Bundle Public Trust Board 5 October 2022

1 09:30 - Chair's Welcome; Apologies and Confirmation of Quorum

Lead: Prof. Steve Field, Chair
Apologies Received:
Ms Dawn Brathwaite, Non-Executive Director (will be available to join the meeting from 11am)
Dr Manjeet Shehmar, Chief Medical Officer (Mr Salman Mirza, Deputy CMO in attendance to represent)
Ms Carla Jones-Charles, Director for Midwifery (Ms Joselle Wright, Deputy Divisional Director for Midwifery in attendance to represent)
Quorum: Quorate
Other Members of Staff and Public in Attendance:
Sophie Stevenson, Deloittes
Craig Bailey

2 09:32 - 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.

Declarations of Interest Front Sheet Sept 2022.docx

Declarations of Interest - Sept 22.pdf

3 09:36 - Minutes of the Last Meeting held on 3 August 2022

Lead: Prof. Steve Field, Chair
Action: To receive and APPROVE as an accurate record

Final draft - minutes of Board held 030822 - for approval.docx

4 09:40 - Matters Arising

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

5 09:42 - Action Log

Lead: Prof. Steve Field
Action: To update actions and close actions as relevant.

Action Log.docx

6 09:47 - Trust Values and Nolan Principles

Lead: Prof. Steve Field, Chair
Action: Trust Board to Note

Nolan Principles of Public Life.docx

7 09:50 - Chair's Report - Verbal

Lead: Prof. Steve Field
Action; To Inform

8 09:55 - Chief Executive's Report

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

Chief Executive report 05.10.22.docx

8.1 10:00 - Chair's Trust Management Committee Report

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

TMC 05.10.22 Report for Trust Board 27.09.22.docx

9 10:05 - Patient Story - Michelle's Story - (Link in description box below to be copied into chrome browser)

Lead: Lisa Carroll, Director of Nursing
Presenter: Kate Salmon in attendance
Action: To Inform
(333) WMH 155114 Patient Story Michelle - YouTube (Please copy this link into your chrome browser to view the patient story via youtube)

10 10:17 - Joint Trust Strategy

Lead: Mr Simon Evans, Chief Strategy Officer
Presented by: Mr Tim Shayes, Deputy Chief Strategy Officer
Action: To APPROVE

Final Trust Strategy - Walsall Board v2.pdf

'Our Strategy' - Final Official Version.pdf

Joint Trust Strategy_Comms Plan_Sept 2022_v2.docx

11 10:22 - Integrated Quality and Performance (IQPR) - (Section Heading)

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

11.1 10:22 - IQPR Summary

iBaps_ExecutiveSummary.pdf

11.2 10:27 - Quality, Patient Experience and Safety - Chair's Report

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

QPES Chairs Board report 23_9_22.docx

11.2.1 10:32 - IQPR - Quality, Patient Experience and Safety (Reference Pack for Information)

iBaps_QPES.pdf

11.3 10:32 - Performance and Finance - Chair's Report (August & September 22)

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

PFC Chair's Report August 22.docx

11.3.1 10:37 - IQPR - Performance and Finance (Reference Pack for Information)

iBaps_PFC.pdf

11.4 10:37 - People and Organisational Development - Chair's Report

Lead: Junior Hemans, Chair, PODC
Action

PODC Highlight Report - TB October 2022.docx

11.4.1 10:42 - IQPR - People and Organisational Development (Reference Pack for Information)

iBaps_PODC.pdf

12 10:42 - Provide Safe, High Quality Care (section heading)

12.1 10:42 - Director of Nursing Report

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

DoN report to Public Trust Board October 2022 Final .docx

12.2 10:47 - Hospital Mortality Report

Lead: Mr Salman Mirza, Deputy Chief Medical Officer (in Dr Manjeet Shehmar's absence)
Action: To Approve, Discuss, Inform and Assure

Trust Board Mortality Report Sept 2022 - Final.docx

12.2.1 10:52 - Palliative Care (Goscote Hospice)

Report has been provided as the response to Action 415 following the Trust Board Meeting held on 3rd August 2022.
Lead: Matthew Dodd, Interim Director of Integration
Action: To Inform

Goscote Hospice update 28.09.22 v2.docx

12.3 10:57 - BREAK

12.4 11:07 - Patient Experience (& Complaints Report)

Lead: Lisa Carroll, Director of Nursing
Presented by: Garry Perry, Associate Director - Patient Relations and Experience
Action: To Inform and Assure

Patient Experience Update - Annual SPaRC report 2021.2022-combined-compressed_1.docx

12.5 11:12 - Director of Midwifery Service Report

Lead: Carla Lloyd-Charles, Director of Midwifery
Presented by: Joselle Wright, Deputy Divisional Director of Midwifery
Action: To Inform and Assure

10. Maternity QPES Sept 2022 v2.pdf

12.6 11:17 - Safeguarding Adults and Children - Quarterly Report

Lead: Lisa Carroll, Director of Nursing
Presenter: Fiona Pickford, Head of Safeguarding
Action:

WHT Safeguarding QPES Q1 (002).docx

17.1 Appendix Safeguarding Plan (August 2022) (003) (002).pdf

17.2 Appendix 2 SafeguardingDashboard_v3.pdf

12.7 11:22 - Trust Risk Register/Board Assurance Framework

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

Trust Board - Risk Management Report - 05.10.2022.docx

TB - Appendix 1 - BAF SO 01 - 03.08.2022.pdf

TB - Appendix 2 - BAF SO 02 - 01.08.2022.pdf

TB - Appendix 3 - BAF SO 03 - 03.08.2022.pdf

TB - Appendix 4 - BAF SO 04a - 01.08.2022.pdf

TB - Appendix 5 - BAF SO 04b - 01.08.2022.pdf

TB - Appendix 6 - BAF SO 04c - 03.08.2022.pdf

TB - Appendix 7 - BAF SO 05 - 01.08.2022.pdf

TB - Appendix 8 - BAF SO 06 - 01.08.2022.pdf

TB - Appendix 9 - June CRR - 07.07.2022.pdf

TB - Appendix 10 - July CRR - 08.09.2022.pdf

12.8 11:27 - Health and Safety Annual Report

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

Health and Safety TB Front Sheet.docx

HS Annual Report 2021-22 Final V1.docx

12.9 11:32 - Director of Infection Prevention and Control Report - Q2 Update

Lead: Lisa Carroll, Director of Nursing
Presented by: Amy Boden, Head of Infection Prevention and Control, Deputy DIPC
Action: To Discuss, Inform and Assure

IPC BAF Q2 update report Trust Board October 2022 (002).docx

12.10 11:37 - Pharmacy and Medicines Optimisation Report

Lead: Mr Salman Mirza, Deputy Chief Medical Officer (on behalf of Dr Manjeet Shehmar, Chief Medical Officer)
Action: To Inform and Assure

Medicines Management Report - Trust Board Oct 2022.docx

12.11 11:42 - Bi-Annual Skill Mix Review

Lead: Lisa Carroll, Director of Nursing
Action: To APPROVE and Discuss

Biannual skill mix review frontsheet Public Trust Board October 2022.docx

WHT Biannual skill mix review June 2022 Public Trust Board October 2022.docx

Notification Letter- Walsall Healthcare NHS Trust- Adult Nursing.pdf

13 11:47 - Complex Case Review

Lead: Mr Salman Mirza, Deputy Chief Medical Officer (on behalf of Dr Manjeet Shehmar, Chief Medical Officer)
Action: To Inform and Assure

Complex case review.pdf

14 11:52 - Care at Home, Work Closely with Partners (Section Heading)

Section Heading

14.1 11:52 - Charitable Funds - Chair's Report

Charitable Funds - Chairs Report 12 Sept 2022.docx

14.2 11:57 - Walsall Together - Chair's Report

Lead: Patrick Vernon, Chair, Walsall Together
Action: To Inform

Walsall Together Partnership Board Highlight Report September 2022 v2.docx

14.3 12:02 - Care at Home Executive Report

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

Care at Home Report Sept 22 v2.docx

Care at Home App 1 - Partnership Operational Performance Pack September 2022.pptx

14.4 12:07 - Emergency Preparedness Annual Self Assessment & EPPR Core Standards

Lead: Ned Hobbs, Chief Operating Officer
Action: To Inform and Assure

Cover Sheet TB - Annual EPRR Assurance Report 2022-23.docx

Walsall Healthcare Annual EPRR Assurance Report 2022-23.pdf

Walsall Healthcare Letter - EPRR Annual Assurance 2022-23 Report.pdf

Copy of Walsall Healthcare NHS core standards for EPRR_July 2022 (Final Version).pdf

14.5 12:12 - Update from the Black Country Acute Collaboration Board

Lead: Simon Evans, Group Chief Strategy Officer
Action: To APPROVE and Inform

WHT Provider Collaboration Rep (merged) Oct 2022 (002).pdf

14.6 12:17 - Sustainability Report including Green Plan Update

Lead: Simon Evans, Interim Chief Officer for Strategy

WHT Trust Board Report - Sustainability.pdf

15 12:22 - Use Resources Well (Section Heading)

15.1 12:22 - Audit Committee - Chair's Report

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

WHT Audit Committee Chairs Reports 02.09.22 (003).docx

15.2 12:27 - Urgent & Emergency Care Resilience: Winter Plan 2022/23

Lead: Ned Hobbs, Chief Operating Officer
Action: To APPROVE

Winter Plan 202223 Front Sheet.docx

Winter Plan 2022-23.pdf

16 12:32 - Value our Colleagues (Section Heading)

16.1 12:32 - Staff Voice - Divisional Spotlight - Occupational Health - Verbal

Lead: Catherine Griffiths, Director for People and Culture
In attendance to present: Maninder Kaur, Occupational Health
Action: To Inform

16.2 12:47 - Trust Board Pledge - People and Organisational Development Committee Update

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

PODC Trust Board Pledge Update - Sept 2022.docx

16.3 12:52 - People Culture - Towards Excellence in People Management

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

Trust Board Report October 2022 - People Culture - Towards Excellence iin People Management Front Sheet Final.docx

People Culture - Towards Excellence 250922 v1.3 Trust Board 2022.docx

People Culture - Patient First Culture Ven Diagram.pdf

People Culture - 7 pillars of patient first care A5 CMYK (3).jpg

17 12:57 - Reports for Information - Minutes of Committee Meetings (Section Heading)

17.1 Minutes of the Quality, Patient Experience and Safety Committee held in July 22

Action: For Information Only

3. Minutes of QPES Committee July.pdf

17.2 Minutes of the Performance & Finance Committee held in July 22

Action: For Information Only

3. Minutes of the PFC 27.07.2022 RC PA.docx

17.3 Minutes of the People and Organisational Development Committee held in July 22

Action: For Information Only

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

17.4 Minutes of the Audit Committee held in June 22

Action: For Information Only

3. Audit Committee Mins 2006 V2 (002) mm.docx

17.5 Minutes of the Charitable Funds Committee held in July 22

Action: For Information Only

3. CF Mins 080722.docx

18 12:59 - Date and Time of Next Meeting - Wednesday 7th December @ 9.30am, Microsoft Teams

19 12:59 - Questions from the Public/Commissioners

20 12:59 - 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.

