Walsall Healthcare NHS
NHS Trust

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 5 NOVEMBER 2020 AT 12:00 VIA MICROSOFT TEAMS AND TELECONFERENCE

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

A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
OPENING ITEMS					
1.	Staff Story	Information	Interim Director of Nursing	Verbal	12.00
2.	Apologies for Absence	Information	Chair	Verbal	12.15
3.	Quorum and Declarations of Interest	Information	Chair	Enclosure	
4.	Minutes of the Board Meeting Held on 1st October 2020	Approval	Chair	Enclosure	
5.	Matters Arising and Action Sheet	Review	Chair	Enclosure	12.20
6.	Chair's Report	Information	Chair	Enclosure	12.25
7.	Chief Executive's Report	Information and Assurance	Chief Executive	Enclosure	12.30
8.	Restoration & Recovery Update	Information Approval	Chief Operating Officer	Enclosure	12.40
9.	COVID-19 Board Assurance Framework	Assurance	Chief Operating Officer	Enclosure	12.50
	VALUE OUR COLLEAGUES				
10.	People and Organisational Development Committee Highlight Report	Assurance/ Information	Chair of PODC	Verbal	12.55
11.	Executive Report – Value Our Colleagues Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of People & Culture	Enclosure	13.00
12.	Safe Staffing Report	Assurance	Interim Director of Nursing	Enclosure	13.15
13.	Freedom To Speak Up Quarterly Report	Information	Freedom To Speak Up Guardian	Enclosure	13.25
14.	Guardian of Safe Working Quarterly Report (a) February to April 2020 (b) May to July 2020	Information	Medical Director	Enclosure	13.35
	USE RESOURCES WELL				
15.	Performance, Finance and Investment Committee Highlight Report	Assurance/ Information	Chair of PFIC	Enclosure	13.45
16.	Executive Report – Use Resources Well Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Finance and Operational Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of Finance/Chief Operating Officer	Enclosure	13.50

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
17.	Emergency Preparedness, Resilience and Response Annual Assurance	Approval	Chief Operating Officer	Enclosure	14.05
COMFORT BREAK – 14.10-14.40					
	PROVIDE SAFE HIGH QUALITY CARE				
18.	Quality, Patient Experience and Safety Committee Highlight Report	Assurance/ Information	Chair of QPES	Enclosure	14.40
19.	Executive Report – Provide Safe High Quality Care Appendix 1: Board Assurance Framework and Corporate Risk Register Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Medical Director / Interim Director of Nursing	Enclosure	14.45
20.	IPC Annual Report	Assurance	Medical Director	Enclosure	15.00
	CARE AT HOME				
21.	Walsall Together Partnership Board Highlight Report	Assurance/ Information	Chair of WTPB	Enclosure	15.05
22.	Executive Report – Care at Home Appendix 1: Board Assurance Framework Appendix 2: Performance Report Appendix 3: Improvement Programme	Assurance/ Information	Director of Integration	Enclosure	15.10
	WORK CLOSELY WITH PARTNERS				
23.	Executive Report – Work Closely With Partners Appendix 1: Board Assurance Framework Appendix 2: Improvement Programme	Assurance/ Information	Chief Operating Officer	Enclosure	15.25
	GOVERNANCE AND WELL LED				
24.	Audit Committee Highlight Report	Assurance/ Information	Chair Audit Committee	Enclosure	15.35
25.	Governance and Well-Led Improvement Programme Update	Information	Director of Governance	Enclosure	15.40
26.	Board Cycle of Business	Approval / Information	Director of Governance	Enclosure	15.45
27.	Use of Trust Seal	Information	Director of Governance	Enclosure	15.50
CLOSING ITEMS					
28.	Questions from the public				15.55
	Date of next meeting Thursday 3rd December 2020				
	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Declarations of Interest			**AGENDA ITEM: 3**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Danielle Oum Chair
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The report presents a Register of Directors' interests to reflect the interests of the Trust Board members. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	It is 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 October 2020

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

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

RECOMMENDATIONS

The Board are asked to note the report

Walsall Healthcare NHS
NHS Trust

MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS WALSALL HEALTHCARE NHS TRUST HELD ON THURSDAY 1 OCTOBER 2020 AT 12:00 P.M. HELD VIRTUALLY VIA TEAMS

Present

Members	
Ms Danielle Oum	Chair of the Board of Directors
Mr John Dunn	Non-Executive Director, Vice Chair Board of Directors
Mr Philip Gayle	Non-Executive Director
Mrs Anne Baines	Non-Executive Director
Mrs Pamela Bradbury	Non-Executive Director
Mr Ben Diamond	Non-Executive Director
Mr Richard Beeken	Chief Executive Officer
Dr Matthew Lewis	Medical Director
Ms Caroline Whyte	Deputy Director of Nursing
Mr Russell Caldicott	Director of Finance and Performance
Mr Ned Hobbs	Chief Operating Officer
In attendance	
Mr Paul Assinder	Associate Non-Executive Director
Mr Rajpal Virdee	Associate Non-Executive Director
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive Officer
Ms Jenna Davies	Director of Governance
Ms Catherine Griffiths	Director of People and Culture
Ms Glenda Augustine	Director of Planning and Improvement
Mrs Trish Mills	Trust Secretary
Members of the Public:	2
Members of Staff:	Pat Usher - Staffside; Jane Wilson – Staffside; Kuldeep Singh for Patient Story
Observers:	Bridgette Hill and Amanda Hennessy - Care Quality Commission
Apologies	
Mrs Sally Rowe	Associate Non-Executive Director
Mr Sukhbinder Heer	Non-Executive Director
Ms Ann-Marie Riley	Interim Director of Nursing

092/20 **Patient Story**

The Board viewed a video about a 22-year-old COVID-19 patient who had been treated in the Critical Care Unit for a number of weeks. At her request, the story was told through the multi-disciplinary team that cared for her, which included nurses, doctors, dieticians and physiotherapists.

The team told of the impact on the patient's physical and mental health of not being able to see her family and the measures they put in place to enable her to stay in contact with her family and to make her stay more bearable. These included using technology to ensure the lines of communication with her family stayed open; positioning the patient in a room by the window so her family could visit her; and helping her to have access to food she wanted.

The Board commended the patient for her strength and perseverance, and thanked her for allowing the Board to hear her story. They also commended the clinical teams for their compassion and caring approach.

The Board heard that the teams are taking the learning they experienced through COVID-19 into a potential second wave, and informing more long-term practices, such as

- Access being constructed to critical care room 17 to allow, where appropriate and safe, family members to enter directly into the ward to see their family.
- The importance of early intervention physiotherapy
- Different ventilation techniques and use of steroids and antibiotics.

093/20 **Quorum and Declarations of Interest**

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

Minutes of the Board Meeting held in Public on 3RD September 2020

094/20 The Minutes **were approved** as a true reflection of the meeting, subject to the following amendments:

Page 3, last bullet point should read 'The Trust had sadly lost two staff members'.

095/20 **Matters Arising and Action Sheet**

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

043/20: (*People and Organisational Development Committee (PODC) at their meeting in June to review remodelling of the workforce to test resilience should there be a second wave, and to include the impact of 'test and trace' on staff availability.* Mrs Griffiths confirmed that PODC have reviewed the workforce model tools, however the impact of track and trace is still being reviewed and will come back to PODC in October.

096/20 **Chair's Report**

The Board received the report from Ms Oum, noting that on 8th September 2020, and in accordance with the Trust's Standing Orders, Chair's Action was taken to amend the Emergency Department New Build Full Business Case to reflect increased costs and include the additional anticipated central income capital stream.

097/20 **Chief Executive Officer's Report**

Mr Beeken informed the Board that, following inspections by the Care Quality Committee (CQC) to the Emergency and Maternity Departments, there remain concerns regarding the care of the deteriorating patient, and in particular, patients with actual or suspected sepsis. An urgent action plan is being developed and will be submitted to the CQC by 2nd October.

Mr Beeken presented his report, drawing the Board's attention to the Trust's strategic objectives through the lens of the national, regional and local system expectations associated with the third phase of national incident management of the COVID-19 pandemic.

Mr Beeken updated the Board on the Strategic Transformation Partnership (STP) Restoration and Recovery planning process, noting he felt there was not enough practical action defined in the STP submission in response to the Phase 3 letter to restart services regarding health inequalities in the Borough of Walsall. Mrs Baines informed the Board that the health inequalities work Walsall Together are developing will be accelerated to support a holistic approach and assist the Trust in steering the STP planning to be more effective in this regard.

Mr Gayle raised concerns that elements of the NHS people plan may not be fully implementable should further funds beyond that confirmed for phase 3 recovery be

available. Mr Beeken and Mrs Griffiths responded that there is a Trust action plan to respond to the national people plan which the People and Organisational Development Committee (PODC) have reviewed, and the executive team will determine which elements, if any, may be at risk within the current income envelope, but ultimately that is a decision which PODC and the Board will make in the round.

The case for change has commenced with respect to acute hospital collaboration across the wider Black Country, and the Trust will keep this distinct from functional collaboration, which is the work developing under the Working With Partners strategic objective. The Board discussed the way in which colleagues would be engaged in the acute collaboration work, and Mr Beeken confirmed that the Trust Management Board (TMB) had been briefed and with effect from the week commencing 12th October, a conversation will start with the broader organisation, including use of the clinical senate forum, particularly for the clinical case for change. Mr Beeken will update the Board on those communications. A leadership development programme for corporate and clinical leaders in the organisation was presented to the TMB and well received. This will be rolled out in conjunction with other leadership programmes already on foot, in a way that takes into account the fact that these leaders have been shouldering a large amount of the burden over the past few months, recognising there is a need to protect development time for this.

Mr Beeken commended Mr Fradgley and the Electronic Patient Record (EPR) team for the successful go-live of stage 1 Medway Patient Administration System. Thanks were also extended to colleagues from Barnsley Hospital Foundation Trust who assisted in the go-live in significant numbers to ensure it was safely implemented.

Mr Gayle asked for the Board to be updated on the process and outcomes of the work underway to target support being provided to the five key services/departments noted in Mr Beeken's report.

Action:

(a) Mr Beeken to update the Board on communications with staff re acute hospital collaboration
(b) Board to be updated on the process and outcomes of the work underway to target support being provided to five key services/departments

098/20 **Restoration and Recovery**

The Board received Mr Hobbs' report, noting that two development sessions took place with the Board in the lead up to the Trust's initial restoration and recovery submission to the STP on 21st September.

The development sessions endorsed the clinical prioritisation of services, those being:

1. Urgent, Emergency and Critical Care services in the community and in the hospital.
2. Urgent Elective services including urgent outpatient, urgent diagnostic and urgent surgical/procedural services (e.g. Cancer pathways)
3. Routine Elective services including non-urgent outpatient, non-urgent diagnostic and non-urgent surgical/procedural services

The sessions considered the worst, likely and best case income scenarios for months 7-12 of the financial year, with the 'likely scenario' enabling a financial plan that would cover the necessary allocation for Winter to support Urgent & Emergency Care and COVID-19 resilience, but would not meet in full the phase 3 letter for elective and day case activity, particularly for routine elective and day cases. The STP Directors of Finance are finalising the income allocation for months 7-12 but the Board heard that the

executive is confident that allocation it will meet 'likely scenario'.

099/20 **Winter Plan**

Mr Hobbs presented the Winter Plan, which had been reviewed and endorsed by the Quality, Patient Experience and Safety Committee (QPES), PODC and the Performance, Investment and Finance Committee (PFIC).

The Winter Plan builds upon the successes of 2019/20, whilst recognising that COVID-19 makes this winter very different. It is therefore an Urgent and Emergency Care, and COVID-19 Resilience Winter Plan, based on a likely further resurgence of COVID-19 in the coming weeks. As a consequence the plan based on three key pillars.

1. A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than just opening more inpatient beds.
2. Following the success of a targeted approach to managing the Festive period last year, the same approach will be adopted for 20/21 (19th December 2020 to 10th January 2021). Operational services over the key weekend and bank holiday days will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges.
3. Maximising the £4.1m Department of Health capital investment recently awarded to ensure our emergency care pathways are COVID-19 resilient. This includes increasing Emergency Department (ED) waiting room capacity, creation of additional assessment unit capacity in Medicine and Surgery, additional cubicle capacity in ED and ensuring sufficient Winter ward capacity through the relocation of the Frail Elderly Service.

Interventions within this year will cost £3.361m plus a further £1.336m of revenue funding to deliver the £4.1m urgent and emergency care capital schemes. The total cost of this year's Urgent and Emergency Care and COVID-19 resilience Winter Plan is therefore £4.697m. This compares to £2.246m in 2019/20, with the increase reflecting the considerably greater resilience needed to safely manage the combination of usual Winter Pressures and COVID-19 resurgence.

Dr Lewis noted that the model will provide better quality of care, better access to the services, specialists, therapies, better access to imaging and endoscopy, and avoiding unnecessary delays in hospital.

Mr Gayle informed the Board that, as Chair of PODC, he would like to see the support that we have on offer for staff already in place more particularly drawn out in the Winter Plan. This will sets a clear message to staff that they are our priority and can see themselves in the plan for what is set to be a non-standard winter.

The Board **approved** the Urgent and Emergency Care and COVID-19 Resilience Winter Plan, noting it was a comprehensive plan built on last winter's successes and in anticipation of a second wave of COVID-19. Initiatives in place to demonstrate that staff are valued and will be supported through the winter pressures were to be included in the plan.

Action:

Initiatives in place to demonstrate that staff are valued and will be supported through the winter pressures were to be included in the Winter Plan.

100/20 **COVID-19 Board Assurance Framework**

The Board reviewed the Board Assurance Framework (BAF) risk for COVID-19. Mr Hobbs informed the board that this risk had been significantly revised since the first wave of COVID-19 and was reflective of the current position.

Mr Hobbs pointed out the score of 20 should be noted as major, not moderate. Mrs Bradbury's requested the rationale for the risk score include the nosocomial deaths in wave 1, and Mr Hobbs confirmed the next iteration would incorporate that.

The gap in assurance on the slower completion of BAME (Black, Asian Minority Ethnic)/vulnerable staff risk assessment was raised by Ms Oum, and Mrs Griffiths informed the Board that completion of risk assessments took a three stage approach, which included a wellbeing conversations with managers to ensure action was taken locally swiftly; a workplace assessment; and then risk stratification tool was deployed. Progress on identifying the changes made to workplace practices has been slower than was desirable, however organisational hierarchies are now being used to drive compliance which will make the second round of assessments more efficient, and has resulted in a 2% overall increase in the completion of assessments. PODC will continue to scrutinise both the quantitative and qualitative aspects of the assessments.

Action

Nosocomial deaths in wave 1 to be included in rationale for risk score.

PROVIDE SAFE, HIGH QUALITY CARE

101/20 **Quality, Patient Experience and Safety Committee Highlight Report**

Mrs Bradbury, Chair of QPES, presented the highlight report from their 24th September meeting, noting as follows:

- The Safe, High Quality Care BAF was presented to QPES on the new template with detailed discussion on related corporate risks.
- The committee endorsed the Urgent and Emergency Care, and COVID-19 Resilience Winter Plan from a quality, patient safety and experience perspective;
- The committee endorsed the Quality Account with the caveat of adding a quality priority for COVID-19.
- The Committee endorsed the St Giles Hospice transfer and were assured that mitigations were in place regarding quality of care and staffing - in particular medical cover.
- The committee were not assured on the process to complete the 'must do' and 'should do' CQC actions, and further information on these will come to the committee in October.
- The quality impact assurance process and governance will be scrutinised by the committee in October.

102/20 **Executive Report – Provide Safe, High Quality Care**

Dr Lewis presented the Safe, High Quality Care executive report covering the BAF and corporate risks, performance and improvement programme elements of this strategic objective, noting as follows:

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

- 19th August: Clinical Commissioning Group (CCG) visit to the Emergency

Department and Maternity, the outcomes of which were largely positive, particularly of our infection prevention and control.

- 8th and 9th September: CQC visiting the ED and Maternity looking at paediatric pathways in the ED.
- 17th September: NHSI who were joined by the CCG visiting Maternity, Neonates, Therapies and the Emergency Department.

Following the visit by the CQC on 8th and 9th September, subsequent concerns were raised by them regarding management of patients with sepsis. The CQC reviewed 22 sets of notes, and with respect to 4 for adults and 4 for children felt these could have been managed better in the recording and management of sepsis. Matters raised included safeguarding mandatory training and the mix of nurses and medical staff to allow them to manage critically ill children. Dr Lewis informed the Board that an action plan had been developed to address all issues raised and provide immediate assurance on the pathways. It was noted that the EPR functionality which is being accelerated in ED and paediatrics, will enable observations on patients to be carried out not only in a way that is mandated, but will enable them to be easily audited.

Dr Lewis noted that response rates to complaints have risen to over 90% which is a significant improvement. The Faculty of Research and Clinical Education (FORCE) were awarded £50,000 from the Clinical Placement Expansion Programme for undergraduate placement expansions, and to support the growth of education and training across healthcare professions.

The Board raised concerns over the number of out of date policies and guidelines and sought assurance on how this was being addressed, particularly as this was a concern raised previously by the Board. Dr Lewis and Ms Davies advised the Board that the divisions have a programme for review of the policies to ascertain if they require updating, or are considered necessary, particularly given recently introduced online resources which may make some policies redundant. The Well Led improvement programme has, as a key priority, the automation of the policy process, including automated reminders which the Trust does not currently have, and has now recruited a policy lead to support the roll-out of that programme and improved IT.

The risk score for corporate risk 2066: (There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience) was reduced from 20 to 16 in response to reduced vacancies and maintenance of fill rates. This was debated in QPES and will be reviewed there regularly to monitor changes over Winter.

The Board heard that measurement of the continuity of care, midwife to birth ratio in maternity services was paused nationally through COVID-19 and is now being restarted. This will be monitored through QPES.

The Chair requested vigilance over the areas where progress is made and then slips back such as policies, level 3 safeguarding and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Ms Whyte noted that level 3 safeguarding is improving, albeit slowly, and is being closely monitored with oversight at QPES. Dr Lewis advised that the conference on MCA/DoLS in July was now available for staff on the Trust intranet; consent forms have been reviewed; easy reference guidance has been issued; and the perfect ward app will provide more localised ownership of the issues and actions.

Action:

QPES were requested to monitor how the perfect ward app provides more localised ownership of issues and actions for MCA/DoLS.

103/20 **Quality Account 2019/20**

The Board received the Quality Account for 2019/2020 which had been reviewed by QPES, and endorsed virtually by the Audit Committee.

The quality priorities for 2020/21 were developed with patients, staff and members of public. The priorities are aligned to and will be driven by the improvement programme, with oversight by QPES on delivery and improvement.

The Quality Account was **approved**, subject to editorial amendments and the inclusion of a further priority on reducing health inequalities given its priority to the Trust.

Action

Inclusion of priority on reducing health inequalities to be included in Quality Account for 2019/20.

CARE AT HOME

104/20 **Walsall Together Partnership Board Highlight Report**

Mrs Baines, Chair of the Walsall Together Partnership Board presented the highlight report from their 23rd September meeting, noting as follows:

- The clinical and service model for enhanced care home support services was approved. This was based on a model the partnership introduced in response to COVID-19, is has now been adopted as a permanent provision, and has been cited as good practice in the Social Care Taskforce Report.
- There are concerns in terms of community colleagues receiving required weekly testing for COVID-19.
- During recent virtual board walks by the Mrs Baines and Mr Diamond with the ED, an increase in mental health attendances, both in terms of volume and severity, were noted. Walsall Together is offering support to mental health partners who are also seeing a similar pattern across the Black Country.
- The Trust Board attended a Board development event on integrated care partnership requirements and options. This will be further explored with the Partnership Board over coming meetings.

105/20 **Executive Report – Care at Home**

Mr Fradgley presented the Care at Home executive report covering the BAF and corporate risks, performance and improvement programme elements of this strategic objective, noting the following:

The inpatient unit formally known as St Giles went live this day, 1st October, and is fully accredited from all aspects including the CQC, and will have its first patient from Monday 5th October.

Health inequalities are being addressed in the Walsall Together with the development of a partnership health strategy, drawing together the various partner roles to strengthen this as a golden thread. A joint strategic lead has been appointed to coordinate this and any actions will be cascaded throughout the partnership to work together to address health inequalities, and individually to provide assurance.

The EPR go-live provides an opportunity to deploy a shared care record across multiple providers.

Availability of swabbing for care home staff remains a concern, with anyone providing care needing a test each 7 days, and the swabbing regime has been unable to match this. Mr Fradgley is monitoring this with Public Health.
The outpatient redesign has 70% of clinics being conducted virtually. The second phase is a major transformation to addresses changes in pathways and will be led by the clinical teams.

VALUE OUR COLLEAGUES

106/20 **People and Organisational Development Committee Highlight Report**
Mr Gayle, Chair of the People and Organisational Committee, presented the highlight report from their meeting on 24th September, noting as follows:

- As discussed earlier in the meeting, Mr Gayle pointed out that the Winter Plan needed to address the health and wellbeing issues for colleagues.
- The Committee received the BAF and corporate risk register, and noted additional controls in place, and were assured on the actions being taken to address the risks.
- Simon Johnson, Engagement Consultant, presented feedback from staff on what 'valuing colleagues' means to them and how to measure this. The Committee has asked for assurance on the plan to continue with engagement initiatives once Mr Johnson's work has finished and that will be considered by the Committee in coming meetings.

Ms Oum informed the Board that the BAME Cabinet, which was established as a Board task and finish group to accelerate the programme of workforce race inequalities had generated a range of short and long term priorities and so was now preparing for the transfer of this work to the Equality, Diversity and Inclusion Group that reports to PODC.

107/20 **Executive Report – Value our Colleagues**

Mrs Griffiths presented the Value our Colleagues executive report covering the BAF and corporate risks, performance and improvement programme elements of this strategic objective, noting as follows:

The feedback which Simon Johnson received from staff on what valuing colleagues means to them will be applied to the Accountability Framework and run through the divisional performance review meetings on a regular basis.

The shared decision making model through the care excellence programme is having a positive impact, with colleagues engaged and seeing the benefits that this is bringing to patient safety, and colleague experience.

Targeted support has been provided to key areas where poor staff experience has been highlighted through staff stories, boardwalks, and 'pull up a chair with the chair'. PODC have oversight of the actions, and it was agreed that a high level overview would be provided to the Board on the outcomes.

Analysis has taken place to ensure the Trust's People Plan encompasses all elements of the National People Plan, and one area identified where the gap is being address is flexible working.

The need to ensure there are clear management structures and hierarchies in place to

drive accountability and ensure data is available in a timely way was brought into focus when reporting on BAME and vulnerable colleague COVID-19 risk assessments. This is being addressed by seeking qualitative measures directly from the divisions and staff themselves, and making the most out of the Electronic Staff Record to extract the quantative measures.

Support is in place via the Faculty of Medical Leadership and Management to develop leaders at the divisional and care group levels. This is coupled with the management development programmes within the Trust's existing offering for wide reaching leadership development to colleagues beyond the divisions and care groups.

108/20 **Safe Staffing**

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

- The Registered Nurse (RN) vacancy rate is currently 7.57%.
- 23 student nurses are expected to convert to substantive posts during September and October so will further reduce the vacancy rate.
- The ward establishment review process is taking place throughout September and will be reported through the Committee structures in October. The role of Nursing Associates will be included in the establishment review, and the Board noted the importance of this programme as a responsible anchor institution, providing opportunities for the people of Walsall, particularly at a time when many of them have lost their jobs.
- The overall Nursing and Midwifery fill rate was 99.45% in August - an increase of 3.4% since July.
- Temporary staff use remains in control limits, primarily due to substantive redeployment and increased empty beds across a number of wards. Ms Whyte, in response to a question on the sustainability of this trend during winter pressures by Mr Beeken, informed the Board that rosters will be closely monitored for early sign off and to enable more timely use of the bank, and use of tier 1 agency over tier 2, particularly in ED where a number of the new RNs will be starting in October and reducing reliance on tier 2.
- Bank utilisation has increased in nursing and strategies to continue a Tier 2 reduction are in place.
- Nursing areas report Red Flags events, i.e. alerts which warn when nurses in charge must act immediately to ensure they have enough staff to meet the needs of patients. In August there were 70 Red Flags, which is a slight increase, with the majority being recorded for the reason of 1:1 care. Red Flags are monitored at twice daily staff meeting and actions put in place.
- A number of steps have been taken to address concerns in Wards 2 and 16 through the triangulation of Red Flags, complaints, harm incidents and matron audits. Reviews outside the division have been conducted and action plans developed which will be monitored through the division and reviewed again in November.

Ms Baines enquired how Ms Whyte and Ms Riley, Interim Director of Nursing, were gaining assurance directly from staff on the front line as to how they are feeling regarding staffing ratios. Ms Whyte informed the Board that she and Ms Riley meet regularly with the front line and more junior levels through several forums including band 5 and 6 calls, and meetings with ward managers and matrons, all of whom can raise concerns with them. In addition, the perfect ward app provides the opportunity to ask more questions of front line staff on staffing levels and capture that more formally than has been possible in the past. Such information will be included in the safe staffing report when that data is available to triangulate the assurance.

109/20 **BAME Colleagues Update**

The Board noted that much of the discussion on risk assessments for BAME and vulnerable colleagues had been discussed in previous agenda items, however Ms Griffiths advised the Board that risk assessments for BAME colleagues is now 95.5%, with 87% of risk assessments being completed overall, and 89% for staff with known risk factors. TMB is working collectively to ensure assessments are completed and to provide the qualitative and quantative data to PODC.

Mr Virdee requested that all line managers are reminded of the importance of documenting reasonable adjustments and any limiting imitation factors in the employee record.

USE RESOURCES WELL

110/20 **Performance, Finance and Investment Committee Highlight Report**

Mr Dunn, Chair of the Performance, Finance and Investment Committee, presented the highlight report from their meeting on 23rd September, noting as follows:

- The quality of papers to the Committee for these meetings was excellent.
- The activity analysis year on year from August 2019 to August 2020 is around 75%, however costs have increased by around £2m. Understanding that COVID-19 is a factor in this, the Committee is looking at this in more granularity in October in order to provide necessary assurance to the Board that this is reasonable.
- The November meeting will review a detailed analysis of the backlog maintenance issues and risks, which will be reported to the Board thereafter.
- The Committee sat in extraordinary session on 28th September to review the Digital Aspirant Funding programme, which will be discussed in the Private Board.

111/20 **Executive Report – Uses Resources Well**

Mr Hobbs and Mr Caldicott presented the Use Resources Well executive report covering the BAF and corporate risks, performance and improvement programme elements of this strategic objective, noting as follows:

The BAF risk was updated with Non-Executive Director input and now reflects the broader resources under the Trust's stewardship, namely financial resources, human resources, physical asset resources (estate and equipment) and technology resources. This has been reflected in updates to the corporate risk register which were discussed at PFIC.

The Trust has delivered the 4-hour Emergency Access Standard for four consecutive calendar months and was the 32nd best performing Trust nationally out of 114 reporting Acute Trusts in August 2020. Mr Hobbs noted that, as the ED team adjusts to the new EPR system, performance will deteriorate in the short term.

The Trust is ahead of its trajectory to recover the DM01 6-week wait Diagnostic standard following the impact of Covid-19 on elective care earlier this year, and is now the 5th best performing Trust nationally out of 123 reporting Acute Trusts in the most recently published national statistics (July 2020).

The Trust is now ahead of its trajectory to recover the 18-week Referral To Treatment waiting time standard following the impact of Covid-19 on elective care earlier this year, and is 32nd best performing Trust nationally out of 122 reporting Acute Trusts in the most recently published national statistics (July 2020). Mr Hobbs noted that the likely

scenario of income modelling does not provide for further resources to invest in shortening elective time.

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

The Trust attained break-even performance for month 5, but did so spending £10.5m more than was provided in the initial block contract, equating to approximately £2m per month in top up funding. The Board noted that the additional top up funding has been paid to the Trust for months 1-4, therefore it is expected that a break-even position will be reported for months 6 also. Mr Caldicott noted that by way of benchmarking, the Trust's level of top up slightly below the average.

Whilst pointing out there is a risk that things may change, Mr Caldicott was confident of securing funding for the likely scenario discussed during the restoration and recovery item. He noted however that there was uncertainty as to the income for months 7-12 at this stage.

The improvement programme development session which the Board participated on ahead of this meeting demonstrated the direction of travel to capture efficiencies under the Use Resources Well objective, and PFIC will continue to have oversight of this.

Whilst there have been significant capital allocations this year to address backlog maintenance, there is still risk in this area, with PFIC discussing the longer term needs and capital funding requirements to mitigate and manage that risk when it meets in November.

Ms Oum queried the process for developing mitigations to address the high risk ratings in the BAF and corporate risk register. Mr Caldicott advised these will be addressed in a number of ways, including certainty on income attainment in the coming weeks; the estates review which has been commenced and will inform mitigation strategies and capital planning for 2021/22; and further development of the improvement programme with respect to efficiencies over the coming months, feeding into the planning cycles at the end of the year.

Ms Oum sought further detail on the cyber-attack risk given that the review date had passed, and Mr Fradgley responded that, as the Trust's Senior Information Risk Officer, there are no risks he feels the need to escalate to the Board, however the assurance will be available following completion of the risk review and third party review, both of which are underway.

WORK CLOSELY WITH PARTNERS

112/20 **Executive Report – Work Closely with Partners**

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

The BAF risk has been updated to reflect evidence of successful partnership working and demonstrable progress in functional service integration in further specialties. This is coupled with the risk that the pace of partnership integration work may be impeded by limited leadership capacity and by the lack of formal integration at organisational levels between Trusts.

The Work Closely with Partners improvement programme reflects the work of Divisional Teams and the progression of functional integration between Acute Hospitals overseen to support improved patient care, and improved working lives for the people of Walsall.

The Urology workstream has been reinstated and held its first network workshop since COVID-19 on 22nd September 2020. Work continues to define and confirm future arrangements for both cancer and benign elective services and emergency urology services.

Radiology has been formally added to the programme and collaborative work between Walsall Healthcare, Royal Wolverhampton and Dudley Group has begun. The second Imaging network workshop took place on 11th September 2020.

The Board discussed the opportunities that exist to collaborate with the mental health trusts and the work that Walsall Together are doing in this regard to lead that partnership working.

GOVERNANCE AND WELL LED

113/20 **Audit Committee Highlight Report**

Mr Caldicott presented the highlight report from the Audit Committee in the Chair, Mr Heer's absence, noting the meeting on 28th September was a focused session for internal audit. At that meeting the internal audit plan was endorsed, noting that the programme encompassed all Head of Internal Audit report requirements.

The Committee received the BAF and Risk management reviews and noted the progress against recommendations with both reviews.

In addition, the Audit Committee endorsed the Quality Account virtually.

114/20 **Revised BAF Reporting and Governance**

The Board received the full BAF, noting that the individual BAF risks had been presented through each of the executive reports above. The Board noted the summary of the BAF risks and the heat map on the revised template.

Ms Davies pointed out that there are gaps in the third line of defence for Value Our Colleagues, but noted that there are planned audits for this year which will close those gaps.

115/20 **Governance and Well Led Improvement Programme Update**

Ms Davies presented the Governance and Well Led Improvement Programme update, noting that the programmes of work for Board Governance; Assurance; and Business Planning Processes were making good progress.

The Integrated Governance programme recently held a workshop to further develop the project initiation document, with a particular focus on tier 2 groups that report into Board committees and their connectivity in an integrated fashion.

Mr Caldicott, the lead for the Accountability and Support programme noted the valuing colleagues elements of the accountability framework have been developed, and the wider framework is being formed by a multi-professional group.

Ms Davies and Mr Caldicott reported they were confident of getting the Integrated Governance and Accountability and Support programmes back on plan and through

Board committee structures by the end of the year.

116/20 **NHSI Undertakings**

The Board reviewed the responses to the revised NHSI undertakings signed by the Trust in October 2019. Ms Davies noted that the first area rated as amber included Board, Executive, and Triumvirate development, all of which are underway or planned.

The Board approved the undertaking responses.

117/20 **Questions from the Public**

Ms Usher, expressed Staffside's support to the strengthening of the Winter plan with the health and wellbeing programmes for staff. Ms Usher offered her assistance to work alongside Ms Davies on the system for policies to ensure staff are not overwhelmed with requests to review policies.

Ms Usher pointed out that the Trust should be sharing the good news stories and telling staff when we are doing well, as it helps to boost morale.

The meeting finished at 15.55.

118/20 Date of Next Meeting
Thursday 5th November 2020

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

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
042/20	04/06/20	BAF & CRR	The BAF will continue to remain on the Board agenda each month until further notice.	Director of Governance	Monthly	Will remain open action for the agenda for foreseeable future	Open
043/20	04/06/20	Performance Report	PODC at their meeting in June to review remodelling of the workforce to test resilience should there be a second wave, and to include the impact of 'test and trace' on staff availability.	PODC	05/11/2020	Verbal update for 5 November meeting *Update from 1 October meeting:* Additional guidance has been received and has been incorporated into restoration and recovery work; a colleague hotline has been established to quickly respond to queries and more active modelling is taking place over the coming weeks. To leave on the action log as PODC is not fully assured. To return 5 Nov. Update for 3 September meeting: This will not be determined until October. Update from 2 July Meeting: To remain open until the impact of track and trace can be determined.	Open
042/20 Pvt Brd	6/4/2020	Impact of COVID-19 on BAME Colleagues	PODC to review quantitative measures i.e. compliance with completion of risk assessments, and qualitative measures i.e. the quality of the conversations and proportion of assessments resulting in change in workplace practices.	PODC	05/11/2020	Verbal update for 5 November meeting *Update from October Meeting:* Action transferred from Private Board 01/10/20. PODC have been updated on quantitative and qualitative measures at the July, August, and September meetings. Further updates will be provided in October and November. Updates have been reported to Board. PODC has requested a process be Committee, and the Trust Board, that workplace practices have changed where appropriate for BAME colleagues as a result of risk assessments. Currently that information is not centrally held, however there is progress on this with Trust Management Board and directorates.	Open

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
085/20	9/3/2020	Value our Colleagues	The use of staffing against the use of beds and the costs included within for ease of comparison to be included in future Safe Staffing reports	Director of Nursing	05/11/2020	Verbal update for November meeting *Update for October meeting:* Work is ongoing with finance colleagues with the aim to have data available from October	Open
097/20 (a)	10/1/2020	Acute Collaboration	Mr Beeken to update the Board on communications with staff re acute hospital collaboration	Chief Executive Officer	05/11/2020	Extensive discussion with Trust Management Board has taken place. Internal clinical senate meetings being planned to engage Matrons and Clinical Directors in the clinical case for change. Further Trust-wide communications were planned but have been deferred owing to the need to get clear messages out re: COVID resilience and IPC	Complete
097/20 (b)	10/1/2020	Acute Collaboration/Value Our Colleagues	Board to be updated on the process and outcomes of the work underway to target support being provided to five key services/departments	Director of People & Culture	05/11/2020	*Update for November meeting:* PODC will receive the full assurance report in December on the outcomes from the Organisational Development work and interventions for each area receiving support. The planned interventions are on schedule.	Open
099/20	10/1/2020	Winter Plan	Initiatives in place to demonstrate that staff are valued and will be supported through the winter pressures were to be included in the winter plan.	Chief Operating Officer	05/11/2020	Complete – updated Winter Plan document with strengthened Staff Wellbeing narrative reviewed at PODC 3 Nov. Remains open until reviewed at PODC.	Open
100/20	10/1/2020	COVID-19 BAF	Nosocomial deaths in wave 1 to be included in rationale for risk score.	Chief Operating Officer	05/11/2020	Complete – included in updated Covid-19 BAF risk assessment.	Complete
102/20	10/1/2020	Safe, High Quality Care Exec Report	QPES were requested to monitor how the perfect ward app provides more localised ownership of issues and actions for MCA/DoLS.	QPES	05/11/2020	Verbal update for November meeting	Open

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
103/20	10/1/2020	Quality Account 2019/20	Inclusion of priority on reducing health inequalities to be included in Quality Account for 2019/20.	Director of Governance	05/11/2020	A Board priority has been added aligned to the Walsall Together priority "supporting and developing collective responsibility to reduce health inequalities and provide better outcomes for the people of Walsall, through the development of a Population Health and Inequalities Strategy for Walsall"	Open
Complete							
Open							
Delayed (1 meeting)							
Overdue (14+ days)							

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Trust Board Chair's Report			**AGENDA ITEM: 6**
Report Author and Job Title:	Danielle Oum, Trust Board Chair	**Responsible Director:**	Danielle Oum, Trust Board Chair
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This is a regular paper providing oversight of Chair and Non-Executive Director activities. The paper includes details of key activities undertaken since the last Trust Board meeting.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no specific risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	This report sets out the commitment of the Board to equality, diversity and inclusion, and the work the Board has done this month to shape the Equality, Diversity and Inclusion Strategy.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

CHAIR'S UPDATE – OCTOBER 2020

1. The Board held two Equality, Diversity and Inclusion Development Sessions on 5th and 19th October. These sessions followed the responses received to the staff survey, discussions held with colleagues during Pull up a Chair with the Chair, staff stories heard at Board, and Board walks, all of which provided an opportunity for the Board to shape the Trust's Equality, Diversity and Inclusion Strategy. The Board discussed its confidence and competence on equality, diversity and inclusion, and committed to 'shifting the dial' on this very important topic. Both the Roger Kline ten actions for Boards and Professor Kevin Fenton's seven actions on health inequalities will feature largely in the strategy. As I mentioned in September, the next step is to finalise the strategy and implementation plan which will be shared with staff, patients and partners.

2. The Pull up a Chair with the Chair sessions have provided a wonderful insight into the issues concerning colleagues at the Trust and I would like to extend my thanks to all who took the time to meet with me. I am continually sharing the themes that arise from these sessions with the wider Board and the executive in order to bring about tangible change.

3. During Freedom to Speak Up month I wrote a blog sharing my reflections on the importance of the Trust progressing against the principles of Freedom To Speak Up.

4. The BAME (Black, Asian, Minority Ethnic) Cabinet continued to meet in October to provide creative thinking and a sounding board in order to accelerate progress on workforce race inequality.

5. I continue to participate in regular COVID-19 updates session with executives and non-executive colleagues, and took part in a regional leadership call with Sir Simon Stevens (CEO NHSI/E) and Amanda Pritchard (Chief Operating Officer NHSI/E) to discuss priorities around restoration of services, the continued response to COVID-19 and national support available to the Trust.

6. An important part of the role of a Board member, and a Chair in particular, is taking place in discussions to understand the wider system issues, risks and opportunities to ensure they are factored into discussions at Board and Board Committees, particularly as we move towards more collaborative ways of working. During the month of October I attended the NHS Midlands STaR Board; NHS Reset Chair's meeting on health inequalities; inequalities planning meeting and working group meetings; Clinical Commissioning Group restoration and recovery meetings and provider collaboration meeting; and Public Health England inequalities sub-group workstream meeting. The acute collaboration sub-group established by the Board met on a number of occasions to support progress of the Trust towards acute collaboration.

7. The Trust's first virtual Annual General Meeting was held on 29th September, and it was a great opportunity to showcase the work that the Trust did in 2019/20, and that which is planned for 2020/21. The video of the meeting, and the Trust's 2019/20 annual report, is available on the Trust website.

8. The Board development session that took place on 1st October provided further detail on the benefits that will be realised from the Trust's Improvement Programme, which revolves around the strategic goals of:

    - **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

    An additional workstream for Governance and Well Led rounds off the programme which will see a number of initiatives over the next three years that will provide the platform to deliver an Outstanding CQC rating by 2022.

9. On 30th October I took part in a livestreamed Teams chat for staff facilitated by Jacqui Watkey of Trust Library Services for Black History Month and Libraries Week. We discussed equality, diversity and inclusion, and reviewed June Sarpong's book Diversify.

MEETING OF THE PUBLIC TRUST BOARD - 5th November 2020			
Chief Executive's Report			**AGENDA ITEM: 7**
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	**Responsible Director:**	Richard Beeken, Chief Executive Officer
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	This report provides the Chief Executive's (CEO) overview of the risks to delivery of the Trust strategic objectives and actions the CEO is leading and sponsoring, to address gaps in controls and assurance. It provides the Trust Board with a view into the delivery of our strategic objectives through the rapidly changing external tactical and strategic context.		
Recommendation	Members of the Trust Board are asked to: • Note the content of the report • Discuss its contents • Determine whether there need to be any changes to the focus and actions of the CEO as reflected in this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report sets out the key immediate and strategic risks to the delivery of our Trust strategic objectives and describes the CEO's personal areas of focus and action to mitigate those risks. The Board are invited to discuss the report and any changes it wishes to see in CEO focus in the coming weeks and months.		
Resource implications	There are no resource implications associated with this paper.		
Legal and Equality and Diversity implications	There are no legal or equality and diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

CHIEF EXECUTIVE'S REPORT – 5th NOVEMBER 2020

1. EXECUTIVE SUMMARY

Last month, the Chief Executive's report and associated Board discussion focused on the ongoing efforts to meet the expectations of the phase three elective, diagnostic and community services recovery agenda. This included considerations as to how, without clarity on the financial envelope for the rest of the financial year, the Trust was to prioritise its actions within an estimated financial envelope. As of this month, that financial income allocation is now certain, thanks to the efforts of our Director of Finance, working closely with Strategic Transformation Partnership (STP) partners, to agree an allocation formula for that income, from within the overall STP allocation. That allocation of course, includes the COVID-19 top up element to our income, prospectively allocated, so we must manage our wave 2 COVID-19 response and winter plan commitments, within that envelope negotiated.

As a Board, we agreed last month that our priorities for the coming period of winter and wave 2 of COVID-19, combined with the restoration, recovery and redesign of services, will be:

- Protecting the most vulnerable in Walsall, particularly through action we can take to reduce the health inequalities in the borough via the Walsall Together partnership
- Maintaining the safest and most responsive urgent and emergency care system we can for winter 2020/21
- Reducing backlogs in urgent elective and cancer elective and diagnostic pathways
- Implementing the practical actions set out in the NHS People Plan, through the Value our Colleagues work stream of our #FromNowOn Improvement Programme

I am assured that all of the above priorities are manageable within the income envelope for the rest of the year, albeit the pace of elective and diagnostic recovery may be slowed, but not reversed, by virtue of either financial or practical capacity constraints caused by winter and COVID-19 pressures beyond that modelled into our winter plan (agreed last month). Our attention is now turned as an organisation to managing the delivery of our strategic objectives, through the immediate filter of an unarguable second wave of COVID-19 already upon us, and the burgeoning demand of winter pressures on our community and acute services:

2. BOARD ASSURANCE FRAMEWORK

2.1 Safe, High Quality Care

Whilst our Board Assurance Framework (BAF) section devoted to this strategic objective, does not explicitly mention emergency access standard (4 hour performance) and associated risks, there is no doubt that this constitutional standard remains the best proxy indicator of patient safety and patient experience, within the urgent and emergency care field. Since the last Board meeting, our emergency services, both community and acute, have come under sustained pressure, reflective of both an increase in the COVID-19 incidence rate in Walsall (229/100,000 at the time of writing) and the onset of acuity and increased admission numbers that we experience in winter. Patient experience has been further compromised in the emergency portals by virtue of:

- Needing to resolve practical system configuration problems following implementing our new Electronic Patient Record (EPR), and;
- Deterioration in patient flow caused by unexpected outbreaks of COVID-19 in non COVID-19 wards within the hospital, necessitating immediate and time consuming moves to protect patients and staff alike

In the coming month, as Chair of the Black Country and West Birmingham (BCWB) Urgent Care Board, I will be resurrecting the process of system self-challenge on whether everywhere is delivering known national best practice in urgent and emergency care. I will also be assisting the Chief Operating Officer, Ned Hobbs, on ensuring that we (Walsall Healthcare) get the maximum from our urgent care capital allocation of £4.1 million, so as to radically improve the segregation of COVID-19 and non COVID-19 streams in urgent care and develop robustly staffed spaces which will mitigate the risk of corridor care delivery at the Trust. Holding everyone to their funded commitments and actions within the Trust winter plan will be a key action of the Trust Management Board going forward.

2.2 Care at Home

There has been good progress over the last month, within the Walsall Together partnership. Developments of note are:

- Increasing sophistication in how the partnership measures its outputs and outcomes through information reporting and evidence
- An enthusiastic response from NHSE/I at a meeting in which the maturity of the partnership and deepening its cohesiveness through deployment of an Integrated Care Partnership (ICP) contract, was tested by them
- Strong relationships now developing with the Primary Care Networks (PCNs) as our Trust is approached to be the vehicle for employing new staff they take on in areas like first contact practitioners and pharmacists

- An agreement with Black Country Healthcare NHS Foundation Trust to include the primary care facing elements of their service, within the scope of the partnership

There are significant potential future risks which we must work with partners to mitigate, most notably those relating to creating the investment needed to meaningfully tackle health inequalities in Walsall and also, ensuring that Walsall Healthcare's leadership of much of the integration agenda, does not lead to our dominance of ideas and action, nor to holding other partners to account for delivery of agreed actions. On the former, we have received correspondence from the Clinical Commissioning Group (CCG) Chief Executive, Paul Maubach, which sets out their commissioning intentions for next year and that clearly articulates how contractually, the CCG will agree with us a population health budget and place more and more services into scope of the ICP, creating the theoretical financial lever for investment in "place". We are keen to ensure that, as soon as possible, primary care services are included within the ICP more overtly and formally.

2.3 Working with partners

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

Over the last month, good progress has been made between the acute hospital leadership teams on further integration of Dermatology, Urology and ENT services. Our next area of focus is on diagnostic/imaging networking, which has significant potential to both standardise to best practice across the STP but also, maximise capacity available for the benefit of all BCWB residents. Over the coming month, I will be pressing the CCG leadership for resources to adequately programme manage integration of our imaging services, as I believe we are close to maximising what our clinical and management teams can deliver, in the context of extraordinary operational and strategic agendas. We are also likely to be working in partnership with The Royal Wolverhampton NHS Trust on the establishment of community diagnostic hubs, aligned again to national strategy.

From a wider, organisational collaboration perspective, we continue to, as a Trust, openly and positively work with partner Trusts on the development of the strategic case for change in organisational leadership and governance. The Trust Board can expect a document for discussion at its December meeting, which will unequivocally set out the benefits we expect to secure for the people of Walsall and our staff, from the collaboration. In possibly December, but more likely January, the Case for Change itself will be considered by all 4 Trust Boards and the CCG governing bodies. During November, we will, as a Trust, open up the clinical case for change conversation with our clinical and managerial leaders, such that we can confidently contribute to the STP-wide clinical case for change, which will necessarily follow and is targeted for Trust Boards towards the end of this financial year.

2.4 Value our colleagues

This month, I focus on the risks associated with "COVID-19 fatigue" and the occasionally fractured staff cohesiveness and esprit de corps which is emerging as a result.

One strong response from the executive team in terms of testing staff/employee temperature and mood, has been the systematic series of visits to every ward, service and department in the Trust, to take opinion on how the first wave of COVID-19 felt for our colleagues and how we might learn lessons to better manage expectations and anxieties as we enter the second wave. We are nearing the end of these visits now and, when combined with evidence from our Freedom To Speak up Guardians, Staff Side colleagues and non-executive led sessions also (I.e. Pull Up a chair with the Chair), we have a rich source of staff opinion at our fingertips now. Themes emerging which we cannot ignore are:

- Huge sense of foreboding about what winter, combined with a second COVID-19 wave, will bring
- Concerns about how staff will protect their family from infection, if they feel the Trust, as a responsible employer, is not doing everything we can to mitigate their risk of exposure to COVID-19
- Levels of emotional and occasionally, physical exhaustion which colleagues still haven't fully recovered from, caused by the first wave
- Perceptions about inequality of treatment, as employees, split by different staff group, or along lines of ethnicity
- A desire to have regular testing available for staff and an increasing demand for transparency regarding the availability and prioritisation of a COVID-19 vaccine

In response to these concerns, over the coming month my team and I will:

- Reduce our time spent in "virtual" meetings so as to increase our presence in our clinical services
- Re-establish the psychological support services which were so well received during the first wave of COVID-19
- Continue to value our colleagues' discretionary effort in extraordinary times by reviewing and where appropriate for example, revising our bank rates of pay
- Assist the People and Organisational Development Committee to scrutinise our approach to the assessment of each individual employee's risk factors and ensuring that there has been positive action taken for those colleagues deemed at greater COVID-19 related risk
- Continue to work with the Black Country Pathology Services leadership on lobbying nationally for the reagent resources required to satisfy both patient and staff demand for COVID-19 testing
- Work with STP partners and the regional team on the detailed logistical planning for the roll out of a possible COVID-19 vaccine. At present, active and detailed planning is being done on both supply, storage and distribution. However, we do not have confirmed details yet about the vaccines themselves, their efficacy or dates of availability. Both Trust Board and staff will be kept appraised immediately, should this situation change

- Continue to publicise our Board intentions and organisational plans on inclusion and equality, seeking to tackle issues which run contrary to our organisational values, at source
- Roll out our new accountability framework, which has valuing our colleagues and more three dimensional measurement of that work, at its heart

2.5 Use resources well

I address the issue of income envelope security in the executive summary section above. With the exception of the possibility of additional winter pressures monies coming to the BCWB system, and these monies if they come at all are likely to be marginal, we have certainty of our finances for the remainder of this year. Our task now, is to seek to mitigate financial risk by:

- Keeping as closely as possible to the winter plan and COVID-19 response commitments, ensuring that when financial run rates exceed plan, mitigating actions, equal to the pressure created, are deployed
- Continuing to use the Use Resources Well workstream of our Improvement Programme, with scrutiny and challenge from the Performance & Finance Committee, to develop robust plans for financial efficiency, based on true service and quality improvement, using improved corporate team support for our clinical services on evidence base, benchmarking and clinical best practice
- Linking our annual planning process to the improvement programme explicitly, so as to eradicate duplication or lack of clarity on organisational priorities and expectations
- Delivering all elements of our capital programme, both routine and developmental, to budget and on time. There are no immediate risks to this objective, at this time
- Continuing to use the Private Finance Initiative (PFI) contract assertively, to hold our Hard Facilities Management provider to account for its actions, particularly on planned maintenance

3. RECOMMENDATIONS

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

MEETING OF THE PUBLIC BOARD – 5th November 2020			
Operational Restoration & Recovery update			**AGENDA ITEM: 8**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer	**Responsible Director:**	Ned Hobbs, Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The Trust Board should be assured that: • The Trust has implemented a clear strategy that segregates the Outpatient & Daycase Centre (PFI) wing of the hospital for planned outpatient, diagnostic and procedural activity based on the specialist recommendations of the Infection, Prevention & Control and Microbiology teams. • Overall Trust referrals received to date are at 58% of pre-COVID-19 norm. • Outpatient capacity has been restored to 76%. The majority of this capacity is and will continue to be delivered by virtual means. • Elective Surgery has successfully recommenced on the Walsall Manor site with a designated post-operative ward and post-operative High Dependency Unit within the segregated elective wing of the hospital. The 5th, 6th and 7th elective operating theatres reopened during September. • Partnership working with Spire Little Aston continues to provide elective theatre capacity to supplement Walsall Manor Hospital capacity. The National contract for this will end by 31st December 2020, and the Surgical Division is currently in dialogue with Spire Little Aston leadership team about the potential to continue to secure access to elective operating capacity. • 6 week wait (DM01) Diagnostic wait times show clear evidence of recovery, and is ahead of trajectory. • Despite deterioration in elective waiting times, as measured through the 18-week RTT performance standard, due to the cessation in routine elective activity through March and April, performance relative to other Trusts continues to improve, at 24th best in the country at the end of August. • Despite significant deterioration in 6-week wait DM01 diagnostics performance due to the cessation in routine elective activity through March and April, performance relative to other Trusts continues to perform very well, with the Trust 13th best in the country at the end of August. The Trust Board will note the following significant risks. • Due to Infection, Prevention and Control precautions, current agreed plans do not deliver sufficient restoration of elective operating theatre capacity to meet the expectations from the Sir Simon Stevens and Amanda Pritchard Phase 3 letter, as debated		

	and agreed through the Restoration and Recovery Board Development sessions. The income scenario adopted includes no additional funding to differentially invest in reducing elective waiting times. • The clinical workforce to deliver elective surgical capacity is the same theatres, anaesthetics and surgical staff who supported Critical Care during the first surge. Protecting the wellbeing of a tired workforce is crucial during restoration, and has affected the pace with which services are restored. • If the Birmingham, Solihull & the Black Country Adult Critical Care collaborative network plan to limit the number of patients in individual critical care networks through inter-hospital transfers does not succeed, restoration and recovery plans will be adversely affected by the need for theatres and anaesthetics staff to support critical care.
Recommendation	The Trust Board is asked to note the contents of this report.
Does this report mitigate risk included in the BAF or Trust Risk Registers?	COVID-19 Corporate Risk 2051, approved at Trust Board 2nd April 2020. Risk 25 - Failure to achieve National Referral to Treatment Standards.
Resource implications	The Trust has responded to NHS England's *Request for Provision of System Capacity Requirements for 2020/21* which included resource requirements to meet NHS England's planning assumptions. The Trust's submission totalled 9.671m of capital and £13.300m of revenue. The Trust has been awarded £4.1m of capital to support Urgent & Emergency Care over Winter, and has received some Critical Care equipment through nationally procured routes. The Trust has received no further Restoration & Recovery capital. STP financial proposition to March 2020/21 for revenue funding is a separate agenda item for Private Board pertinent to Restoration & Recovery.
Legal and Equality and Diversity implications	The Government has agreed new legislation in relation to COVID-19, reflected in the Trust's COVID-19 Governance Continuity Plan updated and approved at Trust Board on 07/05/20.
Strategic Objectives	Safe, high quality care ☒ | Care at home ☒ Partners ☒ | Value colleagues ☒ Resources ☒ |

Walsall Healthcare NHS
NHS Trust

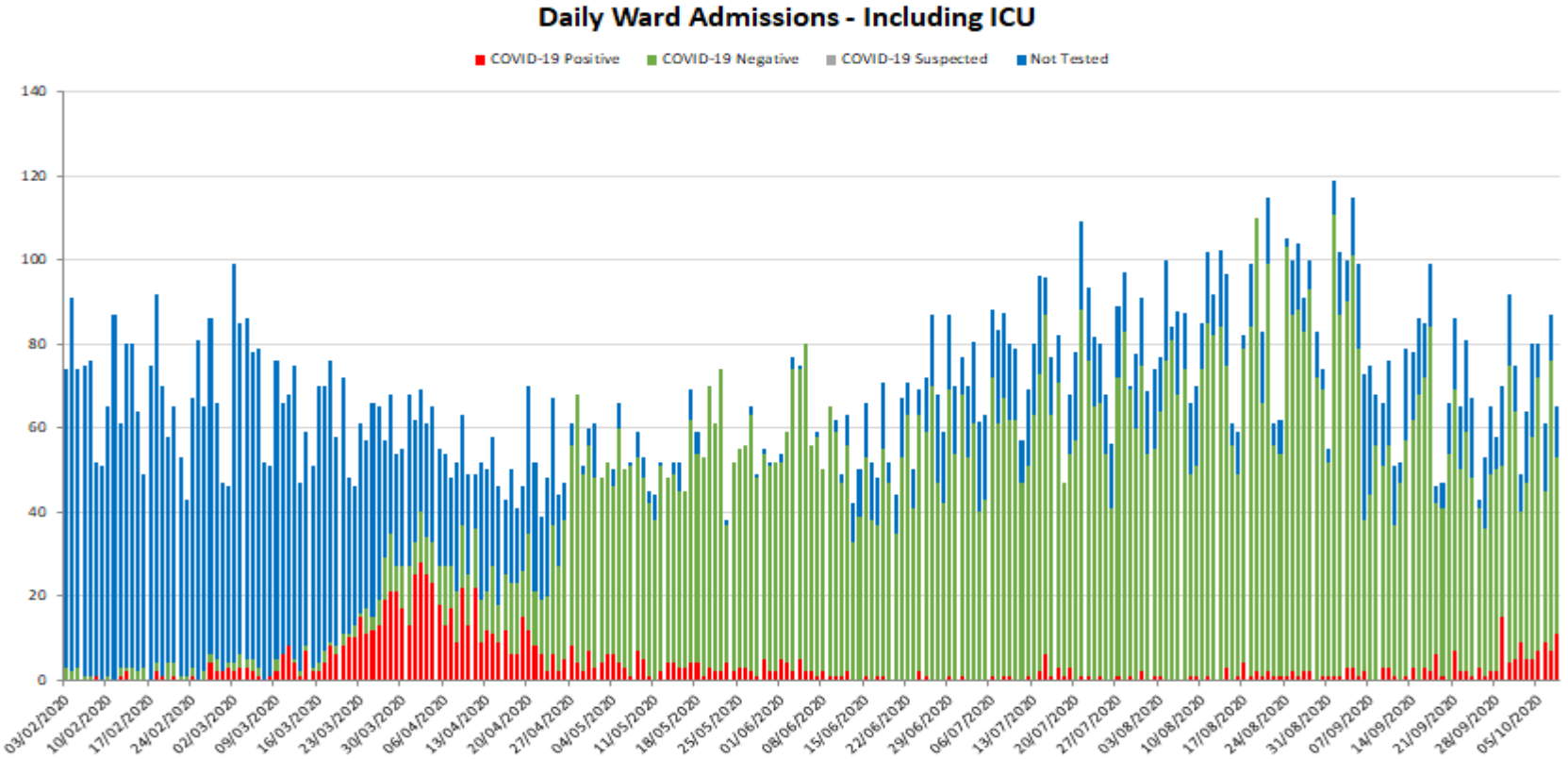
COVID-19 Operational Restoration and Recovery

Trust Board 5th November 2020

Caring for Walsall together

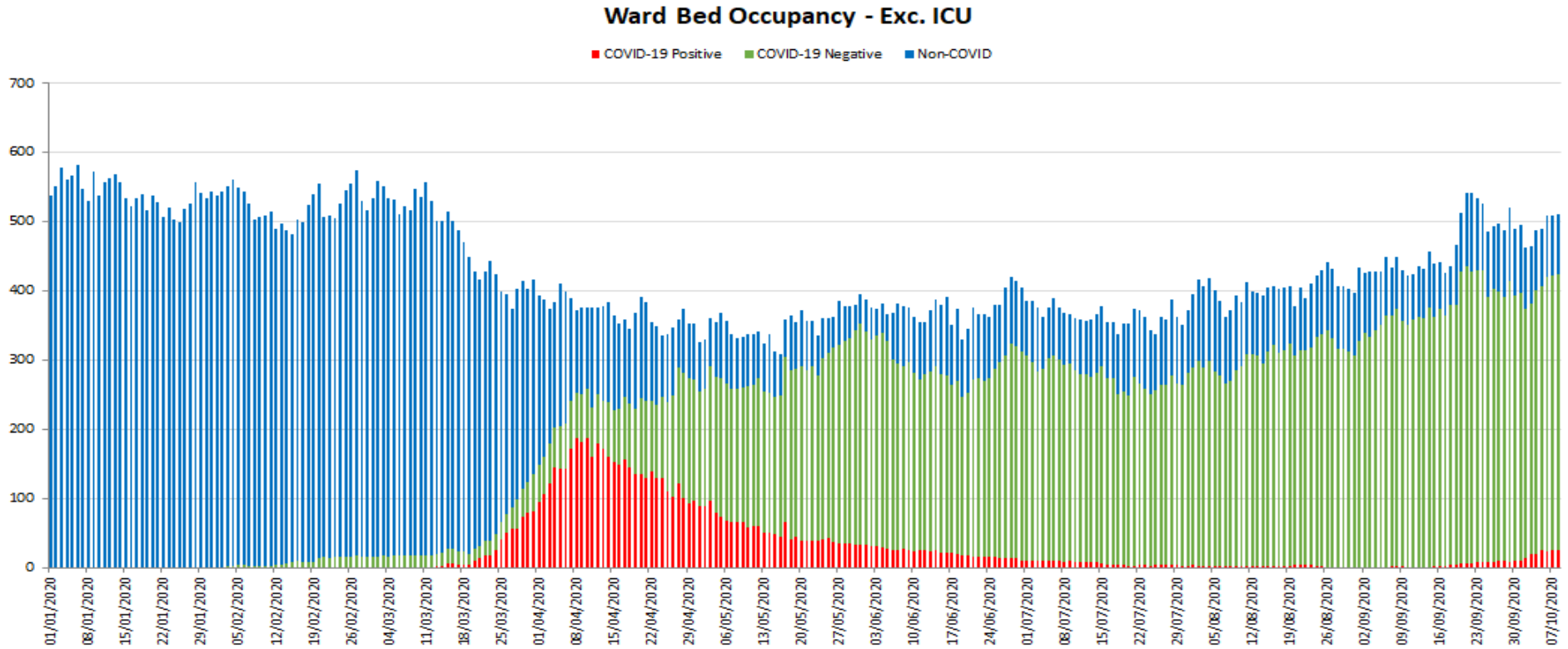
Contents

Introduction and context



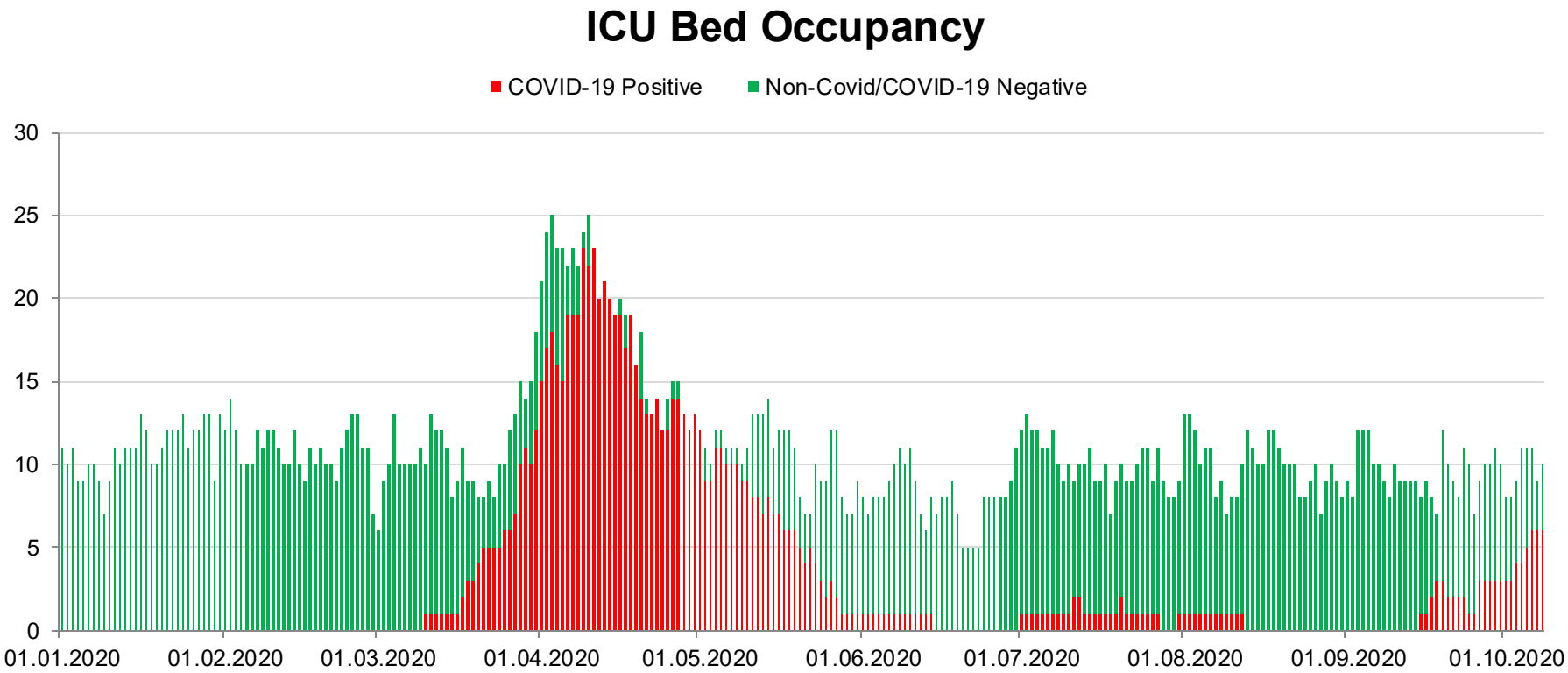
- COVID-19 admissions peaked in early April and are now rising gradually as part of the second surge.

Introduction and context



- Over 50% of inpatients were COVID-19 positive at the peak of the pandemic. Bed occupancy reduced to pre- COVID-19 levels but has now returned to near pre- COVID-19 levels.

