Bundle Public Trust Board 3 August 2022

1 Chair's Welcome; Apologies and Confirmation of Quorum

Lead: Prof. Steve Field, Chair
Apologies Received: Sally Evans, Prof. Patrick Vernon, Ned Hobbs
Quoracy:
In attendance:
Umar Daraz, BCU
Camille Laing (Shadowing Carla Jones-Charles)

2 Declarations of interest

Lead: Prof. Steve Field
Action: Board members to advise of any conflicts of interest pertaining to any item on the agenda which are not declared on the attached register.

2. Public Declarations of Interest APRIL 2022 v 270422.docx

3 Minutes of the last meeting held 8th June 2022

Lead: Prof. Steve Field
Action: To RECEIVE and APPROVE as an accurate record

Final unconfirmed- Public Board Minutes - 08.06.22.docx

4 Matters Arising

Lead: Prof. Steve Field
Action: Any matters arising not on the agenda

5 Action Log

Lead: Prof. Steve Field
Action: To update actions and close actions as relevant.
342 - Ms Carroll to provide verbal update - deferred to October Board date if not agreed closed.
343 - Ms Carroll to provide verbal update - deferred to October Board date if not agreed closed.

List_of_confidential_action_items_Public_Trust_Board_8_June_2022 (1).docx

6 Trust Values and Nolan Principles

Lead: Prof. Steve Field, Chair
Action: Board to note

5.1 The Seven Principles of Public Life - Nolan Principles.pdf

5.2 Vision Values and Objectives v.2.pdf

7 Chair's Report - Verbal

Lead: Prof. Steve Field
Action; To Inform

8 Chief Executive's Report

Lead: Prof. David Loughton, Chief Executive
Action: To Inform

Chief Executive report, 03.08.22.docx

8.1 Chair's Trust Management Committee Reports for June and July 2022

Lead: Prof. David Loughton, Chief Executive
Action: To Inform

TMC 03.08.22, Report for Trust Board, 28.06.22.docx

TMC 03.08.22, Report for Trust Board, 26.07.22.docx

9 Integrated Quality and Performance (IQPR) - (Section Heading)

Lead: Russell Caldicott, Chief Finance Officer

9.1 IQPR - Summary Report

Lead: Russell Caldicott, Chief Finance Officer
Action: to Inform and Assure

IQPR Summary.pdf

9.2 Performance & Finance Committee - Chair's Report (June and July 2022)

Lead: Paul Assinder, Chair, PFIC
Action: To Inform and Assure

PFC Chair's Report July 2022.docx

9.2.1 IQPR - Performance & Finance (Reference Pack for Information)

IQPR PFIC.pdf

9.3 Quality, Patient Experience and Safety Committee - Chair's Report (June and July 2022)

Lead: Dr Julian Parkes, QPES Chair
Action: To Inform & Assure

QPES Chairs report.docx

9.3.1 IQPR - Quality, Patient Experience and Safety (Reference Pack for Information)

IQPR QPES.pdf

9.4 People and Organisation Development Committee - Chair's Report (June and July 2022)

Lead: Junior Hemans, Chair, PODC
Action: To Inform and Assure

July 22 PODC Chairs highlight report.pdf

9.4.1 IQPR - People and Organisation Development (Reference Pack for Information)

IQPR PODC.pdf

10 Provide Safe, High Quality Care (section heading)

10.1 Director of Nursing Report

Lead: Lisa Carroll, Director of Nursing
Action: To Inform and Assure

DoN report to Public Trust Board 3rd August 2022.docx

DoN report - Appendix 2 Cessation of agency Plan June 2022.pdf

10.2 Hospital Mortality Report (April – May 2022)

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Discuss, Inform and Assure

Mortality Report June 22 (v4).docx

10.3 Patient Experience (& Complaints Report) - Quarterly Report

Lead: Lisa Carroll, Director of Nursing
In attendance: Garry Perry, Associate Director, Patient Relations and Experience
Action: To Inform and Assure

11.3 Patient Experience Quarter 1 2022 (002) pv Board.docx

10.4 Continuous Quality Improvement (CQI) - Quarterly Update

Lead: Simon Evans, Interim Chief Strategy Officer
Action: To Inform

WHT TB QI Report - Simon Evans.docx

10.5 Director of Midwifery Report

Lead: Carla Jones-Charles, Director of Midwifery, Gynaecology and Sexual Health
Action: To Discuss, Inform and Assure

Director of Midwifery Report.docx

10.6 Trust Risk Register/Board Assurance Framework

Lead: Kevin Bostock, Director of Assurance
Action: To Inform and Assure

Board - Risk Management Report - 20.06.2022.docx

TMC - Appendix 1 - BAF SO 01 - Safe, High Quality Care - 07.06.2022.pdf

TMC - Appendix 2 - BAF SO 02 - Care at Home - 07.06.2022.pdf

TMC - Appendix 3 - BAF SO 03 - Working with Partners - 07.06.2022.pdf

TMC - Appendix 4 - BAF SO 04a - Leadership Culture & OD - 07.06.2022.pdf

TMC - Appendix 5 - BAF SO 04b - Organisational Effectiveness - 07.06.2022.pdf

TMC - Appendix 6 - BAF SO 04c - Making Walsall & BC BPTW - 07.06.2022.pdf

TMC - Appendix 7 - BAF SO 05 - Use Resources Well - 08.06.2022.pdf

TMC - Appendix 8 - BAF SO 06 - COVID - 08.06.2022.pdf

TMC - Appendix 9 - April CRR - 11.05.2022.pdf

TMC - Appendix 10 - May CRR - 16.06.2022.pdf

10.7 Director of Infection Prevention and Control Report - Quarter 1 Report

Lead: Lisa Carroll, Director of Nursing
In attendance to present: Amy Boden, Head of Infection Prevention and Control
Action: To Discuss, Inform and Assure

IPC BAF Q1 update report Trust Board July 2022.docx

10.8 Mental Health Escalations, Concerns and Recommendations

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To APPROVE, inform and assure

Trust Board paper 2022 Mental Health.docx

10.9 Pharmacy and Medicines Optimisation Report

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform and Assure

Board_Pharmacy Medicines Optimisation.docx

10.10 Safeguarding Adults and Children - Quarterly Report

Lead: Lisa Carroll, Director of Nursing
In attendance to present: Fiona Pickford
Action: To Inform and Assure

11.11 Safeguarding Annual Report.docx

11 Care at Home, Work Closely with Partners (section heading)

Section Heading

11.1 Walsall Together - Chair's Report

Lead: Matthew Dodd, Interim Director of Integration (on behalf of Prof Patrick Vernon)
Action: To Inform

Chairs Report - WTPB July 2022 v2.docx

11.2 Care at Home Executive Report

Lead: Matthew Dodds, Interim Director of Integration
Action: To Inform and Assure

Care at Home Report Jul22 v2.docx

Care at Home - Appendix 1 - Partnership Operational Performance Pack July 2022 (1).pdf

11.3 Charitable Funds - Chair's Report

Lead: Paul Assinder, Chair, Charitable Funds
Action: To Assure

Charitable Funds Chair's Report July 2022.docx

11.4 Charitable Funds Strategy

Lead: Russell Caldicott, Chief Finance Officer (In absence of Sally Evans)
Action: To Inform

1.Front sheet Charitable Funds strategy.docx

Charitable funds strategy.pdf

12 Use Resources Well (Section Heading)

12.1 Audit Committee - Chair's Report

Lead: Mary Martin, Chair, Audit Committee
Action: To Inform and Assure

WHT Audit Committee Chairs Reports 21.06.22 (002).docx

12.2 People and Organisational Development Committee - Joint WHT and RWT Terms of Reference

Lead: Catherine Griffiths, Director of People and Culture
Action: To Inform and Assure

Front Sheet - Revised PODC Terms of Reference - TB 03.08.22.docx

Revised PODC Joint WHT & RWT Terms of Reference.docx

12.3 Sustainability Report

Lead: Simon Evans, Interim Chief Strategy Officer
Action: To Inform

WHT TB Rep Sustainability Aug 22.pdf

12.4 Clinical Fellowship Programme: Medical Briefing update 2021-22

Lead: Dr Manjeet Shehmar, Chief Medical Officer
Action: To Inform & Assure

Clinical Fellowship Programme Board Paper July 2022 Final 22.7.22.docx

12.5 Trust Undertakings pursuant to the powers exercisable by NHS Improvement under or by Virtue of the National Health Service Act 2006

Lead: Kevin Bostock, Director of Assurance
Action: To Inform

Front Sheet for NHSEI Undertakings 25 May 2022 response 30 June 2022 for Public Trust Board 03.08.2022.docx

NHSI Undertakings 25.05.22 (003).pdf

Ms R Farmer, 29.06.22.pdf

13 Value our Colleagues (Section Heading)

13.1 Staff Voice - Staff Story

Lead: Catherine Griffiths, Director for People and Culture
In attendance to present: Karen Rawlings and Nicola Adams
Action: To Inform

Front sheet template PODC pt story.docx

Staff Story - Surgery Success Story - Acute Oncology Service.pptx

14 Reports for Information (Section Heading)

Reports for Information Only.
Action: For Information

14.1 Quality, Patient Experience and Safety Committee - Confirmed Minutes of meeting held June 2022

3. Minutes of QPES Committee June.pdf

14.2 People and Organisational Development Committee - Confirmed Minutes of meeting held June 2022

3. Minutes - People and Organisational Development Committee, June 2022.docx

14.3 Performance and Finance Committee - Confirmed Minutes of meeting held June 2022

3. Minutes of the PFC 29.06.2022 RC PA.docx

14.4 Audit Committee Meeting - Confirmed Minutes of meeting held May 2022

3. Audit Committee Mins 09.05.22a.docx

14.5 Charitable Funds Committee - Confirmed Minutes of meeting held March 2022

CF Mins 140322.docx

14.6 Performance and Finance Committee - Chair's Highlight Report - June 2022

PFC Chair's Report June22.docx

14.7 Quality, Patient Experience and Safety Committee - Chair's Highlight Report - June 2022

QPES Board report 24_6_22 (002).docx

14.8 People and Organisational Development Committee - Chair's Highlight Report - June 2022

June 22 PODC Chairs highlight report.docx

15 Any Other Business

16 Date and Time of Next Meeting

17 Questions from the Public/Commissioners

Chair to confirm whether any questions have been received with the required notice.

18 Resolution

Lead: Chair
Action: The Board to resolve to invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960.
Resolved: that the resolution be approved.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD			
Declarations of Interest			
Report Author and Job Title:	Keith Wilshere Interim Trust Secretary	**Responsible Director:**	Steve Field Trust Board Chair
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• The report presents a Register of Directors' interests to reflect the interests of the Trust Board members.		
Advise	• 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.		
Alert	• There are no alerts associated with this 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/or 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 April 2022

Name	Position held in Trust	Description of Interest
Professor Steve Field	Chair	Chair: Royal Wolverhampton NHS Trust
		Director: EJC Associates
		Trustee for Charity: Pathway Healthcare for Homeless People
		Trustee: Nishkam Healthcare Trust Birmingham
		Honorary Professor: University of Warwick
		Honorary Professor: University of Birmingham
Mr Junior Hemans	Non-executive Director	Non-Executive Director - Royal Wolverhampton NHS Trust
		Visiting Lecturer – University of Wolverhampton
		Director – Libran Enterprises (2011) Ltd
		Chair/Director - Wolverhampton African Caribbean Resource Centre
		Chair - Tuntum Housing Association (Nottingham)
		Company Secretary – The Kairos Experience Ltd.
		Member – Labour Party
		Mentor – Prince's Trust
		Spouse is a therapist at Royal Wolverhampton NHS Trust
Ms Mary Martin	Non-executive Director	Royal Wolverhampton NHS Trust - Non-Executive Director
		Trustee/Director, Non-Executive Member of the Board for the charity - Midlands Art Centre
		LTDTrustee/Director, Non-Executive - B:Music
		Director - Friday Bridge Management Company Ltd
		Non-Executive Director/Trustee - Extracare Charitable Trust (stood down 21 June 21)
Professor Louise Toner	Non-executive Director	Member - Birmingham and Solihull Workforce Action Board and Education Reform Workforce Group
		Associate Dean Faculty of Health, Education and Life, Birmingham City University
		Visiting Professor/Advisory Board Member, Lovely Professional University India
		Chair – Education Focus Group, Birmingham Commonwealth Associated
		Member – Royal College of Nursing – UK
		Member – Greater Birmingham Chamber of Commerce Commonwealth Group
		Teaching Fellow – Higher Education Academy

Name	Position held in Trust	Description of Interest
Mr Paul Assinder	Associate Non-executive Director	Director of Rodborough Consultancy Ltd.
		Governor of Solihull College & University Centre
		Honorary Lecturer, University of Wolverhampton
		Associate of Provex Solutions Ltd.
		Chief Executive Office r- Dudley Integrated Health & Care Trust (ceased February 2022)
Mr Rajpal Virdee	Associate Non-executive Director	Lay Member, Employment Tribunal Birmingham
		Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021)
Mrs Sally Rowe	Associate Non-Executive Director	Executive Director Children's Services - Walsall MBC
		Trustee of the Association of Directors of Children's Services
Dawn Brathwaite	Non-Executive Director	Consultant/Former Partner, Mills & Reeve LLP
Ofrah Muflahi	Associate Non-Executive Director	Board Member, Kidney Care UK (ceased position in March 2022)
		Professional Lead employed at Royal College of Nursing and Member
		Husband an employee of the Royal College of Nursing UK
		Member of the Q Community at Health Foundation
		Husband Director of OBD Consultants, Limited Company
		Member of the UK Oncology Nursing Society
		Member of the Seacole Grou
		Member of Health Inequalities Task Group at Coalition for Personalised Care
Dr Julian Parkes	Associate Non-Executive Director	Lead for Primary Care – Royal Wolverhampton NHS Trust
		Daughter – Nurse at Royal Wolverhampton NHS Trust
		Trustee, Windmill Community Church
Professor David Loughton	Chief Executive	Chief Executive – Royal Wolverhampton NHS Trust
		Health policy advisor to the Labour and Conservative Parties
		Member – Dementia Health and Care Champion Group
		Member of Advisory Board – National Institute for Health Research
		Chair – West Midlands Cancer Alliance

Name	Position held in Trust	Description of Interest
Prof Ann-Marie Cannaby	Interim Deputy Chief Executive/Chief Nursing Officer	Chief Nurse – Royal Wolverhampton NHS Trust
		Director – Ann-Marie Cannaby Limited
		Visiting Professor – Staffordshire University
		Honorary Fellow – La Trobe University, Victoria, Australia
		Teaching Fellow – Higher Education Academy
		Member – Royal College of Nursing
		Visiting Professor – Birmingham City University
		Principal Clinical Advisor – British Telecom
		Member of the Cavell (Charity) Advisory Panel (Volunteer role) commenced April 2022
Mr Russell Caldicott	Chief Officer for Finance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
		Director of Plan 4 E-Health
Dr Manjeet Shehmar	Chief Medical Officer	Company Director Association of Early Pregnancies Units UK
		Executive Member Association of Early Pregnancy Units UK
		Private Practice Health Harmonie ceased August 2021
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy ltd
		Chartered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT
		Sister in Law – Head of Specialist Services St Giles Hospice
Mrs Lisa Carroll	Director of Nursing	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research
		Spouse - RCPCH Assistant Officer for exams
		Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group
		Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)
		Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM

Name	Position held in Trust	Description of Interest
		Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar
Ms Glenda Augustine	Director of Performance & Improvement	No interests to declare
Mr Mike Sharon	Interim Strategic Advisor to the Board	Strategic Advisor to the Trust Board - RWT
		Member of the Liberal Democrat Party
		Wife works as an independent trainer, coach and counsellor. Some of this work is for local NHS bodies (excluding RWT) Wife had undertaken work for Walsall Healthcare NHS Trust as a self-employed trainer.
Mr Matthew Dodd	Director of Transformation Walsall Together	Wife working as a Physiotherapy Assistant at Birmingham Community Health Care
Mr Patrick Vernon	Chair, Walsall Together	Non-Executive Director, Birmingham and Solihull ICS
		Chair of Citizens Partnership, Health Care Investigation Branch
		Specialist Adviser, Centre for Ageing Better
		Sister works as a senior manager at NHS Resolute
		Director - Windrush Legal Advice Clinic
		Director - 38 Degrees
		Director – The Bernie Grant Trust
Mr Kevin Bostock	Director of Assurance	Sole director of a limited company Libra Healthcare Management Limited trading as Governance, Risk, Compliance Solutions
Mr Kevin Stringer	Interim IT Director and SIRO	Chief Financial Officer and Deputy Chief Executive, Royal Wolverhampton NHS Trust
		Treasure, West Midlands Branch – Healthcare Financial Management Association
		Brother-in-law is the Managing Director and Midlands and Lancashire Commissioning Support Unit
		Member of CIMA (Chartered Institute of Management Accounts)
Sally Evans	Director of Communications and Stakeholder Engagement	Director of Communications and Stakeholder Engagement at Royal Wolverhampton NHS Trust
Simon Evans	Interim Chief Strategy Officer	Chief Strategy Officer at Royal Wolverhampton NHS Trust
Mr Keith Wilshere	Interim Company Secretary	Company Secretary at Royal Wolverhampton NHS Trust

Name	Position held in Trust	Description of Interest
		Sole owner, sole trader – Keith Wilshere Associates
		Secretary of Club which is a registered co-operative with the Financial Conduct Trustee, Director (The Royal British Legion Social Club – Beeston)
		Committee member of registered Charity and Limited Company – Foundation for Professional in Services for Adolescents (FPSA)

RECOMMENDATIONS

The Board is asked to note the report

NHS
Walsall Healthcare
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY, 8TH JUNE 2022 AT 09.30AM
HELD AT THE VILLAGE HOTEL, TEMPUS DRIVE, WALSALL AND VIRTUALLY VIA TEAMS

PRESENT

Members

Prof. S Field CBE	Chair of the Board of Directors
Ms M Martin	Non-Executive Director (NED)
Mr P Assinder	Non-Executive Director (NED)
Ms D Brathwaite	Non-executive Director (NED)
Mr J Hemans	Non-Executive Director (NED)
Prof. L Toner	Non-Executive Director (NED)
Mr R Virdee	Associate Non-Executive Director (NED)
Dr J Parkes	Associate Non-Executive Director (NED)
Ms O Muflahi	Associate Non-Executive Director (NED) (virtual attendance)
Prof. D Loughton CBE	Chief Executive
Prof. A-M Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Mr R Caldicott	Chief Finance Officer
Mr N Hobbs	Chief Operating Officer
Ms L Carroll	Director of Nursing
Ms C Griffiths	Director of People and Culture
Dr M Shehmar	Chief Medical Officer
Mr K Bostock	Director of Assurance
Mr M Dodd	Interim Director of Integration
Mr S Evans	Interim Chief Strategy Officer
Ms S Evans	Interim Director of Communications and Engagement

In attendance

Mr M Sharon	Strategic Advisor to the Board
Mr K Stringer	Interim Director for SIRO and IT (virtual attendance)
Mr K Wilshere	Interim Company Secretary
Ms C Jones-Charles	Divisional Director of Midwifery, Gynaecology and Sexual Health
Mr S Mirza	Divisional Director –Division or Surgery
Ms A Hennessy	Care Quality Commission (CQC)
Ms B Hill	Care Quality Commission (CQC)
Mr D Umar	Birmingham City University (BCU)
Prof. P Vernon	Chair, Walsall Together Partnership Board (virtual attendance)
Ms C Hill	Medical Directorate Programme Lead
Ms J Kaur Toor	Senior Executive Assistant/Senior Operational Coordinator
Ms B Edwards	Executive Assistant (observing)

Apologies

Ms G Augustine	Director of Planning and Improvement
Ms S Rowe	Associate Non-Executive Director

282/22	Welcome, Apologies and Confirmation of Quorum
	Prof. Field welcomed everyone to the meeting and noted the apologies that had been received. He introduced Prof. Vernon, Chair of Walsall Together who would be providing the Chair's report for Walsall Together and welcomed him to the Board meeting. He advised that Ms Hill and Ms Hennessey from the CQC and Mr Daraz from BCU were in attendance to observe the Board meeting. Prof. Field noted that Mr Sharon was retiring and leaving the Trust, advising that this would therefore be his last Trust Board meeting. Prof. Field wished Mr Sharon well for the future

	and thanked him for his work and support to the NHS over the years and to the Boards at both Walsall and Wolverhampton NHS Trusts. Prof. Loughton also expressed his thanks to Mr Sharon for his support over the years.
283/22	**Declarations of Interest**
	Prof. Field confirmed there were no further interests declared to those advised in the declaration of interest register. **Resolved: that the Declarations of interest be received for assurance.**
284/22	**Minutes of Last Meeting**
	Prof. Field confirmed the minutes of the meeting held on 6th April 2022 as received and approved as an accurate record, subject to a minor amendment that was received outside of the meeting via Mr Hobbs. **Action: Mrs Toor to amend the minutes to reflect the change by Mr Hobbs.** **Resolved: that the minutes of the last meeting be received and approved.**
285/22	**Matters Arising and Action Log**
	Prof. Field advised that there were no outstanding actions to note. **Resolved: that the action log be reviewed and updated.**
286/22	**Trust Values and Nolan Principles**
	Prof. Field asked the Board to note the Seven Principles of Public Life, the Nolan Principles and the Trust Values and reiterated the importance of the principles. **Resolved: that the Trust Values and Nolan Principles be received and noted.**
287/22	**Chair's Report**
	Prof. Field advised of his recent visit to a Sikh Gurudwara where he had met with members of the congregation, two of which were clinicians in the NHS and who had fed back positively on the improvement in the quality of care over the last 18 months at Walsall Healthcare NHS Trust and who had said that this was also the feedback that they had received as clinicians by their patients. **Resolved: that the Chair's Report be received and noted.**
288/22	**Board Member Attendance Report - 2021/22**
	Mr Wilshere advised of an amendment to the report in relation to Ms Brathwaite's record of attendance. **Action: Mrs J Toor to amend the attendance report in the annual report to reflect Ms Brathwaite's attendance.** **Resolved: that the Board Member attendance report be received for assurance.**
289/22	**Chief Executive's Report**
	Prof. Loughton provided his Chief Executive's report. **Resolved: that the Chief Executive's report be received and noted**
290/22	**Chair's Trust Management Committee Report**
	Prof. Loughton, as Chair of the Trust Management Committee, provided the Chair's report for the Committee meeting held in May 2022. **Resolved: that the Chair's report be received and noted.**
STAFF STORY	
291/22	**Patient Story – Alicia's Story**
	Ms Jones-Charles summarised the patient story regarding 'Alicia' who had shared her experiences as a patient on the maternity ward in 2018, where she had given birth to a son

	who had spent 2 days in neonatal and then again for her pregnancy in the period of Covid-19. Ms Jones-Charles advised the Board that during her second pregnancy, Alicia had contacted the Trust asking for a debrief on the birth of her son in 2018, so that she could be better prepared for the birth of her second child. Ms Carla-Jones said that she had been the member of staff that subsequently debriefed Ms Jones-Charles. She explained that Alicia had given birth to a daughter via emergency Caesarean section in 2019, and due to the difficulties she was experiencing following the birth, she had asked for her husband to be allowed to stay with her. Ms Jones-Charles explained that this had been declined by the ward, due to the restrictions of Covid-19, and Alicia had subsequently called Ms Jones-Charles who had then contacted the ward to determine the situation before agreeing that arrangements be made to allow Alicia's husband to stay with her that night. Ms Jones-Charles said that Alicia was now an active member of the Maternity Voices Partnership and had fed back that her patient journey had been really positive. Ms Jones-Charles said that the Trust was reviewing unconscious bias and said that members of the Maternity Partnership Board would be taking part in cultural competency programmes. Mr Virdee said that unconscious bias can work both ways and that individuals with protected characteristics could also assume that when something had gone wrong that it was due to their race, gender, ethnicity and said that it was important for staff to start recognising unconscious bias. Ms Jones-Charles reported on the work that the Trust had undertaken around patient choice in relation to the maternity wards, maternity voices, undertaking walkabouts and reporting back to patients and staff on the patient safety champions work. Mr Hemans said it was important to share the learning in maternity services and that listening was important regardless of ethnicity. Ms Muflahi said as the NED champion for maternity and neonatal services, it was refreshing to hear that Alicia wanted to be on the maternity services forum to share her experiences and also for the Trust to learn from those experiences. Ms Muflahi said the Trust had to think about the approach to inequalities, particularly in relation to race in maternity services and that they need to ensure that the Maternity Services Partnership Board created the momentum to ensure the patients voice was being heard and acted upon. She suggested widening participation to consider partners and families in these discussions. Prof. Vernon said that he had met with Ms Jones-Charles as part of his induction and thanked her for the work that she was doing with maternity services. He said that at some point Walsall Together would like to share their work to ensure that they were on the same page as the Trust in relation to equality, diversity and inclusion. **Resolved: that the Patient Story be received and noted.**
292/22	**Quality, Patient Experience and Safety (QPES) Chair's Report**
	Dr Parkes provided the highlights from the Chair's report, advising that numbers for stage 2 audits had dropped to 63% and that discussions with a patients relative or attorney had fallen to 53%. He said that manual sepsis audit results in A&E were at 98% and a review of manual audit results, a month in arrears, had been planned as the electronic system was currently unreliable and that manual data was being collected for inpatient sepsis for antibiotics in 1 hr. Dr Parkes reported that mandatory training for level 3 children's safeguarding remained

	below target at 85% and level 3 adult safeguarding training was also below target. He said that additional training was being provided. Dr Parkes reported that 41% of clinical guidelines were past the review date of when guidelines are to be approved by and that a plan was in place with trajectories due to be presented next month. He reported that electronic discharge summaries completed within 48hrs was at 84%. Dr Parkes advised that the wait time for "2 week wait" for symptomatic breast and suspected cancer was now just over 2 weeks and a specialist nurse had been appointed to the service. He said that the waiting list for domiciliary phlebotomy had decreased to 146 and was on target for the 72hr waiting time by the end of May 2022, VTE compliance was below the required target however there were variations in different parts of the service, the 18-week RTT performance remains in line with trajectory and there were 78 open serious incidents on STEIS. Dr Parkes reported that timely observations were now above target at 91% (85% target), falls per 1000 bed days had reduced to 4%, MRI and U/S performance was stable with ultrasound waiting times at 6 weeks and MRI waiting times on course to be 6 weeks by the end of May 2022. He said that elective and day case activity was 113% of pre-Covid level and operating theatre capacity was being prioritised for cases that need operating theatres and that 62% of priority 2 patients had had their procedures within 28 days. He said that the expansion of hours in Care Navigation and Rapid Response was embedded and that seven specialty areas were now research active and a Joint Director of Research was being recruited for WHT & RWT. **Resolved: that the Chair's report for Quality, Patient Experience and Safety be received and noted.**
293/22	**Performance, Finance & Investment (PFIC) Chair's Report**
	Mr Assinder provided highlights from the Chair's report. Ms Martin expressed her concerns regarding the system pressures that the Trust was being put under and the impact on staffing and the difficult decisions having to be made by Staff which could affect patients. **Resolved: that the Chair's report for Performance, Finance & Investment be received and noted.**
294/22	**People and Organisational Development (PODC) Chair's Report**
	Mr Hemans provided highlights from the Chair's report and said that PODC had started discussions on how to re-engage the disability network. He said there was a concern that staff within the Trust were not declaring their disabilities which could be detrimental to them fulfilling their duties. He said that supporting the development of the network would enable the network to in turn support staff in declaring any disabilities they may have and enable their managers to support them through that process. Mr Hemans referred to the race report and said that there remained concern about the bullying and harassment figures within the Trust and that further work was needed. He said that the reception for some of the overseas nurses was of concern and that the Trust did not want to lose the nurses as they were making a significant positive impact and helping to reduce agency spend. Mr Hemans said that the Trust was supporting managers and sharing practice about cultural understanding and awareness. He reported that sickness levels were an issue for the Trust and they were reviewing this further to support staff and get them back to work. Ms Muflahi said that it was crucial that there was a nursing skill-mix across the Board as there was

	evidence to suggest that this positively impacts on the patient delivery of care. She said that whilst recruitment was expanding, the Board needed to ensure that the experience of these overseas nurses was good and that the Trust plan in advance what this might look like in terms of succession planning and recruitment. **Resolved: that the Chair's report for People and Organisational Development be received and noted.**
PROVIDE SAFE, HIGH QUALITY CARE	
295/22	**Director of Nursing Report**
	Ms Carroll reported that 59 falls had been recorded for April 2022, one which had resulted in severe harm and was being investigated as a Serious Incident. She reported that falls per 1000 bed days had been 4% during April 2022 compared to 3% in March 2022. Ms Carroll advised that the Falls Accountability meetings had commenced in April 2022 and would focus on identifying levels of harm and avoidability and the lessons learnt to drive future falls prevention strategies. She reported that as at the end of April 2022, 208 overseas Nurses had commenced working within the Trust and that a business case to support the continuation of international recruitment for the next three years had been approved. She advised that 49 student nurses had attended a careers event where they had indicated an interest in being recruited to areas within the Trust in September 2022. Ms Carroll highlighted two cases of deep surgical site infection within trauma and orthopaedics which had been reviewed in February 2022 and said that both cases had been deemed avoidable. She said the findings had been shared with the division and SSI Group for action and monitoring. Ms Carroll reported there were no reported *'C.difficile'* cases in April 2022 and the Trust had reported a total of 31 cases in the year 2021/22 against a national trajectory of 33. Ms Carroll said that the Mental Capacity Assessment (MCA) Audit for April 2022 showed that 71% of patients who lacked capacity had stage 2 assessments undertaken which had been an increase from 62% in March 2022 and discussion with patient's relatives or attorney had slightly decreased to 53% of cases audited. Ms Carroll reported that the Adult Safeguarding Lead had recently retired but would be returning to the Trust to deliver Safeguarding training and advised that despite improvement plans being presented to the Safeguarding Committee, level 3 training for Safeguarding Adults and Children remains below target. Ms Carroll highlighted that there were significant vacancies in the Health Visiting team and that the Trust was focussing on how it could attract individuals to apply for these posts, how they recruit RNs and provide training opportunities, the use of the Clinical Fellows programme and international recruitment. She said that a task and finish group had been formed to focus on Health visiting recruitment and ensuring that the team continue to deliver a safe service. Ms Carroll reported that 8 Trainee Nursing Associates (TNAs) were expected to qualify in June 2022 and a further 6 expected to complete in September 2022 and that the TNAs which had commenced the programme in September 2021 were expected to qualify in November 2023. She reported the business case to support Nursing Associates (NAs) to train to become Registered Nurses had been supported by the Trust and that recruitment had commenced in May 22 which would enable 10 NAs to commence the 2-year training programme with Birmingham City university in September 2022. Ms Carroll highlighted there had been a decrease in 'off framework' agency use during April 2022 and that the highest use areas for 'off framework' agency staff were ED and

	Endoscopy. She reported that the Emergency Department (ED) and Ambulatory Medical Unit (AMU) business case had been approved by the Investment Group and would replace the temporary staffing use with substantive staff. She added that the Head of Workforce was working with the Divisional Directors of Nursing to ensure a clear plan was in place for ceasing agency use across all general wards over the next few weeks. **Action: Ms Carroll to share the plan for ceasing agency use with board members.** Ms Carroll reported on the International Day of the Midwife on the 5th May 2022 and International Nurses Day on the 12th May 2022 which the Trust had celebrated and said that these events had been a wonderful opportunity to acknowledge the work of Midwives and Nurses and to support the national launch of the 'Enabling Professionalism Framework 2022' and the 'Here for Life Campaign'. Dr Shemar provided an update on the Acute Medical Unit (AMU) Improvement Plan in relation to the safety concerns that had been raised by Health Education England and advised that they now had audits of assurance in place which were mostly around concerns that had been raised around the transfer of emergency unit and the AMU. She said that the Department have monthly audits to show that the triage and referral process is now working and that changes had been made to the rotas so that senior individuals were included on these rotas and gaps in the rotas were being filled via the Clinical Fellowship. Dr Shehmar said that the AMU had also addressed some of the issues around communication and now had in place fully functional white boards which clearly show what tasks were remaining for each patient and which would allow for triage to be undertaken more efficiently. Dr Shehmar reported on the concerns that patients referred to the AMU and ED from their General Practitioners (GPs) had not been clearly visible on their patient lists. She said that these patients were now appearing on the electronic white boards, and that further work was being undertaken with the GP Clinical Forum to ensure that GPs were highlighting these referrals via a call to AMU or ED. Dr Shehmar reported on the work being undertaken with the Care Navigation Centre to support the Centre to operate as the single point of access for GPs who need to make an urgent referral which would help to ensure that GPs were able to access the correct departments. She said there was significant progress with the cultural work via the AMU Board and that coaching had been offered and taken up by all the Consultants who work in AMU, focus sessions had been held with all other teams too, support had been offered to the leadership team too and there was continued work with medical staffing. Mr Hemans asked Ms Carroll if, as well as safeguarding training, there was any opportunity to develop safeguarding and mental health awareness in the community via Walsall Together. He said that due to Covid-19, mental health figures were likely to increase and the Trust should review where they could help alleviate the pressure on the system, such as encouraging and supporting the community with mental health awareness. Mr Hemans said that Wolverhampton NHS Trust had recently undertaken a programme with Black Country Mental Health where they had received funding from Wolverhampton Council to train 60 members of the community, barbers, hairdressers, nail technicians etc., in mental health awareness. He said that 40 members of the community had attended this training and Mr Hemans asked if there was the scope to develop something similar in Walsall with Walsall Together. Ms Carroll said that Walsall Trust had a mental health team with a mental health nurse lead and they work closely with Black Country Health Partnership who support with Child and Adolescent Mental Health services (CAMHS) in the Hospital and they work together to support the Trust and the community.

	Prof. Toner said that it was important that support for young people in schools is also considered and said that she could provide details of individuals in the University who would be able help support and facilitate health visiting discussions. Prof. Loughton said that health visiting remained a concern and said that a task force would be formed across both Walsall and Wolverhampton Trusts to review the number of vacancy rates and to discuss how the system could access faster training for health visitors as this was a high risk. Prof. Loughton queried whether they could access health visitors from overseas. Ms Carroll said this was being revieweed as an option. Prof. Loughton asked Ms Carroll and Ms Debra Hickman (Director of Nursing at Wolverhampton Trust) to discuss forming and leading the task force. He suggested support from the Non-Executive Directors, referencing Prof. Toner's earlier offer of support. He reiterated the importance of understanding whether it was possible to fast-track training for health visitor roles. **Action: Ms Carroll and Ms Hickman to meet and discuss a Task Force for Health Visiting as this was a risk for the Trust. To review the vacancy rates and how to access faster training and recruitment for health visitors.** Dr Shehmar advised a system wide task force group was in place for Child and Adolescent Mental Health Services (CAMHS) as CAMHS was a national issue. She said that the Trust also have a national advisor working with them. Mr Virdee queried the red flags in the DoN report and the assurance in relation to mitigation of these red flags. Ms Carroll advised that it was positive that more staff were reporting and said that the red flags was a national list that the Trust follows. She advised that the Trust's Nursing and Midwifery Board, which meet every month, receive a detailed report of all the red flags. Ms Carroll said that the red flags mainly refer to staffing and advised that currently there had been no incidents which the Trust had not been able to resolve or mitigate. Ms Muflahi said it was positive to hear the progress with Nurse Associate roles. She said that she had met with nursing staff on a recent walkabout of the Trust with Mr Hobbs and asked if there was any assurance in relation to the overseas nurses, from which Countries they had come and that the international nurse recruitment was being implemented ethically. She said that some nurses had been recruited through independent agencies and asked if there was assurance that there was no differential in pay or progression, particularly for the overseas nurses. Prof. Cannaby advised that the Clinical Fellowship roles had not been recruited via agencies and that individuals had applied directly, on an 'earn, learn and return' programme. She said it was important to understand the opportunities that were provided for staff to work and learn in the NHS and confirmed that the overseas nurses received the same terms and conditions as their peers. Prof. Cannaby said that being supported to study was to be seen as a positive and she assured Ms Muflahi that recruitment processes had been ethical and confirmed that they could provide the information to show the Countries that staff had applied from. Prof. Field asked Ms Muflahi to highlight her declarations of interest as it was important for this discussion and for the questions that Ms Muflahi had raised, for the Board and those in attendance, to understand Ms Muflahi's areas of expertise and her role within the RCN and her national role in this area. Ms Muflahi advised that her substantive role was working for the Royal College of Nursing, and her national role was for the nursing support workforce. She explained that she had a particular interest in international nurses. Prof. Field thanked Ms Muflahi and said that as her question had been so well informed that it was important to make people aware of her

	interests. He suggested Ms Muflahi, Prof. Cannaby and Ms Carroll meet and discuss the recruitment programme in more depth, as Ms Muflahi's expertise would be helpful. **Action: Ms Muflahi, Prof. Cannaby and Ms Carroll to meet to discuss in more depth the international nurses recruitment programme.** **Action: Ms Muflahi to review and amend her Declarations of Interest.** Prof. Cannaby said that the international nurses did not want to be known as 'the international nurses' but as nurses that were working at the Trust. She said that the feedback the Trust had received from these nurses was why the focus was on them as 'international' nurses. Prof. Loughton agreed and said that the Organisation would stop referring to these nurses as the 'international' nurses from hereon. Prof. Field thanked everyone for their input and said that these new nurses were valued highly and they were making a positive impact. **Resolved: that the Director of Nursing Report be received and noted.**
296/22	**Patient Experience (& Complaint's report) Annual Report**
	Ms Carroll provided highlights from the Annual Report which consisted of the quarterly reports to Board and which also highlighted the great work of the Patient Experience Team who had undertaken this in partnership with a team of volunteers. Ms Carroll said that the annual report outlined what the Trust had achieved in the last year which included being an early adopter of the National Complaints Framework, raising the unpaid carers role by introducing the Carers passport, the volunteer recovery plan and the friends and family test as well as many more areas including the Manor Lounge for staff. She said that the annual report also set out the key objectives for the next year. Mr Virdee said he was pleased to hear about the work of the volunteers and referring to the breakdown of complaints, he said he had noted that there had been no complaints from the Sikh community. Ms Carroll said she would review this and discuss this with Mr Virdee outside of the meeting. Prof. Cannaby expressed her thanks to Mr Garry Perry and his team for the phenomenal work that they had undertaken and continued to undertake in relation to patient experience. Prof. Field agreed and said that he and Prof. Cannaby would write to Mr Perry to express their thanks. **Action: Prof. Cannaby and Prof. Field to write a letter of thanks to Mr Perry and his team for their work in the Patient Experience team.** **Resolved: that the report from the Patient Experience Bi-monthly Report be noted.**
297/22	**Continuous Quality Improvement**
	Mr Evans highlighted that as part of the Quality Improvement (QI) approach a new structure had been introduced to look at integrating the QI Teams from Walsall and Wolverhampton. He said that the teams would be focussing on the same three themes (Building Capacity & Capability, Supporting Patient Flow and Patient and Staff Safety). Mr Evans advised that Board members had attended a joint Board Development Session with Wolverhampton NHS Trust to discuss QI and that a further session had been arranged for later in the year. Mr Evans said that Walsall Trust have a good national reputation in relation to the ongoing delivery of face-to-face and virtual training of staff from neighbouring trusts and said that in relation to linking in with national teams, the Trust needed to promote that work so that the benefits could be felt through the whole of the Organisation. He said it was helpful to hear

	about the positive impact of QI supporting the working in AMU and said that QI teams were working across the organisation. **Resolved: that the report from the Continuous Quality Improvement Report be noted**.
298/22	**Divisional Director's Midwifery Service Report**
	Ms Jones-Charles highlighted midwifery staffing, starters and leavers and advised that the report had not included the successful recruitment that they had undertaken in April 2022. She said that between now and the end of October 2022 they were likely to completely close their vacancy gap and that their recruitment from abroad had also started to take effect. Ms Jones-Charles referred to the Clinical Negligence Scheme Trust (CNST) and said that she would share CNST updates in her Director of Midwifery report rather than present the Board with a full report at the end of the year. She referred to CNST Action 8 which related to staff training compliance and advised that the Trust was on target to maintain maternity specific compliance. Ms Jones-Charles said that in relation to Ockenden, the Board had declared themselves compliant with Part 1. She said that for Part 2, a high-level gap analysis had been undertaken, including a business case recommending a £2.7m investment over the next 1-3 years for midwifery & obstetrics but also other support services such as neonatal development and surgical capacity development for women, and access to anaesthetics support for patients. Ms Jones-Charles advised that the business case would be presented to the Performance, Finance and Investment Committee for approval. Prof. Field thanked Ms Jones-Charles for the concise presentation of her report. Prof. Cannaby asked what the position of the workforce would be once the students had commenced in September 22. Ms Jones-Charles advised that the service would likely be over-recruited by 2 WTE posts, however this would compensate for maternity leave and she advised that the position was clearly reflected in midwifery service report to PFIC. Mr Assinder referred to CNST Action 8 and asked why the Trust were aspiring to a training compliance of 90% and not 100%. Ms Jones-Charles said that the Trust was aspiring to a 100% compliance target, however, this compliance did include many different staff groups of which a large group would need to be trained over 12 months and therefore they were working to train 90% to meet the national standard. She advised that the CNST recognised this position and advised that the Trust would be targeting those groups who provide a critical service and who were running out of compliance, for example, the delivery suite team. Dr Shehmar referred to the data in relation to caesarean and emergency caesareans and said this data was provided nationally as it changes the maternity pathway for women and particularly first pregnancies. She said that it was important to note that they were supporting the right clinical decision being made at the time of delivery and said that this data had been provided for information and was not used to agree what clinical decisions need to be made about delivery. She said that the obstetrics team would utilise data to ensure that the right decisions were being made clinically. Dr Shehmar advised on the data received from Healthcare Safety Investigation (HCIB) and said it had been reassuring to see that the Trust did not have any themes that were not already captured nationally and to note the improvements that had been made by Ms Jones-Charles and the multi-disciplinary teams. **Resolved: that the Director of Midwifery report be received and noted.**
299/22	**Infection Prevention Control (IPC) Annual Report**
	Ms Carroll provided highlights from the Infection Prevention Control Annual report and

	advised that information in the report had been presented to the Board over the course of the year and detailed the progress made against the 2021/22 annual programme of work, and outlined the plans for infection prevention control for 2022/23. Ms Carroll advised that the Trust had experienced 3 cases of MRSA bacteraemia against a target of zero, there had been 31 toxin positive reportable cases of *'C-Difficile'* against a trajectory of 33. Ms Carroll said that Covid-19 had been a challenging time for both the IPC team and the Trust, with additional demand for prevention and control of infection within healthcare premises. She said that the Trust had been rated as amber by NHSE/I for IPC in December 21 and a re-inspection was due in August 2022 at which she hoped they would be rated green. **Resolved: that the Infection Prevention Control Annual Report be noted.**
300/22	**Audit Committee Annual Review of Activities Report**
	Ms Martin presented the Audit Committee Annual Review of Activities report. **Resolved: that the Audit Committee Annual Review of Activities Report be received and noted.**
301/22	**Pharmacy and Medicines Optimisation Report**
	Dr Shehmar highlighted that audit compliance had been monitored and escalated to Divisions as necessary via the Medicines Management Group. She said that measures had been put in place to strengthen the effectiveness of medicines management through Divisional and Care Group engagement and that risks were being managed and updated by Pharmacy and the respective Divisions through the Divisional Governance Advisors. Dr Shehmar reported that there were now clear improvements in medicines management compliance and this had been achieved through a collaborative effort between pharmacy, the Divisions and Care Groups. Dr Shehmar advised that the known risks in relation to medicines storage and CD record keeping compliance was being monitored and that there were some tentative signs of improvement in some areas. She reported that orders for electronic drug storage units had been raised for AMU, Wards 14-17, Maternity & Ward 24/25 and that the installation of the electronic drug storage units would largely resolve the compliance issues. She explained that Pharmacy were also purchasing a new controlled drug storage unit for the main dispensary. Dr Shehmar said that Controlled Drug record keeping was also being monitored closely and electronic solutions to replace the current paper systems were being considered. **Resolved: that the Pharmacy and Medicines Optimisation Report be noted.**
302/22	**Safeguarding Adults and Children Quarter 4 Report**
	Ms Carroll outlined the key highlights from the Q4 report advising that in February 2022 they had approved a safeguarding business case for expanding the safeguarding team and since then they had successfully recruited a Deputy Head of Safeguarding for Walsall Trust. She reported that the Trust had also recruited to the lead for Safeguarding as Jennifer Robinson had retired, though Ms Robinson would be returning to provide safeguarding training to staff. Ms Carroll advised that there had been staffing shortages in the safeguarding children's team in Q4 which had been due to short term sickness and absences which had since been resolved. She said the Trust was working in collaboration with Wolverhampton NHS Trust in relation to Learning Disabilities (LD) and that a LD nurse was now supporting the Walsall team and the LD agenda, two days a week. Ms Carroll reported that there had been an increase in the cases of domestic violence in comparison to the last quarter, as reported via the Multi-Agency Risk Assessment Conferences (MARAC) and the Multi-Agency Safeguarding Hub (MASH). Ms Carroll said

	that teams were continuing to participate in the Walsall Partnership Board and additional training sessions had also been arranged for staff which would be facilitated by Ms Robinson. She said that the Local Authority and the Clinical Commissioning Group continue to report at the monthly Safeguarding Committees around their assurances for the improvements being made in safeguarding. **Resolved: that the Safeguarding Adults and Children Quarter 4 Report be received and noted.**
303/22	**Nursing Bi-annual Skill Mix Review**
	Ms Carroll advised that the Trust was required to undertake a twice-yearly skill mix review using the national 'Safer Nursing Care Tool'. She reported that the data presented had been collected in January 2022 and that the skill-mix review for this data had been undertaken on all inpatient wards. Ms Carroll said it was important to note that at the time of the review, the Trust was at the peak of the Covid-19 variant 'Omicron'. She said that she would not be recommending any changes to the current establishment and that skill-mix data was currently being collected for the period of June 22 which would be reviewed at the end of the month and presented at a future Trust Board meeting. **Resolved: that the Nursing Bi-annual Skill Mix Review Report be received and noted.**
CARE AT HOME	
304/22	**Walsall Together Partnership Board Chair's Report**
	Prof. Vernon highlighted board assurance and matters of escalation for Walsall Together, advising that there had been no escalations or any matters of significant risk to report. He said that since commencing in his role as Chair of Walsall Together in April 2022, he had attended 2 Walsall Together Partnership Board meetings and had met with Trust Board members and other colleagues in the Trust. He thanked Rachel Gallagher, Matthew Dodd and Michelle McManus for their support and Mr Sharon for his support and induction to his role and wished Mr Sharon well for his retirement. Prof. Vernon said that there was huge pride by the Trust in supporting Walsall Together and that as Chair of Walsall Together, he would maintain a positive relationship with all partners and stakeholders in tackling health and inequalities in Walsall. He advised that Walsall Together were reviewing their place-based approach in line with the Black Country ICS. He said that Walsall Together had put in place new workstreams in relation to governance and were in the process of appointing clinicians to support them in this work and in their options as a partnership. He said that Walsall Together would like for Walsall NHS Trust Board to have a part in that process so that they achieve a collective outcome. Prof. Vernon presented a recent patient story which had been shared at the Walsall Partnership Board and which had raised questions about mental health services such as access from a primary care level, tertiary level, what more they could do at a community level and approaches to developing social prescribing as well as the role of the voluntary sector. Prof. Vernon reported that Walsall Together would continue to work on the transformation agenda and noted the impact that Covid-19 had had on that agenda. He said that as a Board they wanted to ensure they were in synergy with Walsall Healthcare Trust Board and advised that staff and workforce issues and how they get patients and communities to be involved in the transformation agenda would be important. **Resolved: that the Chair of Walsall Together Partnership Board be received and noted.**

	The Board convened for a 10 minute break at 11.20am.
305/22	**Care at Home Executive Report**
	Mr Dodd highlighted the key areas of the report, in relation to workforce from a partnership perspective and assurance that the team were working with Partners in Walsall Together to support the care facilities, care homes and GPs to ensure necessary support and infrastructures in the Community. Mr Dodd said that a review of the apprenticeship levy was also being undertaken as well as training nurse associates and discussions were being held with primary care about joint appointments and also overseas recruitment. Mr Dodd reported that there was continued strong performance in out of hospital care and that in April 2022 the Care Navigation Centre had received 1200 calls and had been able to avoid sending people to hospital, instead using community resources to support patients and provide the care to these patients in their homes. Mr Dodd reported that an impact quantification had been undertaken of what this meant for hospital activity which would enable the team to start to target this to existing services which may need to be expanded. Mr Assinder said trying to quantify the impact on acute bed days was good and asked on thoughts on the different interventions and what that would mean for patients over a longer period of time. Mr Dodd said that the team had started to work with the Academy and the Integrated Care System (ICS) to begin to standardise an evaluation but had not as yet undertaken a deep-dive analysis. Prof. Field said that as a Trust, they need to undertake an external research programme and suggested the Kings Fund or the Health Service Management Centre, Birmingham City University. Prof. Loughton advised Mr Dodd that this external review should be accelerated as an independent evaluation was crucial. **Resolved: that the Care at Home Executive Report be received and noted.**
306/22	**Information Governance Strategy & Policy Documentation Report**
	Mr Bostock reported that the Trust had had an external review commissioned by NHS Digital Cyber Operational Readiness Support Team to look at the Trust's Information Governance Strategy and Policies, following which the NHS Digital team had recommended that the Trust retire the strategy and rewrite a new suite of policies. He said that the Trust had adopted this recommendation and the Strategy had been retired, 7 policies had been reviewed within the last 6 months and the remainder were on schedule to be reviewed and implemented by August 2022. **Resolved: that the Information Governance Strategy & Policy Documentation Report be received and noted.**
307/22	**Information Governance: 2021/22 Data Security & Protection Toolkit (DSPT) Submission Report**
	Mr Bostock reported that the data was due for submission to NHS Digital and advised that at their pre-submission assessment in February 2022, they had met 96 out of the 109 mandatory standards from 10 domain standards. He said that the Trust had received assurances in relation to the remaining number to bring them to 100% and that the governance team would be meeting on the 23rd June to review the Trust submission ahead of submitting it on the 30th June 22. Mr Bostock reported that Grant Thornton, the internal Auditors for the Trust, had carried out a planned assurance review which had returned a grading of significant assurance with some improvement required. He advised that the Trust had also been randomly selected by NHS Digital to have a 2nd audit undertaken, by KPMG, to inform their future processes. He said that this audit had graded the Trust with substantial assurance with improvement

	required and advised however that this grading would not have any impact on the Trust. Prof. Field thanked Mr Bostock for his report and said that this was great progress against an improving trajectory. **Resolved: that the Information Governance: 2021/22 Data Security and Protection Tookit (DSPT) Submission Report be received and noted.**
308/22	**Trust Strategy**
	Mr Evans advised that the Trust was undertaking to develop a joint strategy with Wolverhampton NHS Trust. He outlined the key areas of the report and said that activity and engagement processes had taken place at both Trusts. He reported that the first meeting of the Committee in Common sub-group had been held and had been a positive meeting attended by both Non-Executive Directors and Executive Directors. Mr Evans said that once the new strategy had been implemented, the Trust would have one strategy across the Organisation with 8 enabling strategies. He said that the 8 enabling strategies had been identified in the report and these would help to underpin and support the overall strategy. Mr Virdee said that the Equality, Diversity and Inclusion (EDI) strategy had not been included as an enabling strategy and asked if this was because it would be included as a theme across all the strategies. Ms Griffiths advised that this was correct, and that the EDI strategy would be included in all the enabling strategies as a common theme, however the People Engagement and Organisational Development strategy, which was one of the 8 enabling strategies was based on the Trust's 7 pillars of patient care: - **Put patients at the centre** of every action every time - **Work as a team** to deliver excellent patient experience - **Listen and hear** the patients voice - **Remove barriers** to excellent care - **Work as a team** to create excellent staff experience - **Always caring** to patients, colleagues and self - **Always speak up** to improve patient care. **Resolved: that the Trust Strategy be received and noted.**
309/22	**Green Plan & Sustainability Update**
	Mr Evans provided an update on the good progress which had been made with the Green Plan formalised in February 2022. He said that whilst the Trust had not been achieving the required target, he was pleased with the reduction in relation to anaesthetic gases as they had previously been 1 of the 10 worst Trusts in the Country. He explained that the target was 10% and the Trust had now reported at 11%. Mr Evans said that they would need additional resources to meet the other targets in the Green Plan and said that a plan had been put in place to enable this. He reported that the Trust had undertaken a joint exercise with RWT on the carbon footprint benchmarking, which all Trusts had had to undertake and said that they had made good progress with this. Mr Evans said that the Organisation needed more services to sign up to being greener services however they were now receiving good traction on this. Mr Assinder asked how the PFI relationship would work in terms of delivering the green agenda. Mr Evans said that PFI colleagues were working with the sustainability group and attending all of their monthly meetings. He said that much of the data that was needed would be provided by PFI colleagues and further work was required in relation to this in respect of the Walsall site. Prof. Loughton said it was important to put in place these negotiations with PFI colleagues.

	Mr Evans reported that both Walsall Trust and Wolverhampton Trust have Non-Executive Director Leads for the Sustainability agenda. **Resolved: that the Green Plan and Sustainability Update be received.**
USE RESOURCES WELL	
310/22	**Audit Committee Chair's Report**
	Ms Martin provided the Chair's report, advising that at the last Audit Committee held in May 2022, the Committee had received a report on Security services which stated that 8000 hours had been recorded in the last 12 months where security staff had been required to sit with patients. Ms Martin said that the Audit Committee had agreed that this report should be presented to the Quality, Patient Experience and Safety Committee for further discussion as there was concern that security staff were not trained to sit with some of these patients in the way that they should be. Ms Martin advised that the Audit Committee had been pleased that this had been highlighted to them and said that the security policy was being reviewed in light of this. Prof. Loughton said that a joint discussion was required with both Walsall and Wolverhampton Trusts for a new approach to their security services. He said that they also needed to stipulate how many female security staff had been employed and to re-write some of the contracts to include that security staff should have appropriate training in place to enable them to sit with patients, including first aid mental health training and training for dealing with adolescents. Ms Martin advised that the Annual External audit had been delayed and the Audit Committee would be meeting a week later than planned and said that they were on track to complete the audit at that point. **Resolved: that the Audit Committee Chair's Report be received and noted.**
VALUE OUR COLLEAGUES	
311/22	**Freedom to Speak Up**
	Ms Griffiths presented the Q4 report, highlighting specifically the cultural element in the 'attitudes and behaviours' within concerns that had been raised and said that this was a key part of how the Organisation was changing its culture. Ms Griffiths said that strengthening policies and undertaking rolled-out training had addressed some of the concerns. Mr Virdee referred to civility of staff towards each other and patients and said that whilst the Trust could ask staff to undertake training it would be more difficult to change attitude and asked how this would be managed. Prof. Loughton said that behaviours had to change and the message to all staff had to be that these are the Trust's behaviours towards colleagues and patients and anything else would be unacceptable. Ms Griffiths said that a lot of training had been undertaken for respect and civility with managers and this had continued during the Covid-19 pandemic. Dr Shehmar said that civility and improved patient care had been embedded into other workstreams too and that cultural and behavioural work included all these points and said that the Trust had evidence that behaviours in some areas/Divisions had started to positively change and that individuals were now being managed appropriately. **Resolved: that the Freedom to Speak Up report be received.**
312/22	**Staff Networks**
	Ms Griffiths advised that the Chair of the Women and Allied Networks Group, and Sabrina Richards, were leading on the Staff Networks group and that this group was a key part of both staff and patient experience.

	Prof. Field said it was important to value this work and due to a lack of time, he requested that the Staff Network attend a future Board development session where more dedicated time could be provided to talk about the networks, especially as it also linked in with the Board's earlier discussions in relation to cultures and behaviours. Ms Griffiths said that the Network would appreciate that opportunity. **Action: Ms Griffiths to liaise with Mr Wilshere to agree a date for the Staff Network to attend a future Board development session.** **Resolved: that the Staff Networks presentation be received at a future Board development session.**
313/22	**Guardian of Safe Working Hours – Quarterly Report**
	Dr Shehmar reported that during the Covid-19 pandemic and due to the availability of clinical staff to write reports, reports on 'Guardian of Safe Working Hours' had not been produced and it was why so many reports had been provided at today's Board meeting. Dr Shehmar advised that the Trust was now up to date with their reporting and highlighted the main themes, noting that that these were through Covid-19. She reported on the safety concerns in relation to Senior cover and said that these concerns had been addressed through the Clinical Fellowship Programme, the Medical Workforce Group, as well as reviewing how the Trust had been managing inductions. She said that Trust inductions had now been staggered and they were ensuring that clinical activity would be reduced in August to support supervision of the new doctors. Dr Shehmar advised of the positive feedback received at the most recent junior doctor forum from 3 areas that had been previously headlined in the Guardian of Safe Working Hours report. Mr Hemans commended Mushal Naqvi on the work that she had undertaken in relation to the Guardian of Safe Working Hours. **Resolved: that the Guardian of Safe Working Hours – Quarterly Report be received.**
REPORTS FOR INFORMATION – MINUTES OF COMMITTEE MEETINGS	
314/22	**Quality, Patient Experience and Safety Committee (QPES)**
	The Board Members received, for information, the confirmed minutes of the QPES meeting held in April 2022. **Resolved: that the minutes of the Quality, Patient Experience and Safety Committee Meeting held in April 2022 be received.**
315/22	**People and Organisational Development Committee (PODC)**
	The Board Members received, for information, the confirmed minutes of the PODC meeting held in April 2022. **Resolved: that the minutes of the People and Organisational Development Committee Committee Meeting held in April 2022 be received.**
316/22	**Walsall Together Partnership Board Meeting**
	The Board Members received, for information, the confirmed minutes of the Walsall Together Partnership Board meeting. **Resolved: that the minutes of the Walsall Together Partnership Board Meeting held in April 2022 be received.**
317/22	**Performance, Finance and Investment Committee (PFIC)**
	The Board members received, for information, the confirmed minutes of the PFIC meeting held in April 2022.

	Resolved: that the minutes of the Performance, Finance and Investment Committee Meeting held in April 2022 be received.
CLOSING ITEMS	
318/22	**Any Other Business**
	Prof. Field noted that no other business was raised.
319/22	**Date and time of the next meeting**
	Prof. Field confirmed that the next meeting was to take place on Wednesday, 3rd August 2022.
320/22	**Questions from the Public/Commissioners**
	Prof. Field confirmed that there were no questions raised from the public/commissioners.
321/22	**Resolution**
	To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest. **Resolved: that the resolution be approved.** **The meeting concluded at 13:15**

Walsall Healthcare NHS
NHS Trust

29 July 2022 15:08

List of confidential action items Public Trust Board 8 June 2022

Agenda item		Assigned to	Deadline	Status
3 Minutes of the last meeting				
339.	Minutes of the Last Meeting held on the 6th April 2022	Toor, Jaswinder	27/06/2022	Completed
	Explanation action item Mr Hobbs advised of a typographical amendment to the minutes held of the meeting held on the 6th April 2022, page 5, paragraph 3, which should be amended to read: "Mr Hobbs explained that breast services had been challenged at the Trust and across the Black Country for capacity to see patients within two-weeks for some time and had been further exacerbated by a rise in referrals following wave 1 and the sickness absence of 2 of 3 Consultants at the Trust".			
7.1 Board Member Attendance				
340.	Board Member Attendance Report 2021-22	Toor, Jaswinder	27/06/2022	Completed
	Explanation action item Ms Brathwaite had advised of an amendment to the report in relation to her attendance record for the period 2021-22. Mrs Toor change the report to to reflect the amendment.			
11.1 Director of Nursing Report				
342.	Director of Nursing Report - in relation to nursing agency use	Carroll, Lisa	05/10/2022	Pending
	Explanation action item Ms Carroll agreed to share the plan that the Head of Workforce was working on with the Divisional Directors of Nursing to cease agency use across all general wards.			
343.	Director of Nursing Report - re: Health Visitors	Carroll, Lisa	05/10/2022	Pending

	Explanation action item Prof. Loughton asked Ms Carroll and Ms Hickman to set up a taskforce to review the vacancy rates in health visiting, access to faster training and recruitment, including overseas.			
344.	Director of Nursing Report - Overseas Nursing - Recruitment process	Cannaby, Ann-Marie Prof. Carroll, Lisa Muflahi, Ofrah	04/07/2022	Completed
	Explanation action item Ms Muflahi, Prof. Cannaby and Ms Carroll to meet to discuss the recruitment process for the overseas nursing programme.			
	Explanation Muflahi, Ofrah met on 08.07.2022			
383.	Discussion in relation to overseas nurses and queries raised by Ms Ofrah Muflahi	Muflahi, Ofrah	26/07/2022	Completed
	Explanation action item Prof. Field asked Ms Muflahi to highlight her declarations of interest to understand her areas of expertise and her role within the RCN and her national role in this area. Ms Ofrah Muflahi to review and amend her declarations of interest record accordingly.			
11.2 Patient Experience (& Complaints Report) - Annual Report				
345.	Patient Experience (&Complaints Report)	Cannaby, Ann-Marie Prof. Field, Steve Prof.	01/09/2022	Pending
	Explanation action item Prof. Field and Prof. Cannaby to write to Mr Perry and his team for the work that they have undertaken and continue to do in relation to the patient experience.			
14.2 Staff Networks				
346.	Staff Networks - Presentation to RWT/WHT Board Development Session	Griffiths, Catherine Wilshere, Keith	04/07/2022	Completed

	Explanation action item Mr Wilshere and Ms Griffiths to agree for the Staff Network to attend a future board development session.
	Explanation Wilshere, Keith Arrangements being agreed for a BDS on Staff Networks Provisionally arranged for 2/11/22 pm

The Seven Principles of Public Life
‘Nolan principles’

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

1. Selflessness

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

2. Integrity

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

3. Objectivity

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

4. Accountability

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

5. Openness

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

6. Honesty

Holders of public office should be truthful.

7. Leadership

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

Our **Vision, Objectives & Values**

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

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

Our Vision: **Caring for Walsall together**

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

Our Objectives: **Underpinning the vision**

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

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

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

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

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

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

Walsall Healthcare NHS
NHS Trust

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

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

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

MEETING OF THE PUBLIC TRUST BOARD – 3 August 2022			
Chief Executive Officer's Report			
Report Author and Job Title:	Gayle Nightingale Executive Assistant	**Responsible Director:**	Prof David Loughton CBE, Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• Assurance relating to the appropriate activity of the Chief Executive Officer.		
Advise	• The paper includes details of key activities undertaken since the last Trust Board meeting.		
Alert	• None in this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

CHIEF EXECUTIVE OFFICER'S REPORT

1.0	**Review**
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	**Consultants**
	There has been seven Consultant Appointments since I last reported: **Paediatrics - Sub-Specialty Interest in Acute Paediatrics** Dr Nabil Fassaludhin **Paediatrics Special Interest in Neonates** Dr Pratima Jain **Respiratory Medicine** Dr Indrajit Sau **Physician - Special Interest in Diabetes and Endocrinology** Dr Syed Taqui **Obstetrics** Dr Yomna Salem **Obstetrics and Gynacology** Dr Suravi Ghatak Dr Grisham Smotra
3.0	**Policies and Strategies**
	Policies for June 2022 • Policy Management Quarter 1 Report • CP919 V2 – Operational Policy for the Care of Patients Suffering Major Trauma • CP925 V6 – Resuscitation Policy • HR923 V3 – Flexible Retirement Policy • IPC924 V1 – Waste Management Policy • OP15 V1 - Procurement Policy • OP82 V2 – Not Brought/ Unable to Contact/ No Access and Multiple Cancellation Policy • OP915 V2.2 – Management of Transport Policy **Policies for July 2022** • Policy Report Quarter 2 Report • CP926 V4 – Emergency Department Operational Policy • HS933 V1.3 – Work Equipment Policy

	• HS934 V2 – Working at Height Policy • IPC932 V4 – Personal Protective Equipment (PPE) Policy • OP91 V5 – Data Quality Policy • Process for Acute Epilepsy Transition Trust-wide Standard Operating Procedure (SOP)
4.0	**Visits and Events**
	• Since the last Board meeting, I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since Monday 3 August 2020 I have participated in weekly calls with the Black Country and West Birmingham Strategic Transformation Partnership (STP) on the co-ordination of a collective Birmingham and the Black Country restoration and recovery plan and COVID-19 regional update • 17 May 2022 – was a virtual panel member on the National Financial Talent Pool interviews • 20 May 2022 – virtually met with Dr Helen Paterson, Chief Executive, Walsall Council • 24 May 2022 – participated in the opening of the Leon Talbot Clinical Suite at Holly Bank House • 25 May 2022 – participated in the virtual stakeholder Integrated Care Board (ICB) Chief Executive interviews • 26 May 2022 – undertook a presentation at the Society for Education in Anaesthesia (SEA) UK Annual Scientific Meeting on the provision of medical education and participated in a virtual Black Country Integrated Care System (ICS) Development Workshop • 1 June 2022 – hosted a visit from Professor Tim Briggs, Chair of the Getting It Right First Time (GIRFT) programme and Consultant Orthopaedics • 6 June 2022 - participated in the virtual Joint Liaison Committee with Skanska and presented the staff Long Service Awards with Professor Steve Field, Chairman – virtually • 7 June 2022 – presented the National Institute for Health and Care Research (NIHR) research awards • 21 June 2022 – participated in the virtual The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT) Maternity Safety Executive meeting and participated in a virtual national roundtable discussion on the delivery of the Continuous Improvement programme • 22 June 2022 – presented with Kevin Stringer, Chief Financial Officer (RWT) to the National Financial Academy on the future financial expectations of Trust Boards and chaired a virtual staff briefing • 23 June 2022 – participated in a virtual ICS Development session and an ICS Masterclass and participated in a virtual West Midlands Acute meeting • 27 June 2022 – participated in the virtual Getting It Right First Time (GIRFT) Acute and General Medicine webinar • 28 June 2022 – participated in a Black Country ICS Collaborative Board

	• 4 July 2022 – participated in a Regional NHS Roadshow with Amanda Pritchard, Chief Executive – NHS England/ Improvement (NHSE/I) • 5 July 2022 – joined along with the Mayor of Walsall the Well Wishers Charity event and participated in a virtual Joint Oversight meeting with the ICS and NHS Midlands • 8 July 2022 - participated in a virtual IHSCM Executive Advisory Committee Meeting • 11 July 2022 – participated in a Black Country ICS Clinical Summit • 12 July 2022 – chaired the virtual West Midlands Cancer Alliance Board • 13 July 2022 – chaired the virtual Staff Briefing • 15 July 2022 – held a virtual update meeting with MPs - Eddie Hughes and Wendy Morton
5.0	**Board Matters**
	There were no Board Matters to report on.

MEETING OF THE PUBLIC TRUST BOARD – 3 August 2022			
Chair's report of the Trust Management Committee (TMC) held on 28 June 2022 – to note this was a virtual meeting			
Report Author and Job Title:	Gayle Nightingale, Executive Assistant	**Responsible Director:**	Prof David Loughton, CBE, Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• None in this report.		
Advise	• Matters discussed and reviewed at the most recent TMC.		
Alert	• None in this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

1.0	**Key Current Issues/Topic Areas/ Innovation Items:**
	• There were none this month.
2.0	**Exception Reports**
	• There were none this month.
3.0	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	• Director of Nursing Report • Midwifery Service Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Walsall Together Report • Trust Financial Position (Revenue and Capital) - Month 2 Report • Integrated Quality Performance Report (IQPR) • Workforce Supply Incentive Programme – Black Country Pathology Services (BCPS) Report • Workforce Summary Report • Workforce Metrics Report • Corporate Risk Register/ Board Assurance Framework Report • Commonwealth Games Update Report • Urgent and Emergency Care Centre's Capital Build Update Report • Care Quality Commission (CQC) Action Plan
4.0	**Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting**
	• Director of Nursing – Infection Prevention Annual Report • Freedom to Speak Up Guardian Report • Business Disability Forum - Specific, Measurable, Achievable, Realistic and Time-bound (SMART) Assessment Report • Acute Collaboration Report • Learning from Deaths Report • Research and Development Report • Equalities – Annual Report
5.0	**Business Cases – approved**
	• Discharge Lounge Business Case
6.0	**Policies approved**
	• Policy Management Quarter 1 Report

	• CP919 V2 – Operational Policy for the Care of Patients Suffering Major Trauma • CP925 V6 – Resuscitation Policy • HR923 V3 – Flexible Retirement Policy • IPC924 V1 – Waste Management Policy • OP15 V1 - Procurement Policy • OP82 V2 – Not Brought/ Unable to Contact/ No Access and Multiple Cancellation Policy • OP915 V2.2 – Management of Transport Policy
7.0	**Other items discussed**
	There were none this month.

MEETING OF THE PUBLIC TRUST BOARD – 3 August 2022			
Chair's report of the Trust Management Committee (TMC) held on 26 July 2022 – to note this was a virtual meeting			
Report Author and Job Title:	Gayle Nightingale, Executive Assistant	**Responsible Director:**	Prof David Loughton, CBE, Chief Executive Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• None in this report.		
Advise	• Matters discussed and reviewed at the most recent TMC.		
Alert	• None in this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
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1.0	**Key Current Issues/Topic Areas/ Innovation Items:**
	• There were none this month.
2.0	**Exception Reports**
	• There were none this month.
3.0	**Items to Note – all of the following reports were reviewed and noted in the meeting**
	• Review of Trust Management Committee (TMC) Terms of Reference (TOR) Report • Director of Nursing Report • Midwifery Service Report • Divisional Quality and Governance Report – Medicines and Long-Term Conditions Report • Divisional Quality and Governance Report – Surgery Report • Divisional Quality and Governance Report – Women's, Children's and Clinical Support Services Report • Divisional Quality and Governance Report – Community Services Report • Trust Financial Position (Revenue and Capital) - Month 3 Report • Integrated Quality Performance Report (IQPR) • Walsall Together Report • Workforce Summary Report • Workforce Metrics Report • Care Quality Commission (CQC) Action Plan
4.0	**Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual) – all of the following reports were reviewed, discussed* and noted in the meeting**
	• Acute Collaboration Report • Quarterly Medicines Management Report • Research and Development Report • Digital including Digital Improvement Report • NHS England/ Improvement (NHSE/ I) Undertakings Report • Information Governance (IG) Toolkit Requirements Report • Sustainability and Green Plan Update Report • Urgent and Emergency Care Centre's Capital Build Update Report • Contracting and Business Development Verbal Update •
5.0	**Business Cases – approved**
	• Terms of Reference for the Investment Group • Business Case to fund General Surgery Medial Workforce – Non-elective elements to address Quality and Safety Risks • Business Case too Support the Implementation of the Obstetric Medical Workforce Element of the Recommendations advised from the Final Independent Review of Maternity Services Report (Ockendon)

6.0	**Policies approved**
	• Policy Management Quarter 2 Report • CP926 V4 – Emergency Department Operational Policy • HS933 V1.3 – Work Equipment Policy • HS934 V2 – Working at Height Policy • IPC932 V4 – Personal Protective Equipment (PPE) Policy • OP91 V5 – Data Quality Policy • Process for Acute Epilepsy Transition Trust-wide Standard Operating Procedure (SOP)
7.0	**Other items discussed**
	There were none this month.

Walsall Healthcare NHS
NHS Trust

Integrated Quality & Performance Report

June 2022

Caring for Walsall together

How to Interpret SPC (Statistical Process Control) 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.

IQPR Ragging Methodology

Performing against Trajectory	SPC Assurance	SPC Variation	Rationale	Ragging Applied
Yes			Monthly performance has achieved the set trajectory *and is showing continual improvement in* performance over recent months. In some cases, the current process is fully capable of achieving the target set for the metric.	Green
Yes				Green
Yes				Green
Yes			Monthly performance has achieved the set trajectory but performance across recent months is showing inconsistencies against set trajectories and targets	Amber
Yes				Amber
Yes				Amber
Yes				Amber
Yes				Amber
Yes				Amber

Performing against Trajectory	SPC Assurance	SPC Variation	Rationale	Ragging Applied
No			Monthly performance has not achieved the set trajectory and is showing continual decline in performance over recent months. In some cases, the current process is not capable of achieving the target set for the metric.	Red
No				Red
No				Red
No			Monthly performance has not achieved the set trajectory but performance across recent months is showing improvements towards set trajectories and targets	Amber
No				Amber
No				Amber
No				Amber
No				Amber
No				Amber

EXECUTIVE SUMMARY

QUALITY	PERFORMANCE
• Trust wide CQC action plan with responsible executive directors and identified leads has been established. • Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels remains at a score of 15 and international nurse recrutiment continues at pace. • VTE compliance is 88.45%, a decrease in compliance from 90.96% in May 2022. Divisional teams continue to report on their performance and improvement plans into Patient Safety Group (PSG). • The prevalence of timely observations in June 2022 was 78.02%. Changes have been made to the thresholds for late observations which has seen a significant drop in compliance. • Falls per 1000 bed days was 3.54% in June 2022 and in line with the previous consistent performance. • The Trust target for Clostridium difficile 2022/23 has been set at 27 cases with 4 C.Diff cases reported for June 2022. In all cases reviewed, patients had justifiable antibiotics. • The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 67.33% by E-sepsis audit in June 2022. Manual audits have been ceased. • Safeguarding adults and children's training is achieving trust target for all level 1 and level 2 training. Level 3 adult and children's training remains below trust target. Improvement plans report into safeguarding committee and additional training is being provided by the safeguarding team.	• The Trust continues to deliver the best Ambulance Handover times (<30 minutes) in the West Midlands, being the top performing organisation for 16 out of the last 17 months. This has been achieved despite June 2022 being the 2nd highest month of Type 1 ED attendances on record. The Trust continued to support neighbouring Trusts through receipt of intelligently conveyed ambulances. • 4-hour Emergency Access Standard performance in June 2022 had 72.98% of patients admitted or discharged within 4 hours of arrival to ED. The Trust was ranked 40th nationally out of 111 Trusts • In May 2022, for 62-day Cancer performance the Trust was materially better than West Midlands average (48.7%) and better than national average (61.5%) with 71.8% of our patients treated within 62 days of GP referral • The Trust delivered significant improvements in access to sonography and MRI services following recent challenges, but has experienced issues with Cardiac Physiology and Endoscopy waiting times in the last 2 months. The Trust's 6 Week Wait (DM01) Diagnostics performance is 19th best (May 2022), out of 122 reporting general acute Trusts • The Trust's 18-week RTT performance remains in line with trajectory with 61.87% of patients waiting under 18 weeks at the end of June 2022, the national ranking position is stable at 70th (out of 122 Trusts) for May 2022. The Trust's 52-week waiting time performance is 7th best in the Midlands (out of 20 Midlands Trusts). The Trust now has 861 patients waiting in excess of 52-weeks as at the end of June 2022. • Board should note the following risks: • Patients referred by their GP on 2 week wait suspected cancer and Breast symptomatic pathways are experiencing longer waiting times, despite improved performance in May. Mutual aid has been provided from Royal Wolverhampton Trust, Dudley Group NHS Foundation Trust and Sandwell & West Birmingham.
WORKFORCE	**FINANCE**
• Sickness absence still within a downtrend, despite the Jun-22 rise. • Mandatory training compliance remains stable just below the 90% target. • Uptrend remains in tact, with PDR compliance stablised within the upper half of a 75% - 85% range for several months.	• The Trust enters 2022/23 with clear risks to revenue and capital, income reduced by 57% of Covid-19 resource and an efficiency ask. To maintain financial balance the Trust will need to deliver an efficiency program, cease agency and reduce Covid-19 costs. In addition, the capital allocation is insufficient to resource the program for 2022/23 and additional discussions are ongoing to secure further allocations. • In June of 2022 all Integrated Care Systems (ICS) were allocated additional funding and required by the regulator to review financial outturn following the plan submissions made in April 2022. • Trust Board debated the request, with Executive endorsement (following prioritisation of essential developments) and Performance & Finance Committee approval (via delegation of powers from the Board) an improved planned outturn for the 2022/23 financial year of break-even was submitted (previous submission in April a £7.6m deficit). The ICS also submitting a balanced financial plan for the 2022/23 year. • In month 3 the Trust reported a £0.600m deficit, which is £1.478m adverse to plan. This was driven by higher than planned temporary staffing costs and non achievement of CIP plan, both elements remaining a significant risk to delivery. • The capital expenditure full year plan totals £38m, noting resources for the theatres upgrade are still to be secured. However, the cash position remains strong.

Trust Board Meeting
Committee Chair's Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	**Performance and Finance Committee**
Date(s) of Committee Meetings since last	**Wednesday 27th July 2022**
Chair of Committee:	**Paul Assinder, Non-Executive Director**
Date of Report:	**Wednesday 27th July 2022**

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	**Financial Position 2022/23** **Revenue** • The Trust has a £0.6m YTD deficit to 30th June 2022, with an adverse variance to plan of c£1.4m. There remains significant risk to achievement of the financial plan. • Cost Improvement Plans identified to date total £5.5m, against a target of £6.3m for the year (some elements of the £5.5m rated as high risk). The plan phased to deliver higher savings in the latter half of the year (increasing risk to delivery). • Agency usage (whilst reducing) remains above planned levels. The Director of Nursing has confirmed a plan for reduction in agency usage was being implemented. • The Trust is funded to deliver 104% of 2019/20 elective performance during 2022/23. Current performance totals 88%, so there is a risk of clawback of income (though considered to be low). It is unlikely the Trust will earn further income in year by exceeding the 104% threshold • Sickness remains high and is driving increased costs through payment of premiums for agency staff • The 2022/23 national pay award was announced, whilst expected to be cost neutral owing to NHSEI re-prioritising resources, the detailed costings and indeed notification of enhanced income allocations are yet to be confirmed and so represents a potential risk to delivery of the planned outturn • The ICS has reported a £21m deficit year to date, adverse to plan by c£10m. The performance of the ICS and risk share signed up to by the Trust introduces further risk to attainment of financial outturn **Capital** • The Trust has yet to secure the funds required to deliver the theatres capital programme, whilst work continues with ICS colleagues the re-prioritisation of funds to support the pay award will make this more difficult to secure. • The overall capital programme is c£38m for the year, requiring managing to deliver multi-million-pound developments for the ED, wards, and theatres (noting the current construction industry prevailing conditions).

ADVISE Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought	

Estates Management

- Members requested the estates survey and key risks to be shared at the next meeting
- The ED construction project is set to conclude by the end of October for handover and occupancy (and opening) in middle of November 2022. This is being managed in the knowledge of the current factors impacting on supply within the construction industry

Financial Performance

- Cost Improvement target identification and delivery is being escalated with Operational teams to close the current shortfall. Members are now seeking further assurance over identification of schemes to close the gap and in addition of delivery of current schemes
- Agency costs are reducing month on month owing to successful overseas recruitment drives within Nursing, detailed plans for cessation of Nursing agency have been requested by members. It is also of note that agency targeted reductions have been set at 30%, with the reduction for Walsall to be notified prior to submission of Month 4 reported performance

Performance

- Performance remains strong from the Community Division, with Medically Stable lists low in comparison to historic levels.
- The Community Services Division has bid for additional resources for virtual care, with detailed plans to be presented through the Investment Group that reports to Trust Management Group that results in a model that targets treatment in the Community as opposed to creation of more acute capacity to deliver growth.
- Members received assurances over elective care performance, noting that the MRI waiting time recovery plan has been delivered, with the key concern the continued increase in emergency care referrals.
- A focus is to be placed upon current DNA rates with members questioning the viability of an efficiency gain if this improvement could be delivered, with more information requested for the next meeting.
- Walsall's Community Services have been shortlisted for national exemplar status

Business Cases

- **Obstetric Medical Staffing business case** was approved by members (this a safety issue). Funding is not secured, so will deteriorate the normalised position, until alternative resources can be identified. Members noted a further case is under construction that would increase the ask by c£3m and asked that the Board be alerted to this.

- **Surgery Medical Staffing business case, (On-call rota and Gall Bladder Surgery)** The case is based on a safety need and has identified funds to offset the costs from cancer and winter allocations, on this basis the case was supported by members. It was noted the Chief Operating Officer endorsed within the plan to live within the £4m allocation for winter, this case reducing the allocation further to £1.6m remaining available following previous multi-million-pound cases put to members at earlier meetings.

ASSURE Positive assurances & highlights of note for the Board/Committee	**Revenue** • The Trust Annual Accounts 2021/22 demonstrated achievement of a surplus, Audited accounts receiving a clean bill of health • The Trust has now attained all financial performance targets for the past three financial years • Members received confirmation policies for long and short-term sickness absence management are in place, managers trained in these policies. • Nursing agency usage is reducing within the Trust **Capital & Cash** • The Trust has delivered two theatres full upgrade's, four ward refurbishments and is on target to open the Emergency Department during November 2022 • The Trust has a strong cash position moving into the 2022/23 financial year **Performance** • Performance on elective care is very positive with 52 week waits remaining stable in May 2022. However, members have requested detailed trajectories articulating how the 868 over 52 week waiters & the significant over 18 weeks cohorts will be addressed during the financial year. • An external review has been performed on DNA rates on outpatient pathways. These findings will be implemented to reduce DNA rates. • Medically fit numbers remain low compared to historic levels seen by the Trust • Elective performance is comparable to neighbouring Trusts at 88% of historic elective activity undertaken in 2019/20
Recommendation(s) to the Board	**Board to note:** • The Trust has a financial deficit year to date, driven largely by temporary workforce and Cost Improvement Programme shortfalls (noting impacts of high levels of sickness). Risks regarding ICS financial position and the recent pay award also of note. • Business cases endorsed by Committee were Obstetric medical workforce in response to Ockenden II (noting a further business case is to be presented at c£3m). In addition, the Surgery case was approved, in part though further use of winter resources by the Chief Operating Officer
Changes to BAF Risk(s) & TRR Risk(s) agreed	No changes, as all ratings are red and high for delivery of financial plan and sustainability with BAF & CRR to be reported bi-monthly. However, a request was made from members for the reporting to coincide with Trust Board reporting timelines moving forwards (reports presented to August committee).
ACTIONS Significant follow up	Chief Operating Officer (COO) to report on Cost Improvement and Estates key infrastructure risks, and review of plans to cease agency usage by Chief Nurse. Further updates requested on attendance and pay award impacts once known.
ACTIVITY SUMMARY Major items discussed including those Approved	• Financial deficit year to date - CIP review and temporary workforce oversight • The Business Case for Obstetric medical workforce (noting a further case under development for the remainder of the workforce at c£3m) and Surgery on-call and Gall Bladder surgery approved (the latter utilising further the winter pressures funding by the Chief Operating Officer)
Matters presented for information	N/A

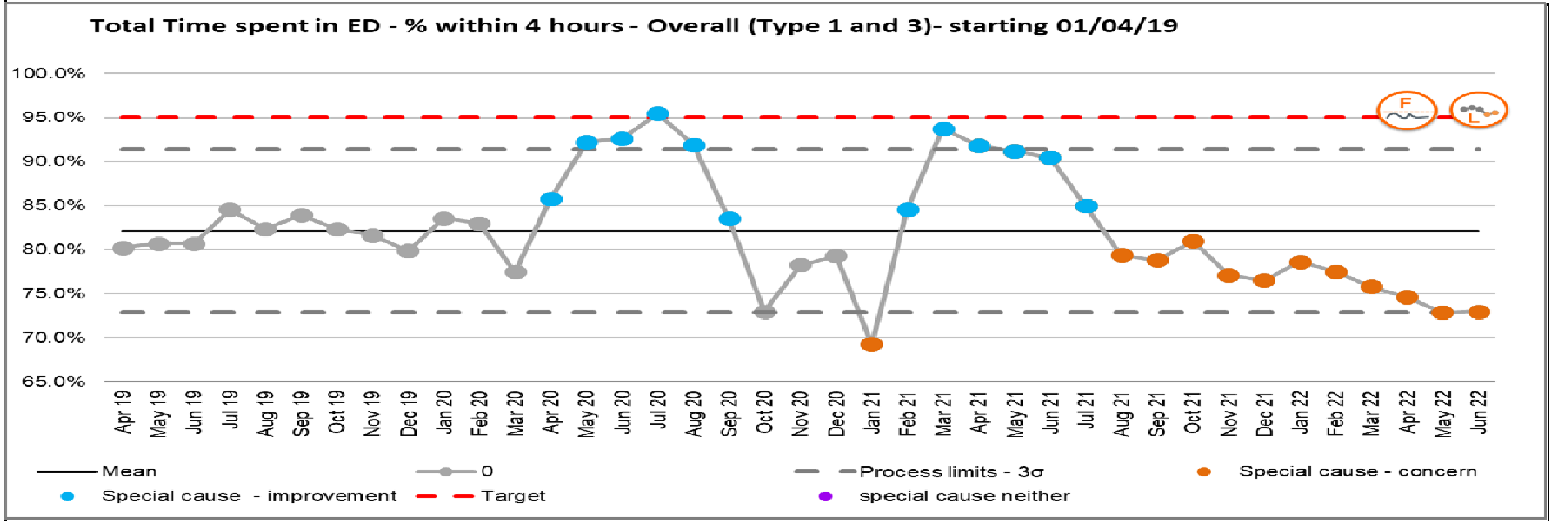
Future work plans	Committee to receive the Digital Strategy and Emergency Preparedness and Resilience Report
Items for Reference	Not applicable

PFIC

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PERFORMANCE, FINANCE & INVESTMENT COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Jun-22	61.87%	62.22%	92.00%		
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Jun-22	861	1025	0		
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Jun-22	89.22%		95.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment	May-22	81.91%		93.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	May-22	50.00%		93.00%		
%	Cancer - 62 day referral to treatment from screening	May-22	100.00%		90.00%		
%	Cancer - 62 day referral to treatment of all cancers	May-22	71.82%		85.00%		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Jun-22	12.83%	1.65%	1.00%		
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Jun-22	72.99%	83.00%	95.00%		
%	Locality Teams - % of Hours Demand Unmet	Jun-22	11.75%		20.00%		
Ave	MSFD - Average number of Medically Fit for Discharge Patients in WMH	Jun-22	50		50		
%	Rapid Response - 2 Hour Response Rate	Jun-22	94.80%		95.00%		

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
%	Rapid Response - % Admission Avoidance	Jun-22	89.20%		87.00%		
£	Total Income (£000's)	Jun-22	30953	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Jun-22	30953	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Jun-22	3705	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Jun-22	3008	See Financial Performance for further detail			

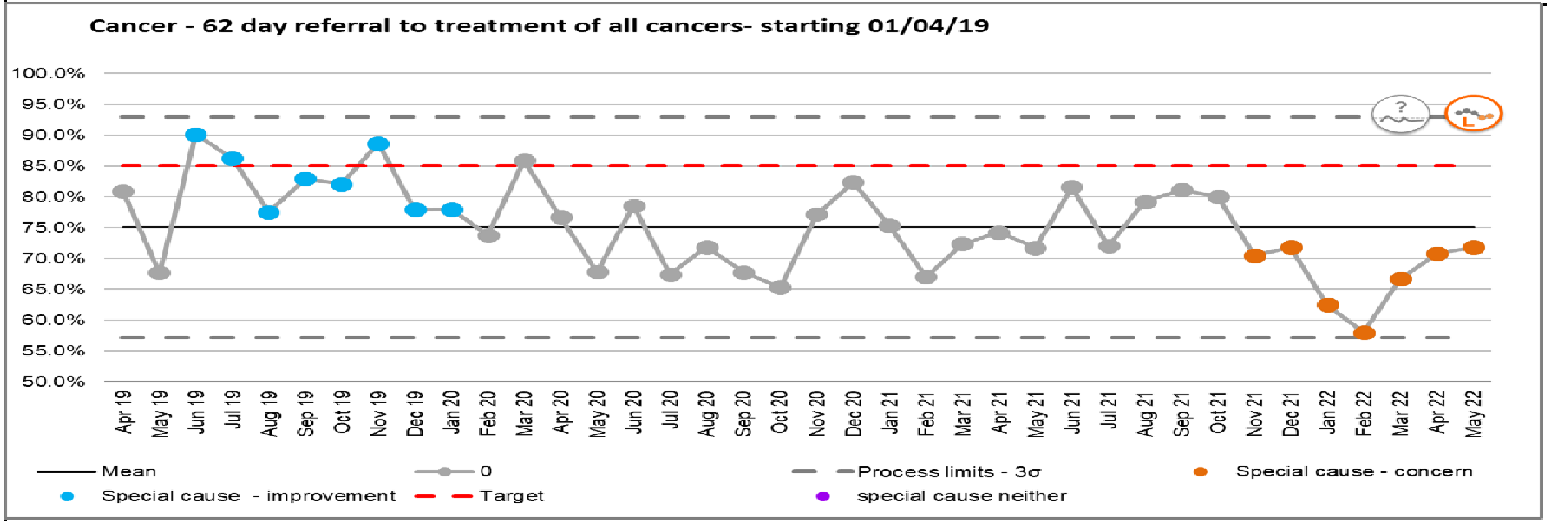
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Jun-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
95.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of A+E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A+E department	Statistical special cause concern from August 2021 to date , performance continues to be lower than the average (11 data points). June's reported performance is 72.98%.	In June 2022, there were 8,506 Type 1 attendances. 7.3% higher than June 2020 and the second highest month of attendances on record, and the highest month of attendances per calendar day on record. This high level of emergency pressure has been experienced across the region.	Funding has been made available to increase ED ACP/Middle Grade support over the next 12 weeks. Post Triage intervention with dedicated clinical space and clinician to quickly discharge non-urgent, low acuity patients. More visible senior clinical leadership on the floor	Introduction of a Emergency Decisions Unit to manage emergency clinical conditions with expected extended LOS in ED. Developing an electronic solution for patient case management in line with the emergency pathway.

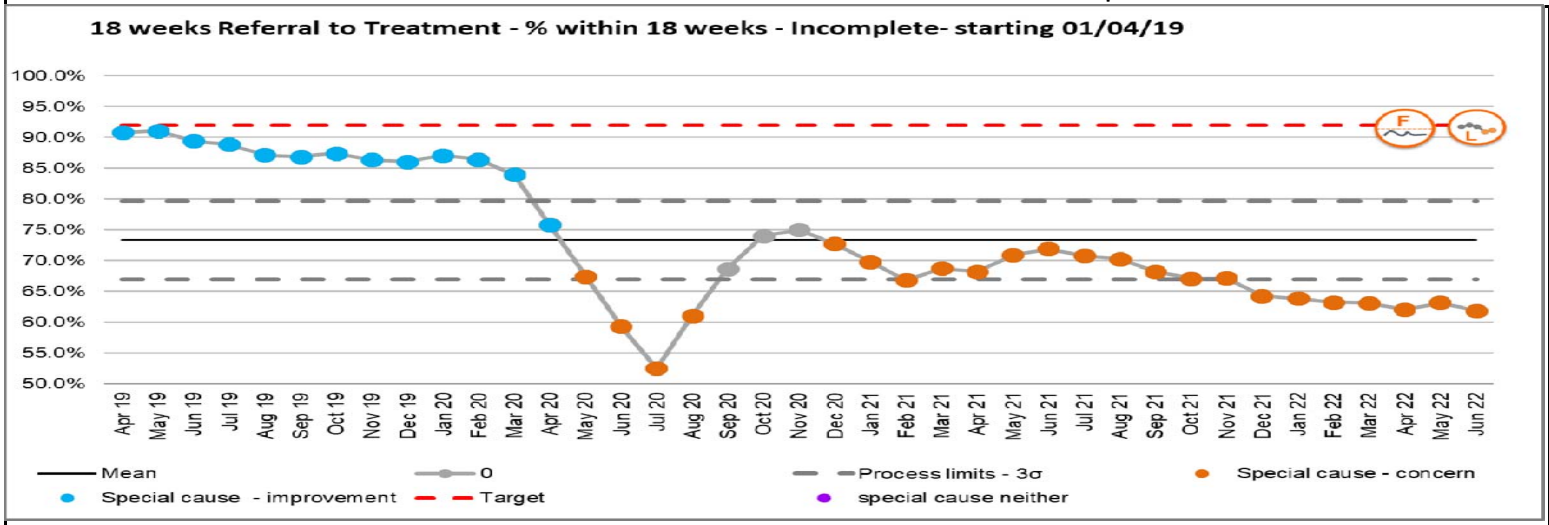
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
May-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
85.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	May's performance shows marginal improvement with performance of 71.8%. However, this is still a statistical special cause concern remaining below the average. May 2022's 62-day performance ranked 30th out of 121 reporting general acute Trusts.	Suspected Breast Cancer and Breast symptomatic outpatient waiting times (as part of the 2WW pathway) have been challenged for some months, and Dermatology is also challenged with capacity.	The Trust has received support for a significant expansion in the Trust's Medical Oncology service and will be recruiting to Consultant, ACP and Pharmacist positions to support clinical and MDT cover over a 52 week basis	The Trust is interviewing for 3 Consultant General Surgeons which will support increased Colorectal cancer capacity.

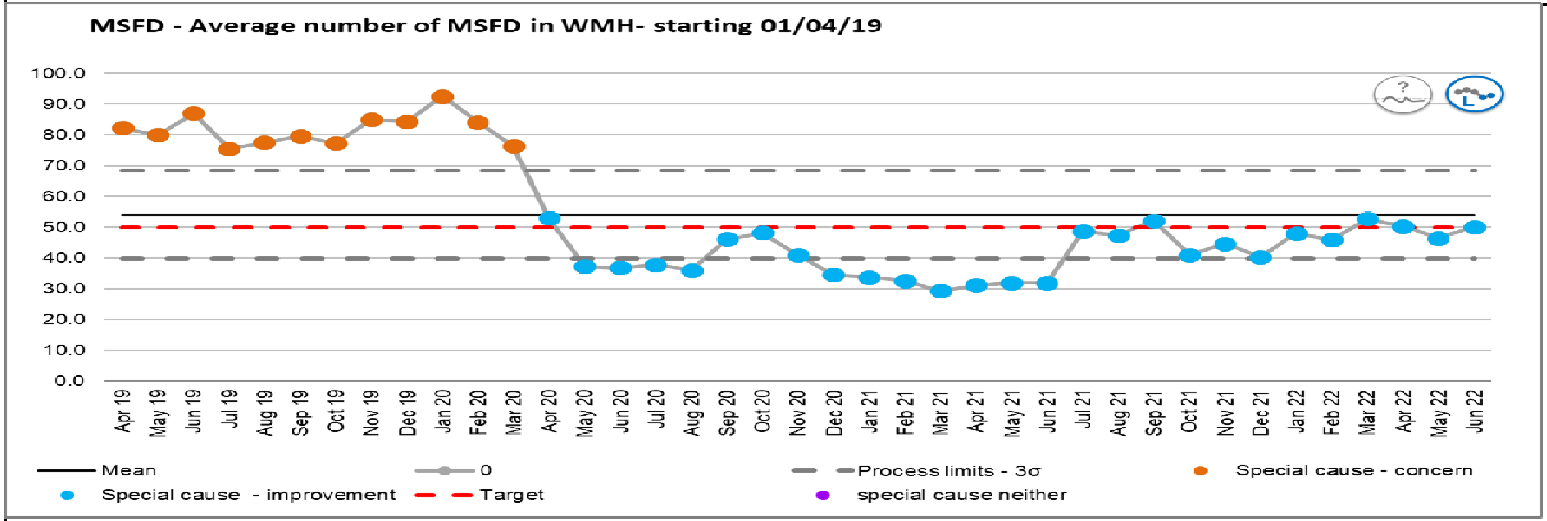
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Jun-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
92.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Performance remains statistically special cause concern. In June 2022, the 18 week RTT incomplete is 61.87%, just below the trajectory. The number of patients waiting greater than 18 weeks have increased in June (May 11,505 vs June 11,993) .	Most challenged services are Trauma & Orthopaedics, Oral Surgery, Urology & Dermatology Short-term sickness – both within the Anaesthetics and Theatre Departments – alongside heightened emergency and trauma demand has resulted in fewer elective sessions running.	Performance meetings provide scrutiny and oversight. Recruitment is underway for the expansion in Orthopaedic (2) and General Surgery Consultants (3), with appointments being made by August 2022	All seven elective theatres remain open since 31 January 2022, with theatre productivity being sustained within the national upper quartile performance. The Trust is ranked 70th out of 121 reporting general acute Trusts in May 2022.

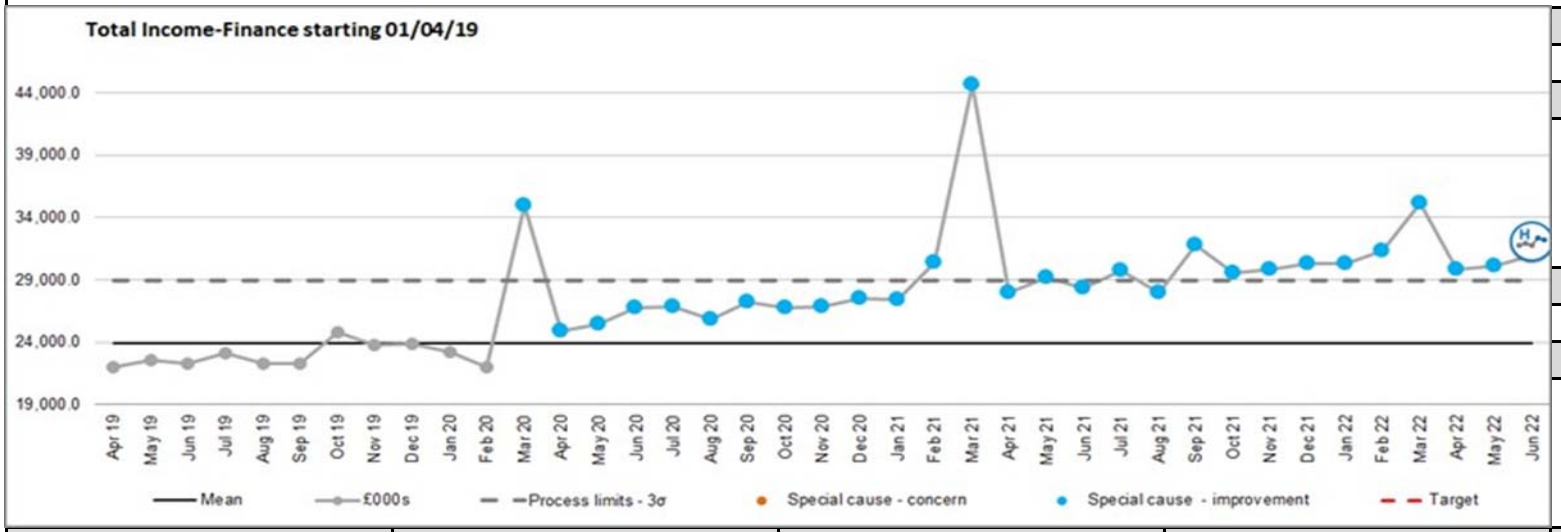
Metric Name: MSFD - Average number of MSFD in WMH



Month
Jun-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
50
Target Achievement
Variation Indicates Consistently Passing the Target

Background	What the chart tells us	Issues	Actions	Mitigations
The number of medically stable for discharge patients (average). These are patients who do not need hospital bed for their acute management	The Service delivered a strong performance in June with the number of MSFD patients being maintained at an average of 50. Despite an unprecedented demand in referrals, the length of stay was maintained at 4 days demonstrating good flow through the pathway.	Demand in terms of the Intermediate Care Service remains high.	Work continues to make efficiencies in the discharge and ICS pathways to ensure minimal delays for patients. Further work is being completed on enabling service to ensure resilience . Number of MSFD patients were maintained at an average of 50 with the length of stay remaining stable	Actions have been taken by the Community Division in reference to the increase in demand. This will provide an increase in capacity in the Hospital Team and resilience within the service.

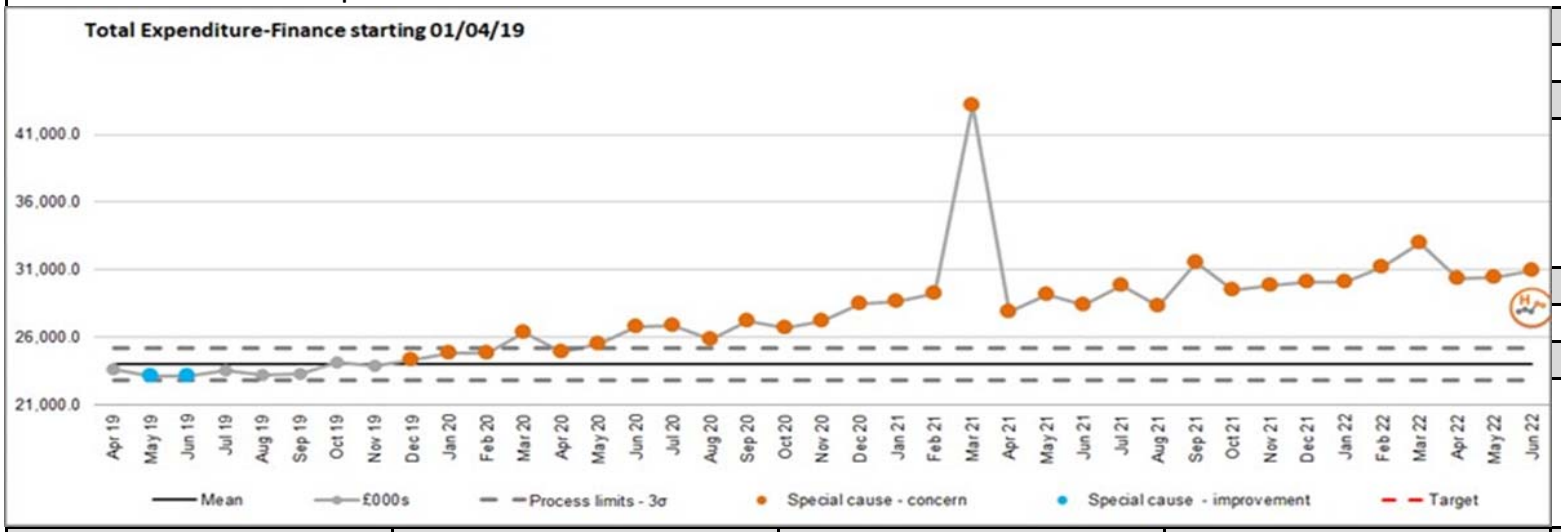
Metric Name: Total Income



Month
Jun-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total income for the Trust	Statistically increase over time, maintaining above upper limit.	It is likely income will decline as the pandemic impact reduces. Covid 19 linked funding decreasing by 57% in 2022/23	The Trust needs to seek appropriate sources of income and cost efficiency to live within the funding envelope	Variable funding sources including risk share and elective recovery funding to be managed to secure as much income as possible to support the Trust planned delivery of breakeven for the financial year.