MEETING OF THE PUBLIC TRUST BOARD			
Declarations of Interest			
Report Author and Job Title:	Keith Wilshere Group Company Secretary	**Responsible Director:**	Prof. Steve Field Chair of the Trust Board
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 ☒		

Employee		Interest Type	Interest Description (Abbreviated)	Provider	
Professor Stephen Field	Chairman	Loyalty Interests	Trustee	Nishkam Healthcare Trust Birmingham	confirmed
Professor Stephen Field	Chairman	Outside Employment	Appointed as an unpaid Trustee for the Charity	Pathway Healthcare for Homeless People (ended April 2022)	confirmed
Professor Stephen Field	Chairman	Loyalty Interests	Director	EJC Associates	confirmed
Professor Stephen Field	Chairman	Loyalty Interests	Chair	Royal Wolverhampton NHS Trust	confirmed
Professor Stephen Field	Chairman	Loyalty Interests	Honorary Professor	University of Warwick	confirmed
Professor Stephen Field	Chairman	Loyalty Interests	Honorary Professor	University of Birmingham	confirmed
Professor Stephen Field	Chairman	Outside Employment	Advisor to Health Holding Company and Board Member of Makkah Health Cluster, Kingdom of Saudi Arabia	Makkah Health Cluster, Kingdom of Saudi Arabia	confirmed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Professor of Nursing Sciences	Birmingham City University	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Visiting Professor (Unpaid assignment)	Staffordshire University	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Teaching (Fellow)	Higher Education Academy	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Member	Royal College of Nursing	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Shareholdings and other ownership interests	Director	Ann-Marie Cannaby Ltd	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Principal Clinical Advisor	British Telecom	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Outside Employment	Honorary Fellow (unpaid assignment)	La Trobe University, Victoria, Australia	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Member of the Advisory Panel - Volunteer role	Cavell (Charity) Advisory Panel	confimed
Professor Ann-Marie Cannaby	Deputy Chief Executive/Group Chief Nurse	Loyalty Interests	Chief Nurse Officer	The Royal Wolverhampton NHS Trust	confimed
Ms Catherine Griffiths	Director of People and Culture	Shareholdings and other ownership interests	Director	Catherine Griffiths Consultancy ltd	confimed
Ms Catherine Griffiths	Director of People and Culture	Loyalty Interests	Member	Chartered Institute of Personnel (CIPD)	confimed
Professor David Loughton	Chief Executive	Outside Employment	Chair	West Midlands Cancer Alliance	confirmed
Professor David Loughton	Chief Executive	Loyalty Interests	Member of Advisory Board	National Institute for Health Research	confirmed
Professor David Loughton	Chief Executive	Loyalty Interests	Chief Executive	Royal Wolverhampton NHS Trust	confirmed
Ms Dawn Brathwaite	Non-Executive Director	Outside Employment	Consultant/Former Partner	Mills & Reeve LLP	confirmed
Mr Edward Hobbs	Chief Operating Officer	Loyalty Interests	Father – Governor Oxford Health FT	Father	
Mr Edward Hobbs	Chief Operating Officer	Loyalty Interests	Sister in Law – Head of Specialist Services St Giles Hospice	Sister in Law	
Dr Julian Parkes	Non-Executive Director	Loyalty Interests	Daughter – Nurse in ED at Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust	confirmed
Dr Julian Parkes	Non-Executive Director	Loyalty Interests	Trustee	Windmill Community Church in Wolverhampton	confirmed
Mr Junior Hemans	Non-Executive Director	Outside Employment	Visiting Lecturer	Wolverhampton University	confirmed
Mr Junior Hemans	Non-Executive Director	Outside Employment	Company Secretary	Kairos Experience Limited	confirmed
Mr Junior Hemans	Non-Executive Director	Outside Employment	Chair of the Board	Wolverhampton Cultural Resource Centre	confirmed
Mr Junior Hemans	Non-Executive Director	Outside Employment	Chair of the Board	Tuntum Housing Assiciation (Nottingham)	confirmed
Mr Junior Hemans	Non-Executive Director	Outside Employment	Director	Libran Enterprises (2011) Ltd	confirmed
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Member	Labour Party	confirmed
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Business Mentor	Prince's Trust	confirmed
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Non-Executive Director	The Royal Wolverhampton NHS Trust	confirmed
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Wife works as a Therapist at The Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust	confirmed
Mr Junior Hemans	Non-Executive Director	Loyalty Interests	Second Cousin works as a Pharmacist at The Royal Wolverhampton NHS Trust	The Royal Wolverhampton NHS Trust	confirmed
Mr Keith Wilshere	Group Company Secretary	Shareholdings and other ownership interests	Sole owner, sole trader	Keith Wilshere Associates	
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Secretary of the Club which is a registered Co-operative with the Financial Conduct Authority.	The Royal British Legion (Beeston) Social Club Ltd	
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Trustee, Director and Managing Committee member of this registered Charity and Limited Company since May 1988.	Foundation for Professional in Services for Adolescents (FPSA)	
Mr Keith Wilshere	Group Company Secretary	Shareholdings and other ownership interests	Sole owner, sole trader	Keith Wilshere Associates	
Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Company Secretary	Royal Wolverhampton NHS Trust	

Mr Keith Wilshere	Group Company Secretary	Loyalty Interests	Committee member of registered Charity and Limited Company – Foundation for Professional in Services for Adolescents (FPSA)	Foundation for Professional in Services for Adolescents (FPSA)	
Mr Kevin Bostock	Group Director of Assurance	Shareholdings and other ownership interests	Sole director	Sole director of 2 limited companies Libra Healthcare Management Limited trading as Governance, Risk, Compliance Solutions and Libra Property Development Limited	Confirmed
Mr Kevin Bostock	Group Director of Assurance	Loyalty Interests	Group Director of Assurance	The Royal Wolverhampton NHS Trust	Confirmed
Mr Kevin Bostock	Group Director of Assurance	Outside Employment	Trustee of a Health and Social Care Charity	Close Care Charity No 512473	Confirmed
Mr Kevin Stringer	Director of IT and SIRO	Outside Employment	Treasurer West Midlands Branch	Healthcare Financial Management Association	
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Brother-in-law is the Managing Director	Midlands and Lancashire Commissioning Support Unit	
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Member	CIMA (Chartered Institute of Management Accounts)	
Mr Kevin Stringer	Director of IT and SIRO	Gifts	Spade used for 'sod cutting'.	Veolia	
Mr Kevin Stringer	Director of IT and SIRO	Loyalty Interests	Chief Financial Officer and Deputy Chief Executive	Royal Wolverhampton NHS Trust	
Mr Kevin Stringer	Director of IT and SIRO	Outside Employment	Interim Director of Finance	The Dudley Group NHS Foundation Trust	
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Royal College of Paediatrics and Child Health (RCPCH) Officer for Research	RCPCH	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - RCPCH Assistant Officer for exams	RCPCH	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Chair of NHS England/Improvement Children and Young People's Asthma Effective Preventative Medicines Group	NHSE/I	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Consultant Paediatrician and Clinical Lead for Respiratory Paediatrics at University Hospitals of North Midlands NHS Trust (UHNM)	University Hospitals of North Midlands NHS Trust	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Guardian of Safe Working and Deputy Clinical Tutor UHNM (ends 1st October 22)	University Hospitals of North Midlands NHS Trust	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - West Midlands National Institute for Health Research (NIHR) Clinical Research Scholar	West Midlands Institute for Health and Clinical Research	confirmed
Ms Lisa Carroll	Director of Nursing	Loyalty Interests	Spouse - Director of Medical Education at UHNM (commenced 1st Sept 22)	University Hospitals of North Midlands NHS Trust	confirmed
Ms Louise Toner	Non-Executive Director	Outside Employment	Associate Dean Faculty of Health, Education and Life Sciences at Birmingham City University	Birmingham City University	
Ms Louise Toner	Non-Executive Director	Outside Employment	Visiting Professor/Advisory Board Member	Lovely Professional University India	
Ms Louise Toner	Non-Executive Director	Outside Employment	Chair - Education Focus Group	Birmingham Commonwealth Association	
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Royal College of Nursing - UK	
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Greater Birmingham Chamber of Commerce Commonwealth Group	
Ms Louise Toner	Non-Executive Director	Loyalty Interests	Member	Birmingham and Solihull Local Workforce Action Board and Education Reform Workforce Group	
Ms Louise Toner	Non-Executive Director	Outside Employment	Teaching Fellow	Higher Education Academy	
Ms Louise Toner	Non-Executive Director	Outside Employment	Non-Executive Director	Royal Wolverhampton NHS Trust	
Ms Louise Toner	Non-Executive Director	Outside Employment	Associate Dean Faculty of Health, Education and Life	Birmingham City University	
Dr Manjeet Shehmar	Chief Medical Officer	Shareholdings and other ownership interests	Company Director Association of Early Pregnancy Units UK Non paying, no profit UK speciality Society for Early Pregnancy. Executive Board Member Secretary Board Member	Association of Early Pregnancy Units UK	Confirmed
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	Executive Member Association	Early Pregnancy Units UK	Confirmed
Dr Manjeet Shehmar	Chief Medical Officer	Loyalty Interests	Company Director	Company Director Association of Early Pregnancies Units UK	Confirmed
Ms Mary Martin	Non-Executive Director	Outside Employment	Trustee/Director, Non Executive Member of the Board for the Charity	Midlands Art Centre	Confirmed
Ms Mary Martin	Non-Executive Director	Outside Employment	Trustee/Director, Non Executive	B:Music Limited	Confirmed
Ms Mary Martin	Non-Executive Director	Outside Employment	Director/Owner of Business	Martin Consulting (West Midlands) Ltd	Confirmed
Ms Mary Martin	Non-Executive Director	Outside Employment	Residential property management company	Friday Bridge Management Company Limited (residential property management company)	Confirmed
Mr Matthew Dodd	Interim Director of Integration	Loyalty Interests	Wife working as a Physiotherapy Assistant at Birmingham Community Health Care	Wife	
Ms Ofrah Muflahi	Associate Non-Executive Director	Outside Employment	UK Professional Lead	Royal College of Nursing	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	Royal College of Nursing	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Mentor	The Catalyst Collective	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Husband an employee of the Royal College of Nursing UK	Husband	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	Q Community at Health Foundation	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Husband Director of OBD Consultants, Limited Company	Husband	Confirmed

Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	UK Oncology Nursing Society	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member	The Seacole Group	Confirmed
Ms Ofrah Muflahi	Associate Non-Executive Director	Loyalty Interests	Member of Health Inequalities Task Group	Coalition for Personalised Care	Confirmed
Mr Paul Assinder	Non-Executive Director	Outside Employment	Honorary Lecturer	University of Wolverhampton	
Mr Paul Assinder	Non-Executive Director	Loyalty Interests	Governor	Solihull College & University Centre	
Mr Paul Assinder	Non-Executive Director	Loyalty Interests	Director	Rodborough Consultancy Ltd.	
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Lay Member	Employment Tribunal Birmingham	Confirmed
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Vice President of Pelsall Branch Conservative Party Association (from 19th June 2021)	Conservative Party Association	Confirmed
Mr Rajpal Virdee	Associate Non-Executive Director	Loyalty Interests	Deputy Chair	Aldridge-Brownhills Conservative Association	Confirmed
Mr Russell Caldicott	Chief Finance Officer	Loyalty Interests	Member of the Executive	West Midlands Healthcare Financial Management Association (HFMA)	
Mr Russell Caldicott	Chief Finance Officer	Loyalty Interests	Director	Plan 4 E-Health	
Ms Sally Evans	Group Director of Communications and Stakeholder Engagements	Outside Employment	Director of Communications and Stakeholder Engagement	Royal Wolverhampton NHS Trust	
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests	Executive Director Children's Services	Walsall MBC	confirmed
Ms Sally Rowe	Associate Non-Executive Director	Loyalty Interests	Trustee	Association of Directors of Children's Services	confirmed
Mr Simon Evans	Interim Chief Strategy Officer	Loyalty Interests	Chief Strategy Officer	Royal Wolverhampton NHS Trust	
Ms Glenda Augustine	Director of Planning and Improvement	No interests to declare			
Mr Mike Sharon		Interim Strategic Advisor to the Board	Strategic Advisor to the Trust Board - RWT	The Royal Wolverhampton NHS Trust	
Mr Mike Sharon		Interim Strategic Advisor to the Board	Member of the Liberal Democrat Party	Liberal Democrat Party	
Mr Mike Sharon		Interim Strategic Advisor to the Board	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.	Various NHS Bodies	

NHS
Walsall Healthcare
NHS Trust

MEETING OF THE PUBLIC TRUST BOARD
HELD ON WEDNESDAY, 3RD AUGUST 2022 AT 09.30AM
HELD 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)
Ms S Rowe	Associate 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)
Prof. D Loughton CBE	Chief Executive
Prof. A-M Cannaby	Group Chief Nursing Officer/Deputy Chief Executive
Mr R Caldicott	Chief Finance Officer
Ms L Carroll	Director of Nursing
Ms C Griffiths	Director of People and Culture
Dr M Shehmar	Chief Medical Officer
Mr K Bostock	Group Director of Assurance
Mr M Dodd	Interim Director of Integration
Mr S Evans	Interim Chief Strategy Officer

In attendance

Mr K Stringer	Director for SIRO and IT
Mr K Wilshere	Group Company Secretary
Ms C Jones-Charles	Director of Midwifery, Gynaecology and Sexual Health
Mr U Daraz	Birmingham City University (BCU) (observer)
Ms C Laing	Shadowing Ms Jones-Charles (observer)
Ms F Pickford	Head of Safeguarding
Mr M Ncube	Deputy Director of Clinical Support Services
Ms D Ohai	Divisional Director of Operations – Women's, Children's & Clinical Support Services
Ms A Downward	Group Communications Officer
Ms A Wallet	Head of Infection Prevention
Mr G Perry	Director Patient Experience
Ms K Rawlings	Divisional Director of Nursing
Ms N Adams	Lead Cancer Nurse, Acute Oncology Service
Ms J Kaur Toor	Senior Executive Assistant/Senior Operational Coordinator
Ms C Dawes	Business Administration Support Officer

Apologies

Prof. P Vernon	Chair, Walsall Together Partnership Board
Ms S Evans	Group Director of Communications and Engagement
Mr N Hobbs	Chief Operating Officer

322/22	**Welcome, Apologies and Confirmation of Quorum**
	Prof. Field welcomed everyone to the meeting and noted the apologies that had been received. He advised Ms Laing was shadowing Ms Charles-Jones and Mr Daraz from BCU as in attendance to observe the Board meeting.
323/22	**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.**
324/22	**Minutes of Last Meeting**
	Prof. Field confirmed the minutes of the meeting held on 8 June 2022 as received and approved as an accurate record. **Resolved: that the minutes of the meeting held on the 8 June 2022 be received and approved.**
325/22	**Matters Arising and Action Log**
	Prof. Field advised that there were no matters arising that were not included within the action log. Action 342– Ms Carroll advised that the cessation paper for reducing the use of agency staff was included in her Nursing Director report and therefore this action was complete and was agreed the action be closed. Action 345 – correspondence of thanks to Mr Perry and his team– Prof. Cannaby confirmed that this action was being undertaken and it was noted as completed and closed.
326/22	**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.**
327/22	**Chair's Report**
	Prof. Field advised of his recent visits to wards and the new Emergency Department (ED) building. He said he had been impressed with the exemplary plans and innovations to observe and teach and he noted improvements in recruitment and the positive and optimistic staff working in the hospital. He reported on the visit he had undertaken with NEDs to Cannock Hospital which was to be used by orthopaedic surgeons to help tackle waiting lists in Walsall. **Resolved: that the Chair's Report be received and noted.**
328/22	**Chief Executive's Report**
	Prof. Loughton provided his Chief Executive's report confirming the appointment of seven consultants. He reported that the Trust was liaising with the Royal Colleges in relation to improving on the Royal Colleges response times for participation in interviews. Dr Shehmar advised she had received an apology from the Royal College of Surgeons for a recent delay to a recruitment process and confirmed that they had agreed to review their processes. Prof. Loughton reported that there was a good relationship with Walsall Council, and advised that he had participated in the opening of the Leon Talbot clinical suite at Hollybank, provided a talk at The National Association of Anaesthetists, presented awards for the National Institute of Health Research in Birmingham and had met with a group of people interested in careers as finance directors. Ms Martin asked Prof. Loughton, as Chair of the West Midlands Cancer Alliance Board, whether he was assured that the West Midlands was working together on the issues with cancer service targets. Prof. Loughton said the Midlands had the worst performance in the Country, and issues had been reported in relation to diagnostics following which there had been investment in diagnostics and looking at patient pathways, and he said that it would take some time to recover. **Resolved: that the Chief Executive's report be received and noted**

329/22	**Integrated Quality and Performance (IQPR) Summary Report**
	Mr Caldicott advised that the summary included the four quadrants (performance, quality, workforce and finance). He highlighted the quality aspects and said that whilst emergency demand was high, the Trust had performed well compared to other organisations. He said the key thread through the quadrants was the substantive workforce and ensuring attendance. **Resolved: that the Integrated Quality and Performance (IQPR) Summary Report be received and noted.**
330/22	**Performance & Finance Committee Chair's Report**
	Mr Assinder reported the Performance and Finance Committee (PFC) had met on the 27 July 2022 and considered the Management Accounts for the first quarter of the financial year. He said that the efficiency programme was currently at £6.3m, and that due to the current inflationary pressures, the NHS pay award would be fully covered by budgetary provision or external funding. He said that the additional costs NHS trusts had experienced related to the Covid-19 streaming process and reported that the deficit position for the first quarter was c£600k, which was an adverse position against a plan of £1.4m. Mr Assinder highlighted the underperformance and under delivery on all individual components of the Financial Plan and reported that there was a shortfall in identifying efficiency schemes in the £6.3m Cost Improvement Programme (CIP) with £5.5m being currently identified, including some rated as high risk. He said some of the Non-Executive Directors had raised concerns on the ability to deliver the £6.3m ask. Mr Assinder said that good progress had been made with the recruitment of overseas nurses and he commended colleagues on the nursing agency cessation plans delivery. He reported on cost pressures due to increases in agency rates, particularly for locum medical staff. He said performance against access and waiting targets continued to be good in emergency and elective care but said that the Committee had been concerned about the ability to reduce long waits in the system. He said the Committee had asked executive colleagues to review the long waits and provide a plan and trajectory to address them. Mr Assinder advised that the Committee had endorsed two business cases for Obstetric Medical Staffing and Surgical Medical Staffing. He said that the Obstetric Medical Staffing was part of the wider planning to achieve the Ockenden 2 recommendations and that the amount of the additional Ockenden business case required Trust Board approval in due course. He confirmed that the Surgical Medical Staffing business case related to the on-call rota and gall bladder surgery from the current budgetary provision. Mr Caldicott said that as the Trust moved further into this financial year, the expectation was that it would need to look further to the efficiency programme in managing growth and future investments. He confirmed the planning position for the following financial year 2023/24 had commenced although guidance and income levels had not been received or confirmed. Ms Martin noted the impacts of the nursing recruitment in reduced agency costs. She queried the overall agency bill for June 22, noting that this had increased whilst the number of hours for agency nursing had reduced with an increase in agency medical staffing costs. She asked what assurance was in place to address the medical agency costs. Dr Shehmar advised that much of the costs related to the recruitment drive at consultant level, whilst the Trust was waiting for the recruited Consultants to start their new contracts. She advised that this matter was being tracked by the medical workforce group. **Resolved: that the Chair's report for Performance & Finance Committee be received and noted.**

