalation for mutual aid support as/when necessary COO update to QPES	Weekly System wide call with National Leads attended by members of executive team COO and Director of Assurance provide report into quality committee from incident management structures				Monthly COO report to QPES
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	COO update to QPES	COO and Director of Assurance provide report into quality committee from incident management structures	BAF SO01 –Safe High Quality Care	None	None	Monthly COO report to QPES
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.	Monthly DoN report for Quality and Workforce is reported to Board	Monthly DoN report for Quality and Workforce is reported to Board	BAF SO01 –Safe High Quality Care	None	None	Monthly DoN report to Trust Board
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Board Risk Appetite work remains under discussion.	Risk is discussed on case by case basis.	BAF SO01 –Safe High Quality Care	Risk appetite to be reviewed by Trust board	None	Monthly BAF review at Risk Management Committee Monitoring at Trust Board
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on	Board Assurance Framework S003 in place and reviewed	Agenda Item on Board Workplan/Agenda	BAF SO03- Working with partners for sustainable staffing	None	None	Monthly BAF review at Risk Management Committee

		Controls	Assurance (positive and negative)	Residual Risk Score/ Risk Register Reference/Links to Risks on Risk Register	Further action needed	Issues currently escalated to Local Resilience Forum/Regional Cell/National Cell	Ongoing Monitoring/Review
	the strategic objectives and these risks are adequately documented on the Board Assurance Framework	monthly					Monitoring at Trust Board
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	Board Assurance Frameworks SOO1 and SOO4b in place and reviewed monthly	Agenda Item on Board Workplan/Agenda	BAF SO01 –Safe High Quality Care BAF SO04b.- organisation effectiveness – recruiting and retaining staff	None	None	Monthly BAF review at Risk Management Committee Monitoring at Trust Board
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	DoN reporting fundamental staffing concerns to CQC and NHSE/I as necessary via relationship manager (CQC) and Regional Chief Nurse. (NHSE/I)	Monthly meeting in place with CQC Weekly DoN/CNO call with Regional CNO in place		None	None	DoN report to Trust Board

Classification: Official

Publication approval reference: PAR1068

Key actions

Winter 2021 preparedness: Nursing and midwifery safer staffing

12 November 2021, Version 1

Trust board members are collectively responsible for workforce planning, practice and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.

- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.

- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.

- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.

- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic – and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

- Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

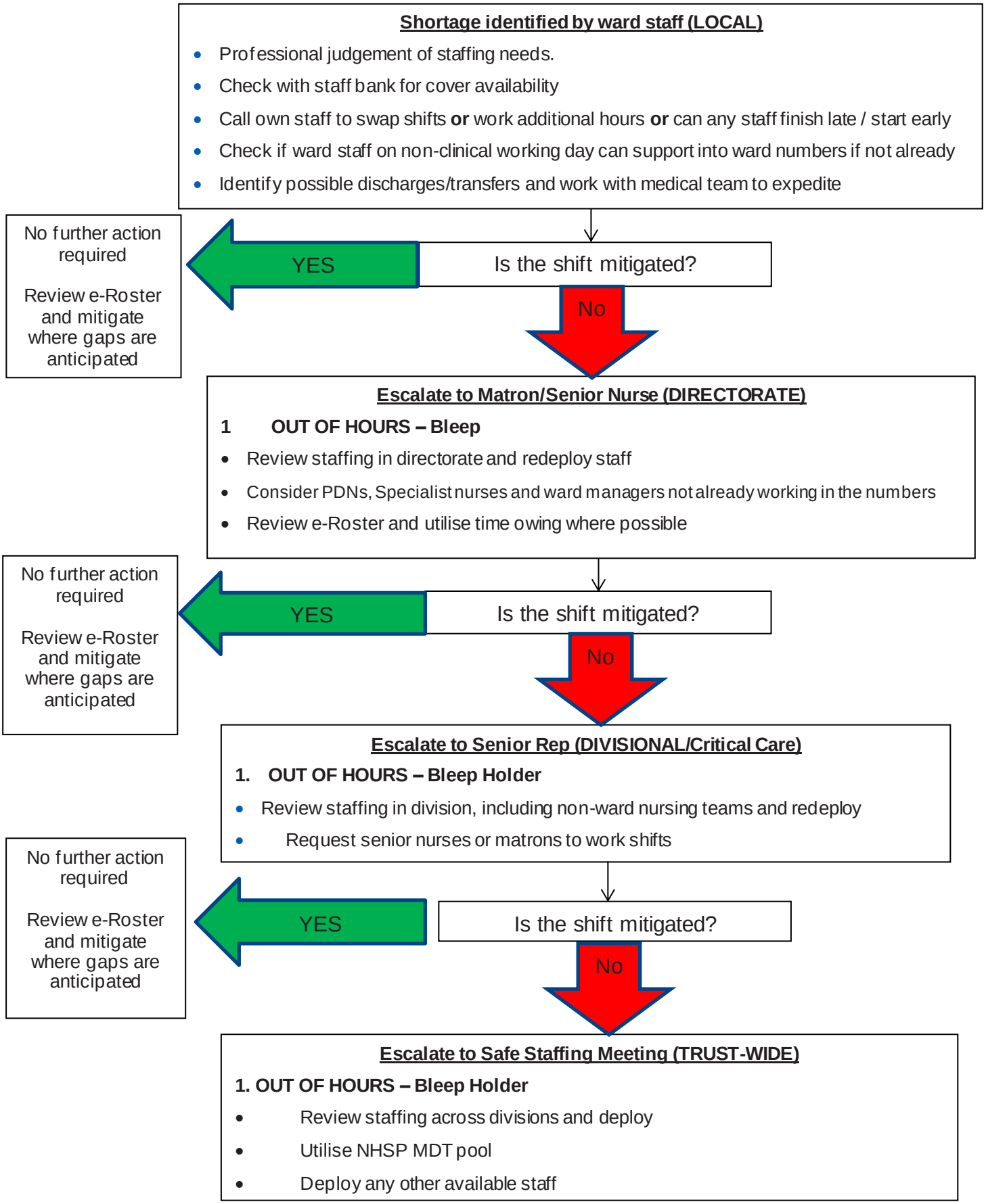
Useful links:

Alongside the formal guidance that has previously been issued in this area, a collection of additional resources has been collated for use by providers. These resources are attached as appendices and/or via the following links:

Planning • NHS England and NHS Improvement: Advice on acute sector workforce models during COVID-19 • NHS England – Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals • NHS England – Nursing and midwifery e-rostering: a good practice guide • Safe midwifery staffing for maternity settings	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessments for staff	**Decision making and escalation** • Appendix 1: Decision and escalation framework tool • Appendix 2: Quality impact assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting
Governance and assurance • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards • Care Quality Commission	**Indemnity and regulation** • NHS Resolution Clinical Negligence Scheme for Coronavirus (CNSC)	**Additional resources** • Report template - NHSI website (england.nhs.uk)

Appendix 1: Decision tool and escalation framework

Flow chart for resolution of staff shortages, to support nurse(s) in charge and matrons on a shift-by-shift basis.



Appendix 2: Example quality impact assessment

Follow this link to view (FutureNHS account required):
https://future.nhs.uk/BeneficialChangesCOVID19/view?objectId=93995109

Appendix 3: Example staffing SBAR Tool

Staffing communication tool using situation, background, assessment, recommendation (SBAR) principles to ensure critical staffing issues are received and actioned.

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

How long has the shift been out to the Hospital Nurse Bank:

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

For boards and senior leaders outlining the pressures on the service and any potential changes in the level of accepted risk.

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Appendix 5: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	**Details**	**Controls**	**Assurance (positive and Negative)**	**Residual Risk Score / Risk register reference**	**Further action needed**	**Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell**	**Ongoing Monitoring / Review**
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*
1.	**Staffing Escalation / Surge and Super Surge Plans**						

1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance						
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.						
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee						
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate						

	shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.						
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.						
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.						

2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.						
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.						
2.9	The trust has robust mechanisms for understanding the current staffing						

	levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver						

	and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.						
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and						

	medium term solutions to mitigate the risks.						
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.						
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.						
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.						

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.						
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework						

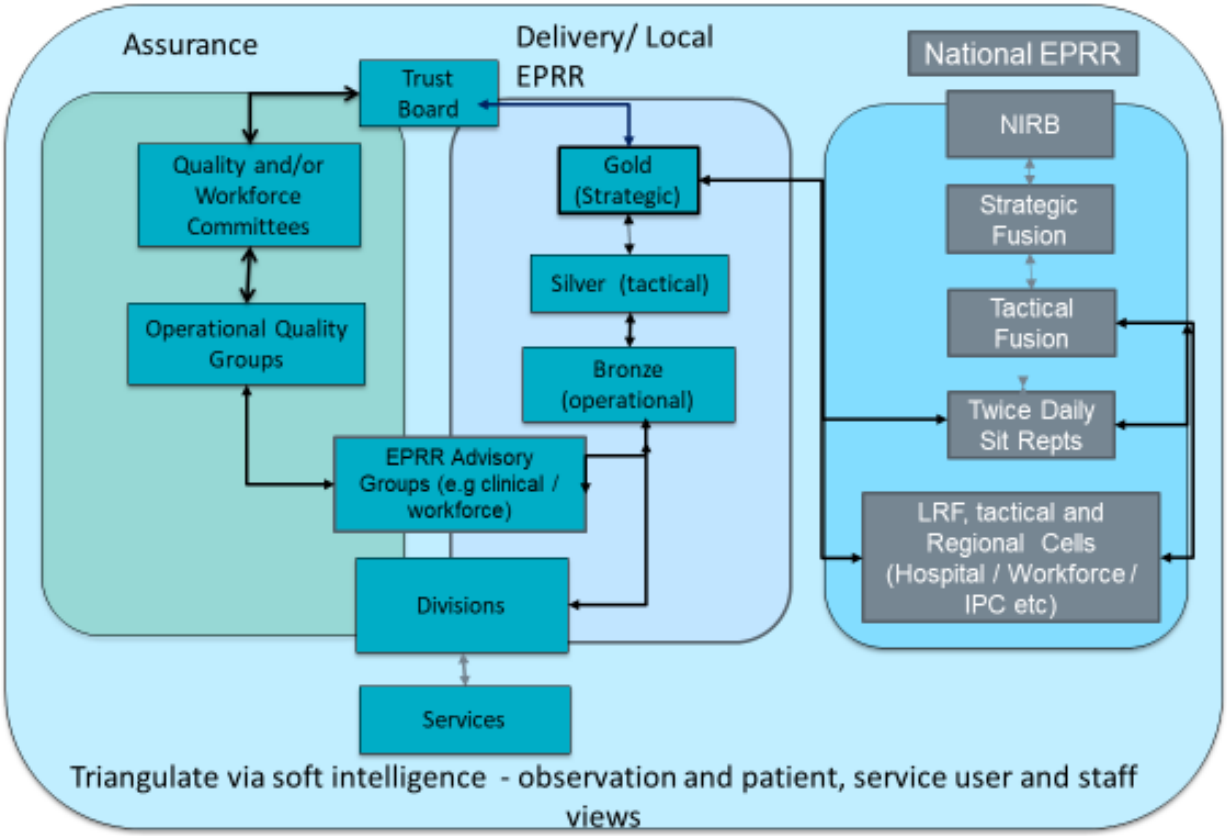
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

The flowchart below is a general illustrative example. It outlines the two arms of a provider governance framework (assurance and delivery) and further indicates the relationships with the national emergency preparedness, resilience and response (EPRR) structures.

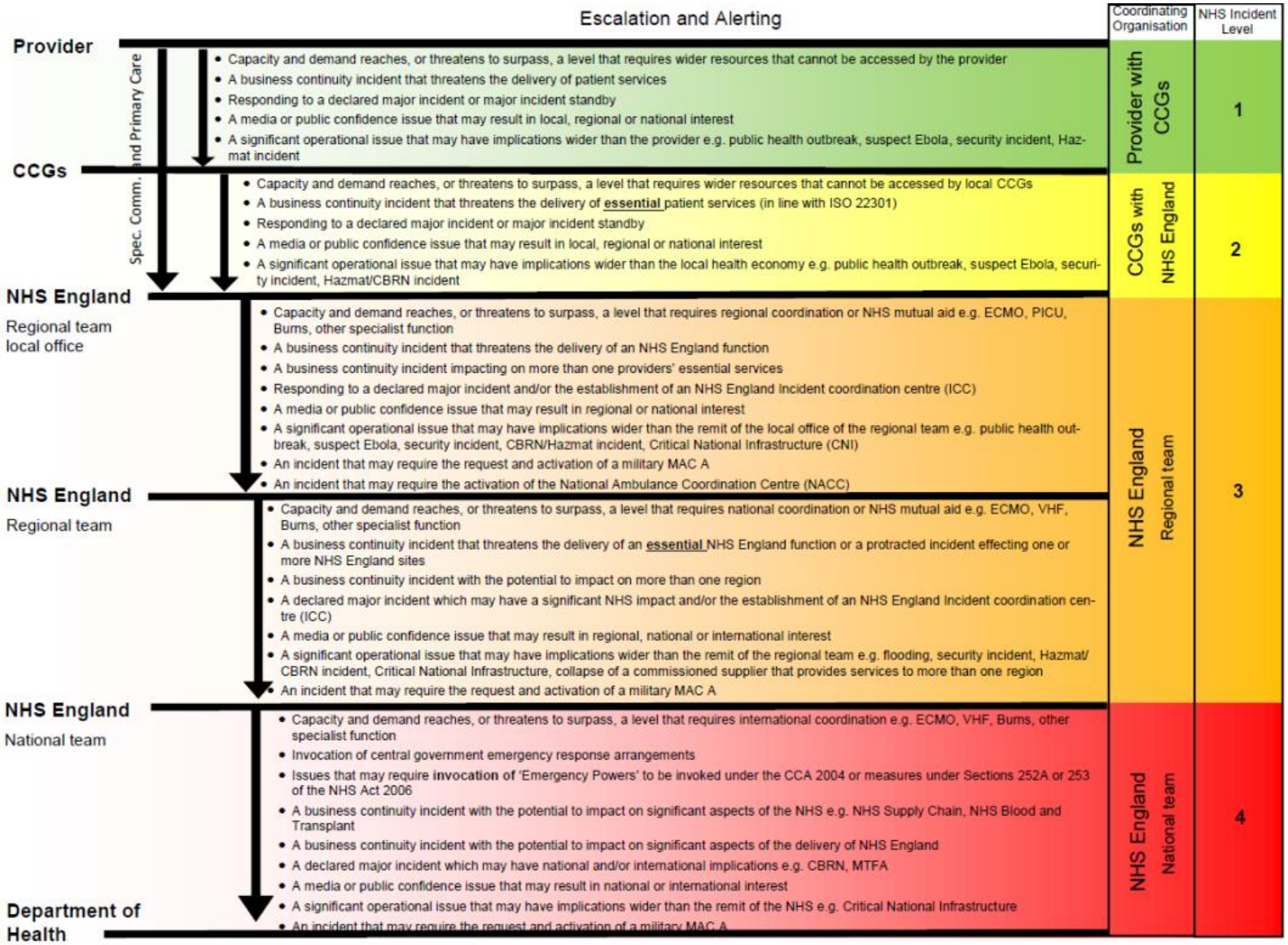
Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

This should be through their existing board assurance routes (ie quality committee, strategic workforce and organisational development committee to the board), to allow the non-executive directors to adequately fulfil their duties of holding the executive director members to account so that quality care is maintained.



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework



Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Nursing Workforce Safeguards			**AGENDA ITEM: 19**
Report Author and Job Title:	Gaynor Farmer Corporate Senior Nurse for Workforce	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• In October 2018 NHSI launched a Workforce Safeguards toolkit to direct Trusts to ensure that there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. • The Trust is required to complete an annual assessment against the safeguards		
Advise	• The Trust is fully compliant with 7 of the 14 indicators sand has ongoing actions to achieve compliance in the remaining 7.		
Alert	• No alerts to report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF Corporate risk 2066; Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels		
Resource implications	None		
Legal and/or 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 ☒		

Nursing Workforce Safeguards Assessment of Trust Compliance

Background

In October 2018 NHSI launched a Workforce Safeguards toolkit to direct Trusts to ensure that there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. The Trust is required to undertake an annual benchmark against the standards and identify any plans to overcome shortfalls in compliance. The Trust reviewed compliance in January 2022 and this paper provides the Trust Board with an overview of compliance against the standards.

The workforce safeguards state that Trusts should ensure they:

- Deploy sufficiently suitable qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively
- Have a systematic approach to determine the numbers of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
- Use an approach that reflects current legislation and guidance where it is available

Trust Assessment January 2022

An initial assessment of compliance against the standards within the Workforce Safeguards toolkit was undertaken in October 2020 and this was updated in January 2022.

The assessment completed in January 2022 demonstrates that the Trust is fully compliant with seven of the fourteen standards and has identified actions in place to achieve compliance by the target dates in the remaining seven. The full assessment document can be found in the appendix.

Areas of focus in 2022

- Include all Model Hospital workforce data available to the Trust in the Monthly Staffing Report.
- Undertake a review of the Trusts Annual Governance Statement to ensure inclusion of staffing governance process and assurance that these are safe and sustainable
- Undertake a review of nursing quality indicators, Perfect Ward audits and reporting and assurance mechanisms to ensure safe staffing reports include quality outcomes, operational and finance performance measures.
- iQPR report to Trust board to triangulate and cross check data on staffing and skill mix with efficiency and quality metrics.
- Quality Impact Assessments (QIA) and Risk Assessments for staffing to be completed for any service change
- New Roles QIA and meeting assurances

Reporting

Progress against the action plan to achieve full compliance and ensure ongoing monitoring will be included in the Nurse Staffing Report to People and Organisational Development Committee on a monthly basis.

Developing Workforce Safeguards Action Plan
Developed and updated: 191020

Recommendation	Trust Position (Aug 2020)
1. Trust must formally ensure NQB (2016) is embedded in their safe staffing governance	Trust has safe staffing governance and reporting in place to comply with safer staffing guidance
	Trust has been working using some data from the Model hospital to allow comparison with peers- this is still in infancy
	Report in patient planned and actual staffing levels on a monthly basis
	Monthly report on in patient staffing levels integrated with Monthly Staffing Report
	Establishment reviews follow a robust methodology which includes a triangulated approach using the recommended NHSi tool (Safer Nursing Care Tool with Hurst Model recommended staffing ratio's)

2. Trust must ensure that the 3 components (see below) are used in their safe staffing processes: A) evidence based tools B) professional judgement C) outcomes	Establishment reviews follow a robust methodology which includes a triangulated approach using the recommended NHSi tool (Safer Nursing Care Tool with Hurst Model recommended staffing ratio's)
	Best practice benchmarks are used and considered for Establishment reviews that have a 'specialism'- i.e. Paediatrics, Midwifery, Intensive Care.
	Professional Judgement is used as part of the review considering the Quality indicators for an area and any factors that fall out of 'norm' for an area.
	Establishment reviews are undertaken in the presence of the Divisional Finance staff and also the Deputy Director of Nursing.

	Outcomes will be evaluated and a joint working group will meet and discuss the evidence gathered and recommendations to add another opportunity for professional judgement and sign off before being presented to Board
3. NHSE/I will base assessment on the Annual Governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable	Annual governance Statement
4. NHSE/I will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complete quality outcomes, operational and finance performance measures	Annual governance Statement
5. NHSE/I will seek assurance through the SOF monitoring performance	Monthly Reports for Nursing Activity and Staffing are part of the normal reporting business. (Monthly Staffing Report/ Quality Report-Oversight)
	Monthly Reports for Nurse Rostering and Red Flag activity to the sub committee Nursing and Midwifery Advisory Forum. (Eroster Report/ Red Flag Report)
6. As part of the safer staffing review, the Director of Nursing and Medical Director, must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	>Nursing- this statement will form part of the establishment Review outcomes paper
7. Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The Board should discuss the workforce plan in a public meeting	

8. Board must ensure that their organisation has an agreed quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital Dashboard. Trust should report on this to their Board every month.	Monthly Quality Report is shared and a Ward Quality Dashboard is in use. Trust has started to use the Perfect Ward app for recording quality
	NHSi Staffing fill rates is reported monthly as part of the Oversight report but does not currently include Model hospital comparisons (previous report iterations have)
9. An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgment and outcomes	Establishment reviews were held formally in October 2019 and the process is currently being undertaken. The Establishment review template for discussion encompasses the recommendations for process from Developing Workforce Safeguards Document.
10. There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	The tool used is the NHSi recommended Safer Nursing Care Tool (Imperial Tool) which includes the Hurst Model for establishment recommendations. Data is not manipulated. The tool gives the flexibility to apply recommended ratio's of staffing for specialised areas.
11. As stated in CQC's Well led Framework guidance (2018) 6 and NQB guidance, any service changes, including skill mix changes must have a full quality impact assessment (QIA) review	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of Divisional QIA and local risk assessments

12. Any redesign or introduction of new roles (including but not limited to Physician Associate, Nurse Associate and Advanced Clinical practitioners) would be a service change and must have a full QIA	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of new role QIA's automatically
13. Given day to day operational challenges, we expect Trusts to carry out business as usual dynamic staff risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described i these risk assessments	There are mechanisms in place for dynamic planning and review of staffing. Twice daily approval meetings happen across the hospital which include a review of staffing in our Community based setting. Escalation processes are in place and in times of extremis we have a mechanism for deploying the 'staffing hub' which is a central control room for staffing management. The site is risk assessed during the twice daily meetings and decisions taken to redeploy, work differently, escalate staffing demand where is impacting quality. There is consideration to Red Flags/Acuity/Enhanced levels of care suring these meetings and not a singular focus on staffing numbers.
14. should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue,(and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example wards , beds and teams, realignment, or a return to the original skill mix	Business continuity plans are enacted where required. Example- Covid19 response. Updates to the actions taken and escalations of concern are included in the Nurse Oversight Report. Information is shared across sub committees in both the Quality, People and Financial work streams.

Identified Action	Owner	Progress Update
>twice yearly data capture from Safer Nursing Care Tool is to be reported to Board	Gaynor Farmer	>19.10.20- the data capture from earlier in the year had completed just prior to Covid pandemic and so wasn't shared with Board. The data was captured and retained. August 20 SNCT data capture will be included with establishment review outcomes and the twice daily normal business (normally complied with) will continue.
>Improve the reporting and comparison of the Monthly Model Hospital data and detail in Staffing papers	Gaynor Farmer	>19.10.20- review of CHPPD data will occur within the Establishment review outputs and a reporting method into the PODC staffing paper will begin from Nov 20
none-embedded practice		
none- embedded practice		
>ensure that all of the Workforce Safeguards inclusions are placed into the methodology for the Establishment reviews	Gaynor Farmer	>19.10.20- The current Establishment Reviews are taking place with a methodology using the SNCT with Hurst Model recommendations included. The reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing. The data capture has included the recommendations from the Developing Workforce Safeguards document.

>ensure that all of the Workforce Safeguards inclusions are placed into the methodology for the Establishment reviews	Gaynor Farmer	>19.10.20- The current Establishment Reviews are taking place with a methodology using the SNCT with Hurst Model recommendations included. The reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing. The data capture has included the recommendations from the Developing Workforce Safeguards document.
	Gaynor Farmer	>19.10.20- The current Establishment Reviews are taking place with a methodology that includes the appraisal of any national benchmarking / guidance for specific areas such as ITU/Paediatrics/Midwifery.
	Gaynor Farmer	>19.10.20- During the current Establishment Reviews there is a discussion exploring the Quality Indicators for that area and asking the representatives to flag any indicators out of norm. Following the data collection a review will take place within Corporate Nursing to establish any additional professional judgement factors that should be considered.
	Gaynor Farmer	>19.10.20- The current Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.

	Gaynor Farmer	>19.10.20- The current Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.
> annual governance statement to be reviewed and a evaluation completed re Nurse Staffing Processes.	Gaynor Farmer	>19.10.20- The Annual Governance Statement to be reviewed and any additional actions to be placed into this document. Sought from Trust Secretary
> annual governance statement to be reviewed and a evaluation completed re Nurse Staffing Processes.	Gaynor Farmer	>19.10.20- The Annual Governance Statement to be reviewed and any additional actions to be placed into this document. Sought from Trust Secretary
none- embedded practice		
none- embedded practice		
>ensure statement is made for Nursing in Establishment review paper	Gaynor Farmer	>19.10.20- Establishment Reviews currently being undertaken. Outcomes report due Nov20
> ensure that the annual workforce plan is updated/ signed off and discussed at a Public Board	Gaynor Farmer	>19.10.20- requested an update from the Workforce and HR team

>developments to include the comparison of Trust data with Model Hospital data are to be progressed once Perfect Ward is embedded	Gaynor Farmer	>19.10.20- currently data cleansing the Perfect Ward data and the aim is to complete this by end of October
>include model hospital benchmark	Gaynor Farmer	>19.10.20- CHPPD comparison to be included from Nov. 20 report
To embed the twice yearly reporting into Business As Usual. Only 1 report has gone in the last 12 months re establishments due to Covid19 pandemic. Ordinarily this is completed	Gaynor Farmer	>19.10.20- Establishment reviews currently underway. Next report of mid year update will be planned for April 2021
no local manipulation. Only amendments are to recommended ratio which is permitted depending on national guidance for a specialism.		
> process for sharing QIA and Divisional risk assessments re staffing to be developed for transparency and reference	Gaynor Farmer	>19.10.20- process to be designed

> process for sharing QIA and New Roles risk assessments re staffing to be developed for transparency and reference	Gaynor Farmer	>19.10.20- process to be designed
> development of a repository to reference the dynamic risk assessments for transparency and reference	Gaynor Farmer	>19.10.20- process to be designed
>develop pa specific inclusion in the Nurse Staffing paper which records any identified in month risks and mitigation.	Gaynor Farmer	>19.10.20- process to be designed

Target Completion Date	RAG status
April 2021 to see 2 captures of SNCT completed and reported to Board. Normal data captures are February and August.	On track
Dec-20	On track
	Complete
	Complete
Nov-20	Complete

Nov-20	On track
Nov-20	On track
Nov-20	On track
Nov-20	On track

Nov-20	On track
Dec-20	On track
Dec-20	On track
	Complete
	Complete
Dec-20	On track
Dec-20	On track

Jan-21	On track
Nov-20	On track
May-21	On track
	Complete
Jan-21	On track

Jan-21	On track
Jan-21	On track
Dec-20	On track

Developing Workforce Safeguards Action Plan
Developed and updated: 12012022

Recommendation	Trust Position (Aug 2020)	Identified Action	Owner	Progress Update	Target Completion Date	RAG status
1. Trust must formally ensure NQB (2016) is embedded in their safe staffing governance	Trust has safe staffing governance and reporting in place to comply with safer staffing guidance	>twice yearly data capture from Safer Nursing Care Tool is to be reported to Board	Corporate Senior Nurse-Workforce	12.01.2022- SNCT data capture is scheduled and happening twice per year. The Trust is currently collecting the SNCT data (Jan 2022)	completed and ongoing	Complete and ongoing
	Trust has been working using some data from the Model hospital to allow comparison with peers- this is still in infancy	>Improve the reporting and comparison of the Monthly Model Hospital data and detail in Staffing papers	Corporate Senior Nurse-Workforce	12.01.2022- The current Staffing Report that is shared with PODC does not include Model Hospital Data and CHPPD benchmarking. This is to be included in future reports to demonstrate our position within our PEER group	01.04.2022	On track
	Report in-patient planned and actual staffing levels on a monthly basis	>this is embedded practice and is reported monthly to PODC as part of the Staffing Paper	Corporate Senior Nurse-Workforce	12.01.2022- The process is embedded	completed and ongoing	Complete and ongoing
	Monthly report on in patient staffing levels integrated with Monthly Staffing Report	>this is embedded practice and is reported monthly to PODC as part of the Staffing Paper	Corporate Senior Nurse-Workforce	12.01.2022- The process is embedded	completed and ongoing	Complete and ongoing
2. Trust must ensure that the 3 components (see below) are used in their safe staffing processes: A) evidence based tools B) professional judgement C) outcomes	Establishment reviews follow a robust methodology which includes a triangulated approach using the recommended NHSi tool (Safer Nursing Care Tool with Hurst Model recommended staffing ratio's)	>ensure that all of the Workforce Safeguards inclusions are placed into the methodology for the Establishment reviews	Corporate Senior Nurse-Workforce	>12.01.2022- The current Establishment Reviews are taking place with a methodology using the SNCT with Hurst Model recommendations included. The reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing. The data capture has included the recommendations from the Developing Workforce Safeguards document.	completed and ongoing	Complete and ongoing
	Best practice benchmarks are used and considered for Establishment reviews that have a 'specialism'- i.e. Paediatrics, Midwifery, Intensive Care.		Corporate Senior Nurse-Workforce	>12.01.2022- The current Establishment Reviews are taking place with a methodology that includes the appraisal of any national benchmarking / guidance for specific areas such as ITU/Paediatrics/Midwifery.	completed and ongoing	Complete and ongoing
	Professional Judgement is used as part of the review considering the Quality indicators for an area and any factors that fall out of 'norm' for an area.		Corporate Senior Nurse-Workforce	>12.01.2022- During the current Establishment Reviews there is a review of the Quality Indicators for that area and asking the Divisional Team to flag any indicators out of norm. Additional professional judgement factors are then considered as part of the review.	completed and ongoing	Complete and ongoing
	Establishment reviews are undertaken in the presence of the Divisional Finance staff and also the Deputy Director of Nursing.		Corporate Senior Nurse-Workforce	>19.10.20- The current Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.	completed and ongoing	Complete and ongoing
	Outcomes will be evaluated and a joint working group will meet and discuss the evidence gathered and recommendations to add another opportunity for professional judgement and sign off before being presented to Board		Corporate Senior Nurse-Workforce	>12.01.2022- The current Establishment Reviews are taking place with Managers/Matrons/Divisional Finance Team and Corporate Nursing.	completed and ongoing	Complete and ongoing
3. NHSE/I will base assessment on the Annual Governance statement, in which Trusts will be required to confirm their staffing governance processes are safe and sustainable	Annual governance Statement	> annual governance statement to be reviewed and a evaluation completed re Nurse Staffing Processes.	Corporate Senior Nurse-Workforce	>12.01.2022- The Annual Governance Statement to be reviewed and any additional actions to be placed into this document. Sought from Trust Secretary	Mar-22	On track
4. NHSE/I will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complete quality outcomes, operational and finance performance measures	Annual governance Statement	> annual governance statement to be reviewed and a evaluation completed re Nurse Staffing Processes.	NHSE/I	>12.01.2022	Ongoing	Ongoing activity by NHSE/I
5. NHSE/I will seek assurance through the SOF monitoring performance	Monthly Reports for Nursing Activity and Staffing are part of the normal reporting business. (Monthly Staffing Report/ Quality Report-Oversight)	>monthy staffing report to PODC in place and staffing statement to QPES. DoN also completes oversight report.	Corporate Senior Nurse-Workforce/ Director of Nursing	12.01.2022- The process is embedded	Ongoing	Complete and ongoing