Metric Name: Total Expenditure

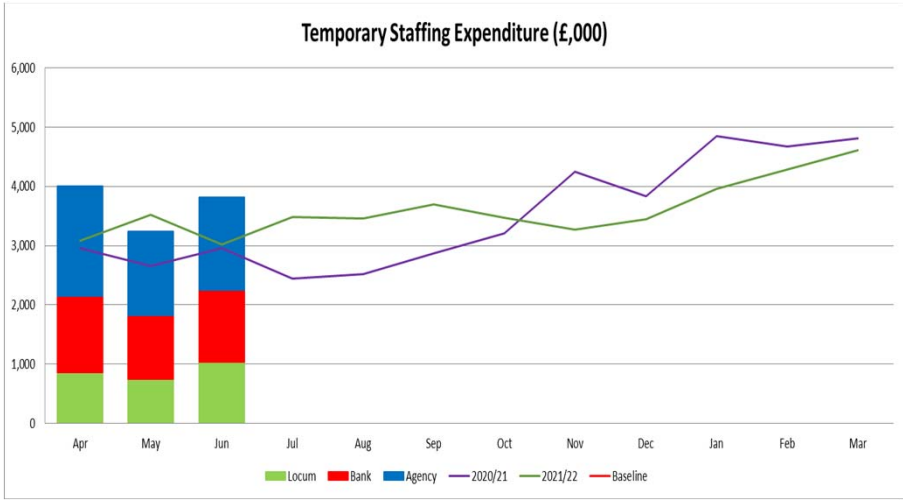


Month
Jun-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

Background	What the chart tells us	Issues	Actions	Mitigations
Total expenditure for the Trust	Statistically increase over time	Expenditure will need to decrease from historically high levels post pandemic	Cost efficiency must be targeted, £6.3m in 22/23	Delivery of the 2022/23 efficiency target of £6.3m. Overseas recruitment through the Clinical Fellowship programme for Medical and Nursing staff to reduce reliance on temporary staffing

Financial Performance to June 2022 (Month 03)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	91,244	90,927	(317)
Subtotal Pay Expenditure	(58,545)	(59,493)	(947)
Subtotal Non Pay Expenditure	(29,015)	(29,253)	(238)
Subtotal Finance Costs	(2,854)	(2,853)	0
Total Surplus / (Deficit)	830	(672)	(1,502)
Donated Asset Adjustment	48	72	24
Adjusted Surplus / (Deficit)	877	(600)	(1,478)



Financial Performance

- The Trust enters 2022/23 with clear risks to revenue and capital, with income reduced by 57% of Covid-19 resource and an efficiency ask.
- To maintain financial balance the Trust will need to deliver an efficiency programme, cease agency and reduce Covid-19 costs.
- In June of 2022 all Integrated Care Systems (ICS) were allocated additional funding and required by the regulator to review financial outturn following the plan submissions made in April 2022.
- Trust Board debated the request, with Executive endorsement and with Performance & Finance Committee approval (through delegation of powers from the Board) an improved planned outturn for the 2022/23 financial year of break-even was submitted (previous submission in April 2022 a £7.6m deficit)
- The ICS also submitting a balanced financial plan for the 2022/23 year. The Executive have met and prioritised essential developments in formation of this plan.
- In month 3 the Trust reported a £0.6m deficit, which is £1.478m adverse to plan. This was driven by higher than planned temporary staffing costs and non achievement of CIP plan, both elements remaining a risk to delivery.
- Walsall is reporting 87% YTD ERF performance against a target of 104%. This is in line with other local providers. May was a stronger month than April

Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 1-4 upgrades
- Capital expenditure totals £8m YTD. This is against an annual programme of c£38m though the Trust is still to secure the capital resources required to finance the theatres case of £4m for the 2022/23 financial year (the scheme continuing into 2023/24).

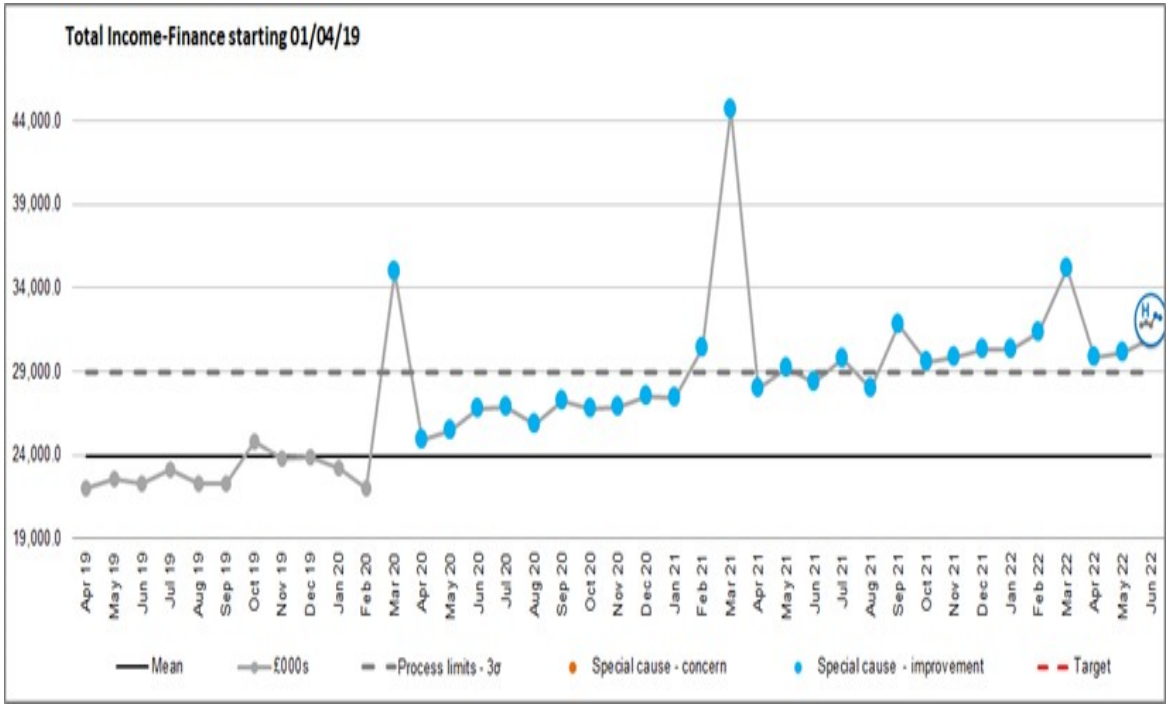
Cash

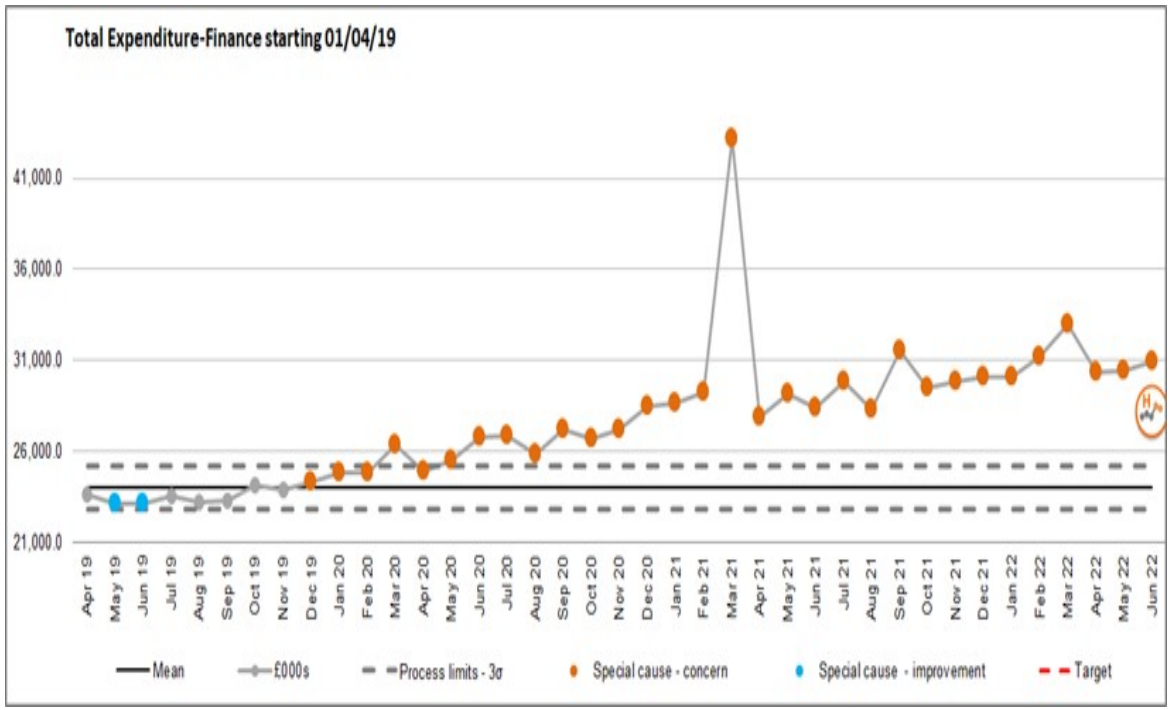
- The Trust continues to have a strong cash position which is sufficient to support a planned revenue deficit plan and the programmed capital expenditure

Efficiency attainment

- The Trust has an annual efficiency target of £6.3m, against which a plan of £5.4m (of which some schemes are rated as red) has been identified, leaving a planning gap of £0.9m.
- YTD performance has been £0.635m against a plan of £0.746m which reflects the plan phasing, if delivered equally through the year the target to date would have been £1.575m.

Income and expenditure run rate charts





Income additional information

- Income has continued to increase year on year, this reflects a level of tariff inflation and growth serviced through the Trust over this period.
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- From October 20 there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.
- In March 2021 the Trust received non recurrent income - £3.2m for annual leave accrual, £4.5m to offset the value of Push stock, £3.7m Digital Aspirant funding, £0.6m in respect of donated equipment.
- The increased income in September 2021 relates to accrued income to offset the impact of the pay award arrears.

Expenditure additional information

- March 2020 costs increased to reflect the Maternity theatre impairment £1m & Covid-19 expenditure
- Costs increased in support of COVID-19, with June and July seeing these costs increase further for elective restart and provision for EPR, Clinical Excellence Awards impacts on cost base, noting a reduction in expenditure in August due to the non recurrent nature of these. Spend increased again in September due to back dated Medical Pay Award, increased elective activity and non recurrent consultancy spend and increased further in Q4 20/21 driven by the additional pressures of a second wave of COVID activity.
- March 21 spend includes non recurrent items such as Annual leave accrual, adjustments for Push stock, and non recurrent spend on the Digital Aspirant Programme offset by income.
- In September 2021 the back dated pay award was paid to staff, increasing in month spend by £2.5m

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Quality, Patient Experience and Safety (QPES)
Date(s) of Committee/Group Meetings	22nd July 2022
Chair of Committee/Group:	Professor Louise Toner
Date of Report:	25th July 2025

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• 2-week suspected breast cancer and Breast Symptomatic Pathways waits have increased with only 50% of patients seen within 14 days of GP referral. Mutual aid is operational. • Level 3 Safeguarding Training – children and adults remains below target despite additional training being made available. • VTE Compliance has deteriorated from 91.3% in May to 88.45% in June • Trust acquired pressure ulcers has increased in hospital and community – this is being explored further. However, Hybrid Mattresses are being purchased and a new risk assessment tool is being implemented – Purpose T - with a view to Trust wide roll out. • Staffing pressures due to sickness continues, within Maternity services impacting on some aspects of care e.g., induction of labour. However, all women received 1:1 care in labour
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Cardiac Physiology an Endoscopy services have both experienced a decrease in capacity due, in the main, to staffing issues whilst MRI and non-obstetric sonography services are showing significant improvements. • Health Visiting workforce is operating at 50% of establishment • Staffing issues and increased referrals to community care impacting on meeting the service demands. • Sepsis Performance continues to be below target in respect of ED and inpatients • News2, Scale 2 issues identified and an e learning package now available to assist in addressing these issues.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Except for medical oncology, elective and day case activity has been restored to 106% of pre covid activity. • Strategy that segregates the Outpatient and the Daycase Centre Wing for planned outpatient, diagnostics and procedural activity has been implemented. • Operating theatre capacity is being prioritised for patients who required their operation to be carried out in theatre. Minor procedures have been relocated. • Cancer performance overall, whilst still below target is performing better than local, regional and national Trusts with 71.8% of patients treated within 62 days of GP referral. • Primary and Community Care activity continues to increase with plans for further expansion in preparation for winter - impacting on reducing • ED attendances and facilitating discharge of medically fit patients. Average wait for MFFD patients is 4 days.
Recommendation(s) to the Board/Committee	That the Board note the report and matters of concern
Changes to BAF Risk(s) & TRR Risk(s) agreed	None
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• There were none
ACTIVITY SUMMARY **Presentations/ for of note received including those Approved**	• Patient Story • Covid 19 Acute Services RR Report • Community Services Report • Safe High Quality Care Oversight Report Maternity Services Update • Serious Incidents Update • CQC Action Plan Update • Maternity Ethnicity Findings • Patient Voice Report
Matters presented for information or noting	• Safeguarding Annual Report • NHSEI Undertakings
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of Reference - following discussions between RWT and WHCT the ToR for QGAC (RWT) and QPES (WHCT) will be reviewed to standardise across both Trusts by October 2022 and thereafter to review and align the cycle of business as far as is possible.
Items for Reference Pack	• None

Walsall Healthcare NHS
NHS Trust

QPES

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE							
No.	Clostridium Difficile - No. of cases	Jun-22	4	2	27	?	
No.	MRSA - No. of Cases	Jun-22	0	0	0	?	
%	VTE Risk Assessment	Jun-22	88.37%		95.00%	?	
%	Sepsis - % of patients screened who received antibiotics within 1 hour - ED (E-Sepsis Module)	Jun-22	67.33%		90.00%	F	
No.	Falls - No. of falls resulting in severe injury or death	Jun-22	0	0	0	?	L
Rate	Falls - Rate per 1000 Beddays	Jun-22	3.54	6.10	6.10	?	
Ave	National Never Events	Jun-22	0	0	0	?	L
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Jun-22	0				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Jun-22	1				
Rate	Midwife to Birth Ratio	Jun-22	30.5	28	28	?	
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Jun-22	23				H
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Jun-22	17				

Metric Name: Clostridium Difficile - No. of Cases

MONTH

	Actual	Traj.
Apr	0	2
May	1	2
Jun	4	2
Jul		2
Aug		2
Sep		2
Oct		2
Nov		2
Dec		3
Jan		3
Feb		2
Mar		3

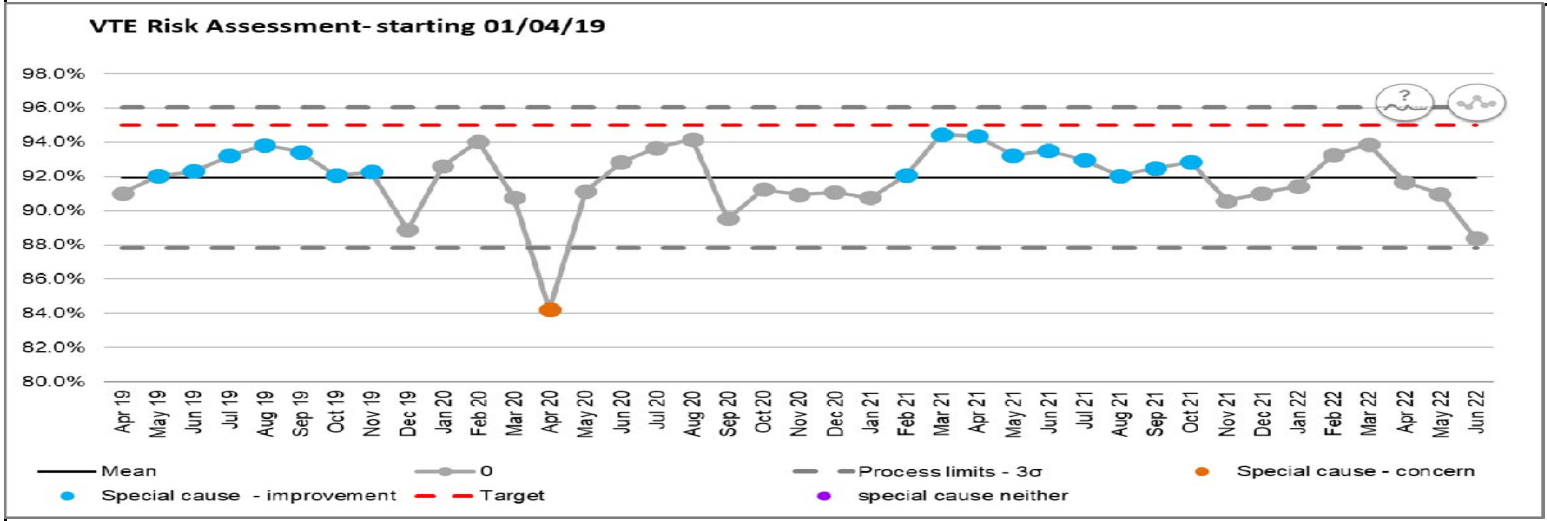
CUMULATIVE

	Actual	Traj.
Apr	0	2
May	1	4
Jun	5	6
Jul		8
Aug		10
Sep		12
Oct		14
Nov		16
Dec		18
Jan		21
Feb		24
Mar		27

Month
Jun-22
Variance Type
Target
Target Achievement
Variation Indicates Consistently Passing the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Minimise rates of Clostridium difficile The Trust target for 2022/23 has been set by commissioners as 27.	No significant variance and year to date cases remain below year to date projected cases.	4 cases of C.Diff was reported in June 2022, review of cases has found that the use of antibiotics was justified.	None required	N/A

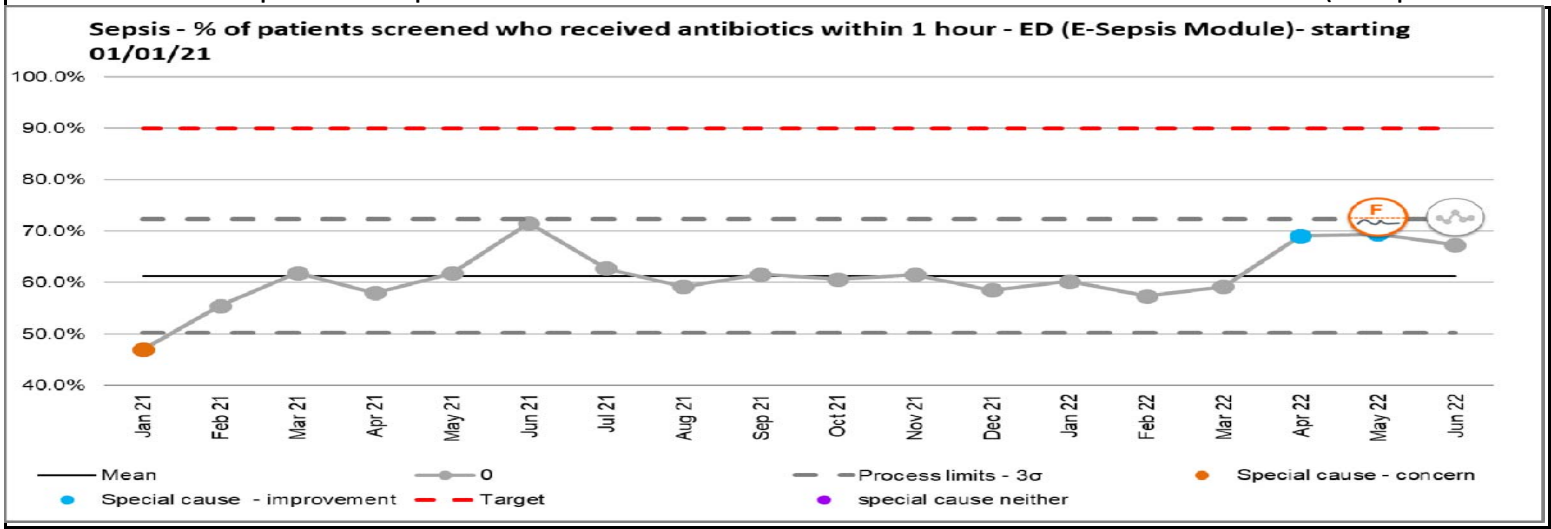
Metric Name: VTE Risk Assessment



Month
Jun-22
Variance Type
Common Cause - No Significant Change
Target
95.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE (agreed cohorts applied)	Performance remains below the trust target of 95%. This remains within normal variation but a downward trend is noted for the past 3 months.	VTE compliance for June 2022 was 88.45% , which continues to be under the 95% target for compliance. Monthly reports continue to be sent to Divisions, in addition to the daily reporting to consultants..	Audits have shown a number of process and IT issues which are now being worked through in QI projects.	Hospital acquired thrombosis (HATS) are reported on Safeguard and discussed at Divisional Quality Boards. HATS are also reported to the Thrombosis Group and each Division continues to report on the outcome of investigations.

Metric Name: Sepsis - % of patients screened who received antibiotics within 1 Hour - ED (E-Sepsis Module)



Month
Jun-22
Variance Type
Common Cause - No Significant Change
Target
90.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Proportion of Service Users presenting as emergencies who undergo sepsis screening and who, where screening is positive, receive IV antibiotic treatment within one hour of diagnosis	The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department in June 2022 was 67.33%, a decrease from 69.44% in May 2022.	Work has progressed with aligning the E-sepsis data with manual audits showing user error exacerbated by a non-user friendly interface. The digital team are addressing this with System C to resolve issues. The reporting contained too much detail making the usefulness complicated.	The PBI report has been refreshed to focus on the Antibiotics within the hour. Sepsis performance is now reviewed via the newly formed deteriorating patient group.	The sepsis team reviews all open sepsis assessments on vital pac ensuring they are closed down when appropriate. They are also responding to sepsis alerted patients.

Trust Board Meeting
Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	People and Organisation Development Committee
Date of Committee/Group	Monday 25th July 2022
Chair of Committee/Group:	Junior Hemans
Date of Report:	Thursday 28th July 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Workforce availability - The committee reviewed the Workforce Metric report and noted that the adverse trend on retention (24 months) amongst qualified nursing & midwifery workforce is at 78.34% and adverse trend on turnover for nursing and midwifery at 13.64%. The overall trust turnover is at 12.48% in month, which is above trust target, the most common reasons remain external promotion, relocation, and work-life balance concerns. Retention and turnover remain a risk to quality and stability of services and patient care. • Workforce availability - The committee noted the impact on availability due to sickness absence, and noted that absence continues to be above target, though the trend is downwards. The impact on availability due to short-term absence continues to be significant – with 40% of absence being short-term in the last month. The absence profiling tool provides a trajectory for reduction in absence rates over the remaining financial year to return to target 4.5%, whilst acknowledging that workplace and economic conditions will continue to be challenging. The long- and short-term sickness rates are reviewed at monthly performance reviews in detail. • The committee received a report which provides additional intelligence on turnover and exit data, this was circulated to committee members and Retention and Work-life balance will be reviewed by the People and Organisation Development committee in August.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The committee noted an increase in the nursing and midwifery vacancy rate at 11.3% from 4% previous month, due to agreed establishment changes in ED, Ambulatory Care and winter planning. The committee reviewed the Cessation of Agency Plan and noted progress. • The committee noted the staff story/ Workforce metric report from Community Division noting that all key workforce KPIs are getting better other than turnover where the performance is deteriorating. There are significant workforce challenges within both Health Visiting and Therapies that are recognized nationally. The cultural elements of performance are improving with staff engagement and morale across the division exceeding the trust results and meeting national benchmarks. The committee noted the good news stories shared by the division as follows: o The Rapid Response team were awarded Placement Provider of the Year at the University of Wolverhampton's 11th Annual Students' Union Awards o The Community Thank You scheme launched so patients and colleagues can recognize those who have gone " above and beyond" o The Child Development Service Team Around the Child were key-note speakers at a conference in Prague o The Lion Talbot Suite opened in memory of a valued colleague. o The Division were invited by the Sam Sherrington team to speak at National Conference
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The Committee received an update report on the system working at the People Board, particularly focusing on the Growing the Workforce of the Future workstream. • The committee received and noted the annual Freedom to Speak up Report and commissioned further work on the trends noted within it relating to the number of concerns raised relating to bullying and harassment. • The committee reviewed the detailed report on colleagues in difficultly noting the data within it and taking assurance from casework being completed within timescales allocated.

Recommendation(s) to the Board/Committee	• To note the report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• There are legal, equality and diversity implications within this report and the Trust Board pledge seeks to address these by providing a route to eliminate discrimination, measure the diversity of the workforce and equality of staff experience and access to recruitment, promotion, career progression, education and training and to improve staff experience by eliminating bullying and harassment within the workforce and create a healthy organisation culture where staff will advocate for the trust as a place to work and a place to be treated.
ACTIONS Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)	• The committee commissioned a detailed report on Retention and Exit Data. • A board development session was agreed to look at the issues relating to work-life balance and the response to addressing the impact and trends identified through the workforce metrics.
ACTIVITY SUMMARY Presentations/Reports of note received including those Approved	• The committee noted the vacancy rate for nursing and midwifery is currently at 11.3% noted within the Safer Staffing Report. • Commission of reports relating to retention, exit monitoring and work-life balance following review of the workforce metrics.
ACTIVITY SUMMARY Major agenda items discussed including those Approved.	• Divisional Success Stories for Community and Workforce Metrics/Culture Heat map for the Division. • Workforce metrics and adverse trends relating to retention and turnover.

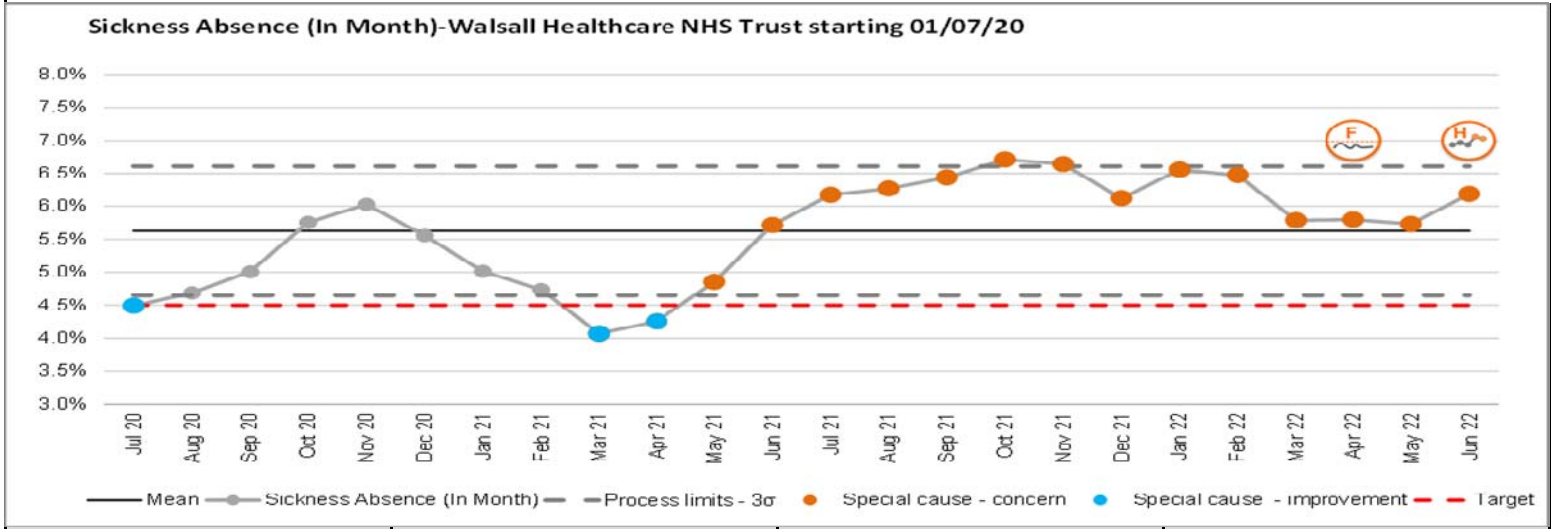
Matters presented for information or noting	• The Health and Safety Group action log and notes. • The Equality, Diversity and Inclusion Group action log and notes. • The Health and Wellbeing action log and notes. • The Education and Training action log and notes. • The JNCC action log and notes. • The LNC action log and notes.
Self-evaluation/ Terms of Reference/ Future Work Plan	• Cycle of Business and Terms of Reference for the People and Organisation Development Committee.
Items for Reference Pack	None

Walsall Healthcare NHS
NHS Trust

POD

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE							
%	Sickness Absence	Jun-22	6.18%		4.50%		
%	PDRs	Jun-22	82.90%		90.00%		
%	Mandatory Training Compliance	Jun-22	88.63%		90.00%		
%	% of RN staffing Vacancies	May-22	11.33%				
%	Turnover (Normalised)	Jun-22	12.48%		10.00%		
%	Retention Rates (24 Months)	Jun-22	81.07%		85.00%		
%	Bank & Locum expenditure as % of Paybill	May-22	9.53%		6.30%		
%	Agency expenditure as % of Paybill	May-22	6.86%		2.75%		

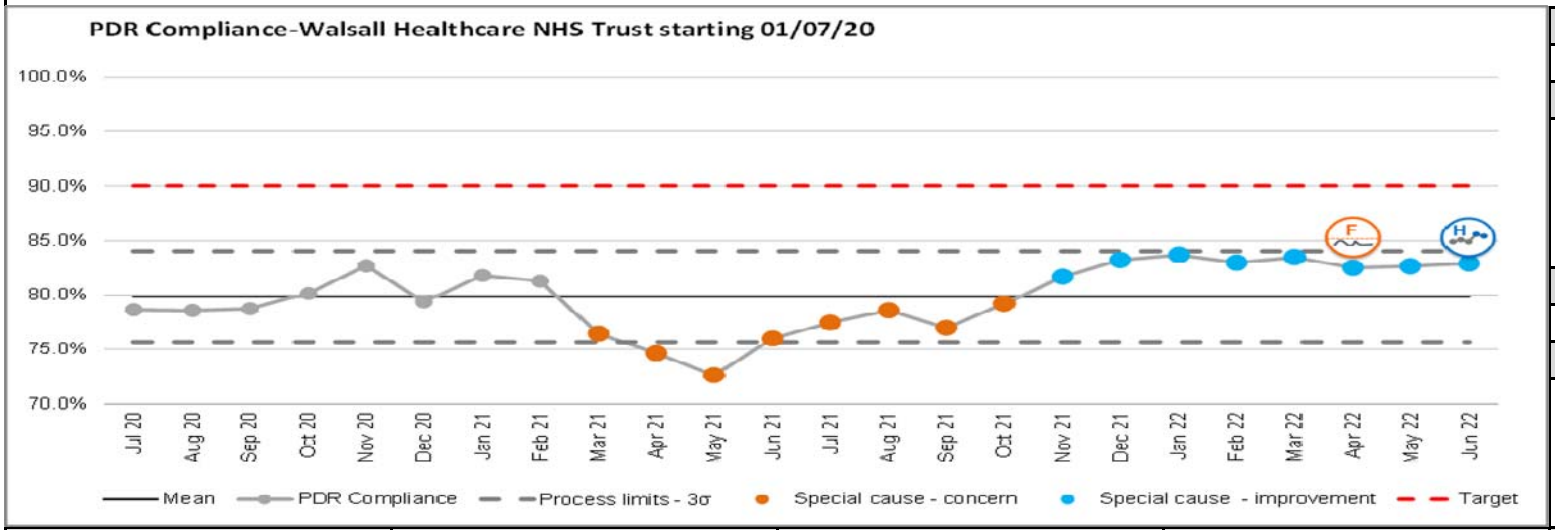
Metric Name: Sickness Absence



Month
Jun-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
4.50%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
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.	Sickness absence still within a downtrend, despite the Jun-22 rise.	Stress/anxiety & musculoskeletal illness are both increasing again.	Realising the procedural improvements and colleague lifestyle benefits identified within the recently drafted Health & Well-Being strategy will represent a significant catalyst towards restoration of pre-pandemic absence levels.	Monitoring of sickness absence includes Executive oversight at the monthly Divisional review meetings. Fast track referrals by the Occupational Health Team to Physiotherapy Services will ensure that injured colleagues receive early recovery interventions.

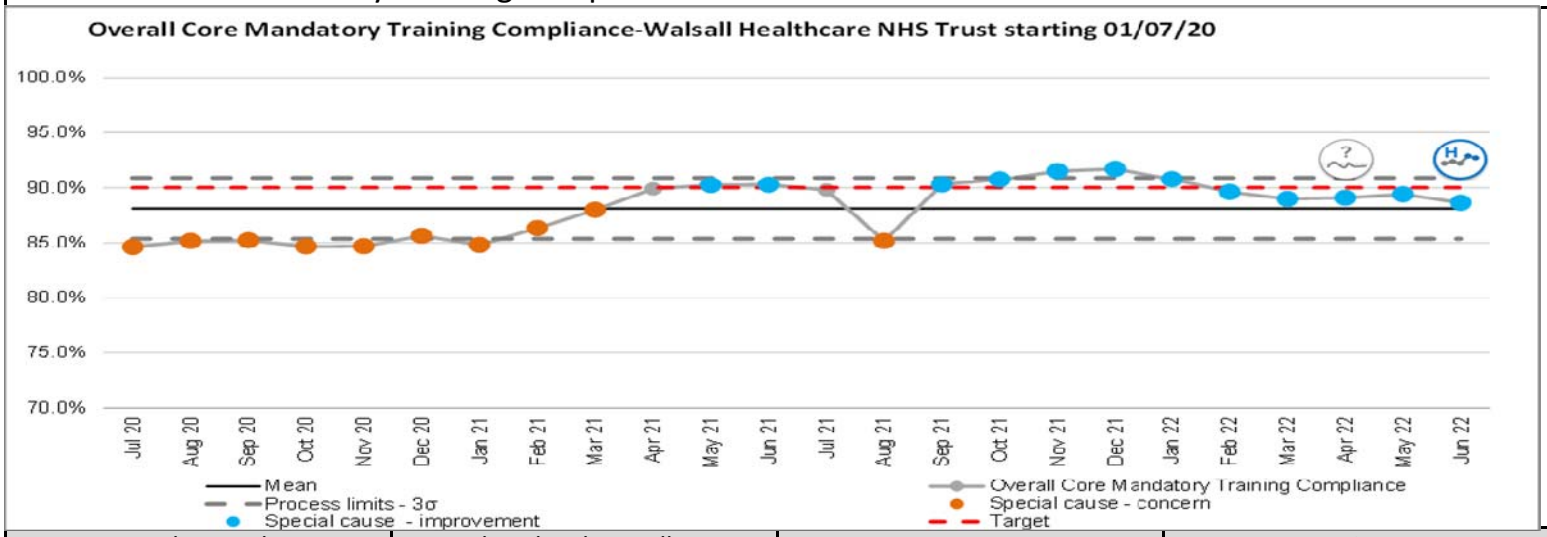
Metric Name: PDRs



Month
Jun-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Consistently Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Appraisal compliance is calculated using exclusion lists.	Uptrend remains in tact, with PDR compliance stablised within the upper half of a 75% - 85% range for several months.	PDR compliance remains relatively high amongst clinical and estates colleagues (an 87% average), but continues to decline amongst Admin & Clerical colleagues (77%).	Divisional talent forums are used as an engagement vehicle to both encourage, and where support is required facilitate, continued compliance improvements; whilst also reinforcing the added value for personal/service development of holding timely appraisal sessions.	Monitoring of PDR compliance is reviewed at the monthly executive led Divisional review meetings.

Metric Name: Mandatory Training Compliance



Month
Jun-22
Variance Type
Special Cause of Improving Nature or Lower Pressure
Target
90.00%
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of the Target

Background	What the chart tells us	Issues	Actions	Mitigations
Training compliance is calculated using exclusion lists.	Mandatory training compliance remains stable just below the 90% target.	Completion of the Patient Handling (80%) and Adult Basic Life Support (68%) competencies key outliners; which if improved would support a reclaim of the 90% overall compliance target.	Collaboration with RWT colleagues continues to align requirements and delivery models for mandatory training.	The project team continues to consult with stakeholders and services to ensure implementation of the Totara LMS is carried out at a pace which does not compromise regulatory or governance commitments.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE Public Trust Board 3rd August 2022			
Director of Nursing Report			
Report Author and Job Title:	Lisa Carroll Director of Nursing Caroline Whyte Deputy Director of Nursing	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• 212 Clinical Fellowship Nurses have commenced employment within the Trust and 170 are registered with the Nursing and Midwifery Council (NMC). • Safeguarding adults and children's training is achieving trust target for all level 1 and level 2 training. • Falls per 1000 bed days was 3.54 during June 2022 (3.81 in May 2022). Weekly falls accountability meetings are continuing, identifying lessons learnt and shared learning.		
Advise	• 4 cases case of Clostridium difficile toxin were reported in June 2022, review of cases has found justified antibiotics. Overall performance year to date remains below trajectory. • Issues with Scale 2 within NEWS2 have been identified and logged as a corporate risk. An e-Learning package has been uploaded to ESR and a roll out plan is in development. • From 13th June 14 departments ceases the use of Tier 2 agency and 5 departments ceased using Tier 1.		
Alert	• Off framework agency use has continued due to short term staff absence predominantly as a result of COVID-19. During June 2022 with a total of 1285.92 hours compared to 950 hours reported in May 2022. • Safeguarding level 3 adults and children's training remains consistently below trust target, additional training is being made available to improve compliance. • Within the ED department, 72.79% of patients received antibiotics within 1st hour and inpatient area performance was 79.61%.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF IPC BAF Corporate risk 2066; Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels Corporate risk 2439: External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' Corporate risk 2917: Inappropriate use of Scale 2 within NEWS2 (Risk Score 20).		

Resource implications	None	
Legal and/or Equality and Diversity implications	No negative impact	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

Walsall Healthcare NHS
NHS Trust

Director of Nursing Report – August 2022

Introduction

The following report details the Trust positon regarding key nurse indicators and the progress towards the strategic objectives detailed in the Trusts Safe, High Quality Care Board Assurance Framework which can be found in Appendix 1.

Current Position

CQC action plan update

The Trust has reviewed all CQC action plans and identified a number of actions that whilst identified in divisional reports require corporate action. A Trust wide corporate action plan with responsible executive Directors and identified leads has been developed and agreed by the Trust Board.

Divisions maintain action plans for ownership, implementation and embedding of practice at local level. Progress is monitored through the Divisional Governance process and fortnightly assurance meeting with members of the executive team.

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Falls

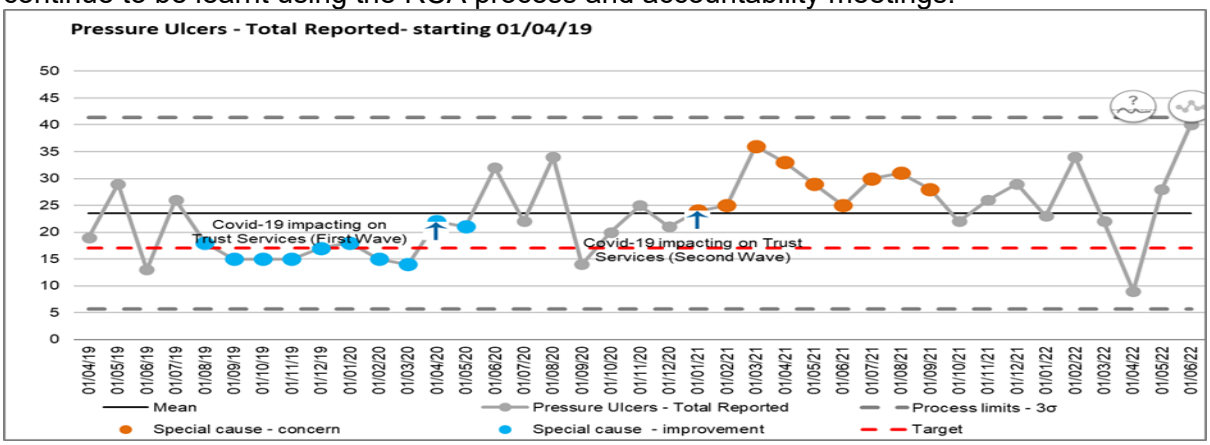
The number of inpatient falls recorded for June 2022 is 57 with 62 reported in May 2022.

The Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days has been achieved continuously for the past rolling 24 months. Falls per 1000 bed days was 3.54 during June 2022 (3.81 in May 2022).

Weekly falls accountability and review meetings are continuing identifying lessons learnt and promoting shared learning. The inaugural Shared Professional Decision-Making Falls Prevention Group meeting took place on the16 June 2022 to focus on improvement through shared learning in the delivery of high-quality care.

Tissue Viability

The number of hospital acquired (new) pressure ulcers reported increased in June 2022. Lessons continue to be learnt using the RCA process and accountability meetings.



The inpatient risk assessment document and intervention chart is being finalised with a plan to commence implementation in mid-July 2022.

Hospital acquired Moisture Associated Skin Damage average at 30 incidents per month. Gama (the company who provide continence products to the Trust) have supported education help reduce incidents and the continence lead is undertake a review of the data to aid development of a proactive continence quality improvement plan.

Venous Thromboembolism (VTE)

VTE compliance for June 2022 was 88.45% compared to compliance for May 2022 of 90.96%; compliance rates have been decreasing since March 2022 and below the 95% target for compliance.

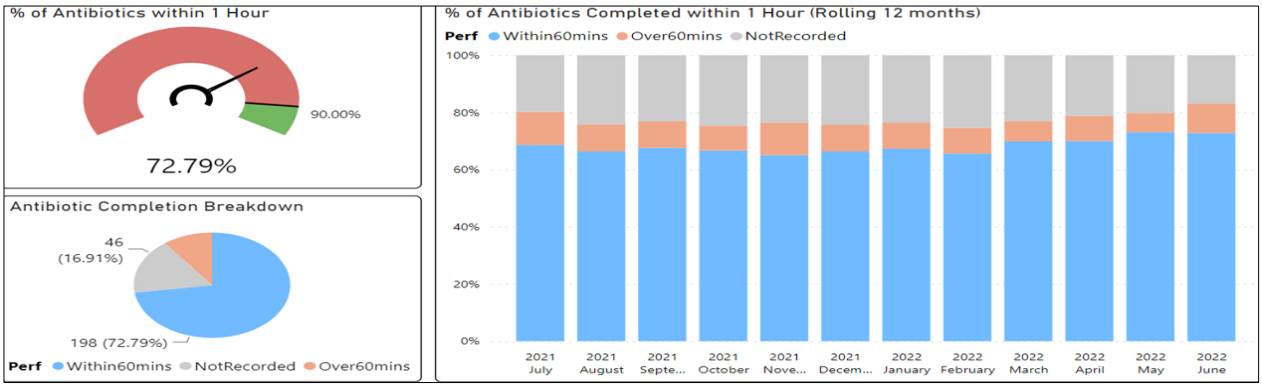
A further report will be presented to QPES following completion of an audit of VTE assessment compliance and acquisition of VTE that was requested by QPES in June 2022.

Sepsis

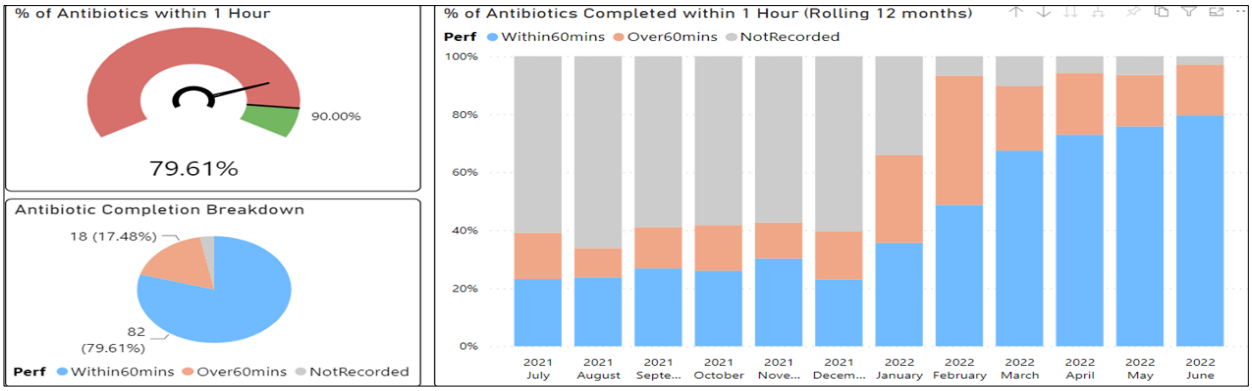
A Trust wide deteriorating patient group commenced in March 2022. The Sepsis Team are in place and have presented the work that they have been doing and audit data to the Patient Safety Group in June 2022.

With the support of the sepsis and outreach teams the electronic data is a reflection of practice and demonstrates that there is still a lot of work to do to improve practice.

ED Performance



Inpatient sepsis performance



104 day harm

There have been 10 patients breaching 104 days for May 2022.

All 10 cases have been reviewed by the Lead Cancer Nurse with independent support from CCG Primary Care Nurse. Of the 10 cases reviewed 6 of those patients were referred to tertiary centres for opinion or opinion and treatment, just one lung patient referred before day 38, hence do not qualify as a Trust breach.

Of the remaining 9 patients; 2 of these are patients were on a Lung cancer pathway, 5 of those Urology cancer pathways and 1 colorectal and 1 gynaecology.

Key themes and trends have been collected from these cases for these specific cancer pathways.

Clostridium difficile (C. diff)

4 acute toxins have been reported in June 2022; review has identified that antibiotics were justified

C.Diff cases

2022/23	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Max cases per month	2	2	2	2	2	2	2	2	3	3	2	3
Actual acute cases	0	1	4									
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Actual cumulative total	0	1	5									

Surgical Site Infections

During the period April to June 2022 the duty microbiologists identified an increase in the number of isolates and clinical surgical site infection following elective and emergency C-section; some cases have required re-admission and further treatment. These cases are being reviewed by the Division with findings escalated to the SSI Group

Outbreak management

The Trust continues to screen al patients admitted to the Trust for COVID-19 and has a programme for repeat screening during a patients stay.

During June 2002 the Trust reported one COVID-19 outbreak on ward 3. This was managed in accordance with the Trusts outbreak policy.

Percentage of observations undertaken within timeframe

Changes have been made to the threshold of late observations, and how late observations are classified. The previous threshold of 33% has been reduced to 10% for all observations at a frequency of greater than 1 hour. The 33% threshold remains in place for observations that are recorded hourly. The Trust target has also increased from 85% to 90%. This has resulted in an expected decrease in observation performance; the results are however in line with the performance at RWT.

The prevalence of timely observations for June was 78.02%, a slight increase from 76.60% in May 2022

Support to the inpatient areas is being provided by the corporate quality team to understand the changes that have been made and work to improve compliance.

Mental Capacity Assessment (MCA)

Data not available at time of writing report. Retrospective data to be shared in September 2022 report.

Safeguarding, Prevent, DoLs, MCA and Dementia Awareness Training

Safeguarding Adult and Childrens levels 1 and 2 training remain above trust target. Level 3 training remains under target for both adults and children. Despite improvement plans being pesented to the safeguarding committee level 3 training for adults and children remains below target.

Additional level 3 safeguarding training sessions are taking place from June 2022.

Safe Staffing

Vacancy position

The RN and Midwifery vacancy rate for June 2022 has increased to 11.3% (4% in May 2022). The increase in vacancy rate is a as a result of investment and the approval of business cases for ED, Ambulatory care and Winter Planning. A business case for AMU was approved at the end of June 2022 and is not included in this vacancy figure.

A task and finish group is focussing on Health Visiting recruitment and ensuring the team continue to deliver a safe service.

Recruitment

212 Clinical Fellowship Nurses are now in post in the Trust. Of these, 170 are now registered with the NMC.

A business case to support the continuation of international recruitment for the next three years has been approved.

Seven Trainee Nursing Associates (TNAs) are expected to qualify in June 2022. A further five are expected to complete in September 2022. Nine TNA's commenced the programme in September 2021 and are expected to qualify in November 2023.

Recruitment has commenced for the NA to RN top up programme which will commence in September 2022.

Thirty-six student nurses have accepted posts across the Divisions commencing in September 2022.

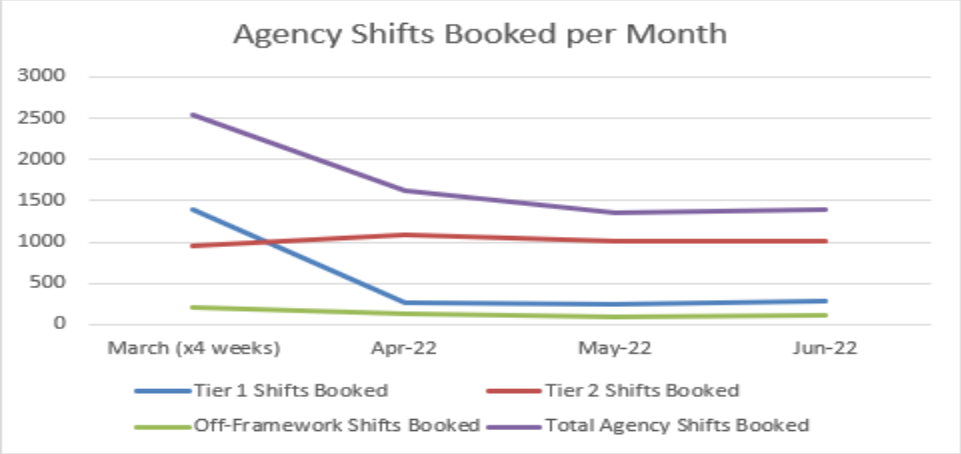
Temporary staffing

There has been an increase in off framework agency use during June 2022 with a total of 1285.92 hours compared to 950 hours reported in May 2022.

The highest use areas for off framework agency staff are ED using 495.75 hours and Endoscopy using 258.67 hours

During June 2022, after 2 weeks of successful reduction there was an increase in Tier 2 in the last week of the month. This was attributed to significant increases within ED (188 hr increase), Ward 14 (161 hr increase), Chemo (38 hr increase) and Ward 9 (346 hr increase).

Agency Cap Performance



Plans are in place to cease the use of agency nurses across the Trust with a primary focus on inpatient areas. From 13th June there are fourteen departments where Tier 2 is no longer permitted and five departments also ceased using Tier 1 agency.

The plan to cease agency use can be found in appendix 2 of this report.

Staffing hub

The Virtual Staffing meetings have returned after the closure of the Staffing Hub at the end of February 2022. Matrons are asked to review the 72 hour forecast as part of that staffing review. The virtual meeting provides oversight of staffing levels across the Trust and supports and facilitates the speedy escalation of issues in relation to staffing, acuity and outstanding shift demand. The staffing meetings occur twice daily and are Matron-led; staffing meeting documentation is being collated after the meeting by Corporate Nursing staff. These meetings provide a forum for re-deploying staff across clinical units and divisions, management of red flags, assurance regarding safe staffing levels across the Trust and escalation if risks cannot be mitigated.

Through the safe staffing meetings 1159 hours of RN and 963 hours of CSW were re-deployed across the Trust during June 2022.

Red Flags

The SafeCare system is in place across the Trust to record staffing numbers, patient acuity and red flags aligned to NICE guidelines. Red Flags are recorded, reviewed and where possible mitigated,

within the safe staffing meeting. Matrons oversee the accuracy of the Red Flags recorded and their appropriateness.

In June 2022 there were 176 Red Flags that were raised and 50 of those were resolved and mitigated during the safe staffing meeting. For the 126 Red Flags that could not be immediately mitigated this is escalated to the appropriate Divisional Director of Nursing for oversight, support, and decisions regarding next steps via the Nursing and Midwifery Advisory Forum.

AMU improvement plan

The AMU Board meet monthly and review the assurance actions specific to the board. The business as usual actions are with the Task & Finish groups to progress.

Progress captured from this groups last meeting are:

- Job planning on AMU is near completion
- Phase 2: AMU culture and leadership development action plan approved at AMU board.
- The AMU team have been reminded to validate the dashboard data to ensure data is accurate.
- Communication team working on communication regarding the workshop sessions to run in the 'daily dose', intranet and the staff Facebook page as well as externally if appropriate.

Update from the Health Education England task and finish group:

- There is a meeting with the Urgent Treatment Centre team and ED to shape a plan for addressing the ongoing process issues.
- There are ongoing issues with GP referrals and a suggestion of implementing a safety net at ED triage to identify them is being discussed.
- Human factors training for the team is also being considered.
- Patient Prioritisation audit is a 100%
- AMU consultant post readvertised
- Rotas continue to improve

Appendix 2 – Walsall Healthcare NHS Trust Cessation of Agency Plan

			Current status	next steps									
			OFF										
			TIER 1 DEACTIVATION				TIER 2 DEACTIVATION				OFF FRAMEWORK DEACTIVATION		
Division	**last review**	**Ward**	**T1 (4 weeks)**	**T1 (2 weeks)**	**T1 (72 hrs)**	**T1 SWITCH OFF**	**T2 (4 weeks)**	**T2 (2 weeks)**	**T2 (72 hrs)**	**T2 SWITCH OFF**	**OF (1 week)**	**OF (72 hrs)**	**OF SWITCH OFF**
MLTC	22.6.22	ED	*from June 13th*	*August 25th*			*from June 13th*	*July 18th*			exec approval only		
MLTC	22.6.22	ED Paeds	*from June 13th*	*August 25th*			*from June 13th*	*July 18th*			exec approval only		
MLTC	22.6.22	Ambulatory Care	*OFF 13.06.22*				*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	FES	*OFF 13.06.22*				*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	W1			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	W2			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	W3			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	W4		*from June 13th*	*from July 18th*			*from June 13th*	*July 18th*		*OFF May 6th*		
MLTC	22.6.22	*AMU*	*from June 13th*	*from July 18th*			*from June 13th*	*July 18th*			exec approval only	OFF July 18th	
MLTC	22.6.22	W7			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*		
MLTC	22.6.22	W14	*OFF 13.06.22*				*OFF 13.06.22*				*OFF June 22nd*		
MLTC	22.6.22	W15			*from June 13th*		*OFF 13.06.22*				*OFF May 6th*		

Appendix 2 – Walsall Healthcare NHS Trust Cessation of Agency Plan

MLTC	22.6.22	W16			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*				
MLTC	22.6.22	W17		*from June 13th*	*July 25th*				*from June 13th*	*July 25th OFF*	*OFF May 6th*				
MLTC	22.6.22	W29			*from June 13th*	*July 18th OFF*	*OFF 13.06.22*				*OFF May 6th*				
MLTC	22.6.22	Endoscopy	*from June 13th*	*July 25th*			*from June 13th*	*July 25th*			exec approval only				
SURG	31.05.22	Chemotherapy		*from June 13th*	*June 29th*			*from June 13th*	*June 29th*		exec approval only				
SURG	31.05.22	ICU	*OFF 13.06.22*						*from June 13th*		exec approval only				
SURG	31.05.22	W9		*June 29th*				*June 29th*			*OFF May 6th*				
SURG	31.05.22	W10			*from June 13th*				*from June 13th*		*OFF May 6th*				
SURG	31.05.22	W11			*from June 13th*		*OFF 13.06.22*				*OFF May 6th*				
SURG	31.05.22	W12			*from June 13th*		*OFF 13.06.22*				*OFF May 6th*				
SURG	31.05.22	W20a	*OFF 13.06.22*				*OFF 13.06.22*				*OFF May 6th*				
SURG	31.05.22	SACU			*from June 13th*		*OFF 13.06.22*				*OFF May 6th*				
MAT		Delivery	*OFF 10.07.22*				*OFF 10.07.22*				*OFF May 6th*				
MAT		Foxglove	*OFF 10.07.22*				*OFF 10.07.22*				*OFF May 6th*				
MAT		W23	*OFF 10.07.22*				*OFF 10.07.22*				*OFF May 6th*				

Appendix 2 – Walsall Healthcare NHS Trust Cessation of Agency Plan

MAT		GOPD	*OFF 10.07.22*				*OFF 10.07.22*				*OFF May 6th*		
PAED		W21	*June 20th*				June 20th				exec approval only		
PAED		NNU		*June 20th*				*June 20th*			exec approval only		
PAED		PAU	*June 20th*				June 20th				*OFF May 6th*		
COMM		Hollybank			*June 13th*	*July 11th OFF*			*June 13th*	*June 27th OFF*	*OFF May 6th*		
COMM		Goscote	not yet discussed- manage case by case				not yet discussed- manage case by case				*OFF May 6th*		

MEETING OF THE TRUST BOARD – Wednesday 3rd August 2022			
Hospital Mortality Report (April – May 2022)			
Report Author and Job Title:	Dr Simon Harlin, Acting Deputy Medical Director Lorraine Moseley Business Manager	**Responsible Director:**	Dr Manjeet Shehmar, Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• The most recent published SHMI value for the 12 month rolling period (published June 2022) March 2021 to February 2022 is 110.63, this is on a downward trend and is on the 90% upper limit range as an amber Trust. • The Trust is ranked 106th out of 122 Trusts across the country for Quarter 4. • In 89.7% of cases reviewed by SJR, deaths were likely not avoidable.		
Advise	• The medical examiner team reviewed April 2022 – 99.2%, May 2022 – 99.2% of the total inpatient deaths • Year to date as assessed by structured judgment reviews (n=244), 0.4% of deaths were thought to be avoidable, 1.6% had strong evidence of avoidability and in 8.2% there was a likely probability of avoidability. These deaths follow our governance process of deeper investigation via the incident reporting framework. • Community ME pilot launched Monday 13th June 2022 with 3 Walsall GP Practices • The Trust has agreed to commission and external review into Mortality to understand how our SHMI and HSMR can be reduced.		
Alert	• There are currently 27 SJRs outstanding and these will be followed up by the Learning from Deaths Administrator		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm • Performance against SHMI is recorded on the trust risk register • Systems and processes for the identification and learning from issues in care have been identified as ineffective by the CCG		
Resource implications	Recruitment to additional posts to support the expansion of the Medical Examiner programme to community		
Legal and/or Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. • National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic	Safe, high-quality care ☒	Care at home ☒	

Objectiveshlight which Trust Strategic objective this report aims to support)	Partners ☒	Value colleagues ☒
	Resources ☒	

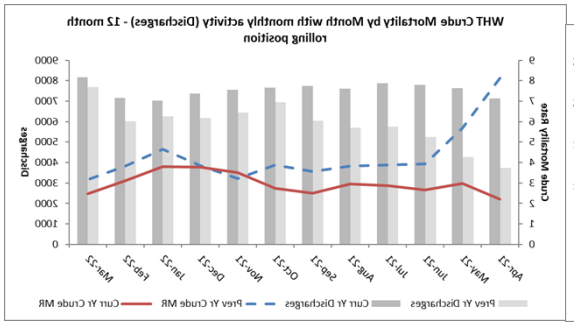
Introduction

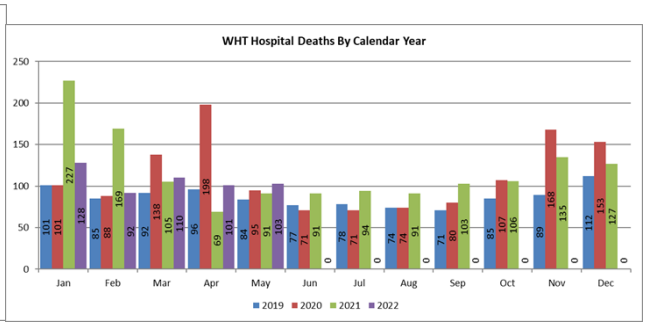
This report details:

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

1. Update on Standardised Mortality Rates (SMRs) and inpatient data relevant to these calculations

1.1 Crude mortality





The crude mortality rate for the period is as follows:

- February 2022 – 3.11%
- March 2022 – 2.47%*

*not verified at time of report

This has fluctuated but is not outside the parameters of expected variation.
Activity levels over this period are as follows:

	Admissions	Hosp Deaths	Total Discharges	Covid Deaths
Apr-22	8201	101	7350	21
May-22	7873	103	7850	14

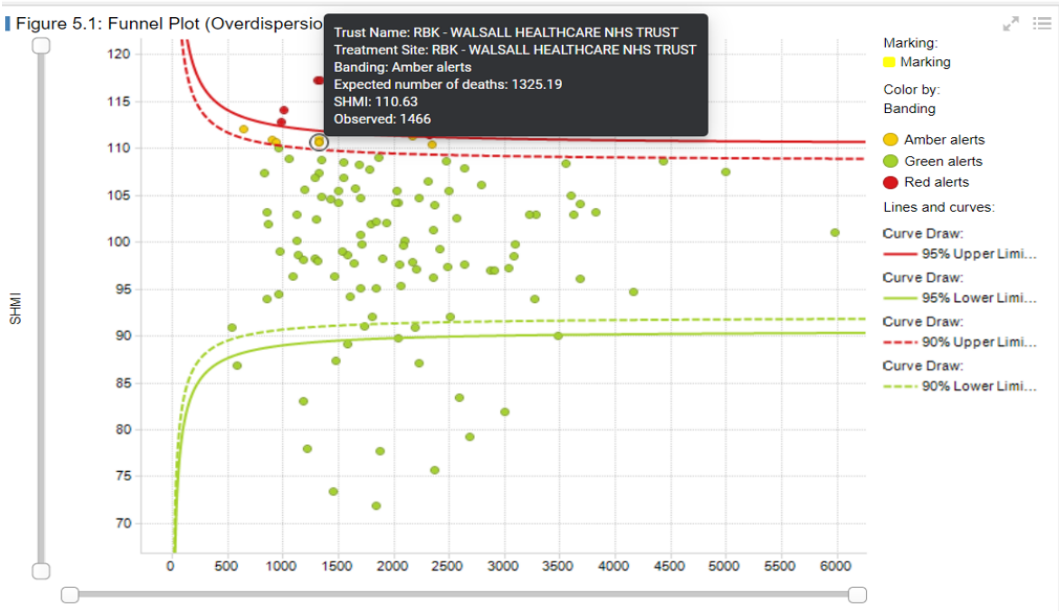
The following table shows in-hospital deaths and crude mortality for the period by SHMI diagnosis for the top 10 presentations in the first 24 hours.

Diagnostic Group (SHMI)	Number of hospital deaths	Number of discharges	Crude mortality rate	Alerting Group on most recent SHMI
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	135	1190	15.63%	
2 - Septicemia (except in labor), 249 - Shock	124	608	23.85%	
99 :: 157 - Acute and unspecified renal failure	44	347	17.58%	
108 - Congestive heart failure; nonhypertensive	38	519	10.98%	
129 - Aspiration pneumonitis; food/vomitus	37	142	35.21%	
127 - Chronic obstructive pulmonary disease and bronchiectasis	34	837	6.69%	
19 - Cancer of bronchus; lung	25	85	47.06%	
42 - Secondary malignancies	18	94	30.85%	
55 - Fluid and electrolyte disorders	18	334	8.08%	
153 - Gastrointestinal hemorrhage	18	343	6.71%	

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

The most recent published SHMI value for the 12 month rolling period (published June 2022) March 2021 to February 2022 is 110.63, this is on a downward trend and is on the 90% upper limit range as an amber Trust.

The Trust is now ranked 106th out of 122 Trusts across the country for this period and is within the expected range.



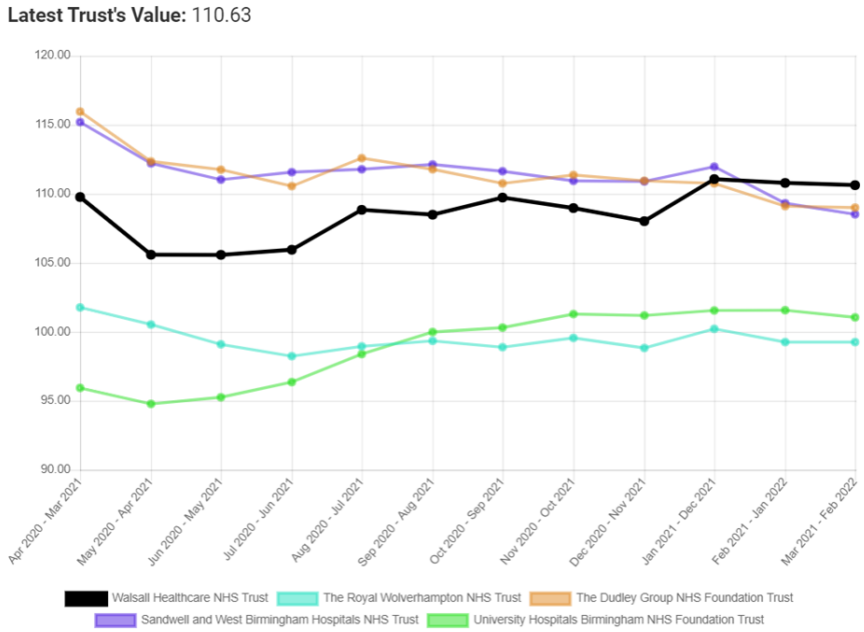
SHMI trend (available data from HED)

Time period	SHMI Value	SHMI Crude Mortality %
April – June 2021	103.99	2.12
July – September 2021	118.36	2.38
October – December 2021	115.71	2.70
March 2021 – February 2022	110.63	2.70

Coding and palliative care (Goscote Hospice)
As previously reported, audits are continuing to establish whether the inclusion of palliative care patients at Goscote Hospice are affecting HSMR data for the Trust.

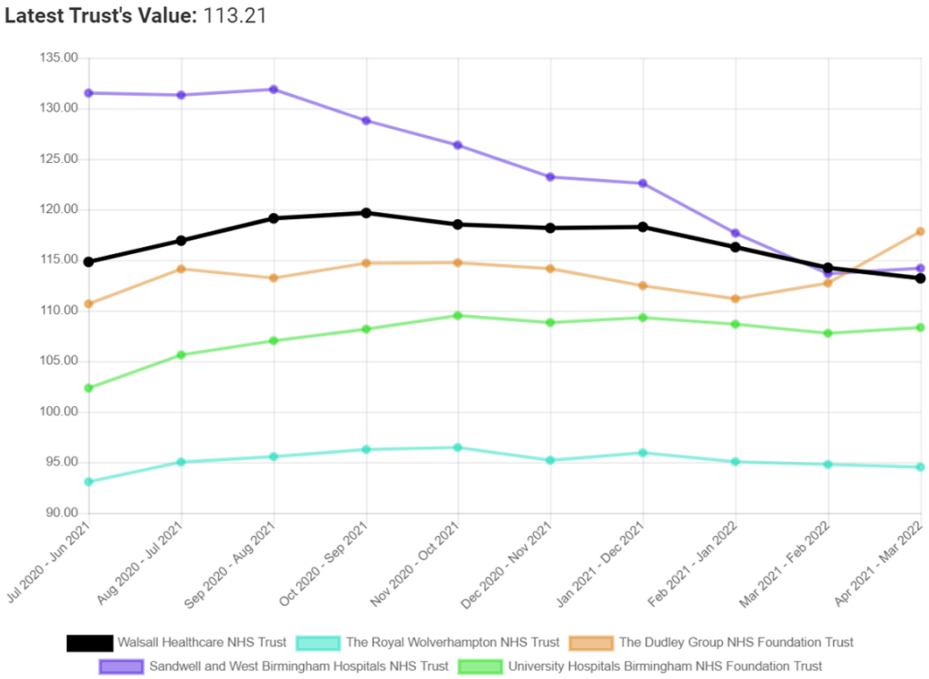
An external review of mortality statistics, coding and the contributory factors to coding has been agreed and will take place over the next few months. Updates will be provided within this report.

1.2 SHMI in comparison with neighbouring Trusts



HSMR

The chart below is taken from available data within HED and illustrates the Trust's performance in relation to peer group as a monthly rolling average. Although HMSR remains higher than the national average which is 99.78 there is a steady reduction in HSMR.



The following table includes the expected HSMR level for March 2022 although this has not yet been verified. It shows a continued decrease in HMSR. This table is for the monthly reported HSMR rather than the rolling 12 month average.

	HSMR
Apr-21	80.02
May-21	113.57
Jun-21	116.52
Jul-21	121.73
Aug-21	125.14
Sep-21	117.36
Oct-21	108.54
Nov-21	128.88
Dec-21	123.20
Jan-22	123.56
Feb-22	106.78
Mar-22	92.59

Alerts

The Trust has these SHMI alerts during this period:

Alert	Alert Period	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score	Alert Level
SHMI	Feb 2021 - Jan 2022	24 - Cancer of breast	2.62	9	105	343.09	Red
	Feb 2021 - Jan 2022	29 - Cancer of prostate	4.75	12	39	252.51	Red
	Feb 2021 - Jan 2022	59 - Deficiency and other anaemia	13.22	24	593	181.54	Red
	Feb 2021 - Jan 2022	19 - Cancer of bronchus; lung	24.63	39	82	158.37	Red

Alerts are investigated by case note review and presented to MSG.

2. Perinatal Mortality (Trust position following Ockenden report)

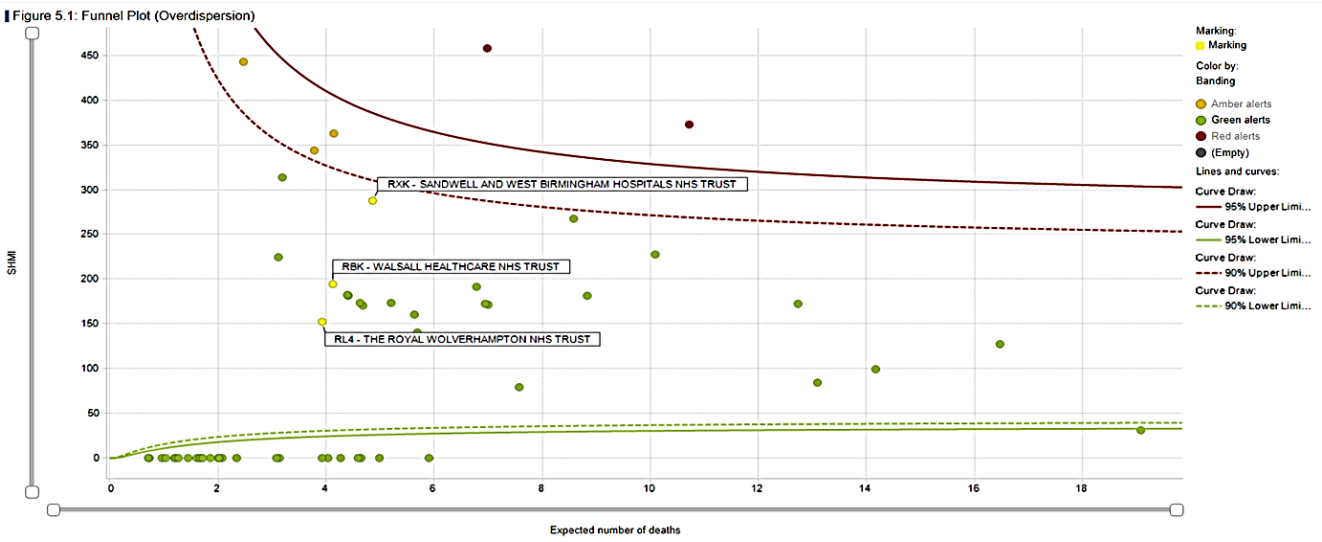
The Trust has reviewed perinatal mortality following the publication of the Ockenden report.

The perinatal mortality SHMI for Walsall Healthcare Trust deaths is reported in HED as 194 for April 21-Jan 22.

Provider	Walsall Healthcare
Data Period	April 2021 - Jan 2022
No. of total discharges	975
Expected number of deaths	4.12
Patients who died at the hospital or within 30 days	8
SHMI	194
HED Assessment	Within range

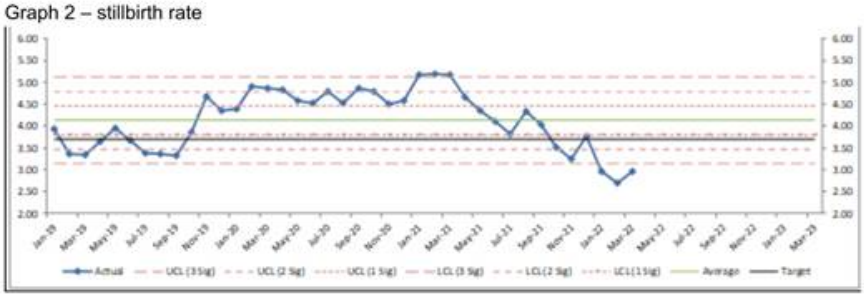
In the patient level data, one case which was a termination of pregnancy has been removed. This reduces the SHMI for perinatal mortality to 169

See below for Black Country acute benchmark. It should be noted that SHMI for perinatal mortality is high in the Black Country at 204. Black Country perinatal mortality is being looked at through the LMNS group and reporting to the ICS.



The maternity dashboard information continues to demonstrate a continued maintenance trajectory for stillbirth and perinatal mortality rates in graph 2.

Graph 2 – stillbirth rate



3. Speciality Audits

a. Nephrology

An audit of patients who developed acute kidney injury and subsequently died for the previous 12 months has been completed. A total of 67 deaths were identified (29 male; 38 female; mean age 74).

Of these patients 61 had developed acute kidney injury (AKI) in the community; 6 had acquired AKI during their hospital stay. The audit recognised that all 6 patients who developed AKI during their hospital stay had been appropriately managed with the AKI pathway. No gaps in care delivery were identified.

The audit has identified the causes of AKI as follows- 28% sepsis; 7% obstructive uropathy; 19% cancer related; 42% multimorbidity and multifactorial.

The development of Walsall Together's community nephrology service is likely to impact on community AKI risk and therefore hospital mortality, so it has been agreed this audit will be reported quarterly instead of annually.

In addition the development of a Same Day Emergency Care (SDEC) pathway for patients identified with AKI in the community will aid in speed of access to specialty nephrology services and improve continuity of care and outcomes for patients. The impacts of this development will monitored also.

b. Ovarian Cancer

The ovarian cancer HED alert audit was fully completed and presented at May's mortality surveillance group (the initial audit hadn't identified all relevant cases). This covered the period from October 2020 to September 2021.

The audit has identified advanced disease at first diagnosis and recurrence, but identified no issues with service provision, access or delays to assessment and treatment.

Numbers of patients who die are small, and, given volumes of disease is low, any slight deviation in numbers of deaths can generate alerts. The present HED alert represented a total of 4 deaths.

No further alerts have been issued, though it was suggested there are some concerns being identified in the pathway presently. These are two fold:

i. Increased reporting times for histology
ii. Access to image guided biopsy

Both issues have been highlighted to NHS improvement and the west midlands cancer alliance.

c. Cancer Services

i. HED Alerts

The excess death alerts received from HED for gastrointestinal, breast, prostate and ovary for the period April 2021 to December 2021 were reviewed. The alerts were generated because the total observed deaths in these diagnostic groups over the period was 30 patients against an expected total of 8.22.

When deaths of patients with both a palliative care diagnosis and under the care of palliative care at Goscote inpatient unit are excluded unit no excess deaths are observed.

A meeting with the lead analyst at HED is arranged to ensure we can apply this logic.

ii. Cancer Improvement

Improvements have been seen in services for patients referred for breast and prostate cancer, and in medical oncology service provision.

The breast cancer service is increasing capacity by an additional 150 clinic appointments per week. All patients will receive gold standard triple assessment of mammography, ultrasound and fine needle aspiration at a single appointment.

The prostate cancer service has introduced a ‘one stop shop’ clinic where patients receive trans-rectal ultrasonography and transperineal biopsy as needed rather than wait between assessment and investigation.

The medical oncology service has secured funding to increase provision to a seven day service (from 5 days) and consultant availability to clinics and MDT across all tumour sites to 52 weeks a year (from 42 weeks). The investment also provides medical oversight for the delivery of immuno- and chemo-therapy in line with standards of care defined within the NHS Standard Contract for Cancer: Chemotherapy.

Delays to oncological assessment and chemotherapy, which have been a factor in 6 serious incidents over the last 12 months, and which are associated with worsened overall survival, will be reduced.

4. Specialty Learning / Feedback

No additional specialty reports other than audits were presented at May's mortality surveillance group. The Child Death Report will be included in the next report to this Group.

5. Deaths reviewed by the Medical Examiner Service

The percentage of deaths reviewed by the Medical Examiner (ME) over the period was as follows:

April 2022 – 99.2%
May 2022 – 99.2%

As previously reported the Medical Examiner service is being rolled out to review community deaths. Following discussions, the pilot scheme will commence on Monday 13th June 2022 with initial evaluation after 4 weeks. The three identified GP practices will take part in the pilot and reporting mechanisms are currently being agreed and implemented. Community deaths reviewed as part of this pilot will be reported alongside inpatient deaths.

One ME commenced on 16th May 2022 with the second ME due to start on 4th July 2022. The MEO post did not attract suitable candidates and will be put back out to advert.

6. Mortality Reviews - Structured Judgement Reviews (SJRs)

6.1 There are currently 27 SJRs outstanding and these will be followed up by the Learning from Deaths Administrator

6.2 Training on the electronic SJR system (CORS) continues with 1:1 training with clinicians taking place weekly.

6.3 There were no LeDeR reviews identified in April and just 1 in May. The learning disabilities team structure has recently changed with a joint service covering Royal Wolverhampton Trust and Walsall Healthcare Trust. Discussions are currently underway on how LeDeR reviews will be reported going forward.

7. SJR outcomes (total deaths reviewed categorised by outcomes)

Score 1 Definitely avoidable		
This Month	0	0.0%
This Quarter (QTD)	0	0.0%
This Year (YTD)	1	0.4%

Score 2 Strong evidence of avoidability		
This Month	0	0.0%
This Quarter (QTD)	2	7.8%
This Year (YTD)	4	1.6%

Score 3a Probably avoidable (more than 50:50)		
This Month	0	0.0%
This Quarter (QTD)	1	3.8%
This Year (YTD)	20	8.2%

Score 3b Probably not avoidable (less than 50/50)		
This Month	2	33.30%
This Quarter (QTD)	9	34.6%
This Year (YTD)	60	24.6%

Score 4 Probably not avoidable		
This Month	4	66.7%
This Quarter (QTD)	13	50.0%
This Year (YTD)	136	55.7%

Score 5 Slight evidence or definitely not avoidable		
This Month	0	0.0%
This Quarter (QTD	1	3.8%
This Year (YTD)	23	9.4%

Year to date as assessed by structured judgment reviews (n=244), 0.4% of deaths were thought to be avoidable, 1.6% had strong evidence of avoidability and in 8.2% there was a likely probability of avoidability. These deaths follow our governance process of deeper investigation via the incident reporting framework.

In 89.7% of cases reviewed by SJR, deaths were likely not avoidable.

Recommendation

Trust Board is asked to note and discuss these report findings.

MEETING OF THE TRUST BOARD **Wednesday 3rd August 2022**			
Patient Voice Report Quarter 1 – April-June 2022			
Report Author and Job Title:	Garry Perry Associate Director Patient Relations and Experience	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	-		
Advise	Response rates for the Friends and Family Test have increased significantly ↑ 973 for Quarter 1 2022 from Quarter 4 2021-2022.		
Alert	The Trust average compliance rate for complaints (response timeframes) for quarter 1 was 83%. This is a decrease of 11% when compared to the previous quarter, which was 94%. Impacted by volume.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☐		

Quarterly Patient Voice Report (April-June 2022)

1. PURPOSE OF REPORT

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

2. BACKGROUND

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

3. DETAILS

3.1 Feedback data

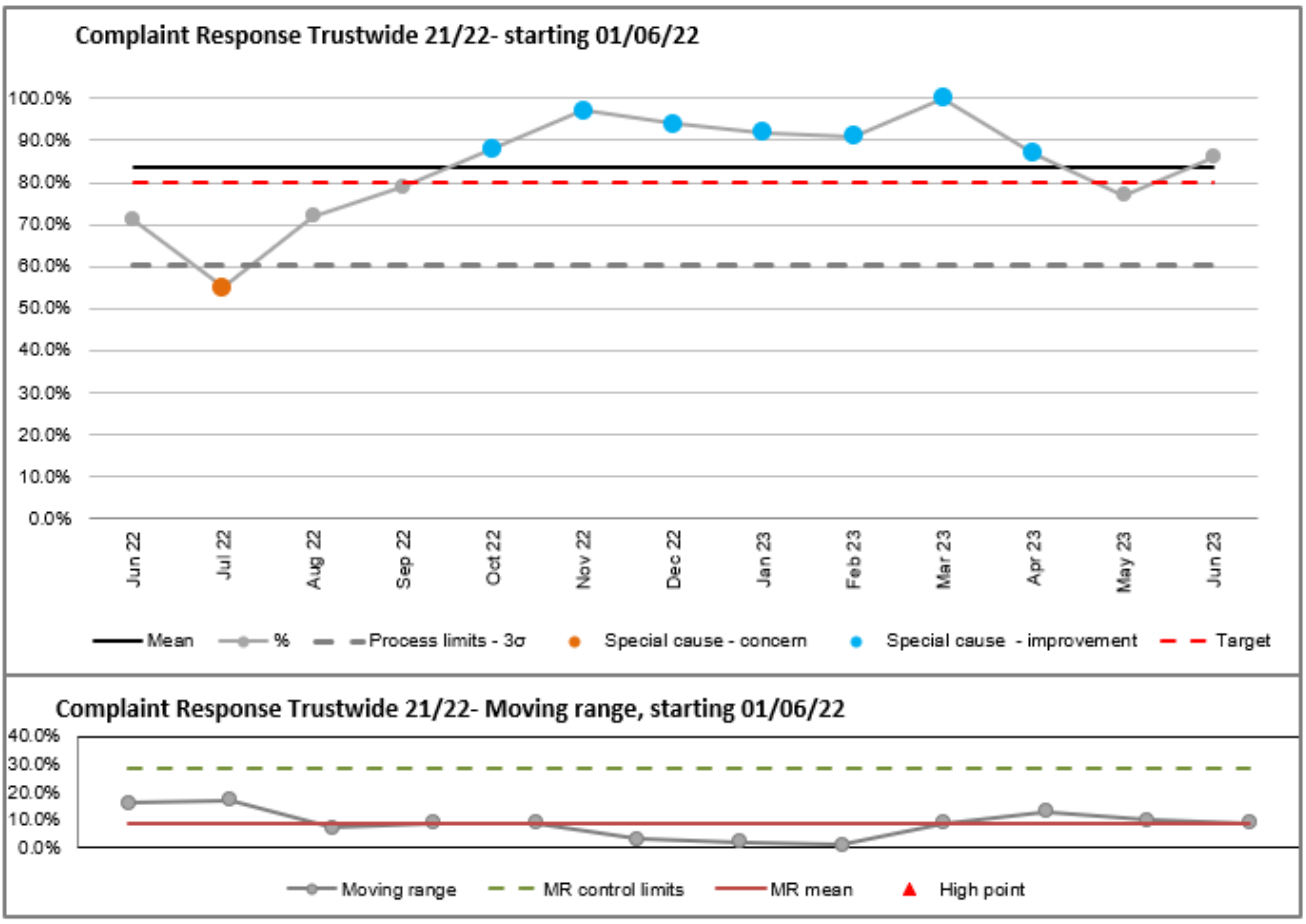
The Trust received a total of **15615** feedback contacts between April and June 2022. Largely attributable to nudge messaging the Friends and Family Test which was switched on in May.

Complaints (including MP letters)	91
Concerns	658
Compliments	99
Friends and Family Test	14694
Mystery Shopping (QR code)	73

Table 1. Patient Feedback by contact type

3.2 Complaints and Concerns

1. The top 3 trends for complaints, concerns and queries in Quarter 1 relate to Clinical care, Assessment and Treatment (317), Appointments (272), and Access (call handling – 78)
2. Surgery received the highest number of contacts with 318, MLTC received 312 and WCCSS received 126 (excluding compliments).
3. 99 Compliments were received with Community receiving the majority (35).



3.4 Complaint response times

The Trust average compliance rate for complaints (response timeframes) for quarter 1 was 83%. This is a decrease of 11% when compared to the previous quarter, which was 94%. This has been impacted by a few contributory factors, including volume, difficulty obtaining health records and statement delays.

4.0 Friends and Family

4.1 Monthly comparison

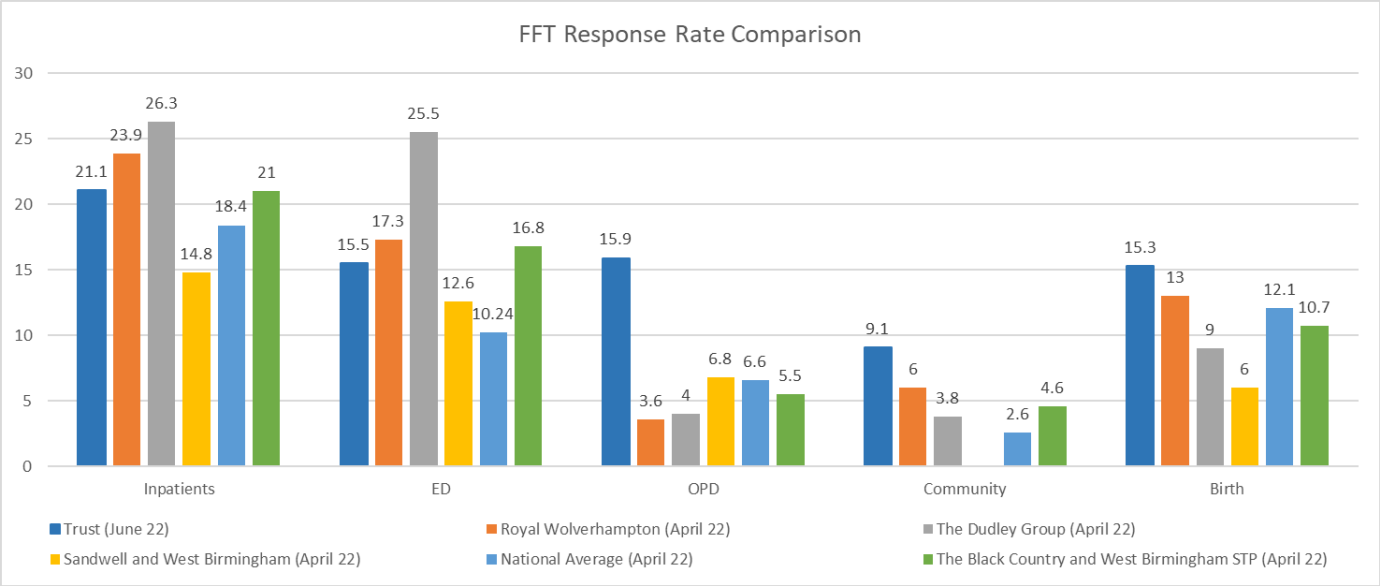
The below table illustrates the month-on-month improvement for the Trust from May to June. Internally the Trust has an improved recommendation in Outpatients and remained consistent in Community and Birth. The Trust has a slight decline (less than 5%) for Inpatients, ED and Postnatal Community and a significate decline (above 5%) in Antenatal and Postnatal Ward. Response rates have improved or remained the same for Outpatients, Community, Birth and Postnatal Community.

Friends & Family Test	Recommendation			Response Rate		
	April	May	June	April	May	June
Inpatients	83%	87%	83% (-3%)	21%	26%	25% (-1%)
Outpatients	91%	90%	91% (+1%)	16%	21%	21% (=)
Emergency Department	73%	75%	72% (-3%)	16%	18%	16% (-2%)
Community	98%	98%	98% (=)	9%	6%	9% (+3%)
Antenatal	86%	95%	86% (-9%)	10%	20%	18% (-2%)
Birth	72%	89%	89% (=)	15%	20%	23% (+3%)
Postnatal ward	93%	82%	74% (-8%)	12%	12%	11% (-1%)
Postnatal community	80%	91%	90% (-1%)	6%	14%	14% (=)

4.2 Response Rate Comparison

The chart below illustrates the Trusts response rate compared locally, regionally, and nationally. Please note, the data for the Trust is for June 22 (Unvalidated) and for April 22 for all over areas. This is due to the NHS England data reporting delay. The Trust has a higher response rate for all FFT touch points when compared to national data and all except ED when compared at STP level. When compared against local organisations in Wolverhampton, Dudley and Sandwell & West Birmingham, the Trust outperformed other organisations for Outpatients, Community and Birth.

***Response rates not available for antenatal or postnatal FFT as no longer published by NHS**



4.3 Recommendation Comparison

The tables below illustrate the Trust recommendation score compared locally, regionally, and nationally. Please note, the data for the Trust is for June 22 (Unvalidated) and for March 22 for all over areas. This is due to the NHS England data reporting delay. When compared nationally, the Trust performs better for Community and equal for Postnatal Community. Comparing regionally the Trust performs better for all touchpoints except Inpatients. When compared against local organisations in Wolverhampton, Dudley and Sandwell & West Birmingham, the Trust outperforms in ED, Community and Postnatal Community.

FFT Recommend	Inpatients	ED	Outpatients	Community
Trust (June 22)	83	72	91	98
Royal Wolverhampton (April 22)	93	70	93	90
The Dudley Group (April 22)	88	68	85	87
Sandwell and West Birmingham (April 22)	84	62	88	
National Average (April 22)	94	75	93	93
The Black Country & West Birmingham STP (April 22)	87	68	89	93

FFT Recommend	Antenatal	Birth	Postnatal Ward	Postnatal Community
Trust (June 22)	86	89	74	90
Royal Wolverhampton (April 22)	71	95	78	83
The Dudley Group (April 22)	91	77	68	
Sandwell and West Birmingham (April 22)	85	63		
National Average (April 22)	91	94	92	90
The Black Country & West Birmingham STP (April 22)	85	81	76	87

5.0 Mystery Patient feedback

The below tables illustrate the Mystery Patient feedback received during quarter 1. The scored questions show an improved picture from April to May, however slight decline in June. A total of 73 Mystery Patient feedback was received in Q1

	April	May	June
Count of Courtesy of the staff rating	5	8	7.2
Count of Environment and hospital facilities rating	5	7.7	6.9
Count of Treated with respect and dignity?	5	8.1	7.8
Count of Involvement in decisions about your care and treatment?	6.7	7.9	6.8

* Scored question calculated using the CQC national survey matrix with scores out of 10.

	April	May	June
Inpatients	6	15	17
Outpatients	5	10	7
Emergency Department	1	0	2
Maternity	2	7	1

6.0 National Survey update:

The **2020** ***Adult Inpatient Survey*** (results published in October 2021) action plan has been populated and evidence where available collated. Initiatives relating to communication, discharge, and providing feedback on care are being developed.

The headline findings for the **2021 survey** have been received and the action plan has been adjusted – the full results are embargoed prior to full publication of the survey later this year.

The preliminary results have been shared with senior leaders and presented to the Patient Feedback Oversight Group.

There will be a renewed focus on noise at night and what constitutes a good ward round which will pick up on the questions were the Trust has scored lower than the national average.

We are working with Healthwatch Walsall who have chosen discharge as an insight priority for them this year. This also mirrors feedback received via the national surveys in addition to complaints and concerns. We have initiated a discharge survey with 55 responses received so far – the survey findings will help inform the discussions in relation to this workstream.

7.Engagement

7.1 Maternity

The 2021 survey findings were published in January 2022 with full national benchmarks. As previously reported following the provisional publication in October, for everything other than visiting the organisation scored around the same or worse than others comparative Trust's.

The Divisional team prepared a presentation on the findings that has been shared with all Maternity staff via a closed Facebook page and through email. It has also been shared with individual staff during their appraisal process.

The following actions have also been progressed:

- Liaison with the Maternity Voices Partnership (MVP) has taken place who have had chance to comment on the findings and contribute to the actions being developed. In terms of the MVP strengthening the membership is key and a co-chair is in place due to the existing chair taking some time away with her new baby.
- Making staff aware of the survey, attending staff meetings and breaking plans down for the next phase which is the 'action phase' has been carried out by the leadership team.
- Postnatal is still currently the experience that women struggle with, and we are trying to strengthen this area, using the MVP link to do that.
- The MVP are supporting the 15 steps observational tool and 15 steps reviews will be undertaken in July supported by Healthwatch Walsall. Antenatal has already completed one with mainly positive observations made in addition to recent observations in the post-natal ward again mainly positive.
- We have also placed three EWE's (Enhancing Ward Experience) volunteers on antenatal and maternity (started at the end of March) part of their role is around engagement with mums on obtaining feedback – specifically FFT and Mystery Patient.
- Mystery Patient and FFT posters are also in place across the inpatient areas
- Our Voice Maternity Survey has been agreed (based on National Survey questions) will go live during July.

WE ARE WALSALL 2040

WE ARE WALSALL 2040 - Organisations from the across Walsall are coming together to develop a vision for the future of the Borough. More than 10,000 residents and businesses will be asked for their views about what they want Walsall to look like and be like in 2040 and beyond. **We are Walsall 2040** will provide a strategic framework for Walsall Council and its partners to prioritise resources and to develop shared ambitions for a Walsall that works for everyone**.** The public engagement phase of **We Are Walsall 2040** has begun and runs throughout the summer. The plan for **We Are Walsall 2040** is expected to be unveiled in the spring of next year. There is a specific engagement piece focussing on the views of new and expectant parents about the kind of Walsall they want to see for their children and support from healthcare providers. We are linked in with this and will test our maternity survey out through the process.

7.2 Maternity Friends and Family Test

Nudge messaging was switched on in May and this along with the actions above has had a positive impact on the Friends and Family Feedback in Maternity. Except for Postnatal Ward, all areas have shown an improved recommendation. The response rate has improved across all areas in Q1 from Q2.

Maternity Nudge Messaging	Recommendation		Response Rate	
	Q4	Q1	Q4	Q1
Antenatal	84%	89% (+5%)	10%	16% (+6%)
Birth	78%	83% (+5%)	15%	19% (+4%)
Postnatal Ward	84%	83% (-1%)	10%	12% (+2%)
Postnatal Community	79%	87% (+8%)	7%	11% (+4%)

*Figures based on the average scores/response rates in the quarters

7.3 Patient involvement Partners (PiP's)

The Patient Partners recently met to discuss the emerging Patient Experience Ambitions. The partners helped to shape the consultation survey and confirmed agreement with the selected priority areas for improvement. The partners have also expressed support in helping us realise the ambition to develop a Patient and Public Engagement Hub.

8.0 Enhancing the Patient Experience

8.1 Visiting – The Welcome Hub

45%
Overall Capacity of Visitors
**Note the capacity figure is calculated from the number of visitors allowed in a 31 day calendar month*

7,128
Total Number of Visits

17
Total Number of Video Calls Carried Out

AMU
Most Visited Ward

Ward 24
Least Visited Ward

14
Total Number of Parcels to Patients Delivered

8.2 Blessed to Bless

We have begun a partnership with **'Blessed to Bless',** a charity that helps feed the homeless and those that are struggling financially.

Blessed to Bless will be supporting us initially with our Hospital to Home Discharge programme based on the discharge lounge - where a food parcel is provided to vulnerable patients leaving hospital with no means of accessing shops or no support network in place. The food parcel supplies an initial provision of long-life milk, sugar, tea/coffee/, juice, biscuits, cereal, pasta, soup, and sauce. Those who agree are also referred to a local network hub for ongoing support such as be-friending and assistance with welfare and benefit maximisation.

8.3 Volunteers

56 Volunteers joined the trust in Q1	Volunteers supporting the hospital in Q1 93
Total Hours Logged in Q1 3577	**Top hours for Q1** 1ST 361 2ND 351 3RD 221

9.0 RECOMMENDATIONS

Note the contents of the report

MEETING OF THE TRUST BOARD - 3/8/22			
Quarterly Update from the Quality Improvement Academy			
Report Author and Job Title:	Kate Salmon Deputy Director of Strategy & Improvement & Joyce Bradley Head of Quality Improvement	**Responsible Director:**	Simon Evans, Interim Chief Strategy Officer
Recommendation & Action Required	Members of the Committee are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• That capacity and capability building in a consistent QI Approach continues in appropriate format with social distancing • Engagement of the QI Academy by operational areas to provide QI approach to making improvements • Addressing the CQC requirements for organisations to develop a mature QI approach		
Advise	• Walsall recognised by the national NHSE/I Increasing Capability Building and Delivery (ICDB) Team for their approach to building capacity and capability • Working more widely with partners across the Black Country and beyond		
Alert	• Opportunities for training and support to areas using a QI approach to improvement are available despite small size of the team.		
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 as a result of this report.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this report.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

QUARTERLY UPDATE FROM THE QUALITY IMPROVEMENT ACADEMY

1. PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Committee of the progress with increasing the capacity and capability of colleagues in an agreed QI Approach, namely the Quality Service Improvement and Redesign (QSIR) programmes across the organisation and beyond through quarter 1 of financial year 2022/23. Further that the report highlights the extent of training and support provided to Black Country partners.

1.2 The paper also informs the Committee of the specific areas of work being supported to apply a QI approach in making improvements in the service.

2. BACKGROUND

2.1 The QI Academy has been delivering the range of QSIR Programmes since January 2019 and supported the development of the QSIR Virtual programme during lockdown in spring-summer 2020.

2.2 The publication of the joint NHSI and Institute of Healthcare Improvement (IHI) document "*Building capacity and capability for improvement: embedding quality improvement skills in NHS providers"* (hereafter referred to as the dosing document) in 2017 was the catalyst to adopt the Quality, Service Improvement and Redesign (QSIR) training to formalise the delivery of training.

2.3 The dosing document identified what level of knowledge, understanding and application was required by different colleagues within the organisation, with different authority and mandates. The QI Strategy has a section identifying the number of colleagues to be trained to what level.

3. DETAILS

3.1 The report sets out what has been achieved within the last quarter and particularly within the ongoing restrictions imposed for compliance with social distancing for programmes which are accredited for face-to-face during the reporting period.

3.2 The report sets out the uptake of the virtual QSIR programme in attempting to meet the identified training levels from the dosing document.

3.3 Through networking and by reputation the Walsall QSIR Virtual programme has had delegates from 15 external NHS organisations attend their programmes, and this continues through the reporting period.

3.4 This quarter saw the delivery of the two Board development sessions which were developed in collaboration with the CQI team at Wolverhampton and the national Improvement Capacity Building and Development Team and representatives from the NHSE Intensive Support team utilising the Making Data Count training with input from the Business Information and Performance teams of both Trusts. The final report is awaited and an action plan will follow.

3.5 Specific elements of work were undertaken by the QI Academy which supported making services safer for patients and staff. This included working with teams ED, AMU, See and Treat and Ambulatory Emergency Care team.

3.6 The attached report identifies the areas which will be the focus of work for the QI Academy during Q2 2022/23 and sets out three broad areas of work:-

- Building Capacity & Capability
- Supporting Patient Flow
- Patient and Staff Safety

3.7 The main pieces of work that will be ongoing for some time will be:-

- Triangulation of Data for Patient Safety which will help identify areas for improvement work moving forward
- Patient Flow through Gynae and Antenatal Clinics – to look at how the clinics can be supported to work more efficiently through understanding the load on each clinician, the cycle time for step and identifying any flow constraints. This is using the Health Care Systems Engineering (HCSE) principles.

3.8 Smaller pieces of work will also be undertaken and are likely to be completed within the next quarter and include:-

- On-going support to the National Team in the development of a virtual facilitation package for trainers in readiness for the next accreditation cycle starting in September.
- Refining the QSIR Delivery plan for the three QSIR programmes and Health Care Systems Engineering throughout the financial year.
- Implementation of Improvement Huddle boards in Chemotherapy and restarting the ones in Cardiology, NNU and PAU.

4. RECOMMENDATIONS

The Committee is asked to **Note:**

4.1 the ongoing delivery of face-to-face and virtual training in accordance with social distancing requirements and the delivery plan requirements

4.2 the ongoing support by the QI Academy to projects using a QI approach to make improvements in the quality or safety of services provided, led by the staff delivering the service

4.3 the plan of work for quarter 2 2022/23

Quality Improvement Academy Update

Quarter 1 – 2022/23

Quality Improvement Academy
Joyce Bradley – Head of Quality Improvement

ACADEMY WALSALL

Walsall Healthcare NHS
NHS Trust

Contents

Executive Summary

The QI Academy has continued to deliver face-to-face training where it can and also QSIR Virtual. Ongoing projects were supported and the team was on-site more during this quarter.

During this quarter work with the ED and AMU teams has continued and expanded to include the See and Treat team, Ambulatory Emergency Care and more in-depth work with Antenatal Clinic has begun.

Two Board development sessions took place raising the profile of Quality Improvement and ensuring that new members of the board had the same level of understanding of using measurement for improvement and how the distorted data from the impact of Covid should be treated.

The report developed from the outputs of the Board development sessions is expected early in Quarter 2 and will inform additional work to be taken forwards in collaboration with the Continuous Quality Improvement (CQI) team at Wolverhampton.

QI Academy – The Team

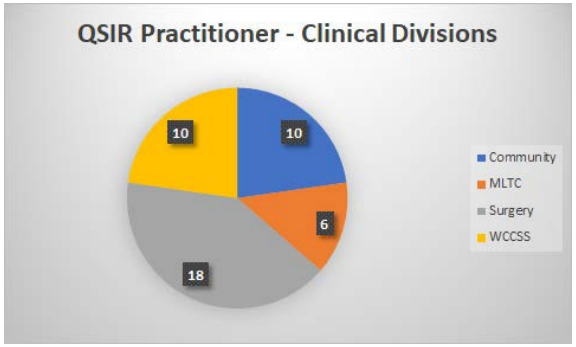
The QI Academy consists of:-

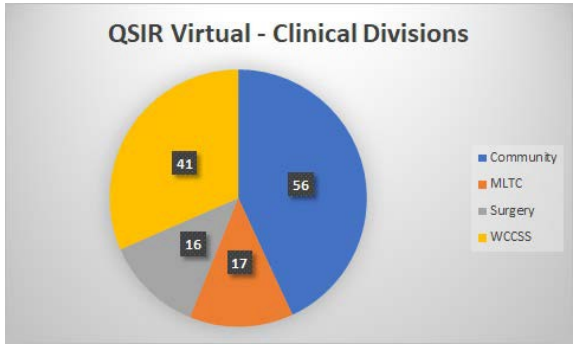
1 x Trust Clinical Lead (2 PA per week) Vacant - interview scheduled in July
4 x Divisional Clinical Leads
1 in post for MLTC, 3 vacant,
1 x Head of Quality Improvement – J Bradley
1 x Quality Improvement Programme Lead – T Johnson
1 x Quality Improvement Facilitator – C Hill (commenced 06/06/22)
1 x Medical QSIR Accredited trainer 0.9 PA per week – Dr Waterhouse
1 X Newly Accredited QSIR Trainer – J Hayman
It is anticipated that the 4 vacancies will be recruited to during Q2 22-23

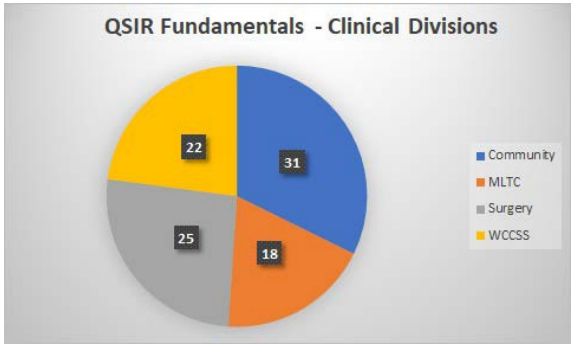
Capacity & Capability

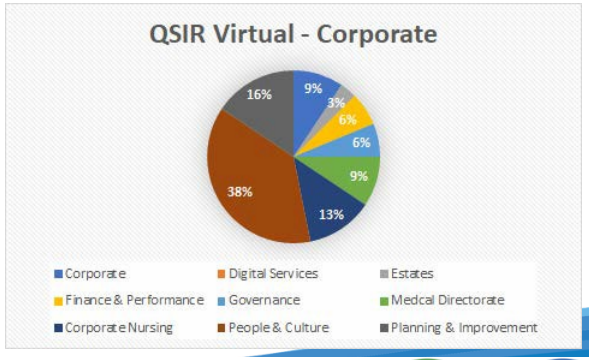
QI Training Delivery

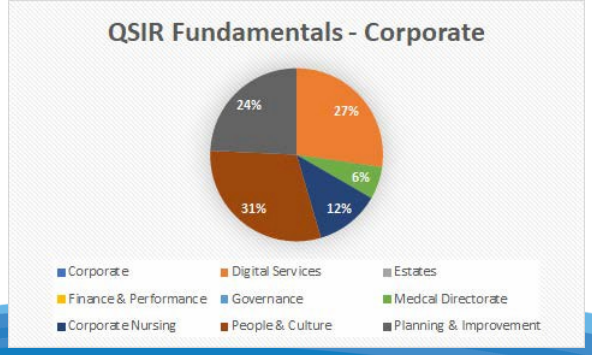
The charts below show the number of staff who have completed the QSIR Programmes January 2019 – end March 2021 – By division







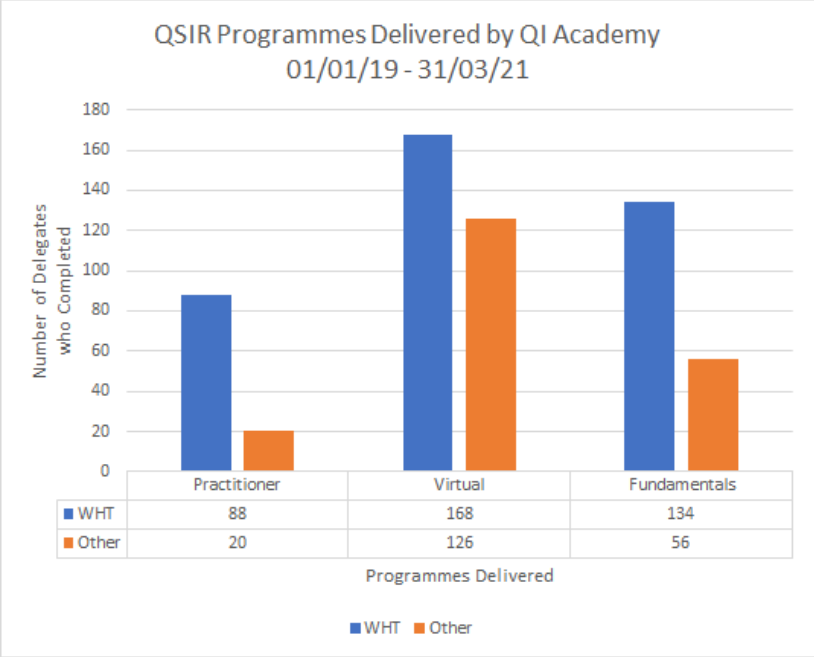




Capacity & Capability

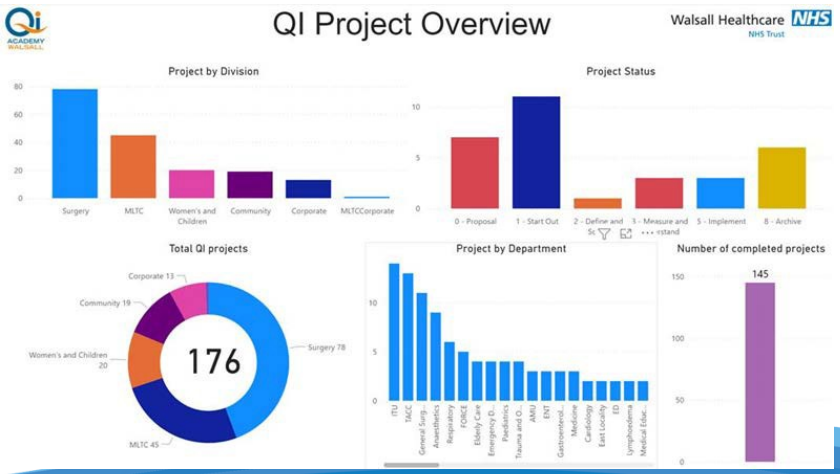
QI Training Delivery

The total numbers of delegates who have completed training delivered by QI Academy since Commencing delivery of QSIR training are shown in the chart below



Dashboard

The QI Academy had an interactive dashboard which enabled drill down to Care Group level. This is being rebuilt to operate in teams in the NHS.net environment along with the QI Project Registry – a snapshot of what it will contain is given below.