331/22	Quality, Patient Experience and Safety Committee Chair's Report
	Prof. Toner provided the highlights from the Quality, Patient Experience and Safety Committee (QPES) held on 22 July 22, which she had chaired in the absence of Dr Parkes. She reported that cancer and ED performance in the Trust was better than regional and national trusts. She reported that whilst the 4 day wait for 'medically fit for discharge' patients had been a challenge for other trusts, the good infrastructure for primary and community care services in Walsall had enabled the Trust to be in an excellent position. Prof. Toner reported that the 2-week wait for suspected breast cancer and breast symptomatic cancer pathway referrals had decreased. She said that mutual aid and plans were in place to increase examinations for patients with suspected cancers. Prof. Toner reported level 1 and 2 safeguarding training for adults and children was on track but highlighted issues with level 3 safeguarding training which required greater commitment of time for clinicians due to the 8 hours required to complete training. She said the Safeguarding team was reviewing alternative methods of presentation. She reported VTE compliance remained a challenge but had decreased between May 22 to June 22. Prof. Toner advised that Trust acquired pressure ulcers had increased and a plan had been put in place to provide hybrid mattresses and a new risk assessment tool was being implemented. She reported on staffing pressures, particularly the impact on maternity services and confirmed that 1:1 care 'in labour' had continued to be provided. She said that Sepsis performance had been below target in respect of ED and inpatients. Ms Martin referred to the report which highlighted the gap in 50% establishment in health visiting workforce and asked what impact this had had on the community services. Prof. Toner confirmed that discussions had taken place as to how the Trust could access health visitor education and training in a flexible way. She said that had been some duplication with health visiting targets as some had been undertaken by GPs and others by health visitors and it had therefore been difficult to gauge the overall impact. Ms Carroll said that a prioritisation plan had been discussed with the Local Authority and the Clinical Commissioning Group (CCG) to ensure that the health visiting workforce had been used to prioritise those areas of most need, and that the Trust was also reviewing registered nurses, school nurses, recruited nursery nurses and public health nurses as a different way to recruit to the workforce. She noted the increase in incident reporting which had reviewed to ensure that there had not been any impact on patients. Ms Carroll reported that she had met with Birmingham City University (BCU) to discuss training of Health Visitors and said that recruitment was challenging due to the lack of trained health visitors and said the Trust was looking at how to recruit more registered nurses and train them in the skills required for health visiting. Prof. Field said that whilst health visiting was an area of concern for the Trust, there was also a national issue of retention and training and that the plan to recruit as described by Ms Carroll was the right strategy. Ms Rowe said that as Director for Children's Services at Walsall Council, she had been involved in discussions at Walsall Council regarding the implications of the lack of health visitors and said that a plan had been put in place on how that would be managed. She said that there was a wider concern in relation to the safeguarding element of the health visiting role as it was less easily accountable, and a key part of their Partnership work was to keep children safe. She said that 0 to 5 and 0 to 2 cohorts had not been attending nursery during Covid-19 and she was acutely aware of the potential implications of that. She said that she understood the recruitment challenge and that the key was the skill mix and she would be working with Ms Carroll and Mr Dodd to undertake this. She said that this matter had also been flagged up formally through the Walsall Safeguarding Partnership with Public Health involved in the discussions.

	Prof. Toner said many of the childrens nurses were undertaking further training to become health visitors. She said that due to the new Nursing and Midwifery Council (NMC) standards for health visiting, school nursing and community nursing, there may be an opportunity to look at providing a dual qualification in Child Nursing/Health Visiting course or any field of nursing. **Resolved: that the Chair's report for Quality, Patient Experience and Safety be received and noted.**
332/22	**People and Organisational Development Committee Chair's Report (June and July 2022)**
	Mr Hemans highlighted that the Committee had undertaken a 'deep dive' into the Community Division and said that the Rapid Response Team had been awarded the Placement Provider of the Year at the University of Wolverhampton's 11th Annual Students Union Awards that recognised the Trust as a good provider. Mr Hemans reported the Community 'Thank you' Scheme had been launched for patients and colleagues to recognise staff who had gone 'over and above' their duties and for their good work. He said the Child Development Service Team were keynote speakers at a conference in Prague and the Leon Talbot Suite had been opened in memory of a recent patient. He reported that the Community Division had been invited by the 'Sam Sherrington' Team to speak at a national conference in recognition of work, despite challenges in turnover rates. Mr Hemans highlighted the challenges in recruitment and turnover rates with leavers mainly citing work-life balance as the reason for leaving. He said that these included returners following the pandemic but who had since decided to leave again. He said that work had been ongoing to bring sickness absence rates down with occupational health cases dealt with on a speedier basis to ensure those on long-term sick were supported in returning to work. Ms Griffiths reported an increase in turnover rates and said vacancy rates in nursing and midwifery had fluctuated as establishments increased with recruitment plans in place to respond. She said that exit interviews were being monitored as leavers had cited work-life balance as the reason for leaving. She that that her team would be looking to consider different work patterns and different types of contracts that might retain staff and said that this was a national issue. She said that the Committee had commissioned an in-depth report to look at what further flexible working might look like. Ms Griffiths referenced the previous sickness levels and increases in absence due to musculoskeletal, stress, anxiety and depression and said that in response to that, additional physiotherapy capacity and counselling capacity had commenced. She said that detailed work had been undertaken with the divisions to look at patterns of absence and recovery post pandemic and to provide divisional managers the support needed to take the decisions they need to take, with a more preventatively focussed health and wellbeing case being worked up to prevent sickness and not just respond to sickness. Mr Hemans advised that the Committee had also discussed generational issues and said that the Trust had proposed to hold a joint Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust Board Development session in relation to this matter, which was scheduled for the 2 November 22. Mr Virdee sought clarification regarding staff on long-term sick who had wanted to leave the Trust. Mr Hemans explained that all long-term sickness cases were reviewed to help colleagues to return to work, however some would not be able to return to work in which case alternative arrangements had to be discussed.

	Dr Shehmar said that the recruitment drive sat alongside the wellbeing work and it was important to keep momentum on this. She said that stress and sickness levels were higher when there were gaps in workforce teams or temporary staffing used. Ms Muflahi queried why there was a delay in the Health & Wellbeing Strategy, as given the post-pandemic challenges around health and wellbeing, it would assist in the sickness management in relation to anxiety and depression. Ms Griffiths advised that the People and Organisational Development Committee had approved the Health & Wellbeing Strategy, however the Trust Board had subsequently agreed to enhance physiotherapy and counselling services and in addition there had been investment for Mental Health First Aid training, which had delayed the publication. She said that the Strategy had been well received by staff and it had opened up conversations and allowed for referrals to happen more effectively. She reported that there were currently 38 Mental Health First Aid trainers within the Trust and that the Trust had been recognised for the pro-active and creative approach. **Resolved: that the Chair's report for People and Organisational Development be received and noted.**
PROVIDE SAFE, HIGH QUALITY CARE	
333/22	**Director of Nursing Report**
	Ms Carroll reported that 57 falls had been recorded in June 22, a reduction from 62 in May 22. She said that the Falls Accountability and Review meetings continued to identify lessons to be learnt and that the first shared Professional Decision-Making Falls Prevention Group meeting had been held in June 22 focussed on shared learning. She reported that education for the new risk assessment documentation in relation to pressure ulcers prior to implementation, had commenced. Ms Carroll advised that hospital acquired Moisture Associated Skin Damage average was at 30 incidents per month and Gama (the company providing continence products to the Trust) had supported education to help reduce incidents, with the continence lead having undertaken a data review to aid the development of a proactive continence quality improvement plan pending the roll-out of the new hybrid mattresses. She said that the monthly reports on VTE compliance showed that the Trust had not achieved the 95% target. She said that this reporting would continue until VTE was included as a mandated field in EPR (electronic patient record). She said that this was a long-term solution and to provide assurance to the Board, monthly manual audits were undertaken for those patients without a VTE risk assessment within the required timeframe to identify if any harm had been caused as a result. Dr Shehmar advised she had been asked to provide assurance around those patients where VTE assessment had not been recorded. She confirmed that there had been no incidents of hospital acquired thrombosis seen with any association with non VTE assessments, as reported through the Thrombosis Group. She said assurance could not be provided at this time for patients who did not have a VTE assessment on FUSION, whether those patients had any other harm or near misses and whether the right clinical decisions had been made. She said all the divisions had been asked to provide audit data for presentation to the Quality, Patient Experience and Safety Committee (QPES) in September 22. Ms Carroll said that the electronic reporting of Sepsis compliance was available and the Sepsis Team had presented the work they had undertaken on audit data to the Patient Safety Group in June 2022. She advised that the Patient Safety Group had been assured the data was accurate in recording the actual position and therefore the manual audits had now ceased. She said the Sepsis team and Outreach team were supporting clinical teams with education, a deteriorating patient group had been established and had met in June 22 and patients with Sepsis were being reviewed by this group.