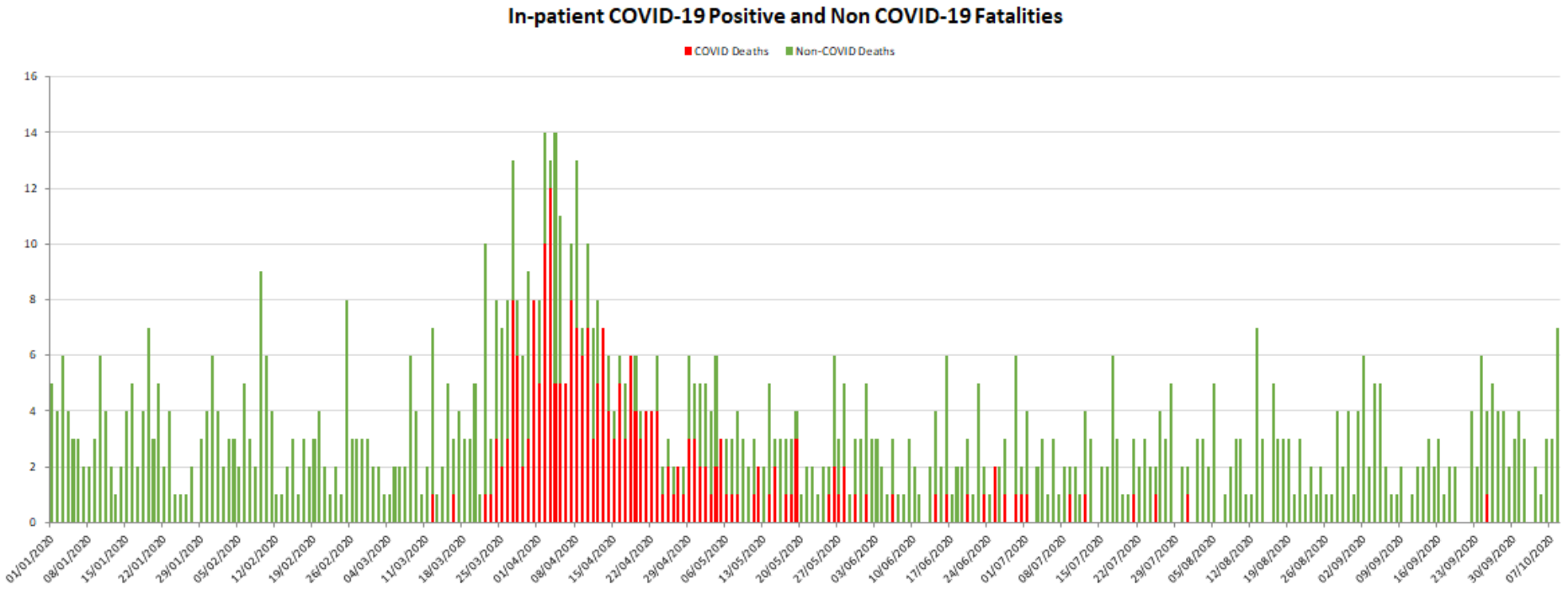
Introduction and context



ITU trebled its usual occupancy during COVID-19 peak. COVID-19 positive ITU patients have been increasing in recent weeks but total occupancy has been maintained thorough transfer out to other units in the Network

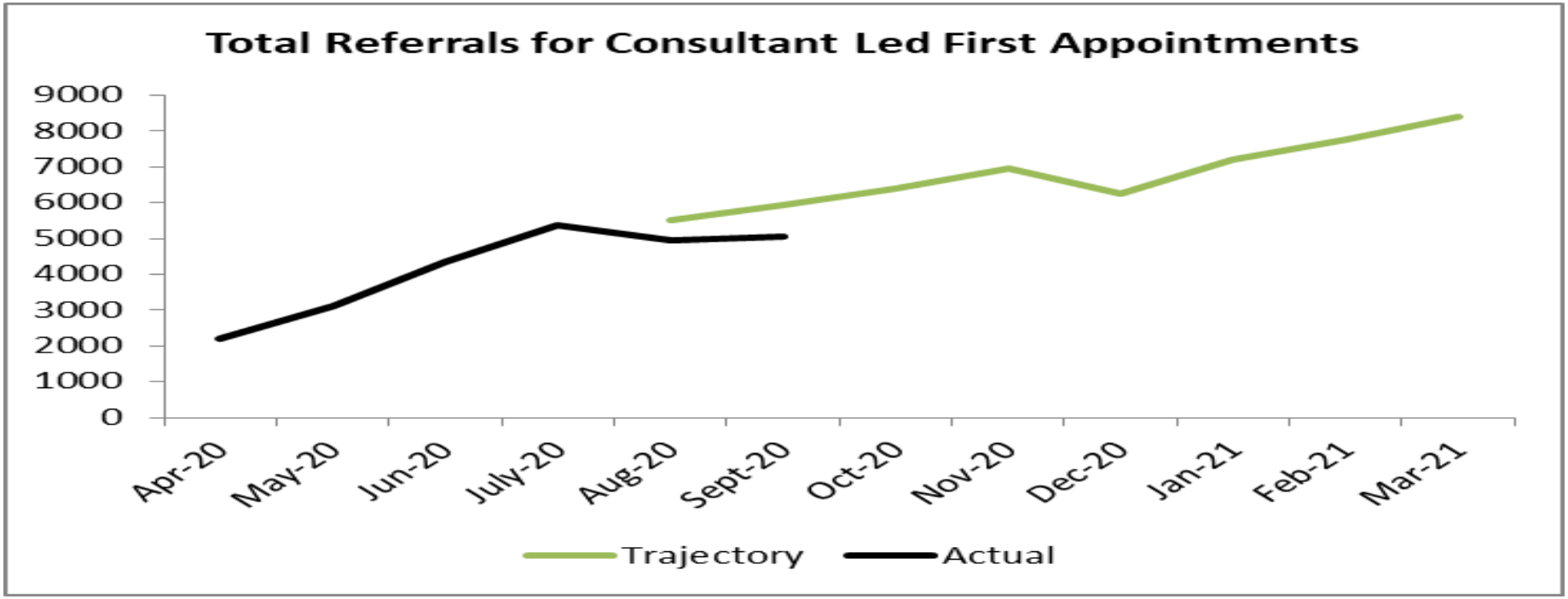
Walsall Healthcare NHS
NHS Trust

Introduction and context



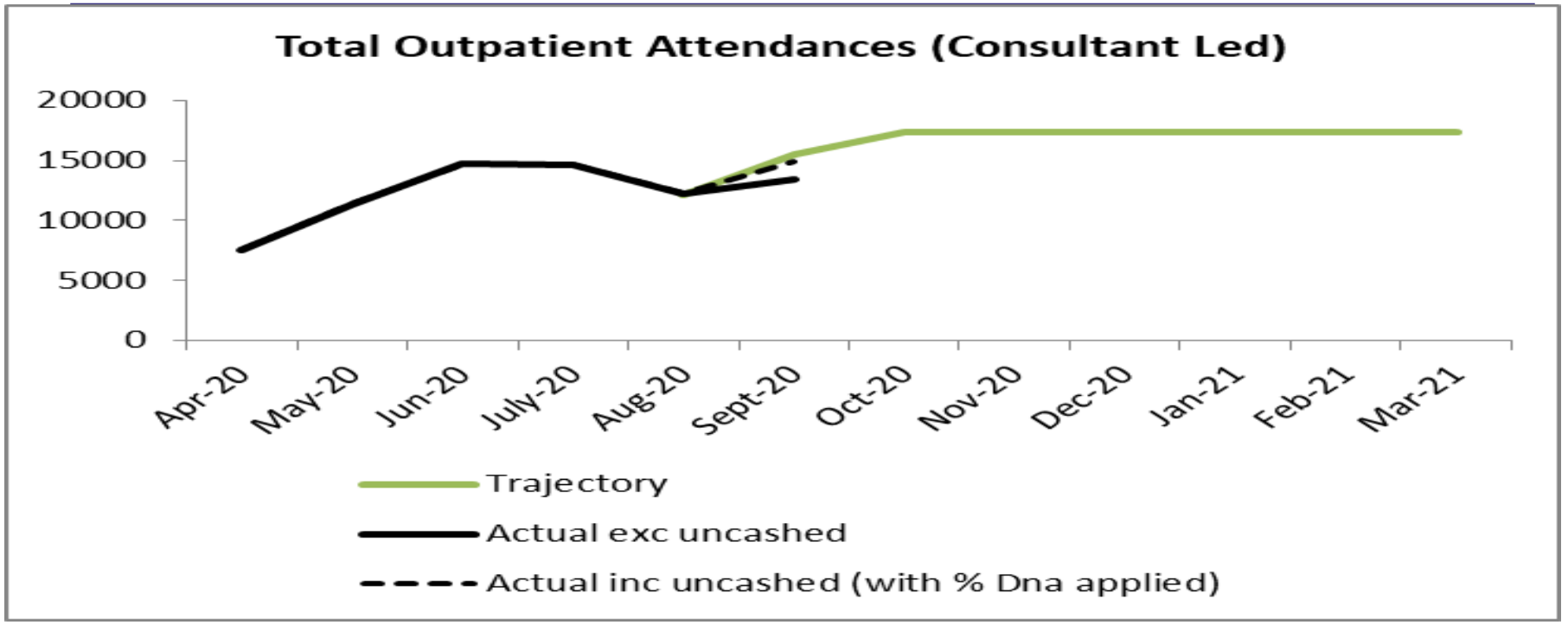
Inpatient hospital deaths peaked in early April and have now returned to pre-COVID-19 levels. Since September there has been an increase in COVID-19 admissions, however thus far they have not resulted in significant COVID-19 positive deaths.

Restoration & Recovery – Referrals



- Overall Trust referrals received to date are at 58% of pre- COVID-19 norm (2019/20 average). September saw similar levels of referrals received as August.

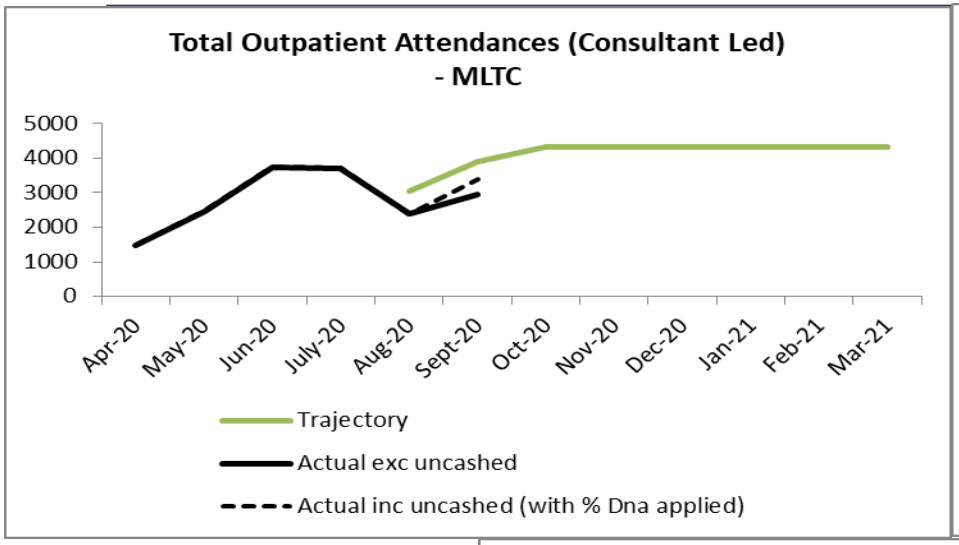
Restoration & Recovery – Outpatients

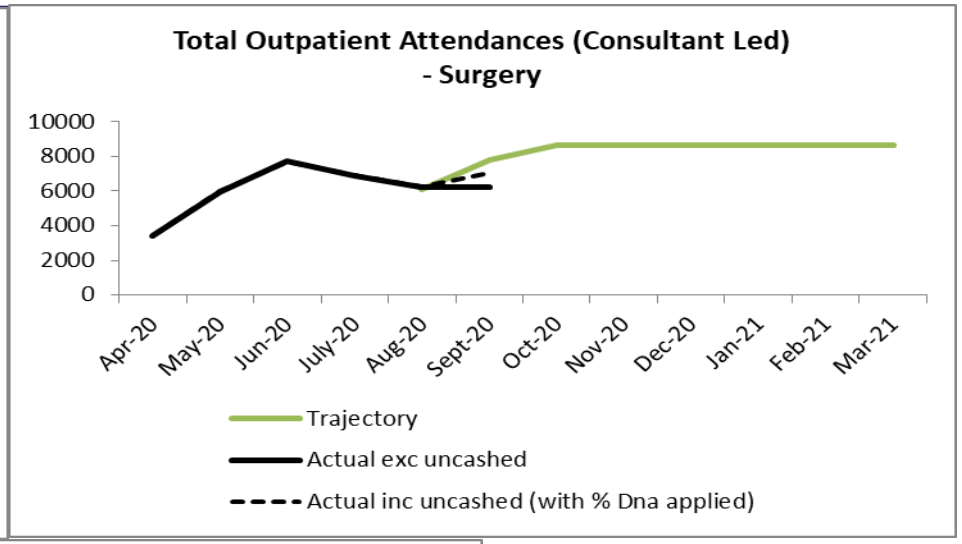


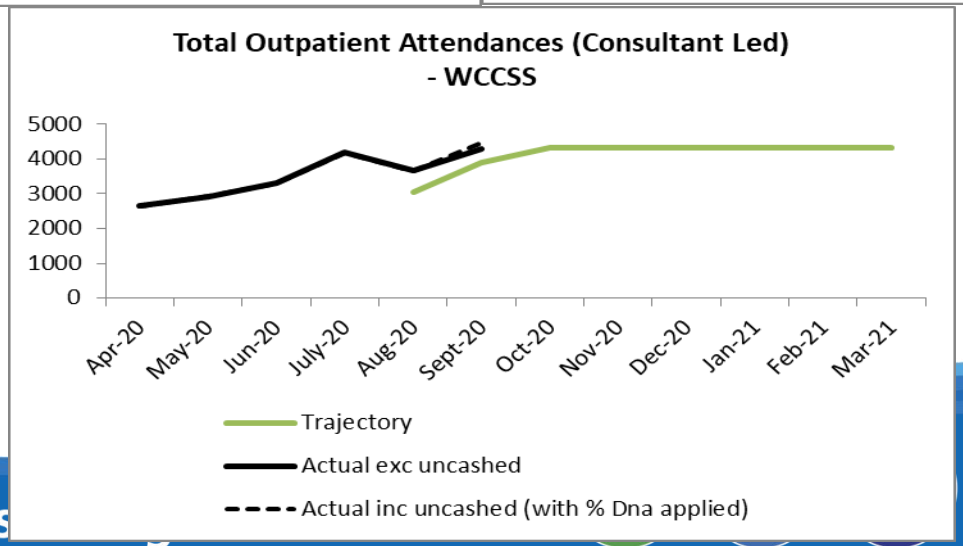
- Overall Trust outpatient activity restored to date is 76% of pre- COVID-19 norm (2019/20 average).
- September's data incorporates estimated additional activity for uncashed clinics following Medway go live mid-month (allowing for average DNA rate)

Walsall Healthcare NHS
NHS Trust

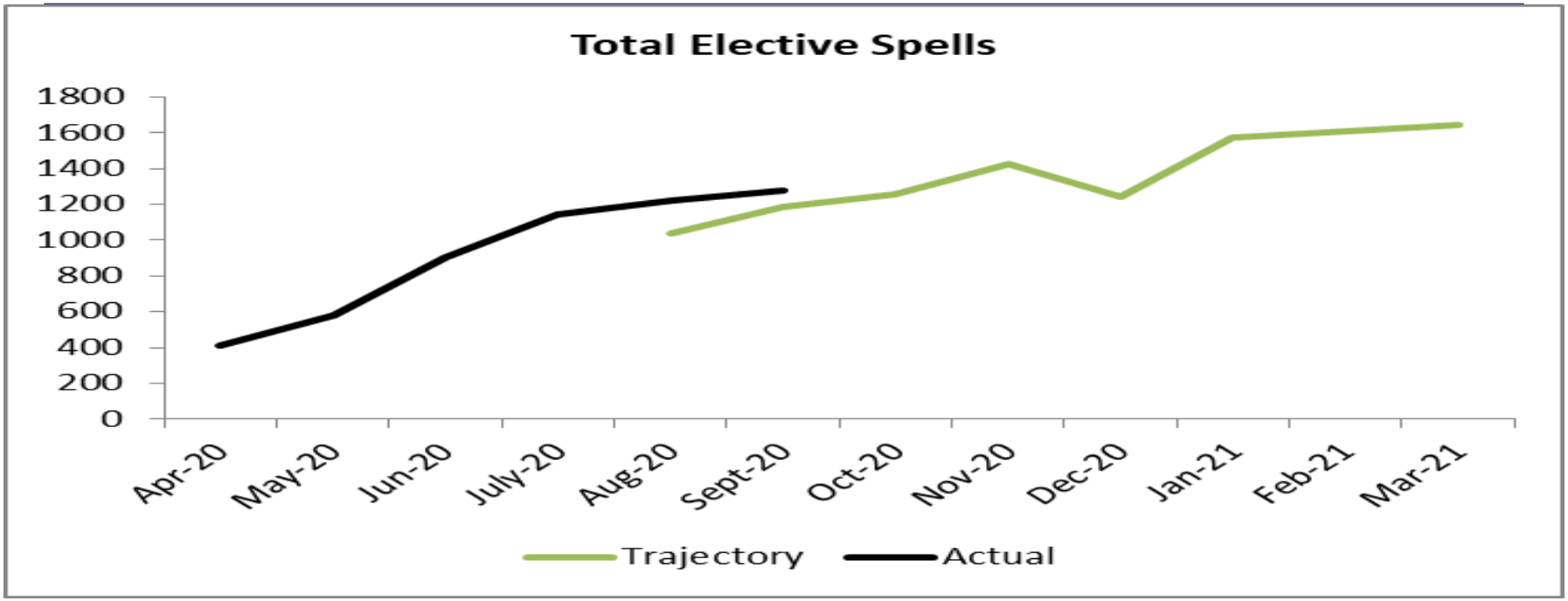
Restoration & Recovery - Outpatients





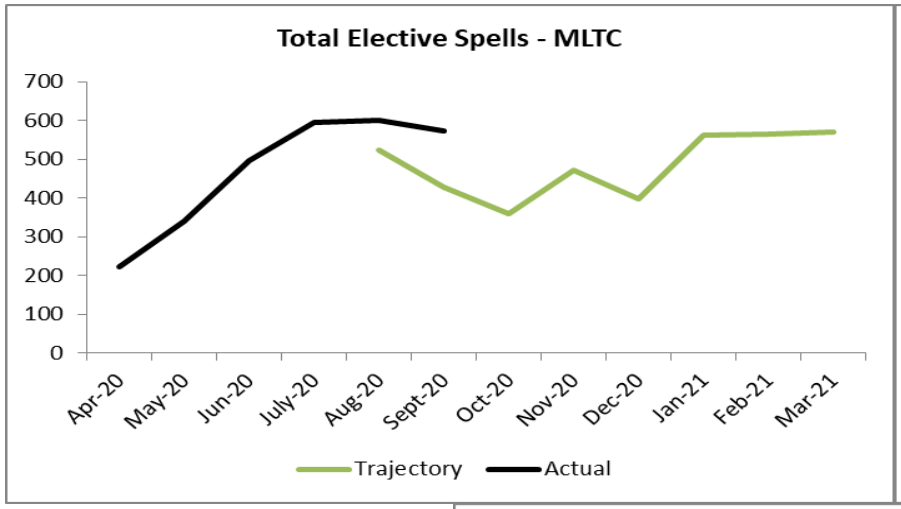


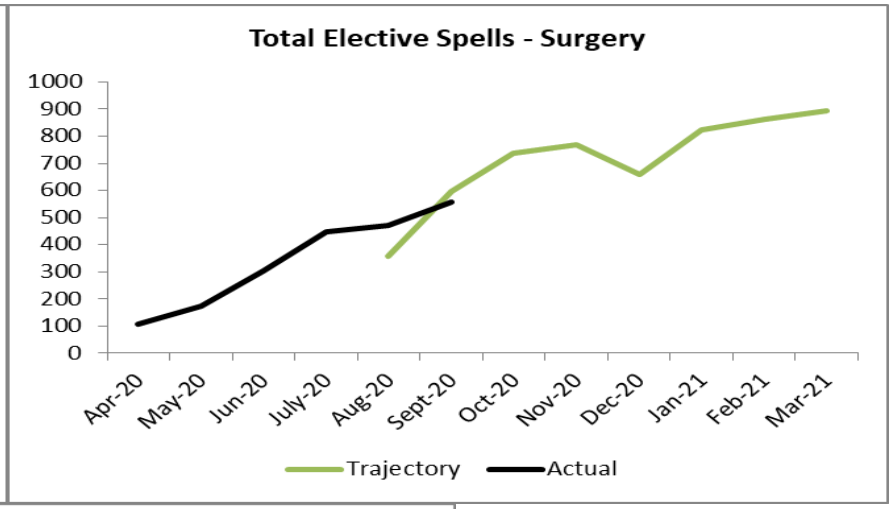
Restoration & Recovery – Electives/Daycases

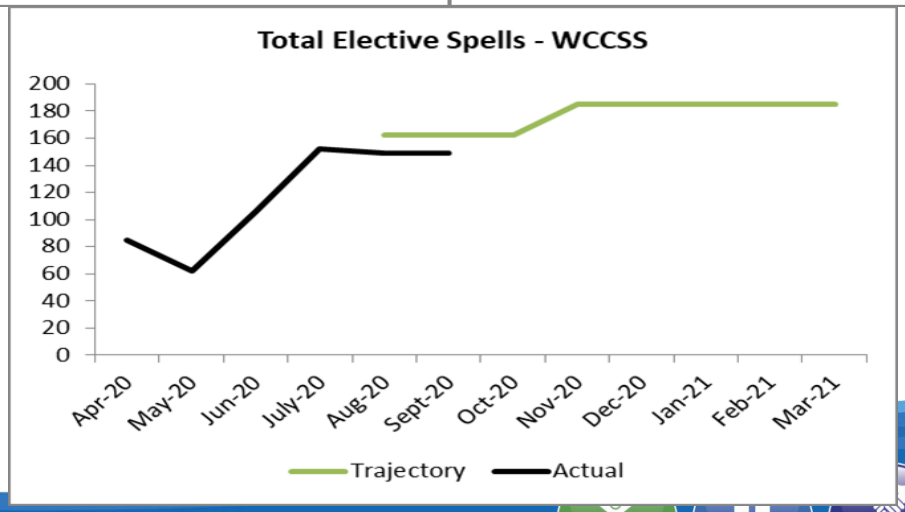


- Overall Trust elective activity restored to date is 62%. Theatre sessions have increased in September with the opening of the 5th, 6th & 7th elective theatre. This now provides 73 elective theatre sessions per week for use.

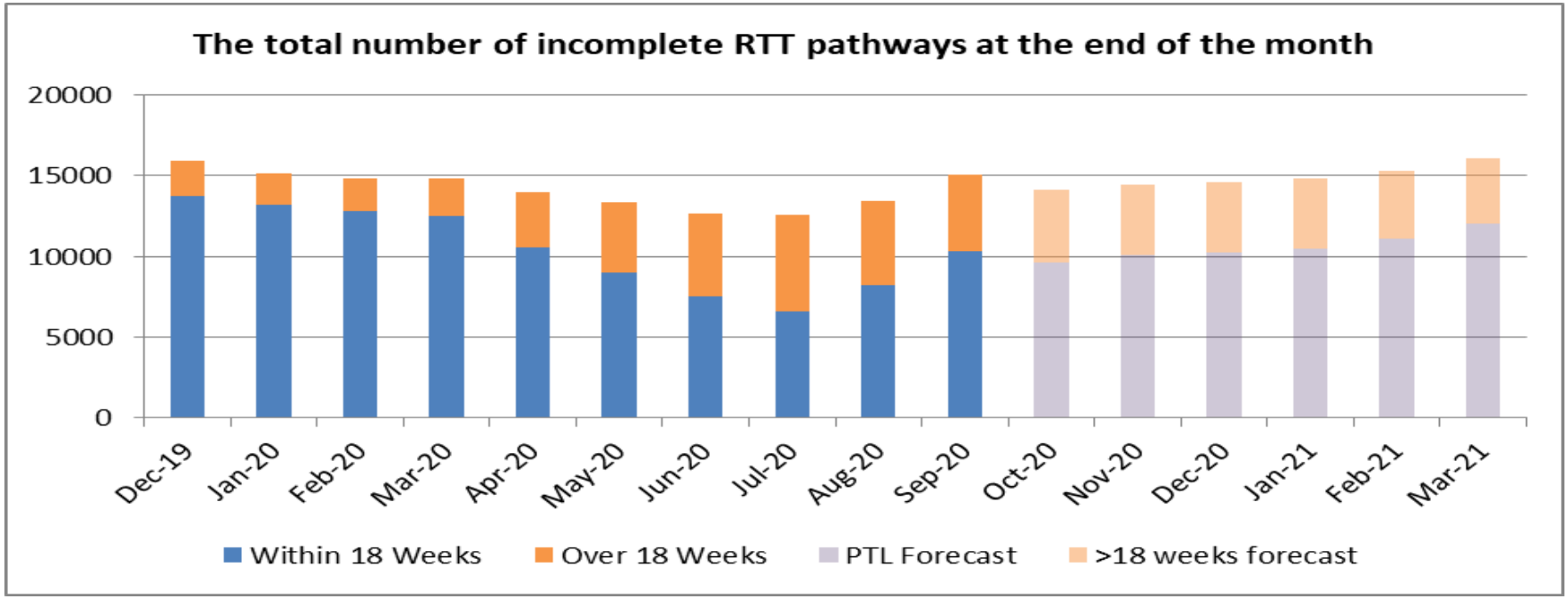
Restoration & Recovery – Electives/Daycases





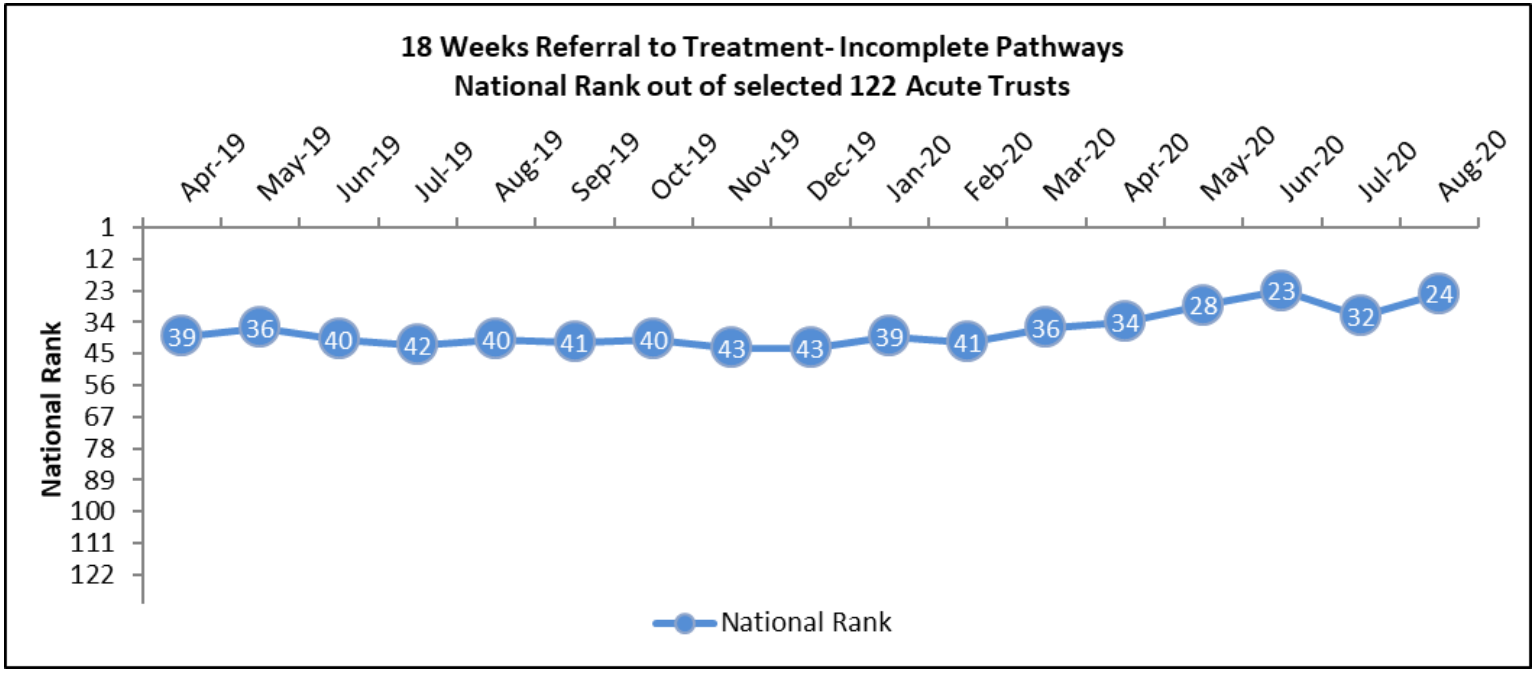


18-week RTT trajectory

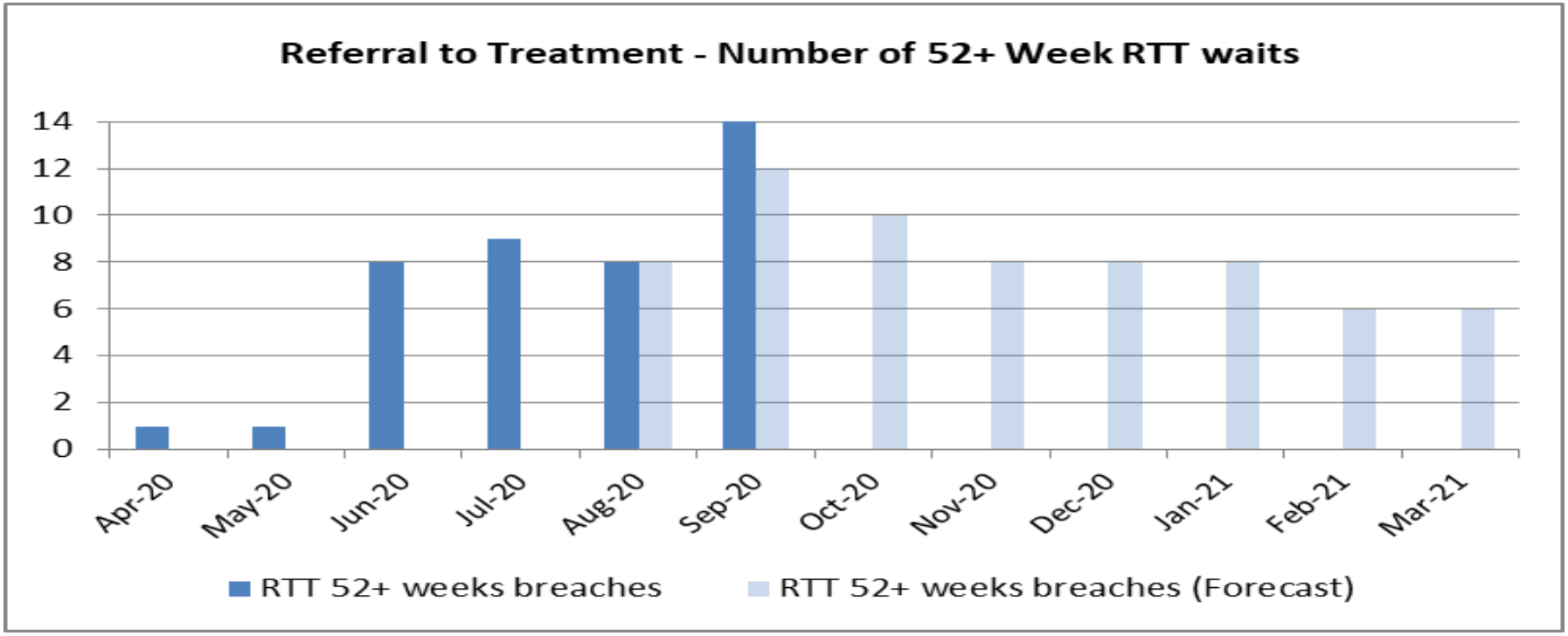


- There are 1,262 fewer patients waiting over 18 weeks at the end of September compared to the end of July. Continued COVID-19 IPC guidance for elective operating theatres will limit the speed with which patients waiting over 18 weeks can be reduced.

18-week RTT trajectory

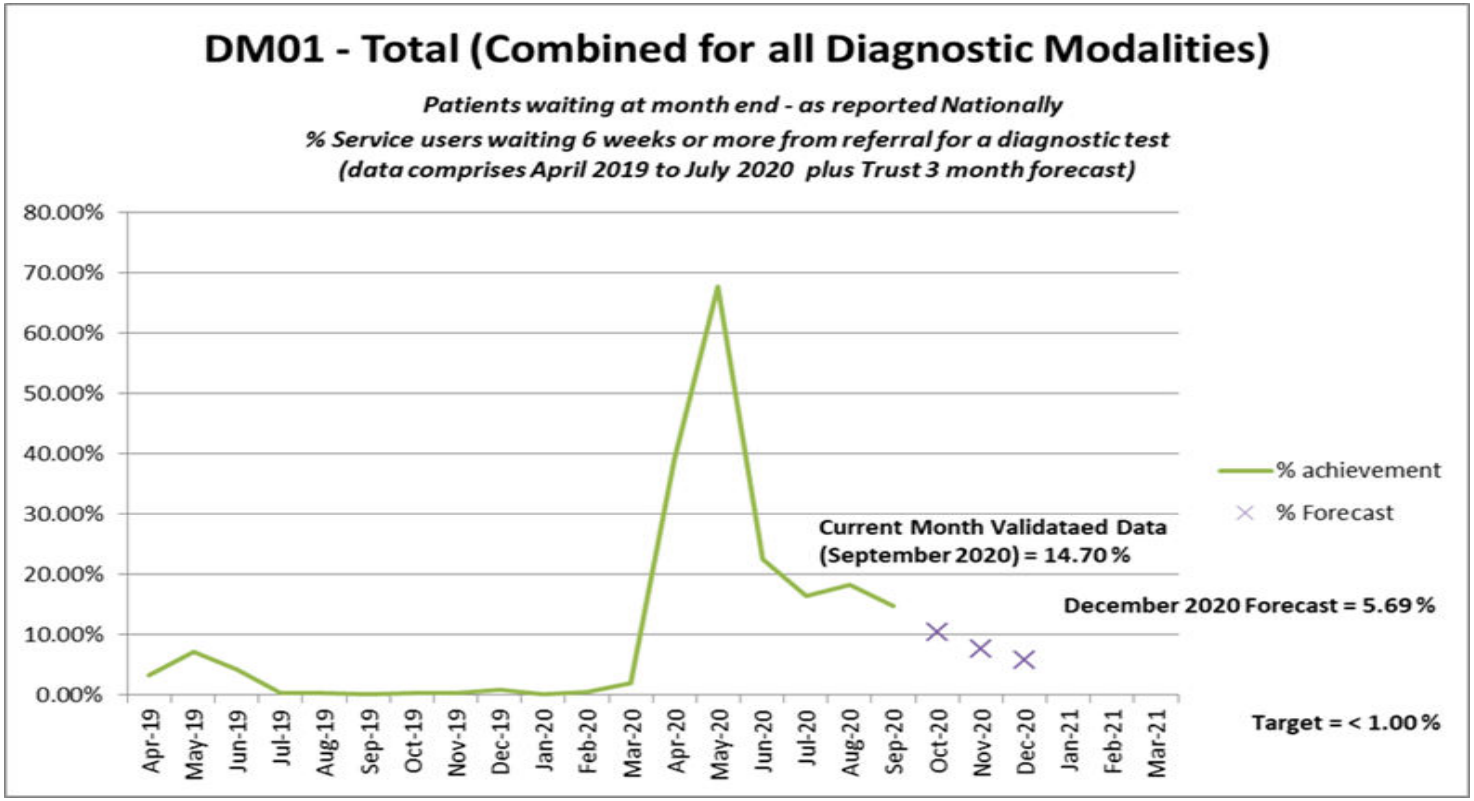


- Board should be assured that the Trust's elective waiting times are in the best quartile nationally, with the latest (August) national ranking placing 18-weeks RTT performance as 24th in the country.



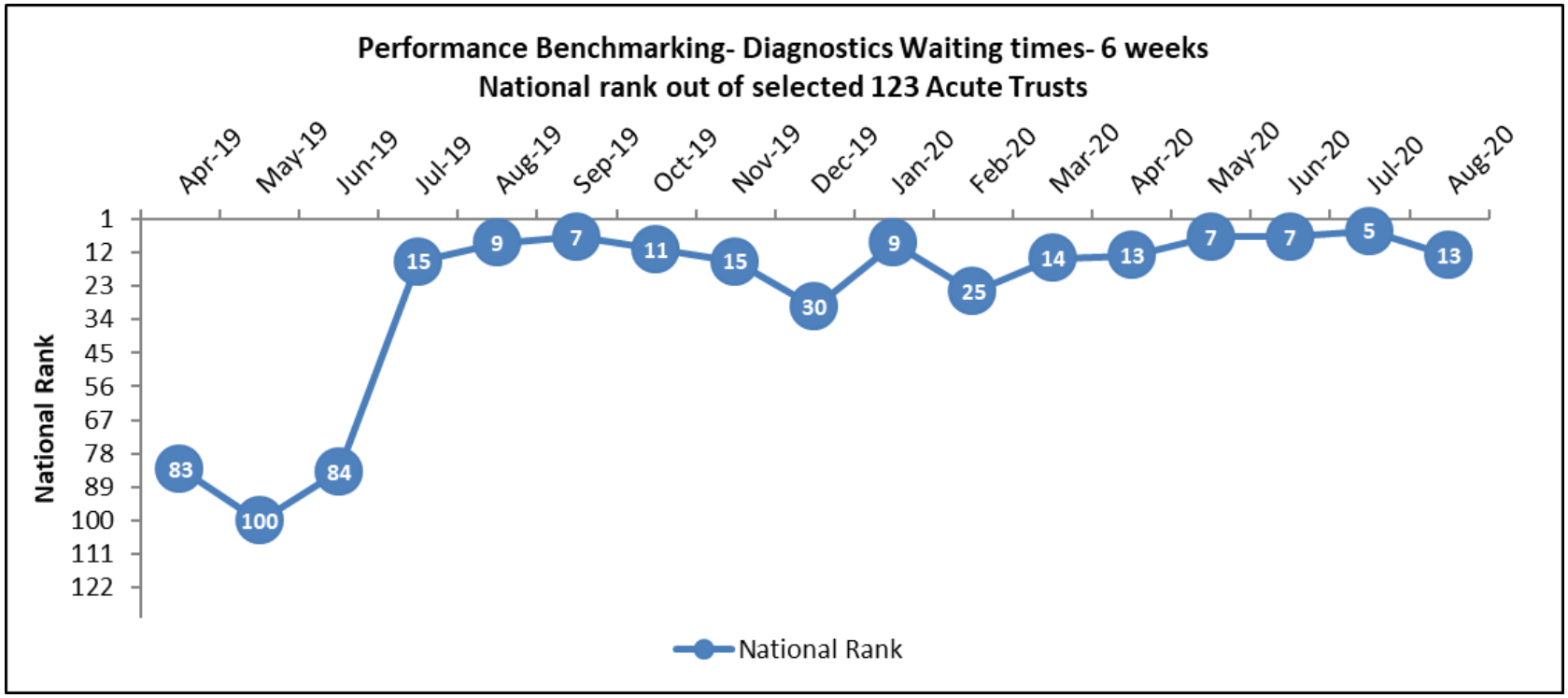
- There were 14 over 52 weeks breaches in September. It is anticipated that additional routine patients will be accommodated with the increase in theatre lists, but the risk of 52 week breaches will remain. The Surgical Division have forecast the number of 52-week breaches anticipated per month.

Elective Restoration – Diagnostics



- The number of patients waiting over 6 weeks for their Diagnostic test continues to reduce.

Elective Restoration – Diagnostics



- Board should be assured that the Trust's diagnostic waiting times are in the best quintile nationally, with the latest (August) national ranking placing DM01 performance as 13th in the country.

PUBLIC TRUST BOARD – 5TH November 2020
AGENDA ITEM: 9

Walsall Healthcare NHS Trust

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

Risk Scoring

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

- The initial wave of Covid-19 has had a profound impact on the workforce of the Trust. Almost 1 in 4 Trust staff who have undergone a Covid-19 Antibody test have been antibody positive suggesting a significant proportion of the workforce has experienced the disease themselves. Moreover, the challenges of managing the initial wave of the pandemic has had significant psychological impact on staff too.
- The Trust is operating in a highly uncertain financial planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19.
- The number of Covid-19 positive inpatients has reduced from over 200 at the peak of the initial wave to less than 10 over Summer 2020, and has subsequently risen to 31 as of 09/10/20.
- Covid-19 has profoundly exposed existing significant health inequalities in the population the Trust serves.
- Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust.
- 43 probable or definite Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	Governance: • Incident Command structure in place incorporating Strategic Command, Hospital Tactical Command, Walsall Together Community Tactical Command and Corporate Tactical Command. • Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. • Specific Covid-19 related SOPs and guidelines	• Individual committees consider specific impact relevant to their portfolio, i.e. Financial matters and Restoration and Recovery of elective services under PFIC; Quality, Safety and Patient experience matters under QPES and Workforce matters including staff wellbeing under P&ODC. • Board Development sessions (x2) on approach to Restoration and Recovery.	• Regional and National Incident Control structure.
Gaps in Control	• National directives and mandates impact on the Trust's ability to make local decisions. • 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	• Cancer waiting times in line with national average • Elective waiting times upper quartile for Diagnostics (DM01) and routine elective treatment (18-week Referral to Treatment)

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

Future Opportunities

- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables
- Opportunity to explore urgent care processes and establishment to deliver increased quality and efficiency of care
- Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough.
- Covid-19 has necessitated closer collaboration with other Acute hospitals which can continue to be built upon.
- Increased profile and appreciation of the NHS within the general public could be 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

Future Risks

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

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

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Approval of UEC & Covid resilience Winter Plan	COO	Oct 2020	Complete – approved at Trust Board 01/10/20	
2.	Completion of £4.1m UEC & Covid resilience Estate works to promote segregated pathways	COO	Dec 2020		
3.	Confirmation of M7-M12 Financial income settlement with STP	DoF	Oct 2020		
4.	Evidence of outcomes of BAME/vulnerable staff risk assessments to be presented to PODC	DoP&C	Nov 2020		

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Valuing Colleagues – Executive Update			**AGENDA ITEM: 11**
Report Author and Job Title:	Catherine Griffiths – Director of People and Culture	**Responsible Director:**	Catherine Griffiths – Director of People and Culture
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery for the valuing colleagues' strategic objective and provides an update on the mitigations in place to manage the risks identified, as well as the actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance relating to the improvement programme valuing colleagues' work-stream and performance against the valuing colleagues' strategic objective, this report highlights successes and identifies gaps and areas for improvement. This report provides an update on actions taken last month relating to the valuing colleagues work-stream of the improvement programme. The following points seek to inform the Trust Board of progress, identify where assurance can be taken and where required to seek approval for actions proposed. 1. The Faculty of Medical Leadership and Management's (FMLM) programme has restarted with invitations and dates being sent. The programme consists of the Triumvirate programme which has 8 modules that run from November 2020 through to May 2021, The Care Group Leaders programme has 2 cohorts with a total of 40 delegates. Again the programme starts in November. It consists of 7 modules and a further 5 internal modules, finishing in May 2021. 2. The Trust Board can be assured that compliance levels on the risk assessments have improved in the month to 95% BAME (Black, Asian, Minority Ethnic) colleague risk assessment and 88% risk assessments reported as completed for all staff. A detailed audit of the outcomes and quality of risk assessments has been undertaken and presented to the People and Organisational Development Committee.		

	3. Trust Board are asked to receive positive assurance arising from the improvement programme work. This includes an assurance that all Project Initiation Documents (PIDs) are authorised and significant progress on defining the benefits and benchmarking has taken place, and to note gaps in assurance and plans to address these gaps. The Board are asked to note that the 2020 NHS Staff Survey is currently available for all colleagues to complete and that data derived from the survey will contribute to the qualitative measures of the improvement programme. 4. The Trust Board are asked to note that the 2020/21 staff flu campaign has commenced helping protect the health and wellbeing of colleagues. This year's campaign is more vital than ever and a detailed action plan is in place which is reviewed a weekly basis by a senior strategic and operational perspective. 5. October has been national 'Speak Up Month'. The Trust Board are assured that the Freedom to Speak Up (FTSU) team have sought to increase knowledge of the service to support staff to share concerns relating to patient safety and workforce inequity. This includes recruiting colleagues from across the Trust to provide confidential links within services to create a culture of speaking up. 6. Trust Board will also be aware that October has been Black History Month, a nationwide celebration of Black History, Arts and Culture throughout the UK. A variety of activities took place across the Trust to celebrate, educate and talk about the experiences of people of Black heritage. These conversations and platforms will be continued and enhanced by the Equality, Diversity and Inclusion Strategy which the Board will receive in December 2020.
Recommendation	The Board is asked to: • Note the scope of leadership and talent management work underpinning the aim of making Walsall the best place to work and approve the scope. • Note the update on the leadership and talent management work and that the strategy framework will be received by the People and Organisational Development Committee (PODC) in November.

	• Note that the delivery is taking place through the valuing colleagues' work-stream of the improvement programme.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk SO4 to provide positive assurance of the mitigations in place to manage this risk and the related corporate risks.
Resource implications	There are resource implications that flow from recommendations in the report. In the short-term, the resource requirements are being met from base budgets. The improvement program and Organisational Development approach will require investment beyond the base budget to achieve the milestones and progress envisaged by 2022. The investment case will be considered through trust governance including People and Organisation Development Committee, Performance Finance and Investment Committee and Quality Patient Experience and Safety Committee before further recommendation to Trust Board.
Legal and Equality and Diversity implications	There is evidence nationally that there are legal, equality or diversity implications relating to the differential experience of black and minority colleagues relating to experience of bullying and harassment and violence at work, as well as career progression and promotion opportunities. Both significantly impact experience of being valued at work. There is also evidence through WDES that colleagues with a disability have a differential and adverse experience and there is the potential that further evidence will emerge for other groups of staff. The leadership and talent management strategy will seek to design the systems and processes governing to mitigate and eliminate this risk, in order to meet the equality outcome envisaged by the board pledge.
Strategic Objectives	Safe, high quality care ☐ / Care at home ☐
	Partners ☐ / Value colleagues ☒
	Resources ☐

1. OVERVIEW

The Board Assurance Framework (BAF) Risk S04 provides that lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care. The Board noted that the Assurance Framework current risk score remains at 20 (major risk), the following actions have been taken to mitigate the risks are as follows:

- Colleagues in at-risk groups have been identified and managed appropriately according to Wellbeing Review and Stratified Risk Assessments. The compliance currently is as follows: 95 % BAME colleagues; 92% other vulnerable groups and 88% whole workforce.

- A detailed insight into the individual outcomes of each risk assessment undertaken and in particular a record of measures put in place in response to the outcome to the assessment at an individual level. To provide this insight, between 12 and 23 October 2020 the People and Culture Directorate undertook an audit of completed risk assessments in partnership with divisional/directorate teams. A total of 1482 risk assessments have been reviewed, representing a sample size of 43.4%. 90% of the data reviewed from the audit related to staff working in a clinical setting. Of the 1482 records obtained 351 (30%) were from colleagues from a Black, Asian and Ethnic Minority (BAME) backgrounds. The People and Organisational Development Committee (PODC) are reviewing this audit and the outcomes at their meeting on 5th November.

- The arrangements for a cohesive leadership and management development programme supporting all levels of managers/leaders throughout the organisation are in place. Of particular importance is the leadership development programmes being introduced.

- The Growth Mindset leadership programme aims to enable a climate of growth, equality and compassionate care. Mindset Practice focuses on developing leadership and staff potential through a climate of growth, inclusion and equality. The online development programme provides 12months access to support ongoing development including a growth tracker to chart development progress. The focus is on devising an implementation plan for roll out in December for the Growth Mindset leadership support and the Mindset to Growth Toolkit designed to support the emotional and psychological journey through change.

- The introduction of the Leading an Empowered Organisation (Leo) Programme is a leadership programme that is recognised as an essential component of safe and effective care, improved staff satisfaction, succession planning and staff retention. It is a three-day programme with a one-day follow-up about 2-3 months after

completion of the course. The programme aims to provide individuals with values and evidence-based skills 'toolbox' that they can use. Roll out of this programme is scheduled for February 2021 and will initially be aimed at middle managers.

- Access to Leadership Circles which are 1-hour sessions for mixed groups of NHS leaders, designed to provide safe space for leaders to come together and share their experiences. Supporting each other to work through complex challenges. They have been designed specifically to offer support for those with people management responsibilities. Circles will be run for groups of 6-25 people, using online platforms for as long as the social distancing restrictions are in force.

- The Institute of Healthcare Management has announced the launch of (IHM) Regional Hubs offering workshops, social events, presentations and meetings. Colleagues have the opportunity to become a member of the IHM, access resources and events.

2. PERFORMANCE REPORT

The workforce metrics performance element of this report takes a standard set of quantitative metrics and tracks performance over time. The workforce performance report is attached at Appendix 2.

3. IMPROVEMENT PROGRAMME

The valuing colleague's improvement programme has sought to assure that the project initiation documents for each of the overarching projects are in place across each of the following three domains.

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

The valuing colleagues work-stream of the improvement programme has been developed to include a specific focus on flexible working to ensure a strategic approach is taken to sustain opportunities harnessed as a result of COVID-19. The focus during October has been refining the benefits and completing the metrics and measurements and identifying enabling resource.

4. RECOMMENDATIONS

The Board is asked to:

- Note the scope of leadership and talent management work underpinning the aim of making Walsall the best place to work and approve the scope.
- Note the update on the leadership and talent management work and that the strategy framework will be received by the People and Organisational Development Committee (PODC) in November.

Walsall Healthcare NHS
NHS Trust

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

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	**4**	**4**			• Staff recommending Walsall as a place to work is below all England average [bottom quartile Q2 2019-2020] • Staff recommending Walsall as a place to be treated is below all England average [bottom quartile Q2 2019-2020] • Staff engagement score in NHS staff survey is below peer comparators • NHS staff survey indicates a lack of inclusive culture with differential staff experience in bullying, harassment, violence, career progression and promotion • NHS staff survey indicates a lack of open culture (speaking up) below peer comparators • The model hospital data indicates bottom quartile performance on workforce indicators such as sickness absence and use of resources • Historical WRES data indicates a lack of progress to tackle barriers to inclusion. • Data and information shared via staff feedback mechanisms evaluating	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:						**Risk Level:**	**8**	

		impact of COVID identifies staff and line managers being fatigued and fearful of the impact that a second wave will have on individuals and staffing levels. • Data and information from staff engagement events have identified the existence of toxic climates in several areas/departments across the Trust where staff have shared stories of unreasonable treatment based on their race, disability, ethnicity and sexuality.	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Values launched and evaluated across the Trust • Staff engagement and communication approach in place • Policy on zero tolerance to violence in place • Behaviour Framework implemented and evidence of practicing behaviours in action to be reviewed within the IPDR process • Values based appraisal process in place which incorporates Talent Management and the ability to track access to career progression and promotion • Increased engagement through engagements and EDI champions • Health and Wellbeing approach based on holistic offering to staff being developed. • Internal staff mental health awareness champions identified. • Restorative Just Culture work initiated and ER casework triaged for opportunities for early resolution. • Staff in at risk groups have been identified and managed appropriately according Wellbeing Review and Stratified Risk Assessments. • Set of measures have been identified to monitor progress against workforce inequalities and employment inequality in Walsall.	• Head of Talent, Resourcing and Inclusion appointed to lead the approach • Analysis against actions required from NHS People Plan against actions progressed under the Valuing Colleagues Improvement Programme has been reviewed by PODC. • PODC approved measures to monitor progress against Trust Board Pledge in place. • STP funding achieved to support training and implementation of restorative just and learning culture. • F2SU strategy agreed at PODC and in place. • Accredited RCN training programme for 60 Cultural Ambassadors has been implemented to support recruitment and selection processes. • Additional HR/OD support in place for 2020 Q3 to support work areas with complex people needs and poor staff experience.	• Quarterly deep dive of key workforce metrics by CCG. • BCWB STP People Plan in development to support implementation of National NHS People Plan. • Midlands NHSE&I monitoring of individual COVID-19 risk assessment performance. • STP and regional NHSE&I monitoring of Trust performance regarding uptake of staff flu programme. • WRES and WDES outcomes monitored at national and regional NHSE&I level.
Gaps in Control	• Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Approaches and resources may be insufficiently robust or at scale to achieve meaningful change • Current Policy framework not fit for purpose – legacy policies are not aligned to the approach • Leadership development programme is in its infancy		

	• Management competency framework is not yet available, impact and evaluation not complete • Resourcing not yet stable – workforce metrics still demonstrate adverse trends • EDI targets at organisational and divisional level have not been developed.		
Assurance:	• Engaging with the wider Trust and TMB on co-designing an Organisation Development Plan – work packages and delivery through the improvement programme • BAME decision making forum has been established to advise and guide the Trust in its understanding of issues facing colleagues from BAME backgrounds in the workplace and what measures can be taken to improve their experiences. • Audit of Individual COVID-19 Risk Assessments undertaken to understand risk levels and outcomes of measures implemented to protect staff.	• People and OD committee of the Board in place to seek assurance, through the cycle of business and review of workforce metric trends. • EDI group led by a Non-Executive director in place to review approach to EDI and delivery of metrics in the EDI strategy framework and Equality Impact Assessment. • PODC receive monthly updates regarding to assure robust arrangements in place to support colleagues through the impact of COVID. • BAME cabinet provides strategic Board focus on EDI. • Board development sessions to support co-design and approval of EDI strategy completed in October 2020. • Staff Inclusion Network established in May and meetings taking place with Network leads across the protected characteristics	• NHSi working with the Trust to develop the FTSU approach and to develop a strategic framework by Q2 for FTSU by 2020-2021 • NHS Leadership Academy working with the Trust on developing leadership capacity and capability, the delivery was scheduled for Q1 2020-21, paused due to Covid response. Revised implementation plan agreed at TMB to commence Q1 2021. • NHSi partner for Retention programme – the 90 day plan is complete, impact on retention rate to be reviewed Q2 1920 • EDI WRES/WDES metrics and other EDI metrics developed for inclusion within the organisation's accountability framework
Gaps in Assurance	• All elements of the Trust Board pledge, bullying harassment, discrimination and listening to the voice of staff. • Lack of an approved EDI Strategy and Delivery Plan could inhibit the scale and pace of progress towards an inclusive culture • Evidence based approach to positive action interventions not yet in place to support EDI objective • Evaluation of zero tolerance to violence not yet evaluated. • NHS staff survey results do not evidence an improvement in staff reporting of an inclusive and open culture • The indicators for staff recommending the Trust as a place to work or a place to be treated have failed to improve significantly. • The staff engagement score has worsened indicating lower levels of staff morale and role satisfaction. • NHSE/I Governance and Accountability review highlighted areas of improvement associated with culture and leadership • No internal audit assurance gained in year • Line managers are required to ensure all staff have received an opportunity to undertake a wellbeing review risk assessment. Not all staff are recorded to have participated in the process. • Benefits of the Valuing Colleagues Programme to be agreed. • An audit against ESR data is being undertake to provide assurance regarding workforce and learning data quality.		

Future Opportunities

- Capitalise on external resource/expertise to establish evidence based best practice
- Closer working with through the STP/LWAB
- Collaborative working with other Trusts to creatively address resourcing matters
- New roles and scenario based workforce planning for full resourcing and consequent impact on staff morale
- To work collaboratively on a Black Country Health and Wellbeing approach to make Walsall and the Black Country the best place to work
- To develop a more structured and inclusive approach to widening participation
- To develop the Trust's profile as an employer of choice by having clear pathways for career development.

- To become an anchor employer within Walsall attracting talent as a result of our EDI approach and strategy.
- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Implementation of cultural ambassadors to enhance recruitment processes and recognise the value of diversity.
- Board EDI development sessions scheduled for October 2020.
- Divisional Board Accountability Framework to monitor on Divisional EDI targets

Future Risks

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

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

No.	Action Required	Executive Lead	Due Date	Progress Report	BRAG
1.	Draft Health & Wellbeing Strategy & Engage and Consult Key stakeholders	Catherine Griffiths	October 2020	•	
2.	Develop and Implement a leadership Development Programme	Catherine Griffiths	March 2021	• Updates shared at Execs and TMB in October 2020 • FMLD programme recommissioned following COVID-19 pause – commence Q1 2021. • Growth Mindset Leadership Development Programme commissioned – due to be implemented from November 2020.	
3.	Launch EIA Policy and Form	Catherine Griffiths	October 2020	• New forms and Policy to be cascaded 12th October . Board and Executive paper EIA prompt sheet developed and uploaded on to Trust Corporate Communications Intranet web pages alongside Corporate communication templates • EIA learning package with EIA Video developed- due to be launched with Policy on 12th October 2020	
4.	Review and relaunch equality impact assessment processes	Catherine Griffiths	March 2021	• Options currently being explored to develop an online version of the EIA proforma via Cloud 2 intranet project and the functionality of share point.	
5.	Agree Valuing Colleagues Improvement Programme Benefits	Catherine Griffiths	November 2020	• Set of qualitative and quantitative benefit measures considered at Improvement Board workshop 02 October 2020.	
6.	Finalise and approve Equality, Diversity and Inclusion Strategy	Catherine Griffiths	November 2020	• Colleague and community engagement and consultation completed in September 2020. • EDIC and Staff Inclusion Network BAME Decision Making Counsel engagement completed. • Board Development sessions on the 5 & 19 October 2020 completed.	
8.	Provide assurance regarding outcomes of individual COVID-19 Risk Assessments	Catherine Griffiths	October 2020	• Detailed audit commissioned between 12-23 October 2020. Initial analysis to be reported to October PODC.	

Walsall Healthcare Risk Register

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

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

Walsall Healthcare Risk Register

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

Action Plan

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2072	Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency.	National planning decisions have impacted the supply of healthcare staff in particular doctors in training and theatre staff and therefore our ability to recruit is reduced .This can drive reliance on temporary staffing arrangements which may impact on quality and financial controls and the fundamentals of care	Clair Bond	1 6	• Process • A values based appraisal process which incorporates Talent Management and the ability to track access to Career progression should assist in retaining the staff already employed	• Valuing Colleagues Improvement Board and PODC. Training and development sessions to support managers. Coaching techniques to support conversations. F2SU approach and feedback. • WRES and WDES performance. 2020 National Staff Survey (results due Feb 2021)	
					• BAF Control 05 • - Working across the system across the STP with HEE partners to define local, collaborative, system and national workforce supply solutions.	• Workforce Plan is reviewed and agreed by TMB and PODC • Workforce STP agenda via STP people board Collaboration with Walsall Together Partnership Board.	
					• Process • Valuing Colleagues Improvement Programme involves a number of work packages which seek to improve staff experience, amplify Walsall as an anchor employer and enhance our ability to attract, recruit, retain and develop the workforce.	• Improvement Programme Board People and Organisational Development Committee. • NHS People Plan - STP People Plan WRES / WDES data	
					• Training • Improvement in education and training offer intended to expand apprenticeship offer, identify and develop new roles on a local and system wider level, and improve the ability to transfer competencies and skills between NHS employers.	• •	
					• Policy • Improve workforce flexibility and availability by harnessing opportunity of agile working within the Trust, standardising job roles / descriptions and supporting the case to align bank processes internally and across the STP system.	• Agile working task and finish group established. • BCWB STP People Board	

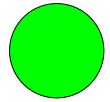
Walsall Healthcare Risk Register

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

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
31/03/2021	Workforce Policy Framework to be aligned to the Valuing Colleagues Improvement Programme	Clair Bond	26/03/2021	31/03/2021
01/04/2020	Participation in STP task and finish group to scope business case and benefits for establishing collaborative nurse and midwifery bank.	Clair Bond	26/03/2021	31/03/2021
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond	26/03/2021	31/03/2021
01/04/2020	The 'New Roles Group' is being reviewed to support the development of new roes, skills and career pathways.	Clair Bond	/ /	12/10/2020
12/10/2020	Enhancing the career progression for non Doctors in Training and supporting career development will increase the ability of WHT to attract and retain talent.	Clair Bond	25/11/2020	30/11/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2093	Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust	Staff are exposed to infection with COVID-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death. Mitigations include national measures to control the outbreak, training for staff in IPC/hand hygiene, provision of appropriate PPE in workplace settings.	Matthew Lewis	2 0	• Training • Systems and processes are in place to ensure designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• During the outbreak wards have gradually been converted to COVID-19 specialist areas, clinical staff have been supported by National Guidance, SOPs, Education by IPT, Matrons and Div DONs. Use of existing policies. PPE training and education has continued through the outbreak in line with the National guidelines including the don and doff of PPE with posters provided to all clinical areas along with links on the Intranet and Daily Dose communications. Staff letters have been sent reminding them of need to be re tested when different masks are received by the Trust. WHT has actively followed National Guidance throughout outbreak guidance from Royal Colleges reviewed and escalated to Strategic command where there is conflicting advice. PHE PPE guidance followed, posters are issued to each clinical area by IPN when a change is made and posted on Daily Dose daily communication. Trust Policies meet the National Cleaning Guidance requirements, with the addition of HPV decontamination where possible. •	
					• Physical Barrier • All staff providing patient care in Covid Area have access to the right PPE appropriate for the clinical situation	• Where specific shortages are reported, a risk assessment is undertaken through Tactical Command Mitigations are put into place. Tactical command and strategic command in place Regular PPE Audit undertaken • No External Assurance available	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Policy • COVID 19 Incident category set up to enable staff to raise concerns relating to Covid-19 and PPE	• Weekly SI meeting in place, with weekly oversight of all incidents raised in relation to COVID-19 Incidents relating to PPE - discussed with staff member at the time, ensure have updated information /poster/policy. Line manager informed if persistent issues or particular team issues. • non available external assurance currently available review commissioned	
					• Process • staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• Covid-19 health and wellbeing group in place and reviewing approach to physical and psychological wellbeing is supported Additional 24/7 mental health support has been deployed Additional occupational health support Health and Wellbeing booklet has been sent out via email and paper copy to all staff in the organisation,. Oversight of Covid-19 health and wellbeing through POD • No external assurance is available at the time	
					• Process • Risk assessment in place to support vulnerable staff with underlying health conditions, to include BAME staff	• Oversight via Corporate Command Oversight via strategic command Oversight via POD EDI group support the development and roll out of BAME risk assessment • No external Assurance available at this time	
					• Policy • There have been a number of staff test positive for COVID and there is evidence that in one department, cases are linked and are formally regarded as an outbreak.	• OH support to track, trace and test. IFC and H&S support to audit areas for compliance with social distancing, PPE and IFC measures. Hand Hygiene and IFC M&S training Colleague COVID Hotline implemented • PHE and NHSE/I support in place to manage and monitor outbreak.	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
27/09/2020	SOP developed and agreed at Tactical. Resources to provide facility for staff testing working around the hours of the patient	Michala Dytor	01/11/2020	06/11/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		testing facility are being identified.					
05/10/2020		Audit of individual risk assessments to be completed y the end of October.	Catherine Griffiths			25/10/2020	30/10/2020
15/07/2020		Every line manager to undertake a stratified risk assessment of at risk/ vulnerable/ BAME groups and returns/ compliance collated by HR.	Catherine Griffiths			11/10/2020	16/10/2020
15/07/2020		Workforce to reflect assurance with regards to completion of risk assessments for 'at risk' staff internally and externally.	Catherine Griffiths			25/10/2020	30/10/2020
15/07/2020		Assessment to be undertaken to determine reasonable adjustments have been put in place to mitigate risk to any staff members identified as being at high risk/ vulnerable.	Catherine Griffiths			11/10/2020	16/10/2020
07/09/2020		Outbreak meeting in place to respond and manage the outbreak. Assurance sought by Trust, PHE and NHSEI that appropriate actions are in place in response.	Matthew Lewis			01/11/2020	06/11/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2095	The demand for 'Personal Protective Equipment' (PPE) has contributed to a national shortage of proper and effective PPE, resulting in delays in obtaining from supply chain impacting on our ability to maintain key critical services and protect staff against COVID-19.	Inabilty of the NHS supply chain to provide an adequate and on-going supply of PPE to meet the demand to ensure that Walsall Healthcare NHS staff are fully protected during the Covid-19 pandemic.	Caroline Whyte	1 6	• Process • Daily PPE meeting with clincial , procurement and distribution staff to review levels and report into tactical command. • Process • Frequent communication via comms route to ensure staff re aware of PHE gudiance in relaiton to correct PPE. • Process • PPE figures fed into tactical comand daily with daily burn rates and usage figures discussed. • Process • External review to be undertaken to provide a diagnostic and assurance around protecting staff in the workplace, whilst delivering care to Covid Patients	• PPE numbers have been reported to QPES in May 2020 • PPE stock levels monitored daily via SIT rep process • Incident Command process in place which oversees the Trusts response to change in national PPE guidance • Infection Prevention and Control framework presented to QPES • PPE stock levels have remained consistent and sufficient for the organisation • • Review has been agreed via strategic command •	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
14/10/2020	Review Trained resource and scope availability of Trained testers with managers to establish a monthly rota.	Caroline Whyte		25/10/2020	30/10/2020
15/05/2020	Daily sitrep of PPE figures into tactical command for oversight and assurance	Gillian Farr		26/12/2020	31/12/2020
15/05/2020	Ensure mutual aid proposal agreed at tactcial command.	Caroline Whyte		26/12/2020	31/12/2020
11/08/2020	Draft a proposal to secure monies to recruit an RPE lead to provide training in all areas of RPE including cascade of FIT Testing	Jenna Davies		18/10/2020	23/10/2020
14/04/2020	A Paper to be presented to Strategic Command outlining approach to Fit Mask testing	Jenna Davies	**Closed**	25/04/2020	30/04/2020
01/05/2020	relevant staff received a letter outlining the FP3 mask trained on and whether they are compliant	Matthew Lewis	**Closed**	04/05/2020	09/05/2020
21/05/2020	IPC Board Assurance Framework to be completed which includes elements of PPE and Health and Safety	Jenna Davies	**Closed**	26/07/2020	31/07/2020
30/06/2020	Source reusable half face masks specifically for high use areas.	Gillian Farr	**Closed**	26/08/2020	31/08/2020
30/06/2020	Procure 2x Portacount meters to facilitate quantitative Fit testing.	Gillian Farr	**Closed**	19/08/2020	24/08/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
01/09/2020	Provide Fit 2 Fit training via external provider to staff particularly in high use areas.					**Closed**	25/09/2020	30/09/2020

Walsall Healthcare NHS
NHS Trust

September 2020 Workforce Metrics

Contents

Walsall Healthcare NHS
NHS Trust

Workforce Performance Summary

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

Appraisal Compliance

- People & Culture colleagues continue to offer PDR training and advice, both face-face and virtually.
- All PDR documents are being reviewed for quality, to ensure the forms submitted evidence a holistic approach to the appraisal process which adds long-lasting value to the colleagues taking part.

Sickness Absence

- The Occupational Health Team have begun the 2020/21 influenza vaccination programme, which is available to all colleagues, with those within patient-facing roles receiving priority appointments to protect their teams, patients and families.
- Whilst sickness levels remain below pre-2020 norms, a rise in COVID-19 related illnesses has contributed towards a spike in September 2020 absence levels.
- A demographical review of absence has revealed that, while all staff groups have experienced sickness levels lower than the seasonal norm, the largest increase in presenteeism was amongst colleagues able to, or currently, working from home.

Mandatory Training Compliance

- The Learning & Development Team continue to engage with divisional colleagues; offering advice about training requirements and resolving any individual barriers to compliance.
- The Workforce Intelligence Team have begun rolling out innovative means of monitoring compliance remotely, via the ESR Business Intelligence platform.
- In response to a tightening of social guidance, the increased use of virtual courses for training will provide improved economies of scales for compliance improvement.