Capacity & Capability

QI Training Delivery

April

- Completed the delivery of a cohort of QSIR Practitioner for Sandwell & West Birmingham enabling them to establish a faculty for delivery of QSIR Programmes once accreditation complete.
- Cohort 19 of QSIR Virtual completed
- Introduction to QI to Student Physios at Wolverhampton University, Midwives and Band 6 Community nurses.

May

- Cohort 11 for QSIR Practitioner Commenced – due to complete in July.
- QSIR Fundamentals delivered for Regional Anaesthetics Trainees – Arranged by Dr Atul Garg
- First of two Trust Board Development Sessions (in conjunction with Wolverhampton) and the national Improvement Capability Building and Delivery (ICBD) Team at NHSEI team supported the delivery of a half day session on Quality Management Systems and how QI is inherent in all areas.

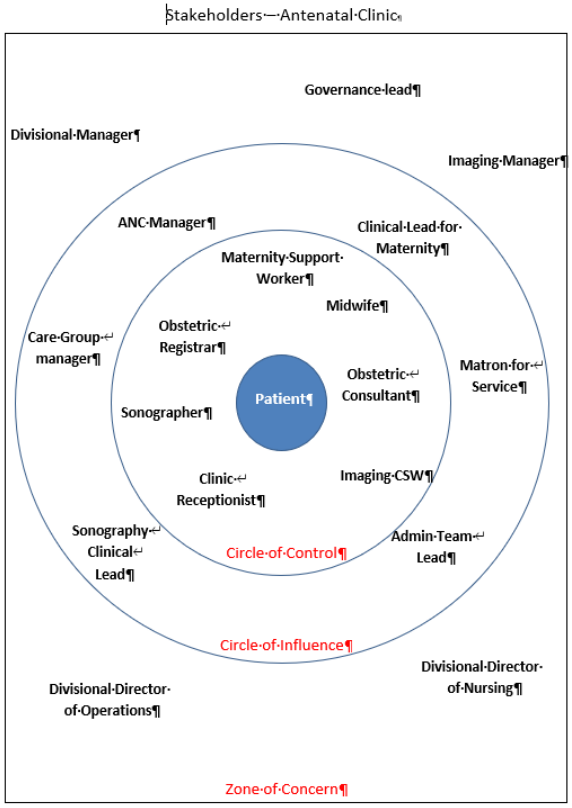
June

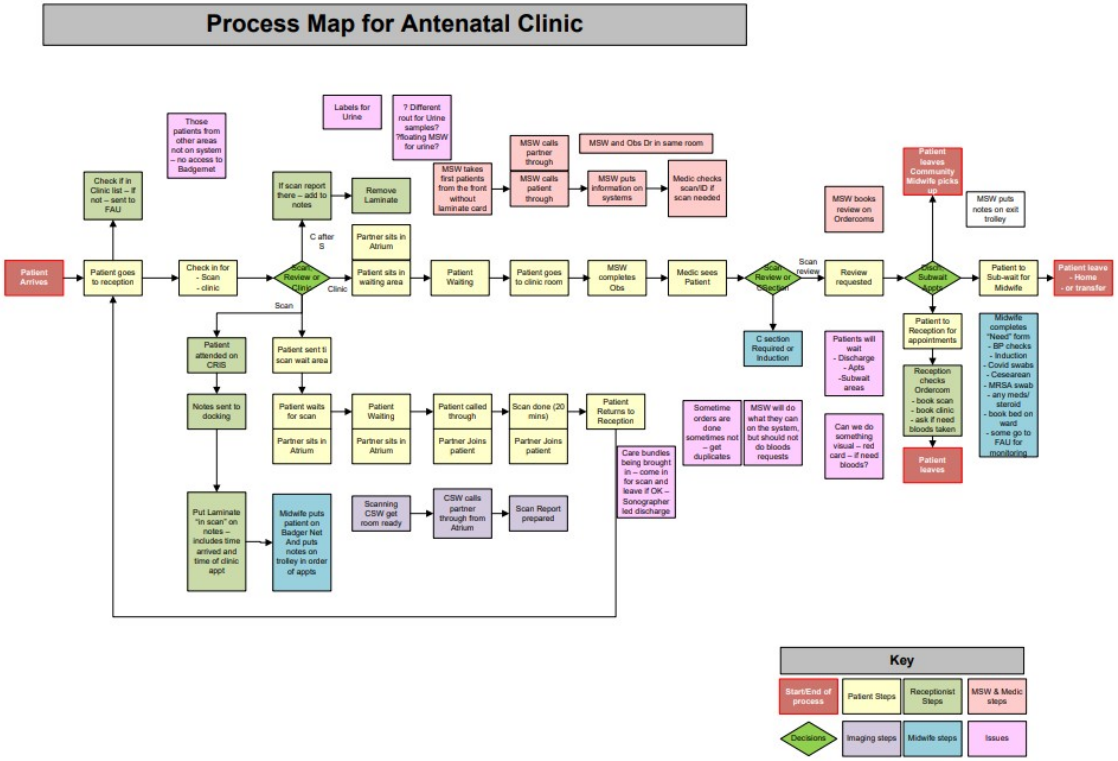
- Second Trust Board Development session – focussing on Measurement for Improvement and co delivered with the Intensive Support Team at NHSEI and ICBD Team. The report on outcomes and next steps due in July.
- Cohort 20 of QSIR Virtual completed
- QSIR Fundamentals completed including delegates from Black Country Health Care NHSFT

Patient Flow

Health Care Systems Engineering (HCSE)

HCSE principles have been applied to measuring the patient flow through the Antenatal Clinic – the image below are the process map and stakeholder map. The measurement of the flow of patients through the clinic is scheduled during July



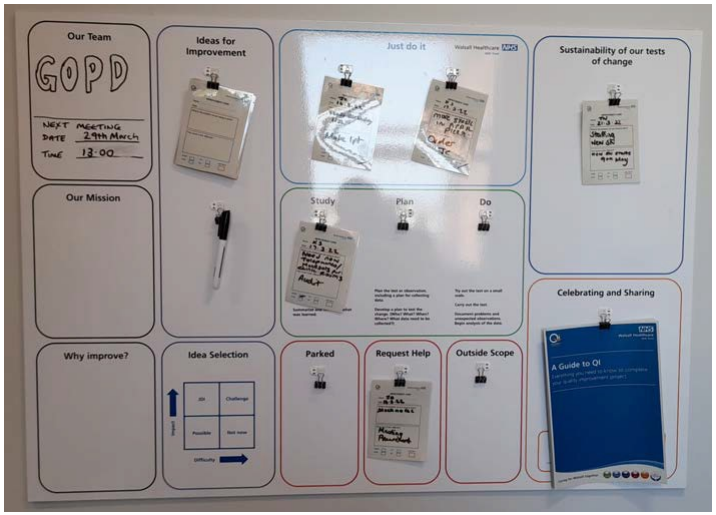


Patient and Staff Safety

QI Huddle Boards

During Q1 the QI Academy has supported additional clinical teams to start using the QI Huddle Boards including Ward 25 and Delivery Suite.

Cardiology, Neo-natal Unit and Paediatric Assessment Unit have all agreed to restart their boards, which had been suspended due to Covid19. A formal training session is being established to introduce rigour to the roll out and will be used moving forwards for new areas which are interested in having a board.



The QI Huddle boards enable those working within a service to identify things which are hindering the smooth running of the service or department and then work through these issues together to resolve them – first ensuring that they are aware of exactly what the problem is.

Tickets with the issues on are used to monitor what has been raised and subsequently monitor their progress through a Study-Plan-Do approach (aligned to PDSA cycles) to ensure that things are resolved.

Plans for Quarter 2 2022-23

Capacity & Capability

- Additional Trainers undertaking the Accreditation process for QSIR delivery
- Delivery of Health Care Systems Engineering mini-masterclass – a half-day session on improving patient flow.
- QSIR Practitioner, Fundamentals and Virtual cohorts subject to social distancing rules where needed
- NHSEI and the Black Country Health Care NHST delegates to start on a WHT delivered QSIR Practitioner cohort.
- Revise the Delivery Plan for training to accommodate additional trainers who are undertaking accreditation

Patient Flow

- Continue working with See and Treat, Ambulatory Emergency Care and development of an Emergency Decision Unit
- Imaging Flow – Pull system, further analysis of data, subject to processes reducing number of mobile x-rays
- Development of second mini-masterclasses on Health Care Systems Engineering and Patient Flow workshops
- Antenatal Clinic Patient Flow work to recommence

Patient and Staff Safety

- QI Huddle Board installation in interested departments
- Refreshed approach to #EndPJPoralysis within the Modular block

Meeting of the Public Trust Board Wednesday 3rd August 2022			
Director of Midwifery Report			
Report Author and Job Title:	Carla Jones-Charles – Director Midwifery Gynaecology and Sexual Health	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• 100% of women received 1:1 care in labour • The service is on track with CNST safety action 6 – Saving babies lives care bundle		
Advise	• Maternity 15 Steps, program that uses an observational approach for service review, was completed with extremely positive feedback from services users on their findings on the 7th July. The service will support the development of an action plan for areas that require strengthening. • Maternity service is working with staff to support areas that require strengthening as highlighted in the staff survey		
Alert	• There continues to be staffing pressures due to staff absence. There has been a rise in absence due to covid and D& V. The team continue to use the escalation policy and business continuity plans. Recruitment continues. The Ockenden business case has been submitted for approval.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF 1: Safe, high-quality care • Risk number 2245: Lack of registered nurses and midwives		
Resource implications	There are no funding resource implications associated with this report.		
Legal and/or Equality and Diversity implications	There are no Legal, Equality and Diversity implications associated with this report		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Director of Midwifery Report

1. PURPOSE OF REPORT

The purpose of the report is to provide an update to assure the Board of the following items;

- Resource
- Perinatal mortality/ morbidity
- Culture
- Engagement with Women & Families

2. BACKGROUND

This report will provide a concise update regarding the on-going position on the elements cited within section 1 by exception.

2.1. Resource

Midwifery Staffing

There continues to be challenges with staffing due to staff absences, the table below is a breakdown of absence for June 2022. The service has continued its active recruitment. Maternity leave continues to run at 5%. Sickness management continues with a rise in D and V and Covid absence. These continues to be managed in line with the Trust policy.
The care group has submitted a business case to address both the maternity leave pressure and the requirements outlined by the final Ockenden report.

Table 1

			Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Women's Services (Are)	Delivery Suite - Nursing	Registered Midwives	9.7%	0.7%	5.5%	11.4%	3.3%	2.1%	32.7%
		Unregistered Nurses	13.6%	1.4%		8.1%	1.2%		24.4%

2.2 Medical staffing

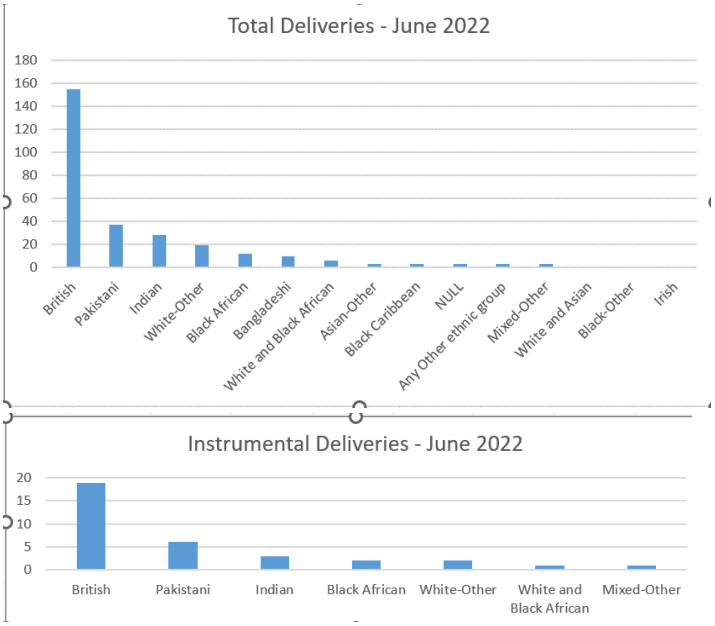
RCOG recommends 60 hours of Delivery suite cover by a resident Consultant for a unit the size of WHT (less than 4000 births). The is currently 81.5 resident hours provided. While this currently covers Obstetrics and gynae emergency, there is significant progress to deliver a separate Consultant rota which will further enhance cover as recommended by the final Ockenden report. The consultant element of the Ockenden business case was approved and there has been the successful recruitment of 3 consultant.

2.3. Activity within the Maternity Unit

Table 2 highlights the delivery activity within Maternity Unit on a month by month basis and the ethnicity data is highlighted in chart 1.

Table 2. Birth Activity July 2021-March 2022

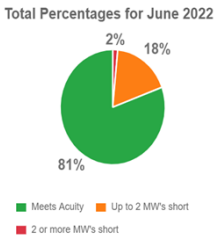
Month	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
No: Births	334	335	313	317	294	311	298	287	331	284	300	285



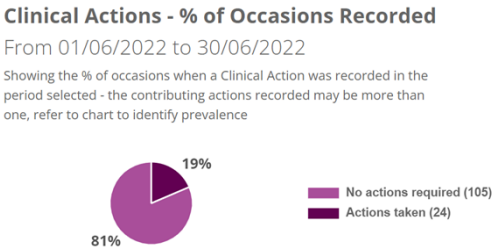
2.4 Acuity

Birth-rate Plus acuity tool is used to monitor the unit's acuity 6 times a day on the delivery suite and assess staffing needs based on activity and complexity of women cared for. The national recommendation is to maintain an average acuity of 85%. The average acuity for June was 81%. Graph 5 acuity for June 2022, graph 6 outlines that 81% of the time no action was required and 19% of the time actions included redeploying staff. There were no red flag events 91% of the time. There were 8 red flag events in total, graph 8. Actions taken were related to delay in induction of labour procedures, graph 9. The delivery suite team leader remained supernumerary. The service continues to maintain 100% 1:1 care in labour.

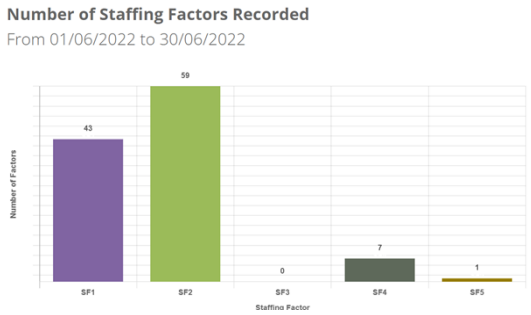
Graph 5



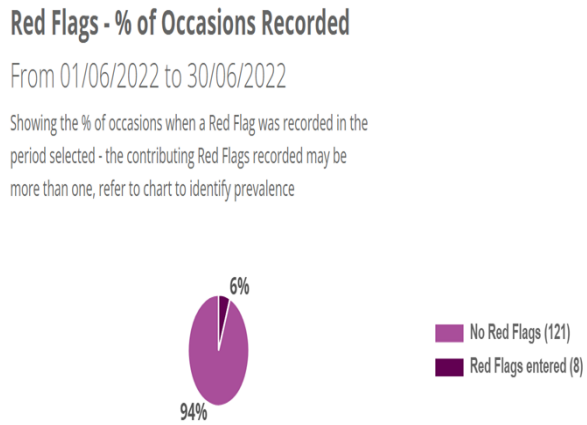
Graph 6



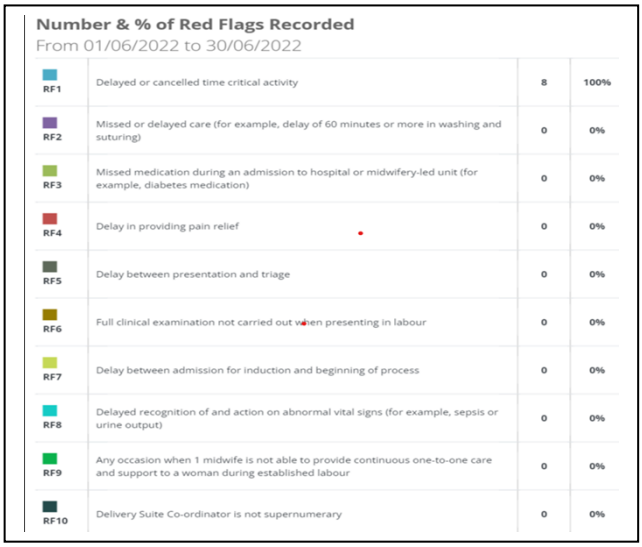
Graph 7



Graph 8



Graph 9

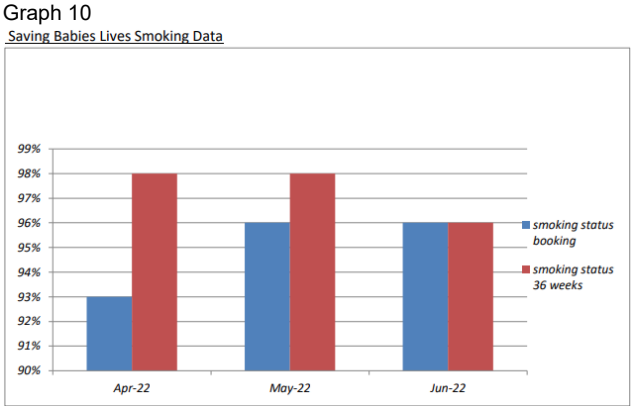


3.0 perinatal mortality/ morbidity

Saving babies lives care bundle is part of the national program and an essential element of CNST. As part of this, maternal smoking cessation and monitoring maternal carbon monoxide (CO), is an element of this. The quarterly report into the service progress against this standard is in appendix (i). The graph demonstrates good compliance for

CO monitoring in line with CNST standards. The overall compliance for this element for CNST is compliant and on track for to meet the standard.

Graph 10



4.0 Culture

4.1 Staff Survey

The staff survey has been shared with the staff and an action plan has been developed. The Top 3 positives across maternity were

- Immediate line manager encourages them at work
- They feel trusted to do their jobs
- Immediate manager cares about their concerns

Top 3 areas for improvement

- "There are enough staff at this organisation for me to do my job properly"

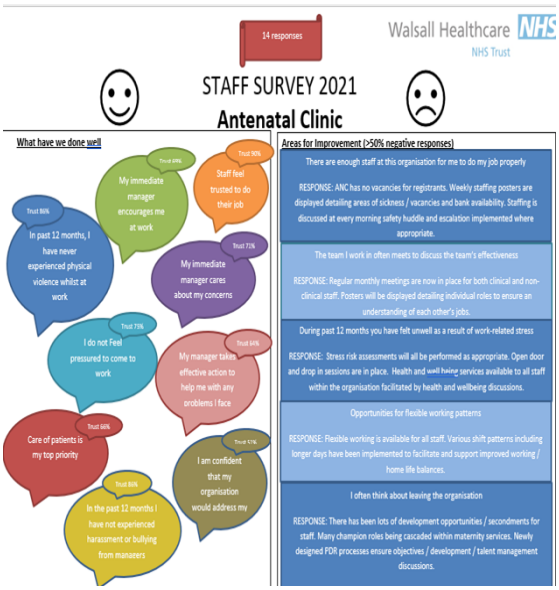
Action: ***National and international recruitment continues. Weekly update on recruitment and staff absence is now shared with all staff.***

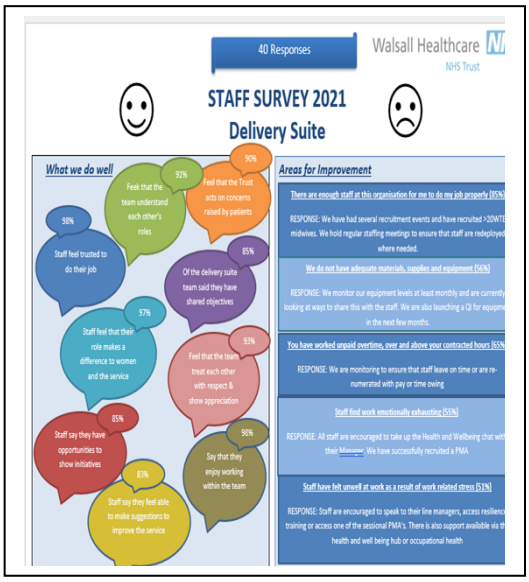
- "The team I work in often meets to discuss the team's effectiveness"

Action: ***Regular monthly meetings have been reinstated for both clinical and non-clinical staff. Posters will be displayed detailing individual roles to ensure an understanding of each other's jobs.***

- "During past 12 months you have felt unwell as a result of work-related stress"

Action: ***Stress risk assessments will all be performed as appropriate. Open door and drop-in sessions are in place. Health and well-being services available to all staff within the organisation facilitated by health and wellbeing discussions***.





4.0 Engagement with Women and Families

Maternity 15 Steps

The 15 Steps for Maternity uses an observational approach to understanding what service users experience as they access local maternity care. This process is conducted in partnership with the maternity voices partnership, the maternity service team and the patient experience team. This program is recommended to be conducted at least annually. The maternity service successfully hosted a '15 steps' engagement on the 7th July. Walsall Healthwatch team were also invited and participated.

Verbal feedback was received on the day, the Director of Nursing and the Clinical Director were both invited and were present. The feedback was very positive with the service user team reporting that staff were –

- Friendly and welcoming
- Professional
- The environment was clean and welcoming
- Positive comments regarding inclusive images
- The Ockenden information board was praised
- Feedback from women receiving care was also positive

The team highlighted areas that could be strengthened to support patient/ families experience –

- Streamlining patient information posters
- Visible information for staff uniforms and ward manager and matron information
- Seating in the Antenatal clinic to supported keeping families together while observing social distancing
- Strengthen information for women with disability, i.e. hearing loop information to be more visible and consider how information is provided for the visually impaired.

- Need for improvement to the estates. Key elements highlighted –
    - Bereavement room location
    - Maternity entrance location
    - Patient areas on the ward could be more central
    - Milk kitchen access

5.0 Serious incidents

There were no new Sis in maternity during June.

6.0 RECOMMENDATIONS

The service is requesting support for the progress of the maternity refurbishment plans and the Ockenden business case. The board is asked to review and note the contents of this report.

Appendix (i)

Saving Babies Lives Version 2

Quarter 1

April to June 2022

Completed for Maternity Governance Group

Purpose of report; to escalate compliance and progress

Author: - Karen Scott

Saving Babies Lives Progress for Quarter 1(April- June 2022 data)

Introduction

This report details Quarter 1 trends in compliance and progress in the 5 elements of Saving Babies Lives Care Bundle Version 2. This is now the seventh report illustrating our compliance for Saving Babies Lives Care Bundle Version 2.

Saving Babies Lives Care Bundle Version 2 was published by NHS England in March 2019. It provides details to providers and commissioners of maternity care assurance around the care bundle for reducing perinatal mortality across England. The long-term plan is the reduction of stillbirth by 50% and reduction of Preterm birth rate from 8-6% by 2025.

There are 5 elements of Saving Babies lives version 2 –with progress indictors in each area and data having to be submitted to demonstrate compliance (compliance should exceed 80 % in all areas)

ELEMENTS	
ELEMENT 1 (E-1)	Reducing Smoking in Pregnancy
ELEMENT 2 (E-2)	Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction
ELEMENT 3 (E-3)	Raising Awareness of Reduced Fetal Movements
ELEMENT 4 (E-4)	Effective fetal Monitoring in labour
ELEMENT 5 (E-5)	Reducing preterm birth

Current Situation-Saving Babies Lives

- Saving Babies Lives midwife now in a permanent role April 2021
  .
- Maternity incentive scheme announced Year 4 and evidence must be provided in all 5 elements from September 2021 until submission date which has now been extended to the January 2023. There are 10 Safety Actions as part of the scheme, Saving Babies Lives Care Bundle is Safety Action 6. The progress indicator is 80% however trusts must have an action plan for achieving greater than 95%.

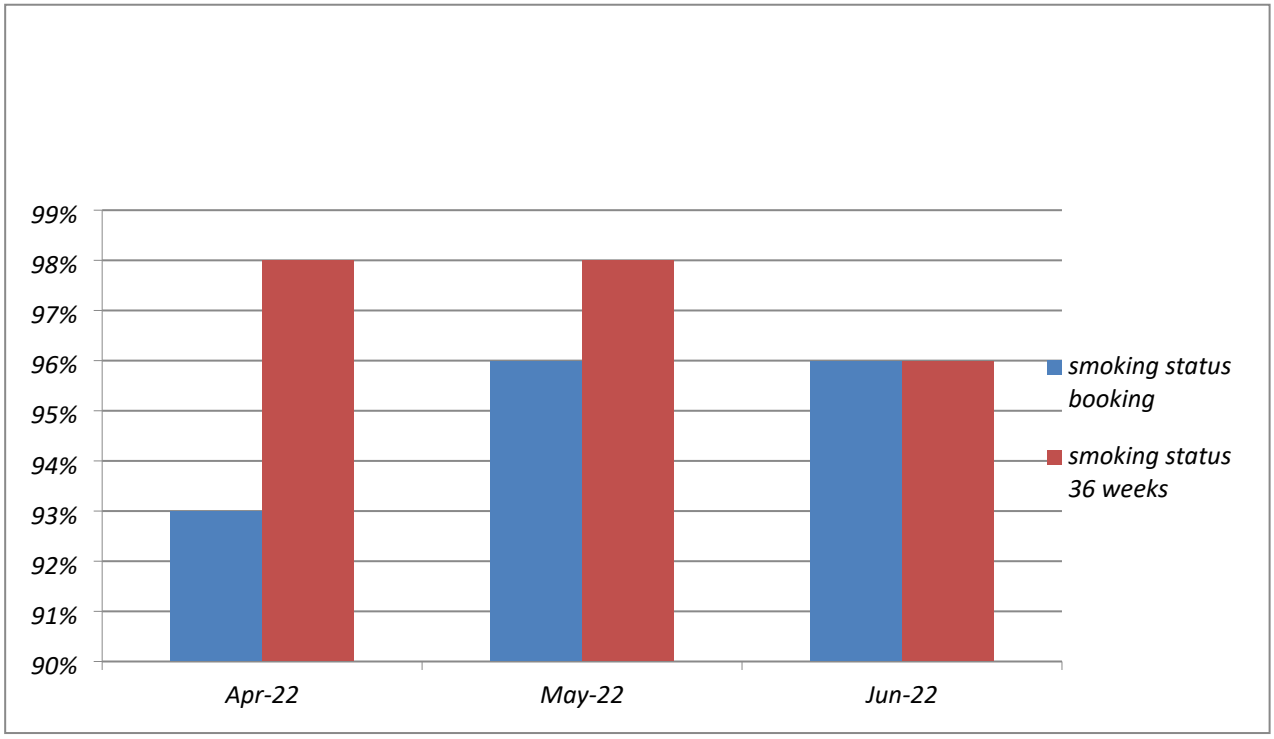
- Monthly newsletter has now been replaced with quarterly report which is produced by the Saving Babies Lives Lead Midwife, emailed to all staff to **update all** on progress, developments, and improvements that is required for the maternity department to meet all 5 elements of Saving Babies Lives.

- This data has been obtained by the Saving Babies Lives Midwife (SBLM) by reviewing and analysing women's records via the Badgernet system. On publication of the new CNST guidance in August 21, Quarter 3 will undertake the review of 20 consecutive women's records for elements 1. Elements 2, 3, 4 and 5 data will be taken from BadgerNet, but reviewed for accurately

  - Quarter 4 January-March 2022
  - Quarter 1 April-June 2022
  - Quarter 2 July-September2021
  - Quarter 3 October-December 2021

Element 1

Saving Babies Lives Smoking Data



Current situation-ELEMENT 1 (Reduction in Smoking in pregnancy)

- Smoking in Pregnancy is monitored by CO (Carbon Monoxide) readings which are recorded at booking, every antenatal appointment and at time of delivery. Smokers are automatically referred to smoking cessation at this time.

- Audits are already undertaken monitoring the number of smokers that are referred monthly to smoking cessation and the success rate of this service. This information is obtained from Badgernet.

Progress since last quarter

- Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service. 100% compliance in this audit for this quarter with women with a CO reading equal or above 4 being referred to smoking cessation.

- CO monitoring Figures for CO monitoring at booking and 36/40 for this quarter remain above 90%, data is being cleansed to remove out of area women from our booking figures as this was artificially lowering the figures.
- CO monitors ordered to replace old and damaged equipment has been obtained
- From the 1st of July partners of Walsall's mum to be, or one family member in the household will be offered support to cease smoking this will consist of a 12-week support programme with their choice NRT. Funding for this service has been secured until March 2023. This service is available even if the pregnant women herself does not smoke.

Actions for upcoming Quarter 2 (July -September 2022)

- Quarterly report distributed to all consultants, managers, and matrons, who distribute to all their staff groups.
- SBLM attends the Community forum to reiterate the importance of recording CO monitoring to meet the element, this is minuted.
- Continuing to attend meetings regarding the business plan for the long-term plan for NRT and pregnant women that smoke when admitted to the maternity unit and acute setting.
- Booking CO readings monitored, and lists are compiled of women who had not had readings done and staff involved which is forwarded to the Community Matron.
- To continue discussing the actions of SBL on the Prompt SD
- To Liaise with HIP team regarding the number of Pregnant women and their Partners that are engaging with the new support package which commenced in July 2022.

Element 2

Current situation-ELEMENT 2 (Risk assessment prevention and surveillance of pregnancies at risk)

- Fetal Growth Restriction (FGR) is risk assessed during pregnancy by the community midwife at booking and ongoing.
- Due to the introduction of SMART booking antenatal assessment all women booked via Badgernet automatically have a risk assessment. This is therefore now 100 %.
- At present there are insufficient staffs qualified to complete Uterine Artery Doppler's. Therefore, all FGR and SGA are classified as having abnormal uterine Doppler's and have serial scans from 28 weeks. If at the Mid T scan, the sonographer has concerns regarding fetal growth these individuals will be referred to fetal medicine. The pathway for this is being updated presently by the sonographers. The fetal Medicine team are also completing training with a view to implement this part of the element in September2022
- CNST requires data that women with raised BMI have growth scans from 32 weeks. However, within the Trust these women have been having growth scans from 28 weeks; this is a local arrangement at present. Therefore, an audit of 10 women's records is reviewed and data obtained for % compliance within this time frame. This is at 100% at present.
- Quarterly audit of the percentage of babies born less than the third centile with a gestation of greater than 37+6 weeks is collected

MONTH	Number of deliveries	BABIES BORN < THIRD CENTILE > 37+6 WEEKS GESTATION	SGA DETECTED BY SFH OR SCAN in these babies
APRIL	286	5babies	2 babies
MAY	301	9 babies	2 babies
JUNE	285	3 babies	1 baby 1 n/a transfer for ARM from New cross

Progress since last quarter

- Quarterly audit of babies born less than the third centile and greater than 37+6 weeks continues
- Registrar (IB) has commenced auditing our entire SGA incidence over a 6-month period that pathways are followed.
- GAP training has increased this quarter to 88% from the 81% last quarter
- Liaising with Newcross re Discussion of risk assessments at 20-week scan – this is not part of our normal maternity practice.

Actions for Quarter 2

- Quarterly report distributed to all consultants, managers, and matrons, who distribute to all their staff groups.
- Practice development midwife highlighting to all managers training figures for their areas.
- Meeting with NHS England regarding the Trust not providing Uterine Artery Doppler (UAD) to high-risk pregnancies, this was escalated at MGG meeting on the 24/06/21 as requiring divisional escalation.

  Action plan formulated for the next 12 months as below

  The network noted the effort by the trust to increase their capacity to offer UAD. In line with previous decisions the clinical network is in a position to approve this deviation subject to it being review in 12 months. The trust will be working towards full compliance with national guidance.

  1. Trust to develop a recovery plan including a training plan with sonographers, progress business case for increase sonography capacity
  2. RWT capacity for UAD - Trust to make enquiries re potential for women to be scanned by RWT as small numbers
  3. Trust to collaborate with SATH around training sonographers
  4. Engagement with SCOR – regional communication from Clinical Network
  5. Review / revisit with Trust in 12 months

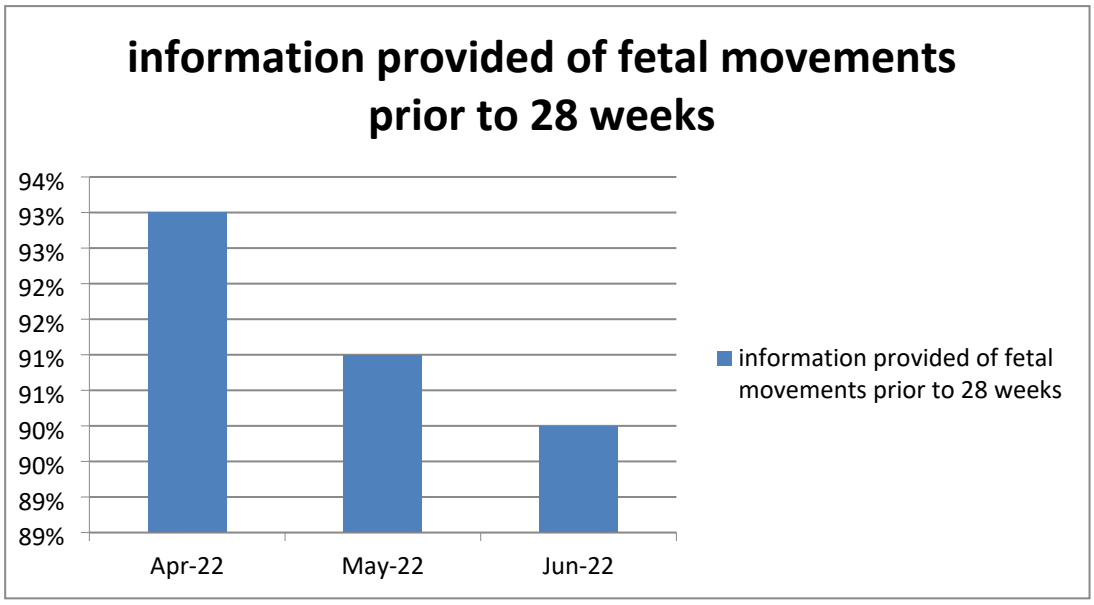
UPDATE

- There are 3 individuals working through a training plan for Uterine artery Doppler the proposed commencing date for this service is the 5th of September 2022, this information has been shared with NHS England and NHS improvements.

- 20-week risk assessment- discussion still taking place regarding this risk assessment being completed by a midwife in ANC following the mid T scan. Hopefully there will be a plan in place for quarter 2

Element 3

SBLv2 data on discussion of fetal movements prior to 28 weeks



Current Situation-Element 3 Raising awareness of Reduced Fetal Movements (RFM)

- Data for this quarter has been taken from Badgernet–, The OOA (out of area women who choose to deliver at out trust but do not live within the boundaries). These women are now highlighted to enable this data to be cleansed.
- Community Midwives ensure all women are aware of the information within the Maternity App
- There were 2 Intra uterine deaths this quarter-Term +1 weeks, attended for induction raised BP, no concerns with fetal movements prior to admission. IUD on admission fetal movement leaflet provided in early pregnancy baby weight 3.300kg and on the 37 centile .This case was identified as a serious incident as induction was not offered or discussed when attending with RFM at 39 weeks.
  The second case G7P6, IUD at 27+5 known oligohydramnios and severe IUGR and multiple cardiac anomalies.

Progress since last quarter

- Communication via Trust Twitter page circulated re RFM continues.
- Community midwives, and all medical staff within clinics are reinforcing the awareness of reduced movements and the importance of attending the hospital for assessment.

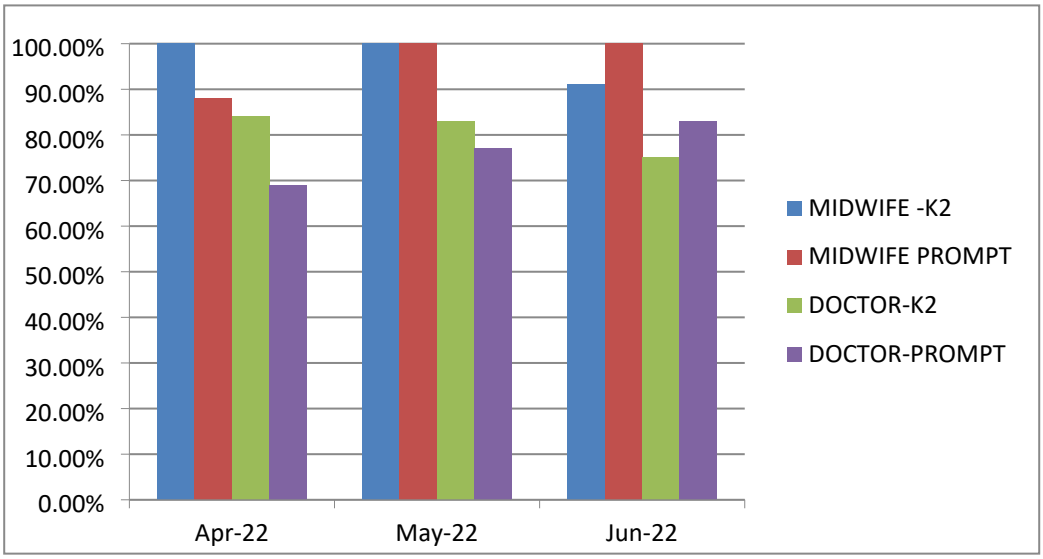
- Data for women regarding Fetal movements is now more accurate with the cleansing of data and the removal of OOA women and late bookers.
- Data for computerised CTG more accurate with cleansing to remove women who attend with RFM less than 28 weeks gestation

MONTH	PERCENTAGE OF WOMEN WITH RFM – HAVING A COMPUTERISED CTG
APRIL 2022	92%
MAY 2022	93%
JUNE 2022	96%

Actions for Quarter 2

- Communications by the SBLM will continue to ensure all medical staff and community midwives are aware re continuing education of information on RFM, and this is documented on Badgernet small drop in compliance this month
- Communications via Twitter continue.
- All Community Midwives will be informed by the SBLM, the importance of ensuring if no smart phone for the maternity App that a RFM leaflet is given and recorded.
- Ongoing training of staff for Computerised CTG, awaiting delivery 10 Huntleigh machines to be used only for AN computerised CTG

Element 4
SBLv2 data on attendance on study days



Current situation-Element 4 Effective fetal monitoring in labour

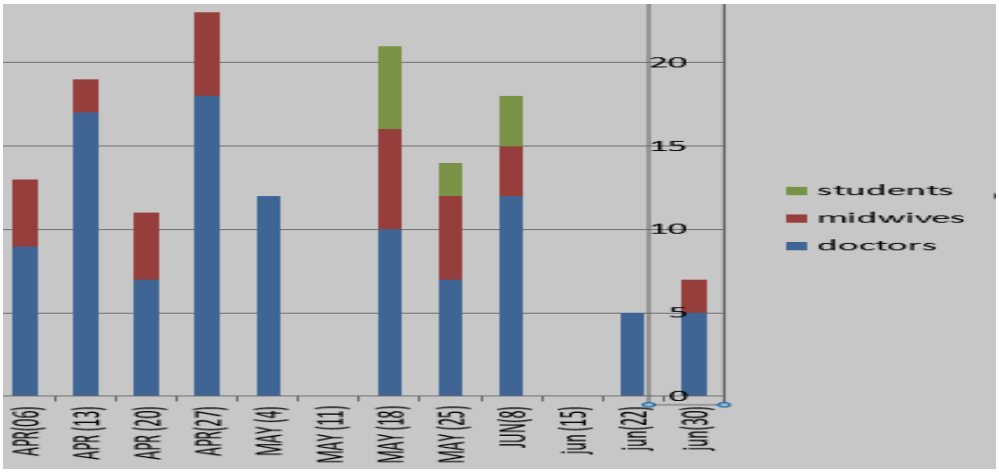
- Prompt training study delivers an MDT based interactive session on the interpretation of CTG, all attendance is monitored by the Continuing Professional Development Midwife (CPD).
- The K2 package for interpretation of CTG and the Physiology of CTG is undertaken by all midwifery and medical staff within the maternity unit. % Compliance is monitored and audited by CPD midwife, however this will be replaced by in-house CTG SD

- Midwives and medical staff are referred to SBLM if not met required standard within the K2 packages. This requires a face-to-face competency document and assessment to become compliant. (2 midwives have met this criteria)
- Midwives who's CTG's have been reviewed within the weekly MDT / ATAIN are referred to the SBLM if required for further action or training. (1 midwives had been referred this quarter)
- CTG display board in the staff room on Delivery Suite is updated monthly with a recent CTG and history, facilitating the MDT to discuss and feedback within a reflective learning process.

Progress since last quarter

- Fetal monitoring study day dates available for the next 12 months and staff have been allocated to attend these .
- Weekly CTG club attendance improving, midwives' attendance dependent on the activity of the unit. 2 meetings cancelled this quarter one due to occurring same day as CTG SD and the other due to technical difficulties with "teams "
- Dates provided on delivery suite for drop-in sessions to discuss CTG cases. This has also been shared on the Maternity staff Facebook page.

Attendance for CTG workshop quarter 1



DATE OF CTG SD	MIDWIVES ATTENDED	DOCTORS ATTENDED
APRIL 2022	14	3
MAY 2022	16	0
JUNE 2022	14	3

Actions for Quarter 2

- To continue with the Weekly CTG meetings and audit attendance. This is presented at MGG quarterly
- The SBLM will continue to action any referrals that she is informed of by the CPD midwife in relation to K2 and MDT weekly meetings
- Display boards updated monthly
- CTG Study Day to continue dates are now available for the next year and to add this data to the attendance for SD.
- Continue CTG drop-in sessions on delivery suite weekly.

Element 5

Current situation-Element 5 Reducing preterm birth

- Community now audit the MSU compliance. There has been 100 % compliance in this quarter for MSU samples being reviewed within 10 days.
- Audit of all women who give birth at < 30 weeks receiving magnesium sulphate 24 hours before delivery. (This % compliance is calculated on the number of women who have met the criteria), shown in table below.
- Audit of all women who give birth <34 weeks receiving antenatal steroids within 7 days prior to birth (this % compliance is calculated on the number of women who met the criteria), shown in table below.
- An Audit of women giving birth in appropriate setting for gestation
- Quarterly report is distributed to all consultants, managers, and matrons, who distribute to all their staff groups.

MONTH	APRIL	MAY	JUNE
Appropriate setting for gestation	1 case on Badgernet Not to be included as TOP 100%	0 cases 100 %	0 cases 100%
Women < 30 weeks receiving mgso4	2 CASES 1 not eligible data as top 1 case 27+4 loading and maintenance 100%	1 CASE 1 case 27+1 loading and maintenance 100%	0 cases 100%
Women < 34 weeks receiving Antenatal steroids within 7 days of birth.	5 CASES 3 cases both doses 1 case dose given more than 7 days due to clinical picture 1 case not applicable as TOP 75%	2 CASES 1 case both doses 1 case only 1 dose due to delivery 100%	3 cases 3 cases all received both doses within a week of delivery 100%

Progress since last quarter

- Data being recorded this quarter for the percentage of preterm deliveries. Element 5 of SBLv2 preterm deliveries to reduce from 8% to 6% by 2025, there has been a decrease in percentage preterm deliveries from quarter 4

MONTH	Nu preterm deliveries (24-36 weeks)	Nu of singleton deliveries	Percentage
APRIL 22	20	279	7.2%
MAY 22	31	299	6%
JUNE 22	22	281	7.8%

Actions for Quarter 2

- Risk assessment for preterm requires adjustment to includes low, intermediate, and high-risk pathways, digital midwife is in correspondence with clevermed to ensure that management plan will pull through to enable this to be added to Badgernet , this is a CNST requirement.
- SBLM will continue to produce a quarterly report to distributed to all consultants, managers, and matrons, who distribute to all their staff groups.
- All managers and matrons within the outpatient department will continue to be informed by the SBLM to ensure all staff refer to the policy in relation to preterm management.
- Community will be monitoring the compliance of repeat MSU's taken when antibiotic and repeat samples are required.
- To monitor the number of preterm deliveries which has decreased from quarter 4
- To complete an audit of 40 consecutive cases of women booking for antenatal care to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high-risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway once this information can be obtained from Badgernet.

MEETING OF THE TRUST BOARD IN PUBLIC Wednesday 3rd August 2022			
Risk Management Report			
Report Author and Job Title:	Vicky Haddock - Head of Risk Management	**Responsible Director:**	Kevin Bostock - Director of Assurance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Assure	• The report ensures that the Trust Management Committee receives summary information on the improvements being made to the Trust's Risk Management process, tools, and templates. • The Board Assurance Framework (BAF) risks that form the Strategic Objective (SO) risk register of the Trust which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels. • Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable Trust Board to maintain effective oversight of SO risks through a regular process of formal review. • Each Lead Director meets monthly with the Head of Risk Management to review their risks that sit on the corporate level element of the Trust Risk Register (CRR) and bi-monthly to review their BAF SO's.		
Advise	• Two of the eight identified Board Assurance Framework Strategic Objective risks have a current **High** rated risk score (15-25), meaning that there is a significant probability that major harm will occur if urgent action is not taken to implement control measures to mitigate these risks. • 18 of the 23 Corporate Risks have a current **High** rated risk score, 15-25 (down from 26 of the 32 in Q3 2021/22).		

Alert	• Elements of the BAF and CRR have lapsed, therefore greater oversight by the Lead Directors is required to ensure risks that they are accountable for, are being updated appropriately within the specified review timescales, with clear SMART actions outlining plans to mitigate the risks and gain assurance of controls being implemented.
	• Of the 23 Corporate Risks, there are:
	  ○ Four actions overdue (down from 43 in Q3 2021/22),
	  ○ Two risks with no progress narrative provided within the specified review timescales (down from 10 in Q3 2021/22),
	  ○ There are no risks without any documented controls (down from three in Q3 2021/22),
	  ○ One risk has not currently confirmed any assurance details (down from three in Q3 2021/22),
	  ○ There are no risks without any documented SMART actions (down from two in Q3 2021/22).
	• The Trust Management Committee (TMC) is asked to:
	  ○ Review and discuss the report.
	  ○ Encourage greater oversight by the Lead Directors of current risks and a coherent approach to strengthening Risk Management within the Trust by proactively identifying, capturing, understanding, agreeing, assessing, and managing risks.		

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

Risk Management Report

1. PURPOSE OF REPORT

The purpose of the report is to provide the Trust Management Committee (TMC) with a status update in relation to; 1) the Board Assurance Framework (BAF) and those risks that site on the corporate level of the Trust Risks Register (CRR), noting the actions in place to support mitigating these risks; 2) the improvement being made to the Trust's Risk Management process, tools, and templates.

This report includes:

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

2. BACKGROUND

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

Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable Trust Board to maintain effective oversight of SO risks through a regular process of formal review. Each Lead Director meets monthly with the Head of Risk Management to review their risks that sit on the corporate level element of the Trust Risk Register (CRR) and bi-monthly to review their BAF SO's.

3. DETAILS

3.1 Board Assurance Framework (BAF)

There are currently eight identified SO risks included within the BAF (Plan - Stage A*) which have been approved by the Trust Board.

In May 2021, the People and Organisational Development Committee (PODC) agreed with the proposal to divide 'BAF SO 04 for Value our Colleagues' into three separate SO risk documents in order to focus on the milestones and outcomes for each sub-work stream within the Value our Colleagues element of the Improvement Programme for the 2021-2022 year. The previous combined BAF SO 04 was then brought to a close.

3.1.1 Current BAF Risks

- BAF SO 01 - Safe, High-Quality Care,
- BAF SO 02 - Care at Home,
- BAF SO 03 - Work with Partners,
- BAF SO 04a - Leadership Culture and Organisation Development,
- BAF SO 04b - Organisation Effectiveness,
- BAF SO 04c - Making Walsall (and the Black Country) the best place to work,
- BAF SO 05 - Use Resources Well,
- BAF SO 06 - COVID.

The updated BAF SO documents are provided for the Committee in Appendix 1 - 8.

3.1.2 BAF Movement

The table below shows the movement of the BAF risk documents from Q4 2021/22 financial year to Bi-Monthly-1 2022/23 financial year (April and May):

Summary Risk Title	SO Under Threat	Change in Current Risk Score					
		2021/22				2022/23	Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	
BAF SO 01 - Safe, High-Quality Care	Safe, high quality care	15 High	25 High	25 High	20 High	20 High	↔
BAF SO 02 - Care at Home	Care at home	9 Moderate	12 Moderate	16 High	16 High	12 Moderate	↓
BAF SO 03 - Working with Partners	Partners	6 Low	6 Low	6 Low	6 Low	6 Low	↔
BAF SO 04 - Value our Colleagues 04a - Leadership Culture & OD	Value colleagues	20 High	16 High	16 High	12 Moderate	12 Moderate	↔
04b - Organisational Effectiveness		20 High	16 High	16 High	12 Moderate	12 Moderate	↔
04c - Making Walsall & BC BPTW		20 High	16 High	16 High	12 Moderate	12 Moderate	↔
BAF SO 05 - Use Resources Well	Resources	15 High	15 High	15 High	15 High	15 High	↔
BAF SO - 06 COVID	Safe, high quality care; Care at home; Partners; Value colleagues; Resources	6 Low	12 Moderate	15 High	12 Moderate	9 Moderate	↓

A summary of the BAF SO; title, risk description, current risk score movement, forecasted risk score movement for the next bi-monthly review** (June and July) and risk review details over the last bi-monthly review** (April and May), is shown below (in risk number order):

- **BAF SO 01 - *Safe, High-Quality Care;*** *we will deliver the best quality of care evidenced by patient experience feedback and good clinical outcomes.*
  - **Risk Description** - *The Trust fails to deliver best care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.*
    - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **20 High** (Severity 4 x Likelihood 5).
    - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same.
    - **Risk Review** - Detailed provided within the BAF SO 01 document.

- **BAF SO 02 - *Care at Home****; we will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall Together.*
  - **Risk Description** - *Failure to deliver care closer to home and reduce health inequalities.*

- **Current Risk Score Movement** - Has reduced in the first bi-monthly period of 2022/23 financial year, from a 16 High (Severity 4 x Likelihood 4) to a **12 Moderate** (Severity 4 x Likelihood 3).
- **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory of risk reduction being confirmed in the second bi-monthly period of 2022/23 financial year.
- **Risk Review** - Detailed provided within the BAF SO 02 document.

➢ **BAF SO 03 - *Work with Partners;*** we will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.

- **Risk Description** - *Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high-quality care.*
  - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **6 Low** (Severity 3 x Likelihood 2).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to reduce to a 3 Very Low (Severity 3 x Likelihood 1).
  - **Risk Review** - Detailed provided within the BAF SO 03 document.

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04a*** *- Leadership Culture & Organisational Development.*

- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the second bi-monthly period of 2022/23 financial year.
  - **Risk Review** - Detailed provided within the BAF SO 04a document.

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04b*** *- Organisational Effectiveness.*

- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the second bi-monthly period of 2022/23 financial year.
  - **Risk Review** - Detailed provided within the BAF SO 04b document.

➢ **BAF SO 04 - *Value our Colleagues;*** *we will be an inclusive organisation which lives our organisational values at all times.* ***04c*** *- Making Walsall (and the Black Country) the Best Place to Work.*

- **Risk Description** - *Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention, and patient care.*
  - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **12 Moderate** (Severity 4 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same, with clarity for the trajectory for risk reduction being confirmed in the second bi-monthly period of 2022/23 financial year.
  - **Risk Review** - Detailed provided within the BAF SO 04c document.

➢ **BAF SO 05 - *Use Resources Well;*** *we will deliver optimum value by using our resources efficiently and responsibly.*

- **Risk Description** - *The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.*
  - **Current Risk Score Movement** - Has remained the same for the first bi-monthly period of 2022/23 financial year, as a **15 High** (Severity 5 x Likelihood 3).
  - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to increase to a 20 High (Severity 5 x Likelihood 4).
  - **Risk Review** - Detailed provided within the BAF SO 05 document.

- **BAF SO 06 - *Covid;*** *this risk has the potential to impact on all of the Trust's Strategic Objectives.*
  - **Risk Description** - *The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.*
    - **Current Risk Score Movement** - Has reduced for the first bi-monthly period of 2022/23 financial year from a 12 Moderate (Severity 3 x Likelihood 4) to a **9 Moderate** (Severity 3 x Likelihood 3).
    - **Forecasted Risk Score Movement for the next bi-monthly review** - Is expected to remain the same.
    - **Risk Review** - Detailed provided within the BAF SO 06 document.

*Plan - Stage A - Refers to the Trust's current BAF template and SO's.

**Bi-Monthly Review - In line with the Trust Boards new cycle of business meeting dates for 2022/23 financial year, the frequency of reporting has been amended from quarterly reporting (2021/22 financial year) to bi-monthly reporting.

3.1.3 BAF Improvements

As part of the improvements currently being made to the Trust's Risk Management processes, tools, and templates, a revised BAF template and interim SO's is currently underway. A summary of the planned stages is shown below:

Timescale	Now - July 2022	July 2022 - September 2022	October 2022*** - onwards
Plan	• Stage A.	• Stage B.	• Stage C.
Position	• Current Board Assurance Framework (BAF) template. • Current Strategic Objectives (SO).	• Revised BAF template. • Revised interim SO's.	• Revised enduring SO's.
Work to be completed	• Specification for new BAF template for Stage B (MH-M, KW, VH, KB, MM). • Dis-establish Stage A and transfer anything relevant to Stage B. • Agree new template for Stage B BAF.	• Commence use of new BAF template for Stage B. • Produce full draft of Stage B BAF with new interim SO's. • Approve and use Stage B BAF template and SO's (review Datix Cloud IQ configuration timeline).	• Review Stage B BAF template in light of new enduring SO's. • Revise and approve Stage C BAF with enduring SO's (review Datix Cloud IQ configuration timeline).
Outcome	• Stage A BAF template no longer used. • Stage A SO's no longer used.	• Stage B BAF template to be in place and used, covering interim SO's.	• Stage C BAF, covering enduring SO's in place.

***Risk Management Module with Datix Cloud IQ - Is provisionally set to go live in October 2022.

3.2 Corporate level of the Trust Risk Register (CRR)

There are currently 23 risks that sit on the corporate level of the Trust Risk Register (Level 4). Not all risk review meeting were attended this month and not all the updates have been provided within the specified review timescale to complete Bi-M1's updates. In each case where there has not been a timely update or progress narrated, escalation to the relevant Lead Director has taken place, in addition this has also been captured at Risk Management Executive Group meeting.

3.2.1 Current Risks

Details of the 23 Corporate Risks (in risk number order) are shown on the dashboard appended to this report (Appendix 10), in addition to their; controls, assurances and actions to be undertaken that will help to mitigate the risk by resolving control and assurance gaps.

3.2.2 CRR Heat Map

The table below shows the current risk score of our Corporate Risks and any amendments since the last report:

Likelihood	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost Certain 5	5:	10:	15:	20: • 1528 ↔ • 2245 ↔ • 2430 ↔ • 2439 ↔ • 2581 ↔ • 2601 ↔ • 2664 ↔ • 2917 ↔	25:
Likely 4	4:	8:	12:	16: • 208 ↔ • 2081 ↑ • 2082 ↔ • 2325 ↔ • 2737 ↔	20: • 2370 ↔
Possible 3	3:	6:	9: • 2587 ↔	12: • 2372 ↓LRR • 2489 ↔ • 2512 ↓LRR • 2540 ↔ • 2768 ↓LRR	15: • 665 ↔ • 1005 ↔ • 2066 ↔ • 2475 ↔
Unlikely 2	2:	4:	6:	8: • 2072 ↓	10: • 2464 ↔
Rare 1	1:	2:	3:	4:	5:
	Severity				

Symbols Key:	Amendment since the previous report:
*	New Corporate Risk.
↓LRR	Risk de-escalated from the Corporate Risk Register (CRR, Level 4) to Local Risk Registers (LRR, Level 1-3).
↑	Increased risk score.
↔	No change to the risk score.
↓	Reduced risk score.

3.2.3 Risk Movement

The table below focuses on the movement of the top 10 risks from Q4 2021/22 financial year to Bi-Monthly-1 2022/23 financial year (April and May):

Risk ID	Risk Title	Quarterly Change in Current Risk Score					
		2021/22				2022/23	Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	
1528	*Potential delay in patient care and patient results.*				20 High	20 High	↔
2245	*Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.*	20 High	20 High	20 High	20 High	20 High	↔
2370	*Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality.*			20 High	20 High	20 High	↔
2430	*Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record.*	20 High	20 High	20 High	20 High	20 High	↔
2439	*External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.*	20 High	20 High	20 High	20 High	20 High	↔

2581	*Internal risk for patients awaiting Tier 4 hospital admission.*		15 High	20 High	20 High	20 High	↔
2601	*Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment, and treatment of the sepsis 6.*		12 Moderate	20 High	20 High	20 High	↔
2664	*Patient Safety and Training Issues in Medicine /ED.*		20 High	20 High	20 High	20 High	↔
2737	*Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy.*			20 High	20 High	16 High	↓
2917	*In appropriate use of SCALE2 within NEWS2.*				20 High	20 High	↔

A summary of the; risk title, risk description, current risk score movement, forecasted risk score movement for next month and risk review details over the last review, is shown below (in risk number order):

- **Risk ID 1528** - *Potential delay in patient care and patient results.*
  - **Risk Description** - *There is a lack of robust electronic alerts for when pathology histology, radiology, microbiology & endoscopy reports are available to view leading to delay in patient care & potentially unnecessary follow up appointments.*
    - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 10th consecutive month (since July 2021).
    - **Forecasted Risk Score Movement for next month** - Is expected to remain the same whilst options are investigated for providing notifications of Results.
    - **Risk Review** - DAG meeting 07/06/2022 about results reporting. All actions updated, with action 1 now being completed.

- **Risk ID 2245** - *Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.*
  - **Risk Description** - *There is a high level of maternity leave within the maternity team, currently totalling 25.1% of registered midwives across all inpatient areas. When this is considered with the normal expected tolerance of 16% A/L which is essential for the health and wellbeing of staff a 3% tolerance for staff training. This is being further exacerbated by an increasing number of staff requiring to self-isolate or quarantine due to Covid-19 procedures. As a result of the above, there is growing concern about the ability to safely provide care across the inpatient team, including 1:1 care in labour, due to the lack of staff available to work. Historically the service has been asked to maintain 10 vacancies due to the planned closure of Foxglove ward and relating to a reduction in birth numbers; this however does not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. This is not a new issue as historically over the last 5 years the team has lost at least 10wte per year due to mat leave.*
    - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 19th consecutive month (since October 2020).
    - **Forecasted Risk Score Movement for next month** - Is expected to remain the same, with the reduced trajectory expected by the end of quarter two of 2022/23 financial year to a 12 Moderate (Severity 4 x Likelihood 3).
    - **Risk Review** - The scheduled monthly risk review meeting was not attended this month however progress narrative was provided within the specified review timescale. Current vacancies are 14.75 WTE (as at the 07/05/2022), with on-going recruitment continuing.

- **Risk ID 2370** - *Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality.*
  - **Risk Description** - *The size and complexity of the population health challenges and health inequalities in Walsall present multiple 'priorities' that cannot all be addressed simultaneously and may result in an inability to make progress in the most efficient and effective way. The inequalities experienced by our population has been further compounded by the COVID pandemic and presents a risk of premature mortality if significant recovery efforts for patients with long term conditions are not undertaken in a timely manner. The national booster vaccination programme has now been prioritised for Primary Care; non-urgent and routine services have been stood down in order to release staff to support the vaccination programme. This may lead to delays in presentations for other conditions and further exacerbate health inequalities and the risk of premature mortality.*
    - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 5 x Likelihood 4) for the 9th consecutive month (since August 2021), with the action deliverable date being amended from 31/05/2022 to 29/07/2022 due to a delay to production of Joint H&WB Strategy.

- **Forecasted Risk Score Movement for next month** - Is expected to remain the same, with the reduced trajectory expected by the end of July 2022 to a 15 High (Severity 5 x Likelihood 3).
- **Risk Review** - Draft PH&I Plan for Walsall has been drafted but cannot be finalised until the overarching strategy is in place, to ensure alignment. Development of population health outcomes is part of wider system work, which is in progress. Need to assess the extent to which WT owns the risk versus HWB Board.

➢ **Risk ID 2430** - *Phase 1: Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record.*

- **Risk Description** - *Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 11th consecutive month (since June 2021), with the risk deliverable date being amended from 31/05/2022 to 30/06/2022 due to the project experiencing unexpected technical and supplier resource issues, that have delayed the ingestion of the records.
  - **Forecasted Risk Score Movement for next month** - Is expected to reduce to an 8 Moderate (Severity 4 x Likelihood 2).
  - **Risk Review** - Medi Viewer and Clinical Noting now live for School Nursing and HV documents. School Nursing and Health Visiting teams have uploaded approximately 12,500 records into Medi Viewer since going live at the end of March. Work continues to ingest the legacy records into Medi Viewer. IMMJ have completed the ingestion of legacy Child Health Records however QA'ing identified an issue impacting some children with multiple legacy records (1,160 records out of 69,000). IMMJ have confirmed this issue is because of the multiple records having the same name. Folding Space have provided a list of children impacted by this issue. IMMJ will reprocess these records following the ingestion of the records held on the shared drives. The service has been informed and requested to continue to view legacy child health records in fusion until resolved. The ingestion of the records held on the shared drives has taken longer than anticipated. The pilot ingestion of the Vulnerable records has identified several issues which need to be worked through and resolved before ingesting any additional records, as well as confirming ingestion timescales. Records relating to 255 Vulnerable children have been ingested and are undergoing Quality Assurance checks. Issues identified during the QA checks (duplicate records and password protected documents), along with the 49 records which failed to ingest into Medi Viewer are currently being investigated by Folding Space and IMMJ. The service has been informed they are required to look in the archive folder on the network drive for these records until ingested into Medi Viewer and have successfully completed QA checks. Timescales for the second phase of the project are currently under review.

➢ **Risk ID 2439** - *External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England*.

- **Risk Description** - *There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains to the Paediatric unit; the lack of adequate service provision externally means we carry a high-level risk internally as a result of holding CYP who are in crisis. Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 8am-6pm. Overall the risks are external to our service*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 14th consecutive month (since March 2021).
  - **Forecasted Risk Score Movement for next month** - Is expected to remain the same, with the reduced trajectory unclear at this stage due to it being a national problem, out of the Trusts control.
  - **Risk Review** - CMO, Lead nurse for MH, CNS for CYP mental health have all continued to engage with the local Mental Health Trust. WHT MH Team have attended and engaged in all transformational work within the ICS and continue to escalate the challenges and risks relating to Tier 4 bed pressures for CYP. Nationally this continues to be a challenge and there has been no change in local guidance or pathways to support CYP in crisis for WHT.

➢ **Risk ID 2581** - *Internal risk for patients awaiting Tier 4 hospital admission*.

- **Risk Description** - *WHT ability to support and manage any CYP awaiting a tier 4 admission. An increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 6th consecutive month (since November 2021).

- **Forecasted Risk Score Movement for next month** - Has not been clarified, risk score reduction trajectory being clarified by the end of June 2022.
- **Risk Review** - MH training for staff has been arranged from June (as per roster availability), this will be delivered by the CNS for CYP. The Rapid Tranquilisation Policy initial draft is complete and requires review by Pharmacy and Medical Teams. Rapid Tranquilisation Policy will then be ratified.

➢ **Risk ID 2601** - *Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6*.

- **Risk Description** - *Failure to report accurate Sepsis data nationally, resulting in non-compliance and increased risk of delivering suboptimal sepsis care/treatment*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 7th consecutive month (since October 2021).
  - **Forecasted Risk Score Movement for next month** - Is not expected to change, with the risk reduction trajectory expected in the second quarter of financial year 2022/23.
  - **Risk Review** - Dashboard has now been completed. Sepsis reporting is being carried out with a mix of manual/electronic reporting. Actions 1 and 6 updated and closed as applicable, with the gaps in controls and assurances updated to clarify movement.

➢ **Risk ID 2664** - *Patient Safety and Training Issues in Medicine / ED*.

- **Risk Description** - *Reputational Impact on the trust regarding Doctors in Training placements. Withdrawal of Doctors in Training placements by Health Education England. Financial reduction of Health Education income*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 8th consecutive month (since September 2021).
  - **Forecasted Risk Score Movement for next month** - Is not expected to change, with the risk reduction trajectory expected in the second quarter of financial year 2022/23.
  - **Risk Review** - No change to risk or update to the actions, as no formal feedback received yet from HEE around the WHT improvement plan. This risk will be reviewed when formal feedback received from HEE. Improvement plan progressing according to timescales and being monitored by AMU Assurance Board.

➢ **Risk ID 2737** - *Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy*.

- **Risk Description** - *Currently there is a resistance / non-adherence with the Trust Medicines policy in several areas of the Trust (as evidence by pharmacy audits)*.
  - **Current Risk Score Movement** - Has remained the same this month as a **16 High** (Severity 4 x Likelihood 4) for a consecutive month.
  - **Forecasted Risk Score Movement for next month** - Has not been clarified.
  - **Risk Review** - Continued monthly CDAO meetings to discuss divisional and care group risks. Divisions and care groups to review actions and streamline to individual wards/departments ensuring actions are measurable. Surgery division have now aligned matrons to care group risk however further work required regarding implementation of controls and actions. Surgery DGA and Divisional DoN supporting care groups with this.

➢ **Risk ID 2917** - *Inappropriate use of SCALE2 within NEWS2*.

- **Risk Description** - *Patients are incorrectly assigned to SCALE2 within NEWS2 when their clinical condition does not indicate this. Risk of patients not being appropriately escalated if they deteriorate due to the parameters within SCALE2 due to staff have not received adequate training regarding the use of SCALE2*.
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 2nd consecutive month (since March 2022).
  - **Forecasted Risk Score Movement for next month** - Has not been clarified.
  - **Risk Review** - The scheduled monthly risk review meeting was not attended this month however progress narrative was provided within the specified review timescale. Issues with upload of training onto ESR being worked through. Training rollout plan being developed.

3.2.3 Trust Risk Register Improvements

As part of the improvements currently being made to the Trust's Risk Management processes, tools, and templates, a review of the full Trust Risk Register risks is currently underway. This includes Local Risk Registers (Level 1-3) and the Corporate Risk Register (Level 4). A summary of the planned stages is shown below:

Timescale	Now - July 2022	July 2022 - September 2022	October 2022*** - onwards
Plan	• Stage 1.	• Stage 2.	• Stage 3.
Position	• Current TRR data in SafeGuard Risk Management system.	• Improved TRR data in SafeGuard Risk Management system.	• Improved TRR data in Datix Cloud IQ Risk Management system.
Work to be completed	• Data cleanse of all TRR risks in SafeGuard, to clarify if the risks are still a valid risk (whether it is controlled or still an active uncontrolled risk), an interim project risk, or a duplicated risk, and ensuring the details provided accurately reflect the current position of the risk. • Provide divisions with dedicated risk management time to support with the above and understand training needs.	• Maintain accurate TRR data in SafeGuard. • Commence project to implement Risk Management module within the new Risk Management system, Datix Cloud IQ. • Draft template for capturing risks within Datix. • Draft configuration of risk options within Datix. • Produce test Risk Management module of Stage 3 within Datix. • Approve Stage 3 template and configuration. • Confirm October 2022*** go live date for Datix (currently a provisional date). • Revise Risk Management tools and templates (Strategy, Policy, SOP, Training material, etc.). • Risk Management tools and templates to go through the Trust's ratification process. • Dis-establish Stage 2 into archive system and transfer anything relevant to Stage 3. • Commence training of Datix system to applicable Trust users.	• Commence use of new Risk Management system, Datix. • Continue training and train the trainer of Datix system to applicable Trust users. • Maintain accurate TRR data in Datix. • Maintain improved Risk Management tools and templates.
Outcome	• Stage 1 TRR data to accurately reflect current position of risks in the Trust. • Divisions to have an improved understanding of the Trust's risk management processes.	• Stage 2 Risk Management system, SafeGuard, no longer used to capture risks (archived). • Stage 3 Risk Management system, Datix, in place and ready for use.	• Stage 3 Risk Management system, Datix, in place and being used.

3.3 Reporting and Assurance

The Board Assurance Framework (Board Assurance Framework (BAF) and corporate level of the Trust Risk Register (CRR) reports will be presented to provide assurance and mitigation where appropriate.

The Head of Risk Management will provide expert support to risk owners in further reviewing and updating risks in order to provide an accurate position statement.

All risks on the CRR will be reviewed in a timely manner to ensure robust actions are agreed, achieved and timescales adhered to. Overdue reviews and actions will be highlighted and escalated.

To ensure the CRR is actively monitored and updated with progress to maintain its current position; the schedule for reviewing corporate risks has been revised allow sufficient time to facilitate confirm and challenge sessions with view to strengthening the quality of risk evaluation, articulation, action planning and progress. These updates then feed into a Risk Management Executive (RME) Group meeting, where all Executive Directors have the opportunity to discuss and challenge their peers BAF and CRR risks.

4. RECOMMENDATIONS

Members of the Trust Management Committee are asked to note the BAF and CRR risk documents and their respective progress. Note the summary information on the improvements being made to the Trust's Risk Management process, tools, and templates.

5. APPENDICES

Appendix 1 - BAF SO 01 - Safe, High-Quality Care
Appendix 2 - BAF SO 02 - Care at Home
Appendix 3 - BAF SO 03 - Working with Partners
Appendix 4 - BAF SO 04a - Leadership Culture and Organisation Development
Appendix 5 - BAF SO 04b - Organisation Effectiveness
Appendix 6 - BAF SO 04c - Making Walsall (and the Black Country) the best place to work
Appendix 7 - BAF SO 05 - Use Resources Well
Appendix 8 - BAF SO 06 - COVID
Appendix 9 - Corporate level of the Trust Risk Register Dashboard - April
Appendix 10 - Corporate level of the Trust Risk Register Dashboard - May

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 01 - Safe, High-Quality Care; We will deliver the best quality of care evidenced by patient experience feedback and good clinical outcomes.**
Risk Description:	The Trust fails to deliver best 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/Chief Medical Officer
Lead Committee:	Quality, Patient Experience & Safety Committee.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **208** - Failure to achieve 4-hour emergency access standard resulting in compromised patient safety and patient experience (Risk Score = 16). • **1528** - Potential delay in patient care and patient results (Risk Score = 20). • **2066** - Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score = 15). • **2245** - Risk of suboptimal care & potential harm to patients from available midwives being below agreed establishment level (Risk Score = 20). • **2325** - Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score = 16). • **2430** - Phase 1: Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record (Risk Score = 20). • **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England (Risk Score = 20). • **2475** - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services (Risk Score = 15). • **2512** - Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes Best Practice Tariff Standards (Risk Score = 16). • **2540** - Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems (Risk Score = 12). • **2581** - Internal risk for patients awaiting Tier 4 hospital admission (Risk Score = 20). • **2587** - Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks (Risk Score = 9). • **2601** - Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment & treatment of the sepsis 6 (Risk Score = 20). • **2654** - Risk of patient harm from significant delay in learning from serious incidents (Risk Score = 12). • **2664** - Patient Safety and Training Issues in Medicine / ED (Risk Score = 20). • **2737** - Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy (Risk Score = 20). • **2768** - Crash Trolley Stock (Risk Score = 12).	**Likelihood = 5 Consequence = 4 = 20 High ↔**
		Forecasted Risk Score Movement for the next Bi-Monthly Review:
		Likelihood = 5 Consequence = 4 = 20 High ↔

Risk Appetite

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

Tolerate Score:	< 9																												

Risk Scoring

Bi-Monthly:	2022/23						2021/22	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
	Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	Q4				
Likelihood:	5						5	• Risk score decreased in line with worst case scenario SHQC risk, Mental Health Act and Tier 4 beds (ID 2475 and 2581) with a risk score of 20. • The Trust's Quality Strategy is evolving to address the emerging priorities from reviews of systems, process and services. • A review of the process for ensuring lessons learnt from incidents and patient feedback is embedded in practice is under way. • CQC action plans requiring corporate action/leadership assigned to an executive Director with oversight at Trust Board. Divisional action plans overseen through divisional performance reviews and Patient Safety Group • The Trust is an early adopter site for the new patient complaint standards and will be rolling these out with additional support from the national team over the coming months. • A number of clinical guidelines, policies and procedures are out of date. The Trust is reviewing the plan for updating these. • Potential to breach statutory requirements under the Mental Health Act due to inconsistent knowledge and application of Trust Policy. • CCG and LA assured that safeguarding systems are embedded. This is supported by spot checks and quality assurance visits to test staff knowledge and increase in incidents reported • An embedded programme for recruitment of international nurses and clinical fellows is in place. • On-going recruitment within maternity services, including international midwifery recruitment • Inability to accurate electronic data pertaining to national standards.	Likelihood:	2	31 December 2022
Consequence:	4						4		Consequence:	5	
Risk Level:	**20 High**						**20 High**		Risk Level:	**10 Moderate**	

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

	through medical and nursing workforce groups with exec oversight • RPE Procedure developed providing guidance on the rationale for use of RPE and managers responsibilities under COSHH Regulations Force 8 SOP in place • Train the tester training completed • Multiple types of FFP3 masks available • Ten Practice Education Facilitators recruited • Manual audit in place to monitor compliance with Sepsis 6. • SORT team established • Medical education group and education and training steering group established • AMU assurance group • Maternity assurance group		
Gaps in Controls:	• Performance targets not being met for all activities, including complaints, Mental Capacity Act compliance and VTE assessments. • Out of date clinical policies, guidelines and procedures. • Training performance not meeting set targets. • Quality Impact Assessment process requires embedding within the trust. • Sepsis audit frequency and performance. • Variability in governance structures and processes • Consistency of Dementia screening. • Failure to demonstrate compliance with terms of the Mental Health Act. • Ability for staff to be released to undertake mandatory training • Reputational Impact on the trust regarding Doctors in Training placements. Potential for withdrawal of Doctors in Training placements by Health Education England. And financial reduction of Health Education income.		

Assurance:	• Process in place through ward, business unit and divisional reviews and sub-committees of QPES to confirm and challenge and gain assurance with overarching report and assurance at QPES.
	• International nurse and clinical fellow recruitment continues.
		• Trust approach to co-production continues to be developed and embedded
		• Learning shared through:
		  • Learning Matters Newsletter published quarterly
		  • Care to share published quarterly
		  • Collaboration with RWT and ICS
		• Monthly assurance meeting with CQC and CQRM meeting with CCG.
			• NHSE/I IPC review – Trust rated as amber
			• Top performing for emergency access standards
			• HEE reviews accepted plans for patient safety concerns
			• Engaging with NHSE for mutual aid in COVID recovery

Gaps in Assurance:	• Some CQC ‘MUST’ and ‘SHOULD’ do actions remain outstanding. • Inconsistent evidence, both through quality governance structures and performance reviews, of practice having changed as a result of learning from adverse events. • Lack of assurance regarding equality, diversity and inclusion and actions to reduced inequalities.		

	• Lack of evidence of risk assessments and quality impact assessments relating to staffing contingency planning and/or activity changes. • Lack of robust strategic approach to ensuring effective patient/public engagement and involvement. • Lack of assurance regarding dementia screening. • Lack of consistent assurance internally regarding staff ability to recognise, report and escalate safeguarding concerns • Lack of assurance from electronic data reporting on national standards

Future Opportunities

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

Future Risks

- Ongoing impact of Covid-19
- Performance targets not being met for all activities, including Mental Capacity Act and VTE.
- Adherence to best practice guidelines
- Availability of information to identify potential outliers and areas of concern

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Define action plan for addressing lack of assurance around provision of services in line with requirements of Mental Health Act	Medical Director	01/12/2021	Risk included on corporate risk register in May 2021. Action plan in place. 14/07/2021 - Business case in development to ensure adequate resource to Mental Health team. To be presented to PFIC July 2021.If approved recruitment will take approx. 3 months. Due date re-aligned to reflect this process 03.11.2021 Business case approved by Trust board and posts currently being recruited to.	
2.	Develop a Clinical Audit Strategy and Policy	Director of Governance	31/01/2022	To be reviewed on completion revised governance structure and commencement in post of Deputy DoN with quality portfolio	
3.	Oversight of progress to address out of date policies and procedures will be strengthened via the Clinical Effectiveness Group which be reflected in the revised terms of reference	Medical Director	01/04/2021	**Complete** - Terms of reference agreed through Clinical	

4.	NHSI re-inspection of cleanliness and IPC practice in maternity services	Director of Nursing	31/01/2022	NHSE/I IPC inspection is booked for 22.06.2021. Report expected end of w/c 12.07.2021. Feedback on the day very positive with no significant concerns. Review undertaken and report received 15.09.2021 - Action plan in place and monitored through IPC committee 03.11.2021 Matron master classes undertaken by NHSE/I. Re inspection expected Jan 2022	
5.	Further develop processes to provide assurance that lessons learnt from adverse events	Medical Director/ Director of Nursing	31/10/2021	Scoping of new ward performance boards continues.	
6.	Development of Patient Engagement and Involvement Strategy	Patient Experience Lead / Lead for Patient Involvement	31/12/2021	03.11.2021 Deputy DoN with portfolio for Patent Voice will lead this work from 08.11.2021	
7.	Review of dementia screening data collection process. Initial deep dive completed. Scoping of improvement options commence April 2021	Director of Nursing	31/01/2022	Scoping of improvement options complete; documentation options still under consideration. Collaboration with RWT to review resources, share best practice and where possible align documentation and process. 14.07.2021 - Monthly audit in place and demonstrates improved compliance with dementia screening. Work is underway to review documentation across WHT and RWT to align. Due date re-aligned to reflect this work 03.11.2021 Alignment between WHT and RWT to be progressed by Deputy DoN with quality portfolio	
8.	Develop Maternity Services BAF	Interim Director of Nursing	30/12/2021	Ongoing review.	

Latest Board/Committee/Group - 11/04/2022
Version V10.1

Walsall Together

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 02 - Care at Home;** We will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall Together.
Risk Description:	Failure to deliver care closer to home and reduce health inequalities.
Lead Director:	Director of Transformation.
Lead Committee:	Walsall Together Partnership Board.

	Title:	Current Risk Score Movement:
Links to Corporate Risk Register:	• Risks in this area relate to Walsall Together partnership risks. • Risks relating to Community Services are updated through the divisional structure. Where relevant, equivalent risks are recorded here, and reframed to reflect the risk to the wider system. • Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together. • Walsall Together Partnership Board Risk Register - Risks accepted or in escalation to Corporate Risk Register: ➢ **2370** - Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality (Risk Score = 20). ➢ **2372** - Workforce capacity and skill mix does not meet the demand within the services in scope (Risk Score = 12).	**Likelihood = 3 Consequence = 4 = 12 Moderate ↓** Forecasted Risk Score Movement for the next Bi-Monthly Review: **Likelihood = 3 Consequence = 4 = 12 Moderate ↔**

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3						4	• Whilst the partnership response to the Omicron variant of COVID-19 has been positive, the impact of cancellations of routine and non-urgent services on longer-term health outcomes is not yet known.	Likelihood:	3	30 September 2022
Consequence:	4						4		Consequence:	3	
Risk Level:	**12 Moderate**						**16 High**		Risk Level:	**9 Moderate**	

								• Operational pressures have reduced in some areas of the system. Staffing levels continue to be impacted by self-isolation and a loss of workforce to other sectors. Demand continues to exceed capacity in several areas. • There are significant workforce challenges across all areas of the partnership. A partnership approach, with clear links into the wider Black Country plans, is required to support recruitment of both professionals into Walsall, and to develop capacity from within the local population by offering clear recruitment, training and development opportunities. • There is instability in the care provider market as a result of recruitment and retention challenges as well as pressures on the financial model for several providers. A full assessment of the risk to the wider system is in progress. • System transformation is governed by the Clinical & Professional Leadership Group with assurance reporting to the Partnership Board. For 2022/23, there is a clear focus on reducing health inequalities using a population health management approach, with reporting aligned to the Health & Wellbeing Board. • Maturing place-based teams in all areas of Walsall on physical health and Social Care. Place-based mental health provision, including IAPT, Primary Mental Health, and additional roles in general practice is not yet established. It is unclear how future contractual arrangements will be aligned to the governance of place-based partnership arrangements. • Further organisational development work is required to secure fully integrated working of the place-based teams; resource to support this process is now secured during 2022/23. • Significant maturity in communications and confidence in Walsall Together however public profile now needs to be established and further work is required to increase visibility across general practice. • Funding has been secured and specification agreed for the development of a fully integrated performance, quality, and risk scorecard. • There is an established place development programme looking at governance, financial and risk management arrangements in the context of the new health and social care legislation.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Executive Director to be advertised • Independent Chair appointed • Partnership Board/Groups and meetings in place. • Business Case developed. • PMO/Project in place and reporting. • Weekly operational coordination taking place. • Covid Vaccine delivery plan in place and operational. • WT acting as recruitment partner for PCNs on some new national roles	• Alliance agreement signed by Partners; a review is in progress and will incorporate any necessary updates to align to the legislative changes • Governance structure in place and working. • S75 in place and operational practices now maturing; plans for expansion to some public health services • Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee. • Business case approved by all partners. • Monthly report to Board and partner organisations.	• External assessment - CQC/Audit. • ICS Scrutiny. • Health and Wellbeing Board Reporting. • Overview and Scrutiny Committee.
Gaps in Controls:	• No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust. This has been mitigated short term with Covid funding, but further work required to establish ongoing formal mechanisms • Commissioner contracts not yet aligned to Walsall Together although PBP planning will resolve this issue in time • Data needs further aligning to project a common information picture. • Effective engagement with community in development with local groups limited due to Covid social restrictions. This is improving but not yet back to pre-COVID arrangements. • Organisational development for wider integrated working is outlined, and expected to mobilise during July and August • Enactment of section 75 in terms of monitoring meetings. • Place based demand and capacity plan addressing the new flows apparent after Covid-19. • There is no clarity on how place-based partnerships will be assessed for readiness to operate within the new legislative arrangements. In the interim, Walsall Together will define a model within the guidance outlined in the Integration White Paper and seek agreement across the Black Country ICS.		
Assurance:	• Divisional quality board now starting to look at the integrated team response. • Risk management established at a programme level and a service level integrating risks.	• Walsall-Together included on Internal Audit Programme. • Walsall Together Committee in place overseeing assurance of the partnership. • ICS oversight of 'PLACE' based model. • Reporting to Board and Partners. • Oversight on service change from other committees.	• NHSE/I support of Walsall Together. • ICS support.
Gaps in Assurance:	• Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections • For Community services and ASC within the Section 75 there is direct accountability to WT / WHT; these formal arrangements do not cover other partners hence limited accountability for delivery of Walsall Together strategic aims.		

Future Opportunities

- Further development of the Governance around risk sharing.
- S75 Deployment based on other services relating to health prevention and public health commissions.
- PCN Integration Agreement and risk share with building trust and confidence.
- Strategic partnership(s) with major primary care organisations to further accelerate vertical and horizontal integration of care in the borough.
- Formal contract through an Integrated Care Provider contract, Lead Provider model or equivalent mechanism.
- Formal working with other partners to support their ability to achieve additional income and support via a partnership approach.
- CQC action oversight group.

Future Risks

- Insufficient promotion of success narrative.
- Inability to deliver enough investment up front to change demand flows in the system.
- Changes to commissioner and provider environment / landscape within the Black Country may change mechanisms for resourcing and resolution of service issues.
- A mechanism for gaining and sustaining resources to support strategic aims for 2022/23+ are unclear.
- National influences on constitutional targets moves focus from place to ICS.
- Retention of inspirational and committed leadership across partners.
- Misalignment of provider strategies created by mergers or form changes or senior personnel turnover.
- Programme Resource - Capacity to deliver the WT programme will become more difficult as more services come into scope.
- Maintenance of the PBP agenda through the ICS Board by both the system partners and the Trust in relation to strategic objectives.
- Transition to a new Chair and Executive Director and maintaining the current BAU

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1..	Develop population health management strategy across Walsall Together and PCNs with clear alignment to a) Joint Health & Wellbeing Strategy, and b) ICS Health Inequalities Transformation Plan.	Director of Integration	Sept 22	The partnership Plan is progressing and at final draft stage. Joint working groups have now been established and there is representation from WT on the ICS Health Inequalities & Prevention Board. The digital PHM module will be implemented in 2022/23, though alternative sources of data and intelligence are already established. There are delays in publication of Joint Health & Wellbeing Strategy, by Health & Wellbeing Board, now expected in July 2022	
2.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure. This should include an outline governance structure that shows the links to other WHT committees and acknowledge the transition to holding a formal ICP contract.	Director of Governance	Sept 22	This work is in progress as part of the development of place-based partnerships and integrated care systems. The proposed legislation is now delayed until 1st July 2022. Development of governance and legal frameworks can only be undertaken following release of national guidance, which is an ongoing process and expected to continue for the remainder of 2021/22 and into Q1 2022/23	

6.	Produce an investment proposal for the WT Partnership for 2022/23 that draws on the evaluation of initiatives from the System Pressures Plan and population health management intelligence, with clear alignment to the national planning guidance around virtual wards, known funding for reducing health inequalities (£2m for Walsall non-recurrent for 2021/22 but with potential for recurrency) and public health/prevention.	Director of Integration	Aug 22	A series of meetings are scheduled during June with key stakeholders within WHT and across the Black Country system	

Latest Board/Committee/Group - 11/04/2022
Version V10.01

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 03 - Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.**
Risk Description:	Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & 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 (Risk Score = 15), ▪ **2072** - Temporary workforce (Risk Score = 12).
	Current Risk Score Movement: **Likelihood = 2 Consequence = 3 = 6 Low ↔**
	Forecasted Risk Score Movement for the next Bi-Monthly Review: **Likelihood = 1 Consequence = 3 = 3 Very Low ↓**

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	2						2	• This risk has remained at a Low score of 6 further to the advancement of a number of key work streams. ▪ Executive group established across provider organisations to review opportunities for collaboration. ▪ Success of Black Country Pathology Service (BCPS).	Likelihood:	1	Q2 2022/23 Subject to implementation of Urology integration plan.
Consequence:	3						3		Consequence:	3	
Risk Level:	**6 Low**						**6 Low**		Risk Level:	**3 Very Low**	

								▪ Transfer of WHT payroll service to RWT. ▪ Advanced collaboration in Dermatology including appointment of joint clinical director, Matron and operational management, cross-site working of Consultant Dermatologists and integrated management structure. ▪ Proposal for fully integrated Urology service between WHT and RWT approved at Committee in Common April 2022. ▪ Health Overview & Scrutiny Committees for Walsall and Wolverhampton endorsed Urology integration proposal. ▪ Integrated ENT on-call rota in place. ▪ Initial discussions re: bariatric services, Haematology, Spinal surgery and radiology. ▪ STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy. ▪ Shared Clinical Fellowship Programme in place with RWT. ▪ Shared international nurse recruitment programme agreed with RWT, and 189 nurses commenced in post (as at end Feb 2022). ▪ New Integrated Supplies and Procurement Department (ISPD) alliance with Royal Wolverhampton NHS Trust and University Hospitals North Midlands NHS Trust commenced April 2021. ▪ First WHT elective Orthopaedic operating list took place at Cannock Hospital in partnership with RWT in July 2021, and weekly operating list established from October 2021. ▪ Mutual aid provided to partner organisations including suspected Skin Cancer patients from SWBH, and intelligently conveyed ambulances from multiple neighbouring Trusts. However, despite progress, integration plans are not all yet fully implemented, and the sustainability of the Urology service prevents the score being reduced further at this stage, until the formal integration proposal is implemented by RWT and WHT, anticipated in July 2022.			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Sustainability review process completed. • Regular oversight through the Board and its sub committees. • Improvement Programme to progress clinical pathway redesign with partner organisations. • Executive to Executive Integration oversight meeting established between WHT and RWT. • Black Country & West Birmingham Acute Care Collaboration (ACC) Programme Board established March 2021. • Four clinical summit meetings have now taken place to review options for clinical collaboration - part of the ACC Programme • PWC commissioned to review clinical collaboration options between all four trust, ACC Programme	• Public Trust Board approved Strategic Collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust at February 2021 Board meetings and approved a Memorandum of Understanding at March 2021 Board meetings. • Public Trust Board approved the formalisation of a Group model with The Royal Wolverhampton NHS Trust, including a Committee in Common at December 2021 Board meeting. The inaugural Committee in Common was held in February 2022.	• Third line of control NHSE/I regulatory oversight. • Black Country & West Birmingham STP plan and governance processes in place.
Gaps in Controls:	• Lack of co-alignment by our organisation and all neighbouring trusts. • Lack of formal integration at Trust level across all four BCWB Acute Trusts. • 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. • Non-clinical service integration such as Payroll & Procurement and elements of Estates functions. • Trust Board receives monthly update reports on the progress of the ACC Programme • Chief Operating Officer and Medical Director interviewed as part of PWC BCWB Acute collaboration work.	• Demonstrable evidence of recent functional integration in ENT, Urology and Dermatology and with the clinical fellowship programme. • Emerging commitment from BCWB Acute Collaboration partners to more formalised collaborative working. • Audit Committee has oversight of partnership working within its terms of reference. • System Review Meetings providing assurance to regulators on progress.	• Progress overseen nationally and locally.
Gaps in Assurance:	• Clinical strategy is still emerging. • Additional pressures with Covid-19 have delayed some elements of acute collaboration, and organisational capacity is concentrated on managing the emerging Omicron wave of the pandemic. • Limited independent assessment of integrated services or collaborative working arrangements. • Embryonic independent evidence-base for successful collaborations to assess progress against.		

Future Opportunities

- Consolidate other services, including back-office functions.
- Collaborate with partner organisations outside the Black Country Acute Trusts, including community and third sector 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.

- Shared Chair and CEO with RWT creates opportunities to accelerate bilateral collaboration with RWT where applicable.
- Formalisation of ICS and ICB structures.

Future Risks

- Conflicting priorities and leadership capacity to deliver required changes.
- STP level governance does not yet have statutory powers.
- Lack of engagement/involvement with the wider public.
- Acute Hospital Collaboration may not progress at the anticipated pace due to the resurgence of COVID-19.
- Disrupted relationships with neighbouring trusts due to altered visions of the form and pace of future collaboration.

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020	**COMPLETE** - Trust Board endorsed the benefits of BCWB Trust collaboration for the population of Walsall	
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	**COMPLETE** - Delayed due to resurgence of Covid-19. To be incorporated into re-phased Improvement Programme Plan for June 2021.	
3.	Assess resource requirement to support Imaging Network programme	G Augustine & N Hobbs	Feb 2021	**COMPLETE** - Delayed due to resurgence of Covid-19. To be discussed at Black Country wide working group in April 2021.	
4.	Approve Urology integration plan through PFIC and Trust Board Committee in Common	N Hobbs	~~Nov 2021~~ Apr 2022	**COMPLETE** - WHT & RWT Committee in Common approved proposal April 2022.	
5.	Implement Urology integration plan	N Hobbs	Jul 2022	**IN PROGRESS**	

Latest Board/Committee/Group - 11/04/2022
Version V10.00

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04a - Leadership Culture & Organisational Development.
Risk Description:	Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.
Lead Director:	Director of People and Culture
Lead Committee:	People & Organisational Development Committee
Links to Corporate Risk Register:	• **2489** - Poor colleague experience in the workplace (Risk Score = 12).

Title:	Current Risk Score Movement:
	Likelihood = 3 Consequence = 4 = 12 Moderate ↔
	Forecasted Risk Score Movement for the next Bi-Monthly Review:
	Likelihood = 3 Consequence = 4 = 12 Moderate ↔

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3						3	*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.* Evidence of gaps in control.	Likelihood:	2	31 March 2023
Consequence:	4						4		Consequence:	4	
Risk Level:	**12 Moderate**						**12 Moderate**		Risk Level:	**8**	

								• Staff recommending Walsall as a place to work and as a place to be treated is below all England average. • Employee Engagement Index of 6.7 below sector average of 7.0 • Bullying and Harassment Index of 7.6 below sector average of 8.1. • EDI Index of 8.7 below sector average of 9.1. • Safety culture index of 6.3 below sector average of 6.8 • WRES indicator 2; recruitment 1.40 [2021] – best performing organisations 1.0 or below. • IPDR rates remain consistently below 90% Trust KPI <u>Progress towards risk control Q4 (Jan, Feb, March)</u> • 2021/22 Q4 National Quarterly Pulse Survey • 2021 National Staff Survey Results received and show real statistically significant improvement across many areas narrowing gap between staff experience at WHCT and staff experience across NHS. • 6.9% increase in BAME representation at bands 8a and above. • Restorative Just & Learning Culture cohorts in place for April and May 2022. • EDIG review of progress against EDI Strategy Delivery Plan - actions remain on target. • Cultural awareness training for 100 clinical leaders commissioned along with train the trainer model. • NHSEI Civility & Respect Programme Kind Life commissioned – due to be released in Q1 22/23. • Detailed schedule of workforce policy review and development in place.			

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Cycle of local Pulse Survey implemented • Participation in NHS National Staff Survey • Equality, Diversity and Inclusion Strategy co-designed through consultation agreed at Board May 2021. • Freedom to Speak-Up (F2SU) Strategy in place and service improvement programme embedded within Value Our Colleagues Improvement Programme.	• People and Organisational Development Committee in place to gain assurance. • Implementation of delivery plan overseen by Equality, Diversity & Inclusion Group (reviewed monthly) and monitored by People and Organisational Committee (PODC) (reviewed quarterly). • Quarterly report to PODC and Trust Board. • Annual update against strategy received by PODC.	• Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Improvement of Workforce Equality and Workforce Disability Standards Performance (WRES / WDES). • Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital.

	• Trust Board Pledge in place to eliminate workplace inequality, detriment, discrimination and bully & harassment. • Divisional cultural heat maps reflecting F2SU, Employee Relations activity (via dashboards) and local staff experience pulse survey produced for Divisional Boards to inform insight into local colleague experience. • Employee Engagement and Experience Oversight Group implemented to engage senior leaders across all divisions to address issues which have a detrimental impact on experience at work. • In depth Restorative Just and Learning Culture (RJLC) training secured for 30 leaders across Trust. • Managers Framework to support management and leadership capability in place.	• Progress against F2SU improvement programme monitored by PODC and Improvement Board. • PODC monitors progress against agreed metrics for Trust Board Pledge and provides assurance to the Board. • Monthly monitoring of Employee Engagement and Experience Oversight Group progress and actions via PODC. • Comparative performance against organisational workforce and culture indictors available via Model Hospital. • Joint Race Code action plan with RWT in place.	
Gaps in Controls:	• Limited capability and capacity to provide depth and breadth of leadership development for leaders / people managers across the Trust. • Workforce policies require review and update. • RJLC and Civility and Respect leadership modules to be developed.		
Assurance:	• Divisional and organisational performance monitored by Accountability Framework. • Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. • Staff recommending Trust as a place to work has increased from 47.8% [20190 to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • WRES indicator 2; recruitment improved from 2.73 [2019] to 1.52 [2020] to 1.40 [2021] • WRES indicator 3; disciplinary improved from 2.04 [2019] to 0.65 [2020] to 0.12 [2021]. • WRES indicator 4; access to non-mandatory training and CPD improved from 1.34 in 2020 to 0.91 in 2021.	• NHSIE support to develop F2SU service and achieve improvements identified within programme. • NHSIE culture programme	• NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.

	• Faculty of Leadership and Management Development programme has commenced Divisional Leadership and Care Group Management Teams. • Increased BAME representation in B7 and above roles from 18.81% to 30% as at 30 December 2021.		
Gaps in Assurance:	• Trust 2021 National Staff Survey results score below sector average for 6/9 indictors (improvement on NSS 2020) • From the early 2021 NSS results 51% of staff feel like the Trust acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or ageLack of senior managers representing ethnic minority and disability. This is an increase from 49% in NSS 2020, however is still below the average for the sector. • Culture and experience of BAME colleagues remains a significant concern – well below the sector average.		

Future Opportunities

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

Future Risks

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

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Restorative Just and Learning Cultural Programme to be implemented for operational managers.	Catherine Griffiths	30/11/2021	Supplier identified. Course content to be developed and agreed by 30 September 2021. This has now been completed and dates for next cohorts are being arranged. Meeting set for 19 November to agree dates for training with provider. 3 x places secured on ICS training. **Complete** - Training dates set for April and May 2022.	
2.	Senior Leadership Team to complete succession and talent mapping	Catherine Griffiths	~~31/10/2021~~ 31/05/2022	Templates and guidance circulated. New Senior Leaders are being actively supported to complete exercise by the end of May 2022.	
3.	As a result from Freedom to Speak up Month review and update Raising Concerns Policy and F2SU strategy for 2022/23 working in collaboration with RWT	Catherine Griffiths	30/04/2022	Updated policy in draft form. To be consulted via internal stakeholders in January 2022 with aim to approve by end of Q4. Ongoing: shared for stakeholder consultation in early March 2022.	
4.	Launch Management Framework and Leadership Development opportunities	Catherine Griffiths	30/11/2021	**Complete** - SLA for leadership development provision with RWT in place. Final sign off for Management Framework to be agreed.	
5.	Establish collaborative working between RWT and WHCT staff inclusion networks	Catherine Griffiths	30/11/2021	**Complete** - EDI leads at RWT and WHCT are developing collaborative working plan. This will be overseen by the HR Collaborative Working Group.	
6.	Internal Audit re Effectiveness of National Staff Survey preparation to be completed.	Catherine Griffiths	30/11/2021	**Complete** - Draft audit complete. Due for finalisation and presentation to Audit committee in November 21.	

7.	Review of leadership offer / options / opportunities across Walsall Healthcare NHS Trust and RWT.	Catherine Griffiths	30/09/2021	**Complete** - Review process agreed between RWT and WHCT leads. Outcome to be reported to future PODC.	
8.	Divisional Leadership Teams to be supported to strengthen accountability towards improving the EDI agenda across their services.	Catherine Griffiths	30/09/2021	**Completed** - Divisional Talent Forums scheduled.	
9.	Staff Engagement and Experience Oversight Group to produce menu of best practice from Divisional feedback re response to NSS and Pulse Survey	Catherine Griffiths	31/08/2021	**Completed**.	
10.	Review of self-assessment / progress against NHS People Plan to be received by PODC in August 2021	Catherine Griffiths	31/08/2021	**Completed** - Presented to PODC in August 2021.	
11.	WRES and WDES national data submission	Catherine Griffiths	31/07/2021	**Completed**.	
12.	Develop and implement a resolution dispute model to replace to resolve conflict in the workplace with early intervention and assess appropriate course of intervention.	Catherine Griffiths	30/06/2022	Draft model agreed in principle with trade unions supported by draft toolkit and procedure. Due for wider consultation end of April 2022	
13.	Roll out Cultural Competency Training for 100 clinical leaders and embed via internal training knowledge and capacity.	Catherine Griffiths	30/09/2022	Provider commissioned and funding secured. Cohorts planned for Q2.	

Latest Board/Committee/Group - 11/04/2022
Version V10.00

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • SO 04b - Organisational Effectiveness.
Risk Description:	Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.
Lead Director:	Director of People and Culture
Lead Committee:	People & Organisational Development Committee

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **2072** - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency (Risk Score = 8).	**Likelihood = 3 Consequence = 4 = 12 Moderate ↔**
		Forecasted Risk Score Movement for the next Bi-Monthly Review:
		Likelihood = 3 Consequence = 4 = 12 Moderate ↔

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3						3	*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.*	Likelihood:	2	30 September 2022
Consequence:	4						4		Consequence:	4	
Risk Level:	**12 Moderate**						**12 Moderate**	Evidence of risk gaps in control.	Risk Level:	**8**	

								• Staff recommending Walsall as a place to work and be treated is below all England average. • Employee Engagement Index of 6.7 below sector average of 7.0. • High reliance on temporary workforce. • Apprenticeship levy underutilised. • High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%. • As of 31 March 2021 there were 98 FTE registered nurse vacancies. • 48 vacancies within band 2 positions in Estates & Facilities (E&F) to be filled during Q1 campaign planned for June. <u>Evidence of risk control Q4 (Jan, Feb, March)</u> • Agreement to procure Learning Management System to synergise with RWT. • Medical Staffing Improvement Programme endorsed at TMC (22 Feb 22) to include: – Review of medical rotas to ensure compliance – Review of roles and responsibilities to determine optimum delivery model. – Assurance of ability to meet 6/8/12 week requirement for Doctors in Training. – Medical establishment model. • Through the international nurse programme 189 nurses have been appointed and are in place from January 2022. • Apprenticeship Levy spends increased to £828,443 (end of Feb 22) compared to £775,493 end of March 2021. • Implementation of Collaborative Locum Medical bank between RWT & WHCT has commenced (aim to implement in Q2).			