	Dr Shehmar said she had spent time with the Sepsis Outreach team to review reporting when a patient triggers on the dashboard to ensure that checks were made every 30 minutes and if appropriate the Sepsis 6 processes were being carried out. She said that the Outreach Team was looking to expand cover out of hours and weekends. Dr Parkes asked for clarification of the data for June 2022 as figures in the Board and QPES reports were different. Ms Carroll said the data should be the same as it was taken from the same source but agreed to check the data and feedback. **Action: - Ms Carroll to double check the June 22 data reported for Board and QPES and feedback to the Board.** Ms Carroll reported there had been 4 *Clostridium Difficile* cases reported in month, under the national target of 27 per year. She said a review of Antimicrobial use had been undertaken which confirmed that the use of antibiotics in these cases had been justified. She reported an outbreak of Covid-19 on Ward 3 in June 22 which had been managed through the Outbreak Policy and said that outbreak meetings with the UK Health Security Agency (UKHSA) had provided positive feedback and commended the Trust for how outbreaks had been managed. Ms Carroll said she had previously reported that the threshold of timely observations had changed in line with best practice and the Royal Wolverhampton NHS Trust. She advised that this had resulted in a decrease in compliance to 77% in May 22 and 78% in June 22. She said the divisions had been asked to provide trajectories and plans to the Patient Safety Group on how to improve compliance. She reported on Safeguarding Level 3 training advising that medical nursing, midwifery and AHPs was now being reported separately. Ms Carroll reported ED and Endoscopy as the highest users of agency staff and off-framework staff and said that agency staff in ED had been offered substantive positions, to cease the use of ED agency in line with the recruitment to the new establishment for ED. She said the clinical fellows had been assigned to endoscopy and had been trained to take up posts to enable agency usage to cease in endoscopy. Prof. Toner queried the surgical site infections focused on elective and emergency c-sections, which had required some patients needing to return for further treatment. Ms Carroll advised that these incidents had been reviewed via microbiology for any lessons learned and she would report back on this matter in her next report to the Trust Board. **Action: Ms Carroll to provide feedback in her next Director of Nursing report on surgical site infections, focused on elective and emergency c-sections which had required some patients needing to return for further treatment.** Prof. Toner referred to the 176 Red flags, 50 of which had been sorted out at the time and queried the other 126 and whether they had impacted on patient care. Ms Carroll explained there had been an increase in staff reporting red flags, and the red flag mitigated at the time related to significant risk, amber risks were safe but need reporting and were reviewed in the Nursing and Allied Health Professionals Forum held monthly to identify if there was any harm. She confirmed no harm had been identified in the past two months. **Resolved: that the Director of Nursing Report be received and noted.** *The Board convened for a 10 minute break at 10.51.*
334/22	**Hospital Mortality Report (April – May 2022)**
	Dr Shehmar reported on the statutory requirement from April 2023 to roll-out the Medical Examiner (ME) pathway to the community where the Trust had been asked to undertake

	pilots. She advised that 5 General Practices had been selected as part of the community pilot and positive feedback had been received from General Practitioners (GPs) within the pilot with more joining week on week. She confirmed the Trust was on track to meet the statutory requirement. Dr Shehmar reported on mortality and the work being undertaken to reduce avoidable deaths. She advised that an external agency, had been commissioned to look at the accuracy of reporting and recording with focus on where improvements could be made, reviewing mortality data and cleansing to help focus on specific disease areas contributing to the Trust's highest rates of avoidable deaths. She said she was liaising with Mr Hobbs and Mr Caldicott in relation to coding and documentation feeding into the data. She explained the Trust was unusual as it had a hospice as part of the Trust and that mortality data was based on the average hospital and the Trust's Hospital Standardised Mortality Rate (HSMR) data showed the Trust as an outlier. She said that work to present data from the palliative care centre in a more meaningful way was being undertaken. Dr Shehmar explained alerts had been received as an outlier, most in relation to cancer. She said that the speciality mortality lead was to review patient notes for learning points. She reported on the perinatal mortality rate as part of Ockenden requirements which was high for the Black Country and advised that when the Trust's patient level data had been reviewed, the Summary Hospital Mortality Indicator (SHMI) data had reduced as a result of validation. She said the Trust had been asked what improvements would be made in relation to perinatal mortality rates and the data had illustrated a sustained reduction in still birth rates as part of the saving babies bundle initiative. Dr Shehmar said that the Mortality Surveillance Group met monthly and identified ways of improvement. She said that Group's report on the acute kidney injury (AKI) pathway, one of the top five causes of death. She said that the Trust had recruited an AKI nurse to support with training, visiting patients and investing in community management of kidney disease with renal clinics set up. Dr Shehmar confirmed no concerns had been reported in patient care relating to ovarian cancer as the denominator was small. She said that there was a generalised theme in relation to reporting times for histology for all cancer pathways and that the Trust was working with the Black Country Pathology Service (BCPS) who had recruited additional consultants to improve turnaround times. She highlighted the cancer improvements made across all areas and main cancer areas of delays around and the increased capacity and staffing. Mr Caldicott confirmed that an annual audit provided assurance on the level and accuracy of coding from patient records. He said that findings indicated that the Trust had a low co-mobility score and it was important to understand where the potential gaps were. He said he would be commissioning a further focussed piece of work for assurance on correct data. Mr Hemans referenced the rising prostate cancer figures and asked if the Trust had been working with Walsall Together (WT) to consider increased awareness and encouragement of males to have checks, use support groups, noting that the national statistics for prostate cancer was 1 in 4 for black men and 1 in 8 for white men. Mr Dodd confirmed WT were providing publicity to increase awareness via advertising. He said that the main focus was on health inequalities, reviewing data to find key issues, ethic composition of community and compiling an action plan to target specific groups and services. Ms Brathwaite asked what the timeline was for the report back and what would be done regarding the hospice figures. Dr Shehmar advised that once finalised they would work in partnership with clinical teams at the Trust to understand the data and identify areas for improvement.

	Dr Parkes referred to the 27 outstanding structured judgement reviews (SJRs) and asked what the timescale was for completion. Dr Shehmar advised that the SJRs related to a particular clinical group who, due to being required to undertake more elective recovery work or front line Covid-19 work, had not been able to prioritise SJRs. She confirmed that a programme had now been put in place to undertake the SJRs. Mr Dodd confirmed palliative care was now part of the Trust following handover from St Giles 2 years ago. He said that following a review of palliative care, there had been a change in the model of care, with shorter lengths of stay being noticed, more intensive management and moving to home being supported in domiciliary settings. Mr Dodd said that this information would need to be included as part of the review. He referenced the discussions around AKI reporting and said that the Community had joined with Nephrologists to jointly fund a post for a consultant to work with GPs to look at population. Prof. Field requested Mr Dodd to provide a short paper to public board when ready to do that to highlight the work being undertaken. **Action: Mr Dodd to provide a paper to a future public board on the initiatives in the community for equalities and health promotion work.** Prof. Toner asked if staffing would be available to support the expansion of the oncology services. Dr Shehmar advised that the medical aspect was a service level agreement (SLA) with University Hospital Birmingham who provide the consultant staff and that nursing staff had been recruited. Dr Shehmar reported that feedback would probably be reported at the next Mortality Group and agreed to report to the Board at the December 22 Board meeting. **Action: Dr Shehmar to report on the feedback on coding and mortality at the December 22 Board meeting.** **Resolved: that the Hospital Mortality Report (April – May 2022) Report be received and noted.**
335/22	**Patient Experience (& Complaint's report) Quarterly Report**
	Mr Perry reported on a decrease in complaint response rates in quarter 1 which had since stabilised. He said that there had been a shift change seen in the Friends and Family (FFT) score and response rates, particularly in maternity with signs of improvement. He said that the Nudge messaging was switched on in May 22 had had a positive impact on the FFT Feedback in Maternity. He reported on the liaison with the Maternity Voices Partnership (MVP) who had commented on findings and contributed to the actions being developed. Mr Perry said that the MVP and Healthwatch Walsall had been supporting the 15 steps observational tool and reviews. He advised that the Mystery Patient and FFT posters had been displayed in inpatient areas and responses had been tracked to score against the national survey. He said the draft findings had been shared with teams but were currently embargoed. Mr Perry reported on the partnership with Blessed to Bless community organisation who work with the homeless or those struggling financially. He said that the organisation was working from the discharge lounge, linking to patients during their discharge process and supporting those who had no social network and a referral mechanism to one of the four hubs in Walsall for ongoing support. He said Blessed to Bless had visited the Manor lounge and was looking to develop support for staff. He reported on the partnership with Juniper training who support young volunteers to get into full time work. Mr Perry advised that a volunteer celebration event was planned for October 22 and that the

	Patient Voice reports were in place across the Trust including Community. He said by autumn all touch points would get visual patient voice reporting including data and improvement actions. Prof. Field commended the work of Mr Perry and his team and said he would arrange a meeting with Mr Perry to discuss further the work with Blessed to Bless. **Action: Prof. Field to arrange a meeting with Mr Perry to discuss the work with Blessed to Bless.** **Resolved: that the report from the Patient Experience Quarterly Report be noted.**
336/22	**Continuous Quality Improvement (CQI) – Quarterly Update**
	Mr Evans reported on the work undertaken in Quarter 1 and the areas of focus for Quarter 2 including capacity, capability, building safety and flow. He said that virtual training had been delivered during Covid-19 and the Trust was now returning to delivering physical training to increase the numbers trained. Mr Evans reported on the two Board development sessions that had been undertaken and said that he would be presenting feedback and recommendations for a development plan, from the National Team on these two sessions at the Committees in Common meeting being held following the Trust Board meeting. Mr Evans confirmed recruitment of the new Trust Clinical Lead (Dr Atul Garg) who would take up the post next month. Dr Shehmar advised Mr Garg was an anaesthetic consultant and was pleased to hear he was already engaging with approved methodologies and interventions for sepsis. Ms Muflahi asked if there was a specific staff quality award to encourage patients and staff to become more involved in quality improvement across the Trust. Mr Evans confirmed there was a specific award as well as the QI awards. **Resolved: that the report from the Continuous Quality Improvement Report be noted**.
337/22	**Director of Infection Prevention and Control (IPC) Quarter 1 Report**
	Ms Wallet reported on the risks from elements of the hygiene code from the Health and Social Care Act and said that risks had reduced or remained static reflecting the work undertaken by the Trust during Quarter 1. She said the key areas to highlight were the continual changes in Covid-19 guidance and the Trust's response to those. She said that the Infection Prevention (IP) and Communications teams had worked together to standardise approaches across WHT and RWT in relation to changes to the guidance. Ms Wallet said she was proud to highlight the work undertaken on the respiratory guidance for staff as this had been showcased and well received at a regional West Midlands Infection Prevention (IP) Society conference and added that other trusts had wanted to adopt the same manual. Ms Wallet reported that infection prevention in a healthcare environment showed overall improvement at over 98% which reflected the refurbishments. She said that areas not scoring well related to those areas not yet refurbished. Ms Wallett reported on the installation of 134 air disinfector units. She said the ability to isolate patients had improved following the installation of 9 segregation pods into the Modular black and Acute Medical Unit and confirmed that '*C-Difficile*' cases were on trajectory with zero Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia and zero Methicillin-Susceptible Staphylococcus Aureus (MSSA) bacteraemia.