	Monthly Reports for Nurse Rostering and Red Flag activity to the sub committee Nursing and Midwifery Advisory Forum. (Eroster Report/ Red Flag Report)	>monthy Red Flag and Eroster Report is submitted to NMAAF	Corporate Senior Nurse-Workforce/ Director of Nursing	12.01.2022- The process is embedded	Ongoing	Complete and ongoing
6. As part of the safer staffing review, the Director of Nursing and Medical Director, must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	>Nursing- this statement will form part of the establishment Review outcomes paper	>ensure statement is made for Nursing in Establishment review paper	Director of Nursing	>statement of support was included in latest establishment review	Ongoing	Complete and ongoing
7. Trust must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The Board should discuss the workforce plan in a public meeting	>ensure an annual workforce plan is completed	> ensure that the annual workforce plan is updated/ signed off and discussed at a Public Board	Corporate Senior Nurse for Workforce	>12.01.2022- requested an update from the Workforce and HR team	Mar-22	On track
8. Board must ensure that their organisation has an agreed quality dashboard that cross checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital Dashboard. Trust should report on this to their Board every month.	Monthly Quality Report is shared and a Ward Quality Dashboard is in use. Trust has started to use the Perfect Ward app for recording quality	>Perfect Ward is currently being reviewed for launch with some amendments being made	Corporate Quality Team	>12.01.2022- Perfect Ward is being relaunched- awaiting update with progress	Mar-22	On track
	NHSi Staffing fill rates is reported monthly as part of the Oversight report but does not currently include Model hospital comparisons (previous report iterations have)	>include model hospital benchmarking in PODC report for Staffing	Corporate Senior Nurse-Workforce	12.01.2022- The current Staffing Report that is shared with PODC does not include Model Hospital Data and CHPPD benchmarking. This is to be included in future reports to demonstrate our position within our PEER group	Mar-22	On track
9. An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS improvement resources. This must also be linked to professional judgment and outcomes	Establishment reviews were held formally in 2021. there is a twice yearly review of SNCT data which will be reported	To embed the twice yearly reporting into Business As Usual. Only 1 report has gone in the last 12 months re establishments due to Covid19 pandemic. Ordinarily this is completed	Corporate Senior Nurse-Workforce	>12.01.2022-SNCT data collection currently taking place with view to completing an outcome report by end of FY2021/22	01/04/2022- ongoing action	Complete and ongoing
10. There must be no local manipulation of the identified nursing resource from the evidence based figures embedded in the evidence based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	The tool used is the NHSi recommended Safer Nursing Care Tool (Imperial Tool) which includes the Hurst Model for establishment recommendations. Data is not manipulated. The tool gives the flexibility to apply recommended ratio's of staffing for specialised areas.	no local manipulation. Only amendments are to recommended ratio which is permitted depending on national guidance for a specialism.	Corporate Senior Nurse-Workforce	>12.01.2022- confirmed no local manipulation and Imperial Tools with licences are in use		Complete and ongoing
11. As stated in CQC's Well led Framework guidance (2018) 6 and NQB guidance, any service changes, including skill mix changes must have a full quality impact assessment (QIA) review	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of Divisional QIA and local risk assessments	> process for sharing QIA and Divisional risk assessments re staffing to be developed for transparency and reference	Corporate Senior Nurse-Workforce	>12.01.22- process to be designed	Apr-22	On track
12. Any redesign or introduction of new roles (including but not limited to Physician Associate, Nurse Associate and Advanced Clinical practitioners) would be a service change and must have a full QIA	QIA process is available and in use for large scale change but Corporate Nursing do not currently have sight of new role QIA's automatically	> process for sharing QIA and New Roles risk assessments re staffing to be developed for transparency and reference	Corporate Senior Nurse-Workforce	>12.01.2022- process to be designed and consider recommencing new roles group	Apr-22	On track
13. Given day to day operational challenges, we expect Trusts to carry out business as usual dynamic staff risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described i these risk assessments	There are mechanisms in place for dynamic planning and review of staffing. Twice daily approval meetings happen across the hospital which include a review of staffing in our Community based setting. Escalation processes are in place and in times of extremis we have a mechanism for deploying the 'staffing hub' which is a central control room for staffing management. The site is risk assessed during the twice daily meetings and decisions taken to redeploy, work differently, escalate staffing demand where is impacting quality. There is consideration to Red Flags/Acuity/Enhanced levels of care suring these meetings and not a singular focus on staffing numbers.	>no action -practice embedded	Corporate Senior Nurse-Workforce	>12.01.2022 process embedded		Completed and Ongoing

14. should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue,(and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example wards , beds and teams, realignment, or a return to the original skill mix	Business continuity plans are enacted where required. Example- Covid19 response. Updates to the actions taken and escalations of concern are included in the Nurse Oversight Report. Information is shared across sub committees in both the Quality, People and Financial work streams.		Corporate Senior Nurse-Workforce	>12.01.2022 process embedded		Completed and Ongoing

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Executive Update – Vaccination As A Condition Of Deployment (VCOD)			**AGENDA ITEM: 20**
Report Author and Job Title:	Catherine Griffiths, Director of People and Culture	**Responsible Director:**	Catherine Griffiths, Director of People and Culture
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	Assure the Board there is a clear plan and process currently being implemented.		
Advise	Advise on the recently amended national legislation in relation to vaccination as a condition of deployment.		
Alert	To alert the Board to the potential staffing impact and employee relations risks.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	To be confirmed		
Resource implications	This is being assessed through the development on an Equality Impact Assessment.		
Legal and/or Equality and Diversity implications	To be confirmed		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Vaccination as a Condition of Deployment - VCOD

1. EXECUTIVE SUMMARY AND BACKGROUND

Background

The Department of Health and Social Care (DHSC) formally announced (9 November 2021) that individuals undertaking CQC regulated activities in England must be fully vaccinated *(having 1st and 2nd doses of the vaccine)* against COVID no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care, private providers, etc.

On 6 January 2022, the Government made new legislation, approved by Parliament, which amended the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"). This extends the scope of mandatory vaccination requirements for staff beyond registered care homes to health and wider social care settings in England.

The regulations provide that the registered person can only deploy or otherwise engage a person for the purposes of the provision of a CQC-regulated activity, in which they have direct, face to face contact with patients and service users, if the person provides evidence that they have been vaccinated with a complete course of a Medicines and Healthcare products Regulatory Agency (MHRA) approved COVID-19 vaccine. This is subject to specific exemptions and conditions.

The Vaccination as a Condition Of Deployment (VCOD) requirements include front-line workers, as well as non-clinical workers not directly involved in patient care but who may have face to face contact with patients, including ancillary staff such as porters, cleaners or receptionists.

The VCOD regulations allow a grace period for compliance and the requirement will come into force on 1 April 2022.

Supplementary guidance advises applying two questions to determine whether staff would be in scope of the regulations:

- Is the individual deployed for the provision of a CQC regulated activity (this includes non-clinical activity)?
- Does the individual have face-to-face contact with patients or service users in their role? This includes entering areas which are utilised for the provision of a CQC-regulated activity which may result in incidental face to face contact with patients or service users

Guidance for determining the meaning of 'engaging a person for the purposes of the provision of a CQC-regulated,' and what would amount to 'incidental face to face' patient or service user contact still lacks some clarity.

Trust Planning

There is a significant amount of effort needed to ascertain which staff are in scope of the regulations, and to encourage those staff who have yet to take the vaccine to do so, providing support to enable staff to gain further information around the vaccine. There is also a need to put in place, where appropriate or possible, arrangements to support unvaccinated staff to find alternative work, either through re-deployment or role re-configuration, as well as ensure fair and robust processes are in place. This will be all alongside the provision of a vaccination service which is accessible to these staff providing first, second and booster vaccines. As such, a plan has been developed and is currently being implemented.

There are two key dates and numbers associated with the mandatory vaccination programme:

- The last date for those who have yet to have a first dose of vaccine, in order to be fully vaccinated by 1 April 2022 is 3 February 2022;
- The date by which staff must have received their second dose is 1 April 2022;

Scope & System Approach

Recognising that the Trust does not operate in isolation, it was identified that there is a need for greater Black Country & West Birmingham ICS/system alignment. As such, a system task & finish group has been established with providers and other NHS representation from across the different organisations. The aim will be to use this working group in order to:

- Provide a sense check between organisations
- Share good practice
- Have a common approach to international nurse recruitment
- Support a joined up approach to any legal questions
- Share any redeployment opportunities
- Have a collective understanding on exemptions
- Agree a common definition on scope.

It has been recognised that determining which staff will be in scope and which out of scope will be a key activity. As such, through working with leaders at the system gold meeting, it has been possible to agree a common definition of who would fall within scope. This is detailed as follows:

Those in scope of the mandatory vaccinations will be staff working in the NHS who have face-to-face contact with patients or service users, in a clinical area, as part of their role. This includes staff entering areas that are utilised for the provision of a CQC-regulated activity

which may result in incidental face-to-face contact with patients or service users in those areas.

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Care at Home Report			**AGENDA ITEM: 22**
Report Author and Job Title:	Michelle McManus, Acting Programme Director	**Responsible Director:**	Matthew Dodd, Director of Transformation
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve ☐ Discuss ☐ Inform ☒ Assure ☒**		
Assure	• This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain. • It includes operational performance for Community Services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1), the latest Board Assurance Framework (BAF) for Care at Home, and an update on place-based partnership arrangements. • The relevant Board Committees were stood down for January, though the detail of the operational performance contained within this report was shared for discussion with the members of the Walsall Together Partnership Board. • Due to the current level of operational pressures, key performance indicators are being monitored at daily community and partnership tactical command meetings, with a clear escalation through to the Trust's gold command if necessary.		
Advise	• Despite growing demand and capacity challenges in some areas, the numbers of patients in the Manor Hospital who were medically fit for discharge reached its lowest ever level at one point in December (15 patients). • The Partnership continued to implement responses outlined in the systems pressure plan, in order to address underlying drivers of demand within the system.		
Alert	• Demand has grown for services in the community during December. • Capacity in some sectors was adversely affected by staffing shortages linked to Covid. • Capacity within Care Homes became an emergent issue during December as homes were closed for infection control and business continuity reasons.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk - Failure to deliver care closer to home and reduce health inequalities, and links to Corporate Risk Register: • Risk 2641 - Delayed discharges at Manor Hospital and other settings for medically stable patients as a result of low availability of packages of care (level 16) • Risk 2624 - Risk of suboptimal levels of care due to capacity not being able to respond quickly enough to fluctuating demand within all areas of the system (level 16)		

Resource implications	Implementation of the approved System Pressures Plan is on track including the associated expenditure and recruitment. Staffing levels continue to be impacted by the Omicron variant of COVID-19.	
Legal and/or Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare. The current operational pressures have further impacted on delivery of routine and non-urgent care services; the extent to which this will impact the longer-term health outcomes and inequalities within our local population is being assessed.	
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒
	Partners ☐	Value colleagues ☐
	Resources ☐	

Care at Home Executive Summary
February 2022

1. PURPOSE OF REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during December 2021.

Detailed discussions in these areas have been covered in the relevant Board Committees in previous months in addition to that noted in the Partnership Board highlight report.

This report covers:

- Operational performance for community services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1);
- Board Assurance Framework (BAF) for Care at Home;
- An update on the place-based partnership arrangements in Walsall and across the Black Country Integrated Care System (ICS).

2. BACKGROUND

Under the Care at Home strategic objective, WHT is the Host Provider for the integration of Walsall Together partners, addressing health inequalities and delivering care closer to home.

3. PERFORMANCE, ASSURANCE AND RISK – COMMUNITY SERVICES

The key risks to community services and assurances around the level of service provision are included in **Appendix 1** and the Walsall Together Partnership Board members have been briefed on these risks in January.

3.1. Demand

Demand for Community Locality Services increased in December while the Care Navigation Centre saw a significant growth in demand. Colleagues within PCNs report growing demand on primary care services during December.

3.2. Capacity – Locality Teams

The cancellation rate for Community Locality Services reduced to 13.5%. Colleagues within PCNs have reported difficulty in accessing clinical space within the global community estate to support new initiatives such as rooms for a paediatrics assessment hub.

3.3. Discharge & Step-Up Pathways

In previous months the Partnership Board has been informed about the impact that the shortage of staff in care agencies created and the mitigations enacted by partners. December was marked by two trends:

- Shortages in capacity within the care home sector as homes were closed due to infection outbreaks (Covid-19) and staff absence due to Covid. The Partnership was closely involved in monitoring the impact on available beds and flow across the system, which has managed to maintain flow but also support the homes in their business continuity arrangements. The position remains volatile and requires constant monitoring, while there is a pressure with getting access to care homes in other boroughs for patients who are not residents of Walsall.
- A focus on hospital discharges by all partners to prepare the system for the anticipated surge in demand over bank holidays combined with Covid surges. This resulted in the numbers of patients in the Manor Hospital who were Medically Stable for Discharge getting down to 15 patients on 24/12/21, which is the lowest ever number for Walsall

In January the volume of referrals to the discharge team has increased and there have been pressures noted in securing placements for residents who live in other boroughs, both of which will be detailed in next month's report.

3.4. System Pressures Planning

Schemes commenced in December such as the Falls Service (designed to relieve pressure on WMAS crews and the emergency Department) while the Care Navigation Centre opened up to GP calls to acute medical teams from 4th January 2022 in an effort to care for some of these people at home, without being conveyed to hospital.

4. BOARD ASSURANCE FRAMEWORK

The overall risk score on the Care at Home Board Assurance Framework (BAF) was updated from level 12 to level 16 to reflect the increased risk score forecast for the end of Q3. As predicted and reported over previous months, several partnership risks have been adversely impacted by the COVID outbreak.

The following risks were accepted onto the Corporate Risk Register in December and January respectively:

- 2372 – The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.
- Risk 2370 – Delays in presentations for other, non-COVID, conditions may further exacerbate health inequalities and increase the risk of premature mortality.

There following risks remain on the Corporate Risk Register with mitigations through the Systems Pressures Plan and partnership governance arrangements:

- Risk 2641 - Delayed discharges at Manor Hospital and other settings for medically stable patients as a result of low availability of packages of care
- Risk 2624 - Risk of suboptimal levels of care due to capacity not being able to respond quickly enough to fluctuating demand within all areas of the system

5. PLACE BASED PARTNERSHIP ARRANGEMENTS

As reported last month, the recruitment to the position of Chair of the Walsall Together partnership is in progress, with shortlisting and interviews scheduled during February.

The Walsall Together Partnership Board (WTPB) development session is scheduled for 16th February, utilising the usual slot of the WTPB meeting to minimise disruption to diaries at a time of continued pressure. The purpose of the session is to reconfirm the commitment to the partnership and agree the strategic priorities for the next 12 months and beyond.

There are no further updates in respect of the relationship between system and place beyond what was reported in December. Walsall Together remains in a strong position to enter into the new legislative arrangements without disruption to existing partnership arrangements.

6. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

APPENDICES

1. Operational Performance Report for December 2021 – Walsall Together

Walsall Together

Walsall Together Partnership Operational Update: January 2022

Matthew Dodd
Director of Transformation

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds					2020-2021
Tier 0: Resilient Communities							
Social Prescribing	whg - No. referrrals received						
	Primary Care - % referrrals received East 1	<0.4%		>= 0.4%			0.55%
	Primary Care - % referrrals received East 2	<0.4%		>= 0.4%			0.50%
	Primary Care - % referrrals received North	<0.4%		>= 0.4%			1.30%
	Primary Care - % referrrals received South 1	<0.4%		>= 0.4%			0.71%
	Primary Care - % referrrals received South 2	<0.4%		>= 0.4%			1.30%
	Primary Care - % referrrals received West 1	<0.4%		>= 0.4%			0.80%
	Primary Care - % referrrals received West 2	<0.4%		>= 0.4%			1.78%

	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Workforce: Anchor institutions	No. staff employed by whg via scheme												68	Awaiting data
	% whg customer's												38%	Awaiting data

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services														
Primary Care	Primary Care Appointment Access - Walsall	>2.0	1.5-2.0	<1.5		2.11	1.81						No data receieved	Awaiting data
	Primary Care Appointment Access - Sandwell & West Brom	>2.0	1.5-2.0	<1.5		2.77	2.32						No data receieved	Awaiting data
	Primary Care Appointment Access - Dudley	>2.0	1.5-2.0	<1.5		2.36	2.00						No data receieved	Awaiting data
	Primary Care Appointment Access - Wolverhampton	>2.0	1.5-2.0	<1.5		3.27	2.80						No data receieved	Awaiting data
	Amber sites (undertake all aspects of contractual work with +ve Covid patients seen in RED sites)					13	13						No data receieved	Awaiting data
	Green sites (undertake all aspects of contract - no face to face appointments)					37	37						No data receieved	Awaiting data
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	10905.5	10347	9450.25	5576	6574.25	5945.25	5769.75	6038	6127	7015.75
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	473	305	623	1020	1453	1546	1557	1255	1271	1093
	% of hours demand unmet	>23%	20%-23%	<20%	4.2%	2.9%	6.2%	15.5%	18.1%	20.6%	21.2%	17.2%	17.2%	13.5%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	29	19	19	27	25	26	26	22	26	24
	No. referrrals received	<100	100-200	>200	29	27	35	37	26	26	34	26	30	27
	No. cases reviewed	<100	100-200	>200	29	27	32	40	90	96	92	88	120	103
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).					2.8%	2.8%	2.9%	2.9%	3.1%	3.1%	3.2%	3.4%	3.3%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).					84.8%	85.5%	84.5%	84.9%	84.4%	84.6%	84.4%	84.4%	84.7%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1		1.2	2.4	3.0	3.0	3.0	3.6	4.8	6.6	7.2
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8		69.3	142.6	186.1	229.7	257.4	306.9	344.6	405.9	437.6
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%		79.0%	83.8%	77.6%	82.8%	85.6%	84.4%	81.7%	85.2%	74.8%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				449	478	494	550	553	617	661	695	738	724
	Care and Support Assessments and 3 Conversations Completed - Total				351	324	302	343	346	341	346	287	313	292
	Monthly Adult contacts completed by Team				1,122	1,030	1,010	1,094	1,025	1,061	1,131	1,071	1,235	1,019
	Total Initial & Subsequent Reviews Completed				451	295	323	334	327	268	290	290	268	249

[Emergent] Score Card for WT Tiers – Tier 2

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Tier 2: Specialist Community Services														
ASC Safeguarding Concerns	Concerns received				297	253	292	307	315	258	286	316	297	265
	Concerns progressing to s42 eqnuiry				72	79	84	83	88	66	81	87	79	83
	% of concerns progressing to s42 enquiry				24%	31%	29%	27%	28%	26%	28%	28%	27%	31%
	Safeguarding cases in progress				39	25	48	15	36	20	17	35	31	7
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,258	1,267	1,259	1,285	1,294	1,330	1,329	1,353	1,325	1,297
	Vacancies	>291	144-291	144<	436	430	441	416	408	368	370	357	412	416
	% vacant beds	>15%	8-15%	8%<	25.7%	25.3%	25.9%	24.5%	24.0%	21.7%	21.8%	20.9%	23.7%	24.3%
	Total No of Care Homes	53<	53-56	>56	57	58	58	58	58	58	58	58	59	59
	Closed to admissions	>8	3-8	3<	14	7	8	8	2	10	12	5	6	28
	% of available homes closed to admissions	>10%	5-10%	5%<	19.7%	10.8%	12.1%	12.1%	3.3%	14.7%	17.1%	7.9%	9.2%	32.2%

Supporting the Covid Vaccination Programme: *Saddlers (and Manor Walk In Centre)*
As of 11/10/21 combined they have delivered 162,761 vaccinations.

[Emergent] Score Card for WT Tiers – Tiers 3 (& 4)

Walsall Together

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Tier 3: Intermediate Care, Unplanned Care & Crisis Services														
Care Navigation Centre	Calls received	<435	435-512	>512	550	580	691	747	821	840	869	925	861	1094
Rapid Response Team	Referrals received	<160	160-247	>247	232	210	216	304	301	334	227	230	264	268
	% admission avoidance	<73%	73%-87%	>87%	77.2%	79.2%	79.6%	78.4%	84.7%	86.8%	79.7%	87.4%	91.7%	90.7%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	29.33	31.13	31.86	31.89	48.56	47.38	52.11	41.00	44.67	40.25
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	2.7	2.7	3.6	3.9	4.2	5.1	4.5	4.5	4.6	3.6
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	30	27	29	N/A	N/A	N/A	N/A	N/A	35	34
	Domiciliary Pathways - Average service users				188	181	180	N/A	N/A	N/A	N/A	N/A	196.5	207.75
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	29	46	49	N/A	N/A	N/A	N/A	N/A	33	50
	Bed-based Pathways - Average beds in use				83	67	61	N/A	N/A	N/A	N/A	N/A	86.5	68.5
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	44	56	90	90	80	72	113	84	94	85
	Early Supported Discharge	40<	40-54	>54	52	51	106	43	48	47	26	35	29	65
	Assisted Discharge	35<	35-50	>50	75	62	71	63	103	61	42	54	42	75
	Prevent Readmission	35<	35-50	>50				63	60	62	20	43	33	32

Tier 0: Walsall's Voluntary & Community Sector – One Walsall

- A renewed campaign for volunteers on vaccine sites began two weeks before Christmas, as we have increased demand from DGFT Workforce Bureau. Volunteers continue to support across the system, volunteer interest has slowed from the initial pandemic response, but the uptake of new volunteer roles remains steady. This is also offset by the number of regular volunteers now consistently supporting the system.
- The demand for mental health services from professionals in the sector continues to increase. Sector representatives are reporting capacity issues due to the number of referrals to their service, without additional resources to cover this. Many are looking to eternal funds to manage this, but this remains a critical concern.
- An alliance of voluntary sector organisations from across the Black Country will be meeting in January to discuss their future involvement in ICS engagement. This will give steer from the BC VCSE regarding genuine commitment from the sector to supporting the system and explore the ways in which it may require support to do so.

Last updated on Dec 2021

Tier 0 Resilient Communities
whg Social Prescribing H Factor Customer Story

- **Background :** N is 25 , White British, Lives in West Walsall , Economically Inactive, Lives in Social Housing
- **Reason for referral :** Loneliness and isolation, anxiety and stress due to social factors , bereavement , drug misuse .
- **N's father had recently died and due to safeguarding concerns N's child has recently been placed in Local Authority Care .**

N was referred by whg's Employment and Training Team . She was in receipt of UC and needed to find a job . However after hearing N's story the ET team recognised that N required additional support before being considered ready for work . A face to face visit was undertaken at N's home . Sufficient time and support was provided for N to tell their story This provided the Link Worker with information concerning N's recent bereavement , N's drug misuse and the impact of N's child being placed in LA Care .

A WEMWBS assessment was completed which showed that N had very low confidence and self esteem , had a lack of support networks , low self worth and a feeling of helplessness along with concerns that N could not manage their situation without help . During the first visit N disclosed a long-term history of substance abuse. N stated that the loss of their father and child made them feel that there was nothing to live for . The Link Worker recorded that N was very emotional and that N's personal appearance demonstrated a lack of self-care leading to self neglect concerns

.At this stage N had not accessed counselling but presented as motivated to take part in the SP programme . N recognised the importance changing behaviours in order to gain access to their child . This motivated N to work with the SP to co design an individual plan of action .

Using Coaching Skills N was encouraged to take part in well-being activities including a local walking group which N reported as helping to clear their mind . It provided N with a routine and access to new social contacts . This improved N's confidence , reduced loneliness and created a sense of wellbeing . Along with the Walking Group N was supported to engage with drug counselling services and bereavement counselling . Support included taking N along to initial appointments , providing travel costs and regular reflective sessions to check progress . N's self-care improved and following sustained attendance at drug counselling sessions , working positively with social workers N has developed and sustained positive routines and behaviours . It is pleasing to report that N's child has now returned to N and we continue to support N to move nearer to employment .

Last updated on Dec 2021

whg/Walsall NHS Trust's Recruitment Programme

whg Work 4 Health programme – Total into employment

68 into employment

*31 in employment and 37 with conditional job offers

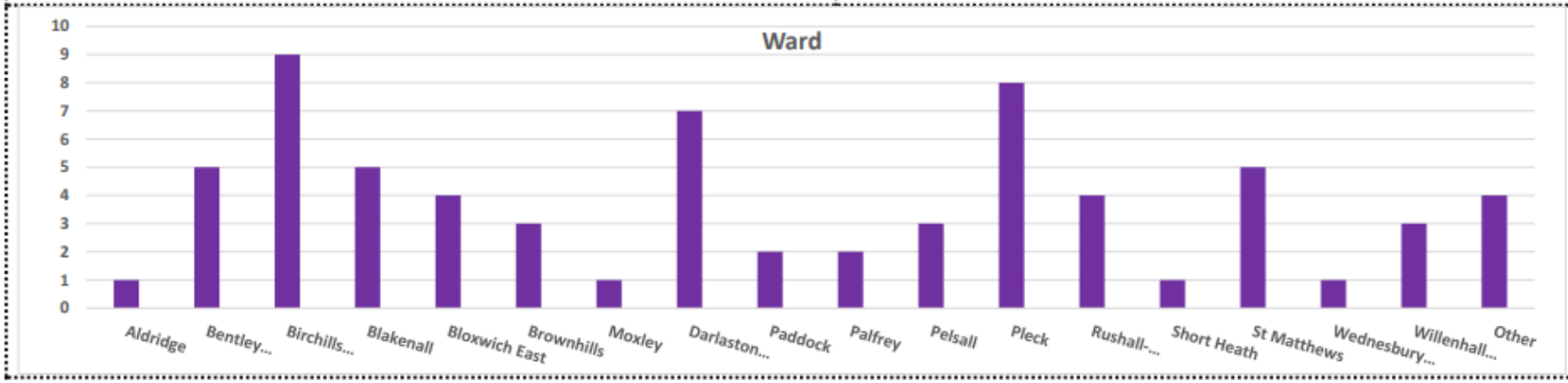
38% whg customer's

18% Male

82% Female

51% BAME

81% Unemployed prior to commencing NHS job role



NHS

Department for Work & Pensions

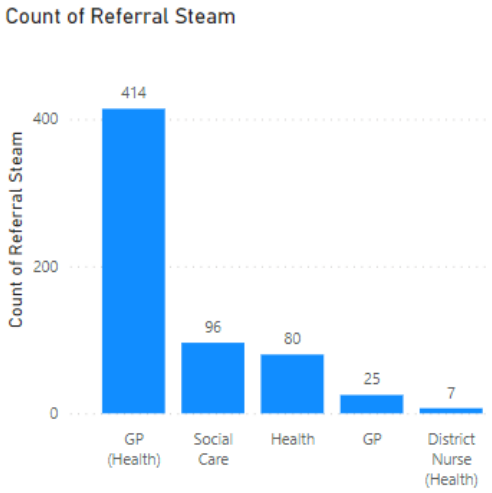
Walsall College

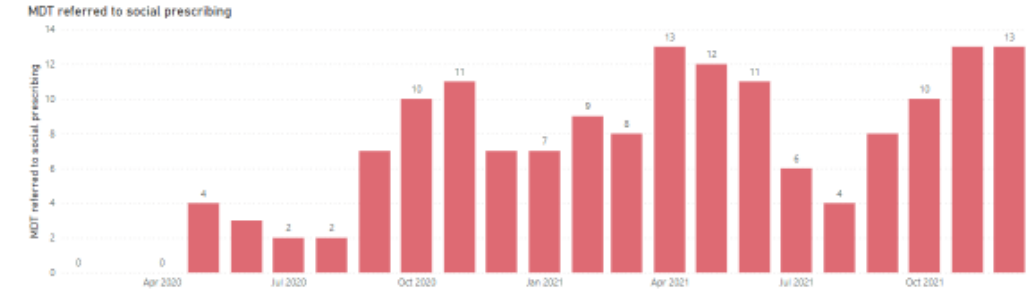
whg

Last updated on Dec 2021

Tier 0: Multidisciplinary Team (MDT)

Demand is significantly below capacity for GP-led Multidisciplinary Team





The service is established for 7 x MDTs with up to 50 cases to be reviewed per week

It has been agreed with PCNs that the risk stratification will change [eg case finding by the MDT Coordinators to focus on people who have had four admissions in the last year]

Further review meeting planned with PCN MDT lead to look at how to increase referrals from other teams

Last updated on Dec 2021

Tier 1: Primary Care Standard Operating Procedure (SOP)

- Primary care operating telephone triage first – if patients require clinical face-to-face (F2F) examination they are invited in for an appointment
- Consultations are being completed via telephone, video consult, online and F2F

Current Pressures:

1. Access to appointments
2. Ongoing delivery of the Vaccine programme Phase 3 & Flu Vaccination (Significant push for Booster for >18 (cohorts 10-12) prior to end of Jan 2022
    - GMS contractual work changes to support vaccination
3. Access to Out-patient services
4. Patient Demand
5. Zero Tolerance and abuse

Last updated on Dec 2021

Tier 1: Primary Care - Driving improvement and reducing variation - how do we select the practices to prioritise?

We have used the data provided by NHSE to help us to prioritise practices. This data has been cut in different ways.

The first is the **performance by place.**

Place Based Area	Sum of List Sizes	Appts Aug 19 per 1000	Appts Aug 21 per 1000	Appt 19 vs 21	% Total App as NON F2F with a GP (August 21)	111 activity Rate Per 1000	A&E Per 1000	A&E Type 1 Per 1000	Emergency Admissions per 1000	Average of score of CQC for Place	Ranking by PCN AND PLACE	NO of Practice in lower Quartile	No of Practices in Place	% of Practices in Lower Quartile in Place Area
Dudley	330060	363.26	389.36	7%	50.35	210.05	378.05	234.57	82.13	2.05	4	3	43	7%
Sandwell	343309	380.80	389.77	2%	60.48	312.70	403.67	275.60	86.31	2.21	2	18	48	38%
Walsall	293876	407.57	440.55	8%	48.64	260.94	304.47	284.76	122.90	2.00	3	10	52	19%
WB	235394	363.88	377.80	4%	41.48	187.73	322.29	273.66	64.21	2.00	5	2	27	7%
Wolverhampton	292521	297.56	310.80	4%	42.78	272.04	383.81	303.82	97.83	2.14	1	19	37	51%
Grand Total	1495160												207	

Significant variation in the number of appointments per 1000 population.