Control & Assurance Framework - 3 Lines of Defence			
	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Participating in STP Acute Collaboration to enable movement of staff via MOU and identify vacancy hotspots. • ESR data cleanse work stream supported by Informatics Team in place to accurately reflect organisational hierarchies.	• People and Organisational Development Committee in place to gain assurance. • Education and Steering Group in place and reports through to PODC for assurance. • Use of temporary staffing and ambition to eliminate agency staff by end of December	• ICS 2021/22 priorities and operational plan. • Annual Internal audit of financial controls and payroll. • Annual ESR Data Quality Audit carried out by ESR. • Assessment of activities in line with

	• International nurse recruitment programme in place supported by Regional NHSIE and RWT Clinical Fellowship Scheme. • Partnership with Walsall Housing Group, Job Centre and local higher education providers to fill all clinical support worker, housekeeping and porter vacancies by end of October 2021. • Community division reviewing therapy services to understand demands and AHP capacity to deliver ensure effective use of resources and support recruitment to existing and new roles in accordance with service pathways. • Implemented Step Into Health programme which connects Trusts with the Armed Forces community, by offering an access route into employment and career development opportunities. • Anchor Employer model in place with WHG • Collaboration with Health Education England to pilot new role of Medical Support Worker.	monitored via PFIC and QPES for assurance.	requirements of National NHS People Plan and BCWB STP People Plan. • Participant of STP collaborate bank proposal. • Leading STP BCWB Workforce Supply Group and member of STP Workforce Flexibility working groups. • Improved outcomes from annual NHS Staff Survey which match sector average scores • Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital. • STP Acute collaboration focus to enable movement of staff across the system and work in partnership to address recruitment hotspots.
Gaps in Controls:	• There is insufficient assurance that medical rota's (excluding senior medics) are compliant with contractual requirements. • There is a lack of alignment between financial data and workforce / recruitment information to accurately reflect and forecast vacancy levels and establishment control • High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%.[March 2021]		
Assurance:	• Model Hospital Use of Resources assessments. • Average 2-year retention rate across the Trust of 82.4%. • Time to hire 55 days - 2nd quartile of Model Hospital data • Clinical Support Worker (CSW) vacancies reduced to 0 as of 31 Mach 2021. • 21/98 nurse vacancies filled by 10 May 2021.	• Implementation of Anchor Institute Recruitment Campaign • Associate Director of AHP appointed and commenced in role [May 2020].	• Work with education organisations and Health education England. • NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.
Gaps in Assurance:	• There is a lack of workforce planning capability across leaders within the Trust. • Lack of ability to meet local and national professional clinical staffing models / guidelines. • There is a lack of clarity regarding roles and responsibilities relating to the appointment, on-boarding and deployment of medical staff.		

Future Opportunities

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

Future Risks

- Workforce exhaustion and/or psychological impact of Covid-19 recovery may impact on the ability of managers to practice compassionate and inclusive leadership.
- Uncertainty regarding senior leadership arrangements of the Trust may impact on ability to; attract, recruit and retain required skills and talent to the organisation.

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Ongoing recruitment and on boarding of international nurses via Clinical Fellowship Programme	Catherine Griffiths	31/12/2022	Ongoing - 189 in place by end of January 2022. Further bid to NHSIE to support recruitment of 140 more throughout 2022/23.	
2	NHSEI sponsored ICS work stream to develop Anchor Institute network across Walsall involving healthcare, local government and voluntary a partners.	Catherine Griffiths	31/03/2022	**Complete** - Lead appointed - hosted by Walsall.	
3	Formal TNA requirements informed by IPDR process to be collated to inform L&D funds and distribution.	Catherine Griffiths	31/01/2022	**Complete** - PDR process updated to support data capture - July 2021.	
4	Establish control review to clarify position of CSW vacancies between financial ledger, ESR	Catherine Griffiths	~~31/12/2021~~ 30/04/2022	Draft reports developed, currently be refined between stakeholders. Pilot 3 month trajectory due to be completed by end of April.	
5	Governance process to enact procurement of Learning Management System to be completed	Catherine Griffith	31/01/2022	**Complete** - Funding agreed from within establishment to procure system.	
6	Medical Staffing Improvement Plan accepted by CMO and DP&C to be shared with clinical leaders and other key stakeholders to identify priorities and engage stakeholders in improvement activity.	Catherine Griffiths	31/07/2022	Additional resources agreed (within budget for 2021/22). Improvement methodology agreed and to be shared with Execs and Senior Medics in January 2022. March update: Stakeholder engagement plan and Improvement programme agreed at TMC in Feb 22.	
7	Report detailing all risks and issues relating to the medical staffing function to be provided to PODC	Catherine Griffiths	31/12/2021	**Complete** - Diagnostic report presented to CMO and DP&C by Interim Head of Medical Staffing (30 December). Proposal agreed and updates to be provided to Executive Committee and Medical Workforce Group.	
8	Completion of Operational Workforce Planning 2022-2023	Catherine Griffiths	31/10/2021	**Complete** - First draft completed and reviewed by PODC.	
9	Official Launch of formal partnership with Walsall Housing Group to support local people into healthcare careers to be completed.	Catherine Griffiths	~~31/08/2021~~ 31/10/2021	**Complete** - Manager's briefings to be completed and post appointed to provide pastoral support for new healthcare workers.	
10	Update report to PODC re Anchor Institute and employment models to include overview of system work streams to be presented in August 2021.	Catherine Griffiths	31/08/2021	**Complete**.	
11	Work with Acute Provider Collaboration to identify hard to recruit roles and staff groups.	Catherine Griffiths	30/09/2021	**Completed** - WHCT paper re recruitment hotspots.	

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

Latest Board/Committee/Group - 11/04/2022
Version V10.00

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 04 - Value our Colleagues;** We will be an inclusive organisation which lives our organisational values at all times. • 04c - Making Walsall (and the Black Country) the Best Place to Work.
Risk Description:	Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care
Lead Director:	Director of People and Culture
Lead Committee:	People & Organisational Development Committee

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **2072** - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency (Risk Score = 8). • **2489** - Poor colleague experience in the workplace (Risk Score = 12).	**Likelihood = 3 Consequence = 4 = 12 Moderate ↔** Forecasted Risk Score Movement for the next Bi-Monthly Review: **Likelihood = 3 Consequence = 4 = 12 Moderate ↔**

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3						3	*Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.*	Likelihood:	2	30 September 2022
Consequence:	4						4		Consequence:	4	
Risk Level:	**12 Moderate**						**12 Moderate**	Evidence of risk gaps in control. • Staff recommending Walsall as a place to work and to be treated is below all England average.	Risk Level:	**8**	

								• Employee Engagement Index of 6.7 below sector average of 7.0. • Lack of SEQOHS accreditation. • Sickness absence levels were 5.3% excluding Covid-19 related absence against target of 4.5% [30 June 2021]. • Lack of recurrent HWB funding to support ambitious and innovative HWB interventions. <u>Evidence of risk control Q4; Jan, Feb & March</u> • Vaccine centre to remain in place and available to staff and general public. • Funding agreed to sustain Covid-19 Team to support IFC and staff / outbreaks etc. until end of September 2022. • As at 4/3/22: 92% colleagues have received first covid-19 vaccine & 88% have received 2nd dose. • Infinity system introduced to monitor staff uptake in recording LFT results. • 22% Managers have completed HWB conversation training. (as at 28 Feb 22) • Health & Wellbeing Strategy to be approved by PODC (April 2022) • Business case for HWB funding developed. • Quarterly assessment against NHSEI HWB Framework details improvements. • SEOHQS evidence has been submitted to external assessors. Awaiting date for formal assessment.			

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Schwartz rounds have been implemented in accordance with Point of Care Foundation license. • Internal Mental First Aider network established, accredited training complete and network contact details and support available to staff promoted. • Detailed project improvement programme plans for; *Health & Wellbeing Strategy*, *Achieving SEQOSH accreditation* and *Enhancing Flexible Working*. • Calendar of Black Country career events in place to attract and recruit to health and social care employment opportunities (NHS, Social Care and Voluntary Sector)	• People and Organisational Development Committee in place to gain assurance. • Monthly Schwartz Round Steering Group established to plan, prepare and debrief agreed rounds. • Colleague Health and Wellbeing Strategy Group meets monthly to progress HWB activity and reports through to PODC. • 2021 Pulse Survey completed (Q2 and Q4) • Assessment against NHSEI HWB Framework completed and reviewed on 1/4ly basis – reported through to PODC.	• Achievement of SEQOHS accreditation and rolling improvement plan in Occupational Health • Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital. • Leading STP (BCWB) Workforce Supply Programme Delivery Group. • Members of STP (BCWB) Work • Leadership & Culture

	• Development of system workforce metric. • Digital passport (improving education and training and mobility of workforce) • Anchor employer • Implementation of BMA Facilities and Fatigue Charter. • Walsall Healthcare NHS Trust Vaccine Centre in place – extension agreed via CCG. • Corporate Command Cell in place to review COVID-19 guidance and implications for staff. Model extended with RWT to collaborate for consistency for staff across both Trusts. • HWB Strategy developed.		• Workforce flexibility & consistency (improving workforce capacity) • Education & Training • Workforce Support (HWB) • Health Education England QA process re-experience of Doctors in Post Graduate Training.
Gaps in Controls:	• The Interim Home Working Procedure requires an update to reflect a strategic approach to agile and flexible working opportunities. • More colleagues require training to apply the CHATS Framework when undertaking HWB conversations • Development of Black Country Employer Brand. • Development of system health and social care roles to support system workforce gaps.		
Assurance:	• Increase in occupational health resources secured. • Divisional and organisational performance monitored by Accountability Framework. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • % of colleagues confirming manager takes interest in wellbeing has increased from 65% to 69% in 2020 NSS. • Stage 3 hearings re ill health capability have reduced. • Opportunities for flexible working patterns increased from 50.9% to 54.6 % in 2020 NSS. • Funding for Covid / infection risk team agreed until September 2022.	• Health and Wellbeing Guardian appointed at Trust Board	• Quarterly deep dive of key workforce metrics by CCG. • NHSIE central and regional team oversight of progress against NHS People Plan. • Development of ICS Workforce Metric • SEQOHS Accreditation.
Gaps in Assurance:	• Lack of recurrent HWB budget • Not all colleagues are recorded as having completed an individual Covid-19 Risk Assessment. [as at 31 December 2021 85% recorded]. • Currently lack ability to consistently achieve and sickness absence levels of 4.5% or below. • 2021 NSS does not reflect improvement in discrimination experienced in the workplace based on race, disability and sexual orientation. • 2021 NSS shows 6% decrease on the number of staff reporting that adjustments have been made to enable them to carry out their work. • 2021 NSS shows 60% of staff think that the Trust respects individual differences (e.g. culture, working styles, backgrounds etc) compared to 69% National Average.		

Future Opportunities

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

Future Risks

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

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	HWB Stake Holder event to take place to identify areas of focus and priority for 22/23.	Catherine Griffiths	31/01/2022	**Complete** - Event booked to take place 10 January 2022. Outcomes to be reported to HWN Strategy Group in February 2022.	
2.	Develop evidenced based Health and Wellbeing Strategy	Catherine Griffiths	30/04/2022	Update - HWB Strategy to be received by PODC in April 2022.	
3.	Business Case for 22/23 HWB funding to complement HWB strategy and support ambitious and innovative interventions.	Catherine Griffiths	31/03/2022	Update to HWB Strategy Group on 6 December 2021	
4.	Achieve Occupational Health accreditation	Catherine Griffiths	31/03/2022	All milestones ahead or on track. Reviewed at HWB Strategy Group 04.01.22. Evidence submitted, waiting a date for formal review / assessment.	
5.	Update interim Home Working Procedure and develop into flexible working strategy for the Trust.	Kevin Bostock	~~30/11/2021~~ 30/06/2022	Under review at Corporate Tactical. Guidance issued in relation to national updates. Strategy to be informed following feedback from agile working questionnaire distributed in November 2021.	
6.	Execute local and ICS action plan to mitigate risks and take relevant actions to meet statutory obligation for staff employed to undertake regulated activities to have received both doses of a recognised Covid-19 vaccine.	Catherine Griffiths	01/04/2022	**Complete** - Government have revoked the regulations. Local Task and Finish Group established. Staff in scope identified. Comms plan in place. ICS collaborative approach being taken.	
7.	Complete Fit Mask trainer the trainer to increase expert resource and enable targeted, local delivery	Lisa Carroll	31/12/2021	**Complete** - Individual accredited to provide training.	
8.	Substantively recruit to Occupational Health Consultant	Catherine Griffiths	30/11/2021	**Complete** - Recruitment paperwork in place. Interview took place 13 September 2021 - conditional offer made. Process to be finalised via RC rep on AAC panel 22/11/2021.	
9.	Complete gap analysis on Health and Wellbeing offer – for completion by end August 2021- to shape HWB strategy	Catherine Griffiths	31/08/2021	**Complete** - Document now supporting completion of National HWB Framework.	
10.	Deep dive review of sickness absence at divisional level	Catherine Griffiths	17/09/2021	**Complete** - Workforce data and narrative from HR Advisory team shared with Divisions for Sept/Oct DPR	
11.	Rapid roll out of Health and Wellbeing Conversation's via CHAT framework following successful pilot	Catherine Griffiths	30/09/2021	**Complete** - Regular training sessions available and training / HWB conversation resources printed and distributed. Intranet site updated and comparison of framework to national training completed.	

12.	Implement regular Fit Mask Testing data reports	Catherine Griffiths	31/10/2021	**Complete** - Action Plan completed by compliance group (HSE, L&D, IFC) and reflected in risk 1937.	
13.	Formally bring OH and HWB services together as one team.	Catherine Griffiths	30/09/2021	**Complete**.	
14.	Data validation re Flu Uptake and Covid vaccinations to be completed.	Catherine Griffiths	30/11/2021	**Complete** - Plan agreed via weekly flu meeting and corporate command. Dashboard in place and weekly WFI report produced for management information.	
15.	All staff to be auto-registered for LAMP testing	Catherine Griffiths	30/11/2021	**Complete** - Process rolled out in November 2021.	
16.	Assurance paper to PODC re measures in place to protect staff from exposure to IFC risks	Catherine Griffiths	30/11/2021	**Complete** - CRR 2093 updated	

Latest Board/Committee/Group - 11/04/2022
Version V10.01

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 05 - Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly.**
Risk Description:	The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & Investment Committee.
Links to Corporate Risk Register:	Title: • **208** - Failure to achieve 4-hour emergency access standard resulting in compromised patient safety and experience (Risk Score = 16). • **665** - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS, etc.) upon a NHS or partner organisation within the West Midlands Conurbation (Risk Score = 15). • **1005** - Insufficient capital funding for the estate contributing to lifecycle, critical infrastructure, and mechanical/engineering risks (Risk Score = 15). • **2081** - Delivery Operational Financial Plan (Risk Score = 16). • **2082** - Future Financial Sustainability (Risk Score = 16).
	Current Risk Score Movement: **Likelihood = 3** **Consequence = 5** **= 15 High ↔**
	Forecasted Risk Score Movement for the next Bi-Monthly Review: **Likelihood = 4** **Consequence = 5** **= 20 High ↑**

Risk Appetite

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

Risk Scoring

Bi-Monthly:	2022/23						2021/22	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
	Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	Q4				
Likelihood:	3						3	Evidence of control: • Achievement of 19/20 and 20/21 financial plans. • Achievement of 21/22 H1 & H2 financial plan. • Adherence to revised financial arrangements during 20/21 as a result of the Covid-19 pandemic, despite significant planning uncertainty • Strong operational performance measured through constitutional standards and associated operational performance metrics. • Development of draft 5-year capital programme • Majority of allied Corporate Risks associated with Use Resources Well mitigated to scores of 16 or less. • Improved Cost per WAU, and operational productivity indicators (Model Hospital) Evidence of gaps in control: • High reliance on temporary workforce has remained, whilst international nurse recruitment is delivered. • West Midlands Ambulance Service Intelligent Conveyancing protocol resulting in significant out of Walsall borough ambulances conveyed to the Trust, forecast to equate to in excess of £1.8m of ED attendance and non-elective admission activity during 22/23 that is not subject to PbR. • Increasing general risk in the UEC system due to high demand on EDs and challenged complex discharge pathways resulting in excessively high hospital bed occupancy. • Risk of recurrent Covid waves, particularly resulting in increased staff absence, and in turn higher reliance on temporary workforce. • Lack of credible capital plan to fully address backlog maintenance requirements, despite 5-year Capital Programme in place. • Draft 22/23 Financial plan results in deficit for the Trust and the STP. Evidence of planning uncertainty: • 22/23 financial planning guidance issued 24/12/21 by NHSEI. Draft plans submitted April 2022 • Revised drafts required June 2022	Likelihood:	2	31 March 2022
Consequence:	5						5		Consequence:	5	
Risk Level:	**15 High**						**15 High**		Risk Level:	**10 Moderate**	

Control & Assurance Framework - 3 Lines of Defence

	1st Line of Defence	2nd Line of Defence	3rd Line of Defence
Controls:	• Financial position reported monthly via Care Groups, Divisions, Divisional Performance Reviews and Executive Governance Structures. • Revised financial governance in place for COVID-19 through the Trust's Governance Continuity Plan. • Board Development session for the Improvement Programme with identified 3-year targeted financial benefits.	• Performance, Finance & Investment Committee in place to gain assurance. • Audit Committee in place to oversee and test the governance/financial controls. • Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation). • Use Resources Well work stream of the Improvement Programme has Governance infrastructure in place. • Establishment of Financial Efficiency Group to oversee cash-releasing Financial Efficiency improvements. Plans identified for original £5.347m 22/23 CIP target, further plans in development to meet £6.3m revised stretch target.	• Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital.
Gaps in Controls:	• Business planning processes require strengthening. • Accountability Framework has been approved however needs to mature and be embedded. • Covid-19 second and third waves significantly exceeded planning parameter assumptions. • Requirement to re-instill culture of continuous financial efficiency improvements following 2 altered financial years during the Covid pandemic.		
Assurance:	• Model Hospital Use of Resources assessments. • Proportion of acute surgical patients managed without overnight hospital stay has risen from less than 30% to over 50%. • Number of patients managed through the Integrated Assessment Unit's Frailty service without overnight hospital stay has increased by over 50%. • Inpatient Length of Stay in MLTC (excluding 0-day LoS) has reduced from over 9 days to less than 8 days on average. • Number of Medically Stable for Discharge inpatients sustained at or slightly below 50 during 21/22. • Delivery of 2020/21 Financial plan, representing the second consecutive year of meeting financial plan, followed by delivery of H1 and H2 2021/22 financial plan, • 99.2% (£5.302m) of 22/23 Cost Improvement Programme target (£5.347m) identified as of 25th May 2022.	• Internal Audit reviews of a number of areas of financial and operational performance • Covid-19 'top-up' resource in line with peers as a percentage of turnover • Top 20 in the country out of 122 general acute reporting Trusts (March 2022) for 6 week wait Diagnostic (DM01) performance • Top 30 (out of 113 reporting general acute Trusts) (Apr 2022) for 4-hour Emergency Access Standard, and Top performing Trust in the West Midlands for 14 out of the last 15 months for Ambulance handover <30 mins • 69th best in the country out of 122 reporting Trusts (Mar 2022) for 18-week RTT performance and 7th lowest proportion of elective waiting list waiting over 52 weeks in the Midlands (out of 20 reporting Midlands Trusts) • 62-day Cancer performance (Mar 2022) materially better than the West Midlands average (56.0%) and in line with the national average (67.4%) with 66.7% of our patients treated within 62 days of GP referral.	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts • Cost per WAU (19/20) now below peer and national median (Model Hospital) • Productivity Opportunity for British Association of Daycase Surgery procedures second lowest quartile (Sep 2021 – Model Hospital). • Average LoS for elective admissions rolling 6 months in line with peer and national median (Sep 2021 – Model Hospital) • Average LoS for emergency admissions rolling 6 months below peer and national median (Sep 2021 – Model Hospital) • Average late starts and average early finishes in Operating Theatres better than peer and national median (Sep 2021 – Model Hospital), and upper quartile performance. • Medical specialties Same Day Emergency Care rates for ambulatory emergency care conditions rated second best in the country by the AEC Network.
Gaps in Assurance:	• NHSi Governance review highlighted areas of improvement for business process and accountability framework. • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident. Time lag on updating of some Model Hospital metrics means there is a delay in receiving some independent assurance of improved financial and operational productivity metrics. • External Audit limited due to Covid-19. • NHS Digital Templar Execs external review (Cyber Operational Readiness Support) has identified improvements required for the Trust's Cyber Security. • Remaining component (15.8%) of 22/23 Cost Improvement Programme to be identified.		

Future Opportunities

- Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area.
- International Nurse Recruitment with RWT to significantly decrease reliance on temporary workforce, particularly during 22/23.
- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners), and following catchment area changes for non-elective care when Midland Metropolitan Hospital opens in 2023, and Sandwell ED closes.
- Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home).
- Improved Equality, Diversity and Inclusion in the Trust to harness the skills of the whole workforce and leadership development programme for Care Group and Divisional leaders to enhance capability (Valuing Colleagues).
- Utilisation of national productivity benchmark information (e.g. GIRFT and Model Hospital) to target work through the Use of Resources Improvement Programme.
- Development of major capital upgrades (e.g. new Emergency Department) to support improved recruitment of staff.
- Harnessing the teamwork and innovation so evident throughout the Covid-19 pandemic to develop service improvements that lead to improved use of resources.
- Capitalising on the digital advancement during Covid-19 to harness technology to improve effective use of resources.
- Rationalising Estate requirements through increased remote working.
- Enhanced leadership capability through Well-led Improvement Programme work stream.

Future Risks

- Draft 22/23 Financial Plan includes a deficit position for the Trust and the STP.
- Covid-19 second and third waves have significantly exceeded planning parameter assumptions, leading to increased costs delivering emergency and critical care, and reduced leadership time dedicated to long time resource planning during the height of the pandemic. Risk of a recurrent waves, particularly impacting staff availability, and thus reliance on temporary workforce.
- National move away from PbR towards block contracts and the associated paradigm shift for elective care in particular.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in remaining.
- Additional costs associated with safe non-elective and critical care during Covid-19.
- Significant changes to elective and non-elective demand during Covid-19 and in 21/22 in emergency care in particular leading to difficulty planning for the future with confidence.
- Insufficient Capital to enable investments in the Estate, equipment and technology that would in turn support more effective use of resources, and significant lead time for deployment of capital.
- Impact of Covid-19 on the wider economy and supply chain markets may destabilise some costs of goods/services upon which the Trust relies.
- Workforce exhaustion and/or psychological impact from Covid-19 may result in higher sickness rates and/or colleagues deciding to leave the healthcare professions, and thus further reliance on temporary workforce.

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

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

5.	Development of 2022/23 Financial plan	R. Caldicott	April 2022	**Complete**	
5.	Development of 2022/23 Efficiency Programme	N. Hobbs	April 2022	**In Progress** – 84.2% of stretch CIP target (£6.3m) identified as of 25th May 2022.	

Latest Board/Committee/Group - 11/04/2022
Version V10.01

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 06 - COVID; This risk has the potential to impact on all of the Trust's Strategic Objectives.**
Risk Description:	The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.
Lead Director:	Chief Operating Officer.
Lead Committee:	Trust Board
Links to Corporate Risk Register:	Title: • **208** - Failure to achieve 4-hour emergency access standard resulting in compromised patient safety & patient experience (Risk score = 16). • **2066** - Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score =15). • **2081** - Delivery Operational Financial Plan (Risk Score = 16). • **2082** - Future Financial Sustainability. (Risk Score = 16).
	Current Risk Score Movement: **Likelihood = 3 Consequence = 3 = 9 Moderate ↓**
	Forecasted Risk Score Movement for the next Bi-Monthly Review: **Likelihood = 3 Consequence = 3 = 9 Moderate ↔**

Risk Scoring

Bi-Monthly:	2022/23 Bi-Monthly 1 (April & May)	Bi-Monthly 2 (June & July)	Bi-Monthly 3 (Aug & Sept)	Bi-Monthly 4 (Oct & Nov)	Bi-Monthly 5 (Dec & Jan)	Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3						4	• The initial wave of Covid-19 had a profound impact on the services that the Trust provides, both in terms of urgent, emergency and critical care services to manage Covid-19 positive patients (in the hospital and the community), and in terms of the reduction in capacity of elective care services. The initial wave had a particularly significant impact on care home residents within the Borough's population. • The Trust is operating in an uncertain financial planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19, and planning for the 22/23 financial year.	Likelihood:	2	30 Sep 2022
Consequence:	3						3		Consequence:	3	
Risk Level:	**9 Moderate**						**12 Moderate**		Risk Level:	**6 Low**	

								• Covid-19 has exposed existing significant health inequalities in the population the Trust serves. Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust. • Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20, with further analysis presented to QPES 28/01/21 confirming 21 probable or definite nosocomial deaths from Covid in Wave 1. • Planning assumptions for a second wave of Covid-19 cases assumed a peak at half the level of the April 2020 peak. In January 2021 the Trust had exceeded 140% of the April 2020 peak. As of 28th March 2022 the Trust's Covid-19 positive inpatients are at 30.3% of the April 2020 peak or 21.2% of the January 2021 peak. • During the Omicron wave, Walsall borough's rolling 7-day average Covid-19 prevalence per 100,000 population reached in excess of 2,500 per 100,000 population, placing significant pressure on staff absence even if vaccination protection meant the number of patients hospitalised with Covid-19 was not as high as previous waves. • The Trust had the 7th highest proportion of its hospital beds occupied by Covid-19 positive patients in the country in early November 2020, and the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. • The Trust consistently had one of the highest Critical Care bed occupancy relative to baseline commissioned capacity across the Midlands region during the second wave. In January 2021 Critical Care bed occupancy has exceeded 250% of baseline commissioned capacity, peaking at 306% of baseline commissioned capacity. The Trust has spent much of 21/22 with its 7th elective operating theatre stood down to release reservist staffing to support Critical Care. • The Trust has 29 Covid positive in-patients within the hospital (as of 07/06/22).			

Control & 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. • Bespoke Incident Command structure in place for Covid-19 Vaccination programme. • Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. • Specific Covid-19 related SOPs and guidelines. • ITU Surge Plan in place. • Covid Streaming processes in place. • Enhanced Health and Safety/IPC Process in place in relation to Covid-19, with particular focus on social distancing, patient/staff, screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance. • Daily risk assessment (RAG rating) of Community Locality teams to prioritise resource according to need.	• Individual committees consider specific impact relevant to their portfolio, i.e. Financial Matters and Restoration and Recovery of elective services under PFIC; Quality, Safety and Patient experience matters under QPES and Workforce matters including staff wellbeing under P&ODC. • Board Development sessions (x2) on approach to Restoration and Recovery from Wave 1. • Covid-19 Deaths incorporated into SJR processes. • Nosocomial Covid-19 Infections are subjected to RCA and reported to the Infection Control Committee.	• Regional and National Incident Control structure. Return to regional Level 3 EPRR Incident since 19th May 2022.
Gaps in Controls:	• Walsall borough disproportionately hard hit. 7th highest proportion of beds occupied by Covid positive patients in the country, in early November 2020. One of the highest Critical Care bed occupancy levels relative to baseline funded Critical capacity in the Midlands Critical Care Network throughout waves 2 in the autumn of 2020 and 3 over the Winter of 2020/21. The Trust had the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. • Resurgence of Covid-19 cases resulting in significant staff isolation required, particularly associated with the Omicron variant wave over Winter 2021/22. • Increased fragility in the domiciliary care market resulting in higher bed occupancy in hospital, and compromised ability to optimally manage Infection Prevention and Control. • Lack of decisions from commissioners of Critical Care Services to recurrently fund increases in Critical Care capacity to give greater resilience for future waves of Covid. • Reduction in elective surgical operating theatre capacity due to requirement to support Critical Care staffing, resulting in prolonged waits for elective surgery. • Vaccine hesitancy, particularly amongst younger people, resulting in unvaccinated COVID-19 positive pregnant women and evidence that Maternal COVID-19 infection is associated with an approximately doubled risk of stillbirth and may be associated with an increased incidence of small-for-gestational age babies. • Increased risk of complications for pregnant women with COVID-19 coinciding with increased birth rate evident during 2021. • High demand on key Covid-19 Community pathways including Community Pulse Oximetry monitoring (Safe at Home pathway) and Long Covid pathways. • Ability for neighbouring Trust's to manage demand from patients conveyed by ambulance resulting in additional ambulance patients being conveyed to Walsall Manor through WMAS Intelligent Conveyancing protocol. • National directives and mandates impact on the Trust's ability to make local decisions. • Ability of the Midlands Critical Care Network to successfully manage demand Critical Care demand across the region. • Unable to progress all elements of the improvement programme owing to capacity of senior leaders. • Comprehensive OD/Culture Improvement plan.		

Assurance:	• IPC Board Assurance Framework.	• Nosocomial Covid-19 infection rate in line with peer-reviewed published evidence. • Antibody positive staff rate in line with BCWB peers. • Financial top up requests in line (or lower) as a proportion of turnover than BCWB peers. • Faculty of Research and Clinical Education evaluation of response to first wave. • 60-day readmission rate for Covid-19 patients in line with peer-reviewed published evidence. • Significantly strengthened inpatient ward nurse establishments approved at Trust Board will support greater resilience in any future waves.	• Top 20 in the country out of 122 general acute reporting Trusts (March 2022) for 6 week wait Diagnostic (DM01) performance. • 62-day Cancer performance (Mar 2022) materially better than the West Midlands average (56.0%) and in line with the national average (67.4%) with 66.7% of our patients treated within 62 days of GP referral • Elective 52-week wait performance 7th best in the Midlands (Mar 2022) out of 20 reporting Trusts. • Top 30 (out of 113 reporting general acute Trusts) (Apr 2022) for 4-hour Emergency Access Standard, and Top performing Trust in the West Midlands for 14 out of the last 15 months for Ambulance handover <30 mins. • CQC Assurance of the IPC Board Assurance Framework. • Productivity of Vaccination Programme compares favourably with other Acute Trusts. • Risk adjusted mortality rate (ICNARC) for Critical Care within expected range despite significant over-occupancy.
Gaps in Assurance:	• Evidence of higher staff absence rates than BCWB peers during initial wave of Covid-19, absence rates consistent with peers in second/third wave		

Future Opportunities

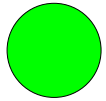
- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables.
- Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough.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

Future Risks

- Potential for further resurgence in Covid-19 cases.
- Limited political appetite to re-introduce lockdown measures evidenced through Governments Autumn and Winter (21/22) Plan A.
- Uncertain vaccine efficacy against novel variants, and vaccine effectiveness waning.
- Ongoing pressure on community services associated with patients rehabilitating following Covid-19, including Long Covid patients.
- Delayed and/or prolonged impact of managing the initial wave, second wave and third wave of the pandemic on staff wellbeing and mental health.
- Potential workforce absence in the event of a further wave.
- Limited management and leadership capacity to address core objectives due to the significant demands of managing covid-19 pandemic, and the restoration and recovery of services affected by covid-19.
- More constrained financial operating environment.
- Logistical challenges of delivering the Covid-19 Vaccination, including the requirement for booster vaccination.

Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)					
No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
6.	Confirmation of 2021/22 Financial arrangements.	DoF	~~Feb 2021~~ Oct 2021	**Complete** - Delayed due to delayed national planning guidance. Q1 and Q2 Financial Plan agreed at Private Board 03/06/2021, with Q3 and Q4 Financial Plan to be received at extraordinary PFIC 20/10/2021.	
7.	Revised staff absence management in the event of positive household contact	DoN (DIPC)	Dec 2021	**Complete** - In line with revised UKHSA and NHSEI guidance	
8.	Revised Covid Contingency Plan in response to the Omicron variant	COO	Dec 2021	**Complete** - Further contingency planning undertaken through Exercise Patton 2 EPRR scenario planning exercise	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
208	Failure to achieve 4 hour emergency access standard resulting in compromised patient safety and patient experience.	Patients are not assessed in the ED department in a timely manner leading to an increase in patient wait times. Although much improved, the risk still occurs when ED attendances are high or there is 'exit' block from the Department. This leads to a poor patient experience as well as adverse clinical outcomes including increased risk of mortality.	Kate Salmon	16	• Process • A governance process is in place to monitor performance throughout the organisation at Performance Finance & Investment Committee meeting on a monthly basis, that is a sub committee of the Trust Board.	• > Monthly reports provided to Performance Finance & Investment Committee (and Quality & Safety for Patient Care Improvement plan progress). > Escalation processes in place through Division to Executives where necessary. • Urgent and Emergency Care Board (UEC) ICS - delivery Board overseeing system response.	
					• Policy • Board approval of EAS improvement Trajectory to meet 95% agreed by Board	• Assured and overseen via divisional governance and performance reviews. • Monthly reporting to NHSi System review meeting oversight via regulator and CCG Newly introduced Flash report sub-60% performance. We are part of the regional UEC ops forum chaired by NHSE where all EAS standards are scrutinised and learning shared across the patch.	
					• Process • Operational demand management policies & procedures in place. Escalation policy in place to manage overcrowding in ED. IP&C policy on Covid Streaming. Covid swab policy.	• Trust's performance is on a continuing improvement trajectory despite high attendances. • NHSE/I & ECIST 'Critical Friend' visit to be arranged for 16th June 2021. Missed opportunities audit undertaken in April and report presented to ED team and at MAC. Further presentations to be made and action plan developed to implement the recommendations. Following perfect week we are invigorating our escalation policy which has worked well.	
					• Physical Barrier • Sufficient ED cubicle capacity to enable effective and timely assessment of patients in ED.	• Additional cubicles in place with the associated staffing. • N/A.	
					• Process • Substantive staff meets the Royal College guidance to provide safe and high quality care, and use our resources well.	• A rolling program of Nurse recruitment with interviews held on a monthly basis. Staffing vacancies reviewed regularly via governance structure. Nurse staffing reviewed daily. Safe staffing report presented to People	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						and OD Committee and Board. Nursing and quality paper to QPES. ED Medical workforce business case approved at Trust Board in June 2020 and will address the royal college guidance. New ED Matron appointed in October. Interviewed for RGN Posts in November and offered: 4 x Band 6, 1 x Band 5 and 8 CSW's. Nurse recruitment continues to improve and recently permission given to over recruit due to number of appointable applicants. Medical recruitment is also progressing well. ED nurse staffing numbers have been reviewed using BEST and Shelford tools. Approval to recruit to the staffing numbers required for Covid segregation from Director of Nursing and approved by Trust board (Oct 2021). • Safe staffing report published monthly on website. Staffing levels are overseen via system review meeting. Agency meeting review with NHSi.	
					• Process • Process agreed with WMAS to meet ambulance handover standards.	• Handover Policy with the Ambulance service in place. Ambulance handover key metrics is monitored at care group, Divisional, performance reviews, PFIC and Board. Additional 9-cubicles has mitigated the risk associated with capacity and social distancing to some extent. 4th consecutive month of being top in the West Midlands for ambulance handover within 30mins with 98% of our patients being transferred within this time. Direct referral and conveyancing from 999's to SACU, AEC and FES now in place, bypassing ED to help improve ambulance handover times and free up capacity in ED. • NHSE/I have introduced an escalation policy and COO must report any delays >60mins within 24 hours along with actions to address delays.	

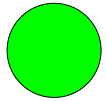
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						Recent performance on 15 mins time to triage has seen a 5% increase from 70 to 75% seen within 15 mins. Ambulance handover within 30 mins remains the best in the West Midlands. See ED activity analysis attached.	
					• Process • The Medically stable for Discharge patients are managed by the ICS team with the Community Division having responsibility for the overall performance. The team arranges placements in nursing and residential homes for patients requiring ongoing care, packages of care and discharge to assess beds in the community.	• The MSFD list is monitored daily by the ICS team and Community Division, 7 days per week. A twice weekly meeting has been taking place with Community Division and COO. • Weekly reporting of MSFD patients and against the 'Criteria to Reside'	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
11/04/2022	PDSA to trial separating the department and running two parallel teams which will enhance visible senior leadership in the department modelling the right culture of intolerance to delays. The department will be split into RATS, Merlin 1&2 (one team) and Majors & Resus (one team).	Kate Salmon		25/05/2022	30/05/2022
03/05/2022	Focus on the role of the Progress Chasers in the department and bring in an experienced Progress chaser to model the behaviours and what is required.	Katie Byrne		22/06/2022	27/06/2022
01/04/2022	To ensure the MSFD list is appropriately overseen and if routinely exceeds 50 patients on a daily basis (>55), to escalate to Community Division and M Dodd, Director. Updated action: review again in one month to ensure MSFD levels are maintained	Kate Salmon		25/05/2022	30/05/2022
11/04/2022	To run a PDSA with a senior decision maker working in Triage.	Kate Salmon		25/05/2022	30/05/2022
01/02/2022	Team to visit Sherwood Forest NHS Trust who are exemplars at achieving the 4 hour EAS	Katie Byrne	**Closed**	16/03/2022	21/03/2022
06/08/2021	Re-submit ED medical workforce and ED nursing establishment review business cases to Investment Group	Ruchi Joshi	**Closed**	21/02/2022	26/02/2022
01/09/2021	Dr Jim Davidson, Regional NHSE/I lead for Emergency and SDEC services to observe our areas - arranged for 7th September 2021. To implement any recommendations following this visit.	Kate Salmon	**Closed**	20/02/2022	25/02/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
665	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	Risk of a deliberate/intentional attack/hack on any part of the IT services and systems within the NHS or partner organisations from an external or internal source which could include infecting computers/networks/ systems with a lethal virus or malware resulting in disrupting to NHS services and NHS care provision.	Richard Pearson	15	• Training • Organisation IT related Disaster Recovery/BC plans. IG and Data protection compliance.	• New EPRR Manager now in post - targeted tabletop business continuity exercises carried out at least annually. • Data security Toolkit rating	
					• Process • Penetration testing undertaken annually through internal audit which identifies necessary digital safety actions required.	• Action plan developed following penetration testing and monitored via digital services governance meeting. • External partner Dionac has carried out an additional penetration test in July 2021. Report relieved late August action plan being created to address findings We are now working collaboratively with RWT to provide additional support and assurance on Cyber actions	
					• Physical Barrier • All vulnerable systems Sandboxed.	• Windows 7 term cut off from network to avoid prospect of viral attack. • Sandbox is a security mechanism for separating running programs, usually in an effort to mitigate system failures or software vulnerabilities from spreading.	
					• Physical Barrier • Windows OS upgrade programme	• All windows 7 devices now upgraded unless they host critical software that does not work on Windows 10. 37 devices remain In these instances the devices will be sandboxed to provide protection • The number of Windows 7 devices is monitored nationally using Microsoft Advanced Threat protection software that is installed on all devices	
					• Physical Barrier • Cyber Next generation measures put in place	• Cyber next generation firewall was put in place early in 2020. Trust physical and wireless network undergoing complete upgrade. Additional intrusion protection measures have been put in place for Log4J. Upgraded replacement firewalls purchased for deployment in 2022 • A next-generation firewall is a part of the third generation of firewall technology, combining a traditional firewall with other network device filtering functions, such as an application firewall using in-line deep packet inspection, an intrusion prevention system.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • NHS Cyber Alert. Membership of NHS Cyber Alert protocol.	• Notifications to key internal staff whenever a new cyber alert is published. This will include Day 0 and Day 0 + 1 threats. Guidance is provided on what action to take and updates on action are provided by the trust • Our responses to Cyber alerts are reviewed and monitored by NHS Digital.	
					• Process • Greater visibility of Cyber agenda and threats	• Dedicated communications plan for Cyber alerts / updates has been created with planned regular comms to be issued moving froward • N/A	
					• Physical Barrier • Installation of Immutable Backup solution Cloudian. This is an object storage solution which protects data from deletion or encryption with S3 Object Lock / WORM (write once, ready many) functionality. Once Object lock is enabled on the data written from the Veeam backup solution, the data is immutable and cannot be altered or deleted until the policy defined retention period is met. This means Ransomware is unable to encrypt or delete this data.	• Solution will be fully installed and configured by end of Sept 2021 • This type of system is required as part of the DSPT requirements	
					• Physical Barrier • Implementation of Multi Factor Authentication when remote access solutions are used to access the trusts network	• •	

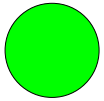
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/01/2021	Penetration test review and mitigations	Richard Pearson	25/09/2022	30/09/2022
01/01/2021	Upgrade works are in progress to replace entire LAN and Wifi infrastructure within the trust.	Richard Pearson	26/05/2022	31/05/2022
15/07/2020	OS upgrade programme to Windows to be undertaken.	Richard Pearson	25/09/2022	30/09/2022
01/11/2021	E-mail migration to be completed to Office 365 and upgrade of Office 2010 suite to O365 version	Richard Pearson	26/05/2022	31/05/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
01/05/2022	Identification and implementation of MFA solution for VPN and VDI connectivity		Richard Pearson			26/07/2022	31/07/2022
24/03/2022	OS build upgrade programme to build 21H2 to be undertaken		Richard Pearson			26/08/2022	31/08/2022
04/05/2022	Confirm Divisional Business continuity plans are in place, available and uptodate		Mark Hart			25/06/2022	30/06/2022
01/04/2022	Implementation of Vulnerability scanning solution		Richard Pearson			26/05/2022	31/05/2022
01/01/2021	0Patch has been installed to mitigate risk until all devices are upgraded to Windows 10		Andrew Griggs		**Closed**	25/11/2021	30/11/2021
01/01/2021	The security perimeter is verified to be at low risk of any suggested external attack gaining entry. Ongoing exercises will verify this security level		Richard Pearson		**Closed**	26/12/2021	31/12/2021
10/12/2021	Response and mitigation to Log4J critical cyber alert		Richard Pearson		**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1005	Insufficient capital funding for the estate contributing to lifecycle, critical infrastructure and mechanical/engineering risks.	Insufficient capital invested annually to reduce the backlog maintenance, critical infrastructure and mechanical/engineering risks within the West Wing & Maternity elements of the estate in respect of theatre upgrades, ward refurbishments, upgrading current facilities and ED schemes. This has resulted in a poor environment in respect of matters such as; ventilation, lifts, lighting, flooring, nurse call and bathroom areas as well as theatres approaching end of life condition where the experience of the patient and staff working within these areas has been significantly reduced.	Jane Longden	15	• Process • Trust Capital Control Group - Finance lead group with clinical divisional and IT representation responsible for collating and monitoring spend requests and allocating capital monies for divisional developments, infrastructure backlog maintained, capital projects and medical equipment. Understanding where the limited capital finance can be effectively prioritised (through ICS allocation and priorities to fulfil all competing bids).	• Regular reporting to PFIC. • Premises Assurance Model (PAM) produced on an annual basis for external publication.	
					• Process • Black Country ICS Capital Streams - review the allocation of money according to the Trusts bids and associated risk assessments. When the size of the ICS capital allocation is insufficient to address, priority is discussed via Trust Capital Control Group.	• System capital envelopes are confirmed in the first quarter of the new financial year, based on similar national quantum and distribution methodology to that used in previous capital planning. • ICS leads are reviewing submissions and contacting individual Trusts for summary of individual items and rationale for inclusion within the programme.	
					• Process • Lifecycle Plan - Prioritisation of high risk items through CIBSE verse failure testing with Project Co./Skanksa.	• > Estates meetings facilitated monthly (informal). > Hard FM monthly meetings to discuss all things relevant to the estate and captured via shared risk register. > Specific estates related groups now established. • Certification.	
					• Process • EPRR Steering Group - Resilience of business continuity programmes.	• TBC. • TBC.	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
16/06/2021	Urgent and Emergency Care Centre works were planned and then commenced in October 2020 with the ground works completed and services connected. The project is on target to finish in Summer 22 within commissioning of services included within this timeframe.	Jane Longden	25/06/2022	30/06/2022
31/01/2022	Wards 16 & 17 and AMU (Ward 5 & 6) are due to be planned for 22/23 financial year.	Jane Longden	26/03/2023	31/03/2023

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
07/10/2021		Capital Programme of works continues. First theatre(6)handover 12th Oct theatre 5 due to start 18th October.	Jane Longden			**Closed**	25/06/2022	30/06/2022
04/03/2022		Further ward upgrades are being programmed in for 2022. W16 & 17 to commence May 22 W5 & W6 to commence around Oct 22 W14 & W15 to commence following this in early 2023 but programme and dates not yet finalised.	Jane Longden			**Closed**	26/03/2023	31/03/2023

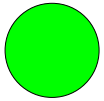
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1528	Potential delay in patient care and patient results	There is a lack of robust electronic alerts for when pathology histology, radiology, microbiology & endoscopy reports are available to view leading to delay in patient care & potentially unnecessary follow up appointments.	Richard Pearson	20	• • Some Gastro Consultants are keeping paper copies of correspondence to remind them to chase results. Other Consultants/Registrars/CNS's keep personal data bases and/or paper diaries.	• TBC - No internal assurance. • N/A	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
14/07/2021	Investigate options for Results Acknowledgement / notifications within ICE	Richard Pearson		26/05/2022	31/05/2022
07/12/2021	Investigate options for Results acknowledgment / notifications within Careflow	Richard Pearson		26/05/2022	31/05/2022
15/11/2021	Pilot of Fusion splash screen by Nishant Gautam (Divisional CCIO) to confirm suitability as interim solution	Richard Pearson	**Closed**	26/01/2022	31/01/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels	Substantive staffing levels are below the agreed safe staffing levels for wards and departments leading to the potential for avoidable harm 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	Caroline Whyte	15	• Process • Interim Process - Use of bank and agency staff to fill gaps in nursing and midwifery rotas.	• Reporting and review of fill rates that report into PODC. • N/A	
					• Process • Twice daily virtual staffing meeting with matron representatives from all divisions. All wards reviewed and rag rated, redeployments agreed from areas and escalations for bank and agency staff agreed. Forward view over weekends and holiday periods.	• Review of safecare red flags when patient care is affected by staffing levels. Robust review of staffing levels on a twice daily basis. Reporting of fill rates into PODC. • N/A	
					• Process • Increased use of Volunteers and Administration roles to complete tasks to free up Registered and unregistered Nurses to deliver direct patient care. EWE volunteers in ward areas to support patient care.	• TBC • N/A	
					• Process • Staff well being policy with additional support identified and put in place to support staff as part of the COVID-19 response. 07/03/2022 - Manor lounge open on ward 29. Staff health and well being support continues	• Monitoring of staff sickness levels and sickness reasons, divisions receiving monthly reports • N/A	

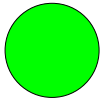
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		for full details**					

Action Plan

Start Date	Action Details / Description	Owner		Reminder Date	Target Date
26/03/2020	Continued proactive recruitment strategy 16/3/21 international recruitment process in progress with first recruits expected April 2021; corporate nursing working collaboratively with HR to ensure we are continually reviewing our retention plans with the aim that we achieve as close to zero vacancies for RNs and CSWs by Q4 4/08/2021 86 international nurses currently in the UK and undergoing induction, training and OSCE completion to gain entry to the NMC register. Aiming for a total of 205 by December 2021	Lisa Carroll		26/07/2022	31/07/2022
04/08/2021	Business case approved in principle at Trust Board September 2021. Finance fully costing and plan of phased implementation to be agreed	Lisa Carroll		26/07/2022	31/07/2022
21/02/2022	Virtual staffing hub to meet twice daily, escalation to temporary staffing as required. Sitrep produced and circulated to key staff.	Caroline Whyte		26/07/2022	31/07/2022
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly. 16/3/21 -The hub is well established and the staffing meetings will continue post COVID. The risk regarding temporary staffing usage is predicted to reduce as the international nurses join establishments. Additional capacity areas have closed reducing the staffing demand - areas closed are Wards 10 and 14 and additional beds on Ward 4 have also closed	Caroline Whyte	**Closed**	26/03/2022	31/03/2022

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	12	• 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 to undertake effective PDR's. Coaching techniques to support conversations. F2SU approach and feedback. Cultural Ambassadors trained and in place on B6 and above recruitment since January 2021 Review of PDR process - October 2021. Pay Progression systems and processes established. • WRES and WDES performance - improvement in 2021 NHS National Staff Survey	
					• Process • - Working across the system across the STP with HEE partners to define local, collaborative, system and national workforce supply solutions. Actions 4996, 4997 & 8609 contribute to mitigation.	• Workforce Plan is reviewed and agreed by TMB and PODC Medical and Nursing Workforce Meetings in place and receiving recruitment trajectory data. Clinical Fellowship Scheme supporting increased recruitment to agreed establishment levels. • Workforce STP agenda via STP people board Collaboration with Walsall Together Partnership Board. ICS approach to HCSW and IR nurses in place.	
					• 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. Action 8610 supporting element of mitigation.	• Improvement Programme Board People and Organisational Development Committee. EDI Strategy and delivery plan approved by Board in April 2021 and monitored via PODC. • ICS People Board WRES / WDES data Staff Survey feedback.	
					• 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	• Via Education and Training Steering Group which reports through to PODC. Faculty of Medical Leadership Development training commenced in Feb 21 for Care Group leadership teams. SLA with RWT re leadership	

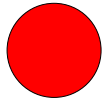
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					skills between NHS employers.	development offer under development. Director of Education and Training across RWT and WHCT to support of quality medical education and development. Managers framework launched in October 2021. • NSS results GMC and NETS survey HEE QA process	
					• 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. Action 772.	• Added as workstream in the Value our Colleagues Improvement Programme. PID completed and monitored via Core Team and exception basis to Improvement Board and PODC. Flexible working policy reviewed and updated Carers passport • BCWB ICS People Board Trust s part of Cohort 1 of the NHSEI Flex for the Future Programme	
					• Process • Partnership with Walsall Housing Group (WHG) to support residents to access foundation roles as first step into NHS career with Walsall focusing on; Clinical Support Workers, House Keeping and Portering roles.	• Bulk recruitment model implemented. Specific induction programmes developed for entry levels roles to support entry into employment, NHS and role. Zero vacancies across HK, Portering and CSW's by end of September 2021 • Anchor Institute Network	
					• Process • Recruitment of international nurses via RWT Clinical Fellowship Scheme in line with NHSEI international recruitment drive. Strong infrastructure to support recruitment, onboarding, CPD requirements and pastoral support. Action 8919 towards mitigation	• Safer Staffing Report to PODC Equality, Diversity and Inclusion Steering Group monitor feedback re experience. BAME Forum provide budding support to nurses from overseas Nursing establishment paper reviewed / approved by Board - 7 October 2021 Clinical fellowship programme with RWT in place • NHSIE Internal Nurse Programme ICS People Board	
					• Policy • Community Division undertaking review of Therapy services to understand the demands and AHP capacity to deliver, ensure effective use of their current resource, support the recruitment to vacancies and	• Associate Director of AHP's appointed in May 2021 A robust action plan has been created around this piece of work, with defined actions, timelines and accountabilities. PODC and Quality Committee oversight in April 2021	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					piloting different ways of working in order to address gaps in the service.	• National AHP Collaboration Network (NHSEI)	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
27/01/2022	To agree a consistent approach in terms of time and pay for all staff groups and that local induction / orientation arrangements build in capacity to complete required training before commencing role.	Marsha Belle		26/05/2022	31/05/2022
27/01/2022	To respond to focus groups and feedback from other forums and establish confidence in data accuracy and reporting and strengthening engagement at divisional level.	Catherine Griffiths		26/05/2022	31/05/2022
01/03/2022	WHCT & RWT to establish joint medical bank.	Clair Bond		26/07/2022	31/07/2022
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond		25/06/2022	30/06/2022
31/03/2021	Workforce Policy Framework to be aligned to the Valuing Colleagues Improvement Programme	Clair Bond		26/10/2022	31/10/2022
30/09/2021	Complete the NHSEI 'Flex for the Future' Cohort (WHCT accepted as participant in first cohort of national programme). Module 1 commenced 30 September 2021.	Marsha Belle		26/05/2022	31/05/2022
03/01/2022	A monthly establish gap report which triangulates recruitment, workforce and financial data will be provided to an agreed committee.	Marsha Belle		01/05/2022	06/05/2022
27/01/2022	To review equipment needs and implement identified resources / equipment and to ensure customers are aware of all channels of contact / communication with the recruitment team.	Marsha Belle	**Closed**	26/03/2022	31/03/2022
24/01/2021	NHSIE funds secured and commission with RWT Nurse Fellowship programme to secure 125 RGN nurses by the of 2021 has been agreed.	Clair Bond	**Closed**	26/03/2022	31/03/2022
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	**Closed**	25/09/2022	30/09/2022

Walsall Healthcare Risk Register

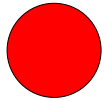
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	Operational expenditure incurred during the current financial year exceeds income allocations, which results in the Trust being unable to deliver the in-year financial plan. This results in us over spending & breaches our statutory break even duty.	Dan Mortiboys	8	• Process • Financial governance and reporting throughout the organisation	• PFIC review the financial performance with Executive on at least a monthly basis. • NHSI receive monthly reports from the Trust. NHSI raise key issues with the Trust. STP Finance receive monthly updates from the Trust and comment as appropriate NHSI governance and Accountability review noted the good level of challenge and oversight of the PFIC Committee	
					• • Through the Trusts Accountability Framework divisions and corporate Areas are held accountable for financial delivery.	• The Accountability Framework has been approved by the Trust Board and there is evidence it is in operation. Processes are all developed and continue to be developed • NHSi Governance and Accountability Framework	
					• Process • Covid Governance process approved by the Board Financial arrangements altered/set by NHSE/I	• Strategic Command oversight of expenditure Finance team oversee the adequacy of the controls, and ensuring the governance process has been followed • NHSI receive regular reports on expenditure and re-imburse as appropriate. Financial arrangements set by NHSE/I have been complied with in 2020/21 with no payments withheld and no issues	
					• • Standing Financial Instructions (SFI) are in place across the Trust	• Breaches reported to Audit Committee IT systems are set up to support the SFIs • Internal Audit and External Audit will do specific pieces of assurance work in this area and more general pieces that reference SFI. Counter fraud in place	
					• • NHSI/E have been asked by Trust Board to do a review on Finance and PMO functions. The draft outcomes of this report support the performance	• Appropriately qualified staff • Draft reporting from NHSE/I	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					of these areas. There is strong control in this area • • Robust financial management arrangements are in place across the organisation	• SFIs are in place Budgetary Control and Virement Policy in place Training for budget holders Financial Business Partners support budget holders Financial reporting process are in place • Positive External Audit opinion Positive internal audit opinion on financial control audit and year on year improvement	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
05/10/2021	Improve current training offer, widen training offer and run face to face sessions post Covid 19. Take into account feedback from those who use the training to improve it.	Dan Mortiboys		25/06/2022	30/06/2022
01/11/2021	There are 5 mitigations to reduce the financial risk which need to be measured collectively as they can compensate for each other. The mitigations are 'business as usual' in nature so reduce agency expenditure, achieve efficiency targets, ensure sufficient social care capacity, manage impact of energy supplies and supply chain and request appropriate income from STP.	Russell Caldicott	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Future Financial Sustainability	There is a risk that the Trust does not break even in line with its statutory duty. Incurring expenditure beyond a breakeven position could cause the regulator to reduce the autonomy of the Trust to incur expenditure and if the trust were not able to access sufficient cash resources could see suppliers stop supply. This could result in reduced services to patients and also reduce opportunities for the trust to benefit from investment. This risk would crystalise in a number of ways, divisions not working with agreed financial envelopes, the Trust investing funds beyond known income envelopes and potentially efficiency programmes not being achieved.	Dan Mortiboys	16	• Policy • PMO function in place to ensure standardisation of good project management process and reporting is in place.	• Improvement programme governance in place for workstream oversight. SRO and Programme manager overseeing programme delivery • Internal Audit have given significant assurance on the current PMO function. (Audit report indicated good progress for the coming financial year 2021/2022) NHSI have reviewed the PMO function and the financial elements	
					• • Overall Programme and Workstreams PIDs in place	• Improvement programme in place to oversee the implementation of the Trust's Improvement Plan Programme plan approved by the Board Workstream PIDs approved by relevant Committees • NHSI/E are in attendance at the Improvement Board and can provide support and challenge as appropriate Internal Audit review of Improvement programme	
					• Process • Benefits realisation process in place	• PIDs including benefits realisation approved through Governance structure PFIC TOR include duties relating to benefits realisation Improvement programme Board in place which includes a duty • N/A.	
					• Process • Monthly meetings of the Improvement Board (Executive led and attended) and workstream level meetings (Use of Resources chaired by Chief Operating Officer)	• The Improvement Board is a primarily Executive led meeting and oversight provided at that level. The Improvement Board and work streams report to Trust Board • N/A.	
					• Process • Financial Performance structures across the Trust (linked to Risk 2081), finally reporting to Performance, Finance and Investment Committee (PFIC)	• Internal Audit review key financial controls on an annual basis • External Audit provide annual view of the Trust's financial reporting	
					• Process • Long Term Financial Plan (LTFP) uses the best information available to predict the future financial position of	• The LTFP is produced and reviewed by professionally qualified accountancy staff who hold specific responsibility for LTFP	

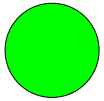
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					the Trust and ensure that the Trust can remain sustainable.	• NHSEI Midlands will review the LTFP of both the Black Country STP and Walsall Healthcare Trust	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
30/09/2021	Produce a new version of the Walsall Healthcare Trust Long Term Financial Plan (LTFP) inline with budget setting.	Russell Caldicott		25/04/2022	30/04/2022
24/12/2021	A balanced financial plan needs to be set. This will be co-ordinated by finance but will also require input from all areas of the organisations	Russell Caldicott		25/04/2022	30/04/2022
01/12/2021	To ensure the investment Group is successful	Dan Mortiboys		25/04/2022	30/04/2022
19/12/2021	Establishment of a group to set and monitor an efficiency programme	Ned Hobbs	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2245	Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.	There is a high level of maternity leave within the maternity team, currently totalling 25.1% of registered midwives across all inpatient areas. When this is considered with the normal expected tolerance of 16% A/L which is essential for the health and wellbeing of staff a 3% tolerance for staff training. This is being further exacerbated by an increasing number of staff requiring to self-isolate or quarantine due to Covid-19 procedures. As a result of the above, there is growing concern about the ability to safely provide care across the inpatient team, including 1:1 care in labour, due to the lack of staff available to work. Historically the service has been asked to maintain 10 vacancies due to the planned closure of Foxglove ward and relating to a reduction	Carla Jones-Charles	20	• Policy • Escalation policy	• Daily Staffing huddles Monitoring of acuity Report into staffing hub - virtual meeting • N/A	
					• Process • Morning staffing review huddle where staff are reallocated to areas of need.	• Morning staffing huddles, 3pm huddle and 10pm huddle with manager on call • N/A	
					• Process • Training requirements and delivery reviewed and streamlined where possible to reduce the amount of time required to complete mandatory training requirements.	• Matrons and Ward Manager update Weekly performance meetings Any changes to training is risk assessed based on training needs for individuals. • N/A	
					• Process • Use of bank and agency staff to improve staffing levels	• Morning staffing huddles 3pm and 10pm huddle • N/A.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		in birth numbers; this however does not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. This is not a new issue as historically over the last 5 years the team has lost at least 10wte per year due to mat leave.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/04/2022	On-going recrutiment of midwifes, including international recruitment programme and offer of fellowship programme.	Carla Jones-Charles		25/09/2022	30/09/2022
06/10/2020	Complete a review of none urgent activity and identify opportunities to undertake new ways of working to support care delivery.	Carla Jones-Charles		25/09/2022	30/09/2022
06/10/2020	Escalate to Executive via TMB and Monthly performance review to seek support to over recruit to manage staffing shortages in respoect of 5 year trajectory of significant numbers of maternity leave.	Carla Jones-Charles	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

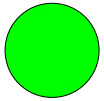
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2325	Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes.	Potential for patient safety to be compromised as a result of delayed or inaccurate decision making from the inability to access all records. Potential risk to patient safety investigations i.e. Root Cause Analysis and delayed timeframes impacting the Division and organisation. Potential negative impact on patient/ service users in regards to the timely and effective investigation processes	Elizabeth Miller	16	• Process • Access Fusion for diagnostic/ clinical overiew	•TBC •TBC	
					• Process • Incident reporting notes if unable to be located within a timely manner	•TBC •TBC	
					• Process • DoC Final Letters to be amended to acknowledge lack of access to patient notes or missing notes	•TBC •TBC	
					• Process • All investigations; TTR, Concise, RCA and complaints to be transparent in acknowledging missing notes or incomplete documentation with direct link with incident number	•TBC •TBC	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
27/03/2022	Review demand and capacity for HRL tasks.	Mark Harrison	26/07/2022	31/07/2022
10/09/2021	Review of Divisional responsibility and resource required for management and re-filing of loose filing. Established process in place for divisional staff to return loose filing into files held in health records does not always occur and then backlogs of loose filing build up.	Mark Harrison	25/05/2022	30/05/2022
10/09/2021	Implementation of EDM (Electronic Document Management system) to digitise current paper records. This will remove the need for paper health records to be utilised.	Mark Harrison	26/08/2022	31/08/2022
10/09/2021	Implementation of onsite scanning bureau to enable day forward scanning to digitise newly created paper content directly into the EDM. This will remove the need for paper to be retained.	Mark Harrison	25/06/2022	30/06/2022
10/09/2021	Investigate resource required to review and scan remaining loose filing into EDM. Whilst scanning Bureau function is being setup it is not resourced to manage and review a large quantity of loose filling. Options to be considered following EDM	Mark Harrison	25/05/2022	30/05/2022

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2370	Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality.	The size and complexity of the population health challenges and health inequalities in Walsall present multiple 'priorities' that cannot all be addressed simultaneously and may result in an inability to make progress in the most efficient and effective way. The inequalities experienced by our population has been further compounded by the COVID pandemic and presents a risk of premature mortality if significant recovery efforts for patients with long term conditions are not undertaken in a timely manner. The national booster vaccination programme has now been prioritised for Primary Care; non-urgent and routine services have been stood down in order to release staff to support the vaccination programme. This may lead to delays in presentations for	Michelle Mcmanus	20	• Process • Development of a Population Health & Inequalities Plan, aligned to the Health & Wellbeing Board JSNA. Alignment of transformation programme and resource to deliver. Key priority for year 1 is to ensure elective recovery does not exacerbate inequalities.	• Oversight of development and implementation of the plan via CPLG with leadership from Public Health • Health & Wellbeing Board System Health Inequalities & Prevention Board	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		other conditions and further exacerbate health inequalities and the risk of premature mortality.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
10/07/2020	"Further development of robust and comprehensive population health data and tools Maturity of Board/Leadership and ability to develop a clear strategy for prioritisation that balances funding, need and stakeholder expectations (including the public)"	Matthew Dodd		26/05/2022	31/05/2022
15/12/2021	Discuss with system health inequalities leads to understand if any modelling and/or actions have been undertaken at Black Country level, and ensure Walsall plans are a) aligned and b) making best use of available resources	Matthew Dodd	**Closed**	11/02/2022	16/02/2022
15/12/2021	Review available data from public health, using knowledge from the pandemic to date, on the potential consequences of delays in presentation of other conditions. PMC to identify high risk areas and options to triage those most in need.	Matthew Dodd	**Closed**	15/04/2022	20/04/2022

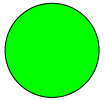
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2372	Workforce capacity and skill mix does not meet the demand within the services in scope.	The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.	Michelle Mcmanus	16	• Process • Consideration of multiple or alternative skill-mix options, recruitment, training and development programme to attract new workforce and upskill existing workforce. Resource to define and deliver the workforce planning, recruitment, training and development is now identified.	• Workforce & OD Steering Group monthly meetings, agreed Terms of Reference and work specifications, established as a formal sub-group of the WTPB. Monthly assurance reporting in place. • ICS Workforce Group	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
03/02/2021	Project initiation documentation for all workforce and OD projects to be approved by WTPB	Michelle Mcmanus		13/05/2022	18/05/2022
05/04/2022	Creation of an anchor employment network for Walsall	Matthew Dodd		26/03/2023	31/03/2023
07/03/2022	Submission of a business case for a pilot to support care providers with a targeted recruitment and retention scheme.	Michelle Mcmanus	**Closed**	15/04/2022	20/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2430	Phase 1: Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record.	Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC, HCPC. These multiple systems are taking time away from seeing and supporting vulnerable children and young people. Project commenced with Phase 1 with agreed objectives as below: * Address child health record issues within School Nursing (SN) and Health Visiting (HV)teams * To provide visibility of SN & HV child records to all children's services within the Trust (Community Paediatric Consultants, Children's Safeguarding,Teenage Pregnancy Team,	Lynn Corbett	20	• Process • Mark Hulston submitted an escalation paper to Digital Programme board on 1st March 2021 regarding the future state and the Feb 2021 plan to drop Folding Space solution and transfer to FUSION via EPDR project. This project is ongoing. See actions below to complete the above. • • Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. See actions listed below.	• Risk discussed and reviewed at monthly Digital Transformation Board, Divisional Quality Board and Divisional Risk meetings with Divisional Governance Advisor. • N/A • Risk reviewed at monthly Digital Transformation Board, Divisional Quality Board and Governance meetings with Divisional Governance Advisor. • N/A	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		HIPS, Paediatric SALT, Paediatric Occupational Therapy, Child Development Centre, Team Around The Child) Phase 2 of the project to be determined on completion of Phase 1.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/12/2021	Ingestion of legacy records into MediViewer; * Child Health Legacy Records (held currently in Folding Space) * School Nursing & Health Visiting Locally Held Electronic Records * Loose Scanning	Mark Harrison		26/05/2022	31/05/2022
02/08/2021	The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people. Over the last 2 years there have been a number of solutions proposed, however these have failed to gain momentum. This has left the service with a number risks which could result in a CQC inspection notice, as neither the current proposed solution for the legacy archive and the active Child Health Records (CHR) via the pre-existing CHR Project scope (2018 to date), nor the Feb 2021 proposed EDMS project additional scope will mitigate the CHR risk without a full consolidation of all records into a single solution. The Project has been given until October 2021 to consolidate all the children's records into one single solution; this covers the current paper records and all the records currently sitting on the shared drives within children's services.	Kelly Geffen	**Closed**	27/02/2022	04/03/2022
02/08/2021	Ensure that while the 12 week plan is in progress, all current and new digital records are ingested directly on to Fusion. All extraneous hard copy records within School Nursing and Health Visiting bases have been boxed and taken off site by supplier on 16th July 21.	Kelly Geffen	**Closed**	27/02/2022	04/03/2022
02/08/2021	To ensure Mediviewer is live for School Nursing to be able to undertake User Acceptance testing. Business change commenced Workshops with School Nursing and Health Visiting teams w/c 26th July 21 for potential migration to Total Mobile.	Kelly Geffen	**Closed**	27/02/2022	04/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
26/11/2021		A 3 month training programme is to be implemented and delivered - staff who require training to be identified.	Stephen Jackson			**Closed**	11/03/2022	16/03/2022
01/07/2021		Deployment, configuration, testing and Trust acceptance of MediViewer product as the strategic solution for Child Health Records.	Mark Harrison			**Closed**	20/03/2022	25/03/2022
20/02/2022		Develop and deploy Careflow PAS clinical noting to School Nursing and Health Visiting for the following forms; Continuation Sheet Chronology Form Care Form	Mark Harrison			**Closed**	23/03/2022	28/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2439	External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.	There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains to the Paediatric unit; the lack of adequate service provision externally means we carry a high level risk internally as a result of holding CYP who are in crisis. Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 8am-6pm. Overall the risks are external to our service.	Jodie Kirby	20	• Training • The RN workforce were trained to sue Storm in previous years and this tool is used almost daily. A full Training review is required and a forward training plan to be developed and incorporated into the annual training programme. Update: March 2022 - Newly appointed Band 7 Paeds Mental Health Lead due to start in post in March 2022; this person will lead on the training of PED, PAU and Ward staff. This training schedule will include in the use of the RCEM risk assessment documentation - moving us away from the current Storm risk assessment.	• The RN workforce were trained in the use of STORM risk assessment as a tool to assess immediate risk. Although this training has not been refreshed, the tool is used on a daily basis and staff are confident in its use. • Work has started at Care Group level with the iCAMHS service to address local training needs for both registered and un-reg staff. We are also receiving e-learning training packages via the CCG in response to our escalation of concern.	
					• Process • Access to iCAMHS is available but restricted.	• No adequate control in place; staff often contact the (adult) crisis team who will offer help as much as they can out of hours. This is inconsistent though. • Awaiting CCG clarification on the commissioning of an accessible out of hours CAMHS/iCAMHS service.	
					• Process • Access to paediatric psychiatry is available but limited.	• No adequate control in place; staff often contact the (adult) crisis team who help as much as they can out of hours. • Awaiting CCG movement in the commissioning of out of hours psychiatry help for CYP at Walsall Healthcare NHS Trust.	
					• Process • There is restricted access to iCAMHS services with referrals being accepted 8am-5pm Mon-Fri and 8am-4am weekends/bank holidays - this therefore can lead to delays in patients being seen on the ward	• No adequate control in place four out of hours referrals; acute staff will sometimes contact the (adult) crisis team who help as much as they can out of hours whilst we await the opening of the iCAMHS service. In hours - iCAMHS and the paeds unit have worked closely to ensure extended weekday and weekend referral hours. • TBC	
					• Process • The service received in Walsall Healthcare NHST from our mental health provider is often not appropriate	• Staff can challenge iCAMHS to provide further information in patient notes however, this will be dependent on their knowledge of gaps in care	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					to meet the complex needs of the CYP in crisis we see on the paediatric ward to assist us in maintaining patients safety.	planning for mental health patients • N/A	
					• Process • Not assured: Services are not commissioned to deliver therapy on the acute ward	• Senior nurses escalate throughout the organisation to highlight CYP experiencing long stays. Weekly multi agency meetings have been set up to allow ward staff, senior nursing staff, CAMHS, Local Authority and the CCG to identify issues and obstacles. • TBC	
					• Process • Escalation: The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads.	• The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads. • TBC	
					• Process • Not assured: Access to places other than a hospital bed.	• TBC • Meeting with the CCG Commissioner and key services on 16 March 2021 to start work on 'alternatives to hospital'.	

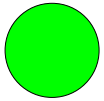
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
04/10/2021	Lead nurse for MH, DON and Medical Director will be involved in the NHSE CAMHS improvement project. Moving forward we will update risk number 2437 following any of the project group meetings/actions/progress.	Jodie Kirby		26/03/2023	31/03/2023
15/11/2021	For the Paediatric division to start a task and finish group to agree and work through an action plan to improve MH tier 4 access and escalation process. To improve patient care and transfer .	Charlotte Yale		26/07/2022	31/07/2022
17/05/2021	Meeting held with NHSEI Quality Team on 17/5/21 to discuss (a) sharing best practice, (b) system escalation process. Further meetings to include lead CYP commissioner (Mags Courts) and BCH reps (e.g. Mark Weaver).	Matthew Lewis	**Closed**	12/05/2021	17/05/2021
28/04/2021	Divisional team to escalate to the corporate team as discussed in RME.	Louise Holland	**Closed**	23/05/2021	28/05/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
12/07/2021	Clarification around expectations for transferring patients with previous clinical information from MH to ED.		Matthew Lewis			**Closed**	/ /	12/07/2021
16/07/2021	Medical Director - executive lead for mental health to escalate to NHSE and head of CCG regarding the impact and risk associated to WHT.		Matthew Lewis			**Closed**	/ /	16/07/2021
03/08/2021	Lead for Mental Health JK to devise an action plan and GAP analysis for the Executive lead for mental health to support an action plan for safe practice		Jodie Kirby			**Closed**	25/11/2021	30/11/2021
09/01/2022	To escalate suboptimal service delivery and engagement with external agencies providing support and care for children in crisis - this is inclusive of social care and mental health services.		Charlotte Yale			**Closed**	02/02/2022	07/02/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2464	Failure to comply with Trust Policy & breaching regulation due to individuals smoking in no smoking zones.	There is an increase fire hazard risk due to individuals smoking next to storage areas around the Trust that contain flammable liquids.	Jane Longden	10	• Policy • No Smoking Policy in place to cover the national update that advised all healthcare settings should be smoke free environments for staff and patient, for public health and wellbeing purposes.	• TBC • N/A	
					• • Communication via; Daily Dose, Snap Comms App, etc. to explaining the risks of smoking outside flammable cupboard and support available to patients and staff to stop smoking.	• TBC • N/A	
					• • No smoking signage present within the vicinity of flammable cupboards.	• TBC • TBC	
					• Process • Staff from external security contractor have been formally written to by their employers to avoid any breaches regarding this processs. Skanska are compliant at present in regard to this issue.	• Feedback on site about regular offenders is pursued by E&F department. • External Contractors are supporting staff by smoking off si	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
04/01/2022	CCTV installation upgrade, to cover prime smoking spots	Jane Longden	26/05/2022	31/05/2022
31/01/2022	Confirmation required from People and Culture to confirm where they are at with the design of the new improved Trust no smoking signage.	Michala Dytor	26/05/2022	31/05/2022
01/01/2020	No Smoking Policy to be ratified and rolled out, to clarifies the support offered to patients and staff, to enable a smoke free environment. As well as holding staff to account of breaching the No Smoking Policy.	Michala Dytor	25/06/2022	30/06/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2475	The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.	The Trusts inability as a Mental Health (MH) provider to comply with its legal & moral responsibilities of the MH provider status, as well upholding the MHA Code of Practice, has the potential for: > Individuals who require mental health services to; o Not be effectively or safely treated which could ultimately lead to a lack of appropriate admission for individuals in need of urgent care/an increase in avoidable harm, o Not have their civil rights upheld as patients may be detained illegally (due to no section/appropriate beds), > Staff; o To face verbal abusive, physical violence, & aggression, resulting in emotional destress &/or physical injuries, o To treat individuals unlawfully without such knowledge, due to	Jodie Kirby	15	• Process • Staffing Resource - To ensure that MH services within the Trust meet our strategic objectives. 3 year MH Strategy underdevelopment to include longer term strategic objectives. This includes the identification of additional MH trained resource required.	• Escalated to DON who will pick up with the exec team to see where it sits within the trust strategy. • SLA in place temporarily until we recruit staff into post	
					• Training • Standard MH Training - To ensure that all policy & process changes have been captured, so that training material is up to date & reflects the current processes. A review of the Standard MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or more frequently when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover chances made. Evidence of this is stored [location] of the actions taken.	• training is being developed in line with best practice and up to date evidence base. • The MH project group has this on the agenda. Level 1 training has been agreed and in place. IKON training now being rolled out across the trust	
					• Training • Standard MH Training Reporting - To ensure all staff have accessed the Standard MH Training & that they go through refresher training schedules at least yearly. On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all staff required to complete the Standard MH Training within each relevant ward, against the	• Once all training has been agreed for MH training, this will then be automatically be available on ESR annually. • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		lack of awareness & understanding of the statutory guidance, o To undergo unnecessary risk if they haven't had the relevant MH training, o To experience psychological side effects following traumatic events, o To impact on recruitment, retention & safe staffing numbers, o To experience poor morale levels, > Wider patients/visitors; o To raise complaints due to not receiving the relevant service they need & within an acceptable timeframe, o To be inappropriately detained for their safety, o To experience psychological destress &/or physical injuries, o To experience reduced flow & capacity due to rooms/equipment being damaged & awaiting repair, > The Trust;			record of staff held in Electronic Staff Record (ESR) who have completed the Standard MH Training & are still within their 12 month timeframe. Thus ensuring there are no overdue Standard MH Training requirements. Where the reconciliation of staff names held in ESR does not mirror staff active in each of the relevant wards, an investigation is conducted to highlight staff who have breached the 12 month timeframe as well as those due to breach the 12 month timeframe within the next 2 months (including all new employees). This is highlighted to staff & evidence of this is stored [location] of the actions taken.		
					• Training • Specialist MH Training Passports - To ensure that all policy & process changes have been captured, so that training material is up to date & reflects the current processes. A review of all the Specialist Unit Specific MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover chances made. Evidence of this is stored [location] of the actions taken.	• Security team have now undertaken IKON training • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	
					• Training • Specialist MH Training Passports Reporting - To ensure all specialist unit staff have accessed the additional	• ED have completed the design of their training passports. Next is for staff to be engaged in the training. Awaiting paediatrics team to design	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		o To have low recruitment & retention rates, o To undergo reputational damage, o To experience financial implications (complaints, litigation claims, compensation, damage to physical estate, cost of bank/agency staff), o To be without rooms/equipment whilst repairs are carried out, o To failure patient wait time targets, o To breach legislation & be non-compliant with the MHA, o To have our CQC service rating reduced to inadequate where special measures may need to be introduced.			Specialist Unit Specific MH Training & that they go through refresher training schedules at least yearly. On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all special unit staff (ED, Ward 21, Ward 29, AMU) required to complete the Specialist Unit Specific MH Training (Patient Restraint Training, Management of Actual or Potential Aggression Training) within each relevant special unit ward, against the record of staff held in ESR who have completed the Specialist Unit Specific MH Training & are still within their 12 month timeframe. Thus ensuring there are no overdue Specialist Unit Specific MH Training requirements. Where the reconciliation of staff names held in ESR does not mirror staff active in each of the relevant special unit ward, an investigation is conducted to highlight staff who have breached the 12 month timeframe as well as those due to breach the 12 month timeframe within the next 2 months (including all new employees). This is highlighted to staff & evidence of this is stored [location] of the actions taken.	their training passport. • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	
					• Policy • MH Policy - To ensure the MH Policy accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH Policy is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model	• Draft policy is under review to have the updates of the Mental Health ACT embedded • Draft policy is under review to have the updates of the Mental Health ACT embedded	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					(Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.		
					• Process • MH SOP - To ensure the MH SOP accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH SOP is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.	• SOP has been signed off by executive lead for mental health • SOP is readily available to staff	
					• Policy • MH LWP - To ensure the MH SOP accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH LWP is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable,	• SOP was completed and is out in practice whilst we await the MHA policy • SOP was completed and is out in practice whilst we await the MHA policy	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.		
					• Process • Local Reporting - To ensure daily MH admissions are recorded & reported accurately. On a daily basis when the Matrons conduct their ward visits, they record if anybody have been detained or admitted under the MHA. Where records identify this finding, this data is passed to MH Reporting Administrator/Manager [job title TBC] [Further detail required - To understand where we have patients on a 5-2 or a 17 leave. Who, what, when, how, why, exceptions, evidence].	• The evidence of the audit is stored and staffing allowing , daily audits are completed. • Audit of all MH activity that is monitored can be compared with SLA activity to ensure activity is correct.	
					• Process • External Reporting - To ensure quarterly MH admissions are recorded & reported accurately. On a quarterly basis the MH Reporting Administrator/Manager [job title TBC] will conduct validation checks to ensure that the MH admissions recorded across the Trust mirrors up with [further detail required - To manage & monitoring the MH data for audit purposes to be sent to CQC quarterly. Who, what, when, how, why, exceptions, evidence].	• Daily walk conducted by admin or OPMHLT staffing - staffing available . This is will assured once MHA administrators are in post. • Specialist team within WHT are completing daily audit in the absence of a MHA administrator team.	

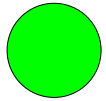
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
31/05/2021	Lead Nurse for Mental Health and the OPMHLT are planning to develop and deliver training on :- MHA awareness , IKON, Mental Health Level 1,2 and 3.	Jodie Kirby	25/06/2022	30/06/2022
12/05/2021	Lead Nurse for Mental Health will review the policy and escalate to exec level the difficulties in access to the MHA administrator - for joint update of the policy. Plan to work with RWT to review MHA policy.	Jodie Kirby	26/05/2022	31/05/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
08/06/2021	To complete a review of the MHA SLA and governance process that WHT are responsible for . To feedback to the Executive lead for mental health the suggested staffing / resource required to ensure the MHA code of practice is adhered to and the MHA law is upheld. Escalated to Steering group to resolve and progress on 26/7/21		Jodie Kirby			26/05/2022	31/05/2022
15/11/2021	Mental Health training is available across the organisation for MHA awareness, ligature Cutters, IKON, Mental Health Level 1,2 and 3.		Jodie Kirby			25/06/2022	30/06/2022
15/11/2021	For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for Surgery) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.		Salman Mirza			26/05/2022	31/05/2022
15/11/2021	For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for MLTC) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.		Nuhu Usman			26/05/2022	31/05/2022
15/02/2022	For the lead nurse for mental health , matron for mental health and mental health act administrators to review the current arrangement for mental health act tribunals , then to develop an SLA to bridge any GAP in services.		Jodie Kirby			25/06/2022	30/06/2022
03/01/2022	Undertake analysis to identify where our staffing resource gaps are.		Jodie Kirby			25/06/2022	30/06/2022
01/03/2022	AN audit is to be completed for the use of mental health act and mental health patient support.		Jodie Kirby			26/05/2022	31/05/2022
15/11/2021	For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for Community) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.		Kelly Geffen	**Closed**		06/02/2022	11/02/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2489	Staff or patients/carers could experience discrimination by the Trust or those employed by it.	A significant loss of workforce diversity, talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work (reduction in effort above and beyond contractual requirements), lack of opportunity to develop and progress, not feeling safe due to unacceptable behaviours such as racism, bullying and harassment, workforce fatigue and not valued for the incredible job that they do and therefore not recommending the trust as a place to work or a place to be treated.	Clair Bond	12	• BAF Control 04 • Value Our Colleagues Improvement Programme in place - workstreams based around three core domains; (i) leadership, culture and organisational development, (ii) organisational effectiveness and (iii) making Walsall and the Black Country the best place to work.	• monitored via PODC, Improvement Board and VOC Core Team. Core set of measures from base line year 2019, foundation year 2020 through to 2022/23. Accountability Framework and Divisional Performance reviews • National Staff Survey WRES, WDES indicators CQC assessment / rating	
					• BAF Control 04 • A Staff Experience and Engagement Oversight Group has been established to provide assurance to PODC on behalf of the board re; staff engagement processes/systems, shared decision making councils, involvement of diversity in decision making, increasing staff survey participation levels. Action 8620 details mitigating action.	• Terms of Reference agreed. Outputs monitored via PODC on a monthly basis - divisional leaders present NSS action plans. Action Plan in place 2021 Pulse Survey completed. Internal Audit review of NSS Process completed. • National Staff Survey (2021) National Quarterly Pulse Survey 21/22 Q4. WRES, WDES, Gender Pay Gap report	
					• Policy • Equality, Diversity and Inclusion Strategy in place supported by detailed 9 point delivery plan.	• Equality, Diversity and Inclusion Group to monitor progress against delivery plan on a monthly basis and report to PODC on a quarterly basis. • Legal duties in line with Public Sector Equality Duty 2011 and Equality Act 2010. WRES, WDES and Gender Pay Gap reports Race Code Assessment complete and reported to PODC in September 2021.	
					• BAF Control 04 • Freedom to Speak Up service in place - improvement programme agreed to develop and embed the service.	• Lead Non-executive director. Regular access to Exec Team and Board 1/4ly reports to PODC and Board re F2SU activity Operational support in place Confidential Contact Link network stablished across the Trust Speak Up training available for all staff to access. Improvement plan monitored via PODC and Improvement Board. • Development of service supported by NHSIE and NGO F2SU index available from NSS	

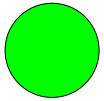
Walsall Healthcare Risk Register

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
20/12/2021	Expand the RCN Cultural Ambassador programme to support colleagues involved in formal employment relations processes.	Michala Dytor		25/06/2022	30/06/2022
01/12/2021	To develop a strategic approach to dispute resolution.	Clair Bond		26/07/2022	31/07/2022
01/11/2021	Business case to outline funding requirements to complement HWB strategy to support ambitious and innovative to be completed. - ongoing as a cost pressure request	Tamsin Radford		14/06/2022	19/06/2022
01/04/2022	Cultural Competency Awareness Programme commissioned and due to be initiated in Q3 22/23. Q1 Planning and Q2 Pilot / train the trainer.	Marsha Belle		26/10/2022	31/10/2022
27/01/2022	The Exit interview process is being updated and embedded within the retention framework - focusing on stay conversations.	Marsha Belle		26/05/2022	31/05/2022
27/01/2022	Ensure the Staff Experience & Engagement Oversight Group is reactivated from March 2022 onwards to inform action plan for PODC, TMC and Board discussions over March and April 2022.	Catherine Griffiths	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

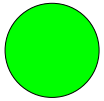
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2512	Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes Best Practice Tariff Standards.	Paediatric Diabetes Best Practice Tariff is based on meeting 14 specific quality standards ensuring children and young adults with diabetes are receiving effective and responsive care. There are 10 standards WHT are not meeting which pose significant patient safety risks to this vulnerable population. - Impact of risk includes: - Lack of psychology for children who are struggling to come to terms with their LTC - Lack of dietetic capacity - Lack of consultant capacity to cover MDT and on call out of hours - A general gap in out of hours on call cover - Very limited capacity in transitional management of patients from age of 16 - 19 years - This being a particularly vulnerable stage in their lives where young adults often do not cope with	Stephen Jackson	12	• Process • Annual PIED assessment completed for each patient over 8 years of age.	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register. Risk has been agreed and escalated to the Corporate Register. • N/A	
					• Process • Monthly meetings with CAMHS psychiatrist consultant for supervision	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register. • N/A	
					• Process • CAMHS referral for patients is possible.	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register. • N/A	
					• Process • September 2020 Benchmarking exercise completed against the 14 Paediatric best practice standards	• Escalated to senior management teams and identified requirement to update current business case and resubmit to TMB • WHT has funded membership through Community Division to Regional Children's and Young Peoples network to help support Trust to meet standards	
					• Process • Discussed at Risk Management Executive for consideration of risk to be escalated to Corporate and has been agreed.	• Agreed at Risk Management Executive on 15 February 2021 for risk to be escalated to the Corporate Risk Register. • N/A	
					• Process • Paediatric National Peer Review completed in Walsall resulting in a serious concerns letter being presented to the Executive Team. This letter highlights gaps within the Trust which the business case aims to resolve.	• Action Plan has been completed, rag rating all gaps highlighted within the Peer Review and plans in place to improve with current resources available, however approval of the business case is required to meet all of the BPT Standards and Quality Peer Review Metrics. • The Royal College of Paediatrics and Child Health issued their serious concerns communication on the 4 Jan 2021 and will be requesting an up date of progress imminently.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		their diabetic control increasing their risk of serious short and long term complications which can have life limiting outcomes Benchmarking against the standards has been completed and is attached to this risk. Best practice tariff funding has been received during 2021 and a recruitment plan is currently being progressed. See action for details.					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/09/2021	Recruiting to newly established funded posts 1. Transition nurse 1wte Band 6 , aim to be in post January 22, - will mitigate a further 1 non achieving standard by Q4 2021/22 (Standard 1) and a further 5 standards by end of Q1 2022 (Standards 3/4/5/7/and 12) and standard 13 by end of Q2 2022 2. Recruitment of 0.5wte Dietician by end of Q4 21/22 which will mitigate non achievement of Standard 3 and 6 by end of Q1 2022 3. Administrative support recruitment will be recruited by end of Q3 2021 which will support overall standards 4. Recruitment of psychologist - currently having problems with recruitment - actions in place to resolve but may not be in post until 2022/23 which will support Standard 9	Stephen Jackson	25/06/2022	30/06/2022
11/01/2021	1, There must be a clear transition policy (Policy currently being reviewed by lead PDSN , compliance with recommendations will be included in transition nurse objectives with aim to meet by Q2 22) 2. Transition operational policy required , which must include a structured 'high HbA1C' policy, a clearly defined 'did not attend/was not brought' policy, taking into account local safeguarding children board policies, and evidence of patient feedback on the service (Trust has Safeguarding policy, needs review of certain elements , high HBAIC policy requires attention which is part of lead PDSN objectives) plan to mitigate by Q1 2022	Stephen Jackson	25/06/2022	30/06/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2540	Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems	There is a risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems. Ineffective safeguarding systems include: - Safeguarding identified as a theme of concern in CQC reports with Section 29a notice and must do actions. - Staff ability to recognise, report, and escalate actual or potential safeguarding concerns. - Low levels of Level 3 safeguarding training. - Low levels of adult safeguarding referrals from Trust in Local Authority. - CCG and CQC report no assurance of learning from safeguarding incidents due to repeated themes in incidents requiring independent investigation.	Jennifer Robinson	12	• Process • The safeguarding adults policy supports staff in safeguarding practice by the recognition and referral of any safeguard concerns that staff encounter in the practice.	• Safeguard system used to record safeguarding related incidences monthly reporting commenced to the Divisions Reporting through safeguarding committee weekly training compliance reports received escalation reports to safeguarding committee safeguarding bespoke training as required 07/03/2022 - progress against safeguarding development plan reviewed at monthly safeguarding committee. Safeguarding dashboard in place with evidence of compliance and where not compliant plan to achieve • Monthly CQR provides an element of scrutiny safeguarding performance framework development and reporting quarterly to the CCG CCG assurance of quality of L3 training 07/03/2022 - progress against safeguarding development plan reviewed at monthly safeguarding committee. CCG and LA are members of committee. Safeguarding dashboard in place with evidence of compliance and where not compliant plan to achieve. Shared with CCG and LA at CQR Meeting	
					• Training • Training compliance for level 3 safeguarding adults is below the expected performance compliance. Training is delivered monthly- (2or 3 sessions) delivered via teams. These are reviewed by the Divisions	• Weekly training compliance reports are received from workforce intelligence The Divisional leads are required to report monthly through safeguarding committee regarding training compliance and actions taken to improve compliance • Reporting through CQR	
					• Process • The external concerns received have identified some emerging themes which cannot provide assurance that ward / departments have implemented actions agreed as part of their feedback reports	• Safety briefings completed and disseminated across the teams to reinforce emerging themes and compliance with policy 07/03/2022 - safeguarding development plan in place. Evidence of compliance with actions reviewed at monthly safeguarding committee. Actions in	

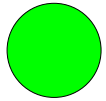
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						place to achieve where not yet compliant • LA monitoring number, appropriateness and quality of Safeguarding concerns received from WHT 07/03/2022 - safeguarding development plan in place. Evidence of compliance with actions reviewed at monthly safeguarding committee. Actions in place to achieve where not yet compliant. CCG and LA are members of Safeguarding committee. Safeguarding dashboard shared at CQR Meeting	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
12/07/2021	Schedule of be- spoke sessions to wards / department	Jennifer Robinson	25/06/2022	30/06/2022
12/07/2021	Delivery of Level 3 Safeguarding adults training	Jennifer Robinson	26/07/2022	31/07/2022
12/07/2021	revise training to reinforce emerging themes from concerns raised continue to develop safeguarding briefings as necessary	Jennifer Robinson	15/06/2022	20/06/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2581	Internal risk for patients awaiting Tier 4 hospital admission	WHT ability to support and manage any CYP awaiting a tier 4 admission. An increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey. 1)There is no provision of mental health training to ward staff but a misplaced conception that the staff at WHT are trained to meet the needs of CYP in crisis. 2)There is no access to mental health support or advice out of hours 3)There is no access to Paediatric psychiatry out of hours 4)There is restricted access to iCAMHS services with referrals being accepted 8am-4pm Mon-Fri and 8am-3pm weekends/bank holidays 5)The service received in WHT from our mental health	Jodie Kirby	20	• Training • Staff to have the required knowledge and skills to manage mental health patients who are awaiting tier 4 admission. Staff to have the knowledge to understand and utilise the mental health act appropriately.	• Mental health act awareness training is available for all staff to access via ESR • There is no external assurance due to gaps in provision	
					• Training • To abide by the mental health act and uphold patient section 132 rights . To be able to utilise section 5(2) appropriately and lawfully.	• Mental Health Act awareness training is accessible via ESR • No external assurance	
					• Process • For patients to have a mental health assessment within ED or PAU to avoid admission to the paediatric ward. This will enable an appropriate assessment and diversion from the acute hospitals to link in with CAMHS community.	• Recruitment processes are currently being undertaken to recruit a band 7 MH Nurse to work in ED to provide support to staff managing MH patients. This will contribute to the effectiveness of admission avoidance • No external Assurance, CAMHS do not currently support ED or admissions	
					• Process • For patients who are admitted to the ward to be supported by discharge planning at the point of admission. For patients to receive appropriate assessment, MDT working that is conducive for proactive discharge approaches.	• WHT are recruiting a mental health staff member to support and work with the paediatric division to develop clearer discharge planning process and MDT working. • none - continued challenges with the ICAMHS/CAMHS service delivery to WHT	
					• Process • To review and audit the current process for MH training within the Paediatric Division.	• Band 7 CNS appointed, awaiting start date. MHA and IKON training readily available for staff to attend. • CAMHS should be delivering in house training to paediatric staff. .	
					• Process • To have an escalation process where ward staff can escalate appropriately to CAMHS and/or Social Care when required.	• Lead Nurse for MH is working with Children's commissioner to agree and complete escalation process for CAMHS and Social Care. Currently in draft format. Paediatric team have support and access to escalate to lead nurse for MH for advice and guidance. • Children's commissioner is aware of the challenges and supportive of escalation.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		provider is not appropriate to meet the complex needs of the CYP in crisis we see on the paediatric ward. There is no detailed/shared risk assessments from iCAMHS and often no detailed plans of care to support non-mental health staff 6)There are often delays in discharge whilst discussions, assessments, reassessments and reviews (such as CTR's) are undertaken between social care and mental health. These delays often span into weeks and the CYP is kept on the ward with little engagement or therapeutic support from other agencies which contribute to deteriorations in behaviours. This is not in the CYP's best interest and is detrimental to their health and wellbeing. 7)There are often elongated periods of time between the decision to transfer the CYP into foster			• Policy • An established and embedded risk assessment tool for use within paediatric ED and paediatrics to enable WHCT to identify patient risks and put in place appropriate care planning to support patient needs. • Policy • To have a ratified rapid tranquilisation policy for children/young people.	• Staff access the MH team within the trust for support and guidance. • N/A • TBC • N/A	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		care (either a placement or high risk foster placement) and their actual movement out of the organisation. There seems to be no alternative to a hospital bed for CYP in crisis in Walsall. 8)There is no access to a 136 suite for CYP in Walsall. The local one is Wolverhampton, however this is a joint suit and is often in use for adults. These suites/locations are typically provided by the mental health trust and patients are taken to them by the by the police or other services for a full and proper assessment of their mental health needs. For example, The Redwoods Centre, Shrewsbury is able to meet the needs of both adults and children if required. The service is available 24 hours a day and 365 days a year and assessment can lead to a voluntary or compulsory hospital					

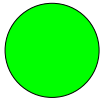
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		admission, or discharge to the community with appropriate sign posting and mental health service follow up in place.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
12/07/2021	staff to have a training plan for mental health awareness	Jodie Kirby		26/07/2022	31/07/2022
17/02/2022	For a rapid tranquilisation policy to be ratified and available for use within paediatrics.	Raghu Krishnamurthy		25/06/2022	30/06/2022
12/07/2021	For staff to have mental health act training and de-escalation training (IKON)	Charlotte Yale		25/06/2022	30/06/2022
12/07/2021	Staff required to facilitate admission avoidance and to complete mental health assessments within ED and PAU, to support patient discharge. To engage with the commissioners and the MH trust to have an improved CAMHS service.	Jodie Kirby		25/06/2022	30/06/2022
12/07/2021	Senior CAMHS staff member required to work with the paediatric department to focus on planning for discharge on arrival, care planning, risk management and wider patient discharge MDTs.	Jodie Kirby	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2587	Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks.	The Trust does not have sufficient numbers of staff fit mask tested on two different masks in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19), due to vacancies and on-going sickness and absence challenges. Staff are at risk of developing disease as a result of inhalation of harmful substances, disease spread, associated illness, skin damage &/or other conditions, mortality. Trust is at risk of liability claims & dissatisfaction as a result of failing to adequately protect staff health.	Caroline Whyte	9	• Process • High risk areas undertaking AGPs are priority areas for fit mask testing. • Training • Staff fit tested and passed on two masks. • Process • Fit mask testing complaicne is a standing agenda item and reviewed / discussed at trust wide PPE group.	• Fit mask figures avilable for high risk AGP areas • N/A • Figures dicussed at PPE group and circulated to the divisions. • N/A • Minutes and compliance records from meeting • N/A	

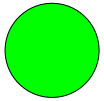
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
30/09/2021	Support a fit testing solution plan to enable all existing staff & new staff who will be users of FFP3s, to be released for fit testing.				Caroline Whyte	26/07/2022	31/07/2022
08/03/2022	Figures to be obtained and reported monthly: Staff fit tested in high risk areas as agreed by PPE group All clinical staff fit tested figures.				Lisa Carroll	25/09/2022	30/09/2022

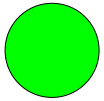
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2601	Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6.	Failure to report accurate Sepsis data nationally, resulting in non-compliance and increased risk of delivering suboptimal sepsis care/treatment.	Lorraine Moseley	20	• Policy • National Early Warning Score within the Management of the Deteriorating Patient Policy V1.000. • Training • Vital Pack Training, ALS, ILS, BLS, and E-sepsis Training. • Process • E-sepsis module EPR	• Vital Pack electronic patient system Management of the Deteriorating Patient Policy V1.000. • Management of the Deteriorating Patient Policy V1.000. • > ALS and BLS are mandatory via ESR reporting. > All above training modules have an element of sepsis training/education incorporated. • Mandatory compliance figure is reported via ESR as needed centrally. • > Interim paper version in ED as a work around for the time being, which is audited monthly. > The dashboard front page will highlight the 'Golden Hour' for antibiotics. • N/A.	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
23/07/2021	Full review of E-sepsis module, function and suitability. Consideration of reverting back to paper in the interim.	Lorraine Moseley		25/09/2022	30/09/2022
23/07/2021	Issue reviewed by working group -discussions around reporting suggests major changes to information collected for reporting purposes. To be following up at subsequent meetings. Completion date reviewed - update by System C not expected until September 2022	Lorraine Moseley		25/09/2022	30/09/2022
30/03/2022	The Vital Pack Training, to be discussed with the Trainer and the CD in ED to review Training Material.	Lorraine Moseley		25/06/2022	30/06/2022
01/03/2022	Redesigning the dashboard, so the front page is only concerned with the 'Golden Hour' for antibiotics.	Lorraine Moseley		27/05/2022	01/06/2022
23/07/2021	Current Trust deteriorating patient policy is out of date (as of July 2020), requires immediate update.	Manjeet Shehmar	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2664	Patient Safety and Training Issues in Medicine / ED	Reputational Impact on the trust regarding Doctors in Training placements. Withdrawal of Doctors in Training placements by Health Education England. Financial reduction of Health Education income.	Louise Nickell	20	• Process • MLTC attend AMU Assurance Board to monitor action plan	• AMU Assurance Board; minutes, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • Medical Education Group (MEG) - The Clinical tutor will provide a report around the summary position for the risk against HEE concerns. The meeting will be chaired by the Medical Director as an overview/scrutiny meeting and the occurrence will be monthly.	• Medical Education Group (MEG); minutes of Meeting, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • Postgraduate Medical Education Committee (PMEC) oversees plan and progress against plan, chaired by the clinical tutor. The college tutor will report on the progress of the HEE risk actions.	• Postgraduate Medical Education Committee (PMEC); minutes of meeting, action log and attendees notes. • Action log is maintained in line with HEE progress report.	
					• Process • Junior Doctors Forum is now aligned to the GOSW Forum, to listen to Junior Doctors concerns/feedback.	• Medicine JDF taking place at the required frequency in line with their training programme. • Medicine JDF taking place at the required frequency in line with their contractual and training programme requirements.	
					• Process • Education and Training Steering Group (E&TSG) meeting occurs quarterly and is chaired by the Director of Education and Training. The Clinical Tutor will present an updated report around the HEE risk.	• Education and Training Steering Group (E&TSG); minutes, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • WHT's submission of their (non patient safety issues) improvement plan to HEE.	• Documented improvement plan, with progress and action narrative against applicable items. • Action log is maintained in line with HEE progress report.	