Walsall Healthcare NHS Trust

SPC Summary Dashboard - Retention (24 Months)

*Exclusions Apply – See Appendix A	September 2020 Outturn	Numerator: FTE Now (24 Months+ Service)*	Denominator: FTE 24 Months Previous*	Will We Meet The Target? (85%)	Is Performance Stable?	Analysis Page
WH Trust	**81.3%**	2659.77	3271.53	**No**	**Getting Worse**	8
Adult Community	**80.2%**	418.23	521.57	Sometimes	Yes	-
Estates & Facilities	**86.9%**	215.93	248.63	**Yes**	Yes	-
MLTC	**77.9%**	475.39	610.59	**No**	**Getting Better**	-
Surgery	**84.6%**	548.65	648.73	Sometimes	**Getting Worse**	-
WCCSS	**76.7%**	626.56	816.73	**No**	**Getting Better**	-
Chief Executive Directorate	**55.6%**	5.00	9.00	**No**	**Getting Better**	-
Finance Directorate	**80.1%**	64.12	80.04	**No**	Yes	-
Governance Directorate	**59.8%**	20.47	34.23	**No**	**Getting Worse**	-
Informatics Directorate	**86.5%**	101.35	117.10	**Yes**	Yes	-
Medical Directorate	**84.0%**	18.72	22.29	Sometimes	Yes	-
Nurse Directorate	**107.5%**	64.65	60.13	Sometimes	**Getting Better**	-
Operations Directorate	**116.0%**	23.13	19.94	**Yes**	**Getting Better**	-
People & Culture Directorate	**93.9%**	66.83	71.20	Sometimes	**Getting Better**	-
Transformation & Strategy	**94.7%**	10.73	11.33	**Yes**	Yes	-

Walsall Healthcare NHS
NHS Trust

SPC Summary Dashboard – Sickness Absence

	September 2020 Outturn	Numerator: FTE Days Lost During September 2020	Denominator: FTE Days Available During September 2020	Will We Meet The Target? (4.5%)	Is Performance Stable?	Analysis Page
WH Trust	**4.8%**	5242.29	108576.45	Sometimes	Yes	8
Adult Community	**3.3%**	547.06	16617.13	Sometimes	**Getting Better**	-
Estates & Facilities	**8.8%**	663.15	7552.40	**No**	Yes	-
MLTC	**5.0%**	1059.50	21290.31	Sometimes	Yes	-
Surgery	**6.1%**	1335.22	21796.55	**No**	Yes	-
WCCSS	**4.8%**	1254.25	26401.33	Sometimes	Yes	-
Chief Executive Directorate	**2.0%**	6.00	300.00	**Yes**	Yes	-
Finance Directorate	**1.1%**	26.00	2403.74	Sometimes	Yes	-
Governance Directorate	**0.6%**	5.00	799.40	Sometimes	Yes	-
Informatics Directorate	**2.2%**	84.55	3835.52	Sometimes	**Getting Better**	-
Medical Directorate	**9.2%**	93.00	1014.62	Sometimes	Yes	-
Nurse Directorate	**4.3%**	103.76	2425.20	Sometimes	Yes	-
Operations Directorate	**3.7%**	30.00	807.80	Sometimes	Yes	-
People & Culture Directorate	**1.3%**	66.83	2776.46	Sometimes	Yes	-
Transformation & Strategy	**0.0%**	0.00	556.00	Sometimes	**Getting Better**	-

Walsall Healthcare NHS Trust

SPC Summary Dashboard – Mandatory Training Compliance

	September 2020 Outturn	Numerator: Competencies Completed	Denominator: Competencies Required	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**86.5%**	38006	43936	**No**	**Getting Better**	8
Adult Community	**96.3%**	6794	7053	Sometimes	**Getting Better**	-
Estates & Facilities	**91.9%**	3264	3550	**No**	**Getting Better**	-
MLTC	**80.4%**	6528	8116	**No**	Yes	-
Surgery	**82.0%**	7035	8575	**No**	**Getting Better**	-
WCCSS	**88.3%**	9790	11093	Sometimes	**Getting Worse**	-
Chief Executive Directorate	**71.4%**	65	91	**No**	**Getting Better**	-
Finance Directorate	**93.5%**	757	810	Sometimes	Yes	-
Governance Directorate	**90.6%**	250	276	Sometimes	**Getting Worse**	-
Informatics Directorate	**94.0%**	1353	1440	Sometimes	Yes	-
Medical Directorate	**93.4%**	339	363	Sometimes	**Getting Better**	-
Nurse Directorate	**89.6%**	887	990	Sometimes	Yes	-
Operations Directorate	**88.9%**	295	332	**No**	**Getting Better**	-
People & Culture Directorate	**84.9%**	897	1057	Sometimes	**Getting Worse**	-
Transformation & Strategy	**93.2%**	177	190	Sometimes	Yes	-

Walsall Healthcare NHS
NHS Trust

SPC Summary Dashboard – Annual Appraisal Compliance

*Exclusions Apply – See Appendix A	September 2020 Outturn	Numerator: Appraisals Completed*	Denominator: No. Colleagues Eligible For Appraisal*	Will We Meet The Target? (90%)	Is Performance Stable?	Analysis Page
WH Trust	**74.9%**	2484	3315	**No**	Yes	8
Adult Community	**89.4%**	474	530	Sometimes	Yes	-
Estates & Facilities	**73.2%**	240	328	Sometimes	**Getting Worse**	-
MLTC	**67.1%**	374	557	**No**	**Getting Worse**	-
Surgery	**65.7%**	428	651	**No**	**Getting Worse**	-
WCCSS	**87.4%**	701	802	Sometimes	**Getting Worse**	-
Chief Executive Directorate	**66.7%**	4	6	Sometimes	Yes	-
Finance Directorate	**54.2%**	39	72	**No**	**Getting Worse**	-
Governance Directorate	**36.4%**	8	22	**No**	**Getting Worse**	-
Informatics Directorate	**60.5%**	78	129	**No**	**Getting Worse**	-
Medical Directorate	**90.5%**	19	21	Sometimes	Yes	-
Nurse Directorate	**59.0%**	46	78	**No**	**Getting Worse**	-
Operations Directorate	**61.5%**	16	26	**No**	Yes	-
People & Culture Directorate	**65.4%**	51	78	Sometimes	**Getting Worse**	-
Transformation & Strategy	**40.0%**	6	15	**No**	**Getting Worse**	-

Walsall Healthcare NHS
NHS Trust

Workforce Metrics

Workforce Profile	As at 31/03/2020	Target	2020/21												YTD Change - Since 31/03/20
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Substantive Staff FTE	3598.64		3612.02	3622.55	3667.89	3679.03	3658.38	3626.71	-	-	-	-	-	-	28.07
Substantive Staff FTE (Ex. Rotational Drs)	3513.84		3526.82	3537.75	3583.09	3596.23	3580.58	3541.51	-	-	-	-	-	-	27.67
Substantive Staff Headcount	4220		4246	4259	4305	4313	4295	4275	-	-	-	-	-	-	55
Bank Staff Only Headcount	925		999	1015	995	998	1008	1035	-	-	-	-	-	-	110
% Staff from a BME Background	28.03%		28.14%	28.17%	28.11%	28.13%	28.44%	28.72%	-	-	-	-	-	-	0.69%

Workforce Profile BY Staff Group (FTE)	As at 31/03/2020	Target	2020/21												YTD Change - Since 31/03/20
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Add Prof Scientific and Technic	121.77		122.34	122.69	120.69	122.27	121.68	124.41	-	-	-	-	-	-	2.64
Additional Clinical Services	619.10		615.85	616.39	623.22	625.37	626.99	623.50	-	-	-	-	-	-	4.40
Administrative and Clerical	807.03		804.47	806.79	819.07	825.11	829.16	826.46	-	-	-	-	-	-	19.43
Allied Health Professionals	221.43		222.60	221.93	225.53	228.17	228.17	228.87	-	-	-	-	-	-	7.43
Estates and Ancillary	252.47		250.75	250.13	250.23	250.06	249.21	249.01	-	-	-	-	-	-	-3.46
Healthcare Scientists	45.22		45.52	43.93	42.93	43.62	43.22	43.22	-	-	-	-	-	-	-2.00
Medical and Dental	363.71		364.51	360.34	358.94	356.24	358.69	369.19	-	-	-	-	-	-	5.48
Nursing and Midwifery Registered	1159.93		1155.45	1145.99	1145.11	1146.82	1145.04	1143.27	-	-	-	-	-	-	-16.65
Students	8.00		30.53	54.36	82.16	81.36	56.23	18.79	-	-	-	-	-	-	10.79

Workforce Profile	2019/20	Target	2020/21												YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Change in Workforce Profile WTE (Ex. Rotational Drs)	-		12.98	10.93	45.33	13.14	-15.64	-39.07	-	-	-	-	-	-	-
Starters WTE	482.66		57.27	27.53	46.49	28.69	98.00	43.67	-	-	-	-	-	-	301.65
Leavers WTE	547.19		21.69	26.12	16.15	25.15	132.65	35.95	-	-	-	-	-	-	257.72
TUPE in WTE	0.00		0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	0.00
TUPE Out WTE	1.40		0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	0.00

Turnover % (Normalised) - Rolling 12 Months	2019/20	Target	2020/21												2020/21 Average
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Overall Turnover	11.64%	10%	12.43%	9.79%	8.39%	7.15%	7.90%	9.21%	-	-	-	-	-	-	9.14%
Add Prof Scientific and Technic	20.04%	10%	16.89%	21.05%	22.13%	22.44%	21.63%	20.00%	-	-	-	-	-	-	20.69%
Additional Clinical Services	11.04%	10%	12.55%	10.77%	11.69%	8.11%	7.66%	12.09%	-	-	-	-	-	-	10.48%
Administrative and Clerical	10.97%	10%	14.11%	8.22%	4.16%	4.02%	6.86%	8.60%	-	-	-	-	-	-	7.66%
Allied Health Professionals	14.78%	10%	14.62%	13.04%	12.30%	9.69%	8.80%	7.53%	-	-	-	-	-	-	11.00%
Estates and Ancillary	7.17%	10%	7.92%	6.86%	6.17%	5.88%	4.19%	3.48%	-	-	-	-	-	-	5.75%
Healthcare Scientists	10.35%	10%	11.73%	13.02%	7.01%	7.25%	7.42%	7.24%	-	-	-	-	-	-	8.94%
Medical and Dental	8.05%	10%	6.44%	6.79%	8.49%	7.97%	7.09%	6.84%	-	-	-	-	-	-	7.27%
Nursing and Midwifery Registered	12.48%	10%	12.28%	9.51%	7.90%	6.79%	8.06%	9.04%	-	-	-	-	-	-	8.93%

Walsall Healthcare NHS
NHS Trust

Workforce Metrics

Retention	2019/20	Target	2020/21											2020/21 Average
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Retention Rate (12 Months)	91.57%		89.95%	89.97%	90.08%	90.64%	91.00%	91.28%	-	-	-	-	-	-	90.49%
Retention Rate (24 Months)	82.61%	85%	81.95%	81.91%	82.37%	82.84%	82.72%	81.30%	-	-	-	-	-	-	82.18%
Retention Rate (5 Years)	61.32%		63.15%	62.78%	63.45%	63.42%	63.35%	62.38%	-	-	-	-	-	-	63.09%

Retention Rate (24 Months)	2019/20	Target	2020/21											2020/21 Average
	Mar-19		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Add Prof Scientific and Technic	84.30%	85%	72.66%	70.29%	72.28%	71.09%	74.48%	76.06%	-	-	-	-	-	-	72.81%
Additional Clinical Services	77.47%		80.06%	80.69%	80.58%	80.61%	81.03%	77.56%	-	-	-	-	-	-	80.09%
Administrative and Clerical	88.05%		89.79%	89.03%	90.06%	90.78%	90.90%	89.02%	-	-	-	-	-	-	89.93%
Allied Health Professionals	74.24%		75.90%	74.83%	75.52%	76.39%	74.81%	74.93%	-	-	-	-	-	-	75.39%
Estates and Ancillary	90.10%		87.10%	87.74%	88.88%	89.44%	85.84%	85.71%	-	-	-	-	-	-	87.45%
Healthcare Scientists	76.61%		75.37%	75.37%	73.55%	78.96%	76.45%	75.19%	-	-	-	-	-	-	75.81%
Medical and Dental	83.15%		85.16%	84.74%	85.08%	85.18%	85.08%	82.85%	-	-	-	-	-	-	84.68%
Nursing and Midwifery Registered	81.89%		78.52%	78.91%	79.09%	79.58%	79.76%	78.98%	-	-	-	-	-	-	79.14%

Sickness Absence	2019/20	Target	2020/21											2020/21 Average
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
% Sickness Absence In Month	6.82%	4.50%	8.34%	5.99%	4.93%	4.28%	4.22%	4.83%	-	-	-	-	-	-	5.43%
% Sickness Absence (Rolling 12 Months)	5.61%	4.50%	5.83%	5.82%	5.75%	5.63%	5.52%	5.48%	-	-	-	-	-	-	5.67%
FTE Days Lost	73437		8986	6733	5405	4861	4777	5242	-	-	-	-	-	-	6001
% Short Term Sickness	30.27%		28.21%	22.98%	26.72%	28.53%	29.84%	37.67%	-	-	-	-	-	-	28.99%
% Long Term Sickness	69.73%		71.79%	77.02%	73.28%	71.47%	70.16%	62.33%	-	-	-	-	-	-	71.01%
Estimated Cost of Sickness £	£6,433,476		£835,103	£564,120	£446,924	£404,236	£390,296	£432,158	-	-	-	-	-	-	£512,140

Top 3 Sickness Reasons (FTE Days Lost)	2019/20	Target	2020/21											% Change - (YTD Avg)
	Monthly Avg.		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Anxiety/stress/depression/other psychiatric illnesses	1523.2		2075.5	2087.0	1701.9	1457.1	1336.4	1364.7	-	-	-	-	-	-	9.66%
Back Problems	436.4		438.7	610.6	602.4	580.6	702.9	605.0	-	-	-	-	-	-	35.19%
Other musculoskeletal problems	590.2		670.6	586.7	524.8	404.7	426.9	484.1	-	-	-	-	-	-	-12.53%

Education / OD	2019/20	Target	2020/21											2020/21 Average
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Core Mandatory Training	81.59%	90.00%	82.33%	82.44%	83.46%	85.69%	86.48%	86.50%	-	-	-	-	-	-	84.48%
Appraisal	80.27%	90.00%	75.05%	72.85%	71.68%	73.53%	76.72%	74.93%	-	-	-	-	-	-	74.13%

Walsall Healthcare NHS
NHS Trust

Workforce Metrics

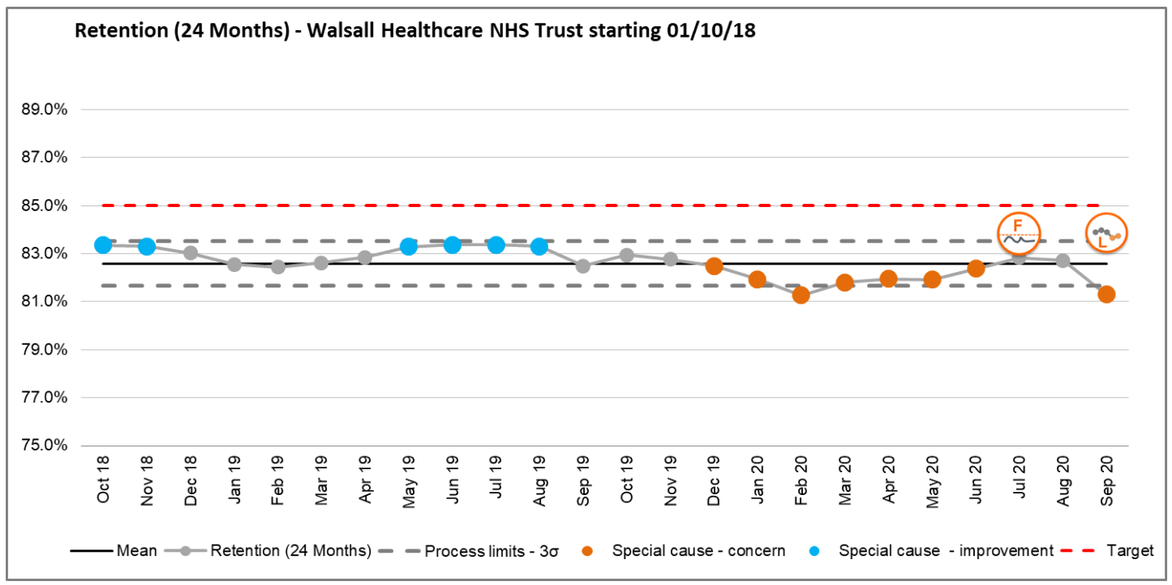
Agency Spend (£000's)	2019/20	Target	2020/21											YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Agency Spend	**£10,087**		£1,298	£1,137	£814	£700	£802	£921	-	-	-	-	-	-	£5,672
Nursing and Midwifery Registered	£5,155		£842	£617	£536	£258	£297	£296	-	-	-	-	-	-	£2,846
Qualified Scientific, Therapeutic and Technical	£703		£305	£305	£305	£305	£305	£305	-	-	-	-	-	-	£1,828
Support to Clinical Staff	£148		£2	£41	£9	£13	£17	£13	-	-	-	-	-	-	£96
of which support to nursing staff	£45		£16	£16	£16	£16	£16	£16	-	-	-	-	-	-	£94
NHS Infrastructure Support	£576		£340	£398	£416	£398	£378	£419	-	-	-	-	-	-	£2,350
Medical and Dental	£3,505		£315	£315	£107	£224	£303	£380	-	-	-	-	-	-	£1,644
of which Consultants	£992		£128	£126	£48	£85	£100	£148	-	-	-	-	-	-	£635
of which Career/Staff Grade	£1,376		£101	£103	£57	£119	£124	£153	-	-	-	-	-	-	£657
of which Trainee Grades/Trust Grade	£1,137		£86	£86	£2	£20	£79	£78	-	-	-	-	-	-	£352

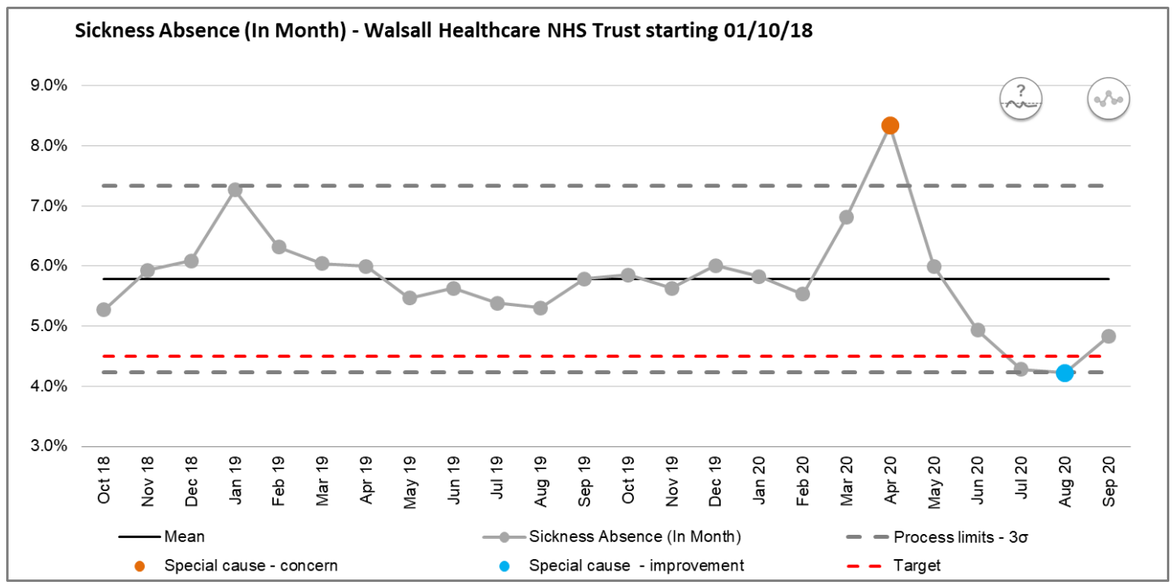
Bank Spend (£000's)	2019/20	Target	2020/21											YTD Total
			Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Bank Spend	**£15,073**		£1,653	£1,524	£2,143	£1,744	£1,715	£1,811	-	-	-	-	-	-	£10,590
Nursing and Midwifery Registered	£4,267		£448	£441	£439	£459	£521	£512	-	-	-	-	-	-	£2,820
Qualified Scientific, Therapeutic and Technical	£0		£2	£2	£2	£2	£2	£2	-	-	-	-	-	-	£10
Support to Clinical Staff	£3,458		£379	£338	£341	£319	£355	£405	-	-	-	-	-	-	£2,138
of which support to nursing staff	£3,240		£1,946	£1,946	£1,946	£1,946	£1,946	£1,946	-	-	-	-	-	-	£11,678
NHS Infrastructure Support	£1,028		£735	£735	£735	£735	£735	£735	-	-	-	-	-	-	£4,412
Medical and Dental	£6,320		£729	£611	£1,257	£862	£678	£758	-	-	-	-	-	-	£4,895
of which Consultants	£3,658		£368	£327	£566	£471	£353	£512	-	-	-	-	-	-	£2,596
of which Career/Staff Grade	£1,880		£213	£150	£274	£270	£216	£164	-	-	-	-	-	-	£1,286
of which Trainee Grades/Trust Grade	£782		£148	£134	£418	£121	£109	£82	-	-	-	-	-	-	£1,013

Establishment Gap By Staff Group (FTE)	2019/20	Target	2020/21											YTD Change - Since 31/03/20
	Mar-20		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	
Total Establishment Gap	**358.86**		**348.66**	**312.07**	**282.79**	**262.14**	**191.71**	**297.89**	**-**	**-**	**-**	**-**	**-**	**-**	**-60.97**
Additional Clinical Services	92.30		58.31	24.59	-2.08	-15.92	-1.77	31.74	-	-	-	-	-	-	-60.56
Administrative and Clerical	73.68		88.75	88.32	77.25	72.38	66.91	64.30	-	-	-	-	-	-	-9.38
Allied Health Professionals	21.08		24.04	22.98	21.32	17.88	16.68	14.74	-	-	-	-	-	-	-6.34
Estates and Ancillary	39.17		43.73	47.02	46.75	47.69	48.44	49.13	-	-	-	-	-	-	9.96
Healthcare Scientists	3.18		0.46	2.15	1.97	2.88	1.44	1.70	-	-	-	-	-	-	-1.48
Medical and Dental	33.25		38.52	38.34	44.06	47.23	-27.26	34.54	-	-	-	-	-	-	1.29
Nursing and Midwifery Registered	95.07		96.77	90.59	102.04	103.42	96.09	105.56	-	-	-	-	-	-	10.49
Professional and Scientific	1.13		-1.92	-1.92	0.08	-4.82	1.18	2.18	-	-	-	-	-	-	1.05
Students	0.00		0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-	0.00

Trust Analysis & Performance Drivers

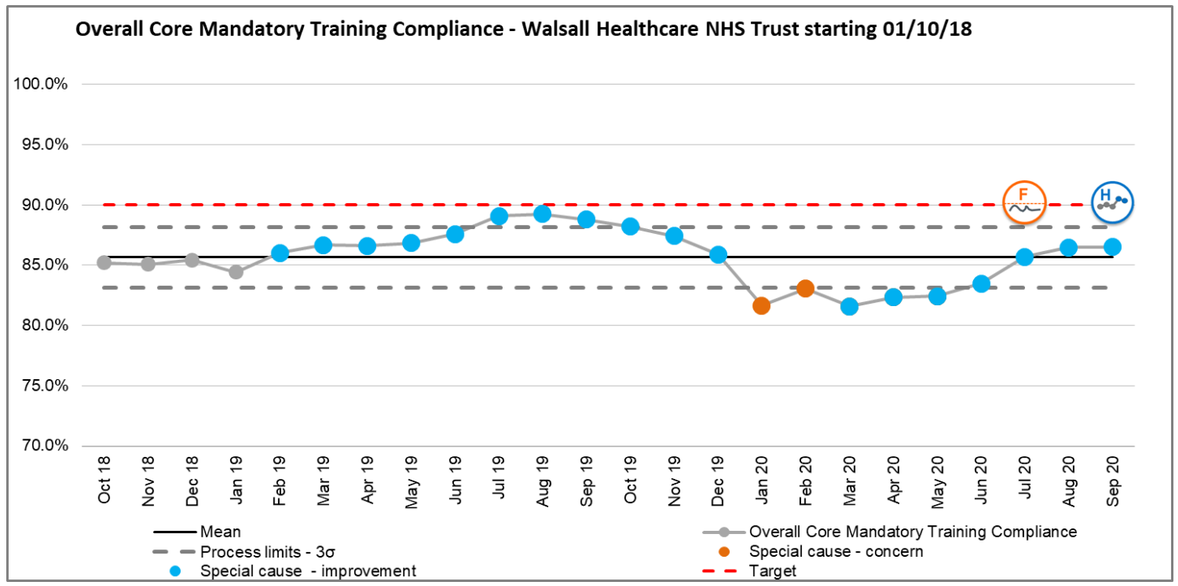
What Does The Data Tell Us?					
Are We Hitting The Target?			Is Performance Stable?		
Sometimes	Yes	No	Yes	Getting Worse	Getting Better

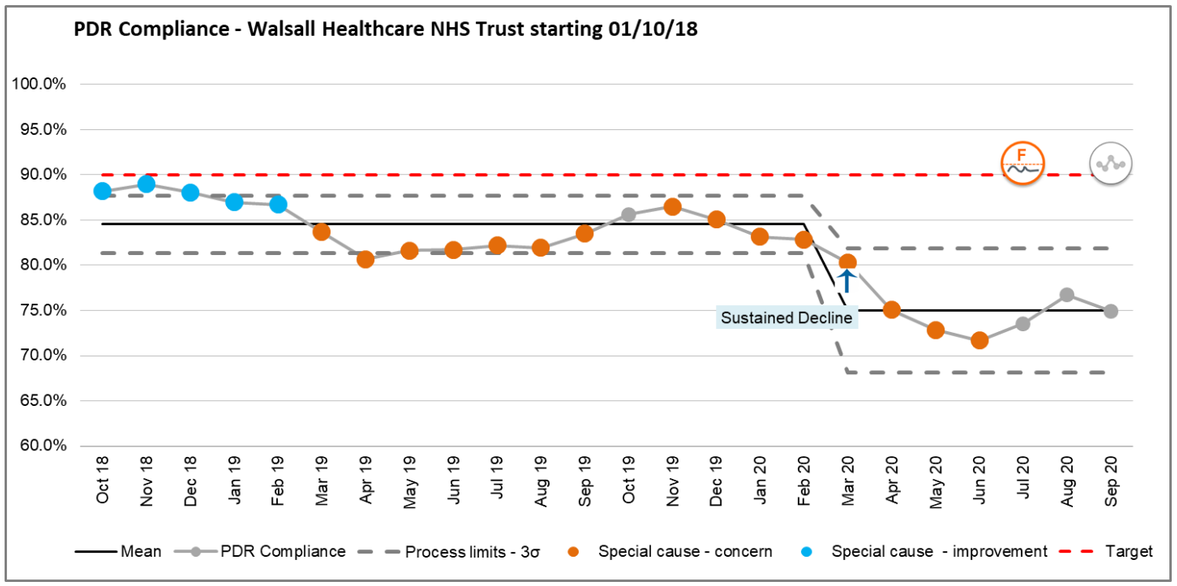




- 82% average maintained despite recent fluctuations in retention rates.
- High Retention = Admin/Estates/AHP | Low Retention = Clinical Support

- Significant growth in Cold/Cough/Influenza & COVID-related absences.
- Long-term absence falling; performance driven by short-term episodes.





- 7th month of improvement represents a sustained upward trajectory.
- All competencies show progression towards the target.

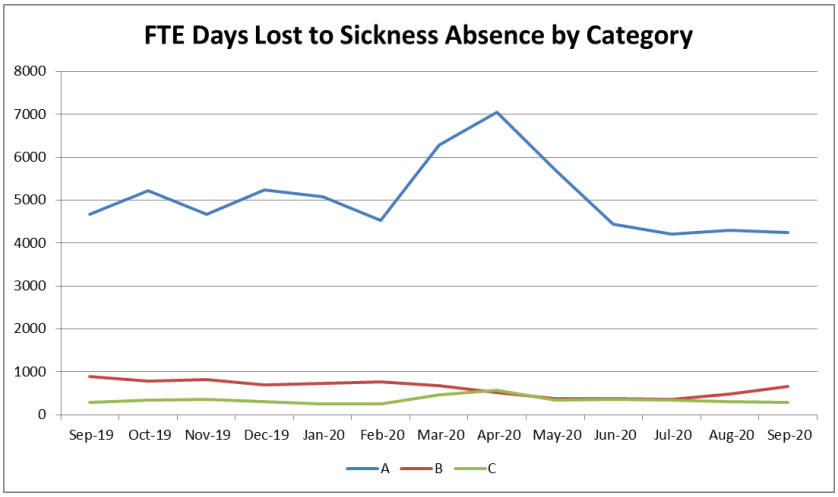
- Compliance has fallen to a 75% average since Mar-20.
- Compliance remains is lowest amongst Admin & Clerical Colleagues.

Appendix A – Absence Review by Working Demographic

In the lieu of definitive intelligence about individual colleague remote working arrangements, this review of sickness absence is aligned to the survey of workforce availability; conducted in response to the COVID-19 pandemic and redeployment planning needs.

Category	Description
A	Staff Required to work on-site.
B	Staff whose job enables them to and can work from home.
C	Staff whose job role has not been identified in a) or b) above.

Substantive Headcount by Category & Staff Group	A	B	C	Grand Total
Add Prof Scientific and Technic	137	10	0	147
Additional Clinical Services	680	60	0	740
Administrative and Clerical	207	593	157	957
Allied Health Professionals	253	10	3	266
Estates and Ancillary	373	10	0	383
Healthcare Scientists	50	1	1	52
Medical and Dental	383	5	0	388
Nursing and Midwifery Registered	1303	23	5	1331
Students	12	6	0	18
Grand Total	**3398**	**718**	**166**	**4282**



Colleague absence records were triangulated against the workforce availability survey to investigate recent sickness trends. Sickness amongst Category A colleagues has reduced by 9% over the past year. There has been a 25% drop in absence for Category B colleagues. Absence amongst the 166 Category C colleagues returned to and now exceeds 2019 levels. Recent increases in sickness are attributable to rising absence amongst colleagues able to/currently working from home (Category B).

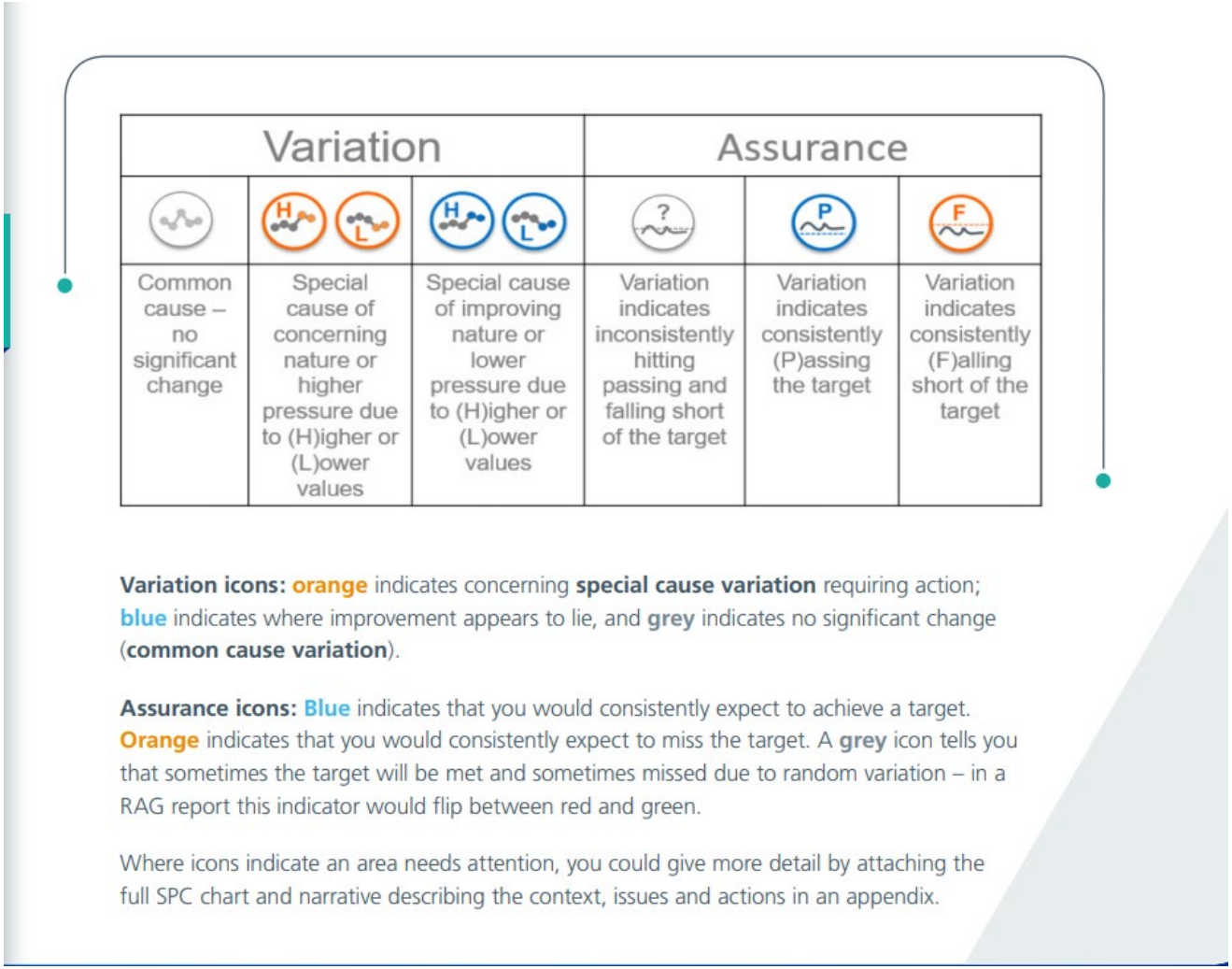
The findings of this review evidence a correlation between access to flexible working and reduced absence levels. That said, the recent rise in absence amongst colleagues able to/currently working from home supports the focus on holistic health and well-being approaches which recognise the differing needs/circumstances of colleagues, tailoring absence management interventions where possible.

Appendix B - Supplementary Comments

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

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

Appendix C - Using the SPC Charts



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

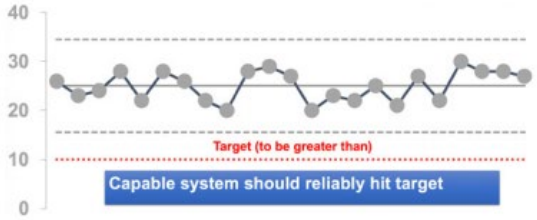
Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

Appendix C - Using the SPC Charts

The position of a target line in relation to the process limits will inform you if your indicator can hit a target or threshold consistently, by random chance, or not at all.

If your target line is in between the process limits be cautious about reacting to success (green) and failure (red) when natural variation may be causing the target to be passed or failed. Remember that approximately 99% of data points should fall within the process limits. These graphs will help guide your action:

Improvement Analysts **Alex and Thomas,** discuss the presence of target lines in statistical process control (SPC) charts for assurance.



Making data count | NHS Improvement. 2019. Making data count — strengthening your decisions. [ONLINE] Available at: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL.pdf. [Accessed July 2019].

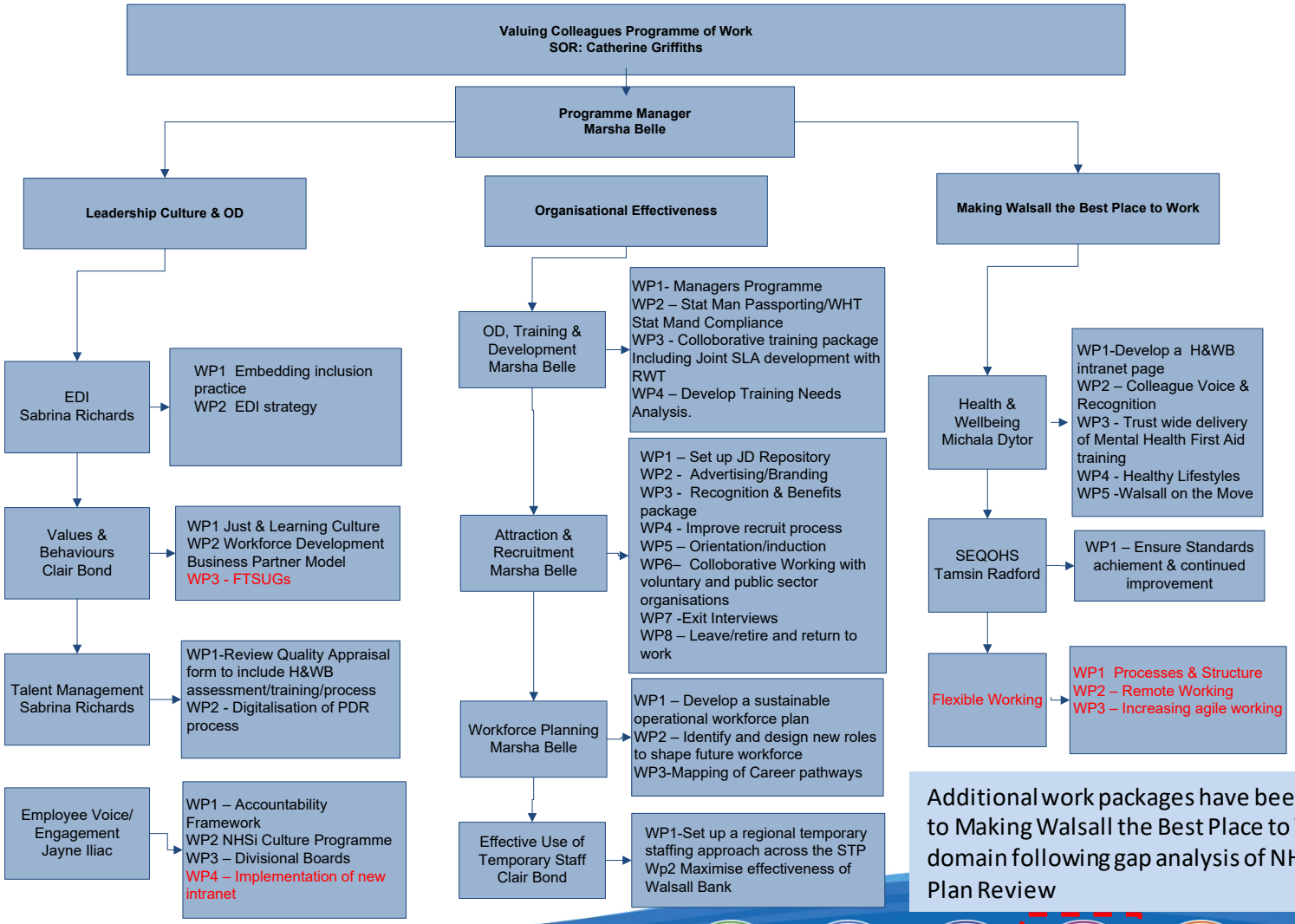
Appendix D - HR KPI RAG Rating Scales

Safeguarding Children Level 1	<85%	86% - 95%	>=95%
Safeguarding Children Level 2	<76%	76% - 85%	>=85%
Safeguarding Children Level 3	<76%	76% - 85%	>=85%
Safeguarding Adults Level 1	<85%	86% - 95%	>=95%
Safeguarding Adults Level 2	<76%	76% - 85%	>=85%
Safeguarding Adults Level 3	<76%	76% - 85%	>=85%
PREVENT Level 1 & 2	<76%	76% - 85%	>=85%
PREVENT Level 3	<76%	76% - 85%	>=85%
All Other Mandatory Training Attendance	<81%	81% - 90%	>=90%
Appraisal rate	<81%	81% - 90%	>=90%
Sickness Absence %	>5%	4.5% - 5%	<=4.5%
Turnover	>11%	10% - 11%	<=10%

Appendix E - Training & Appraisal Exclusion Lists

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

Work Breakdown Structure



Additional work packages have been added to Making Walsall the Best Place to Work domain following gap analysis of NHS People Plan Review

Monthly Project Tracker

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

Key Points to Note:

- We have reviewed original timelines for delivery of key objectives for the H&WB Project in year 1 and we are now re-phasing delivery of the above work package to be delivered in Qtr 4 rag rating remains amber.
- Due to poor compliance rates of PDR Talent Management project has also been rag rated amber.
- Temp Staffing rag rating remains amber awaiting decision on next steps from STP

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	As a result of COVID organisational recovery and potential Wave 2 of the COVID pandemic it could impact on overall delivery of this programme of work and associated benefits		Reporting progress and escalating slippages through Governance Framework
	Concerns regarding workforce data quality have been raised with regards to ESR, Training data		Data lessons learnt session to be held on the 9th Oct An action plan will be developed Analytical resource being explored
Issues	Capacity of team to deliver programme of work in line with BAU requirements whilst responding to requirements of COVID recovery		On going review of resource requirement via weekly huddle meetings with work stream leads and identifying alternative subject expert matter to support with delivery. Moving Improvement work into BAU. Specific HR / OD support has been commissioned to support teams with complex needs.
Dependencies	Safe High Quality Care, Pathway to excellence programme of work		Joint work shop required to define workforce model / employment model –and design principles (org and team levels) to be established
	Well Led Programme of Work		Joint working to define clear aims and objectives to deliver Accountability Framework and business partner models
	Effective Use of Resources		Temporary Staffing and Estates Utilisation
	Temporary Staffing		Safe High Quality Care and Working with Partners

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Safe Staffing Report			**AGENDA ITEM: 12**
Report Author and Job Title:	Caroline Whyte Interim Deputy Director of Nursing	**Responsible Director:**	Ann-Marie Riley Interim Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	Registered Nurse (RN) vacancy rate is currently 7.57% which is the same as last month. 10 whole time equivalent (WTE) student RNs are expected to convert into substantive positions during October. The overall nursing and midwifery fill rate was 97.1% in September and was a decrease of 2% since August. Occupancy varied in September between 60% to 99%, with mean inpatient occupancy of 83%. Overall temporary staffing use in nursing remains within control limits and is less than pre COVID-19 period. Reasons for this are substantive staff redeployments, lower absence levels and reduced occupancy across wards. There were 543.5 hours of registered nurse, and 289 hours of clinical support worker (CSW), redeployment organised through the daily staffing meetings in September to support safe staffing across the Trust. Bank shift utilisation decreased during the last 2 weeks of September and fell to levels seen in April. Strategies to continue to avoid Tier 2 usage continue, however we have seen an increase in Tier 2 usage throughout September. NHSI agency cap breaches have increased during September but continued to remain within control. Off framework use in September was 154 hours; this is a significant increase on the month before. Bookings of temporary staff for sickness absence and COVID-19 backfill did not exceed the number of hours recorded for clinical support workers. There was some elevation in bookings against registered nurse sickness and COVID-19 related absence. There continued to be an under booking of maternity leave cover as a reason for bank requests, this will be discussed at the Nursing, Midwifery and Allied Healthcare Professionals Advisory Forum (NMAAF) and reiterated at the monthly Workforce Transformation meetings. Allied Healthcare Professionals have a vacancy gap reported of 51.24 whole time equivalents. A self-assessment against the NHSI Developing Workforce Safeguards Guidance (2018) has been completed and is attached at Appendix 1		
Recommendation	The Trust Board is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust	BAF S01: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022		

Risk Registers? please outline	Corporate Risk 2066: There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience	
Resource implications	COVID impact - staff are working in different ways and locations; risk to staff health and well-being; impact on training and continual professional development	
Legal and Equality, Diversity and Inclusion implications	COVID-19 has impacted disproportionally on males and people who are from BAME background Work is underway to better highlight equality, diversity and inclusion issues affecting the nursing, midwifery and allied health professional workforce	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

1.0 Nurse Staffing Update

1.1 Vacancy Position

The Registered Nurse (RN) vacancy position for September is 7.57% (Chart 1). As previously explained, nursing associate (NA) vacancies were excluded. These were included in vacancy position reports pre July, as well as the planned student nurse starters. 10 newly qualified RNs are planned to join the Trust in October benefitting each Division. Table 1 shows the divisional RN vacancy position.

The Central Recruitment Team have launched a task and finish group to commence work related to the Nursing and Midwifery recruitment strategy to ensure that it is aligned to support operational changes and service re-design. This will support us to ensure the safest staffing levels possible are achieved whilst COVID-19 and operational challenges continue.

Chart 1: Nursing and Midwifery vacancy % (excluding nursing associates)

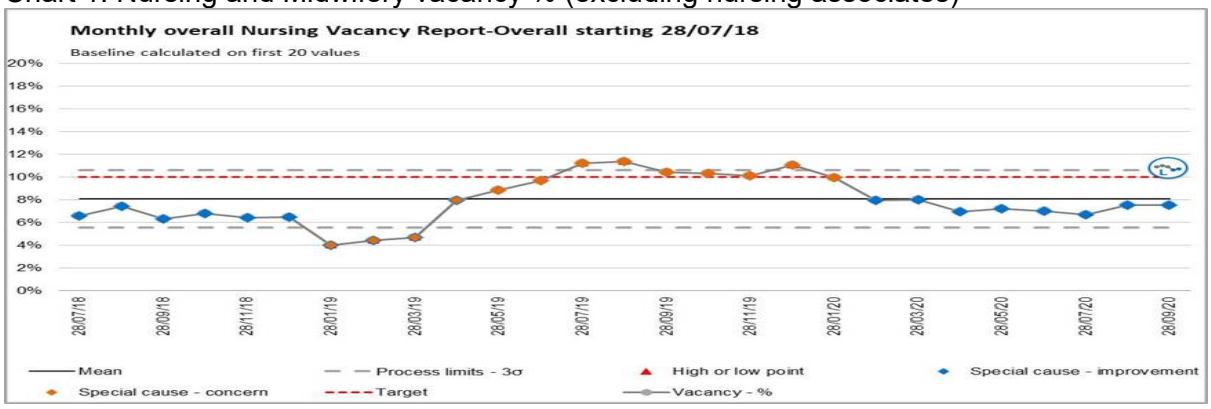


Table 1: Divisional RN vacancies

Division	RN Vacancy WTE
MLTC	14.06
SURGERY	37.35
WCCCS	53.24
COMMUNITY (DN)	13.0

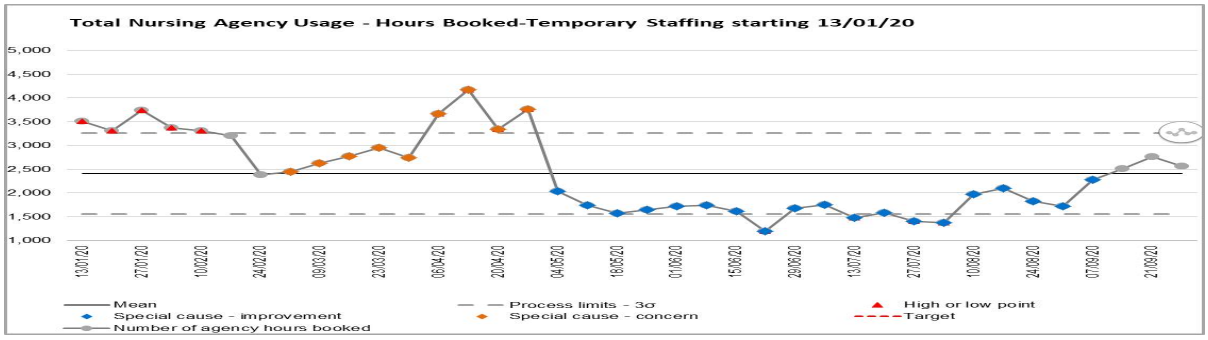
There are a total of 59.32 whole time equivalents (WTE) NA posts within establishments. Unfortunately the numbers of NA trained, or available externally for recruitment, does not match the WTE numbers placed into the budgets. The vacancy position for NAs remains at 76% with 15.18 WTE NAs in post. The vacant gaps for these positions are predominantly filled with either bank or agency Band 5 nurses and lead to an additional £6.31/hr (potential >£10k/wk) cost pressure for every shift filled with a bank B5 RN.

Nursing Establishment reviews commenced in September and are continuing throughout October and are including a review the NA position.

1.2 Temporary Staffing Analysis of Hours used

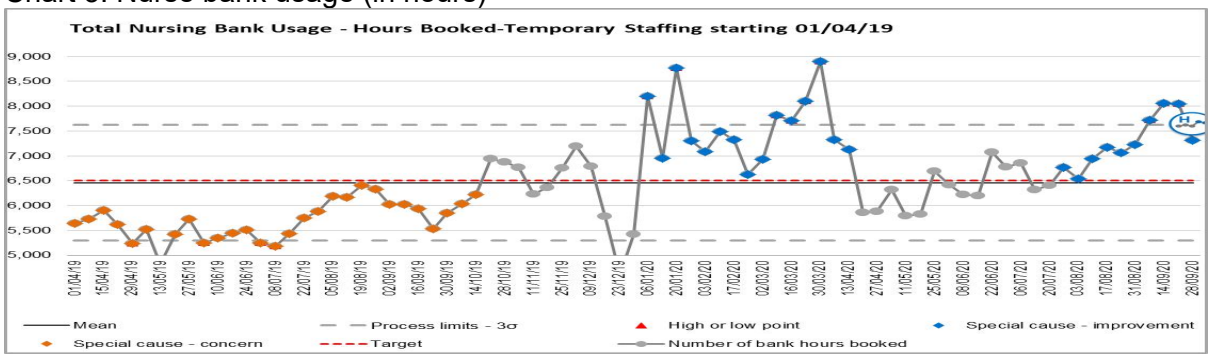
RN agency usage increased during September, with the final week seeing a slight reduction (Chart 2).

Chart 2: Nurse Agency usage (in hours)



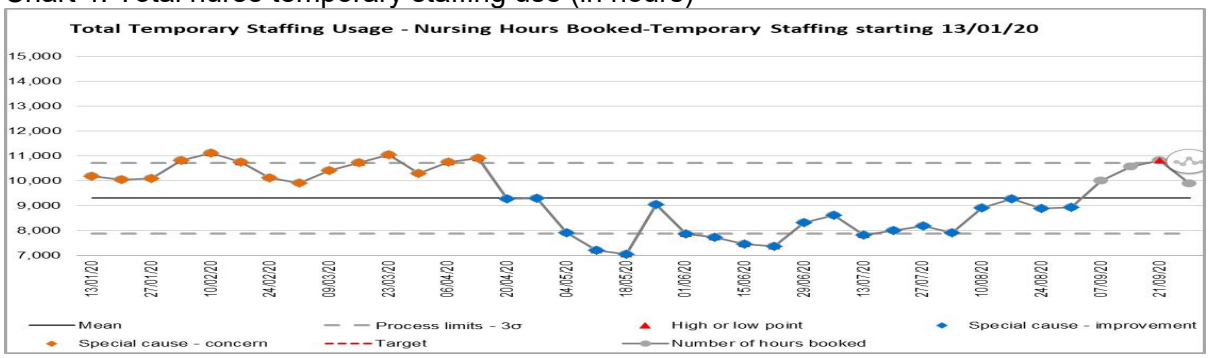
Bank shift utilisation (Chart 3) decreased during the last 2 weeks of September and fell to levels seen in April. Approaching the end of September many bank staff were indicating dissatisfaction with the decision to cease bank pay rates introduced during COVID-19 from 1st October; this has been escalated to Tactical Command. The impact of these changes is becoming evident and close monitoring of this situation is continuing.

Chart 3: Nurse bank usage (in hours)



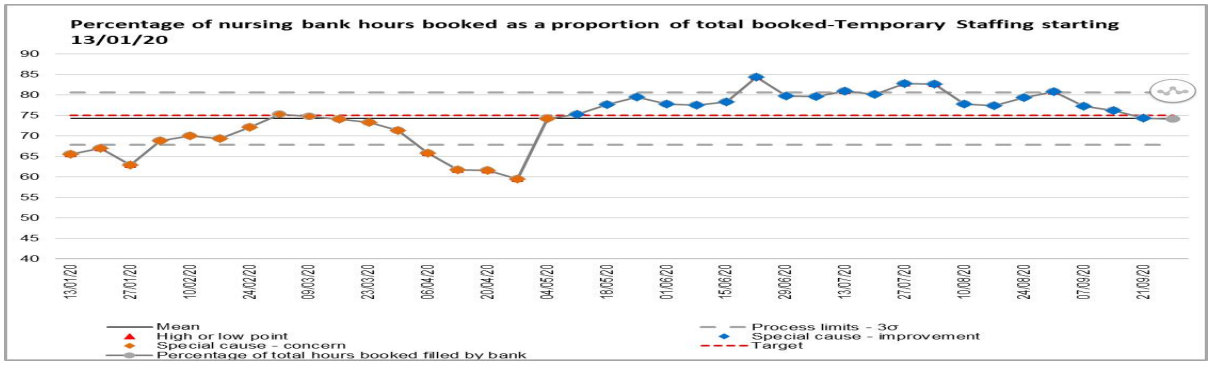
The beginning of September saw an increase in booked temporary staffing hours overall for RN and CSW combined, and by the last week of September we saw a decrease again. Overall use (see Chart 4) in nursing remains within control limits and is less than pre COVID-19. Reasons for this are effective oversight and implementation of substantive staff redeployment opportunities.

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



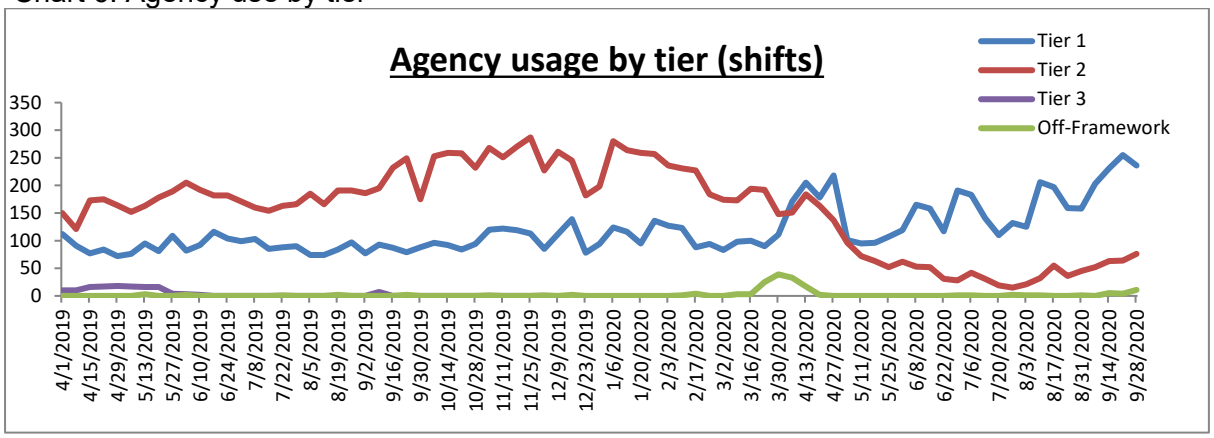
Bank as a proportion of temporary staffing use has fallen throughout September (see Chart 5) and by the end of September was just under achieving our 75% target; we had not seen a reduced fill at this level since May. Bank staff pay rates were increased by £3 per hour during the COVID-19 period and contributed significantly to overall fill improvements.

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



Agency use by Tier has changed significantly since March (chart 6) and we continue to see higher Tier 1 use than Tier 2, though Tier 2 use did increase during September. There is a sustained effort in Tier 2 avoidance and strategies are in place to support areas before consideration of expensive agency though these strategies are impacted by any Covid related activity which has increased across the Hospital towards the end of September.

Chart 6: Agency use by tier

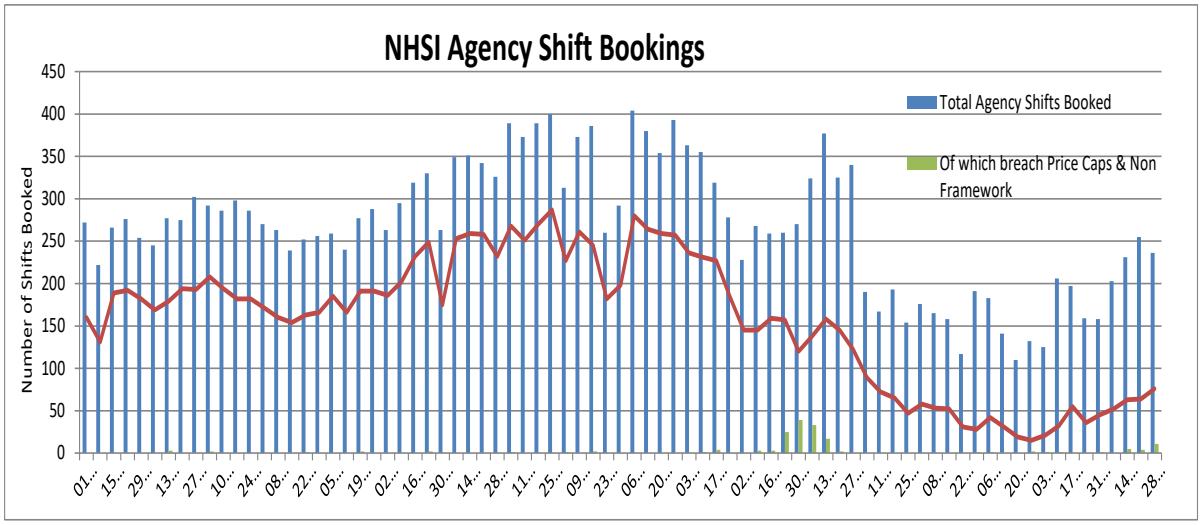


Tier 2 use increased to levels similar to April (Chart 6). Tier 2 increases can be attributed to heightened levels of demand across the site and increased requests numbers in Emergency Department (ED) and some of the ward areas for COVID-19 streaming, and infection prevention and control reasons, towards the end of September.

Matrons ensure that in the twice daily staffing meetings opportunities are sought to redeploy personnel where this is safe to do so. In September, before consideration of escalation to Agency Tier 2, Matrons redeployed 543.5 hours of substantive RN and 289.5 hours of CSW from reviews during staffing approval meetings.

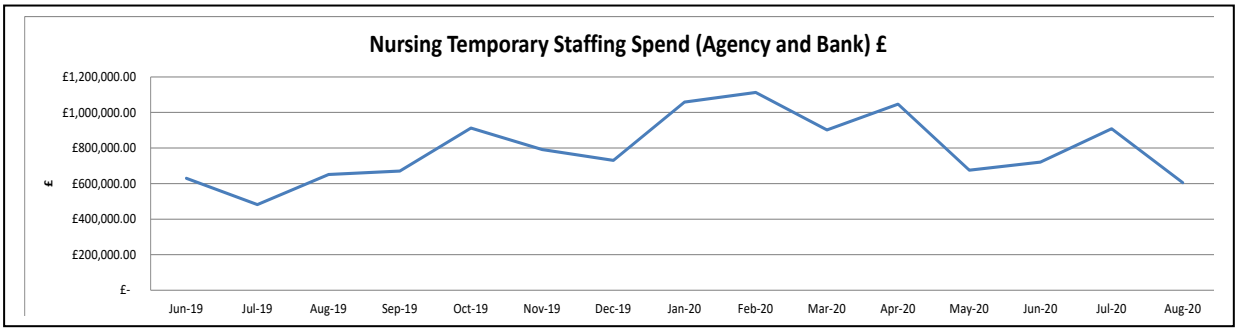
NHSI Agency Cap Breaches (Chart 7) have continued to be reported weekly to NHSI and increased during September to levels seen in May. There was 154 hours of Off Framework use in September and these were 23 hours for ED and 131 hours for the Intensive Care Unit (ICU). An increase in COVID-19 related activity has prompted the use of Off Framework shifts.

Chart 7: Agency cap performance



At the time of writing the report, no finance update had been received regarding the Temporary Staffing spend in September. August data is shown in Chart 8.

Chart 8: Nursing temporary staffing spend



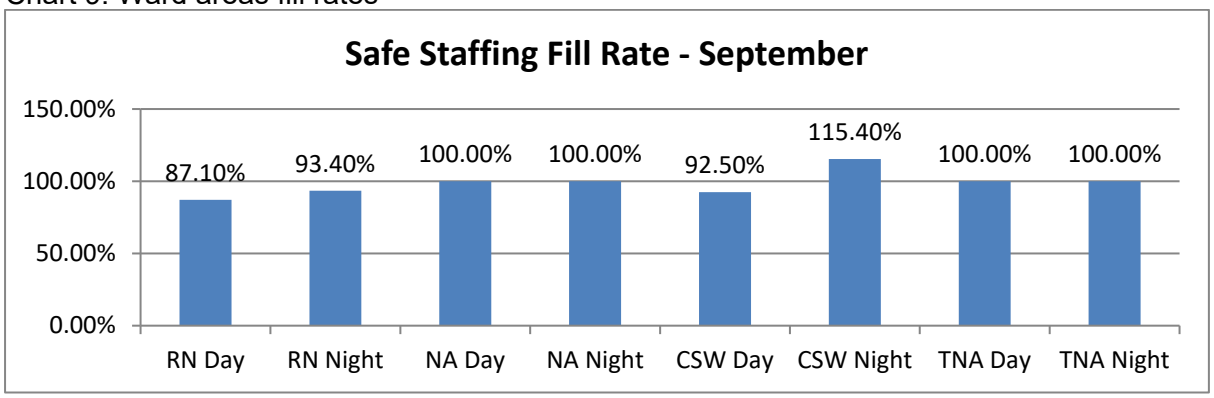
Additional controls are to be put in place to provide greater assurance for temporary staffing bookings where the request is for additional capacity or to provide enhanced supervision (where a patient requires 1:1 care). We are reviewing the current list of booking reasons and aim to reduce this, and we are also scoping the feasibility of requesting a vacancy number in order to book bank/agency shifts against a vacancy so we can better manage these requests. Further discussion around this will form part of the Nursing Establishment Reviews.

1.3 Staffing Fill Rates

Lowest fill rate was seen in the day RN at 87.1% (Chart 9) this is the same as the previous month. The overall fill rate (combined RN and CSW) was 97.1%, a reduction of 2% since August. Reduced bed capacity within some ward areas has meant that when backfill for shortfalls was sought it was considered safe to not escalate shifts on some days. Bed occupancy varied in September between 60 to 99% with mean inpatient occupancy of 83%. This calculation is based on adult in-patient wards, excluding paediatric and maternity, who do not use agency for temporary staffing. 20a and 20b were also excluded due to the nature of their current operation of arrivals, day-case, non-Covid in-patients and HDU. Further work is taking place within the division to understand the changes in bed base and staffing numbers.

Redeployed staff have supported the maintenance of good fill rates although we are mindful of the potential impact to staff morale if individuals are regularly redeployed.

Chart 9: Ward areas fill rates



1.4 Staff sickness and Temporary staffing cover

Registered nurse sickness absence has remained static during September (Chart 10) and remains at the lowest level since September 2018. CSW sickness absence (Chart 11) has increased and is approaching levels seen in May / June.

Chart 10: Sickness Absence RN (ESR data)

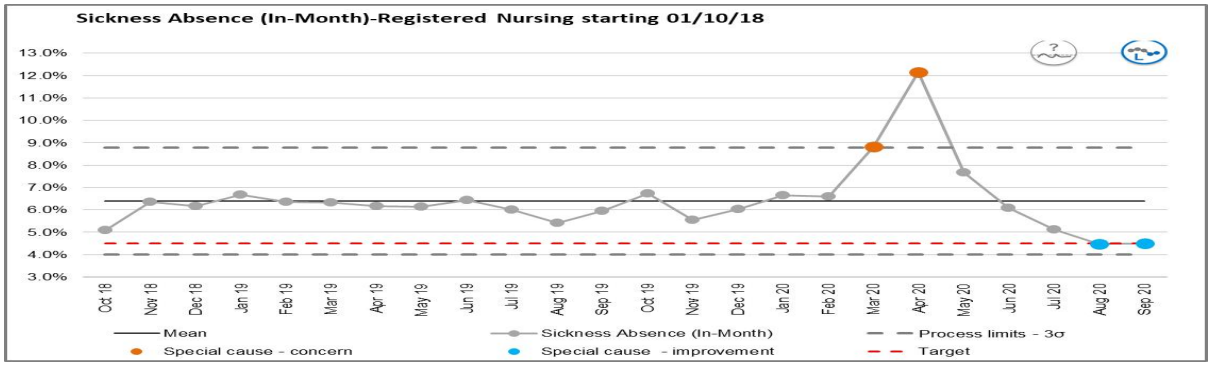
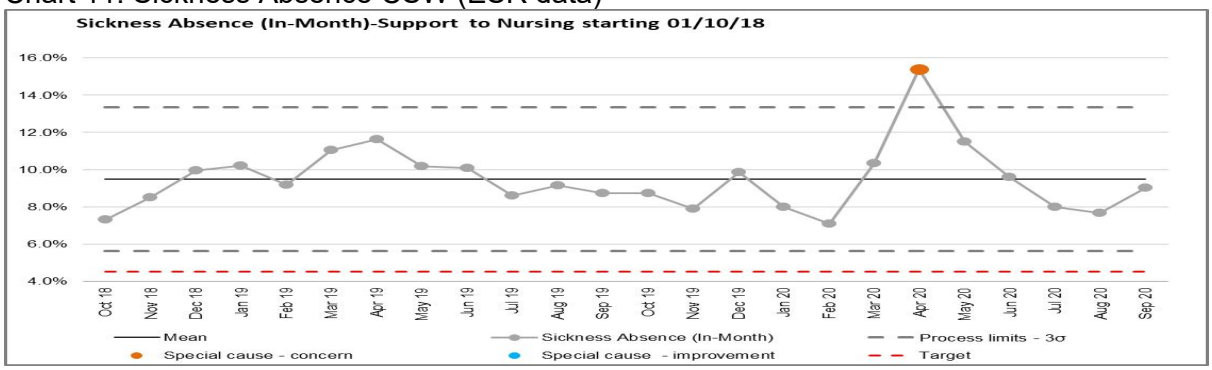


Chart 11: Sickness Absence CSW (ESR data)



The levels of sickness absence recorded in the Eroster Systems for the month of September is shown in Table 2.

Table 2: Eroster Systems Absence levels

Staff Type	Sickness Absence Hours (Eroster)
RN	6807
CSW	7151.5

In addition to sickness absence, in the Eroster systems we have the recorded numbers of COVID-19 Related 'other leave' which areas will backfill using the sickness reason for Temporary Staffing (Table 3).

Table 3: Eroster Systems Covid related absence levels

Staff Type	Covid Related Absence Hours (Eroster)
RN	1277(more than double of last month)
CSW	805 (almost double of last month)

Comparison to temporary staffing bookings for sickness and COVID-19 related absence highlights that for RN's there was 1605 hours over booking of hours, for CSW there was 2456 hours less than the levels of absence (Table 4). .

Table 4: Comparison of Sickness/Covid Absence against Temporary Staffing

Staff Type	Sum of Covid Related Absence Hours + Sickness Absence	Temporary Staffing Hours Cover for Sickness and Covid related absence
RN	8084 hrs (5885hrs last month)	9689 (variance = +1605 hrs)
CSW	7956 hrs (5906 last month)	5500 (variance = -2456 hrs)

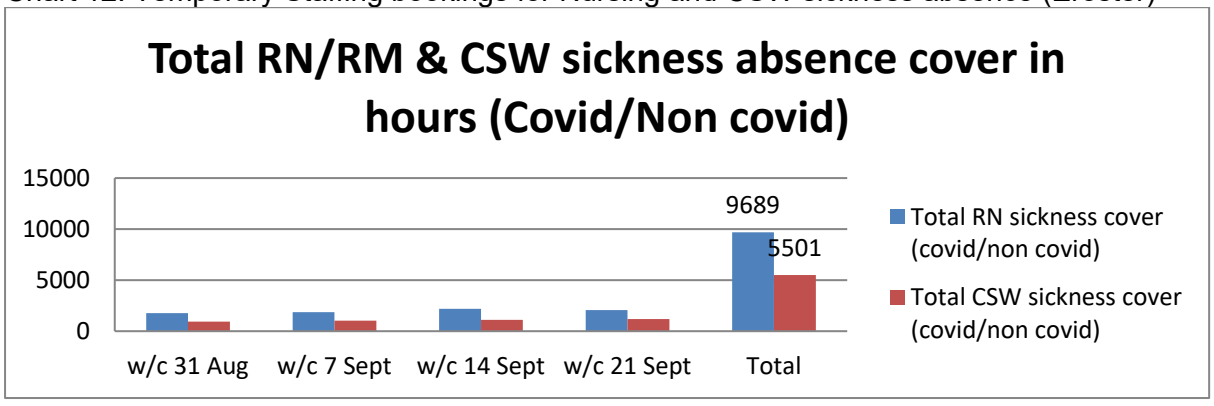
Previous comparison between booked hours and absence reasons shows that maternity leave is often under used and Roster Managers 'default' to using sickness in error, this has occurred again during September, this will be discussed at next NMAAF and Workforce Transformation meetings.