Generally consistent proportions of non face to face appointments across 2 places but higher in 3 places

Last updated on Nov 2021

Tier 1: Driving improvement and reducing variation in Walsall

WALSALL 3rd Ranked

Place Based Area	PCN	Sum of List Sizes	Appts Aug 19 per 1000	Appts Aug 21 per 1000	Appt 19 vs 21	% Total App as NON F2F with a GP (August 21)	Sum of 111 Per 1000	Sum of A&E Per 1000	Sum of A&E Type 1 Per 1000	Sum of Emergency Admissions per 1000	Average of CQC	Ranking by PCN ONLY	Ranking by PCN AND PLACE	No of Practice in lower Quartile
Walsall	East 1	33159	444.10	442.62	0%	64%	210.47	306.76	259.57	121.23	1.88	20	7	1
	East 2	42481	442.88	453.90	2%	41%	236.86	276.48	253.64	121.42	2.00	13	6	0
	North	52474	432.86	431.15	0%	40%	281.68	312.59	305.01	135.11	2.10	4	1	4
	South 1	42860	364.33	451.98	24%	48%	261.81	286.12	277.23	114.26	2.11	8	4	2
	South 2	41664	341.64	417.63	22%	42%	269.59	281.59	266.83	119.72	2.00	12	5	0
	West 1	34620	424.93	459.62	8%	59%	287.98	326.23	308.69	129.78	2.00	5	2	1
	West 2	46618	406.71	433.29	7%	60%	266.81	340.34	313.44	117.34	1.88	7	3	2

Some variation - range: 417 - 459

Range 40– 64%

Priority PCN

Last updated on Nov 2021

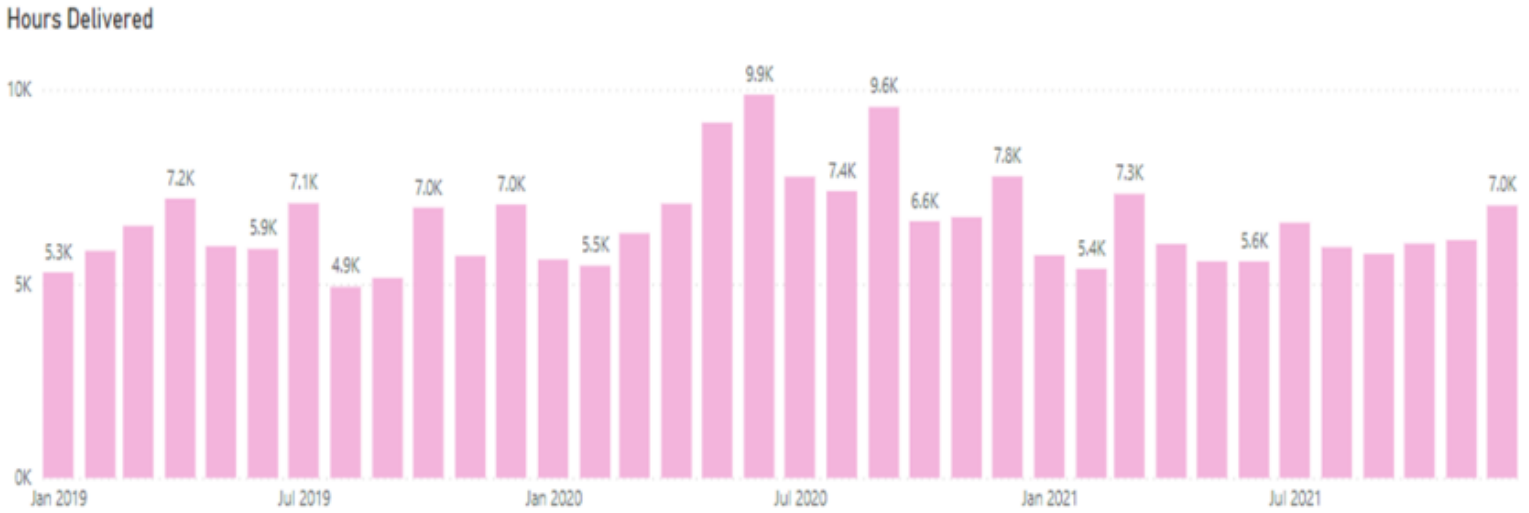
Tier 1: Primary Care Network(PCN) – Additional Roles Reimbursement Scheme (ARRS)

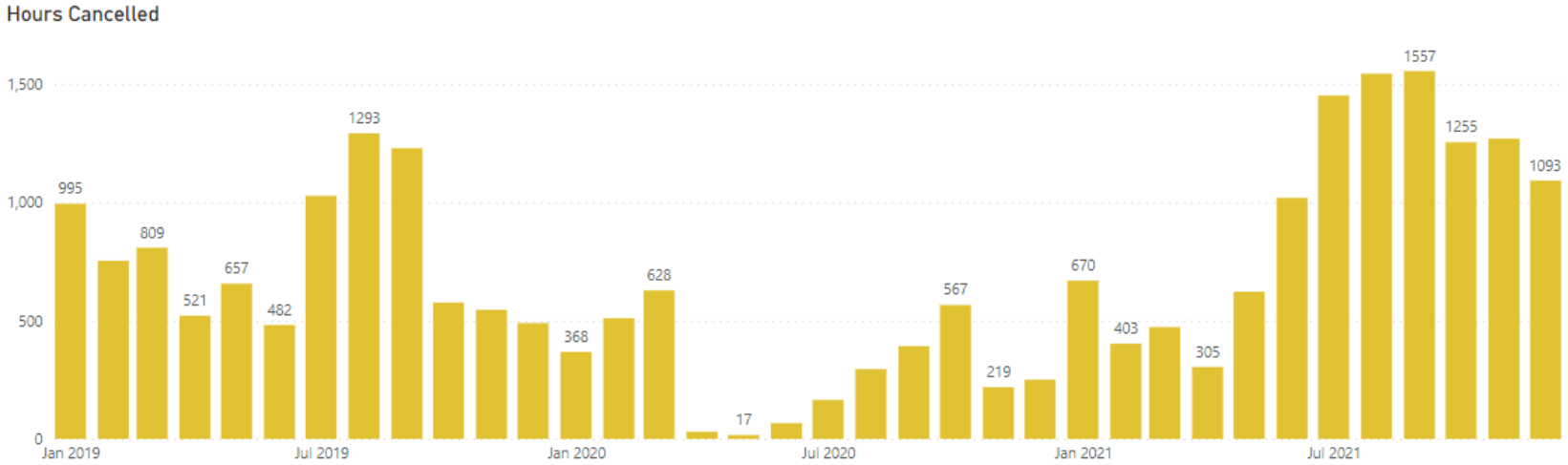
- Currently 3 projects involving PCN ARRS and WT.
  - First Contact Practitioner (FCP)
  - Nursing Associates (NA)
  - Mental Health Practitioner
  - FCPs currently working in 4 PCNs – Data to follow in future meetings – initial feedback is very positive with reductions in MSK referrals and increase in access in primary care
- NAs awaiting start date – x1 NA started in South 2 PCN further interviews on the 10.12.21
- Mental Health Practitioner recruitment has been challenging with x1 successful applicant - pilot to take place in South 2 PCN is underway
- Risk – SLAs are currently the hold-up which have taken a considerable amount of time to draft.

Last updated on Dec 2021

Tier 1:

Community Nursing Capacity and Demand: In December 2021, Community Services delivered more hours than the previous month and cancelled the fewest hours since June 2021



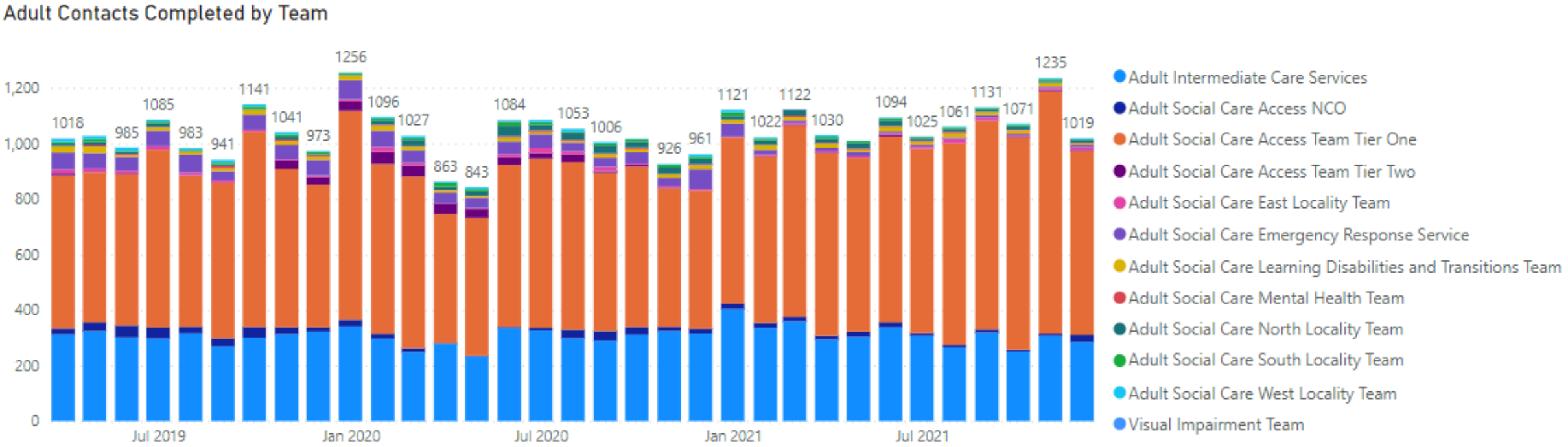


The Locality Teams delivered more hours in December than in November and October the most since March 2021. The teams also cancelled less hours than October and November and the least since June 2021. This is as a result of the actions that have been and continue to be taken by the Community Division in response to workforce challenges that the Locality Teams are experiencing.

- A review of capacity and demand modelling has enabled increased efficacy of staff and skill mix in meeting caseloads
- The Locality Teams have now merged into one Care Group this has enabled greater Cross locality working to ensure priority patients are seen
- Additional resource has been redirected from other Teams (Locality Rapid Response, Diabetes and Podiatry) in order to minimise the number of patient hours being cancelled

Last updated on Dec 2021

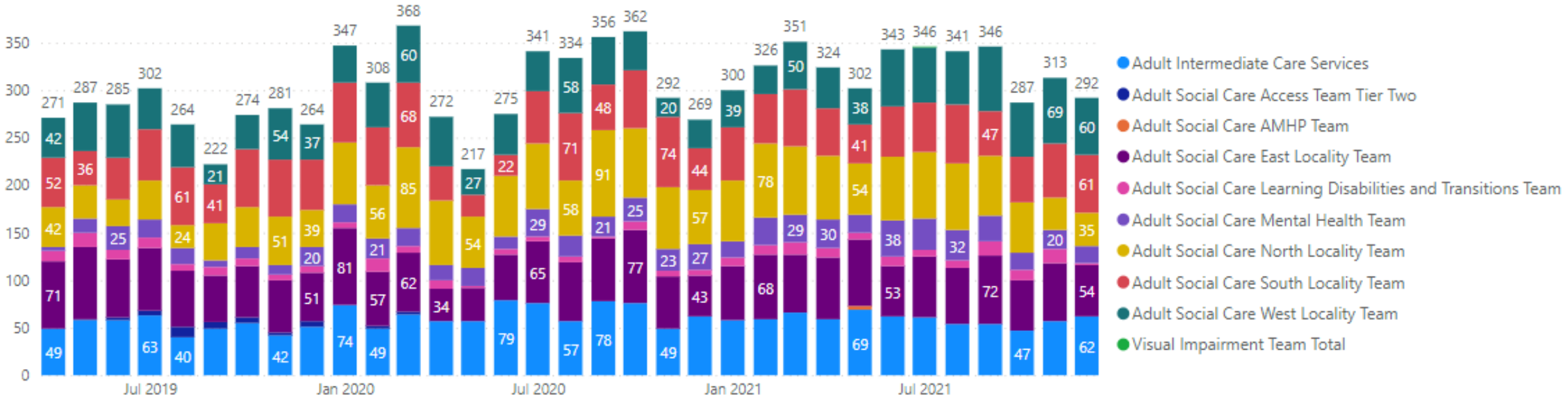
Tier 1:
Adult Social Care



Demand coming into Adult Social Care has increased with an additional two hundred contacts in November. Absence levels has remained roughly the same over the last three months across teams therefore we have continued to maintain normal activity for completion of Care Act assessments and prioritised our reviews to support individuals with change of need.

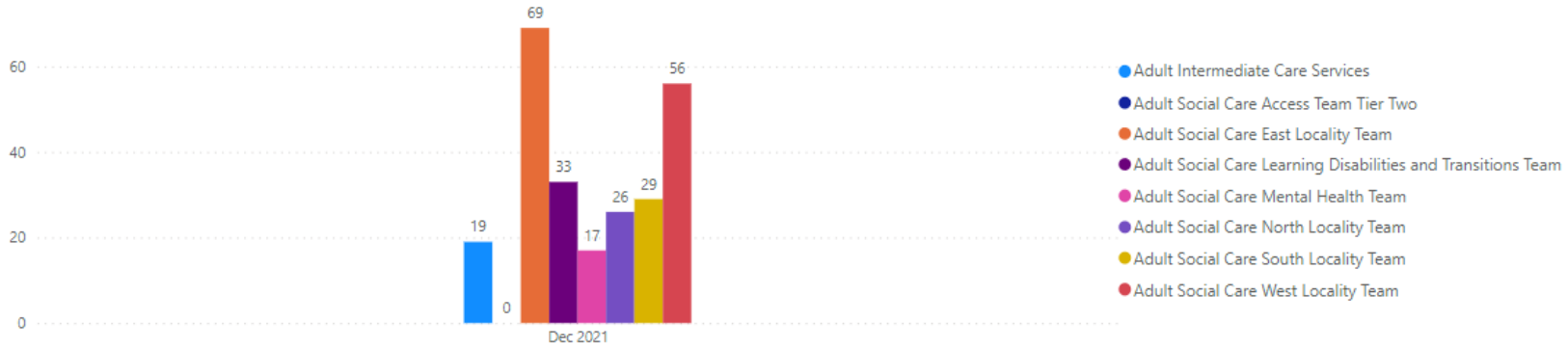
Last updated on Dec 2021

Care and Support Assessments and 3 conversations completed

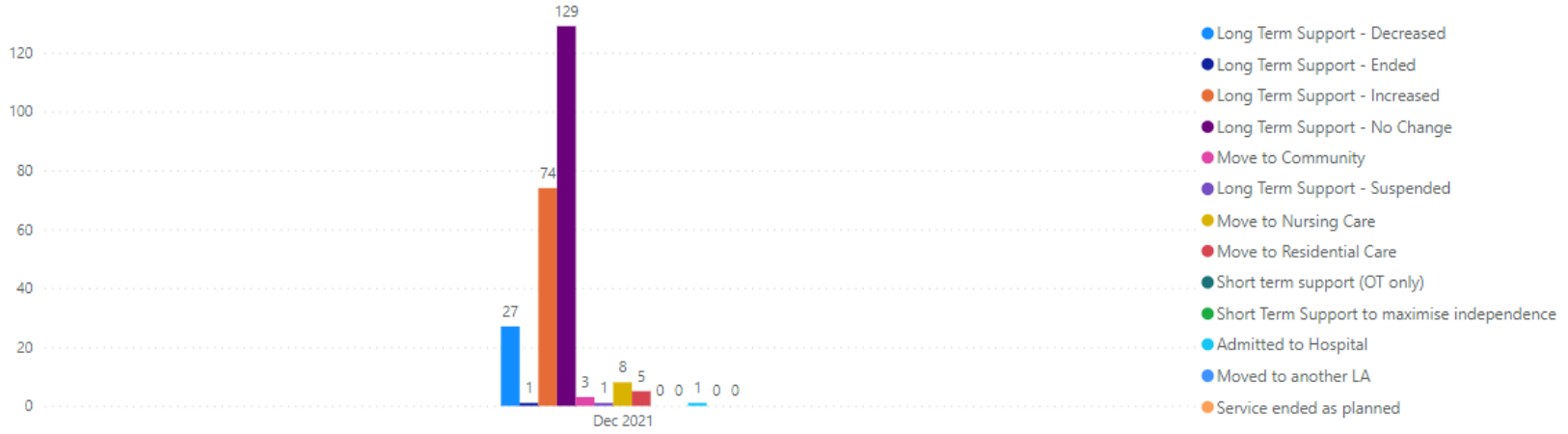


Last updated on Dec 2021

Initial and Subsequent Reviews Completed by Teams



Initial and Subsequent Review Outcomes



Date	Sum of Total Initial and Subsequent Reviews Completed
Feb-21	380
Mar-21	451
Apr-21	295
May-21	323
Jun-21	334
Jul-21	327
Aug-21	268
Sep-21	290
Oct-21	290
Nov-21	268
Dec-21	249

Last updated on Jan 2022

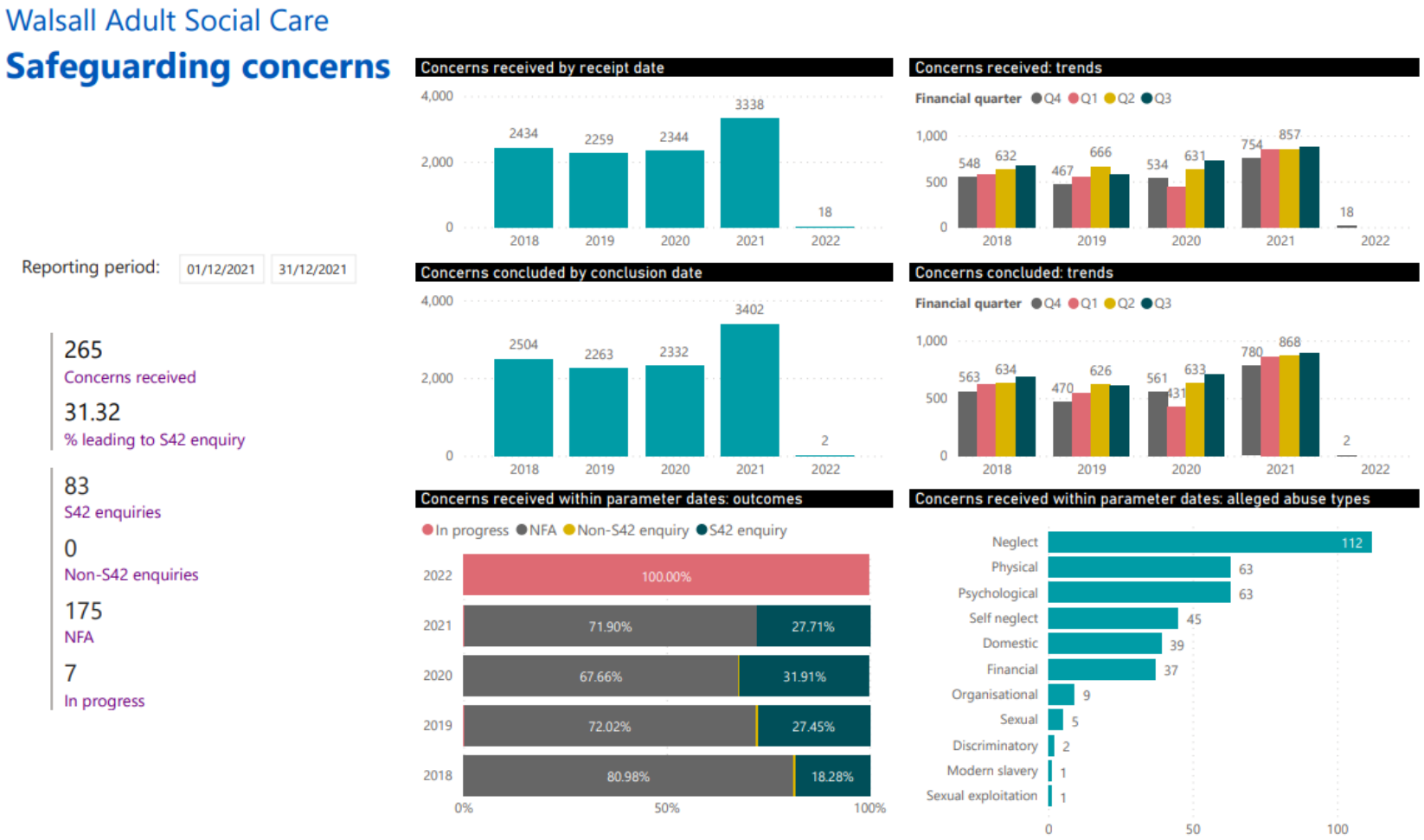
Tier 2:
Adult Social Care

ASC have received 265 concerns which is a reduction of 35 referrals on the previous month.

The number of cases progressing to a s42 enquiry is a 31.32% received which is higher than the previous period. Work has been undertaken to work with partners around the quality and making of referrals which may account for the progressed activity. We will continue to monitor the quality of referrals and further analysis will be undertaken at the request of the safeguarding partnership (jan 2022)

There are currently 7 open s42 enquiries. Focussed activity in concluding work and MSP in a timely way is a key priority.
Neglect & Physical abuse are the two highest categories of alleged abuse in this period.

Making safeguarding personal and working with individuals and their advocates to achieve their outcomes remains integral to the safeguarding process. Assurance is provided through continued single agency and multi agency audit schedules.



Last updated on Dec 2021

Walsall Together

Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2021/22

Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	April 21/22 Data	May 21/22 Data	June Q1 Data	July 21/22 Data	Aug 21/22 Data	Sept Q2 Data	Oct 21/22 Data	Nov 21/22 Data	Dec Q3 Data	Jan 21/22 Data	Feb 21/22 Data	Mar 21/22 Data	21/22 Target	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2211	2245	2203	2193	2180	2167	2153	2159	2151					
	AACM	1895	1951	1954	2045	2100	2188	2211	2245	2203	2193	2180	2167	2153	2159	2151					
	Ian Staples, Jennie Pugh & Jeanette Knapper	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**				**100.0%**	
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	15	15	16	16	17	17	18	19	19				12	
	AACM	551	585	587	596	574	573	540	545	548	550	546	553	558	565	568					
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**2.8%**	**2.8%**	**2.9%**	**2.9%**	**3.1%**	**3.1%**	**3.2%**	**3.4%**	**3.3%**					
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	458	466	463	467	461	468	471	477	481					
	AACM	551	585	587	596	574	573	540	545	548	550	546	553	558	565	568					
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**84.8%**	**85.5%**	**84.5%**	**84.9%**	**84.4%**	**84.6%**	**84.4%**	**84.4%**	**84.7%**					
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	2	4	5	5	5	6	8	11	12				15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500	167,500					
	Ian Staples, Jennie Pugh & Jeanette Knapper	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**1.2**	**2.4**	**3.0**	**3.0**	**3.0**	**3.6**	**4.8**	**6.6**	**7.2**				**9.1**	
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	35	72	94	116	130	155	174	205	221				335	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500	50,500					
	Ian Staples, Jennie Pugh & Jeanette Knapper	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**69.3**	**142.6**	**186.1**	**229.7**	**257.4**	**306.9**	**344.6**	**405.9**	**437.6**				**671.8**	
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	113	95	111	101	107	103	89	69	77					
	Provider Services	317	130	266	73	91	125	143	113	141	122	125	122	109	81	103					
	Matthew Dodd & Jennie Pugh	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**79.0%**	**83.8%**	**77.6%**	**82.8%**	**85.6%**	**84.4%**	**81.7%**	**85.2%**	**74.8%**				**85.0%**	

Last updated on Jan 2022

Tier 3:
Care Navigation Centre (CNC): The number of referrals increased significantly during December.

The number of referrals to the CNC increased significantly during December.

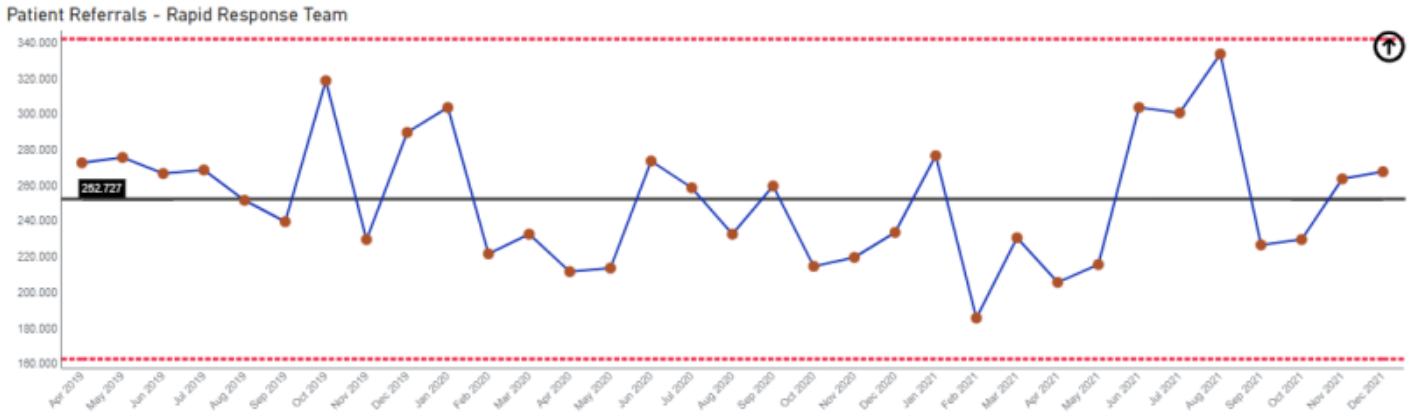
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on ED and hospital admissions.

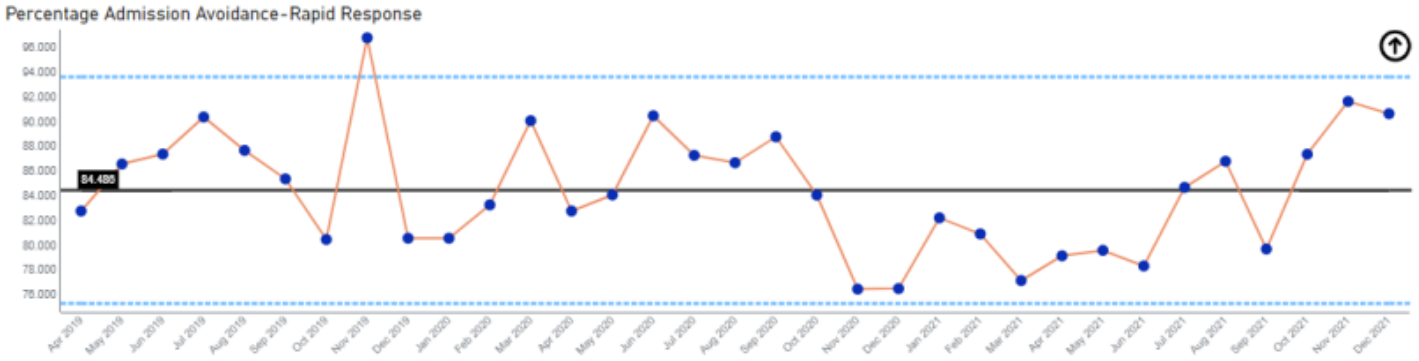
The high volume of calls are a result of the enhanced service that has been implemented. This includes a further expansion of CNC capacity, streaming patients directly from WMAS to Community pathways and services including a further strengthening of disposition pathways into Rapid Response and Integrated Front Door teams.

Additionally, a 999/111 SPA has been implemented through CNC for ED divert into FES, AEC, SACU and Gynae Early Pregnancy services.

Last updated on Dec 2021

Tier 3: Rapid Response
The pattern of demand is changing [impact of CNC]



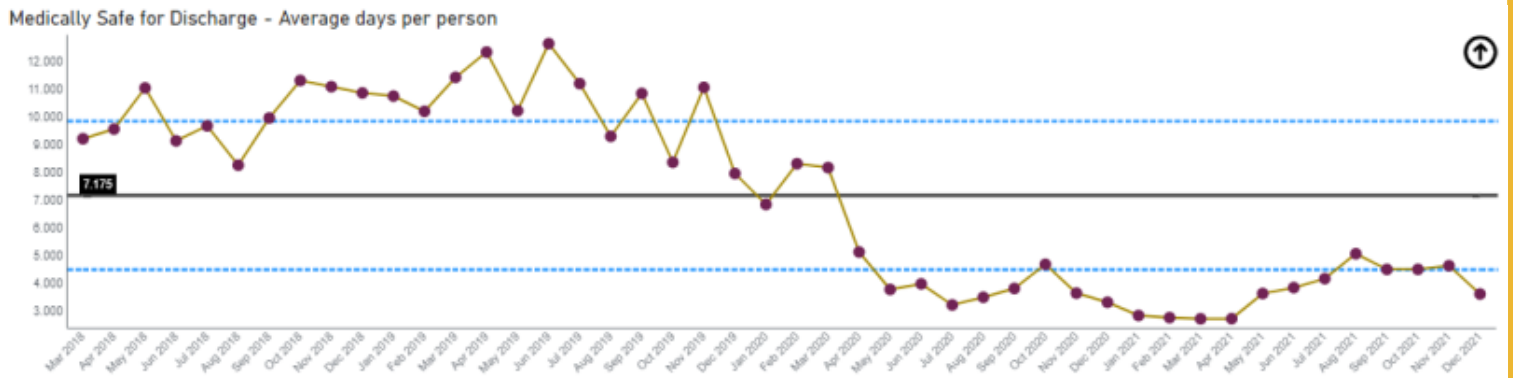


Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity of the service.

Plans to add more capacity and resilience for Rapid Response through Winter have been implemented in order to manage the increase in dispositions from WMAS and NHS 111.