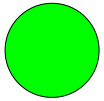
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/11/2021	Continued work of the improvement plan.	Louise Nickell		08/01/2023	13/01/2023
13/01/2022	PMEC meetings to include risk and updates against risk. discussion at PMEC to	Ravi Kainth	**Closed**	08/01/2023	13/01/2023

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
	include progress against improvement plan. First PMEC is 10.03.22							
17/02/2022	WHT to submit (non patient safety issues) improvement plan to HEE by 12th April 22.		Louise Nickell			**Closed**	14/04/2022	19/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2737	Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy	Currently there is a resistance / non-adherence with the Trust Medicines policy in several areas of the Trust with regard to (as evidence by pharmacy audits): 1. drug storage in clinical areas, specifically the requirement for medicines cupboards and fridges to be kept locked and tidy (to determine medication stored in areas) at all times, for drug storage rooms to be locked, for temperature of drug storage areas to be maintained below 25 degrees celsius. 2. CD audit with regard to: correct process for recording receipts and issues in the CD record book, signing for receipt of CDs in CD requisition book and recording of stock reconciliation checks. Implications to non-compliance include: - financial - stock leakage if cupboards	Gary Fletcher	16	• Policy • There is an up to date Trust Medicines Policy (Enduring) available on the trust intranet system.	• Monthly audits and monitoring by the pharmacy department to support and deliver a 'safer drugs' approach, which is fed back to each individual area on a regular basis and escalated via MMC to board level. Incident forms are completed following a medication error and acted upon and forms completed following a non-compliant audit • N/A	
					• Process • Monthly audits undertaken in all ward areas who have medicine supplied via pharmacy.	• Monthly audits completed by pharmacy team. Monitoring of non-compliance via incident forms and escalation through from dept to corporate level • N/A	
					• Training • 95% of nursing staff to receive refresher training with regards to safe storage of medication and are familiar with medicine policy and medicines management handbook to aid skills and competencies.	• Training video to be developed. • N/A	
					• Process • Safe and appropriate drug storage is required for wards areas to comply with safe storage and management of medicines management in line with Trust Medicines Policy.	• Pharmacy to be involved in further refurbishments and to advise on safe storage of medication. • Business case submitted for funding of pyxis machines within medicines division.	
					• Process • Pharmacy Management Team to meet with DGA's for WCCSS, MLTC, Surgery and Community to obtain assurance regarding care group actions pertaining to medicines management compliance.	• Bi - Monthly meetings to be held with DGA's for updates in relation to their divisions medicines management compliance. • N/A.	
					• Process • To replace paper based controlled drug registers and requisitions with electronic registers (eCDRx).	• Monthly CD audits are being completed by pharmacists and pharmacy technicians. • Cost implication, i.e. software purchase and technical support.	
					• Process • CDAO to meet with To3 to seek assurance regarding divisional compliance with medicines management for WCCSS, MLTC,	• Regular monthly meeting scheduled with divisional To3 to review controls and actions and update regarding division compliance. • N/A	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		unlocked, stock wastage if not stored at correct temperature, potential risk of access and administering incorrect drug/fluid (particularly in emergency situations) which may lead to clinical claims of negligence. - reputational - omissions/errors to drug administration, poor audit trail of compliance, incidents leading to serious investigations and involvement of commissioners, potential involvement of law enforcement agency, MHRA - patient safety - poor audit tail leads to omission/drug errors, incorrect doses being administered, potential risk of harm to patient or death, risk of incident leading to harm, may lead to lack of availability of drug to treat patients, potential risk of patient dissatisfaction with care provide by trust (also			Surgery and Community		

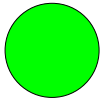
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		reputational) - Estates - poor state of repair (or response to repair in timely manner) of drug storage cupboard, door, locks, fridges					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
12/01/2022	Pharmacy Management Team to meet with To3 and DGA's for WCCSS, MLTC, Surgery and Community to obtain assurance regarding care group actions pertaining to medicines management compliance.	Gary Fletcher	24/07/2022	29/07/2022
01/11/2021	Funding for air conditioning unit across the trust where medication is stored to maintain temperature below 25 degrees.To approve funding and install air conditioning unit in all drug storage areas.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding for appropriate drug storage facilities, including locked drug rooms. To ensure all areas where medication is stored is locked as required in the medicines policy.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding approval for electronic controlled drug management system. Scope funding for new software.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding for pyxis machine across all sites where medication is stored.	Gary Fletcher	25/06/2022	30/06/2022
08/03/2022	MSO and Pharmacy Governance advisor to work in conjunction with FORCE team to develop medicines management fundamentals of care e-learning module and training video.	Gary Fletcher	09/11/2022	14/11/2022
05/04/2022	Quarterly CD audits to be completed by pharmacists and pharmacy technicians to evidence controlled drug compliance according to Trust policy.	Elizabeth Payne	25/11/2022	30/11/2022

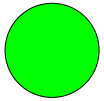
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2768	Crash Trolley Stock	Risk of harm to patients as well as the reputation of the trust as a result of out of date critical care equipment, inappropriately stocked/overstocked items in crash trolleys and lack of local audits/checks on crash trolleys evidenced by unsatisfactory crash trolley audit data (2019-2021)	Steven Cornforth	12	• Process • Resus team to conduct two checks a week to cover all trolleys across the Trust over a 12 month period.	• Adequate audit results. • None.	
					• Process • Areas to conduct daily and weekly checks of all trolleys across their area.	• Complete trolley check book daily and weekly following completion of trolley checks. • None.	
					• Process • Weekly checks to now be a 2 person process, one person required to be a registered member of staff. Coms to be sent out to reflect this.	• TBC • None	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
26/04/2022	Resus team to audit trolley check books during audit	Steven Cornforth	26/05/2022	31/05/2022
02/05/2022	Resus team to audit compliance with this and address issues where required	Steven Cornforth	26/05/2022	31/05/2022
30/11/2021	Work with Ravi Kainth on a business case- ravi has recently led the a project at RWT to introduce a 'sealed tray' system. ?if we can extend service across both sites	Ravi Kainth	27/03/2023	01/04/2023

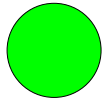
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2917	Inappropriate use of SCALE2 within NEWS2.	Patients are incorrectly assigned to SCALE2 within NEWS2 when their clinical condition does not indicate this. Risk of patients not being appropriately escalated if they deteriorate due to the parameters within SCALE2 due to staff have not received adequate training regarding the use of SCALE2.	Caroline Whyte	20	• Process • Quality team will review all patients on SCALE2 daily with the support of critical care outreach at the weekend.	• Daily audit of numbers of patients on SCALE2 and it's appropriateness. • None	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
23/03/2022	FORCE team have immediately commenced 1:1 training on ward areas.	Lorna Kelly	25/06/2022	30/06/2022
23/03/2022	Scope further training in the use of SCALE2 within NEWS2 for all clinical staff	Lorna Kelly	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
208	Failure to achieve 4-hour emergency access standard resulting in compromised patient safety and patient experience.	Patients are not assessed in the ED department in a timely manner leading to an increase in patient wait times. Although much improved, the risk still occurs when ED attendances are high or there is 'exit' block from the Department. This leads to a poor patient experience as well as adverse clinical outcomes including increased risk of mortality.	Rob Ankcorn	16	• Process • A governance process is in place to monitor performance throughout the organisation at Performance Finance & Investment Committee meeting on a monthly basis, that is a sub committee of the Trust Board.	• > Monthly reports provided to Performance Finance & Investment Committee (and Quality & Safety for Patient Care Improvement plan progress). > Escalation processes in place through Division to Executives where necessary. • Urgent and Emergency Care Board (UEC) ICS - delivery Board overseeing system response.	
					• Policy • Board approval of EAS improvement Trajectory to meet 95% agreed by Board	• Assured and overseen via divisional governance and performance reviews. • Monthly reporting to NHSi System review meeting oversight via regulator and CCG Newly introduced Flash report sub-60% performance. We are part of the regional UEC ops forum chaired by NHSE where all EAS standards are scrutinised and learning shared across the patch.	
					• Process • Operational demand management policies & procedures in place. Escalation policy in place to manage overcrowding in ED. IP&C policy on Covid Streaming. Covid swab policy.	• Trust's performance is on a continuing improvement trajectory despite high attendances. • NHSE/I & ECIST 'Critical Friend' visit to be arranged for 16th June 2021. Missed opportunities audit undertaken in April and report presented to ED team and at MAC. Further presentations to be made and action plan developed to implement the recommendations. Following perfect week we are invigorating our escalation policy which has worked well.	
					• Physical Barrier • Sufficient ED cubicle capacity to enable effective and timely assessment of patients in ED.	• Additional cubicles in place with the associated staffing. • N/A.	
					• Process • Substantive staff meets the Royal College guidance to provide safe and high quality care, and use our resources well.	• A rolling program of Nurse recruitment with interviews held on a monthly basis. Staffing vacancies reviewed regularly via governance structure. Nurse staffing reviewed daily. Safe staffing report presented to People	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						and OD Committee and Board. Nursing and quality paper to QPES. ED Medical workforce business case approved at Trust Board in June 2020 and will address the royal college guidance. New ED Matron appointed in October. Interviewed for RGN Posts in November and offered: 4 x Band 6, 1 x Band 5 and 8 CSW's. Nurse recruitment continues to improve and recently permission given to over recruit due to number of appointable applicants. Medical recruitment is also progressing well. ED nurse staffing numbers have been reviewed using BEST and Shelford tools. Approval to recruit to the staffing numbers required for Covid segregation from Director of Nursing and approved by Trust board (Oct 2021). • Safe staffing report published monthly on website. Staffing levels are overseen via system review meeting. Agency meeting review with NHSi.	
					• Process • Process agreed with WMAS to meet ambulance handover standards.	• Handover Policy with the Ambulance service in place. Ambulance handover key metrics is monitored at care group, Divisional, performance reviews, PFIC and Board. Additional 9-cubicles has mitigated the risk associated with capacity and social distancing to some extent. 4th consecutive month of being top in the West Midlands for ambulance handover within 30mins with 98% of our patients being transferred within this time. Direct referral and conveyancing from 999's to SACU, AEC and FES now in place, bypassing ED to help improve ambulance handover times and free up capacity in ED. • NHSE/I have introduced an escalation policy and COO must report any delays >60mins within 24 hours along with actions to address delays.	

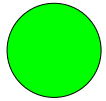
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						Recent performance on 15 mins time to triage has seen a 5% increase from 70 to 75% seen within 15 mins. Ambulance handover within 30 mins remains the best in the West Midlands. See ED activity analysis attached.	
					• Process • The Medically stable for Discharge patients are managed by the ICS team with the Community Division having responsibility for the overall performance. The team arranges placements in nursing and residential homes for patients requiring ongoing care, packages of care and discharge to assess beds in the community.	• The MSFD list is monitored daily by the ICS team and Community Division, 7 days per week. A twice weekly meeting has been taking place with Community Division and COO. • Weekly reporting of MSFD patients and against the 'Criteria to Reside'	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
06/06/2022	ED to send Senior Clinical Rep to Operational Meetings three times a day	Rob Ankcorn		03/07/2022	08/07/2022
11/04/2022	PDSA to trial separating the department and running two parallel teams which will enhance visible senior leadership in the department modelling the right culture of intolerance to delays. The department will be split into RATS, Merlin 1&2 (one team) and Majors & Resus (one team).	Rob Ankcorn		11/07/2022	16/07/2022
03/05/2022	Focus on the role of the Progress Chasers in the department and bring in an experienced Progress chaser to model the behaviours and what is required.	Katie Byrne		22/06/2022	27/06/2022
01/04/2022	To ensure the MSFD list is appropriately overseen and if routinely exceeds 50 patients on a daily basis (>55), to escalate to Community Division and M Dodd, Director. Updated action: review again in one month to ensure MSFD levels are maintained	Rob Ankcorn		25/06/2022	30/06/2022
01/02/2022	Team to visit Sherwood Forest NHS Trust who are exemplars at achieving the 4 hour EAS	Katie Byrne	**Closed**	16/03/2022	21/03/2022
06/08/2021	Re-submit ED medical workforce and ED nursing establishment review business cases to Investment Group	Ruchi Joshi	**Closed**	21/02/2022	26/02/2022
01/09/2021	Dr Jim Davidson, Regional NHSE/I lead for Emergency and SDEC services to observe our areas - arranged for 7th September 2021. To implement any recommendations following this visit.	Rob Ankcorn	**Closed**	20/02/2022	25/02/2022
11/04/2022	To run a PDSA with a senior decision maker working in Triage.	Rob Ankcorn	**Closed**	25/05/2022	30/05/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
665	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	Risk of a deliberate/intentional attack/hack on any part of the IT services and systems within the NHS or partner organisations from an external or internal source which could include infecting computers/networks/ systems with a lethal virus or malware resulting in disrupting to NHS services and NHS care provision.	Richard Pearson	15	• Training • Organisation IT related Disaster Recovery/BC plans. IG and Data protection compliance.	• New EPRR Manager now in post - targeted tabletop business continuity exercises carried out at least annually. • Data security Toolkit rating	
					• Process • Penetration testing undertaken annually through internal audit which identifies necessary digital safety actions required.	• Action plan developed following penetration testing and monitored via digital services governance meeting. • External partner Dionac has carried out an additional penetration test in July 2021. Report relieved late August action plan being created to address findings We are now working collaboratively with RWT to provide additional support and assurance on Cyber actions	
					• Physical Barrier • All vulnerable systems Sandboxed.	• Windows 7 term cut off from network to avoid prospect of viral attack. • Sandbox is a security mechanism for separating running programs, usually in an effort to mitigate system failures or software vulnerabilities from spreading.	
					• Physical Barrier • Windows OS upgrade programme	• All windows 7 devices now upgraded unless they host critical software that does not work on Windows 10. 37 devices remain In these instances the devices will be sandboxed to provide protection • The number of Windows 7 devices is monitored nationally using Microsoft Advanced Threat protection software that is installed on all devices	
					• Physical Barrier • Cyber Next generation measures put in place	• Cyber next generation firewall was put in place early in 2020. Trust physical and wireless network undergoing complete upgrade. Additional intrusion protection measures have been put in place for Log4J. Upgraded replacement firewalls purchased for deployment in 2022 • A next-generation firewall is a part of the third generation of firewall technology, combining a traditional firewall with other network device filtering functions, such as an application firewall using in-line deep packet inspection, an intrusion prevention system.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • NHS Cyber Alert. Membership of NHS Cyber Alert protocol.	• Notifications to key internal staff whenever a new cyber alert is published. This will include Day 0 and Day 0 + 1 threats. Guidance is provided on what action to take and updates on action are provided by the trust • Our responses to Cyber alerts are reviewed and monitored by NHS Digital.	
					• Process • Greater visibility of Cyber agenda and threats	• Dedicated communications plan for Cyber alerts / updates has been created with planned regular comms to be issued moving froward • N/A	
					• Physical Barrier • Installation of Immutable Backup solution Cloudian. This is an object storage solution which protects data from deletion or encryption with S3 Object Lock / WORM (write once, ready many) functionality. Once Object lock is enabled on the data written from the Veeam backup solution, the data is immutable and cannot be altered or deleted until the policy defined retention period is met. This means Ransomware is unable to encrypt or delete this data.	• Solution will be fully installed and configured by end of Sept 2021 • This type of system is required as part of the DSPT requirements	
					• Physical Barrier • Implementation of Multi Factor Authentication when remote access solutions are used to access the trusts network	• •	

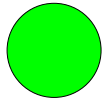
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/01/2021	Penetration test review and mitigations	Richard Pearson	25/09/2022	30/09/2022
01/01/2021	Upgrade works are in progress to replace entire LAN and Wifi infrastructure within the trust.	Richard Pearson	25/11/2022	30/11/2022
15/07/2020	OS upgrade programme to Windows to be undertaken.	Richard Pearson	25/09/2022	30/09/2022
01/11/2021	E-mail migration to be completed to Office 365 and upgrade of Office 2010 suite to O365 version	Richard Pearson	26/07/2022	31/07/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
01/05/2022	Identification and implementation of MFA solution for VPN and VDI connectivity		Richard Pearson			26/07/2022	31/07/2022
24/03/2022	OS build upgrade programme to build 21H2 to be undertaken		Richard Pearson			26/08/2022	31/08/2022
04/05/2022	Confirm Divisional Business continuity plans are in place, available and uptodate		Mark Hart			25/06/2022	30/06/2022
01/04/2022	Implementation of Vulnerability scanning solution		Richard Pearson			26/07/2022	31/07/2022
01/01/2021	0Patch has been installed to mitigate risk until all devices are upgraded to Windows 10		Andrew Griggs		**Closed**	25/11/2021	30/11/2021
01/01/2021	The security perimeter is verified to be at low risk of any suggested external attack gaining entry. Ongoing exercises will verify this security level		Richard Pearson		**Closed**	26/12/2021	31/12/2021
10/12/2021	Response and mitigation to Log4J critical cyber alert		Richard Pearson		**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1005	Insufficient capital funding for the estate contributing to lifecycle, critical infrastructure and mechanical/engineering risks.	Insufficient capital invested annually to reduce the backlog maintenance, critical infrastructure and mechanical/engineering risks within the West Wing & Maternity elements of the estate in respect of theatre upgrades, ward refurbishments, upgrading current facilities and ED schemes. This has resulted in a poor environment in respect of matters such as; ventilation, lifts, lighting, flooring, nurse call and bathroom areas as well as theatres approaching end of life condition where the experience of the patient and staff working within these areas has been significantly reduced.	Jane Longden	15	• Process • Trust Capital Control Group - Finance lead group with clinical divisional and IT representation responsible for collating and monitoring spend requests and allocating capital monies for divisional developments, infrastructure backlog maintained, capital projects and medical equipment. Understanding where the limited capital finance can be effectively prioritised (through ICS allocation and priorities to fulfil all competing bids).	• Regular reporting to PFIC. • Premises Assurance Model (PAM) produced on an annual basis for external publication.	
					• Process • Black Country ICS Capital Streams - review the allocation of money according to the Trusts bids and associated risk assessments. When the size of the ICS capital allocation is insufficient to address, priority is discussed via Trust Capital Control Group.	• System capital envelopes are confirmed in the first quarter of the new financial year, based on similar national quantum and distribution methodology to that used in previous capital planning. • ICS leads are reviewing submissions and contacting individual Trusts for summary of individual items and rationale for inclusion within the programme.	
					• Process • Lifecycle Plan - Prioritisation of high risk items through CIBSE verse failure testing with Project Co./Skanksa.	• > Estates meetings facilitated monthly (informal). > Hard FM monthly meetings to discuss all things relevant to the estate and captured via shared risk register. > Specific estates related groups now established. • Certification.	
					• Process • EPRR Steering Group - Resilience of business continuity programmes.	• TBC. • TBC.	

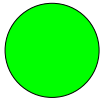
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
16/06/2021	Urgent and Emergency Care Centre works were planned and then commenced in October 2020 with the ground works completed and services connected. The project is on target to finish in Summer 22 within commissioning of services included within this timeframe.	Jane Longden	25/06/2022	30/06/2022
31/01/2022	Wards 16 & 17 and AMU (Ward 5 & 6) are due to be planned for 22/23 financial year.	Jane Longden	26/03/2023	31/03/2023

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
07/10/2021		Capital Programme of works continues. First theatre(6)handover 12th Oct theatre 5 due to start 18th October.	Jane Longden			**Closed**	25/06/2022	30/06/2022
04/03/2022		Further ward upgrades are being programmed in for 2022. W16 & 17 to commence May 22 W5 & W6 to commence around Oct 22 W14 & W15 to commence following this in early 2023 but programme and dates not yet finalised.	Jane Longden			**Closed**	26/03/2023	31/03/2023

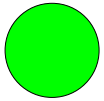
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1528	Potential delay in patient care and patient results	There is a lack of robust electronic alerts for when pathology histology, radiology, microbiology & endoscopy reports are available to view leading to delay in patient care & potentially unnecessary follow up appointments.	Richard Pearson	20	• • Some Gastro Consultants are keeping paper copies of correspondence to remind them to chase results. Other Consultants/Registrars/CNS's keep personal data bases and/or paper diaries.	• TBC - No internal assurance. • N/A	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
07/12/2021	Investigate options for Results acknowledgment / notifications within Careflow	Richard Pearson		26/07/2022	31/07/2022
15/11/2021	Pilot of Fusion splash screen by Nishant Gautam (Divisional CCIO) to confirm suitability as interim solution	Richard Pearson	**Closed**	26/01/2022	31/01/2022
14/07/2021	Investigate options for Results Acknowledgement / notifications within ICE	Richard Pearson	**Closed**	26/05/2022	31/05/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels	Substantive staffing levels are below the agreed safe staffing levels for wards and departments leading to the potential for avoidable harm 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	Caroline Whyte	15	• Process • Interim Process - Use of bank and agency staff to fill gaps in nursing and midwifery rotas.	• Reporting and review of fill rates that report into PODC. • N/A	
					• Process • Twice daily virtual staffing meeting with matron representatives from all divisions. All wards reviewed and rag rated, redeployments agreed from areas and escalations for bank and agency staff agreed. Forward view over weekends and holiday periods.	• Review of safecare red flags when patient care is affected by staffing levels. Robust review of staffing levels on a twice daily basis. Reporting of fill rates into PODC. • N/A	
					• Process • Increased use of Volunteers and Administration roles to complete tasks to free up Registered and unregistered Nurses to deliver direct patient care. EWE volunteers in ward areas to support patient care.	• TBC • N/A	
					• Process • Staff well being policy with additional support identified and put in place to support staff as part of the COVID-19 response. 07/03/2022 - Manor lounge open on ward 29. Staff health and well being support continues	• Monitoring of staff sickness levels and sickness reasons, divisions receiving monthly reports • N/A	

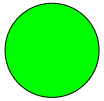
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		for full details**					

Action Plan

Start Date	Action Details / Description	Owner		Reminder Date	Target Date
26/03/2020	Continued proactive recruitment strategy 16/3/21 international recruitment process in progress with first recruits expected April 2021; corporate nursing working collaboratively with HR to ensure we are continually reviewing our retention plans with the aim that we achieve as close to zero vacancies for RNs and CSWs by Q4 4/08/2021 86 international nurses currently in the UK and undergoing induction, training and OSCE completion to gain entry to the NMC register. Aiming for a total of 205 by December 2021	Lisa Carroll		26/07/2022	31/07/2022
04/08/2021	Business case approved in principle at Trust Board September 2021. Finance fully costing and plan of phased implementation to be agreed	Lisa Carroll		26/07/2022	31/07/2022
21/02/2022	Virtual staffing hub to meet twice daily, escalation to temporary staffing as required. Sitrep produced and circulated to key staff.	Caroline Whyte		26/07/2022	31/07/2022
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly. 16/3/21 -The hub is well established and the staffing meetings will continue post COVID. The risk regarding temporary staffing usage is predicted to reduce as the international nurses join establishments. Additional capacity areas have closed reducing the staffing demand - areas closed are Wards 10 and 14 and additional beds on Ward 4 have also closed	Caroline Whyte	**Closed**	26/03/2022	31/03/2022

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	8	• 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 to undertake effective PDR's. Coaching techniques to support conversations. F2SU approach and feedback. Cultural Ambassadors trained and in place on B6 and above recruitment since January 2021 Review of PDR process - October 2021. Pay Progression systems and processes established. • WRES and WDES performance - improvement in 2021 NHS National Staff Survey	
					• Process • - Working across the system across the STP with HEE partners to define local, collaborative, system and national workforce supply solutions. Actions 4996, 4997 & 8609 contribute to mitigation.	• Workforce Plan is reviewed and agreed by TMB and PODC Medical and Nursing Workforce Meetings in place and receiving recruitment trajectory data. Clinical Fellowship Scheme supporting increased recruitment to agreed establishment levels. • Workforce STP agenda via STP people board Collaboration with Walsall Together Partnership Board. ICS approach to HCSW and IR nurses in place.	
					• 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. Action 8610 supporting element of mitigation.	• Improvement Programme Board People and Organisational Development Committee. EDI Strategy and delivery plan approved by Board in April 2021 and monitored via PODC. • ICS People Board WRES / WDES data Staff Survey feedback.	
					• 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	• Via Education and Training Steering Group which reports through to PODC. Faculty of Medical Leadership Development training commenced in Feb 21 for Care Group leadership teams. SLA with RWT re leadership	

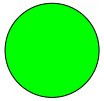
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					skills between NHS employers.	development offer under development. Director of Education and Training across RWT and WHCT to support of quality medical education and development. Managers framework launched in October 2021. • NSS results GMC and NETS survey HEE QA process	
					• 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. Action 772.	• Added as workstream in the Value our Colleagues Improvement Programme. PID completed and monitored via Core Team and exception basis to Improvement Board and PODC. Flexible working policy reviewed and updated Carers passport • BCWB ICS People Board Trust s part of Cohort 1 of the NHSEI Flex for the Future Programme	
					• Process • Partnership with Walsall Housing Group (WHG) to support residents to access foundation roles as first step into NHS career with Walsall focusing on; Clinical Support Workers, House Keeping and Portering roles.	• Bulk recruitment model implemented. Specific induction programmes developed for entry levels roles to support entry into employment, NHS and role. Zero vacancies across HK, Portering and CSW's by end of September 2021 • Anchor Institute Network	
					• Process • Recruitment of international nurses via RWT Clinical Fellowship Scheme in line with NHSEI international recruitment drive. Strong infrastructure to support recruitment, onboarding, CPD requirements and pastoral support. Action 8919 towards mitigation	• Safer Staffing Report to PODC Equality, Diversity and Inclusion Steering Group monitor feedback re experience. BAME Forum provide budding support to nurses from overseas Nursing establishment paper reviewed / approved by Board - 7 October 2021 Clinical fellowship programme with RWT in place • NHSIE Internal Nurse Programme ICS People Board	
					• Policy • Community Division undertaking review of Therapy services to understand the demands and AHP capacity to deliver, ensure effective use of their current resource, support the recruitment to vacancies and	• Associate Director of AHP's appointed in May 2021 A robust action plan has been created around this piece of work, with defined actions, timelines and accountabilities. PODC and Quality Committee oversight in April 2021	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					piloting different ways of working in order to address gaps in the service.	• National AHP Collaboration Network (NHSEI)	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
27/01/2022	To agree a consistent approach in terms of time and pay for all staff groups and that local induction / orientation arrangements build in capacity to complete required training before commencing role.	Marsha Belle	25/06/2022	30/06/2022
01/03/2022	WHCT & RWT to establish joint medical bank.	Clair Bond	26/07/2022	31/07/2022
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond	25/06/2022	30/06/2022
31/03/2021	Workforce Policy Framework to be aligned to the Valuing Colleagues Improvement Programme	Clair Bond	26/10/2022	31/10/2022
30/09/2021	Complete the NHSEI 'Flex for the Future' Cohort (WHCT accepted as participant in first cohort of national programme). Module 1 commenced 30 September 2021.	Marsha Belle	26/08/2022	31/08/2022

Walsall Healthcare Risk Register

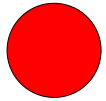
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	Operational expenditure incurred during the current financial year exceeds income allocations and/or the financial plan agreed with the ICS, which results in the Trust being unable to deliver the in-year financial plan. This results in us overspending & breaches our statutory break-even duty. This could constrain the ability to further develop and invest in services.	Dan Mortiboys	16	• Process • Financial governance and reporting throughout the organisation	• PFIC review the financial performance with Executive on at least a monthly basis. • NHSI receive monthly reports from the Trust. NHSI raise key issues with the Trust. STP Finance receive monthly updates from the Trust and comment as appropriate NHSI governance and Accountability review noted the good level of challenge and oversight of the PFIC Committee	
					• • Through the Trusts Accountability Framework divisions and corporate Areas are held accountable for financial delivery.	• The Accountability Framework has been approved by the Trust Board and there is evidence it is in operation. Processes are all developed and continue to be developed • NHSi Governance and Accountability Framework	
					• Process • Covid Governance process approved by the Board Financial arrangements altered/set by NHSE/I	• Strategic Command oversight of expenditure Finance team oversee the adequacy of the controls, and ensuring the governance process has been followed • NHSI receive regular reports on expenditure and re-imburse as appropriate. Financial arrangements set by NHSE/I have been complied with in 2020/21 with no payments withheld and no issues	
					• • Standing Financial Instructions (SFI) are in place across the Trust	• Breaches reported to Audit Committee IT systems are set up to support the SFIs • Internal Audit and External Audit will do specific pieces of assurance work in this area and more general pieces that reference SFI. Counter fraud in place	
					• • NHSI/E have been asked by Trust Board to do a review on Finance and PMO functions. The draft outcomes of this report support the performance	• Appropriately qualified staff • Draft reporting from NHSE/I	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					of these areas. There is strong control in this area • • Robust financial management arrangements are in place across the organisation	• SFIs are in place Budgetary Control and Virement Policy in place Training for budget holders Financial Business Partners support budget holders Financial reporting process are in place • Positive External Audit opinion Positive internal audit opinion on financial control audit and year on year improvement	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/03/2022	The COO leads cash releasing saving programme	Ned Hobbs		25/04/2023	30/04/2023
25/05/2022	Finance staff to work at ICS level to determine an over arching plan and then develop a deliverable plan for Walsall	Russell Caldicott		26/06/2022	01/07/2022
25/05/2022	The trust runs an Investment Group to manage investment within affordable levels	Roseanne Crossey		/ /	26/05/2022
05/10/2021	Improve current training offer, widen training offer and run face to face sessions post Covid 19. Take into account feedback from those who use the training to improve it.	Dan Mortiboys	**Closed**	26/10/2022	31/10/2022

Walsall Healthcare Risk Register

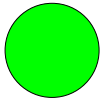
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Future Financial Sustainability	There is a risk that the Trust does not break-even in line with its statutory duty. Incurring expenditure beyond a break-even position could cause the regulator to reduce the autonomy of the Trust to incur expenditure and if the Trust were not able to access sufficient cash resources could see suppliers stop supply. This could result in reduced services to patients and also reduce opportunities for the Trust to benefit from investment. This risk would crystalise in a number of ways, divisions not working with agreed financial envelopes, the Trust investing funds beyond known income envelopes and potentially efficiency programmes not being achieved.	Dan Mortiboys	16	• Policy • PMO function in place to ensure standardisation of good project management process and reporting is in place.	• Improvement programme governance in place for workstream oversight. SRO and Programme manager overseeing programme delivery • Internal Audit have given significant assurance on the current PMO function. (Audit report indicated good progress for the coming financial year 2021/2022) NHSI have reviewed the PMO function and the financial elements	
					• • Overall Programme and Workstreams PIDs in place	• Improvement programme in place to oversee the implementation of the Trust's Improvement Plan Programme plan approved by the Board Workstream PIDs approved by relevant Committees • NHSI/E are in attendance at the Improvement Board and can provide support and challenge as appropriate Internal Audit review of Improvement programme	
					• Process • Benefits realisation process in place	• PIDs including benefits realisation approved through Governance structure PFIC TOR include duties relating to benefits realisation Improvement programme Board in place which includes a duty • N/A.	
					• Process • Monthly meetings of the Improvement Board (Executive led and attended) and workstream level meetings (Use of Resources chaired by Chief Operating Officer)	• The Improvement Board is a primarily Executive led meeting and oversight provided at that level. The Improvement Board and work streams report to Trust Board • N/A.	
					• Process • Financial Performance structures across the Trust (linked to Risk 2081), finally reporting to Performance, Finance and Investment Committee (PFIC)	• Internal Audit review key financial controls on an annual basis • External Audit provide annual view of the Trust's financial reporting	
					• Process • Long Term Financial Plan (LTFP) uses the best information available to predict the future financial position of	• The LTFP is produced and reviewed by professionally qualified accountancy staff who hold specific responsibility for LTFP	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					the Trust and ensure that the Trust can remain sustainable.	• NHSEI Midlands will review the LTFP of both the Black Country STP and Walsall Healthcare Trust	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
30/09/2021	Produce a new version of the Walsall Healthcare Trust Long Term Financial Plan (LTFP) inline with budget setting.	Russell Caldicott		25/04/2022	30/04/2022
24/12/2021	A balanced financial plan needs to be set. This will be co-ordinated by finance but will also require input from all areas of the organisations	Russell Caldicott		25/04/2022	30/04/2022
01/12/2021	To ensure the investment Group is successful	Dan Mortiboys		25/04/2022	30/04/2022
19/12/2021	Establishment of a group to set and monitor an efficiency programme	Ned Hobbs	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2245	Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.	There is a high level of maternity leave within the maternity team, currently totalling 25.1% of registered midwives across all inpatient areas. When this is considered with the normal expected tolerance of 16% A/L which is essential for the health and wellbeing of staff a 3% tolerance for staff training. This is being further exacerbated by an increasing number of staff requiring to self-isolate or quarantine due to Covid-19 procedures. As a result of the above, there is growing concern about the ability to safely provide care across the inpatient team, including 1:1 care in labour, due to the lack of staff available to work. Historically the service has been asked to maintain 10 vacancies due to the planned closure of Foxglove ward and relating to a reduction	Carla Jones-Charles	20	• Policy • Escalation policy	• Daily Staffing huddles Monitoring of acuity Report into staffing hub - virtual meeting • N/A	
					• Process • Morning staffing review huddle where staff are reallocated to areas of need.	• Morning staffing huddles, 3pm huddle and 10pm huddle with manager on call • N/A	
					• Process • Training requirements and delivery reviewed and streamlined where possible to reduce the amount of time required to complete mandatory training requirements.	• Matrons and Ward Manager update Weekly performance meetings Any changes to training is risk assessed based on training needs for individuals. • N/A	
					• Process • Use of bank and agency staff to improve staffing levels	• Morning staffing huddles 3pm and 10pm huddle • N/A.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		in birth numbers; this however does not account for the acuity of patients requiring care and peaks and troughs in the numbers of births. This is not a new issue as historically over the last 5 years the team has lost at least 10wte per year due to mat leave.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/04/2022	On-going recrutiment of midwifes, including international recruitment programme and offer of fellowship programme.	Carla Jones-Charles		25/09/2022	30/09/2022
06/10/2020	Complete a review of none urgent activity and identify opportunities to undertake new ways of working to support care delivery.	Carla Jones-Charles		25/09/2022	30/09/2022
06/10/2020	Escalate to Executive via TMB and Monthly performance review to seek support to over recruit to manage staffing shortages in respoect of 5 year trajectory of significant numbers of maternity leave.	Carla Jones-Charles	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2325	Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes.	Potential for patient safety to be compromised as a result of delayed or inaccurate decision making from the inability to access all records. Potential risk to patient safety investigations i.e. Root Cause Analysis and delayed timeframes impacting the Division and organisation. Potential negative impact on patient/ service users in regards to the timely and effective investigation processes	Elizabeth Miller	16	• Process • Access Fusion for diagnostic/ clinical overiew	•TBC •TBC	
					• Process • Incident reporting notes if unable to be located within a timely manner	•TBC •TBC	
					• Process • DoC Final Letters to be amended to acknowledge lack of access to patient notes or missing notes	•TBC •TBC	
					• Process • All investigations; TTR, Concise, RCA and complaints to be transparent in acknowledging missing notes or incomplete documentation with direct link with incident number	•TBC •TBC	

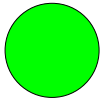
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
27/03/2022	Review demand and capacity for HRL tasks.	Mark Harrison	26/07/2022	31/07/2022
10/09/2021	Review of Divisional responsibility and resource required for management and re-filing of loose filing. Established process in place for divisional staff to return loose filing into files held in health records does not always occur and then backlogs of loose filing build up.	Mark Harrison	26/07/2022	31/07/2022
10/09/2021	Implementation of EDM (Electronic Document Management system) to digitise current paper records. This will remove the need for paper health records to be utilised.	Mark Harrison	26/08/2022	31/08/2022
10/09/2021	Implementation of onsite scanning bureau to enable day forward scanning to digitise newly created paper content directly into the EDM. This will remove the need for paper to be retained.	Mark Harrison	26/07/2022	31/07/2022
10/09/2021	Investigate resource required to review and scan remaining loose filing into EDM. Whilst scanning Bureau function is being setup it is not resourced to manage and review a large quantity of loose filling. Options to be considered following EDM	Mark Harrison	26/07/2022	31/07/2022

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

implementation.

Walsall Healthcare Risk Register

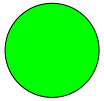
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2370	Delays in presentations for other, non-COVID conditions may further exacerbate health inequalities and increase the risk of premature mortality.	The size and complexity of the population health challenges and health inequalities in Walsall present multiple 'priorities' that cannot all be addressed simultaneously and may result in an inability to make progress in the most efficient and effective way. The inequalities experienced by our population has been further compounded by the COVID pandemic and presents a risk of premature mortality if significant recovery efforts for patients with long term conditions are not undertaken in a timely manner. The national booster vaccination programme has now been prioritised for Primary Care; non-urgent and routine services have been stood down in order to release staff to support the vaccination programme. This may lead to delays in presentations for	Michelle Mcmanus	20	• Process • Development of a Population Health & Inequalities Plan, aligned to the Health & Wellbeing Board JSNA. Alignment of transformation programme and resource to deliver. Key priority for year 1 is to ensure elective recovery does not exacerbate inequalities.	• Oversight of development and implementation of the plan via CPLG with leadership from Public Health • Health & Wellbeing Board System Health Inequalities & Prevention Board	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		other conditions and further exacerbate health inequalities and the risk of premature mortality.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
10/07/2020	"Further development of robust and comprehensive population health data and tools Maturity of Board/Leadership and ability to develop a clear strategy for prioritisation that balances funding, need and stakeholder expectations (including the public)"	Matthew Dodd		24/07/2022	29/07/2022
15/12/2021	Discuss with system health inequalities leads to understand if any modelling and/or actions have been undertaken at Black Country level, and ensure Walsall plans are a) aligned and b) making best use of available resources	Matthew Dodd	**Closed**	11/02/2022	16/02/2022
15/12/2021	Review available data from public health, using knowledge from the pandemic to date, on the potential consequences of delays in presentation of other conditions. PMC to identify high risk areas and options to triage those most in need.	Matthew Dodd	**Closed**	15/04/2022	20/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2430	Phase 1: Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record.	Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC, HCPC. These multiple systems are taking time away from seeing and supporting vulnerable children and young people. Project commenced with Phase 1 with agreed objectives as below: * Address child health record issues within School Nursing (SN) and Health Visiting (HV)teams * To provide visibility of SN & HV child records to all children's services within the Trust (Community Paediatric Consultants, Children's Safeguarding,Teenage Pregnancy Team,	Lynn Corbett	20	• Process • Mark Hulston submitted an escalation paper to Digital Programme board on 1st March 2021 regarding the future state and the Feb 2021 plan to drop Folding Space solution and transfer to FUSION via EPDR project. This project is ongoing. See actions below to complete the above. • • Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. See actions listed below.	• Risk discussed and reviewed at monthly Digital Transformation Board, Divisional Quality Board and Divisional Risk meetings with Divisional Governance Advisor. • N/A • Risk reviewed at monthly Digital Transformation Board, Divisional Quality Board and Governance meetings with Divisional Governance Advisor. • N/A	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		HIPS, Paediatric SALT, Paediatric Occupational Therapy, Child Development Centre, Team Around The Child) * Phase 2 of the project to be determined on completion of Phase 1. * Staff have access to all folders which contain the child health records, these are stored on the shared drives. IT have confirmed on 19/05/2022 that they are unable to provide audit trails which can confirm if staff have accessed folders over the past 2 plus years. This means that any point, any staff can have inadvertently or intentionally amended or deleted a record or entry that they had written, or a colleague had written and we would be unaware that this has happened.					

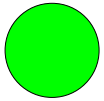
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
01/12/2021	Ingestion of legacy records into MediViewer; * Child Health Legacy Records (held currently in Folding Space) * School Nursing & Health Visiting Locally Held Electronic Records * Loose Scanning		Mark Harrison			25/06/2022		30/06/2022
02/08/2021	The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people. Over the last 2 years there have been a number of solutions proposed, however these have failed to gain momentum. This has left the service with a number risks which could result in a CQC inspection notice, as neither the current proposed solution for the legacy archive and the active Child Health Records (CHR) via the pre-existing CHR Project scope (2018 to date), nor the Feb 2021 proposed EDMS project additional scope will mitigate the CHR risk without a full consolidation of all records into a single solution. The Project has been given until October 2021 to consolidate all the children's records into one single solution; this covers the current paper records and all the records currently sitting on the shared drives within children's services.		Kelly Geffen			**Closed**	27/02/2022	04/03/2022
02/08/2021	Ensure that while the 12 week plan is in progress, all current and new digital records are ingested directly on to Fusion. All extraneous hard copy records within School Nursing and Health Visiting bases have been boxed and taken off site by supplier on 16th July 21.		Kelly Geffen			**Closed**	27/02/2022	04/03/2022
02/08/2021	To ensure Mediviewer is live for School Nursing to be able to undertake User Acceptance testing. Business change commenced Workshops with School Nursing and Health Visiting teams w/c 26th July 21 for potential migration to Total Mobile.		Kelly Geffen			**Closed**	27/02/2022	04/03/2022
26/11/2021	A 3 month training programme is to be implemented and delivered - staff who require training to be identified.		Stephen Jackson			**Closed**	11/03/2022	16/03/2022
01/07/2021	Deployment, configuration, testing and Trust acceptance of MediViewer product as the strategic solution for Child Health Records.		Mark Harrison			**Closed**	20/03/2022	25/03/2022
20/02/2022	Develop and deploy Careflow PAS clinical noting to School Nursing and Health Visiting for the following forms; Continuation Sheet Chronology Form Care Form		Mark Harrison			**Closed**	23/03/2022	28/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2439	External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.	There is a nationally accepted risk to CYP in crisis owing to the lack of mental health service provision. The NHS Plan is looking to address this with improved funding to be made available however, whilst we wait to see the outcome of this the risk remains to the Paediatric unit; the lack of adequate service provision externally means we carry a high level risk internally as a result of holding CYP who are in crisis. Nationally there are issues in accessing Tier 4 beds and locally we have a CAMHS service that is only available 8am-6pm. Overall the risks are external to our service.	Jodie Kirby	20	• Training • The RN workforce were trained to sue Storm in previous years and this tool is used almost daily. A full Training review is required and a forward training plan to be developed and incorporated into the annual training programme. Update: March 2022 - Newly appointed Band 7 Paeds Mental Health Lead due to start in post in March 2022; this person will lead on the training of PED, PAU and Ward staff. This training schedule will include in the use of the RCEM risk assessment documentation - moving us away from the current Storm risk assessment.	• The RN workforce were trained in the use of STORM risk assessment as a tool to assess immediate risk. Although this training has not been refreshed, the tool is used on a daily basis and staff are confident in its use. • Work has started at Care Group level with the iCAMHS service to address local training needs for both registered and un-reg staff. We are also receiving e-learning training packages via the CCG in response to our escalation of concern.	
					• Process • Access to iCAMHS is available but restricted.	• No adequate control in place; staff often contact the (adult) crisis team who will offer help as much as they can out of hours. This is inconsistent though. • Awaiting CCG clarification on the commissioning of an accessible out of hours CAMHS/iCAMHS service.	
					• Process • Access to paediatric psychiatry is available but limited.	• No adequate control in place; staff often contact the (adult) crisis team who help as much as they can out of hours. • Awaiting CCG movement in the commissioning of out of hours psychiatry help for CYP at Walsall Healthcare NHS Trust.	
					• Process • There is restricted access to iCAMHS services with referrals being accepted 8am-5pm Mon-Fri and 8am-4am weekends/bank holidays - this therefore can lead to delays in patients being seen on the ward	• No adequate control in place four out of hours referrals; acute staff will sometimes contact the (adult) crisis team who help as much as they can out of hours whilst we await the opening of the iCAMHS service. In hours - iCAMHS and the paeds unit have worked closely to ensure extended weekday and weekend referral hours. • TBC	
					• Process • The service received in Walsall Healthcare NHST from our mental health provider is often not appropriate	• Staff can challenge iCAMHS to provide further information in patient notes however, this will be dependent on their knowledge of gaps in care	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					to meet the complex needs of the CYP in crisis we see on the paediatric ward to assist us in maintaining patients safety.	planning for mental health patients • N/A	
					• Process • Not assured: Services are not commissioned to deliver therapy on the acute ward	• Senior nurses escalate throughout the organisation to highlight CYP experiencing long stays. Weekly multi agency meetings have been set up to allow ward staff, senior nursing staff, CAMHS, Local Authority and the CCG to identify issues and obstacles. • TBC	
					• Process • Escalation: The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads.	• The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads. • TBC	
					• Process • Not assured: Access to places other than a hospital bed.	• TBC • Meeting with the CCG Commissioner and key services on 16 March 2021 to start work on 'alternatives to hospital'.	

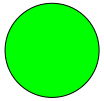
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
04/10/2021	Lead nurse for MH, DON and Medical Director will be involved in the NHSE CAMHS improvement project. Moving forward we will update risk number 2437 following any of the project group meetings/actions/progress.	Jodie Kirby		26/03/2023	31/03/2023
15/11/2021	For the Paediatric division to start a task and finish group to agree and work through an action plan to improve MH tier 4 access and escalation process. To improve patient care and transfer .	Charlotte Yale		26/07/2022	31/07/2022
17/05/2021	Meeting held with NHSEI Quality Team on 17/5/21 to discuss (a) sharing best practice, (b) system escalation process. Further meetings to include lead CYP commissioner (Mags Courts) and BCH reps (e.g. Mark Weaver).	Matthew Lewis	**Closed**	12/05/2021	17/05/2021
28/04/2021	Divisional team to escalate to the corporate team as discussed in RME.	Louise Holland	**Closed**	23/05/2021	28/05/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
12/07/2021	Clarification around expectations for transferring patients with previous clinical information from MH to ED.		Matthew Lewis			**Closed**	/ /	12/07/2021
16/07/2021	Medical Director - executive lead for mental health to escalate to NHSE and head of CCG regarding the impact and risk associated to WHT.		Matthew Lewis			**Closed**	/ /	16/07/2021
03/08/2021	Lead for Mental Health JK to devise an action plan and GAP analysis for the Executive lead for mental health to support an action plan for safe practice		Jodie Kirby			**Closed**	25/11/2021	30/11/2021
09/01/2022	To escalate suboptimal service delivery and engagement with external agencies providing support and care for children in crisis - this is inclusive of social care and mental health services.		Charlotte Yale			**Closed**	02/02/2022	07/02/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2464	Failure to comply with Trust Policy & breaching regulation due to individuals smoking in no smoking zones.	There is an increase fire hazard risk due to individuals smoking next to storage areas around the Trust that contain flammable liquids.	Jane Longden	10	• Policy • No Smoking Policy in place to cover the national update that advised all healthcare settings should be smoke free environments for staff and patient, for public health and wellbeing purposes.	• TBC • N/A	
					• • Communication via; Daily Dose, Snap Comms App, etc. to explaining the risks of smoking outside flammable cupboard and support available to patients and staff to stop smoking.	• TBC • N/A	
					• • No smoking signage present within the vicinity of flammable cupboards.	• TBC • TBC	
					• Process • Staff from external security contractor have been formally written to by their employers to avoid any breaches regarding this processs. Skanska are compliant at present in regard to this issue.	• Feedback on site about regular offenders is pursued by E&F department. • External Contractors are supporting staff by smoking off si	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
04/01/2022	CCTV installation upgrade, to cover prime smoking spots	Jane Longden	25/06/2022	30/06/2022
31/01/2022	Confirmation required from People and Culture to confirm where they are at with the design of the new improved Trust no smoking signage.	Michala Dytor	13/07/2022	18/07/2022
01/01/2020	No Smoking Policy to be ratified and rolled out, to clarifies the support offered to patients and staff, to enable a smoke free environment. As well as holding staff to account of breaching the No Smoking Policy.	Michala Dytor	25/06/2022	30/06/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2475	The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.	The Trusts inability as a Mental Health (MH) provider to comply with its legal & moral responsibilities of the MH provider status, as well upholding the MHA Code of Practice, has the potential for: > Individuals who require mental health services to; o Not be effectively or safely treated which could ultimately lead to a lack of appropriate admission for individuals in need of urgent care/an increase in avoidable harm, o Not have their civil rights upheld as patients may be detained illegally (due to no section/appropriate beds), > Staff; o To face verbal abusive, physical violence, & aggression, resulting in emotional destress &/or physical injuries, o To treat individuals unlawfully without such knowledge, due to	Jodie Kirby	15	• Process • Staffing Resource - To ensure that MH services within the Trust meet our strategic objectives. 3 year MH Strategy underdevelopment to include longer term strategic objectives. This includes the identification of additional MH trained resource required.	• Escalated to DON who will pick up with the exec team to see where it sits within the trust strategy. • SLA in place temporarily until we recruit staff into post	
					• Training • Standard MH Training - To ensure that all policy & process changes have been captured, so that training material is up to date & reflects the current processes. A review of the Standard MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or more frequently when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover chances made. Evidence of this is stored [location] of the actions taken.	• training is being developed in line with best practice and up to date evidence base. • The MH project group has this on the agenda. Level 1 training has been agreed and in place. IKON training now being rolled out across the trust	
					• Training • Standard MH Training Reporting - To ensure all staff have accessed the Standard MH Training & that they go through refresher training schedules at least yearly. On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all staff required to complete the Standard MH Training within each relevant ward, against the	• Once all training has been agreed for MH training, this will then be automatically be available on ESR annually. • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		lack of awareness & understanding of the statutory guidance, o To undergo unnecessary risk if they haven't had the relevant MH training, o To experience psychological side effects following traumatic events, o To impact on recruitment, retention & safe staffing numbers, o To experience poor morale levels, > Wider patients/visitors; o To raise complaints due to not receiving the relevant service they need & within an acceptable timeframe, o To be inappropriately detained for their safety, o To experience psychological destress &/or physical injuries, o To experience reduced flow & capacity due to rooms/equipment being damaged & awaiting repair, > The Trust;			record of staff held in Electronic Staff Record (ESR) who have completed the Standard MH Training & are still within their 12 month timeframe. Thus ensuring there are no overdue Standard MH Training requirements. Where the reconciliation of staff names held in ESR does not mirror staff active in each of the relevant wards, an investigation is conducted to highlight staff who have breached the 12 month timeframe as well as those due to breach the 12 month timeframe within the next 2 months (including all new employees). This is highlighted to staff & evidence of this is stored [location] of the actions taken.		
					• Training • Specialist MH Training Passports - To ensure that all policy & process changes have been captured, so that training material is up to date & reflects the current processes. A review of all the Specialist Unit Specific MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover chances made. Evidence of this is stored [location] of the actions taken.	• Security team have now undertaken IKON training • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	
					• Training • Specialist MH Training Passports Reporting - To ensure all specialist unit staff have accessed the additional	• ED have completed the design of their training passports. Next is for staff to be engaged in the training. Awaiting paediatrics team to design	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		o To have low recruitment & retention rates, o To undergo reputational damage, o To experience financial implications (complaints, litigation claims, compensation, damage to physical estate, cost of bank/agency staff), o To be without rooms/equipment whilst repairs are carried out, o To failure patient wait time targets, o To breach legislation & be non-compliant with the MHA, o To have our CQC service rating reduced to inadequate where special measures may need to be introduced.			Specialist Unit Specific MH Training & that they go through refresher training schedules at least yearly. On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all special unit staff (ED, Ward 21, Ward 29, AMU) required to complete the Specialist Unit Specific MH Training (Patient Restraint Training, Management of Actual or Potential Aggression Training) within each relevant special unit ward, against the record of staff held in ESR who have completed the Specialist Unit Specific MH Training & are still within their 12 month timeframe. Thus ensuring there are no overdue Specialist Unit Specific MH Training requirements. Where the reconciliation of staff names held in ESR does not mirror staff active in each of the relevant special unit ward, an investigation is conducted to highlight staff who have breached the 12 month timeframe as well as those due to breach the 12 month timeframe within the next 2 months (including all new employees). This is highlighted to staff & evidence of this is stored [location] of the actions taken.	their training passport. • Once all training has been agreed for MH training, this will then be automatically be available on ESR annually.	
					• Policy • MH Policy - To ensure the MH Policy accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH Policy is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model	• Draft policy is under review to have the updates of the Mental Health ACT embedded • Draft policy is under review to have the updates of the Mental Health ACT embedded	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					(Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.		
					• Process • MH SOP - To ensure the MH SOP accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH SOP is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.	• SOP has been signed off by executive lead for mental health • SOP is readily available to staff	
					• Policy • MH LWP - To ensure the MH SOP accurately reflects the requirements of the MHA Code of Practice & CQC legislations. A review of the MH LWP is conducted by MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable,	• SOP was completed and is out in practice whilst we await the MHA policy • SOP was completed and is out in practice whilst we await the MHA policy	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken.		
					• Process • Local Reporting - To ensure daily MH admissions are recorded & reported accurately. On a daily basis when the Matrons conduct their ward visits, they record if anybody have been detained or admitted under the MHA. Where records identify this finding, this data is passed to MH Reporting Administrator/Manager [job title TBC] [Further detail required - To understand where we have patients on a 5-2 or a 17 leave. Who, what, when, how, why, exceptions, evidence].	• The evidence of the audit is stored and staffing allowing , daily audits are completed. • Audit of all MH activity that is monitored can be compared with SLA activity to ensure activity is correct.	
					• Process • External Reporting - To ensure quarterly MH admissions are recorded & reported accurately. On a quarterly basis the MH Reporting Administrator/Manager [job title TBC] will conduct validation checks to ensure that the MH admissions recorded across the Trust mirrors up with [further detail required - To manage & monitoring the MH data for audit purposes to be sent to CQC quarterly. Who, what, when, how, why, exceptions, evidence].	• Daily walk conducted by admin or OPMHLT staffing - staffing available . This is will assured once MHA administrators are in post. • Specialist team within WHT are completing daily audit in the absence of a MHA administrator team.	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
31/05/2021	Lead Nurse for Mental Health and the OPMHLT are planning to develop and deliver training on :- MHA awareness , IKON, Mental Health Level 1,2 and 3.	Jodie Kirby	25/06/2022	30/06/2022
28/07/2021	To complete a review of the MHA SLA and governance process that WHT are responsible for . To feedback to the Executive lead for mental health the suggested staffing / resource required to ensure the MHA code of practice is adhered to and the MHA law is upheld.	Jodie Kirby	22/07/2022	27/07/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		Escalated to Steering group to resolve and progress on 26/7/21					
15/11/2021		Mental Health training is available across the organisation for MHA awareness, ligature Cutters, IKON, Mental Health Level 1,2 and 3.	Jodie Kirby			25/06/2022	30/06/2022
15/11/2021		For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for MLTC) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.	Nuhu Usman			26/05/2022	31/05/2022
15/02/2022		For the lead nurse for mental health , matron for mental health and mental health act administrators to review the current arrangement for mental health act tribunals , then to develop an SLA to bridge any GAP in services.	Jodie Kirby			25/06/2022	30/06/2022
03/01/2022		Undertake analysis to identify where our staffing resource gaps are.	Jodie Kirby			25/06/2022	30/06/2022
15/11/2021		For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for Community) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.	Kelly Geffen		**Closed**	06/02/2022	11/02/2022
15/11/2021		For the DGA to work with the Divisional Leadership Triumvirate to create a Divisional risk (for Surgery) regarding the risk surrounding the take up of Mental Health training inclusive of MHA awareness, ligature cutters, IKON, MH level 1,2 & 3.	Salman Mirza		**Closed**	26/05/2022	31/05/2022
12/05/2021		Lead Nurse for Mental Health will review the policy and escalate to exec level the difficulties in access to the MHA administrator - for joint update of the policy. Plan to work with RWT to review MHA policy.	Jodie Kirby		**Closed**	26/05/2022	31/05/2022
01/03/2022		AN audit is to be completed for the use of mental health act and mental health patient support.	Jodie Kirby		**Closed**	26/05/2022	31/05/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2489	Staff or patients/carers could experience discrimination by the Trust or those employed by it.	A significant loss of workforce diversity, talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work (reduction in effort above and beyond contractual requirements), lack of opportunity to develop and progress, not feeling safe due to unacceptable behaviours such as racism, bullying and harassment, workforce fatigue and not valued for the incredible job that they do and therefore not recommending the trust as a place to work or a place to be treated.	Clair Bond	12	• BAF Control 04 • Value Our Colleagues Improvement Programme in place - workstreams based around three core domains; (i) leadership, culture and organisational development, (ii) organisational effectiveness and (iii) making Walsall and the Black Country the best place to work.	• monitored via PODC, Improvement Board and VOC Core Team. Core set of measures from base line year 2019, foundation year 2020 through to 2022/23. Accountability Framework and Divisional Performance reviews • National Staff Survey WRES, WDES indicators CQC assessment / rating	
					• BAF Control 04 • A Staff Experience and Engagement Oversight Group has been established to provide assurance to PODC on behalf of the board re; staff engagement processes/systems, shared decision making councils, involvement of diversity in decision making, increasing staff survey participation levels. Action 8620 details mitigating action.	• Terms of Reference agreed. Outputs monitored via PODC on a monthly basis - divisional leaders present NSS action plans. Action Plan in place 2021 Pulse Survey completed. Internal Audit review of NSS Process completed. • National Staff Survey (2021) National Quarterly Pulse Survey 21/22 Q4. WRES, WDES, Gender Pay Gap report	
					• Policy • Equality, Diversity and Inclusion Strategy in place supported by detailed 9 point delivery plan.	• Equality, Diversity and Inclusion Group to monitor progress against delivery plan on a monthly basis and report to PODC on a quarterly basis. • Legal duties in line with Public Sector Equality Duty 2011 and Equality Act 2010. WRES, WDES and Gender Pay Gap reports Race Code Assessment complete and reported to PODC in September 2021.	
					• BAF Control 04 • Freedom to Speak Up service in place - improvement programme agreed to develop and embed the service.	• Lead Non-executive director. Regular access to Exec Team and Board 1/4ly reports to PODC and Board re F2SU activity Operational support in place Confidential Contact Link network stablished across the Trust Speak Up training available for all staff to access. Improvement plan monitored via PODC and Improvement Board. • Development of service supported by NHSIE and NGO F2SU index available from NSS	

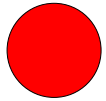
Walsall Healthcare Risk Register

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
20/12/2021	Expand the RCN Cultural Ambassador programme to support colleagues involved in formal employment relations processes.	Michala Dytor		25/06/2022	30/06/2022
01/12/2021	To develop a strategic approach to dispute resolution.	Clair Bond		26/07/2022	31/07/2022
01/11/2021	Business case to outline funding requirements to complement HWB strategy to support ambitious and innovative to be completed. - ongoing as a cost pressure request	Tamsin Radford		14/06/2022	19/06/2022
01/04/2022	Cultural Competency Awareness Programme commissioned and due to be initiated in Q3 22/23. Q1 Planning and Q2 Pilot / train the trainer.	Marsha Belle		26/10/2022	31/10/2022
27/01/2022	The Exit interview process is being updated and embedded within the retention framework - focusing on stay conversations.	Marsha Belle		26/07/2022	31/07/2022
27/01/2022	Ensure the Staff Experience & Engagement Oversight Group is reactivated from March 2022 onwards to inform action plan for PODC, TMC and Board discussions over March and April 2022.	Catherine Griffiths	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2540	Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems	There is a risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems. Ineffective safeguarding systems include: - Safeguarding identified as a theme of concern in CQC reports with Section 29a notice and must do actions. - Staff ability to recognise, report, and escalate actual or potential safeguarding concerns. - Low levels of Level 3 safeguarding training. - Low levels of adult safeguarding referrals from Trust in Local Authority. - CCG and CQC report no assurance of learning from safeguarding incidents due to repeated themes in incidents requiring independent investigation.	Fiona Pickford	12	• Process • The safeguarding adults policy supports staff in safeguarding practice by the recognition and referral of any safeguard concerns that staff encounter in the practice.	• Safeguard system used to record safeguarding related incidences monthly reporting commenced to the Divisions Reporting through safeguarding committee weekly training compliance reports received escalation reports to safeguarding committee safeguarding bespoke training as required 07/03/2022 - progress against safeguarding development plan reviewed at monthly safeguarding committee. Safeguarding dashboard in place with evidence of compliance and where not compliant plan to achieve • Monthly CQR provides an element of scrutiny safeguarding performance framework development and reporting quarterly to the CCG CCG assurance of quality of L3 training 07/03/2022 - progress against safeguarding development plan reviewed at monthly safeguarding committee. CCG and LA are members of committee. Safeguarding dashboard in place with evidence of compliance and where not compliant plan to achieve. Shared with CCG and LA at CQR Meeting	
					• Training • Training compliance for level 3 safeguarding adults is below the expected performance compliance. Training is delivered monthly- (2or 3 sessions) delivered via teams. These are reviewed by the Divisions	• Weekly training compliance reports are received from workforce intelligence The Divisional leads are required to report monthly through safeguarding committee regarding training compliance and actions taken to improve compliance • Reporting through CQR	
					• Process • The external concerns received have identified some emerging themes which cannot provide assurance that ward / departments have implemented actions agreed as part of their feedback reports	• Safety briefings completed and disseminated across the teams to reinforce emerging themes and compliance with policy 07/03/2022 - safeguarding development plan in place. Evidence of compliance with actions reviewed at monthly safeguarding committee. Actions in	

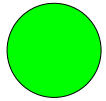
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						place to achieve where not yet compliant • LA monitoring number, appropriateness and quality of Safeguarding concerns received from WHT 07/03/2022 - safeguarding development plan in place. Evidence of compliance with actions reviewed at monthly safeguarding committee. Actions in place to achieve where not yet compliant. CCG and LA are members of Safeguarding committee. Safeguarding dashboard shared at CQR Meeting	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
12/07/2021	Schedule of be- spoke sessions to wards / department	Lisa Carroll	25/06/2022	30/06/2022
12/07/2021	Delivery of Level 3 Safeguarding adults training	Lisa Carroll	26/07/2022	31/07/2022
12/07/2021	revise training to reinforce emerging themes from concerns raised continue to develop safeguarding briefings as necessary	Lisa Carroll	15/06/2022	20/06/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2581	Internal risk for patients awaiting Tier 4 hospital admission	WHT ability to support and manage any CYP awaiting a tier 4 admission. An increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey. 1)There is no provision of mental health training to ward staff but a misplaced conception that the staff at WHT are trained to meet the needs of CYP in crisis. 2)There is no access to mental health support or advice out of hours 3)There is no access to Paediatric psychiatry out of hours 4)There is restricted access to iCAMHS services with referrals being accepted 8am-4pm Mon-Fri and 8am-3pm weekends/bank holidays 5)The service received in WHT from our mental health	Jodie Kirby	20	• Training • Staff to have the required knowledge and skills to manage mental health patients who are awaiting tier 4 admission. Staff to have the knowledge to understand and utilise the mental health act appropriately.	• Mental health act awareness training is available for all staff to access via ESR • There is no external assurance due to gaps in provision	
					• Training • To abide by the mental health act and uphold patient section 132 rights . To be able to utilise section 5(2) appropriately and lawfully.	• Mental Health Act awareness training is accessible via ESR • No external assurance	
					• Process • For patients to have a mental health assessment within ED or PAU to avoid admission to the paediatric ward. This will enable an appropriate assessment and diversion from the acute hospitals to link in with CAMHS community.	• Recruitment processes are currently being undertaken to recruit a band 7 MH Nurse to work in ED to provide support to staff managing MH patients. This will contribute to the effectiveness of admission avoidance • No external Assurance, CAMHS do not currently support ED or admissions	
					• Process • For patients who are admitted to the ward to be supported by discharge planning at the point of admission. For patients to receive appropriate assessment, MDT working that is conducive for proactive discharge approaches.	• WHT are recruiting a mental health staff member to support and work with the paediatric division to develop clearer discharge planning process and MDT working. • none - continued challenges with the ICAMHS/CAMHS service delivery to WHT	
					• Process • To review and audit the current process for MH training within the Paediatric Division.	• Band 7 CNS appointed, awaiting start date. MHA and IKON training readily available for staff to attend. • CAMHS should be delivering in house training to paediatric staff. .	
					• Process • To have an escalation process where ward staff can escalate appropriately to CAMHS and/or Social Care when required.	• Lead Nurse for MH is working with Children's commissioner to agree and complete escalation process for CAMHS and Social Care. Currently in draft format. Paediatric team have support and access to escalate to lead nurse for MH for advice and guidance. • Children's commissioner is aware of the challenges and supportive of escalation.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		provider is not appropriate to meet the complex needs of the CYP in crisis we see on the paediatric ward. There is no detailed/shared risk assessments from iCAMHS and often no detailed plans of care to support non-mental health staff 6)There are often delays in discharge whilst discussions, assessments, reassessments and reviews (such as CTR's) are undertaken between social care and mental health. These delays often span into weeks and the CYP is kept on the ward with little engagement or therapeutic support from other agencies which contribute to deteriorations in behaviours. This is not in the CYP's best interest and is detrimental to their health and wellbeing. 7)There are often elongated periods of time between the decision to transfer the CYP into foster			• Policy • An established and embedded risk assessment tool for use within paediatric ED and paediatrics to enable WHCT to identify patient risks and put in place appropriate care planning to support patient needs. • Policy • To have a ratified rapid tranquilisation policy for children/young people.	• Staff access the MH team within the trust for support and guidance. • N/A • TBC • N/A	

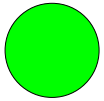
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		care (either a placement or high risk foster placement) and their actual movement out of the organisation. There seems to be no alternative to a hospital bed for CYP in crisis in Walsall. 8)There is no access to a 136 suite for CYP in Walsall. The local one is Wolverhampton, however this is a joint suit and is often in use for adults. These suites/locations are typically provided by the mental health trust and patients are taken to them by the by the police or other services for a full and proper assessment of their mental health needs. For example, The Redwoods Centre, Shrewsbury is able to meet the needs of both adults and children if required. The service is available 24 hours a day and 365 days a year and assessment can lead to a voluntary or compulsory hospital					

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		admission, or discharge to the community with appropriate sign posting and mental health service follow up in place.					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
12/07/2021	staff to have a training plan for mental health awareness	Jodie Kirby		26/07/2022	31/07/2022
17/02/2022	For a rapid tranquilisation policy to be ratified and available for use within paediatrics.	Raghu Krishnamurthy		25/06/2022	30/06/2022
12/07/2021	For staff to have mental health act training and de-escalation training (IKON)	Charlotte Yale		25/06/2022	30/06/2022
12/07/2021	Staff required to facilitate admission avoidance and to complete mental health assessments within ED and PAU, to support patient discharge. To engage with the commissioners and the MH trust to have an improved CAMHS service.	Jodie Kirby		25/06/2022	30/06/2022
12/07/2021	Senior CAMHS staff member required to work with the paediatric department to focus on planning for discharge on arrival, care planning, risk management and wider patient discharge MDTs.	Jodie Kirby	**Closed**	26/03/2022	31/03/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2587	Risk of staff harm due to insufficient numbers of staff fit mask tested on two different masks.	The Trust does not have sufficient numbers of staff fit mask tested on two different masks in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19), due to vacancies and on-going sickness and absence challenges. Staff are at risk of developing disease as a result of inhalation of harmful substances, disease spread, associated illness, skin damage &/or other conditions, mortality. Trust is at risk of liability claims & dissatisfaction as a result of failing to adequately protect staff health.	Caroline Whyte	9	• Process • High risk areas undertaking AGPs are priority areas for fit mask testing. • Training • Staff fit tested and passed on two masks. • Process • Fit mask testing complaicne is a standing agenda item and reviewed / discussed at trust wide PPE group.	• Fit mask figures avilable for high risk AGP areas • N/A • Figures dicussed at PPE group and circulated to the divisions. • N/A • Minutes and compliance records from meeting • N/A	

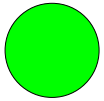
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
30/09/2021	Support a fit testing solution plan to enable all existing staff & new staff who will be users of FFP3s, to be released for fit testing.				Caroline Whyte	26/07/2022	31/07/2022
08/03/2022	Figures to be obtained and reported monthly: Staff fit tested in high risk areas as agreed by PPE group All clinical staff fit tested figures.				Lisa Carroll	25/09/2022	30/09/2022

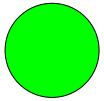
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2601	Inadequate Electronic Module for Sepsis/deteriorating patient identification, assessment and treatment of the sepsis 6.	Failure to report accurate Sepsis data nationally, resulting in non-compliance and increased risk of delivering suboptimal sepsis care/treatment.	Lorraine Moseley	20	• Policy • National Early Warning Score within the Management of the Deteriorating Patient Policy V1.000. • Training • Vital Pack Training, ALS, ILS, BLS, and E-sepsis Training. • Process • E-sepsis module EPR	• Vital Pack electronic patient system Management of the Deteriorating Patient Policy V1.000. • Management of the Deteriorating Patient Policy V1.000. • > ALS and BLS are mandatory via ESR reporting. > All above training modules have an element of sepsis training/education incorporated. • Mandatory compliance figure is reported via ESR as needed centrally. • > Interim paper version in ED as a work around for the time being, which is audited monthly. > The dashboard front page will highlight the 'Golden Hour' for antibiotics. • N/A.	

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
23/07/2021	Issue reviewed by working group -discussions around reporting suggests major changes to information collected for reporting purposes. To be following up at subsequent meetings. Completion date reviewed - update by System C not expected until September 2022	Lorraine Moseley		25/09/2022	30/09/2022
30/03/2022	The Vital Pack Training, to be discussed with the Trainer and the CD in ED to review Training Material.	Lorraine Moseley		25/06/2022	30/06/2022
23/07/2021	Current Trust deteriorating patient policy is out of date (as of July 2020), requires immediate update.	Manjeet Shehmar	**Closed**	26/03/2022	31/03/2022
01/03/2022	Redesigning the dashboard, so the front page is only concerned with the 'Golden Hour' for antibiotics.	Lorraine Moseley	**Closed**	27/05/2022	01/06/2022
23/07/2021	Full review of E-sepsis module, function and suitability. Consideration of reverting back to paper in the interim.	Lorraine Moseley	**Closed**	25/09/2022	30/09/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2664	Patient Safety and Training Issues in Medicine / ED	Reputational Impact on the trust regarding Doctors in Training placements. Withdrawal of Doctors in Training placements by Health Education England. Financial reduction of Health Education income.	Louise Nickell	20	• Process • MLTC attend AMU Assurance Board to monitor action plan	• AMU Assurance Board; minutes, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • Medical Education Group (MEG) - The Clinical tutor will provide a report around the summary position for the risk against HEE concerns. The meeting will be chaired by the Medical Director as an overview/scrutiny meeting and the occurrence will be monthly.	• Medical Education Group (MEG); minutes of Meeting, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • Postgraduate Medical Education Committee (PMEC) oversees plan and progress against plan, chaired by the clinical tutor. The college tutor will report on the progress of the HEE risk actions.	• Postgraduate Medical Education Committee (PMEC); minutes of meeting, action log and attendees notes. • Action log is maintained in line with HEE progress report.	
					• Process • Junior Doctors Forum is now aligned to the GOSW Forum, to listen to Junior Doctors concerns/feedback.	• Medicine JDF taking place at the required frequency in line with their training programme. • Medicine JDF taking place at the required frequency in line with their contractual and training programme requirements.	
					• Process • Education and Training Steering Group (E&TSG) meeting occurs quarterly and is chaired by the Director of Education and Training. The Clinical Tutor will present an updated report around the HEE risk.	• Education and Training Steering Group (E&TSG); minutes, action log and attendees noted. • Action log is maintained in line with HEE progress report.	
					• Process • WHT's submission of their (non patient safety issues) improvement plan to HEE.	• Documented improvement plan, with progress and action narrative against applicable items. • Action log is maintained in line with HEE progress report.	

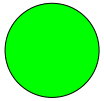
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/11/2021	Continued work of the improvement plan.	Louise Nickell		08/01/2023	13/01/2023
13/01/2022	PMEC meetings to include risk and updates against risk. discussion at PMEC to	Ravi Kainth	**Closed**	08/01/2023	13/01/2023

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
	include progress against improvement plan. First PMEC is 10.03.22							
17/02/2022	WHT to submit (non patient safety issues) improvement plan to HEE by 12th April 22.		Louise Nickell			**Closed**	14/04/2022	19/04/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2737	Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy	Currently there is a resistance / non-adherence with the Trust Medicines policy in several areas of the Trust with regard to (as evidence by pharmacy audits): 1. drug storage in clinical areas, specifically the requirement for medicines cupboards and fridges to be kept locked and tidy (to determine medication stored in areas) at all times, for drug storage rooms to be locked, for temperature of drug storage areas to be maintained below 25 degrees celsius. 2. CD audit with regard to: correct process for recording receipts and issues in the CD record book, signing for receipt of CDs in CD requisition book and recording of stock reconciliation checks. Implications to non-compliance include: - financial - stock leakage if cupboards	Gary Fletcher	16	• Policy • There is an up to date Trust Medicines Policy (Enduring) available on the trust intranet system.	• Monthly audits and monitoring by the pharmacy department to support and deliver a 'safer drugs' approach, which is fed back to each individual area on a regular basis and escalated via MMC to board level. Incident forms are completed following a medication error and acted upon and forms completed following a non-compliant audit • N/A	
					• Process • Monthly audits undertaken in all ward areas who have medicine supplied via pharmacy.	• Monthly audits completed by pharmacy team. Monitoring of non-compliance via incident forms and escalation through from dept to corporate level • N/A	
					• Training • 95% of nursing staff to receive refresher training with regards to safe storage of medication and are familiar with medicine policy and medicines management handbook to aid skills and competencies.	• Training video to be developed. • N/A	
					• Process • Safe and appropriate drug storage is required for wards areas to comply with safe storage and management of medicines management in line with Trust Medicines Policy.	• Pharmacy to be involved in further refurbishments and to advise on safe storage of medication. • Business case submitted for funding of pyxis machines within medicines division.	
					• Process • Pharmacy Management Team to meet with DGA's for WCCSS, MLTC, Surgery and Community to obtain assurance regarding care group actions pertaining to medicines management compliance.	• Bi - Monthly meetings to be held with DGA's for updates in relation to their divisions medicines management compliance. • N/A.	
					• Process • To replace paper based controlled drug registers and requisitions with electronic registers (eCDRx).	• Monthly CD audits are being completed by pharmacists and pharmacy technicians. • Cost implication, i.e. software purchase and technical support.	
					• Process • CDAO to meet with To3 to seek assurance regarding divisional compliance with medicines management for WCCSS, MLTC,	• Regular monthly meeting scheduled with divisional To3 to review controls and actions and update regarding division compliance. • N/A	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		unlocked, stock wastage if not stored at correct temperature, potential risk of access and administering incorrect drug/fluid (particularly in emergency situations) which may lead to clinical claims of negligence. - reputational - omissions/errors to drug administration, poor audit trail of compliance, incidents leading to serious investigations and involvement of commissioners, potential involvement of law enforcement agency, MHRA - patient safety - poor audit tail leads to omission/drug errors, incorrect doses being administered, potential risk of harm to patient or death, risk of incident leading to harm, may lead to lack of availability of drug to treat patients, potential risk of patient dissatisfaction with care provide by trust (also			Surgery and Community		

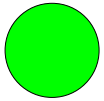
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		reputational) - Estates - poor state of repair (or response to repair in timely manner) of drug storage cupboard, door, locks, fridges					

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
12/01/2022	Pharmacy Management Team to meet with To3 and DGA's for WCCSS, MLTC, Surgery and Community to obtain assurance regarding care group actions pertaining to medicines management compliance.	Gary Fletcher	24/07/2022	29/07/2022
01/11/2021	Funding for air conditioning unit across the trust where medication is stored to maintain temperature below 25 degrees.To approve funding and install air conditioning unit in all drug storage areas.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding for appropriate drug storage facilities, including locked drug rooms. To ensure all areas where medication is stored is locked as required in the medicines policy.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding approval for electronic controlled drug management system. Scope funding for new software.	Gary Fletcher	26/07/2022	31/07/2022
01/11/2021	Funding for pyxis machine across all sites where medication is stored.	Gary Fletcher	25/06/2022	30/06/2022
08/03/2022	MSO and Pharmacy Governance advisor to work in conjunction with FORCE team to develop medicines management fundamentals of care e-learning module and training video.	Gary Fletcher	09/11/2022	14/11/2022
05/04/2022	Quarterly CD audits to be completed by pharmacists and pharmacy technicians to evidence controlled drug compliance according to Trust policy.	Elizabeth Payne	25/11/2022	30/11/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2917	Inappropriate use of SCALE2 within NEWS2.	Patients are incorrectly assigned to SCALE2 within NEWS2 when their clinical condition does not indicate this. Risk of patients not being appropriately escalated if they deteriorate due to the parameters within SCALE2 due to staff have not received adequate training regarding the use of SCALE2.	Caroline Whyte	20	• Process • Quality team will review all patients on SCALE2 daily with the support of critical care outreach at the weekend.	• Daily audit of numbers of patients on SCALE2 and it's appropriateness. • None	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
23/03/2022	FORCE team have immediately commenced 1:1 training on ward areas.	Lorna Kelly	25/06/2022	30/06/2022
23/03/2022	Scope further training in the use of SCALE2 within NEWS2 for all clinical staff	Lorna Kelly	26/08/2022	31/08/2022

Walsall Healthcare NHS Trust

MEETING OF PUBLIC TRUST BOARD Wednesday 3rd August 2022			
Infection Prevention and Control Q1 Update			
Report Author and Job Title:	Amy Boden Head of Infection Prevention and Control, Deputy DIPC	**Responsible Director:**	Lisa Carroll, Director of Infection Prevention and Control and Director of Nursing.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	• Ongoing COVID-19 pandemic with rising inpatient numbers and ongoing changes to testing and infection prevention guidance. • 0 Acute Acquired MRSA bacteraemia's to report for Quarter 1 • 5 Acute Acquired C.difficile toxin cases to report for Quarter 1 against a trajectory of 6 • 0 Acute Acquired MSSA bacteraemia's to report for Quarter 1 • Elements of the IPC BAF demonstrate a reduced risk score due to improvements being made in the environment and practice improvements captured in audits • Next external IPC review at the Trust will take place on 15th August 2022		
Recommendation	The report is for information and to promote the sustainability of improvements made across the organisation in infection prevention and control practices.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Findings and gaps in assurance are included on the IPC BAF assurance tool.		
Resource implications	None		
Legal and Equality and Diversity implications	None		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Action	Required action	Q2 2021/22	Q3	Q4	Q1 2022/23 current position	Change in level of risk
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other services users.	12	12	12	6	↓
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	20	12	8	6	↓
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	6	4	4	4	→
4	Provide suitable accurate information on infections to services users, their visitors and any person concerned with providing further support or nursing/medical care, in a timely fashion	3	3	3	3	→
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	6	6	8	6	↓
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	6	3	6	6	→

7	Provide or secure adequate isolation facilities	20	20*	20	12	↓
8	Secure adequate access to laboratory support as appropriate	12	12	8	6	↓
9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections	6	6	6	6	→
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	6	8	6	4	↓

Details of gaps in control/assurance captured in IPC BAF

Changes to COVID-19 guidance

Trust colleagues have demonstrated improved compliance in reviewing patients according to the respiratory pathway. The Infection Prevention Team and Consultant Microbiologist updated the latest respiratory pathway manual in Quarter 1. This manual has been positively received and recently presented at an Infection Prevention Society conference to showcase best practice. There continues to be changes to National and Regional guidance based on the evolving situation of the pandemic, which continues to pose a risk due to ensuring messages are disseminated effectively across clinical teams.

Infection Prevention in the healthcare environment

The old estate and current poor condition of some of the wards has resulted in a number of department environment audits not achieving >90% compliance score. Divisional teams have demonstrated robust actions at Infection Prevention and Control Committee to mitigate risks and refurbishment plans continue to improve aspects of the hospital estate. A revisit from NHSE is scheduled on 15th August 2022.

The environmental control group continues since commencement in 2021 with good representation from the divisions and escalation of issues, leading to more responsive environmental work. Papers from these meetings are shared in the estates and facilities report to Infection Prevention and Control Committee.

To improve indoor air quality across areas of the emergency pathway that does not have optimum mechanical ventilation, the Trust purchased 134 air disinfector units. These have been installed across areas of the Manor Hospital, palliative care centre, Hollybank House and in sexual health services. This has received positive recognition externally for the efforts the Trust have made to improve indoor air quality to prevent transmission of COVID-19 and virus particles that can circulate through the air.

Staff members undertaking routine lateral flow device testing

While Trust guidance requests staff to undertake twice weekly asymptomatic lateral flow testing, data demonstrates poor compliance in staff reporting on the Infinity system. Communications are regularly shared to promote undertaking lateral flow testing.

Ability to isolate patients

The limited availability of side rooms in the Trust can lead to an inability to isolate all patients who require isolation in a timely manner. The Manor Hospital now has nine Bioquell isolation pods installed to improve available segregation facilities. While this has improved ability to isolate patients with suspected/ confirmed infection, with increasing trend in COVID-19 presenting to the hospital and contacts generated, isolation facilities remain a high demand, leading to some patients not being isolated as per Trust policy, such as MRSA colonised patients or patients awaiting CPE screens.

Performance: Infection Prevention and Control Alert Organisms

***Clotridioides difficile* infection**

The Trust has a target set for 27 acute acquired cases of C.difficile. This is a target reduction of 6 cases following achievements in 2021/22. For Quarter 1 there have been 5 acute acquired C.difficile toxin cases reported. Findings so far indicate justified antibiotics and one incident of delayed sampling. Learning is shared at Infection Prevention and Control Committee and divisional quality meetings.

2022/23	April	May	June
Max Cases per Month	2	2	2
Actual acute cases	0	1	4
Cumulative YTD projected	2	4	6
Acute Cumulative actual	0	1	5

MRSA Bacteraemia

There have been 0 MRSA bacteremia's to report for Quarter 1. The Infection Prevention Team have launched a quality improvement project in Quarter 1 to achieve prompt prescribing of MRSA decolonisation on identification of a positive case.

MSSA Bacteraemia

There have been 0 MSSA acute acquired bacteremia's to report for Quarter 1.

Gram-negative Bacteremia's

National target for E.coli bacteremia's at the Trust are 50 for the year. Nine cases were reported in quarter 1.

National target for Klebsiella bacteremia's at the Trust is 27 for the year. Five cases were reported in quarter 1.

National target for Pseudomonas bacteremia's at the Trust is 10 for the year. 0 cases were reported in quarter 1.

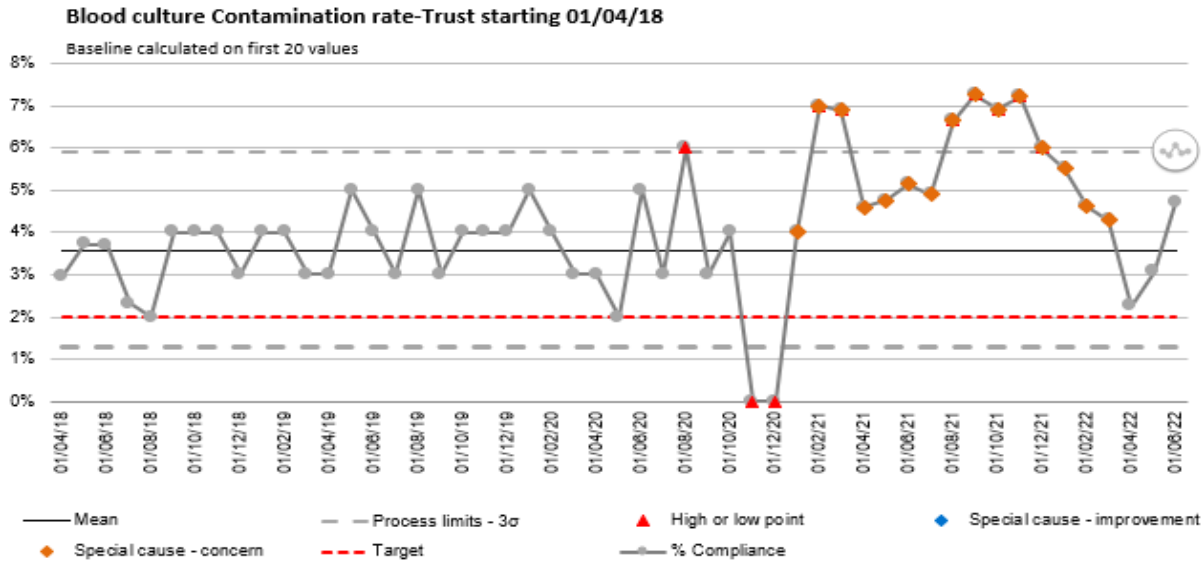
The Infection Prevention Team are participating in a Gram-negative steering group across the Midlands and work on Quality Improvement projects locally to prevent different system infections, including pneumonia and urinary tract infections.

Carbapenemase producing Enterobacteriaceae (CPE)

0 cases of CPE to report for Quarter 1.

Blood culture contaminates

Blood culture contamination rates were 4.4% in June 2022, higher than target of 3%. The Infection Prevention Team are working with support services to work towards a model with the phlebotomy team to undertake blood cultures with an aim to reduce incidence of contaminates.



Outbreaks and Incidents

COVID-19: During Quarter 1, there were 51 bay closures due to COVID-19. These were picked up as incidental findings during day 3-5 of admission via routine PCR testing. Four wards were closed during the quarter due to COVID-19 outbreaks. In quarter 1 there have been a total of 84 cases of COVID-19 that meet the health care acquired definition. The

majority of these have been identified via asymptomatic testing. Each case is reviewed by the IPC team as well as a review of compliance to COVID-19 guidance in the ward setting.

Suspected Norovirus: 6 bays were closed during quarter 1 due to suspected Norovirus. All were negative and promptly reopened.

CPE History: 1 bay was closed during Quarter 1 due to a patient with known history of CPE being admitted into a bay. No further cases have been identified.

Monkeypox

There is currently an international outbreak of Monkeypox; this was initially managed as a high consequence infectious disease (HCID) but since more epidemiological data has been sourced in this outbreak, this clade of Monkeypox has been stepped down as a HCID.

In June, the Trust experienced managing 1 positive case who accessed Trust services. This was managed according to National guidance and the Infection Prevention Team and Occupational Health were praised externally for their prompt responses to the case.

End of Report.

<table>
<tr><th colspan="4">MEETING OF THE TRUST BOARD – Wednesday 3rd August 2022</th></tr>
<tr><td colspan="4">Mental Health escalations, concerns and recommendations</td></tr>
<tr><td>Report Author and Job Title:</td><td>Jodie Kirby
Lead Mental Health Nurse</td><td>Responsible Director:</td><td>Manjeet Shehmar
Chief Medical Officer</td></tr>
<tr><td>Recommendation & Action Required</td><td colspan="3">Members of the Trust Board are asked to:
Approve ☒ Discuss ☐ Inform ☒ Assure ☒</td></tr>
<tr><td>Assure</td><td colspan="3">• Mental Health risks have reduced since the programme of work (risk 2475) Risk 2475 has reduced from 25 to 15</td></tr>
<tr><td>Advise</td><td colspan="3">To meet the regulatory requirements of the CQC, Walsall HT registered as a mental health provider with the CQC in June 2020. Based on the standards and evidence of excellent mental health care, Walsall are proactively working towards meeting parity of esteem and excellent mental health care. However there are challenges to meeting excellent care:-
Current suboptimal delivery of the core 24 service, suboptimal delivery of mental health training for staff . Overall, this impacts on the quality of care delivered to patients suffering from mental health illness who attend WHT.

Lead Nurse for mental health and mental health team have continued to engage with external MH trust with transformational work and working groups. There are aspirations to deliver excellence in mental health care and deliver parity of esteem.

There have been continued MH related incidents across the organisation , the WHT mental health team share incidents with external partners and are developing shared learning process to improve patient experience.</td></tr>
<tr><td>Alert</td><td colspan="3">• Continued incidents relating to suboptimal mental health care
• Basic mental health training now available for acute trust staff, there is a more robust mental health training package required.
• Continued incident reports being submitted due to suboptimal response times from external agencies relating to mental health and social care.
• Increase in section 136 attendances to the ED
• Nationally there is a continued challenge with access to TIER 4 beds.
• Locally and nationally there has been an increase in MH patients presenting to the ED.</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td colspan="3"><table>
<tr><td>4 Corporate Risk Register</td><td>19/03/21</td><td>2439</td><td>External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.</td></tr>
<tr><td>4 Corporate Risk Register</td><td>08/04/21</td><td>2475</td><td>The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.</td></tr>
<tr><td>4 Corporate Risk Register</td><td>12/07/21</td><td>2581</td><td>Internal risk for patients awaiting Tier 4 hospital admission</td></tr>
</table></td></tr>
<tr><td>Resource implications</td><td colspan="3">The financial implications of these proposals are not detailed in this paper.</td></tr>
<tr><td>Legal and/or Equality and Diversity implications</td><td colspan="3">CQC regulation 13 states:
1) Care or treatment for service users must not be provided in a way that:
a. includes discrimination against a service user on grounds of any protected characteristic (as defined in section 4 of the Equality Act 2010) of the service user,
b. includes acts intended to control or restrain a service user that are not necessary to prevent, or not a proportionate response to, a risk of harm posed to the service user or another individual if the service user was not subject to control or restraint,</td></tr>
</table>

	c. is degrading for the service user, or d. significantly disregards the needs of the service user for care or treatment. 2) A service user must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. CQC also lists the following legislation under regulation 13: • MH is recognised in law as a protected characteristic • Children and Young Persons Act 1933 • Equality Act 2010 • Equality Act 2010: Chapter 1 (protected characteristics) Chapter 2 (prohibited conduct) and Chapter 3 (services and public functions) • Human Rights Act 1998 • Mental Capacity Act 2005 • Mental Capacity Act Code of Practice • Mental Health Act 1983 • Mental Health Act 2007 and Code of Practice	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☒
	Resources ☒	

Mental Health escalations, concerns and recommendations

1. PURPOSE OF REPORT

The purpose of this report is to provide feedback following the mental health audit findings and summarise the current appeared challenges and options for discussion.

2. BACKGROUND

To meet the regulatory requirements of the CQC, Walsall HT registered as a mental health provider with the CQC in June 2020. To maintain this registration, the CQC requires the follow standards to be achieved: -

- Patient centred care/holistic
- Abide by the Mental Health Act (MHA)
- Adhere to patient rights under the Mental Health Act
- Adhere to the MHA administration duties set out within the act (i.e., store section papers for 30 years, scrutinise papers, adhere to patient rights)
- Evidence of least restrictive practice
- Evidence and audit all MHA detentions within WHT
- Provide safe, effective, caring, responsive and well-led services. https://www.cqc.org.uk/sites/default/files/20201016b_AMSAT_report.pdf

Based on the standards and evidence of excellent mental health care, Walsall are now able to monitor and manage the mental health act. There have been continued challenges engaging with the local mental health trust to support patient care and treatment. The Lead nurse for Mental Health is continuing to meet and liaise with the Mental Health service leads within the local mental health trust and work towards a robust MHA process for all patients within WHT.

There are continued suboptimal levels of mental health care delivered due to:

- Suboptimal training package for Acute trust staff to enhance staff knowledge and skills to support mental health patients within WHT.
- Continued incident reports being submitted due to suboptimal mental health care delivered.
- Nationally there is a continued challenge with access to TIER 4 beds.
- Suboptimal CAMHS service delivery – there is no service delivered to CYP in crisis who attend ED, this is not adhering to the minimum national standards.

Locally and nationally there has been an increase in MH patients presenting to the ED.

3. DETAILS

The Mental Health Team

Safe Staffing: -
A business case was produced and presented to Execs in July 21. The MH team were able to successfully appoint to all posts. The staff commenced in post between December 2021 – March 2022.

- One of the new staff to the WHT has been awarded an internal award for their support provided to the ED team.

The WHT mental health team has continued to develop and focus on excellent patient care for mental health patients within the trust.
There have been continued challenges and great demand for the WHT mental health team, this is due to many factors.

- Challenges to deliver CORE24 services to royal collage of psychiatry standards
- Challenges to deliver CAMHS services to the ED and PAU. There has been a prolonged response at times to the inpatient wards due to CAMHS availability and service spec.
- National increase in mental health presentations to the acute trusts
- Other factors such as social, domestic, financial, war and any other factor that may contribute to any person's health and mental wellbeing.
- Nationally mental health crisis has increased and there is well documented evidence that mental health illness and demand will be exponential.
- WHT staff have also been affected by COVID-19, this can impact on staffing levels, recruitment and retention. This has a direct impact on the ability of staff to attend and engage in training.

Training: .
Due to the impacts of COVID, recruitment, retention and other training demands.

The table below represents the number of staff who have accessed the training.

The MH team are continuing to offer training and are aiming to develop an accessible training packages to support staff in practice..

2021 to date	WHT
IKON	101
Ligature Cutters	528
Level 1	563

ED/AMU/Paeds:- have raised challenges to releasing staff to attend training. However, the CNS for CYP & Adults (WHT MH team) have now designed a flexible training plan to support staff attendance. The CNS for paediatrics will be delivering bespoke training to the paediatric team as of June 2022.

Awareness within the Trust: -
Since the recruitment of the mental health act administrators there has been a significant decrease in mental health act incidents. There is a clear audit of all mental health act detentions and process now being embedded within the organisation.

RCEM – ED risk assessment tool
WHT mental health team have been supporting ED to develop and roll out the RCEM risk assessment tool. This is to go live in June and the ED team alongside the WHT mental health team have carried out audits and developed this tool within the EPR. This is a positive step to enable MH risk to be identified at triage and enable to staff to have an understand of support required for the patient whilst awaiting the formal MH assessment from the external partners.

Plan:- QI initiative:
- The RCEM paediatric risk assessment tool is being developed through the "we can talk project"
- WHT CNS for ED and Paediatrics are working with the paediatric team to roll out the risk assessment across the paediatric areas in preparation for the new ED and pathways.

Incident Themes:
The list below highlights the common theme that are raised to the MH team within WHT (the MH team respond swiftly and offer support/ guidance for the trust) : -

- Absconding patients (all areas)
- Absconding patients ED

- Lack of a streamlined service for external services for MHA process
- Challenges with completing section 5(2) MHA 1983
- Suboptimal attendance and training and meetings relating to QI.
- Police 136 process, access to MHA suite, and management of patients under section 136.
- Increase in section 136 attendances to ED
- Support children under section 136 suit as CAMHS currently do not offer any support to ED.
- Challenges to access the local 136 suite for CAMHS.
- Supporting patients and plans of care for Tier 4 admissions
- Supporting Paediatric division with the gaps in CAMHS provision
- Supporting WHT with gaps in CORE24 provision
- Supporting and escalating through appropriate routes
- Overuse of restraint/inappropriate restraint by security staff/ward staff
- Frequent admissions/HISU
- Direct admissions to the paediatric ward for patients who have no physical health cause.

The MH team at WHCT and RWT conducted an audit to further understand the issues and the findings are being worked through with partners in the Mental Health Trust.

Mental Health Team's project group

WHT mental health working group has completed 118 actions out of 125 – the group hopes to have completed all actions by July 2022.
This group has been running since July 2021.

4. RECOMMENDATIONS for 2022.

4.1 Use of Force Act 2018:-

A recommendation for the trust to scope and understand the development of a restrictive interventions policy to support adherence to the use of force act based on a gap analysis which has been undertaken by the MH lead nurse.

- The Act sets out the requirements for the organisation to follow to ensure that all patients who are detained under the MHA 1983 with a requirement to be restrained are supported through appropriate process and monitoring.
- The Act stipulates those responsible are aware of the ACT and have practiced restraint that adheres to the restraint reduction network standards of practice.

4.2 Eating disorder updates and change in practice:-

Hospital admissions for eating disorders increased by 84% in the last five years and there have been changes to the Royal College of Psychiatrists eating disorder guidelines. The launch for this guidance highlighted a noted increased in eating disorder deaths within acute trusts and the correlation between death and delays for refeeding in an emergency presentation to acute trusts.
The Trust will be starting a working group to review the policy, practice, and implementation for the MEED guidance.

4.3 Review the training for acute trust staff :-

The current training package available for staff is a level 1 standard which is required as foundation training. A new Mental Health training module will be developed with the divisional teams to ensure each area has the correct access to MH training that is required to support the acute trust staff to manage mental health illness whilst they are admitted.

MEETING OF THE TRUST BOARD – Wednesday 3rd August 2022			
Medicines Management Report			
Report Author and Job Title:	Gary Fletcher Director of Pharmacy	**Responsible Director:**	Dr Manjeet Shehmar Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	Corporate risk 2737: Risk of patient harm, Trust reputational damage and breach of Regulatory Compliance, due to non-adherence with the Trust Medicines Management Policy has been reduced to a score of 16 based on the following: • It is through the Medicine Management Group that audit compliance is being monitored and escalated to Divisions where necessary • Measures have been put in place to strengthen the effectiveness of medicines management through Divisional and Care Group engagement and the risk register • Projects to support communication and education of staff are being set up which include video training and face to face. • There are now clear improvements in medicines management compliance and this has been achieved through a collaborative effort between pharmacy the Divisions and Care Groups.		
Advise	• The known risks regarding medicines storage and controlled drugs record keeping compliance continues to be monitored. There are some signs of improvement in some areas. • Electronic drug storage units have been purchased for refurbs on Ward 5/6, Wards 14-17, Maternity & Ward 24/25.The installation of electronic drug storage units will largely resolve the compliance issues. Pharmacy are also purchasing a new controlled drug storage unit for the main dispensary. This work is reliant on the ward refurbishment timelines. • Controlled Drug record keeping is also being monitored closely and electronic solutions to replace the current paper systems is being considered.		
Alert	• Pharmacy over across the Trust is being evaluated • There are no new issues which require escalation.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The main risks identified are concerned with the level of compliance with the Medicine Policy which is managed through Corporate risk 2737 and associated Divisional and Care Group risks.		
Resource implications	Resource may be required to address pharmacy cover gaps once this evaluation is complete. Funding will be required for an electronic controlled drugs record		

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

Medicines Management Report

1. PURPOSE OF REPORT

The purpose of this report is to inform and assure the Committee on the management of medicines within the Trust. This is achieved through the activity of the Medicines Management Group and its sub-groups.

2. PHARMACY AND MEDICINES MANAGEMENT

The responsibility for medicines management within the Trust rests with the Medical Director with delegated responsibility to the Director of Pharmacy, who is also the Controlled Drugs Accountable Officer (CDAO) for the Trust.

The Medicines Management Group (MMG) is the group which has oversight of medicines management and usage. The MMG is chaired by the Medical Director or by the Director of Pharmacy in the absence of the Medical Director. The MMG meets on a monthly basis with the exception of August and December.
The MMG met on:

- 28th April 2022
- 23rd May 2022
- 27th June 2022

The MMG reports directly into the Clinical Effectiveness Group on a quarterly basis.
The MMG receives reports from a number of sub-groups.

Since the previous report in April 2022 there have been a number of developments with regard to improving medicines management across the Trust and to evidence compliance with the Medicines Policy.

Controlled drugs

MLTC

- Ongoing QI project around CD meds management in ED. In June improvement in ED red resus CD standards from 78% to 80% and in blue resus compliance remains

steady at 78%; however, reduction in compliance in ED main from 71% to 60% due to slippage in complete record of signatures for administration and destruction (main areas for focus B1 and C3 remain which relate to requisitions being signed and error recording in CD register). The QI project around CD meds management will be rolled out to other wards/departments.

- QI project in ED continuing.
- Ward 15 - 73% compliance - non-compliant with C1, C3 and C5.
- Ward 17- 67% compliance - non-compliant with B1, C1, and C3.
- Ward 29 - 83% compliance - non-compliant with B1 and C3.
- Cardiac Intervention Unit - 78% -non-compliant with C1 and C3.

Surgery

- DTC Theatre 3 -100% compliant
- DTC Theatre 5 – 100%
- OPD Dental – 100%
- DTC Theatre 10 - 100% compliant.
- DTC Theatre 8 - remains at 91% compliant upon re-audit.
- DTC Theatre 9 - remains at 91% compliant upon re-audit.
- DTC Theatre 6 - 73% - non-compliant with C1, C3 and E1.
- DTC Recovery- improved from 64% to 73% compliance upon re-audit improving compliance with E1 - remains non-compliant with C1, C3 and D1.
- Gynae Theatre 11 - 78% compliance - non-compliant with B1 and C3
- Gynae Theatre Recovery - 78% compliance - non-compliant with B1 and C3
- Ward 22 – initial compliance 90% due to non-compliance with C3 - improved to 100% on re-audit.
- Overall, surgery shows good compliance with standards

WCCSS- 2 areas audited

- Ward 21 -89% compliance- non-compliant with C3
- Ward 28 – 78% compliance – non-compliant with C1 and C3
- Ward 25 – 80%

Community

- SRU – 90%

The CDAO is reviewing the CD audits at a weekly CD meeting in pharmacy where action to be taken around non-compliant audit standards is discussed i.e.re-audit of the specific non-compliant standards and, where these continue to be non-compliant, ensuring a Safeguard incident is raised to prompt an action plan. The results of each CD audit, and where necessary, the re-audit and logged Safeguard incident are being added to the relevant risk in the risk register.

Pharmacy have been working with nursing staff to produce a short (6 mins) video recording of good practice around controlled drugs. The content has now been reviewed and finalised and will be made available to all staff via the Trust Intranet in July. If this proves to be successful, it will be taken forward as an addition to mandatory training for nursing and medical staff.

As part of the QI work on ED the move to SAD type registers has resulted in an improvement in record keeping. These registers will now be implemented on all wards and will replace to old style record books.

Risk Register

Risk 2737 has been placed on all Divisional and Care Group risk registers around the non-compliances to the Safe and Secure Handling of Medicines and Controlled drugs Audit. This has shown to improve local ownership of this the management of medicines at a ward level which is evidenced by some improvement in the management of controlled drugs which has been presented in the above section. The care groups are currently reviewing their evidences with a view to downgrading the risk scores. The Corporate risk has been reviewed in June and has now been reduced from 20 to 16. With the evidencing of further improvements at care group level, the Divisional risks will be reviewed next month.

Ward storage

Wards are now required to use the Tendable app to complete ward storage audits (medicines management (medicine room) inspection report) which provide evidence towards divisional care group medicines management risk.

19 areas completed a medicines management (ward storage) audit in June 2022 which was uploaded to Tendable; 2 areas completed additional audits (AMU x2 and PAU x3). However, 11 areas did not complete and upload a medicines management (ward storage) audit in June 2022. This has been escalated to respective Divisions for action.

Overall, standards above 80% compliance except for:

- 78% compliance with medicines being locked away and not left out unattended
- 76% compliance with Drugs Room being free of clutter

The Pharmacy Medical Safety Officer (MSO) and Governance lead are continuing to do spot checks against the Tendable audits to ensure consistency.

A task and finish group has been set up with members from RWT (including MSO and Pharmacy DGA) and RWT, to be chaired jointly by the Director of Pharmacy RWT and WHT, whose aim is to look at medicines' storage standardisation across both sites. Site visits at both sites have identified similar issues such as use of keys and Digi locks, in place of swipe cards, lack of medicines storage and quality of medicine cupboards not in accordance with British Standard 2881 as per Health Building Note 14-02 – Medicines storage in clinical Areas (https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN-14-02-Medicines-storage-in-clinical-areas.pdf) and RPS Professional guidance on the safe and secure handling of medicines (https://www.rpharms.com/recognition/setting-professional-standards/safe-and-secure-handling-of-medicines/professional-guidance-on-the-safe-and-secure-handling-of-medicines)

If the T&F group proves to be successful it will become a standing joint medicines storage group.

Further developments include:

- Funding secured to purchase automated ward storage cabinets across Wards 14-17 and Ward 5 as part of the refurbishment programme. The projects also include swipe card access to drug storage areas, electronic temperature monitoring and air temperature control., this will allow for the above standard to be achieved consistently across these ward areas.
- WCCSS are purchasing automated ward storage cabinets for 21, PAU and wards 24-25, this will help to ensure that there is a robust process for the handling of To Take Out pre packed medication which has been an area of concern for this division.
- The new build ED will include air temperature monitoring, swipe card access to drug areas and electronic drug storage units in four locations – ED, PAU, AMU and ED Resus.
- The above project timelines are all dependent upon the Refurb Project plan. The Machines are the last to go in before re-opening. The machines are all on order and BD are included in the project planning and discussions.
- Pharmacy is installing an electronic cabinet for controlled drugs. This will enhance security within pharmacy and make the audit trail paperless. There are also options being explored to extend the electronic stock control system into ward areas which will provide an opportunity to replace paper based audit trails.
- Pharmacy has begun some work with Corporate Quality Nurses – Rachel Tomkins and Kelly Saville – to set up workshops for nursing staff to focus on discussions around NMC professional accountability & responsibility, and legal aspects of practice and medicines. Initially the work will focus on Divisions, but potentially will be expanded and become part of regular professional updates.

Further projects and work

Missed or omitted doses

The most frequently reported medicine error at WHT is around missed and omitted doses. As this is also a common theme to RWT, pharmacy is working closely with the Head of Nursing of Quality to disseminate some of the improvement RWT have made across to WHT.

Pharmacy Quality Improvements

Pharmacy has their own Quality Improvement group. Some of the projects that are currently being undertaken include:

- Controlled drugs management- initial aims to improve controlled drugs compliance across ward 27 and accident and emergency
- Oxygen prescribing- to improve oxygen prescribing in AMU, once this has been achieve the work will be disseminated to other clinical areas.

- Discharge Medication Service (DMS), which is a CQUIN to improve the communication to community pharmacies on the electronic discharge summary around medication changes. In Q1 this CQUIN target has been exceeded and the expectation is that it will be met by year end.
- Environmental sustainability. Pharmacy is part of the joint RWT/WHT "Greener NHS" group and is focussing initially on reduction I the use of anaesthetic gases.

Medical Gases

- The Medical Gases Group last met on 30th June 2022.
- VIE replacement – initial works have commenced, with a view to completion in September.
- Training for nurses acting as Designated Nursing Officers has been arranged
- A survey by the consultant anaesthetists has been completed and suggests that the use of nitrous oxide across the Trust is very small. Further discussions are ongoing regarding the merits of decommissioning the piped nitrous oxide and manifold system and switching to portable cylinders. A risk assessment will be completed by the anaesthetists, pharmacy and E&F for any changes in the delivery of nitrous oxide gas.
- In order to enhance security around the nitrous oxide store and manifold rooms, WHT and RWT security are working on the installation of security camera to monitor those areas. In addition, E&F have (in July) implemented a bar code tracking system provided by our gas supplier Air Liquide. This will allow full audit trail of bottled gases and identification of location. This will be particularly helpful with the security of nitrous oxide cylinders.
- "Greener NHS" – WHT is success story with regard to nitrous oxide and desfluorane usage – Trust was one of the top users in the country and this has now significantly decreased.

Policies and procedures

The following policies have been reviewed and approved:

- Medicines Policy
- Self-administration policy
- Defective medicines Policy
- To take out medicine pre pack policy
- Antimicrobial policy
- Medicines Reconciliation Policy
- Immunoglobulin Policy

Non Medical Prescribing (NMP)

Audits and self-declarations have been received from nom medical prescribers. Ten non-medical prescribers have been removed from the trust NMP register due to failing to submit

their audit and self-declaration in line with the NMP Policy and governance process for NMP's.

CQUIN Update

There are two CQUIN relating to medicines.

- DMS – 1.5% of all discharges to be referred to community pharmacy for medicines review via Pharmoutcomes. On target at 1.7%.
- Antibiotic usage in UTI – 60% compliance with set standards required. On target at 70%

Progress on these is reported on a monthly basis to the Medicines Management Group.