Table 5: Comparison of Maternity/Paternity absence against Temporary Staffing

Staff Type	Maternity/Paternity Absence hrs	Temporary Staffing Hours Cover for maternity/paternity related absence
RN	4381 (more than last month)	1416 (variance = under booked by 2965 hrs)
CSW	2187 (less than last month)	486 (variance = under booked by1701 hrs)

Chart 12 shows the sickness and COVID-19 related temporary staffing bookings per week

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



Additional Capacity across the hospital site – September:

Area with increase in staffing numbers	RN increase per 24 hrs	CSW increase per 24 hrs	Total Hrs Required
Ward 12	23 hrs	34.5 hrs	RN = 690 hrs CSW = 103.5 hrs
Ward 10 Gaps			RN = 970 hrs CSW = 652 hrs
ED (Medway related from 19th)	46 hrs	46 hrs	RN = 506 CSW = 506
ED (Sepsis Nurse from 19th)	23 hrs	0	RN = 253 hrs
Ward AMU (Medway related)		11.5 hrs	CSW = 253 hrs
ICU Additional Capacity			RN = 111.5 hrs CSW=18 hrs
Total Required for Month			**RN =2419 CSW = 1469.5**

- Ward 12 staffing levels remained at COVID-19 levels
- Staff required in Ward 10 despite redeployments from 20a & 20b, gaps in staffing were covered with temporary staffing
- ED Medway additional support agreed support till Oct 31st
- ED Sepsis RN in place as CQC must do. This is mitigation until the digital solution can be safely implemented

1.5 Community Temporary Staffing Spend

The most recent update for Community temporary staffing spend in July saw an increase to 35k as they were still managing Covid related care. Finance information has not been updated to include community since July however we are working with finance to design a swift methodology for them to have the timesheet data that comes into the temporary staffing finance weekly tracker.

RN / RM Community total absence (ESR data) was 7627 hours in September and for CSW there was 2114 hours of absence which is a reduction since last month, see Table 6. The Division do not use agency.

Table 6: Community sickness absence in August (Covid and Non Covid)

Type of absence	Where?	FTE Days Lost	3/7ths of FTE Day lost*	Conversion to hrs (@11.5hrs)
RN/RM sickness absence and Covid related Absence (ESR data)	Community	1547.61	663.26	**7627 hrs**
CSW sickness absence and Covid related Absence (ESR data)	Community	428.99	183.85	**2114 hrs**

Community reviews through the Nursing Workforce Transformation meetings continue, which had not previously occurred within the Trust. This has included reviewing the baseline inclusions of their vacancy reporting etc. There was recognition that some alignment and review of budget lines needs to occur within the Division to support improved clarity of where roles sit and which services may have depleted levels of staff in post. The Divisional Business Advisor has been requested to review budget lines for the Division so that they can be cross referenced with bookings in the Workforce Transformation Meetings.

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

2.0 Allied Healthcare Professionals Update

Work has continued to gather the Allied Healthcare Professional information re vacancies in month. Currently there is not a single route of oversight that gathers this data and a lot of the information is held within the division. Work will continue to determine how this information could be sourced and avoid the risk of 'double counting'. Work is also continuing to gather information on bank bookings per department for analysis and appropriate challenge to be put into place, these areas use a paper timesheet process for any Bank worked. Information gathered so far from service leads is shown in Table 7 and shows a total gap of 51.24 WTE, a rise since last month but this month's data now includes Operating Department Practitioners (ODP's).

Table 7: Allied Health Professionals Vacancy (WTE)

	Band 5 Vacancy (WTE)	Band 6 Vacancy (WTE)	Band 7 Vacancy (WTE)	Band 8+ Vacancy (WTE)
Physiotherapy	3.0	2.0	0.2	0
OT acute	0.4	1.69	0	0
Diagnostic Radiography	4.0	0.21	1.49	1
Dietetics	1.0	(1.0) funded by paeds business case	0	0
Podiatry	0	0	(1.6)	0
SLT	2	0.39	0.99	(0.2)
Orthoptics	0	0.04	0.04	0
ODP's	30.22	0	0	0
Audiology	0	0	0	0
CMU Neuro	0	0	0	0
Clinical Psychology	0	0	0	0
Specialist complimentary therapy	0	0	0	0
Paramedics	0	0	0	0
Sonography	N/A	N/A	1.57	1
Bereavement services	0	0	0	0
Pharmacy	0	0	0	0
TOTAL GAP	**40.62 WTE**	**4.33 WTE**	**4.29 WTE**	**2 WTE**

(Bracketed number is over established)

Appendix 1

NHSI Developing Workforce Safeguards Guidance (2018)

1. Update on self-assessment

This report provides an update in relation to the 'Developing Workforce Safeguards' document from NHSI (2018) and how Walsall Healthcare NHS Trust Nursing benchmark against this. A link to the guidance is below.

https://improvement.nhs.uk/resources/developing-workforce-safeguards/

In October 2018, NHSI launched a Workforce Safeguards toolkit to inform Trusts how best to ensure that there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. NHSI will assess our compliance annually.

Key recommendations are that we:

- 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

The Corporate Nursing team have undertaken an initial assessment of our compliance against the workforce safeguards toolkit which demonstrated that we are largely compliant with the recommended actions in the toolkit, however there are areas where we could improve:

- Recording and identifying risks around safe staffing within the day to day operational management of staffing
- There is more work to do to ensure that we benchmark with peers by using the Model Hospital workforce data.
- More robust recording and cataloguing of quality impact assessments and risk assessments relating to safe staffing undertaken at Divisional level which are then available to Corporate Nursing; to include a process for dynamic risk assessments to be undertaken and recorded.

The self-assessment and action plan was reported to the People and Organisational Development Committee on 3rd November, who will continue to monitor the action plan as part of the monthly Nurse Staffing Report.

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Freedom to Speak Up Quarters 1 and 2 2020/21			**AGENDA ITEM: 13**
Report Author and Job Title:	Val Ferguson Shabina Raza Kim Sterling Freedom to Speak Up Guardians	**Responsible Director:**	Catherine Griffiths Director of People and Culture
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	Presenting analysis of the number of concerns generated though Freedom to Speak Up (FTSU) from 1st April 2020 to 30th September 2020. In addition, the report provides an update of the key work of the guardians to date.		
Recommendation	The Trust Board are asked to: 1. Note the report and discuss the contents within 2. Commit to making Speaking Up routine day-to-day practise 3. Support further work required to progress the FTSU function to improve the Trust's safety culture		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The work programme described within this report will provide positive assurance to the Trust board on the following BAF risk: Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.		
Resource implications	There are some costs implications associated with following this programme of work, all resource will be aligned through existing budgets.		
Legal and Equality and Diversity implications	Black, Asian or minority ethnic employees often face more barriers than non BAME employees when raising concerns. The data available is not yet sufficient to reliably determine and evidence equality and diversity impacts. This is being addressed through collecting concerns electronically through the incident reporting system, Safeguard and work being undertaken by the Equality, Diversity and Inclusion Committee.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

FREEDOM TO SPEAK UP REPORT

QUARTERS 1 AND 2 2020/21

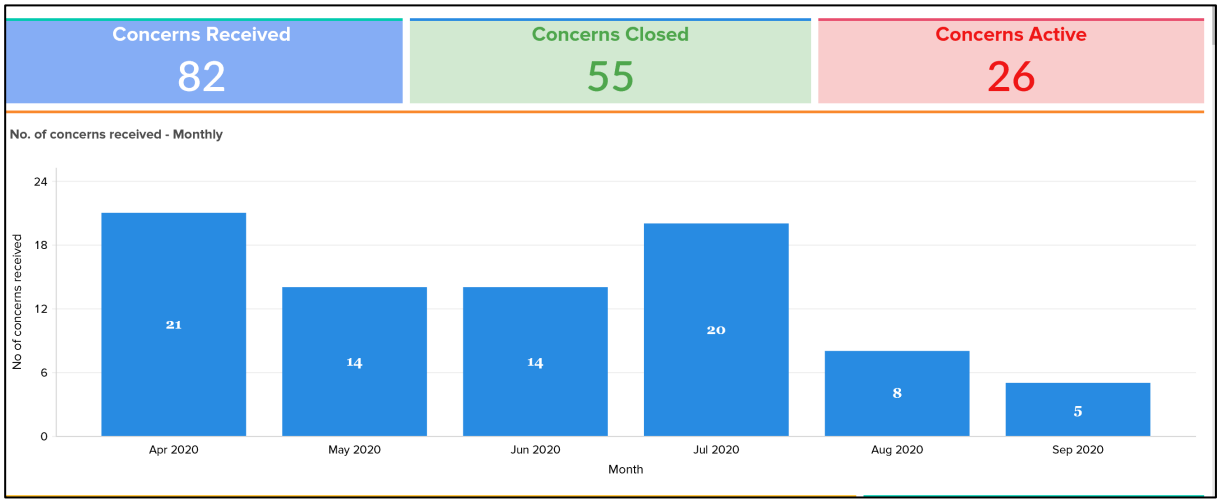
1. Introduction

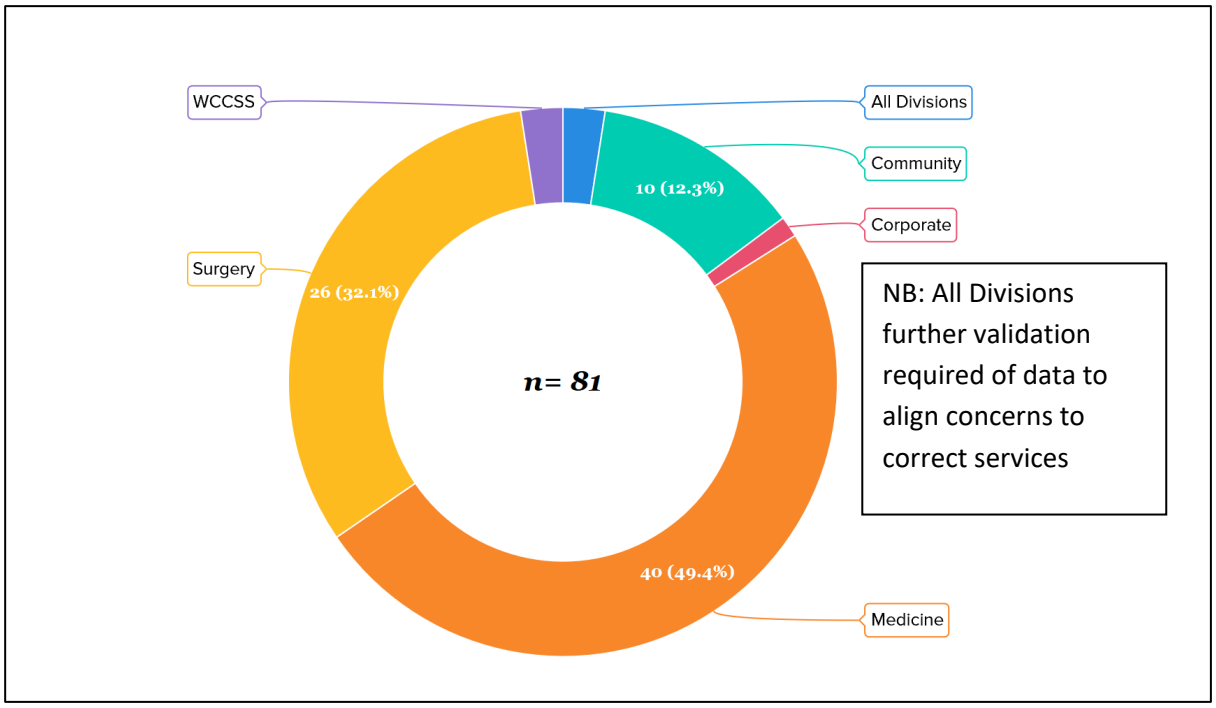
During Quarter 1 and Quarter 2, (82) concerns were raised through the Freedom to Speak up Guardians (FTSUG) via a number of platforms i.e. Safeguard Incident reporting System, face to face with Guardians, telephone and email routes. The intention of this report is to detail the nature of concerns raised and outcomes using charts and information generated by the newly developed FTSUG Dashboard. In addition we are going to detail the initiatives undertaken in response to the COVID-19 pandemic. We are also including progress related to the FTSUG Strategy implementation plan which is now reporting progress through the Valuing Colleagues Programme of work.

2. Concerns Raised

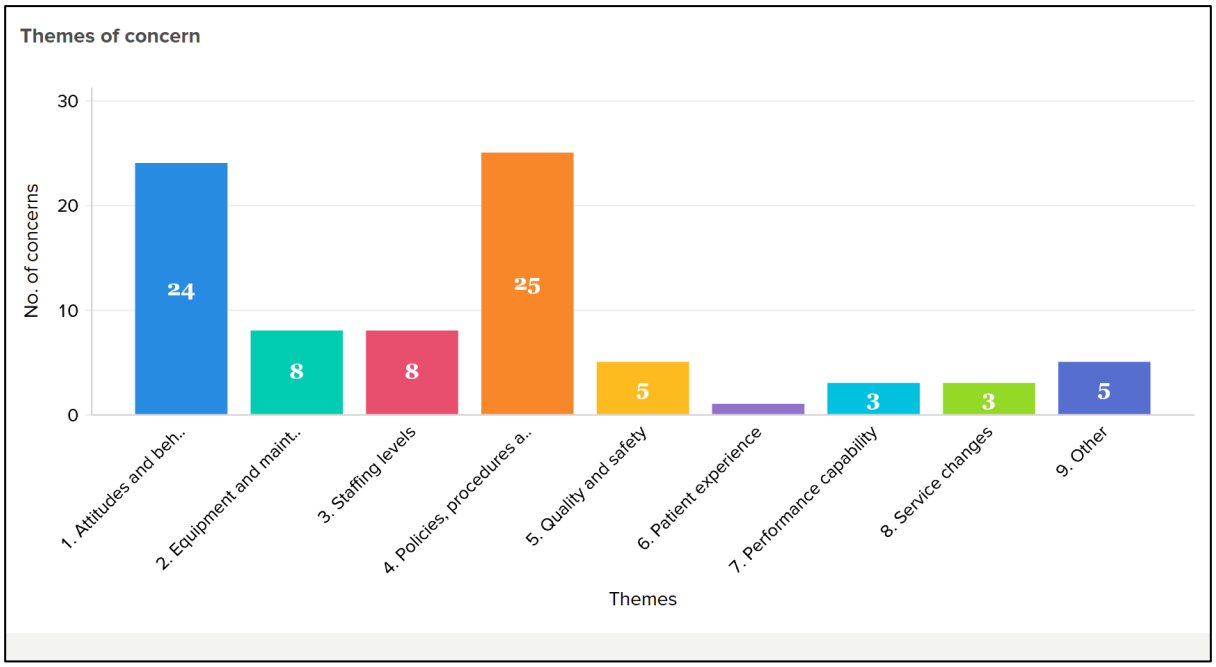
The following information reflects concerns that have been recorded on the Speaking Up tracker. Concerns are recorded in accordance with guidance from the National Guardians Office. Concerns are themed in line with categories issued to NHS Trusts by the NGO. The following information is presented so that patterns emerge over time, whilst being mindful about the need for confidentiality. The data is intended to draw attention to particular issues, patterns of activity or themes:

Concerns Breakdown: The graph below clearly demonstrates an increase in concerns raised during the months of April 20 to July 20. This increase can be correlated directly with the impact of the first wave of COVID-19. Of the 82 concerns raised during this period 67% were addressed and closed, however a further 32% remain active. This is primarily due to delays from Divisions and Services responding to FTSUG requests to meet, and responding to correspondence to resolve concerns. In addition a high number of the concerns that remain open are related to areas within the organisation that have had legacy issues related to team working, staff morale and attitudes and behaviours. A programme of organisational development work has commenced to work with these teams and we anticipate that through this work we will be in a position to close off a large percentage of these active concerns.

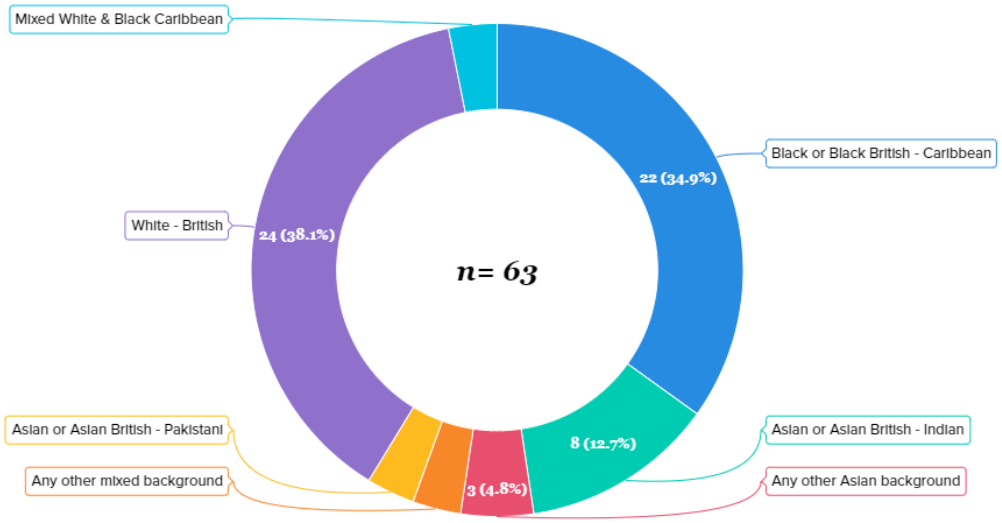




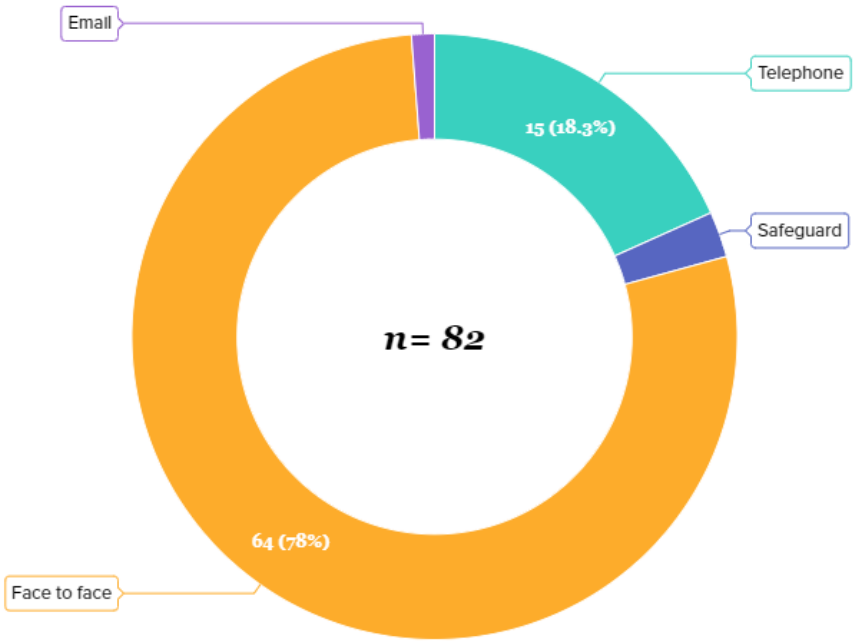
In can be concluded from the above graph that the Division of Medicine and Long Term Conditions generated the highest % of concerns. The top 3 themes being Attitude and Behaviour/Policies and Procedures and Staffing levels. A further breakdown of the data provided evidence that during the COVID-19 period and beyond that staff experienced difficulty around Personal Protective Equipment (PPE), the lack of compassionate leadership and kindness, shielding and remote working. Extensive work is being led and undertaken within particular wards and departments to develop and sustain a safe work environment.



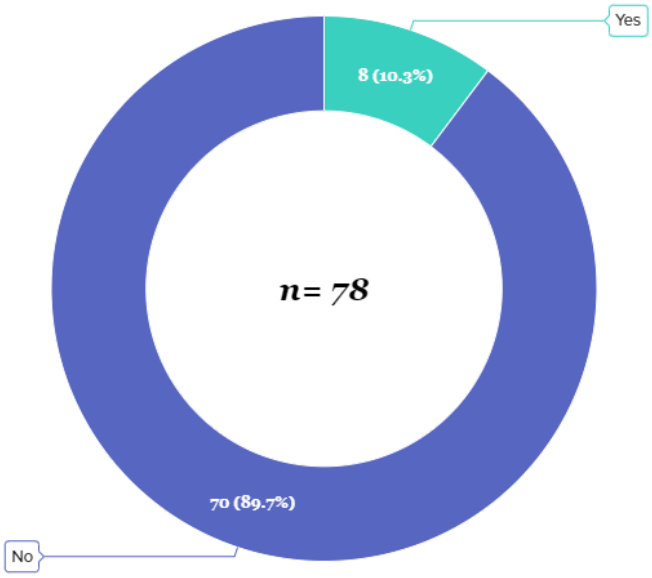
Ethnicity Breakdown (Q1 and Q2, 2020)



Communication Method (Q1 and Q2, 2020)



Concerns received anonymously (Q1 and Q2, 2020)



On conclusion of the data it can be seen that concerns have significantly increased compared to previous quarters. The reasons for this are as follows:

- Working in closer partnership with the Communication team to raise the profile of FTSUG work
- The power of “word of mouth referral” from other staff that have raised concerns with a positive/successful outcome.
- Scheduled FTSU walk rounds to ward and department promoting the service and interacting
- with staff
- The increased accessibility of the Guardian team in the MLCC.
- The increased use/accessibility of the Guardian via their mobile phone and answering service.
- A full-time guardian support of the service
- Impact of Pandemic

3.0 The guardians are working on a number of initiatives to date including:

3.1 Colleague Health & Wellbeing Weekly Meetings
At the start of the pandemic, this group was established to action concerns raised by staff. It was to address the issues as a matter of urgency. The group was led by Ben Diamond, Non-Executive Director and concerns addressed and escalated by Human Resources, Union Representatives, FTSUGs, and Occupational Health.

3.2 Call with Band 7 Nursing

Weekly conference calls with ward managers and one of the FTSUGs as well as the Director of Nursing.

3.3 Pull up a chair session with the Chair

This was initiated by the Guardians to demonstrate commitment to speaking up. All members of the Board were asked at the Board Development session to make pledges to demonstrate their on-going support.

3.4 Presentation to Private Board focusing on experience of BAME Staff during COVID-19:

The Board were interested in the concerns of staff from a BAME background during the pandemic. They were keen to unpick issues in light of the death of George Floyd and the growing Black Lives Matter movement.

3.5 Newsletter

The first edition on the FTSU newsletter published in Daily Dose and circulated via engagents. It has been used in promotional work when raising awareness of Speaking Up

4.0 **Trust Board Session in May 2020 (with presentation)**

- Developed and presented FTSU Strategy
- Developed a Freedom to speak up bulletin - launched in Speak Up October
- Completed a Project Initiation document (Which clearly highlights the work planned for the FTSU – which is time-lined)
- Advertised expression of interest for FTSU confidential contact links
- Developed a FTSU electronic dashboard
- Developing a link with the divisions and initiating a more robust training package for the leadership team to respond to concerns – re: leadership/compassionate management
- Looking at a joint way of working with other forums- staff side, HR, BAME council etc. to standardise practice through a joint steering group.

5.0 **Freedom to speak up reporting form (Appendix 1)**

In order to expand on the platforms available for all groups of staff to raise and report concerns, the guardians are currently in the process of setting up an online form which staff can use to register their concerns. The form is being created using Microsoft Forms which is endorsed by our Trust.
The form can be accessed by staff from any office or personal device and they do not need to be on Trust intranet to be able to submit their concerns. This will provide an additional avenue to the current means of reporting concerns within the organization and encourage staffs who wish to report this way.

The form will be programmed to transfer any submitted concern data to a master spread sheet automatically, which is currently being designed to provide a standardized reporting approach where data can be easily collected and reported on.

In order to make it easier for Walsall Healthcare staff to remember the link, an easy to remember domain has been created: www.freedom2speak.co.uk

6.0 **FTSU dashboard (Appendix 2)**

The FTSU team, in collaboration with the Project Management Office, is in the process of creating a digital reporting dashboard. This initiative is unique to our Trust and there is currently no precedence

of digital reporting in the region.

The dashboard will be programmed to link with the master spread sheet and using advanced automation features, non-identifiable concerns data such as number of open/closed concerns by division, age group, ethnicity, staff group, themes etc. will get refreshed on the dashboard at pre-defined intervals without a need for any manual intervention.

The aim of this initiative is to promote openness and transparency on concerns raised by the staff (without compromising confidentiality) and ensure that the divisions have an insight on issues related to their domain for better accountability.

7.0 **Speak up Month- October**

The guardians are working closely alongside colleagues throughout the trust to promote 'Speak up' month and work with other events during October to have more impact and reach out to all staff groups. For example, joint events with the Equality and Diversity Group and the BAME council are being utilized to celebrate Black history month and address difficulties that vulnerable groups like BAME staff may have when raising concerns.

Due to the current COVID-19 climate, the planning of promotional events for the guardians has been somewhat restricted. However, the guardians are currently working closely alongside communications to run as many events as possible to raise awareness of speak up month throughout October. For example, the guardians will be on the shop floor promoting their service and interacting with many colleagues as possible within the trust and community settings. A series of virtual drop in sessions and virtual staff clinics will be ran throughout October for staff to access and cater for hard to reach staff and will include availability access to the FTSUGs out of hours and weekends.

8.0 **Supporting our BAME staff**

BAME staff are one of the main vulnerable groups, especially during the COVID-19 pandemic, who are likely to be more reluctant to raise concerns due to the fear of facing detriment, as evidence from various sources suggest. The risks associated with this have been recognised and were acknowledged by the national Workforce Race Equality Standard (WRES) and Freedom to Speak Up Leads. On 15 June 2020, all trusts had been informed about the joint working that had been currently underway to improve the experience of BAME staff across the NHS. It also highlighted the important need of ensuring safe methods of speaking are made available to this vulnerable group of staff to encourage staff to come forward and raise concerns. The Freedom to Speak up Guardians have been working closely with the BAME Council, Health and Wellbeing Committee and Valuing Colleagues forum to ensure initiatives are implemented to help promote this.

9.0 **FTSU confidential links**

To expand the FTSU team further and ensure diversity and wider representation, we are currently in the process of recruiting 'FTSU confidential links.'

FTSU confidential links will support our freedom to speak up guardians to help staff raise concerns. We as a Trust are committed in protecting the safety of our patients and staff by fostering a culture of openness and transparency where everyone feels comfortable and welcomed in raising concerns. We want Walsall Healthcare NHS Trust to be recommended as a place to work and recommended as a place to be treated. Currently we have had various interests in the role already, all of which are from various staff groups, ethnicity, banding and backgrounds.

Our aim is to recruit a minimum of 10-15 FTSU confidential links by November 2020.

10.0 Training and education

Virtual clinics and educational surgeries for FTSU training for managers will be promoted and available for senior managers to access to address training needs around FTSU throughout October. A series of quizzes/word searches will also be available and promoted to staff throughout speak up month to make training more interactive and enjoyable improving overall engagement.

After seeking guidance and approval for our draft-training package for managers around freedom to speak up, we have been informed that the NGO are currently working in partnership with Health Education England to develop specific training materials. This is to ensure that there is a consistent approach in training for all trusts and national standards required for training by the NGO are met. It is therefore imperative that we await the release of this training program (estimated release date: December 2020) to ensure consistency across the region.

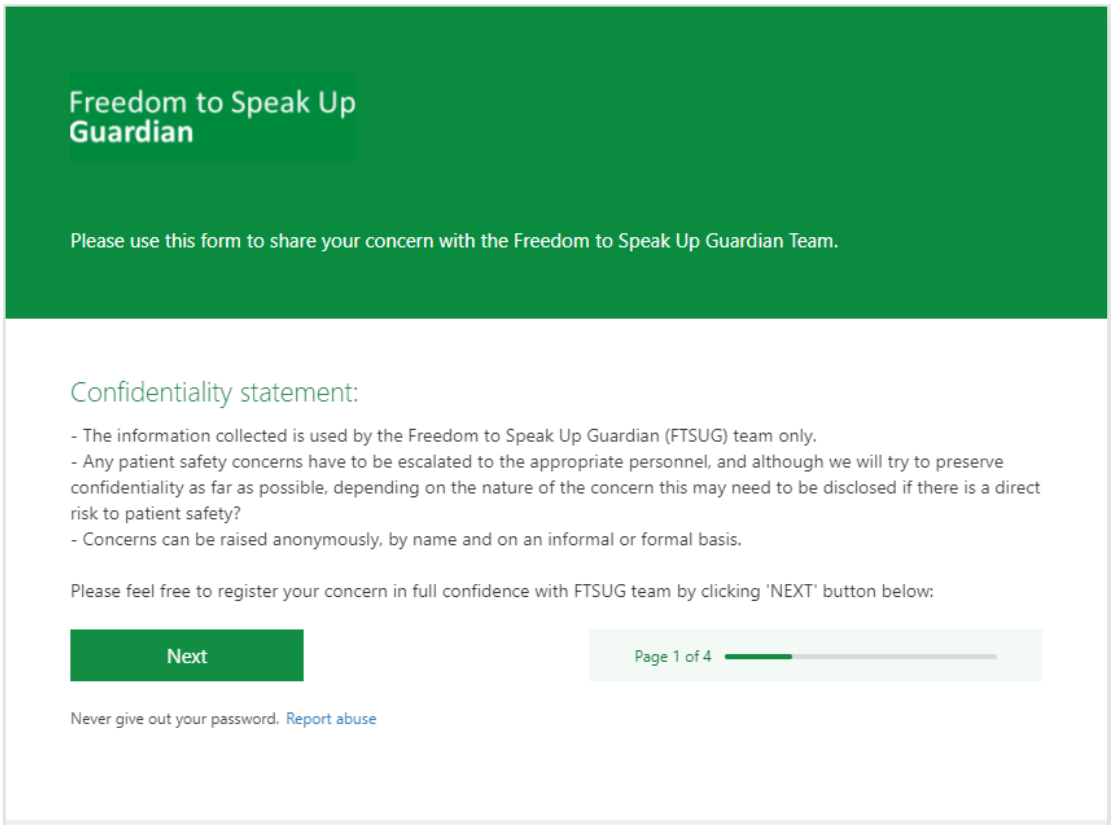
In the interim, the guardians have encouraged managers to undergo training via the freedom to speak up training modules/videos available on the HEE website and as part of their attendance at Trust induction.

11.0 Recommendations

The focus going forward over the next quarter will be:

- Continue to implement the actions from the Freedom to Speak Up implementation plan
- Carry out an evaluation of Speak Up Month
- Complete recruitment process for Confidential Contact Links
- Launch FTSU Web Form
- Launch FTSU Dashboard
- Review Policies and procedures
- Working collaboratively with NGO to launch Training package
- Create a FSTU Charter

Appendix 1


Freedom to Speak Up
Guardian
Please use this form to share your concern with the Freedom to Speak Up Guardian Team.
Confidentiality statement:
- The information collected is used by the Freedom to Speak Up Guardian (FTSUG) team only.
- Any patient safety concerns have to be escalated to the appropriate personnel, and although we will try to preserve confidentiality as far as possible, depending on the nature of the concern this may need to be disclosed if there is a direct risk to patient safety?
- Concerns can be raised anonymously, by name and on an informal or formal basis.
Please feel free to register your concern in full confidence with FTSUG team by clicking 'NEXT' button below:
Next
Page 1 of 4
Never give out your password. Report abuse

Freedom to Speak Up Guardian

* Required

Please tell us about yourself

1. Name (optional)

Enter your answer

2. Job Title (optional)

Enter your answer

3. Gender *

Select your answer

4. Ethnicity *

Select your answer

5. Division *

Select your answer

6. Department *

Enter your answer

7. Staff Group *

Select your answer

8. Length of time in the Trust *

Select your answer

9. Length of time in current position *

Select your answer

10. Contact number (optional)

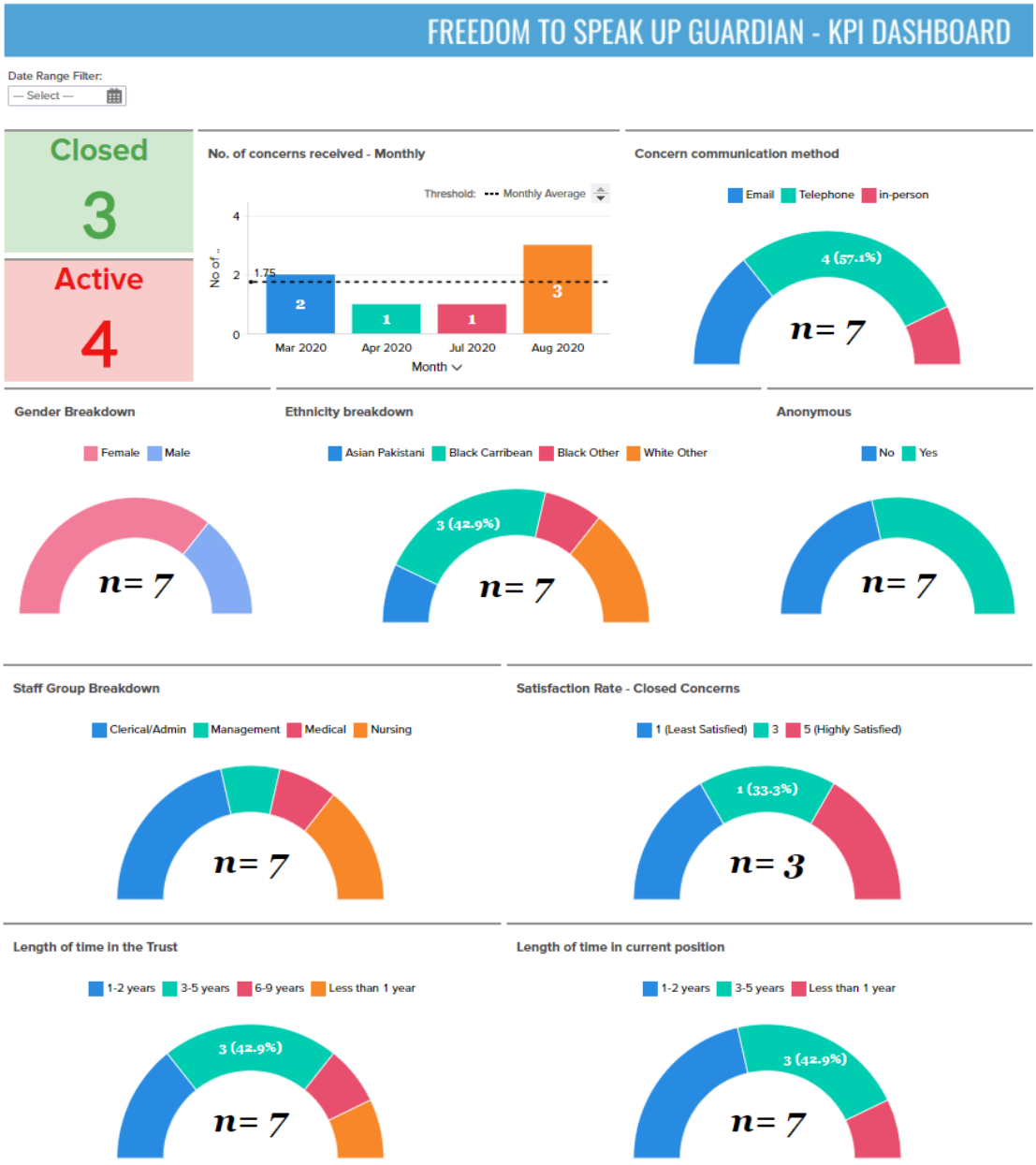
Enter your answer

11. Email address (optional)

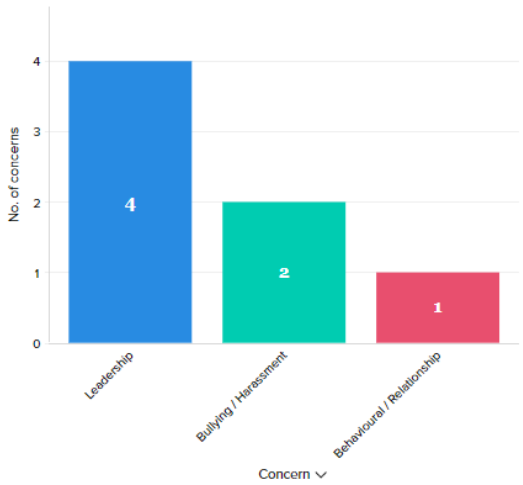
Enter your answer

Back | Next | Page 2 of 4

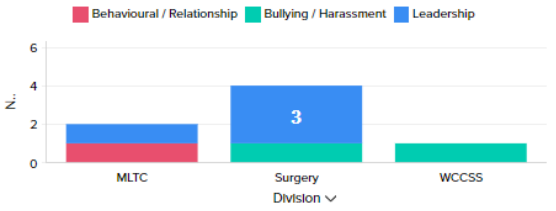
Appendix 2


FREEDOM TO SPEAK UP GUARDIAN - KPI DASHBOARD
Date Range Filter:
--- Select ---
Closed
3
Active
4
No. of concerns received - Monthly
Threshold: Monthly Average
No of :
4
2
0
1.75
2
1
1
3
Mar 2020
Apr 2020
Jul 2020
Aug 2020
Month
Concern communication method
Email
Telephone
in-person
4 (57.1%)
n= 7
Gender Breakdown
Female
Male
n= 7
Ethnicity breakdown
Asian Pakistani
Black Carribean
Black Other
White Other
3 (42.9%)
n= 7
Anonymous
No
Yes
n= 7
Staff Group Breakdown
Clerical/Admin
Management
Medical
Nursing
n= 7
Satisfaction Rate - Closed Concerns
1 (Least Satisfied)
3
5 (Highly Satisfied)
1 (33.3%)
n= 3
Length of time in the Trust
1-2 years
3-5 years
6-9 years
Less than 1 year
3 (42.9%)
n= 7
Length of time in current position
1-2 years
3-5 years
Less than 1 year
3 (42.9%)
n= 7

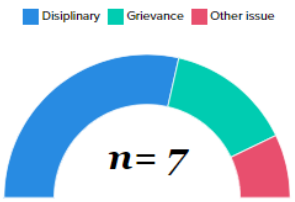
Themes of concern



Division



Grievance/disciplinary/other issue



Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Guardian of Safe Working Hours **Quarterly report – February to April 2020**			**AGENDA ITEM: 14(a)**
Report Author and Job Title:	Mushal Naqvi, Guardian of Safe Working Hours (GOSWH)	**Responsible Director:**	Matthew Lewis, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report covers the following elements: • Introduction and context of the Guardian of Safe Working Hours role • Guardian's quarterly report for February, March & April 2020 • Summary of progress and concerns		
Recommendation	Members of the Trust Board are asked to note the report for assurance and discuss the contents		
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	Implementation of the revised Junior Doctor contract may adversely impact on rotas and the ability to cover services effectively resulting in additional workforce requirements		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☒		

GUARDIAN OF SAFE WORKING QUARTERLY REPORT ON SAFE WORKING HOURS OF DOCTORS IN TRAINING FEB/MAR/APR 2020

1. PURPOSE OF REPORT

The purpose of the reports is to provide a report from the Guardian of Safe Working to the Board on the safety of doctors' working hours and rota gaps as required under the terms and conditions of the 2016 Junior Doctor Contract.

2. BACKGROUND

GUARDIAN OF SAFE WORKING - Safeguarding the working hours of doctors
The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The guardian of safe working has been introduced to protect patients and doctors by making sure doctors aren't working unsafe hours.

To do this, the guardian will:

- act as the champion of safe working hours
- receive junior doctors trainees' exception reports and record and monitor compliance against the 2016 terms and conditions of service for doctors in training
- escalate issues to the relevant executive director or equivalent for decision and action
- intervene to reduce any identified risks to junior doctors or their patients' safety
- undertake a work schedule review where there are regular or persistent breaches in safe working hours
- distribute monies received as a consequence of financial penalties, to improve junior doctor training and service experience.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures ensure the safety of doctors and therefore of patients.

For more information about the guardian role, visit
www.nhsemployers.org/juniordoctors

3. EXECUTIVE SUMMARY

- The majority of exception reports were submitted by FY1 level this quarter
- The number of exception reports remain within the expected limits until the onset of the COVID-19 pandemic, where there were lower than expected numbers of reports
- Over two thirds of exception reports were from General Medicine with the remaining third emanating from the Obstetrics & Gynaecology department; unusually, there were no exception reports from General Surgery this quarter
- The main reason to exception report this quarter related to insufficient staffing levels and working hours
- There were no Immediate Safety Concerns (ISCs) this quarter
- COVID-19 may have compounded engagement by supervisors with the exception reporting system as fewer review meetings occurred this quarter
- Clarity regarding the available GOSWH funds remains outstanding despite my best efforts on this regard
- There still remains a lack of admin linked to the guardian role during this quarter, making the role more onerous than the 1PA it has been allocated and compounding the timely submission of board reports
- Lessons could be learnt from the junior doctor redeployment rota process where in the event of a second wave, junior doctors should be involved in the solution from the outset

Essential data for this quarter

Not made available by HR dept.

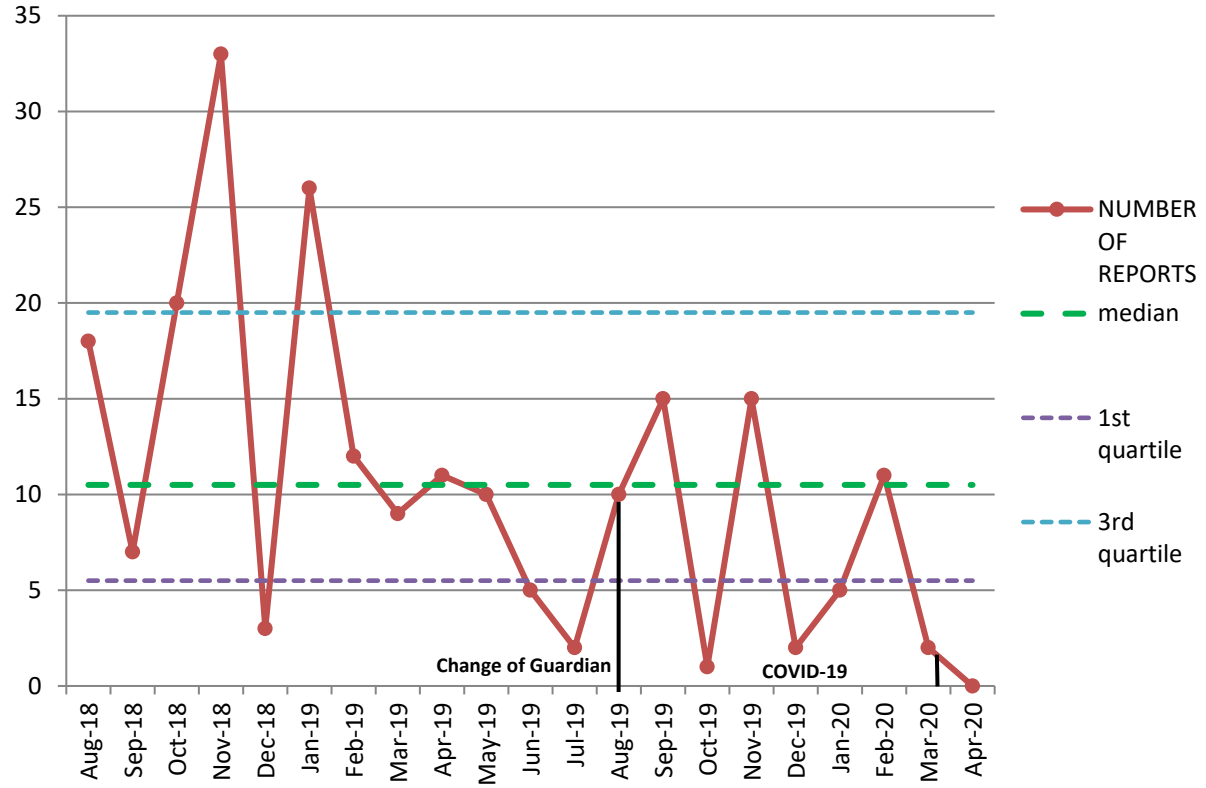
Exception Reports

Total number of exception reports received per month within this quarter:

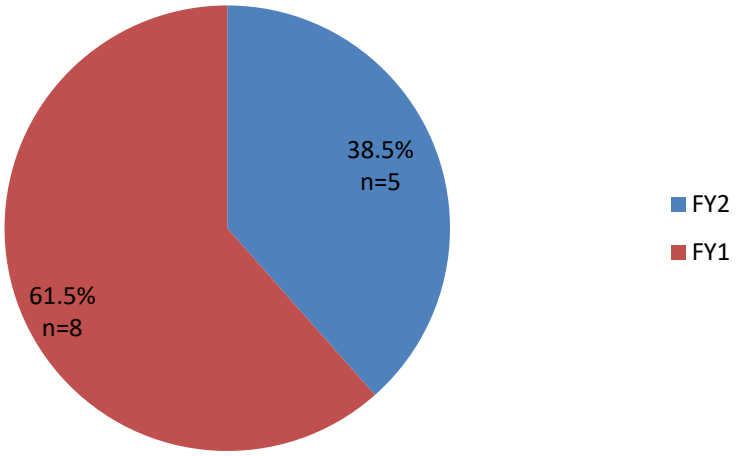
	Immediate safety concerns (ISCs)	Total hours of work and/or pattern	Service support available	Working hours/pattern AND Service support	Educational opportunities/ support	TOTAL
FEB 20	0	5	1	5	0	**11**
MAR 20	0	0	2	0	0	**2**
APR 20	0	0	0	0	0	**0**
QUARTER	**0**	**5**	**3**	**5**	**0**	**13**

Trend in Exception Reporting

The number of exception reports for this quarter was lower than expected for the months of March and April, corresponding with the timing of the COVID-19 pandemic in the UK.

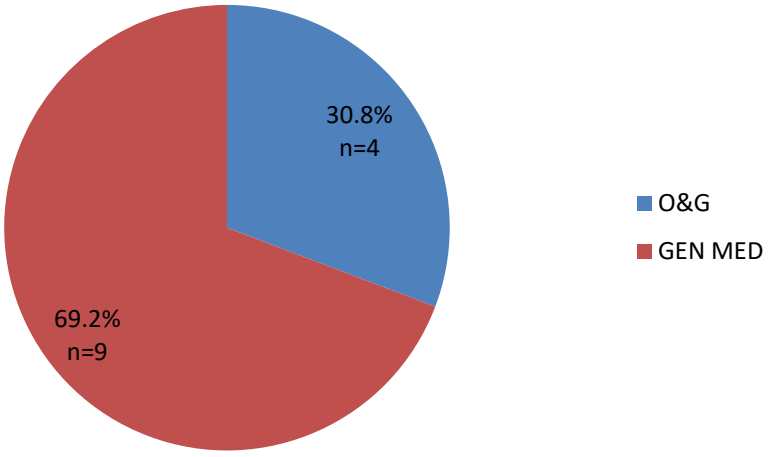


Similar to previous quarters, FY1 level doctors submitted the majority of exception reports:

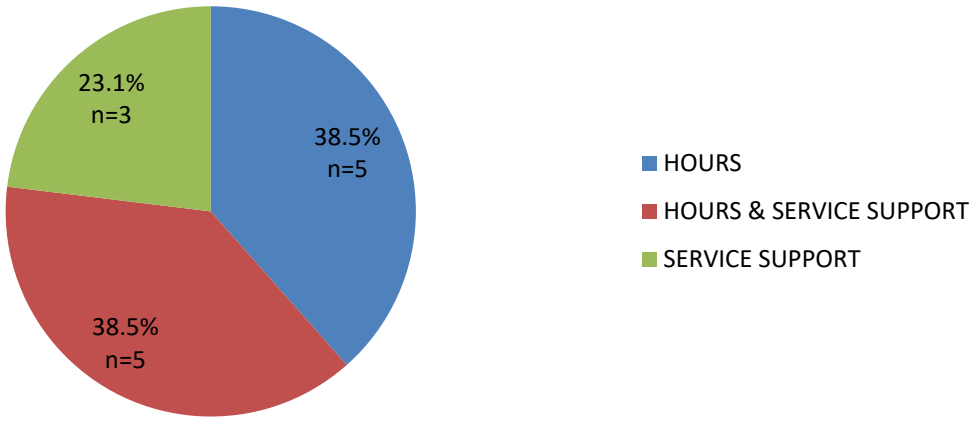


The mean number of days between an exception occurring and the exception being reported is 3.7 days (median = 2 days, range = 0 – 16 days)

Just over two thirds of the exception reports related to Medicine with the remainder from Obstetrics & Gynaecology; unusually this quarter, there were no exceptions reports from the Surgery department:



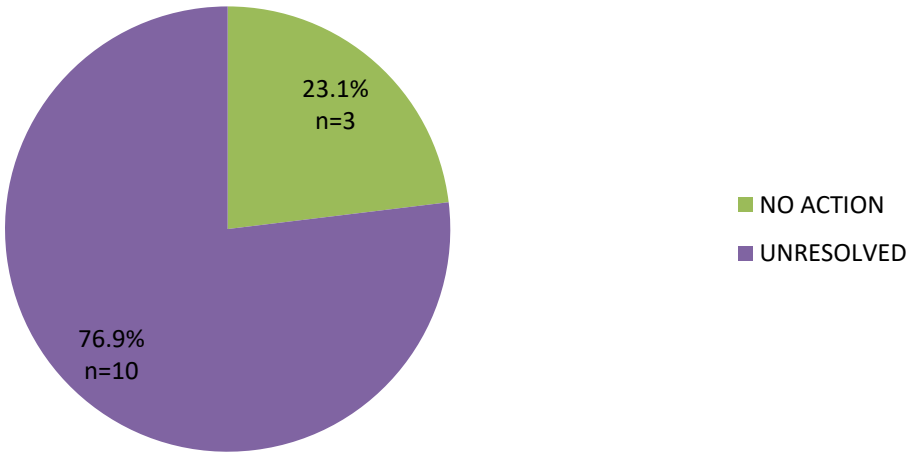
Almost 40% of exception reports related total hours worked with a further almost 40% relating to both total hours worked together with issues regarding the service support available. The remainder of reports submitted were purely regarding the service support available. There weren't any immediate safety concerns or exception reports relating to an Educational issue this quarter:



Resolutions

Total number of exception reports per month within this quarter resulting in:

	TOIL granted	Payment for additional hours	Work schedule reviews	Resolved – no action required	Unresolved	**TOTAL**
FEB 20	0	0	0	1	10	**11**
MAR 20	0	0	0	2	0	**2**
APR 20	0	0	0	0	0	**0**
QUARTER	**0**	**0**	**0**	**3**	**10**	**13**



Over three quarters of exception reports for this quarter were unresolved; this may be due to the lack of availability of clinical/educational supervisors to conduct review meetings with junior doctors due to the COVID-19 response. The remaining exception reports were closed and no action was required. On personally reviewing the 10 outstanding exception reports, I organized payment as compensation for 9 of the exceptions (compensation couldn't be given to the 10th report as there was insufficient detail in the exception report to give payment, despite my efforts to gain this information from the junior doctor concerned). None of these payments incurred a Guardian fine.

The mean number of days between an exception report being submitted by a trainee and a review meeting occurring between the trainee and their supervisor was 7 days (median = 4 days, range = 4 – 13 days).

Work Schedule Reviews

No work schedule reviews were conducted this quarter.

Detail of Immediate Safety Concerns and Actions Proposed and/or Taken

There were no ISCs in this quarter.

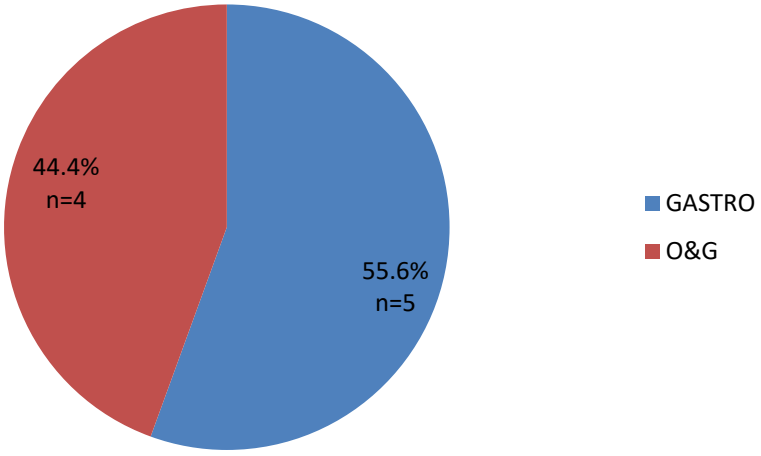
Fines Levied Against Departments This Quarter

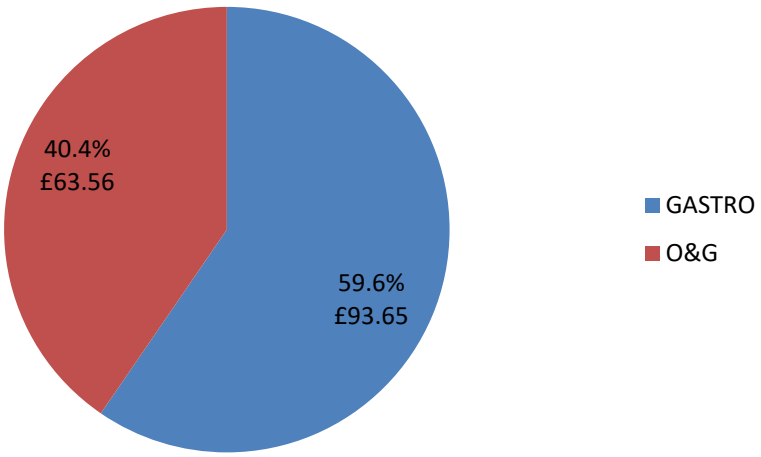
No fines were levied this quarter.

I personally reviewed the 10 outstanding exception reports, resulting in two FY1s and one FY2 being compensated as detailed further down in my report for the additional hours they had worked; these additional hours worked did not result in breeching the 2016 contract

TCS, therefore no fine was levied and the junior doctors concerned were paid the entire amount.

The charts below show the distribution of exception reports resulting in payment according to specialty and expenditure on exception reports according to specialty, respectively, for the last quarter:





Balance at End of Last Quarter	Not known + £61.10
Fines Paid to GOSWH This Quarter	£0
Expenses This Quarter	£0
Total Paid to Trainees this Quarter	£157.21
Balance at End of this Quarter	Not known + £61.10

Having met with the finance department to resolve the concern mentioned in my first quarterly report regarding the GOSWH funds being ring-fenced, and despite promises by the finance department to get back to me with the information required to complete my report, disappointingly, this has not been the case and the issue remains unresolved.

Rota Gaps and Vacancies this Quarter

Not made available by HR dept.

Junior Doctor Forums and Junior Doctor Engagement

The quarterly Junior Doctor Forum (JDF) meeting was postponed this quarter due to the COVID-19 pandemic.

Qualitative Information

In response to the COVID-19 pandemic, redeployment rotas needed to be designed and put in to action at speed, including for many of the junior doctors. Unfortunately, I was only involved in this process just prior to implementation as a cursory final check. I expressed my concern at the lack of junior doctor involvement in the process and at the very least the opinion of the junior doctor local negotiating committee representative ought to be sought. Additionally, within hours of having been shown the redeployment rota, I was able to gain junior doctor feedback, which I forwarded to stakeholders. The feedback largely expressed concern with the rota where junior doctors felt it was not fit for purpose. Nevertheless, the new rota was implemented in any case. However, within 48 hours it was necessary to draw up a further rota where junior doctors were involved in the process and came up with the solution which worked in practice.

Issues Arising

I hope that we have learnt from this experience of implementing redeployment rotas for junior doctors during COVID-19, where in the event of a second wave, junior doctors would be considered key stakeholders, and vital to the success of such rotas an therefore involved from the outset of such discussions.

Actions Taken to Resolve Issues

Since my last report where junior doctors' exception reports highlighted the risks associated with the lack of doctor's offices on the surgical wards, further progress has been made by the Surgical department; the previously identified locations on each ward have now had orders placed for the equipment/furnishing required in order to make them fit for purpose.

Support for Guardian Role

Amount of time available in job plan for guardian role:	1 PA/4 hours per week
Admin support provided to the guardian:	0 WTE
Amount of job planned time for educational supervisors	0.25 PAs/trainee (with a max of 0.5PAs/2 hours per week)

Summary

As previous quarters, the majority of exception reports were submitted by FY1 level doctors. However, although at the start of this quarter the numbers of exception reports were within the expected limits, with the onset of the COVID-19 pandemic there was a dramatic drop in exception reporting.

Over two thirds of exception reports were from General Medicine with the remaining third emanating from the Obstetrics & Gynaecology department; unusually, there were no exception reports from General Surgery this quarter. The main reason to exception report related to working hours or otherwise insufficient staffing levels, which then impacted on working hours. There weren't any immediate safety concerns this quarter.

The COVID-19 pandemic appears to have compounded engagement by supervisors with the exception reporting system as understandably, fewer review meetings occurred this quarter.

Issues in implementing redeployment rotas for junior doctors were encountered, but the solution was achieved by engaging junior doctors in the process – a lesson I hope is taken on board in the event of a second wave.

Questions for Consideration

As guardian, I am comfortable with the overall safety of working hours in the organisation in this quarter, taking into account the unprecedented events which have occurred. Issues mentioned previously regarding the lack of doctor's offices on the Surgical wards are in the process of being resolved. The situation relating to ring-fencing of guardian fund remains outstanding despite my best efforts and therefore requires escalation for resolution.

I would therefore ask the board to note the report and to consider the assurances provided by the guardian.

I would also like to take this opportunity to commend and recognize the true professionalism and resilience of our junior doctors in their response to the peak of the coronavirus pandemic and offer our heartfelt thanks for all of their hard work.

Walsall Healthcare NHS
NHS Trust

Appendix.

SUBMISSION DATE	DATE OF EXCEPTION	NUMBER OF DAYS FROM INCIDENT TO SUBMISSIO	DAY OF EXCEPTION	TYPE OF REPORT	TIME OF DAY	SPECIALTY	SUB-SPECIALITY	WARD	GRADE	DATE OF MEETING	NUMBER OF DAYS BETWEEN SUBMISS	OUTCOME	COMMENTS	PAYMENT TO I	PAYMENT TO GOS
03/02/2020	03/02/2020	0	MONDAY	WORKING HOURS/PATTERN	EVENING FINISH	OBS & GYNAE	OBS & GYNAE	O&G	FY1			OUTSTANDING	NO ANESTHETIST IN MORNING (DLEAYED START) AND DIFFICULT LAST CASE. WORKED 1HR OVER END OF SHIFT	£15.89	
10/02/2020	10/02/2020	0	MONDAY	WORKING HOURS/PATTERN & SERVICE SUPPORT	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY1			OUTSTANDING	FY1 ON WARD ASKED TO CROSS-COVER AMU AND GP TRAINEE ENDURED SHARPS INJURY AND WENT TO A&E. WORKED 1HR	£15.89	
18/02/2020	18/02/2020	0	TUESDAY	WORKING HOURS/PATTERN & SERVICE SUPPORT	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY1			OUTSTANDING	IMMEDIATE SAFETY CONCERN - DOWNGRADED BY GOSWH. MIN OF 2 JUNIORS ON WARD - FY1 AND FY2 ON THIS OCCASION BUT FY2 HAD TEACHING		
19/02/2020	19/02/2020	0	WEDNESDAY	WORKING HOURS/PATTERN	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY1			OUTSTANDING	WORKED 1HR OVER END OF SHIFT.	£15.89	
20/02/2020	20/02/2020	0	THURSDAY	WORKING HOURS/PATTERN & SERVICE SUPPORT	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY1			OUTSTANDING	PHLEBOTOMY ROUND DELAYED UNTIL 3PM RESULTING IN DELAY IN RETURN OF RESULTS. WORKED 1HR OVER END OF SHIFT.	£15.89	
21/02/2020	18/02/2020	3	TUESDAY	WORKING HOURS/PATTERN & SERVICE SUPPORT	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY2			OUTSTANDING	ONLY FY1 AND FY2 ON WARD AND FY2 HAD TEACHING IN AFTERNOON UNTIL 4PM. WORKED 1HR OVER END OF SHIFT.	£18.39	
22/02/2020	19/02/2020	3	WEDNESDAY	WORKING HOURS/PATTERN	EVENING FINISH	MEDICINE	GASTROENTEROLOGY	16	FY2			OUTSTANDING	WORKED 1HR 30MINS OVER END OF SHIFT.	£27.59	
22/02/2020	21/02/2020	1	FRIDAY	SERVICE SUPPORT & IMMEDIATE SAFETY CONCERN	NIGHT ON CALL	MEDICINE	GEN MED	AMU	FY2	06/03/2020	13	RESOLVED - NO ACTION TAI	SHO MEANT TO BE ON CALL WAS ACTUALLY ON A/L		
26/02/2020	24/02/2020	2	MONDAY	WORKING HOURS/PATTERN	EVENING FINISH	OBS & GYNAE	OBS & GYNAE	O&G	FY1			OUTSTANDING	DELAYED STARTING AFTERNOON ANTENATAL CLINIC AS DELAYED FINISH IN THEATRE IN MORNING FOR COMPLICATED CASE. ??WORKED 1HR OVER END OF SHIFT	£15.89	
26/02/2020	20/02/2020	6	THURSDAY	WORKING HOURS/PATTERN & SERVICE SUPPORT	EVENING FINISH	OBS & GYNAE	OBS & GYNAE	O&G	FY1			OUTSTANDING	ONLY FY1 AND REG TO SEE 30 PATIENTS IN ANTENATAL CLINIC WHICH OVER-RAN. ??WORKED 1HR OVER END OF SHIFT.	£15.89	
26/02/2020	10/02/2020	16	MONDAY	WORKING	EVENING FINISH	OBS & GYNAE	OBS & GYNAE	O&G	FY1			OUTSTANDING	??WORKED 1HR OVER END OF SHIFT	£15.89	
02/03/2020	22/02/2020	9	SATURDAY	SERVICE SUPPORT & IMMEDIATE SAFETY CONCERN	NIGHT ON CALL	MEDICINE	GEN MED	AMU	FY2	06/03/2020	4	UNRESOLVED - NO ACTION TAKEN	SHO MEANT TO BE ON CALL WAS ACTUALLY ON A/L. NO COVER ARRANGED FOR WHOLE WEEKEND DESPITE RAISING		
02/03/2020	23/02/2020	8	SUNDAY	SERVICE SUPPORT & IMMEDIATE SAFETY CONCERN	NIGHT ON CALL	MEDICINE	GEN MED	AMU	FY2	06/03/2020	4	RESOLVED - NO ACTION TAI	SHO MEANT TO BE ON CALL WAS ACTUALLY ON A/L. NO COVER ARRANGED FOR WHOLE WEEKEND DESPITE RAISING CONCERNS ON THE FIRST DAY OF THIS		

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Guardian of Safe Working Hours **Quarterly report – May to July 2020**			**AGENDA ITEM:** **15(b)**
Report Author and Job Title:	Mushal Naqvi, Guardian of Safe Working Hours (GOSWH)	**Responsible Director:**	Matthew Lewis, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The report covers the following elements: • Introduction and context of the Guardian of Safe Working Hours role • Guardian's quarterly report for May, June & July 2020 • Summary of progress and concerns		
Recommendation	Members of the Trust Board are asked to note the report for assurance and discuss the contents		
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	Implementation of the revised Junior Doctor contract may adversely impact on rotas and the ability to cover services effectively resulting in additional workforce requirements		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☒		

GUARDIAN OF SAFE WORKING QUARTERLY ON SAFE WORKING HOURS OF DOCTORS IN TRAINING MAY/JUN/JUL 2020

1. PURPOSE OF REPORT

The purpose of the reports is to provide a report from the Guardian of Safe Working to the Board on the safety of doctors' working hours and rota gaps as required under the terms and conditions of the 2016 Junior Doctor Contract.

2. BACKGROUND

GUARDIAN OF SAFE WORKING - Safeguarding the working hours of doctors
The safety of patients is a paramount concern for the NHS. Significant staff fatigue is a hazard both to patients and to the staff themselves. The guardian of safe working has been introduced to protect patients and doctors by making sure doctors aren't working unsafe hours.
To do this, the guardian will:

- act as the champion of safe working hours
- receive junior doctors trainees' exception reports and record and monitor compliance against the 2016 terms and conditions of service for doctors in training
- escalate issues to the relevant executive director or equivalent for decision and action
- intervene to reduce any identified risks to junior doctors or their patients' safety
- undertake a work schedule review where there are regular or persistent breaches in safe working hours
- distribute monies received as a consequence of financial penalties, to improve junior doctor training and service experience.

The role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours for the junior doctors employed by the Trust. The work of the guardian will be subject to external scrutiny of doctors' working hours by the Care Quality Commission (CQC) and by the continued scrutiny of the quality of training by Health Education England (HEE). These measures ensure the safety of doctors and therefore of patients.

For more information about the guardian role, visit
www.nhsemployers.org/juniordoctors

3. EXECUTIVE SUMMARY

- No exception reports were submitted in this quarter
- Similar findings were experienced throughout the Region
- The reduction in exception reports may be a reflection of junior doctors being involved in covid rota designs and therefore this practice is something we should aim to continue, moving out of the first wave of covid-19
- Feedback from junior doctors redeployed to medicine suggest the number of doctors redeployed was surplus to requirement – a more flexible approach perhaps ought to be taken in the event of a second wave
- In the event of a second wave where redeployment of junior doctors may be required once again, clarity over the terms of pay should be in place prior to redeployment
- The end of year JDF meeting provided valuable feedback which will be taken on board in the next quarter
- Although there remained a lack of admin linked to the guardian role during this quarter, more recently this issue has been addressed
- Despite the recent administrative assistance for the guardian role, gaining timely information to complete the guardian reports still remains a challenge and onerous task; a more efficient system needs to be employed moving forward

Essential data for this quarter

Not made available by HR dept.