Last updated on Dec 2021

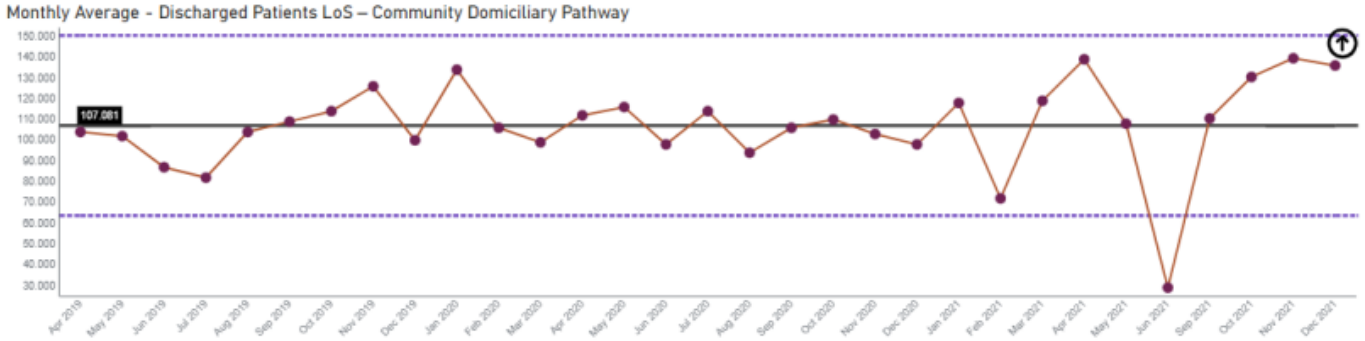
Tier 3: Medically Stable for Discharge (MSFD): numbers remain low

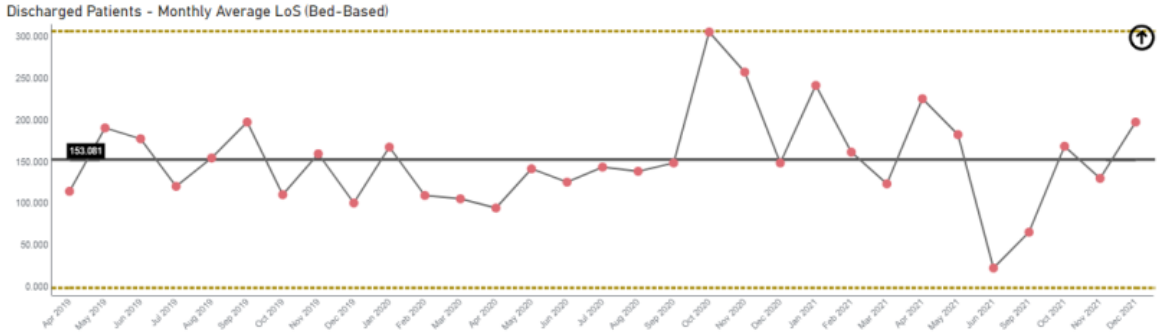


- The improved performance reported in October was maintained in November. This is as a result of the actions that have been taken by the Community Division, ICS and partners in response to the difficulties being experienced in commissioning and providing packages of care.
- The response has led to an additional 700 hours of domiciliary care being procured and delivered by the market with a further 200 being procured for Winter from the beginning of December.
- Additionally, patients are being placed on an interim basis into care home beds rather than being discharged back home with a care package, while continuing to seek a package of care to enable them to be cared for in their own home. Plans for an expansion of beds are being prepared for the Winter period to provide further resilience
- Work is being undertaken to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients. Further work is being completed on enabling service to ensure resilience through the Winter period
- Work is continuing on bolstering up the admission avoidance activity and interventions of the hospital to try and reduce dependency and reduce the demand for packages of care.

Last updated on Dec 2021

Tier 3: Domiciliary and Bed-Based Pathways



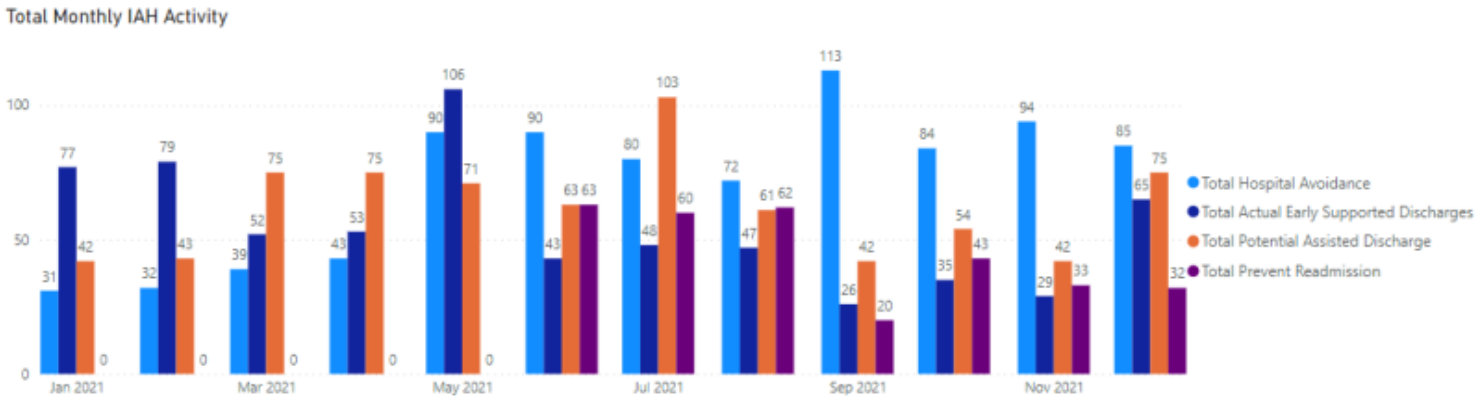


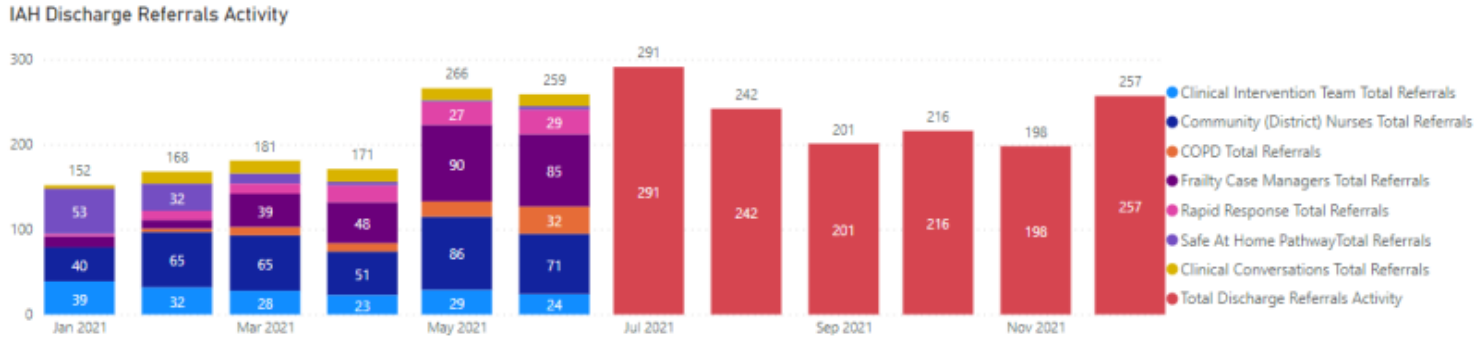
- Therapy demands and the change in national model is having a significant impact on community ICS therapists, unplanned crisis demands and hospital discharges remain key priorities in patient safety.
- Due to Covid, individuals have been more unwell and therefore have needed rehab/Reablement for a longer period of time- Long Covid MDT exceptional success.
- There is a recruitment plan underway for gaps in the social care workforce which is impacting on LOS

Last updated on Dec 2021

Tier 3/4:
Integrated Assessment Hub:

Walsall Together





Integrated Assessment Hub

- **Hospital Avoidance:** This IAH pathway enables people directly contacting the Frail Elderly Service or Ambulatory Care at the Manor with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead and receive a community-based assessment & clinical review, thereby avoiding conveyance to hospital.
- An enhanced service has been implemented through the Winter period where the pathway will be extended to patients attending ED. This will enable patients to be streamed, clinically assessed and dispositioned into Community pathways that are appropriate to manage their conditions and provide the support that they need.

Last updated on Dec 2021

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 02 - 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 deliver care closer to home and reduce health inequalities.
Lead Director:	Director of Transformation.
Lead Committee:	Walsall Together Partnership Board.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• Risks in this area relate to Walsall Together partnership risks. • Risks relating to Community Services are updated through the divisional structure. Where relevant, equivalent risks are recorded here, and reframed to reflect the risk to the wider system. • Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together. • Risk register for the Walsall Together Partnership Board – risks accepted or in escalation to Corporate Risk Register: ➢ **2370** - Population Health Management (Risk Score = 20). ➢ **2372** - Workforce capacity and skill mix does not meet the demand within the services in scope (Risk Score = 16) ➢ **2624** - System demand and capacity including primary care, social care, acute hospital, mental health and community nursing teams (Risk Score = 16). ➢ **2626** - *COVID vaccinations uptake in ethnic minority communities* (Risk Score = 16). ➢ **2641** - Delayed discharges at Manor Hospital and other settings for medically stable patients as a result of low availability of packages of care(Risk Score = 16).	**Likelihood = 4 Consequence = 4 = 16 High** ↑ Forecasted Risk Score Movement for Q4: **Likelihood = 4 Consequence = 4 = 16 High** ↔

Risk Appetite

Status:	Hungry	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 21	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 25																									

Risk Scoring

Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3	4	4		• Demand on partnership services continues to climb quickly as the Covid risks decreasing presenting additional pressure on urgent care. In addition to routine services, the system is now administering booster vaccines. • Operational pressures are continuing across the system following the restart of routine activity post-COVID. Whilst staffing levels continue to be impacted by self-isolation and a loss of workforce to other sectors, demand is exceeding capacity in several areas. The care provider market has been impacted by COVID and Brexit and there is a	Likelihood:	3	30 September 2022
Consequence:	3	3	4			Consequence:	3	
Risk Level:	**9 Moderate**	**12 Moderate**	**16 High**			Risk Level:	**9 Moderate**	

					shortage in packages of care (POC) for people MSFD within Walsall Manor and other healthcare settings. There is a further risk to capacity and flow during the winter pressures period, although a robust Systems Pressures Plan has been developed and there are business continuity plans in place in case of deterioration. • There are significant immediate and medium-term workforce challenges across all areas of the partnership. A partnership approach, with clear links into the wider Black Country plans, is required to support recruitment of both professionals into Walsall, and to develop capacity from within the local population by offering clear recruitment, training and development opportunities. A series of workforce development proposals have been endorsed by the Partnership Board and will be implemented over the next 12 months. • System transformation is governed by the Clinical & Professional Leadership Group with assurance reporting to the Partnership Board. In advance of 2022/23, this will ensure a clear focus on reducing health inequalities using a population health management approach, with reporting aligned to the Health & Wellbeing Board. • Maturing place-based teams in all areas of Walsall on physical health and Social Care. Place-based mental health provision, including IAPT, Primary Mental Health, and additional roles in general practice is not yet established. It is unclear how future contractual arrangements will be aligned to the place-based integration of services. • Further organisational development work is required to secure fully integrated working of the place-based teams; resource to support this process is now secured for 12 months. • Significant maturity in communications and confidence in Walsall Together however public profile now needs to be established and further work is required to increase visibility across general practice. • Funding has been secured and specification agreed for the development of a fully integrated			

					• performance, quality and risk scorecard. • There is a Partnership Board development session in February to review priorities for the next 12 months and beyond in the context of the expected new legislation for Integrated Care Systems and Place-Based Partnerships.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Executive Director to be advertised • Non-Executive Director / Chair to be advertised (in progress) • Partnership Board/Groups and meetings in place. • Business Case developed. • PMO/Project in place and reporting. • Daily operational coordination taking place. • Covid Vaccine delivery plan in place and operational. • WT acting as recruitment partner for PCNs on the new national roles	• Alliance agreement signed by Partners; a review is in progress and will incorporate any necessary updates to align to the proposed legislative changes • Governance structure in place and working. • S75 in place and operational practices now maturing; plans for expansion to some public health services • Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee. • Business case approved by all partners. • Monthly report to Board and partner organisations.	• External assessment - CQC/Audit. • ICS Scrutiny. • Health and Wellbeing Board Reporting. • Overview and Scrutiny Committee.
Gaps in Controls:	• No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust. This has been mitigated short term with Covid funding, but further work required to establish ongoing formal mechanisms • Commissioner contracts not yet aligned to Walsall Together although PBP planning will resolve this issue in time • Data needs further aligning to project a common information picture. • Effective engagement with community in development with local groups limited due to Covid social restrictions. This is improving but not yet back to pre-COVID arrangements. • Organisational development for wider integrated working is outlined, thought detailed proposals are still being worked up and are likely to experience further delays in Q4 2021/22 due to COVID operational pressures. • Enactment of section 75 in terms of monitoring meetings. • Place based demand and capacity plan addressing the new flows apparent after Covid-19. • Variance in the understanding of other place based services in scope across the Black Country which is preventing the ICS due diligence commencing. It is likely that current CCG arrangements will be extended beyond April 2022.		
Assurance:	• Divisional quality board now starting to look at the integrated team response. • Risk management established at a programme level and a service level integrating risks.	• Walsall-Together included on Internal Audit Programme. • Walsall Together Committee in place overseeing assurance of the partnership. • ICS oversight of 'PLACE' based model. • Reporting to Board and Partners. • Oversight on service change from other committees. • Safeguarding board to align reporting with WTPB.	• NHSE/I support of Walsall Together. • ICS support.

Gaps in Assurance:	• Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections although Walsall Together put forward as part of national PBP development (on waiting list). • For Community services and ASC within the Section 75 there is direct accountability to WT / WHT; these formal arrangements do not cover other partners hence limited accountability for delivery of Walsall Together strategic aims.

Future Opportunities

- Further development of the Governance around risk sharing.
- S75 Deployment based on other services relating to health prevention and public health commissions.
- PCN partnership alignment and risk share with building trust and confidence.
- 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 or equivalent mechanism.
- Formal working with other partners to support their ability to achieve additional income and support via a partnership approach.
- CQC action oversight group.

Future Risks

- Insufficient promotion of success narrative.
- Inability to deliver enough investment up front to change demand flows in the system.
- Changes to commissioner and provider environment / landscape within the Black Country may change mechanisms for resourcing and resolution of service issues.
- A mechanism for gaining and sustaining resources to support strategic aims for 2021/22+ are unclear.
- National influences on constitutional targets moves focus from place to ICS.
- Retention of inspirational and committed leadership across partners.
- 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 more services come into scope.
- Maintenance of the PBP agenda through the ICS Board by both the system partners and the Trust in relation to strategic objectives.
- Transition to a new chair and Executive Director and maintaining the current BAU

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Agree an investment plan initially with commissioners through 2021/22 funding round to address the current gaps in funding provision.	Director of Integration	July 21	Work is complete to confirm maintenance of transformation funding for the diabetes and care home services into established baselines. A longer-term conversation is still to be coordinated with other PBPs through the ICS board for Health Commissioning. A series of meetings are scheduled during Q4 2021/22, following the expected release of national planning guidance in December 21.	
2.	Agree & implement joint service development opportunities between Walsall Together and PCNs that foster improved delivery of care through more integrated working.	Director of Integration	~~July 21~~ Oct 21	**Complete** - Several joint service development opportunities are included in the 2021/22 Plan, with PCN-based population health management priorities forming the basis of the forward-look programme. To varying degrees, all of these projects are in progress. The transfer of Practice-based Pharmacists is complete.	

3.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations.	Director of Integration	~~July 21~~ Oct 21	**Complete** - The Resilient Communities Steering Group is established with ToR and monthly meetings. The forward-look programme and all ongoing strands of work have been incorporated into the Transformation Programme for 2021/22 and 2022/23. The work stream has presented to WTPB (March 2021) the following next steps: • Discussion at the CPLG to confirm the local population challenges that we want to address, aligning to population health management and inequalities priorities for the partnership. • Establishment of the Steering group including confirmation of membership and Terms of Reference. • Review of the multiple strands of work pertaining to citizen and communities engagement to create a single, defined approach. • Review of the full proposal to Changing Futures and proposal for how some or all of the elements can be taken forward without the external investment.	
4.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital work stream).	Director of Integration	~~July 21~~ March 22	As reported previously, the final strategy is interdependent with the production of the Health & Wellbeing strategy and refreshed JSNA, which was presented to the HWB in October. The partnership Plan is progressing and will be presented for approval in February 2022, ready for implementation from 1st April 2022. Amber due to potential minor delays to implementation of the digital element – this will not delay production and implementation of the overall PHM&I Plan.	
5.	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.	Director of Governance	~~July 21~~ March 22	This work is in progress as part of the development of place-based partnerships and integrated care systems. The proposed legislation will come into effect on 1st April 2022. Development of governance and legal frameworks can only be undertaken following release of national guidance, which is an ongoing process and expected to continue for the remainder of 2021/22.	

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Board Assurance Framework and Corporate-element of the Trust Risk Register Report			**AGENDA ITEM: 23**
Report Author and Job Title:	Vicky Haddock - Head of Risk Management	**Responsible Director:**	Kevin Bostock - Director of Assurance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• These Board Assurance Framework (BAF) risks form the Strategic Objective (SO) risk register of this organisation which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels. • Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable Trust Board to maintain effective oversight of SO risks through a regular process of formal review. • Each Lead Director meets on a monthly basis with the Head of Risk Management to review their BAF and risks that sit on the Corporate-element of the Trust Risk Register (CRR).		
Advise	• Seven of the eight identified Strategic Objective Board Assurance Framework risks have a current **High** rated risk score (15-25), meaning that there is a significant probability that major harm will occur if urgent action is not taken to implement control measures to mitigate these risks. • 26 of the 32 Corporate Risks have a current **High** rated risk score (15-25).		

Alert	• Note the report has been written against the backdrop of the current Covid-19 pandemic and the additional operational challenges that it has placed on the organisation, with some of the monthly Risk Review meetings being stood down.
	• Elements of the BAF and CRR have lapsed, therefore greater oversight by the Lead Directors is required to ensure the risks that they are accountable for, are being updated appropriately within the specified review timescales, with clear SMART actions outlining plans to mitigate the risks and gain assurance of controls being implemented.
	• Of the 32 Corporate Risks, there are:
	  ○ 43 actions overdue,
	  ○ 10 risks with no progress narrative provided within the specified review timescales,
	  ○ 3 risks with no documented controls and/or assurances,
	  ○ 2 risks with no documented SMART actions.
	• The Trust Board is asked to:
	  ○ Review and discuss the report.
	  ○ Encourage greater oversight by the Lead Directors of current risks and a coherent approach to strengthening Risk Management within the Trust by proactively; identifying, capturing, understanding, agreeing, assessing and managing risks.		

Does this report mitigate risk included in the BAF or Trust Risk Registers?	Risk implications are outlined within the document.		
Resource implications	Risk implications are outlined within the document.		

Legal and/or Equality and Diversity implications	The BAF and indeed elements of the attached risks form part of our registration and licence requirements to both NHSI and CQC, which may result in regulatory or legal action under the Health and Social Care Act. There is clear evidence[1] of unequal and differential impact of COVID-19 on sections of our society including differential impact associated with levels of deprivation, occupations and ethnicity. 1. https://www.health.org.uk/sites/default/files/upload/publications/2020/Build-back-fairer-the-COVID-19-Marmot-review.pdf#:~:text=Building%20back%20fairer%20will%20require%20fundamental%20thinking%20about,must%20be%20dealt%20with%20at%20the%20same%20time	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Board Assurance Framework and Corporate-element of the Trust Risk Register

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Board with a status update in relation to the Board Assurance Framework (BAF) and those risks that site on the Corporate-element of the Trust Risks Register (CRR), noting the actions in place to support mitigating these risks.

This report includes:

- A summary of both the overall number and grade of risks contained in the BAF and CRR;
- A description of the high risks included on the BAF and CRR;
- A description of any changes made to the BAF and CRR;
- A description of the BAF and CRR reviewed; and
- A description of the BAF and/or CRR agreed risks to close or de-escalate.

2. BACKGROUND

These BAF risks form the Strategic Objective (SO) risk register of this organisation which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels.

Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable Trust Board to maintain effective oversight of SO risks through a regular process of formal review. Each Lead Director meets on a monthly basis with the Head of Risk Management to review their BAF and CRR risks.

3. DETAILS

3.1 Board Assurance Framework (BAF)

There are currently eight identified SO risks included within the BAF risk register which have been approved by the Trust Board.

In May 2021, the People and Organisational Development Committee (PODC) agreed with the proposal to divide 'BAF SO 04 for Value our Colleagues' into three separate BAF risk documents in order to focus on the milestones and outcomes for each sub-work stream within the Value our Colleagues element of the Improvement Programme for the 2021-2022 year. The previous combined BAF SO 04 was then brought to a close.

3.1.1 Current BAF Risks

- BAF SO 01 - Safe, High Quality Care,
- BAF SO 02 - Care at Home,
- BAF SO 03 - Work with Partners,
- BAF SO 04a - Leadership Culture and Organisation Development,
- BAF SO 04b - Organisation Effectiveness,
- BAF SO 04c - Making Walsall (and the Black Country) the best place to work,
- BAF SO 05 - Use Resources Well,
- BAF SO 06 - COVID.

The updated BAF documents are provided for the Trust Board in Appendix 1 - 8.

3.1.2 BAF Movement

The table below shows the quarterly movement of the BAF risk documents:

Summary Risk Title	SO Under Threat	Quarterly Change in Current Risk Score				
		Q1 2021/22	Q2	Q3	Q4	Quarter Change
BAF SO 01 - Safe, High Quality Care	Safe, high quality care	15 High	25 High	25 High		↔
BAF SO 02 - Care at Home	Care at home	9 Moderate	12 Moderate	16 High		↑
BAF SO 03 - Working with Partners	Partners	6 Low	6 Low	6 Low		↔
BAF SO 04 - Value our Colleagues	Value colleagues	20 High	16 High	16 High		↔
○ 04a - Leadership Culture & OD		20 High	16 High	16 High		↔
○ 04b - Organisational Effectiveness		20 High	16 High	16 High		↔
○ 04c - Making Walsall & BC BPTW						
BAF SO 05 - Use Resources Well	Resources	15 High	15 High	15 High		↔
BAF SO - 06 COVID	Safe, high quality care; Care at home; Partners; Value colleagues; Resources	6 Low	12 Moderate	15 High		↑

A summary of the; BAF title, risk description, current risk score movement, forecasted risk score movement for quarter four (Q4) and risk review details over the last quarterly (Q3), is shown below (in risk number order):

- **BAF SO 01 - *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.*
    - **Current Risk Score Movement** - Has remained the same this quarter as a **25 High** (Consequence 5 x Likelihood 5).
    - **Forecasted Risk Score Movement for Q4** - Has not been provided at this stage.
    - **Risk Review** - The BAF has four overdue actions, with an addition three due by the end of January 2022. There has been no progress narrative provided

within the specified review timescale and the BAF review remains outstanding. At Risk Management Executive Group meeting held 10/01/2022, Dr Manjeet Shehmar advised it had been agreed at QPES that the BAF title needed to be revised. As such Dr Shehmar has met with Simon Evans regarding review the overall Strategic Objective. Further update expected in April 2022.

- **BAF SO 02 - *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 deliver care closer to home and reduce health inequalities*.
    - **Current Risk Score Movement** - Has increased this quarter, from a Moderate 12 (Consequence 3 x Likelihood 4) to a **16 High** (Consequence 4 x Likelihood 4) which has been predicted due to previous underscoring.
    - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
    - **Risk Review** - The BAF has one overdue action, with progress narrative provided within the specified review timescale within the BAF. At Risk Management Executive Group meeting held 10/01/2022, Michelle McManus advised due to the increased health inequalities and potential detraction in health outcomes across the population, off the back of the pandemic, this further supports the current increased risk score movement this quarter. The overdue action is largely as a result of the degree of uncertainty on what is happening with the establishment of the ICS, which has put that action on hold. That said, the action will be reviewed and updated ahead of the next scheduled Risk Review meeting.

- **BAF SO 03 - *Work with Partners;*** *we will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System*.
  - **Risk 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*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **6 Low** (Consequence 3 x Likelihood 2).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 3 Very Low (Consequence 3 x Likelihood 1), subject to assurance on and approval of the Urology integration plan, which remains on track for an April 2022 implementation.
    - **Risk Review** - Progress narrative provided within the specified review timescale within the attached BAF.

- **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times*. ***04a*** *- Leadership Culture & Organisational Development*.
  - **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **16 High** (Consequence 4 x Likelihood 4).
    - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
    - **Risk Review** - The BAF has two overdue actions, with progress narrative provided within the specified review timescale within the BAF. At Risk

Management Executive Group meeting held 10/01/2022, Catherine Griffiths advised it had been agreed at PODC that due to the BAF rework underway further updates wouldn't be expected until April 2022.

- **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times*. ***04b*** *- Organisational Effectiveness*.
  - **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **16 High** (Consequence 4 x Likelihood 4).
    - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
    - **Risk Review** - The BAF has one overdue action, with an addition three due by the end of January 2022. Progress narrative provided within the specified review timescale within the BAF. At Risk Management Executive Group meeting held 10/01/2022, Catherine Griffiths advised it had been agreed at PODC that due to the BAF rework underway further updates wouldn't be expected until April 2022.

- **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times*. ***04c*** *- Making Walsall (and the Black Country) the Best Place to Work*.
  - **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **16 High** (Consequence 4 x Likelihood 4).
    - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
    - **Risk Review** - Progress narrative provided within the specified review timescale within the BAF. At Risk Management Executive Group meeting held 10/01/2022, Catherine Griffiths advised it had been agreed at PODC that due to the BAF rework underway further updates wouldn't be expected until April 2022.

- **BAF SO 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 & 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, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **15 High** (Consequence 5 x Likelihood 3).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 10 Moderate (Consequence 5 x Likelihood 2).
    - **Risk Review** - Progress narrative provided within the specified review timescale within the attached BAF.

- **BAF SO 06 - *Covid;*** *this risk has the potential to impact on all of the Trust's 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*.
  - **Current Risk Score Movement** - Has increased this quarter, from a Moderate 12 (Consequence 3 x Likelihood 4) to a **15 High** (Consequence 3 x Likelihood 5) which has been predicted due to the increased transmissibility of the Omicron variant, and therefore there is increased risk of staff absence as a result of being Covid positive or living with a Covid positive household member.
  - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
  - **Risk Review** - Progress narrative provided within the specified review timescale within the attached BAF.

3.2 Corporate-element of the Trust Risk Register (CRR)

There are currently 32 risks that sit on the Corporate-element of the Trust Risk Register. Unfortunately not all risk review meeting were attended this month and not all of the updates have been provided within the specified review timescale to complete quarter three's (Q3's) updates. In each case where there has not been a timely update or progress narrated, escalation to the relevant Lead Director has taken place, in addition this has also been captured at Risk Management Executive Group meeting.

3.2.1 Current Risks

Details of the 32 Corporate Risks (in risk number order) are shown on the dashboard appended to this report (Appendix 9), in addition to their; controls, assurances and actions to be undertaken that will help to mitigate the risk by resolving control and assurance gaps.

3.2.2 Risk Movement

The table below shows the quarterly movement of the top 10 risks that have a risk score of 20 (in risk number order):

Risk ID	Risk Title	Quarterly Change in Current Risk Score				
		Q1 2021/22	Q2	Q3	Q4	Quarter Change
2245	*Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.*	20 High	20 High	20 High		↔
2370	*Population Health Management.*			20 High		New Corporate Risk
2430	*Risk of harm to children due to fragmented record storage.*	20 High	20 High	20 High		↔
2439	*External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.*	20 High	20 High	20 High		↔
2475	*The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.*	25 High	25 High	20 High		↓
2581	*Internal risk for patients awaiting Tier 4 hospital admission.*		15 High	20 High		↑
2601	*Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6.*		12 Moderate	20 High		↑
2664	*Patient Safety and Training Issues in Medicine /ED.*		20 High	20 High		↔
2737	*Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy.*			20 High		New Corporate Risk
2774	*The government has confirmed that all NHS staff, health and social care workers, and volunteers working in England who have face-to-face contact with service users, will need to provide evidence that they have been fully vaccinated against COVID-19 unless they are medically exempt.*			20 High		New Corporate Risk

	This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.					

A summary of the; risk title, risk description, current risk score movement, forecasted risk score movement for quarter four (Q4) and risk review details over the last quarterly (Q3), is shown below (in risk number order):

- **Risk ID 2245** - *Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level*.
  - **Risk Description** - *There is a high level of maternity leave within the maternity team, currently totalling 25.1% of registered midwives across all inpatient areas. When this is considered with the normal expected tolerance of 16% A/L which is essential for the health and wellbeing of staff a 3% tolerance for staff training. This is being further exacerbated by an increasing number of staff requiring to self-isolate or quarantine due to Covid-19 procedures. As a result of the above, there is growing concern about the ability to safely provide care across the inpatient team, including 1:1 care in labour, due to the lack of staff available to work. Historically the service has been asked to maintain 10 vacancies due to the planned closure of Foxglove ward and relating to a reduction in birth numbers; this however does not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. This is not a new issue as historically over the last 5 years the team has lost at least 10wte per year due to mat leave*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **20 High** (Consequence 4 x Likelihood 5).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 12 Moderate (Consequence 4 x Likelihood 3).
    - **Risk Review** - Recruitment drive continues however numbers are low. There have also been 3 retirements and 2 leavers which have added to the vacancies. Recruitment fayre planned for January 2022. The risk has two overdue actions.

- **Risk ID 2370** - *Population Health Management*.
  - **Risk Description** - *The size and complexity of the population health challenges and health inequalities in Walsall present multiple 'priorities' that cannot all be addressed simultaneously and may result in an inability to make progress in the most efficient and effective way. The inequalities experienced by our population has been further compounded by the COVID pandemic and presents a risk of premature mortality if significant recovery efforts for patients with long term conditions are not undertaken in a timely manner. The national booster vaccination programme has now been prioritised for Primary Care; non-urgent and routine services have been stood down in order to release staff to support the vaccination programme. This may lead to delays in presentations for other conditions and further exacerbate health inequalities and the risk of premature mortality*.
    - **Current Risk Score Movement** - Agreed on to the Corporate-element of the Trust Risk Register at Risk Management Executive Group meeting 10/01/2022 as a **20 High** (Consequence 5 x Likelihood 4).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 10 Moderate (Consequence 5 x Likelihood 2).