3. REGULATORY

- General Pharmaceutical Council pharmacy premises – renewed annually in October, no inspection due.
- Wholesale Dealers Licence [WDA(H)] – last inspection July 2019. No inspection due.
- Home Office Controlled Drug Licence – no inspection due. Renewal completed in March 2023.

4. RECOMMENDATIONS

Board to note that whilst there remain some areas where compliance to the Medicines Policy with regard to drug storage and CD record keeping requires improvement, there has been a general improvement in awareness of issues and good compliance in a number of areas. Measures are being implemented to educate staff as well as the implementation of electronic solutions. Risk 2737 and associated risks will provide greater accountability through the care groups and Divisions with regard to compliance.

MEETING OF THE TRUST BOARD **Wednesday 3rd August 2022**			
WHT Safeguarding Service Annual Summary Report (April 2021 – March 2022)			
Report Author and Job Title:	Fiona Pickford Head of Safeguarding	**Responsible Director:**	Ann-Marie Cannaby
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• A Safeguarding Business Case was agreed in Q4, allowing for the expansion of the Safeguarding Service Team. All key posts have now been recruited to. • Substantial work has been undertaken regarding the completion of actions outlined in the WHT Safeguarding Development Plan during 2021. • Progress has continued to be noted within Walsall Safeguarding Partnership in respect of the oversight of actions completed by WHT following a review of local case review actions that were outstanding prior to COVID. • WHT participated in Walsall Partnership assurance audits in respect of Section 11 (Children Act 2004) and Care Act (2014). The feedback from the partnership was that WHT had good governance arrangements overall. • The Trust Safeguarding Group (formerly known as Trust Committee) has been well attended from CCG, WLA and all WHT Divisions.		
Advise	• The learning disability agenda (within the Trust is being scoped via collaboration work with Royal Wolverhampton Hospital Trust (RWT) and WH. • Significant staff shortages within maternity (during Q1 and Q4) resulted in a lower-than-expected compliance for supervision. Additional group supervision sessions were provided thereafter to address this during Q1 2022. • WHT Safeguarding Policies have been reviewed on a regular basis and an action plan has been developed to maintain focus.		
Alert	• Safeguarding training compliance has varied during 2021 – 2022. A review of the delivery and content of safeguarding children and adult training is to be prioritised for Q2/Q3. • During April 2021 to March 2022 there were 109 referrals sent in to Walsall social care that met the criteria for a safeguarding Section 42 enquiry. General care, acts of omission, neglect and poor discharge concerns were the main themes.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risks implicated in this report		

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

WHT Safeguarding Service Annual Summary Report (April 2021 – March 2022)

1. PURPOSE OF REPORT

The aim of this annual report is to provide information, evidence, and assurance of the Trust's continued commitment to effective safeguarding measures, during the period April 2021 to March 2022. The report is presented against set objectives, which are detailed in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs - 2020). This was previously known as the Wolverhampton Clinical Commissioning Group (WCCG) Assurance Framework for Safeguarding Children and Adults with Care and Support Needs, 2017 and is aligned to national and local safeguarding standards including the requirements from CQC and Wolverhampton Safeguarding Together Partnership.

2. KEY POINTS FROM THE REPORT

- Provide assurance to the Trust Board that the organisation is fulfilling its safeguarding obligations as defined within the assurance framework by providing appropriate responses against each section.
- Provide assurance to service commissioners and regulators (CQC and NHS Improvement) and partners (Walsall Safeguarding Partnership and Walsall Local Authority) that the Trust safeguarding activity and programme over the year continues to develop.
- Appraise the Trust about the activity and function of the safeguarding team and the support it provides to operational and clinical service delivery.
- Ensure through investigations, audit and training that patients, service users and carers know that the safeguarding of children and adults is a Trust priority.
- WHT participated in the Walsall Safeguarding Partnership (WSP) Care Act 2014 assurance self – assessment process for adults and was rated as 'good'.
- WHT participated in the WSP Section 11 (Care Act 1989/2004) self – assessment process for children and was also rated as 'good'.
- A safeguarding development plan that was created to provide a focus for actions to be resolved following a concern raised by WLA and CCG in relation to the care and treatment of patients on a ward has progressed significantly. To note that all key areas have been addressed and future monitoring of safeguarding issues will continue to be discussed at the Trust Safeguarding Group.
- The dataset that supports the recording of, and compliance against DBS checks has been under review (from Q4) following concerns raised that the information has not been robust. A joint working group across WHT and RWT has been convened to review the groups of staff who require regular checks, and to establish how these are recorded on the Trust IT system.
- The number of Deprivation of Liberty Safeguards (DoLS) referrals has shown a slight variation throughout the year but has ranged from 78 – 93 per quarter. WHT are

working with RWT safeguarding service to prepare for the planned introduction of Liberty Protection Safeguards in 2024.

- All WHT Safeguarding policies have been reviewed during 2021/22 and will be mapped against local and national standards. This is joint work being undertaken with RWT.
- Safeguarding training (Children and Adult) has been monitored monthly and discussed at the Trust Safeguarding Group. Compliance across Level 1,2,3 and 4 has varied occasionally due to staff sickness, poor attendance, and late cancellation. The training content, training programme and delivery options are to be reviewed across WHT and RWT during Q2/Q3.
- Safeguarding Supervision uptake has been good for Named Safeguarding Professionals and for the Trust. It was noted that during Q1 and Q4 maternity staff had a reduction in their compliance due to staff sickness. Further 'mop up' safeguarding supervision has been given (via groupwork sessions).
- An internal WHT Safeguarding Practice Review Group was developed during Q2, chaired by Deputy Head of Safeguarding at RWT to take responsibility and monitor the implementation of action plans that arise from Walsall Practice Review Group and the national Learning Disabilities Mortality Review (LeDeR) Group. WHT have contributed to all requested chronologies and reports throughout 2021 – 2022.
- Key themes identified following the review of adult cases include: the recognition of self neglect, safety regarding smoking and the use of oxygen therapy at home (and ensuring there is a robust mental capacity assessment in place) and the long-term health implications for patients who are refusing to eat.
- 109 referrals met the criteria for a section 42 enquiry (Care Act 2014). The key themes noted were general poor care, acts of omission, neglect and poor discharge concerns.
- During Q1, WHT safeguarding adult team commenced a campaign to raise awareness and risk across the Trust supported by CCG and WLA. As a result, ward staff were supported to escalate safeguarding issues. A questionnaire was used with staff to establish the baseline knowledge of safeguarding within the Trust, and it has provided assurance that overall staff had a reasonable understanding of the safeguarding agenda (and ability to know their role withing this process).
- Outline the proposed areas of development for 2022 – 2023

3. DETAILS

WHT Safeguarding Service Annual Summary Report

April 2021 – March 2022

Fiona Pickford

Head of Safeguarding

Introduction

The aim of this annual report is to provide information, evidence and assurance of the Trust's continued commitment to effective safeguarding measures, during the period April 2021 to March 2022. The report is presented against set objectives, which are detailed in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs - 2020). This was previously known as the Wolverhampton Clinical Commissioning Group (WCCG) Assurance Framework for Safeguarding Children and Adults with Care and Support Needs, 2017 and is aligned to national and local safeguarding standards including the requirements from CQC and Wolverhampton Safeguarding Together Partnership.
The report aims to:

- Provide assurance to the Trust Board that the organisation is fulfilling its safeguarding obligations as defined within the assurance framework.
- Provide assurance to service commissioners and regulators (CQC and NHS Improvement) and partners (Walsall Safeguarding Partnership and Walsall Local Authority) that the Trust safeguarding activity over the year continues to develop.
- Appraise the Trust regarding the activity and function of the safeguarding team and the support it provides to operational and clinical service delivery.
- Ensure that patients, service users and carers know that the safeguarding of children and adults is a Trust priority.
- Outline the proposed areas of development for 2022 – 2023

Safeguarding Legislation and Standards:

- The Safeguarding Vulnerable Group Act (2008)
- The Mental Capacity (Amendment) Act (2005/2019)
- CQC Essential Standards (2013)
- Children Act (1989/2004)
- Care Act (2014)
- Working Together to Safeguard Children (2018)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: RCN (2019)
- Adult Safeguarding: Roles and Competencies for Health Care Staff: RCN (2018)
- Prevention of Terrorism Act (2005)
- Counter Terrorism and Security Act (2015)
- Walsall Safeguarding Partnership
- NHS Black Country and West Birmingham Clinical Commissioning Group – Walsall Place

Details of progress during 2021/2022 are described against each standard specified within the framework.

1: Safeguarding Governance & Leadership:
Health providers are required to demonstrate clear governance arrangements and that they have safeguarding leadership, expertise and commitment at all levels of their organisation and that they are fully engaged and in support of local accountability and assurance structures, the Safeguarding Partnerships, and in regular monitoring meetings with commissioners.

1.1 WHT Safeguarding Service Team Structure 2021/22

The current safeguarding team structure provides assurance that the Trust is compliant with employing the statutory named professionals for children – Named Nurses (NN), a Named Midwife (NM from March 2022) and a Named Doctor for safeguarding children. (See **Appendix 1 -Team Structure).**

1.2 WHT Safeguarding Children and Adult Governance and Accountability Framework

All Staff: All staff within WHT have a commitment to protect children and adults at risk from harm and abuse and to work in accordance with all Trust policies and procedures.

The Chief Nurse: Is the nominated Director/Executive Lead responsible for coordinating the management of safeguarding and to ensure that the Board receives sufficient assurance on the effectiveness of the service.

The Director of Nursing is the nominated chair of the Trust Safeguarding Group (TSG).

The Head of Safeguarding (Trust Named Nurse): Manages the Children and Adult Safeguarding Service and provides expert leadership on all aspects of the safeguarding agenda. The Head of Safeguarding is responsible for the development and implementation of systems and processes, working with partner agencies in line with local and national standards and legislation and ensures that there is appropriate implementation of relevant internal and external targets and standards, contributing to national and local inspections and assessments of safeguarding arrangements. The Head of Safeguarding provides assurance to the TSG and is the nominated representative at the Walsall Safeguarding Partnership.

WHT Named Doctor/s: There is a Named Doctor for Safeguarding Children. The post holder supports the Head of Safeguarding and Chief Nurse.

WHT Named Nurses for Safeguarding Children, Adults and Maternity: The roles, responsibilities and competence of Named Nurses and support staff are set out in Safeguarding children and young people: roles and competences for health care staff (2019) and Adult safeguarding: roles and competencies for healthcare staff (2018). The WHT Named Nurse/Professionals for Safeguarding have had key roles within WHT:

- To provide an expert high quality support service to all health professionals working with adults, children and families within WHT.
- To be available to give advice and support Monday to Friday 08.30 to 16.30 for safeguarding children and 09.00 to 17.00 for safeguarding adults.
- To provide robust interactive support to WHT hospital and community sites.
- To represent the Trust at all appropriate subgroups or committees aligned to the Walsall Safeguarding Partnership.
- To contribute to planning/implementation across the organisation in respect of safeguarding children and adult issues.
- To work collaboratively with multi-disciplinary and mu multi-agency teams including the Police and Social Care. During 2021-2022 the Multi Agency Safeguarding Hub (MASH) for children, Domestic Abuse Triage and adult safeguarding referral service continued to develop with involvement from the WHT Safeguarding Service. *To note there will be a further review of provider contributions to MASH during 2022 in response to a recent child practice review case*.
- To contribute to the Walsall (and external Local Authority Areas) Multi Agency Risk Assessment Conferences (MARAC) meeting held fortnightly. WHT have contributed to 100% of meetings either face to face or virtually.
- To attend related Walsall Partnership meetings to contribute to the key priority areas: Exploitation, Neglect and Domestic Violence.

- To work closely with NHS Black Country and West Birmingham CCG (Walsall Place) Designated Professionals for Children and Adults. This included the opportunity to access safeguarding supervision every 3 months.
- To contribute to the delivery of the Trust safeguarding training programme as described in the intercollegiate document (Children 2018, Adult 2019). As part of this process the training programme has been reviewed to ensure training groups and delivery standards remain robust. Training has been delivered both face to face and via MS Teams. Bespoke training has been provided throughout the year too.
- To support with safeguarding supervision to specific staff across the Trust. A cascade model of safeguarding supervision is provided in WHT to practitioners working directly with children and families across all thresholds, including those children who are subject to a S47 plan. The delivery of supervision is also provided by the team to key areas (acute paediatrics and emergency department). Throughout 2021, the team have implemented 'floor walks' across the Trust on a regular weekly basis.
- To provide specialist health advice and support to front-line staff for court work, strategy meetings and case conference purposes. This activity is reported monthly to Trust Safeguarding Group.
- To participate in quality assurance work via the Walsall Partnership Multi Agency Audit programmes and WHT Trust internal audit programmes.
- Undertake internal management reviews (IMR), safeguarding case reviews for children, adult and domestic homicide review purposes, Learning from Death Reviews for LD patients (LeDeR), including leading on RCA's for the Trust.
- To identify any current gaps in practice which requires addressing
- To co-ordinate the Trust's statutory responsibility to review safeguarding incidents against the Trust (S42 cases) which meet the threshold for multi-agency oversight.

During 2021/22 the Safeguarding and Looked After Children Administration Team expanded their role to include providing additional support to the adult team in the following areas:

- Management of safeguarding referrals and queries from external sources
- Co-ordination of all incoming and external safeguarding enquiries.
- Preparation of safeguarding paperwork which includes induction documentation for new starters in the Team; training packs; IT systems/Adult and Children Safeguarding database/Information access.
- Oversight of patient databases to flag safeguarding concerns.
- Maintenance of the databases that capture the safeguarding children and Looked after Children activity.

1.3 WHT Safeguarding and Quality Assurance Process 2021-2022

During 2021-2022 the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) and dataset was adopted to provide information and evidence that safeguarding responsibilities were being met by the organisation. The outcome of this process has continued to inform the WHT Trust Board; the Black Country and West Birmingham CCG (Walsall) and Walsall Safeguarding Partnership of the progress being made to safeguard local children, young people and adults.
In November 2021, WHT participated in the Walsall Safeguarding Partnership (WSP) Care Act Assurance self-assessment process and was rated as 'good'
In addition, during Q3, WHT participated in the WSP Section 11 (Care Act 1989/2004) self-assessment process and was also rated as 'good'.

1.4 WHT Trust Safeguarding Group (TSG)

The oversight of the Trust Safeguarding arrangements has been undertaken by the Trust Safeguarding Group (formerly known as Trust Committee). The Group has met on a monthly basis and attendance has been good (including participation from Walsall Local Authority, CCG and all WHT Divisions). The terms of reference for the Trust Safeguarding Group was reviewed in Q1 and via quarterly reporting, provides assurance that the experience of patients is fully compliant to the Mental Capacity Act 2005 and the Care Quality Commission's Essential Standards of Quality and Safety in relation to the Safeguarding agenda. TSG provides assurance to the Trust Board through reports to the Quality Patient Experience and Safety Committee (QPES) that different elements of the Safeguarding Children, Young People and Adults agenda are comprehensively addressed across WHT. The TSG continues to be chaired by WHT Director of Nursing.

During 2021 a concern was raised by the WLA and CCG in relation to the care and treatment of patients on one of the designated elderly care wards. This prompted a general review of safeguarding in Q1, and as a result a Safeguarding and Quality Steering group was instigated by the CCG and LA to support WHT to provide the assurances that concerns were effectivity being resolved. A safeguarding development plan was created to provide a focus for actions to be resolved. All key areas have now been addressed, and future monitoring of safeguarding items are discussed at the Trust Group. (**See Appendix 2 – Safeguarding Development Plan**)

2: Safety

All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect; are compliant with the Counterterrorism and Security Act 2015, and to assure themselves, regulators and their commissioner that these are working. These arrangements include:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults as appropriate. Safeguarding responsibilities are included in all staff job descriptions.
- A suite of safeguarding policies.
- Effective arrangements for engaging and working in partnership with other agencies.
- Identification of a Named Doctor and Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding children.
- Named professionals for Children and Young People in Care.
- Identification of a Named Lead for Adult Safeguarding.
- MCA lead – this must include the statutory role for managing adult safeguarding allegations against staff.
- Prevent Lead.
- Developing an organisational culture such that all staff are aware of their personal responsibility to report concerns and to ensure that poor practice is identified and tackled.
- Policies, arrangements and records to ensure consent to care and treatment are obtained in line with legislation and guidance including the MCA 2005 and Children Acts 1989/2004.

2.1 WHT Safeguarding arrangements 2021-2022

- Throughout 2021, WHT recruitment process continued to be compliant with the NHS Employment Standards which requires: Identity checking processes, requirement to ascertain references and details of employment history, requirement and process for applying for and reviewing DBS checks and a procedure for checking professional registrations and qualifications. The dataset that supports the recording of, and compliance against DBS checks has been under review following concerns raised that the information is not robust. A joint working group across WHT and the Royal Wolverhampton NHS Trust has since convened in 2022 to review the groups of staff who require regular checks, and to establish how these are recorded on the organisation IT systems.

- The WHT Safeguarding Team is in place and covering all key roles. During Q4 additional funding was secured to expand the team to include;
- A Deputy Head of Safeguarding (Band 8b) – start date is September 2022
- 2 Safeguarding Adult Nurse (Band 6) posts – start date is July 2022
- A Safeguarding Business Support Manager (Band 5) – currently in recruitment
- The WHT Named Midwife for Safeguarding (Band 8a) was recruited to during Q4 (subsequently commenced in post April 2022). This post holder will work closely with hospital and community teams to ensure there is a safe high quality service provision to service users by the continual development of practice in the light of research, evidence and audit against clinically relevant standards as an individual practitioner.
- The WHT acute learning disability nurse post (1.0wte) is provided through Black Country Healthcare NHS Foundation Trust. A review of the service has commenced in Q4 to consider the needs of the Trust and to understand the service specification that is currently in place. The national and local requirements reinforce the need to ensure that the Trust has an appropriate provision of support in place for patients who enter care with LD/Autism. To note that in Q1, RWT LD team will be providing interim support to the Trust to review the current provision and to outline any gaps.
- WHT has a Named Nurse for Safeguarding Adults who leads on the PREVENT agenda, and as part of that role, ensures that the Trust contributes to the identification, referral and information sharing in regard to those persons who are identified as supporting terrorism or right-wing ideology. The Trust has updated and approved its Prevent Policy in 2022. Basic (Level 1 & 2) Prevent training compliance was reduced to below 95% during Q1 and has thereafter increased to 95.1% in March 22. Prevent training (Level 3,4 &5) compliance has remained buoyant at over 95%. There has been 1 Prevent referral made by the Trust during 2021/22 as expected. There are plans during 2022-2023 to raise the profile of this agenda within ED and community settings.
- WHT has a Named Nurse for Safeguarding Adults who leads on the MCA/DoLS agenda. This role covers the delivery of bespoke training, oversight of audit activity and the coordination of targeting wards to raise the profile of this agenda. The Director of Nursing receives a monthly update report on patients who have been detained under the DoLS framework. The number of DoLS referrals has shown a slight variation throughout the year; Q1 = **79**, Q2 = **78**, Q3 = **93**, Q4 = **90**. (**See Appendix 3 – Safeguarding Dashboard)**. WHT are working with RWT safeguarding adult team to prepare for the planned introduction of Liberty Protection Safeguards in 2024 (known as LPS) by reviewing the processes within the 2 Trusts as part of a future partnership collaboration group set up within the region.
- WHT Safeguarding policies have been reviewed during 2022:
- Safeguarding Adult Policy – Updated and will be reviewed again in October 2022
- Safeguarding Children Policy – To be reviewed and updated by Q2.
- Mental Capacity Act Policy – Rewritten in Q4 and out for comments/consultation in June 2022
- DoLS Policy – Reviewed in Q4 and out for comments consultation in June 2022
- Prevent Policy – Rewritten in Q4. For review again in 2024
- Safeguarding Supervision Policy – Rewritten in Q3 and to be presented to Policy Group August 2022
- Domestic Abuse Policy (Organisation and Staff) – New policy in development for completion Q2
- Managing Allegations against Staff Policy – New policy in development phase for completion Q2/3
- WHT has continued to work closely with social care and the police within MASH to ensure safeguarding referrals have a 'health' oversight. WHT participate in all respective MASH/Local Authority referral meetings to review the Trust contribution and ensure that all systems and information sharing processes are robust in regard to safeguarding enquiries for children under Section 47 (Children Act) and investigations for adult under Section 42 (Care Act).

3: Training
Health providers must ensure the effective training of all staff commensurate with their role and in accordance with updated intercollegiate competencies relating to:

- Safeguarding Adults
- Safeguarding Children
- Children and Young People in Care
- Prevent
- Domestic Violence
- MCA and DOLS
- Learning Disabilities

3.1 Safeguarding Children and Adult Training progress 2021-2022

- WHT Safeguarding Training (Children and Adult Levels 1-3) has been monitored on a monthly basis during 2021-2022 at TSG to ensure that compliance is achieved. **(See Appendix 3: Safeguarding Dashboard)**
- Members of WHT Board received safeguarding training in November 2021. This is an annual training event and will be repeated again in November 2022.
- A review of the cohort of staff required to complete Safeguarding Adult level 3, was undertaken in Q2 to ensure that it reflected the learning outcomes documented within the Adult Safeguarding: roles and competencies for healthcare staff (2018).
- All mandatory safeguarding training has been delivered via eLearning or via IT platform during COVID.
- The Safeguarding Training Compliance report (outlined within the safeguarding dashboard) confirms that overall training compliance during 2021-2022 for children levels has varied, with good overall data in relation to Level 1 and 2, with a slight reduction noted for Level 3 in February and March 2022. Staff who had not completed their training have been requested to do so. Additional training dates have been set up to support staff to attend during Q4/Q1.
- Adult training compliance also confirms a variation in compliance. Level 1 and 3 compliance reduced significantly during Q4 due to a combination of staff absences and shortages. Additional training sessions have also been set up to ensure staff have access to more dates. During Q4/Q1 6 additional training sessions have been included. Staff who have not completed their training have been requested to do so.
- Domestic Violence Training has been incorporated into children and adult training packages (Level 3) and there will be a general review of WHT domestic violence training following the introduction of the forthcoming DV Policy.
- The MCA/DoLs training compliance during 2021-2022 has shown a moderate reduction in Q1, and on an upward trend at the end of Q4 following ongoing discussions at the Trust SG Group. Bespoke MCA/DoLS training is provided to all ward areas, and from Q2 this information will be recorded too.
- The Safeguarding Adult Team are 100% compliant with their Level 4 training
- The Safeguarding Children Team are 50% compliant with their Level 4 training due to external training being cancelled. Additional national training has been sourced for Q1/Q2.
- Domestic Violence Training has been incorporated into both children and adult training packages.
- The provision of LD training within WHT will be reviewed in 2022 (as part of the anticipated national Oliver McGowan training programme) and will form part of the LD review being undertaken at WHT. LD training is currently included as part of the adult training programme.
- In addition to mandatory training the safeguarding team has continued to offer bespoke training in targeted clinical areas.
- WHT hosted a Prevent Seminar event in Q3 with support from Walsall partners.
- Looked after Children (Children in Care) training has continued to form part of the Children Level 3 training package.

4. WHT Safeguarding Team Supervision Compliance:
Safeguarding Named Doctor/Nurse/Midwife/Named Professionals have access to advice and support and a minimum of quarterly supervision with Designated Professionals.

4.1 Safeguarding Team Supervision Summary Q1 – Q4:

The WHT Named Professionals are required to access personal safeguarding supervision on a regular basis (every 3 months). This is predominantly provided by the CCG Designated Nurse or via an external qualified supervisor. The compliance for 2021 – 22 is outlined below. The compliance depicts 87.5%, as a result of staff absences.

WHT Named Professionals:	**Safeguarding Team Supervision Compliance**	**Outstanding**
Q1 Named Nurses x 8	100% (8 out of 8)	0 outstanding in Q1 2021
Q2 Named Nurse x 8	87.5% (7 out of 8)	1 outstanding in Q2 2021
Q3 Named Nurses x 8	87.5% (7 out of 8)	1 outstanding in Q3 2021
Q4 Named Nurses x 8	87.5% (7 out of 8)	1 outstanding in Q4 2022
Named Doctor (Children) **Q1 – Q4**	100% (1 out of 1)	0 outstanding Q1-4
Trust Head of Safeguarding	Fully compliant with external supervisor Q1 – Q4	0 outstanding Q1-4

4.2 Safeguarding Team News 2021-2022

- All WHT Named Professionals were offered access to personal supervision on a quarterly basis, non-compliance was in the main due to staff leave and significant staff shortages during Covid. This was escalated and raised at the Trust Safeguarding Group.
- A new Named Doctor for Safeguarding Children was appointed during Q2.
- During Q3, the Safeguarding Children Supervisors from the 0-19 service joined the Corporate Safeguarding Team on an interim basis.
- A new Named Nurse (22.5 hours) was also seconded from the 0-19 service during Q4 to provide additional support to the team.

5. WHT Organisation Safeguarding Supervision Compliance:
Professionals supervising staff or working on a day-to-day basis with children and families
Should have child and adult protection supervision available to them appropriate to their role and responsibility in order to promote good standards of practice.

5.1 Supervision Compliance 2021-2022

- Safeguarding supervision is provided via a cascade model style approach (with Named Nurses/Professionals and other staff trained to deliver supervision within the Trust). Compliance figures indicate that generally this model appears to have been successful during COVID but will need to be reviewed again.
- Due to significant staff shortages within the safeguarding children team, there has been a delay in reviewing the mode of delivery, but this will be addressed as part of the work plan aligned to the Deputy Head of Safeguarding (due to commence in post September 2022).
- Practitioners working within school nursing and health visiting have been offered regular face to face or group supervision every 4 months.
- The Acute and Community Midwives have been offered supervision every 3 months via the Named Midwife or other qualified midwife.
- During 2021 the safeguarding service provided visible leadership to the ward and community areas to raise awareness of the safeguarding agenda and to offer support as needed. This activity has been recorded and presented to TSG on a monthly basis.
- The Safeguarding Supervision Policy has been amended and will be presented to the Trust Policy Group in Q2 (2022).
- 2 safeguarding supervision training events were commissioned during 2021 for 15 WHT staff to attend. The focus of this training was a general update and introduction to 'Think Family' concepts within the safeguarding agenda.

5.2 RWT Staff Safeguarding Supervision Summary Q1 – Q4

Total number of Health Visitors or School Nurses (HV/ScN) identified to receive safeguarding supervision within timescale (combined)	**Total number of staff who attended within timescale**	**Total number of midwives identified to receive safeguarding supervision within timescale**	**Total number of staff who attended within timescale.**
Q1 – 47 **(HV = 33, ScN = 14)**	HV – 23/33 = 70% ScN – 14/14 = 100%	**Q1 - 30**	22 = 73% (*Staff sickness*)
Q2 – 46 **(HV = 32, ScN = 14)**	HV – 22/32 = 69% ScN – 12/14 = 85%	**Q2 – 34**	33 = 97%
Q3 – 56	HV – 35/37 = 95%	**Q3 –27**	492 = 85%

(HV = 37, ScN = 19)	ScN – 17/19 = 89%		
Q4 – 51 **(HV =37, ScN = 14)**	HV – 37/35 = 95% ScN – 14/14 = 100%	**Q4 – 31**	23 = 73% (*Staff sickness*)

The above data demonstrates that there is good overall compliance for staff receiving supervision on a regular basis. It is noted that during Q1 and Q2 there has been a decrease recorded for Children Service (HV) compliance due to significant staff shortages due to COVID and vacancies within the service. Compliance has increased over Q3 and Q4. Maternity supervision was reduced slightly during Q1 and Q4 as a result of significant sickness within the service too. To note that during the end of Q4/Q1 group supervision has been implemented to ensure that staff had access to advice and guidance. All staff who were outstanding with their supervision training during Q1 – Q4 were requested to complete.

5.3 Staff Supervision Training Update

WHT Named Professionals are fully trained to deliver safeguarding supervision but will have further access to safeguarding supervision training during 2022-2023. There will also be a roll out of training following the release of the new safeguarding supervision policy (during Q3/Q4).

6: Safeguarding Activity and Process

Health providers are required to provide chronologies and reports for Section 42 Enquires, Child Practice Reviews, Child Death Reviews, Domestic Homicide Reviews, Safeguarding Adult Reviews and any other learning reviews as required, on time and in line with Safeguarding Partnerships and Community Safety Partnerships Terms of Reference and templates. Resulting organisational action plans must be addressed as agreed by the Safeguarding Partnerships and DHR Standing Panels.

6.1 WHT Compliance 2021-2022

- During 2021-22 WHT were represented at all respective partnership safeguarding groups across the region; including Walsall Partnership Practice Review Group (known as PRG), Learning from Death Reviews regarding LD patients (LeDeR) Steering Group, Community Safety Partnership meetings (regarding Domestic Homicide Reviews) and local authority meetings following cases that met the threshold for Section 42 partnership oversight.
- WHT Internal Practice Review Group was developed in Q2, chaired by Deputy Head of Safeguarding (RWT). Terms of reference have been written and this group is responsible for monitoring the implementation of the action plans that arise from Walsall PRG and LeDeR Steering Group.
- WHT have contributed to all requested chronologies and reports throughout 2021.
- There has been 3 Safeguarding Adult Reviews (SAR 6,7,8) and 1 Child Safeguarding Practice Review (CSPR) commenced during 2021. All cases are currently in the review stage.
- During 2021 progress has been made with concluding outstanding WHT actions linked to historical cases which were not progressed due to COVID.

From Q1 WHT has ensured that learning from all types of previous reviews has been disseminated Trust wide via:

- Trust brief
- Daily Dose
- 7 Minute briefings
- Bespoke/Training
- Specific targeting of professionals/wards

Recommendations are also embedded within mandatory and bespoke safeguarding training and through the supervision process.
Single agency action plans have also been discussed and updated at:

- The WHT Emergency Department Informal Safeguarding Meetings (Children)
- The Trust Safeguarding Committee Group
- Divisional Governance meetings (Safeguarding and Trust wide)
- Matrons and Heads of Nursing meeting from Q4
- Practice Review Group
- WHT internal CSPR/SAR/DHR Meeting
- Operational Meetings (Safeguarding Children, CYPiC, Learning Disability and Safeguarding Adults)

Key themes identified for adult cases include recognition of self-neglect, safety regarding smoking and using oxygen therapy at home, ensuring there is a robust mental capacity assessment in place and the long-term health implications for patients who are refusing to eat.

6.2 Section 42 Enquiries

- In the 12 month period from April 2021 to March 2022, there was a total of 109 referrals (Q1 = 26, Q2 = 33, Q3 = 29, Q4 = 21) that met the criteria for a section 42 enquiry (as per the Care Act 2014). General care, acts of omission, neglect and poor discharge concerns were the main themes identified within these reviews.
- A monthly meeting between WHT and Walsall Local Authority has been set up from May 2022 to review all open S42 cases and to ensure that progress and action planning is implemented to address concerns.
- The activity for S42's is reported on a monthly basis and presented to TSG for oversight.

7: Learning Disability Mortality Programme (LeDeR)
Health providers are required to fully engage with the Learning Disability Mortality Programme (LeDeR) by reporting deaths, identifying suitable reviewers, completing reviews, implement subsequent local and national learning and allowing timely access to patient information as part of the LeDeR process.

7.1 Learning Disability Mortality Programme (LeDeR)

- WHT has attended the regional 'Learning from Death Review Group' (LeDeR) during 2021, attendance at this meeting has been reviewed and will now be represented by the RWT Lead Learning Disability Nurse, who is providing professional support to the Trust during 2022.
- All LD patients (4 years above) who die are reported to the LeDeR programme for their case to be reviewed. WHT have referred 15 cases into the programme during the past 12 months.
- The Lead LD Nurse is attending WHT Mortality Review Group to ensure the profile of these cases are in line with national reporting and oversight requirements.

8: Safeguarding Assessment Processes
Health providers are required to provide evidence that patient assessment processes within
The organisation identifies appropriate risk and need, and result in an appropriate response; including where the criteria for statutory enquiries are met/or not met.

8.1 Update on WHT Safeguarding Assessment Processes 2021-2022

- Throughout 2021-2022, WHT Children's Service (Health Visitors/School Nurses/Children Community Teams) and Maternity staff have contributed to the various Walsall early help and prevention services that are commissioned to support vulnerable people including looked after children and those who require the support from teenage pregnancy services.
- WHT have contributed to the domestic abuse agenda through their input into Domestic Abuse Daily triage and the MARAC (Multi Agency Risk Assessment Conference) process by scoping relevant victim information on patient electronic records covering both adult and children activity. WHT contributed to 100% of meetings either face to face or via remote correspondence. Work is continuously undertaken to raise the profile of domestic abuse in view of isolation and restrictions placed on vulnerable people during COVID. Domestic Violence/Abuse will remain a focus for the Trust during 2022. The forthcoming DV Policy will also raise the profile within the Trust to ensure staff are supported with making effective referrals to MARAC too.
- The Safeguarding Children and Adult team have continued to raise the profile of safeguarding via the 'floor walks' undertaken across the Trust (and particularly at Walsall Manor Hospital). This has been well received across the Trust.
- During Q1, WHT Safeguarding Adult Team commenced a campaign to raise awareness of safeguarding and risk within the Trust supported by CCG and LA. As a result, ward staff have been supported to escalate safeguarding issues as required and in a timely manner. A questionnaire was used with staff to establish the baseline knowledge of safeguarding within the Trust, and it has provided assurance that overall staff had a reasonable understanding of the safeguarding agenda (and ability to know their role within this process).
- WHT Safeguarding Service continue to provide an advice call service: Monday to Friday 8.30 -5 (children) or 9-5 (adults). The number of calls and associated activity are collated and have been reported to the TSG on a monthly basis.
- The WHT Named Nurse for Children continues to be provide cover within Walsall MASH for safeguarding children referral activity and for Domestic Abuse Triage. This covers Monday to Friday as per MASH requirement. WHT have provided 100% cover during 2021 – 2022. MASH checks have risen by over 20% in Q4. (Q1 = 829, Q2 = 902, Q3 = 945 and Q4 – 1279). It has been recognised that the cases are more complex now, and poor mental health issues form a significant theme in relation to the cases discussed.
- During Q1 – Q4, the safeguarding service supported practitioners to complete court statements requested by local authority legal services. The health visiting, school nursing service and neonatal unit staff received the majority of requests for statements to be prepared for the Courts. Court statement activity has been buoyant (Q1 = 29, Q2 = 22, Q3 = 51 and Q4 = 40).
- Throughout Q1-Q4, the Trust Safeguarding Group received a monthly report outlining the number of DoLS applications and the number of safeguarding referrals that met the threshold for S42 criteria for investigative work. The outcome of patients who were treated under a DoLS process was also reported to CQC as per statutory requirement.
- WHT utilise the Child Protection Information Sharing (CP-IS) model within ED, Maternity and Children Ward. This is a national process, endorsed by CQC, which helps health and social care staff share information securely on vulnerable children (known to social services as a Looked after Child or on a Child Protection Plan) who present at NHS premises for treatment options. This enables safeguarding services to provide better care and earlier interventions for children who are considered vulnerable and at risk. The effectiveness of this process requires a review, which will be undertaken during Q2.
- The RWT Lead Nurse for LD has commenced a review of the flagging process of patients with a LD/Autism diagnosis during Q4. This work will be progressed over 2022/2023.

9: Safeguarding Audit
Health providers are required to provide evidence of incremental improvement of processes over time through; regular evaluation through audit, leading to required improvements in the light of their efficiency, effectiveness and flexibility.

9.1 WHT evidence of incremental improvement of processes during 2021-2022:

- During Q1 WHT Safeguarding Children Team participated in a multi-agency case file audit to consider the impact of 'Neglect' with the focus on agency recognition, impact, agency response, stakeholder engagement, communication pathway and the voice of the child. As a result of this work, a multi-agency action plan was developed which has focused on the use of appropriate assessment tools for staff to use to identify those cases that may require escalation or intervention. WHT attend the partnership neglect group, and during 2022 will be contributing to the neglect strategy roll out process across Walsall.
- WHT participated in Walsall Partnership assurance audits in respect of Section 11 of the Children Act 2004, and Care Act 2014. The feedback during Q3/Q4 from the Walsall Partnership was that WHT had good governance arrangements overall. Positive feedback referred to WHT having effective governance, training, service engagement and working within the 'Think Family' model.
- During Q4 WHT participated in a multi-agency audit in regard to people in a position of Trust. The feedback session is to be conducted in Q1.
- During Q4 WHT participated in the audit to assess if practice was in keeping with the Protocol for Injuries in Non-Mobile Children presenting in the Emergency Department. The findings are yet to be published and the feedback sessions will be held during Q1/Q2.
- Throughout Q4, WHT, Walsall Local Authority and Walsall CCG met to conclude the actions that were highlighted and progressed as part of the actions cited within the safeguarding development plan. The work has progressed significantly in relation to these concerns (raised during 2021) and improvement noted as a result. The safeguarding development plan now forms part of the normal reporting process through the Safeguarding Group and continues to provide assurance to the CCG and Local Authority.
- An audit (planned during Q4) related to WHT and compliance with the use of the Child Protection Information Sharing System (CP-IS) has been delayed until Q2 2022.
- The safeguarding team continued to undertake the Trust audit around RESPECT and MCA completion for those adults deemed to lack capacity in relation to the decision. Results have been disseminated to the Divisional teams for review and reported corporately through PBI reports.
- WHT have participated in reviewing services in advance of the expected SEND inspection and Joint Targeted Area Inspection (JTAI) which is due at the end of 2022.

10: National Reports / Inquiries
Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.

10.1 Liberty Protection Safeguards

- In July 2018, the government published a Mental Capacity (Amendment) Bill, which passed into law in May 2019. It replaces the Deprivation of Liberty Safeguards (DoLS) with a scheme known as the Liberty Protection Safeguards. Fact sheets were provided by the Department of Health in 2020, outlining the key changes that will be introduced, although practice guidance which was expected to

be released in 2021, has been delayed. This will impact on the planned implementation date, which has already been moved to October 2023. WHT will be working with RWT to address the practice guidance once published, and an audit of patient's records (to ensure MCA is embedded in practice) will be undertaken as part of the benchmarking for this anticipated process.

10.2 Inquiries

- During Q1 (2022) there is an anticipated Walsall SEND inspection, which the Trust will be co-operating with.
- During 2022, the Trust will be responding to any actions referenced within the Child Safeguarding Practice Review (Star/Arther) which is to be released during May 2022.

10.3 Key priorities for WHT Safeguarding Service for 2022/2023:

- To complete the recruitment of staff within the safeguarding team by Q3.
- To review and combine safeguarding children and adult practices across WHT and RWT organisation.
- To develop a single reporting framework/annual report for WHT/RWT in 2023.
- To ensure that all key Walsall Partnership meetings are attended by WHT.
- To complete all outstanding actions from CSPR/DHR/SAR/LeDer and internal case reviews.
- Audit the CPIS system of identification of children subject to child protection plans, when visiting ED.
- Review the Trust Safeguarding Training programme in Q3/4
- Work internally and externally with key partners to ensure that WHT supports the work regarding 'Making Safeguarding Personal for adults and children' approach through reporting processes to Trust SG Group
- To identify patients with a LD/Autism diagnosis
- To review WHT Children and Adult Safeguarding Policies and ensure compliant with national and local policies or standards
- In readiness for the implementation of LPS, WHT will need to embed the MCA agenda within practice and participate with regional leads to develop systems and processes that will address the requirements following the anticipated introduction of LPS in 2023.
- To monitor and review the role of WHT health representation within MASH.
- To review DBS compliance across the Trust.

4. RECOMMENDATIONS

The Committee is asked to receive the report for information and assurance

APPENDICES

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Walsall Together Partnership Board
Date(s) of Committee/Group Meetings	Wednesday 20th July 2022
Chair of Committee/Group:	Professor Patrick Vernon
Date of Report:	27th July 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Demand on services is still at a sustained high level • Delays in two projects within the transformation programme were identified and rectification actions agreed • The remaining place based workstreams have now identified Senior Responsible Officers • A detailed breakdown of the ICS funding expenditure was shared with the WT Partnership Board
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The Walsall Together Partnership Board met on Wednesday 20th July 2022, chaired by Professor Patrick Vernon • There were 3 items for escalation to the Trust Board, they are. [1] The sustained demand within the system and the pressures faced by teams to ensure effective service delivery. [2] Resource allocation from system to place and the rigidity of funding application processes [3] To raise awareness of discussions around the ongoing cost of living
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The spending plan for the next instalment of ICS funds was approved by the board • The board also agree the governance for the spending will sit with the WT Senior Management Team • There will be no formal board meeting in August, the slot will be used for a workshop to discuss the Place Based Development work
Recommendation(s) to the Board/Committee	• Members of the Trust Board are asked to note the contents of this report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• Partners received an overview of the Partnership Risks for which the Partnership Board is the monitoring group. Key themes within the risks reflect the continued demand across the system. The detail of the risks was reviewed and approved.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Workshop to be held in August for all partners to review Governance and scope of services for Walsall Together

ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	**User Story: Walsall Housing Group (whg) Social Prescribing Programme** The Board were presented with a story from an individual who had been supported through the whg social prescribing team. The presentation outlined the interventions that had been delivered and how they had increased the person's self-esteem and skills. The individual involved was assisted to take part in whg's stay safe befriending campaign that was established during the pandemic, and this proved to be a gateway to securing employment as a Community Connector. The presentation outlined innovative ways of making links within hard-to-reach communities and with people who often decline educational resources. The discussion highlighted the support offered by Walsall College and outlined different social prescribing models within the borough and how they could provide support to more people. **Transformation Update**: The Board took assurance that there were no new or significant risks to delivery of the transformation programme. There are currently 2 live projects that are facing obstacles but all of them have robust actions to address the issues.

ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	**Operational Update:** In June the high level of demand on services provided within the Partnership was sustained. There had been a visit to Walsall from the National Discharge team looking at good practice and they had highlighted the willingness of teams across partners to work together for the benefit of the patient / citizen. There was discussion about the process and level of detail required to gain funds form the Black Country system to support initiatives at place. **Place Based Development**: The board received assurance that the agreed workstreams within the place development programme are being mobilised. Senior Responsible Officers for the two remaining workstreams have now been identified. Details of the expenditure of the ICS funds for 2021/22 and 2022/23 were shared with the group. It was agreed that the governance for the spending plan will sit with the WT Senior Management Team. There was a discussion regarding proposals around governance and scope of services for the place-based partnership. It was agreed that August board meeting slot will be used for a workshop to consider these in more detail. **Cost of living crisis:** There was a discussion about the impact of the cost-of-living crisis. This included findings from all areas and organisations within the partnership and the effects it is having on staff as well as residents. The board has tasked the Resilient Communities steering group to map out current services and infrastructure within Walsall to address some of the impacts. **Items for Escalation:** There were 3 formal items for escalation to the Trust Board. 1. The sustained demand within the system and the pressures faced by teams to ensure effective service delivery. 2. Resource allocation from system to place and the rigidity of funding application processes **3.** To raise awareness of discussions around the ongoing cost of living crisis
Matters presented for information or noting	• Clinical and professional leadership group highlight report • Workforce & OD steering group highlight report
Self-evaluation/ Terms of Reference/ Future Work Plan	• Through the discussion at the WTPB, there was reflection on the cost-of-living crisis and the significant impact on many citizens in Walsall, recognising the implications for health and wellbeing
Items for Reference Pack	N/A

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 3rd August 2022			
Care at Home Report		**AGENDA ITEM:**	
Report Author and Job Title:	Michelle McManus, Acting Programme Director	**Responsible Director:**	Matthew Dodd, Director of Transformation
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒		
Assure	• Hospital avoidance and step-up pathways continued at the same levels within the borough and performance remained strong in the Care Navigation Centre. This has helped to relieve pressure on the Ambulance Service as well as the hospital sector		
Advise	• The partnership is awaiting NHSE/I approval for bids submitted in May around the development of virtual wards and out of hospital schemes related to the use of technology • Walsall Together has presented its work on discharge practice and admission avoidance to the NHSE/I national team for Hospital Discharge & Recovery • Walsall Together has submitted a proposal to NHSE/I to become a National Discharge Exemplar site • Walsall Together is reviewing governance models and in-scope services for place-based partnership arrangements within Walsall		
Alert	• There is sustained demand for support around complex hospital discharge and although the average number of days medically stable for discharge has remained stable, the overall number of people waiting rose in June and is following a similar trend in July		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk - Failure to deliver care closer to home and reduce health inequalities		
Resource implications	Bids have been submitted to NHSE around the development of virtual wards and hospital at home schemes related to the use of technology		
Legal and/or Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence locally and nationally. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Care at Home Executive Summary
August 2022

1. PURPOSE OF REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain during June 2022.

Detailed discussions in these areas have been covered in the relevant Board Committees in previous months in addition to review by the Walsall Together Partnership Board.

This report covers:

- Operational performance for community services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1)
- An update on the transformation of services and place-based partnership arrangements in Walsall

2. BACKGROUND

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

3. PERFORMANCE, ASSURANCE AND RISK – COMMUNITY SERVICES

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

The WT Senior Management Team and WT Tactical Command continue to focus on the impact of operational performance and pressures on the citizens of Walsall and how it affects their health & well-being.

3.1 Demand: Demand for Community Locality Services remained stable at 6,658 hours of care, while the Care Navigation Centre saw a sustained high level of demand with 1,307 calls. This demand profile was also reflected within primary care services in June

3.2 Capacity:

Locality Teams: The Locality Community Teams met 88.2% of the demand in month, compared with its delivery of 93.6% in May. Work around recruitment and sickness management continues as the response to the variation seen in capacity.

Discharge & Step-Up Pathways: The number of people at Walsall Manor Hospital who were medically stable for discharge increased from 47 in the previous month to 50 in June. The length of staff for each person who was medically stable for discharge

remained stable at 4 days, reflecting increased demand. Within community pathways, the average length of stay for people discharged from interim care home placements remained high at 40 days. The overall number of people in community beds remained in excess of the local standard. These trends have continued in the early part of July and measures to address them have been commenced. A multifactorial approach is being implemented which includes a plan submitted to the National Discharge Exemplar team as well as a review of discharge team capacity at Walsall Manor Hospital.

Systems Pressure Plan: The Partnership awaits a decision around the £1.2m set of proposals that were submitted to NHSE/I in May against the Service Development Fund. A request for further bids against the SDF and Ageing Well funds has been requested from NHSE/I and outline proposals have been submitted.

4. RISK REGISTER

The overall risk score on the Care at Home Board Assurance Framework (BAF) has remains at level 12, reflecting the assurance available regarding the partnership's ability to respond to significant system pressures. The BAF remains under review by the partnership and in parallel to the review of the Trust Strategy.

The following risk remains on the Corporate Risk Register:

- Risk 2370 – Delays in presentations for other, non-COVID, conditions may further exacerbate health inequalities and increase the risk of premature mortality.

The following risk has been de-escalated following assurance that services have continued to operate despite continued pressure on the workforce due to Covid and recruitment challenges. It will continue to be monitored at divisional level and across the Walsall Together partnership:

- 2372 – The appropriate workforce and skill mix required to deliver the business case model may not be available. This is further exacerbated by the COVID-19 pandemic and Brexit. There are shortages across several staff groups.

5. PLACE-BASED PARTNERSHIP DEVELOPMENT

The Walsall Together place development programme has been agreed by the Partnership Board. There are six workstreams: Finance & Contracting; Integrated Governance; Data & Intelligence; Workforce & OD; PCN Integration; Citizen Voice which will focus on implementing the requirements of the Integration White Paper. At its meeting in July, the Partnership Board discussed proposed governance structures and services that were to be considered in-scope for the place-based partnership. A workshop is planned for the middle of August to examine these further.

6. RECOMMENDATIONS

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

APPENDICES

Appendix 1: Operational Performance Report for June 2022: Walsall Together

Walsall Together

Walsall Together Partnership Operational Update: July 2022

Matthew Dodd
Director of Transformation

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds					2020-2021	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Tier 0: Resilient Communities												
Social Prescribing	whg - No. referrrals received							47	43	33	32	33
	Primary Care - % referrrals received East 1	<0.4%		>= 0.4%			0.55%					
	Primary Care - % referrrals received East 2	<0.4%		>= 0.4%			0.50%					
	Primary Care - % referrrals received North	<0.4%		>= 0.4%			1.30%					
	Primary Care - % referrrals received South 1	<0.4%		>= 0.4%			0.71%					
	Primary Care - % referrrals received South 2	<0.4%		>= 0.4%			1.30%					
	Primary Care - % referrrals received West 1	<0.4%		>= 0.4%			0.80%					
	Primary Care - % referrrals received West 2	<0.4%		>= 0.4%			1.78%					

	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Workforce: Anchor institutions	No. staff employed by whg via scheme												68	No data receieved	75	79	86	96	96	100
	% whg customer's												38%	No data receieved	37%	37%	38%	39%	38%	38%

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services																				
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	10905.5	10347	9450.25	5576	6574.25	5945.25	5769.75	6038	6127	7015.75	6228.5	5210.5	5713.5	5495.25	6452.75	5871.5
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	473.00	305.00	623.00	1019.75	1452.50	1545.50	1556.50	1255.25	1271.00	1093.25	860.50	920.00	1172.50	906.00	438.25	787.00
	% of hours demand unmet	>23%	20%-23%	<20%	4.2%	2.9%	6.2%	15.5%	18.1%	20.6%	21.2%	17.2%	17.2%	13.5%	12.1%	15.0%	17.0%	14.2%	6.4%	11.8%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	29	19	19	27	25	26	26	22	26	24	26	23	25	25	26	28
	No. referrals received	<100	100-200	>200	29	27	35	37	26	26	34	26	30	27	25	24	22	19	30	39
	No. cases reviewed	<100	100-200	>200	29	27	32	40	90	96	92	88	120	103	108	89	117	83	102	142
Adult Social Care	1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	<100%		100%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).					2.8%	2.8%	2.9%	2.9%	3.1%	3.1%	3.2%	3.4%	3.3%	3.3%	3.3%	3.6%	3.8%	4.0%	3.9%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).					84.8%	85.5%	84.5%	84.9%	84.4%	84.6%	84.4%	84.4%	84.7%	84.9%	84.9%	85.1%	85.6%	85.7%	85.7%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1		1.2	2.4	3.0	3.0	3.0	3.6	4.8	6.6	7.2	7.8	9.0	11.9	0.6	0.6	1.8
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8		69.3	142.6	186.1	229.7	257.4	306.9	344.6	405.9	437.6	479.2	510.9	562.4	47.5	108.9	140.6
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%		79.0%	83.8%	77.6%	82.8%	85.6%	84.4%	81.7%	85.2%	74.8%	81.8%	80.4%	78.1%	84.6%	86.9%	79.3%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				449	478	494	550	553	617	661	695	738	724	831	718	930	905	939	989
	Care and Support Assessments and 3 Conversations Completed - Total				351	324	302	343	346	341	346	287	313	292	296	429	316	280	327	358
	Monthly Adult contacts completed by Team				1,122	1,030	1,010	1,094	1,025	1,061	1,131	1,071	1,235	1,019	1,228	1,207	1,314	1,162	1,247	1,207
	Total Initial & Subsequent Reviews Completed				451	295	323	334	327	268	290	290	268	249	288	304	372	265	241	267

[Emergent] Score Card for WT Tiers – Tier 2

Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Tier 2: Specialist Community Services																				
ASC Safeguarding Concerns	Concerns received				297	253	292	307	315	258	286	316	297	265	291	336	323	284	381	354
	Concerns progressing to s42 eqnuiry				72	79	84	83	88	66	81	87	79	83	73	91	79	76	61	65
	% of concerns progressing to s42 enquiry				24%	31%	29%	27%	28%	26%	28%	28%	27%	31%	25%	27%	24%	27%	16%	18%
	Safeguarding cases in progress				39	25	48	15	36	20	17	35	31	7	34	86	63	80	84	129
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,258	1,267	1,259	1,285	1,294	1,330	1,329	1,353	1,325	1,297	1,269	1,276	1,293	1,326	1,333	1,321
	Vacancies	>291	144-291	144<	436	430	441	416	408	368	370	357	412	416	494	432	409	418	431	403
	% vacant beds	>15%	8-15%	8%<	25.7%	25.3%	25.9%	24.5%	24.0%	21.7%	21.8%	20.9%	23.7%	24.3%	28.0%	25.3%	24.0%	24.0%	24.4%	23.4%
	Total No of Care Homes	53<	53-56	>56	57	58	58	58	58	58	58	58	59	59	60	60	59	61	60	58
	Closed to admissions	>8	3-8	3<	14	7	8	8	2	10	12	5	6	28	20	13	8	9	8	18
	% of available homes closed to admissions	>10%	5-10%	5%<	24.6%	12.1%	13.8%	13.8%	3.4%	17.2%	20.7%	8.6%	10.2%	47.5%	33.3%	21.7%	13.6%	14.8%	13.3%	31.0%

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

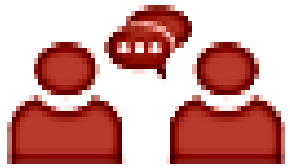
[Emergent] Score Card for WT Tiers – Tiers 3 (& 4)

Walsall Together

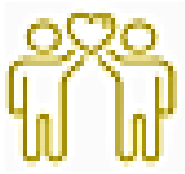
Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Tier 3: Intermediate Care, Unplanned Care & Crisis Services																				
Care Navigation Centre	Calls received	<435	435-512	>512	550	580	691	747	821	840	869	925	861	1094	1225	1170	1338	1278	1270	1307
Rapid Response Team	Referrals received	<160	160-247	>247	232	210	216	304	301	334	227	230	264	268	260	254	294	281	294	242
	% admission avoidance	<73%	73%-87%	>87%	77.2%	79.2%	79.6%	78.4%	84.7%	86.8%	79.7%	87.4%	91.7%	90.7%	90.4%	91.3%	85.7%	91.9%	89.2%	98.0%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	29.33	31.13	31.86	31.89	48.56	47.38	52.11	41.00	44.67	40.25	48.00	45.88	52.67	50.28	46.40	50.10
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	2.7	2.7	3.6	3.9	4.2	5.1	4.5	4.5	4.6	3.6	3.4	3.5	3.8	4.3	4.0	4.0
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	30	27	29	N/A	N/A	N/A	N/A	N/A	35	34	32	26	28	28	27	25
	Domiciliary Pathways - Average service users				188	181	180	N/A	N/A	N/A	N/A	N/A	196.5	207.75	200.2	181.5	180.25	198.25	213.6	222.2
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	29	46	49	N/A	N/A	N/A	N/A	N/A	33	50	43	38	37	54	48	48
	Bed-based Pathways - Average beds in use				83	67	61	N/A	N/A	N/A	N/A	N/A	86.5	68.5	74	82.5	90	75	82	81
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	39	43	90	90	80	72	113	84	94	85	158	168	162	210	193	224
	Prevent Readmission	35<	35-50	>50				63	60	62	20	43	33	32	41	37	27	20	19	10
	Early Supported Discharge	40<	40-54	>54	52	53	105	43	48	47	26	35	29	65	35	44	45	29	31	48
	Assisted Discharge	35<	35-50	>50	75	75	71	63	103	61	42	54	42	75	54	40	35	56	68	76

Tier 0 Resilient whg The H Factor Social Prescribing Programme .

20 Referrals received



83 Clever Conversations



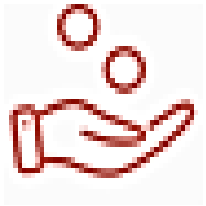
13 sign up to the Social Prescribing programme

13 Co – production of a WOOP Plan

(Wish Outcome Obstacle Plan)

7 Completed of a WOOP Plan

5 Referrals into training and education



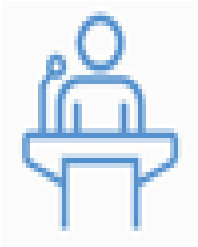
7 Referral Money Advice

Tier 0 Resilient Communities Kindness Counts Loneliness and Isolation

42 Clever Conversations

485 ONS Isolation assessments Completed as part of the Kindness Rocks engagement activity

2 Home visits or 1 to 1 face to face visits completed & 40 Phone calls



4 Community Events held

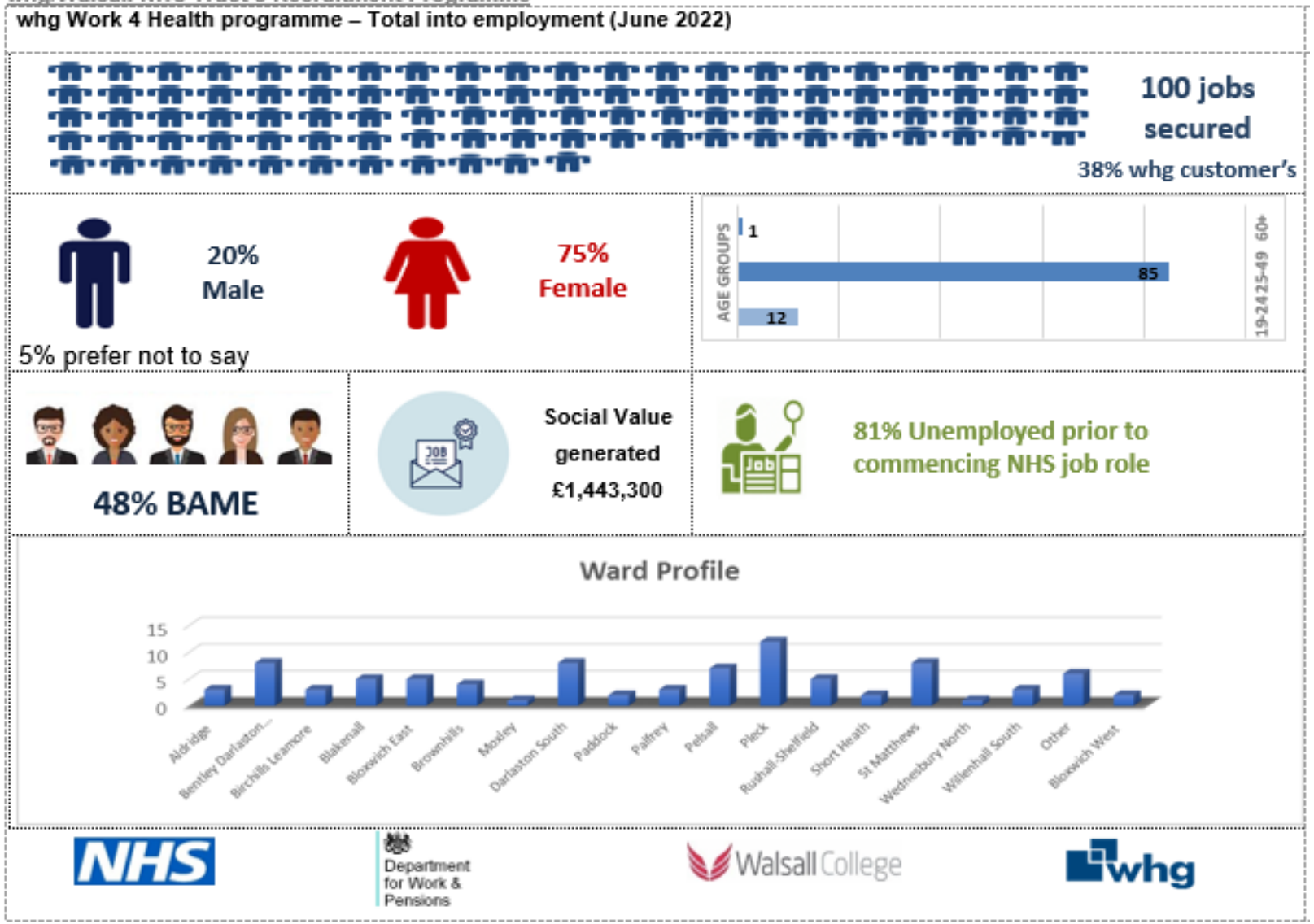
2 Referral Money Advice

2 Referrals into training and education

TIER 2 Workforce Development Work 4 Health

Walsall Together

whg/Walsall NHS Trust's Recruitment Programme



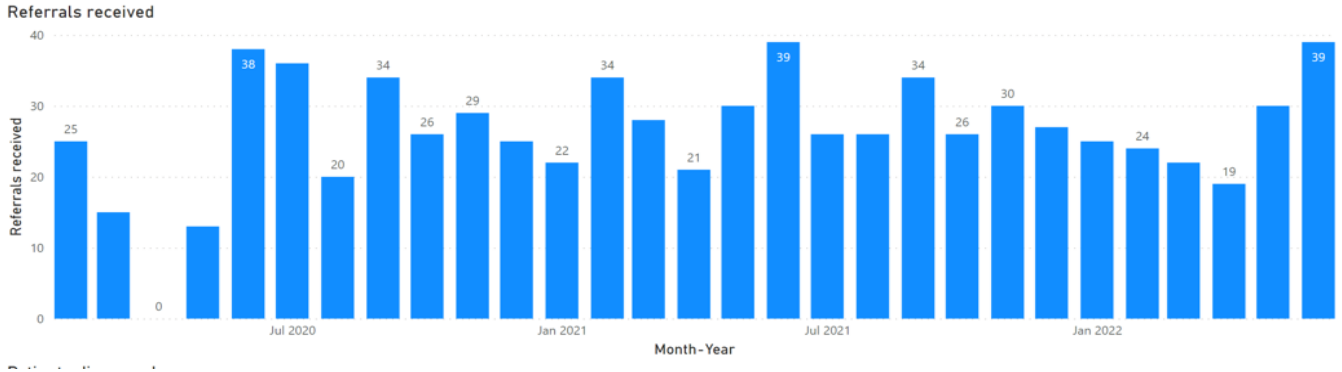
Tier 0: Walsall's Voluntary & Community Sector – One Walsall

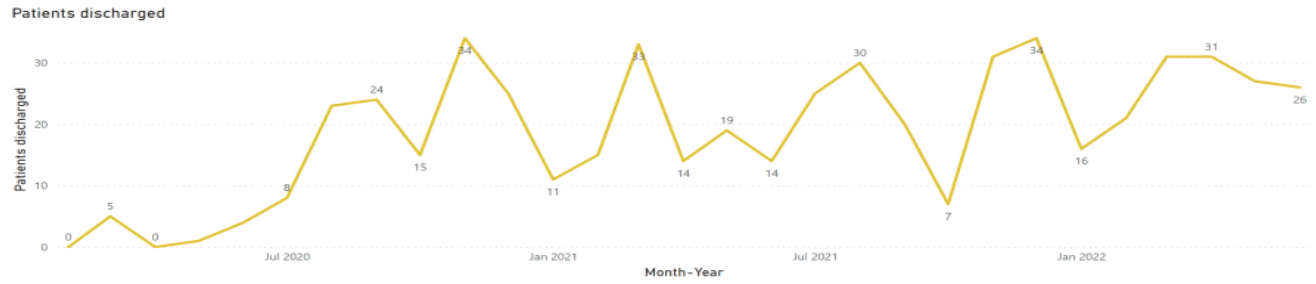
- Work is now underway to promote the Queen's Volunteer Awards ahead of this year's Jubilee. Several Jubilee events are begin held across the borough supported by various funding streams, including events in Mossley, Palfrey and Brownhills.
- Collaborative work and consortia approaches are emerging as a consistent theme for the sector, as groups identify partners to bid for potential contracts for community delivery. This is an encouraging trend as groups look increasingly to work together to enhance their capacity, sustainability and social value.
- Another trend emerging is the continued popularity of Community Interest Companies (CIC). OW will be launching a package of training, support and networking to enhance the offer that social enterprises offer in Walsall
- The six shortlisted applicants for the Health inequalities will be engaging shortly with quality assurance assessments via the One Walsall Development Tool), which will look at financial stability, governance, safeguarding and other areas that will assure funders of project delivery.

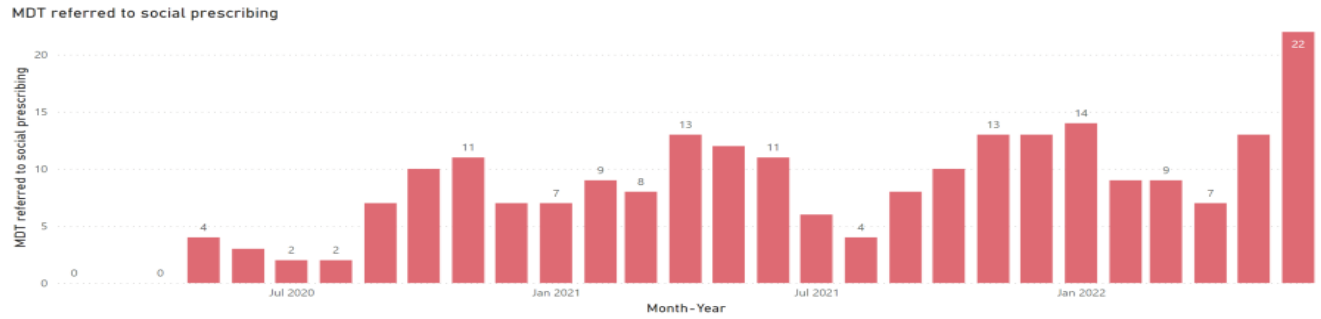
Last updated on May 2022

Tier 1: Multidisciplinary Team (MDT)

Demand is significantly below capacity for GP-led Multidisciplinary Team







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

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

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

Last updated on May 2022

Tier 1: Primary Care Standard Operating Procedure (SOP)

- Primary care offering patients F2F appointments via patient choice, the appointment books are a blend of F2F, telephone calls and online offering

Current Pressures:

1. Access to appointments
    - LTC management backlog
    - Out patients backlog
    - Acute Covid appointments
2. Management of QoF and local commissioned services
3. Access to Out-patient services
4. Patient Demand
5. Zero Tolerance and abuse

Last updated on May 20212

Tier 1: Primary Care Appointment Access (Mar 2022)

- Black Country STP
  - 647,216 appts
  - 585,334 attended (90.43%)
  - 37,848 – DNA (5.84) up by 0.5%
  - X1 appt per 2.3 patients (appt vs patient)

- 66% F2F appts up (64% Mar 2022)

- Slight drop in appointments in May in comparison with March due to x3 public holidays

Last updated on May 2022

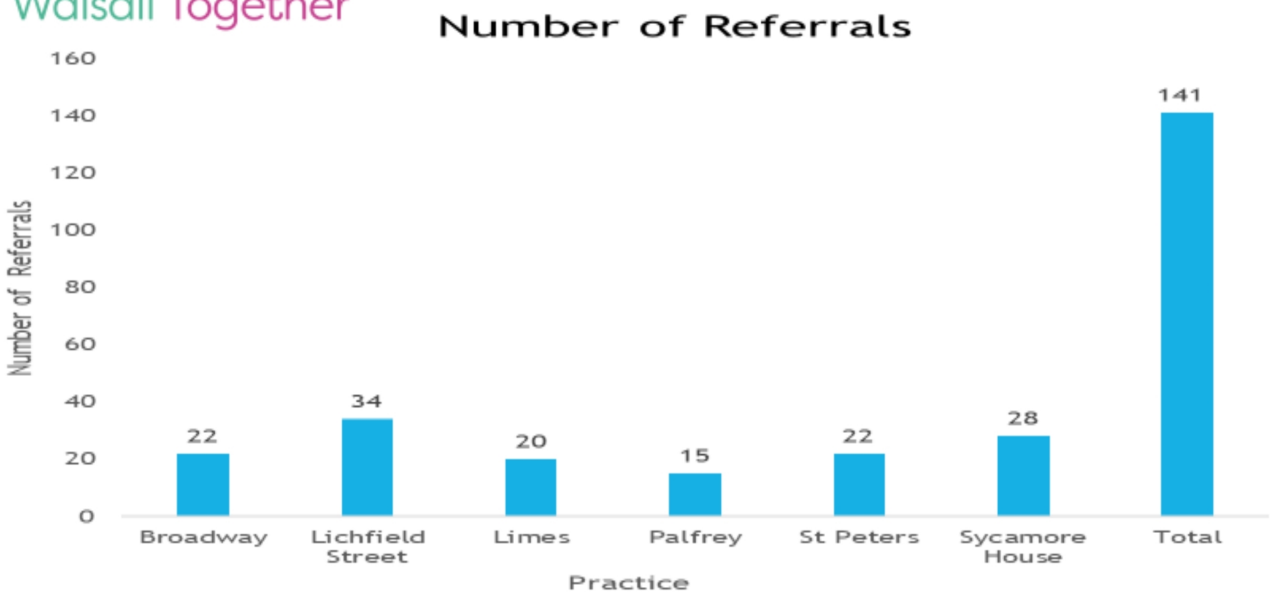
Tier 1: Primary Care Network(PCN) – Additional Roles Reimbursement Scheme (ARRS)

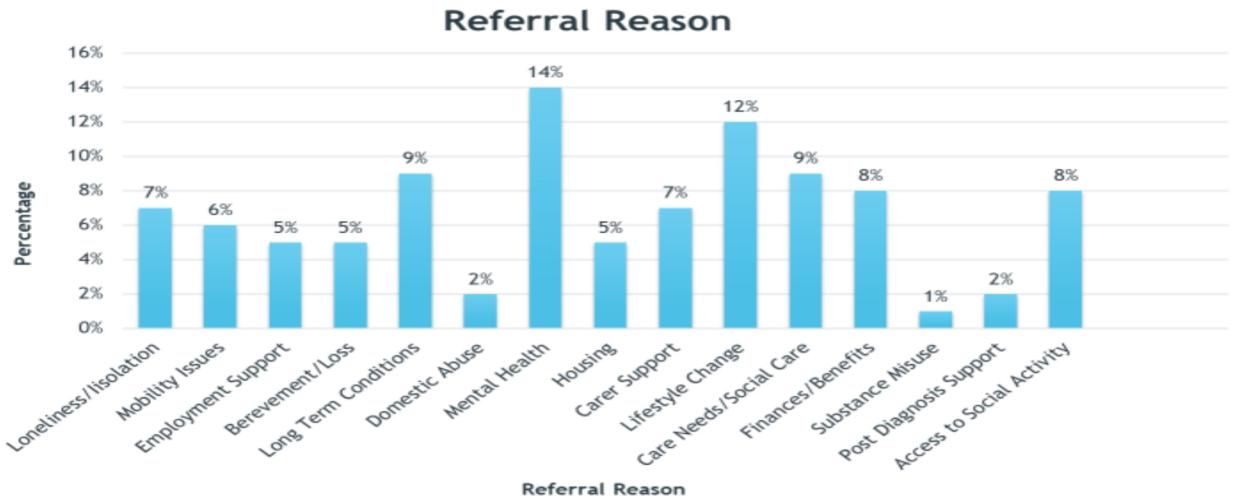
- Currently 3 projects involving PCN ARRS and WT.
  - First Contact Practitioner (FCP) - **x1 WTE in South 2 and 0.33 WTE starting in North via WHT , West , East & South 1 have sourced their own FCPs.**
  - First Contact Mental Health Practitioner - **x4 currently in place in South 2 , West 1 & 2 and East 1 via Mental Health Trust**
  - SPs development and collaboration
- Mental Health Practitioner recruitment and retention has been challenging with x4 successful applicants in post. North , South 1 , East 2 still outliers
- SPs have met at WHG with plans to share best practice and further strategic development for wider collaborative working

Last updated in July 2022

Social Prescribing – South 2

- 140-150 referrals per quarter on average - 1.5% over the full financial year
- Mental Health and Finance the majority of the issues
- SPs supporting wider PCN work in:
  - Increasing uptake in cervical screening
  - Weight management referrals
  - Cancer Care support Review

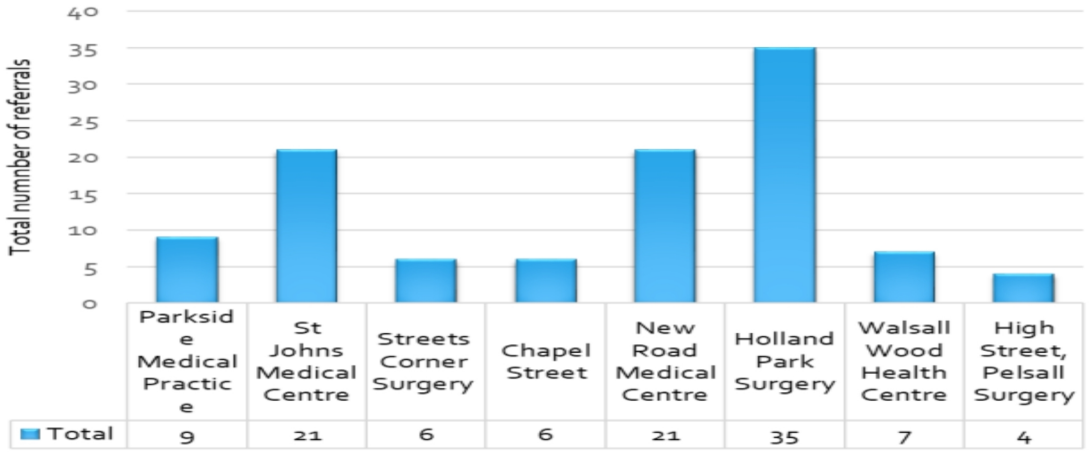


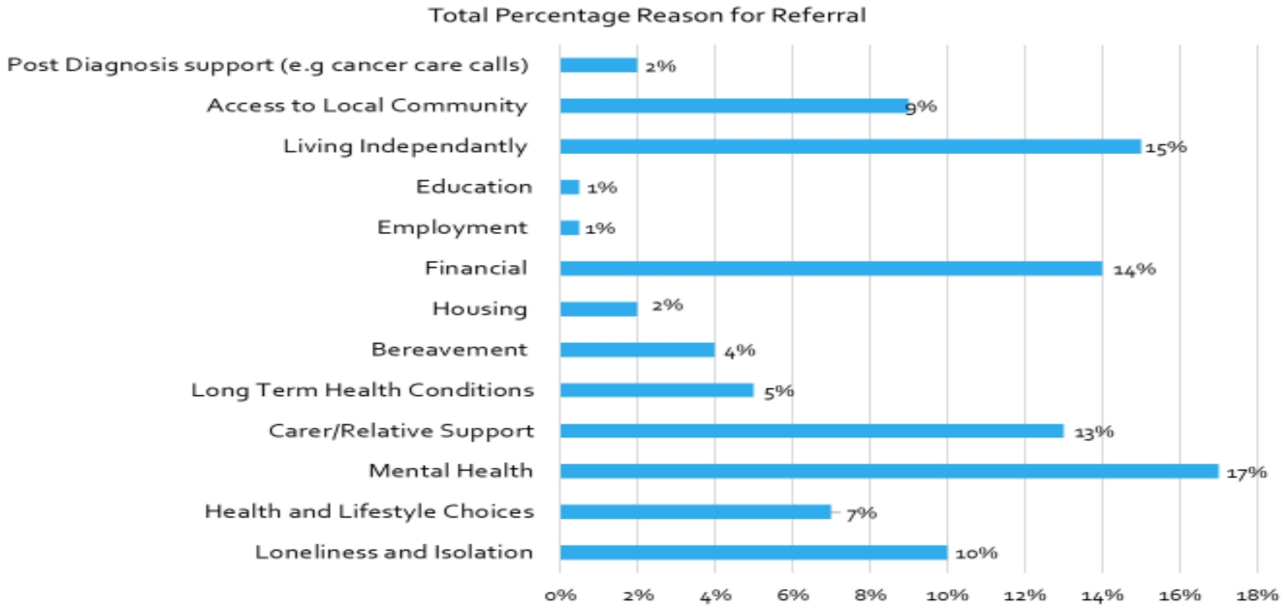


Last updated on July 2022

Social Prescribing – EAST 1

- 100 –130 referrals per quarter on average - 1.73% over the full financial year
- SPs supporting wider PCN work in:
  - Increasing uptake in cervical screening
  - Weight management referrals
  - Cancer Care support Review

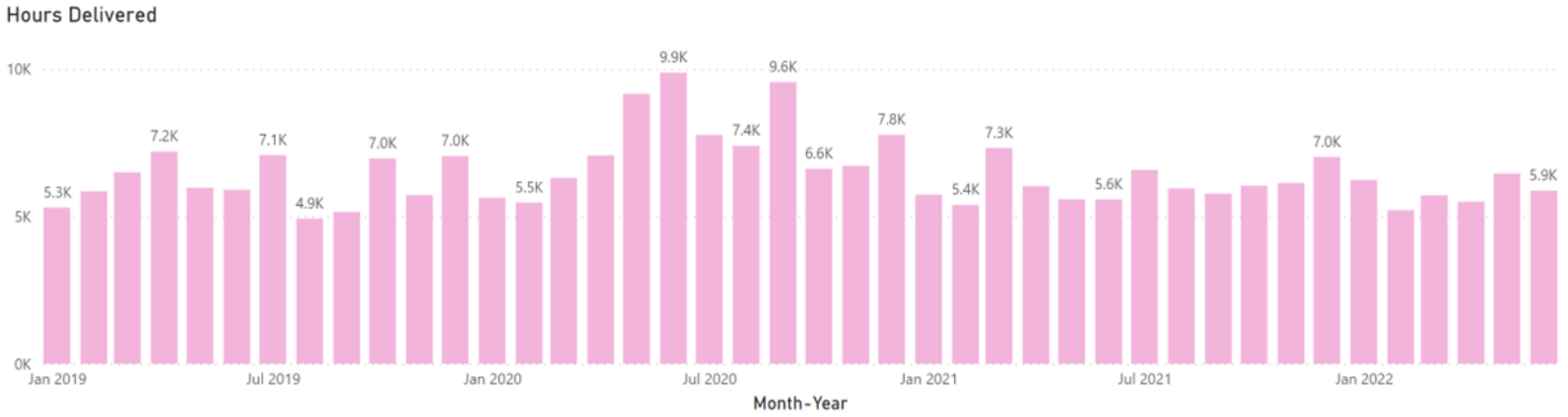


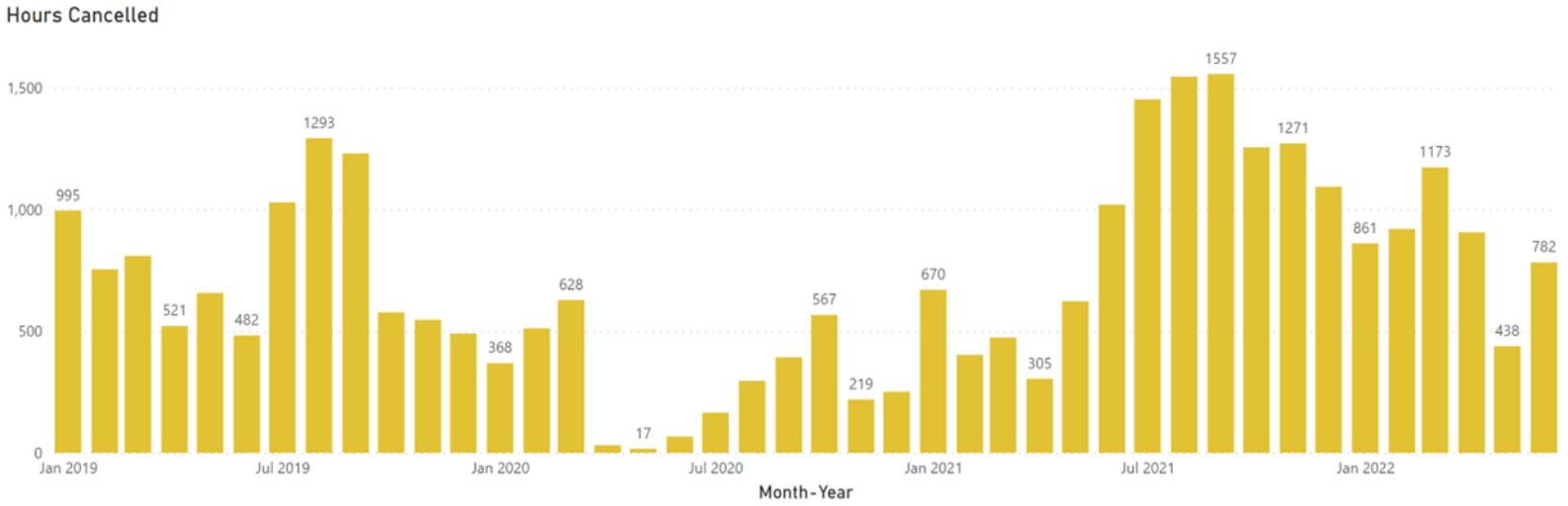


Last updated on May 2022

Tier 1:

Community Nursing Capacity and Demand: In June 2022, Locality District Nursing Teams delivered less hours and cancelled more hours than the previous month.





The Locality Teams delivered nearly 6000 hours.

Sickness absence increased during June impacting on the hours that the team were able to deliver.

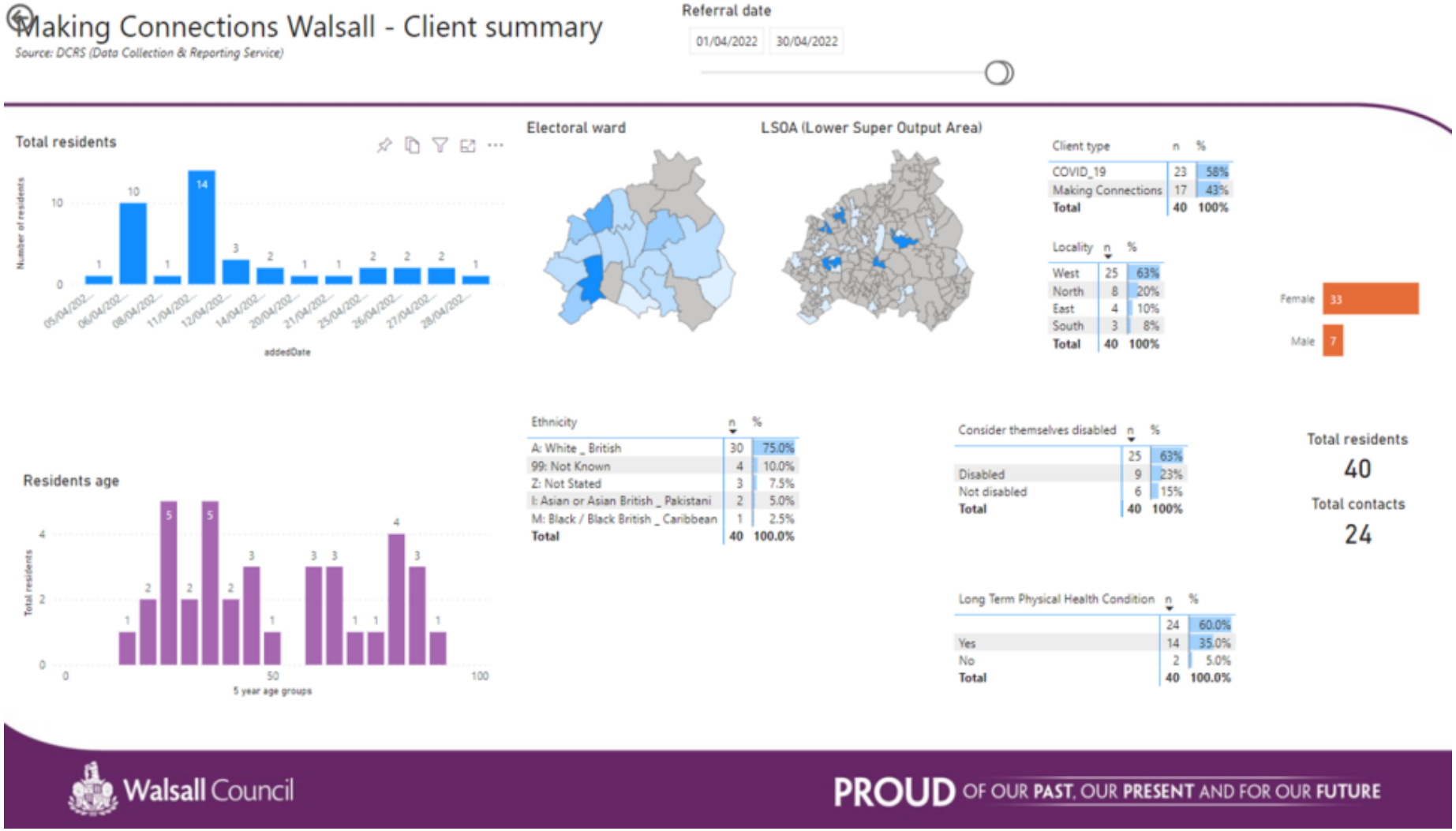
Complexity of patients remains an issue and impacts on service delivery. During June, the Locality teams continued to see significant levels of complexity which included Palliative patients requiring syringe pumps and also complex social issues due to the late palliative diagnosis.

Additionally, complex wound care that required negative pressure and an influx in patients referred from the front door service and patients stepped down from the complex case managers.

These factors impacted on the number of hours that could be delivered and the number that were cancelled.

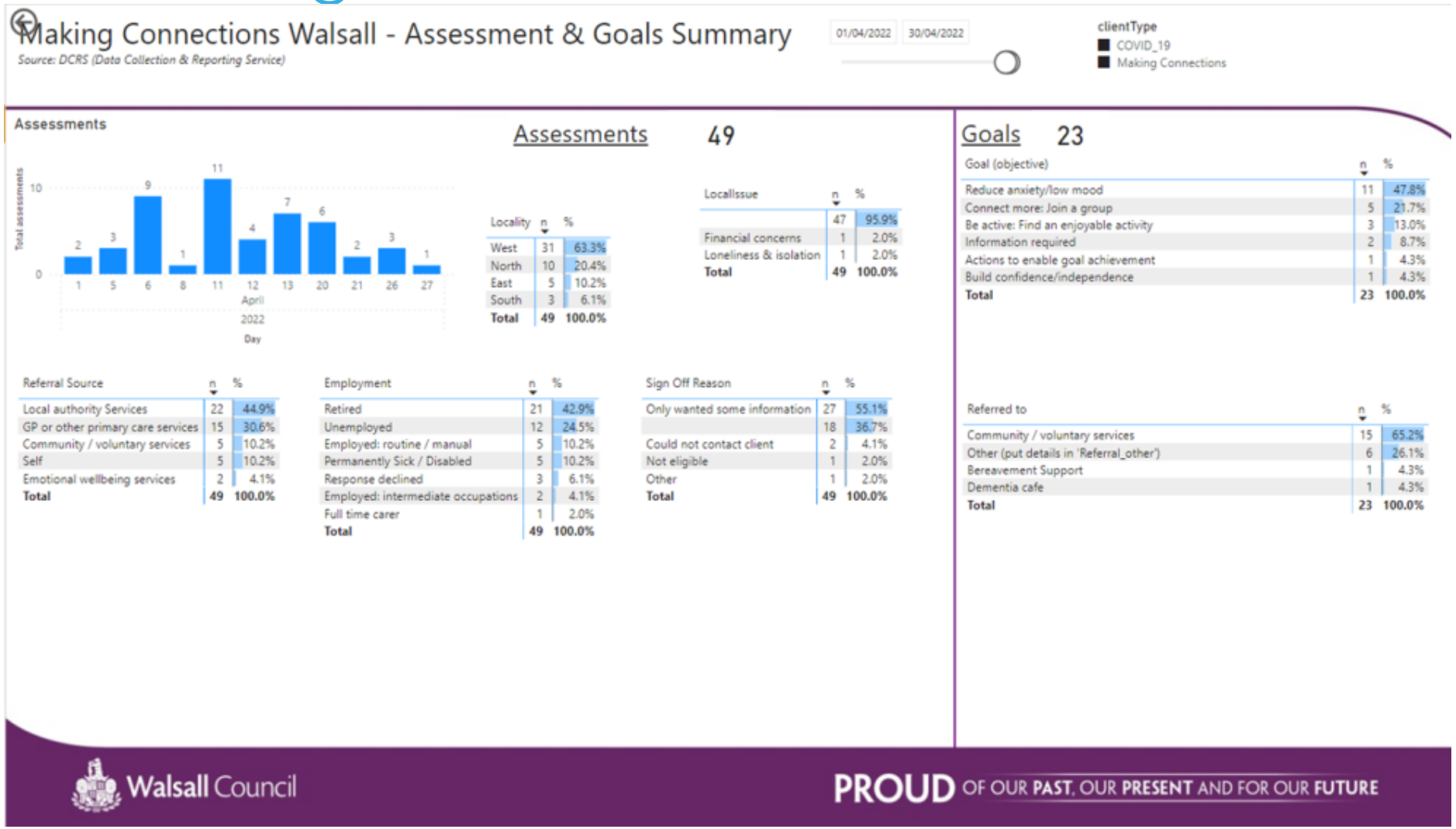
Last updated on July 2022

Tier 1: Making Connections Walsall



Last updated on July 2022

Tier 1: Making Connections Walsall



Last updated on May 2022

Tier 1: Walsall Primary Care Mental Health Service (PCMHS) and Additional Role Reimbursement Scheme (ARRS) - Primary Care Mental Health Practitioners (PCMHP) May update

We had recruited 3 WTE of our 7 ARRS workers for year 1

ARRS Workers in Post

- West 2 – 0.4 WTE
- West 1 – 1 WTE
- East 1 – 0.6 WTE

ARRS workers due to start:

- South 2 -1 WTE

- Continuing with a rolling 3 month recruitment programme & we are working with workforce & development to explore initiatives to support recruitment due to lack of suitable candidates applying for the role

- Banding/NMP under review

- We have appointed a B5 to B6 Clinical Development Role with a view to preparing for B6 ARRS Worker/PCMH Nurse roles

Last updated on June 2022

PCMH Nurse PCN Alignment

- Due to the issues around recruiting to the ARRS roles we are moving forward to align PCMH nurses back with GP surgeries/PCNs
- We are returning back to F2F working offering telephone/video conferencing where this is patient preference and where indicated/appropriate
- The nurses have approached surgeries to determine room availability
- Where an ARRS workers is appointed the PCMH Nurse will receive referrals direct form the ARRS workers
- May was busy with the number of referrals picking up again and coming through to the service

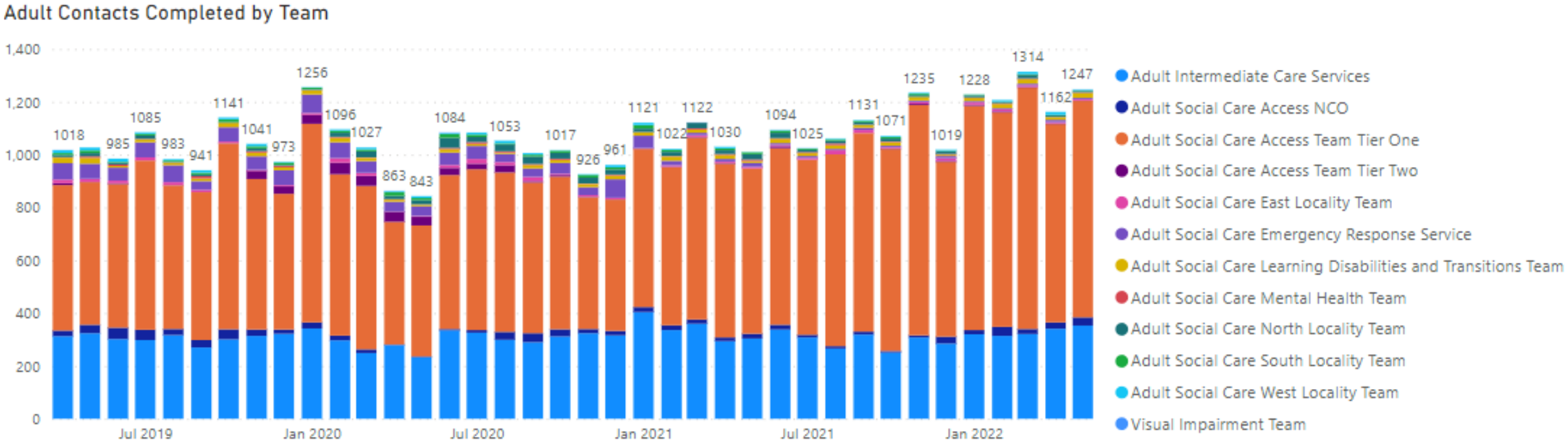
Last updated on June 2022

Activity – May 2022

PCN Name	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Total
East 1 PCN	44	64	67	44	49	268
East 2 PCN	50	39	43	38	60	230
North PCN	80	61	92	68	73	374
South 1 PCN	65	67	61	47	60	300
South 2 PCN	39	33	43	33	37	185
West 1 PCN	41	53	46	34	51	225
West 2 PCN	66	56	66	31	56	275
Total	385	373	418	295	386	1865

Last updated on June 2022

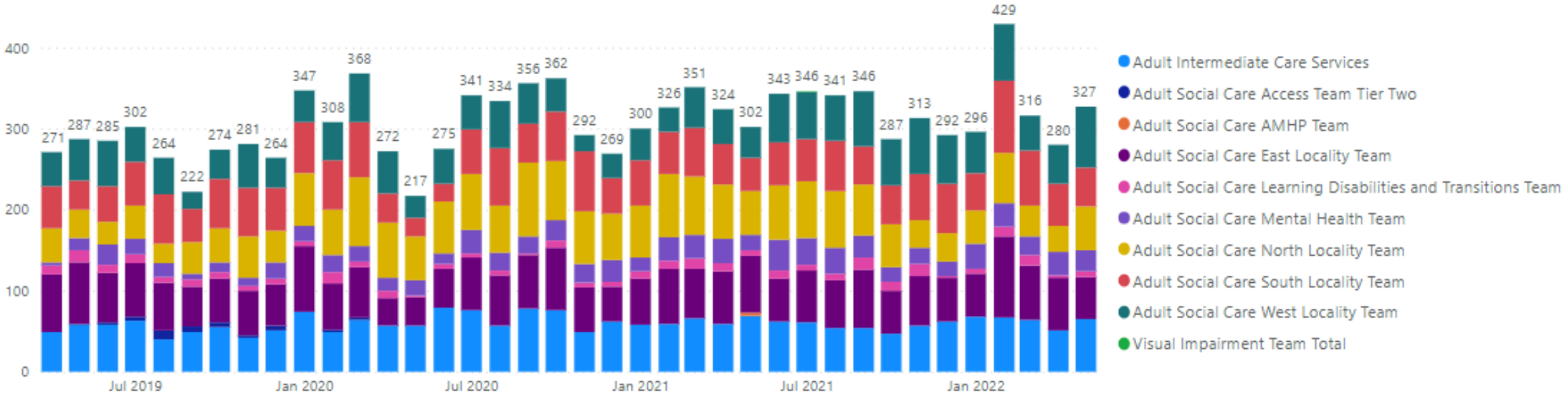
Tier 1:
Adult Social Care



Demand coming into Adult Social Care has increased again in June which has diverted resources to support therefore seeing a decrease in assessments and safeguarding.

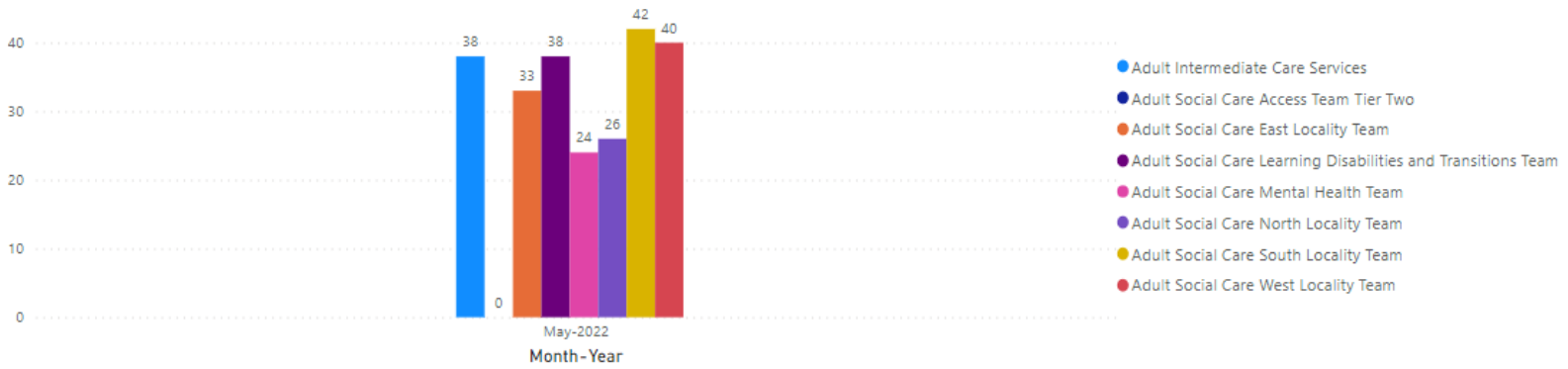
Last updated on July 2022

Care and Support Assessments and 3 conversations completed

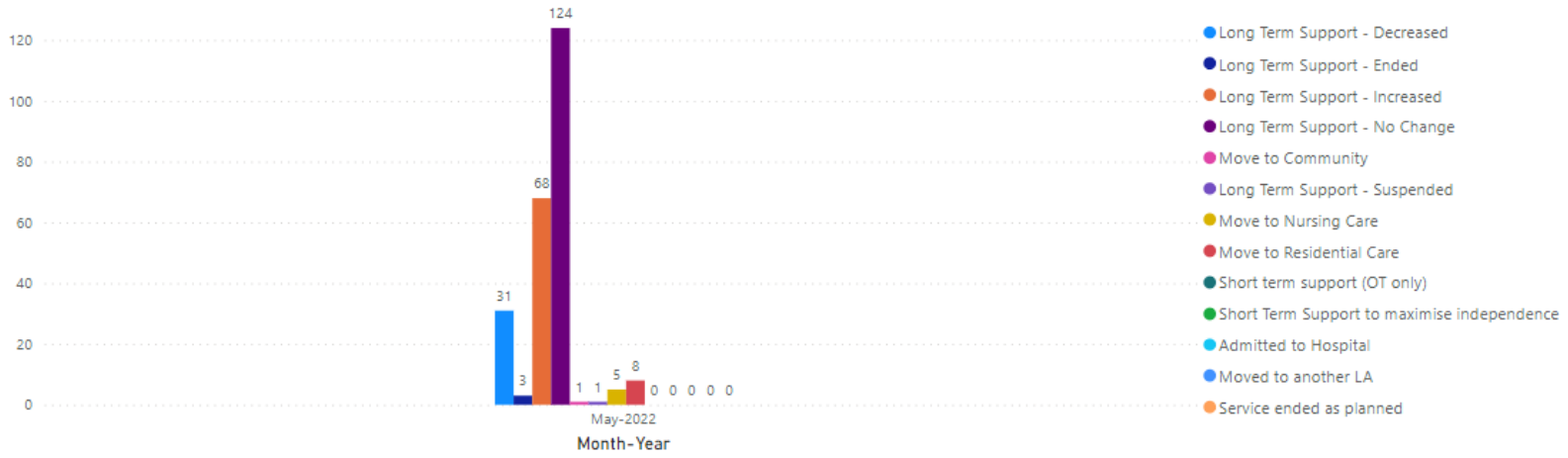


Last updated on July 2022

Initial and Subsequent Reviews Completed by Teams



Initial and Subsequent Review Outcomes



Date267	Sum of Total Initial and Subsequent Reviews Completed
Feb-21	380
Mar-21	451
Apr-21	295
May-21	323
Jun-21	334
Jul-21	327
Aug-21	268
Sep-21	290
Oct-21	290
Nov-21	268
Dec-21	249
Jan-22	288
Feb-22	304
Mar-22	372
Apr-22	265
May-22	241
Jun-22	267

Last updated on July 2022

Tier 2:
Adult Social Care

ASC have received 354 concerns which is a decrease of 27 cases on the previous month.

The number of cases progressing to a s42 enquiry is higher than on the previous period.

There are currently 65 opens 42 enquiries. This has been raised with managers to ensure the timely completion of enquiries which includes caused enquiries. Emphasis has also been placed on the need to inform people including referrers of outcomes following enquiries.

Neglect & Psychological abuse remain the two highest categories of alleged abuse in this period.