	Ms Wallet reported there had been 51 Bay closures due to Covid-19 in quarter 1. She confirmed there had been no resulting harms and there had been a significant change in guidance for screening patients on development of symptoms. She reported on the Monkey Pox virus, with one case managed early in the outbreak and which had been subsequently stepped down, with positive feedback received from UKHSA and NHSE/I on the Trust's response to contact tracing and management. Prof. Loughton commended Ms Wallet and the team for their good work and said he would arrange a walkabout with her to the ward areas. **Action: Following the Quarter 1 report to Trust Board, Prof. Loughton commended Ms Wallett and her team for their good work and agreed to arrange a walkabout to ward areas with Ms Wallett.** **Resolved: that the Infection Prevention Control Quarter 1 Report be noted.**
338/22	**Divisional Director's Midwifery Service Report**
	Ms Jones-Charles reported that the 'Saving Babies Lives' Care Bundle was part of a National programme and an essential element of the Clinical Negligence Scheme for Trusts (CNST). She said that the maternal smoking cessation and monitoring maternal carbon monoxide (CO) was also an element of this and reported that the overall compliance was on track to meet the standard. Ms Jones-Charles reported on progress in reducing the staffing gap with 17 new starters commencing in October. She said that 1:1 care in labour continued, and the Trust was working with staff to support and update around vacancy pressures. She said that the Division was working collaboratively with the Patient Experience Team on the maternity 15 steps and had received lots of useful feedback. She said the maternity bereavement room, location and entrance required changing as part of this feedback and would be included as part of the maternity environment improvement work which was anticipated to start in early autumn. Mr Hemans referred to the bereavement room to support parents and said that the People and Organisational Development Committee was intending to carry out a deep dive in maternity as a learning exercise for the Committee and to hear about the positives and the challenges. Ms Jones-Charles welcomed this. Ms Rowe noted the good progress and said that Walsall had one of the highest infant mortality rates in the country for 0-2s. She said that work was being undertaken for the development of family hubs with Walsall Together and the Children's Strategic Alliance and said it would be helpful to think how maternity could link into that. Ms Jones-Charles said that when recruitment had completed she would welcome the involvement with these groups. Dr Shehmar advised of the concerns raised by neighbouring trusts in relation to medical staffing and the supervision of junior doctors in obstetrics and said that the Trust had also had recent concerns raised by junior doctors. She said that the Trust had a plan in place to support the junior doctors and asked that this information be included in the reports to the Board. Ms Jones-Charles said that this would be added to the next report. **Action: Ms Jones-Charles to include in her next Divisional Director's Midwifery Service report, the plan in place for junior doctors in obstetrics.** **Resolved: that the Director of Midwifery report be received and noted.**
339/22	**Trust Risk Register/Board Assurance Framework**
	Mr Bostock reported on the period ending June 2022 and advised of two risks related to the

	Board Assurance Framework on the Risk Register. He said that both risks had mitigation measures in place and were being monitored regularly by nominated executives and operational teams. He said the overdue reviews identified in the cover report related to recording in the system and were not related to the review of risks on time and that this would be corrected for future reports. **Resolved: that the Trust Risk Register/Board Assurance Framework report be received and noted.**
340/22	**Mental Health Escalations, Concerns and Recommendations**
	Dr Shehmar provided an update on the work to mitigate the risks in relation to mental health reporting. She referred to Risk 2475, an internal risk regarding the Trust's responsibility against the Mental Health Act (MHA) and Care Quality Commission (CQC) regulations and the recommendation to put in place a team and system to provide regulatory requirements. She confirmed that a Mental Health team and administrative team were in place to support audits, training and assurance and that the risk score had reduced from 25 to 15. Dr Shehmar advised on the work with partnership organisations to address other risks, with executive level meetings and a commitment to address these. She said the wider risks regarding tier 4 beds, had progressed with the Integrated Care System (ICS) mental health workstream. She said that training had been put in place around the MHA on restraint and ligatures, and whilst there had been some challenges in releasing staff for training, there was a plan and trajectory for the high risk areas to ensure training was accessible. Dr Shehmar said that as incidents still took place in the Trust, other gaps in service would be addressed. Mr Hemans said it was good to hear of progress, particularly in partnerships and reported on a scheme undertaken at RWT with Wolverhampton Council, where the Council had supported the funding of training up to 60 barbers, nail technicians, hairdressers in mental health care and awareness. He asked if there was anything Walsall Council and Walsall Together could do in supporting similar training into the community for those with mental health issues. **Resolved: that the Mental Health Escalations, Concerns and Recommendations be received and noted.**
341/22	**Pharmacy and Medicines Optimisation Report**
	Dr Shehmar reported that adherence to drug audits at ward level were tracked and reported at the Patient Safety Group and the Medicines Management Group which had noted the improvement in audits and the increased awareness of the regulations. She said that some aspects were still not being consistently achieved and the team had been looking at the audit tool to understand and focus on interventions to address any gaps. She reported on the electronic drug cabinets that would be installed when refurbishments had been carried out. Dr Shehmar said that due to specific risks in working in the community areas, the pharmacy teams had been providing additional audits and a training video had been made available to improve awareness. She said that the improvement in medications storage compliance was being tracked through the Tendable ward app and that the issue of security for medical gases had been addressed by the installation of CCTV. She confirmed that there were no regulatory inspections due. Ms Martin welcomed the implementation of electronic storage on refurbished wards and queried the funding for the refurbishments. Mr Caldicot advised that the electronic storage was funded by the League of Friends Charity and the funds for the ward refurbishments had been secured within the Capital Programme. He advised that the funding for the theatre

	refurbishment upgrades had not been secured. **Resolved: that the Pharmacy and Medicines Optimisation Report be noted.**
342/22	**Safeguarding Adults and Children Quarterly Report**
	Ms Pickford reported on the substantial work that had been undertaken on completion of the actions outlined in the Safeguarding Development Plan. She said the work completed to date had been well received by key agencies and they had received assurance from partnerships. Ms Pickford said that the Team had participated in Section 11 of the Children's Act and Care Act for Adults processes and partners had reported back on good governance overall for training and management. Ms Pickford advised on the review of the Learning Disability agenda for the Trust. She highlighted that safeguarding training compliance had varied through the year mainly due to staff shortages, and that training was available on e-learning. She reported that compared to at March 22, the Trust was now compliant for the children's level 3 training. She said that the team had been working to identify any training that could be undertaken jointly across both Walsall and Wolverhampton Trusts. She reported there had been 109 referrals sent to Walsall Social Care regarding the care and treatment of patients which had generated a section 42 enquiry and that the Trust was working with the Local Authority to review the threshold criteria. She reported that a training package was being developed which would be shared with the Trust Board at the Trust Board in December 22. **Action: Ms Pickford to share the training package for the Learning Disability agenda, at the Trust Board in December 22.** Ms Pickford advised of an anomaly in section 5.2 of the report, column 4 which should read total number 492 equivalent to 23% (not 85%). Ms Pickford agreed to amend and recirculate the report to Board members. **Action: Ms Pickford to amend data in section 5.2 which should read "total number 492 equivalent to 23% (not 85%).** Mr Hemans asked when the review would be complete and updates rolled out to staff. Ms Pickford advised that meetings had been set up with the Local Authority from September 22 and she would report back to the Board in quarter 3. Ms Rowe offered her support, in her role as Director of Childrens Services, to assist with the conversations with the Local Authority in relation to the Section 42 matter. Prof. Field asked Ms Pickford report back on these discussions at the next Trust Board meeting. **Action: Ms Pickford to report back at the October 22 Trust Board meeting, the discussions with the Local Authority in relation to the Section 42 threshold criteria.** *The Board convened for a 10 minute break at 12.26 – 12.40* **Resolved: that the Safeguarding Adults and Children Quarter 4 Report be received and noted.**
CARE AT HOME	
343/22	**Walsall Together Partnership Board Chair's Report and Care at Home Executive Report**
	Mr Dodd reported on both reports advising the Partnership Board had met on 20 July 22. He said that the three key themes were the sustained demand in the system affecting all partners, re-affirming the role of the partners in supporting demand, working on the interface

	issues, reducing duplications and looking at targeted investment. Mr Dodd reported on the Centre and PLACE, regarding development funding and priorities and provided as an example, the anticipated paediatric virtual wards funding and issues of how that to links to primary care. Mr Dodd reported on the local contribution of PLACE to the costs of living crisis and potential pressures on the health and wellbeing of the local population. He reported that work undertaken locally had been recognised and a presentation had been provided to a national discharge taskforce on what had been different in Walsall and why it had worked. He said a bid had been submitted to the National Discharge Exemplar sources to become one of the pilot projects. He said the Partnership would focus on development work linked into the integration white paper and that a clearer focus on PLACE based partnerships was required. Mr Dodd reported that debates and working groups were taking place at the Partnership Board level. Prof Field commended Mr Dodd and the team for their excellent work. Mr Caldicott echoed the comments of Prof. Field and said that it was important to ensure visibility in the Organisation as well as the Partnership Board and how that was being modelled and worked through the Investment Group, Performance and Finance Committee and to ensure that key performance indicators (KPIs) had been captured and risks evaluated. **Resolved: that the Chair of Walsall Together Partnership Board be received and noted.**
344/22	**Charitable Funds Chair's Report**
	Mr Assinder reported on the significant amount of fundraising activity which had been undertaken and said that the Well Wishers charity was one of the Mayor's charities this year. He reported that he, and Mr Caldicott, had met with representees of the Patel family who had kindly donated a cheque for £120k from the estate of a former patient that was gratefully received. Mr Assinder reported on the work undertaken with Mr Caldicott and the Brokers on the investment portfolio to assure that the Trust had been best placed to withstand any turmoil in the market. He said the Committee had approved the new 3 year fundraising strategy that had been developed in association with colleagues at RWT. He said the plan was to strengthen the Well Wishers brand and develop opportunities to work with other commercial partners locally. **Resolved: that the Charitable Funds Chair's Report be received and noted.**
345/22	**Charitable Funds Strategy**
	Mr Caldicott presented the Strategy which he advised was a trustee model and that voting members of the Board would be trustees of the Well Wishers Charity. He reported that he, and Mr Assinder, were meeting regularly with the Charity Committee and said that Well Wishers resources had been received from donations, legacies and grants. He said that the Trust would be looking to maximise and engage with the local business community and raise awareness internally and externally to expand on this. Mr Caldicott commended the Fundraising Manager, Ms Georgie Westley for her excellent work and advised that additional support had been provided to her to enable her to continue and expand the role within the community. He said he was pleased the Charity had been nominated by the Mayor and reported on an appeals launch which had taken place Hollybush Garden Centre that had been well attended by public and businesses. **Resolved: that the Charitable Funds Strategy Report be received and noted.**