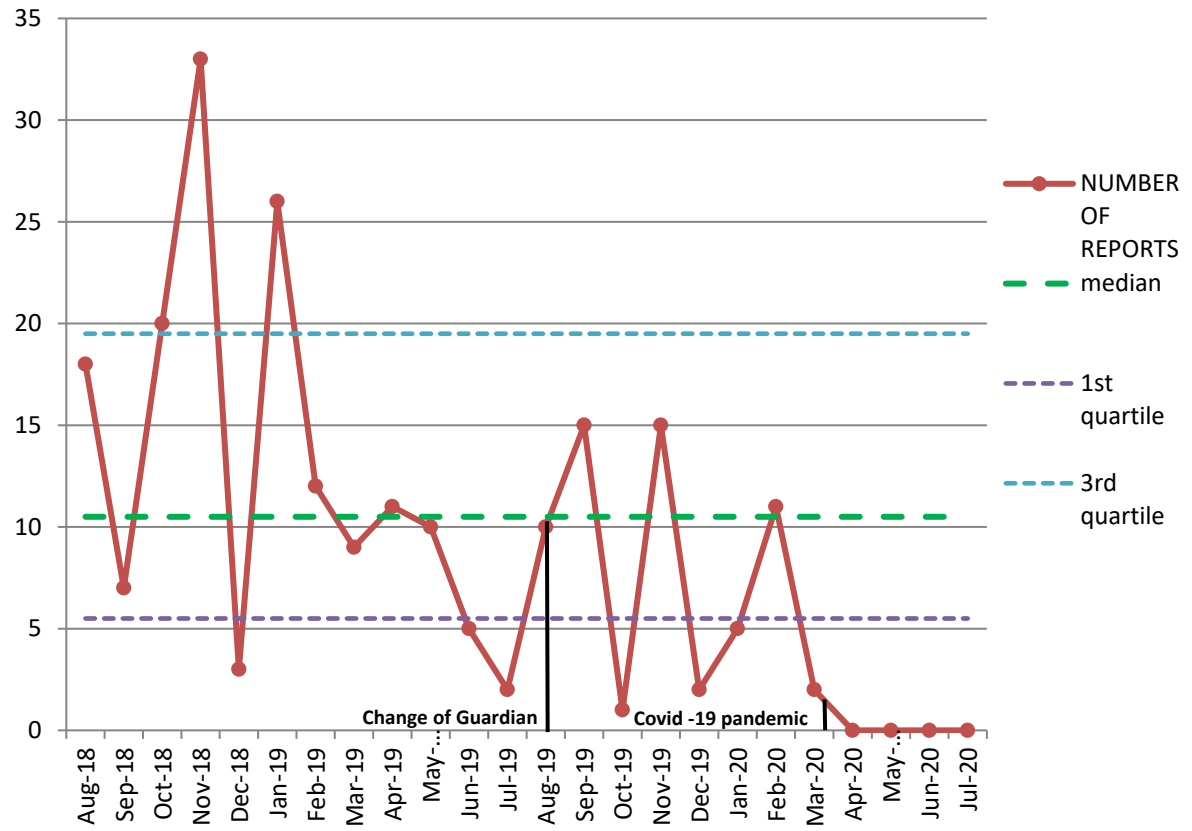
Exception Reports

Total number of exception reports received per month within this quarter:

	Immediate safety concerns (ISCs)	Total hours of work and/or pattern	Service support available	Working hours/pattern AND Service support	Educational opportunities/ support	**TOTAL**
MAY 20	0	0	0	0	0	**0**
JUN 20	0	0	0	0	0	**0**
JUL 20	0	0	0	0	0	**0**
QUARTER	**0**	**0**	**0**	**0**	**0**	**0**

Trend in Exception Reporting

Throughout the covid-19 pandemic, very unusually, no exception reports were submitted.



Resolutions

Total number of exception reports per month within this quarter resulting in:

	TOIL granted	Payment for additional hours	Work schedule reviews	Resolved – no action required	Unresolved	**TOTAL**
MAY 20	0	0	0	0	0	**0**
JUN 20	0	0	0	0	0	**0**
JUL 20	0	0	0	0	0	**0**
QUARTER	**0**	**0**	**0**	**0**	**0**	**0**

Work Schedule Reviews

No work schedule reviews were conducted this quarter.

Detail of Immediate Safety Concerns and Actions Proposed and/or Taken

There were no ISCs in this quarter.

Fines Levied Against Departments This Quarter

No fines were levied this quarter and no payments were made.

Balance at End of Last Quarter	Not known + £61.10
Fines Paid to GOSWH This Quarter	£0
Expenses This Quarter	£0
Total Paid to Trainees this Quarter	£0
Balance at End of this Quarter	Not known + £61.10

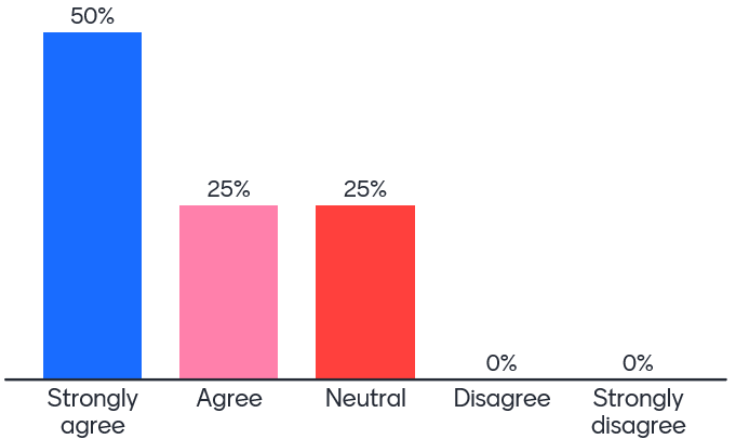
Rota Gaps and Vacancies this Quarter

Not made available by HR dept.

Junior Doctor Forums and Junior Doctor Engagement

An end of year Junior Doctor Forum (JDF) meeting was held online for the first time in July. The purpose of this JDF was to gain feedback from the outgoing junior doctors. The feedback results are as follows:

If I had a reason to exception report I would feel comfortable to submit a report



What are your thoughts on exception reporting?

What were the good things about working as a Junior Doctor at Walsall or what things were done well here in the last year?

What would improve the working environment for you at Walsall Manor or what could we do better next year?

3 things which should be included in the induction process for exception reporting/GOSWH role

What would help encourage you and your colleagues to attend & participate in junior doctor forum meetings?

Qualitative Information

During the coronavirus pandemic where redeployment rotas were implemented at speed, junior doctors were involved in the design of these rotas. This may explain the lack of exception reports during this period and moving forward, we should endeavour for junior doctors to continue to be involved in their own rota designs.

For those junior doctors redeployed to medicine, there were expressions of unhappiness as the redeployed junior doctors often felt surplus to requirement with little to do, which was

particularly difficult to process when their fellow colleagues who weren't redeployed were working harder than usual to make up for the lack of staff. There were also reports of junior doctors ordinarily on the medical rota getting more time off to usual due to the additional staff made available through redeployment.

Junior doctors worked additional hours as a consequence of COVID-19 rotas as well as working shifts which may have been of higher intensity. Also, many did not manage to take all the leave they had remaining. During the pandemic, junior doctors were assured that they would be paid for their work and accepted this on good faith. However, following the peak of the pandemic, it was only following much discussion that junior doctors were paid as promised which they received after leaving the Trust. This has meant that junior doctors working additional hours in good faith once again in the event of a second wave will be less likely and I suspect if this were necessary, then payment terms would need to be clarified in advance of junior doctors undertaking additional hours.

On attending the Regional Guardian meeting, the dramatic reduction of exception reports during the COVID-19 pandemic has been an experience shared throughout the West Midlands. These monthly meetings have also allowed sharing of best practice.

Issues Arising

Gaining timely information for the guardian quarterly report has been extremely challenging of late, despite my best efforts and more recently, in spite of having gained administrative help for the guardian role.

Actions Taken to Resolve Issues

Although administrative assistance wasn't available for the guardian role during this quarter, I am pleased to report that recently this issue has been addressed.

Much of the feedback received at the quarterly JDF has been taken on board and I plan to bring these changes into practice for the next quarter.

Support for Guardian Role

Amount of time available in job plan for guardian role:	1 PA/4 hours per week
Admin support provided to the guardian for this quarter:	0 WTE
Amount of job planned time for educational supervisors	0.25 PAs/trainee (with a max of 0.5PAs/2 hours per week)

Summary

No exception reports were submitted during the months of the first wave of the coronavirus pandemic – similar findings having been noted throughout the Region. This could be related to junior doctors having been actively involved in the design of covid rotas – practice which we should therefore consider continuing with, moving out of the first wave of COVID-19.

Feedback from junior doctors on redeployment rotas suggest that we redeployed more junior doctors than necessary and perhaps we need to take a more flexible approach should there be a second wave; junior doctors could remain on standby for redeployment, and only move when necessary. Equally they should be able to return back to their base team when not required with more ease. Payment for covid rotas in response to a second wave should also be clarified in advance this time round.

The end of year GOSWH JDF meeting was held online for the first time this quarter and valuable feedback was received which I will be taking on board for the next quarter.

And finally, a more efficient system needs to be in place to obtaining the timely information for completing the guardian reports.

Questions for Consideration

As guardian, I am comfortable with the overall safety of working hours in the organisation during this unprecedented quarter. Issues relating to the gaining the timely information from the Human Resources department and the Finance department for the quarterly guardian report requires attention and escalation for resolution.

I would therefore ask the board to note the report and to consider the assurances provided by the guardian.

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Performance, Finance & Investment Committee (PFIC) Highlight Report			**AGENDA ITEM: 15**
Report Author and Job Title:	Trish Mills, Trust Secretary	**Responsible Director:**	Mr John Dunn – Chair of PFIC (Non-Executive)
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Performance, Finance & Investment Committee meetings on 28th October 2020. The report sets out escalations for the attention of the Trust Board, key issues discussed and work underway. - Good progress was acknowledged on the Board Assurance Framework for the Use of Resources and Work Closely With Partners strategic risks. The Committee will focus on selected risks in the corporate risk register at its November meeting. - The Trust achieved a break-even reported position for September 2020. The Committee continues to hold discussions to fully understand how costs have changed due to the COVID-19 environment and national guidance. - The Committee noted the Trust's budget allocation for remainder of year covers the likely scenario presented to the Board in October. - There is fundamentally good progress on the Restoration and Recovery plan. There are risk factors should COVID-19 patient presentation be higher than forecast, and related to their length of stay and its effect on patient flows. Modelling work will be presented to the next meeting to understand the impact of these risks. - Good performance on constitutional standards continues both in community and the acute, however the Emergency Department has seen deterioration in the 4 hour standard. The familiarisation process for staff on the newly introduced Electronic Patient Record (EPR) in September was a contributory factor, however there is an 8 week action plan to address the root causes of the deterioration. The Committee will continue to monitor the effect of COVID-19 and winter pressures on this standard.		

	- The Committee approved the electronic document management contract award for the scanning of patient records. - The Committee approved additional investment in resources to support the Trust's Improvement Programme. - The Committee endorsed the Emergency Preparedness, Resilience and Response Annual Assurance letter, which is before the Board for approval at this meeting. - The introduction of the EPR and its successful go-live during the weekend of 19th and 20th September was applauded by the Committee, who noted the scale of this important transformation. The Committee passed its thanks to the EPR team and to the divisions and teams who supported the go-live. The next meeting of the Committee will take place on 25th November 2020.	
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.	
Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to the BAF risk for use of resources and working with partners, and associated corporate risks.	
Resource implications	The resource implications are set out in this highlight report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

MEETING OF THE PUBLIC TRUST BOARD 5th NOVEMBER 2020			
Use Resources Well Executive Report			**AGENDA ITEM: 16**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance	**Responsible Director:**	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Use Resources Well strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Use Resources Well and NHS constitutional standards successes and areas for improvement. This report recognises the extraordinary circumstances that the Trust has operated in thus far this financial year, and the altered financial arrangements as a consequence of the national level 4 incident prompted by the COVID-19 pandemic. It updates Board members on the confirmed financial settlement for Months 7-12 of this financial year, and remaining items of uncertainty associated with this settlement. This report identifies continued strong operational performance in national rankings for the elective NHS Constitutional standards. It also shares with Board members the impact of adjustment to the new Electronic Patient Record in the Emergency Department and the significant impact on Emergency Access Standard performance as a result.		
Recommendation	Members of the Trust Board are asked to note the contents of this report, and the next steps: i. Additional work with each division on quantification of the Improvement Programme efficiencies in November 2020 ii. Development of a Trust Estates strategy		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S05 – Use Resources Well to provide positive assurance that there are mitigations in place to manage this risk and the related corporate risks.		

Resource implications	This strategic objective is: *We will deliver optimum value by using our resources efficiently and responsibly* October Public Trust Board approved the Trust's Urgent and Emergency Care and COVID-19 resilience Winter Plan, at a cost of £4.697m which is accounted for in the likely financial modelling scenario for months 7-12.	
Legal and Equality and Diversity implications	There is clear evidence that greater deprivation is associated with a higher likelihood of utilising Emergency Department services, meaning longer Emergency Access Standard waiting times will disproportionately affect the more deprived parts of the community we serve. Whilst not as strongly correlated as emergency care, there is also evidence that socioeconomic factors impact the likelihood of requiring secondary care elective services and the stage of disease presentation at the point of referral. Consequently, the Restoration and Recovery of elective services, and the reduction of waiting times for elective services must be seen through the lens of preventing further exacerbation of existing health inequalities too.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

USE RESOURCES WELL

1. EXECUTIVE SUMMARY

This report recognises the extraordinary circumstances that the Trust has operated in thus far this financial year, and the altered financial arrangements as a consequence of the national level 4 incident prompted by the COVID-19 pandemic. The Trust has incurred significant additional costs associated with COVID-19 (£13.7m YTD at Month 6) to ensure patients and staff are kept safe.

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

This report summarises the impact of the adjustment to the new Electronic Patient Record in the Emergency Department (ED), and the consequent impact on Emergency Access Standard.

This report identifies the confirmed income settlement for months 7-12 of this financial year, and the remaining uncertainties regarding the financial settlement.

This report also highlights to the Board the emerging risk that the nationally set assumptions in relation to COVID-19 positive hospitalisations, which were used to underpin the Trust's Urgent & Emergency Care and COVID-19 Resilience Winter Plan may be at risk of being exceeded. Namely, the assumption of a 2nd COVID-19 peak being at 50% of the April peak may be exceeded given recent trends and local prevalence. Should this happen, both the operational plan and financial plan could be affected.

2. BOARD ASSURANCE FRAMEWORK

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

This month's cycle for BAF risk updates has incorporated the uncertainty associated with Month 7-12 financial settlement and the development of the Improvement Programme benefits quantification (as presented to Board Development session on 1st October).

Emerging evidence since this month's cycle of BAF updates highlights a further growing risk. At the point of writing this report (26th October 2020), the Trust has 66 COVID-19 positive inpatients. The nationally set assumptions underpinning the Phase 3 Restoration and Recovery plans for Q3 and Q4 of this financial year assumed a second COVID-19 peak at 50% of the April peak. At the time of writing the Trust has already exceeded 30% of the April peak, and has the 25th highest proportional COVID-19 positive bed occupancy out of 127 reported Trusts nationally. Walsall borough continues to have growing prevalence of COVID-19 in the community and so it is highly likely that hospital admissions will continue to rise over the next fortnight at least, and thus the risk of the second surge exceeding 50% of the April peak is growing. This risk will formally be included in the BAF risk update during November, as it could impact on both operational and financial plan delivery across Q3 and Q4 of this financial year.

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

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

3. PERFORMANCE REPORT

Financial

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

The Trust has exceeded the emergency budget allocation set by the centre by £13.7m year to date. However, the financial regime enables Trusts to seek additional income to offset the impact of COVID-19, and the Trust has requested this additional income as a 'top up' of £13.7m to enable reporting of a break-even position as at month 6.

The Trust remains below the level of elective activity seen in 2019. Emergency Department attendances in September were 91.26% of September 2019 attendance levels. Whilst costs remain higher than previous years and above the baseline plan, largely driven by temporary workforce costs that exceed historic levels. As the Trust seeks to increase elective activity (as per national guidance stipulated in the Phase 3 letter from Sir Simon Stevens and Amanda Pritchard) this will result in a potential risk to delivery of current performance and/or achievement of break-even financial performance (Corporate Risk Register Risk 2081).

An operational plan has been developed through the Restoration and Recovery work and financial modelling completed, with the modelling identifying a likely income

scenario and run rate modelling for the remainder of the financial year (presented through Board Development and received by the Performance, Finance and Investment Committee).

Whilst this plan delivers key elements prioritised within the Board setting within an income envelope that is likely to be available, it does not deliver historic levels of elective performance. The key risk to the plan remains the uncertainty over the financial consequences of non-delivery of historic elective activity (for which NHSEI will reduce income allocations at a Strategic Transformation Partnership (STP) level).

The actual income to be earned for months 7-12 and residual level of deficit for the Trust in 2020/21 is still subject to some debate at STP level, namely because there are insufficient funds to support all requests. The current proposal sees the Trust receiving the income in the likely income scenario and run rate modelling. The STP as a whole is working to a deficit plan of £27.1m with the Trust having a £3.8m deficit in year. The deficit for the Trust is driven by omissions contained within NHSEI's income allocation methodology (the overall deficit of the STP a consequence of these income allocation shortfalls).

The Trust has also received capital allocations in year totalling in excess of £20m, with key risks now centring around the ability to utilise this financing in year. However, this funding is insufficient to offset the backlog maintenance risk the Trust is exposed to and so a full estates strategy has been requested to be provided to the Performance, Finance and Investment Committee. The Trust held discussions with NHSEI regarding a further allocation of £2m to support Critical Care but unfortunately received no award.

<u>Operational</u>

Elective Care:

The Trust can continue to deliver strong performance in DM01 (6 week wait diagnostics) and 18-week Referral to Treatment (RTT) NHS Constitutional Standards.

The Trust is ahead of its trajectory to recover the DM01 6-week wait Diagnostic standard following the impact of COVID-19 on elective care earlier this year, and is currently the 13th best performing Trust nationally out of 123 reporting Acute Trusts in the most recently published national statistics (August 2020). Reported performance has improved further in September with the proportion of patients waiting over 6 weeks reducing to 14.7%

The Trust is now ahead of its trajectory to recover the 18-week Referral To Treatment waiting time standard (68.6% vs a trajectory of 51.6% in September) following the impact of COVID-19 on elective care earlier this year, The Trust's 18-week RTT national ranking position has improved to 24th best in the country in August out of 121 reporting Trusts, and September has shown the second consecutive month of improvement since the pandemic, with performance improving further to 68.7% waiting less than 18 weeks.

The Trust's Cancer waiting times performance benchmarks reasonably, but with clear opportunity for improvement. A newly constituted weekly Cancer Waiting Times PTL and Performance meeting has been instituted by the newly in post Director of Operations for Surgery and commenced on 30th September 2020.

In the likely scenario financial model adopted for months 7-12, there are insufficient resources to enable differential investment in elective services to accelerate reduction in the number of patients waiting, and length of time that patients are waiting, for treatment. This in turn means the elective activity targets set in Sir Simon Stevens and Amanda Pritchard's Phase 3 letter are unlikely to be met.

Emergency Care:

The Trust implemented the first phase of its new Electronic Patient Record (EPR) on the weekend of 19th/20th September. This included the ED moving from a paper-based clinical record to an electronic clinical record for the first time. Both EPR and ED teams have worked very hard to make the transition, and the new EPR is generally well-received within ED. However, it has resulted in a significantly longer cycle time for ED's own part of the pathway with the following impact:

- An over 15 percentage point reduction in weekly 4-hour Emergency Access Standard performance from 90% to less than 75%.
- From over 60% of patients triaged within 15 minutes to less than 40%.
- Ambulance handover <30mins reducing from over 98% to 90%
- Percentage of patients seen by a doctor/practitioner within 60 minutes of arrival has reduced from 55% to less than 40%.
- Mean total time in ED for non-admitted patients has increased by 33% from 2hr 15 to over 3hrs.

Mitigating actions to address and improve the position have included;

- Invited review by Barnsley Hospital EPR team to make recommendations on configuration changes to the ED Medway and Cas Card system to save clinician time. The majority of these have now been implemented, within a week of receipt of report.
- The MLTC Division has instituted an 8-week ED improvement programme, led by the Deputy Director of Operations for MLTC who has been released from other commitments to provide dedicated leadership to this work.
- Executive-led review of Nurse staffing arrangements to ensure nurse staffing is not a further compounding factor.

October will be the first full month post go-live and so monthly reported EAS performance will deteriorate further before it recovers.

4. IMPROVEMENT PROGRAMME

The Use Resources Well workstream of the improvement programme continues to mature. Operational productivity workstreams associated with restoration and recovery

are well developed in Medicine & Long Term Conditions and Surgery. The Capital Programme and its concurrent impact on medical equipment resources and improvements to the Estate is now defined with far greater clarity, and with the added strength of £3.7m Critical Infrastructure capital and £4.1m Urgent & Emergency Care capital. The Estates team are actively bidding for Public Sector De-Carbonisation capital funds to accelerate work to improve the energy efficiency of the Trust, and in turn improve its environmental sustainability and its financial efficiency too.

Significant work has been undertaken to assess and quantify the benefits associated with all Improvement Programme workstreams in recent weeks. These were presented at the Improvement Programme Board Development Session on 1st October 2020, and are now subject to refinement and assessment of the level of ambition contained within the plans.

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

5. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Note the contents of the report.
- Note the following actions;
    i. The delivery of financial efficiencies to improve run rate is key to ensuring future financial sustainability. Quantification of the Improvement Programme efficiencies presented to the Board on 1st October 2020 provided a level of assurance regarding the level of efficiencies that could be delivered, additional work with each division is planned in November 2020 to maximise the opportunity to identify further areas of delivery focus to support the ambition to be outstanding
    ii. Externally commissioned expertise will facilitate the development of a Trust Estates strategy to support coherent stewardship of this key resource.

APPENDICES

1(a). Board Assurance Framework Risk S05
1(b). Corporate Risk Register
2(a). Performance Report (Finance and Constitutional Standards)
2(b). Performance Dashboard
3. Improvement Programme update

Walsall Healthcare NHS Trust

Risk Summary			
BAF Reference and Summary Title:	**BAF 05 Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly**		
Risk Description:	The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets, and technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, and constrains available capital to invest in Estate, Medical Equipment and Technological assets in turn leading to a less productive use of resources.		
Lead Director:	Chief Operating Officer	**Supported By:**	
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title**		**Current Risk Score**
	•Risk 208 – Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk score = 12) •Risk 274- Failure to resource backlog maintenance and medical equipment replacement costs results in the organisation being unable to deliver fundamental clinical services and care (Risk Score=20) •Risk 665 - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation. (Risk Score=15) •Risk 1005- The Trust has insufficient resources available to ensure the essential maintenance of the Trust's Estate. (Risk Score=16) •Risk 1155 - Failure to demonstrate fire stopping certification for all areas of the Trust would breach fire safety regulation, risking public/ patient safety. (Risk Score=16) •Risk 2081- Operational expenditure incurred during the current financial year exceeds income allocations, which results in the Trust being unable to deliver a break even financial plan. (Risk Score =16) •Risk 2082-Failure to realise the benefits associated with the outcomes of the improvement programme work-streams, results in the Trust not delivering efficiencies required to attain agreed financial control targets, and deliver financial balance without central support, which therefore impacts on the Trusts ability to deliver financial and clinical sustainability. (Risk Score =16) •Risk 2188 (NEW) - A continued dependency on suboptimal legacy patient information infrastructure, will limit the flow of clinical information, reduce professional confidence and increase administrative burden for healthcare professionals, ultimately impacting on patient care and the ability to transform healthcare services. (Risk Score = 10		**20 (Major)**

Risk Scoring								
Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Rationale for Risk Level**	**Target Risk Level (Risk Appetite)**		**Target Date**
Likelihood:	**4**	**4**			Evidence of risk control • Achievement of 19/20 financial plan. Evidence of risk gaps in control • The Trust experienced run rate risk for the 19/20 financial year that led to needing to re-forecast outturn during the financial year. • High reliance on temporary workforce • Lack of credible plan to address backlog maintenance requirements. Evidence of planning uncertainty • The Trust has an Emergency Budget for April 2020 to September 2020, however formal income levels are not yet finalised for the full 20/21 financial year. • Financial improvement planning and delivery has been impacted by Covid-19.	**Likelihood:**	**2**	31 March 2021
Consequence:	**5**	**5**				**Consequence:**	**5**	
Risk Level:	**20 (Major)**	**20 (Major)**				**Risk Level:**	**10 (Moderate)**	

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Finance reported monthly via Divisional Performance Reviews and Executive Governance Structures • CIP Governance processes in place • Revised financial governance in place for COVID-19 • Board Development session for the Improvement Programme with identified 3-year targeted financial benefits.	• Performance, Finance & Investment Committee in place to gain assurance • Audit Committee in place to oversee and test the governance/financial controls • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation) • Use of Resources work-stream identified as part of the Improvement Programme	
Gaps in Control	• Business planning processes require strengthening • Accountability Framework has been approved, however needs review further to the NHSI Governance Review report • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident • Evidencing oversight of the controls in force to monitor and regulate temporary workforce – Implementation of Allocate progressing throughout the Trust (Medical and Nursing) and Internal Audit conducting a full review of controls in force. • Leadership development needs at Care Group, Divisional and corporate support service levels.		
Assurance:	• Model Hospital Use of Resources assessments	• Internal Audit reviews of a number of areas of financial and operational performance	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts
Gaps in			

Assurance	• NHSi Governance review highlighted areas of improvement for business process and accountability framework. • External Audit limited due to Covid-19 • NHSI review meetings urgently on hold • Internal Audit core financial controls not completed. • Absence of a confirmed Month 7 -12 20/21 financial plan

Future Opportunities

- Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area.
- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners).
- Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home).
- Utilisation of national productivity benchmark information (e.g. GIRFT and Model Hospital) to target work through the Use of Resources Improvement Programme
- Development of major capital upgrades (new Emergency Department) to support improved recruitment of staff.
- Harnessing the teamwork and innovation so evident throughout the Covid-19 pandemic to develop service improvements that lead to improved use of resources.
- Capitalising on the digital advancement during Covid-19 to harness technology to improve effective use of resources.
- Rationalising Estate requirements through increased remote working.
- Enhanced leadership capability through Well-led Improvement Programme workstream.

Future Risks

- Likely move away from PbR towards block contracts.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in 20/21.
- Additional costs associated with safe non-elective and critical care during Covid-19, and planning for a potential second wave.
- Significant impact on elective and non-elective demand during Covid-19, leading to difficulty planning for the future with confidence.
- Insufficient Capital to enable investments in the Estate, equipment and technology that would in turn support more effective use of resources, and lead time for deployment of capital.
- Planning guidance stipulation that receipt of FRF is 50% dependent on delivery of STP financial plan.
- Adverse impact of Britain's exit from the European Union on business continuity and the Trust’s financial position.
- Supply costs are more volatile within the market based on supply and demand associated with Covid-19.
- Workforce exhaustion and/or psychological impact from Covid-19 results in higher sickness rates and further reliance on temporary workforce.

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
2.	Review and update Accountability Framework further to the NHSI Governance Review report.	R. Caldicott	Oct 2020		
3.	Financial regime post 31st September 2020 to be approved by Board in October 2020- Russell Caldicott	R. Caldicott	Oct 2020		
4.	All work-streams to have Improvement programme benefits defined -	G. Augustine	Oct 2020	**Complete – Presented to Trust Board Development Session on 1st October 2020**	

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee – Highlight Page

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

Key Areas of Success

- Despite cessation of most routine 6 Week Wait (DM01) Diagnostics during March and April, and the associated deterioration in waiting times, the Trust's national ranking position continues to remain strong, at 13th best in the country in August out of 123 reporting Trusts. The Trust's DM01 performance has improved further in September and remains on trajectory.
- Despite cessation of routine elective services during March and April, the Trust's 18-week RTT national ranking position has improved to 24th best in the country in August out of 121 reporting Trusts, and September has shown the second consecutive month of improvement since the pandemic, with performance improving further to 68.7%.
- Cancer waiting time standards are showing common cause variation. The Division of Surgery have instituted a weekly Cancer PTL Performance meeting with representation from each Tumour site to review patients on an active cancer pathway, identify necessary improvements and govern delivery of those necessary improvements.
- The Trust has achieved a break-even financial position so far for 2020/21 financial year. However, the Trust required additional funding of £13.7m to attain break-even for months 1-6 (August request for additional funds was c£3.3m) and slightly more than the average due to backdated doctors pay costs and costs linked to EPR.
- The Trust has secured income allocations from the STP for months 7-12 of the financial year aligned to that anticipated within the Operational Plans presented to members at development sessions and through Performance, Finance & Investment Committee
- The Trust has had confirmation of the award of additional capital resources for Urgent and Emergency Care (£4.1m) and Theatre Air Handling Units (£3.7m) in year

Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee – Highlight Page

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

Key Areas of Concern

- The Trust implemented the first phase of it's new Electronic Patient Record (EPR) on the weekend of 19th/20th September. This included the Emergency Department moving from a paper-based clinical record to an electronic clinical record for the first time. Both EPR and ED teams have worked very hard to make the transition, and the new EPR is generally well-received within Emergency Department (ED). However, it has resulted in a significantly longer cycle time for ED's own part of the pathway with the following impact: An over 15 percentage point reduction in 4-hour Emergency Access Standard performance from 90% to less than 75%.

  Mitigating actions to address and improve the position have included;

  1. Invited review by Barnsley Hospital EPR team to make recommendations on configuration changes to the ED Medway and Cas Card system to save clinician time. The majority of these have been implemented within a week of receipt.
  2. Instituted an 8-week ED improvement programme, led by the Deputy Director of Operations for MLTC who has been released from other commitments to provide dedicated leadership to this work.
  3. Executive-led review of Nurse staffing arrangements to ensure nurse staffing is not a further compounding factor.
- October will be the first full month post go-live and so monthly reported EAS performance will deteriorate further before it recovers.
- 18-week RTT and 6 Week Wait (DM01) Diagnostic performance has deteriorated significantly due to COVID-19 resulting in routine elective work (diagnostics, outpatients and elective surgery/procedures) being suspended in March and April. The need to maintain appropriate segregation and Infection Prevention and Control procedures to minimise the risk of in hospital transmission of COVID-19 will mean capacity for routine surgery/procedures is constrained for some time.
- The Trust will receive income as a 'block' for months 7-12 of the 2020/21 financial year. In addition, the Trust will receive fixed allocations for COVID-19 and growth. If allocations are insufficient the Trust will need to reduce expenditure, as there is no facility available to claim additional funds.
- The STP will have elective activity targets for the remaining months of the financial year. It is implied if the Strategic Transformation Partnership does not achieve these targets there could be financial 'penalties'. While the calculation is yet to be confirmed, there is risk for the Trust if targets are not achieved.
- Temporary workforce costs remain higher than the baseline period and will be a key focus for ensuring delivery of financial balance moving forward.

Key Actions Taken

- Financial modelling has taken place for months 7-12 to ensure operational plans are aligned to expected levels of income now secured. Divisional performance will be reported monthly against agreed run rates within these plans and presented through the governance forums of the Trust
- Financial modelling has taken place to analyse year on year temporary staffing costs and a review of temporary workforce controls will be undertaken by the Trust's Internal Auditors

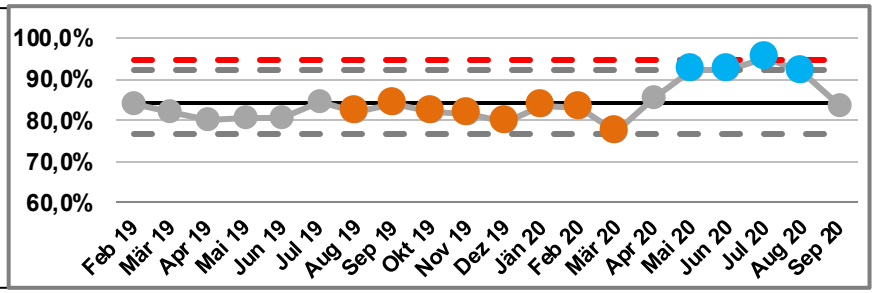
Walsall Healthcare NHS
NHS Trust

Performance, Finance and Investment Committee

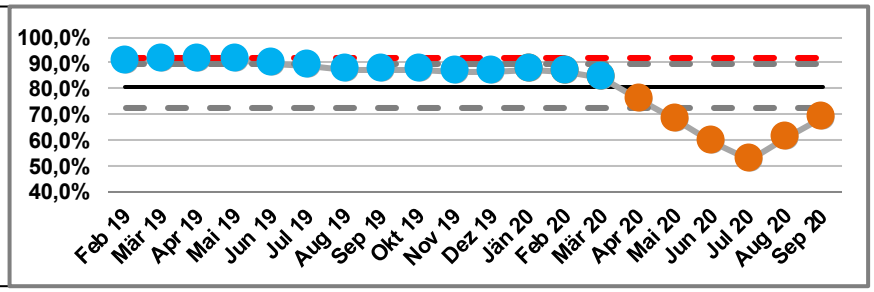
SPC Key

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

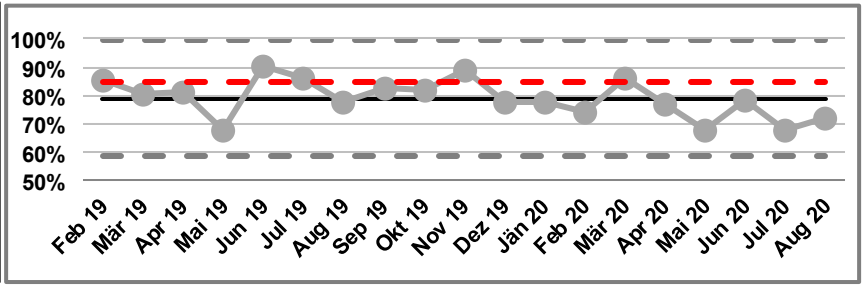
ED - % within 4 hours – Overall (Type 1 & 3)



18 weeks RTT – Incomplete Pathways



Cancer 62 Day RTT



Emergency/Urgent Care

In September ED type 1 attendances decreased by 1.3% to 6275 from August's 6359. This represents 91.6% of last year's monthly activity – down from August's 93%. NHSE have reported ED attendances plateauing across the Midlands and this has been mirrored at Walsall. EAS achieved 83.5% of patients admitted or discharged within four hours of arrival. This represents a significant deterioration on August's 91.8% and a return to the long run average. This fall in performance has been because of three issues – all of which can be alleviated from within the Division: the introduction of Medway, ED staffing difficulties and occasions of poor flow (Exit Block) out of the ED.

Referral to Treatment (RTT)

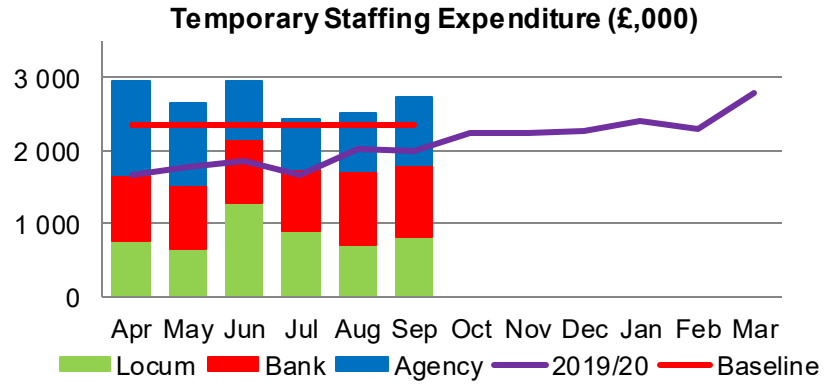
RTT incomplete performance has improved to 68.7% and materially ahead of forecast (Forecasted at 51.62%). All Divisions have improved their performance during September, with congratulations to WCCS in achieving the National Standard for RTT.

Cancer

The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 71.8%. The Trust did not achieve the 62 day consultant upgrade with a performance of 82.1%. From October, the Trust increased the amount of operating theatres in use from 3 to 7. Services continue to access Little Aston to support restoration and prioritise cancer cases. During September DOS introduced a new cancer tracking performance meeting, chaired by the Divisional Director of Operations. New reports support targeted review of pathways. Early outputs are encouraging in terms of reducing total PTL numbers and expediting diagnostics and treatments.

Financial Performance to September 2020 (Month 6)

	Plan YTD Sep £000s	YTD Sep Actual £000s	YTD Variance £000s
Income			
Clinical Contract Income	122,640	122,047	**(593)**
Additional Covid Top-up	0	13,678	**13,678**
Other Income (Education&Training)	3,576	3,727	**151**
Other Income (Other)	21,822	17,629	**(4,193)**
Subtotal Income	**148,038**	**157,082**	**9,044**
Pay Expenditure			
Substantive Salaries	(80,718)	(83,188)	**(2,470)**
Temporary Nursing	(7,230)	(7,630)	**(400)**
Temporary Medical	(5,508)	(6,539)	**(1,031)**
Temporary Other	(1,314)	(2,096)	**(782)**
Subtotal Pay Expenditure	**(94,770)**	**(99,452)**	**(4,682)**
Non Pay Expenditure			
Drugs	(9,474)	(8,255)	**1,219**
Clinical Supplies and Services	(9,150)	(7,371)	**1,779**
Non-Clinical Supplies and Services	(8,730)	(9,026)	**(296)**
Other Non Pay	(18,168)	(25,099)	**(6,931)**
Depreciation	(2,964)	(3,334)	**(370)**
Subtotal Non Pay Expenditure	**(48,486)**	**(53,086)**	**(4,600)**
Interest Payable	(4,782)	(4,633)	**149**
Subtotal Finance Costs	**(4,782)**	**(4,633)**	**149**
Total Surplus / (Deficit)	**0**	**(89)**	**(89)**
Donated Asset Adjustment		89	**89**
Adjusted Surplus / (Deficit)	**0**	**(0)**	**(0)**



Financial Performance

- The Trust reported a £13.7m overspend versus block and top up funding from NHSIE. Per the guidance the Trust has assumed a further receipt of income totaling £13.7m to cover these overspends and is therefore reporting break-even performance
- The adverse variance of £4.2k on other income is driven largely by new guidelines for COVID-19 resulting in our not being able to charge the CCG for IT, Property Services and other services (£3.3m), the Trust has also lost income on car parking, R&D and accommodation charges (£0.7m)
- The Trust's substantive pay has increased in September to £14.1m due to back dated Medical Pay Award, temporary workforce expenditure remains over baseline plan and historic levels.
- Other non pay expenditure is higher, largely due to monthly support costs for the Electronic Patient Record being chargeable this year and costs associated with delays to go live, combined with COVID-19 related costs incurred

Capital

- The Trust has submitted a revised capital plan of £16.5m, though has subsequently received £4.1m for Urgent and Emergency Care (taking the program to £20.6m). Key will be the ability of the Trust to commit and spend the resource during the financial.
- The expenditure to date on capital totals £4.5m

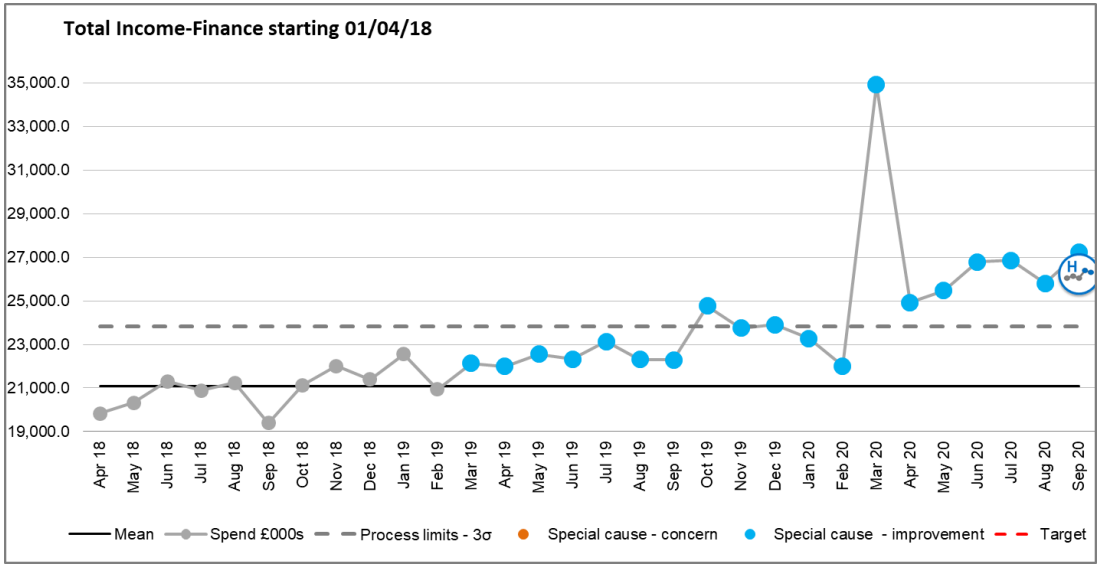
Cash

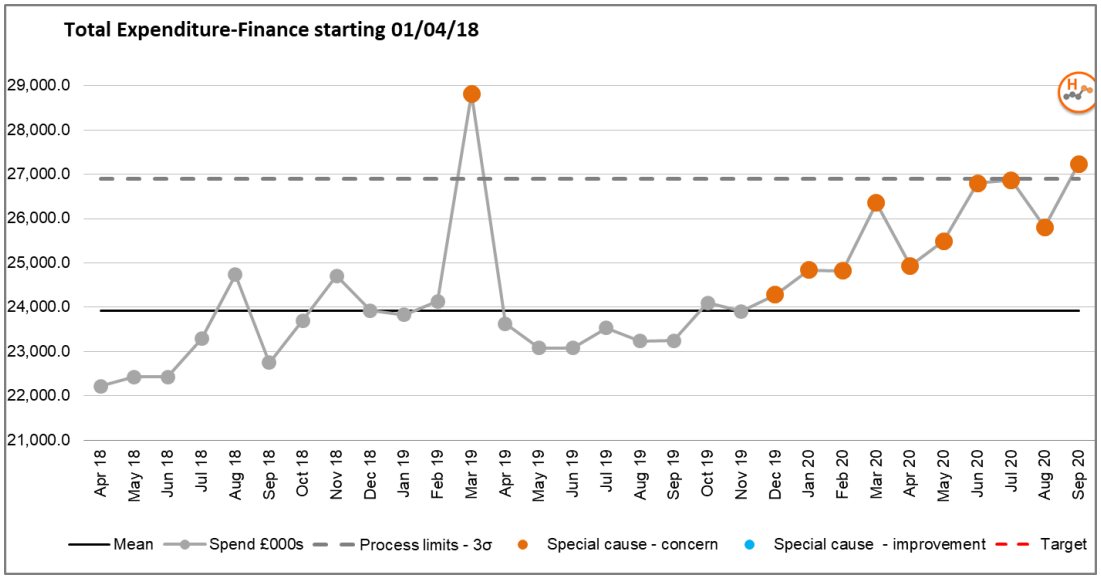
- Actual cash holding was £43.5m due to the contract payment being paid a month in advance in accordance with the emergency funding guidance from NHSIE. The Trust has been made aware of NHSEI seeking to recover this advance payment prior to close of the financial year

Efficiency attainment

- The emergency budget planning letter and guidance states there is 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.

Income and expenditure run rate charts





Income additional information

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

Expenditure additional information

- March 2019 the Trust accounted for the ICCU Impairment of £6.2m
- March 2020 costs increased to reflect the Maternity theatre impairment £1m & COVID-19 expenditure
- Throughout April and May 2020 costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base, noting a reduction in expenditure in August due to the non recurrent nature of these. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend.

Summary

The Trust is reliant on top up funding to deliver break-even performance, with monthly run rate moving from £25m to £27m per calendar month. For the remainder of the year costs will need to remain within the endorsed Operational plans (the income envelope for 2020/21 now known) if the Trust is to attain a balanced financial plan.

Cash Flow Statement & Statement of Financial Position (M6)

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending September 2020	Year to date Movement
	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	4,544
Depreciation and Amortisation	3,334
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	17,853
Increase/(Decrease) in Trade and Other Payables	20,783
Increase/(Decrease) in Stock	46
Interest Paid	(4,176)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	42,384
Cash Flows from Investing Activities	
Interest received	**0**
(Payments) for Property, Plant and Equipment	**(6,037)**
Receipt from sale of Property	**0**
Net Cash Inflow/(Outflow)from Investing Activities	**(6,037)**
Net Cash Inflow/(Outflow) before Financing	36,347
Cash Flows from Financing Activities	(1,891)
Net Increase/(Decrease) in Cash	**34,456**
Cash at the Beginning of the Year 2020/21	9,056
Cash at the End of the September	43,512

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending September 2020	Balance as at 31/03/20	Balance as at 31/09/20	Year to date Movement
	'£000	'£000	'£000
Total Non-Current Assets	**144,866**	**146,205**	**1,339**
Current Assets			
Receivables & pre-payments less than one Year	39,001	21,019	(17,982)
Cash (Citi and Other)	9,056	43,512	34,456
Inventories	2,620	2,574	(46)
Total Current Assets	50,677	67,105	16,428
Current Liabilities			
NHS & Trade Payables less than one year	(25,955)	(21,533)	4,422
Other Liabilities	(1,480)	(26,212)	(24,732)
Borrowings less than one year	(134,693)	(2,082)	132,611
Provisions less than one year	(437)	(437)	-
Total Current Liabilities	(162,565)	(50,264)	112,301
Net Current Assets less Liabilities	**(111,888)**	**16,841**	**128,729**
Non-current liabilities			
Borrowings greater than one year	(116,013)	(116,013)	-
Total Assets less Total Liabilities	(83,035)	47,033	130,068
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	68,300	198,455	130,155
Revaluation	14,832	14,832	-
Income and Expenditure	(166,167)	(166,165)	2
In Year Income & Expenditure	-	(89)	(89)
Total TAXPAYERS' EQUITY	(83,035)	47,033	130,068

Walsall Healthcare NHS
NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
%	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)	85.73%	92.21%	92.62%	95.43%	91.88%	83.50%	90.35%	95.00%	81.77%	F	H
%	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED	70.21%	74.72%	78.86%	80.29%	79.35%	58.23%	73.60%	100.00%	62.37%	F	H
No.	Ambulance Handover - No. of Handovers completed over 60mins	0	0	1	0	5	20	26	0	312	?	
%	Cancer - 2 week GP referral to 1st outpatient appointment	94.20%	95.84%	93.17%	93.00%	92.06%	86.29%	91.83%	93.00%	84.07%	?	
%	Cancer - 62 day referral to treatment of all cancers	76.67%	67.80%	78.57%	67.44%	71.83%	65.52%	71.17%	85.00%	80.93%	?	
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	75.82%	67.41%	59.32%	52.50%	61.06%	68.66%				F	L
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	1	1	8	9	8	14	41	0	0	?	H
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test	39.09%	36.99%	22.47%	16.32%	18.24%	14.70%	21.48%	1.00%	1.63%	?	H
No.	No. of Open Contract Performance Notices	9	9	9	9	9	9		0		F	L
CARE AT HOME												
%	ED Reattenders within 7 days	8.61%	8.84%	7.82%	8.45%	8.78%	6.63%	8.14%	7.00%	7.60%	?	
RESOURCES												
%	Outpatient DNA Rate (Hospital and Community)	11.33%	5.28%	5.11%	6.76%	10.25%	11.42%	8.30%	8.00%	10.44%	?	
%	Theatre Utilisation - Touch Time Utilisation (%)	36.47%	58.08%	47.06%	62.98%	67.50%	43.61%	52.97%	75.00%	85.42%	?	L
%	Delayed transfers of care (one month in arrears)	2.54%	2.82%	2.23%	2.57%			2.54%	2.50%	3.68%	?	L
No.	Average Number of Medically Fit Patients (Mon&Thurs)	53	36	37	39	35	46					L
No.	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)	5.00	4.00	4.00	3.00	3.00	4.00					L
£	Surplus or Deficit (year to date) (000's)	0	0	0	0	0	0					

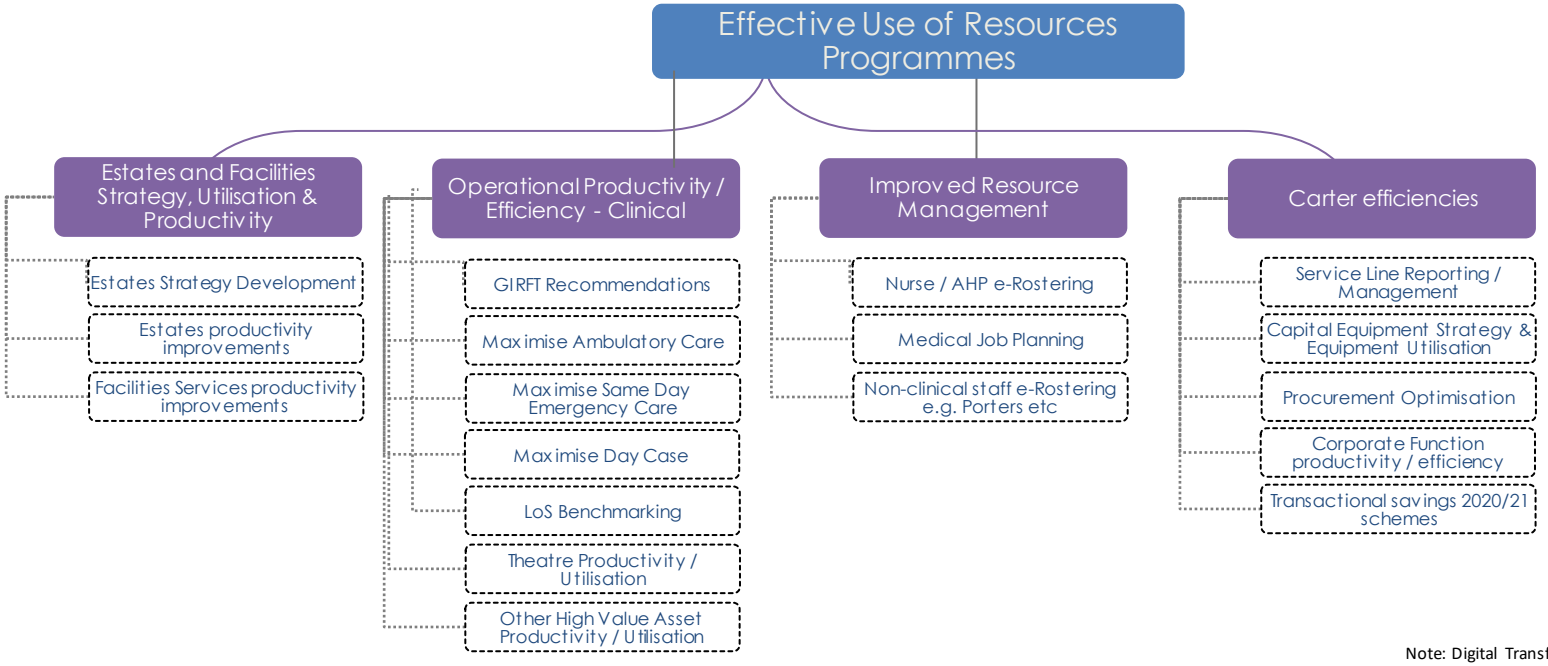
Walsall Healthcare NHS Trust

PERFORMANCE, FINANCE AND INVESTMENT COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
£	Variance from plan (year to date) (000's)	0	0	0	0	0	0					
£	CIP Plan (YTD) (000s)											
£	CIP Delivery (YTD) (000s)											
£	Temporary Workforce Plan (YTD) (000s)	2300	4700	7000	9400	11700	14100					
£	Temporary Workforce Delivery (YTD) (000s)	2900	5600	8600	11000	13500	16300					
£	Capital Spend Plan (YTD) (000s)											
£	Capital Spend Delivery (YTD) (000s)		1300	3000	3800	4300	4500					

Work Breakdown structure

The following diagram represents the full current scope of work proposed for delivery through this workstream:



Note: Outpatients Transformation being delivered through the Care at Home workstream due to WT links

Note: Digital Transformation is now being delivered through the Working with Partners workstream due to WT links

Effective Use of Resources Workstream Development update
October 20 IP Board / PFIC

Project administration							Project Initiation							Project tracking							Risk summary		
Project ref.	Strategic workstream	Focus area	Project title	Workstream lead	Division/function	Project Lead	Project brief	Implementation Plan	Risks, issues and mitigation	Benefits/cost assessment	Stakeholder engagement	QIA/EDI	PID sign-off	Project mobilisation	Define and scope	Measure and understand	Design and plan	Pilot and implementation	Sustain and share	Benefit assessment and project close-out	Project delivery	Project resource availability	Benefits realisation
EUoR1	Effective Use of Resources	Estates and facilities	Estates strategy development	Jane Longden	Corporate	TBC																	
EUoR2			Estates productivity improvements	Jane Longden	Corporate	TBC																	
EUoR3			Facilities productivity improvements	Jane Longden	Corporate	TBC																	
EUoR4		Operational Productivity/efficiency	Operational productivity - MLTC	Kate Salmon	MLTC	TBC																	
EUoR5			Operational productivity - Surgery	William Roberts	Surgery	TBC																	
EUoR6			Operational productivity - WCCSS	Delreita Ohai	WCCSS	TBC																	
EUoR7		Improved Resource Management	Nurse/AHP eRostering	Gaynor Farmer	All Divisions	Gaynor Farmer																	
EUoR8			Medical job planning	Charlotte Hill	All Divisions	Charlotte Hill																	
EUoR9			Non-clinical staff eRostering	Garnor Farmer/Charlotte Hill	Corporate	TBC																	
EUoR10		Carter efficiencies	Service Line Reporting/Management	Dan Mortiboys	All Divisions	TBC																	
EUoR11			Capital equipment strategy and equipment utilisation	Michael Koushi	Corporate	TBC																	
EUoR12			Procurement optimisation	Dan Mortiboys	Corporate	TBC																	
EUoR13			Corporate functions productivity/efficiency	Dan Mortiboys	Corporate	TBC																	
EUoR14			2020/21 savings	Kate Salmon	MLTC	Various																	
EUoR15				William Roberts	Surgery	Various																	
EUoR16				Delreita Ohai	WCCSS	Various																	

Workstream / Project admin Info

PID development status

Project Implementation status

Key risks, issues & dependencies

	Description	RAG	Board escalation / assurance comments
Risk	Provision of sufficient capital each year to deliver proposed projects. This is particularly a risk for Estates and Facilities Productivity improvement projects.	A	The development of a three year capital investment strategy to ensure delivery of each project is supported effectively.
Risk	A second wave of Covid 19 diverts attention away from the Improvement Programme onto solely operational management activities.	A	
Issue	There are a number of areas where progress appears to be slow, with Improvement Programme activities appearing to be being relegated to a second order priority.	A	Clarification needed with certain individuals/teams about the priority rating of the Improvement Programme against other competing activities.
Issue	There are a number of competing processes being used across the Improvement Programme which have had the tendency to introduce confusion.	A	Activity to streamline a number of processes and documents being used is underway, to ensure clarity across all Effective Use of Resources activities.
Dependency	Interdependencies with other Improvement Programme workstreams.	A	Work is underway to ensure work across all workstreams is complementary and furthers the delivery of the whole Improvement Programme.

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
EPRR Annual Assurance Report			**AGENDA ITEM: 17**
Report Author and Job Title:	Mark Hart Head of EPRR	**Responsible Director:**	Ned Hobbs Chief Operating Officer
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	To assure the Trust Board that the Trust has met the annual assurance of Emergency Preparedness, Resilience and Response that is required by NHS England. This report sets out the amended annual assurance process for 2020-21, the Trust's summary response, and outlines our fresh approach to the programme for the year ahead to enhance standards and practices that will align to the Trust's vision and objectives. The report was considered by the Performance, Finance and Investment Committee on 27th October 2020.		
Recommendation	The Trust Board is asked to: • Approve our response to the Annual assurance Process for EPRR. • Note our approach for the next 12 months.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk 1005 - Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks. Risk 2051 – Covid19 Risk 665 - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation		
Resource implications	Very limited resource implications. Division and corporate services to support work programme.		
Legal and Equality and Diversity implications	There is evidence that COVID-19 has disproportionately affected certain communities, and thus it is reasonable to assume other EPRR incidents may not have an equal impact across the population we serve. For this reason, it is of added importance that our EPRR arrangements are as resilient as possible.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL ASSURANCE PROCESS AND WINTER PLANNING 2020-21

1. PURPOSE OF REPORT

The purpose of the report is to assure the Trust Board that the Trust has completed the annual assurance of Emergency Preparedness, Resilience and Response (EPRR) that is required by NHS England.

2. BACKGROUND

It is a mandatory requirement for all organisations that receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. However, due to the national response to COVID-19 since March 2020 it is recognised that the regular process would be excessive, particularly with organisations now preparing for potential further local and regional surges, as well as the upcoming seasonal pressures, European Union Exit risk and the operational demands of restoring and recovering services.

Therefore by exception, the NHS has directed an amended process that was communicated by letter on 20 August 2020, a copy of which is attached at Appendix 2. The assurance process is only to focus on three areas:

- Progress made by organisations that were reported as partially or non-compliant in the 2019/20 process;
- The process of capturing and embedding the learning from the first wave of the covid-19 pandemic;
- Inclusion of progress and learning in winter planning preparations.

The EPRR Steering Group completed the requirement in September 2020 and submitted the summary in the required format as requested.

3. DETAILS

The key deadlines for the annual process are set out below:

- 31 October 2020: statements of assurance are made to regional EPRR teams by Clinical Commissioning Groups (CCGs)
- 31 December 2020: regional EPRR teams submit their statement of assurance to the national EPRR team
- 28 February 2021: national EPRR team to have completed conversations with regional teams
- 31 March 2021: national EPRR assurance reported to the NHS England and NHS Improvement board and Department of Health and Social Care.

The combined Black Country CCGs requested statements from all Trusts by 16 September 2020. Walsall Healthcare NHS Trust submitted on time, with a copy of the key statements at Appendix 1.

The statement was required to include the following points:

- the updated assurance position of any organisations that were rated partially or non-compliant in 2019/20;
- assurance that all the relevant commissioners and providers of NHS-funded care have undertaken a thorough and systematic review of their response to the first wave of the COVID-19 pandemic, and a plan is in place to embed learning into practice;
- confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system.

Whilst the EPRR work programme was affected by the national response to COVID-19 and many planned training sessions, exercises and plan reviews postponed, the actual activation and response arrangements have offered significant learning, a real understanding of the EPRR function across the organisation and a reshaping of our current and future approach and activities.

The landscape has significantly altered and with a new Head of EPRR in post since July, a refreshed approach to reaching full compliance of the core standards and setting of high quality practices and procedures across the Trust is already underway. A longer term process to build a resilient organisation, agile and robust to meet core business and any incident/emergency is underway in parallel.

4. RECOMMENDATIONS

The Trust Board is asked to:

- **Approve** our response to the Annual assurance Process for EPRR.
- **Note** our approach for the next 12 months.

Appendix 1: Walsall Healthcare Annual Assurance for EPRR Submission 2020-21.

Appendix 1: Walsall Healthcare Annual Assurance for EPRR Submission 2020-21

Walsall Healthcare EPRR Assurance 2019-2020 Summary

2018/2019 RATING

Partially Compliant

PROGRESS MADE AGAINST RATING

Progress made on all areas outlined in the subsequent Action Plan. The Trust's response to the covid-19 pandemic has slowed the final refinement and embedding of some of these improved practices. Summary of progress as follows:

- Duty to Maintain Plans; all plans/policies in date. Some planned exercises to test and assure including Protected Individual Plan were postponed. This is a priority in the current Work Plan.
- Warning & Inform. Strategy reviewed. Fully compliant.
- Business Continuity. Progress made but embedding of continuous improvement, monitoring and evaluation yet to be embedded. Remains a priority in current Work Plan.
- CBRN. Decontamination availability 24/7, PRPS suit availability, equipment checks and training in place and firmly established. Fully compliant.

New Head of EPRR joined late July; short summary report of improvement and current position will be forwarded separately to CCG in October.

PANDEMIC 1ST WAVE LESSONS LEARNED

The Trust's response to the national pandemic has offered confidence in its preparedness, resilience and response capabilities. Whilst the speed, scale and intensity of the early phase was unprecedented and response ongoing, the Trust has commissioned a range of learning events and summits. EPRR have specifically co-ordinated tailored events to seek insight, capture good practices and areas for improvement. Key themes have included Preparedness, Information Management, Action Setting, Decision Making, Operating Environment, Command and Control, Communication and People.

The lessons have fed two EPRR priorities; contingency planning for probable local and regional surges or possible national surge in the next 12 month and secondly, wider learning into all other related EPRR plans, practices and activity.
Key programmes to draw lessons include:

Tactical Command Team Reflection. Aim was through the facilitated set of reflection sessions for Tactical Command team individuals, learn and embed from recent experiences, so that the Trust can enhance resilience and any response in the next 12 months ahead. Report distributed and recommendations being taken forward appropriately under EPRR Steering Group oversight.

EPRR Support Lessons. Aim to reflect and learn from experiences of all participants of the EPRR support cell. Report and recommendations produced are under EPRR Steering Group oversight.

Exercise MUIRFIELD conducted in late August further reviewed the Trust's tactical preparedness for the potential escalation of covid-19 so the Trust is ready to respond in the next 12 months. Trust Plan with Divisional contingency is current in draft, linked to Public Health planning with further workshops and a local multi-agency exercise planned.

WINTER PLANNING

Significant winter planning with STP colleagues is well underway. EPRR was heavily involved last year in the Trust Winter Arrangements, the previous learning and the learning from last winter. Covid-19 learning and further contingency planning is embedded across other work streams preparing for winter.

Exercise MUIRFIELD looked at the challenges of covid-19 contingency planning with other significant winter pressures; Divisional Workshops are currently exploring the challenges further. The Trust is supporting a Walsall council led multi-agency Outbreak Plan Exercise in early October. Robust command and control arrangements, sound and extensive surveillance nationally and locally with triggers and activation procedures being refined. Further exercise planned to test Covid-19 Surge Contingency Plan.

Publications approval reference: 001559

NHS England and NHS Improvement
Skipton House
80 London Road
SE1 6LH

To: NHS Accountable Emergency Officers
NHS England and NHS Improvement:
Regional Directors
Regional Heads of EPRR
Regional Directors of Performance and Improvement
Regional Directors of Performance

20 August 2020

Dear colleague

Emergency preparedness, resilience and response (EPRR) annual assurance process and winter planning for 2020/21

We would like to thank you and your team for your outstanding leadership and support during these exceptional times and for the care delivered to patients. Our collective focus over recent years to improve and embed good robust, evidence-based and tested EPRR practice across the NHS has undoubtedly contributed to the system-wide response to COVID-19.

The events of 2020 have tested all NHS organisation plans to a degree above and beyond that routinely achievable through exercises or assurance processes. However, our statutory requirement to formally assure ourselves of EPRR readiness in our own organisation and the wider NHS remains.

We recognise that the detailed and granular process of previous years would be excessive while we prepare for a potential further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services. This letter sets out the amended process for 2020/21 which will focus on three areas:

1) progress made by organisations that were reported as partially or non-compliant in the 2019/20 process
2) the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic
3) inclusion of progress and learning in winter planning preparations.

1. Progress of partially or non-compliant organisations

Organisations that were rated partially or non-compliant in the 2019/20 process will have undertaken a great deal of work through their action plans to address gaps. Much of this will have been carried out ahead of the COVID-19 pandemic which began in the UK in January 2020. The 2020/21 process seeks to understand their improved status.

2. The identification and application of learning from the first wave of the COVID-19 pandemic

The comprehensive and extensive response to the first wave of the COVID-19 pandemic has provided all health organisations with a unique opportunity to identify and embed lessons into EPRR practice. The 2020/21 process seeks to ensure that all NHS organisations have begun the process to systematically and comprehensively identify, learn and embed lessons to improve EPRR practice.

3. Incorporating progress and learning into winter planning arrangements

As in previous years there is also a wider programme of winter planning and assurance. This work will draw on existing processes, including this one, to supplement assurance conversations. The 2020/21 process seeks to ensure this learning is embedded in winter preparedness.

Action to take/next steps

All NHS organisations will already be undertaking reviews of their response to the first wave of COVID-19 and embedding learning into arrangements ahead of any possible second wave.

Clinical commissioning groups (CCGs)[1] are asked to submit a statement of assurance to the relevant NHS England and NHS Improvement regional head of EPRR by 31 October 2020.

This statement should include:

1) the updated assurance position of any organisations that were rated partially or non-compliant in 2019/20 (this may include the CCG itself)
2) assurance that all the relevant commissioners and providers of NHS-funded care have undertaken a thorough and systematic review of their response to the first wave of the COVID-19 pandemic, and a plan is in place to embed learning into practice
3) confirmation that any key learning identified as part of this process is actively informing wider winter preparedness activities for your system.

Our regional head of EPRR will undertake structured conversations with CCGs as necessary to better understand their statements.

Our regions will submit their statement of assurance to the director of EPRR (national) by 31 December 2020.

This statement should include the same elements as the CCGs: an update on the 2019/20 partially or non-compliant organisations and the identification and embedding of learning through an appropriate process.

[1] CCGs hold local statutory functions. However, in many parts of the country CCGs have come together to operate as sustainability and transformation partnerships (STPs) or integrated care systems (ICSs). Where this is the case, the term CCG should also be read as STP or ICS. Local reporting for this process will be agreed with your regional head of EPRR.

Our national EPRR team will undertake conversations with each region in advance of preparing a national statement of assurance for the NHS England and NHS Improvement board and the Department of Health and Social Care (DHSC).

The annual EPRR assurance process traditionally places local health resilience partnerships (LHRPs) in a central role for local leadership. Given the planning nature of LHRPs and the current response position of the NHS, it is not considered appropriate for LHRPs to lead the assurance this year. We expect that LHRPs will maintain a critical role in future EPRR assurance processes, and outputs from the 2020/21 process will be shared with LHRP co-chairs at the appropriate time.

Summary

You are asked to ensure you have undertaken a comprehensive and thorough review of learning from the first wave of the COVID-19 pandemic, that you have a process to convert the learning into practice and those partially or non-compliant organisations in the 2019/20 assurance process report their updated compliance rating (using the 2019/20 assurance criteria).

Please note the following deadlines:

- 31 October 2020: statements of assurance are made to regional EPRR teams by CCGs
- 31 December 2020: regional EPRR teams submit their statement of assurance to the national EPRR team
- 28 February 2021: national EPRR team to have completed conversations with regional teams
- 31 March 2021: national EPRR assurance reported to the NHS England and NHS Improvement board and DHSC.

If you have any further queries, please do not hesitate to contact Stephen Groves or your regional head of EPRR.