Walsall Adult Social Care

Safeguarding concerns

Reporting period: 01/06/2022 30/06/2022

354
Concerns received

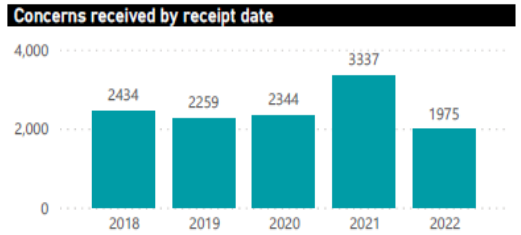
18.36
% leading to S42 enquiry

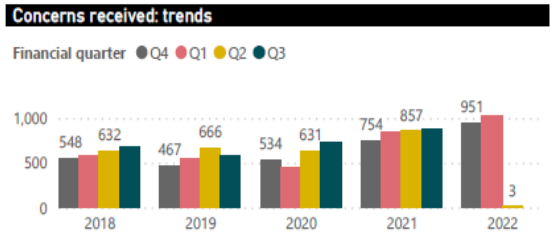
65
S42 enquiries

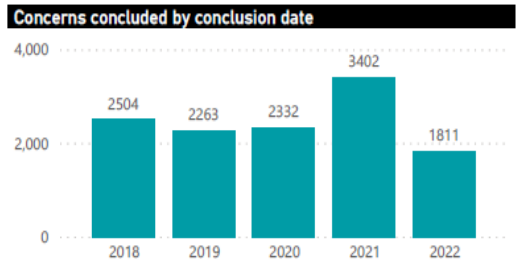
0
Non-S42 enquiries

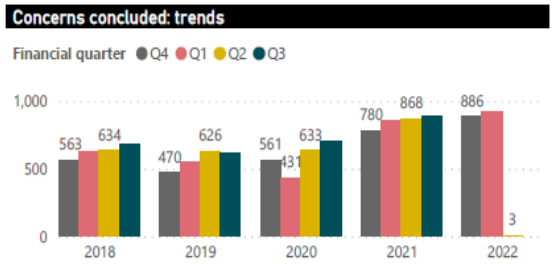
160
NFA

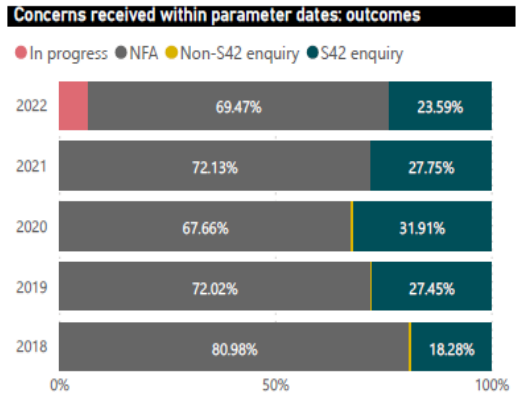
129
In progress

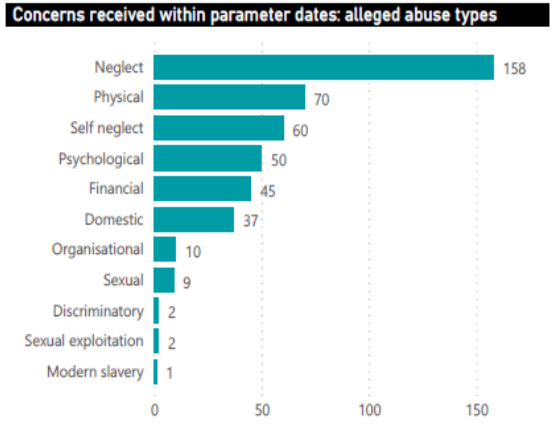












Last updated on July 2022

Walsall Together

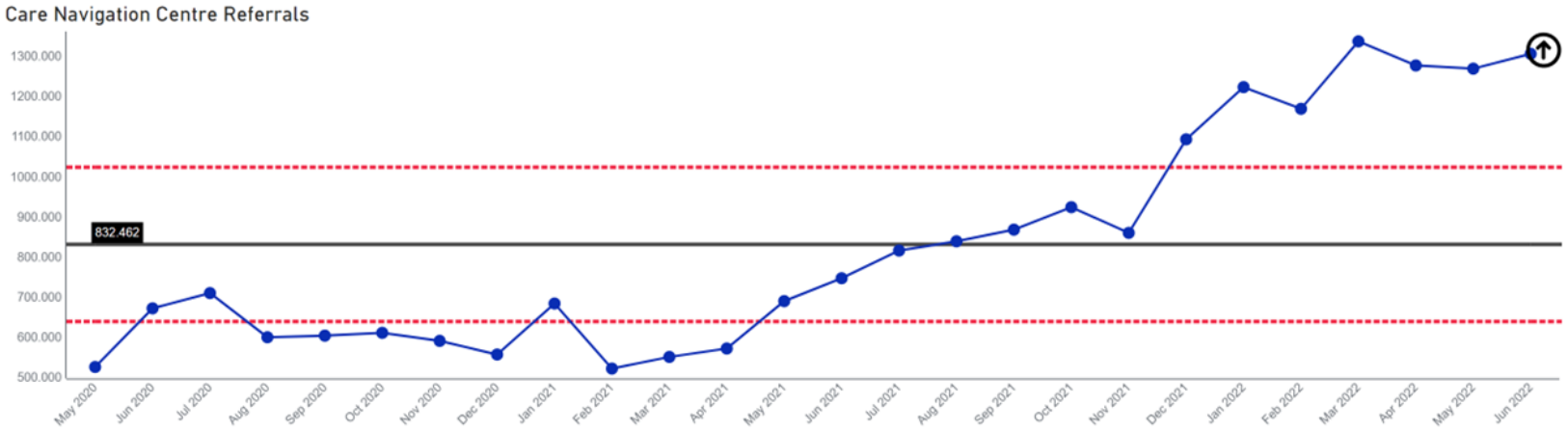
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

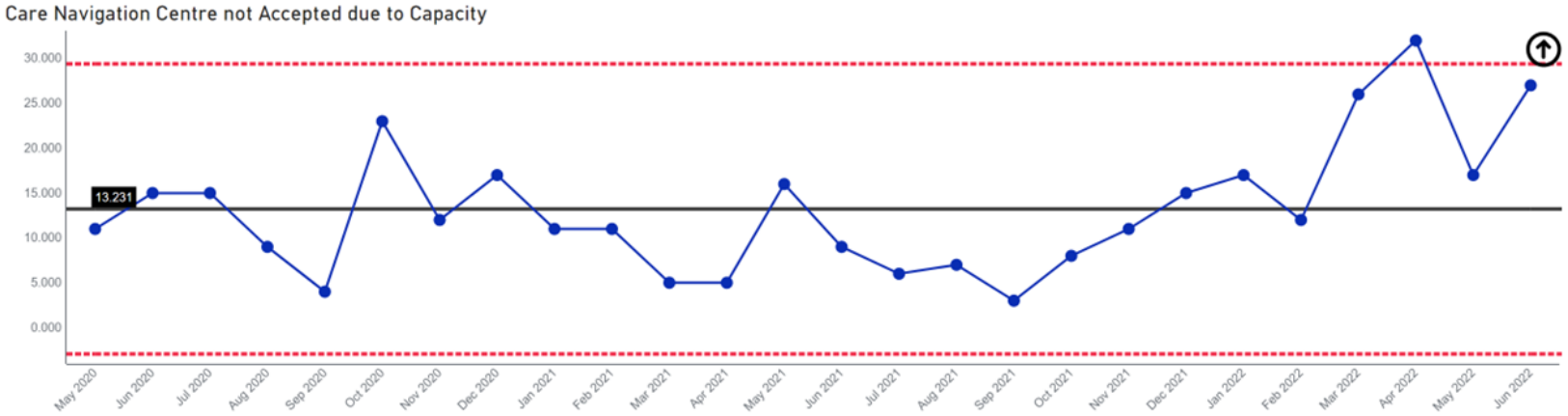
Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	21/22 Result	April 22/23 Data	May 22/23 Data	June Q1 Data	July 22/23 Data	Aug 22/23 Data	Sept Q2 Data	Oct 22/23 Data	Nov 22/23 Data	Dec Q3 Data	Jan 22/23 Data	Feb 22/23 Data	Mar 22/23 Data	22/23 Target	Comments
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2183	2187	2181	2198											
	AACM	1895	1951	1954	2045	2100	2188	2183	2187	2181	2198											
	Jennie Pugh	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**										**100.0%**	
1E: Proportion of adults **(aged 18-64)** with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	21	20	21	21										12	
	AACM	551	585	587	596	574	573	576	527	531	538											
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**3.6%**	**3.8%**	**4.0%**	**3.9%**											
1G: Proportion of adults **(aged 18-64)** with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	490	451	455	461											
	AACM	551	585	587	596	574	573	576	527	531	538											
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**85.6%**	**85.7%**	**85.7%**										**80.0%**	
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	7	11	22	10	24	18	20	1	1	3										15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500											
	Jennie Pugh	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**0.6**	**0.6**	**1.8**										**9.1**	
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts speadsheet.	271	309	311	329	301	311	284	24	55	71										300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500											
	Jennie Pugh	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**47.5**	**108.9**	**140.6**											
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	79	93	106	96											
	Provider Services	317	130	266	73	91	125	103	110	122	121											
	TBC	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**84.6%**	**86.9%**	**79.3%**										**82.0%**	

Last updated on July 2022

Tier 3:

Care Navigation Centre (CNC): Received a high number of referrals in June 2022.





The CNC continued to receive a high level of referrals in June 2022.

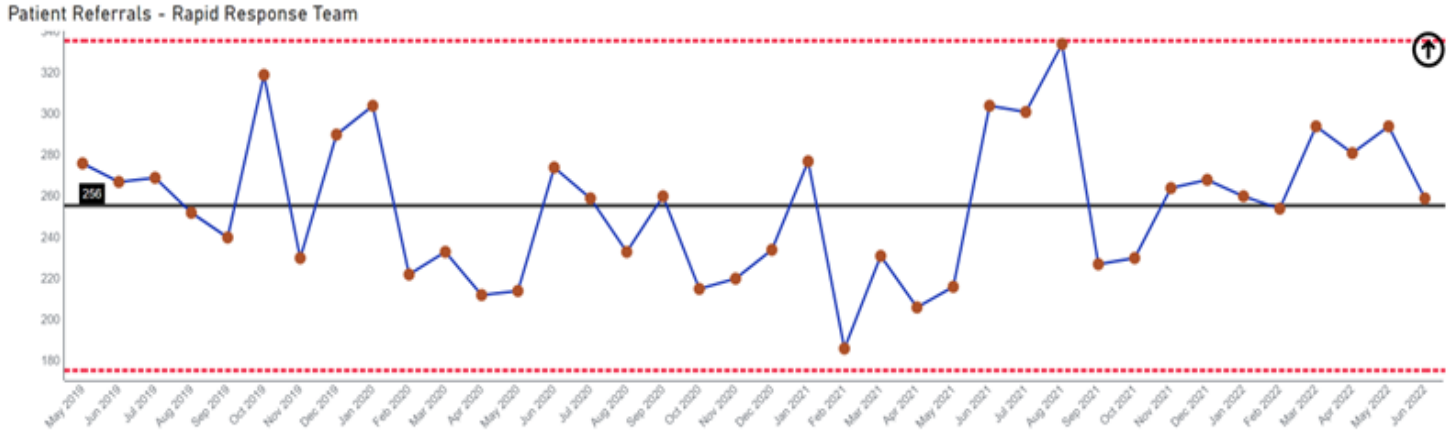
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

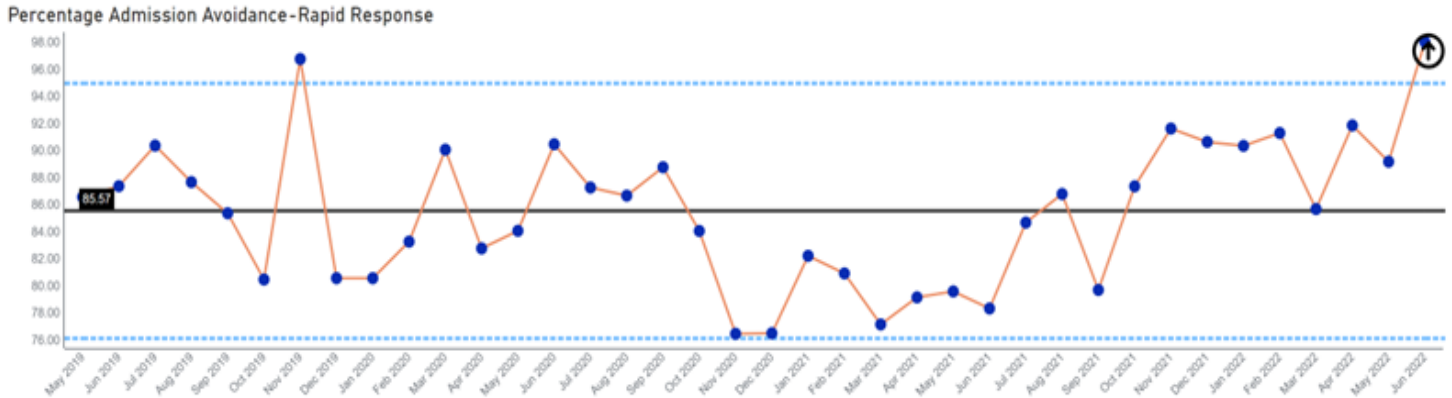
The high volume of calls are a result of the enhanced service that has been implemented. This includes a further expansion of CNC capacity, streaming patients directly from WMAS to Community pathways and services including a further strengthening of disposition pathways into Rapid Response and Integrated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

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

Last updated : July 2022

Tier 3: Rapid Response
The high levels of admission avoidance are being maintained





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

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

Last updated on July 2022

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 50 patients during June 2022

The number of patients on the MSFD list averaged 50 patients during June 2022. This was due to high demand for the service. Despite the high numbers of patients, the average length of stay was maintained at 4 days.

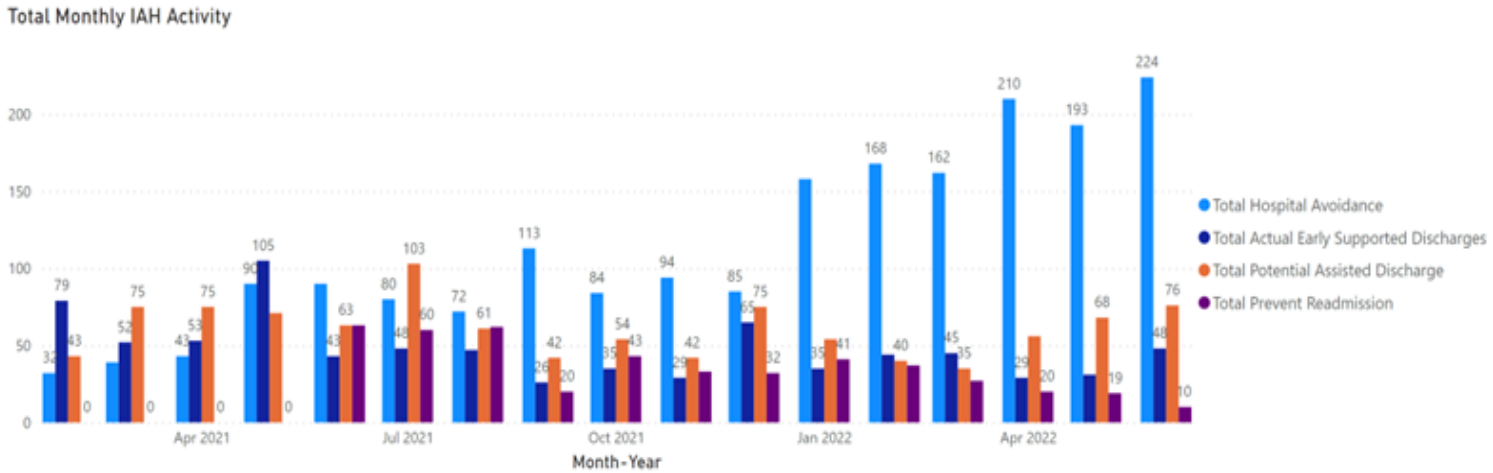
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

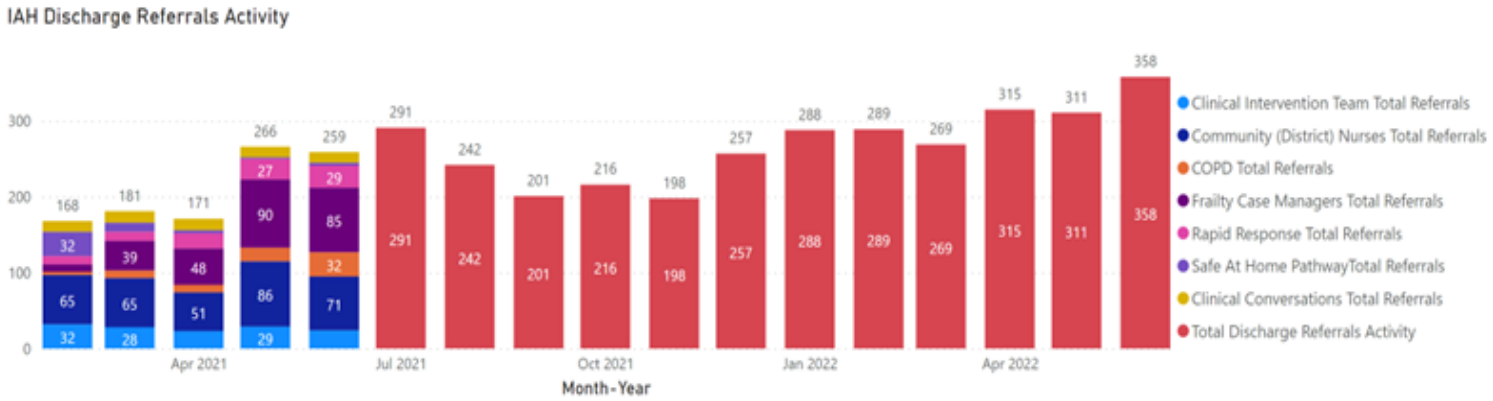
Patients continue to be placed on an interim basis into care home beds while continuing to seek a package of care to enable them to be cared for in their own home. Further work is being completed to reduce the number of patients in beds through expediting their discharge to home.

Work is continuing on bolstering up the admission avoidance activity and interventions of the hospital to try and reduce dependency and reduce the demand for packages of care.

Last updated : July 2022

Tier 3/4:
Integrated Assessment Hub:





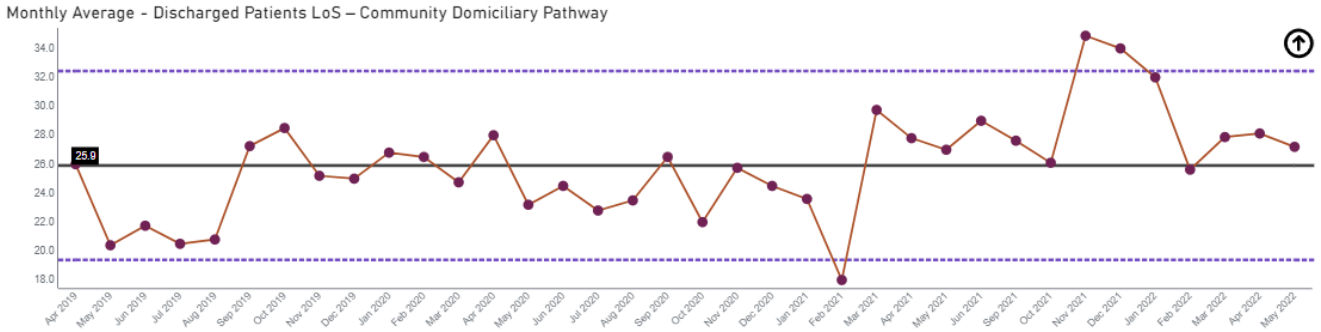
Awaiting Team level referrals activities from Total Mobile system configuration from July 2021

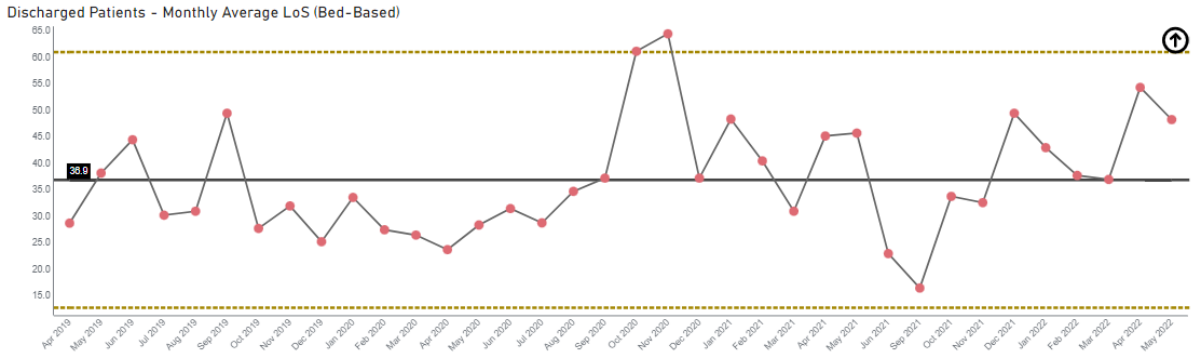
Integrated Assessment Hub

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

Last updated on July 2022

Tier 3: Domiciliary and Bed-Based Pathways





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

Last updated on June 2022

Trust Board Meeting
Committee Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	**Charitable Funds Committee**
Date(s) of Committee Meetings since last	8th July 2022
Chair of Committee:	**Paul Assinder, Non-Executive Director**
Date of Report:	21st July 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	• There are no matters of concern to alert the Board of Trustees to at the present time.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	**Charity's Investment Portfolio and Market turmoil** The Committee considered the financial statements for 2021/22, which advised that the value of the Charity's investment portfolio reduced by £16,000 during the year. • The Committee noted that that there would be expected volatility in the markets during the short term (due to the war in Ukraine, Brexit and the oil crisis etc), with the hope that the markets would commence some form of recovery in the medium term. • Members noted that the performance of the portfolio had been satisfactory considering the turmoil in the markets but to gain further assurance Mr Assinder & Mr Caldicott had met with Mr Ian Burrows from Brewin Dolphin, on 27th June. Members were reassured that Brewin Dolphin had a good understanding of the portfolio and the risks associated with the current market conditions. The value of the portfolio has recovered slightly in the new financial year. **Walsall Hospital League of Friends** • The League of Friends Charity is no longer operating in the Hospital but has a residual balance of funds held. The Committee has previously asked Mr Bostock to examine legal processes for the smooth transfer of charitable balances with the Charity Commission. • Mr Caldicott updated the meeting on discussions that had been held with the League of Friends, who were supportive of making purchases for the Trust to utilize available funds. Dr Shehmar and Mr Caldicott had met with the League of Friends to discuss the purchase of a quantity of pharmacy cabinets.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	**Charity Fundraising** • The Committee were delighted to note that Well Wishers was the Mayor of Walsall's chosen charity for her Mayoral year. • The Committee approved a Business Case for the appointment of an A&C Band 4 part time fundraiser to support the Charity's fundraising efforts. A 2-1 positive return on investment is anticipated and the Committee will evaluate the success of the case in two year's time. **Charity Expenditure** • The Committee considered a quarterly report (April – June) for items of expenditure under £5,000 approved under delegated procedures by Fund Managers, equating to £18,600. Members noted the content of the report and approved the spending as detailed. • Other than the Business Case for the Fundraiser (above) there were no further requests for spending approval to be considered by Committee or for onward referral to the Board of Trustees.
Recommendation(s) to the Board	**Board to note:** • Members approved a Draft Well-wishers Fundraising Strategy for 2022 to 2025. Following the development of performance metrics the final Strategy will go forward to a future Trust Board meeting.
Changes to BAF Risk(s) & TRR Risk(s) agreed	None
ACTIONS **Significant follow up**	None

ACTIVITY SUMMARY Major agenda items discussed including those Approved	This was a routine quarterly meeting of the Committee.
Matters presented for information or noting	Well-wishers Fundraising Strategy (as above)
Self-evaluation/ Terms of Reference/ Future Work Plan	Not applicable
Items for Reference Pack	Not applicable

MEETING OF THETRUST COMMITTEE – Wednesday 3rd August 2022 Fundraising Strategy			
Report Author and Job Title:	Georgie Westley Fundraising Manager	**Responsible Director:**	Sally Evans, Group Director of Communications Stakeholder Engagement
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐ (Select the relevant action required)		
Assure	• The Strategy sets out the priorities for 2022- 225		
Advise	• The Strategy provides a background including our objectives, key messages and who our audience will be. WE have also included the risks associated with our priorities and how we will evaluate the charities success.		
Alert	• There are no alerts associated with this 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/or 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 ☒		

GENERAL GUIDANCE

Overall, the paper/report must not exceed 6 pages maximum in total – the front sheet 1-2 pages maximum, and the summary report no more than 4-5 pages maximum.

- Text should be Arial 12 and left justified as this is easier to read and more accessible.
- Margins should be set to 1.8cm top, bottom, left and right to maximise the use of the page.
- Ideally, paragraphs and pages should be numbered.
- If abbreviating to an acronym, write out the name in full once and provide the acronym in brackets then using the acronym throughout the remainder of the document.
- Use the Equality Impact EIA Prompts appended to this document* when reviewing that front sheet section before completion.

The Company Secretary can provide coaching and guidance for report writers if required and on request. This general guidance is to be deleted when used for a report.

The next section identifies the format which should be used when a report is being written:

[Insert Title of report]

1. PURPOSE OF REPORT

The purpose of the reports is to…….
The purpose of a report is to be clear on what the reader needs to do as a result of reading your report, ideally in only one or two sentences. Moreover, your purpose informs all the other aspects of the report, including background, details, and recommendations. This can also be regarded as the Executive Summary but must not be a direct repeat of the front sheet.

2. BACKGROUND

The background summary provides the background information for the reader who may not be familiar with the details. Explain the background to the issue / proposal so that the reader can quickly grasp what is being presented, the context in which it is being presented and why. Keep it brief and refer members to links to other information, for example appendices or further reading in the reading room section of Board pad etc.

3. DETAILS

This is the main substance of your report. This section should clearly set out the main points the key issues raised by the report and outline the evidence for and against any proposed actions and the solution.

4. RECOMMENDATIONS

Clearly set out the recommendations and proposed actions arising from the conclusions reached by the report.
The recommendation should match the action required on the front sheet of the report.

APPENDICES

(List any appendices and/or references of significance. Do not embed documents under any circumstances)

REFERENCE PACK

Any other information provided or regarded as important can be provided as a Reference Pack that will appear in the papers with the maximum 6-page front sheet and summary.

*** Legal and/or Equality and Diversity implications - (Protected) Groups to consider.**

Gender	**Race**	**Disability**
Consider potentially differential impact on men or women.	Consider language, interpretation, translation and potential cultural differences impacts, and known health inequalities.	Consider the potential impact on the wide range of disabilities and illness including mental health, learning, physical, visual, hearing, communication and neuro-diverse including access, information and any adaptations that could be made.
Religion/beliefs	**Sexual Orientation**	**Age**
Consider the potential impact on beliefs practices, observances, festivals and attendant cultural differences and any accommodations that could be made.	Consider the potential impact on the wide range of orientations across the LGBTQ+ communities and any accommodations that could be made including for those undergoing gender re-assignment.	Consider the potential impact on all age groups from the very young to seniors including access, understanding, access and resources.
Pregnancy	**Partnership Status**	**Carers**
Consider the potential impact on pregnant women, their partners and families, new mothers including those feeding/nursing.	Consider the potential impact on those in the range of partnerships and any adaptations that could be made.	Consider the potential impact on Carers and their characteristics (see above).

Considering potential impact – treatments, controls, and mitigations.
If you identify potential impact, next consider whether any adaptations, accommodations, changes, or re-design could be made that would lessen, reduce, or negate the potential impact. Also consider whether the extent of potential impact be considered as unlawful discrimination? If so, you may need to refer to the full EIA to assess the impact and risk. Finally consider whether consultation with representative groups regarding characteristics might help formulating alternatives.

Why is this important?
Public Sector bodies have a duty to uphold equality and be inclusive of diversity, to end unlawful discrimination and improve equity of opportunity and access for all – whether staff, patients, families, or people in general. It may mean you need to reflect on previous assumptions about others, and to take a non-discriminatory view deliberately and thoughtfully.

Walsall Healthcare NHS
NHS Trust

well wishers
Raising funds to make a difference

Walsall Healthcare Charity (no 1057416)
Well Wishers

Fundraising Strategy (DRAFT April 22)
September 2022 - 2025

Introduction

Walsall Healthcare NHS Trust is an integrated Trust and the only provider of NHS acute care in Walsall, providing inpatient and outpatient services at the Manor Hospital as well as a wide range of services in the community.

Walsall Manor Hospital houses the full range of district general hospital services under one roof.

The £170 million development of the Pleck Road site was completed in 2010 and the continued upgrading of existing areas ensures the Trust now has a state-of-the-art Critical Care Unit, Neonatal Unit, Obstetric Theatre and Integrated Assessment Unit facilities. Work on its multi-million pound new Emergency Care development which will house a new Emergency Department (including Children's Emergency Department), co-located Paediatric Assessment Unit, Acute Medical Unit and Urgent Care Centre is also due to be completed in autumn 2022.

The Trust provides high quality, friendly and effective community health services from 60 sites including Health Centres and GP surgeries. Covering Walsall and beyond, its multidisciplinary services include rapid response in the community and home-based care, so that those with long-term conditions and the frail and elderly, can remain in their own homes to be cared for wherever appropriate.

Walsall Together is a partnership of health, social care, housing, voluntary and community association organisations that are working together to improve physical and mental health outcomes, promote wellbeing and reduce inequalities across the borough.
As a partnership it is focused on reducing health inequalities by focusing on not just health but the wider determinants of health, such as housing, education and employment and the vital role that people and communities play in health and wellbeing. Reducing health inequalities means giving everyone the same opportunities to lead a healthy life, no matter where they live or who they are. Prioritising early intervention and prevention rather than treatment, Walsall Together looks at ways to support people and communities to live independently and have active, prosperous and healthy lives.

Background

This document sets out the fundraising strategy for Walsall Healthcare's charity; "Well Wishers". The Charitable Fund is a registered charity, number 1057416.

Walsall Healthcare NHS Trust has delegated the responsibility to manage the Charitable Fund to its Charitable Funds Committee. The Chair of the committee is a Non-Executive Director of the Board and the Executive Lead is Director of Finance and Performance. Fundraising sits within the portfolio of Communications, Marketing and Engagement. There is a dedicated Fundraising Manager and a business case has been put forward to appointment a Fundraising Support Officer - both will feed into the Charitable Funds Committee and sit within the Communications Department.

Well Wishers Brand Statement

Our Vision – to raise money for things over and above what the NHS is able to provide

Our Mission – to make a different to the experience of staff, patients and their families using our services

Walsall Healthcare NHS Trust's Vision of Caring for Walsall is underpinned by five strategic objectives:

- **Safe, high quality care - "We will deliver excellent quality of care"**
- **Care at Home - "We will host the integration of Walsall together partners, addressing health inequalities and delivering care closer to home"**
- **Work 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"**

The organisation's values, as chosen by staff, were launched in July 2018 however over the next 24 months you will see a joint set of values and a refreshed vision in-line with the collaborative working between Walsall Healthcare NHS Trust and the Royal Wolverhampton NHS Trust.

Our Vision and Values provide the backdrop that drives our fundraising activities.

While there has been a longstanding tradition of giving in Walsall, it is an area that has some of the highest levels of poverty in the country and its economic position is a difficult one. The Trust's income from charitable donations has been unpredictable in recent years. In 2021, however, there was an increase in funds and a change in the investment company saw funds well above the reserve.

Income into the Trust Charitable Fund has been inconsistent as shown here:

15/16 £316k
16/17 £553k (including £327k LoF – net £327k)
17/18 £315k (including £139k LoF – net £176k)
18/19 £272k (including £37k LoF – net £235k)
19/20 £236k (including £30k LoF – net £206k)
20/21 £443k (including £17k LoF – net £426k)

The income has been generated through donations, legacies, fundraising events and investments. This also includes funds from the League of Friends charity (LoF) that until recently played a huge part in raising funds for the Hospital. Funds were ringfenced for medical equipment. Unfortunately due to the pandemic and a number of internal issues they no longer work from within the Trust and therefore their support has ceased.

The market value of the investments improved by £176,000 by the end of March 2021 as the restructured portfolio recovered during the COVID-19 Pandemic. During the year the Charity realised a net gain on revaluation and disposal on the portfolio

investments totaling £256,000 which contributed to the overall increase (i.e. £560,000) in the Charity's available funds.

The value of the Portfolio has fluctuated considerably in the last few years as a consequence of a reduction in the level of donations, increased levels of expenditure and commitments, and the economic uncertainty created by Brexit and the most recent global pandemic (COVID-19). The investment manager's growth strategy was affected by the significant loss in value of investments during 2019/20 and the Trust's cash requirement to settle creditor commitments. The investments have recovered whereby a significant number (40%) that had fallen below their original investment cost are now on par if not exceeding the initial investment.

The approach to fundraising has historically been primarily reactive. This has highlighted the need for a dedicated resource in Fundraising to develop a more proactive and strategic approach along with a review of systems and processes to ensure Best Practice.

In 2016 the Charitable Funds Committee appointed a full-time Fundraising Manager, Georgie Westley, to lead the implementation of fundraising throughout the Trust and surrounding areas. The post-holder also holds Engagement and Membership in her title.

The Fundraising Manager has focused on networking, promotion (both within the organisation and externally) and more targeted engagement. She has established an annual events calendar, which includes larger charity events, and has provided opportunities for partnerships with local businesses, Walsall Black, Asian and Minority Ethnic communities and borough organisations.

The considerable efforts that have been made to raise the profile of Well Wishers are proving successful with the creation of a Fundraising Hub and a seating area within the main atrium of the hospital. This also shows that there is still much to be done at this local level before any consideration could be given to establishing a large scale appeal for a major project such as a new build.

As Walsall Manor Hospital is not a specialist centre it cannot compete with the likes of Birmingham Children's Hospital for example and there is also reluctance among communities to pay for things they believe the NHS should provide. The provision of a new unit, for example, is perceived by the public as something that should not need fundraising. Enhancements to improve the patient experience within that unit, however, would be looked upon favourably by the public.

Objectives

The purpose of this strategy is to outline some of the driving forces influencing fundraising, particularly the Trust's Charitable Fund, and to look at how we can respond to these challenges to maximise the potential for raising awareness and

funds. This may be through the fundraising department's own activities or through joint activities with charitable and other partners.

We want to ensure that the strategic priorities of the Trust Charitable Funds are aligned to the Trust's wider objectives in order to support its wider ambitions and commitments.

The charity is engaged with Walsall Healthcare NHS Trust's planning for major capital developments to ensure any opportunities for fundraising are maximised. For example the Fundraising team is currently working alongside Urgent and Emergency Care Centre Development Project Team on a Heritage Lottery grant for internal and external work and also supporting the ICU Team on its plans for an external rehabilitation area. In the community, plans are still in place to create a stroke rehab area in the grounds of Hollybank House and this will be funded through a current appeal.

We need to see greater engagement with staff, patients, key stakeholders and the public who are all invaluable in helping us to raise the charity's profile, enhance the Trust's reputation and create a greater awareness of the services that we offer to the residents of Walsall and beyond. This could be achieved through greater social media presence including online activities/sales and frequent charity roadshows across all sites.

Well Wishers is in place to support the health and welfare of patients through improvements to the patient environment, supporting staff training to improve patients' care and the purchase of additional equipment.

With the growth of the charity team we will achieve a more proactive and strategic approach to fundraising to ensure we continue to capture the "hearts and minds" of the people of Walsall and support the development of new services and innovation. The Fundraising Manager will continue to work with Communications to build meaningful relationships with individuals, organisations and businesses and community groups. For fundraising to be truly effective significant effort is required to build on, manage and service these relationships.

We want to raise the profile of Well Wishers both internally and externally which will help drive up income and donations.

We need to explore wider opportunities to boost income including sourcing potential bids as well as greater engagement from the larger businesses in the area for example whg and South Staffs Water.

Further encouragement and support will be provided to people and organisations which organise fundraising events of their own and greater effort will be made to encourage others to get involved.

We need to continue to build the charity's presence on digital and social media networks. All events, donations and appeals are promoted via these channels and this in turn encourages others to participate or organise their own events. This will

also include looking at selling goods from the fundraising hub online and providing online events if appropriate.

Key messages

Well Wishers will aspire to:

Continue to support healthcare improvements which enable local people to live healthy lives.

Continue to support the Health & Wellbeing agenda for staff across the Trust.

Play a key role in the development of first class healthcare for the patient population

Support individual Fund Holders/staff/volunteers so that they can ensure correct spending of funds

Fundraise on a rolling basis for the Charitable Fund for use at a local level by specific institutions /services/projects or small partnerships/collaborations

Ensure excellent Value for Money for those who 'invest' in the charity and keep them updated and informed.

Become the preferred charity of choice for local people

As a small, local charity, Well Wishers is competing with national charities such as Macmillan Cancer Support. Its unique selling point is the fact that the public can see

exactly where their donations go – they are not “swallowed up” in admin fees or other hidden costs. When Well Wishers raised £15,000 for a new sensory room refurbishment at the Child Development Centre in Shelfield, for example, everyone who supported through fundraising activities or donations was invited to its official opening.

Fundraisers and supporters are able to specify which service or area (funding pot) they want their donations to be used for. We often have grateful former cancer patients, for example, who want to support the Chemotherapy Unit.

Donations from patients, family members, carers, organisations, businesses and individuals provide valuable support for the activities, equipment and service enhancements that are outside the core funding responsibilities of the NHS, or which are unaffordable to the trust and do not fall within the terms associated with contracted services.

To achieve our aim the charity will focus on a number of key priorities which will best be achieved by working in partnership with staff, patients and the public and this commitment will underpin the strategic vision of the charity.

Target Audience

Walsall Healthcare staff and volunteers

Trust Board

Local businesses – including a focus on maximising opportunities through match funding projects or Corporate Social Responsibility

Partners

The public

Media

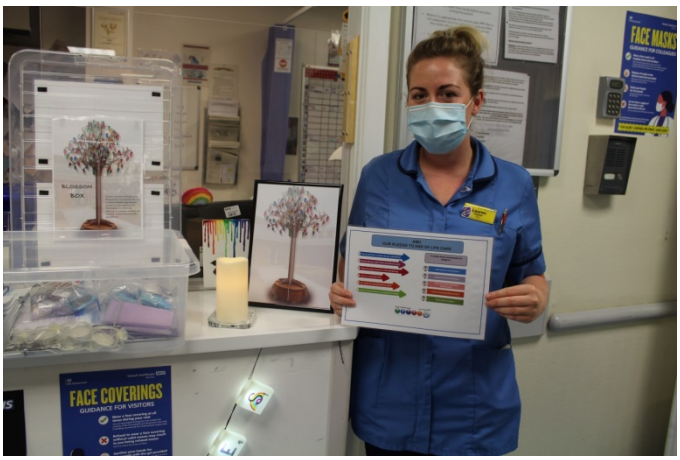
Key achievements

There have been many notable achievements over the last few years and these include:

- The creation of “Lolly’s Place” – a “chill out” room on our paediatric ward in memory of a teenage asthma sufferer

- Reflection/Remembrance area - working with staff and external companies, an area of reflection/remembrance has been created at the hospital site for all of those in our community affected by Covid-19. This also houses the reflection stones, an event supported by the charity in June 2020
- Providing TVs for refurbished wards
- After the fundraising team distributed support rainbows across the Trust during the pandemic the team arranged for these to be made into a large rainbow artwork as a lasting reminder of the support the NHS received
- Establishment of the Fundraising Hub
- Playing a part in the HWB support across the Trust during the pandemic
- Supporting Goscote Hospice – one example is making Christmas come early for end of life patients
- A revamped seating area near the Level 1 café for patients to take a break

- Provision of Blossom Boxes to improve and standardise end of life and bereavement care for hospital inpatients and strengthen support for their families and carers
- NHS 73rd Birthday and The Big Tea
- Funding for our Community Neurological Rehabilitation Team to train in adaptive Tai Chi to support patients to manage their conditions such as Parkinson's Disease and Multiple Sclerosis
- Purchase of an additional scooter to help less mobile patients get to their appointments
- Refurb of patient/family rooms on wards
- A makeover for the Discharge Lounge for patients waiting to go home



- Becoming a member of the Best of Walsall group for businesses
- Establishing Make A Will Fortnight with local firm Enoch Evans
- Creating a Well Wishers marketing pack allowing companies to use Trust's TV screens, atrium space, Daily Dose and social media which will in return increase funds and provide sponsorship for events funded through the charity
- Becoming a member of NHS Charities
- Becoming a member of Black Country & West Birmingham STP
- Increase in invites to talk at local groups including Hindu ladies friendship group, Rotary Clubs, Best of Walsall, Soroptismist Groups
- Close relationship with local faith groups
- Increased local media coverage
- Chosen charity for Best of Walsall, Marks & Spencers (Wednesbury) and Saddlers shopping centre, WARRANT
- Successful Christmas appeals
- Greater social media presence
- Opportunity to share in Pioneer magazine FOC – distributed locally

The impact of Covid-19

Well Wishers has been and continues to be affected significantly by the Covid-19 pandemic as it meant for a lot of the time face to face fundraising activities have had to stop. This includes events and activities in the atrium and the sale of goods has dropped through the Fundraising Hub. This is improving especially since the return of signed in visitors.

Income generated through the Fundraising Team's previous office, the Purple Hub saw sales and donations for the financial period 1/4/19 – 31/3/20 reach **£77,166.46** and this has funded some of the items above and inspires the team to aim for this amount - if not more - when the time allows.

A marketing pack has been put together, in partnership with Best of Walsall, which will generate income for the charity. This will hopefully be launched during 2022 as it was also put on hold due to the pandemic. It would have been inappropriate to launch

it at a time when services are still subject to restoration and recovery and there are much fewer numbers of visitors in the hospital to see TV adverts or browse stands.

During the pandemic, however, relationships with the local community and businesses has grown through the support to NHS staff and their health and wellbeing. We have also benefited from some sizable monetary donations; particularly as thank yous for care received.

Whilst core fundraising activity paused, the charity has had a key role during the pandemic, acting as a collection point for the donations that have been pouring into the Trust such as meals, drinks, snacks, uniform bags and visors.

The charity adapted with no events but realised that it needed to look at different ways it can fundraise and will look to run on-line fundraising/selling. The charity will also continue to liaise with and inform valuable links with members of the community which it hopes to continue to work with and knows it could turn to for support.

This has proved an important time for the charity to support the health and wellbeing of staff and relationships are very strong now between the charity and a number of large clinical areas including ICU. The charity will continue to support the HWB agenda.

Priorities for 2022 - 2025

Well Wishers charity hub:

Now that the charity has its own hub and money is secured through NHS Charities' funding for a full refurbishment, the fundraising team will continue to develop this base and use it to its full potential for not only selling goods and being a place for information but also a marketing area for businesses signed up to the marketing pack and local stalls who rent a space. The hub will be used to its full potential and added resource through the submission of a recent business case will ensure that the Fundraising Manager can pursue further external support from local businesses and community groups and look for opportunities through bids/business cases on a larger scale.

Achieving our vision and mission:

A huge piece of work will be carried out across the Trust to ensure that colleagues are fully aware of the charity, how charitable funds are used and how they can benefit their work area and the care they provide. It will also explain how staff can get involved including encouragement to become a Fundraising Ambassador for the charity. The team will work with divisional fund managers to ensure they are aware of funds available for their service, that people are supported in applying and filling out necessary forms when applying for funds, that presentations for applications over £5,000 are presented personally to the Trustees and that the process is quick and efficient.

Legacies:

Although the charity has during 2021 and 2022 received a number of large legacies we need to maximise potential legacy donations as these are difficult to forecast year on year. One idea is to launch a Leave a Legacy Campaign. Guidance has been provided by a local solicitors and assurance around legacy donations dropping nationally has been given. Working with contacts in the media and our community the aim of the Leave a Legacy campaign is to have a higher profile within the community and within the hospital and increase the number of legacies left.

We have also worked closely with the family of a former patient who left a considerable legacy which has been featured in our newsletter and social media. We will continue to use this legacy as an example and as part of the Leave a Legacy Campaign.

Relationships are being developed between the Goscote Hospice (formerly St Giles) helped by the fantastic support the charity provided to some of its End of Life patients pre-Christmas. Work will continue with the team to provide fundraising events and raise awareness.

Current organisations which support the charity, potential growth and Corporate Responsibility (CSR):

We have many organisations/businesses that the team can currently turn to for support including

- Warrant
- Best of Walsall (hosting over 300 businesses)
- Supermarkets (incl. Tesco's, Morrison's and Asda)
- Enoch Evans Solicitors
- Coinadrink
- Homeserve
- Wolverhampton Wanderers
- Walsall FC
- Muslim Association (Walsall)
- Darbar Sri Guru Granth Sahib Ji
- Blakemore's
- Step's to Work

There is a potential that we could expand the support we receive from the above through community bids, CSR, 1-1 meetings, business breakfasts, marketing pack and building a more personal robust relationship.

The charity is currently looking to work with more companies to support them in playing their responsible part in society and giving back to society, a big part of which is supporting a charity. We are launching this through Linkedin as this is the platform to reach larger companies but also covering it through all social media currently in place. This will be followed up by a press release and then approaching businesses in Walsall, for example Severn Trent Water Board, Walsall Housing Group as

previously mentioned. We will also look to expand relationships with the above mentioned.

Pot Luck Lottery:

To relaunch the Pot Luck lottery – particularly as many newer staff are unaware of it. To also strength the administration of this to ensure the lottery is dealt with in a timely manner.

Well Wishers charity and Royal Wolverhampton Charity:

Both charities while stand alone will be looking to carry out joint charity events that will support the collaborative working between Walsall Healthcare NHS Trust and Royal Wolverhampton NHS Trust. This will be events that can be done across both sites like NHS Big Tea and the Queens Platinum Jubilee.

The charities will also look to support services that are supported over both trusts e.g. Pathology, Stroke.

Both charities will also support each other on the sharing of information and contacts.

Key priorities 2022 onwards:

The charity will focus on the priorities above with a number of other key priorities listed below which will best be achieved by working in partnership with staff, patients and the public and this commitment will underpin the strategic vision of the charity. The ongoing impact of the Covid-19 pandemic along with current financial restraints on the country will also have to be managed and the effect monitored closely.

- Well Wishers roadshow - in particular raising awareness across community, paying particular attention to Goscote Hospice
- Capital Projects – Urgent and Emergency Care Centre build, Ward refurb, Chapel Refurb, ICU rehab
- Fund Managers' focus
- Legacy giving
- Charity Ambassadors
- Corporate Social Responsibility
- Collaborative working with RWT charity
- Making good use of national events, for example Queen's Platinum Jubilee
- Growing the Fundraising Team
- Social media presence
- Refurbishment of Fundraising Hub
- On line events and retail
- Set a number of KPI's to show and encourage growth and support

Risks

The ongoing Covid-19 pandemic

The current economic climate. Inflation is at an all-time high causing the cost of living to rise which along with the Russian invasion of Ukraine means donations to the charity could be one of the areas to be affected by the community and businesses due to financial constraints or choosing to support other areas of need and poverty.

The charity is competing for a share of people's disposable income in a crowded marketplace at a time when the economic environment continues to be difficult as well as the NHS facing significant financial challenges and pressures.

The Fundraising Team is very small, consisting of a Fundraising Manager only, which has an impact on forward planning time as well as some day to day tasks.

Communications support is limited due to other priorities which delays development work.

Gaining support from Trust Board is difficult – non-attendance at, or support for, events.

Staff – support with fundraising, awareness of charity & procedures. Staff lack of motivation with the Trust in general.

Closer collaboration and support is needed with finance colleagues.

Evaluation:

The charity's success will be measured against the following:

- Income against target
- Expenditure against budget
- Number of people who pledge a legacy/donate/fundraise/hold events
- Increase in staff signing up to the lottery
- "Adoption" of Well Wishers as the chosen charity of a local business or organisation especially those wishing to achieve their Corporate Social Responsibility.
- Greater support from colleagues – many of whom could host/organise fundraising activities

- Wider recognition of the Well Wishers brand
- Further increase in media coverage and social media followers

Audit Committee
Chair Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Audit Committee
Date(s) of Committee/Group	Tuesday 21st June 2022 – Virtual meeting
Chair of Committee/Group:	Mary Martin
Date of Report:	Thursday 28th July 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Local Counter Fraud raised a concern around bank timesheets which are paper based and a possible case of a member of bank staff alerting a time sheet after approval. This arose from a hand over case from GT to RSM. This is being investigated and any required mitigations put in place.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	. • The committee were advised that around 1600 staff do not have an email addresses. This makes communication more complex and carrying out the staff survey problematic. A presentation on mitigations and future plans around staff communications is scheduled for the next meeting. • The ongoing work on bringing policies and guidelines in line with policy for their review highlights only 50% of polices (total around 260-270) in date and only 52% of guidelines (total around 285-295) in date. All beyond their review date are clinically assessed to ensure they can remain in place. Progress will continue to be monitored by QPES and Audit committee.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Grant Thornton's Head of Internal Audit report was partial assurance with some improvement required. This is the third year with the same rating although improvement was noted. A road map to monitor improvement has been requested. • RSM presented the final Internal Audit plan for 2022/23 which was agreed. • The Annual Report and Accounts were approved under delegated authority.
Recommendation(s) to the Board/Committee	•
Changes to BAF Risk(s) & TRR Risk(s) agreed	• No report received but now scheduled for every meeting of the Audit Committee

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Early warning alerts from Performance and Finance Committee regarding the Internal Audit plan specification around Waiting List Initiatives. • Early warning from QPES around VTE, Servicing of Medical Equipment and Controlled drugs. Clinical audits covering these areas to be planned. • External Audit and Internal Audit recommendations implementation will be tracked during 2022/23.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Internal Audit report (GT) on CQC improvement plan was Significant assurance against compliance, oversight and reporting, partial assurance with some improvement required around evidence and significant assurance with some improvement required against sustainability. • Internal Audit report (GT) on Board Assurance Framework was partial assurance with improvement required.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Counter Fraud progress report was discussed • The External Audit Management Letter was approved
Matters presented for information or noting	
Self-evaluation/ Terms of Reference/ Future Work Plan	
Issues identified potentially relating to Equality, Diversity, and Inclusion	

MEETING OF THE TRUST BOARD **Wednesday 3rd August 2022**			
Revised Terms of Reference for the People and Organisational Development Committee			
Report Author and Job Title:	Catherine Griffiths – Chief People Officer	**Responsible Director:**	Catherine Griffiths – Chief People Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• The terms of reference for the People and Organisation Development Committee have been reviewed and approved by the Committee for WHT.		
Advise	• The same terms of reference have also been reviewed and approved by the People and Organisation Development Committee at RWT for consistency purposes.		
Alert	• The cycles of business for each respective committee have been reviewed to ensure consistency.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The terms of reference for the People and Organisation Development Committee and the cycle of business provide the committee with assurance on the BAF and Trust Risk Register.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	The terms of reference for the People and Organisation Development Committee include oversight and assurance on the legal, equality & diversity implications risks and issues within the Trust.		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

PEOPLE & ORGANISATIONAL DEVELOPMENT COMMITTEE (PODC)

TERMS OF REFERENCE

Trust Strategic Objectives	To attract, retain and develop all employees and improve employee engagement year on year
BAF & Trust Risks	• Identify and monitor any new risks relating to Trust's Workforce agenda. • Review the Board Assurance Framework ("BAF") for risks within the Valuing Colleagues strategic Objective on a frequency set out in the Risk Management Policy. • Be assured that there are plans in place to address gaps in controls and gaps in assurance, and oversight of such plans.
Meeting Purpose/Remit	The purpose of the committee is to provide the Board with assurance that: • The organisational development and workforce strategy, structures, systems and processes are in place and functioning to support employees in the provision and delivery of high quality, safe patient care • Processes are in place to support optimum employee, engagement, wellbeing and performance to enable the delivery of strategy and business plans in line with the trust's values • The Trust is meeting its legal and regulatory duties in relation to its employees • Where there are human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives, that these are being managed in a controlled way through the Trust Management Committee. • The organisational culture is diagnosed and understood and actions are in place to ensure continuous improvements in culture. To provide assurance on the following key areas of workforce governance: • Resourcing • Skills • Leadership & Culture • Staff Engagement • Wellbeing • Productivity

	• Equality, Diversity and Inclusion Agenda
Responsibilities	The Committee will lead on the assurance of the workforce and organisational development including ensuring that: 1. Legal and regulatory requirements relating to the workforce are met. 2. There is an overarching organisational development and human resources strategy that enables the Trust to deliver its strategy, vision and values 3. Effective identification and mitigation of Human Resources risks within the supporting infrastructure of the Board Assurance Framework and Risk Register 4. Robust workforce planning and recruitment processes are in place, supported with attraction and retention approaches, to ensure that the Trust has a workforce to deliver its strategy and annual plan 5. Mechanisms are in place and effective to communicate with and inform the workforce in relation to strategy as well as constitution, values and ethos. 6. The Trust is monitoring staff engagement and experience, reviewing staff surveys (national & local) and delivering its plans to achieve a highly motivated and engaged workforce to enhance the quality of patient care 7. There are mechanisms in place to effectively diagnose the organisational culture and ensure focus on driving through a positive organisational culture as monitored through the national staff survey 8. There are processes in place to identify and develop organisational structures, leadership and management capability to ensure the delivery of the Trust's strategy 9. Arrangements are in place for the effective training and education of the workforce in all professions and disciplines 10. The Trust is delivering its ambition and legal obligations in relation to the Equality, Diversity and Inclusion of the workforce 11. Processes and resources are in place, to ensure the development of healthy teams and indicators of poor team health are acted upon, as well as support the wider Trust H&WB agenda. 12. National reports and best practice relating to Human Resource Management and OD is shared, reviewed for relevant findings and actions and the necessary actions implemented. 13. To oversee the requirements and governance assurance against the national agenda for Developing Workforce Safeguards Supplementary areas for assurance: 14. Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team. 15. By exception, consider concerns raised by staff and receive assurance on how these concerns are being dealt with.

	16. Review the Board Assurance Framework/Trust Risk Register high scoring risks for assurance on traction of actions, and adequacy of controls and assurances taken e.g. staffing. 17. To review and monitor effectiveness of workforce related strategies and key performance indicators such as: ○ Staff survey results (local and national) ○ Attendance levels ○ Demographic makeup of the organisation ○ Turnover ○ Occupational health data ○ Recruitment ○ Annual Workforce plan 18. The Trust has in place the range of policies necessary to effectively manage the workforce and allow for fair and consistent treatment of staff as well as receives assurance and recommends support for policies relevant to HR/OD/Education/Training and Occupational Health, on behalf of the Trust. 19. Ensure the Trust's people and organisational development policies and procedures are current, based on best practice, and compliant with relevant legislation and guidelines
Authority & Accountabilities	The People and Organisational Development Committee is established to evaluate and report on the workforce/OD agenda and the operation of risk management systems and controls to the Trust Board. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference obtaining independent advice if necessary. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee shall transact its business in accordance with national/local policy and in conformity with the principles and values of public service (GP01).
Reporting Arrangements	The minutes will be submitted to the Trust Board, and the Chair shall report on the main issues discussed and decisions made, highlighting any matters of concern or significant risks identified.
Membership	• Chair of the Committee (NED) • Chief People Officer • One other Executive Director to join on a rolling attendance basis • Two Non-Executive Directors • Deputy Chief People Officer • One Deputy Chief Operating Officer (on a rotational basis) • Divisional Manager Estates & Facilities • Director of Nursing / Deputy Chief Nurse • Chief Allied Health Professional (AHP)

	• Deputy Chief Medical Officer • Director of Governance or Deputy • Staffside Lead
Attendees – as required	• Associate Director of People • Head of Education & Training • Head of Nursing - Workforce • Head of Occupational Health and Wellbeing • Security Manager • Other Operational Leads, as required, which may include: Heads of HR Advisory, Resourcing, Equalities and Workforce, as appropriate • Other attendees may be requested to attend the meeting by the Chair or may attend with the permission of the Chair.
Chair	The Chair of the committee shall be the Trust board nominated Non-Executive Director and if he/she is absent, another NED from those present at the meeting
Quorum	Chair, (or nominated Deputy), and 4 other members, one of whom must be: • An Executive director • A Non-Executive director • A Divisional Deputy COO or nominated representative
Frequency of meetings	The committee will meet 9 times per year.
Administrative support	The HR & OD department will provide administrative support. Agenda and papers will be circulated 4 working days prior to the meeting.
Standards	• NHS Improvement Single Oversight Framework (to include Quality Governance and Well led guidance) • Equality Act, NHS Equality Delivery System, Workforce Race Equality Scheme, Workforce Disability Equality Scheme, Gender Pay Gap • NHS Employers standard recruitment checks • Medical & Dental and NHS Terms & Conditions
Standard agenda items	• Key Updates and Workforce Performance • Items for formal review and sign off • Strategic Focus Areas • Key Risks
Review of WODC Performance & Effectiveness	• To be carried out on a bi-annual basis

Subgroups	• Operational Workforce Group • Equality & Diversity group • Academy Steering Group • Medical Workforce Group
Date Approved	Trust Board – April 2022
Date Review	March 2023

MEETING OF THE Trust Board – 3 August 2022			
Sustainability Report			**AGENDA ITEM:**
Report Author and Job Title:	Janet Smith Head of Sustainability	**Responsible Director:**	Simon Evans Interim Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• To provide assurance that the Trust's Green Plan is aligned with the priorities of the Greener NHS agenda and will enable the Trust to evidence that we are working towards achieving the NHS commitment to achieve net zero carbon status by 2040.		
Advise	• To advise on the potential opportunities to the Trust in the next five years and to continue to enhance the ability of the Trust Sustainability Group in helping to move forward and meet the Greener NHS targets. • Advise on opportunities to promote the Trust Sustainability Agenda. • To strengthen the working relationship with the Black Country ICS Sustainability Group and other national and international Sustainability Groups to maximise opportunities for shared learning and best working practices.		
Alert	• To note, react and adapt to emerging factors affecting the delivery of Sustainable Healthcare in the next five years		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There is no risk implication associated with this report		
Resource implications	Revenue and Capital funding required to implement sections of the Green Plan, but external funding sources will be targeted for future investment in technologies, equipment, training and supplies to reduce the Trust's Carbon footprint.		
Legal and/or 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 ☒		

Sustainability Report

1. PURPOSE OF REPORT

The purpose of the reports is to provide an update on the progress of the Trust compliance to the requirements and priorities of the Greener NHS agenda.

2. BACKGROUND

The Department of Health acknowledges that the health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint and has a major role to play in achieving the UK carbon reduction target. The NHS has therefore committed to being the world's first 'net zero' National Health Service by setting two targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

On 30 September 2020, the roadmap to delivering a net zero National Health Services was published. It required each Trust to publish a Green Plan by 14 January 2022 and set out the key priority areas and target and commitments to achieve net zero carbon by 2040.

The Trust Board approved the Trust Green Plan on 2nd February 2022.

3. DETAILS

This report focuses on the progress of Green Plan implementation, Midlands Region Greener NHS Programme deliverables, funding opportunities as well as the action priorities in the next 6 months.

Green Plan implementation

a) ***Reduction of the proportion of desflurane used in surgery to less than 5% of overall volatile anaesthetic gases by volume by 31 March 2023***. As of May 2022, the proportion of desflurane used in surgery is at 3.2%. This is an exceptional achievement given that the Trust usage in April was at 44.1% which at the time the highest in both the region and the country. The Anaesthetic Department will continue implement the reduction measures to further reduce use.

b) ***Sustainability Champions*** – 40 staff signed up as sustainability champions with a commitment to carry out one action to reduce their own and their department carbon footprint thus contributing to the reduction of the Trust carbon footprint.

c) ***Greening Services Scheme*** – Paediatrics department Greener Inhalers Scheme

d) ***Travel and Transport*** – 10% reduction on National Express tickets through the bespoke Trust ticketing portal. Patients and visitors to the Trust will enjoy the same discount when the patient/visitors' ticketing portal is signed off by Trust stakeholders. Other benefits such as free 1 week ticket for new starters will also be available. National Express will provide a quarterly carbon reduction report to the Trust which will be reported against staff commuting and patient travel carbon footprint.

e) ***Energy and Gas*** – 3,741.24 tonnes of CO2e were saved by switching the Trust electricity supply to green energy source.

f) ***Freecycling Scheme*** – 24 out of specification bedside lockers were donated to Medical Aid UK who will put them in use in healthcare projects in developing countries. This saved the Trust 4.8 tonnes of CO2e.

UK Emissions Trading Schemes (UK ETS) carbon emissions allocation breaches

The Trust has been issued a penalty notice by the Environment Agency for breaching its UK ETS allocation. Penalty notices are expected be issued year on year as the Trust continues to breach its allocation. Appendix 1 shows future ETS allocations, actual emissions, and penalties that the Trust will likely pay in the future. The penalty cost will depend on the actual yearly carbon price. It is recommended that the Trust invest funds in decarbonising its heating system to comply with emissions target.

Funding opportunities

1. Public Sector Decarbonisation Scheme (PSDS3b) going live in July and application window open in September.
2. Healthier Futures Action Fund - available to support small innovation projects that contribute to the delivery of high-quality care, while reducing emissions and improving the sustainability of the NHS. £3,000 – £15,000 per project.

Action priorities of the next 6 months are the following:

1. Development, sign off and implementation of the Trust Sustainability Communication Plan including publishing the Trust Sustainability webpage and recruitment of carbon champions.
2. Update Green Plan carbon reduction targets and action plan based on the result of the carbon footprinting exercise.
3. Recruit clinical and non-clinical services in “Greening Services Scheme”.
4. Expand the use of the Sustainability Impact Assessment tool (SIA) in business development, investment, and procurement decisions to allow the Trust to show verifiable progress towards reduction in carbon intensive activities in the delivery of our service.
5. Mid-year review of the Green Plan.
6. Sign off an adaption plan as required in the newly released Green Plan guidance.

Carbon reduction initiatives that require capital funding are:

1. Implementation of mixed recycling scheme in all Trust sites. This includes the funding required to implement the walking aids reuse scheme.
2. Transition of Trust grey fleet to zero emissions vehicle. The 2022-23 NHS Standard Contract requires the Trust to put in place a transition plan.
3. Decarbonising Trust estates with heat decarbonisation as priority

4. RECOMMENDATIONS

To discuss the progress, the carbon footprinting result, the priorities for the next 6 months, the funding opportunities, and the resource implication for planned initiatives.

Walsall Emissions Trading Scheme (ETS) Tracker **Appendix 2**

Year	**2021**	**2022**	**2023**	**2024**	**2025**
Target (UK ETS Allocation under permit number UK-E-IN-12580)	4,643	4,517	4,390	4,264	4,138
Adjusted target	4,643	4,517	4,390	4,264	4,138
Actual Emissions	5,321	*5,300*	*5,300*	*5,300*	*5,300*
Variance	678	783	910	1,036	1,162
Variance %	15%	17%	21%	24%	28%

Penalty cost	**2021**	**2022**	**2023**	**2024**	**2025**
Carbon Price	£ 47.96	£ 81.25	£ 60.00	£ 60.00	£ 60.00
Total penalty	£ 32,517	£ 63,619	£ 54,600	£ 62,160	£ 69,720

*2022 Carbon Price is a projected at end of the year based on UK trading trends

*2026 - 30 allocations are expected to follow a downward trajectory

MEETING OF THE TRUST BOARD – Wednesday 3rd August 2022			
Clinical Fellowship Programme: Medical Briefing update 2021-22			
Report Author and Job Title:	Zoe Marsh, Associate Director of People and Programme Director	**Responsible Director:**	Dr Manjeet Shehmar, Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	Walsall Healthcare NHS Trust adopted the Clinical Fellowship programme for Medical staff in 2021		
Advise			
Alert			
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Clinical Fellowship Programme: Medical

1. PURPOSE OF REPORT

1.1 This report is to inform of the full adoption of the Clinical Fellowship Programme (CFP) for Medical Staff at Walsall Healthcare NHS Trust (WHT) by reducing multiple tiers of doctors with differing education offerings, to ensure there is parity across this group, with access to education and supervision.

1.2 The CFP is open to all doctors outside of a formal UK training programme, whether UK graduates or international and provides full support, regardless of their Career Pathway.

1.3 There are 4 levels of Clinical Fellow posts.

- Clinical Fellow – Core Trainee level
- Senior Clinical Fellow – Middle Grade
- Advanced Fellow – Pre CCT (pre-consultant)
- Advanced Fellow – Post CCT (consultant equivalent)

1.4 The posts offer a 1–3-year clinical role (80%), education (20%). All Fellows have an assigned Clinical and Educational Supervisor, and access to funded academia

1.5 The CFP operates as a shared service function in collaboration with The Royal Wolverhampton NHS Trust, with each Trust contributing to the central core infrastructure.

2. BACKGROUND

2.1 The temporary staffing spend for medical staff at WHT was c£14.36m (21/22) ref appendix A, c£15m (20/21) and c£10M (19/20).

2.2 A business case presentation for WHT to adopt the CFP was presented at the July 2021 meeting of WHT Medical Advisory Committee. There was a strong appetite to take this forward, and acknowledgment of the quality, safety and financial benefits to supporting the delivery of safe and effective care whilst valuing our medical staff. The business case was approved at Performance and Finance Investment Committee Board 2021.

2.3 In 2021, WHT took the decision to implement the CFP offering across the organisation which would aim to eradicate most agency spend for doctors below consultant level, and additionally developing a pipeline of consultants, aiming to reduce the reliance of agency doctors at consultant level.

2.3 A business case was approved in September 2021, providing investment of £267k to fund the infrastructure for programme implementation and ongoing support.
A return on investment is expected once the Trust appoints 6 clinical fellows, saving an average of c£37,000 for each fellow appointed, a significant cost pressure saving compared with agency and locum spend on medical staff.

3. PROGRAMME BENEFITS/CASE FOR CHANGE

1 Non-Training Grade (NTG) and Locally Employed Doctor (LED) opportunities are ad-hoc and do not make the best use of timely and robust processes to benefit the Trust.

2 A high percentage of Training Doctors opt to leave the training programme. The direction of travel for this initiative supports attracting and retaining junior doctors.

3 Rota gaps coupled with sickness and other ad hoc gaps add further pressure to junior doctor's workforce planning and recruitment.

4 Whilst the precise gaps in staffing often become known with little notice, it is a practical certainty that there will be gaps, with some areas more affected than others, leading to workforce issues, which impacts on patient safety.

5 It is recognised that the cost pressures incurred by the Trust around agency spend could be mitigated by a coordinated approach to filling gaps through longer term fixed contracts.

3.1 OBJECTIVES

1. To replace short-medium term locum appointments with a cohort of longer-term high quality clinical fellow appointments.

2. Deliver a high calibre Fellowship programme for all doctors outside of a formal training Programme (NTGs/LEDs) to support retention and development of medical staff.

3. Alignment of existing NTG/LEDs to CFP.

3.2 DESIRED OUTCOMES

1. Significantly reduce medical staffing reliance on agency.

2. Improve patient safety and experience.

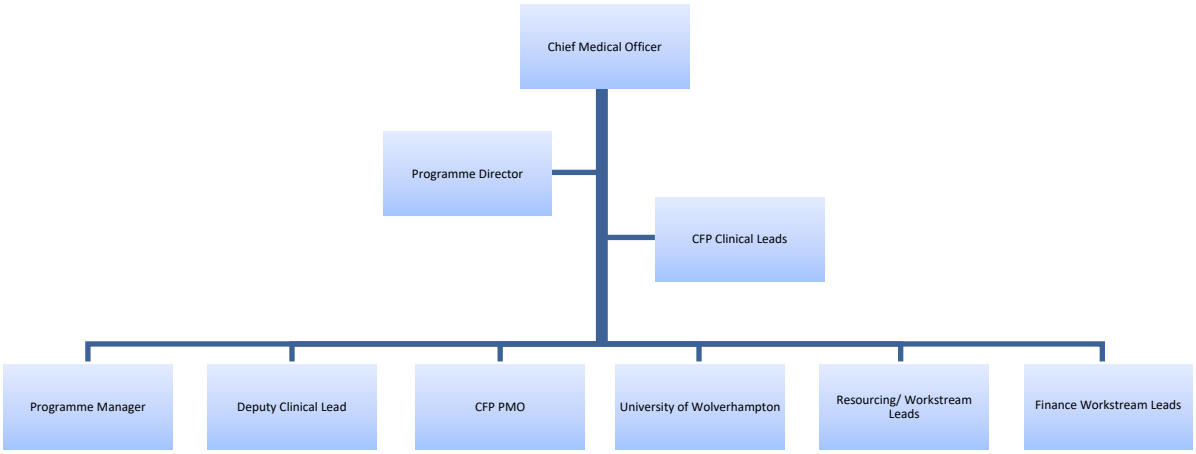
3. Improve morale of the post graduate doctor workforce.

4. Have only a 4-tier system below SAS and Consultant level.

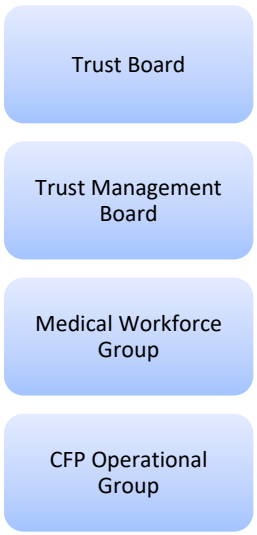
5. Make WHT the place of choice for medical staff on an international and national platform.

4 PROGRAMME AND GOVERNANCE STRUCTURE

4.1 Programme Structure



4.2 Governance structure



5 RECRUITMENT AND RETENTION

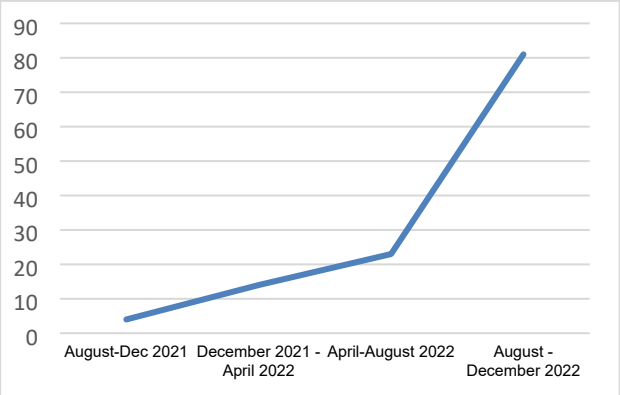
5.1 24 Clinical Fellows are in post.

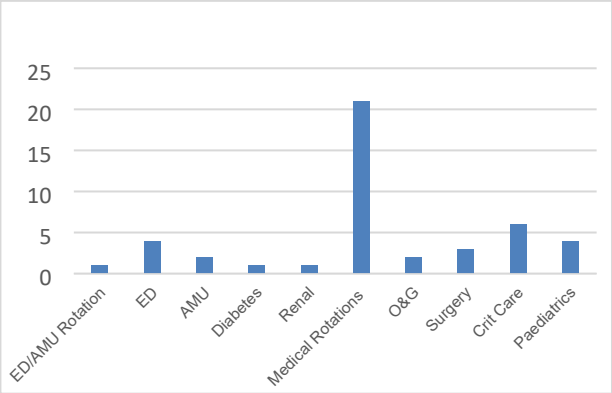
5.2 50 Fellows are currently in the Recruitment stages.

5.3 7 LEDs will be moving into to CFP posts by August 2022.

5.4 It is expected the number of existing LEDs moving into CFP posts will further increase between August and December 2022.

5.5 The graphs below are indicative of the number of Fellows appointed to the programme with a breakdown by specialty. The sharp incline would include the conversion of existing LEDs to the CFP.





5.6 Where it is identified that a division/directorate requires Clinical Fellow(s) to fill vacancies and subsequently reduce locum spend, the monitoring of savings will be the responsibility of the Divisional Team through the Medical Workforce Group (MWG).

5.7 It is acknowledged that monitoring savings will be complex, and will predominantly be cost avoidance of (agency) spend.

5.8 An additional 34 Fellow have been recruited to support the rota expansion for General Medical/AMU from August 2022.

5.9 There will be delays in arrivals so will be a short term continued reliance on temporary staffing during August/September/October. This may result in a further increase in Locum expenditure short term but should see reductions from December onwards.

6 EXIT ROUTES

6.1 2 Clinical Fellows have left the programme since implementation to 31 March 2022

Clinical Fellow Exit Route	Total
UK HEE Programme	1
Other NHS Trust	1

7 QUALITY AND SAFETY

1. It is widely acknowledged that agency doctor work can attract risk due to the nature of working in unfamiliar settings with new teams for short periods of time.

2. One of the key drivers of the CFP is to ensure we recruit doctors that will provide high quality patient care and ensure patient safety.

7.1 Appraisal and Revalidation

1. As at 31 March 2022, no Clinical Fellows were due appraisal or revalidation.

7.2 Serious Untoward Incidents (SUI)

1. As at 31 March 2022, no Clinical Fellows were directly involved in Serious Untoward Incidents during 2021/2022.

8 EDUCATION and SUPERVISION

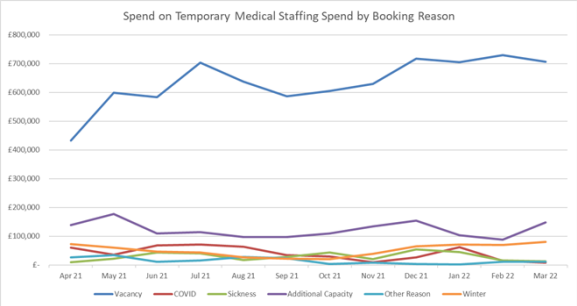
8.1 5 CFs have enrolled on the UoW MSc Programme since Jan 2022.

9 CONCLUSIONS

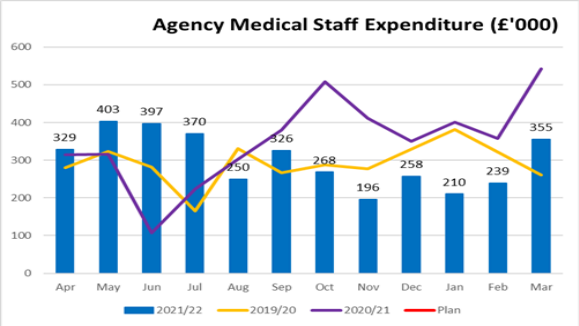
Over a short period of time CFP has made significant strides in achieving its goals in recruitment and education of Clinical Fellows and providing them with general and pastoral support. This has been achieved without compromising quality and patient safety. Over the coming months the aim is to consolidate the gains in Education and quality, expand the CFP in speciality areas and develop home grown consultants.

APPENDICES

Appendix A (data source financial management)

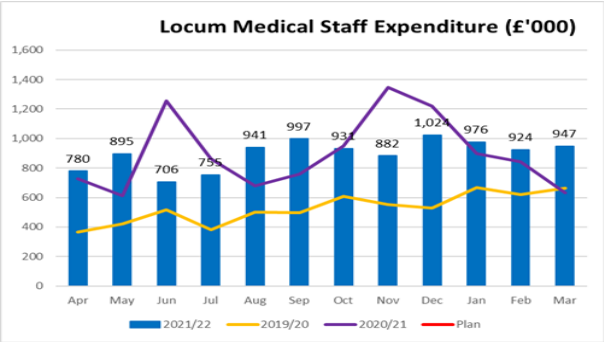


The breakdown by reason from the TempRE booking system shows that Vacancies remain the biggest reason for booking temporary staffing and this has remained consistently high for the last few months. There has also been an increase in bookings for additional capacity.



The graphs show the level of spend on temporary medical staffing compared to prior years broken down into Bank and Agency.

This shows that Agency medical staffing spend has been below the levels seen in previous years during winter but has spiked in March taking us above pre pandemic levels but remaining below the spend seen last year.



Locum medical staffing has remained flat over the last few months taking us above the level of spend seen in the previous year and remaining well above pre-pandemic levels.

MEETING OF THE – Public Trust Board 03 August 2022			
Trust Undertakings pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006			
Report Author and Job Title:	Kevin Bostock Director of Assurance	**Responsible Director:**	Kevin Bostock Director of Assurance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Be Informed ☒ Receive Assurance ☐		
Assure	• The report and attachments provide signposting to other documents that provide assurance e.g., action plan outputs and monitoring.		
Advise	• The report and attachments are provided to advise of the undertakings that the Trust has accepted to deliver.		
Alert	• The report and attachments are to alert the Trust Board to the issues raised in the undertakings and the plans in place to improve.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The improvements committed to in the undertakings will positively impact on all strategic objectives, to some extent.		
Resource implications	There are no resource implications associated with this report that the Trust has not already committed to in the redesign and restructure of governance.		
Legal and/or Equality and Diversity implications	All legal and equality & diversity implications have been considered, evaluated, and acted upon in all actions, workflows and changes stemming from the undertakings.		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

UNDERTAKINGS

NHS TRUST:

Walsall Healthcare NHS Trust ("the Trust")
Moat Road,
Walsall,
West Midlands,
WS2 9PS

DECISION:

On the basis of the grounds set out below and pursuant to the powers exercisable by NHS Improvement under or by virtue of the National Health Service Act 2006 and the TOA Directions, NHS Improvement has decided to accept undertakings from the Trust.

BACKGROUND:

NHS Improvement has issued a compliance certificate against the 2019 undertakings in recognition of progress against the quality, financial performance and operational performance issues identified at the time. However, due to quality and governance concerns remaining, it is appropriate that new undertakings are put in place to address the actions from the latest CQC inspections and to demonstrate progress against the improvement plan required.

DEFINITIONS:

In this document:

"the conditions of the Licence" means the conditions of the licence issued by Monitor under Chapter 3 of Part 3 of the Health and Social Care Act 2012 in respect of which NHS Improvement has deemed it appropriate for NHS trusts to comply with equivalent conditions, pursuant to paragraph 6(c) of the TOA Directions;

"NHS Improvement" means the National Health Service Trust Development Authority;

"TOA Directions" means the National Health Service Trust Development Authority Directions and Revocations and the Revocation of the Imperial College Healthcare National Health Service Trust Directions 2016.

GROUNDS:

1. The Trust

   The Trust is an NHS trust all or most of whose hospitals, facilities and establishments are

situated in England.

2. Issues and need for action

NHS England and NHS Improvement has reasonable grounds to suspect that the Trust has provided and is providing health care services for the purposes of the health service in England while failing to comply with the following conditions of the Licence FT4(5)(a) to (g), excluding (d), and FT4(6)(a)to (f).

In particular:

Quality Improvement / Governance

2.1. The Trust exited Special Measures in July 2019. A requirement of the Trust exiting Special Measures was that there was a comprehensive exit support plan in place which aqdressed the outstanding CQC areas of concern. The previous undertaking focused on those areas where additional support / focus was required.

2.2. In March 2021, the CQC undertook a targeted inspection of Medical Care (including older people's care), the resulting report, which was published in May 2021 identified that overall the services were assessed as Requires Improvement. However, the Trust was assessed as being Inadequate for the safe, responsive and well led domains.

2.3. A CQC inspection of Maternity services was undertaken in July 2021. The report, which was published in October 2021, rated Maternity services overall as Requires Improvement. In addition, the safe, effective and well led domains were also rated as Requires Improvement.

2.4. Although there were specific issues identified relating to medical and maternity care provision, an overarching theme from both CQC inspections highlighted the lack of oversight and insufficient governance arrangements.

2.5. In addition, NHS England and NHS Improvement has undertaken both a Trust governance review (looking at corporate, clinical and financial governance) and a targeted surgical division governance review.- Both of which identified common themes regarding the lack of robust governance and oversight arrangements.

2.6. In April 2021, the Trust formed a collaboration agreement with Royal Wolverhampton NHS Trust (RWT). As part of this collaboration, a diagnostic was undertaken which identified the following key issues:

2.6.1. Elements of structure and process did not adequately support robust assurance in relation to patient safety and outcomes, including incident management.
2.6.2. Risks on the risk register were not well defined. or recorded so did not properly support the Board Assurance Framework (BAF)
2.6.3. There was a lack of standardised reporting to provide reliable assurance.
2.6.4. There were low numbers of adult safeguarding referrals which did not align with the reported incidence of safeguarding incidents.
2.6.5. Serious Incidents (SI) were not following the prescribed SI process.
2.6.6. There was a lack of clarity and understanding of the role of the governance team by front line clinical teams and vice versa.

2.7. The staff survey results published in 2021 highlighted that, although some improvements had been made, the Trust was a negative outlier against a number of the measures.

2.8. The Trust has a CQC Well Led rating of Requires Improvement and over the last 12 months has seen a significant turnover of the Board.

3. Failures and need for action

3.1. These failings by the Trust demonstrate a failure of governance arrangements including failure to establish and effectively implement systems or processes:

3.1.1. to ensure compliance with the Trust's duty to operate efficiently, economically and effectively;
3.1.2. for timely and effective scrutiny and oversight by the Board of the Trust's operations;
3.1.3. to ensure compliance with healthcare standards binding on the Trust;
3.1.4. to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
3.1.5. to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
3.1.6. to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery.

3.2. Need for action:

NHS England and NHS Improvement believes that the action which the Trust has undertaken to take pursuant to these undertakings, is action required to secure that the failures to comply with the relevant requirements of the conditions of the Licence do not continue or recur.

4. Appropriateness of Undertakings

In considering the appropriateness of accepting in this case the undertakings set out below, NHS England and NHS Improvement has taken into account the matters set out in its Enforcement Guidance.

UNDERTAKINGS

NHS England and NHS Improvement has agreed to accept and the Trust has agreed to give the following undertakings.

1. Quality Improvement and Governance

1.1. The Trust will take all reasonable steps to address the concerns identified in, but not limited to, the CQC Reports, including carrying out the actions set out in the CQC Report in accordance with timescales as determined by the CQC such that, upon re-inspection by the CQC, the Trust will no longer be found to be 'inadequate' in any of the CQC domains in relation to Medical Care Services.

1.2. The Trust will develop a comprehensive Improvement Plan, in response to the CQC inspection recommendations and any further independent reviews, and submit to

NHS England and NHS Improvement by 30 June 2022.

1.3. The Trust will keep the Improvement Plan and its delivery under review. Where matters are identified which materially affect the Trust's ability to deliver the Improvement Plan, whether identified by the Trust or another party, the Tru,st will notify NHS England and NHS Improvement as soon as practicable and update and resubmit the Improvement Plan within a timeframe to be agreed by NHS England and NHS Improvement.

1.4. The Trust will ensure that the delivery of the Improvement Plan and other measures to improve quality and operational performance do not compromise its overall financial position. The Trust will keep the financial cost of its quality improvements under close review and will notify NHS England and NHS Improvement as soon as practicable of any matters which are identified as potentially having a material impact on the Trust's overall financial position.

1.5. The Trust will ensure that it has in place:

1.5.1. sufficient and effective Board, management and clinical leadership capacity and capability; and
1.5.2. appropriate governance systems and processes, to enable it to address the issues specified in paragraph 2.
1.5.3. The Trust to submit an update of its revised governance and oversight arrangements to NHS England and NHS Improvement by 30 June 2022.

1.6. The Trust to submit a progress update in relation to the actions it has taken in response to the staff survey findings.

1.7. The Trust to submit a copy of its Board development programme to NHS England and NHS Improvement by 30 June 2022.

1.8. The Trust to ensure that it creates a positive culture where people feel that they can speak up, that their voice will be heard and lead to learning and improvement. This will be by demonstrating that there are effective processes to receive systemic staff feedback and that there is a review mechanism in place.

2. Programme management

2.1. The Trust will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

2.2. Such programme management and governance arrangements must enable the board to:

2.2.1. obtain clear oversight over the process in delivering these undertakings;
2.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and
2.2.3. hold individuals to account for the delivery of the undertakings.

3. Access

3.1. The Trust will provide to NHS England and NHS Improvement direct access to its advisors, programme leads and the Trust's board members as needed in relation to the matters covered by these undertakings.

4. Meetings and reports

4.1. The Trust will attend meetings or, if NHS England and NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England and NHS Improvement.

4.2. The Trust will provide such reports in relation to the matters covered by these undertakings as NHS England and NHS Improvement may require.

Any failure to comply with the above undertakings may result in NHS England and NHS Improvement taking further regulatory action. This could include giving formal directions to the trust under section 8 of the National Health Service Act 2006 and paragraph 6 of the TOA Directions.

THE TRUST

Signed 

or Chief Executive of Trust)

Dated 25-5-22

NHSENGLANDandNHSIMPROVEMENT

Signed

Rebecca Farmer

Director of Strategic Transformation (West Midlands) and member of the Regional Support Group (Midlands)

Dated 25.05.2022

Walsall Healthcare NHS
NHS Trust

Date: 29 June 2022

Rebecca Farmer
Director of Strategic
Transformation (West Midlands)
and member of the Regional
Support Group (Midlands)
NHS England and NHS
Improvement

(Sent by e-mail)

Manor Hospital
Moat Road
Walsall
West Midlands
WS2 9PS

Tel: 01922 721172
Email: David.Loughton@nhs.net
Website: www.walsallhealthcare.nhs.uk

Dear Rebecca

Re: Trust undertakings to demonstrate compliance with the following conditions of the NHS Provider Licence FT4(5)(a) to (g), excluding (d), and FT4(6)(a) to (f).

Further to receipt of your letter of undertakings signed and returned by me on 25 May 2022 (copy attached) this letter sets out the Trust's response as requested by 30 June 2022.

Specifically:

1. Quality Improvement and Governance

1.1. The Trust will take all reasonable steps to address the concerns identified in, but not limited to, the CQC Reports, including carrying out the actions set out in the CQC Report in accordance with timescales as determined by the CQC such that, upon re- inspection by the CQC, the Trust will no longer be found to be 'inadequate' in any of the CQC domains in relation to Medical Care Services.

1.1 Response

The Trust developed a revised Care Quality Commission (CQC) Action Plan in August 2021. This action plan shall hereinafter be referred to as the Improvement Plan. The Improvement Plan was developed to address the regulatory breaches identified in the Care Quality Commission (CQC) reports published on 25.07.2019, 17.11.2020, 19.05.2021 and the report published on 01.10.2021 was added to it. The Trust formed a supportive collaboration with The Royal Wolverhampton NHS Trust in April 2021 and subsequently a long-term collaboration from January 2022. The collaboration has provided substantial support at executive leadership level and the Board is now constituted with 75% new Executive Directors and 3 new Non-Executive Directors (since mid-2021).

The Trust is taking all reasonable steps to reduce the likelihood that upon re- inspection by the CQC, the Trust will no longer be found to be 'inadequate' in any of the CQC domains in relation to Medical Care Services. Specifically, Medical Care (including older peoples care).

1.2. The Trust will develop a comprehensive Improvement Plan, in response to the CQC inspection recommendations and any further independent reviews and submit to NHS England and NHS Improvement by 30 June 2022.

1.2 Response

The Trust's Improvement Plan in response to the CQC reports published on 25.07.2019, 17.11.2020, 19.05.2021 and the 01.10.2021 was in existence (August 2021) prior to the receipt of letter of undertakings (May 2022) and is appended to this letter. Private Trust Board 'CQC Action plan progress reports' against the identified actions are appended. Also appended is the June 2022 Internal Auditors report on their assessment of assurance evidence to underpin a selection of actions that the Trust has made progress with.

NHS England and Improvement carried out a Trust wide Review of Accountability and Governance in March 2020 and a Limited Scope Governance Review of the Surgery Division in September 2021. The themes (structures, data / technology, leadership / accountability / strategy, culture / engagement, risk and improvement) from the two NHS England and Improvement reports have local action plans that have been mapped and are encompassed in the CQC requirements as well as the local action plans and the governance function repurposing work that is underway.

Health Education England carried out a review of the medical training environment and the report was received in March 2022. A separate Action Plan in response to this review is appended (12 April 2022).

There have also been two invited reviews by the Royal College of Surgeons regarding a particular surgeon, they are not included in this response because they contain patient level data and are responded to separately with NHS England and Improvement, Integrated Care Board, Care Quality Commission and independent oversight and involvement in the actions that arise from them.

1.3. The Trust will keep the Improvement Plan and its delivery under review. Where matters are identified which materially affect the Trust's ability to deliver the Improvement Plan, whether identified by the Trust or another party, the Trust will notify NHS England and NHS Improvement as soon as practicable and update and resubmit the Improvement Plan within a timeframe to be agreed by NHS England and NHS Improvement.

1.3 Response

The Improvement Plan (CQC action plan) is kept under live review by the Assurance Team and an update is provided to the Private Trust Board at each sitting. It is also reviewed at Trust Management Committee each month. The Trust Executive Team will, of course, notify NHS England and Improvement as soon as reasonably practical of any material matter that affects the Trusts ability to deliver the Improvement Plan. Appended are the last six reports to the Private Trust Board.

1.4. The Trust will ensure that the delivery of the Improvement Plan and other measures to improve quality and operational performance do not compromise its overall financial position. The Trust will keep the financial cost of its quality improvements under close review and will notify NHS England and NHS Improvement as soon as practicable of any matters which are identified as potentially having a material impact on the Trust's overall financial position.

1.4 Response

The Trust commits to ensuring that the delivery of the Improvement Plan and other measures to improve quality and operational performance do not compromise its overall financial position. The costs are kept under review monthly with budget meetings to balance quality improvement and financial requirements with the standards required from the quality and financial statutory landscape.

1.5. The Trust will ensure that it has in place:

1.5.1. sufficient and effective Board, management and clinical leadership capacity and capability; and

1.5.1 Response

Since August 2021 the Board has been substantially revised and 75% of Executives have changed, there have also been substantial changes to the Medical, Nursing and Allied Healthcare Professional leadership. The Executive Team consists or the following appointments since August 2021:

- *Chief Executive Officer (CEO) – Walsall NHS Trust and The Royal Wolverhampton NHS Trust*
- *Chief Nursing Officer, Deputy CEO - Walsall NHS Trust and The Royal Wolverhampton NHS Trust*
- *Director of Assurance - Walsall NHS Trust and The Royal Wolverhampton NHS Trust*
- *Chief Strategy Officer - Walsall NHS Trust and The Royal Wolverhampton NHS Trust*
- *Director of IT and SIRO - Walsall NHS Trust*
- *Director of Communications and Stakeholder Engagement - Walsall NHS Trust and The Royal Wolverhampton NHS Trust*
- *Chief Medical Officer – Walsall NHS Trust*
- *Director of Nursing – Walsall NHS Trust*

Pre-existing Executive Team members:

- *Chief Operating Officer – Walsall NHS Trust*
- *Chief Financial Officer – Walsall NHS Trust*
- *Director of People and Culture – Walsall NHS Trust*
- *Director of Planning and Improvement – Walsall NHS Trust*

There have been three new Non-Executive Directors (NED's) starting in the last six months to add to the pre-existing NED's and Chair.
All have passed the Fit and Proper Persons Test arising from the Fit and Proper Persons Regulations as defined in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 5

In the last six months the Medical Leadership Structure has been strengthened with the addition of a new Deputy Medical Director, two Associate Medical Directors, one for Workforce and one for Consultant Leadership.

Over the same period clinical leadership capability has been improved in a number of ways at divisional and care group levels. The Trust assessed its medical leadership structure against the NHSEI toolkit for Maternity service, increasing the Programmed Activities allocated for the Clinical Director for Maternity, the Gynaecology Governance Lead and the Maternity Governance Lead. Furthermore, the Trust has appointed into a Clinical Director role for Clinical Support Services for the first time and has introduced a combined Emergency Medicine & Acute Medicine Clinical Director post. The Trust also has a number of clinical leaders undertaking NHS Leadership Academy development courses and Masters degrees, in addition to Divisional and Care Group Clinical Leaders having completed a Faculty of Medical Leadership & Management multi-professional leadership development programme.

In the last six months the Nursing and AHP Leadership Structure has been strengthened by the appointment of an (Interim) Associate Deputy Director of Nursing for Digital and Innovation. The Senior Nursing Leadership has seen embedding of a collaborative structure with Senior Nurses having portfolios shared across the Trust and The Royal Wolverhampton NHS Trust. The collaborative nursing structure is appended (March 2022).

1.5.2. appropriate governance systems and processes, to enable it to address the issues specified in paragraph 2.

1.5.2 Response

The governance function has been extensively reviewed in the last ten months with a co-design and engagement process including representatives from NHS England and Improvement, CCG, The Royal Wolverhampton NHS Trust, Walsall Healthcare Central Governance Team, and Divisional Leadership Teams. This has resulted in a redesign and business case. See appended Business Case (26 April 2022) and Board Governance Restructure and Positioning Paper (8 June 2022) and Collaborative Assurance Structure (April 2022).

The improvements include a complete governance team restructure, technology improvements with Datix Cloud IQ (all modules) and InPhase for CQC compliance and quality standards monitoring, Audit, Quality Improvement and Policy management.

There is also an information re-architecting to create 'golden thread' dashboards at 5 levels, Department, Care Group, Division, Trust, and Group. This will ensure that consistent data is collected, interpreted, acted upon, and escalated for decision with clarity form floor/ward to board.

1.5.3. The Trust to submit an update of its revised governance and oversight arrangements to NHS England and NHS Improvement by 30 June 2022.

1.5.3 Response

See appended Business Case (26 April 2022) and Board Governance Restructure and Positioning Paper (8 June 2022) and Collaborative Assurance Structure (April 2022).

1.6. The Trust to submit a progress update in relation to the actions it has taken in response to the staff survey findings.

1.6 Response

The progress in relation to the staff survey findings are demonstrated in the Board Sub Committee Report (27 June 2022) and slide deck (25 May 2022) appended.

1.7. The Trust to submit a copy of its Board development programme to NHS England and NHS Improvement by 30 June 2022.

1.7 Response

The Trust has a Board Development Programme running from April 2022 to January 2023 when it will be evaluated and renewed based on ongoing need. The programme and timeframe is appended.

1.8. The Trust to ensure that it creates a positive culture where people feel that they can speak up, that their voice will be heard and lead to learning and improvement. This will be by demonstrating that there are effective processes to receive systemic staff feedback and that there is a review mechanism in place.

1.8 Response

The Trust remains committed to the 'Freedom to Speak Up' (FtSU) function, it is accordingly increasing awareness across the Trust of the FtSU service. The Board remain committed to support embedding FtSU as business as usual in line strategic intention of the National Guardian's Office.

A revised set of FtSU objectives have been launched recently, designed with the Guardians:

The objectives are;

1. *The Executive Team and all managers model the behaviours required to promote an open and positive organisational culture.*
2. *The Executive Team will remove barriers to facilitate a diverse and inclusive approach to speaking up, particularly amongst vulnerable groups such as, but not limited to, BAME and LGBT+ staff members who can sometimes feel more reluctant to raise concerns.*
3. *The means to provide advice and listen to staff in relation to concerns they have raised are created*
4. *Managers and FtSU Guardians create and implement a process to ensure staff receive timely feedback and details of what action has been taken when concerns have been raised.*
5. *Staff know how to access the Trust's speaking up channels and where to go for support and advice on how to raise concerns*

   There has been progress made on the freedom to speak up culture which is evidenced by board reports and the F2SU index on the NHS National Staff Survey.

   Q4 2021/22 FtSU Trust Board report is appended.

2. Programme management

2.1. The Trust will implement sufficient programme management and governance arrangements to enable delivery of these undertakings.

2.1 Response

The Trust has modified the pre-existing Programme Management Office function to focus its activity to more nuanced improvement activities. The oversight of the implementation and sustaining of improvements emanating from the CQC and other broad scope reports have been built into Business-as-Usual workstreams reporting into the Trust Management Committee, Board Sub Committees and Board. Improvement Programme Q3 2021/22 Update Report is appended (2 February 2022).

2.2. Such programme management and governance arrangements must enable the board to:

2.2.1. obtain clear oversight over the process in delivering these undertakings.

2.2.1 ***Response***
The reporting through Trust Management Committee, Board Sub Committees and Board provides this clear oversight.

2.2.2. obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and

2.2.2 Response
The risks to the successful achievement of the undertakings are live, feed through the Business-as-Usual Risk Register and Board Assurance Framework process because they relate to risks to the delivery of the Trusts services.

2.2.3. hold individuals to account for the delivery of the undertakings.

2.2.3 Response
The delivery of the undertakings is managed through the Improvement Plan/s the deliverables being allocated to the relevant Executive Directors portfolio. The Executive Directors are held to account through the oversight and challenge from Trust Management Committee, Board Sub Committees and Board.

3. Access

3.1. The Trust will provide to NHS England and NHS Improvement direct access to its advisors, programme leads, and the Trust's board members as needed in relation to the matters covered by these undertakings.

3.1 Response
The Trust Executive Team are committed to Providing NHS England and NHS Improvement direct access to its advisors, programme leads, and the Trust's board members as needed in relation to the matters covered by these undertakings.

4. Meetings and reports

4.1. The Trust will attend meetings or, if NHS England and NHS Improvement stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England and NHS Improvement.

4.1 Response
The Trust Executive Team are committed, with reasonable notice, to attending meetings and conference calls, at such times and places, and with such attendees, as may be required by NHS England and NHS Improvement.

4.2. The Trust will provide such reports in relation to the matters covered by these undertakings as NHS England and NHS Improvement may require.

4.2 Response

The Trust Executive Team are committed, with reasonable notice, to provide such reports in relation to the matters covered by these undertakings as NHS England and NHS Improvement may require.

I trust that this letter and supporting documents satisfied the response required by 30 June 2022.

If you require any further data, information, evidence, or assurance we shall be pleased to supply it with reasonable notice. Equally, if any officer or officers from NHS England and Improvement would like to make a site visit to meet the current Executive Team or teams at any level in the Trust, we would be happy to demonstrate, in person, the improvements that have already and continue to be made.

Yours sincerely

Professor David Loughton CBE CIHSCM
Chief Executive

MEETING OF THE TRUST BOARD – 3rd August 2022			
Acute Oncology Service – Patient Story			
Report Author and Job Title:	Karen Rawlings – Divisional Director of Nursing	**Responsible Director:**	Karen Rawlings – Divisional Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure			
Advise	• To inform members of the Trust Board around a recent patient story and positive experience when contacting the Acute Oncology 7 day service.		
Alert			
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report		
Resource implications	There are no resource implications associated with this report		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper		
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Acute Oncology Service - Compliment

“I rang the Acute Oncology team yesterday morning to say I was feeling unwell and spoke to Emily. She went through all the symptoms with me in detail and arranged for to me to go to ward 19 right away.

Emily came to see me while I was in ward 19 and explained everything that what was happening and checked again later to see that I was OK. I have to say I was feeling very weak and tired yesterday and Emily made the experience so much better than it would otherwise have been. In fact I think it was Emily's bubbly and positive nature that kept me going while at the hospital all day.

Emily has also phoned me today to see if I'm feeling better now, which I am, how kind is that of her.

Please pass on my sincere thanks to Emily.”

Walsall Healthcare NHS
NHS Trust

MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON FRIDAY 24th JUNE 2022 AT 11.30 AM HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Dr J Parkes	Non-Executive Director (Chair)
Mr K Bostock	Director of Assurance
Mrs L Carroll	Director of Nursing
Mrs O Muflahi	Associate Non-Executive Director
Dr M Shehmar	Chief Medical Officer
Prof L Toner	Associate Non-Executive Director
Mr R Virdee	Associate Non-Executive Director

In attendance

Dr A Garg	Clinical Lead ICU (observing)
Mr S Jackson	Director of Operations, Community (on behalf of Mr M Dodd)
Mrs D Ohai	Director of Operations, WCCSS (on behalf of Mr N Hobbs)
Mr P Richardson	Head of Performance & Quality – Estates & Facilities
Mrs A Hill	Executive Assistant (minutes)

Apologies

Prof A M Cannaby	Deputy Chief Executive/CNO
Mr M Dodd	Interim Director of Integration
Mr N Hobbs	Chief Operating Officer
Mrs C Jones-Charles	Divisional Director of Midwifery
Mr K Wilshere	Company Secretary

234/22	**Welcome and Introductions**
	Dr Parkes welcomed everyone to the meeting and introductions were made.
235/22	**Apologies for Absence**
	Apologies for absence, as listed above, were noted.
236/22	**Quorum and Declarations of Interest**
	The meeting was quorate in line with the Terms of Reference paragraph six. There were no declarations of interest raised. The meeting was recorded.
237/22	**Minutes of Previous Meeting**
	The minutes from the 20th May 2022 meeting were agreed as a true record.
238/22	**Items for Redaction**
	It was noted that in the 104 day harm report, it referred to 'Patient Chaser' and this terminology was changed to 'Cancer Navigator'. There were no further items for redaction and the minutes were approved for publication.

239/22	Matters Arising & Action Log

Action Log

- 221/22 – postcode information to be included in the Community Services report for long covid referrals, phlebotomy, and diabetes services. No update for June, carried forward to July meeting.
- 222/22 – inpatient manual data to be included in SHQC report – not included as there is electronic data that has greater levels of assurance included in the report.
- 222/22 - Falls data to be separated into community and acute trust for next meeting. Data not included in this month's report but will be included next month.
- 223/22 – ethnic breakdown to be categorised using the census ethnicity categories – not implemented in the June report but will be included in July's report.
- 224/22 May and June reports included in the papers for June to consider. Action closed. Timings of meetings where there is a shorter timescale to complete discussion – no update available, carried forward to July meeting.

Matters Arising

- Security Staff sitting with patients who are deemed a risk to themselves

Mr Richardson introduced this item for discussion which was sent to QPES for discussion from PFIC (Performance and Finance Committee).

A collaboration is now in place in Estates & Facilities with RWT and there have been discussions concerning patient watch and the brief that the security guards receive prior to commencing watch over a patient, A paper has been produced to analyse current practice. In 2021 there were 8000 hours' worth of patient watch logged at a cost of £120,000. RWT have risk assessment documentation including the categorisation and risk levels of patients requiring 1 to 1 care.

Mrs Carroll advised that patient care is a clinical care responsibility that sits with nursing and medical staff after risk assessment and with support from other specialist teams and only in extreme cases of violence with the support of security staff but the risk assessment and plan of care should be carried out in the clinical area and not be the responsibility of security.

Dr Shehmar advised that this needs further discussion outside of QPES with the Executive Team and a revised paper can then be bought back to QPES for further consideration.

Mr Richardson advised that the Advanced Observation Policy is currently under review and the patient watch process will be contained within that policy.

Professor Toner and Mrs Muflahi agreed with the comments above and advised that this needs to be managed at Health & Safety Committee and with the Executive Team prior to further discussion at QPES. Mrs Muflahi advised that the prevention and management of violence and aggression training is a mandated training within clinical teams and it does need to be managed at Health & Safety committee with mitigations in place for staff who sit outside of

	clinical teams who experience violence and aggression to protect both patients and staff in these circumstances. It was agreed that Mrs Carroll and Dr Shehmar would discuss outside of the meeting and ensure that the paper was put through due process.
240/22	**Patient Story**
	Mrs Carroll introduced the patient story – Alicia's story of the care she received in maternity services. She is now part of the maternity voices partnership and giving good support and guidance. Professor Toner advised it was a good story with useful learning. Mr Rajpal added that it was good to see the patient involvement with the Trust. It was agreed that a patient story will be included in all future meetings, but committee members are asked to view the recording prior to the meeting.
241/22	**Covid-19, Acute Services Access/Restoration & Recovery Update**
	The Trust has successfully restored elective and day case activity to 116% of pre-Covid norm comparing May 2022 with May 2019. There were 583 elective surgical procedures completed through operating theatres which is an increase from 483 in April. The Trust's 6 Week Wait (DM01) Diagnostics performance has reduced slightly to 9.04% for May but the Trust currently stands at 15th in National standing out of 122 and 4th in the Region. Key areas of challenge for the month were MRI and Sonography but both of those areas are fully recovered, and the interventions have been successful. Current areas of concern are Endoscopy and Echocardiology, interventions are in place and should see some improvement next month. Cancer waiting time standard, 70.8% of patients are currently treated within 62 days of GP referral which is better than the West Midlands average of 51.5% and consistent with the National average of 65.2%. The Trust's 18-week RTT performance remains within trajectory with 63.15% of patients waiting under 18 weeks at the end of April 2022 which places the Trust 7th out of 20 Trusts in the Midlands and 67th out of 122 Nationally. There are currently 766 patients waiting in excess of 52-weeks but there has been a reduction in this for the third successive month. The two week wait for suspected cancer and breast symptomatic pathways are experiencing longer waiting times and patients are currently being booked in on day 15 but this needs to be bought into the 14 day standard, with 62.3% of patients being seen within two weeks. Mutual aid is being received from RWT and has been extended to include Dudley and Sandwell. The Trust is currently offering mutual aid to RWT for the two week waits for Gynaecology and continues to support UHB and Leicester in their long waits over 104 weeks for General Surgery, Orthopaedics and Gynaecology. The Trust has not achieved the objective of 104% activity to access ERF additional funding and continues to work towards that. The Trust has exceeded the objective to achieve increased diagnostic activity to 120% of the 2019-20 activity levels.