USE RESOURCES WELL	
345/22	**Audit Committee Chair's Report**
	Ms Martin provided the Chair's report and raised her concerns on the number of staff who did not have email addresses or access to email. She said that this would have implications for how the Trust communicates with staff and the Audit Committee had requested a special report on how this would be mitigated. Prof. Loughton reported that this was a problem area for certain groups of staff and advised that hard copies of information was made available to these staff groups. Mr Caldicott reported that work was being undertaken on how best to engage with the affected staff groups. **Resolved: that the Audit Committee Chair's Report be received and noted.**
346/22	**People and Organisational Development Committee – Joint WHT and RWT Terms of Reference**
	Mr Griffiths reported on the Terms of Reference and Cycle of Business advising they were for information and approval and were consistent across both Walsall and Wolverhampton Trusts. **Resolved: that the People and Organisational Development Committee – Joint WHT and RWT Terms of Reference be received and approved**
347/22	**Sustainability Report**
	Mr Evans reported on the Trust's position for reducing the use of anaesthetic gases. He reported that the position on desflurane had been achieved but would not be deliverable until March 2023. He explained that, since May 22, the Trust had been within the required target. Mr Evans advised that the Trust had been fined £32k this year for its level of carbon admissions outside tolerance levels and would be incurring these charges next year too. He said the reasons for the heat and energy usage was known and work being had been carried out on the carbon footprint exercise with the Sustainability team working with the Estates team on the data gathered to develop a plan to address this. He said that this information would be included in a future Trust Board report. Prof. Field acknowledged that the targets had been set to ensure trusts were following the correct carbon footprint, however he could not appreciate the fines when that money could be used for patient care. Mr Caldicott advised he would discuss the matter of the fines with Mr Evans outside of the meeting. **Action: Mr Caldicott and Mr Evans to meet to discuss the matter of the fines incurred due to the Trust's carbon output and how these could be avoided.** **Resolved: that the Green Plan and Sustainability Update be received.**
348/22	**Clinical Fellowship Programme: Medical Briefing update 2021-22**
	Dr Shehmar reported that 24 Clinical Fellows had now commenced at the Trust and a further 50 additional Fellows had been recruited to and were currently going through the recruitment process. She reported that 7 locally employed doctors had changed their contract to the Clinical Fellowship Scheme, which had helped with the workload and in supporting teams to address key safety issues and concerns raised by Health Education England (HEE). She said that this would impact on Trust locum rates and that a plan was in place to cease support via locums. Dr Shehmar reported that 2 Clinical Fellows had recently left the programme, one of whom had undertaken a training programme and the other had relocated to another trust. She said that as the education tariff had been addressed, she had been able to provide the correct type of clinical and educational supervision for the Fellows and would be looking at the

	requirements for recruitment, appraisal and revalidation. She said that the Trust had undertaken a review of the quality of care the Fellows had been providing and confirmed that no serious incidents had occurred where Fellows had been directly involved. She reported that five Fellows had enrolled in the Wolverhampton University MSE Programme. **Resolved: that the Clinical Fellowship Programme: Medical Briefing update 2021-22be received**
349/22	**Trust Undertakings pursuant to the powers exercisable by NHS Improvement under or by Virtue of the National Health Service Act 2006**
	Mr Bostock reported on the Undertakings issued by NHSE/I at the end of May 2022 as a result of a post pandemic review of undertakings of all trusts in the Country. He said that following the Care Quality Commission (CQC) inspection of Medicine in March 21, the Trust had been provided an overall rating of the medical services as 'inadequate' and of maternity in July 21 which remained at 'Requires Improvement'. Mr Bostock said the response required from the Trust related to the previous 12 months and reported that significant progress had since been made which had been acknowledged. He reported on oversight arrangements and advised that quarterly meetings had been held with NHSE/I and the Integrated Care Board (ICB) to provide updates and information. He said that the feedback from the ICB, NHSE/I and CQC had acknowledged the significant improvements regarding transparency and reliability of the Trust with a greater degree of confidence in the direction of travel. **Resolved: that the Trust Undertakings pursuant to the powers exercisable by NHS Improvement under or by Virtue of the National Health Service Act 2006 be received** **Prof Loughton left the meeting.**
VALUE OUR COLLEAGUES	
350/22	**Staff Voice – Staff Story**
	Ms Rawlings provided the Staff Story, outlining the investment into the Acute Oncology Service (AOS) to provide a 7-day service for patients to improve patient experience. She said the AOS service provides care for patients attending the hospital to undergo various cancer treatments with some patients being admitted to hospital as they were unwell. Ms Rawlings reported on a patient's journey and her interactions with the AOS nurse, Emily, who had taken the first call. She said that patient's experience was that she had been met on her arrival and had been checked on by Emily throughout the day and that Emily's positive and bubbly nature had helped her throughout her stay. She said that the patient had appreciated the kind gesture of Emily checking in on her by ringing her at home following her discharge the following day and had asked for her sincere thanks to be passed on to Emily. Ms Rawlings reported that the improvements made to AOC had been discussed in PODC and she introduced Nicky Adams, Lead Cancer Nurse to explain these improvements to the Board in more detail. Ms Adams said the biggest challenges in providing cancer care occurred when patients presented as an emergency at hospital and unexpected admissions which would result in longer and poorer patient experiences. She said this had been first identified in deficiencies in the management of people admitted for complications of cancer in 2008 with the 'Better for Worse Report' and said this was later the inception of the 'Acute Oncology Services' as a specialty in its' own right for hospitals with an ED. She was pleased to advise that the AOS had commenced in Walsall in 2011 and that she had been the first nurse consultant in the region to have initiated that service.

	Ms Adams reported on the investment into the 7-day AOS that had had had positive effects on patient quality and safety with patients having been seen within 24 hours of admission, education and training for staff across all disciplines, extension of nursing triage service to access telephone advice 7 days a week and the development of other ambulatory pathways for patients managed in a day case setting rather than being admitted. Prof. Field commended the work of the Ms Adams, Ms Rawlings and the team and suggested a visit to the team from the Non-Executive Directors later in the year. **Action: Prof. Field and the Non-Executives to visit the Acute Oncology Service.** Dr Shehmar said this was a good example of improvements that could be made when data was reviewed and said that some of these changes had been made following the Learning from Deaths and Serious Incident Reviews and the actions that had needed to be taken. **Resolved: that the Staff Voice – Staff Story be received**
REPORTS FOR INFORMATION – MINUTES OF COMMITTEE MEETINGS	
351/22	**Quality, Patient Experience and Safety Committee (QPES)**
	The Board Members received, for information, the confirmed minutes of the QPES Committee held in June 2022. **Resolved: that the minutes of the Quality, Patient Experience and Safety Committee held in June 2022 be received for information.**
352/22	**People and Organisational Development Committee (PODC)**
	The Board Members received, for information, the confirmed minutes of PODC held in June 2022. **Resolved: that the minutes of the People and Organisational Development Committee held in June 2022 be received for information.**
353/22	**Performance and Finance Committee (PFC)**
	The Board Members received, for information, the confirmed minutes of the PFC held in June 2022. **Resolved: that the minutes of the People and Organisational Development Committee held in June 2022 be received for information.**
354/22	**Audit Committee Meeting**
	The Board Members received, for information, the confirmed minutes of the Audit Committee held in May 2022. **Resolved: that the minutes of the Audit Committee Meeting held in May 2022 be received for information.**
355/22	**Charitable Funds Committee**
	The Board Members received, for information, the confirmed minutes of the Charitable Funds Committee held in March 2022. **Resolved: that the minutes of the Charitable Funds Committee held in March 2022 be received for information.**
356/22	**Performance and Finance Committee (PFC)– Chair's Highlight Report**
	The Board Members received, for information, the Chair's Highlight Report for the PFC held in June 2022 **Resolved: that the Chair's highlight report from the PFC held in June 2022 be received for information.**
357/22	**Quality, Patient Experience and Safety Committee (QPES)– Chair's Highlight Report**
	The Board Members received, for information, the Chair's Highlight Report from the QPES

	held in June 2022 **Resolved: that the Chair's highlight report from the QPES held in June 2022 be received for information.**
357/22	**People and Organisational Development Committee (PODC) – Chair's Highlight Report**
	The Board Members received, for information, the Chair's Highlight Report from PODC held in June 2022 **Resolved: that the Chair's highlight report from the PODC held in June 2022 be received for information.**
358/22	**Any Other Business**
	Prof. Field noted that no other business was raised.
359/22	**Date and time of the next meeting**
	Prof. Field confirmed that the next meeting was to take place on Wednesday, 5 October 2022.
360/22	**Questions from the Public/Commissioners**
	Prof. Field confirmed that there were no questions raised from the public/commissioners.
361/22	**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 13:10**