Yours sincerely

Stephen Groves

Director of EPRR (National)

Daniel De Rozarieux

National Director of Elective and Emergency care and Operations and Performance

cc NHS England and NHS Improvement Business Continuity team
CCG Accountable Officers
CCG Clinical Leads
CSU Managing Directors
Clara Swinson, Director General for Global and Public Health, DHSC
Emma Reed, Director, Emergency Preparedness and Health Protection Policy Global and Public Health Group, Department of Health and Social Care
LHRP co-chairs

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Quality, Patient Experience and Safety Committee (QPES) Highlight Report			**AGENDA ITEM: 18**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mrs Pamela Bradbury – Chair of QPES (Non-Executive Director).
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Quality and Patient Safety Committee meetings on 29th October 2020. Of note are: - First time parents who had their baby at the Primrose Ward during the pandemic provided the patient story for the Committee. The parents were anxious about coming into the hospital during the pandemic but said they felt supported and reassured enough to enjoy the birthing experience, with the father being equally involved with the mother and baby. - In line with best practice from the Academy of Medical Royal Colleges, outpatient clinic letters are now addressed to the patient, copying in the GP, rather than directly to the GP. This has improved communication with patients and facilitates self-care. - The quality performance dashboard – a copy of which is on the Board agenda under Safe, High Quality Care - continues to show gaps in metrics, and the committee will review this in more detail over the next few meetings to gain assurance. - The Committee heard that a better understanding of drugs and ventilation to treat COVID-19 patients, as well as new pathways, community models of care, and support packages for staff, are supporting safe restoration of services. - The quality impact assessment for the re-opening of the Midwifery Led Unit (MLU) following closure during COVID-19 was reviewed. - The Infection Prevention and Control Annual Report was reviewed and is on the agenda for this Board meeting. Assurance on the 2020/21 plan will be provided to the Committee by exception on a quarterly basis. - The Committee reviewed the priorities it set for the 2020/21 year, and approved its revised cycle of business following		

	revisions to its terms of reference in July. - An update was provided on the CQC action plan and the framework to oversee progress with open actions. An evidence repository had also been developed to demonstrate compliance with the assurance process. - Members raised concerns regarding out of date clinical policies and procedures and the impact this could have on clinical practice. The Governance and Well-Led workstream of the Improvement Programme is reviewing the policy process trust-wide to introduce automation and efficiencies, with other workstreams, including Provide Safe High Quality Care, reviewing policies and procedures relevant to their remit. It is intended that this will reduce the volume of policies, with further mitigations including staff being encouraged to utilise the available clinical library of policies and other tools, and the review of policy and procedure that takes place as part of any incident review process. - There are concerns about the requirement for staff going into care homes to have weekly COVID-19 swabbing. Community Services are unable to access the swabs required to implement this, however they are currently working with the care homes and commissioners to provide additional support. The next meeting of the Committee will take place on 26th November 2020
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.
Risk in the BAF or Trust Risk Register	This report aligns to BAF risk S01 for safe high quality care and COVID-19 BAF risk S06.
Resource implications	There are no new resource implications associated with this report.
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper

Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Safe High Quality Care – Executive Update			**AGENDA ITEM: 19**
Report Author and Job Title:	Ann-Marie Riley, Interim Director of Nursing Matthew Lewis, Medical Director	**Responsible Director:**	Ann-Marie Riley, Interim Director of Nursing Matthew Lewis, Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Safe High Quality Care ("SHQC") strategic objective and provides an update on the mitigations in place to manage the risks identified, as well as the actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance relating to the Safe High Quality Care improvement programme work-stream and performance against the related strategic objective, successes and areas for improvement.		
Recommendation	1. Note the update to Trust Board on actions taken relating to the Improvement Programme through Quality, Patient Experience & Safety Committee (QPES) and supporting groups. 2. Note the highlighted updates to BAF risk S01 and related risks on the Corporate Risk Register. 3. Note the relevant updates and assurance in relation to the performance report 4. Note the progress made within the three key elements of the Safe High Quality Care (SHQC) improvement plan 5. Note the update from the Care Quality Commission (CQC) based on the evidence submitted for the inspection 8 and 9 September visit to the Emergency Department and Maternity		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report highlights updates relevant to Board Assurance Framework (BAF) Risk SO1 and provides assurance or mitigations in place to manage this risk. The related corporate risks are: **Risk 208**: Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks		

	Risk 274: Failure to resource backlog maintenance and medical equipment replacement **Risk 2260**: Lack of a whole system approach across health and social care for the management of Children and Young People (CYP) in mental health or behavioural crisis which will replace **Risk 1986** (Delays in access to Tier 4 in-patient psychiatric care for Children and Young People; **Risk 2066**: There is a lack of skilled registered nurses and registered midwives on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care, and excellent patient and staff experience. This risk has been reviewed and a recommendation made to increase the risk to 20 given current challenges maintaining fill, reduced bank fill for clinical support workers, additional capacity concerns and impact of COVID-19	
Resource implications	Current resource implications relate to the delivery of the Safe High Quality Care improvement programme	
Legal and Equality Diversity implications	Failure to deliver safe, high quality care may result in further breaches of legal requirements under the Health and Social Care Act 2008	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

Safe High Quality Care – Executive Update

1. EXECUTIVE SUMMARY

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

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

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

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

The Director of Nursing and Medical Director continue work to develop a multi-professional Care Excellence Strategy to drive multi-disciplinary collaboration to support the achievement of care excellence across patient outcomes, patient experience and staff experience; and develop an environment in which clinical excellence will flourish. The final stage of staff consultation is now complete which saw the development of a shared professional practice model across nursing, midwifery, allied health professionals and medical teams. A broader consultation will now take place so teams can vote for their preferred professional practice model from the four suggested options.

2. BOARD ASSURANCE FRAMEWORK

Our strategic objective is to deliver excellent quality of care as measured by an outstanding CQC rating by 2022. The BAF risk score currently remains at 16.

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

2.1 Controls

Faculty of Research and Clinical Education

The team have bid for national monies to support international recruitment. We have bid to support clinical support staff who worked as RN's in another country to gain the necessary requirements to register with the Nursing and Midwifery Council as a registered nurse. Work is still underway to provide required information to support the bid and we will update if we have been successful as the funding allocations are made.

Quality Review in place with NHSEI/CQC

8 and 9 September: CQC visiting the Emergency Department and Maternity - there were four inspectors each day. On review of the evidence submitted the CQC raised concern with management of sepsis in paediatrics, and paediatric emergency department staffing in relation to maintaining two paediatric nurses on each shift. Immediate interim actions were put in place to mitigate risk until we are able to support the safe delivery of care with our digital platform via Medway.

2.2 Gaps in Controls update

NHSEI review of Maternity regarding insufficient assurance on infection control standards

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

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

- We are working closely with governance, and the Well Led workstream, to ensure our policies and procedures are up to date and in line with best practice. There are currently 107 policies that are out of date. 41 of these are aligned to the SHQC workstreams and relevant leads have been contacted and we are monitoring progress closely.

2.3 Rationale for current score

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

<u>Gaps in Controls:</u>

- Preventing future deaths notice for Venous thromboembolism (VTE)
- Sepsis audit frequency and performance
- New Electronic Patient Record not yet functioning at full capacity

<u>Gaps in assurance:</u>

- Inconsistent evidence both through quality governance structures and performance reviews, of practice having changed as a result of learning from Root Cause Analysis (RCAs)
- Gaps in assurance noted from the recent CQC inspection including management of sepsis and robust audit data; gaps in ability to have two paediatric nurses rostered each shift in paediatric Emergency Department
- Complaints highlighting failure to deliver consistently high standards of care, poor patient experience
- CQC inpatient survey 2019 results

- Lack of assurance regarding equality, diversity and inclusion and actions to reduce inequalities

2.4 Future opportunities

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

2.5 Link to Corporate Risk

Risk 1986 has been updated as indicated below:

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

Risk 2260: Lack of a whole system approach across health and social care for the management of Children and Young People (CYP) in mental health or behavioural crisis which will replace.

3. PERFORMANCE REPORT

The performance dashboard was presented at the Quality, Patient Safety and Experience Committee, noting that it continues to have gaps in data, which will be reported through QPES in the coming months.

There has been one severe harm incident reported in September incurring a fractured neck of femur on the Acute Medical Unit (AMU).

Two key areas of concern from the data available are dementia screening performance and mental capacity assessment performance; both areas are subject to reviews to understand the drop in performance in month.

4. IMPROVEMENT PROGRAMME

Currently there are an estimated 111 distinct projects with approximately 164 distinct metrics within the SHQC improvement programme with new projects being as needed. Where possible we aim to bench mark our performance against peers with the aim that we continually outperform peers. The benefits realisation work demands analysis against benchmark data across a range of sources including the Model Hospital database and this

work has commenced. A suite of SPC charts highlighting our current performance across a range of metrics, and how we benchmark against peers, requires development. There has been progress against each of the three key workstreams within the SHQC programme.

4.1 CQC action plan

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

4.2 Pathway to Excellence

As previously noted our new Care Excellence Strategy continues to be developed and the work to benchmark our KPI's is still to be concluded.
A core team continue to scope policies, procedures and Scopes Of Practice related to the SHQC workstream to ensure these are up to date and in line with best practice.
Two new shared decision making councils have launched in our neonatal unit and paediatric assessment unit. The first Leadership Council will meet this month where council chairs will meet with the Director of Nursing and Director of People and Culture to share their projects and seek support as required.

4.3 Care Excellence

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

- The terms of reference of the Medicines Safety group are being reviewed with a new programme of work to address areas where concerns have been identified
- EPR roll out phase one complete - agreement to implement eSepsis module for adults and paediatrics
- Deep dive for pressure ulcers in community resulting in an action for the reporting /new referrals
- There continues to be good progress with the cancer pathway action plan. The roles of the Trust Cancer Team have been reviewed and the Trust has committed to a joint Quality Improvement programme with University Hospital Birmingham (UHB) to improve the tertiary referral processes and multi-disciplinary working. A new process for flagging suspected malignancies on imaging has been implemented for in-patients. This aligns with the process for outpatients and will reduce missed and delayed reports. Positive feedback has been received from patients and no new serious incidents have been raised. A more detailed spotlight paper presented to QPES in October.
- A new template has been introduced for speciality groups to focus the lessons learnt and improvements made to reduce avoidable harm in order to provide the Mortality

Surveillance Group with assurance of learning. Joint work has been planned within the STP Mortality Leads group to learn from each other. A focus on COVID-19 and coding is planned in October.

- Lessons Learnt group has been established and has a wide membership to include Quality Improvement, governance, legal, patient complaints and Divisional teams as well as communications. The first Trust Learning Newsletter will be completed in October. The group is piloting ideas such as learning walks and learning boards following ward reviews to gain assurance and evidence of learning.

5. RECOMMENDATIONS

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

APPENDICES

Appendix 1 (a): BAF Risk S01

Appendix 1 (b): Corporate Risk Register

Appendix 2: Performance Report

Appendix 3: Improvement Programme Update

Walsall Healthcare NHS Trust

Risk Summary			
BAF Reference and Summary Title:	**BAF 1: Safe, high quality care: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022**		
Risk Description:	**The Trust fails to deliver excellence in care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.**		
Lead Director:	Director of Nursing	**Supported By:**	Medical director
Lead Committee:	Quality, Patient Experience and Safety Committee		
Links to Corporate Risk Register:	**Title** • 208 Failure to achieve 4 hour wait as per National Performance Target of 95%, resulting in patient safety, experience and performance risks • 274 Failure to resource backlog maintenance and medical equipment replacement • 2066 Lack of registered nurses and midwives • 2260 Lack of a whole system approach across health and social care for the management of Children and Young People (CYP) in mental health or behavioural crisis.		**Current Risk Score** **16 (High)**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	4	4			• Lack of a clear quality strategy impacts on our ability to accurately monitor and assure care outcomes • Significant gap in the Trust's approach to patient engagement and patient involvement. • Impact of pandemic of COVID-19 resulting in changes in practice and delivery of care from central government command and control resulting in reactive policy and clinical practice changes • Failure to complete CQC Must and Should Do actions • Gaps in the number and quality of clinical guidance, policies and procedures to ensure safe and quality care • Quality reviews have been commissioned in light of concerns that have been raised about delivery care through anonymous and overt routes (including safeguarding and CQC) • Initial concerns into audit and data registration have been raised by the Royal College of Surgeons (awaiting final report) • Duty of Candour below target performance level	Likelihood:	2	31 March 2021
Consequence:	5	4				Consequence:	5	
Risk Level:	High 20	High 16				Risk Level:	Mod 10	

Walsall Healthcare NHS Trust

				• Failure to deliver 7 Day Services to provide uniform levels of care throughout the week • Failure to demonstrate that the trust is identifying and addressing inequalities in health • Delays in cancer diagnosis and treatment pathways		

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Clinical Guidelines/Policies and Standard Operating Procedures in place • Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels • Staffing meetings twice a day with agreed escalation process. • Central staffing hub co-ordinates nurse staffing numbers in line with acuity and activity • Clinical audit programme & monitoring arrangements • Safety Alert process in place • Freedom to speak up process in place • Covid-19 SJR have been undertaken for all deaths • GIRFT Meetings reinstated Thrombosis committee reinstated • Agreement and plan to implement the electronic sepsis bundle for adults and children. • Process of assurance for lessons learnt being developed • CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital.	• Patient Experience group in place • Robust governance and quality standards managed and monitored through the governance structures of the organisation, performance reviews and the CCG/CQC • Learning from death framework supporting local mortality review. • Faculty of Research and Clinical Education (FORCE) established to promote research and professional development in the trust • Perfect Ward app allows local oversight of key performance metrics	• Annual External Audit of Quality Account • CQC Inspection Programme • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM) • NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of Social distancing, Patient/Staff screening and PPE Guidance • Quality Review 6 monthly reviews in place with NHSi/CQC
Gaps in Control	• Clinical audit monitoring arrangements to be reviewed and strengthened • VTE performance continues to be below the Trust Target • Deterioration in the Trust's complaints response performance		

Walsall Healthcare NHS Trust

	• Mental Capacity Act compliance below the Trusts Standards • Out of date clinical Policies, Procedures and SOP's • Training performance not meeting set targets • Mandatory training below acceptable levels of completion • Quality Impact Assessment process is not yet established within the trust • Preventing future deaths notice for VTE • Sepsis audit frequency and performance • New Electronic Patient Record not yet functioning at full capacity		
Assurance:	• Quality Governance process are in place with oversight and escalation process in place throughout the organisation. Escalations are reported to QPES each month. • Ward Review process in place which provides assurance on the quality of care • Improvement programme in place to oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality Care • Signed SLA with Mental Health Trust to support the organisation to meet the requirements of our CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital.	• Quality, Patient Experience and Safety Committee meets monthly and provides assurance to the Board on quality outcomes • Duty of Candour is reported quarterly, and patient experience is reported monthly to QPES • Patient priorities for 2021 identified, which will form part of Quality Account objectives	• External Performance review meetings in place with NHSi/CQC/CCG • Monthly Quality meetings with NHSi and CQC • External review undertaken on the SI processes • CQC report (2019) showed improvement and the Trust was rated as 'outstanding' for caring • NHSI and CCG reviews of IPC practice in ED and Maternity have not highlighted any immediate concerns.
Gaps in Assurance	• Outstanding CQC 'MUST' and 'SHOULD' do actions remain outstanding • Trust CQC rating requires improvement • Quality Concerns raised to CQC • A number of national audits outcomes remain below national average • NHSi review insufficient assurance on infection control standards resulting in RED rating • External audit Assurance relating to the annual quality account has been deferred owing to COVID-19 • Inconsistent evidence both through quality governance structures and performance reviews, of practice having changed as a result of learning from RCAs • Gaps in assurance noted from the recent CQC inspection including management of sepsis and robust audit data; gaps in ability to have two paediatric nurses rostered each shift in paediatric ED • Complaints highlighting failure to deliver consistently high standards of care, poor patient experience • CQC inpatient survey 2019 results • Lack of assurance regarding equality, diversity and inclusion and actions to reduced inequalities		

Walsall Healthcare NHS Trust

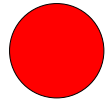
Future Opportunities
• Improvement programme offers consistency in methodologies and documentation used across transformation programmes • Care Excellence Programme offer a structured programme to achieve excellence in care outcomes, patient/public experience and staff experience • Availability and implementation of new technologies as a clinical or diagnostic aid (such as: electronic patient records, e-prescribing and patient tracking; artificial intelligence; telemedicine). • Development of Prevention Strategy • Development of a Quality Assurance Framework
Future Risks
• Resources to deliver the improvement programme. • Resources to deliver the Care Excellence Programme and Pathway to Excellence Programme • Potential second wave of Covid-19 • Dependence on the success of interdependencies from other work-streams. • Failure to develop and maintain relationships with key stakeholders. • Finance and resources. • Maintaining alignment between SHQC Programme priorities and the activities taking place in Divisions • Communications across the organisation to share programme objectives

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

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Staffing Risk • red flag process being embedded, escalation SOP in development • implementation of Allocate in line with business case, review of KPI's and temporary staff booking reasons • QIA's to be undertaken for every area that has nursing associate role within establishment • Establishment review in progress • Self-assessment against NHSI Developing Workforce Safeguards (2018) underway	Ann-Marie Riley	30.11.2020	The establishment review will conclude at the end of October 2020 and presented to QPES in November 2020 Self-assessment against NHSI Developing Workforce Safeguards Guidance completed and will be reported to QPES in October 2020	
2.	Care Excellence • Care Excellence strategy in development • Final phase of consultation to take place in September	Ann-Marie Riley & Matthew Lewis	01/04/21	Final phase of the strategy consultation is complete. A voting process for the preferred professional practice model will launch in October 2020	

3.	Patient Experience • Reviewing TOR for patient experience group • We have developed 12 patient priorities – the action plans for these are underdevelopment • Recreation of Thrombosis Committee to guide VTE practice and monitor compliance and outcomes	Ann-Marie Riley & Matthew Lewis	1/12/20		

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
193	Consultant Radiology capacity is significantly below the required numbers to meet current KPIs within its current numbers if organisational funding support for the continued use of outsourcing were to end. Many staff report high numbers of cases in top quartile in benchmarking national data which is currently being assessed to identify if this is a significant risk factor to patient care.	From April 2019, national standard of 28 diagnostic cancer pathway (Imaging component 1 week turnaround) has been in place for cancer targets but these are not sustainably deliverable under current workforce and equipment capacity. Reduced effectivness of the diagnostic aspect of the of the patient pathway will lead to reduced effectiveness of the whole trust to meet national standards e.g. cancer, 18 week and AE. This would lead to low performance ratings with improvement notices and possible national media coverage. Length of stay will also be increased. Complaints from consultants and clinical teams due to reports being unavailable and potential for wasted outpatient appointments as a	Louise Holland	1 5	• • • • Inpatient and urgent examinations are prioritised for reporting • • Radiologists are contacted on an adhoc basis to reivew cases which need urgent review • • Clinical team respond to requests to expedite individual cases • • A&E referrals are prioritised • • WLI reporting sessions underway with Divisional and Trust agreement to maintain these at 2 week maximum from examination to report • • Consultant radiologists have increased clinical PAs for a 12 month period • • Out of hours radiologist on call duties have been outsourced to a private provider and equivalent PAs reinvested into 7 day working for Consultant Radiologist team • Natural Barrier • Approval of business case for radiology capacity	• • • • • • • • • • • • • • • • • •	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		result. This may result in low staff morale and breeches of 18 week targets Low staff morale affecting all members of the imaging team, associated with not being able to provide a high quality service and concern for the implications of this. In addition, high levels of stress as staff are placed under pressure by colleagues to respond to requests to expedite the reports. Risk of adverse publicity due to individual patients informing the press of negative experience or failure to meet national targets attracting media attention. This may result in local media coverage with short term reduction in public confidence. Risk of mis-diagnosis by radiologists due to increased speed of reporting to accommodate					

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		demand, associated with failure to review all images fully due to speed of reporting and/or interruptions to clinical reporting sessions. This has the potential to lead to patient formal complaints and litigation claims between £10,000 and £100,000 There are specific service impacts on MSK, Head and Neck (thyroids), Cardiac CT, CT Colon and AKI Ultrasound.					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/09/2020	Business case to be developed to secure funding for recruitment of Consultant Radiologists.	Harinder Rai	25/10/2020	30/10/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	There is potential for a risk of lack of skilled registered nurses (RN's)/registered midwives (RM's) on a shift by shift basis affecting our ability to consistently maintain delivery of excellent standards of care delivery and excellent patient and staff experience. Staffing any additional capacity that is required puts additional pressure on RN/RM/ staffing demand and there is a risk that these areas cannot be staffed adequately. The current COVID-19 pandemic may put unprecedented pressure on our staffing supply across all grades of nursing and midwifery staff	Lack of skilled registered nurses/midwives on a shift by shift basis leading to: _Poor patient experience leading to increase in complaints, increase in PALS referrals _Increase in episodes of harm, including falls, pressure ulcers, deconditioning, dehydration and malnourishment, loss of continent function; potential increase in incidents/SI's _Increased stress and poor staff morale caused by suboptimal staffing levels _Increased reliance on temporary staffing which has a potential negative impact both financially and to the ward/department skill mix **See Risk Assessment attached for full details**	Caroline Whyte	20	• • Development of two staffing hubs manned by the Nursing Team - one for general areas and one for Critical Care. These hubs will oversee the deployment of staff across all Professional Groups. 17/6/20 the staffing hub is no longer required as the staffing position is currently stable. If COVID demand increases then the hub will be reinstated 20/10/20 - staffing hub for nursing reinstated	• Daily reviews of staffing levels by Ward, Monitoring of the number of patient harm incidents reported. Monitoring of the number of complaints, whistle blowing and freedom to speak up concerns raised. •	
					• • Community Teams reviewing and adjusting caseloads as required. Roster sign off reduced to two weeks for the next three months. Use of bank/agency to cover short term gaps. Block booking in place for Critical Care. Deployment of Corporate Nurses at times of high pressure. 17/6/20 - Roster sign off timelines returned to normal, critical care bookings no longer required to previous level as ITU capacity remains stable	• 6 Monthly review and annual management board sign off of Nursing/Midwifery establishments to ensure appropriate planned staffing levels. Daily review of staffing numbers by ward and moving staff to support areas of short staffing. •	
					• • Increased use of Volunteers and Administration roles to complete tasks to free up Registered Nurses to deliver direct patient care. 17/6/20 Volunteer support no longer required to initial levels	• •	
					• • Identification of essential training required to maintain competence and safety (COVID-19). Use of bank/agency staff to support essential training. 17/6/20 - training completed at height of COVID demand -not currently required	• Overview of compliance levels at Performance Meetings. Rapid response to falls in levels of essential role based training. •	
					• • Staff well being policy with additional support identified and put in place to	• Monitoring of staff sickness levels and sickness reasons •	

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

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
26/03/2020	Review of TNA requirements for the next 12 months and develop case of need for consideration when COVID019 response is no longer required. 17/6/20-review of initial NA modelling and budget changes underway 7 Sept 2020 -establishment review underway, will be completed in Sept and reported to committees in Oct	Ann-Marie Riley	25/10/2020	30/10/2020
26/03/2020	Strategy to be developed to recruit International Nurses who are currently in the UK working as HCA's but need support to register with the NMC as an RN when COVID-19 response is no longer required, 17/6/20 Renewed focus on recruitment opportunities now possible as COVID demand stabilised 14/9/20 -new national funding to be available to support this initiative - awaiting further information 20/09/20 - Response from NHSI received and funding available made clear. Very tight turnaround for further information to support progression of the bid which is being worked through by Kelly Geffen.	Ann-Marie Riley	26/12/2020	31/12/2020
26/03/2020	Continued proactive recruitment strategy	Ann-Marie Riley	26/03/2021	31/03/2021
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly.	Caroline Whyte	26/12/2020	31/12/2020

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2260	Lack of a whole system approach across health and social care for the management of children and Young People (CYP) in mental health or behavioural crisis.	CYP, staff other patients and familes are at increased risk of harm due to numerous factors in relation to CYP being admitted to Walsall Healthcare NHS Trust: - Lack of out of hours CAMHS service causes a delay in formal risk assessment by a specialist in CYP mental health and delayed identification of risk factors. - Delayed access to Tier 4 beds means that CYP do not recieve they require as an in-patient children's ward can not provide specialist mental provision. - Lack of appropriate social care placements for CYP with behavioural crisis (not reaching Tier 4 criteria) meaning the emotional health and well-being needs are not met. - The distruptive nature at times, means staff on the paediatric unit can not give timely care to	Charlotte Yale	1 2	• Policy • Policy available for the management of CYP with mental health and self harm	• Staff are aware of the policy but recognise that a policy may be of little use in an escalating situation. SOP availale for therapuetic intervantion and holding. •	
					• Training • Staff have received STORM training, risk assessment training for non-mental health providers.	• The unit has train the trainers, All CYP attending PAU receive STORM risk assessment. •	
					• Process • High risk CYP are supervised by a CSW who has received addtional training to provide 1 to 1 supervision.	• Patients who are deemed to be of high risk recieve adequate supervision. Bank security guards are used for addtional security to the wards / PAU. •	
					• Physical Barrier • Anti-ligature estates are available on Ward 21 and PAU.	• Patient moves are required to free up room for high risk patients. PAU room one to be used when room 6 is in use. •	
					• Process • Use of SBAR tool to communicate the high risk nature of individual patients and assess changes in mood on a shift by shift basis. This also allows hourly face to face check for patients, not receiving one to one supervision.	• •	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		other unwell patients.					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/08/2020	Escalation to the CCG for consideration in commissioing intentions.	Matthew Lewis	26/03/2021	31/03/2021
01/09/2020	Divisional DoN to meet with school nursing lead for further scoping of opportunities for early intervention work.	Charlotte Yale	25/11/2020	30/11/2020
01/09/2020	Representation at risk stratification meeting and health and well-being board.	Charlotte Yale	25/11/2020	30/11/2020

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
SAFE, HIGH QUALITY CARE												
No.	Sleeping Accommodation Breaches	63	83	63	0	0	0	209	0	0		
No.	HSMR (HED) nationally published in arrears	144.19	129.5	109.07	103.86				100	110.28		
No.	SHMI (HED) nationally published in arrears	143.8	119.58	110					100	110.73		
Rate	Crude Mortality Rate	8.07	5.67	3.9	3.85							
No.	Number of Deaths in Hospital	198	95	71	71	74	80	589		1093		
%	% of patients who achieve their chosen place of death	65.28%	59.65%	72.31%	67.27%	71.70%	61.67%	66.30%		57.63%		
No.	MRSA - No. of Cases	0	0	0	0	0	0	0	0	4		
No.	Clostridium Difficile - No. of cases	4	3	3	3	3	2	18	26	36		
%	Sepsis - % of patients screened who recieved antibiotics within 1 hour - ED			86.18%				86.18%				
%	Sepsis - % of patients screened who received antibiotics within 1 hour - Inpatients											
%	Deteriorating patients: Percentage of observations rechecked within time	79.70%	86.40%	89.09%	89.70%	90.03%	89.15%		85.00%			
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	1.52	0.73	1.24	0.9	0.72	0.57					
Rate	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.24	0.48	0.69	0.45	0.86	0.31					
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	15	7	12	9	9	8	60		128		
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	7	14	20	13	25	9	88		86		
No.	Falls - Total reported	75	68	58	57	60	42	360		932		
Rate	Falls - Rate per 1000 Beddays	5.63	6.52	4.75	4.66	5.21	3.26		6.1			

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
No.	Falls - No. of falls resulting in severe injury or death	0	0	3	0	3	1	1	0	20		
No.	Falls - Avoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0	1	0			1	0	16		
No.	Falls - Unavoidable Falls resulting in severe harm or injury (subject to RCAs)	0	0					0		4		
%	VTE Risk Assessment	84.24%	91.13%	92.83%	93.67%	94.15%	89.51%	91.23%	95.00%	92.22%		
No.	National Never Events	0	0	0	0	0	0	0	0	1		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	4	3	16	7	10	11	51		94		
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	0	0	0	0	0	0	0		5		
No.	Clinical incidents causing actual harm severity 3 to 5 - Hospital Acquired	16	18	30	24	26	17	131		287		
No.	Clinical incidents causing actual harm severity 3 to 5 - Community Acquired	6	6	6	6	10	8	42		29		
%	% of total incidents resulting in moderate, severe harm or death	2.70%	2.83%	3.54%	3.27%	3.46%	2.49%	3.07%		2.37%		
%	Trust-wide Safety Index - % of medication incidents resulting in harm (one month in arrears)	24.24%	14.04%	13.98%	22.06%	32.00%		17.59%	12.00%	14.30%		
No.	No. of reported medication incidents level 3, 4 or 5 (one month in arrears)	0	1	2	0	2		5	0	4		
Rate	Midwife to Birth Ratio	32.0	29.6	33.4	32.7	30.8	28.5		28			
%	One to One Care in Established Labour	100.00%	98.36%	99.10%	99.07%	100.00%	97.20%	99.01%	100.00%	99.20%		
%	C-Section Rates	29.63%	33.94%	30.03%	29.62%	25.42%	30.11%	29.74%	30.00%	30.16%		
%	Instrumental Delivery	6.91%	7.42%	6.48%	6.79%	8.88%	4.55%	6.85%	10.00%	7.52%		
%	Induction of Labour	39.73%	38.27%	39.01%	43.95%	43.48%	42.65%	41.20%		39.09%		

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	12.94%	15.61%	14.81%	14.62%	15.53%		14.80%	10.00%	11.50%		
%	Electronic Discharges Summaries (EDS) completed within 48 hours	89.77%	88.65%	90.10%	88.73%	87.82%	84.98%	88.16%	100.00%	84.59%		
%	Dementia Screening 75+ (Hospital) (Internal audit Dec17 onwards) (one month in arrears)	33.33%	98.31%	62.69%	87.04%	82.46%	48.28%	74.91%	90.00%	69.32%		
%	Compliance with MCA 2 Stage Tracking	73.91%	64.44%	75.00%	36.84%	85.71%	46.67%	62.79%	100.00%	62.61%		
%	Complaints - % responded to within 30 working days	27.59%	20.00%	53.85%	77.78%	92.86%	57.14%	51.82%	80.00%	43.45%		
%	Complaints - % responded to within 45 working days	27.59%	40.00%	69.23%	77.78%	92.86%	66.67%	58.18%		59.82%		
No.	No. of Open Complaints	55	43	39	42	43	52					
No.	No. of Closed Complaints	8	6	9	23	15	12	73		211		
No.	Longest Wait for an Open Complaint	414	431	139	143	117	98					
No.	Clinical Claims (New claims received by Organisation)	14	5	14	6	7	9	55		132		
No.	No urgent op to be cancelled for a second time	0	0	0	0	0	0	0	0	0		
%	% of RN staffing Vacancies	8.88%	7.95%	7.42%	6.89%	5.15%		7.26%		9.71%		
%	Friends and Family Test - Inpatient (% Recommended)		89%	89%	87%	88%	88%		96%			
%	Friends and Family Test - Outpatient (% Recommended)		88%	88%	88%	92%	92%		96%			
%	Friends and Family Test - ED (% Recommended)		85%	85%	81%	79%	73%		85%			
%	Friends and Family Test - Community (% Recommended)					63%	95%		97%			
%	Friends and Family Test - Maternity - Antenatal (% Recommended)					100%	89%		95%			

Walsall Healthcare NHS
NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

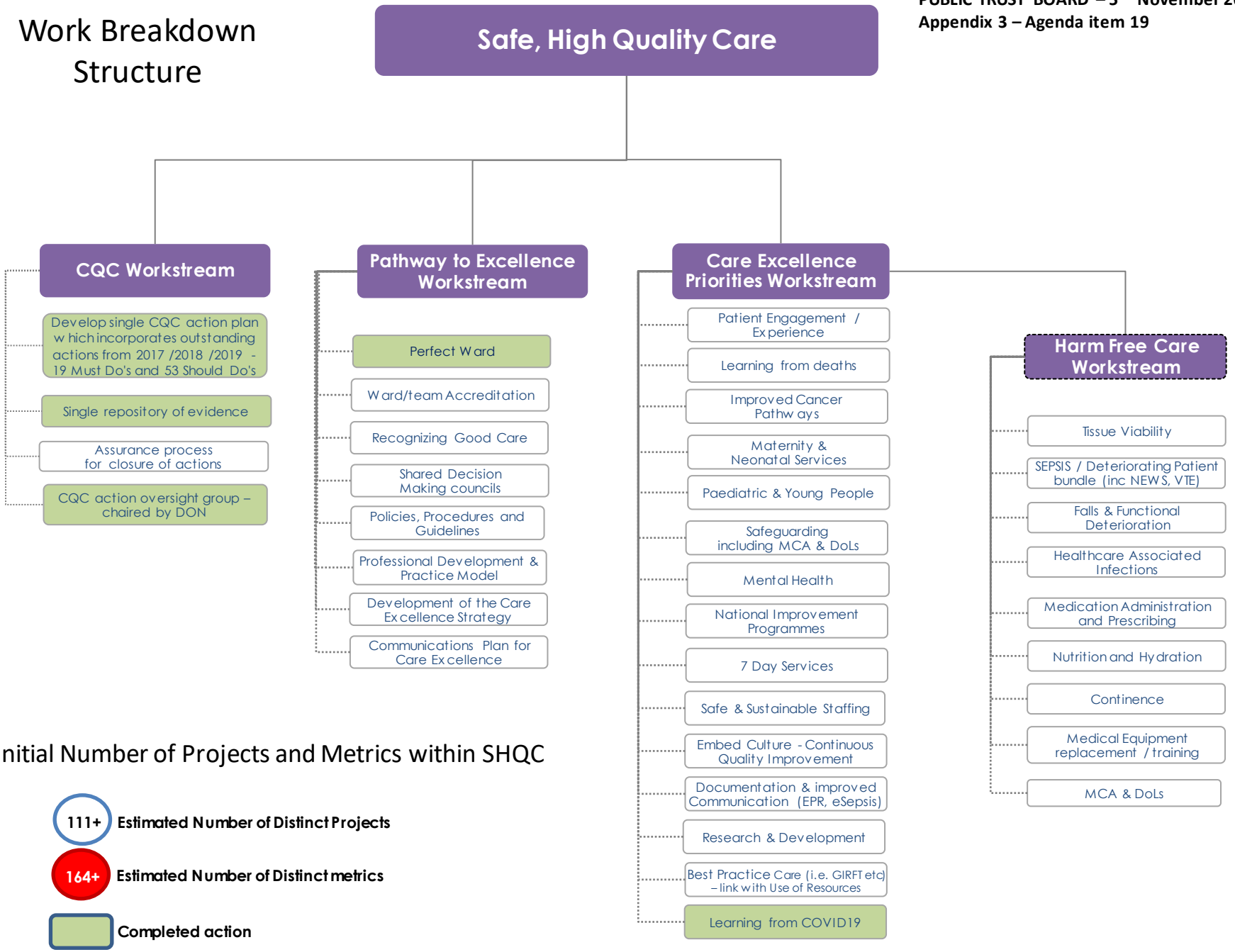
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
%	Friends and Family Test - Maternity - Birth (% Recommended)					94%	79%		96%			
%	Friends and Family Test - Maternity - Postnatal (% Recommended)					86%	70%		92%			
%	Friends and Family Test - Maternity - Postnatal Community (% Recommended)								97%			
%	PREVENT Training - Level 1 & 2 Compliance	90.65%	90.70%	90.64%	92.12%	92.91%	93.34%		85.00%			
%	PREVENT Training - Level 3 Compliance	79.97%	80.82%	82.68%	85.44%	86.79%	86.74%		85.00%			
%	Adult Safeguarding Training - Level 1 Compliance	95.47%	96.55%	95.07%	96.34%	96.26%	97.18%		95.00%			
%	Adult Safeguarding Training - Level 2 Compliance	84.14%	86.38%	88.94%	91.22%	93.01%	93.50%		85.00%			
%	Adult Safeguarding Training - Level 3 Compliance	58.30%	56.77%	55.96%	58.83%	66.01%	67.33%		85.00%			
%	Children's Safeguarding Training - Level 1 Compliance	86.46%	88.42%	89.81%	92.27%	95.53%	96.43%		95.00%			
%	Children's Safeguarding Training - Level 2 Compliance	86.43%	86.94%	86.54%	88.44%	90.60%	89.94%		85.00%			
%	Children's Safeguarding Training - Level 3 Compliance	78.97%	78.89%	79.46%	82.18%	82.00%	81.06%		85.00%			

Walsall Healthcare NHS Trust

QUALITY, PATIENT EXPERIENCE SAFETY COMMITTEE

		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	2020/21 YTD	2020/21 Target	2019/20 YTD	SPC Variance	SPC Assurance
RESOURCES												
No.	Total Deliveries	297	277	323	314	299	279	1789	3739	3661		

Work Breakdown Structure



Initial Number of Projects and Metrics within SHQC

111+ **Estimated Number of Distinct Projects**

164+ **Estimated Number of Distinct metrics**

Completed action

Safe, High Quality Care Project Tracker
October Improvement Board

Project Admin							PID Generation							Project Tracking									
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Engagement	QIA/EDI	PID Sign-off	Project Mobilisation	Define & Scope	Measure & Understand	Design & Plan	Pilot & Implement	Sustain & Share	Benefit Assessment and Project Close-out	Project Delivery	Project Resource Availability	Benefits Realisation
		CQC Recommendations	Develop Single CQC action plan which incorporates outstanding actions from 2017/2018/2019	Ann-Marie Riley	All Divisions	Wendy Prestage				N/A		QIA Drafted									Green	Amber	Amber
		Pathway to Excellence	Perfect Ward	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte			Reviewed Monthly	Drafted		QIA Drafted									Green	Amber	Amber
			Ward Accreditation	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte				Drafted		QIA Drafted									Green	Amber	Amber
			Recognising Good Care	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte				Drafted		QIA Drafted									Green	Amber	Amber
			Shared Decision Making Councils	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte		Rolling Programme as areas identified				QIA Drafted									Green	Amber	Amber
			Policies, Procedures & Guidelines	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte		Review built into each project		Reported ny Governance and WL		QIA Drafted									Green	Amber	Amber
			Professional Development & Practice Model	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte		Programme for training being developed		Drafted		QIA Drafted									Green	Amber	Amber
			Care Excellence Strategy Development	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte				Drafted		QIA Drafted									Green	Amber	Amber
			Care Excellence Comms & Engagement Plan	Kerry Jones / Ann-Marie Riley	Trust	Caroline Whyte				Drafted		QIA Drafted									Green	Amber	Amber
		Care Excellence Priorities	Patient Experience & Involvement, Self-care Management and Volunteer Service	Ann-Marie Riley	Trust	Louise Mabley				Drafted		QIA Drafted									Green	Green	Amber
			Learning from Deaths	Manjeet Shehmar	Trust	Manjeet Shehmar				Drafted		QIA Drafted									Green	Green	Amber
			Improved Cancer Pathways	Manjeet Shehmar	Trust	Charlotte Hill				Drafted		QIA Drafted									Green	Green	Amber
			Maternity & Neonatal Services	Manjeet Shehmar	WCCSS	Carla Jones-Charles / Fateh Ghazal						QIA Drafted									Green	Green	Amber
			Paediatric & Young People	Caroline Whyte	WCCSS	Charlotte Yale / Suzanne Jarvis / Anjan Bhaduri						QIA Drafted									Green	Green	Amber
			Safeguarding	Ann-Marie Riley	Trust	Nuala Waide				Drafted		QIA Drafted									Green	Green	Amber
			Mental Health,	Ann-Marie Riley	Trust	Nuala Waide				Drafted		QIA Drafted									Green	Amber	
			National Improvement Programmes	Matthew Lewis	Trust	24 Programme Leads				Drafted		QIA Drafted									Green	Amber	
			Seven Day Services	Lorraine Moseley	Trust	Lorraine Moseley / Kelly Geffen		on-going programme		Drafted		QIA Drafted									Green	Green	Amber
			Safe and Sustainable Staffing	Gaynor Farmer	Trust	Charlotte Hill (CFP) / Gaynor Farmer/ Kelly Geffen				Drafted		QIA Drafted									Green	Green	Amber
			Embedding a culture of Continuous QI	Joyce Bradley	Trust	Joyce Bradley				Drafted		QIA Drafted									Green	Green	Amber
			Documentation & improved Clinical communication	Mathew Lewis	Trust	Charlotte Hill / TBA				Drafted		QIA Drafted									Green	Amber	Green
			Research & Development	Matthew Lewis	Trust	Marie Lewis				Drafted		QIA Drafted									Green	Green	
			Best Practice Care (i.e. CBPT)	Matthew Lewis	Trust	Lorraine Moseley		on-going programme through to 2021		Drafted		QIA Drafted									Green	Green	
			Learning from COVID19	Manjeet Shehmar	Trust	Manjeet Shehmar				Drafted		QIA Drafted									Green	Green	
		Harm Free Care	Tissue Viability	Doyle	Trust	David Powell / Tissue Viability Team				Drafted		QIA Drafted									Green	Amber	Green
			Sepsis/Deteriorating Patient Bundle (inc NEWS, VTE)	Manjeet Shehmar	Trust	Carlotte Hill				Drafted		QIA Drafted									Green	Green	Amber
			Falls & Functional Deterioration	Doyle	Trust	Jo Adams				Drafted		QIA Drafted									Green	Green	Green
			Healthcare Associated Infections	Mathew Lewis	Trust	Mandy Reagrond				Drafted		QIA Drafted									Green	Green	Green
			Medication Administration and Prescribing	Manjeet Shehmar	Trust	Liz Payne Medicines Safety Officer				Drafted		QIA Drafted									Green	Green	Green
			Nutrition and Hydration	Caroline Whyte	Trust	David Powell / Catherine Gallimore / Linda Bramwich				Drafted		QIA Drafted									Green	Green	Green
			Continence	Caroline Whyte	Trust	David Powell / Michelle Windsor				Drafted		QIA Drafted									Green	Amber	Green
			Medical Equipment - Training Programme	Lorraine Moseley	Trust	Lorraine Moseley / Michael Kosafo		On-going as equipment replaced		Drafted		QIA Drafted									Green	Green	Amber
			MCA & DOLs	Ann-Marie Riley	Trust	Charlotte Hill (MCA DOLLS as above)				Drafted		QIA Drafted									Green	Green	Amber

Project Progress Key: Blue - completed; Green – Mature /Good progress; Amber - Maturing / Slow Progress; Red - No significant progress; Grey - Not planned to start / Not relevant

Good progress made across the workstream this month on maturing PID development in preparation for formal review / sign off

Key Risks, Issues & Dependencies

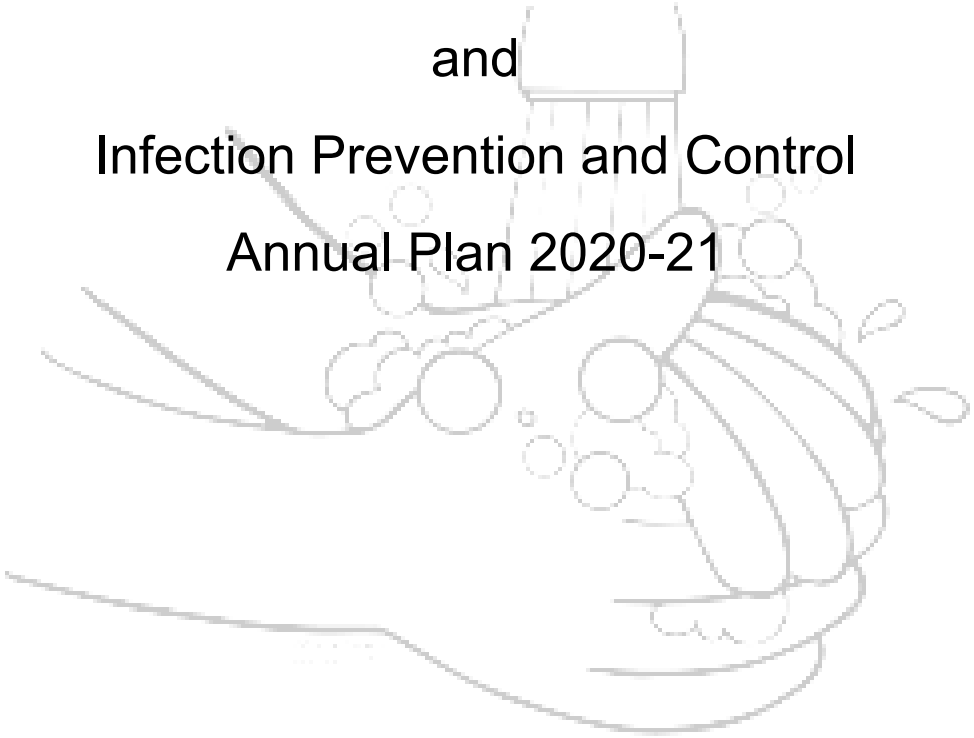
	Description	RAG	Board Escalation / Assurance Comments
Risks	COVID-19 2nd wave	R	
	Project support resource: interim roles not substantively funded. Scale of support required yet to be fully assessed.	R	Resourcing paper being produced for IP Board
	Clinical engagement: Clear engagement strategy needed	A	Trust wide engagement plan being drawn up
	Management of inter dependencies within Improvement Programmes	A	IP Board to review
Issues	A lot of new processes and systems being implemented (Pathway to excellence, Perfect ward, EPR) so potential for organisational fatigue	A	Comms Strategy to provide clarity on impact
	Staff focus on restoration and recovery plans impacting pace of delivery	A	
	Medicine safety: external review of older people rules for assessment of care delivery	A	
Dependencies	Workforce and culture development and requiring Valuing Colleagues involvement	G	Dependency meeting held SHQC, GWL, VC
	Digital transformation	G	Discussed with Keith Dibble

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Infection Prevention and Control Annual Report and Annual Plan 2019/20			**AGENDA ITEM: 20**
Report Author and Job Title:	Louise Fox Clinical Lead for Infection Prevention and Control	**Responsible Director:**	Dr Matthew Lewis Medical Director Director of Infection Prevention and Control
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report details the activities and performance of the Infection Prevention and Control (IPC) Team during the 2019/20 year. The report also outlines the proposed action plans for the 2020/21 year. The report was originally due to be written and presented in the first quarter of this year but was deferred due to the pressures of the COVID-19 outbreak. The outbreak itself largely occurred during the year 2020/21 and will be covered in next year's report. Key points to note: • The Trust has been rated 'RED' by NHS Improvement for Infection Prevention and Control since 16th April 2019 • The Trust has achieved the planned infection control activities outlined in the annual programme 2019/20 including planned audits and teaching sessions • Against the Hygiene Code, the Trust is fully compliant with 5/10 measures and partially compliant with 5/10 measures • The Trust experienced 4 cases of MRSA bacteraemia during 2019-20 against a zero tolerance • There were 36 toxin positive reportable cases of Clostridium *Difficile* (C. diff) against a trajectory of no more than 26 cases, ending the year 10 cases over trajectory • Mandatory surgical site surveillance was completed in elective Orthopaedic hip and knee replacements for 2 quarters, no infections were identified • There were 25 bay closures and 4 full ward closures due to norovirus outbreaks and 28 bay closures and 1 full ward closure due to Influenza		
Recommendation	Members of the Trust Board are asked to note the information in the Infection Prevention Annual Report for assurances purposes and to approve the annual plan. This report has been considered by the Quality, Patient Experience and Safety Committee on 29th October 2020.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care Risk 2066: Essential staff training and overview of compliance	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

Walsall Healthcare NHS
NHS Trust

Infection Prevention & Control
Annual Report 2019-20
and
Infection Prevention and Control
Annual Plan 2020-21



Dr Matthew Lewis
Director of Infection Prevention & Control and Medical Director

Louise Fox
Matron Infection Prevention and Control

Mandy Beaumont
Head of Infection Prevention and Control

Infection Prevention & Control Annual Report 2019-20

Contents

Appendices

Executive Summary

- The Trust is currently rated RED by NHS Improvement for Infection Prevention and Control (see Appendix 1 for summary of rating criteria)

- The Trust has achieved the planned infection control activities outlined in the annual programme 2019/20 including planned audits and teaching sessions

- The Trust experienced 4 cases of MRSA bacteraemia during 2019-20 against a zero tolerance

- There were 36 toxin positive reportable cases of Clostridium *Difficile* (C. diff) against a trajectory of no more than 26 cases, ending the year 10 cases over trajectory.

- Mandatory surgical site surveillance was completed in elective Orthopaedic hip and knee replacements for 2 quarters, no infections were identified.

- There were 25 bay closures and 4 full ward closures due to norovirus outbreaks and 28 bay closures and 1 full ward closure due to Influenza.

1. Introduction

Healthcare Associated Infections (HCAI) can cause harm to patients, compromising their safety and leading to a suboptimal patient experience and increased length of stay in hospital. Maintaining low rates of HCAI remains a cornerstone of the Trust's approach to providing safe, high quality care across all the services. The Trust has been working hard to improve infection prevention and to raise rating by NHSI back to green. The following report will demonstrate the work that has been done.

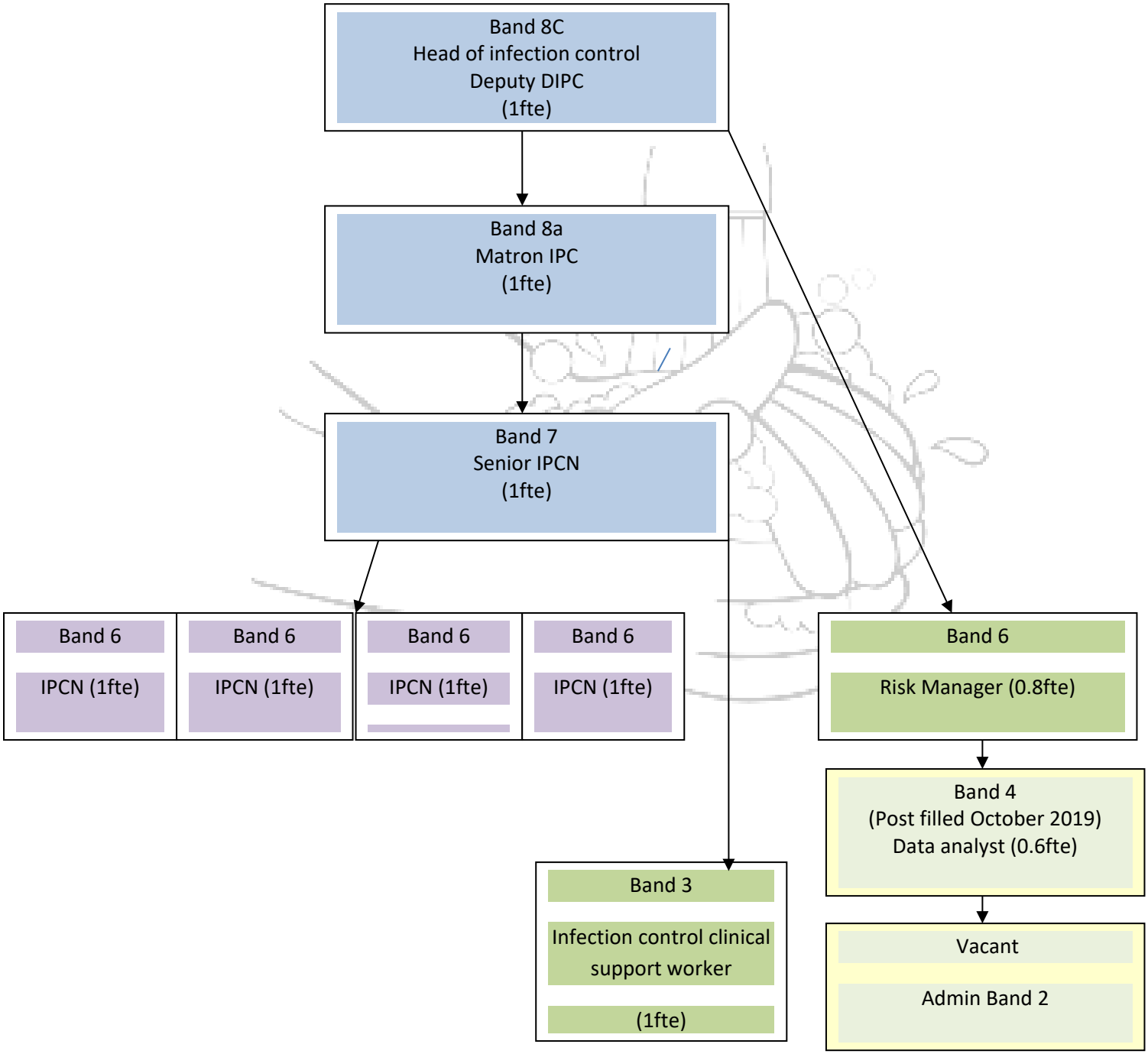
2. Reporting arrangements

The Infection Prevention & Control Team (IPCT) is based at the Manor Hospital site. The IPCT works closely with Divisional Directors of Nursing, Consultant Microbiologists, Antimicrobial Pharmacist, Walsall Public Health and Public Health England.

The role of Director of Infection Prevention and Control (DIPC) was undertaken by the Director of Nursing until February 2020 when the role was passed to the Medical Director. Both Directors report directly to the Chief Executive on matters pertaining to infection prevention and control in line with the requirements of the Health and Social Care Act 2008. The role of Deputy DIPC post is undertaken by Head of Infection Prevention and Control.

The Infection Prevention and Control Committee (IPCC) is chaired by the DIPC or Deputy DIPC and met monthly during 2019-2020.

3. IPC team structure 2019/20



Links to Clinical Governance/Risk Management/Patient Safety

The DIPC attends the Quality, Patient Experience and Safety (QPES) Committee and Infection Control specialists attend the Health and Safety Committee and Divisional Quality Boards.

Monthly reports are prepared by the IPCT and presented to the IPCC (monthly), QPES (annually) and the Board. Ad hoc reports and audit requests are also undertaken to meet service requirements.

5. Infection Prevention and Control Committee (IPCC)

The role of the IPCC is to provide strategic direction for the prevention and control of Healthcare Associated Infections (HCAI) in Walsall Healthcare Trust. The committee members manage the performance the organisation against National Infection prevention and control standards, requirements and mandates, and the Trust's own policies and procedures. It ensures that there is a strategic response to new legislation and national guidelines. In addition, the committee seeks assurance from the divisions and ensures compliance with the Health and Social Care Act 2008. Membership of the committee is detailed in Appendix 1.

Compliance with The Health and Social Care Act is measured using the hygiene code. A full assessment of this was undertaken in December 2019; ongoing monitoring of the action plan is undertaken at infection control committee.

A summary of compliance at the end of the financial year 2019/20 can be seen in Appendix 2.

Groups reporting into Infection Control Committee

Decontamination Group

The HSDU (Hospital Sterilisation Disinfection Unit) is a purpose built building that is situated opposite the main hospital. This is a standalone building and provides its own steam to run all critical services. HSDU is an ISO 13485:2016 accredited service and provides a service to Walsall Healthcare and the Community. HSDU is audited on a yearly basis by our external auditors SGS, who are an inspection, verification, testing and certification company. We also conduct internal audits on a monthly basis by our own internal auditors who have been trained by SGS, this includes yearly management review meetings which address non-conformances, supplier failures, quality performance, education & training, customer feedback, MHRA (Medicines Health Products and Regulatory Authority) alerts, water safety and any new legislation. Discussions also take place regarding any departmental changes and improvements that can be made of the service This is all reported to the external auditors and quarterly to IPCC.

The department has had a new R.O Plant and Water Softener due to having issues with high conductivity in our water supply, which have now been resolved.

HSDU provides decontamination services (over 7 days) throughout the Trust with our main customers being Theatres. In 2019/20, we produced approx. 61,510 trays and 45,787 pack/supplementary items.

HSDU also provides an endoscope decontamination service for Endoscopy, ENT, Urology and Theatres (over 6 days) which was JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accredited in April 2019.

Decontamination group meetings take place quarterly and cover all aspects of decontamination throughout the Trust and reports to IPCC.

Discussions are taking place with The Royal Wolverhampton Trust with regards to centralising the sterile services within the 2 Trusts. No decisions have been made at this time.

Antimicrobial Management:

Since November 2018, the Trust continues to follow its antimicrobial strategy, which describes the basics of good prescribing antibiotics (an evidenced-based formulary) with processes to ensure antibiotic prescriptions are optimised (education, audit with feedback, dosing calculators, etc), and methods to ensure patients are discharged as quickly as possible (e.g. outpatient parenteral antibiotic therapy (OPAT) and new 'discharge enabling' antibiotics). To support the antimicrobial stewardship team (AMST) in these goals, it reports to both the Infection Control Committee and Medicines Management Group. To achieve the strategy, the AMST plan of work is:

- Praising well-performing units – a recent example being ward 16.
- Feeding back and providing support on antimicrobial prescribing across the Trust.
- Monthly monitoring of key standards of antimicrobial prescribing: indication, duration and 72h review.
- Teaching and training of junior doctors, medical consultants, pharmacists and non-medical prescribers.
- Better antibiotic use: a new formulary, IV infusion of antibiotics on ITU, lower dosing of carbapenems, improved confidence in gentamicin with a desktop calculator.
- Ongoing visibility of the AMST on the wards and supported by colleagues in pharmacy.
- Supporting discharge: OPAT – this will ensure patients discharged on OPAT remain safe; a formulary request for the addition of fosfomycin as an oral discharge enabling drug.
- Closer attention by AMST on those units using high volumes of high-risk antibiotics: cephalsporins, carbapenems, piperacillin-tazobactam (Tazocin) and quinolones.

Successful outcomes for the AMST in the last 12 months have included:

- Improved OPAT governance with regular multi-disciplinary team meeting, ensuring the right patient receives OPAT at the right time, for the right reason and the correct duration.
- Completion of an entirely revised antimicrobial formulary, due for publishing in August 2020.
- Development of evidence-based dosing calculators, including gentamicin and obesity-adjusted eGFR calculators, in readiness for the new formulary.
- Critical appraisal of antimicrobial dosing changes required in certain physiological states, including obesity and critical illness, in readiness for the new formulary.
- Introduction of 24h infusion pumps of some antibiotics, allowing early discharge of patients who otherwise would have needed prolonged admission for IV therapy.
- Introduction of novel antimicrobials which allow rapid discharge, e.g. dalbavancin and fosfomycin.
- Closer restrictions on carbapenem prescribing, including prescribing guidelines, and greater use of carbapenem sparing drugs, such as temocillin.
- Better assessment of allergy status, allowing alternative less costly and less toxic antimicrobials to be used thanks to greater appreciation of the individuals' allergy status.
- Development of an induction training plan for new starters in August 2020, encouraging holistic patient assessment when considering a diagnosis of infection and prescription of antimicrobials.
- Introduction of procalcitonin measurement on the Integrated Critical Care Unit, which enables prompt antimicrobial discontinuation.

<u>Water Safety Group</u>

The Water Safety Group provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring water related hazards are assessed and monitoring/control measures developed and instigated.

The aim of the Water Safety Group is to ensure the safety of all water used by patients, visitors, relatives and staff, to minimise the risk of infection associated with waterborne pathogens across WHT estate.

The Group meet on a monthly basis and work closely with the Infection Prevention Team. The group's remit is to:

- Ensure the Water Safety Plan is reviewed.
- Review and action risk assessments and other associated documentation.
- Review new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required standards.
- Ensure maintenance and monitoring procedures are in place.

- Surveillance of environmental monitoring, specifically in respect of determining water sampling requirements and agreeing location of augmented areas.
- Ensure augmented units within the Trust are tested monthly and results are reviewed and actioned as required.

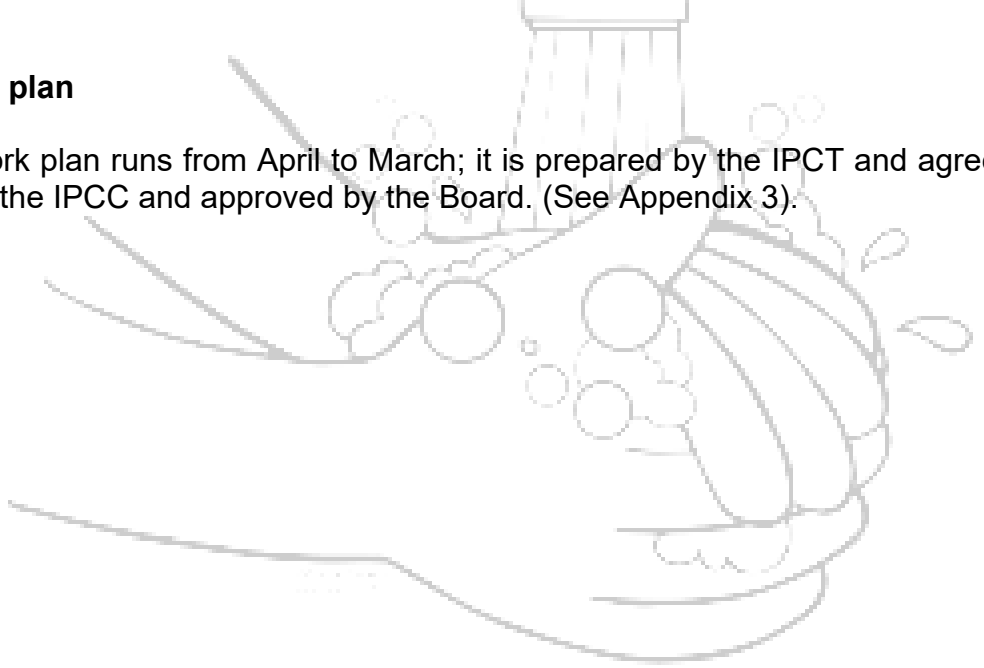
The remit will include all elements as per Section 6.9 of Health Technical Memorandum 04-01 Part B 2016.

Sharps Safety Group

The Sharps Safety Group meets quarterly. The group reviews any incidents relating to sharps inoculation and monitors the trends in incidents by both staff groups and place of work. The findings from this support the education of staff and the drive to ensure safe practices take place, including implementation of safety devices. The sharps safety group report is taken to IPCC by the Lead Occupational Health Nurse.

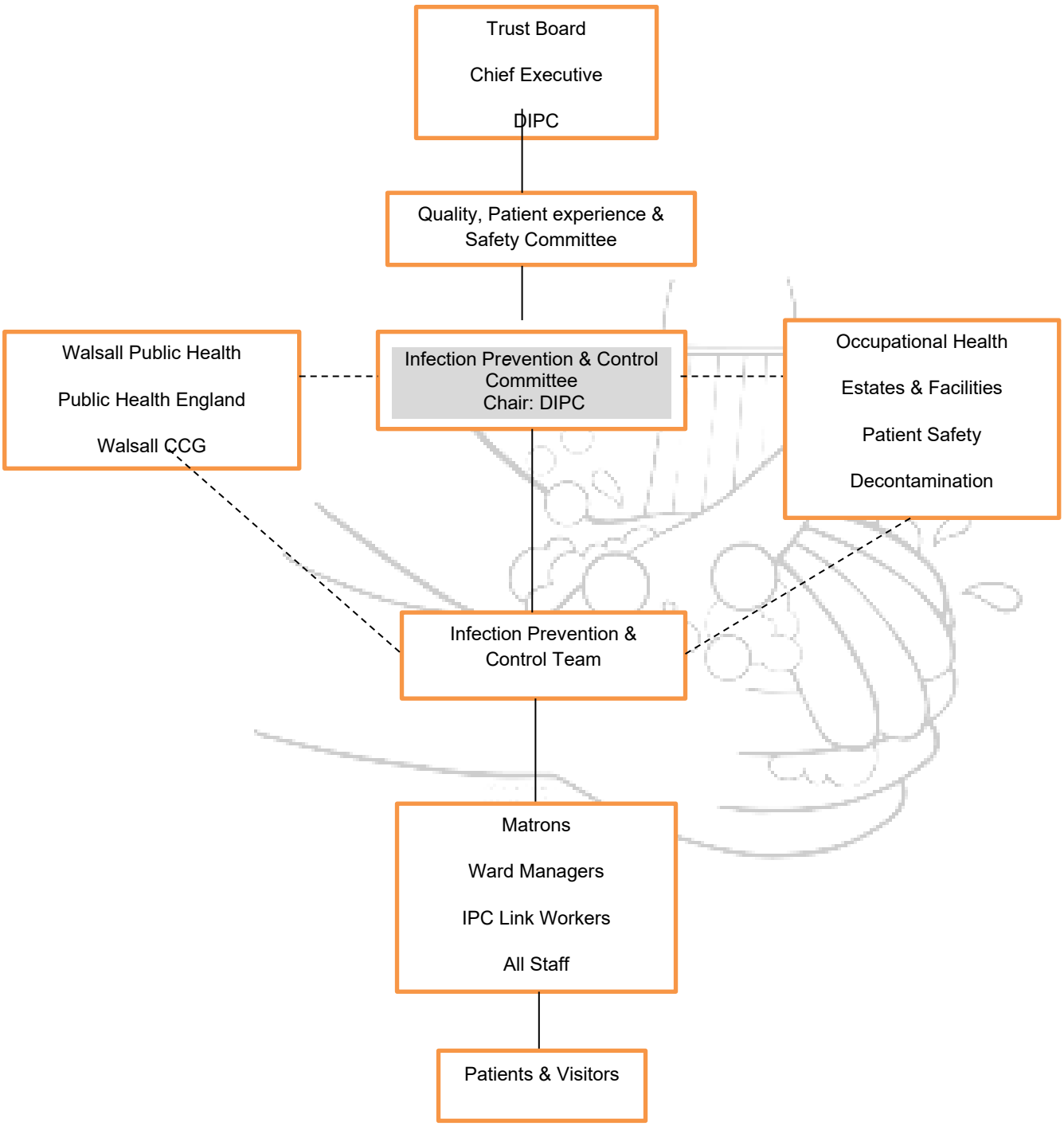
Annual work plan

An annual work plan runs from April to March; it is prepared by the IPCT and agreed each year by the IPCC and approved by the Board. (See Appendix 3).



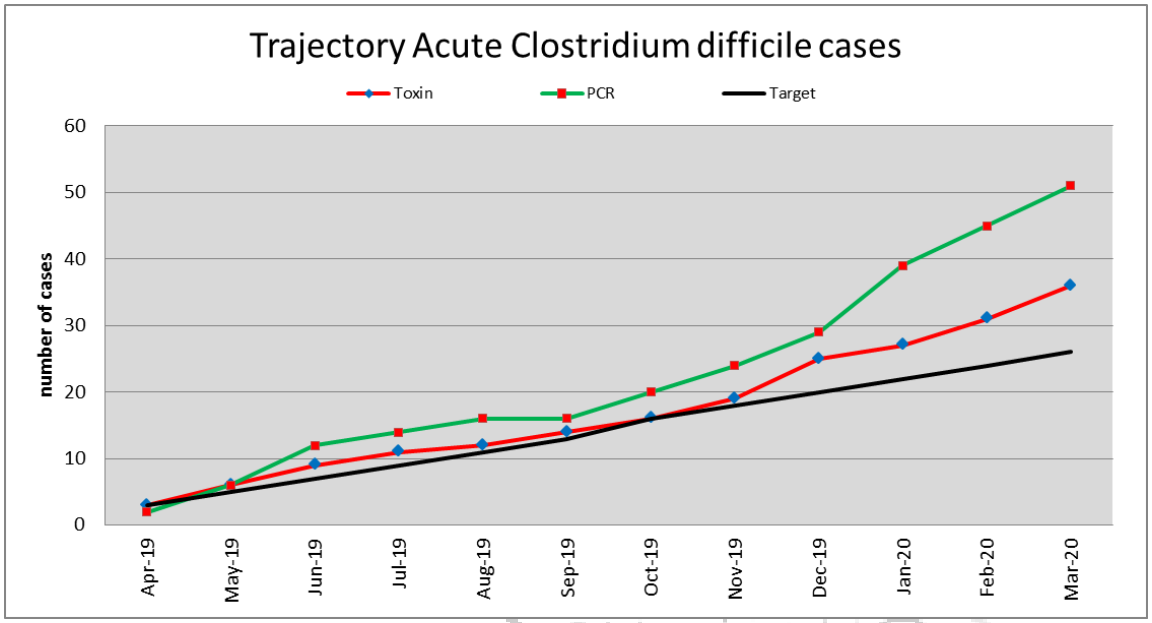
6. The Assurance Framework for Infection Prevention & Control

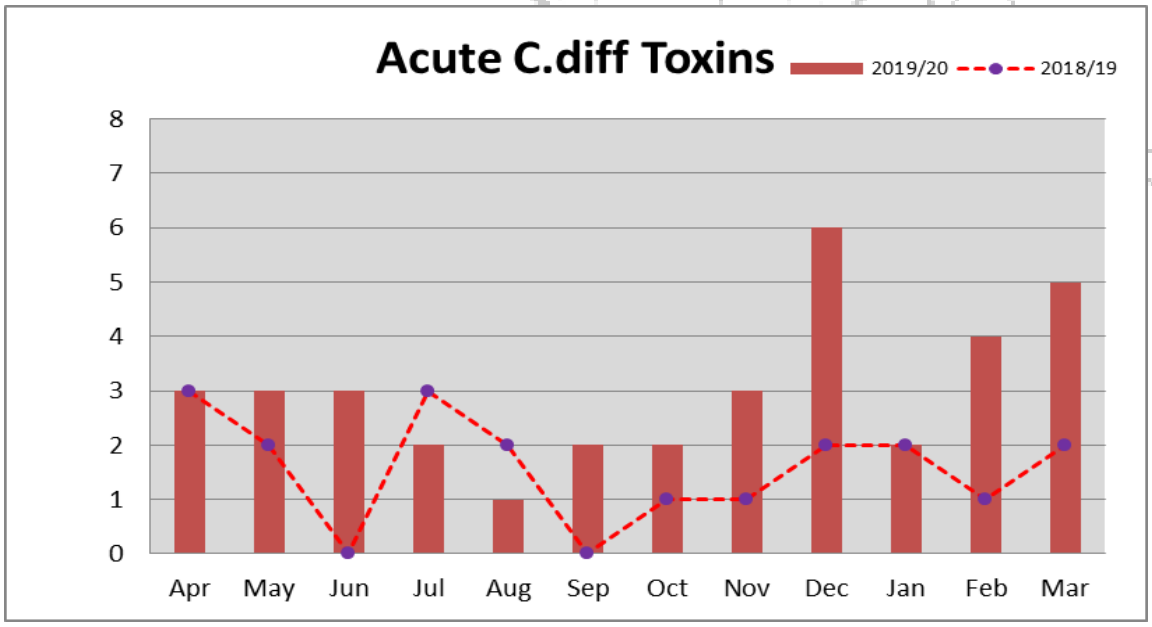
The Assurance Framework for Infection Prevention & Control and reporting arrangements for the Infection Control Committee for Walsall Healthcare NHS Trust are as follows:



7. Hospital acquired *Clostridium difficile*

The graphs below identify *Clostridium difficile* hospital attributed toxin positive specimens at the Manor Hospital between April 2019 and March 2020.