- **Risk Review** - Updated to reflect implications of the recent guidance to cancel non-urgent and routine primary care services and acknowledging that further cancellations of elective and other routine activity in other providers is highly likely in coming weeks.

➢ **Risk ID 2430** - *Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record*.
- **Risk Description** -
  - *Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people*.
    - **Current Risk Score Movement** - Has remained the same this quarter as a **20 High** (Consequence 4 x Likelihood 5).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to an 8 Moderate (Consequence 4 x Likelihood 2).
    - **Risk Review** - The scheduled monthly risk review meeting was not attended this month, the risk has three overdue actions. No progress narrative was provided within the specified review timescale and the risk review remains outstanding.

➢ **Risk ID 2439** - *External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England*.
- **Risk Description** - *There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains to the Paediatric unit; the lack of adequate service provision externally means we carry a high level risk internally as a result of holding CYP who are in crisis. Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 8am-6pm. Overall the risks are external to our service*.
  - **Current Risk Score Movement** - Has remained the same this quarter as a **20 High** (Consequence 4 x Likelihood 5).
  - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
  - **Risk Review** - Progress narrative has not been provided within the specified review timescale and the risk review remains outstanding. There is also one overdue action within this risk.

➢ **Risk ID 2475** - *The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services*.
- **Risk Description** - *The Trusts inability as a Mental Health (MH) provider to comply with its legal & moral responsibilities of the MH provider status, as well upholding the MHA Code of Practice*.
  - **Current Risk Score Movement** - Has reduced this quarter from a 25 High (Consequence 5 x Likelihood 5) to a **20 High** (Consequence 5 x Likelihood 4).
  - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 15 High (Consequence 5 x Likelihood 3).

- **Risk Review** - There are continued incidents and risk to patients and the organisation. The MHA administrators are now in post and have identified further issues with the delivery and management of the MHA - however there is a proactive plan to action all concerns. The other vacancies that have been interviewed have been appointed to and will have a start date in February 2022.

➢ **Risk ID 2581** - *Internal risk for patients awaiting Tier 4 hospital admission*.
- **Risk Description** - *WHT ability to support and manage any CYP awaiting a tier 4 admission, with an increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey*.
  - **Current Risk Score Movement** - Has increased this quarter from a 15 High (Consequence 3 x Likelihood 5) to a **20 High** (Consequence 4 x Likelihood 5) due to previous underscoring.
  - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
  - **Risk Review** - There are continued admissions to the paediatric ward that are patients awaiting a Tier 4 bed. There is a national crisis for Tier 4 beds - especially for specialities such as eating disorders. WHT continues to engage with the MH Trust and we are incident reporting proactively. Director of Nursing for WHT has arranged a senior meeting to review CYP MH admission pathways due to the impact and safe management of CYP in crisis on paediatric ward.

➢ **Risk ID 2601** - *Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6*.
- **Risk Description** - *Failure to report accurate Sepsis data nationally, resulting in non-compliance and increased risk of delivering suboptimal sepsis care/treatment*.
  - **Current Risk Score Movement** - Has increased this quarter from a 12 Moderate (Consequence 3 x Likelihood 4) to a **20 High** (Consequence 4 x Likelihood 5) due to previous underscoring.
  - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to an 8 Moderate (Consequence 4 x Likelihood 2).
  - **Risk Review** - Weekly meetings to discuss E-Sepsis system. System C investigating issues with recording, feedback due January 2022. There is also three overdue actions within this risk.

➢ **Risk ID 2664** - *Patient Safety and Training Issues in Medicine / ED*.
- **Risk Description** - *Reputational Impact on the Trust regarding Doctors in Training placements. Withdrawal of Doctors in Training placements by Health Education England. Financial reduction of Health Education income*.
  - **Current Risk Score Movement** - Has remained the same this quarter as a **20 High** (Consequence 4 x Likelihood 5).
  - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
  - **Risk Review** - No further changes to the risk, still awaiting the second response letter from HEE detailing any concerns outside of the initial patient safety concern. There are currently no open actions raised against this risk, despite gaps in controls and assurances being documented, actions to be added to clear gaps.

- **Risk ID 2737** - *Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy*.
  - **Risk Description** - *Currently there is a resistance / non-adherence with the Trust Medicines policy in several areas of the Trust with regard to (as evidence by pharmacy audits).*
    - **Current Risk Score Movement** - Agreed on to the Corporate-element of the Trust Risk Register at Risk Management Executive Group meeting 08/11/2021 as a **20 High** (Consequence 4 x Likelihood 5).
    - **Forecasted Risk Score Movement for Q4** - Is expected to remain the same.
    - **Risk Review** - CD audits findings (Sept/Oct/Nov 2021) and safe storage weekly spot checks emailed to risk owners for all divisions to ensure they are cited on audit findings and advised to update action plans accordingly.

- **Risk ID 2774** - *The government has confirmed that all NHS staff, health and social care workers, and volunteers working in England who have face-to-face contact with service users, will need to provide evidence that they have been fully vaccinated against COVID-19 unless they are medically exempt. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline*.
  - **Risk Description** - *There are staff that work in front line roles and have face to face contact with service users that have not received both doses of the COVID-19 vaccine and therefore in line with the new statutory regulations with effect from 1 April 2022, will not be able to continue in their role. This may mean that the staffing levels in some services will be adversely affected and may also affect recruitment to key roles. Where redeployment is not possible, there is a risk that staff may be dismissed from their role*.
    - **Current Risk Score Movement** - Agreed on to the Corporate-element of the Trust Risk Register at Risk Management Executive Group meeting 29/11/2021 as a **20 High** (Consequence 4 x Likelihood 5).
    - **Forecasted Risk Score Movement for Q4** - Is expected to reduce to a 12 Moderate (Consequence 4 x Likelihood 3).
    - **Risk Review** - All actions reviewed in light of publication of national guidance (released by NHSIE 06/12/2021) and following ICS and local T&F group meetings. Additional action relating to IG data processing requirements recorded. The risk has one overdue action.

3.3 Reporting and Assurance

The Board Assurance Framework (Board Assurance Framework (BAF)) and Corporate-element of the Trust Risk Register (CRR) reports will be provided for information to the Trust Board on a monthly basis and on a quarterly basis, at the end of each quarter, they will be presented with this formal report to provide assurance and mitigation where appropriate.

The Head of Risk Management will provide expert support to risk owners in further reviewing and updating risks in order to provide an accurate position statement.

All risks on the CRR will be reviewed in a timely manner to ensure robust actions are agreed, achieved and timescales adhered to. Overdue reviews and actions will be highlighted and escalated.

To ensure the CRR is actively monitored and updated with progress to maintain its current position; the schedule for reviewing corporate risks has been revised allow sufficient time to facilitate confirm and challenge sessions with view to strengthening the quality of risk evaluation, articulation, action planning and progress. These updates then feed into a Risk Management Executive (RME) Group meeting, where all Executive Directors have the opportunity to discuss and challenge their peers BAF and CRR risks.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the BAF and CRR risk documents and their respective progress.

5. APPENDICES

BAF SO 06 - COVID
Corporate-element of the Trust Risk Register Dashboard

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 06 - COVID; This risk has the potential to impact on all of the Trust's 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.
Lead Committee:	Trust Board
Links to Corporate Risk Register:	Title: • **208** - Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk score = 16). • **2066** - Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score =15). • **2081** - Delivery Operational Financial Plan (Risk Score = 9). • **2082** - Future Financial Sustainability. (Risk Score = 12). • **2093** - Risk of staff contracting COVID-19 through the course of their duties in WHC NHS Trust. (Risk Score = 6). • **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 (Risk Score = 9).
	Current Risk Score Movement: **Likelihood = 5 Consequence = 3 = 15 High ↑** Forecasted Risk Score Movement for Q4: **Likelihood = 5 Consequence = 3 = 15 High ↔**

Risk Scoring

Quarter:	Q1 2021/22	Q2	Q3	Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	2	4	5		• 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. By May 2020, almost 1 in 4 Trust staff that had undergone a Covid-19 Antibody test had been antibody positive that suggested a significant proportion of the workforce had experienced the disease themselves. Moreover, the challenges of managing the initial wave of the pandemic had a significant psychological impact on staff too. • The Trust is operating in an uncertain financial	Likelihood:	2	30 June 2022
Consequence:	3	3	3			Consequence:	3	
Risk Level:	**6 Low**	**12 Moderate**	**15 High**			Risk Level:	**6 Low**	

					planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19, and planning for the 22/23 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. • Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20, with further analysis presented to QPES 28/01/21 confirming 21 probable or definite nosocomial deaths from Covid in Wave 1. • Planning assumptions for a second wave of Covid-19 cases assumed a peak at half the level of the April 2020 peak. In November 2020 the Trust exceeded 80% of the April peak in terms of Covid-19 positive bed occupancy. In January 2021 the Trust had exceeded 140% of the April 2020 peak. As of 27th December 2021 the Trust's Covid-19 positive inpatients are at 16.5% of the April 2020 peak or 11.5% of the January 2021 peak. Walsall borough's rolling 7-day average Covid-19 prevalence per 100,000 population has now risen to in excess of 500/100,000 however, and are on trajectory to be the highest since January 2021 by the end of December 2021 as a result of the Omicron variant. • The Trust had the 7th highest proportion of its hospital beds occupied by Covid-19 positive patients in the country in early November 2020, and the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. • The Trust consistently had one of the highest Critical Care bed occupancy relative to baseline commissioned capacity across the Midlands region during the second wave. In January 2021 Critical Care bed occupancy has exceeded 250% of baseline commissioned capacity, peaking at 306% of baseline commissioned capacity. The Trust has spent much of 21/22 with its 7th elective operating theatre stood down to release reservist staffing to support Critical Care.			

					• The Trust has been successful in rolling out the Pfizer Vaccine to Patients and staff across BCWB Health and Social Care organisations, with 90 of all staff having received their first vaccination, 87% having received their 2nd vaccination and 57% having received their booster vaccination (as of 17/12/21). • The success of the vaccination programme has reduced the conversion of community cases into hospitalisations, however this has meant that community prevalence is sustained at higher levels, particularly with the increased transmissibility of the Omicron variant, and therefore there is increased risk of staff absence as a result of being Covid positive or living with a Covid positive household member • The Trust has 31 Covid positive in-patients within the hospital (as of 27/12/21).			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	<u>Governance</u>: • Incident Command structure in place incorporating Strategic Command, Hospital Tactical Command, Walsall Together Community Tactical Command and Corporate Tactical Command. • Bespoke Incident Command structure in place for Covid-19 Vaccination programme. • Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. • Specific Covid-19 related SOPs and guidelines. • ITU Surge Plan in place. • Covid Streaming processes in place. • Enhanced Health and Safety/IPC Process in place in relation to Covid-19, with particular focus on social distancing, patient/staff, screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance. • Daily risk assessment (RAG rating) of	• 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 from Wave 1. • UEC and Covid resilience Winter Plan approved by Trust Board October 2021. • Covid-19 Deaths incorporated into SJR processes. • Nosocomial Covid-19 Infections are subjected to RCA and reported to the Infection Control Committee.	• Regional and National Incident Control structure. Return to national Level 4 EPRR Incident on 13th December 2021.

	Community Locality teams to prioritise resource according to need.		
Gaps in Controls:	• Walsall borough disproportionately hard hit. 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 throughout waves 2 in the autumn of 2020 and 3 over the Winter of 2020/21. The Trust had the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. • Resurgence of Covid-19 cases resulting in significant staff isolation required, particularly associated with the Omicron variant wave over Winter 2021/22. Government Autumn and Winter Plan (21/22) that is unlikely to re-introduce significant social restrictions and thus community prevalence is likely to remain high resulting in significant staff members required to isolate due to being positive, or having a positive household member. • Increased fragility in the domiciliary care market resulting in higher bed occupancy in hospital, and compromised ability to optimally manage Infection Prevention and Control. • Significantly increased Critical Care demand resulting in a dilution of ratios of specialist Critical Care Nurses to patients, partially mitigated through use of Category B and Category C registrants. • Reduction in elective surgical operating theatre capacity due to requirement to support Critical Care staffing, resulting in prolonged waits for elective surgery. • Vaccine hesitancy, particularly amongst younger people, resulting in unvaccinated COVID-19 positive pregnant women and evidence that Maternal COVID-19 infection is associated with an approximately doubled risk of stillbirth and may be associated with an increased incidence of small-for-gestational age babies. • Increased risk of complications for pregnant women with COVID-19 coinciding with increased birth rate evident during 2021. • High demand on key Covid-19 Community pathways including Community Pulse Oximetry monitoring (Safe at Home pathway) and Long Covid pathways. • Ability for neighbouring Trust's to manage demand from patients conveyed by ambulance resulting in additional ambulance patients being conveyed to Walsall Manor through WMAS Intelligent Conveyancing protocol. • 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. • 60-day readmission rate for Covid-19 patients in line with peer-reviewed published evidence.	• Elective waiting times Top 20 in the country for Diagnostics (DM01) and Top half nationally for routine elective treatment (18-week Referral to Treatment) in Oct 2021 national reported performance, out of 122 general acute Trusts. • GP referred Cancer treatment commencing within 62-days 21st (Oct 2021) out of 122 general acute Trusts. • Elective 52-week wait performance 6th best in the Midlands (Oct 2021). • Top 40 in the country (out of 113 reporting general acute Trusts) (Nov 2021) for the 9th consecutive month for 4-hour Emergency Access Standard, and Top3 in the West Midlands out of 14 reporting Trusts for Ambulance handover <30 mins for the 13th

			consecutive month, 9 of which have been top performing Trust in the region. • CQC Assurance of the IPC Board Assurance Framework. • Productivity of Vaccination Programme compares favourably with other Acute Trusts. • Risk adjusted mortality rate (ICNARC) for Critical Care within expected range despite significant over-occupancy.
Gaps in Assurance:	• Lack of assurance of communications within the organisation to ensure that staff members feel well informed and engaged. • Evidence of higher staff absence rates than BCWB peers during initial wave of Covid-19, absence rates consistent with peers in second/third wave		

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 group.

Future Risks

- Potential for further resurgence in Covid-19 cases over Winter 2021/22, associated with Omicron variant.
- Risk of further resurgence coinciding with RSV season, influenza season and norovirus season.
- Limited political appetite to re-introduce lockdown measures evidenced through Governments Autumn and Winter (21/22) Plan A.
- Uncertain vaccine efficacy against novel variants.
- Ongoing pressure on community services associated with patients rehabilitating following Covid-19, including Long Covid patients.
- Delayed and/or prolonged impact of managing the initial wave, second wave and third wave of the pandemic on staff wellbeing and mental health.
- Potential workforce absence in the event of a further 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, including the requirement for booster vaccination.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
6.	Confirmation of 2021/22 Financial arrangements.	DoF	~~Feb 2021~~ Oct 2021	**Complete** - Delayed due to delayed national planning guidance. Q1 and Q2 Financial Plan agreed at Private Board 03/06/2021, with Q3 and Q4 Financial Plan to be received at extraordinary PFIC 20/10/2021.	
7.	Revised staff absence management in the event of positive household contact	DoN (DIPC)	Dec 2021	**Complete** - In line with revised UKHSA and NHSEI guidance	
8.	Revised Covid Contingency Plan in response to the Omicron variant	COO	Dec 2021	**Complete** - Further contingency planning undertaken through Exercise Patton 2 EPRR scenario planning exercise	

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Charitable Funds Committee Highlight Report			**AGENDA ITEM: 24**
Report Author and Job Title:	Mr Paul Assinder – Committee Chair and Non-Executive Director	**Responsible Director:**	Mr Paul Assinder – Committee Chair and Non-Executive Director
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The Charitable Funds Committee met on Thursday 9th December 2021. Key points for the attention of the Trustees are: **Introduction** 1. This was a routine meeting of the Committee but we were joined by David Judge, Investment broker from Brewin Dolphin Co and Mark Surridge, Director of Mazars, Auditors to the Charity. **2020/21 Annual Accounts & Audit statement** ***(The Charity is required to submit audited accounts to the Charity Commission each year)*** 2. Mark Surridge, Mazars, advised the Committee that his audit of the Charity's Annual Report and Accounts had concluded. He congratulated the Charity on the thoroughness of its governance and will issue a 'clean' and unqualified audit certificate. 3. Associated with the audit process, the Committee approved the detail of a Letter of Representation to Mazars; noted the Auditors opinion; and now recommend to the Trustees (at the January Board) the adoption of the 2020/21 Report and Accounts and their filing to the Charity Commission. 4. As a reminder, the Accounts recorded that The Charity had a brought forward balance of £370k at the 1st April 2020 but ended the year with a fund balance at 31 March 2021 of £930k (principally reflecting a recovery in the book value of investments in the year). **Investment Portfolio** ***(The Charity retains brokers to invest the accumulated funds of the Charity)*** 5. David Judge, Investment Manager, Brewin Dolphin, attended the meeting. Brewin Dolphin were appointed in September 2021 and have begun working to reshape the portfolio. The Committee noted the ethical restrictions placed on the brokers and endorsed the strategy for diversification, in line with the low appetite for risk applied to this portfolio. 6. Brewin Dolphin has made good early progress and the Committee will keep their work under close scrutiny.		

	Fundraising Activities 7. Georgie Westly presented on a wide range of fundraising activities over the recent quarter, in spite of covid restrictions. These include: Will Writing — Trust Gots Talent (15 Oct) Movember — Pumpkins Festive Markets **Bids for Charitable Spending** **Quarterly Review of Expenditure Below £5k** ***Fund Managers and Fund Divisional Directors together have the delegated authority to authorise expenditure from charitable funds below the £5,000 level.*** 8. The charity has approved expenditure under delegated authority, in the quarter totalling £31,220.02, from requests below the £5,000 level. The Committee scrutinised this spending. 9. There were no bids for spending above £5,000. **Quarterly Financial Performance July – September 2021** 10. For YTD, the Charity has grown in value from £930k to £945k. Outstanding spending commitments of £174k leave an uncommitted balance available of £771k. 11. The Committee commended a publicity & information campaign to promote fund holders to consider further plans for spending for the benefit of patients and staff. 12. The Committee considered its Reserves Policy (of at least £500k balance) and resolved that this should remain unchanged. **Governance** 13. A review of the Charitable Funds Policy is being conducted and it was agreed to harmonise policy with RWT's Charity where practicable The Committee meets quarterly, with the next scheduled meeting taking place on 17th March 2022.
Recommendation	The Committee recommend to the Trustees (at the January Board) the adoption of the 2020/21 Report and Accounts and their filing to the Charity Commission.
Risk in the BAF or Trust Risk Register	There are no risk implications in this report.
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 ☒	

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Five Year Strategy Update			**AGENDA ITEM: 25**
Report Author and Job Title:	Roseanne Crossey, Head of Business Development and Planning	**Responsible Director:**	Simon Evans, Interim Director of Planning and Improvement.
Recommendation & Action Required	Members of the Committee are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	The current strategic objectives within WHT's strategy are still relevant, with the exception of the organisational objective, ***to be rated Outstanding by 2022.***		
Advise	The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) intend to develop a joint strategy and set of objectives for approval by both Boards in August 2022.		
Alert	A formal procurement process is underway to appoint an external company to garner feedback from key stakeholders to inform the document.		
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	The budget for the internal and external engagement being undertaken by an external company is £50K.		
Legal and/or 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 ☒		

Development of a Joint Strategy between The Royal Wolverhampton NHS Trust (RWT) and for Walsall Healthcare NHS Trust (WHT).

1. PURPOSE OF REPORT

1.1 The purpose of the report is to seek approval from the Board for the extension to the current organisational strategy and to approve the development of a joint strategy with The Royal Wolverhampton NHS Trust.

1.2 Further, given the timeframe and the current operational and financial pressures of the organisation, to seek approval to immediately remove the corporate objective, ***to be rated Outstanding by 2022***.

1.3 The paper also informs the Board of the process that is underway to support the above, if approved.

2. BACKGROUND

2.1 Guidance from the NHS Long-term Plan promotes the need for greater collaboration among organisations. The Boards of both Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT) have already agreed to work more closely together, and the trusts now share a joint Chair and CEO as well as other joint appointments across the organisations. There are numerous examples of how this joint working has developed, and it now seems appropriate that the organisations should be guided by a joint strategy.

3. DETAILS

3.1 The NHS Long-term Plan has an emphasis on collaboration and integration of services, organisations and systems as part of a “duty to collaborate”. Increasingly trusts are being encouraged to support one another across and beyond their own organisation. NHS Trusts are being asked to support neighbours to develop capabilities and build resilience.

3.2 In this spirit both WHT and RWT have been collaborating more closely in the last year, including some joint appointments to their respective Boards.

3.3 The current strategies of both organisations will expire at the end of March 2022, and work on the development of a new strategy has been delayed because of the impacts of the pandemic and the emergence of the Omicron variant.

3.4 Given the joint working already in place, it is proposed that the new strategy is a joint one across both WHT and RWT.

3.5 A procurement process is underway to secure the services of an external company to undertake internal and external engagement as part of the development of this strategy as well as completing a PESTLE analysis of the external environment. This work commenced in Quarter 4 of 2021/22 and the new strategy is proposed for sign off at Trust Board in August 2022.

3.6 The proposed timetable for the joint strategy development is outlined below:

- Mid-April - Responses from external providers
- Late April – Mid June – external and further executive level engagement
- End of June – recommendations through trusts' governance committees
- August - Trust Board approval

3.7 It is worth noting that the trust's current strategic objectives are still fit for purpose given the NHS is largely focussing on recovery and restoration from COVID, and so the proposed extension to the strategy proposes very little risk. The exception being the corporate objective, ***to be rated Outstanding in 2022,*** the achievement of which is not feasible given the timeframe and the organisational and financial pressures currently being faced.

3.7. Until the time that the joint strategy is approved, it is proposed that the existing strategy and organisational objectives of the trust remain in place, with the exception of the one, ***to be rated Outstanding by 2022,*** for the reasons outlined above.

4. RECOMMENDATIONS

The Board is asked to **approve:**

4.1 The development of a joint strategy with RWT.

4.2 The immediate withdrawal of the corporate strategic objective, ***to be rated Outstanding by 2022****,* given the unfeasibility of the objective given the timeframe and the current operational and financial climate.

4.3 The extension of the current organisational strategy until a new, joint strategy with RWT is approved by the respective Trust Boards in August 2022.

REFERENCES

The development of a joint strategy between the two organisations will take account of the key national policy documents, including:

- The NHS Long Term Plan
- NHS Operational Priorities 2021/22
- 'Integrating Care: Next steps to building strong and effective integrated care systems across England' (NHSEI November 2020)
- 'Integration and Innovation: working together to improve health and social care for all' (Department of Health and Social Care, February 2021)
- 'Legislating for Integrated Care Systems – five recommendations to Government and Parliament' (NHSEI February 2021)
- 'NHS Provider Selection Regime – consultation on proposals' (NHSEI February 2021)

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 2nd February 2022**			
Green Plan – Walsall Healthcare NHS Trust			**AGENDA ITEM: 26**
Report Author and Job Title:	Janet Smith Joint Head of Sustainability	**Responsible Director:**	Simon Evans Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	To provide assurance that the Trust Green Plan has a strategy to address the emerging requirements of NHSE&I Greener NHS agenda and will allow the Trust to prove that we are working towards the NHS commitment to achieve zero carbon status by 2040. The team are currently exploring all opportunities which are beneficial to the Trust to maximise financial, clinical and carbon saving benefits.		
Advise	To advise on the potential opportunities to the Trust in the next five years and to continue to raise the profile of the Trust Sustainability Group in helping to move forward and meet the national targets. The Trust has commissioned external support to calculate, monitor and report on the Trust's carbon footprint in line with emerging guidance and advise further on opportunities to promote the Sustainability Agenda. The Trust is working alongside the Black Country Integrated Care Systems (ICS), Sustainability Network Groups and local partners to maximise opportunities for shared learning and best working practices.		
Alert	That national changes in Government Policy, new legislation and the broader NHS system requirements are understood as we move towards a national model of a carbon-free culture.		
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	Delivering the actions detailed in this green plan need to be appropriately resourced with the right capital investment and investment in capacity in parts of the Trust to lead the implementation of these actions. It will need ongoing targeted investment and an aligned financial policy and decision-making process. There are actions in this plan that are either cost neutral or can provide immediate cost benefit. Implementation of these actions will be prioritised whilst funding is found for those actions that requires it. External funding opportunities from the government directed UK-wide ambition for net zero will be sought.		
Legal and/or 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 ☐		

GREEN PLAN – WALSALL HEALTHCARE NHS TRUST

1. PURPOSE OF REPORT

To present the five-year Trust Green Plan outlining the key priorities of the Trust sustainability agenda and to ensure compliance with NHSE/I requirements.

2. BACKGROUND

NHS England is committed to becoming the world's first 'Net Zero Carbon' health service to mitigate the impact of climate change and its profound threat to the health of the nation. It is estimated that the nation's health and care system is responsible for 4-5% of the country's carbon footprint and the public health impacts associated with poor air quality are borne by the NHS through the increased support it must provide citizens living in affected areas. NHS England set two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2039

The October 2020 'Delivering a 'Net Zero' National Health Service' NHS report sets out a clear plan with milestones to achieving 'net zero carbon' covering both care delivery (the NHS Carbon footprint) and the entire scope of NHS emissions (the NHS Carbon Footprint Plus). It includes an expectation that all NHS organisations will also be required to have a Board-level lead, responsible for leading on net zero and the broader green NHS agenda.

3. DETAILS

Walsall Healthcare NHS Trust has compiled this Green Plan to take a coordinated, strategic, and action-oriented approach to sustainability, ensuring sustainable healthcare is delivered to ensure services remain fit for purpose today, and for the future.

This Green Plan establishes the Trust's sustainable vision, our targets, and the actions by which to achieve this vision. It is intended to enable the Trust to implement the essential measures to reduce our carbon emissions and contribute to the reduction in air pollution in our local area. The areas where measures will be focused are:

- Workforce and system leadership
- Sustainable models of care
- Digital Transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

These key areas of focus are drawn from national policies and guidance that are detailed further in Section 3 "Drivers for Change"

The Trust's plan is challenging, aiming to address our legal obligations and contribute beneficial outcomes to deliver the sustainability vision for the wider Black Country Integrated Care System (ICS). For the plan to be successful it requires everyone within the Trust to work collaboratively with other partners whose services impact all facets of healthcare provision including clinicians looking at care pathways, procurement for goods and services, and finance to where investment is needed to meet standards and generate efficiencies.

It is hoped this plan will be approved by the Board and shared with stakeholders in accordance with the 2020/2021 NHS Standard Contract. The plan will be in place for a maximum of five years (2021 – 2026) with a regular annual progress report provided in relation to the actions of the Plan in the Trust's Annual Report.

Appendix A of this Green Plan provides an overview of the current actions taken by the Trust to achieve the mandatory conditions set out in Section 18 of the NHS Standard Contract, Appendix B details future proofing actions the Trust will adopt to further contribute to sustainable healthcare. The targets set in appendix b will be refreshed in April 2022 when the Trust carbon footprinting exercise is completed and the results are received.

4. RECOMMENDATIONS

To approve The Green Plan for Walsall Healthcare NHS Trust

APPENDICES

Green Plan – Walsall Healthcare NHS Trust

Green Plan

Walsall Healthcare NHS Trust

January 2022

Quality information

Prepared by	Checked by	Verified by	Approved by
Yasmin Ansell Junior Consultant Climate Change, Sustainability and Resilience	Rebecca Maskrey Consultant Climate Change, Sustainability and Resilience	Eoin Harris Associate Director – Climate Change, Sustainability and Resilience	Kat Lees Project Manager Climate Change, Sustainability and Resilience

Revision History

Revision	Revision date	Details	Authorized	Name	Position
P01	31.03.2021	Final Issue	Kat Lees	Kat Lees	Project Manager
P02	26.11.21	Revision to align with Green Plan Guidelines released June 2021 and NHS Estates Net Zero Carbon Delivery Plan published in December 2021	Janet Smith	Janet Smith	Joint Head of Sustainability – Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

Prepared for:

Walsall Healthcare NHS Trust

Prepared by:

Yasmin Ansell
Junior Consultant

AECOM Limited
Sunley House
4 Bedford Park, Surrey
Croydon CRO 2AP
United Kingdom

T: +44 20 8639 3500
aecom.com

Revised by:

Janet Smith
Joint Head of Sustainability
Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust

Contents

Tables

1. Introduction

NHS England is committed to becoming the world's first 'Net Zero Carbon' health service[1] to mitigate the impact of climate change and its profound threat to the health of the nation. It is estimated that the nation's health and care system is responsible for 4-5% of the country's carbon footprint and the public health impacts associated with poor air quality are borne by the NHS through the increased support it must provide citizens living in affected areas.

The October 2020 'Delivering a 'Net Zero' National Health Service' NHS report sets out a clear plan with milestones to achieving 'net zero carbon' covering both care delivery (the NHS Carbon footprint) and the entire scope of NHS emissions (the NHS Carbon Footprint Plus). It includes an expectation that all NHS organisations will also be required to have a Board-level lead, responsible for leading on net zero and the broader green NHS agenda. It demonstrates how it's proposed actions will improve patient care, deliver sustainable healthcare and supporting the reduction of health inequalities. While the overall NHS carbon footprint has reduced by 62% when compared with 1990 levels, reducing current emissions to net zero still presents a significant challenge.

Since April 2020, a growing number of local authorities, government departments, and NHS organisations have declared 'climate emergencies' otherwise viewed as public health emergencies. NHS organisations understand the severity of impacts due to climate change and acknowledge the solutions and commitments which can be taken to reduce these (i.e., Net Zero carbon targets by 2040).

Some larger Trusts are now announcing a faster timeline of delivery of the Net Zero agenda. The impact of climate change and sustainability is appearing on Trust Board Assurance Frameworks and Corporate Risk Registers more frequently.

Walsall Healthcare NHS Trust has compiled this Green Plan to take a coordinated, strategic, and action-oriented approach to sustainability, ensuring sustainable healthcare is delivered to ensure services remain fit for purpose today, and for the future. It is hoped this plan will be approved by the Board and shared with stakeholders in accordance with the 2020/2021 NHS Standard Contract. The plan will be in place for a maximum of five years (2021 – 2026) with a regular annual progress report provided in relation to the actions of the Plan in the Trust's Annual Report.