	The Trust has seen 43% of PL2's within 30 days in the last month. Dr Parkes observed that the Trust has made good progress in restoring and recovery of services. Professor Toner queried if the areas of challenge in Cardiology and Endoscopy have been caused by workforce issues? Mrs Ohai advised that there have been increased referrals in these areas and demand management and collaboration work is underway to assist with this and there have also been issues with workforce sickness which has particularly affected the small team in Endoscopy. Dr Shehmar advised it is important to mention how hard the teams have been working to achieve this increase in performance, particularly in light of the ability to offer mutual aid to other areas. However, it is essential to ensure there are processes in place to ensure that this increase in performance does not affect quality of care and advised that the Executive Team are monitoring this closely.
242/22	**Community Services Report**
	There has been an improvement in the Locality District Nursing Teams delivering nearly 1000 hours of care than in April and 500 less hours cancelled. Sickness absence has improved within the team and specialist nurses are supporting the teams to deliver quality care. The Care Navigation Centre saw a high number of referrals and were able to deal with the demand within the existing capacity. Strong referrals are being received from GP's, care homes and families and carers. Data on referrals in domiciliary care will be included in next month's report. Referrals being made via the Care Navigation Centre and Rapid Response are working well and helping to reduce hospital attendance. The Integrated Assessment Hub also saw a strong performance, particularly in admission avoidance activity and there has been some additional work on capacity on ward areas to encourage more patients to be sent into community pathways and discharged earlier to be supported within the community. Medically fit for discharge saw an improved performance in May, maintaining an average of 46 patients on the list and a length of stay averaging 4 days, despite the increase in referrals made into the service. Work is continuing with acute wards to ensure the right referrals are made into intermediate care and providing data within the report for information where the improvement work is taking place. There have been two serious incidents in Community Services in June which are currently going through the Serious Incident and Route Cause Analysis process and action plans are being developed. The incidents are relating to pressure ulcer care and more detail will be given in next month's report once the results of the reviews are available. Professor Toner noted that it was good to see the impact that the work Community Services is having within the Trust particularly admission avoidance and medically fit for discharge. She also queried the two key areas of risks that were identified within the report: Paediatric Diabetes Service and Phlebotomy Service. Mr Jackson advised that all but one post has been recruited to in the Diabetes service and this is the part time psychologist post which has now been regraded as an 8b

	post and readvertised. The Phlebotomy service have increased the number of phlebotomists within the service, and this should increase the capacity to reduce the numbers of patients waiting and work is underway to ensure increased efficiency in this service. Mrs Muflahi queried the falls service that has been established in the division. Mr Jackson advised that this service is for when patients fall in their own homes or care homes and call West Midlands Ambulance Service (WMAS). In these cases a referral is made from WMAS to the Care Navigation Centre who despatch a rapid response team to physically assess the patient. Care services are then set up for the patient or in the case of a suspected fracture or more urgent treatment required, they will refer back to WMAS and that call will be reprioritised. This is a newly set up partnership service with WMAS to ensure an appropriate response to patient needs. Mrs Muflahi also enquired if there has been any progress with long covid in paediatric services. Mr Jackson advised there has been no progress but will include this information in next month's report. **Action – progress on long Covid service in Paediatrics services to be bought to July meeting.**
243/22	**Safe High Quality Care Oversight Report**
	There were 62 falls reported in May, with falls per 1000 bed days at 3.81. There was one fall incident reported with moderate harm that is currently under investigation. Mrs Carroll gave assurance that hospital and community data will be split and included in next month's report. Weekly falls accountability and review meetings are continuing each month and are receiving increasing engagement. The first shared professional decision-making falls prevention group meeting with RWT has now taken place with good opportunities for shared learning and improvements. The total number of Trust acquired pressure ulcers in May 2022 was 29 and the data shows that April 2022 was much lower than other months. A new risk has been placed on the risk register regarding mattresses with the current old mattresses within the Trust a potential risk to patients with their default settings. There is a process in place for checking the current mattresses and their settings in order to mitigate risk. A hybrid mattress evaluation has been completed and the new provider will be announced at the end of June. There will be no need for specialist mattresses and the hybrid mattresses can be utilised for all patient groups. VTE compliance for May 2022 remains static at 90.96% and assurance is given through the Thrombosis Group that these do not lead to hospital acquired thrombosis. This data is shared with the divisions and there is an ongoing QI project underway. There have been 13 patients breaching 104 days for April and all have been reviewed by the Lead Cancer Nurse with support from the CCG. Of these, 5 of the cases were referred to tertiary centres for opinion and treatment before day 38, 5 patients were on a lung cancer pathway, 2 on urology cancer pathways and 1 was colorectal. Deteriorating Patient Group monthly meeting is continuing and is focussing on issues with SCALE2 within NEWS2 and a sticker which clearly identifies the

	reasons that a patient is on SCALE 2 is now being piloted in two areas and is seeing improvement with use of this sticker and there are plans to roll this out within the Trust. Sepsis data is being reviewed by the Deteriorating Patient Group. The sepsis data contained in this report showing in ED 73.06% of patients received antibiotics within the first hour and 75.81% in inpatient areas, but now with the scrutiny and validation by the Sepsis Team there is assurance that this data is accurate. The manual audit has not been progressed because there is now validation from the Sepsis Team for every patient that goes onto the sepsis pathway, however it is acknowledged that there is much more work to be done in this area. Dr Shehmar advised that she is carrying out a walkabout with the Sepsis Team next week to understand what additional support the team need. Dr Parkes acknowledged the work that is being done but cautioned that there is still a concern with the number of sepsis cases and asked if there is confidence that the data now being received is accurate. Mrs Carrol gave assurance that the data is accurate. Professor Toner expressed concern regarding the two serious pressure ulcer incidents within Community Services and also advised it was good to see the pilot for the Purpose T pressure ulcer risk assessment tool commencing as in studies it had been identified that in some cases staff were using equipment inappropriately or un-necessarily. Mrs Carroll advised that one of the pressure ulcer incidents was around the fact that the family had stepped down care in the community, but the results of these reviews will be shared with Committee once the investigations are completed. There has been one incidence of C.Diff in May and there is continued focus on antimicrobial stewardship and environmental cleanliness standards. Changes have now been made to the threshold of late observations, and how late observations are classified. The Trust target has increased from 85% to 90%. The hourly previous threshold of 33% has been reduced to 10% for all observations. This has resulted in an expected decrease in observation performance with the prevalence of timely observations for May being 76.60%. Work is taking place with the Practice Education Facilitators and the Outreach Team with education in the changed parameters to ensure staff are undertaking observations in a timely fashion. These changes were important to be made and are in line with those at RWT and National Guidance and an improved trajectory is expected in coming months. Mental Capacity Act Assessment audit for May shows that 65.24% of patients who lacked capacity had a stage 2 assessment undertaken. The Trust is increasing the number of training sessions for this, Safeguarding Level 3 and a focus on completion of ReSPECT forms is taking place and an improvement should be seen in the coming months. Patient experience information is now included in the report. National Inpatient Survey has been completed and results are currently embargoed but will come through to QPES once the work has been finalised.

	It was agreed at Patient Safety Group to revert back to paper based observations and sepsis scoring within Paediatric areas whilst further work is underway following the concerns highlighted with the new Paediatric Early Warning Score tool (PEWS) following an independent review of a child death. There is a national pilot scheme, but the Trust were unable to be part of this. However, results of this should be released in September and it is hoped to commence use of the new nationally approved system later this year. Progress against clinical guidelines was discussed at the previous meeting and the new Deputy Medical Director will be Clinical Lead for guidelines for the Trust and will be meeting with all the guideline leads to ensure they are updated in a more timely manner. Additional training is planned for controlled drugs and the new Pyxis system, which are the automated storage and dispensing units, have been ordered and liaison is taking place with Estates and Facilities Team as they are reliant on the ward restoration programmes due to having to be built in units. Mental Health Act Policy has now been ratified and is going through governance process. MCA data is now in the report as an SPC chart and highlights the common cause variability and saw some improvement in March up to August last year and that is related to the training push that took place last year. The AMU Improvement Project significant improvement this month has been the response to Health Education England with the Trust sending back compliant rotas, which means an addition of 15 extra staff on the Junior Doctor GIM rota, which will significantly improve this risk and work is ongoing with the funding and the role specificity of this which will include some new ways or working with ACPs and Physician Associates. Mr Virdee queried the data on falls in the community and in the hospital and whether there is a way to find out if they are the same patients? Mrs Carrol advised that it is a different cohort of patients but if a patient has fallen and is discharged on a community pathway, this is noted. Dr Parkes queried the lack of improvement in MLTC VTE compliance which is fairly static at 80%. Dr Shehmar advised that a QI project was carried out in AMU relating to focus and leadership and performance did improve but reduced once this leadership changed. The long-term plan is that once the Electronic Patient Record (EPR) system is in place, VTE will be a mandated step within the patient record. The full programme of EPR is on trajectory for completion in a year's time but an updated paper on this will be bought to September QPES. Dr Shehmar gave assurance to Committee that regular audits are completed by an independent team led by the Clinical Lead for Thrombosis and hospital acquired thrombosis cases are all reviewed and results show that the assessments are carried out but not recorded appropriately. **Action – Dr Shehmar to bring a report from the Thrombosis Group to July QPES to give assurance that VTE compliance is not causing harm and also provide an update on the EPR implementation to September meeting.**

	Mrs Muflahi asked if the 42 overseas nurses that have not gone through the NMC process are all band 4 level and Mrs Carroll confirmed this is the case and that they are all supported workers in the process of obtaining their Objective structure Clinical Examinations (OSCE's). Mrs Muflahi expressed concern regarding the Health Visitor vacancy of 50% and Mrs Carroll advised there is a prioritisation plan in place to address health visiting recruitment and to look at various different options to progress recruitment in this area. Professor Toner also advised that discussions are underway with the University to look at this area and development of an apprenticeship programme for health visiting courses.
244/22	**Maternity Services Update**
	There continues to be staffing challenges within the service mainly due to staff sickness as the recruitment process has been successful and should be up to almost full establishment by September. Assurance was given to Committee that 100% of women received 1:1 care in labour. The STP-wide Maternity Transformation Programme has commenced with a focus on providing continuity of care for pregnant women. It has been acknowledged that this is contingent on maternity services having full staffing levels. Clinical Negligence Scheme for Trusts (CNST) has been relaunched and work is underway to submit compliance by January 2023. The SI that was presented in May has been downgraded after collaboration with RWT. The patient requested a termination due to lethal abnormality and was fully counselled and consented by the registrar, but the registrar did not complete the required forms pursuant to the Abortion Act 1997. The CCG have agreed to this downgrade. The Ockenden gap analysis has been presented and the business case has been developed to support the requirements of the final Ockenden report.
245/22	**Serious Incident Progress Report Update**
	May report and June reports are both included in the papers containing data for April and May. There was a reduction from 1724 total incidents across the Trust in April to 1626 in May. Reduction from 15 serious incidents report in April to 9 in May. There was a reduction from 155 infection control related incidents, mainly Covid related in April, to 128 in May. 34 moderate or severe harm incidents (graded at that severity at the point of reporting, not at the point of confirmation) with a reduction to 31 in May. Statutory Duty of Candour Stage 1 compliance reduced from 73% in April to 71% in May and Stage 2 from 67% in April to 50% in May. The backlog of serious incident actions has reduced from 18 in April to 16 in May and there are some additional delayed actions which are currently being analysed that may fall into the business-as-usual category which are incidents that have occurred post to the ringfenced backlog cohort.

	Mrs Muflahi acknowledged that there has been a lot of challenging work carried out in this area. She advised it would be helpful to see the thematic learning points that were raised in the report from WCCS. Mr Bostock advised that a member of staff is now in place to create quarterly learning reports from various sources of data to develop a clear profile of learning points and how this will lead to reduction in likelihood of issues recurring. The Datix module specifically related to learning will be introduced in October which will capture this data. Mr Virdee asked if there has been a change in culture and behaviour in the organisation relating to serious incident reporting. Mr Bostock advised that policies and processes have all been reviewed but the culture changes take more time. There is now increased focus on reporting and underpinning work is taking place, but improvements may not be seen until next year within the reporting charts.
246/22	**Clinical Audit & Effectiveness Update**
	The quarterly report for Q4 was included in the papers which has been presented to the Clinical Effectiveness Group. Nice guidance and any alerts are passed to the relevant areas and a number of the clinical audit reports are completed by the care groups and there are still a few requiring completion but there is action plan in place to address these. There have been some breaches for cancer response times for cancer advice, but this is due to the SLA that was set up with the Oncology Team with USB having no provision to carry this work out. This has now been resolved and the SLA changed to ensure time for the consultants to carry out this work. There is one alert in breach regarding the Steroid emergency card due to a delay in ratification in the policy going through the ratification process. The report shows a positive move in improvement within the Trust. Trauma and Orthopaedics were one of the lowest performing specialities in mortality and audit results and over the last couple of years this service has improved through the QI methodology and have been awarded the Audit Prize from HQIB because of the way they have used audit to improve the service. This is now the methodology of improvement within the Trust for all teams to use their audits and clinical outcome data to triangulate improvement with the support of the QI team. From the national clinical audit outcome table contained within the report, it is possible for the specialities to focus in to look at which parameters in the national audits they need to focus on and identify their areas of improvement. National Emergency Laparotomy Audit successfully submitted 84 cases out of a total of 117 procedures identified by the surgical team which indicated a fall below the 80% required for the submission standards. This is an improvement from previous submissions but not where the Trust would like to be. This highlights how when there is electronic data capture at source this will help capture accurate data and supports the clinical team. Bowl cancer initial data submission has been completed but there are concerns regarding the data quality and there will be a move to transfer to real time data submission for bowl cancer with the data clerk in future.

	Patient reported outcome measures will be fed back to consultants so they are aware of their performance and areas that need improvement in their service. Heart failure audit is now achieving real time data entry and have attained over 80% requirement. A clinical audit forward plan has been developed and is included in the report. Divisional plans have been requested for each area of how to improve their submission and the improvements that will be achieved through this. National Safety Standards for Invasive Procedures (NatSSIPs) has now significantly improved and there is NatSSIP completion and assurance through audit in most areas. Teams are currently reviewing this to ensure there are forms for every procedure.
247/22	**Safeguarding Q4 Report**
	The Safeguarding business case has been approved and successful recruitment has taken place with the Deputy Safeguarding Manager and Adult Safeguarding Lead. The Safeguarding Midwife is already in post and further recruitment in the business case is underway. There has been significant sickness absence within the Safeguarding Children's Team which has resulted in greater pressure on that service. Plans are in place to complete the recruitment process in this area as soon as possible to alleviate some of the pressure. Sickness absence has now been resolved during Q1. Lead Nurse for Safeguarding Adults has now retired and returned to carry out Safeguarding Level 3 and MCA training over the next few months. There has been a significant increase in the number of cases going through MARAC and MASH of 50% reflecting a national trend but this has put further pressure on the Children's Safeguarding Team. The CCG have reported significant progress around the assurance given by the Safeguarding Improvement Plan and this will continue to be updated and developed. Mrs Muflahi advised it is good to see that a scoping exercise is taking place around the Learning Disability agenda but expressed disappointment in the recording of a cannula left in a patient's arm on discharge. Mrs Carroll advised that this incident was an omission, there is a discharge checklist that should have been followed and there is some work ongoing with the Quality Team regarding discharge and some additional support from the LD team at RWT.
248/22	**Mortality (SHMI and HSMR) Report**
	This report covers the period April – May 2022. SHMI for this period is 110 recorded amber nationally on the 90th upper limit range and the Trust is ranked 106th out of 122 Trusts nationally. All deaths are reviewed by Structured Judgment Reviews (SJR) and a breakdown is included in the report. In 0.4% of the deaths in this period were deemed to be avoidable, in 8.2% there was a likely probability of avoidability but this is a subjective judgment and for all of these cases they will have an incident filed and an investigation carried out. If after review they are deemed to have been avoidable, they will have a serious incident raised and an RCA carried out.

	The top 10 causes of death are mainly respiratory causes and there is ongoing work being carried out with respiratory pathways both in the Trust and the ICS (Integrated Care System) through the acute collaboration and there is an ICS group focussing particularly on COPD and hospital and community acquired pneumonia. Although the HMSR remains higher than the national average, there is a steady reduction. As previously advised, the Trust's HSMR is affected by including Goscote Hospice in the mortality data and if this is taken out it brings this figure down. The Trust has agreed to commission an external review into Mortality to understand how the SHMI and HSMR can be reduced. The Trust has reviewed perinatal mortality following the publication of the Ockenden report. The reported SHMI is reported as 194 and following case reviews it was noted that some of the cases reported nationally are actually where there have been terminations of pregnancy such as for foetal abnormality and when these are removed, it reduces the SHMI to 169. It is noted that SHMI for perinatal mortality is high in the Black Country at 204 and there is work to reduce perinatal mortality rate by the LMNS (Local Maternity & Neonatal System) Group. The SPC chart included in the report shows that through implementing the safer baby care bundle the still birth rate is continuing to reduce. There has been some focus on nephrology pathway in particular acute kidney injury pathway and an audit has been carried out on patients who developed acute kidney injury and a business case has been agreed within the acute pathway for some additional speciality nursing staff within the acute kidney pathway. There have been several HED (Healthcare Evaluation Data) alerts in the cancer pathways, some of them are rare cancers and case reviews are carried out and not found any gaps in care. There has been a focus on improvements in bowel cancer urology and oncology. The Trust is mandated by September to role out the Community Medical Examiner process and has started a pilot with three practices and is on trajectory to go live in September. Mr Virdee asked if it was possible to identify any patterns in the mortality data relating to health inequalities and Dr Shehmar advised that a recent mortality summit was held to look at mortality data and what work needed to be carried out in terms of health and inequalities and a report was produced for the ICS Board which can be circulated to Committee. **Action – Dr Shehmar to circulate the mortality summit paper relating to health inequalities to Committee members for information.**
249/22	**Hospital Food Standards Report**
	In 2021 the Trust launched a Nutrition Ambition 2021-2024, and this incorporates the Government's independent review of NHS hospital food and the recommendations they made in October 2020. There are four key areas; to deliver outstanding nutrition and hydration care; optimise nutritional assessment and care planning; provide high quality food to meet the news of patients and promote a safety culture around nutrition and hydration. This paper details progress to date against the Ambition and shows that the Covid pandemic had an impact on the original target dates. This Ambition will be

	overseen by the Nutrition Steering Group who will review and realign the target dates and a quarterly update will be bought to QPES.
250/22	**Care Planning Annual Report**
	The Annual Care Planning Report was included in the papers, written by the Head of Nursing for Quality. Work has taken place on risk assessments and a revision of documentation to be launched in July to ensure all risk assessments and care planning is evidence-based and simple and easy to use with individualised care plans in place for patients in line with National guidance, including communication and handover tools which have been developed through engagement with clinical teams. The paper details the initiatives achieved to date and those planned and will be bought to QPES on a quarterly basis for update.
251/22	**104 Day Harm Update**
	Better assurance can now be provided to QPES through this report with the Lead Cancer Nurse and independent input from Primary Care Nursing reviewing all the case notes for the 104-day breaches and clear focus is being gained on where to make improvements. From the trend analysis it shows the top categories are urology and colorectal pathways. The main focus with Colorectal is to streamline the referrals and flow of patients as there are a large number of referrals currently. It was found that some of the community patients had not received their fit tests and this is being worked on via the joint clinical group with GPs with a clearer referral pathway for those patients who have not received a fit test to be redirected to their GP to carry this out prior to attendance at hospital. The colorectal navigator is now in post and the lead specialist nurse has been working with the cancer navigators to look at the role and improvements in the cancer pathways. The Urology service is moving over to RWT and improvements in tracking are now in place. The diagnostic outpatient processes have been streamlined and work has been carried out on cystoscopy, with the Trust now having the highest cystoscopy rates in the Country for diagnostics and concentration now is around early staging scans with the division of WCSS to ensure improved care pathways are in place.
252/22	**Exception Reports from Sub Groups**
	No exception reports were received for discussion.
253/22	**Any Other Business**
	Chair has received a form from the Trust Secretary asking for the top 3 issues arising from QPES Committee to be given to the Chief Executive. Some discussion took place regarding corporate risk register is the indicator of the main issues being raised at QPES. It was agreed by Committee that clarification would be sought from the Trust Secretary on this information request. **Action – Mr Bostock to speak to Mr Wilshere to seek more clarity on the request.** It was noted by Committee that it appears that some of the reports uploaded to IBABS had their data corrupted within the uploaded report and Mr Bostock agreed to contact Mr Wilshere to advise on these issues.

	Action – Mr Bostock to speak to Mr Wilshere regarding uploading reports to IBABS and the issues of corrupted reports.
254/22	**Matters for Escalation to the Trust Board**
	There were no items for escalation to Trust Board.
255/22	**Reflections on the Meeting**
	Meeting finished at 1.40 pm.
256/22	**Date of Next Meeting**
	Friday 22nd July 2022 at 11.30 am

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 27TH DAY OF JUNE 2022 AT 13:30
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Present

Mr Junior Hemans (CHAIR)	Non- Executive Director
Mr Paul Assinder	Non-Executive Director
Ms Clair Bond	Deputy Director of People and Culture
Ms Catherine Griffiths	Director of People and Culture
Mrs Lisa Carroll	Director of Nursing
Mrs Karen Rawlings	Divisional Director of Nursing – Surgery
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead
Mr Brad Allen (Minutes)	Executive Personal Assistant

Apologies

Mrs Jane Wilson	Joint Staff Side Lead
Ms Maria Arthur	Deputy Director of Assurance
Mr Kevin Bostock	Director of Assurance

34/22	**Chair's welcome, apologies, and confirmation of quorum**
	The Chair welcomed all members to the meeting and passed on his thanks for their attendance. The Chair declared the meeting to be quorate in line with recommendations as set out within the terms of reference. Formal apologies were received and noted as above.
35/22	**Declarations of Interest**
	There were no declarations of interest submitted or raised at the meeting.
36/22	**Minutes of Previous Meeting – April 2022**
	Committee **resolved** to approve the minutes of the meeting that took place on Monday 23rd May 2022 as a true and accurate record of discussions and decisions that took place.
37/22	**Matters arising and Action Log**
	The Action Log was reviewed and updated by action owners as necessary by utilising the iBabs service.
38/22	**Staff Story – Division of Surgery**

	Mrs Rawlings introduced the item and gave a brief overview of a recent compliment received by a member of staff following an extension to the Acute Oncology Service to seven days per week. Mrs Rawlings explained that following a recent increase to patients accessing the service, a Business Case was developed to ensure the service could be available to patients between the hours of 08:00 and 20:00 each day to respond to queries of patients suffering from cancer-related symptoms. She explained that having the service more accessible to patients on a more frequent basis resulted in increased turnaround times and increased levels of positive patient experience. Mr Assinder thanked Mrs Rawlings for her report and expressed his thanks and support for the recent improvements made to the service. Ms Griffiths concurred with points raised by Mr Assinder and stated this was an excellent example of the service listening and acting upon feedback from both staff and patients. Mrs Rawlings thanked members for their feedback and advised that as a result of the extension, an additional four Senior Nurses had been recruited into the service, all of whom have a vast array of knowledge and experience in dealing with those diagnosed with Cancer. Mr Hemans expressed the importance of ensuring success stories such as the extension to the Acute Oncology Service are shared for wider learning and advertisement of good practice within the organisation. Mrs Richards thanked Mrs Rawlings for her report and stated that it was an excellent example of the Trust delivering on its priority of delivering care closer to home. Mrs Rawlings then went on to share examples of best practice within the Sepsis Team where priorities have recently been reviewed to introduce a specific team to work between 08:00 and 20:30, where some staff teach other Nursing colleagues on Sepsis Awareness within clinical areas to support them with their time commitments. Mrs Rawlings advised that Sepsis Staff have now been issued with a Red uniform to improve their visibility. Mr Hemans passed on his thanks to Mrs Rawlings and her team for their hard work within both specialities. There were no further comments or questions from members, therefore the report was **noted.**
39/22	**Divisional Workforce Metrics – Surgery**
	Mrs Rawlings introduced the report, but there were no quries from members.

	There were no comments or questions from members, therefore the paper **noted.**
40/22	**Trust Workforce Metrics**
	Ms Griffiths introduced the report and advised that sickness levels were rising, particularly short term sickness episodes due to Covid and self isolation, and informed the committee that changes were due from NHS employers on the treatment of Covid related sickness. Mr Hemans queried what measures could be implemented ahead of the winter period to support staff across various areas to ensure staffing does not reach critical levels. Mrs Carroll advised members that due to increased levels in Covid-19, the Country was now officially in Wave Four due to restrictions being lifted and more people socialising indoors. Ms Griffiths stressed the need to invest in additional pro-active wellbeing mechanisms and campaigns to support staff within work, as well as in their return phase, especially with Musculoskeletal cases. Mr Assinder queried if those staff who are absent from work and whom cannot work from home are tasked with updating their Mandatory Training compliance to ensure the Trust reaches its targets. Ms Griffiths responded to this to confirm that alternative duties including updating mandatory training and auditing work do take place. Relating to retention she advised that a review would need to take place around designing work differently and improving the flexibility and agility of workforce deployment. She advised that opportunities are offered to staff to speak independently to members of the Human Resources team to support retention efforts, however, Ms Griffiths emphasised that this was not being picked up as quickly as it could. Mrs Carroll advised that on average, the minimum timeframe for staff testing positive was five days, however warned these could be up to ten or eleven. Mrs Carroll stated that teams must do all they can to support colleagues in completing Mandatory Training from home, but must be mindful that some staff are not able to work from home. Mr Assinder queried if the Electronic Staff Record system had the capability to trigger absences to prompt staff into completing their Mandatory Training. Ms Griffiths responded to this and advised that regular compliance records were generated and sent to Managers on a regular basis to allow them to monitor levels and prompt staff to update.

	Mr Hemans pointed out that some members of staff may not have access to a work or personal device which may hinder them accessing services to update their compliance. Mrs Carroll raised concern around the winter period as the Trust had not yet seen anticipated levels of flu due to restrictions being in place. However, Mrs Carroll advised that booster vaccinations were likely to be imminently recommended to minimise numbers and provide additional protection. She advised that more work needs to be done to promote booster vaccinations for Flu within all areas due to increased levels of anxiety. Mr Hemans queried whether a reminder could be sent to staff within the Trust's Daily Dose to remind them of the recommendations to minimise the possibility of contracting Covid-19 and Flu. Mrs Carroll concurred with Mr Hemans and stated that initiatives are in place to promote the Hands, Face, Space and Ventilation incentive to protect staff. Mr Assinder referred members to the Mandatory Training element of the report and queried why a reduced level of Administrative and Clerical Staff were compliant in their competencies. Ms Griffiths advised that although figures were low for administrative and clerical staff, regular communications with Managers were taking place to improve overall figures. She advised the figures for clinical staff have reached the trust target. Mrs Richards stated that on-going works to improve overall Mandatory Training and Sickness Absence levels were taking place, with targeted emails being sent to Managers to encourage them to undertake training where appropriate, as well as to emphasise the importance of Appraisals. Ms Bond advised that there is a considerable amount of work being undertaken by Human Resources Representatives to target Corporate areas. However, it was identified there were elements of training requirements in Managers that would need to be addressed. Ms Bond advised that advice and guidance has recently been sent to Managers for their reference. Ms Griffiths concluded that the Trust had recently experienced issues with the completion of Appraisals and as a result, Managers will be reminded with stronger messaging should results not be acquired. There were no further comments from members, therefore the report was **noted.**
41/22	**Safe Staffing**

	Mrs Carroll introduced the report as read and advised that an increase in vacancy rate had been reported at 4%, with the Health Visiting Team being stood at an overall 50% vacancy rate. In terms of mitigation, Mrs Carroll advised different methods of recruitment are currently being investigated with some staff, such as Nursery Nurses, undertaking training to support in areas such as the Health Visiting Team. Mrs Carroll then went on to advise that a total of 212 overseas Nurses had been recruited, with 170 being registered with the Nursing and Midwifery Council. Mrs Carroll advised that in addition to General Nurses, a number of Midwives had been recruited, but are yet to commence employment in the Trust, with an additional 21 being interested in joining the organisation. Mrs Carroll updated members on progressions made to Nursing Associate programmes and informed committee that a further 8 were due to qualify in July 2022, with an additional 6 due to complete during September 2022. She advised that more Associates are being offered opportunities to joint the programme to qualify as Registered Nurses. Mrs Carroll then advised that levels of off-framework were decreasing sufficiently to achieve the Trust's target of eliminating its usage altogether. In terms of risks, Mrs Carroll advised colleagues that an additional risk had been added to the Trust's Risk Register relating to Bank Nursing staff mandatory training levels not being sufficient. She advised that those who remain insufficiently trained will be written to in order to complete. Mr Hemans referred Mrs Carrol to Mental Health Clinical Support Worker numbers and queried whether there had been an increase in interest/numbers. Mrs Carroll responded to Mr Hemans to confirm a number of candidates had submitted their applications and were now going through the recruitment process. Mr Assinder praised the overall position of staffing numbers and expressed his support for the overseas nursing recruitment campaign. He advised the importance of focus being made to transitioning from reliance on agency staffing to more substantive approaches. Mrs Carroll responded thanked Mr Assinder for his comments and advised that improvements are being made to the reliability on agency staffing and that with more substantive staff commencing employment in the Trust that this would have a positive impact to falls figures and complaints. She emphasised that this would not be an immediate change, but members would see gradual improvements with more staff joining the organisation.

	Mr Hemans stressed the importance of ensuring all new-starters are made to feel welcome and supported. Mrs Carroll agreed with points raised by Mr Hemans and advised that Mrs Barbara Wren would be undertaking some sessions with colleagues to ensure they feel welcomed into the organisation. Mr Hemans raised concern with International Nurses being referred to as Overseas/International Nurses and requested that members move away from utilising this label. Mrs Carroll assured Mr Hemans that every effort is being made to encourage staff to move away from this labelling. There were no further comments from members, therefore the paper was **noted.**
42/22	**LGBTQ+ Inclusion Report**
	Mrs Richards introduced the report and gave an overview of the inclusivity measures implemented by the Trust to improve staff experiences. She then went on to advise that a recent application had been made to ascertain Rainbow Badge status, in which the Trust has been successful in order to review and understand staff priorities to implement change where needed. Mrs Richards went on to advise members that policies are continually reviewed to ensure up-to-date recommendations are followed and implemented across the Trust for both staff and patients. Mrs Richards then went on to update members on recently held discussions with the Walsall Pride Committee and LGBTQ+ charities in Birmingham to include developments to LGBTQ+ Inclusivity within the Trust on their website for reference. Mrs Richards advised members that a recruitment drive was underway to appoint a new, voluntary Chair and Vice Chair of the Trust's LGBTQ+ inclusivity Group. Mrs Richards concluded by advising members that the Trust was now part of a regional LGBTQ+ support group in which staff from Walsall are invited to attend Birmingham Pride in September 2022. Mr Hemans referred Mrs Richards and members to section 3 of the report where it mentioned additional good practice. He queried what had been identified and then questioned who would be included within the membership of the interview panel for the roles of Chair and Vice Chair of the LGBTQ+ Inclusion Group.

	Mrs Richards responded to Mr Hemans and stated that the LGBTQ+ Foundation had issued some specifics as to how we can embrace LGBTQ+ patients, as well make it clear to the public that we are an inclusive and respectful organisation. She advised that recent communications had been sent to a member of the Care Group Management Team who will be part of the report when presented to committee. Mrs Richards then went on to advise members of recent conversations held with the LBGTQ+ network Chair at The Royal Wolverhampton NHS Trust, of whom has agreed to work in partnership to acquire funds for training, of which will be offered to staff to improve their knowledge of Transexual issues and more. There were no further comments from members, therefore the report was **noted.**
43/22	**PULSE and Staff Survey**
	Ms Bond introduced the report as read and began by providing a brief update on works undertaken on a divisional level in terms of staff experience and oversight following staff survey results for the reference of the committee. Ms Bond then referred members to slide one of the presentation of which gave an overview of as to what the core questions were from the National Pulse Survey within quarter one. She then advised that quarter two was due to be rolled out to staff on Friday 1st July 2022. Ms Bond stated that actions from the previous set of results were on going within Divisions, with each of them now being discussed at Divisional Performance Reviews to monitor progress. Ms Bond then went on to refer members to other appendices within the report, one of which detailed the Patient First culture which is being developed in partnership with colleagues in Wolverhampton. Ms Bond also advised that staff members working on the Bank will be included in October 2022's staff survey to improve oversight of services. Ms Griffiths expressed her support for the progressions made in the previous set staff survey results and suggested it may be useful for the committee to have oversight as to how each action plan by Division is progressing each month. She also advised that regular communications will be sent to staff to encourage them to complete when the latest survey is made available. Mr Assinder praised the improvements made to response rates from the previous staff survey and suggested that utilising the seven question framework would prove beneficial to staff when taking time to complete. He also suggested that sharing positive news stories in the Trust where actions from the previous set of results have been acted on was vital to the success of the next set of results.

	There were no further comments from members, therefore the paper was **noted.**
44/22	**Board Assurance Framework and Corporate Risk Register**
	Ms Bond introduced the report and referred members to the two initial Trust Risks, with the first being difficulty in recruiting and retaining staff. Ms Bond advised that for the second time in a row, the Trust had reduced the overall scoring of the risk from 12 to 8, with further actions being closed around recently held recruitment road-shows. Considerations have been made as to whether the action could be further de-escalated, but due to recruitment and retention levels not meeting standards, it was decided the risk remain the same. Ms Bond advised that further and more specific details around actions taken on retention would need to be reviewed and included within the report prior to further de-escalation. Ms Bond then referred members to the Board Assurance Framework of which had been updated to ensure actions included within the log reflected recent efforts. She advised that further guidance was required as to how staff could bring all three actions together prior to formal overview at the committee in September 2022. There were no further comments or questions from members therefore the report was **noted.**
45/22	**Items for Information**
	It was **resolved** by members that each paper included within this section be noted. Ms Griffiths referred members to the Health and Wellbeing paper, particularly to the Occupational Health Investment Case of which was reported to be being discussed by members of the Governance team prior to formal approval. Ms Griffiths assured members that the paper had been mapped against National Health Service England/Improvement Frameworks. Ms Griffiths then referred members to a late business case that was circulated for information detailing plans to improve staffing levels within the recruitment team. Ms Griffiths advised that additional staffing was required due to demand in the service increasing to 120% and gave examples. Ms Richards expressed her support for the paper and stated that the volume of workforce compared to the demand from services across the organisation was not sufficient and stated it was good to see the Trust investing in the service,

	Mr Hemans agreed with points raised by Mrs Richards and placed on record his thanks for the Recruitment Team's efforts during the Covid-19 pandemic to ensure staff were recruited, despite limited resources. Ms Griffiths assured Mr Hemans she would pass on her thanks to the recruitment team on the committee's behalf. There were no further comments from members.
46/22	**Escalations to the Trust Board**
	It was **resolved** that the following escalations be made to the Trust board for reference/further intervention: - Issues with recruitment and retention to staff. - Recruitment Staffing Business Case - Increase in Nursing staff following recruitment drive. - Recent improvements LGBTQ+ actions and recruitment of Chair and Vice Chair to the inclusion Group.
47/22	**Any other Business**
	There were no additional items of business raised by members for discussion.
48/22	**Date and Time of the Next Meeting**
	Monday 25th July 2022 – 13:30 – Via Microsoft Teams.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE HELD ON WEDNESDAY 29th JUNE 2022 AT 15:00 HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mr P Assinder	Non-Executive Director **(Chair)**
Mrs M Martin	Non-Executive Director
Mr R Caldicott	Chief Financial Officer
Mr N Hobbs	Chief Operating Officer
Mr M Dodd	Interim Director of Transformation
Mr S Evans	Interim Chief Strategy Officer **(Left after Item 44/22)**

In Attendance

Mrs L Carroll	Director of Nursing
Dr M Shehmar	Chief Medical Officer **(Left after Item 43/22)**
Mr D Mortiboys	Operational Director of Finance
Ms C Griffiths	Chief People Officer **(Left after Item 43/22)**
Miss B Edwards	Executive Assistant **(Minutes)**
Ms L Robling	Bevan Brittan Representative **(Item 45/22)**

Apologies

Mrs D Brathwaite	Non-Executive Director

40/22	**Chair's welcome; apologies and confirmation of quorum**
	Mr Assinder welcomed everyone to the meeting. Mr Assinder raised concern regarding the late distribution of papers for Business Cases and the Cost Improvement Programme. Apologies for absence are noted above. The meeting was declared quorate in line with Item 6 of the Committee's Terms of Reference. The Committee has no decision-making authority unless there are 2 Non-Executive Directors and 2 Executive Directors present.
41/22	**Declarations of interest**
	There were no declarations of interest raised.
42/22	**Minutes of last meeting held on: Wednesday 25th May 2022 and Friday 17th June 2022**
	Minutes for the meeting on Wednesday 25th May 22 and Friday 17th June 2022 were approved as accurate records.
43/22	**Matters arising and action log**
	138/21 Financial Reports - Sickness Mr Assinder welcomed Ms Griffiths to the meeting. Ms Griffiths informed members there was headroom for sickness costed into budgets but stated the Trust was consistently above that, operating at a 6% level which had created an impact on workforce availability. Ms Griffiths added this caused additional costs in relation to finding cover whether it be bank or

	agency expenditure. High levels of agency expenditure and members acknowledged the consequence on the quality of patient care and the impact on staff morale. It was added the Trust was looking at increasing the amount of time staff are at work and are healthy. Ms Griffiths advised there had been an increase in short term sickness for Covid and long-term sickness with work progressing within the Divisions to support early return. Mrs Griffiths noted her believe this could be improved and a team of HR practitioners has been pulled together, the intention being to include clinicians to ensure focus was being placed upon sickness and the management of absence. Ms Griffiths stated the divisions were seeking support in this area and raised delays experienced from the recruitment team as a concern at Divisional Performance Reviews. However, members were reminded that not all divisions are performing equally in relation to attendance at work, with a workforce modelling tool designed to review absence rates and the levels of sickness absence. It was noted that sickness absence is currently known and reported, though this new model is being reviewed by corporate colleagues. It was expressed to members that support was required by the Divisions to contribute to reducing the absence rates to 4.5% by the end of the year with a stretched target of 3.5% the following year. To support achievement of this, a further business case was being developed for presentation to the Investment Group health and wellbeing, with focus on musculoskeletal injuries, mental health support and podiatry. Ms Griffiths stated the big drive to increase mental health support produced a reduction of 33% in mental health related absence, though it was noted absence increased and this could classification. Mrs Griffiths noted the interim measures are reflected within the case in the form of a multidisciplinary team, with additional capacity and existing resources reprioritised. Ms Griffiths informed members there had been an increase in staff that are leaving the Trust due to work life balance. It was further stated it had been raised at the HRD network that staff were picking up additional bank shifts at other organisations. Ms Griffiths stated a financial wellbeing questionnaire had been started. Mr Hobbs advised members the reduction was yet to be modelled and benefits quantified (to include financial savings) he expected this to increase savings opportunity for the year. Mr Hobbs added the Divisions were asking for support in managing sickness both long and short term in ensuring staff stay well and get back to work quickly. Mr Caldicott expressed that it was important to build key performance indicators for any case for investment, with the trajectory around sickness

	reduction that enables officers to be held to account when the financial model demonstrates an overspend year to date, Mrs Griffiths is describing further investment and development of a case for presentation to Investment Group. Mr Caldicott further stated these KPI's will need to ensure visibility of benefits to ensure accountability with key targeted trajectories located within the financial modelling (within run rate). Mr Caldicott expressed concern over the traction and delivery needed to be shown to attain the plan. The financial modelling as set out by Mrs Griffiths and her teams working with the Divisions, will enable a revised run rate model for presentation back through Executive and Committee. Mr Caldicott stated these targets were key if the Trust was going to move back into the target run rate, with further monitoring to ensure it was being delivered moving forward. Mr Caldicott noted that irrespective of the outcome of the business cases referred to Mrs Griffiths, the Divisions had a significant role to play to support improved attendance. Ms Griffiths noted the dependency on having the right level of health and wellbeing resource in place to achieve the reductions in absence at the pace required. Mrs Martin requested assurance from Ms Griffiths that the Trust had current approved policies for both short and long term sickness. Ms Griffiths confirmed this and added that sickness meeting was very focused through the attendance at work policy but expressed there was more that could be done in relation to having somebody at work doing something rather than being at home. Ms Griffiths stated the policy was being reviewed as it had been in place for over 2 years and clarified that the manager is the person who can be most affect the length of somebody being off sick, by proactively managing their swift return with adjustments. Also, if staff are off for a long periods they become disengaged with work and consequently be off longer. Ms Griffiths agreed to develop the trajectories, but noted some investment was required within the health and wellbeing services to drive that trajectory. Mrs Martin expressed that she was glad to hear the support being provided by the HR team and questioned the training available for divisional managers. Ms Griffiths advised when the policy was launched there was extensive training for managers. Mrs Martin further stated she was glad the policies are in place and training provided to managers, so improvements can be delivered. Members informed that stress tended to be a culmination of home and work. Mr Assinder thanked Ms Griffiths for the update and informed members this issue was on the Board members agenda and requested Ms Griffiths provided a further update in a few months' time as appropriate. Ms Griffiths agreed.

44/22	**Integrated Care Systems Update**
	Mr Evans presented to members. It was noted the formal end of the CCG and the STP arrangements and formal commencement of the ICS alongside the ICB and ICP with the first public Board meeting due to take place on Friday 1st July 22. Mr Evans informed members there would be no further public announcements following the Chief Executive announcement. Members noted that work was progressing at pace around the target operating model which needed to be in place by March 2023.
45/22	**PFI Contractual Update**
	Ms Robling joined the meeting. Mr Caldicott introduced the report, providing members with background on the case. Ms Robling updated on the progress of the investigation and recommendations. Members endorsed the recommendations of the report in progressing the commercial claim for mediation, committing a further small amount of resource as defined within the paper (under £20,000).
46/22	**Financial Reports (Month 2)**
	Mr Caldicott presented to members and were informed the Trust was in a deficit of £600k at the end of May, reminding members this was going to be a challenging plan with the key drivers of the deficit being cessation of agency and delivery of a Cost Efficiency Programme. Regarding agency, whilst delayed from initial projections, Mrs Carroll had been doing a lot of work and trajectories were being formed for agency cessation. Indeed, levels of agency tier have ceased in month and reductions in expenditure evident, though these trajectories are yet to be shared with Executive and Committee the reduced expenditure in this area is welcomed. Mr Caldicott stated that assurance was needed in relation to attainment of the Cost Improvement Programme (CIP). Mr Caldicott advised the risk was greater than reported owing to the back phasing of delivery (the position would deteriorate a further c£0.7m if the CIP targeted savings had been modelled in equal twelfths. Mr Caldicott noted planned savings total c£4.7m as opposed to the target of £6.3m, with a significant amount of the schemes in the £4.7m rated as high risk. CIP delivery is therefore a significant risk to attainment of a balanced financial plan for 2022/23. Mr Caldicott noted the teams supporting Mr Hobbs and the operational teams to identify schemes and deliver savings, supported by the program office led by Mr Evans. Mr Caldicott highlighted to members the Elective Recovery Funds (ERF) performance was at 87% of 2019/20 baseline activity and income, the Trust needing to exceed 104% of 2019/20 baseline activity to secure

	further income. On this basis it is very unlikely the Trust can secure any further income in this financial year. There was a risk the Trust could have funding reduced as rules allow the regulator to withdraw funds if systems do not exceed this 104% target. However, verbal assurances have been received around allocations that were made to systems that funds will not be reduced for not hitting the 104% (this would be an issue for all systems if enacted) Members were reminded the system took a risk on receipt of ERF totalling £8.6m for performance above 104%. Members were advised the system is not hitting above 104% but there was a pot of money nationally and centrally to fund those requests, which potentially could be recycled to close that gap. However, Mr Caldicott could not assure members this would happen at this time. Mr Caldicott advised members the Capital to support theatres is still not secure, stating this to be the most critical ask around Capital. Members were also informed of delays associated with completion of the Emergency Department new build and the Trust was pushing ahead to get it concluded. Members were advised a report on the new ED was later on the agenda, but it was escalated there would be a 4-week delay on handover, resulting in this being the middle of November 22, before occupancy by the services and the opening. Mr Assinder noted ERF had improved in month to 91% which was an improvement on April 22, but still a distance off from 104%. Mr Assinder further raised the Trust was not seeing the benefit of the increase of recruitment, particularly the international nurses, in reduced agency expenditure. Mr Hobbs advised that all the Trust's within the ICS were delivering less than 104%. It was added the Trust was performing well on elective and day case procedures but relatively low on outpatient activity, noting there is a counting change for day-case that is significantly distorting performance in this area. Mr Hobbs expressed there was a low probability that any many of the ICS trusts would end up above 104%. Mr Hobbs stated he would support Mr Caldicott's analysis of reductions for activity being below 104%, discussions regionally confirming that he did not think there would be an intent to penalise organisations financially as this would affect lots of providers and he again supported Mr Caldicott's view of a low financial risk of being penalised but also a low opportunity to get above 104%. Mrs Carroll advised that off framework agency had been switched off in 23 areas with the remaining 8 must seek approval from Director of Nursing, Deputy Director of Nursing or the On Call Director. Members noted tier 2 level agency was offline in 17 areas, the remaining areas still have the ability request agency and tier 1 agency had been switched off for 9 areas. Mrs Carroll advised there was a plan for the cessation of tier

	2 with a timeline of 2 to 3 weeks whilst tier 1 agency was going to be more gradual. Mr Assinder questioned if there was a clear plan to get back on to trajectory. Mrs Carroll advised the tier 1 plan had only just been finalised and still needed to be shared with the Executive Team. Mrs Martin questioned what the Trust's agency cap was. Mrs Martin further questioned if following the revision of the budgets, have the budgets gone out to the divisions for them to run. Mr Mortiboys confirmed and stated budget statements had gone out and performance against these budgets is issued at the end of the month. Mrs Carroll confirmed the cap in numbers of shifts and would share with members the value of the cap post meeting. Mrs Martin questioned the date for the handover of the ED. Mr Caldicott advised the contractual timeframe was 28th September 2022 and the agreed revised contractual handover was 29th October 2022. Mr Caldicott advised handover period would take until the middle of November for clinical teams to occupy the new building, it would take 2 weeks before the services could be relocated. **Action** - **Agency cap to be included in future financial reports.**
47/22	**Performance Constitutional Standards Report**
	Community Mr Dodd presented to members. Members were informed there was increased demand but the services had managed. It was reported pressures were being seen from the front door due to the increased number of patients that are being referred through with complex requirements. Mr Dodd informed members the length of stay target for the medically fit was below 4 days and that out of hospital care remained strong. Members were informed that bids had been put forward for the service development fund to develop out of hospital care using virtual wards and technology to the extent of £1.1m. Mr Dodd expressed that it was being indicated that the bids would be supported but final confirmation would be at the end of July 22. It was added securing the bids was important in terms of keeping activity out of the hospital and managing patients at home. Mr Dodd advised formal notification would be given to the organisation once official confirmation is received. Mr Assinder questioned if locations had been determined for the service expansion. Mr Dodd confirmed and stated he knew that it would be built on expanding existing services to allow rapid expansion. Members were informed this would allow the addition of a paediatric virtual ward and that the children's team was looking forward to using it. Mr Dodd advised there was a model utilised at Dudley NHS Foundation Trust to support keeping children in the system without them needing to go to hospital.

	Mr Assinder stated paediatric diabetes had been escalated as an issue and a lack of psychology cover. Mr Dodd confirmed there had been a long-standing issue, centring upon the best practice tariff and it had been highlighted that the money was available for recruitment. It was expressed it had been a long recruitment process, but progress was ongoing. It was highlighted within the report that all posts would be recruited to by Quarter 1 and Mr Dodd agreed to provide an update on the position at the next meeting. <u>Restoration and Recovery and Constitutional Standards</u> <u>Acute</u> Mr Hobbs presented to members. Positive assurance was provided in relation to elective care with the MRI waiting time recovery plan had been delivered. It was added the 52 week breach position remained stable and non-admitted patients that are on outpatient pathways continue to decrease. Patients referred for suspected breast cancer are being booked at 15 days but there had been a further reduction to 14 days. It was escalated the main areas of concern were from elective pathways including endoscopy and cardiography diagnostic, but Mr Hobbs advised recovery plans were in place and were not to the extent of concern that was for ultrasound and MRI. Mr Hobbs stated the demand for urgent and emergency care service was continuing to increase at alarming levels with May 2022 being the highest month of attendance on record with the prediction June 2022 could be even higher. It was expressed ambulance handover times continued to be strong but patients were being assessed in a timely manner within ED. Mr Hobbs advised the ED Medical Workforce business case approval would put the Trust in a better position once posts are recruited to, but members were informed there would be some risk over the next 4 months during the recruitment phase. Mr Hobbs advised emergency activity was mirrored at other organisations and the Trust wasn't experiencing the pressures alone. Mrs Martin questioned if the plan suggested satisfied the decline in performance. Mr Hobbs confirmed the Trust was clear on the understanding the cases for deteriorating performance. Mr Hobbs added the Trust had good flow out of the emergency department onto wards with support from the Community division but expressed there was insufficient clinical decision-making capacity to take decisions in a timely manner. Members were informed that data showed that the Trust performance was like other organisations and in May 2022 ranked 42 out of 112 reporting Trusts. Mr Hobbs advised that ECIST had provided an external review. Members were informed the Getting It Right First-time review was the national programme for ED. It was highlighted following the review there was good flow out of the ED but reported fragile capacity within the department both

	environmentally and clinical staffing. Members we're informed plans were in place to address with a medium-term solution with further recruitment. Mrs Martin questioned the Trust's DNA rates and its impact and how the Trust is managing it. Mr Hobbs expressed concern around the booking processes for outpatient pathways, but an external review had been commissioned and the Trust has received a draft report with a number of recommendations, these will improve DNA rates. Mrs Martin questioned if there would be a potential CIP if the DNA rates were reduced. Mr Hobbs confirmed that this would not provide CIP. Mrs Martin stated that DNA costed the Trust and impacted negatively on patients that were waiting for appointments.
48/22	**Efficiency Programme**
	Mr Hobbs presented to members. It was noted in May 22 the Trust had identified 84.2% of the £6.3m stretch target, but there was further work being progressed to increase the value of schemes to target. Mr Hobbs advised there had been extensive work with the operational Divisions, Improvement teams and the Finance team and the percentage of the red rated schemes have moved, 58% of schemes identified rated green. It was noted that a decision had been taken to remove zero value schemes which had reduced the plan from £5.3m to £4.7m and would pose a risk in terms of delivery of the target. Mr Hobbs summarised, further schemes had been identified by the Divisions and that he felt confident the Trust could achieve the £5.3m target but further work was required to try and achieve the £6.3m. Members were informed in months 1 and 2, the Trust delivered £338k in savings against a target of £546k. Good assurances had been received from the Women's, Children's and Clinical Support Services and Mr Hobbs advised he was confident the programme would continue to move in the right direction. Mrs Martin suggested another colour was used within the report to display unidentified and expressed the importance of keeping focus on the total target of £6.3m, this being the value needed to attain the plan for the year. Mr Assinder expressed delivery of the target £6.3m would be of financial and reputational benefit to the organisation to deliver. Mr Assinder acknowledged the hard work to date but asked for a strong message to be shared with the divisions and the wider organisation to ensure the target is achieved. Mr Hobbs agreed, Mr Caldicott added that attainment of Cost Improvements is key to supporting the significant investments into services seen by the Trust over the recent past, this was a motivation to continue to deliver efficiencies.

49/22	Surgery Mutual Aid
	Mr Assinder raised to members that Mutual aid from University Hospital Birmingham and Leicester had been discussed previously. Members noted due to the cost of the case, after Committee it would need to progress to Private Trust Board for approval. Mr Hobbs presented the Trust had the ability to treat 171 patients from across T&O, General Surgery and Gynaecology from other organisations over a 3-month period. It was confirmed the 1st 20 patients had formally transferred over. Mr Hobbs added there had been a detailed bottom-up costing to undertake the work that resulted in a figure of 133% of normal average tariff for those specialties being needed to balance the books, the Trust billing the Black Country ICS. Mr Hobbs advised this had been verbally supported by Matthew Hartland. It was confirmed Mr Hobbs was seeking written confirmation, but all parties are supportive of getting patients treated. Mr Assinder expressed this would give the Trust's waiting list benefit and expressed the start date was 11th June 2022. Mr Hobbs agreed and added there were 22 patients at the formal term to provide a transfer from UHB to the Trust. It was added the patients had undergone their outpatients' appointments and are undergoing their pre-assessment. Mrs Martin questioned the approval of the case if the work had already started. Mrs Martin expressed she was very supportive of the case and glad the work has been put together but added the importance of having capacity to do the work. Mr Hobbs confirmed to members whilst pre-assessment had been completed, no patient was yet treated. Mr Caldicott advised the contentious part was getting the written agreement to ensure there was a resource baseline. Mr Caldicott raised to members that a further benefit would be for Walsall patients treated to improve performance against the Elective Recovery Fund target of 104% of baseline activity. **Resolution:** **Subject to written consent for the funds transfer, the business case was supported by members.**
50/22	**Nursing Workforce in Acute Medical Unit**
	Mrs Carroll presented to members. Members noted the case had been discussed through Executive Team and had been supported as a priority case. It was confirmed the case was aligned following a statement of view of acuity and dependency using the safe nursing care tool for AMU and the review from Health Education England. It was reported at the end of last year there were significant concerns around clinical care and the number of clinical incidents that were reported. Mrs Carroll confirmed the same approach had been taken with the establishment reviews. It was

	noted there would a ratio of 1 to 6 for 45 beds with a high dependency ratio of 1 to 3. Mrs Carroll confirmed the case had been prioritised and following the review the number of staff was increased and benefits were starting to be seen. Mr Caldicott confirmed this level of resource was included with in the plan, though brought to members attention the need to be aware of the benchmarking. As whilst the ratio of staff is comparable to Wolverhampton's as evidenced within the case, the number of these high-cost area beds was significantly higher compared to turnover, Walsall seeking 45 beds and Wolverhampton (whose turnover is double that of Walsall) having 49. Members were asked to be mindful of this fact and further potential questions from the centre in relation to comparisons contained within the benchmark section. **Resolution:** **The business case was endorsed for Board approval.**
51/22	**Discharge Lounge**
	Mr Hobbs presented to members. It was noted to support the reduction in temporary workforce, reliance on the non-recurrent winter plan interventions had been reduced. This was piloted during the last winter and proved to be successful. The case would provide an establishment all year and the nursing team have applied the same process form a professional quality and safety check on establishments. Mr Hobbs advised the timings on a weekday would be 7am till 10pm and weekends would be 8am till 8:30pm. Mr Assinder stated this was a precommitment of the winter plan allocation that was provided for in the 22/23 budget. **Resolution:** **The business case was approved.**
52/22	**Commonwealth Game Update**
	Mr Hobbs confirmed plans were in place to cover off 3 potential risks. These were an increase in emergency care demand due to the increase of number of people in the West Midlands and the heightened risk of an incident. Media focus on the West Midlands was also highlighted as a risk. The Trust had made good progress on the lead up and was reflected in the Self-Assessment (Appendix 1). The Committee passed on its appreciation to Mr Hobbs and the Emergency Preparedness Resilience and Response Team.
53/22	**Corporate Risk Register and Board Assurance Framework**
	The Corporate Risk Register and Board Assurance Framework were opened for questions by members.

	Mr Caldicott highlighted to members a lot of resource had been committed within a financial plan that was dependent upon delivery of the savings program and cessation in agency usage. Whilst plans were in place, Mr Caldicott noted Agency costs are continuing and the Cost Improvement Program has risk in addition to a current shortfall in plans of c£1.6m. Mr Caldicott stated he was concerned over the impact on delivery these key elements were having on the financial plan, stating use of resources should be reviewed to ensure the current position was accurately reflecting the risks facing the Trust. Recommending members seek further assurance ahead of the next meeting. Mr Assinder noted Mr Caldicott's comments and agreed at the next meeting he would like the Committee to review the risk register and ensure the risk has been articulated appropriately.
54/22	**Any other business**
	There was no any other business raised.
55/22	**Date of next meeting: Wednesday 27th July 2022 at 15:00**

Walsall Healthcare NHS
NHS Trust

MEETING OF THE AUDIT COMMITTEE HELD ON MONDAY 9TH MAY AT 9.00 a.m. HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mrs M Martin	Non-Executive Director (Chair)
Mr P Assinder	Non-Executive Director
Mr J Hemans	Non-Executive Director
Mrs L Toner	Non-Executive Director

In attendance

Mr K Bostock	Director of Assurance
Mr R Caldicott	Chief Financial Officer
Mr D Mortiboys	Operational Director of Finance
Mr P Richardson	Head of Performance & Quality – Estates & Facilities Item 06/22
Mr K Stringer	Interim IT Director & SIRO
Mrs A Ward	Executive Assistant
Mr M Surridge	External Audit – Mazars
Mrs E Mayne	Internal Audit – Grant Thornton
Mrs M Wren	Internal Audit – Grant Thornton
Mr A Hussain	Internal Audit – RSM
Ms E Simms	Local Counter Fraud – RSM

Apologies

Mr J Parkes	Non-Executive Director

01/22	**Welcome and Introductions**
	Mrs Martin welcomed everyone to the meeting.
02/22	**Apologies for Absence**
	Apologies for absence, were recorded as listed above.
03/22	**Quorum and Declarations of Interest**
	The meeting was declared quorate in line with Item 6 of the Terms of Reference. The Committee has no decision-making authority unless there are 2 Non-Executive Directors present. Mrs Martin asked if there were any declarations of interest, particularly in relation to the agenda items. There were no declarations of interest raised.
04/22	**Minutes of Previous Meeting**
	The minutes of the previous meeting held on 7th February 2022, were agreed as a true record.
05/22	**Matters Arising & Action Log**
	The action log was discussed and updated. Items 133 and 134 had both been closed by their owners but were still pending on the log, administrator to close on the system.

	Item 131: Mr Hemans advised that he had not yet been able to discuss with the Director of People and Culture regarding the process for the Staff Survey, confirming that he was due to do so and the action could be closed. **Item 137**: Mr Wilshere provided a verbal update regarding Conflicts of Interest advising that a new system had been introduced from April which incorporates all staff through the Electronic Staff Record. It was noted that a considerable number of staff had already completed their declarations during the first month, a system check will be completed, and a written report provided to the June Audit Committee. Conflicts of Interest to be included in the business cycle moving forward. **Action**: **Conflicts of Interest to be an agenda item for the June meeting, Mr Wilshere to bring a report**
06/22	**Security Report**
	Mr Richardson joined the meeting to present the Security Report. Mrs Martin requested that moving forward the report should be a high-level strategic report, suggesting that a discussion with the Chief Operating Officer may be beneficial. Highlights of the issues of concern were presented to the meeting: Liquid oxygen – cameras are now in place around the storage area, the storage area has been increased to four reserve tanks to improve resilience. The new compound for the increased oxygen is being built and there will be cameras on this once completed. Patient Watch – reported through the Health & Safety Committee the concern around patient watch requests from nursing staff, as security staff may not be the most appropriate people to sit with a patient. The Health and Safety Committee will be undertaking a review of the criteria around patient watch, the financial element involved and appropriate processes for these patients. A total of 8000 hours was recorded for patient watch during 2020/21, it was noted that these patients often have complex mental health needs and there is no appropriate risk assessment undertaken. Following review by the Health & Safety Committee, there will be further discussion held at the Mental Health Steering Group. Mrs Toner queried the training that was provided to security staff, Mr Richardson responded that Multi Agency Public Protection Arrangement (MAPPA) training was provided for security staff, however, Mr Richardson's view was that security staff should not be left alone with these patients. A discussion took place regarding the number of incidents that involved weapons, alcohol and drugs with Mr Assinder confirming that he was happy to be part of the discussion outside the meeting. Mr Bostock confirmed that the situation had deteriorated during the pandemic advising that the Trust did not have the infrastructure to deal with mental health patients apart from short term assessments, which has had a huge impact on the numbers of patient watches. The Trust had engaged at regional and national level around the issues and a visit from NHSE/I was undertaken last week the feedback from which was that despite the issues faced the Trust was seen as an active and responsible provider. Mr

	Bostock further confirmed that a business case was being written in relation to increasing the mental health team, the risks were on the risk register and the SLA for the security team was being reviewed. Mrs Martin asked about the timelines for the review of policies, Mr Wilshere advised that the Enhanced Observation Policy was scheduled for this month's meeting. Mrs Martin further queried about having security in ED and the support for staff, Mr Richardson advised that this was particularly about having security staff in ED permanently, there had been some liaison with Royal Wolverhampton NHS Trust regarding ED security, particularly in relation to the new build, which was making progress. It was noted that the main problem at Walsall was the lack of tier 4 beds for children with no tools in place to deal with this. Mrs Martin thanked Mr Richardson advising that this was a huge concern and requesting that Quality, Patient Experience & Safety Committee review this, Mrs Toner confirmed that she would discuss with Mr Parkes. Mrs Martin requested that a review of the whole operational site be picked up with Paul Smith as he takes over from Paul Richardson, Audit Committee to note the concerns and track through the policy being ratified at future meetings. **Action**: **Audit Committee to note the concerns and track progress with the Enhanced Observation Policy at future meetings.** **Security to be an agenda item for QPES, Mrs Toner to discuss with Mr Parkes**
07/22	**Single Tender Actions**
	Mr Caldicott presented the report, highlighting that there were a considerable number of the items that were framework purchases. Mr Caldicott confirmed that moving forward there would be a review of what needed to be brought to Audit Committee, with the focus on highlighting items for escalation. Members of Audit Committee noted the content of the report.
08/22	**Losses & Special Payments**
	Mr Caldicott presented the report which was taken as read. Mr Assinder queried the incidents advising that a considerable amount of money was being paid out and requested assurance that there had been the appropriate review of the cases. Mr Mortiboys confirmed that a rigorous process was in place which was supported by NHS Bodies and had taken some time to resolve before payment made. Mr Mortiboys confirmed that a deep dive and review of the cases would be undertaken which would include checking for previous claims by individuals. Mrs Martin queried the payments that were COT agreements, Mr Mortiboys advised that he was aware that the payments were part of a legally binding agreement around discrimination. Mr Caldicott confirmed that he would discuss and provide a definitive response from the Director of People & Culture along with confirming whether the employees concerned were working in the organisation or not. **Action**:

	Detailed deep dive and review of special payments made to be undertaken – Mr Mortiboys **Mr Caldicott to provide a definitive explanation around COT payments in the Trust Board report following a discussion with the Director of People & Culture, confirmation to be included regarding the employment status of the person mentioned in the report.**
09/22	**Improving Cyber Resilience**
	Mr Stringer presented the report advising that a considerable amount of work was being undertaken on both sites around cyber security with fire walls and enhanced security in place. Mr Stringer confirmed that nothing specific had happened to date and the organisation was as resilient as it could be, also that weekly updates were taking place. It was noted that the organisation was in good health from a cyber point of view but there would be no opportunity to relax the guard. Mrs Martin confirmed that there was time in the Audit Programme to support the reviews. Members of the Audit Committee noted the content of the report.
10/22	**Internal Audit Progress Report – GT**
	Mrs Mayne presented the Progress Report advising that the team were three quarters of the way through the programme, the outcome of which was significant assurance with some improvement required noting that there were really strong controls in place around tracking of workstreams. The programme of work for the Board Assurance Framework, Risk Management and CQC Must Do, Should Do review would commence next Monday. The Head of Internal Audit Opinion will be provided to the June meeting, the outcome of which was noted as likely to be partial assurance, considering that the Trust had directed work at riskier areas. Mrs Mayne confirmed that her team were working to get traction on the recommendation implementation to have items completed and would be using the escalation process where necessary. Mrs Mayne advised that the collation of the review of training had not been undertaken and was being discussed to hand over to RSM. Mrs Martin queried the timeline for the two pieces of work that were in progress and the completion of the annual report, Mrs Mayne confirmed that Mrs Wren would be leading on the Board Assurance Framework and Risk Management and would have sufficient information to provide the report in one week. The CQC work will commence from 16th May with outcomes by the end of that week. The Head of Internal Audit Opinion will be shared with Mr Caldicott and Mr Wilshere with confirmation provided that all reports would be available for the Audit Committee in June. Mr Hemans advised that the lack of traction was a little disappointing around reporting querying what the issue was and what needed to be undertaken to ensure staff buy in, Mr Caldicott advised that he felt the organisation was in a better position than previously, there is an escalation process in place which is being used and creating responses. Training days have been provided for the Wider Trust Board and discussions held at Performance Reviews with the Divisions is bringing staff on side. Attendance at Audit Committee by Executive members will assist in improving performance moving forward, however, Mr Caldicott advised that he felt it would take a further 12 months before the escalation policy was not having to be used. Mrs Martin suggested that the Executive Board member for each piece of work that is being presented should be asked to attend Audit Committee to give them the opportunity to have a two-way dialogue with Audit Committee, to be discussed further outside the meeting.

	Action: **Mrs Martin and Mr Caldicott to discuss inviting Executive colleagues to join Audit Committee for the presentation of Internal Audit reports for which they are the Executive sponsor**
11/22	**Internal Audit Data Security & Protection Toolkit - GT**
	Mrs Wren presented the report advising that the outcome was positive with a significant level of assurance and some improvement required. This was noted as a low risk with a recommendation that the organisation should record evidence for Data Security Protection Toolkit submission. Mrs Martin queried whether the evidence would be available for the submission, Mr Stringer confirmed that a detailed action plan had been drawn up by the Information Governance Steering Group with the level of detail required, monitored by the Information Governance Lead.
12/22	**Internal Audit Improvement Programme – GT**
	Mrs Wren presented Part One of the Improvement Programme report which had reviewed the embeddedness of governance arrangements. The report had considered the Executive led review undertaken in June 2021 and provided a significant level of assurance with some improvement required. The number of recommendations from 2021 had been reviewed to ensure they were embedded, 8 of the 9 were embedded, one recommendation had been superseded as part of the changing governance arrangements and there were two low risk recommendations made. Mrs Mayne advised that she would need to see the reports from RSM presented in order to be able to take all the assurance into account for the Head of Internal Audit Opinion, this was agreed by the Chair. Mr Caldicott recorded his thanks to Mrs Mayne and the team at Grant Thornton for their work with the organisation and wished them well for the future.
13/22	**Internal Audit Plan & Local Counter Fraud – RSM**
	Mr Caldicott introduced the report confirming that following a tender process the contract for Internal Audit was awarded to RSM. A detailed piece of work had been completed looking at the profile of the Trust, the list of areas of concern and areas for potential benefit engaging with the teams across the organisation. Mr Caldicott confirmed that 125 days would be contracted 61 days of the contract will be for statutory work, the report identifies the priorities for the Trust and had been presented to the Executive team. Mr Hussain summarised the Internal Audit work advising that there had been a good level of engagement with Executive colleagues. The statutory elements for review would be: • Board Assurance Framework • Risk Management • Data Security Protection Toolkit • Key Financial Controls The remaining areas would cover across: • Risk exposure – financial, digital, operational, clinical • Data quality – sepsis • Temporary staffing – effective rostering • Cyber security • Efficiency programme

	• Covid recovery Mr Assinder highlighted that priorities of Trusts change throughout the year and requested an explanation of how competing priorities would be managed requesting some assurance regarding the role of the Audit Committee and the Chair of Audit Committee in between meetings around prioritisation. Mr Hussain advised that once the areas put forward had been approved, he would be working with the Director of Assurance regarding areas that were excluded from the plan in the first instance. A discussion took place regarding the mapping process, Mr Hussain confirmed that five areas had been agreed by the Executive and Mr Bostock confirmed that these were areas where there was no strong assurance in place, it was agreed following discussion that Mr Bostock and Mr Hussain would meet to discuss areas of work that were not included in the original plan and following that meeting a summary be circulated to members and to be an agenda item for the June meeting. Mrs Martin confirmed the acceptance of the recommendation to use 125 days of Internal Audit work for this year and advised that the Audit Committee were very aware of the need to keep the work under review, including how the days are used and that there may be a need to reassess. Mrs Martin advised that any changes would need to be brought to the attention of the Audit Committee or the Chair of Audit Committee. **Action**: **Meeting to be held between Mr Bostock and Mr Hussain regarding areas of work that were not included in the work plan. Summary of the meeting to be circulated to members of Audit Committee.** **Update on the Internal Audit Work Plan to be an agenda item for the June meeting**.
14/22	**Local Counter Fraud Plan**
	Ms Simms confirmed that she had provided a report just prior to the commencement of the Committee, which was circulated to members. Ms Simms advised that the team were agreeing the work protocols providing an overview of the 55-day workplan. Addressing the primary risks to the Trust, providing awareness work and training for staff around fraud risks. Primary areas of focus will be: • Conflicts of interest • Procurement • Invoice fraud • Recruitment Areas of added value – benchmarking for single tender waivers, reactive referrals, mandate fraud and gifts and hospitality. Mrs Martin confirmed that the plan would be kept under review by Audit Committee.
15/22	**Internal Audit – Electronic Patient Record – RSM**
	Mr Hussain presented the report reviewing the implementation of the Electronic Patient Record programme looking at monitoring of the project, governance arrangements and management of the project. The findings were that there was a project framework in place with a number of areas for improvement six high recommendations and eight medium recommendations were raised. Concern was highlighted in relation to the approval of the business case, the lack of clinical

	input and approval, and risk of inappropriate scrutiny. RSM suggested a retrospective piece of work be carried out for clinical review to ensure it fulfils the clinical needs of the Trust. Quality Impact Assessment was not undertaken and due diligence of the supplier were not the latest and most applicable, the provider of a service should be subject to the latest checks available. Further recommendations included the updating of the Terms of Reference for the Digital Programme Board, change requests should have been reviewed by clinical staff and there are no training records available in relation to the Electronic Patient Record. It was noted that no benefit realisation was in place and the Digital Programme Board nor the Trust Board had received a report from System C. Mr Caldicott confirmed that since the initial inception of work on the Electronic Patient Record the clinical leadership team in the Trust had changed, noting that there was a need to document decisions to ensure clarity when officers are no longer in post. Mr Caldicott confirmed that he was in agreement with a full review. Mr Assinder requested that the cover of the document be changed to show that the report belonged to Walsall Healthcare NHS Trust. Mr Assinder confirmed that the Medical and Nursing Director at the time had a keen interest in the clinical activity of the agenda, however, the Trust Board focused on the equality and diversity and quality impact of the agenda. Mr Stringer apologised for the document having the wrong header and confirmed that the document provided a review of the key elements of the portfolio that he would be working on with key learning points identified further noting that medical records and the use of paper is a large piece of work moving forward.
16/22	**Internal Audit – Medical Records – RSM**
	Mr Hussain presented the report advising that the review looked at the robustness including security, maintenance, processes, movement and storage. There was a theme around policies and procedures with actions highlighted as follows: • Policies to be reviewed on the back of the EPR implementation • Policies that have been used from other organisations need rebranding • Standard Operating Procedures need to be updated • Swipe access should be implemented for the Medical Records department • New Standard Operating Procedures required for: Creating new medical records Disposal and destruction of medical records • Sample testing of the ID locator system as concerns have been raised regarding its accuracy Mr Hussain confirmed that there was a significant backlog of loose filing with additional resources provided to address the issue. The report recognised the need for the provision of awareness training for staff around the risks and implications for patient safety around the issue of loose filing. A discussion took place regarding policies with Mr Bostock advising of the comprehensive review that was being undertaken of all policies. Mr Wilshere has the list and would confirm the list for the next meeting. Confirmation of the cleansing process for policies was provided and policies that are incorrect or obsolete will be removed. Mr Bostock confirmed that all the medical records policies were correctly included in the list of policies for review. Mr Wilshere advised instruction or guidance should not be confused with procedure and procedure would change very little. Mr Caldicott advised that the report highlighted the need for moving away from paper records and having the electronic patient record in place as a matter of urgency. Confirmation was provided that the child health records implementation

	into the Electronic Document Manager system was nearing completion, once completed the team would move on to looking at the process for adult records, noting that Richard Pearson would be the best person to provide an update and timeframes for the journey from paper to electronic record. Updates on the work around medical records to be provided to Audit Committee, Mr Stringer confirmed that the Chief Medical Officer is keen to re-establish the Medical Records Group to monitor progress with the work. Mr Stringer left the meeting. **Action**: **A comprehensive list of the Policies that are under review to be provided to the June Audit Committee – Mr Wilshere**
17/22	**External Audit**
	Mr Surridge confirmed that the work on the financial statement had commenced confirming that there was no need to change the audit strategy. Mr Surridge noted that expenditure recognition was a big issue for the NHS this financial year and the approach is consistent with the planning that had taken place and was on track to have the work completed by June. Mr Surridge advised that he had not received the Annual Report or Governance Statement, discussion has been held with the Company Secretary regarding this. Mr Wilshere confirmed that the majority of the content was available but some key information was still missing, the available information would be provided to External Audit.
18/22	**Review of Annual Report**
	Mr Wilshere confirmed that update that had been provided to External Audit, regarding the completion of the report. **Action**: **Annual Governance Statement and Annual Report to be provided to External Audit and received at Audit Committee in June – Mr Wilshere**
19/22	**Draft Accounts Review**
	Mr Mortiboys presented the report advising that the accounts were filed with NHS England in line with the deadline and shared with External Audit. The audit of accounts for 2021-22 were now being conducted face to face, currently working to plan. The accounts post audit will be received at the June meeting along with the ISO 260. Members were appreciative of the analytical review paper provided with the report, Mr Assinder expressed the view that it had been a challenging year and thanked Mr Caldicott, Mr Mortiboys and the team for going the extra mile to respond to the challenges and steering the organisation to a small surplus. Mr Assinder discussed the staffing costs comparison, feeling that the expenditure on temporary staffing was fairly flat over the two years one of the key elements for financial recovery moving forward is addressing temporary staffing costs, Mr Assinder suggested that a good start has been made and through Performance, Finance & Investment Committee would be looking for progress in this area. **Action**: **Post Audit Accounts and ISO 260 to be received at the June Audit Committee – Mr Caldicott**
20/22	**Review of Governance Arrangements**

	Mr Bostock confirmed to the meeting that the Internal Audit review of the Board Assurance Framework and Risk Register had commenced but had not been completed. Mr Bostock confirmed that the team were looking to the future with implementation of Datix for the Board Assurance Framework and Risk Management module which is scheduled to be ready for use from 1st August 2022. Confirmation was provided that the strategic objectives are being reviewed and will be commencing later in the year through the new platform with a revised Board Assurance Framework and Risk Register. Mrs Martin asked if there would be any reports for the next meeting, Mr Bostock confirmed that these would be provided. **Action**: **Mr Bostock to provide Board Assurance Framework and Risk Register reports to the June meeting.**
21/22	**Annual Audit Committee Report**
	Mrs Martin presented the Annual Audit Committee Report, which was taken as read, confirmation was provided that the repot would be included in the Annual Report for the Trust.
22/22	**Any Other business**
	There were no further items for discussion
23//22	**Matters for Escalation to Trust Board**
	Mrs Martin highlighted the following items that she would be escalating to Trust Board. • The discussion around security and difficult patients • Paul smith from RWT will be taking over security for both Trusts • Cyber risk – to advise on the ongoing work with Internal Audit review • Summary of the progress with completing last year's Internal Audit work • Approved this year's Internal Audit plan and to note the support needed to ensure completion • Two pieces of work commissioned by incoming SIRO have a lot of recommendations and learning included • The DSTP return is on track • Board Assurance Framework and Corporate Risk Register continues • The audit committee will monitor closely the suggested IA audits which did not make it into this year's programme • Request for delegated authority for Audit Committee regarding the approval of accounts.
24/22	**Reflections on meeting**
	Mr Hemans commented regarding the mental health risks querying whether a review of what other Trusts were undertaking should be held, Mr Caldicott confirmed that he would discuss tier 4 beds with the Deputy Director of Nursing. Mr Bostock confirmed that mental health issues in Acute Trusts was a national problem and a recent visit from NHSI had confirmed that the organisation was performing well against other Trusts. **Action**:

	Mr Caldicott to discuss the issue of provision of Tier 4 beds for CAMHS patients with the Deputy Director of Nursing Meeting finished at 10.55 a.m.
25/22	**Date & Time of Next Meeting**
	Monday 13th June 2022 at 9.00 a.m.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE CHARITABLE FUNDS COMMITTEE HELD ON MONDAY 14TH MARCH 2022 AT 10.00 a.m. HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Mr Paul Assinder	Non-Executive Director (Chair)
Mr Kevin Bostock	Director of Assurance
Mr Russell Caldicott	Director of Finance & Performance
Mrs Sally Evans	Director of Communications & Stakeholder Engagement
Miss C Griffiths	Director of People & Culture (Item 61/21)

In attendance

Mr Dan Mortiboys	Operational Director of Finance
Dr T Radford	Occupational Health Consultant (Item 61/21)
Mrs A Ward	Executive Assistant
Mrs Georgie Westley	Fundraising Manager

Apologies

Mr Trevor Baker	Chief Financial Accountant

48/21	**Welcome and Introductions**
	Mr Assinder welcomed everyone to the meeting.
49/21	**Apologies for Absence**
	Apologies for absence, were noted as listed above.
50/21	**Quorum and Declarations of Interest**
	There were no declarations of interest raised in relation to the agenda items. The meeting was deemed quorate in line with the terms of reference paragraph 6; the committee has no decision-making authority unless three members are present, which must include the Non-Executive Director Chair, One Executive Director and one other member.
51/21	**Minutes of Previous Meeting**
	The minutes of the previous meeting held on 9th December 2021 were agreed as a true record.
52/21	**Matters Arising & Action Log**
	The action log was discussed and updated. 55/20 Mrs Westley provided an update around the kiosks, agreement had been reached that further quotations should be sought, Mr Assinder suggested that Procurement should be able to assist with obtaining quotations, Mr Caldicott agreed to follow up. 20/21 NHS Charities bid in relation to Walsall Together, confirmation was provided that a report had been received just prior to the meeting, Mr Caldicott to review the report prior to circulation to members. It was agreed that the action could be closed.

	26/21 Mr Caldicott confirmed that there had been some discussion regarding the Chapel refurbishment with agreement that the work will be put through the Nursing budget with a donation of £50,000 from the Charity. The delay was caused by a thorough review of the plans for the project with a ceiling of £400,000 for the whole project. Mrs Westley requested the Chapel Refurbishment as a standing agenda item due to the necessity to report to NHS Charities regarding the allocation of funds. Mr Assisnder queried the carrying forward of money into the 2022/23 financial year, Mr Caldicott confirmed that it would be a capital project for 2022/23, with no issues around carrying the funds over.
53/21	**Fundraising Strategy**
	Mrs Evans presented the Strategy advising that Mrs Westley had completed the work on the document and extended her appreciation and thanks. Members agreed that the document was an update on what had previously been discussed and noted that the following should be included: • Terminology to be updated • Update on where the Trust is currently • Include the League of Friends • Pages to be numbered • Reflect the collaboration • Inclusion of strategic relationships with local suppliers • Inclusion of legacy giving A discussion took place around the inclusion of additional information regarding staff and colleagues, what the intended message was and where the document would be shared. Mrs Evans confirmed that there was a need to agree more corporate sponsorship with the development of a Fund-Raising team to pursue bigger opportunities, ensure clear KPI's were in place and a clear focus on income growth. Members expressed their concern that there would be a drop in financial giving due to world events; Mr Assinder drew attention back to the challenge by the Finance Director around the target audience for the Strategy. Confirmation was received in relation to a legacy gift of £135,000 and also the work with Tilbury Douglas to make contact with some of their large suppliers in the Walsall area. Mr Caldicott requested the business case for the Band 4 post along with updated information around achievements and benefits to patients and staff that would enable Trustees to understand how they could support the charity, concern was expressed, however, regarding the difficulty of obtaining Executive and Trustee support. Confirmation was received that the Strategy would be presented to the Trust Board for final approval, once approved staff can be updated, and the Strategy circulated with the marketing pack to corporate sponsors to encourage support. Following discussion, it was agreed that the Strategy should span 3 – 5 years and have at least three big items included, noting that the world is changing, people will be financially worse off and the income stream from investments will be challenging. Mr Bostock advised that a fourth strand of the work would be around networking with other NHS Charities, particularly Royal Wolverhampton Trust. Further discussion was held around large appeals and items that were required by the Trust such as a CT Scanner for the new Emergency Department or for refugees, Mrs Westley confirmed that a lorry full of goods had just left for Poland from the hospital and previously there had been support from the Charity for

	Afghan ladies using into Maternity Services. It was noted that there were quite a few small funds with the suggestion that amalgamation would enable bigger projects to be funded, Mr Assinder suggested that diplomacy would be needed when tackling the merging of funds, it was agreed following discussion that Mr Mortiboys would discuss further with Mr Baker. Mr Assinder thanked members for the really useful debate confirming the need to support Mrs Westley to update the document, Mrs Evans confirmed that she would assist to update with the key points raised in the meeting and confirmed that a final version would be available in June along with the marketing pack. It was agreed there would be a version circulated by the end of April to members with two weeks for comments. **Action**: **Business Case for the Band 4 Fundraising Support Post to be provided to Mr Caldicott for Review – Mrs Evans** **The Fundraising Strategy to be circulated to Charitable Funds Members by the end of April with a 2 week window for Comments back to Mrs Evans.** **Discussion to be held within Finance regarding the amalgamation of small funds – Mr Mortiboys & Mr Baker**
54/21	**Fundraising & Marketing Update**
	Mrs Evans advised that Mrs Westley would present the report, however, she wished to acknowledge and highlight the work that Mrs Westley had undertaken to make the last days of patients better. Mrs Westley highlighted the partnership with Tilbury Douglas and confirmed the Charity would be signing up to 'Linked In' through the Communications team. The Trust have been nominated as the Charity of the Year for business in Walsall to support and Mrs Westley confirmed that she is working with Walsall Football Club and Home Serve in relation to sponsorship. Projects highlighted included £18,000 to refresh the Neonatal Child Development Centre, noting that there was some money available through League of Friends and also in the legacy fund. It was noted that an amount of £130,000 is to be donated by a family from a sale of a property as a legacy gift, which it was felt could be good publicity for the Charity. Mr Caldicott advised that in relation to the League of Friends funds there had been some discussion regarding donating resources for Pharmacy cabinets and some additional resources go to ITU. Mr Caldicott advised that the League of Friends were looking to realign and mend relationships which was for discussion moving forward and may need to be included in the Strategy. Mr Assinder expressed the view that it was good there was still dialogue, noting the concerns regarding previous behaviours and offered to help. Mr Bostock was asked to assist with having the correct governance in place, Mr Bostock confirmed that he would undertake a deep dive and discuss further with Mrs Westley. Events for the remainder of the year had been circulated with requests for staff to get involved. Mrs Westley asked for information regarding the Jubilee Celebrations, Mrs Evans advised that there had been no discussion at Trust Board, confirming that she would report to the April Trust Board after reviewing the funding available. Mrs Westley confirmed that she had a plan and was putting in a

	bid for external funding. Mr Assinder confirmed that he would list the forthcoming events in the Highlight report to the Trust Board and muster some support from Board members. Mr Assinder thanked Mrs Westley for her work. **Action**: **Deep dive to be undertaken around the Governance in relation to the League of Friends Charity – Mr Bostock**
55/21	**Performance of Investment**
	Mr Mortiboys presented the report to the end of December 2021 advising that the portfolio had made a small gain, the stock market variation was noted as between 2 – 8%, the portfolio is being well managed to minimise the impact of world issues and the Finance team would be working closely with Brewin Dolphin on the investment portfolio. Mr Assinder advised that the warning was noted and asked for a view on the portfolio, Mr Mortiboys advised of the stock volatility. Mr Caldicott requested time to understand the report and from the Committee go back to Brewin Dolphin to see whether the Charity funds are exposed to Russian entities and asking how they would be managing the portfolio at this time. There was a need to understand the strategy of the investments and whether the Charity would be better with a cash holding. It was agreed following discussion that Mr Assinder and Mr Caldicott would take up the discussion with Brewin Dolphin. **Action**: **Update to be provided to the April Trust Board in relation to planning of Jubilee Celebrations – Mrs Evans** **Discussion to be held with Brewin Dolphin regarding the Investment Portfolio exposure and the way forward in the current climate – Mr Caldicott, Mr Assinder**
56/21	**Quarterly Review of Expenditure Below £5k**
	Mr Mortiboys presented the report advising that £32,696.47 had been authorised by Fund Managers during the last quarter. Members noted the content of the report and approved the spending as detailed.
57/21	**Expenditure Requests £5k - £99,999**
	Mr Mortiboys confirmed that there had been no requests between £5k - £99,999.
58/21	**Expenditure Requests £100k plus**
	Mr Mortiboys advised that there had been no requests over £100,000, however, it was noted that the Consultant in Occupational Health would be attending the meeting later in relation to an NHS Charities bid.
59/21	**Quarterly Review of Charitable Income & Expenditure**
	Mr Mortiboys presented the report advising that there were several funds in deficit, however, there were plans for these balances within the reserves policy, the Charitable Funds were in a good position, however, it was noted that there will be an impact from recent world events. Mr Mortiboys advised that Enoch Evans had contacted to say that the bungalow bequeathed to the Charity had sold for £238,000, Enoch Evans have asked for the Trust to confirm that they were happy with the process, members advised that in order to provide the confirmation

	requested there would need to be a formal review process completed. Mr Mortiboys advised that the sale of the property would be a cash receipt to the Charity and would improve the income and expenditure position substantially. Appendices to the report show the funding of previous staff vouchers would be taken from the monies received from the sale of the property along with a complete breakdown of the funds received from NHS Charities. Mr Assinder noted the clear set of reports, a sum of £36,000 was still available from NHS Charities along with £16,000 of Covid-19 funding, requesting Mrs Westley to look at how this funding could be utilised. Mr Assinder queried the request by Enoch Evans with Mr Bostock, Mr Mortiboys advised that the total receipt for the property was £288,000, Enoch Evans have charged £50,000 in fees. Mr Bostock advised that he felt the charges were high and was unsure about how the charges could be justified. A discussion took place regarding whether the Trust should just acknowledge the net payment received or whether there could be any challenge, Mr Caldicott expressed the view that the Trust should not be writing to confirm their acceptance but consider the position regarding a challenge. Confirmation was provided that a discussion had been held with the Company Secretary, whose advice was not to commit to anything the Committee is not comfortable with, Mr Assinder therefore summed up that the Charity had no basis for commenting, it was for the Executors to satisfy themselves and the Charity had no interest in this.
60/21	**Reserves Policy**
	Mr Mortiboys advised that the reserves policy was to keep £500,000 in the fund and currently the Charity is comfortably above this amount, previously it had been agreed not to vary from the £500,000. Mr Assinder noted that there was a significant amount of uninvested cash available in the charity advising that he felt there was some work to do on the cash situation and asked members if they were comfortable with the situation. Mr Caldicott acknowledged the cash but posed the question that now may not be the right time to invest, suggesting that the cash should be kept, and a decision made at the next Committee. Mr Assinder requested that there be discussion with Brewin Dolphin, Mr Mortiboys confirmed that there would be discussion with the Brokers and an update provided between meetings.
61/21	**NHS Charities Bid**
	Mr Assinder welcomed Dr Radford to the meeting and requested an overview of the funding request. Dr Radford advised that the bid was in relation to Covid-19 recovery to support mental health and wellbeing in NHS staff and volunteers whose needs have been generated by the pandemic. The organisation currently does not have what is needed and have not had the involvement of an organisation psychologist to provide the information. The work had commenced, and an initial report provided, however, more time is needed to look at different groups and what can run alongside current health and wellbeing, the project would also fit into the work the ICS are doing. Year two would be for supporting the clinical need, work on bereavement with a 2-year plan for data collection and delivering interventions along with developing a business case for future work advising that the benefits will be: • Improved staff survey and pulse survey engagement, health & wellbeing, advocacy scores and results. • Reduction in sickness absence rates for staff mental health and

	musculoskeletal disorders • Increased engagement in health & wellbeing initiatives once Covid-19 issues addressed • Reduction in referrals to Occupational Health for staff mental health and musculoskeletal disorders Costs were noted as £55,000 for the first year and £40,000 for the second year. Mr Assinder queried whether there would be academic accreditation, Dr Radford advised that would depend on who was engaged, there would be a publication at the end of the project, confirming that the scheme would also be part of a research project. Further discussion took place regarding engaging the local Research and Development team along with discussing further with Royal Wolverhampton Trust. Confirmation was provided that discussions had been held in relation to the project at the Collaborative Working Group, however, the funding would not be available to both Trusts, Royal Wolverhampton Trust may be able to put in a bid in a similar approach once some of the findings are known from the Walsall project, although currently Royal Wolverhampton have no intention of taking part in this project. Mr Caldicott suggested that there would be an opportunity for sharing of outcomes and would support moving forward, he noted, however, that there seemed to be a long process for evaluation and queried whether there would be work going on rather than just waiting. Dr Radford confirmed this was the case, health & wellbeing work will continue along with mental health support for staff, the project is an addition to assist in planning. Miss Griffiths joined the meeting, Mr Assinder welcomed Miss Griffiths and advised that Dr Radford had provided an overview of the project. Mr Assinder appraised of the challenge around Royal Wolverhampton and the length of time to evaluate and form actions. Miss Griffiths responded that the organisation would be continuing with the measures already in place confirming that the request is for a structured response for the recovery process. The value will be that it is structured, and evidence based which would need to be scaled across both sites, however, currently the team do not know what Royal Wolverhampton would need, once the results are in the health and wellbeing response will be tailored accordingly followed up by a research paper. Mr Assinder queried the Executive support for the project, Miss Griffiths advised of the discussion and unanimous support which was confirmed by Mr Caldicott. Members approved the NHS Charities bid for a recovery grant, with a request for an update at the September meeting. **Action**: **An update to be provided to the September meeting regarding the NHS Charities bid in relation to Covid-19 Recovery – Mrs Westley, Dr Radford**
62/21	**Any Other business**
	Mr Assinder advised that he wished to have a discussion regarding the support post for Fundraising asking how to commence the process. Mrs Evans confirmed that the job description was written, and the team were awaiting the financials for the business case. Mr Caldicott posed the question of what the benefit would be to the Charity as a consequence of spending £30,000 per annum, suggesting that the request should be taken to the Trustees for assurance. Mrs Evans advised that there was a business case for evidence which once completed would be circulated to members. A query was raised whether the post should be

	substantive or fixed term, with Mrs Evans confirming that the purpose of the post was to free up the time of Mrs Westley to focus on other projects, the person appointed may not bring in additional funds, but it was felt that there would be a difference by the end of year two. Mr Caldicott confirmed that he would support a substantive post but there was a need to articulate the intrinsic benefits. Mrs Evans requested virtual approval from members via email once the business case has been circulated. Members agreed with the approach. **Action**: **Virtual approval of the Business Case for the Band 4 Fundraising Support Post to be provided following circulation – ALL** Mr Mortiboys advised that Mrs Jones – Charitable Funds Accountant had left the organisation since the last Charitable Funds Committee, thanks were expressed to Mrs Jones for the work that she had undertaken on behalf of the charity. Mr Assinder queried the cover arrangements, Mr Mortiboys confirmed that recruitment would be taking place for the Financial Accounting team.
63/21	**Matters for Escalation to Trust Board**
	Mr Assinder confirmed that he would be bringing the following items to the attention of the Trust Board. • Awareness of Jubilee events • Awareness of fundraising events moving forward • Review of Investment Portfolio in light of recent world events Discussion also took place about highlighting the legacy transaction, Mr Assinder advised that he would think carefully around this matter as the Trust Board was a public meeting.
64/21	**Reflections on meeting**
	Members reflected on the meeting commenting that the Strategy will be a strong driver for the charity moving forward. Thanks were extended for the work on the Charitable Strategy. The meeting closed at 11.47 a.m.
65/21	**Date & Time of Next Meeting**
	Friday 17th June 2022 at 10.00 a.m.

Trust Board Meeting
Committee Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	Performance and Finance Committee
Date(s) of Committee Meetings since last	Wednesday 29th June 2022
Chair of Committee:	Paul Assinder, Non-Executive Director
Date of Report:	Wednesday 29th June 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board**	Financial Position 2022/23 Revenue • The Trust has a £0.6m YTD deficit to 31st May 2022, with significant risk to achievement of the financial plan. Drivers are Cost Improvement Programme shortfalls and continued temporary workforce usage. • Cost Improvement Plans identified to date total £4.7m, against a target of £6.3m for the year (some elements of the £4.7m are rated as high risk). The Committee seek further assurances on delivery in year. • The Trust received funding to deliver 104% of elective performance for 2022/23. Current performance totals 87%, so there is a risk of clawback of income (though this is considered to be low). However, it is unlikely the Trust will earn further income in year (by exceeding the 104% threshold). • Agency usage (whilst reducing) remains above planned levels. The Director of Nursing confirming a plan for reduction in agency usage was being implemented. • Sickness now exceeds 6% and is also driving increased costs through payment of premiums for agency staff. Capital • The Trust has yet to secure the funds required to deliver the theatres capital programme- work continues with ICS colleagues. • The overall capital programme is c£38m for the year, requiring managing to deliver multi-million-pound developments for the ED, wards, and theatres (noting the current construction industry prevailing conditions). Performance Issues • May 2022 experienced very high Emergency Department attendances, impacting upon performance of the 4-hour standard. However, relative performance remains strong in this area and ambulance handover exceptional in comparison to the wider system • Commonwealth Games, starting in a month may impact activity at the Manor site.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	Integrated Care System • New Integrated Care System arrangements go live on 1st July 2022. The first Chair and Chief Executive Officer meeting on provider collaboration has been held, chaired by Sir David Nicholson. • The Chief Executive of the Integrated Care Board has now been announced. Estates Management • Members reviewed the Private Finance Initiative (PFI) performance report. Financial Performance • Cost Improvement target identification and delivery is being escalated with Operational teams to close the current shortfall. Members are now seeking further assurance over identification of schemes to close the gap and in addition of delivery of current schemes. • Agency costs are reducing month on month owing to successful overseas recruitment drives within Nursing, detailed plans for cessation of Nursing agency have been requested by members. Performance • Performance remains strong from the Community Division, with Medically Stable lists low in comparison to historic levels. • The Community Services Division has bid for additional resources for virtual care, with detailed plans to be presented through the Investment Group that reports to Trust Management Group. • Members received assurances over elective care performance, noting that the MRI waiting time recovery plan has been delivered. • The key concern remains the significant increase in emergency care referrals. • A focus is to be placed upon current DNA rates with members questioning the viability of an efficiency gain if this improvement could be delivered. Business Cases • Surgery Mutual Aid – approved for endorsement at Trust Board owing to value, subject to securing income allocations identified. • Acute Medical Unit (AMU) – Mr Caldicott highlighted the high number of AMU beds (45) compared to Wolverhampton (49) and different care model. Case approved for endorsement Trust Board. • Discharge Lounge – approved by members (value not requiring further presentation to Trust Board)

ASSURE **Positive assurances & highlights of note for the Board/Committee**	Financial Position 2022/23 Revenue • The Trust Annual Accounts 2021/22 demonstrated achievement of a surplus, the Audited accounts receiving a clean bill of health from the External Auditors and have been filed within national deadlines. • The Trust has now attained all financial performance targets for the past three financial years. • The Cost Improvement Programme (CIP) efficiency ask has 58% of schemes now rated low risk. • Members received confirmation policies for long and short-term sickness absence management are in place, managers trained in these policies. • Nursing agency usage is reducing within the Trust. Capital & Cash • The Trust has delivered two theatres full upgrade's, four ward refurbishments and is on target to open the Emergency Department during November 2022. • The Trust has a strong cash position moving into the 2022/23 financial year. Performance • Performance on elective care is very positive with 52 week waits remaining stable in May 2022. • An external review has been performed on DNA rates on outpatient pathways. These findings will be implemented to reduce DNA rates. • Medically fit numbers remain low compared to historic levels seen by the Trust. • MRI recovery plan has been implemented successfully within the Trust and improved diagnostics performance attained.
Recommendation(s) to the Board	Board to note: • High Emergency attendances continuing into May 2022, but the Trust is demonstrating relatively high benchmark performance in elective and emergency care, with low Medically fit numbers. • Trust has a financial deficit year to date, driven by temporary workforce and Cost Improvement Programme shortfalls (noting impacts of high levels of sickness). • Committee endorsed the Discharge Lounge business case and recommended endorsement for AMU and Surgery Mutual Aid by the Trust Board.
Changes to BAF Risk(s) & TRR Risk(s) agreed	There were no changes, though Mr Caldicott requested a review of financial delivery and future sustainability owing to the Trust moving into deficit and current temporary workforce costs continuing with shortfalls on CIP identified.
ACTIONS **Significant follow up**	Cost Improvement Programme - review of process by Non-Executive colleagues and the Chief Operating Officer (COO) and review of plans to cease agency usage by Chief Nurse.
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Financial deficit year to date - CIP review and temporary workforce oversight with high relative benchmark performance delivered through Operational teams. • The Business Case for Mutual Aid was supported (subject to written confirmation of the funds transfer) • AMU Nursing Workforce Business Case was also supported. • The Discharge Lounge Business Case was approved under delegated powers.

Matters presented for information or noting	Corporate Risk Register and Board Assurance Framework
Self-evaluation/ Terms of Reference/	Not applicable
Items for Reference	Not applicable

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Quality, Patient Experience and Safety (QPES)
Date(s) of Committee/Group Meetings	24th June 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	24th June 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Mental Capacity Audit shows 65.24% who lacked capacity had stage 2 assessment • Prevalence of timely observations has fallen to 76.6% following a tightening of the thresholds for late observations • Sepsis data is now collected electronically. Within ED 73.06% of patients had antibiotics within 1 hour. For inpatients this is 75.81% • Level 3 children's and adult's safeguarding remains below target. Additional training is being provided • 42% of clinical guidelines are "past the review date." This date is set when the guidelines are approved. There are 121 past the review date. • Electronic Discharge Summaries completed within 48hrs is stable but low at 84.96% • Community Services have declared 2 serious incidents regarding pressure are care. The process around delivery rather than availability have been immediately revised
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Wait time for "2 week wait" for symptomatic breast and suspected cancer now 15 days • Waiting list for domiciliary phlebotomy decreased to 125 and the routine waiting time is now 5 days • VTE Compliance is below target at 90.96% but with variation in different parts of the service (MLTC 81.66%). This area will form part of the portfolio for the newly appointed Deputy Chief Medical Officer • The 18-week RTT performance remains in line with trajectory and the 52 week waiting time is now reducing

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Falls per 1000 bed days is low at 3.68% • MRI and U/S performance remains stable. Ultrasound and MRI waiting time is now 6 weeks • Elective and day case activity is 116% of pre-COVID level (May 2019 to May 2022) • Safe at Home and Long COVID pathways performing well and funding secured until March 2023 • 212 nurses recruited from overseas have commenced employment at the trust • The significant serious incident backlog has reduced to 16 actions, each with clear deliverables • Perinatal mortality continues to follow flat trajectory at the lower end of the control lines • The most recently published SHMI value for the 12 month rolling period (published June 2022) March 2021 to February 2022 is 110.63. This is on a downward trend and is on the 90% upper limit range as an amber Trust.
Recommendation(s) to the Board/Committee	That the Board note the report and matters of concern
Changes to BAF Risk(s) & TRR Risk(s) agreed	None
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	•
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	Presentations received included • Community Services Report • Safe High Quality Care Oversight report • Maternity Services update • Serious Incident Update • Clinical Audit report • Safeguarding report • Mortality and SHMI report • Hospital Food Standards report • Care planning annual report
Matters presented for information or noting	• 104 day Harm Update report
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of Reference received
Items for Reference Pack	•

Trust Board Meeting
Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	People and Organisation Development Committee
Date of Committee/Group	Monday 27th June 2022
Chair of Committee/Group:	Junior Hemans
Date of Report:	Thursday 7th July 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• Workforce availability - The committee reviewed the BAF and corporate risk relating to recruiting and retaining staff and agreed that this remains a corporate risk, (although action to mitigate this risk through increased recruitment with expanded international and local recruitment has impacted on vacancy rate), the risk cannot be further de-escalated because adverse turnover and retention rates continue to have a negative impact on workforce availability. The committee noted the increased trend nationally relating to retirement. The committee noted that activity levels in recruitment increased by 108% in the last year, whilst this has had a positive impact on vacancy rates, to order to maintain workforce levels, the turnover and retention rates must also be stable. Since they are not, retention remains a risk to quality and stability of services and patient care. • Workforce availability - The committee noted the impact on availability due to sickness absence, and noted this has returned to 8.25%, which is being impacted by Covid and isolation rates, leading to an immediate impact on availability due to short-term absence. The committee noted that support and resource has been prioritised to support the divisions on work to manage this. The focus on long-term absence case management is established (71% of absence is long-term), and additional occupational health and wellbeing resource are being recruited to support with MSK related absence and preventative work as well as targeting immediate and additional mental health support for the workforce. An absence profiling tool provides a trajectory for reduction in absence rates over the remaining financial year to return to target 4.5%, whilst acknowledging that workplace and economic conditions will continue to be challenging. The long- and short-term sickness rates are reviewed at monthly performance reviews in detail. • The committee noted the adverse movement on workforce metrics voluntary resignations due to work-life balance at 4 times the usual monthly volume citing this reason for leaving the trust. The committee commissioned additional intelligence on turnover and exit data.

ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The committee noted an increase in the nursing and midwifery vacancy rate at 4% from 1% previous month, however, remains within tolerance. There are focus areas for recruitment, Health Visiting is one: overall 50% vacancy rate. In terms of mitigation, Nursery Nurses, undertaking training to support in areas such as the Health Visiting Team. The International programme has 170 nurses registered with he NMC. Additional 21 midwives have accepted offers of employment with the trust. The Nursing Associate programme has a further 14 associates due to qualify by September 2022 and the pathway to quality from NA to Registered Nurse is now available. Mental Health Clinical Support Worker recruitment has been initiated. Work continues to recruitment to the bank. The committee noted the reduction in agency staffing contained within the Nursing Safer Staffing report, noting that the more substantive approaches would have a positive on the quality of patient care. • The committee noted that the trust is in the process of appointing a voluntary Chair and Vice Chair for the Trust's LGBTQ+ Inclusivity Group. The Trust is part of a regional LGBTQ+ support group and Walsall Pride and will be joining Birmingham Pride in September 2022. • The committee noted that the recent application to achieve Rainbow Badge status will help the trust review and understand staff priorities to implement change where needed. The review of trust policies has been started. The LGBTQ+ foundation has given the trust guidance on how to ensure it embraces LGBTQ+ patients and ensures the public are aware we are an inclusive and respectful place to work and be treated. The committee noted the joint work taking place between WHT and RWT on continuing to develop the staff networks and ensuring staff voice is consistently and inclusively heard, listened to and acted upon.

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The Committee received a report on the 2021 NHS Staff Survey taking assurance that divisional action plans following the 2021 survey are in place. The plans follow the People Promise and are monitored through the Staff Engagement and Oversight Group re-established from March 2022, these involving senior leadership and representation from each division. Although there is much more work to do, it is possible to see signs of progress made as statistically significant improvement in closing the gap between the Trust's staff experience responses and the national average staff experience responses has been made. The committee took assurance on the preparation plans for the 2022 NHS survey and noted the framework for developing a patient first culture is embedded in the approach. • The Committee received an update from the Division of Surgery updating on an innovative staff and patient led quality improvement work for the Acute Oncology Service, the Divisional Director of Nursing described re-design of the service which was staff and patient led to provide a personal call system able to fast-track admission where required and to otherwise support patients at home. The committee heard a patient compliment which outlined the positive impact on that patient's care. The committee commended the work particularly noting the involvement of both staff and patients in designing the improvement showing the positive impact of listening and hearing the patient's voice as well as empowering staff to make the changes that make the difference to patients.
Recommendation(s) to the Board/Committee	• To note the report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• There are legal, equality and diversity implications within this report and the Trust Board pledge seeks to address these by providing a route to eliminate discrimination, measure the diversity of the workforce and equality of staff experience and access to recruitment, promotion, career progression, education and training and to improve staff experience by eliminating bullying and

ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• The Staff Network group for Disability will be re-established to raise awareness of disability in the workforce. Assurance regarding the completion of this action will be provided by the Equality, Diversity and Inclusion Group. • The Committee endorses the request for protected time and budget for staff network leads and awaits the outcome of the investment case submitted to enable culture improvement. • The Committee requested greater assurance with regard to how divisions ensure feedback is provided to colleagues who raise concerns via Divisional Performance Reviews and to receive an assurance report at a future Committee. • The committee commissioned a board development session to support the development of the employment model.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• The committee noted the vacancy rate for nursing and midwifery is below 1% and the international recruitment program has successfully inducted 208 registered nurses to the Trust. •
ACTIVITY SUMMARY **Major agenda items discussed including those Approved.**	• The terms of reference for the People and Organisation Development Committee and the Annual Cycle of Business were both accepted and recommended for approval at Trust Board. • The Committee commended progress against the Annual Equality, Diversity and Inclusion Report and Plan and recommended that the Trust Board note the achievement and approve the delivery plan for the 2023-2024 year. • The Committee received an update on the work of the Staff Networks and noted the challenges relating to securing protected time and budget to accelerate the work and outcomes. •
Matters presented for information or noting	• The committee received a deep dive into key workforce indicators across Estates and Facilities noting considerable improvement to workforce metrics, particularly noting reduction in sickness absence levels, above Trust average compliance levels for appraisal and meeting the statutory and mandatory training levels. • The committee noted significant assurance on the trust meeting the requirements of the National People Plan. • The committee noted the update on the Trust People Strategy and approved extending the date for completion in line with the national People Plan.
Self-evaluation/ Terms of Reference/ Future Work Plan	•

Items for Reference Pack	• The Annual EDI Report and Plan is at appendix 1 for information and assurance. • Staff Network update report.