The Trust carries out root cause analyses (RCAs) on all Trust apportioned *Clostridium difficile* cases. These are reported to the divisional quality meetings and at IPCC. 36 RCA's were undertaken for the toxin positive *Clostridium difficile* during 2019-20.

The findings are given below:

Total Acute Toxin cases	36
Total Acute PCR cases	51
Period of increased incidence	1
Avoidable	7
Unavoidable	29

Between April 2019 and March 2020 there have been 36 cases confirmed of acute *C. diff* Toxins against annual trajectory of 26.

Of the 36 cases 29 were deemed unavoidable and 7 avoidable.

Avoidable cases

- 5 inappropriate acute antibiotics with failure to review therapy
- 2 community onset cases with delay in specimen making case acute

Common Trends

- Multiple antibiotics in last 6 weeks
- Over 65
- PPI
- Previous history of *C. diff*

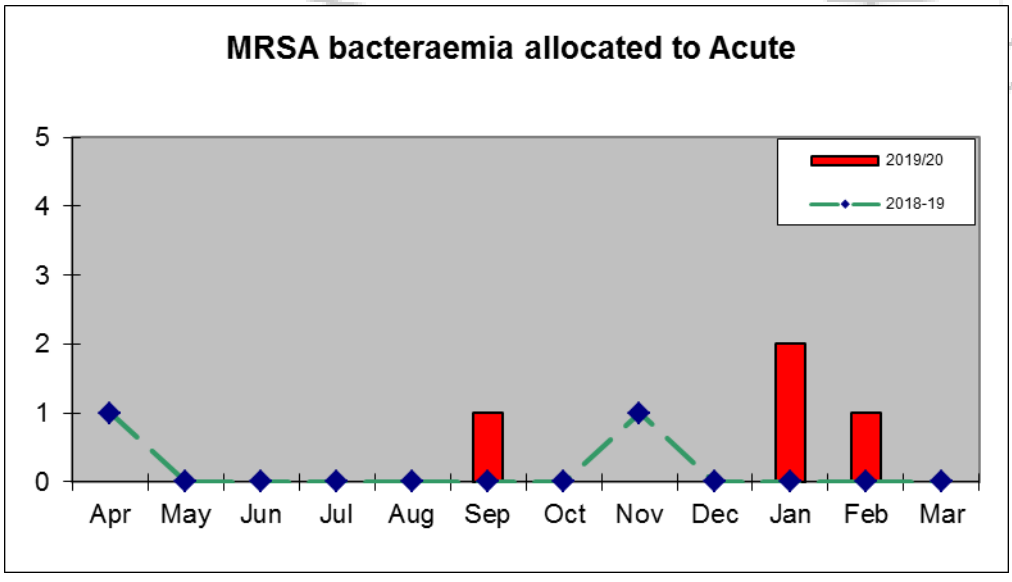
Trend issues

- Delay in sending specimens for *C. diff* testing
- Failure to isolate at time of specimen
- Delay in isolation when confirmed
- Failure or delay in sending clinical specimens to confirm correct antibiotic therapy / confirmation of infective organism

In light of the increased incidence of *C. diff* in the trust, a Task and Finish Group has been established to learn from our experiences and to advise on further actions.

8. Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia

There were 4 cases of MRSA bacteraemia (blood-stream infection) attributed to the Manor Hospital during 2019-20.



A total of 4 MRSA's bacteraemias were reported. Root causes were:

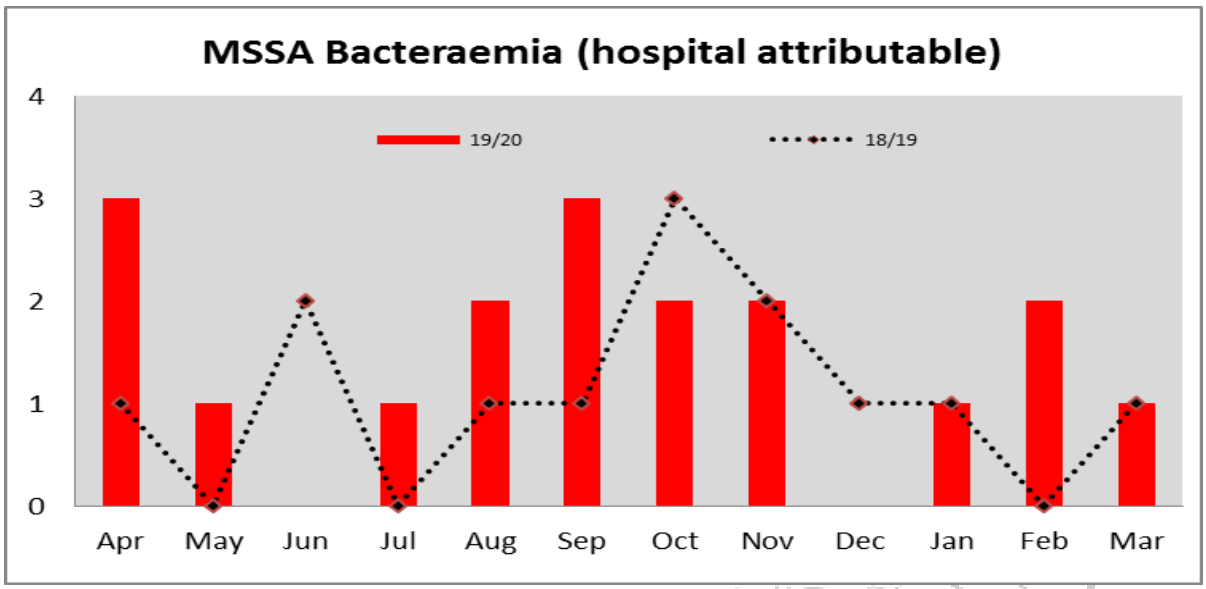
Case 1 - MRSA growth isolated from old chest drain. Avoidable
Case 2 – Infected Gout unavoidable

Case 3 – Cannula avoidable
Case 4 – Contaminant – avoidable

The main learning was management of cannulas.

9. Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia

There has been a total of 19 hospital attributed cases of MSSA bacteraemias during 2019-20. This represents an increase of hospital cases by 5 in 2018-19.

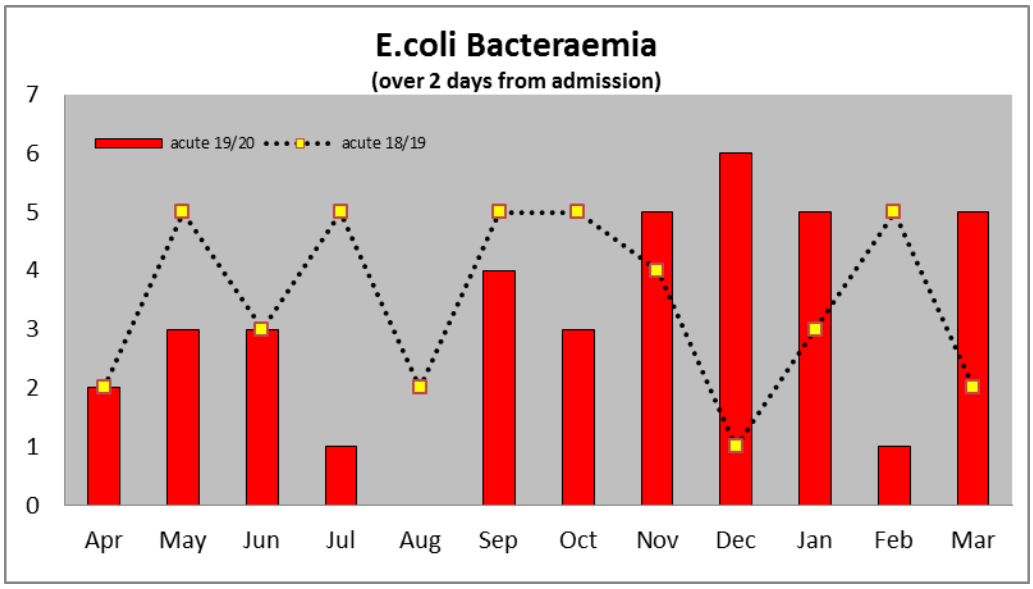


There continues to be no local or national mandatory reporting trajectories for MSSA. It is not anticipated that there will be any national trajectories for 2020-21. However, the Infection Prevention & Control Team aims to maintain low rates of MSSA and investigate all cases to ascertain if there are further actions that can be taken. Performance of MSSA bacteraemia continues to be monitored at Infection Prevention and Control Committee.

A total of 19 hospital associated cases were reported in 2019-2020 compared to 13 reported 2018-2019. All cases are reviewed on an individual basis to determine cause and avoidability. In total, 10 were reported as avoidable and 9 unavoidable. The table-top reviews of the acute cases highlighted issues around cannula care, maintenance, documentation and VIP scores.

10. *E. coli bacteraemia*

There was a total of 38 hospital attributed cases of *E. coli* bacteraemia in 2019-20, compared with 42 in 2018-19. All cases are reviewed on an individual basis to determine cause and potential learning. There were no HCAI cases identified. In addition, there is a Walsall-wide working group to reduce the gram negative infections across the borough. This group has representation from Walsall Healthcare NHS Trust, Walsall CCG, Walsall Health protection unit and Black Country Partnership Mental Health Trust. This work is fed back through the governance structures of each organisation including the Infection Prevention and Control Committee at the Trust.

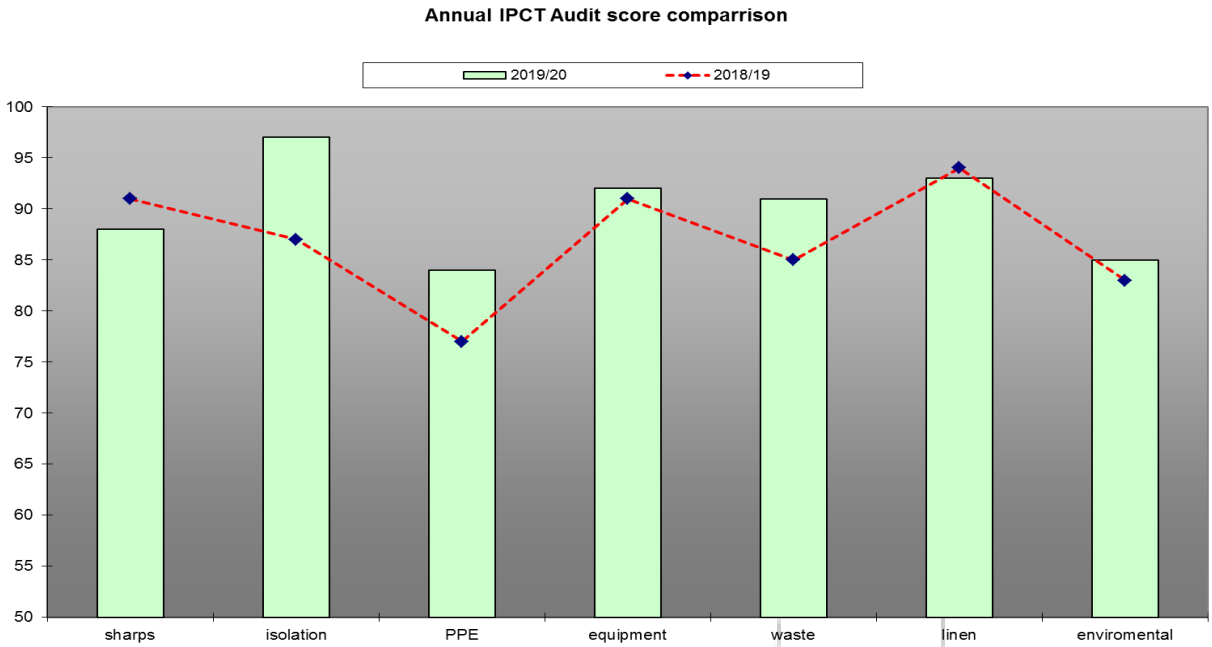


11. Acute Services Infection Prevention audits

The following infection prevention audits were undertaken during 2018-19 covering the Manor Hospital site. A comparison to similar audits undertaken during the previous year 2018-19 is provided in the table below.

Audit results are shared with Heads of Service and are reported to and discussed at Infection Prevention and Control Committee and Divisional Quality team meetings.
Any non-compliance is fed back to the area at the time of audit. These annual audits are in addition to monthly observational audits for all ward areas which were undertaken monthly by the Infection Prevention & Control Team during the year with Matrons.

Audit	2019/20	2018/19	Signs of improvement
Sharps	88	91	↓
Isolation	97	87	↑
PPE	84	77	↑
Patient Equipment	92	91	↑
Waste	91	85	↑
Linen	93	94	↓
Environmental	85	83	↑



12. Outbreaks of Infection

The IPCT recognises and responds to any significant episode, incident or outbreak of infection. Incidents and outbreaks may be reported in several different ways: by the clinical areas, through microbiology results, IPC visits to the ward. All outbreaks and incidents are included in the IPCT monthly reports and reported via the Infection Prevention and Control Committee.
Outbreaks of Healthcare Associated Infection are reported via the Trust's reporting arrangements as serious incidents. An outbreak report is also prepared for the Infection Prevention and Control Committee for significant outbreaks to ensure any relevant lessons are learnt. An outbreak committee is convened to manage and monitor the situation.

Outbreaks of infection for example Norovirus, influenza or periods of increased incidence of *Clostridium difficile* are classified as serious incidents and reported on the serious incident reporting system STEIS. A full investigation and 50 day report is subsequently submitted.

Norovirus

Total number of confirmed cases = 54
Full ward Closures norovirus = 4
Bay closures norovirus = 25

The following tables identify outbreaks of Norovirus at the Manor hospital between April 2019 and March 2020.

Bay closures - norovirus

Month	Ward	Number of bays	Number of confirmed cases	Total number of days closed	Total blocked bed days
May 19	1	1	1	2	1
May 19	3	2	1	4	8
June 19	14	1	1	2	1
September 19	17	1	0	2	6
October 19	3	1	0	1	0
October 19	7	2	1	3	13
October 19	1	1	0	1	0
November 19	3	1	0	1	0
December 19	29	3	0	1	1
December 19	AMU	1	0	2	0
December 19	29	1	1	1	3
December 19	3	1	1	3	6
December 19	9	1	0	1	3
December 19	14	2	2	8	7
December 19	1	1	3	7	2
January 20	14	1	1	2	0
January 20	11	2	1	7	7
February 20	17	1	1	8	11
February 20	AMU	1	1	2	2
February 20	1	1	1	6	0
February 20	9	1	0	1	0
March 20	9	1	3	4	5
March 20	7	1	3	7	5
March 20	15	1	1	5	0
March 20	12	1	1	5	0

Full ward closures – norovirus

Month	Ward	Number of confirmed cases	Total number of days closed	Total blocked bed days
May 19	15	9	13	81
December 19	1	7	19	51
February 20	1	12	12	48
February 20	1	2	4	8

Influenza

Where a positive Flu has been identified in a bay the positive patient has been isolated and the bay has been closed for observation for minimum of 48 hours for signs of any spread. Patients in the bays have also been assessed regarding their vaccination status and need for prophylactic antivirals.

Bay closures influenza

Month	Ward	Number of bays	Number of confirmed cases	Total number of days closed	Total blocked bed days
April 19	AMU	1	1	4	2
April 19	15	1	1	5	1
April 19	AMU	1	1	2	1
May 19	16	1	1	2	1
May 19	15	1	1	2	1
November 19	AMU	1	1	2	1
December 19	AMU	1	1	3	4
December 19	16	1	2	3	10
December 19	AMU	1	1	1	3
December 19	AMU	1	1	2	0
December 19	AMU	1	1	2	1
December 19	16	1	1	2	0
December 19	FES	1	1	2	4
December 19	4	2	5	8	0
December 19	29	1	1	2	0
December 19	15	1	1	2	1
December 19	AMU	1	2	1	0
December 19	10	1	1	3	9
December 19	7	1	1	5	0
December 19	23	1	1	1	2
December 19	AMU	1	1	2	2
December 19	AMU	1	1	3	3
December 19	15	1	1	4	1
December 19	15	1	1	2	2
December 19	AMU	1	1	2	0
January 20	16	1	1	2	0
January 20	AMU	1	1	2	0
February 20	AMU	1	1	4	8

Ward flu closures influenza

Month	Ward	Number of confirmed cases	Total number of days closed	Total blocked bed days
April 19	14	4	4	3

Other closures

Bay closures

Month	Ward	Total number of days closed	Reason for closure
June 19	AMU	2	CPE screening
October 19	AMU	1	CPE screening
October 19	AMU	13	CPE screening
October 19	AMU	1	CPE screening

Full ward closures

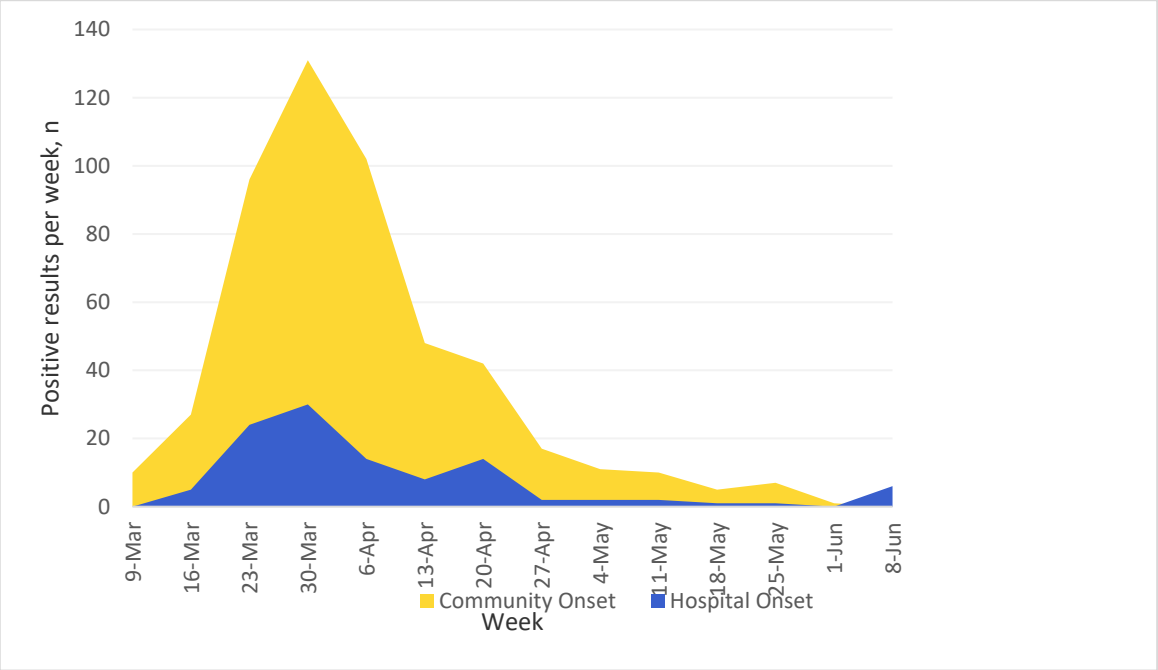
Month	Ward	Total number of days closed	Reason for closure
September 19	1	9	CPE screening following positive case confirmed on ward
December 19	15	6	Mass treatment all staff and all patients for scabies
January 20	3	2	Mass treatment all staff and all patients for scabies
January 20	23	3	Mass treatment all staff and all patients for scabies

COVID 19

In December 2019 a novel coronavirus (COVID-19) caused an outbreak in Wuhan, China, and soon spread to other parts of the world.

The Trust followed national guidance regarding precautions that needed to be taken to prevent the spread of the virus. The infection control team increased the service by providing additional cover over weekends and evenings.

In April 2020 the number of cases continued to rise in the UK. No outbreaks were declared by the Trust due to Covid in February 2020. The following chart demonstrates the dramatic rise in cases commencing in March 2020. The arrows show the key interventions made during this time. A full review of positive patients is currently underway.



Date	Measure	Outcome
16th March	PPE limited only for contact with suspected or confirmed COVID-19 cases.	Potential increase in cases
	Guidance changed from using FFP3 to surgical mask with confirmed or suspected cases.	
21st March	Hospital closed to visitors.	Potential decrease in cases
24th March	Encouraged retesting of symptomatic patients due to high false negative rate.	Potential increase in cases
2nd April	Patients not required to be COVID negative before can be discharged home.	Potential decrease in cases
3rd April	PPE usage for all patient contact.	Potential decrease in cases
26th April	Introduction of routine COVID-19 swab on admission including those already admitted	Potential decrease in cases
27th April	COVID-19 testing extended to non-elective admissions	Potential decrease in cases
27th May	COVID-19 serology antibody test started	Potential decrease in cases

14. Surgical Site Surveillance

In 2004 it became a mandatory requirement for all trusts undertaking orthopaedic surgery to conduct surveillance of surgical site infections, using the Surgical Site Infection (SSI) Surveillance Service of Public health England, (PHE). The data set collected as part of the surveillance is forwarded to HPE for analysis and reporting. Surveillance is divided up into quarters (Jan-Mar, Apr-Jun, July-Sept and Oct-Dec) and each site is required to participate in at least one surveillance period every 12 Months in at least one orthopaedic category.

In 2019, the Trust completed two quarters mandatory surveillance:

Quarter 1 (April – June 2019)

- Modules completed were Total Hip Replacements and Total Knee Replacements.
- No surgical site infections were identified during the surveillance period

Category	Total no of records submitted	No of SSI inpatient	No of SSI readmission	Total SSI
Hip Replacement	61	0	0	0
Knee Replacement	79	0	0	0

Quarter 2 (October 2019 – December 2019)

- Modules completed Total Hip Replacements and Total Knee Replacements.
- No surgical site infections identified during the surveillance period

Category	Total no of records submitted	No of SSI inpatient	No of SSI readmission	Total SSI
Hip Replacement	41	0	0	0
Knee Replacement	54	0	0	0

15. Education

Education remains a core element of the work of the Infection Prevention & Control Team in both hospital and community settings. The IPCT contribute to the Trust Induction and Mandatory Updates and a range of planned and bespoke education sessions whenever a specific need arises, including for blood cultures and intravenous line care.

During 2019/20 the team

- Completed 142 formal teaching sessions
- Facilitated 20 student nurse placements and 3 post grad placements
- Provided ward based education and support within clinical areas.
- Held quarterly link worker education meetings
- Supported infection control link worker programme

Infection control week

Week commencing 14th October the Infection Prevention and Control team completed ward based training and awareness sessions during the week which included:

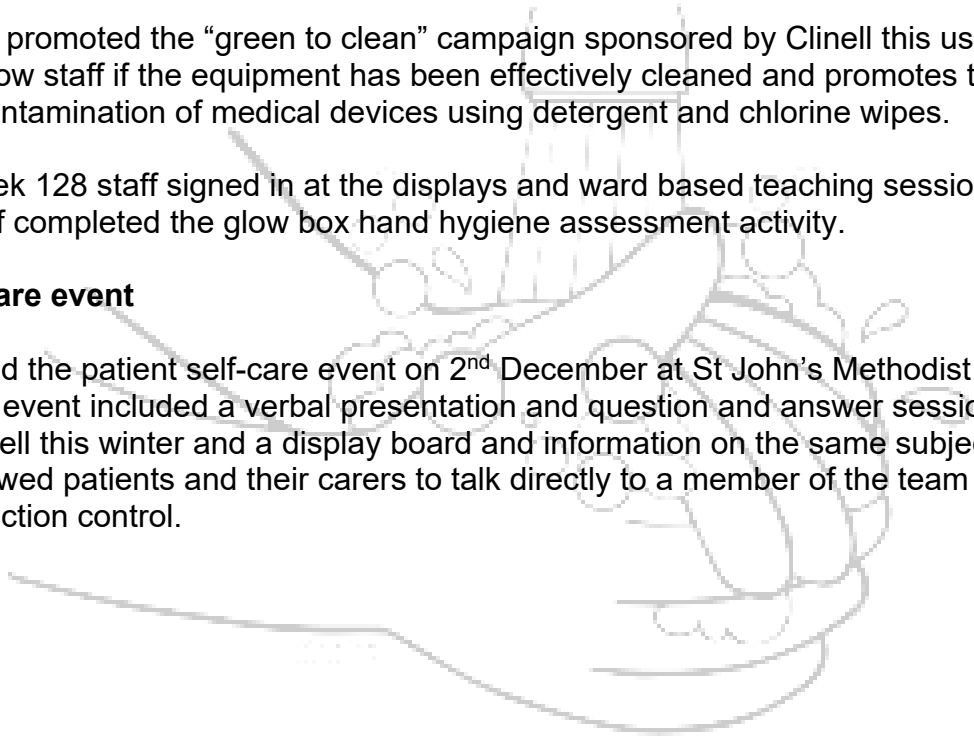
- Display boards in atrium with focus for staff on basic infection control standards and precautions
- Display board focus for staff and public with a focus of keeping well this winter.
- Use of the glow and tell machine
- Ward based teaching on decontamination, hand hygiene and basic standards
- An infection control quiz for staff
- A ward based infection control information board competition

The team also promoted the “green to clean” campaign sponsored by Clinell this uses UV indicator to show staff if the equipment has been effectively cleaned and promotes the Trust policy for decontamination of medical devices using detergent and chlorine wipes.

During the week 128 staff signed in at the displays and ward based teaching sessions and a total of 73 staff completed the glow box hand hygiene assessment activity.

Patient self-care event

IPCT supported the patient self-care event on 2nd December at St John’s Methodist Church Bloxwich. The event included a verbal presentation and question and answer session regarding how to keep well this winter and a display board and information on the same subject.
The event allowed patients and their carers to talk directly to a member of the team covering all aspects of infection control.

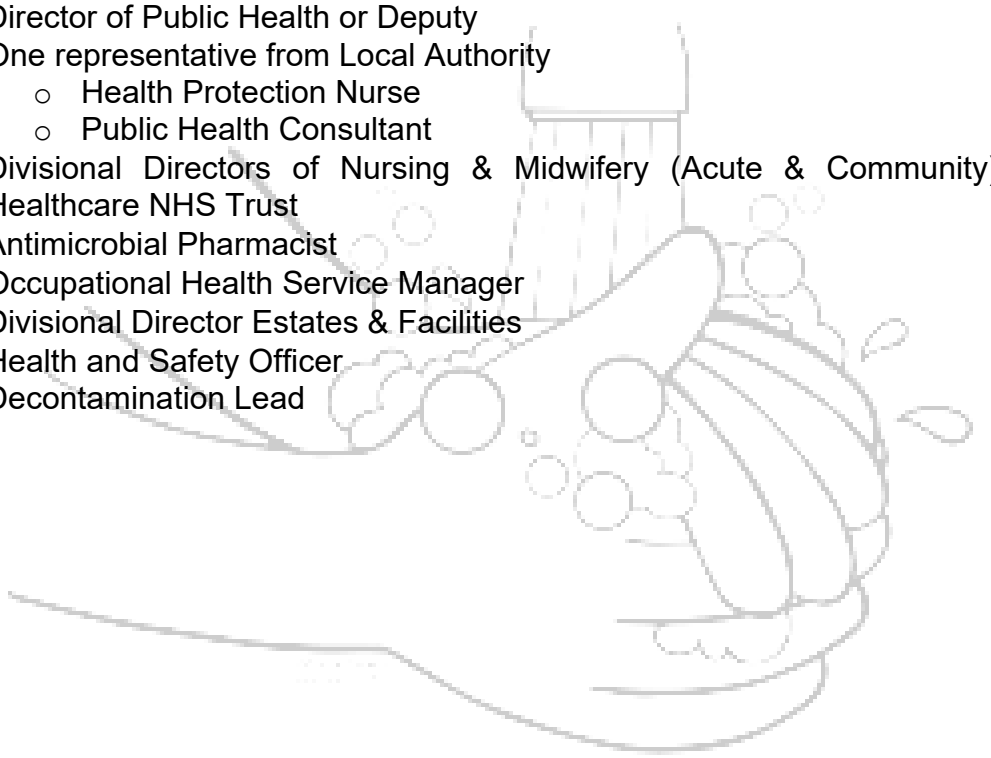


Appendix 1

1. Membership of the Infection Control Committee

3.1 The Group will comprise:

- Medical Director / Director of Infection Prevention and Control (DIPC) (Chair)
- Director of Nursing or Deputy
- Head of Infection Prevention (Deputy Director of Infection Prevention)
- Infection Prevention Team Members
- Consultant Microbiologists
- Divisional Directors of Nursing
- Allied Health Professional Representative
- CCG Lead for Quality
- Public Health England representative
- Director of Public Health or Deputy
- One representative from Local Authority
    - Health Protection Nurse
    - Public Health Consultant
- Divisional Directors of Nursing & Midwifery (Acute & Community) – Walsall Healthcare NHS Trust
- Antimicrobial Pharmacist
- Occupational Health Service Manager
- Divisional Director Estates & Facilities
- Health and Safety Officer
- Decontamination Lead



Appendix 2

CQC Hygiene Code Compliance Report Summary (Updated December 2019)

Criterion 01:	**Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.**	**Partial Compliance**
Criterion 02:	**Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.**	**Partial Compliance**
Criterion 03:	**Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk if adverse events and antimicrobial resistance.**	**Partial Compliance**
Criterion 04:	**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.**	**Fully Compliant**
Criterion 05:	**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**	**Fully Compliant**
Criterion 06:	**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**	**Fully Compliant**
Criterion 07:	**Provide or secure adequate isolation facilities.**	**Partial Compliance**
Criterion 08:	**Secure adequate access to laboratory support as appropriate.**	**Fully Compliant**
Criterion 09:	**Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.**	**Partial Compliance**
Criterion 10:	**Providers have a system in place to manage the occupational health needs of staff in relation to infection**	**Fully Compliant**

Appendix 3 – Annual plan 2020/21

Annual objective	Intervention	Measure of success
To increase hand hygiene training uptake to 90% in all Trust staff	IPCT to explore the potential to increase access via infection prevention champions in each clinical area	90% of the work force (excluding those staff on long term sick and maternity leave) have received annual training in hand hygiene
An Infection Prevention and Control Annual report is presented to the Trust Board and is available to the public	Completion of annual report delayed to the end of July 2020 due to pandemic.	The Infection Prevention Annual report can be accessed via WHT Internet page and is part of the Public Board papers
WHT own objectives for 2020/21 as follows: • MRSA bacteremia zero tolerance • 26 *C.difficile* toxin cases • Reduction in *E.coli* bacteremia	IPCT to ensure shared learning from cases is incorporated into the divisional quality reports IPCT to identify themes and devise a QIP working with appropriate clinical staff IPCT to arrange quarterly meetings with CCG to review cases and agree if any lapse in care has occurred.	There are no cases of MRSA bacteraemia reported in patients who have been in hospital over 48 hours There are no more than 26 cases of C. diff infection reported in patients who have been in hospital for more than 48 hours. The Trust can demonstrate a reduction in the number of cases of bacteraemia occurring in patients who have been in hospital over 48 hours. Successful completion of QIP
Maintain and further develop robust surveillance systems using ICNet reporting facility to ensure prompt reporting of infections and appropriate actions are taken by clinicians to prevent cross infection or avoidable harm to service users, staff or the general public	Business case supported to purchase addition ICNET outbreak module. Embedding new module into everyday practice.	New outbreak module implemented and in full use by IPCT
Lead on any IPC clinical incidents:	IPCT will support divisions on serious incidents relating to HCAI deaths or incidents where infections are major cause of the SI. This work will need additional support when reviewing IPCT will review how lessons learned from the reviews are shared	All IPC clinical incidents are reviewed, and lessons shared throughout the Trust effectively
To develop an annual audit plan	All clinical areas will be audited at least annually	Findings will be reported to Div DONs and action plans will be monitored at the ICC

Annual objective	Intervention	Measure of success
The Perfect Ward is being introduced at WHT	IPCT will support the implementation of the Perfect Ward initiative and the infection prevention element to enable staff to have more ownership of IPC	Ward dashboards show that clinical staff are using the perfect Ward tool to evaluate infection prevention standards in their area. The reports from the Perfect Ward will be able to show an improvement in infection control practices and procedures on each ward.
Patients are not put at risk of environmental contamination.	IPCT to develop a deep clean plan with facilities and estates to deliver the cleaning programme	No patients acquire an infection from the hospital environment
Capital planning and refurbishment takes into account infection prevention and control requirements	IPCT will play an active role in the restoration and recovery works. IPCT support the ongoing development of new builds and minor works	IPC considerations are demonstrated in capital planning programmes
Patients and visitors have access to accurate information about infections	IPCT to review all leaflets and ensure that there is complete suite available in a format that the clinical staff can use	Leaflets available in printable version and on website
All eligible long stay patients are offered influenza vaccine during 20020/21 flu season	Agreement via ICC that all eligible long stay patients are offered flu vaccine. IPCT to support this initiative	Long stay patients will receive flu vaccine if they want it. Reduction in number of patient acquiring flu whilst in hospital due to immunity
There will be a network of infection prevention champions in all clinical areas	IPCT to support the work of the IPC Champions in their clinical area to support them to undertake small QIP projects, audits and hand hygiene training	Named champions in each clinical area. Excellent attendance at quarterly meetings Evidence of increased hand hygiene compliance Small QIP projects being undertaken
The IPC Teams page will provide an excellent resource to staff and patients regarding infection prevention and control	IPCT will develop and keep up to date the teams page for the Trust website	The Teams page will be comprehensive and update on a regular basis as needs arise. There will be evidence that the Teams page is regularly used by clinical staff

Annual objective	Intervention	Measure of success
Infection prevention and control to remain on the staff induction programme	During 2020/21 this resource is on-line only. The on-line resource has been evaluated. IPCT to review effectiveness.	The infection prevention training on induction is fit for purpose and staff feel confident that they not what to do to keep themselves, patients and colleagues safe from avoidable infection
There are adequate numbers of side rooms available to isolate patients	IPCT to actively seek additional alternatives to side rooms and make recommendations to the Board	There are adequate side rooms for use during the winter months. There is a reduction in the number of safeguarding reports completed due to lack of isolation facilities
There is a Covid 19 policy available with up to date advice for staff on the management of individual cases and clusters	IPCT will develop a COVID 19 policy	The Covid 19 policy will be written and available to staff and that there is evidence that policy is followed.
The Trust will have access to the IPCT 7 days a week	An options appraisal and business case will be developed to assess the IPCT ability to deliver 7 day a week working	Approval of business case and implementation of extended service
The Trust has adequate facilities to ensure deep cleaning can be undertaken to a high level of effectiveness	A review of review of the hydrogen peroxide vapour machines and the introduction of ultraviolet light to be undertaken	Approval of business case and implementation of extended service
The Trust IPC strategy will be up to date	Workshops will be undertaken to develop the IPC strategy	The IPC strategy will be approved and supported by the Trust Board
The Trust will have adequate isolation facilities available	A review of existing isolation facilities and options appraisal to be undertaken using historical breaches to focus on where further facilities are required	Patients are isolated according to need and the number of breaches is reduced

Appendix 4 – Escalation Criteria

IPC Escalation F	Key Indicators	Response
RED	MRSAb: > x6 per annum. CDI: > plan for 3 consecutive months AND outside national guide for rolling 12/12 rate. CDI: recurring reported outbreaks reported to PHE/CCG. Recurrent outbreaks reported (not including norovirus). CQC: IPC MUST do-several issues/Enforcement notice issued by CQC. Serious incident/never event related to IPC. Negative press in public domain. NHSI: serious IPC concerns identified during visit e.g. cleanliness, governance	Identify lapse in care data following review by local CCG. Focussed improvement offer: Lead by; NHS Improvement, or CCG or PHE (dependent up on issue at the time). Request pre-visit documentation. Peer team: IPC leads (2-4), +/- Chief pharmacist, Quality lead, CCG IPC lead, CQC, PHE IPC lead, NHSE, specialist advisor as identified. Participate in Risk Sharing calls and Risk Summits as and when required. Formal report and action plan request. Follow up action.
AMBER	MRSAb: 3-5 per annum. CDI: > plan for 2 consecutive months AND outside national guide for rolling 12/12 rate . CDI: outbreak reported to PHE/CCG. Intermittent outbreaks reported. Concerns raised by arms-length bodies e.g. CQC (MUST do-single item issue/SHOULD do), PHE, CCG. NHSI: IPC concerns identified but the trust has responded to these and is addressing in a timely manner.	Identify lapse in care data following review by local CCG. Observe data. Liase with quality team, CCG and PHE.
GREEN	MRSAb: 0-2/per annum. CDI: on plan/rate. CDI: no outbreaks reported to PHE. No concerns raised by CQC, PHE, CCG. No serious incidents identified.	No action required.
Standard oversight/work		To include but not limited to: QI Collaborative programmes: acute trust, community/MH/ambulance. Reactive response e.g. SI major outbreaks, National issues e.g. ebola. Offer to support focused inspections by CQC or others e.g. PHE Support the regional teams with IPC update training and issues such as KLOE for IDMs Telephone consultation. DIPC support /development. Updates on national agendas etc. Study days. Networking: PHE, CCGs, NHSE National groups/reviews etc. Quality summits if IPC indicated.

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Walsall Together Partnership Board (WTPB) Highlight Report			**AGENDA ITEM: 21**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mrs Anne Baines – Chair of WTPB (Non-Executive Director)
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☐		
Executive Summary	The report provides the key messages from the Walsall Together Partnership Board meeting on 21st October 2020. The key points for the attention of the Trust Board are: - Partners are developing an approach which links demand on services to the right groups in an integrated way to ensure both physical and mental health issues are addressed simultaneously. - Two new risks have been to, and are being managed through, the partnership risk register. The first was highlighted to the Trust Board in October and is the lack of access to timely swabbing for care home staff. The second is the lack of available resources to implement new models of care and associated benefits. - The partnership approach to health inequalities was debated at length. Further work to develop a baseline and to gain community input will take place. - The Care Quality Commission (CQC), in their review of best practice across system working during COVID-19, praised the work of Walsall Together and the approach and commitment of partners.		
Recommendation	Members of the Board are asked to note the report.		
Risk in the BAF or Trust Risk Register	This report aligns to the BAF risks for Care at Home (S02) and COVID-19 (S06)		
Resource implications	There are no new resource implications associated with this report.		
Legal, Equality and Diversity implications	There are no legal, or equality & diversity implications in this paper, however the developing approach to health inequalities is noted.		
Strategic Objectives	Safe, high quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

WALSALL TOGETHER PARTNERSHIP BOARD

KEY AREAS FOR CONSIDERATION BY THE BOARD

The Committee met on 21st October, with the meeting Chaired by Mrs Anne Baines, Committee Chair and Non-Executive Member of the Walsall Healthcare Trust Board. The meeting was quorate, with all partner organisations represented.

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

1. Patient Story

Healthwatch presented the story of a patient that has been suffering with diabetes and pain due to fibromyalgia and detailed her referral to the Pain Therapy Team at Walsall Healthcare Trust and Improving Access to Psychological Therapies (IAPT) talking therapies. The Board heard of the impact of COVID-19 in restricting access to face to face therapies, and the effect that had on the patient's mental and physical health.

Healthwatch has responded to this patient and others by holding Diabetes UK and diabetes team peer support group meetings to help to connect others, and provide a platform to discuss self-management and address isolation.

The Board heard of the desire of patients to better understand the services and specialities available to patients through the IAPT programme, and to ensure consistency of referrals and after care. The Board took an action to look into referrals to the Pain Therapy Team and to how partners are linking demands on services to the right groups in an integrated way to ensure both physical and mental health issues are addressed simultaneously.

2. Operational Update

Key performance indicators were reviewed for partners noting:

- Across the system there is a return to several command and control meetings in response to growing COVID-19 challenges. There is also a continued focus on staff health and wellbeing.
- Referrals to the care coordination service remain high. This work is being absorbed by the Rapid Response Team with increased support provided by the Locality Teams.
- The enhanced support team commenced weekly ward rounds in all older peoples care homes on 1st October. Further work is underway to strengthen this model with the patients' GPs.
- The numbers of patients at Walsall Manor Hospital who are medically stable remain at a reduced level.

- The reactivation of Decision Support Tools is progressing well within the Intermediate Care Service and locality teams.

- There are concerns about the requirement for staff going into care homes to have weekly COVID-19 swabbing. Community Services are unable to access the swabs required to implement this. This has been added to the risk register.

- One Walsall is continuing to engage with the voluntary sector, promoting its development tool and training programme to support the sustainability and development of voluntary, community and social enterprise organisations.

- There continues to be significant pressure on Mental Health inpatient beds. Black Country Healthcare is in the early stages of developing a regional strategic approach for inpatient care.

- A review of Primary Care recovery and restoration has been undertaken as the system is seeing increased numbers of COVID-19 positive cases.

3. Programme Update

The overall status of the transformation programme is amber due to some milestones that are delayed or overdue, primarily due to partnership preparations for the second wave of COVID-19.

The board reviewed those milestones that were delayed but expected to recover, and those for which a re-profiling will be required. The next meeting will focus on this, as well as understanding the impact of any delays or re-profiling. The Board will consider additions to the programme including the new models of care pathways and Integrated Care Partnership roadmap, and their expected outcomes, as well as the respective contributions of partners to these.

4. Health Inequalities

The Board were provided with an overview of the current system thinking in respect of health inequalities and the various strands of work that are taking place. The Board will continue to draw out the substance of this work, developing a baseline which demonstrates what partners are currently doing to address health inequalities, and listening to what communities need, prior to developing a strategy to address this in an integrated way. The message was clear that health inequalities must be the strand that runs through all programmes delivered through Walsall Together.

5. Walsall Housing Group Health and Wellbeing Approach

The Walsall Housing Group health and wellbeing approach, which is being co-created in consultation with customers and Board members, was well received by the Board. Partners were invited to feedback on the approach, which has health inequalities as its focus.

6. Walsall Together Effectiveness Review

The Board approved its annual report for 2019/20, and made amendments to its terms of reference, which will be endorsed at the next meeting. The Board's priorities for the 2020/21 year include:

- Continued integrated response to community needs arising from COVID-19 transmission
- Development of integrated approach to addressing health inequalities and wider determinants of health
- Continued delivery of Business Case through development of local services based on increased levels of engagement and co design with local communities
- Agreement of Partnership outcome measures to assess continuous health improvement
- Consideration of ICP status journey/options and agreed direction of travel

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Care at Home Executive Report			**AGENDA ITEM: 22**
Report Author and Job Title:	Michelle McManus Walsall Together Programme Manager	**Responsible Director:**	Daren Fradgley Executive Director of Integration, Deputy CEO
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This paper provides an overview of the risks to delivery of the Care at Home strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Walsall Together, successes and areas for improvement.		
Recommendation	Members of the Trust Board are asked to NOTE the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk- S03 Failure to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities. BAF Risk – SO1 Deliver Safe, High Quality Care		
Resource implications	There are no new resources requests associated with this report.		
Legal and Equality and Diversity implications	The issue of health inequalities is rightly receiving growing prominence in all forums across Walsall Together. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare. There are multiple workstreams that have given focus to this issue within the forward look programme, which were discussed at the October meeting of the Walsall Together Partnership (WTP) Board.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

WALSALL TOGETHER REPORT
OCTOBER 2020

1. PURPOSE OF REPORT

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

2. KEY AREAS OF SUCCESS

Across the system there is a return to several command and control meetings in response to growing COVID-19 challenges. There is also a continued focus on staff health and wellbeing. There are clear implications for operational service delivery, particularly as we move towards Winter and the frequency of these meetings is being stepped up again as planned.

Referrals to the care coordination service remain high as planned. This work is being absorbed by the Rapid Response Team with increased support provided by the Locality Teams. Recruitment into the service is in progress and will be operational from Holly Bank House in November. This will add further capacity to the operational teams as it gains its own identity. Referrals are now open to West Midlands Ambulance Service (WMAS) although the demand from this source remains comparatively low. Work is ongoing to better understand how to improve the pathway links from WMAS given this route has the greatest impact for admission avoidance that is yet explored.

The enhanced support team commenced weekly ward rounds in all older peoples care homes on 1st October. Further work is underway to strengthen this model with the patients' GPs. The funding for this in the short term coming from the COVID-19 pot, a substantive funding model needs to be sourced or the team removed.

The numbers of patients at Walsall Manor Hospital who are medically stable remain at a reduced level. Actions taken throughout COVID-19 remain standard practice and the demand for intermediate care discharge services is increasing. The associated resource required is within winter forecast levels currently.

The reactivation of Decision Support Tools (DSTs) process is progressing well within the Intermediate Care Service (ICS) and locality teams. Risks relating to discharge of patients into care homes is described in section 3 but the initial slow down due to its reintroduction has now been mitigated successfully.

Recruitment of an additional Nurse to support the new practice of Trusted Assessor is in progress. Additional funding support is being sourced from the Clinical

Commissioning Group (CCG) ensuring that the performance outlined above can be maintained.

Within the Improvement Programme, the outpatients workstream continues to progress. In line with last month's report, initial workshops with the Surgery division have taken place and dates are confirmed in November for MLTC and Women's and Children's divisions. These workshops will inform the delivery plan for Walsall Together for the remainder of the 2020/21 financial year and beyond and also inform the direction of travel within the context of any future Integrated Care Provider contract. The key next steps for this workstream is to ensure visibility of the progress within Walsall Together, which is not currently showing on the Improvement Programme reporting. The outpatient workstream therefore has been designed as a three phase process, phase 1 being the COVID-19 response, phase 2 looking at future state models and design principles and phase 3 deploying those principles.

The transformation elements of Walsall Together are starting to show slippage against a number of key milestones. These are discussed in section 3. Despite additional operational pressures, progress has been made in several areas and 33% of all milestones in the Programme Plan (Jul-20 to Mar-21) have now been completed. The following milestones have been achieved over the last reporting period:

- Primary Care Network (PCN) social prescribers are now attending multi-disciplinary team (MDT) meetings in all localities and accepting referrals;
- A high-level pathway for alignment of PCN social prescribing with the service provided by Walsall Housing Group (WHG) has been agreed;
- Several of the posts identified in the Walsall Healthcare NHS Trust (WHT) investment case have been recruited to, the management of change for Rapid Response is in progress, and a location for Care Coordination has been established;
- The high level model for specialist MDTs in respiratory and cardiology have been agreed;
- Health visiting and school nursing have transferred into the community division and therefore Walsall Together;
- The Family Safeguarding Model went live on 1st September (after pausing from 1st April); 13 children in 9 families have been accepted into the service;
- Preparation work for the step-up pilot in the Intermediate Care Service (ICS) is now completed and is expected to go-live in October.
- Enhanced support to care homes implementation has commenced in line with the proposals that were approved during September
- Additional capacity for IV therapies to be delivered in the Community, as part of the WHT investment case, has been achieved and is operational
- A pilot for Community Services to deliver First Contact Practitioner Physiotherapy has been successfully completed in one GP practice and discussions to roll out across more practices are in progress
- The integrated Shared Care Record is on track for the first stage of implementation and will be available to support the complex multi-disciplinary

team (MDT) meetings between community services and primary care during November.

- The Walsall Together Communications Lead is currently developing a Communications and Engagement (C&E) Strategy for the partnership that will be presented to the WTP Board in November. It includes a refresh of the vision, aims and objectives of the partnership with a view to strengthening the language pertinent to improving equality and reducing inequalities.

As you can see, whilst the plan has seen some slippage, significant progress is still being made and mitigations for the slippage are transparently shared and discussed in the Walsall Together Partnership Board.

3. AREAS OF CONCERN

There are concerns about the requirement for staff going into care homes to have weekly COVID-19 swabbing. Community Services are unable to access the swabs required to implement this in a timely manner. It raises concerns about the viability of the commissioned strategy to support care homes over the Winter. It is reflected on the Walsall Together risk register and is currently without full mitigation at the time of writing although several options are actively being explored

While the length of stay of patients being discharged from community pathways remains stable, there is a growing concern about delayed discharges due to enhanced infection control measures for care homes. To date the underlying performance and patient experience remains stable at 3 days, those awaiting discharge that has previously positive covid tests continues to challenge and in extremis has added an additional 15 patients onto the list and doubled the length of stay. Options for better patient experience and timely discharged are actively being explored by the partnership

The case mix and demand profile for community services continues to change with more amber-rated risk patients and fewer lower risk rated (green) patients. This is a direct result of the continued complexity being managed within the community. There are still shortfalls in capacity, however these are at a lower rate than pre-COVID-19 and are dynamically managed on a daily basis. Additional hours have been put into the system to respond to the growing complexity, largely by more efficient use of the staff hours. However, greater gains from a programme of work focusing on self-care is the step required to release additional capacity. Whilst this work has been ongoing for 6 weeks now, it will take up to 6 months to fully complete.

As the operational pressures attributable to COVID-19 and Winter increase, several areas of the transformation element of Walsall Together are now delayed. The WTP Board resolved to accept delays in those milestones for which a recovery plan had been identified and to accept a revised Programme Plan with re-profiling of milestones for which delivery has been more significantly impacted. All of the milestones are expected to be recovered before the end of the financial year, subject to any risks relating to increased COVID-19 pressures. The operational risks associated with the delays are mitigated in the short term. This will be monitored by the WTB Board.

4. KEY PRIORITIES

As reported last month, the partnership continues to give focus to the operational preparedness for the second wave over and above the usual Winter pressures. A Winter Plan has been developed across all system partners and there has been a return to several Command & Control system meetings that were established during the first wave of COVID-19.

Alongside the operational focus, the partnership has now started the governance work for the next stage of the partnership. This will allow the necessary contractual mechanisms to support the level if integrated care necessary to impact on reducing health inequalities and improving the outcomes for our population. This topic has been discussed in previous Board papers and was given dedicated time at a recent Board Development Session. To support implementation, a Core Team has been established with senior representation across all affected partner organisations with appropriate governance and assurance reporting both within Walsall Together and into the respective statutory governing bodies. The workstreams within the Walsall Together programme have been aligned to those of the ICP Core Team to ensure appropriate focus and resource allocation, whilst maintaining focus on the wider transformation priorities of the partnership. This work has also been shared with NHSI and is fully supported as one of the lead places in the Strategic Transformation Partnership (STP).

5. CONTROLS AND ASSURANCE

The WTP Board continues to meet monthly and is well attended. There has been an increased focus on the governance associated with risk and assurance to ensure that an integrated position is reported to the WTP Board. Resource from Walsall Healthcare as host provider has been identified to provide oversight and expertise in risk management. Within an agreed governance process, dedicated risk management meetings is being established with senior representatives across the partnership to ensure risks are identified, recorded and monitored appropriately.

The format of the Senior Management Team (SMT) meetings has been revised to ensure the Team can provide appropriate assurance to the WTP Board. The core SMT is now meeting on a fortnightly basis for an extended 2-hours to ensure sufficient time on the agenda for a) operational oversight and b) delivery of the transformation. The operational leads within the SMT continue to meet on a weekly basis.

The Clinical and Professional Leadership Group (CPLG) meets monthly, Chaired by the Director of Public Health. The Group ensures clinical and professional oversight and input into the Walsall Together programme. Early discussions have taken place to review the membership and purpose of the Group to ensure it can better support the partnership's approach to tackling health inequalities and the development of a Population Health Management Strategy. A review of the Group's effectiveness to date and future priorities is being undertaken in early November.

Alignment of governance and reporting mechanisms between the Walsall Together programme and the Care at Home workstream in the Improvement Programme have concluded. Several Walsall Together projects have been identified for increased oversight and assurance via the Improvement Programme. These are projects where the accountability for delivery needs to sit at least jointly with a division other than Community Services, for example, the Integrated Front Door.

6. RECOMMENDATIONS

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

APPENDICES

1. Board Assurance Risk S02 – Care at Home
2. Operational Performance
3. Care at Home Improvement Programme

Risk Summary

BAF Reference and Summary Title:	**BAF SO2 - Care at Home – We will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall together.**
Risk Description:	**Failure to work with partners and communities to understand population health and inequalities, integrate place based services and deliver them through a whole population approach would result in a continuation of poor health and wellbeing and widening of health inequalities.**
Lead Director:	Director of Integration — **Supported By:**
Lead Committee:	

Links to Corporate Risk Register:	Title	Current Risk Score
	• Risks in this area relate to Walsall Together programme risks the biggest ones are associated with the limited investment and the size and complexity of the population health challenges • None programme risks relating to Community Services at the current time. These are updated through the divisional structure. • Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together • Risks associated with creating an ICP contract will be considered through a formal due diligence process, supported by NHSE/E	**12 (Moderate)**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	3	3			• Continuation of engagement with PCNs but it is not as progressive as required at this point • Maturing place-based teams in all areas of Walsall on physical health and Social Care. Additional integration required for Mental Health although planning underway but not committed yet. • Communications Lead now in post and broader stakeholder communications underway • Commencement of system data but this is very much in its infancy • Walsall Together shortlisted for national governance award • Risk Stratification process for COVID developed with partners which demonstrates the evolving maturity of the partnership • Substantial improvements in medically stable for discharge before and during Covid 19 • Virtual clinics and community outpatients progressing at a quicker pace now Covid response in place • Partnership approach agreed for mortality reviews with care homes	Likelihood:	2	31 March 2021
Consequence:	4	4				Consequence:	4	
Risk Level:	12	12				Risk Level:	Mod 10	

Control and Assurance Framework – 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Executive Director recruited	• Alliance agreement signed by Partners	Enactment of section 75 in terms of Monitoring

	• Non-Executive Director appointed • Partnership Board/Groups and meetings in place Business Case developed PMO/Project in place and reporting	• Governance structure in place and working. • Development of a S75 nearing completion and operational practices in place • Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee • Business case approved by Partners • Monthly report to Board and partner organisations	meeting External assessment – CQC/Audit STP Scrutiny Health and Wellbeing Board Reporting Scrutiny Committee
Gaps in Control	• No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust • Commissioner contracts not yet aligned to Walsall Together • Data needs further aligning to project a common information picture • Effective engagement with community in development with local groups • Organisational development for wider integrated working not yet outlined or agreed		
Assurance:	• Risk management now underway at a locality level. • Divisional quality board now starting to look at the integrated team response.	• Walsall Together included on Internal Audit Programme • Walsall Together Committee in place overseeing assurance of the partnership • STP oversight of 'PLACE' based model • Reporting to Board and Partners • Oversight on service change from other committees	• NHSE/I support of Walsall Together • STP support
Gaps in Assurance	• Internal Audit not complete • Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections		

Future Opportunities

- Further development of the Governance around risk sharing
- S75 Deployment based on other services
- Pooled resources and pathway redesign such as out patients
- PCN partnership alignment and risk share
- Covid-19 offers an opportunity to increase the pace of delivery and more importantly stress test benefits before substantive deployment
- Strategic partnership(s) with major primary care organisations to further accelerate vertical and horizontal integration of care in the borough
- Formal contract through an ICP mechanism
- Formal working with other partners to support their ability to achieve additional income and support via a partnership approach
- QC action oversight group

Future Risks

- Insufficiently robust evidence of impact
- Insufficient promotion of success narrative
- Inability to deliver enough investment up front to change demand flows in the system.

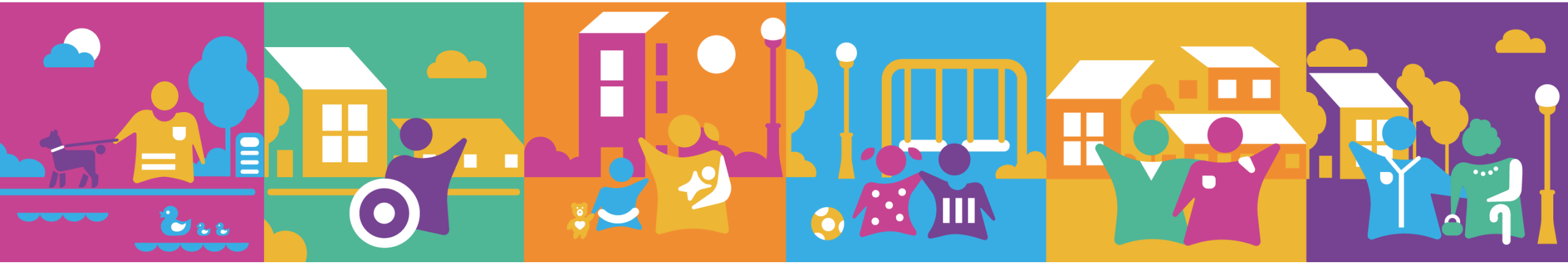
- National influences on constitutional targets moves focus from place to STP
- Retention of inspirational and committed leadership across partners
- Estates – ability to fund the full business case offering (4 Health & Wellbeing Centres)
- Misalignment of provider strategies created by mergers or form changes or senior personnel turnover
- Lack of uninterrupted community clinic space due to Covid Restrictions

Further Actions (to further reduce Likelihood / Impact of risk in order to achieve Target Risk Level in line with Risk Appetite)					
No.	**Action Required**	**Executive Lead**	**Due Date**	**Quarter 1 Progress Report**	**BRAG**
1.	Agree a joint business plan for Walsall Together and PCNs that describes how the enhanced and additional roles within the PCN contract will integrate with community services	Daren Fradgley	Dec 20		
2.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations	Daren Fradgley	Dec 20		
3.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital workstream)	Daren Fradgley	Mar 21		
4.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure. This should include an outline governance structure that shows the links to other WHT committees and acknowledge the transition to holding a formal ICP contract.	Jenna Davies	Mar 21		
5.	Agree a Communications & Engagement Strategy for Walsall, aligning work across all partner organisations, that clearly articulates the ambition for addressing health inequalities and how we will achieve coproduction with our citizens and communities	Daren Fradgley	Dec 20		
6.	Prepare for implementation of a formal ICP contract under a Lead Provider model with WHT as Lead Provider. This will include confirmation of all services in scope and a clear rationale for the change in the context of improving outcomes for the population.	Daren Fradgley	April 21		

Walsall Together

Walsall Together Partnership Operational Update

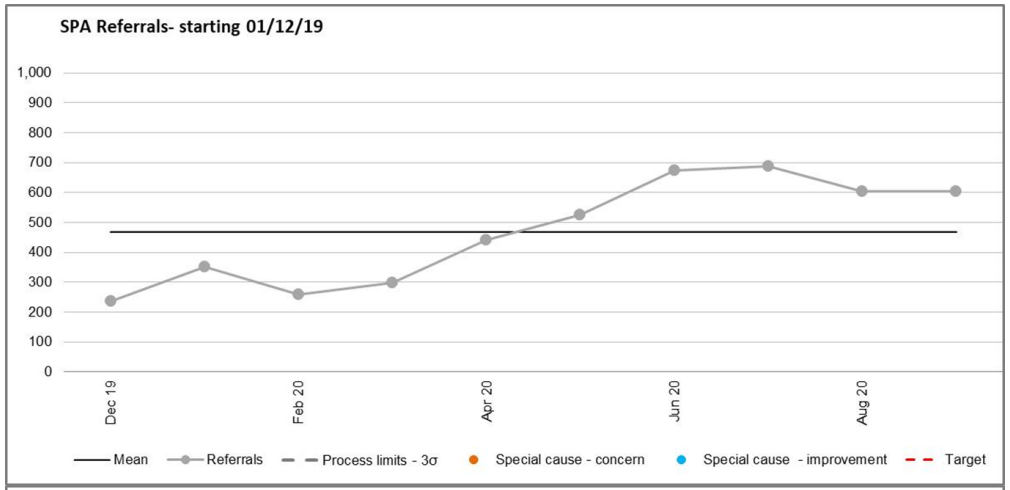
Daren Fradgley
Director of Integration / Deputy CEO

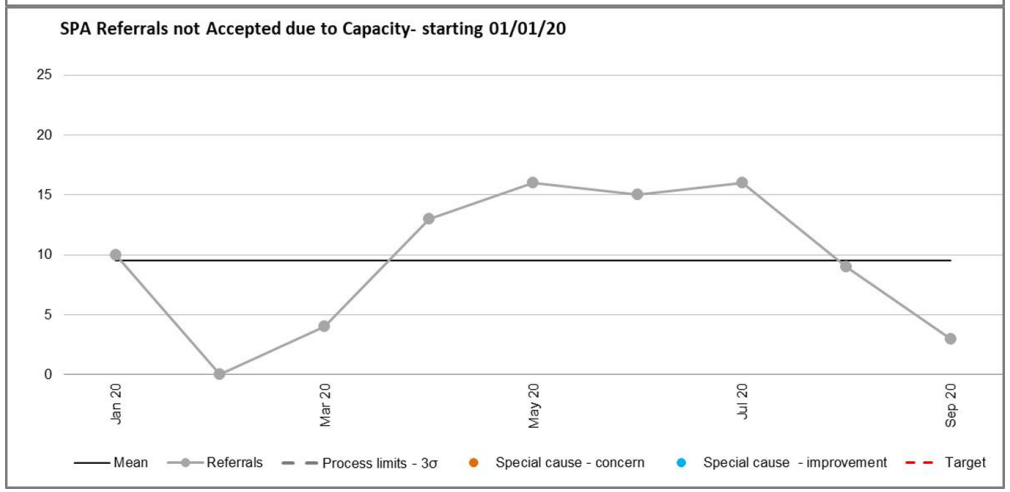


Collaborating for happier communities

Contents

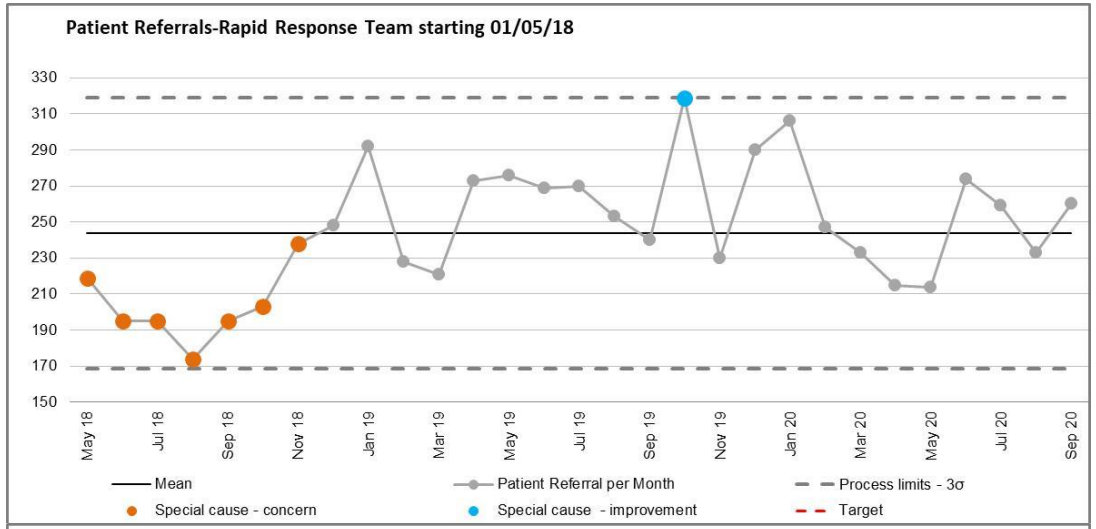
Care Coordination Service

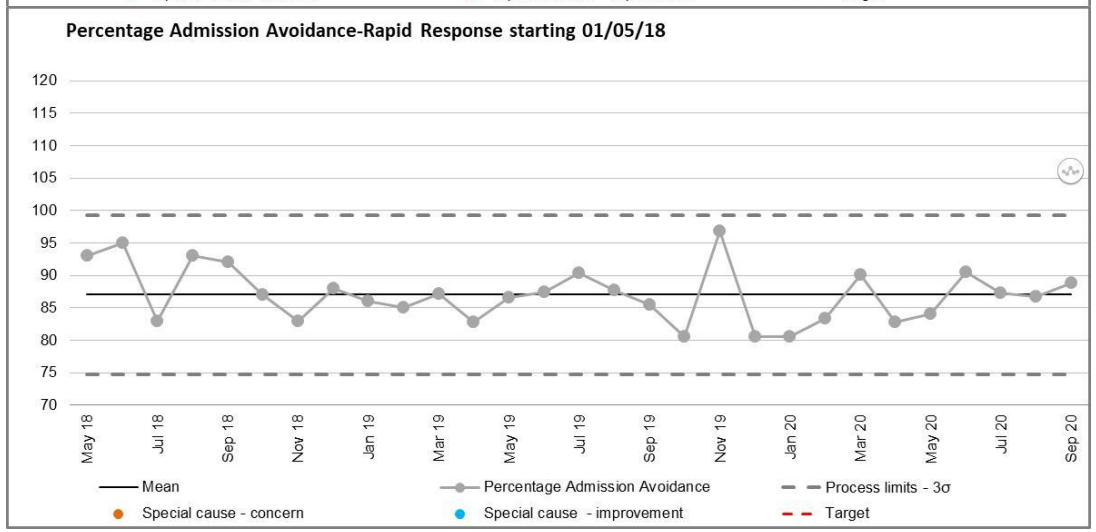




- The number of referrals for Care Coordination Centre remains stable and capture patients that without timely intervention would result in an attendance at ED. These have been mainly from GPs. A focused piece of work is underway to increase the referral numbers from WMAS and other partners as part of the resilience plans for winter and preparation for wave 2 Covid
- The Centre will shortly become a stand-alone service as planned, with continued recruitment in progress. Initially the service will deliver 8-6pm, 7 days a week, but increased through recruitment to support additional hours.