Appendix A of this Green Plan provides an overview of the current actions taken by the Trust to achieve the mandatory conditions set out in Section 18 of the 2020/2021 NHS Standard Contract, Appendix B details future proofing actions the Trust will adopt to further contribute to sustainable healthcare.

The Impact of the Coronavirus Pandemic

The pandemic has fundamentally changed the way the NHS operates. The Walsall Healthcare NHS Trust is looking to learn from the experience of the last year and continue to build on and develop the positive changes in service delivery initiated during the pandemic. An example of this being where some outpatient services are provided in part using technology for 'virtual' appointments, reducing risk of cross-infection but also reducing the environmental impact of patients travelling to and from face-to-face appointments.

NHS Staff are working from home in much greater numbers and are using information technology (IT) conferencing facilities for meetings. This significant change in how we work will reduce the subsequent carbon and particulate matter emissions associated with travel and in some cases estate. It will have impact on the plan for sustainability for years to come and future discussions in relation to the Trust achieving its sustainability goals will include how the benefits of these changes can be maximised.

[1] NHS (2020) Delivering a 'Net Zero' National Health Service

2. About Walsall Healthcare NHS Trust

Bringing together services from Walsall Hospital Trust and Walsall Community Health, Walsall Healthcare NHS Trust (hereafter referred to as the 'Trust') was formed on the 1st of April 2011 to provide integrated care to 270,000 members of the community within Walsall, South Staffordshire, and the wider Black Country.

Our 4,200 members of staff provide high-quality care across a range of services. We are the only provider of NHS acute care in Walsall, providing inpatient and outpatient services at Walsall Manor Hospital as well as a wide range of services in the community including homebased care, smoking, drug and alcohol support alongside medical, nursing, and therapy care for people living with cancer and other serious illnesses.

As a Trust, we occupy several sites across Black Country including:

1. Walsall Manor Hospital;
2. 18 non-inpatient sites; and
3. 16 leased sites from NHS property services.

In addition to the above, we will soon be opening a new £36 million Emergency Department at Walsall Manor Hospital, which will replace the current building where currently, the physical environment struggles to meet increasing patient demand.

We recognise that our healthcare services have the potential to cause a range of environmental impacts. It is therefore our ambition and responsibility to provide high-quality health care that not only enhances patient experience, but delivers healthcare in an environmental, socially, and financially sustainable way.

2019/2020 Key Green Statistics

	We produce **10,629** tCO2e per annum from direct operations.		
	We produce **1,153** tonnes of waste per annum		We have a **recycling rate of 44%** (507 tonnes) from all waste produced by the Trust.
	We have introduced bicycle parking on-site for staff, promoting sustainable travel.		We are reducing our use of plastics by signing up to the Plastics Pledge.

Our Vision

We recognise that sustainable development is a critical factor in our organisation being able to deliver world class healthcare, both now and in the future.

This **Green Plan** seeks to reiterate the Trust commitment to sustainable healthcare and establishes the Trust's sustainable vision, our targets and the actions by which to achieve this vision. It is intended to enable the Trust to implement the essential measures to reduce our carbon emissions and contribute to the reduction in air pollution in our local area. The areas where measures will be focused are:

- Workforce and system leadership
- Sustainable models of care
- Digital Transformation
- Travel and transport
- Estates and facilities
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

These key areas of focus are drawn from national policies and guidance that are detailed further in Section 3 “Drivers for Change”

The Trust’s plan is challenging, aiming to address our legal obligations and contribute beneficial outcomes to deliver the sustainability vision for the wider Black Country Integrated Care System (ICS). For the Plan to be successful it requires everyone within the Trust to work collaboratively with other partners whose services impact all facets of healthcare provision including clinicians looking at care pathways, procurement for goods and services, and finance to where investment is needed to meet standards and generate efficiencies.

3. Drivers for Change

Sustainable healthcare in the NHS is driven through national and international policy, legislative and mandated requirements and healthcare specific requirement from the Department of Health and NHS England. Legislative, policy and guidance drivers for change in relation to this Green Plan are provided in Table 1.

The Intergovernmental Panel on Climate Change (IPCC) and the World Health Organisation (WHO) have laid guidelines to ensure sustainable development is adopted into law, policy, and practice. These guidelines explain the urgent need to mitigate and to adapt to the impacts of climate change, to realise the wider co-benefits for both environmental and health outcomes.

The importance of sustainable healthcare is reflected within national legislative drivers and mandated sustainability reporting within the public sector. This is the case for the NHS through the NHS Long Term Plan and the NHS Standard Contract and aligns with Her Majesty’s (HM) Treasury Sustainability Reporting Framework and the NHS Estates Return Information Collection.

The Carter Report (2016) reinforced the need for action, highlighting the inefficient use of energy and natural resources as a major concern which requires attention. These areas of work are identified within the NHS ‘Delivering a Net Zero National Health Service’, which also notes the requirement for all NHS Trusts to have a Board approved Green Plan, in keeping with the 2020/2021 NHS Standard Contract terms.

Table 1. Legislation, Policy and Guidance Sustainability Drivers for Change

Legislative	Description	How it relates to the Trust
Civil Contingencies Act 2004	Requires certain organisations to prepare for adverse events and incidents (e.g. extreme weather events and their impact upon health and healthcare delivery).	This will aid the Trust to set future targets to include Climate Change in future Contingency plans.
Climate Change Act 2008 (2050 Amendment) Order 2019	Legally binding framework to achieve a target of 100% reduction in carbon emissions (net zero carbon) by 2050 against the 1990 baseline.	The Trust has targets to reduce GHG emissions from the premises in-line with targets under the Climate Change Act 2008 (2050 Amendment) Order 2019.
Public Services (Social Values) Act 2012	Requires commissioners to consider economic, social and environmental benefits in the procurement of goods and services on a value for money basis.	The Trust is aiming to consider and assess sustainability as a key factor when procuring new services and products.
The Waste (England and Wales) (Amendment) Regulations 2012	Requires all waste materials to be treated in accordance with the waste hierarchy, prevention, reuse, recycling, other recovery and finally disposal.	The Trust has targets to encourage sustainable use of resources through encouraging reuse and recycling practices for waste materials.
Mandatory in the NHS	**Description**	**How it relates to the Trust**
2020/2021 NHS Standard Contract Service Conditions	Service Condition 18 covers sustainable development, specifically; minimising adverse environmental impacts (18.1), maintaining a Green Plan and demonstrating and providing a summary of progress in its annual report (18.2) , and how the Trust will contribute towards a 'Green NHS' with regard to NHS Long Term Plan commitments.	The Trust has provided a Green Plan. This Plan will demonstrate how the Trust will align with the conditions outlined in Section 18 of the Standard Contract Service conditions.
HM Treasury's Sustainability Reporting Framework	Mandates companies and public bodies to disclose their sustainability and environmental performance.	The Trust has provided a Board approved Green Plan, which will disclose sustainability and environmental performance.
Public Health Outcomes Framework	The Health Protection and Resilience domain within the framework contains the indicator 'Public sector organisations with a Board-approved Sustainable Development Management Plan'.	The Trust has provided a Board approved Green Plan.
International	**Description**	**How it relates to the Trust**
Intergovernmental Panel on Climate Change (IPCC) AR5 2013	Key IPCC action in the preparation of a comprehensive report on scientific, technical and socio-economic knowledge in relation to climate change.	This will aid the Trust to set future targets to include Climate Change in future Contingency plans.
United Nations (UN) Sustainable Development Goals (SDG's) 2016	17 goals providing a framework for action by 2030.	SDG's will help inform the Trust's future ambitions with regards to sustainable practices.
United Nations (UN) Paris Agreement 2015	Limit the global average temperature to 1.5 degrees Celsius above pre-industrial levels to significantly reduce the risks and impacts of climate change.	The UK has signed up to the Paris Agreement. The Trust will look to reduce GHG and Carbon emissions in the future to align with the 'Delivering a Net-Zero NHSs to aid targets of the Paris Agreement.
World Health Organisation (WHO) toward environmentally sustainable health systems in Europe 2016	Sets out the benefits of fostering environmental and sustainability in health care systems.	The Trust is looking to improve healthcare sustainability through reducing GHG emissions, travel and logistics, alongside sustainable use of resources.

World Health Organisation (WHO) Health 2020; European policy for Health and Wellbeing	Aims to support action to 'significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality'	The Trust is committed to delivering high-quality and sustainable healthcare.
The Global Climate and Health Alliance 2011; Mitigation and Co-benefits of Climate Change	Outlines how climate change mitigation measures can be win-wins for people and the planet.	This will aid the Trust to set future targets to include Climate Change in future Contingency plans.
UK Guidance	**Description**	**How it relates to the Trust**
National Policy and Planning Framework 2018	Sets out the Government's planning policies for England with a specific section on Promoting Healthy Communities	The Trust is promoting healthy communities through the encouragement of sustainable travel.
Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013	Sets out the UK's capacity to adapt to the future challenges of climate change and the degree to which adaptation action is already being implemented.	This guidance will help the Trust set future targets to include Climate Change in future Contingency plans.
Department for Environment, Food and Rural Affairs (DEFRA) Government Buying Standards for Sustainable Procurement 2016	This guidance sets out mandatory procurement guidance for governmental departments for goods, services, works and utilities in a way that benefits not only the organisation, but also society and the economy, while minimising damage to the environment.	The Trust is working with the Black Country and West Birmingham Sustainability Transportation Partnership to collectively consult on the opportunities to deliver sustainable procurement.
The Stern Review 2006; the Economics of Climate Change	Sets out the economic costs of climate change and concluded the benefits of strong and early action far outweigh not acting.	The Trust is looking to reduce GHG emissions from the premise to help reduce the future impacts of climate change to people and the environment.
Health Protection Agency (HPA) Health Effects of Climate Change 2012	Provides evidence of the risks to public health from climate change in the UK.	
The National Adaptation Programme 2013; Making the country resilient to the changing climate	Sets out what government, businesses and society are doing to become more climate ready. Health and resilient communities have its own chapter.	
Department of Environment, Food and Rural Affairs (DEFRA) 25 Year Plan	Chapter three is dedicated to connecting people to the natural environment.	The Trust is promoting healthy communities and connection with nature through the encouragement of sustainable travel.
Circular Economy Package Policy (2020)	Identifies steps for reducing the amount of waste generated and establishes a long-term path for management of waste by increasing recycling rates and promoting a circular economy (CE) process along the whole lifecycle of products, keeping resources within the economy for as long as possible.	The Trust is aiming to keep resources within the economy for as long as possible by (where appropriate) encouraging recycling and reuse of materials in turn of disposal.
Our waste, our resources: A Strategy for England	Sets out the need for waste minimisation alongside moving towards a circular economy to help minimise damage to our natural environment.	
Health specific requirements	**Description**	**How it relates to the Trust**
Delivering a 'Net zero' NHS	Provides the scale and pace of change required within the NHS to deliver a net zero carbon health service.	The Trust is looking to reduce GHG emissions.

How to produce a Green Plan: A three-year strategy towards net zero	Provides a structured way for each Trust and ICS to set out the carbon reduction initiatives that are already underway and their plans for the subsequent three years (2022/23-2024/25)	The has developed a Green Plan which demonstrates how the Trust will align with the conditions outlined in Section 18 of the Standard Contract service conditions to help achieve a "Greener NHS".
NHS Long term Plan	Specific commitments on sustainability including the carbon targets in the Climate Change Act 2008, targets to improve air quality and assurances with respect to waste and water. It identified the NHS as an 'anchor institution'	The Trust has targets to reduce GHG emissions from the premise in-line with targets under the Climate Change Act 2008. The Trust are looking to improve sustainability through travel and logistics alongside sustainable use of resources.
NHS Operational Planning and Contracting Guidance 2020/21	Commits the NHS to developing a plan to reach net zero carbon as part of the 'For a Greener NHS' Programme, setting out guidance for NHS organisations to develop a 'Green Plan'.	The Trust has developed a Green Plan. This Plan has demonstrated how the Trust will align with the conditions outlined in Section 18 of the Standard Contract Service conditions to help aid a 'Greener NHS'.
The Marmot Review 2010; Fair Society, Healthy? Lives	Independent review regarding health inequalities in England. The proposals align with the objectives of the Green Plan.	This paper aligns with the objectives of the Trust's Green Plan.
Five Year Forward View 2015 and 5YFV: Next Steps 2017	A key inclusion in the 5YFV was a footnote stating that STPs and ICSs must assess their contribution to local environmental, economic and social wellbeing.	The Trust is promoting healthy communities and local environments through the encouragement of sustainable travel, reduction of GHG emissions and sustainable use of resources.
Adaptation Report for the Healthcare System 2015	SDU with support from NHSE and PHE nominated as reporting authority for health sector under provisions in Climate Change Act 2008.	The Trust has targets to reduce GHG emissions from the premise in-line with targets under the Climate Change Act 2008.
The Carter Review 2016	Highlights the inefficient use of energy and natural resources as a major concern which requires attention.	The Trust is looking to reduce emissions from GHGs in line with the Climate Change Act 2008.
National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012	Public Health Guidance 41 addresses local measures to promote walking and cycling as forms of travel and recreation.	The Trust is promoting healthy communities and connection with nature through the encouragement of sustainable travel.
Health Technical Memoranda (HTM)'s and Health Building Notes (HBN)'s	Provides guidance on standards for healthcare systems with regards to waste, energy, and water.	The Trust is looking to improve sustainability through the sustainable use of resources including waste, energy and water.
The Black Country Sustainable Transformation Partnerships (STP) Plans	A plan to set out how Black Country and West Birmingham will create a sustainable health and care system for the local population.	The Trust is a part of the STP and through this Green Plan is committing to becoming a green trust which will align with the wider goals of the STP Plan.

4. Areas of Focus

The structure of this section has been formulated to align with *Delivering a net zero National Health Service* to simplify the tracking and reporting process. This includes:

- Workforce and system leadership
- Estates and facilities
- Travel and transport
- Climate adaptation
- Capital projects
- Sustainable models of care
- Digital transformations
- Medicines
- Supply chain and procurement
- Food and nutrition
- Adaptation

As each green 'area of focus' has different aspects that can be applied to different areas of the Trust; for example, resource use can be influenced by policy decisions, procurement and staff engagement.

Where appropriate, each area has been further split, aligned, and assessed in its applicability to the Trust considering four cross cutting themes: Governance and Policy, Core Responsibilities, Procurement and Supply Chain, and Working with Patients, Staff and Local Communities.

Appendix A of this Green Plan provides an overview of the current actions taken by the Trust to achieve the mandatory conditions set out in Section 18 of the 2020/2021 NHS Standard Contract. This overview also demonstrates the future actions the Trust will take to progress sustainability within the Trust regarding the key areas of focus.

Workforce and System Leadership

Sustainable, effective, and resilient healthcare services depend on a culture that understands and values environmental and social resources alongside costs. Although there is demonstrably high awareness of individuals working in the Trust about the need to embed sustainability in Trust policies, processes and services and we need to harness this into a cohesive force to effect behavioural change in Trust activities. Engagement at all levels with the public, service users, trade unions and staff can provide the basis for positive action at every level.

The Trust will ensure that the sustainability agenda is supported from Board and Executive Directors and that a corporate approach will promote this agenda and consider such issues in any future development.

A Sustainability Group will be established. It will be responsible for ensuring the delivery of the Trust's Green Plan, to lead corporate activities to embrace sustainable development, tackling health inequalities and reducing the Trust's carbon footprint through value for money solutions that enable the achievement of the Trust's service and estate strategies.

The group will report on progress against the action plan and escalate any issues or risk items as appropriate to the Finance, Performance and Investment Committee, the Trust Management Committee (TMC) and the Trust Board as shown in the governance and reporting structure (Figure 1). The TMC will have oversight of the implementation of the Green Plan. It will ensure that a detailed Sustainable Development update is included in the Trust Annual General Report.

The Trust Board will consider and approve the Green Plan and associated monitoring and reviewing of performance against targets and approve any changes to the plan over the course of its duration.

Membership of the Sustainability Core Group will comprise of the following Trust officers, who will have lead responsibilities as identified:

- Head of Sustainability - Chair
- Head of Estates and Facilities Management
- Hotel Services Management

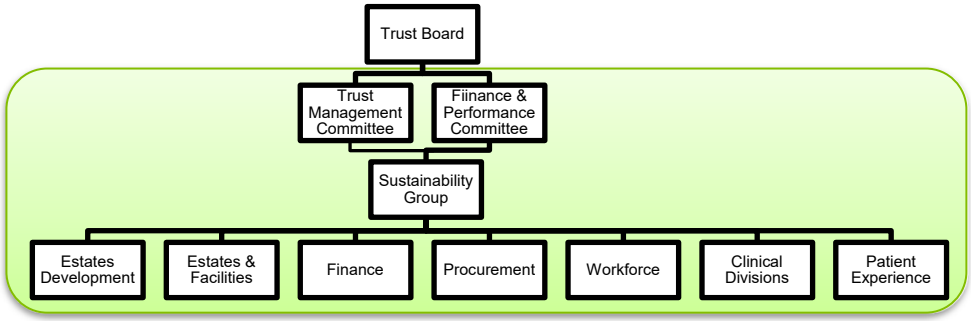
- Waste Management
- Procurement Management
- HR/Workforce Management
- Finance Management
- ICT Services
- Infection Prevention
- Pharmacy
- Clinical Management (target area)
- Patient Experience (target area)

The membership of the Group will be reviewed annually to ensure that it best reflects the requirements of governance within the Trust. Members will be required to attend at least two thirds of the Group meetings in any accounting year. The day-to-day management of the Green Plan delivery will be overseen by the Head of Sustainability who will report to the Trust Chief Strategy Officer.

The Trust Sustainability group will be responsible for raising awareness of sustainability and communicating the Trust Green Plan to staff, service users, local community, regional networks such the Black Country ICS Sustainability Network group, other healthcare commissioners and providers as well as national partners. This will be delivered through:

- Use of media
- Engagement campaigns
- Awards and rewards

Figure 1. Governance and Reporting Structure



Estates and Facilities

The Trust aspires to use energy efficient equipment for all its organisational assets where it is practicable to do so. This includes large assets, such as buildings and critical operational plant and equipment e.g., boilers or chiller plants, through to smaller assets such as mobile clinical equipment or computers, mobile assets, and equipment used in the community.

The Trust is focussed on the continual reduction of operational resource use, and running costs of essential utilities such as water, electricity, gas, and fuel oil, which can also provide opportunities for cost reductions. The Trust will continually monitor and report utility consumption data and the associated CO2e emissions.

The Trust will assess and implement any recommendations relating to environmental impacts during maintenance and capital upgrades of the Trust's assets and utilities. Prioritisation will be given where upgrades, replacement or removal of assets and utilities can improve energy efficiency. It is an ambition that future asset purchases/leases will include an energy evaluation at business case stage, especially for ICT and items of medical and other equipment.

The Trust will implement the following priority actions from the NHS Estates Net Zero Delivery Plan which was published in December 2021:

1. Achieve 80% carbon footprint reduction from our building energy and water use by:
    a. Reducing emissions by minimising heat loss from buildings
    b. Mitigating issues with peaks in demand and reducing overall energy demand
    c. Reducing energy bills
    d. Switch to 100% clean renewable energy
    e. Prepare buildings for electricity-led heating
    f. Switch to non-fossil fuel heating
    g. Increase on site renewables
2. Eliminate waste, turning all waste into resource by increasing resource productivity and reducing volume of residual waste
3. Eliminate harmful exhaust emissions from our fleet by using Ultra Low Emission Vehicles (ULEV) and Zero Emission Vehicles (ZEV) and establishing EV ready estates
4. Eliminate emissions from the goods and services we buy in estates and facilities by:
    a. Ensuring our suppliers meet the minimum standards expected on net zero and social value
    b. Ensuring all our construction and capital spend is net zero carbon and all tenders include a minimum of a 10% weighting for social value
    c. Increasing healthier, more sustainable menu choices
5. Increase our resilience to climate related severe weather events
6. Reducing emissions from staff commuting by supporting and encouraging our staff to make lower carbon travel choices through access to sustainable travel benefits such as cycle to work scheme, discounted travel card scheme, etc.

Travel and Transport

We are committed to reducing the environmental impacts of staff travel and the logistics associated with our Trust. Actions we have already undertaken to do so include:

Governance and Policy

✓ Provide travel reimbursement to employees who use their vehicle for work duties in line with the NHS Terms and Conditions of Service[2]. We currently reimburse employees 20p per mile when using pedal cycles to make journeys to encourage sustainable travel.

✓ Provide appropriate reimbursement to employees when they use public transport for businesses purposes.

Core Responsibilities

✓ We have conducted a staff travel survey to understand the barriers and enablers in encouraging staff to adopt more sustainable travel options.

✓ We have produced a Travel Plan which outlines objectives and targets alongside implementation, monitoring and marketing measures to increase sustainable travel within our Trust.

Procurement and Supply Chain

✓ We have requested funding for two of our community vehicles (porter van and HSDU van) to switch to electric. It is our intention to upgrade our leased vehicles to electric in accordance with the NHS Terms and Conditions of Service. the Trust is prioritising the leasing of low and ultra-low carbon vehicles which are consistent with the UK's carbon reduction strategies and safeguarding of the environment.

✓ We have requested Government funding to aid the instalments of electric charging ports in car parks for both staff and patients.

Working with Staff, Patients and Communities

✓ We encourage staff to use ultra-low emission vehicles using NHS Fleet Solutions[3]. NHS Fleet Solutions offers a substantially larger range of electric and hybrid

[2] The NHS Staff Council (2019), NHS Terms and Conditions of Service – Amendment Number 41

[3] Fleet my new car (2021), NHS Fleet Solutions [accessed at: https://nhsfleetsolutions.co.uk/]

vehicle for staff to lease than ultra-low emission (ULEV) petrol or diesel vehicles. Within this scheme, staff have the option pay for installation of a home EV point through monthly instalments, in-turn of paying for costs up-front.

✓ Secure bicycle parking areas have been introduced on-site for staff use.

In addition to the above, we will take further actions to further promote sustainable travel and logistics within our Trust. Actions to futureproof sustainable travel and logistics are detailed in Table 2.

Table 2. Futureproofing Actions – Travel and Transport

Cross cutting theme	Action	Date	What does success look like?	Responsible Department
Core Responsibilities	Install appropriate levels of electric (EV) charging points for electric cars for staff, porters, and patients where new car parking is constructed.	Subject to funding	**N**umber of EV charging points are installed within the new Emergency Department car park.	Estates and Facilities
	Review and extend the Walsall Manor Hospital 2020 Travel Plan[4] to the rest of the Trust sites.	April 2021	An updated Travel Plan has been produced to set out aims to encourage sustainable travel within the Trust.	Estates and Facilities
	Increase the number of employees travelling to work by public transport, car sharing, and cycling over a five-year period as outlined within our Travel Plan 2020.	2025	55% of staff will travel to work via public transport. 24% of staff will travel to work via two-wheel travel.	Estates and Facilities
	Production of Green Travel Plan in accordance with requirements of NHS Net zero Document, as part of their annual planning and reporting.	April 2022	**Green Travel Plan produced**	Estates and Facilities
Procurement and Supply Chain	Adopt low and ultra-low carbon vehicles when leasing new vehicles in-line with NHS Terms and Conditions of Service.	2024	**50%** proportion of the Trust's leased vehicles are low/ultra-low.	Estates and Facilities
Working with Staff, Patients and Communities	Progress internal communications, marketing plans and 'welcome packs' for new members of staff to encourage sustainable travel through travel subsidisation, designated cycle routes and Cycle2work days as detailed in the Travel Plan 2020.	2021	Communications (via newsletters, notice Boards, intranet etc) have been delivered to staff to inform them of Cycle2work schemes and travel subsidisation.	Communications Team
	Invest in IT infrastructure to aid staff to effectively work from home after the COVID-19 pandemic, reducing transport to site.	2022	Staff will not be required to attend the office 5-day a week.	ICT Services
	As described in our Travel Plan, we will Increase facilities which enable staff to cycle to work including secure cycle stands, shower facilities, changing rooms, drying facilities.	2023	100% of secure cycle stands, shower facilities and changing rooms are on-site for staff use detailed in the Travel Plan is delivered.	Estates & Facilities

[4] Walsall Healthcare NHS Trust (March 2020) Manor Hospital: Workplace Travel Plan

Climate Adaptation

Due to climate change, heatwaves, storms, and floods are affecting the way that care is delivered across the NHS. Scientific evidence strongly indicates that these events will become more frequent over the next 30 years. Actions we have already taken to mitigate against the effects of climate change are listed below:

Core Responsibilities

✓ The Trust currently has a contingency plan which addresses the actions which will be taken should we experience any extreme events such as ice and snow, heavy rain, high winds, and excessive heat all of which may arise due to climate change.

Actions to be undertaken to further futureproof the Trust's premises to the impacts of climate change are included in Table 3.

Table 3. Futureproofing Actions - Climate Adaptation

Cross cutting theme	Action	Date	What does success look like?	Responsible Department
Governance and Policy	Complete a climate change risk assessment, highlighting areas within the Trust that are most susceptible to the impacts of climate change.	2022	A climate change risk assessment has been completed.	Estates and Facilities
Core Responsibilities	Update air handling units to help aid ventilation on-site within any ward upgrades.	2022	The new Emergency Department will hold air handling units to aid on-site ventilation.	Estates and Facilities
Procurement and Supply Chain	Complete an evaluation/risk assessment of critical supplies which could be affected by climate change.	2022	A climate change risk assessment for all critical supplies has been completed. Alternative suppliers have been identified where significant risks have been found.	Procurement Department
Working with Staff, Patients, and Communities	Create a communication plan to aid awareness of the impacts of climate change and importance of adaptation to both staff and patients.	2022	Communications (via newsletters, notice Boards, intranet etc) have been delivered to staff and patients to inform them of risk of climate change and key mitigation/ adaptation measures.	Communications Team

Green space and biodiversity play a key role in improving patient recovery rates and patient experience, as well as supporting staff wellbeing. Since 2009, the NHS Forest has planted over 65,000 trees across 180 NHS sites, increasing green space, improving air quality and mental health, and capturing carbon. The Trust will look to work with NHS Forest and enable the integration of green space into its clinical and working environments. This will include consideration of tree planting, placing bee boxes on site roofs, and integrated allotment space which can be used in our mental health facilities for non-standard therapy.

[5] Infrastructure carbon review 2013 - Capital carbon covers greenhouse gas emissions arising from the creation, refurbishment, and end of life treatment of assets such as buildings and infrastructure.

Capital Projects

Carbon emissions associated with UK construction has risen by 60% between 2010 and 2018. Carbon emissions associated with construction are better known as Capital Carbon[5]. So why is Capital Carbon on the rise? There is a strong argument that the UK is investing in more construction projects now, however data highlights that construction practices has not improved and are still too reliant on heavy materials, like concrete and steel, that require enormous levels of energy to produce, transport and dispose of. Although there is awareness within the Trust of the need to reduce its capital carbon footprint. Work is on-going to develop this area to allow this to become a part of future contractual awards to minimise carbon impact in the delivery of new facilities across the estate.

NHS England and NHS Improvement is expected to issue before the end of 2021 the NHS Net Zero Carbon Building Standard which is intended to create a clear set of performance criteria relating to various elements of a net zero carbon building – both in construction and in operation. The Standard will lay in the foundation for all major construction and refurbishment projects in the NHS, including the New Hospital Programme (NHP) and wider Healthcare Infrastructure Plan (HIP) that is expected over the next decade. The Standard areas of focus are:

1. Whole Life Net Zero Carbon
2. Embodied Carbon
3. Operational Energy Carbon.

This section of the Green Plan will be updated to align with the requirements of the Standard on its publication.

Design of buildings

Effective capital carbon reduction requires investment in the early project development stages to allow for a realistic analysis of the equivalent carbon in each design option which

should include space type technology classification, structural capacity, flexibility, and adaptability. The analysis should look at the embodied carbon in the specified materials and products, the transportation of such materials/products to site, energy used in the construction process, staff travel transportation and disposal. A substantial amount of time will be required to conduct these calculations if they are to be anywhere near realistic – this may inflate tender/project costs as we ask consultants and contractors to calculate and provide such information.

The conventional construction process often means that engagement with material and product suppliers is last on the list, however early consideration, and consultation with them is paramount. This allows us to understand the embodied carbon in their products that can be set as a baseline against the commonplace solution. Suppliers are already starting to detail the % constituent materials in their products, packaging weight and end of life recyclability potential. Some are even going one step further by providing the embodied carbon footprint figure per unit length/weight of their products. Such suppliers are likely to benefit from providing such data as designers are more likely to specify/recommend the use of products that wear their carbon footprint on their sleeve as it facilitates the carbon analysis process. Furthermore, it motivates the supply chain to reduce the embodied carbon of their products by optimising raw material extraction and product processing practices or looking for more local suppliers.

Streamline use of materials

The Trust should focus on identifying and taking advantage of opportunities of re-using, recycling, and extending the life of existing assets where possible and appropriate prior to considering new developments. For example, opportunities could be sought to design new assets so that existing foundations, soil excavated, and recovered materials could be reused for new capital projects – but this is a challenging process.

Reduce waste and buy locally

Re-using, recycling, and choosing products with longer lifespans is also effective in reducing capital carbon by mitigating waste. Landfill produces methane which is 80 times more warming to the atmosphere than CO2 over a 20-year period. According to the United Nations University, in 2019, the world generated 53.6 million metric tons (Mt), and only 17.4% of this was officially documented as properly collected and recycled. It grew with 1.8 Mt since 2014, but the total e-waste generation increased by 9.2 Mt. This indicates that the recycling activities are not keeping pace with the global growth of e-waste.

When choosing new products and materials, priority should be given to those with a higher recycled content (e.g., locally recycled aggregates) and request that suppliers remove packaging from all orders where possible. Transportation of goods to worksites can be a significant contributor to capital carbon. Procurement of materials and equipment should target sourcing materials from suppliers that are local to the Trust wherever possible which has the added value of supporting our local communities. Where transportation is required, consideration should be given to optimising the load in transit and enquiring about alternative options to traditional diesel/petrol-based road vehicles, for example electric vehicles where this is practical.

Sustainable Care Models

Sustainable care models[6] can deliver better health outcomes and wellbeing by enabling and enhancing an integrated approach to care. It will enable the development of resilience with individuals and their communities whilst reducing environmental impacts.