Rapid Response

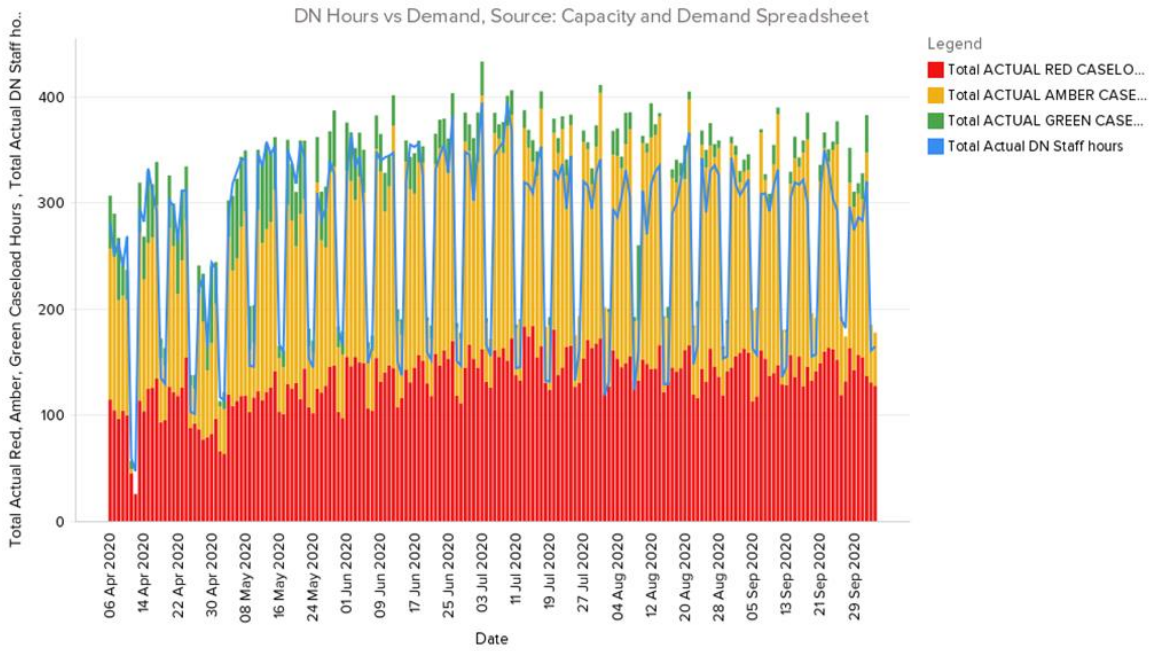




- This chart shows the activity for Rapid Response over a longer time frame. The aim was to have at least 300 new referrals into Rapid Response per month. The Care Coordination / SPA function is receiving levels of referrals as planned but it transpires that the triage function is able to deal with them using other resources available within the community rather than via Rapid Response.

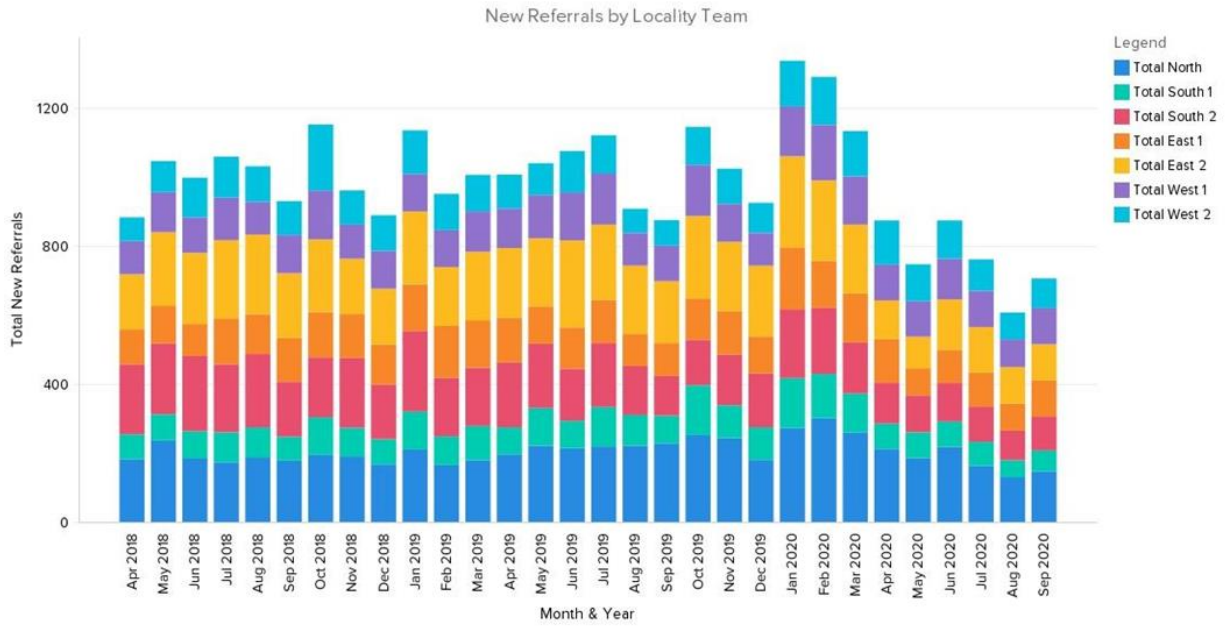
- This provides the opportunity to work with WMAS to increase the level of referrals into the Care Coordination Centre as the capacity exists to deal with them

Community Nursing Capacity and Demand



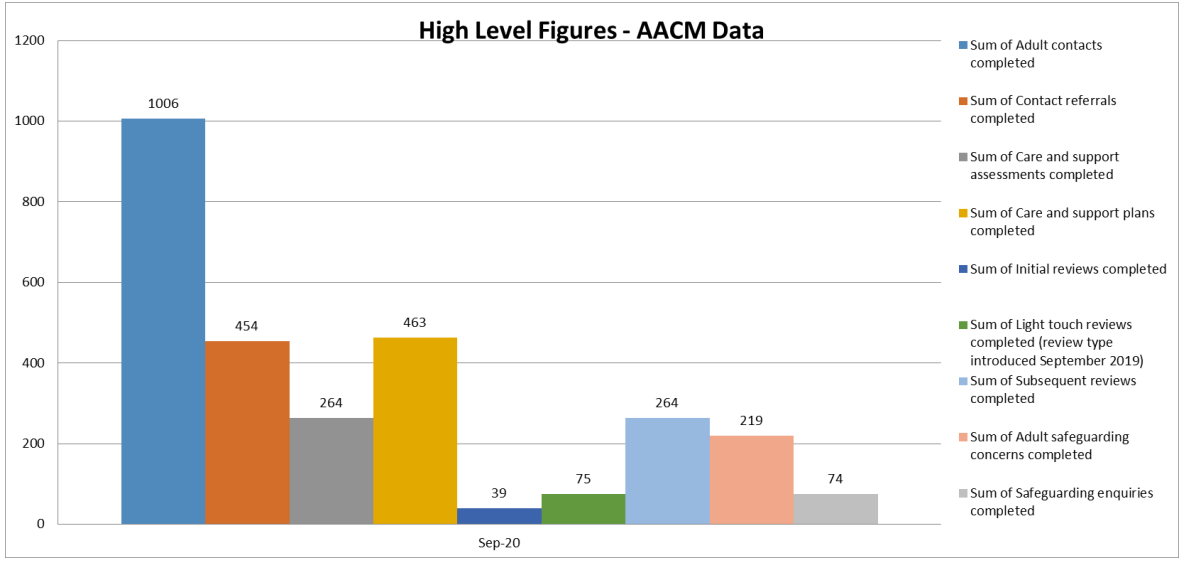
- The case mix / demand profile for community services is changing with more amber-rated patients and fewer green rated ones. This is a direct result of the continued complexity being managed within the community
- There are still shortfalls in capacity however these are at a lower rate than pre-Covid and are dynamically managed on a daily basis. Additional hours have been put into the system to respond to the growing complexity largely by more efficient use of the staff hours. However greater gains from a programme work focusing on self care will be the next urgent step required to release additional capacity

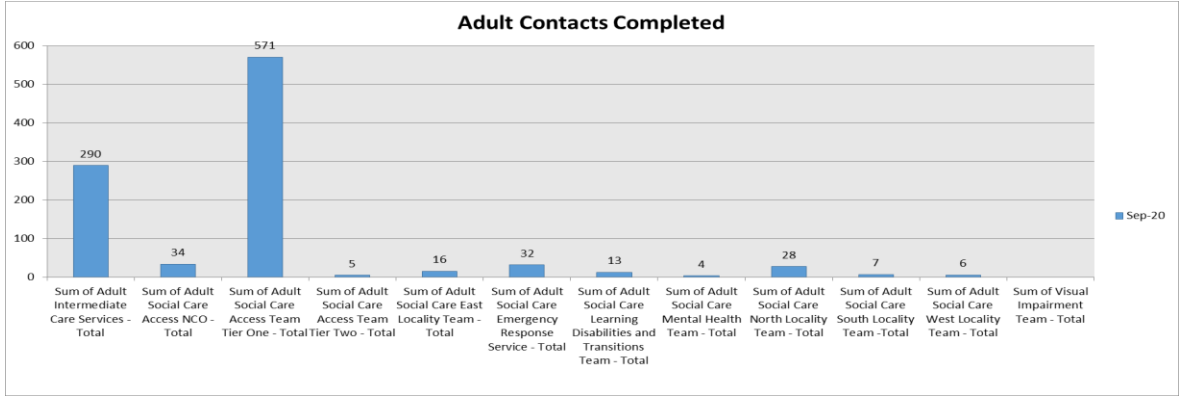
Locality Teams New Referrals



- The number of new referrals is lower than usual and in part this reflects the reduction in hospital-based elective activity that would have generated demand (e.g. wound care)
- A reported in previous months, the patients normally newly referred into the service are now already know due to case load now present. It is considered a formal shift the in the patient flows that is not expected to change post covid and work on outpatient re design will follow shortly to support the activity shift

Adult Social Care



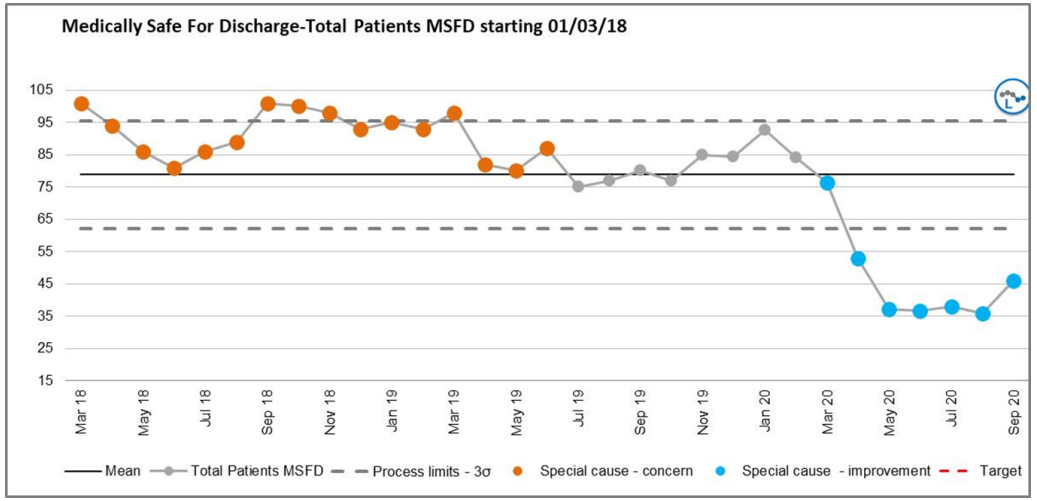


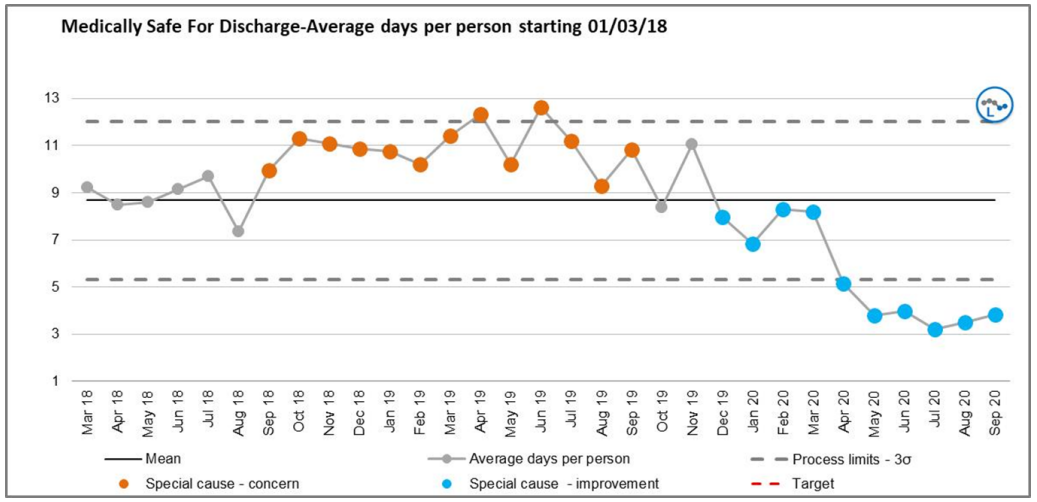
The slide for ASC has been revised to show the work and output for the service this month.

This is work in progress but also show the trend and going forward the locality trends.

Now that the section 75 is live a full integrated reporting suite is in development that will show health and care data together rather than in sperate slides. This will evolve over the next 3 months

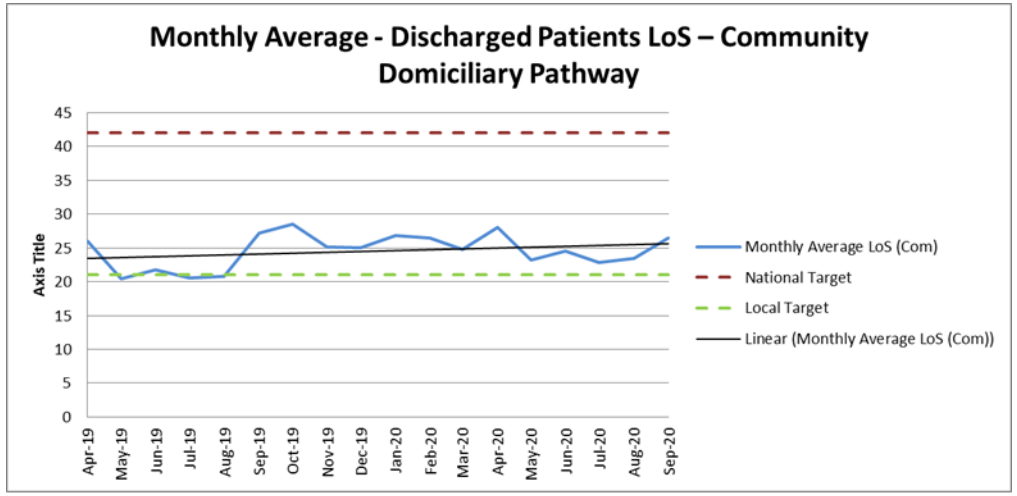
Medically Stable for Discharge

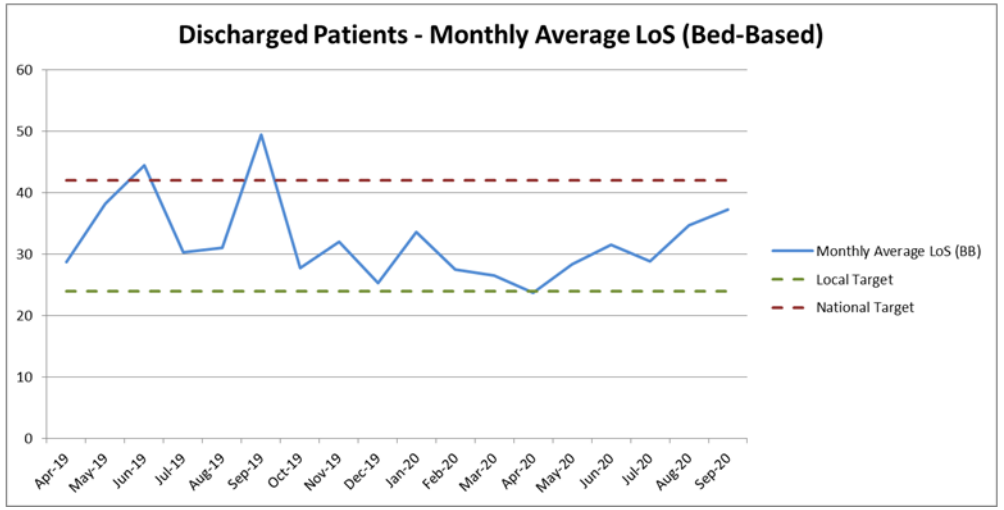




- Covid actions that are aimed at reducing both numbers and length of stay remain standard practice, the demand for ICS services for discharge pathways is increasing.
- The activation of DSTs to exit ICS pathways has commenced as of 1st September. With some early signs of success. However this will eb fully monitored as we move into the winter months and at the time of writing the numbers are more challenged by the infection control processes around this patient group than the DST process.
- Recruitment in progress for additional Nurse to support new practice of trusted assessor and all ward referrals/ paperwork. Additional support being sourced- supported funding from CCG.

Domiciliary and Bed-Based Pathways





- While the length of stay of patients being discharged from community pathways remains stable, this does not reflect on the fact that there is a significant cohort of people in community beds awaiting DST (64 people @ 08/10/20)
- The DST process has now been resumed, this enables new DSTs 6 weeks to process and work on the backlog at the same time.
- Swabbing: PHE guidance indicates that all staff going into homes should have weekly Covid swabs to ensure they are clear, but Community Services are unable to access swabs in sufficient numbers to implement this.
- Reduced access to care homes is a broader significant risk in terms of the ability of the health care system to review residents and provide early clinical interventions and may impact on the work of the Enhanced Care Home Team which launched for Older people care homes on the 1st October.

Care Home Update

- Daily data collection continues between the Quality in Care team and homes:
  - Resident numbers have increased slightly. Vacancy levels remain significant
  - Deaths have returned to normal levels
  - 2 COVID-19 deaths since start of June (0 since end of July)
  - Public Health monitoring and responding to suspected/confirmed cases and outbreaks

- Care homes have access to swabbing via national online portal. Challenges remain and increasing with system:
  - Increased delay in return of results
  - Increased number of staff testing positive

- Risk stratification currently not identifying any issues of concern outside of known outbreaks. Sites continuing to add to national tracker

Care Homes Update

Provider	Covid-19 - Confirmed or suspected Deaths	Non Covid 19 related since 1st of April 2020	Overall deaths since 1st of April 2020.
1	0	53	53
2	6	43	49
3	17	3	20
4	6	13	19
5	13	3	16
6	8	7	15
7	2	11	13
8	8	4	12
9	7	5	12
10	7	5	12

Total Number of Homes
57

Total Number of Beds
1769

Total Number of Residents
1303

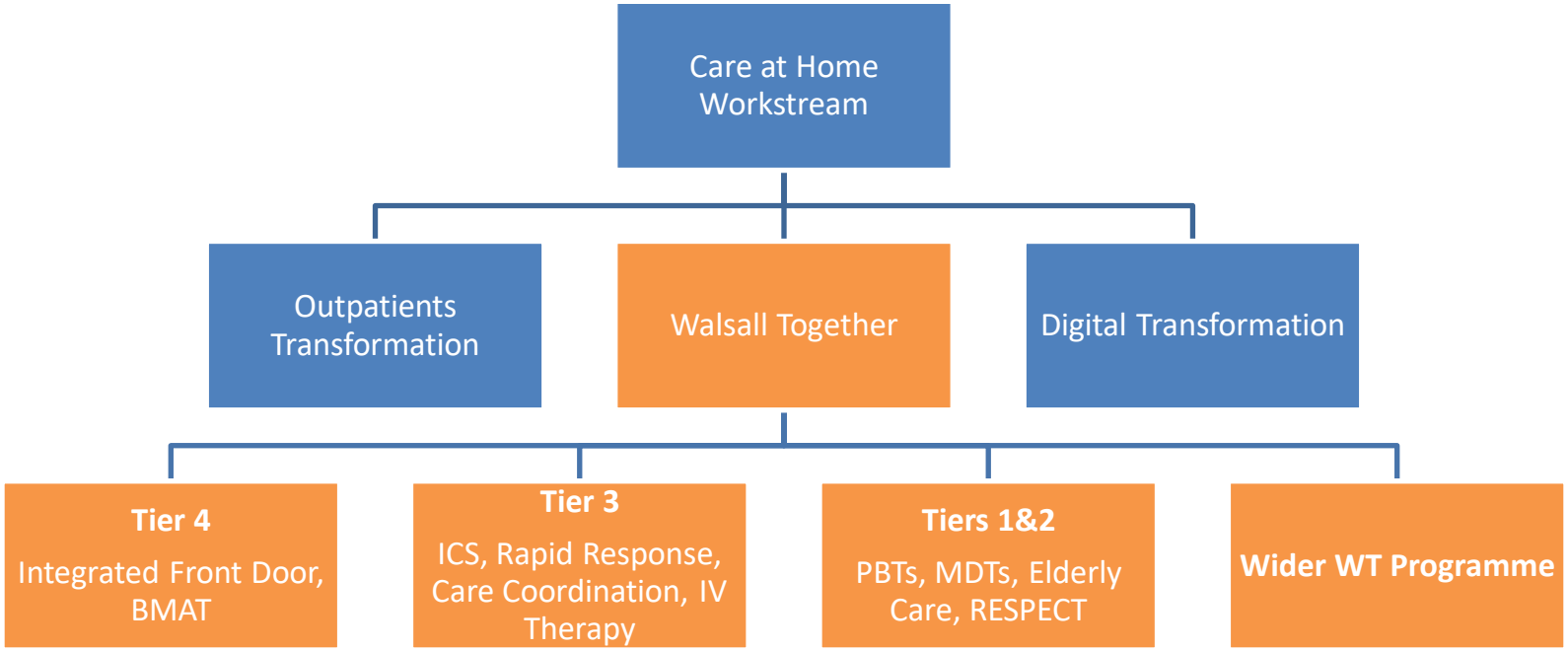
Total Number of Staff
1972

Total Staff Absence
97

Total Number of Deaths (Self-Reported)
350

Suspected COVID Deaths (Self-Reported)
141

Care at Home Workstream Structure



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

Project Admin							PID Generation							Project Tracking							Risk Summary Status		
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Enagement	QIA/EDI	PID Sign-off	Project Mobilisation	Define & Scope	Measure & Understand	Design & Plan	Pilot & Implement	Sustain & Share	Benefit Assessment and Project Close-out	Project Delivery	Project Resource Availability	Benefits Realisation
CaH 1	Care at Home	Outpatient Transformation (One PID has been completed for these areas)	Advice and Guidance rollout	Keith Dibble / Jane Hayman	Cross Division	Jane Hayman / Kay McHugh				Drafted									TBC	TBC	Amber	Amber	Amber
CaH 2			Virtual technology roll out	Keith Dibble / Jane Hayman	Cross Division	Richard Pearson / Roz Geary				Drafted						N/A			TBC	TBC	Amber	Green	Green
CaH 3			Referral Assessment Service	Keith Dibble / Jane Hayman	Cross Division	Jane Hayman / Kay McHugh				Drafted								TBC	TBC	TBC	Green	Amber	Green
CaH 4			Implement Modality outpatient clinics	Keith Dibble / Jane Hayman	MLTC & Surgery	Modality Partnership				Drafted						N/A		TBC	TBC	TBC	Amber	Amber	Amber
CaH 5		Walsall Together	BMAT	Ann-Marie Riley?	Cross Division	Jo Adams?															Red	Red	Red
CaH 6			Integrated Front Door	Matthew Dodd	MLTC & Community	Michael Cox																Red	Red
CaH 7			ReSPECT	?	Cross Division	Michael Cox															Amber	Green	Green
CaH 8			Maternity (TBC)																				

Project Progress Key:
- Blue - completed
- Green – Mature / Good progress
- Amber - Maturing / Slow Progress
- Red - No significant progress
- Blank - Not planned to start / Not relevant

Workstream / Project Admin Info

PID Development Status

Project Implementation Status

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	**Risks required from Walsall Together**		
	Resource supporting the OPD transformation has been diverted back into EPR and secondment of specialist from NHSD concludes on 9th October	R	Resourcing model required as part of Phase 2 planning
	Resource for funding the Modality partnership / activity is not agreed	R	Update requested from Executive team
	There is insufficient capacity in community estates to enable the roll out of Community Outpatients clinics with partners in each of the localities	A	It may be that a community hub can be developed at a vacant GP practice setting at Pelsall Village. Community services are currently embarking on the capacity required for services going forward
Issues	**Issues required from Walsall Together**		
	SOP developed that makes clear the mechanism for capturing face 2 face (F2F) telephone and telemedicine activity, however < 15% have been identified to date. This puts contract setting for 2021/22 at risk	A	Numbers are slowly increasing and time lag was always anticipated. Access / Booking team engaged now which should see number increasing going forward. This is being monitored weekly through the project team.
	General Practice feel dis-engaged from the clinical model development at WHT	A	Invite GP representation to the planned outpatient workshop. Improve WHT engagement at Clinical Advisory Group

MEETING OF THE PUBLIC TRUST BOARD – 5th NOVEMBER 2020			
Working with Partners			**AGENDA ITEM: 23**
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer	**Responsible Director:**	Ned Hobbs, Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Working with Partners Strategic Objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. The Collaborative Working and Integration Executive Group Meeting (CWIEG) between Royal Wolverhampton Hospital NHS Trust (RWT), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT) has now been reinstated and has met on 30th June, 11th August and 13th October since reinstatement. The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals. This report highlights particular progress in Urology, Dermatology and Radiology services.		
Recommendation	Members of the Trust Board are asked to note the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S04 Working with Partners to provide positive assurance the mitigations in place to manage this risk and the related corporate risks There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		

Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☐	

WORKING WITH PARTNERS

Executive Report

1. EXECUTIVE SUMMARY

COVID-19 affected the ability of the Trust to formally oversee and manage the programme of integration between Acute Hospital services. However, COVID-19 has necessitated significant collaboration between Trusts on many matters including mutual aid for Personal Protective Equipment, standardisation of policies in relation to the workforce, approaches to restoration and recovery planning, and shared learning to deal with a novel virus pandemic.

As a result, collaboration between Black Country Trusts is stronger due to the experience of this year. There is a clear appetite to use this opportunity to build upon those foundations and progress functional service integration where there is a clear opportunity to improve care for the patients we serve and/or to improve the working lives of our staff. There is also growing evidence of collaborative working in the context of Restoration & Recovery of services following the initial peak of COVID-19 within the Black Country.

The Board Assurance Framework (BAF) risk has been extensively reviewed and materially re-written. It was received and endorsed by Performance, Finance & Investment Committee in September 2020.

2. BOARD ASSURANCE FRAMEWORK

The BAF risk recognises the risk, previously shared with Trust Board that COVID-19 affected the pace with which functional collaboration with Acute Hospital partners in the Black Country could progress. The Collaborative Working and Integration Executive Group Meeting (CWIEG) between Royal Wolverhampton Hospital NHS Trust (RWT), The Dudley Group NHS Foundation Trust (DGFT) and Walsall Healthcare NHS Trust (WHT) has now been reinstated and has met on 30th June, 11th August and 13th October since reinstatement.

The BAF risk was reviewed in detail by the Chief Operating Officer, Medical Director and Director of Governance. The risk has been brought up to date to reflect the evidence of successful partnership working, the demonstrable progress in functional service integration in further specialties now, but also the risk that the pace of partnership integration work may be impeded by limited leadership capacity and by the lack of formal integration at organisational levels between Trusts. A specific BAF risk action related to ensuring the Imaging Network programme has sufficient resources allocated to it has been added.

3. IMPROVEMENT PROGRAMME

The Working with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals overseen through CWIEG to support improved patient care, and improved working lives for our people. Key highlights from the last month, to draw out for the Board's attention are as follows:

Urology

The important workstream of Urology has been reinstated and held its first network workshop since COVID-19 on 22nd September 2020. The session reviewed a Urology Cancer Network presentation, Clinical Nurse Specialist collaboration, delivery of 7-day service standards, and provision of sub-specialist female urology services for which the Black Country is under-served and for which Walsall has expressed interest in being the lead provider for.

Furthermore, Urology services are undertaking a capacity and demand review of emergency workload to inform joint on-call arrangements with a formal Urology Network across the Black Country including Royal Wolverhampton, Walsall Healthcare, Dudley Group and Sandwell & West Birmingham Trusts. The Trust continues to recognise that a joint approach to on-call and cover of emergency Urological admissions with Wolverhampton would be beneficial.

Work continues to identify benefits of joint approaches to Cancer Multi-disciplinary Team (MDT) and Specialist Multi-disciplinary Team (SMDT) meetings to support with expediting diagnostics and treatment for our patients. Internally, Urology are reviewing Consultant job plans to maximise the productivity within the service.

Work continues to define and confirm future arrangements for both cancer and benign elective services and emergency urology services. The Urology network is now progressing with greater pace and it was agreed that any formal changes made would target commencement on 01 April 2021.

Radiology

Whilst there were no further meetings were scheduled in October, the Imaging Network will now form part of the wider collaborative networks across the Black Country. The Key projects remain the same:

<u>Community Diagnostics Hubs</u>

Following an agreement to co-locate Community Diagnostic Hubs with Rapid Diagnostic Centres, there was agreement between the Trusts of the need to lead this

within the NHS, as opposed to by independent sector providers. The Organisational Leads are being identified to progress this.

Workforce - service resilience, numbers and skill mix

The expectation is that the metrics from each organisation be shared at the next meeting in relation to: outsourcing and clinical and practitioner staffing.

Assets - location, usage, and leveraged procurement opportunities

Work continues to quantify usage across Trusts with a view to leverage the economy of scale across the Black Country and reduce equipment costs.

Demand, capacity & performance insights

Demand and capacity modelling and forecast activity projections have been undertaken for Diagnostic services, including Radiology, as part of the response to Sir Simon Stevens and Amanda Pritchard's Phase 3 letter. The letter includes the ambition to return to 100% of pre COVID-19 activity levels in October 2020.

The Imaging Team has already begun to reap benefits from working collaboratively by seeking to adopt best practice and identifying areas for improvement using benchmarking. A Multidisciplinary Service meeting was held with the wider Imaging team, week commencing 19 October 2020. Following a review of the report Diagnostics: Recovery and Renewal October 2020 from the Chair of the Independent Review of Diagnostic Services for NHS England, Professor Sir Mike Richards CBE, a workforce plan is being developed. This includes the introduction of Associate Practitioners for Imaging, a well-established role nationally that we are yet to adopt.

Dermatology

Progress continues in the Dermatology workstream, supported by the joint Clinical Directorship of Dr James Halpern. Workstream groups continue to meet regularly and project team meet weekly. An overarching programme plan with milestones, risks and benefits has been completed and is monitored by the project team and steering group.

We are currently identifying, funding and developing a cross-site Matron post. Cross-site working is being scoped and honorary contracts being put in place to allow RWT nurses to assist with patch test and photochemotherapy (PUVA) clinics and training for WHT nurses. There are some capacity issues with nurse clinics at RWT presently due to delays from Circle in taking on the phototherapy contract.

The draft business case for Microscopically Controlled (Mohs) Surgery is progressing with costings for necessary Estates work on RWT site being worked up. The case will be presented at Steering Group meeting for initial approval to move forward. The SLA

between the two organisations will be developed over the coming months on similar principles to that of the Black Country Pathology Service.

Paediatric surgery pathways are now in place at RWT, unfortunately, delayed due to Estates work needed to accommodate paediatrics in what is usually adult clinic space. Joint clinics between Dermatology and Paediatrics have begun. There is now a mandatory photography system in place to reduce clinical risk in cancer pathways.

Medical students are now rotated to WHT for General Dermatology teaching.

Demand & Capacity work is being undertaken on both sites and workforce analysis is to be started. The first Dermatology Newsletter has been developed and distributed to all staff, and an information session was held last week to keep the wider teams updated on progress.

The next Dermatology Partnership Steering Group meeting is scheduled for 10 November 2020.

HSDU

The Trust has now received a draft report on opportunities for collaboration in the delivery of Sterile Services. This report will be received by the Trust Management Board in November, jointly presented by the Division of Surgery, and the Estates Division.

4. RECOMMENDATIONS

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

APPENDICES

1. BAF SO3
2. Improvement Programme update

Risk Summary			
BAF Reference and Summary Title:	**BAF S03 Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System**		
Risk Description:	**Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.**		
Lead Director:	Medical Director	**Supported By:**	Chief Operating Officer & Executive Director for Planning and Improvement
Lead Committee:	PERFORMANCE, FINANCE, AND INVESTMENT COMMITTEE		
Links to Corporate Risk Register:	**Title** • There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce		**Current Risk Score** **12 (Moderate)**

Risk Scoring

Quarter	Q1	Q2	Q3	Q4	Rationale for Risk Level	Target Risk Level (Risk Appetite)		Target Date
Likelihood:	**3**	**3**			This risk has been reduced to moderate due to the advancement of a number of key work streams. Black Country Pathology Service (BCPS) • Executive group established across provider organisations to review opportunities for collaboration • Transfer of WHT payroll service to RWT • Advanced collaboration in dermatology including appointment of joint clinical director Advanced discussions in Urology including cross site working • Integrated ENT on-call rota in place • Initial discussions re: bariatric services and radiology • STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy • Advanced discussions taking place with RWT to create a shared Clinical	**Likelihood:**		31 March 2021
Consequence:	**4**	**4**				**Consequence:**		
Risk Level:	**12**	**12**				**Risk Level:**	**2 (low)**	

					Fellowship Programme. Despite progress, integration plans are not yet fully implemented		

Control and Assurance Framework – 3 Lines of Defence			
	1st Line of Defence	**2nd Line of Defence**	**3rd Line of Defence**
Controls:	• Collaborative working and integration executive group in place • Sustainability review process completed • Regular oversight through the Board and its sub committees • Improvement Programme to progress clinical pathway redesign with partner organisations		• Third line of control NHSE/I regulatory oversight • Black Country and West Birmingham STP plan and governance processes in place
Gaps in Control	• Lack of co-alignment by our organisation and neighbouring trusts • Lack of formal integration at Trust level • Mandated arrangements by regional networks		
Assurance:	• Track record of functional integration of clinical services including hyper acute stroke, vascular surgery, cardiology, rheumatology, ophthalmology, neurology, oncology, black country pathology service and OMFS	• Demonstrable evidence of functional integration in ENT, Urology and Dermatology • Three out of the four Acute Collaboration partners have committed to collaborative working. • Audit Committee has oversight of partnership working within its terms of reference. • System Review Meetings providing assurance to regulators on progress	• Progress overseen nationally and locally
Gaps in Assurance	• Clinical strategy is still emerging • CCG currently in a state of transition • Additional pressures with Covid-19 have delayed acute collaboration • Sandwell and West Birmingham NHS Trust has not yet committed to formal collaborative working. • Limited independent assessment of integrated services or collaborative working arrangements		

Future Opportunities

- Strengthen formal collaboration with Sandwell & West Birmingham
- Consolidate other services, including back office functions
- Collaborate with partner organisations outside the Black Country, including community and third party organisations
- Promote Walsall as an STP hub for selected, well-established services
- Collaborative working during COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign

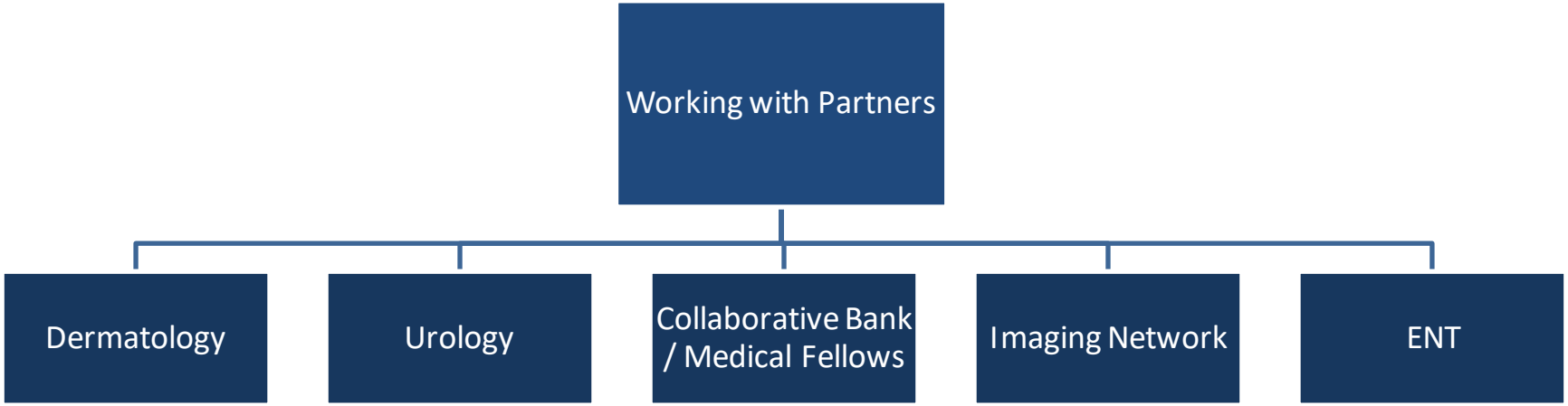
Future Risks

- Conflicting priorities and leadership capacity to deliver required changes
- STP level governance does not have statutory powers
- Lack of engagement/involvement with the wider public
- Acute Hospital Collaboration may not progress at the anticipated pace if a resurgence of COVID-19 coincides with a challenging winter.
- Disrupted relationships with neighbouring trusts due to altered visions of the form and pace of future collaboration

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

No.	Action Required	Executive Lead	Due Date	Quarter 1 Progress Report	BRAG
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020		
2.	Develop over-arching programme plan to support individual projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work).	Programme Manager	Dec 2020		
4.	Assess resource requirement to support Imaging Network programme	G Augustine & N Hobbs	Nov 2020		

Working with Partners Workstream Structure



Working with Partners Workstream Development update
October 20 IP Board / PFIC

	Project Admin							PID Generation							Project Tracking							Risk Summary Status		
	Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Enagement	QIA/EDI	PID Sign-off	Project Mobilisation	Define & Scope	Measure & Understand	Design & Plan	Pilot & Implement	Sustain & Share	Benefit Assessment and Project Close-out	Project Delivery	Project Resource Availability	Benefits Realisation
	PW 1	Partnership Working	Functional Collaboration	Dermatology	Kate Salmon	MLTC	Sarah Haywood															Green	Green	Green
	PW2			Urology	Kim Skeling	Surgery	Julie Earl															Green	Green	Green
	PW3			Collaborative Nurse Bank	Gaynor Farmer	Corporate	Gaynor Farmer															Green	Green	Amber
	PW4			Medical MTI	Charlotte Hil	Corporate	Charlotte Hil															Green	Green	Green
	PW5			Imaging Network	Delreita Ohai	WCCSS	Alan Deacon															Green	Green	
	PW10																							

Project Progress Key:
- Blue - completed
- Green – Mature / Good progress
- Amber - Maturing / Slow Progress
- Red - No significant progress
- Blank - Not planned to start / Not relevant

Workstream / Project Admin Info

PID Development Status

Project Implementation Status

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	For Dermatology and Urology projects there is a risk that the on-going Covid pandemic will delay progress	R	Significant progress on Dermatology has been made utilising Teams meetings and regular monthly meetings have now been established for Urology. Covid and winter plans to be put in place to mitigate impact on service provision
	Dermatology – Lack of clinical engagement on both sites	A	Clinical Director appointed to work across both Trusts
	Nurse Bank - Nursing staff not transient enough to avoid agency	A	No support required
	Imaging Network - Project Affordability. WHT may be a smaller party in a much bigger collaboration.	A	Project support required
Issues	IT Interface between the Walsall and Wolverhampton sites	A	
	Decommissioning of General Dermatology services at RWT has resulted in a reduction in budget. As a consequence service is potentially over established	R	Over establishment will need to be addressed through redeployment or vacancies, however there is potential for PUVA and Biologic clinics to be sub-contracted back to RWT which will mean it will be necessary to retain staffing levels.
Dependency	• Collaborative Working and Integration Executive Group • STP Bank Collaboration Programme • PACS replacement • New equipment implementation		

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Audit Committee Highlight Report			**AGENDA ITEM: 24**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Mr Sukhbinder Heer Chair of Audit Committee (Non-Executive Director)
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Audit Committee meeting on 12th October 2020. The report sets out escalations for the attention of the Trust Board, and key issues discussed and work underway. 1. The Board agreed that the Chair of the Audit Committee will provide assurance on the effectiveness of risk management at the Trust. This will be done bi-annually, and is included in the Committee's cycle of business. The assurance report is attached at Appendix 1. 2. The Committee approved its revised cycle of business following amendment to its Terms of Reference in August. 3. Concern was raised by the Committee that there was reduced focus on internal audit responses. A review is therefore taking place of the timelines on outstanding recommendations, bearing in mind realistic timeframes for their implementation, together with any flexibility that might be built into the audit plan given the current COVID-19 and winter pressures. The next meeting of the Audit Committee will be on 18th January 2020.		
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Audit Committee is essential to Trust Board managing risk across the organisation.		
Resource implications	Poor internal control and/or management of risk would almost certainly result in financial loss.		

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

Appendix 1

Risk Management Assurance

The Trust recognised weaknesses in the approach to risk management, both from the maturity of the systems and processes but also the understanding of risk management across the workforce, and this was highlighted as part of the Trust's Annual Governance Statement for 2019/20

Internal Audit conducted a risk management review as part of its 2018/19 plan, for which the Trust received 'no assurance'. As part of the 2019/20 review the Trust received an improved assurance rating as some progress had been made by the Trust in developing its risk management arrangements during the year. The 2019/20 review concluded that the Trust needed to prioritise the strengthening of risk management arrangements to ensure that the overall governance underpinning the Trust's delivery of its strategic objectives is a firm foundation, creating the ability to remain agile within the current challenging health environment.

In response to the internal audit reports and ongoing concerns highlighted within the Annual Governance Statement, the Trust developed a robust action plan to address the issues. On the request of the Board it was agreed that a biannual assurance report from the chair of Audit Committee would be presented to provide assurance on the progress being made against the plan.

At the August Audit Committee, we received the full Board Assurance Framework which had been presented to the relevant Committees. The Committee chairs provided assurance that their Committees had adequately reviewed and challenged the Board Assurance Framework. The Committee approved a revised reporting framework for the Corporate Risk Register and the Board Assurance Framework.

At the meeting in October the Committee was once again provided with a full Board Assurance Framework on the updated template. As part of the updates from each of the Committees they provided feedback to the Committee on the Board Assurance Framework and any areas of positive or negative assurance, together highlighting gaps in control.

To assist the Audit Committee to provide assurance to the Board, Audit Committee agreed with Internal Audit colleagues that they would provide an assurance report throughout the year. The first report was presented to the Audit Committee in October and provided detail against the 2 Board Assurance Framework recommendations (and resulting 6 actions) and 7 Risk Management recommendations (and resulting 14 actions) from the previous internal audit reports.

The report from internal audit provided members of the Audit Committee with assurance that progress was being made in line with the agreed plan. From the high-

risk recommendations, internal audit provided assurance that the revised reporting met the required standards and was being consistently reported across all of our Board Committees and into the Board. Internal Audit also provided assurance on the strengthening of the risk management Governance both at Board Committee level and also at the Executive level with the establishment of an Executive Risk Management Committee chaired by the Chief Executive.

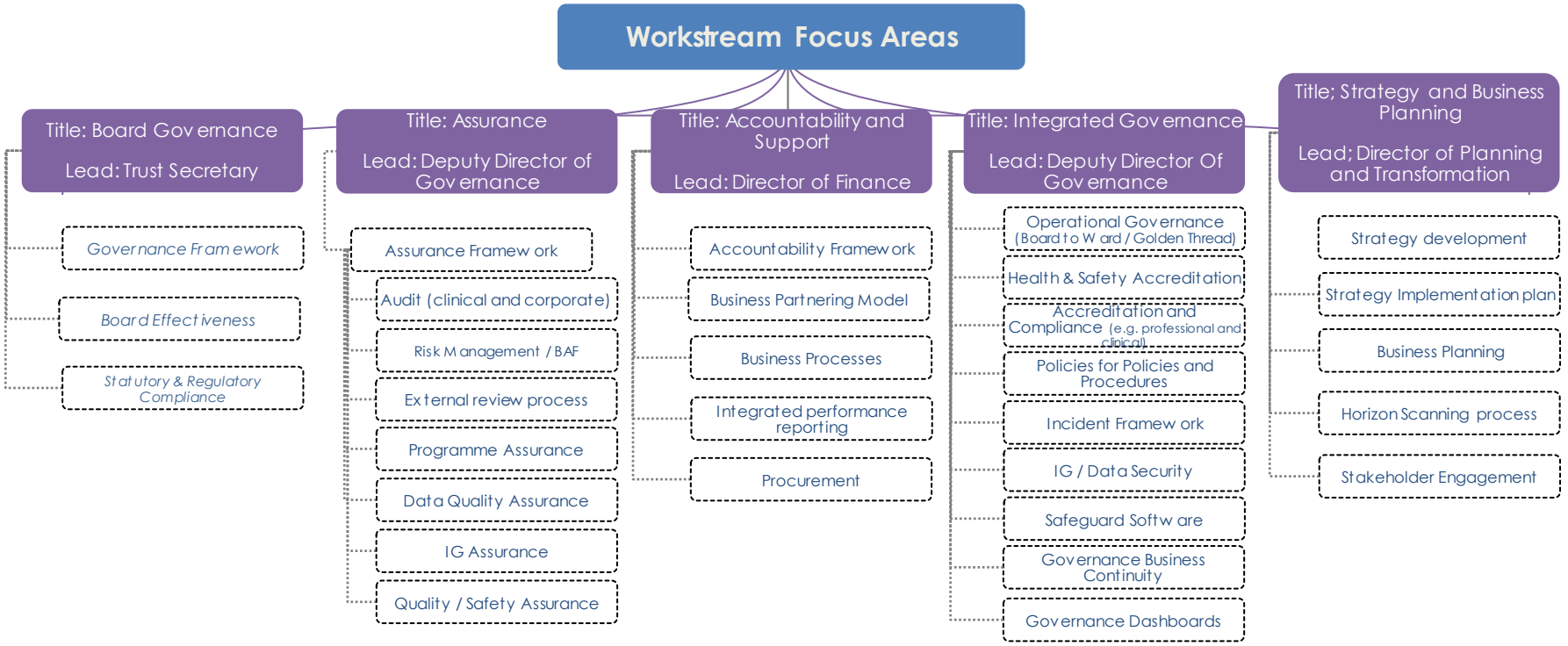
At the Committee meeting we noted that a number of actions were due to be completed in October and we will receive an update on these recommendations at our meeting in January.

As an Audit Committee we are pleased and assured that positive progress is being made, we note there is still progress to be made on embedding the three lines of defence, and ensure that communication between committees in terms of risk is improved.

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Well Led Improvement update			**AGENDA ITEM: 25**
Report Author and Job Title:	Dave Dingwall Programme Lead	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The overall aim of the well Led improvement workstream is to improve the Trusts leadership, governance and assurance structures using the CQC Well Led Key Lines of Enquiry (KLOE). This workstream was added to the improvement in April 2020. The workstream is now being supported by a programme manager, which has enabled for the existing Project Initiation Documents (PIDs) to be refined and the benefits have been further defined. Progress has been impacted by operational pressures including a CQC unannounced inspection. The Accountability & Support PID / Project documentation has not be available to assess / report. The programme manager has been working with the workstream lead to develop the PID, and the PID will be presented for final sign off ahead of the Improvement Programme Board. The Integrated Governance plan is still at low level of maturity, however the PID will be presented for final sign off ahead of the Improvement Programme Board in November.		
Recommendation	Members of the Trust Board are asked to note the report and the risks to the delivery of the workstream		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Well led workstream is fundamental in terms of Risk Management and improvements of risk management systems and processes. The delivery of actions contained within the workstream will create a stronger control environment within the Trust.		
Resource implications	There is a risk outlined in the paper in relation to resource to deliver the programme, however any additional resource requirements would be requested via business case and appropriate approval processes.		

Legal and Equality and Diversity implications	Boards have a duty to demonstrate measurable outcomes that build patient, public and stakeholder confidence that their organisations are providing Safe and High-Quality care. Robust governance processes and open, transparent leadership should give staff at all levels confidence about their capability to maintain and continuously improve services.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Work Breakdown Structure



Governance & Well Led PID status update
October 2020 IP Board

Project Admin							PID Generation						
Project Ref	Strategic Workstream	Focus Area	Project Title	Workstream Lead	Division / Function	Project Lead	Project Brief	Implementation Plan	Risks, Issues & Mitigations	Benefits / Costs Assessment	Stakeholder Enagement	QIA/EDI	PID Sign-off
GWL 1	Governance & Well-Led	Board Governance	Governance Framework	Trish Mills		TBC							
GWL 2			Board Effectiveness	Trish Mills		TBC							
GWL 3			Statutory & Regulatory Compliance	Trish Mills		TBC							
		Assurance	**Quality Assurance**										
GWL 4			Assurance Framework	Diane Halliley		TBC							
GWL 5			Audit (Clinical & Corporate)	Diane Halliley		TBC							
GWL 6			Risk Management BAF	Diane Halliley		TBC							
GWL 7			External Review Process	Diane Halliley		TBC							
GWL 8			Programme Assurance	Diane Halliley		TBC							
GWL 9			Data Quality Assurance	Diane Halliley		TBC							
GWL 10			IG Assurance	Diane Halliley		TBC							
GWL 11			Quality/Safety Assurance	Diane Halliley		TBC							
		Accountability & Support	**Accountability & Support - high level PID**	Russell Caldicott			TBC	TBC	TBC	TBC	TBC	TBC	TBC
GWL 12			Accountability Framework	Russell Caldicott		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
GWL 13			Business Partnering Model	Russell Caldicott		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
GWL 15			Integrated Performance Reporting	Russell Caldicott		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
GWL 16			Procurement	Russell Caldicott		TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
		Intergrated Governance	**Integrated governance - high level PID**	Nicola Boyes									
GWL 18			Operational Governance - Ward to Board	Nicola Boyes		Nicola Boyes							
GWL 19			Health & Safety Accreditation	Nicola Boyes		Simone Smith		On Hold					
GWL 20			Accreditation & Compliance	Nicola Boyes		Sue Jink							
GWL 21			Policies for policies & procedures	Nicola Boyes		TBC							
GWL 22			Incident Framework	Nicola Boyes		Emily Goss							
GWL 23			IG/data security	Nicola Boyes		Sharon Thomas							
			Ulysses SafeGuard System	Nicola Boyes		Temp - Nicola Boyes							
GWL 24			Governance Business Continuity - refresh	Nicola Boyes		TBC							
GWL 25			Governance Dashboards	Nicola Boyes		TBC							
		Strategy & Business Planning	**Strategy &Business planning - high level PID**	Roseanne Crossey									
GWL 26			Strategy development (2021-26)	Roseanne Crossey		Roseanne Crossey							
GWL 27			NHSEI Annual Plan	Roseanne Crossey		Roseanne Crossey							
GWL 28			Annual Business Planning Cycle (internal)	Roseanne Crossey		Roseanne Crossey							
GWL 30			Stakeholder Communications & Engagement	Roseanne Crossey		Roseanne Crossey							

Key Points to Note:

- Board Governance PID ready for sign-off
- Assurance and Strategy / Planning PIDs maturity well
- Accountability & Support PID / Project documentation unavailable to assess / report
- Integrated Governance plans still at low level of maturity

Key Risks, Issues & Dependencies

	Description	RAG	Board Escalation / Assurance Comments
Risks	Insufficient engagement of colleagues in workstream or solution development	A	Engage Sophie Powers to assist development of Comms and Engagement plan for Gov and Well Led
	Improvement work streams are not fully integrated with the strategic and annual planning and business processes	A	Roseanne attendance at wider IP meetings confirmed
Issues	Identification of sources of compliance information	R	Lessons Learned workshop proposed by JD / DD
	No confirmed resource available to develop revised assurance framework or to be the day to day lead on the Accountability & Support workstream	R	Meeting tba with Jenna / Dave / Russ to resolve
	Core and project team capacity constraints leading to delays in PID development / finalisation	R	CQC reporting has compounded delays, team to carve out time over next 2 wks
Dependencies	Interdependencies between all aspects of the Governance and Well Led workstream to be fully identified and managed	A	Workshop on 30th Sept held to improve alignment
	Safe, High, Quality Care (SHQC) and Valuing Colleagues	A	Cross-workstream dependency workshop held and actions confirmed
	Effective use of Resources – need session to agree dependencies and actions	R	Meeting to be arranged by JD/DD

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Trust Board and Committee Cycles of Business			**AGENDA ITEM: 26**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☒ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	Following a review of the effectiveness of Board Committees and revisions of Terms of Reference, revised cycles of business have been developed for each Committee. As a consequence, the Trust Board annual cycle of business has also been updated to reflect Committee changes. Attached at Appendix 1 is the revised Trust Board cycle of business, which also incorporates the cycle for the Board of Trustees.		
Recommendation	The Trust Board is asked to approve the revised annual cycle of business.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

TRUST BOARD CYCLE OF BUSINESS 2020/21

PAPER	FEEDER COMMITTEE	NOTE ON FREQ.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
Cycled for that month	Agenda setting prompt																
GENERAL																	
Chair's Report	None	Monthly													Chair	Information	To include details of board development programme and board walks
Chief Executive's Report	None	Monthly													CEO	Information	
Patient Story	QPES	Bi-Monthly													DoN	Information	
Staff Story	PODC	Bi-Monthly													DP&C	Information	
Performance Reports* (Operational Performance; Quality and Safety; Finance; Workforce)	PFIC PODC QPES WTPB	Monthly													Various	Assurance	To inform the Board of the performance against the key performance indicators. The Trust has an obligation to meet operational, financial and contractual targets. Committee specific scorecards are presented to Board Committees to facilitate closer scrutiny and support discussions around matters delegated by the Board. *Presented by the Director as part of their executive report under the relevant strategic objective. Quality Dashboard: NQB Guidance - Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board every month: Care Excellence dashboard being developed which will be reported via QPES within the SHQC paper for the quality aspects and red flags; establishment review determines the agreed skill mix etc. and model hospital benchmarks at PODC;
SAFE HIGH QUALITY CARE																	
QPES Committee Highlight Report	QPES	Monthly													QPES Chair	Assurance	To provide assurance on key work of this Board Committee and escalate matters as appropriate
Improvement Programme Update	QPES	Monthly													MD/DoN	Assurance	Updates presented by the Directors as part of their executive report under the relevant strategic objective.
Quality Account	QPES/Audit	Annually													Dir Gov	Approval/Assurance	License Condition FT4. The Board is required to discuss the Quality Account in a public session prior to submission. Quality Account filing date - 30 June
Mortality (SHMI and HSMR) Report	QPES	Quarterly		Q4			Q1 AR			Q2			Q3		MD	Assurance	To monitor the Trust's mortality performance. National requirement to report to Trust Board. Learning from Deaths Framework
Patient Experience Annual Report	QPES	Annually													DoN	Approval/Assurance	
7 Day Services Board Assurance Framework	QPES	Bi-annually?													MD	Assurance	Self-assessments of delivery of the 7DS clinical standards. Formally assured by the trust board twice a year - in spring and autumn.
Safeguarding Annual Report	QPES	Annually													DoN	Assurance	Combined report for children and vulnerable adults. To provide assurance on meeting statutory compliance with safeguarding legislation.
Infection Prevention & Control Annual Report	QPES	Annually													MD	Assurance	To include annual report and annual work plan. Assurance on compliance with Health & Social Care Act Hygiene Code.
PLACE Inspection Findings & Action Plans	QPES	Annually													DoN	Assurance	Patient Led Assessment of the Care Environment (PLACE). Assessment linked to rights of the patient under NHS Constitution to be treated in a clean, safe, secure and suitable environment and to receive suitable and nutritious food and hydration
NHS Resolution Maternity Incentive Scheme	QPES	Biannually													DoN	Assurance	Bi-annual to Board. Board sign off action plan and assurance on compliance. Submission due 20 May 2021.
CQC Action Plans	QPES	Ad hoc													Dir Gov	Approval/Assurance	Action plan agreed by board and then overarching implementation through Board Committees

TRUST BOARD CYCLE OF BUSINESS 2020/21

PAPER	FEEDER COMMITTEE	NOTE ON FREQ.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
CARE AT HOME																	
WTPB Highlight Report	WTPB	Monthly													Chair WTPB	Assurance	To provide assurance on key work of this Board Committee and escalate matters as appropriate
Improvement Programme Update	None	Monthly													DoI	Assurance	Updates presented by the Director as part of their executive report under the relevant strategic objective.
Integrated Care Partnership Update	None	Quarterly													DoI	Assurance	
WORKING WITH PARTNERS																	
Improvement Programme Update	PFIC	Monthly													COO	Assurance	Updates presented by the Director as part of their executive report under the relevant strategic objective.
Acute Collaboration Update	None	Quarterly													CEO	Assurance	
PFIC Highlight Report	PFIC	Monthly													Chair PFIC	Assurance	To provide assurance on key work of this Board Committee and escalate matters as appropriate
Improvement Programme Update	PFIC	Monthly													COO	Assurance	Updates presented by the Director as part of their executive report under the relevant strategic objective.
Winter Plan	PFIC	Annually													COO	Approval/Assurance	To provide assurance that there is a winter plan developed to ensure operational resilience for the winter period.
Business Cases Above £750,000	PFIC	Ad Hoc													DoF	Approval	As required
Agree budget setting principles	PFIC	Annually													DoF	Approval	
Operational Plan	PFIC	Annually													COO	Approval/Assurance	Approval of plan then quarterly updates to PFIC
Financial Plan	PFIC	Annually													DoF	Approval	
Capital Programme	PFIC	Annually													DoF	Approval	
Estates Strategy	PFIC	Annually													COO	Approval/Assurance	Board approves strategy. Updates/Assurance through PFIC report. Date TBC through PFIC
Digital Strategy	PFIC	Annually													DoI	Approval/Assurance	Board approves strategy. Updates/Assurance through PFIC report
Emergency Preparedness Resilience and Response Annual Report and NHS Assurance	PFIC	Annually													COO	Assurance	The Civil Contingencies Act 2004 and NHS EPRR Framework require NHS acute organisations to plan for, respond to and recover from major incidents. Report details the work of the emergency planning team.
VALUE OUR COLLEAGUES																	
PODC Highlight Report	PODC	Monthly													Chair PODC	Assurance	To provide assurance on key work of this Board Committee and escalate matters as appropriate
Improvement Programme Update	PODC	Monthly													DP&C	Assurance	Updates presented by the Director as part of their executive report under the relevant strategic objective.
Update on compliance to Board Pledge	PODC	Bi-annually													DP&C	Assurance	Sources of assurance regarding the Board Pledge. Trust is required by the Equality Act 2020 to eliminate discrimination, victimisation and harassment, advance quality and opportunity and foster good relations between different groups.
Safe Staffing Report	PODC														DoN	Assurance	In October 2018, NHSI launched a Workforce Safeguards toolkit to inform Trusts how best to ensure that there are appropriate safeguards in place that support NHS boards to make informed, safe and sustainable workforce decisions. NHSI will assess compliance annually. https://improvement.nhs.uk/resources/developing-workforce-safeguards/
Establishment Review	PODC	Bi-Annually													DoN	Assurance	NQB guidance - As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

TRUST BOARD CYCLE OF BUSINESS 2020/21

PAPER	FEEDER COMMITTEE	NOTE ON FREQ.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
Guardian of Safe Working Report	PODC	Quarterly		Q4			Q1			Q2			Q3		MD	Assurance	\demonstrates the work of the guardian in championing safe working hours to ensure protection of patients and doctors. Board to receive assurance that risks are reduced to ensure the safety of patients and staff.
Freedom To Speak Up Report	PODC	Quarterly			Q1			Q2 AR			Q3			Q4	FTSU Guardian	Assurance	Thematic reporting to the board on the themes and issues being reported to FTSU Guardians. Public Interest Disclosure Act.
Equality, Diversity & Inclusion Annual Report	PODC	Annually													DP&C	Assurance	Trust is required by the Equality Act 2020 to eliminate discrimination, victimisation and harassment, advance quality and opportunity and foster good relations between different groups. Trust is required to publish equality data annually.
National Staff Survey and Action Plan	PODC	Annually													DP&C	Assurance	Overview of the NHS National Staff Survey. Supports objective to be employer of choice. Action plan reported to PODC.
Equal pay audit and transparent pay policy	PODC	Annually													DP&C	Assurance	Included in Annual Report
Workforce Plan	PODC	Annually													DP&C	Assurance	NQB Guidance: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive leaders. The board should discuss the workforce plan in a public meeting.
Responsible Officer Revalidation/Appraisal	PODC	Annually													MD	Assurance	To provide assurance that requirements are being met/governance arrangements are robust. Statutory obligation.
Annual Flu Report	PODC	Annually													DP&C	Assurance	
Workforce Disability Equality Standards Report	PODC	Annually													DP&C	Assurance	In annual report - AGS.
Workforce Race Equality Standards Report	PODC	Annually													DP&C	Assurance	In annual report - AGS.
Health and Wellbeing Strategy	PODC	Annually													DP&C	Approval	
Health and Safety Policy - next update TBC	PODC	When Cycled													Dir Gov	Approval	As required in line with policy cycle
GOVERNANCE AND WELL LED																	
Audit Committee Highlight Report	Audit	Quarterly													Chair Audit	Assurance	To provide assurance on key work of this Board Committee and escalate matters as appropriate
Chair's Action Taken Since Last Meeting	None	Ad Hoc													Chair	Endorsement	Agenda setting prompt
Audit Committee Risk Report	Audit	Bi-annually													Chair Audit	Assurance	To provide assurance on effectiveness of Risk Management from the Audit Committee
RemCom Highlight Report	RemCom	Bi-annually													Chair RemCom	Assurance	To provide assurance to Private Board on key work of this Board Committee and escalate matters as appropriate
Improvement Programme Update Well Led	None	Monthly													Dir Gov	Assurance	Updates presented by the Director as part of their executive report under the relevant strategic objective.
Effectiveness of Committees	Audit/All	Annually													Dir Gov	Approval/Assurance	Committees review effectiveness at first meeting of the year (as per TORs). Goes to Audit in July and Board in Aug. License Condition FT4
Board Effectiveness	None	Annually													Dir Gov	Review	License Condition FT4
Board Cycle of Business	None	Annually													Dir Gov	Approval	License Condition FT4
Timetable for Board and Committee Meetings		Annually													Dir Gov	Approval	Schedule of meeting dates for the following year for the Board and its Committees
Governance Handbook/Manual	Audit	Annually													Dir Gov	Approval	
Board Development Cycle	None	Quarterly													Dir Gov	Approval	Forthcoming development forward plan
Review of Registers	Audit	Annually													Dir Gov	Assurance	Annual declaration of interest, gifts and hospitality, commercial sponsorship. To Audit in January.

TRUST BOARD CYCLE OF BUSINESS 2020/21

PAPER	FEEDER COMMITTEE	NOTE ON FREQ.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	LEAD	PURPOSE	COMMENT/COMPLIANCE
Use of Seal	Audit	Quarterly													Dir Gov	Assurance	Standing orders requires the reporting of the use of the Trust Seal to the Board
Standing Orders, Standing Financial Instructions and Schemes of Delegation	Audit/PFIC	Annually													DoF/Dir Gov	Approval	The Standing Orders, Standing Financial Instructions and Scheme of Delegation are the Trust's core corporate governance documents which describe how the Trust Board conducts its business. Amendments are proposed on the recommendation of the Audit committee. PFIC review proposed amendments to Standing Financial Instructions. Cycled to Audit Committee in October.
Annual Compliance with Provider License	Audit	Annually													Dir Gov	Approval	License condition G6 and FT4 Self-Certification.
Annual Report and Accounts	Audit	Annually													DoF/Dir Gov	Approval	For approval of the annual report and annual accounts. To include annual governance statement. Annual accounts filing date - 24 May
Annual external audit letter	Audit	Annually													DoF	Assurance	Cycled to Audit in July
Corporate Risk Register	All	Quarterly													Dir Gov	Assurance	To inform the Board of the trust's highest rated risks. Currently presented monthly, however Risk Management Strategy provides this is quarterly
Board Assurance Framework	Audit	Quarterly													Dir Gov	Approval	To receive assurance in relation to the management and mitigation of the risks as appropriate and that the BAF remains reflective of the current risks to achievement of the strategic objectives. The Board is responsible for identifying and monitoring risks to the achievement of the strategic objectives. Currently presented monthly, however Risk Management Strategy provides this is quarterly
Fit and Proper Person Declaration	RemCom	Annually													Dir Gov	Assurance	License condition FT4. To provide assurance that the members of the Trust board meet the requirements of Regulation 5 of the CQC fundamental standards
Risk Management Strategy and Policy	Audit	Annually													Dir Gov	Approval	To review and approve the risk management strategy and policy.
Risk Appetite Statements Review	Audit	Annually													Dir Gov	Approval	Annually reviewed to ensure risk appetite statements remain current and relevant
BOARD OF TRUSTEES																	
Annual account																	Audited accounts to be submitted to Charities Commission by 31 January
Annual report on Committee effectiveness	Charitable																

Abbreviation	Position	Name
Chair	Trust Board Chair	Danielle Oum
Chair QPES	Chair of Quality, Patient Experience and Safety Committee	Pamela Bradbury
Chair PFIC	Chair of the Performance, Finance and Investment Committee	John Dunn
Chair PODC	Chair of the People and Organisational Development Committee	Philip Gayle
Chair WTPB	Chair of the Walsall Together Partnership Board	Anne Baines
Chair Audit	Chair of the Audit Committee	Sukhbinder Heer
Chair Remcom	Chair of Nominations and Remuneration Committee	Danielle Oum
CEO	Chief Executive Officer	Richard Beeken
DoI	Director of Integration/Deputy CEO	Daren Fradgley
MD	Medical Director	Matthew Lewis

TRUST BOARD CYCLE OF BUSINESS 2020/21

Abbreviation	Position	Name
DoN	Director of Nursing	Ann-Marie Riley
DoF	Director of Finance	Russell Caldicott
COO	Chief Operating Officer	Ned Hobbs
DP&C	Director of People and Culture	Catherine Griffiths
Dir Gov	Director of Governance	Jenna Davies
DP&I	Director of Performance and Improvement	Glenda Augustine
FTSU Guardian	Freedom To Speak Up Guardian	Val Ferguson, Kim Sterling, Shabina Raza

MEETING OF THE PUBLIC TRUST BOARD – 5th November 2020			
Use of Trust Seal			**AGENDA ITEM: 27**
Report Author and Job Title:	Trish Mills Trust Secretary	**Responsible Director:**	Jenna Davies Director of Governance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	In accordance with the Trust's Standing Orders the Seal of the Trust is affixed to a document that has been authorised by a resolution of the Board or of a Committee of the Board, or where the Board has delegated its powers[1]. Use of the Trust Seal is reported at least quarterly, with the report containing details of the seal number, the description of the document and date of sealing[2]. The following has been noted in the Register of Sealings: Transaction number 163 dated 15th June 2020 for 'License to assign – change of name – Cention Plc'. The document was witnessed by Richard Beeken and Jenna Davies.		
Recommendation	The Trust Board is asked to note the use of the Trust Seal, with such report having been reviewed by the Audit Committee on 12th October.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☒		

[1] Standing Order 8.2
[2] Standing Order 8.3