The Trust will factor sustainability impacts of its current and future models of care whilst safeguarding clinically effective, safe, and high-quality healthcare services. It will actively participate in the NHS Improvement Outpatient Transformation Program which is designed to transform how health and social care work together. The Trust will introduce a Sustainability Impact Assessment (SIA, Appendix D) to assess the combined environmental and social impacts of proposed policies, programmes, strategies, and actions plans. It will promote the use of the Carbon Reduction Crib Sheet (Appendix E) which provides practical and easy to follow steps in reducing carbon footprint.

As the current COVID-19 global pandemic has revealed, some environmental improvements can be made as demonstrated by the implementation of virtual consultations which reduced travel impacts.

[6] Delivering a net zero National Health Service October 2020 – Section 4.1 Sustainable care models

The NHS Long Term Plan set out a commitment to deliver a new service model for the 21st century which include a focus on sustainability and reduced emissions. Multiple commitments and initiatives are in progress such as:

- Boosting “out of hospital care”
- Digitally enabling primary and outpatient care
- Increasing focus on population health
- Optimising the location of care which ensures that patients interact with the service in the most efficient place
- Embed best clinical practice to further progress on care quality and outcomes as exemplified by Getting if Right First Time (GIRFT) approach
- Set out clear priorities for diseases which contribute the most to ill health
- Improve outcomes for patients by delivering faster diagnosis and treatment through Rapid Diagnostic Centres (RDCs)
- More action on prevention and health inequalities
- support digital transformation, seeking to mainstream digitally enabled care across all areas of the NHS

Digital Transformations

Digital technology is a significant part of our everyday lives improving the way we socialise, shop and work. It also has great potential to improve how the NHS delivers its services in a new and modern way, providing faster, safer, and more convenient care.

The NHS Long Term Plan published in January 2019 sets out the ambitions for improvement over the next decade. The plan underpins the importance of technology in the future NHS; setting out the critical priorities that will support digital transformation.

The Trust will engage closely with NHSX to deliver its own digital transformation of care such as:

- Developing digital care pathways
- Rapid and secure data sharing
- Expansion of virtual consultations
- Remote monitoring of health conditions

Our People

Our workforce is key to ensuring our organisation is sustainable, and every person within the Trust has a part to play. We will empower our staff to take responsibility for sustainability. In the future, the Trust will embed sustainability throughout its organisation by (as appropriate) including it with:

- Business code of conduct
- Workforce training programmes (NHS England are developing tailored induction modules for all NHS England and NHS Improvement staff to support staff understanding of the links between health and climate change, and interventions they can take to reduce emissions, as well as a dedicated net zero training package for staff working in estates and facilities will be developed at an NHS national level).
- Objectives in annual appraisal reviews for all staff (in relation to sustainability related to their specific job roles); and
- The adequate provision of staff to manage sustainability activities, e.g., head of sustainability, sustainability clinical lead, estates & facilities management, procurement lead, infection prevention lead, communications lead, etc (where appropriate)

Supply Chain and Procurement

The Trust is currently supplied by both NHS Supply Chain and associated suppliers to deliver environmentally and cost-efficient services. NHS Supply Chain operations is accredited with the International Environment Management Systems Standard: ISO 14001:2015, setting objectives to help maintain and improve environmental performance within its key UK distribution centres.

To help further reduce environmental impacts from the healthcare service, NHS Supply Chain has introduced the single-use plastics pledge. In addition to this, compliance with the Labour Standards Assurance Scheme and the UK Modern Slavery Act 2015 is adopted within the NHS Supply Chain, helping secure wider social and ethical benefits to the community.

The Trust will assess procurement and suppliers based upon the NHS Standards of Procurement. Engagement is vital to this process, and the Trust will work with all purchasing stakeholders (e.g., facilities management and clinicians) to incorporate sustainability decisions into the design of the clinical care models it provides. Where suppliers and procurement decisions are made from the NHS Supply Chain, the Trust will consider environmental, social, and economic impacts within the whole ICS supply chain lifecycle including product design, material selection, packaging, transportation, warehousing, distribution, consumption, and disposal.

The Trust joined the University Hospitals North Midlands procurement hub on 1st April 2021. A key part of this move will be the ability to enable the championing of sustainability through procurement and supply decisions.

The Trust use Sustainable Impact Assessments (SIA's) alongside championing social, economic, and environmental benefits as 'award criteria' for supplier contracts to direct future sustainable procurement decisions. Before the end of the decade, the Trust will no longer purchase from suppliers that do not meet or exceed our commitment to net zero.

Actions we have already undertaken as a Trust to promote the sustainable use of resources include:

Governance and Policy

- ✓ Removal of all plastic straws, stirrers, and cutlery as required within draft Environmental Protection (Plastic Straws, Cotton Buds and Stirrers) (England) Regulations 2020 [7] within the Trust.

Core Responsibilities

- ✓ We are reducing volumes of waste produced on-site by; separating out our cardboard waste for separate recycling, introducing a food de-hydrator onto site, and changing print settings so that staff are encouraged to print double sided to reduce paper usage.

Procurement and Supply Chain

- ✓ Signatory to the single-use plastics pledge[8] and actively reducing single-use plastic products used on-site.
- ✓ Purchase products through the NHS supply chain to automatically be compliant with the plastics pledge. Where external alternative suppliers are used, the Trust has obtained suitable alternatives to single-use plastics.
- ✓ We are working with our catering and retailers to reduce single use plastic used within our Trust. Our catering team and retailers have implemented environmental policies to promote sustainable use of resources and waste recycling and reduction.

We further promote the sustainable use of resources through educating staff, encouraging sustainable procurement choices as well as considering take back and reuse of trust equipment. Details of activities required to support this are provided in Table 4.

Table 4. Futureproofing Actions – Supply Chain and procurement

Cross cutting theme	Action	Date	What does success look like?	Responsible Department
Core Responsibilities	Create a plan to allow for the reuse and recycling of walking aids, in-line with the 40% target of all walking aids refurbished in the next five years (as stated within the 'Delivering a 'Net Zero' National Health Service).	2021 and 2026	A Plan has been completed to address how the Trust will meet the five-year target. The Trust will encourage and welcome the return of walking aids from patients.	Therapy Services
	Increase the digitisation of Trust activities to reduce office paper by 50%, with a switch to 100% recycled content paper for all office-based functions.	2023	Office paper use will be reduced by 50%. All paper used for office-based functions will be 100% recyclable.	ICT Services/ Procurement
	Donate goods such as mattresses, old office chairs, laptops	2021	The Trust has identified appropriate charities to donate used goods to,	Estates & Facilities – Waste Manager

[7] Environmental Protection (Plastic Straws, Cotton Buds and Stirrers) (England) Regulations 2020

[8] NHS Supply Chain, (2020), Single-Use Plastics Pledge, Suitable product alternatives – catering consumables

Cross cutting theme	Action	Date	What does success look like?	Responsible Department
	and monitors to reuse and charitable organisations to avoid disposal.		this has been communicated to all staff.	
	Install radar and automatic release taps within any new builds and water flow restrictors within the retained state to reduce water waste.	2022	The new Emergency Department will have radar and automatic release taps. Retained estates will have flow restrictors.	Estates & Facilities
	Hold meetings with the waste contractor to explore increasing the number of recycled waste stream bins provided on-site.	2021	Introduce additional waste streams to separate out recycled materials from Site i.e. plastics, paper, metal, glass.	Estates & Facilities
Procurement and Supply Chain	Conduct a full review of supplier sustainability once we have joined the new University Hospitals North Midlands procurement hub.	2021	Identify supplies and procurement areas which can be improved to champion sustainability.	Procurement
Working with Staff, Patients and Communities.	Work with infection control to deliver a communications plan to staff providing information on what materials can be disposed of via the general and offensive waste stream. Aiming to reduce the volume of offensive waste produced within our Trust.	August 2021	Posters, newsletters, and communication through the intranet has been distributed to educate staff on correct waste disposal practices.	Communications Team
	Re-invigorate the sustainability Campaign, 'Bright Ideas' to encourage all stakeholders to bring ideas to the forum and work collaboratively to achieve our goals.	2022		Communications Team

Medicines

Medicines used by the NHS accounts for 25% of its carbon emissions. A small group of medicines account for a larger portion of the emissions, these are: anaesthetic gases (2% of emissions) and inhalers (3% emissions). Carbon emissions from anaesthetic gases and inhalers occur at the point of use whilst the remaining 20% medicines emissions are primarily from the embodied carbon of the specific product resulting from manufacturing and freight.

The Trust medicines carbon emissions excluding anaesthetic gases and inhalers will be established once the carbon footprinting exercise is completed by end of March 2022. The footprinting exercise will identify specific groups of medicines with large carbon emissions. A detailed proposal of reduction interventions will be presented, discussed, and agreed by the Sustainability Group. Once agreed, the interventions will be integrated in this Green Plan during its scheduled refresh in July 2022.

Anaesthetic Gases

The NHS Long Term Plan committed to lowering the carbon footprint from anaesthetic gases by 40% through transforming anaesthetic practice. This requires actions to shift from Desflurane which has the highest global warming potential (GWP) at 2540 to Sevoflurane which at 130 GWP is the least polluting alternative.

Similarly, to Inhalational anaesthetic agents (IAAs), nitrous oxide is a potent greenhouse gas. Although its GWP is less than half that of the least polluting IAA (sevoflurane), at 290, nitrous has a much greater atmospheric longevity (114 years). In addition, as a carrier gas it is usually administered in a high fractional concentration, accounting for an estimated 99.5%+ of the climate impact potential of anaesthetic gasses/IAAs (Axelson). Medical nitrous oxide accounts for approximately 1% of atmospheric nitrous oxide, or 0.07% of all global warming factors. Given that nitrous oxide also appears to worsen

cardiovascular outcomes after anaesthesia, the continued use of nitrous oxide is increasingly difficult to justify.[9]

Low Carbon Inhalers

Inhalers are used in a variety of respiratory conditions, ranging from asthma to chronic obstructive pulmonary disease. Most of the emissions come from the propellant in metered-dose inhalers (MDIs) used to deliver the medicine, rather than the medicine itself. The NHS Long Term Plan set targets to deliver significant and accelerated reductions in the total emissions from the NHS by moving to lower carbon inhalers, such as dry powder inhalers (DPIs). Achieving the required reduction in emissions from inhalers will only be possible by:

- significantly increasing the use of DPIs, which may be clinically equivalent for many patients, and come with significantly lower carbon emissions
- increasing the frequency of the greener disposal of used inhalers
- supporting the innovation in and use of lower carbon propellants and alternatives.

National Targets

Emissions reduction targets for anaesthetic gases and inhalers are set at national level. The current targets are:

1. Anaesthetic gases - Ensuring the proportion of desflurane to sevoflurane used in surgery is no more than 10% by volume in any given provider by April 2022
2. No more than 45% non-salbutamol inhalers prescribed are metered-dose inhalers
3. Deliver up to 75% reduction in nitrous oxide carbon emissions

As of July 2021, Desflurane use in the Trust stands at 55% which is 45% higher than the target and the highest usage of Desflurane in England. Radical measures such as complete removal of Desflurane in anaesthetic machines and clinical justification for its use will need to be implemented to achieve mandated reduction by April 2022.

Latest reports from the Nitrous Oxide Project by the Association of Anaesthetists showed that wastage from piped manifold systems is a far more significant problem than that of persistent clinical usage. An assessment of the condition of the Trusts' gas manifolds and distribution system will be carried out. This will allow the Trust to determine the source, the extent of wastage, identify and then implement a solution.

Food and Nutrition

Food's carbon footprint is the greenhouse gas emissions produced by growing, rearing, farming, processing, transporting, storing, cooking, and disposing of the food we eat.

NHS England estimates that hospital food and catering produce 1,543 ktCO2e of carbon dioxide each year, equating to approximately 6% of the NHS's total carbon footprint[10]. It is committed to providing healthier, locally sourced food to improve wellbeing while cutting emissions related to agriculture, transport, storage, and waste across the supply chain and on NHS estate.

The result of the Hospital Food Review published in October 2020 makes the following 8 recommendations to improve staff and patient health and wellbeing through hospital food:

1. Catering staff support: introduce professional qualifications and standards for hospital caterers, provide more training and reward excellence with pay progressions.
2. Nutrition and hydration: ensure importance of food services is understood and integrated within patient recovery, hospital governance and staff training.
3. Food safety: ensure food safety through open communication channels to address safety concerns, by appointing food safety specialist and upholding standards.
4. Facilities: provide funding to equip and upgrade hospital kitchens, provide 24/7 services for staff and patients, prioritise providing health-enhancing meal.
5. Technology: every hospital should implement a digital ordering system by 2022 to collate food choices, manage allergies and diets, and minimise waste.

[9] Environment FAQs | Association of Anaesthetists
[10] Delivering a net-zero national health service - food, catering, and nutrition

6. Enforcing standards: food and drinks standards should be statutory and inspected by the CQC, a forum should be established to share exemplary best practice.
7. Sustainability and waste: ensure government food procurement standards are upheld. NHS Trust should agree on common method of monitoring food waste.
8. Going forward: establish an expert group of hospital caterers, dietitians, and nurses to monitor progress, accountable to the Secretary of State for Health and Social Care.

Considering the recommendations above, the Trust will carry out the following actions:

1. Assess the condition of catering facilities for both patient and staff and recommend actions to equip and upgrade if necessary.
2. Agree and implement a common method of monitoring food waste.
3. Source food locally to reduce carbon emissions from transporting food.
4. Implement a digital ordering system in partnership with Royal Wolverhampton NHS Trust.
5. Work with NHS Supply Chain in reducing plastic packaging of food supplies sourced from the chain.
6. Device a plant-based menu to reduce use of meat and provide more choice to both patients and staff.

Carbon/GHG's

In 2008, the Climate Change Act set national targets for the reduction of carbon emissions in England against a 1990 baseline. To help the NHS reach targets under the Climate Change Act alongside its overarching target of delivering a net-zero health service, this Plan details the provision of the Trust's annual GHG emissions for 2019/20, approximated with the NHS Carbon Footprint (shown in Appendix C). The following scopes been considered when considering the Trust's NHS Carbon Footprint:

- Greenhouse Gas Protocol (GHGP) Scope 1: Direct emissions from owned or directly controlled sources, on site
- GHGP Scope 2: Indirect emissions from the generation of purchased energy, mostly electricity.
- GHGP Scope 3: All other indirect emissions that occur in producing and transporting good and services (including the full supply chain).

Emissions have been calculated using available 2019/20 Estates Returns Information Collection (ERIC) data. As a Trust, we currently emit 10,629 tCO_2e per annum when approximated with the NHS Carbon Footprint. Table 5 shows our total emissions broken down via scope and sector, this is also demonstrated within and Figure of this Plan.

Table 5. 2019/20 Total Scope 1, 2 and 3 Emissions and Sector Type

Sector	Scope 1 (tCO_2e)	Scope 2 (tCO_2e)	Scope 3 (tCO_2e)	Total (tCO_2e)
Waste	-	-	55	**55**
Energy	5,629	3,507	1,041	**10,177**
Water			33	**33**
Travel			364	**364**
Total	***5,629***	***3,507***	***1,493***	***10,629***

NHS Carbon Footprint scope 1 emissions such as: NHS Fleet and leased vehicles, anaesthetics, and NHS facilities alongside scope 3 emissions: metered dose inhalers, have been excluded from total emissions due to difficulty in obtaining this data.

Figure 2. 2019/20 Total GHG Emissions (tCO2e) by Scope Type

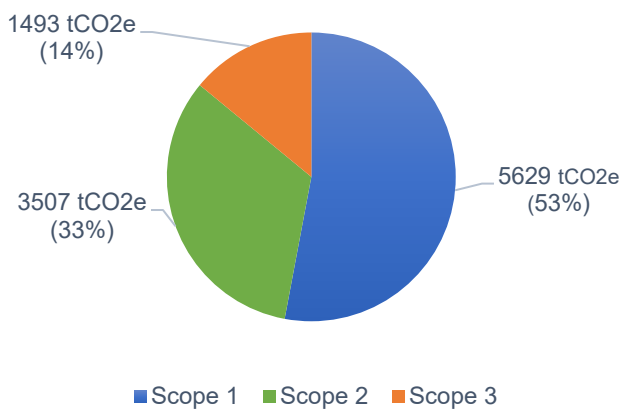
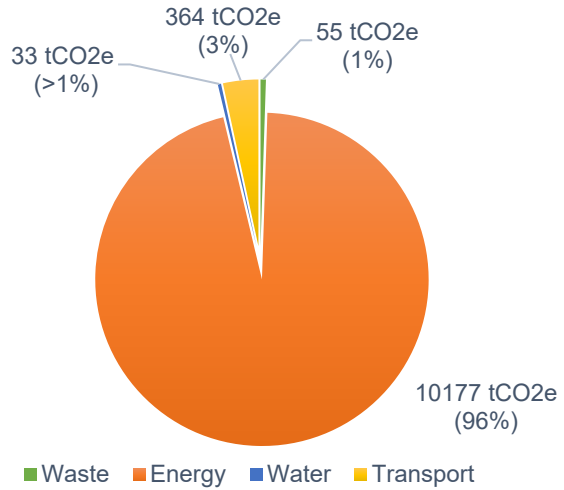


Figure 3. 2019/20 Total GHG Emissions (tCO2e) by Sector



There are some emissions which fall outside of the NHS Carbon Footprint GHGP Scopes 1, 2 and 3. These 'additional' emissions (include patient and visitor travel to and from NHS services in addition to medicines used within the home) make up the NHS Carbon Footprint Plus, including all three GHGP scopes alongside additional emissions. The diagram found Appendix C explains the NHS Carbon Footprint and NHS Carbon Footprint Plus in more detail.

The Trust will continue to provide an annual GHG emission update to the Board approximated with the NHS Carbon Footprint and NHS Carbon Footprint Plus, helping to work towards targets set out within: 'Delivering a 'Net Zero National Health Service':

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2039.

It is understood that a new energy strategy will be developed this year by NHS England, any learnings from this will be applied to the Trust's current energy/building management operations. As a Trust, we have already taken the following actions to reduce Carbon/GHG emissions:

Actions we have already taken to reduce our GHG emissions are as follows:

Core Responsibilities

- ✓ We provide annual reporting on GHG emissions to help identify how we will reach targets under the Climate Change Act 2008.
- ✓ We have provided a Carbon Reduction Plan for Walsall Manor Hospital to identify the technologies needed on-site to reduce GHG emissions by 36% by 2024.
- ✓ We are in the process of requesting funding to phase out gas (and oil backup) heating within the Trust to switch to a combined approach with renewable heating.

So, we can continue to reduce Carbon/GHG emissions within the Plan period and meet our targets, future actions will be undertaken as shown in Table 6.

Table 6. Futureproofing Actions – Reduction of Carbon/GHG Emissions

Cross cutting theme	Action	Date	What does success look like?	Responsible Department
Core Responsibilities	Provide an annual GHG emission update to the Board approximated with the NHS Carbon Footprint and NHS Carbon Footprint Plus.	2022	Annual reporting includes all NHS Carbon Footprint and Plus data.	Sustainability Group
Core Responsibilities	Upgrade our estate so that all lighting is upgraded to LEDs via the NHS Energy Efficiency Fund (NEEF).	2024	All lighting within the Trust is LED.	Estates & Facilities
Core Responsibilities	Insulation improvements will be made to steam raising boilers and Low Temperature Hot Water Boilers.	2024	All boilers will have upgraded insulation.	Estates & Facilities
Procurement and Supply Chain	Move towards on-site renewable energy and remove coal and oil heating systems within the Trust as soon as possible, with complete phase-out over the coming years.	2024	Renewable energy is used on-site. Coal and Oil heating has been phased out.	Estates & Facilities
	Purchase 100% renewable energy from April 2021	April 2021	The Trust will purchase 100% renewable energy.	Estates & Facilities
	Move to lower carbon inhaled such as dry powder inhalers (DPI's), increasing the frequency of the green disposal of used inhalers, support innovation in use and lower carbon propellant and alternatives	2024	DPIs are supplied when prescribing inhalers. Inhalers are disposed on in a green way. Innovation has been supported to find low-carbon alternatives.	Clinical Leads – respiratory & primary care
Working with Working with Staff, Patients and Communities	Designate an awareness/ sustainability champion for the Trust.	2022	The Trust will have a sustainably champion.	Communications Team

5. Tracking Progress and Reporting

Vital to the development of the Trust's sustainability aspirations, is the monitoring and reporting of our progress. NHS England and NHS Improvement (NHSEI) is developing a reporting and monitoring tool to track overall organisational performance. Pending the publication of the tool, we will use the NHS Greener Data Collection template to monitor the Trust performance against national and regional deliverables with additional (specific) reporting provided for the following areas:

- Organisational carbon Footprint against Climate Change Act reduction requirements.
- Building Energy, water and waste use, and associated carbon emissions.
- Hot spot procurement emissions; using the Sustainability Reporting Portal.
- Staff travel: monitoring and reporting should be completed via the Health Outcomes of Travel Tool (HOTT).
- Climate Change Risk Assessment; and
- Progress against each of the high level aims and objectives of the Green Plan.

Annual returns, such as the Estates Return Information Collection (ERIC), the Premises Assurance Model (PAM), HM Treasury's report will also be used to inform sustainability reporting. The progress of the actions outlined in this Green Plan, will be reported quarterly to the Trust Board and a detailed sustainable development update will be included in the Trust Annual General Report.

6. Communication

In the future, a communication strategy for sustainability, aligned with the Trust's corporate communications strategy, will be employed. It is likely to include:

- Internal communications e.g., newsletters, internal magazines, champions networks etc. and;
- External communications e.g., trade bodies, awards, industry journals, case studies etc.

In support of the environmental agenda, the Trust is a part of the Black Country ICS that has created an active sustainability network with leads from each partner organisation. It is the intention that our participation in this network will assist in collaboration to foster group learnings and potential opportunities to develop efficiencies of scale.

7. Risk

In delivering our sustainability targets and agenda, and where significant risks are identified, these will be recorded and monitored through our existing internal risk and governance process. Risks that have already been identified during the development of this plan include:

- Not obtaining finance/funding to deliver commitments, those regarding to the instalment of EV charging points for electric cars for staff and patients on-site, alongside funding to enable the Trust to phase out oil heating and switch to a combined approach with renewable electricity.
- Not meeting carbon reductions goals; and
- Non-compliance with legislation.

As appropriate, these risks will be logged on the Trust's corporate risk register, reviewed and updated regularly.

8. Finance

Delivering the actions detailed in this green plan need to be appropriately resourced with the right capital investment and investment in capacity in parts of the Trust to lead the implementation of these actions. It will need ongoing targeted investment and an aligned financial policy and decision-making process. It also requires investment in our staff, ensuring that they understand what they can do to contribute to the Trust response to climate change, and have the knowledge and skills to implement new ways of working to embed sustainability within strategic and operational processes so it becomes part of business as usual.

These net zero goals need to be aligned with existing commitments as far as possible; for example, ensuring that new builds and major refurbishments adheres to the need to reduce emissions and routine replacement of equipment consider energy efficiency improvement and reduce emissions.

There are actions in this plan that are either cost neutral (replacing single use plastic items with alternative product at the same cost) or can provide an immediate cost benefit (reduction in printing and move to recycled paper). Implementation of these actions will be a priority whilst funding is found for those actions that requires it.

The Trust will actively seek and take advantage of opportunities to access funds from the government directed UK-wide ambition for net zero such as:

1. Public Sector Decarbonisation Scheme.
2. NHSX - Digitising Clinical Pathways
3. NHSX – Digital Health Partnership Award
4. SBRI Healthcare Competition 20 – opens in spring 2022

Appendix A - Walsall Healthcare NHS Trust; Current Actions and Success Indicators

Condition	Green area of focus	Cross-cutting themes	Condition	Has the condition been met?	What does success look like?	Supporting Text
18.4.1.1	Travel and Logistics	Procurement and Supply Chain	Take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles.	✘	***90%***proportion of the Trust's fleet will be low/ultra-low emission vehicles by 2028 and 100% zero emission vehicles by 2030 Annual reports and subsequent road maps will be provided to set out how the Trust aim to meet the NHS Long Term Plan commitment of 90% NHS fleet to use low, ultra-low and zero-emission vehicles by 2028.	We have requested funding for two of our community vehicles (porter van and HSDU van) to be electric. We have future aspirations to upgrade our leased vehicles to electric in accordance with the NHS Terms and Conditions of Service, the Trust is prioritising the leasing of low and ultra-low carbon vehicles which are consistent with the UK's carbon reduction strategies and safeguarding of the environment.
18.4.1.3	Travel and Logistics	Governance and Policy / Working with Staff, Patients and Communities	Develop and operate expenses policies for Staff which promote sustainable travel choices.	✓	**[X]** % of staff will travel to work via public transport. **[X]** % of staff will travel to work via two-wheel travel. Communications (via newsletters, notice Boards, intranet etc) have been delivered to staff to inform them of Cycle2work schemes and travel subsidisation. Staff will not be required to attend the office 5-day a week. X secure cycle stands, X shower facilities and X changing rooms are on-site for staff use.	We provide travel reimbursement to employees who use their vehicle for work duties in line with the NHS Terms and Conditions of Service. We currently reimburse employees 20p per mile when using pedal cycles to make journeys to encourage sustainable travel. We provide appropriate reimbursement to employees when they use public transport for businesses purposes. Some outpatient services being provided in part using technology for 'virtual' appointments, reducing risk of cross-infection but also reducing the environmental impact of patients travelling to and from face-to-face appointments. Government funding has been requested to aid the instalments of electric charging ports in car parks for both staff, porters and patients. Secure bicycle parking areas have been introduced on-site for staff use.
18.4.1.4	Travel and Logistics	Procurement and Supply Chain	Ensure that any car leasing schemes restrict high-emission vehicles and promote ultra-low emission vehicles	✓	This is embedded within our NHS Fleet Solutions.	Staff can adopt ultra-low emission vehicles using NHS Fleet Solutions. NHS Fleet Solutions offer a substantially larger range of electric and hybrid vehicle for staff to lease than petrol and diesel cars. In addition to this, staff can pay monthly in their lease for the installation of a home EV charging point, in-turn of paying for this cost up-front.
18.4.1.2	Carbon/GHG's	Procurement and Supply Chain	Take action to phase out oil and coal for primary heating and replace them with less polluting alternatives.	✓	Subject to funding, the Trust will run on a combined approach with renewable power, not gas and oil backups.	We are in the process of requesting funding to phase out gas (and back up oil) heating within the Trust to switch to a combined approach with renewable heating.
18.4.2.1	Carbon/GHG's	Governance and Policy/Core Responsibilities	To reduce greenhouse gas emissions from the Provider's Premises in line with targets under the Climate Change Act 2008.	✘	A Carbon Reduction Plan will be produced for the entirety of the Trust.	We provide annual reporting on GHG emissions to help identify how we will reach targets under the Climate Change Act 2008. We have provided a Carbon Reduction Plan for Walsall Manor Hospital to identify the technologies needed on-sit e to reduce GHG emissions by 36% by 2024.
18.4.2.2	Carbon/GHG's	Procurement and Supply Chain	In accordance with Good Practice, to reduce the impacts from the use, or atmospheric release, of environmentally damaging fluorinated gases used as anaesthetic agents and as propellants in inhalers, including by appropriately reducing the proportion of desflurane to sevoflurane used in surgery to less than 20% by volume, through clinically appropriate prescribing of lower greenhouse gas emitting inhalers, and the appropriate disposal of inhalers.	✘	Reduced use of desflurane to 10% in proportion to sevoflurane used in surgery. Achieve 75% reduction in nitrous oxide carbon emissions	Inhalers provided/used in the treatment of service users with respiratory conditions would be CFC-free, as standard within the UK, and would follow the treatment regime prescribed by a service user's respiratory specialist of GP. As a Trust, we also dispense dry powder inhales which do not operative as an aerosol system.
18.4.2.3	Adaptation	Core responsibilities	To adapt the Provider's Premises and the way Services are delivered to mitigate risks associated with climate change and severe weather.	✘	Air handling units will have been updated to aid ventilation on-site and within wards.	The Trust currently have a contingency plan which addresses the actions which will be taken by the Trust should we experience any events such as ice and snow, heavy rain, high winds, and excessive heat all of which may arise due to climate change. The Trust is looking to conduct ward upgrades. As part of this, Walsall are looking to change their air handling units to help aid ventilation and therefore helping mitigate to climate change and a rise in atmospheric temperatures.

Condition	Green area of focus	Cross-cutting themes	Condition	Has the condition been met?	What does success look like?	Supporting Text
18.4.3	Supply Chain and Procurement	Governance and Policy	Single use plastic products and waste, and specifically how it will with effect from 1 April 2020 cease use at the Provider's Premises of single use plastic straws and stirrers unless there is clinical need to do so for medical purposes, as would be permitted by the draft Environmental Protection (Plastic Straws, Cotton Buds and Stirrers) (England) Regulations 2020, if enacted, and by no later than 31 March 2022.	✓	This is embedded within our procurement policy.	We have removed plastic straws, stirrers, and cutlery (with the exception of plastic cutlery for mental health patients in the interest of health and safety) as required within draft Environmental Protection (Plastic Straws, Cotton Buds and Stirrers) (England) Regulations 2020.
18.4.3.1	Estates & Facilities	Core responsibilities	Reduce waste and water usage through best practice efficiency standards and adoption of new innovations	✓	The Trust has identified appropriate charities to donate used goods to, this has been communicated to all staff. The new Emergency Department will have radar and automatic release taps. Retained estates will have flow restrictors. Posters, newsletters, and communication through the intranet has been distributed to educate staff on correct waste disposal practices. Introduce additional waste streams to separate out recyclate materials from Site i.e. plastics, paper, metal, glass. Office paper use will be reduced by 50%. All paper used for office-based functions will be 100% recyclable. 'Bright Ideas' campaign has been re-invigorated.	We are reducing volumes of waste produced on-site by; separating out our cardboard waste for separate recycling, introducing a food de-hydrator onto site, and changing print settings so that staff are encouraged to print double sided to reduce paper usage.
18.4.3.2	Supply Chain and Procurement	Governance and Policy	reduce avoidable use of single use plastic products, including by signing up to and observing the Plastics Pledge	✓	This is embedded within out procurement policy	We have signed up to the single-use plastics pledge and are actively reducing single-use plastic products used on-site.
18.4.3.3	Supply Chain and Procurement	Procurement and Supply Chain	so far as clinically appropriate, to cease use at the Provider's Premises of single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics;	✓	Identify supplies and procurement areas which can be improved to champion sustainability.	The Trust purchase products through the NHS supply chain, automatically be compliant with the plastics pledge. Where external alternative suppliers are used, the Trust looks obtained suitable alternatives to single-use plastics. We are working with our catering companies and retailers to reduce single use plastic used within our Trust. Our catering team and retailers have sustainability plans to promote sustainable use of resources and waste recycling and reduction. We are switching from Black Country Alliance to University Hospitals North Midlands procurement hub on the 1st April to see that sustainability is championed through procurement and supply decisions.
18.4.3.4	Supply Chain and Procurement	Procurement and Supply Chain/ Core responsibilities	to reduce the use at the Provider's Premises of single-use plastic food and beverage containers, cups, covers and lids;	✓	Identify supplies and procurement areas which can be improved to champion sustainability.	We are working with our catering companies and retailers to reduce single use plastic used within our Trust. Our catering team and retailers have sustainability plans to promote sustainable use of resources and waste recycling and reduction. We are switching from Black Country Alliance to University Hospitals North Midlands procurement hub on the 1st April to see that sustainability is championed through procurement and supply decisions.
18.4.3.5	Supply Chain and Procurement	Working with staff and patients	to make provision with a view to maximizing the rate of return of walking aids for re-use or recycling and must implement those plans diligently.	✘	A Plan has been completed to address how the Trust will meet the 40% target of all walking aids refurbished in the next 5-years. The Trust will encourage and welcome the return of walking aids from patients.	The Trust will use the guidance on walking aid reuse and medical device remanufacture for NHS trusts published in December 2021 to establish a walking reuse scheme.
18.5	Sustainable Care Models/Monitoring	Procurement and Supply Chain	The Provider must, in performing its obligations under this Contract, give due regard to the potential to secure wider social, economic, and environmental benefits for the local community and population in its purchase and specification of products and services, and must discuss and seek to agree with the Co-ordinating Commissioner, and review on an annual basis, which impacts it will prioritise for action.	✓		We are switching from Black Country Alliance to University Hospitals North Midlands procurement hub on the 1st April to see that sustainability is championed through procurement and supply decisions.

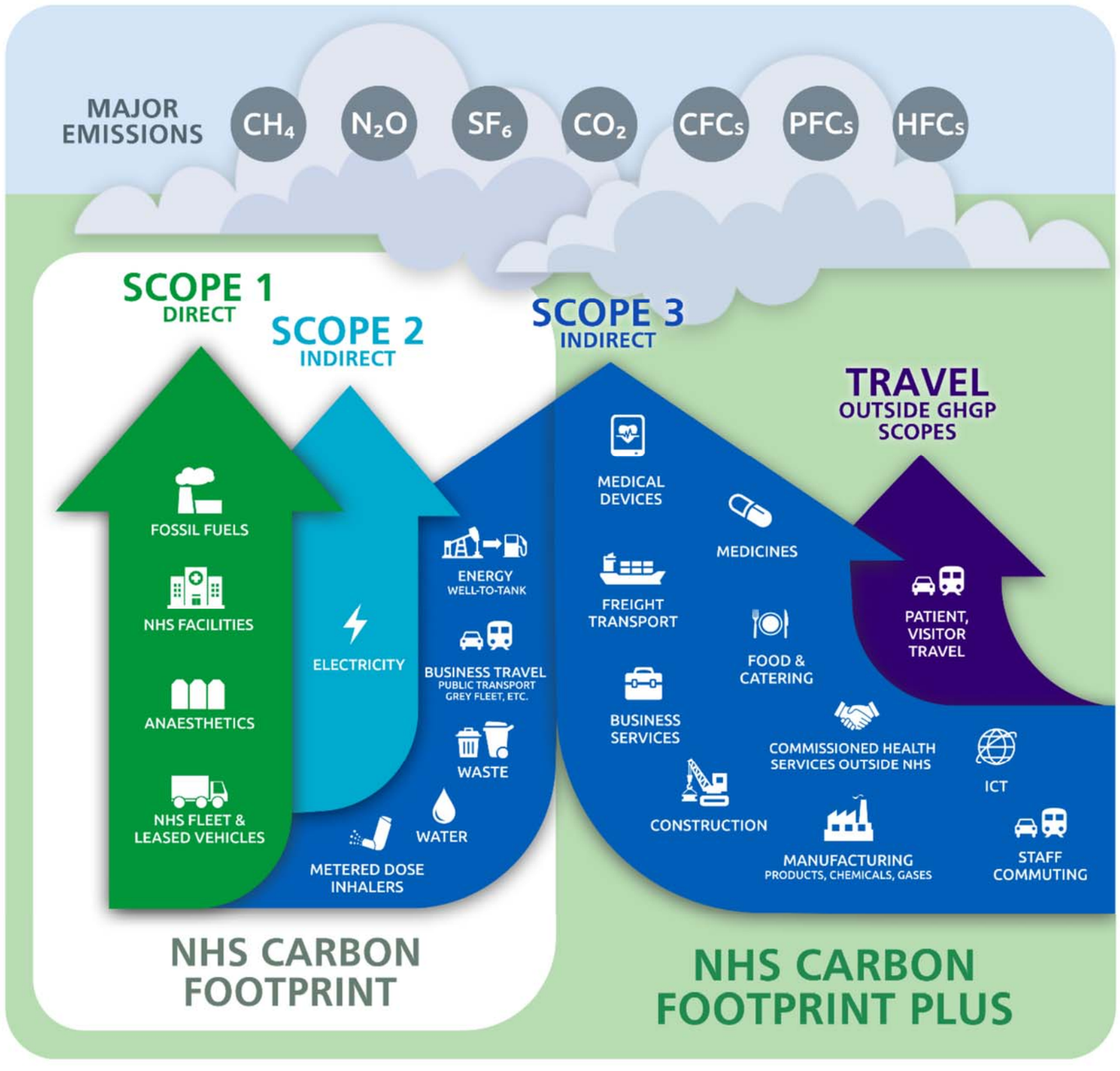
Appendix B – Future Proofing Actions

Focus Area	Cross cutting theme	Action	Date	What does success look like?	[Responsibility]
Sustainable Travel and Logistics	Core Responsibilities	Install appropriate levels of electric (EV) charging points for electric cars for staff, porters, and patients where new car parking is constructed.	Subject to funding	**[X]** number of EV charging points are installed within the new Emergency Department car park.	Estates & Facilities
Sustainable Travel and Logistics	Core Responsibilities	Review and extend the Walsall Manor Hospital 2020 Travel Plan[11] to the rest of the Trust sites.	April 2021	An updated Travel Plan has been produced to set out aims to encourage sustainable travel within the Trust.	Estates & Facilities
Sustainable Travel and Logistics	Core Responsibilities	Increase the number of employees travelling to work by public transport, car sharing, and cycling over a five-year period as outlined within our Travel Plan 2020.	2025	**[X]** % of staff will travel to work via public transport. **[X]** % of staff will travel to work via two-wheel travel.	Estates & Facilities
Sustainable Travel and Logistics	Core Responsibilities	Production of Green Travel Plan in accordance with requirements of NHS Net zero Document, as part of their annual planning and reporting.	April 2022	Green Travel Plan produced	Head of Sustainability
Sustainable Travel and Logistics	Procurement and Supply Chain	Adopt low and ultra-low carbon vehicles when leasing new vehicles in-line with NHS Terms and Conditions of Service.	Subject to funding	90%proportion of the Trust's fleet will be low/ultra-low emission vehicles by 2028 and 100% zero emission vehicles by 2030	Estates & Facilities
Sustainable Travel and Logistics	Working with Staff, Patients and Communities /	Progress internal communications, marketing plans and 'welcome packs' for new members of staff to encourage sustainable travel through travel subsidisation, designated cycle routes and Cycle2work days as detailed in the Travel Plan 2020.	2021	Communications (via newsletters, notice Boards, intranet etc) have been delivered to staff to inform them of Cycle2work schemes and travel subsidisation.	Communications Team
Sustainable Travel and Logistics	Working with Staff, Patients and Communities /	Invest in IT infrastructure to aid staff to effectively work from home after the COVID-19 pandemic, reducing transport to site.	2022	Staff will not be required to attend the office 5-day a week.	Human Resources/Workforce
Sustainable Travel and Logistics	Working with Staff, Patients and Communities /	As described in our Travel Plan, we will Increase facilities which enable staff to cycle to work including secure cycle stands, shower facilities, changing rooms, drying facilities.	2023	[X] secure cycle stands, [X] shower facilities and [X] changing rooms are on-site for staff use.	Estates & Facilities
Adaption	Governance and Policy	Complete a climate change risk assessment, highlighting areas within the Trust that are most susceptible to the impacts of climate change.	2022	A climate change risk assessment has been completed.	Head of Sustainability/Estates & Facilities
Adaption	Core Responsibilities	Update air handling units to help aid ventilation on-site within any ward upgrades.	2022	The new Emergency Department will hold air handling units to aid on-site ventilation.	Estates & Facilities
Adaption	Procurement and Supply Chain	Complete an evaluation/risk assessment of critical supplies which could be affected by climate change.	2022	A climate change risk assessment for all critical supplies has been completed. Alternative suppliers have been identified where significant risks have been found.	Procurement
Adaption	Working with Staff, Patients, and Communities	Create a communication plan to aid awareness of the impacts of climate change and importance of adaptation to both staff and patients.	2022	Communications (via newsletters, notice Boards, intranet etc) have been delivered to staff and patients to inform them of risk of climate change and key mitigation/ adaptation measures.	Communications Team
Supply Chain and Procurement	Core Responsibilities	Create a plan to allow for the reuse and recycling of walking aids, in-line with the 40% target of all walking aids refurbished in the next five years (as stated within the 'Delivering a 'Net Zero' National Health Service).	2021 and 2026	A Plan has been completed to address how the Trust will meet the five-year target. The Trust will encourage and welcome the return of walking aids from patients.	Therapies Department
Digital Transformations	Core Responsibilities	Increase the digitisation of Trust activities to reduce office paper by 50%, with a switch to 100% recycled content paper for all office-based functions.	2023	Office paper use will be reduced by 50%. All paper used for office-based functions will be 100% recyclable.	ICT/Operational Teams/Procurement
Supply Chain and Procurement	Core Responsibilities	Donate goods such as mattresses, old office chairs, laptops and monitors to reuse and charitable organisations to avoid disposal.	2021	The Trust has identified appropriate charities to donate used goods to, this has been communicated to all staff.	Estates & Facilities
Capital Projects	Core Responsibilities	Install radar and automatic release taps within any new builds and water flow restrictors within the retained state to reduce water waste.	2022	The new Emergency Department will have radar and automatic release taps. Retained estates will have flow restrictors.	Estates & Facilities
Estates & Facilities	Core Responsibilities	Hold meetings with the waste contractor to explore increasing the number of recyclate waste stream bins provided on-site.	2021	Introduce additional waste streams to separate out recyclate materials from Site i.e. plastics, paper, metal, glass.	Estates & Facilities
Supply Chain and Procurement	Procurement and Supply Chain	Conduct a full review of supplier sustainability once we have joined the new University Hospitals North Midlands procurement hub.	2022	Identify supplies and procurement areas which can be improved to champion sustainability.	Procurement
Estates & Facilities	Working with Staff, Patients and Communities.	Work with infection control to deliver a communications plan to staff providing information on what materials can be disposed of via the general and offensive waste stream. Aiming to reduce the volume of offensive waste produced within our Trust.	August 2021	Posters, newsletters, and communication through the intranet has been distributed to educate staff on correct waste disposal practices.	Estates & Facilities/Infection Prevention Team
Workforce and System Leadership	Working with Staff, Patients and Communities.	Re-invigorate the sustainability Campaign, 'Bright Ideas' to encourage all stakeholders to bring ideas to the forum and work collaboratively to achieve our goals.	2022		Communications Team
Reduction of Carbon/GHG Emissions	Core Responsibilities	Provide an annual GHG emission update to the Board approximated with the NHS Carbon Footprint and NHS Carbon Footprint Plus.	2022	Annual reporting includes all NHS Carbon Footprint and Plus data.	Head of Sustainability

[11] Walsall Healthcare NHS Trust (March 2020) Manor Hospital: Workplace Travel Plan

Reduction of Carbon/GHG Emissions	Core Responsibilities	Upgrade our estate so that all lighting is upgraded to LEDs via the NHS Energy Efficiency Fund (NEEF).	2024	All lighting within the Trust is LED.	Estates & Facilities
Reduction of Carbon/GHG Emissions	Core Responsibilities	Insulation improvements will be made to steam raising boilers and Low Temperature Hot Water Boilers.	2024	All boilers will have upgraded insulation.	Estates & Facilities
Reduction of Carbon/GHG Emissions	Procurement and Supply Chain	Move towards on-site renewable energy and remove coal and oil heating systems within the Trust as soon as possible, with complete phase-out over the coming years.	2024	Renewable energy is used on-site. Coal and Oil heating has been phased out.	Estates & Facilities
Reduction of Carbon/GHG Emissions	Procurement and Supply Chain	Purchase 100% renewable energy from April 2021	April 2021	The Trust will purchase 100% renewable energy.	Estates & Facilities
Reduction of Carbon/GHG Emissions	Procurement and Supply Chain	Move to lower carbon inhaled such as dry powder inhalers (DPI's), increasing the frequency of the green disposal of used inhalers, support innovation in use and lower carbon propellant and alternatives	2024	DPI's are supplied when prescribing inhalers. Inhalers are disposed on in a green way. Innovation has been supported to find low-carbon alternatives.	Sustainability Clinical Lead/Respiratory Team
Reduction of Carbon/GHG Emissions	Working with Staff, Patients and Communities.	Designate an awareness/ sustainability champion for the Trust.	2022	The Trust will have a sustainably champion.	Head of Sustainability

Appendix C – ‘Delivering a ‘Net Zero National Health Service’ NHS Carbon Footprint and NHS Carbon Footprint Plus



Appendix D – 'Sustainability Impact Assessment'

Sustainability Impact Assessment (SIA) for Business Development, Investment and Procurement Decisions

Walsall Healthcare NHS Trust

Theme	Review Questions	Impact	Description of Impact	Actions to mitigate negative aspects and enhance positive impacts
	ENERGY – consider whether the project leads to: • an increase, or decrease, in the amount of electricity or battery usage • an increase, or decrease, in the amount of heating/hot water required • an increase, or decrease, in carbon emissions from building energy use	Choose an item.	*Example:* *Introduction of a new piece of equipment will increase energy use and will lead to extra waste from its processing.* *Additional electrical sockets and network points in an office will lead to increase in energy use*	*Example:* *Equipment is most energy efficient available. Process in place to ensure equipment is turned off when not in use. Staff trained on minimising energy use at induction.* *Staff to ensure that sockets are turned off when not in use*
	WATER – consider whether the projects leads to: • an increase/decrease in the amount of water used • an upgrade of existing plant & distribution facilities • an increase/decrease in substances to be disposed of to foul sewer	Choose an item.	*Example:* *Introduction of a new piece of equipment will reduce the amount of water required for a range of lab diagnostic tests.*	*Example:* *In addition to water savings, the equipment will be turned off when not in use and staff are trained on this at induction.*
	WASTE – consider whether the project leads to: • an increase or decrease in the amount of waste generated • a variation in the type of waste to be disposed of, affecting segregation i.e. more/less hazardous	Choose an item.	*Example:* *Project will involve opening a new community outreach clinic, generating both clinical and non-clinical waste.*	*Example:* *Provision for segregated recycling. Trust standard reusable sharps bins installed. Waste Manager consulted ahead of project commencement to seek other improvement opportunities.*
	CAPITAL PROJECTS – each building or refurbishment work should consider: • energy use, including natural light, ventilation and renewable energy • water use, including conservation measures • use of space as a community resource/social enterprise • enhancing green spaces & biodiversity • embodied carbon, operational carbon, whole life cycle carbon in designing the building	Choose an item.	*Example:* *Project will involve new building extension, providing office accommodation and associated facilities.*	*Example:* *Sustainability Team involved at feasibility stage to ensure exemplar sustainable healthcare building design as standard. BREEAM 'Outstanding' as the aim (minimum of 'Excellent').* *Complies with Net Zero Carbon building standards*
	JOURNEYS - consider whether the project leads to an increase or decrease in: • 'care miles' i.e. care closer to home, telemedicine, repeat appointments • access to services for vulnerable or disadvantaged groups • sustainable travel options, i.e. walking, cycling, public transport, electric car	Choose an item.	*Example:* *Patients to access care through community health centres, reducing travel to hospital. Staff will travel from hospital to health centres to deliver care.*	*Example:* *Patient letters will encourage use of public transport.* *Appointments will be coordinated to ensure staff travel between sites is minimised.*
	PROCUREMENT - all procurement related to the project should consider: • whole life costs, i.e. procurement vs. revenue costs (£ and carbon) • supporting local businesses, small businesses and social organisations • promotion of ethical procurement and labour standards • food/catering from local, seasonal and sustainable suppliers • social value, i.e. producing a local benefit through employment/training • wider health impacts, such as antibiotic use, air pollution, modern slavery	Choose an item.	*Example:* *Part of this project will be subcontracted and local community groups could deliver these services.* *This project will include procurement of low value goods which might be manufactured in areas known for labour standards issues.*	*Example:* *Community groups will be invited in to find out more about the project, prior to tendering.* *Bidding companies will be asked to provide their Modern Slavery Statement and to disclose how they ensure labour standards with foreign manufacturers.*
	MODELS OF CARE - consider the impact the project may have on: • 'care miles' and delivering care in settings closer to people's homes • promoting prevention, healthy behaviours, mental wellbeing, living independently and self-management • reducing avoidable hospital admissions or admissions to residential care • delivering integrated care, streamlining care pathways	Choose an item.	*Example:* *This project will lead to increased care delivered in community settings.* *This project will reduce readmissions and promote independent self-managed care.*	*Example:* *Consideration will be given to patients' access to community care centres and the use of technology to monitor health aspects.*
	ADAPTATION - consider if the project is impacted by climate change, such as: • hotter, drier summers; milder, wetter winters; increased extreme weather events, including flooding and heatwaves • support for vulnerable groups, including the elderly, people with long-term health conditions and those with mental health illnesses	Choose an item.	*Example:* *The project will provide support to elderly patients to prepare for discharge.*	*Example:* *Guidance will be provided to patients on discharge to raise awareness of: the health impacts of heat (and how to minimise risk) and the health impacts of fuel poverty (and the support available for insulation & boiler upgrades).*
	SOCIAL VALUE/ PEOPLE: Consider whether your project can support social value by: • employment opportunities including disadvantaged groups, i.e. long-term unemployed, people with learning disabilities • training of existing staff or apprenticeship opportunities • health and wellbeing, flexible hours or childcare / carer support • increasing community resilience & a reduction in social isolation • Implementation of measures to reduce in health inequalities and enhanced access to services • increasing participation of patients, the public and strategic partners	Choose an item.	*Example:* *This project will lead to the creation of two new roles.* *This project is awarding business to a local SME/ VCSE* *This project will provide a new model of care for particular group.* *This project is co-designed andcreated with patients / public*	*Example:* *HR will be contacted to see if an apprenticeship role can be considered and to identify support for disadvantaged groups to apply for roles.* *Consultation will take place with the care group and related stakeholders. Consideration will be given to barriers of access faced by disadvantaged groups.*

For help in completing this form please contact the Head of Sustainability at janetsmith3@nhs.net or 01902695350 Version 0.1 (21.05.2021)

Appendix E – ‘Carbon Reduction Crib Sheet’

Carbon Reduction Crib Sheet

Walsall Healthcare NHS Trust

Theme	Actions to Consider
	ADMIN AND SUPPORT FUNCTIONS – consider the way we work • Go paperless – double side printing and copying only if necessary and use recycled paper • Send less email – a single email has a carbon footprint of 4g of CO2 and an email with attachment has a carbon footprint of up to 50g of CO2 • Use workspaces such as sharepoint portal to store, access and manage meeting documents. This will avoid sending out large amount to data via email as well as printing large amount of document • Buy less – review consumables use; only buy items that you can't do without and switch to low carbon alternatives • Use laptop instead of desktop computer. A laptop requires less energy than a desktop • Ensure regular equipment maintenance – Visual safety inspection, scheduled maintenance service, etc • Turn off computer devices including monitor, docking station, etc.
	WATER – consider the way we use water: • Don't leave taps running • Report leaks • Supply washbowl in staff kitchen to avoid washing up under running water • Water Safety –Unused outlets are flushed inline with the Water Safety policy
	WASTE – consider how we can reduce, reuse and recycle: • Reduce use of single use plastic products – pens, cups, cutleries, drinks bottle, etc • Reduce use of products that use non-recyclable packaging and switch to products with non-plastic or fully recyclable packaging • Reuse furniture and equipment before buying new • Upgrade computers instead of buying new • Recycle old computers • Use rechargeable batteries instead of single use batteries • Implement waste segregation
	BUILDING AND ENERGY – consider the way we use our spaces: • Implement agile working – hot desking and working from home; • Turn off lights and equipments when not in use for 30 minutes or more • Avoid leaving equipment on standby • Unplug phone and other chargers • Replace lighting with LED • Ensure efficient heating – blocking drafts, closing windows/doors, use of insulation, etc • Replace single glazed windows • Use natural ventilation in areas where mechanical ventilation and/or cooling is not a service requirement • Change from gas boilers to heat pumps powered by green electricity, also consider reversible heat pumps which can also provide cooling. • New builds consider whole life costs not just Capital cost to build but also the cost of operating it such as utility and maintenance Revenue costs. • New Builds consider flexibility in build with easy to reconfigure for other use later in the life of the building. • Switch to energy efficient equipment
	BUSINESS TRAVEL AND STAFF COMMUTING - consider how we can reduce our travel carbon footprint: • Replace business trips with video conferencing such as Teams • Replace face to face meetings with telephone or use Teams • Enabling wider access to portable digital systems for clinicians in the field, reducing the need to travel back to home base for data input • Reducing business travel by supporting remote ways of working • Encourage staff to use sustainable travel options – walking, cycling, public transport, electric/hybrid car • Raise awareness of onsite cycling support facilities – secure parking, shower, changing facilities, locker area • Raise awareness of electric vehicle charging facilities • Switch to ULEV or electric vehicle
	PROCUREMENT – consider Why/Where/ what we buy: • Implement a first in, first out system of inventory to reduce wastage particularly on perishable items • Review consumables supply requirements and cut out items that your team can do without • Purchase sustainable alternatives for office equipment, furniture, consumables etc • Reduce procurement miles by supporting local businesses • Engage with suppliers on reducing packaging waste particularly plastic packaging • Whole life costs, i.e. procurement vs. revenue costs (£ and carbon) • Buy food/catering supplies from local, seasonal and sustainable suppliers • Social value, i.e. producing a local benefit through employment/training • Wider health impacts, such as antibiotic use, air pollution, modern slavery
	MODELS OF CARE - consider what/where/how we provide our service • Reducing ‘care miles’ by implementing a virtual triage, appointment management and virtual clinics and delivering care in settings closer to people's homes • Provide training to clinician on how to conduct virtual clinic • Embed best clinical practice to further progress on care quality and outcomes as exemplified by Getting if Right First Time (GIRFT) approach • Promoting prevention, healthy behaviours, mental wellbeing, living independently and self-management • Reducing avoidable hospital admissions or admissions to residential care • Delivering integrated care, streamlining care pathways
	ADAPTATION – consider the impact of climate change in planning and delivering services • Hotter, drier summers; milder, wetter winters; increased extreme weather events, including flooding and heatwaves • Support for vulnerable groups, including the elderly, people with long-term health conditions and those with mental health illnesses • Ensuring that the facilities where we deliver services are fit for purpose and resilient against the impact of climate change
	SOCIAL VALUE/ PEOPLE: Consider whether our service can support social value through: • Employment opportunities including disadvantaged groups, i.e. long-term unemployed, people with learning disabilities • Training of existing staff or apprenticeship opportunities • Focus on staff health and wellbeing, flexible hours or childcare / carer support • Implementation of measures to reduce in health inequalities and enhanced access to services • Increasing participation of staff, patients, the public and strategic partners

For further assistance on the content of this sheet, please contact the Head of Sustainability at janetsmith3@nhs.net or 01902695350 Version 0.1 (21.08.2021)

MEETING OF THE PUBLIC TRUST BOARD Wednesday 2nd February 2022			
Improvement Programme: Quarter 3 Update Report			**AGENDA ITEM: 27**
Report Author and Job Title:	Polly Kaur Head of Improvement/Paul Steventon, Head of Strategic Finance	**Responsible Director:**	Simon Evans Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	• All schemes covered as part of the Improvement Programme have been discussed with the relevant Executive lead		
Advise	• The current Improvement Programme will be re-focussed to reflect the current position and priorities • Two new groups will be established to oversee the efficiency agenda across the trust and the development of new business cases.		
Alert	• The improvement team will continue to be available for all areas where risks and issues require programme support		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report aims to mitigate against: BAF 06: 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 form delivering its strategic objectives and annual priorities. BAF: Use Resources Well		
Resource implications	Alignment of adequate programme management support to all workstreams.		
Legal and/or Equality and Diversity implications	For each workstream/project there will be a: • Quality Impact Assessment • Equality and Diversity Impact Assessment, and • Information Governance/Data Protection Impact Assessment		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

IMPROVEMENT PROGRAMME UPDATE REPORT
January 2022

1. Background

The Trust Board has received routine progress update reports on the status of the Improvement Programme since its inception in 2019. This report will provide the latest update position and will also make recommendations following the Executive-led review for each of the work streams as they are currently established.

Work to review the improvement plan was initially undertaken in June 2021, when all the projects were reclassified following discussions with the workstream leads. This was undertaken as it was identified that some of the original projects were either completed, no longer relevant in that they did not require transformation or quality improvement support, were now 'business as usual' or had been superseded by other events. As a result of this exercise, the following categories were introduced to help classify the improvement programme within each work stream:

- Transformation
- Business Development
- Quality Improvement
- Business As Usual

Following this re-classification process, the total number of Improvement projects that require support dropped from 161 to 88.

2. Summary

Since November 2021, more detailed work has been undertaken with each Executive lead to understand the on-going commitment required to deliver the outstanding projects within each work stream. As can be seen from the table below, the remaining programme has now reduced further and there is a different focus to the overall programme:

Workstream	Number of Schemes as at June 2021	Closed	Efficiency Group	Improvement Team	BAU	Paused
Provide Safe High-Quality Care	9	9	0	0	0	0
Care at Home	14*	6	0	0	8*	0
Work Closely with Partners	5	0	0	5	0	0

Workstream	Number of Schemes as at June 2021	Closed	Efficiency Group	Improvement Team	BAU	Paused
Value our Colleagues	9	8	0	0	0	1
Use of Resources	40	8	22	0	0	10
Governance and Well Led	11	0	0	0	11	0
Total	88	31	22	5	19	11

*Includes 8 IT projects which are monitored through IT Governance framework.

It should also be noted that some of the projects that have been paused are pending business case approval or are being validated at divisional level. The intention is for these projects to be reviewed pending the outcomes of the evaluations.

As can be seen from the data, a number or work streams now have either zero projects or have projects that have a financial or efficiency focus. This includes schemes that are within the Use of Resources Theme.

The Board can be assured that all schemes within the improvement programme have been assessed by the Executive lead and the relevant programme manager from the improvement team. As a result, all schemes that have been closed have an identifiable governance route so that the on-going monitoring and reporting can be picked up as business as usual through routine reporting.

3. Proposed Developments

After discussions with Executive colleagues using the evidence from this latest position, it is proposed that the improvement programme is reorientated so that it more accurately supports the priorities and needs of the organisation.

3.1 The Governance and Well-Led Theme still has a number of live projects which require continued oversight. Where required, the improvement team will continue to support this work stream under the leadership of Kevin Bostock as Director of Assurance. Outputs from this group will be reported through to TMC and the Trust Board.

3.2 A number of schemes have already moved out of existing work streams and are currently being supported by the Quality Improvement Team. It is proposed all schemes continue and the monitoring and reporting of schemes come through the existing education committee and relevant sub-committees as appropriate.

3.3 The Use of Resources Theme will grow to include all of the existing projects that have been identified to have a cost saving or efficiency focus, plus any schemes that the division are currently working on as part of an efficiency programme. It is proposed that an Efficiency Group is established with a specific agenda focussing on cost improvement and efficiency. It is recommended that this will be chaired by the Chief Operating Officer, who is lead executive for the majority of influenceable spend. This will be supported by the PMO from

the existing improvement support team. Other Executives will also attend to provide additional scrutiny and each Division will be invited to present their updates on the efficiency plan. Outputs from this group will be reported through to TMC and Performance, Finance and Investment Committee.

3.4 As a result of this review, all of the other work streams will formally close as part of the improvement programme. As identified earlier in the paper, any on-going schemes will be discussed with Executive leads to ensure they have an identified monitoring and reporting route and will be classified as business as usual.

3.5 The final proposal within this paper concerns the larger and more significant projects of work that are being undertaken or considered across the Trust. Most of these usually require the development of a business case and will be supported in some way by a member of the improvement team and other groups such as the information team or finance team. As it stands with the current process, all current business cases will, eventually, come via Executives for discussion prior to going through to a sub-committee and onwards for approval. However, there is not one agreed route within the organisation and frequently multiple Business cases are often developed that are working their way through the Trust reporting structure. This is not helpful when trying to align resource and priorities and neither is it efficient nor easy for operational and clinical staff to navigate.

To address this issue, it is proposed that a new Investment Group is established that will provide a formal gateway assessment process for all business cases across the organisation. This will be Chaired by the Chief Strategy Officer and will be supported by the planning PMO. All Executives will be invited to attend the meeting in order that business cases are considered from all perspectives prior to any recommendations being made. The outcomes of the Group will report through to TMC, Performance, Finance and Investment Committee and Board (where appropriate for SFI considerations). It is hoped that this process will provide one clear pathway for all business cases, provide robust and clear governance and should speed up the decision-making process.

3.6 Finally, as a direct consequence of these proposals, increased flexibility and responsiveness to the needs of the organisation will be built in to the current improvement team. This will be achieved by freeing capacity from current structures and allowing them to respond to issues and priorities as the business needs desire. Early evidence of the success of this approach has already been seen with the team able to respond to requests for additional support from the Medical Director and Director of Nursing.

4. Recommendations

The Trust Board are asked to approve the following recommendations:

1. Re-prioritisation of the Improvement Programme and the reporting arrangements for the existing work streams
2. The development of an Efficiency Group chaired by the Chief Operating Officer
3. The development of an Investment Group chaired by the Chief Strategy Officer