Walsall Healthcare NHS
NHS Trust
28 September 2022 11:58

List of action items

Agenda item		Assigned to	Deadline	Status
Public Trust Board 03/08/2022 12.3 Sustainability Report				
418.	Sustainability Report - Mr Caldicott and Mr Evans to meet to discuss the matter of fines incurred due to the Trust's carbon output and how these fines could be avoided.	Caldicott, Russell Evans, Simon	26/09/2022	Overdue
Public Trust Board 03/08/2022 10.10 Safeguarding Adults and Children - Quarterly Report				
467.	Safeguarding Adults and Children Quarterly Report - Ms Pickford agreed to share with the Board in December 22, the training package being developed for the Learning Disability Agenda	Carroll, Lisa	07/12/2022	Pending
Public Trust Board 03/08/2022 10.2 Hospital Mortality Report (April – May 2022)				
416.	Hospital Mortality Report - Dr Shehmar to report at the December 22 Trust Board -the feedback on coding and mortality	Shehmar, Manjeet	07/12/2022	Pending
Public Trust Board 03/08/2022 10.2 Hospital Mortality Report (April – May 2022)				
485.	Hospital Mortality Report - Mr Dodd to provide a paper to public board on Health Inequalities strategy to the Board in December 22.	Dodd, Matthew	26/11/2022	Pending
Public Trust Board 03/08/2022 10.3 Patient Experience (& Complaints Report) - Quarterly Report				
465.	Patient Experience (& Complaints Report) - Prof. Field to arrange a meeting with Mr Perry to discuss the work with Blessed to Bless	Field, Steve Prof.	04/01/2023	Pending
Public Trust Board 03/08/2022 13.1 Staff Voice - Staff Story				
470.	Staff Voice, Staff Story - Acute Oncology Service - Following the presentation to Trust Board, Prof. Field agreed that he and the Non	Field, Steve Prof.	04/01/2023	Pending

Agenda item		Assigned to	Deadline	Status
	Executive Directors would visit the Acute Oncology Service later in the year.			
Public Trust Board 03/08/2022 10.7 Director of Infection Prevention and Control Report - Quarter 1 Report				
466.	Director of Infection Prevention and Control Report - Prof. Loughton to arrange a walkabout to the wards with Ms Wallett	Loughton, Prof. David	30/11/2022	Pending
Public Trust Board 03/08/2022 10.5 Director of Midwifery Report				
417.	Director of Midwifery Report - Ms Jones-Charles to include in her next Director of Midwifery report, the plan in place for junior doctors in obstetrics	Jones-Charles, Carla	28/09/2022	Completed
	Explanation action item Complete: An update also being provided at September QPES			
Public Trust Board 03/08/2022 10.1 Director of Nursing Report				
413.	Director of Nursing Report - Sepsis data - Ms Carroll to review the June 22 data presented to Board and QPES and confirm accuracy	Carroll, Lisa	26/09/2022	Completed
414.	Director of Nursing Report - Ms Carroll to add to future Director of Nursing reports - feedback on lessons learned following surgical site infections, focused on elective and emergency c-sections which had required some patients needing to return for further treatment	Carroll, Lisa	26/09/2022	Completed
	Explanation action item Update: 23/9/22 - feedback has been included in Director of Nursing Report to Board			
Public Trust Board 03/08/2022 10.10 Safeguarding Adults and Children - Quarterly Report				
468.	Safeguarding Adults and Children Quarterly Report - Ms Pickford to amend the data in section 5.2 to read "total number 492 equivalent to 23%".	Carroll, Lisa	15/09/2022	Completed

Agenda item		Assigned to	Deadline	Status
	Explanation action item Amendment to Report completed and revised report shared via ibabs.			
Public Trust Board 03/08/2022 10.2 Hospital Mortality Report (April – May 2022)				
415.	Hospital Mortality Report - Mr Dodd to provide a report to a future public board regarding pallative care and community initiatives	Dodd, Matthew	28/09/2022	Completed
	Explanation action item Mr Dodd advised that a report on palliative care would be presented to the Board in October 2022.			

Nolan Principles of Public Life & Trust Values

NHS
Walsall Healthcare
NHS Trust

Committee on Standards in Public Life - Guidance

The Seven Principles of Public Life

Published 31 May 1995

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.*

Principle	*I will show this by*
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 – 5 October 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 five Consultant Appointments since I last reported: **Trauma and Orthopaedics** Dr Venugopal Guduri Dr Mohamed Mussa Dr Shafiq Shahban **General Surgery and Colorectal** Dr Muhammad Tayyab **General Surgery and Upper Gastrointestinal (UGI)** Dr Syed Kabir
3.0	**Policies and Strategies**
	• Policy Management Report **August 2022** • CP51 V6 - Point of Care Testing (POCT) Policy • OP936 V1 - Walsall Healthcare Digital Services Password Policy **September 2022** • CP45 V3 - Eating and Drinking with Acknowledged Risk (EDAR) Adult Policy • CP945 V2 - Referral of Registrants to the Nursing & Midwifery Council Policy • CP946 V3 - Nice Guidance Policy • IP930 V2 - Outpatient Parenteral Antimicrobial Therapy (OPAT) Policy • MH927 - Rapid Tranquilisation Policy • OP937 V1 - Log File Retention Policy • OP943 V4.1 Clinical Coding Policy and Procedures • Guidelines for the Management of Gestational Trophoblastic • The use of Zoll End Tidal C02 (ETC02) in the management of adult in hospital cardiac arrests Trust wide – standing 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 • 20 July 2022 – virtually met with Dr Helen Paterson, Chief Executive – Walsall Council and participated in a virtual Walsall Proud Partnership (WPP) meeting • 26 July 2022 – chaired the virtual Trust Management Committee • 29 July 2022 – Eddie Hughes MP, undertook a site visit of the new Emergency Department • 3 August 2022 – chaired the virtual Staff Briefing • 4 August 2022 – undertook a site visit of Medical Records and participated in the virtual Black Country Collaborative Executive Committee • 9 August 2022 – presented as part of the West Midlands Cancer Alliance the Cancer Dashboard to Professor Tim Briggs, Chair of the Getting It Right First Time (GIRFT) programme and Consultant Orthopaedic Surgeon • 6 September 2022 - participated in a Black Country ICS Collaborative Board • 8 September 2022 – joined the NHS Providers Chairs and Chief Executives Network event • 9 September 2022 – virtually met with Mark Axcell, Chief Executive – Black Country Integrated Care System (ICS) • 12 September 2022 – joined the NHS Improvement (NHSI) Insight visit • 13 September 2022 - – participated in the virtual Regional Black Country Quarterly System Review meeting and welcomed new Consultants as part of their induction programme • 15 September 2022 – participated in the virtual Joint Negotiating Committee (JNC)
5.0	**Board Matters**
	There were no Board Matters to report on.

MEETING OF THE PUBLIC TRUST BOARD – 5 October 2022			
Chair's report of the Trust Management Committee (TMC) held on 27 September 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**
	• Review of Trust Management Committee (TMC) Terms of Reference (TOR) Report • Director of Nursing Report • Midwifery Service Report • Nursing and Midwifery Workforce Report • Safeguarding Adults and Children Report • Children and Young People Letter Feedback • Learning From Deaths 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 • Corporate Risk Register/ Board Assurance Framework (BAF) • Care Quality Commission (CQC) Action Plan • CQC Action Plan Evidence Audit Progress Report • Health Inequalities Verbal Report • Trust Financial Position (Revenue and Capital) - Month 5 Report • Integrated Quality Performance Report (IQPR) • Contracting and Business Development Verbal Report • Walsall Together Report • Workforce Summary Report • Workforce Metrics Report • Acute Collaboration Report
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**
	• Annual Health and Safety Report • Cancer Services Report • Tobacco Dependency Support Report • Emergency Preparedness Resilience Response (EPRR) Self-assessment Core Standards Report • Research and Development Report • Property Management Report • Urgent and Emergency Care Resilience – Winter Plan 2022/23 • Urgent and Emergency Care Centre's Capital Build Update Report • Industrial Action Planning - Briefing Paper

5.0	**Business Cases – approved**
	• Business Case to fund Additional Recruitment Roles • Business Case to fund Clinical Systems Team Staffing • Business Case to fund a Radiologist • Business Case: to fund a Managing Director for Research and Development at Walsall Healthcare NHS Trust (WHT) and The Royal Wolverhampton NHS Trust (RWT)
6.0	**Policies approved**
	• Policy Management Report **August 2022** • CP51 V6 - Point of Care Testing (POCT) Policy • OP936 V1 - Walsall Healthcare Digital Services Password Policy **September 2022** • CP45 V3 - Eating and Drinking with Acknowledged Risk (EDAR) Adult Policy • CP945 V2 - Referral of Registrants to the Nursing & Midwifery Council Policy • CP946 V3 - Nice Guidance Policy • IP930 V2 - Outpatient Parenteral Antimicrobial Therapy (OPAT) Policy • MH927 - Rapid Tranquilisation Policy • OP937 V1 - Log File Retention Policy • OP943 V4.1 Clinical Coding Policy and Procedures • Guidelines for the Management of Gestational Trophoblastic • The use of Zoll End Tidal C02 (ETC02) in the management of adult in hospital cardiac arrests Trust wide – standing Operating Procedure (SOP)
7.0	**Other items discussed**
	There were none this month.

MEETING OF THE TRUST BOARD – 5th October 2022			
Final Approval of 'Our Strategy'			
Report Author and Job Title:	Tim Shayes – Deputy Chief Strategy Officer	**Responsible Director:**	Simon Evans, Group Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐		
Assure	• The development of the strategy has followed a previously agreed process encompassing a wide range of internal and external stakeholders, led by the sub-group of the Committee in Common.		
Advise	• The sub-group of the Committee in Common has approved 'Our Strategy' for consideration by the Board. • If approved, 'Our Strategy' will be publicised in line with the associated Communications Plan		
Alert	• None		
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 from the strategy itself		
Legal and/or Equality and Diversity implications	N/A – the strategy seeks to address inequalities		
Strategic Objectives	The strategy proposes a new set of strategic aims and objectives		

Executive Summary

This paper presents the final version of 'Our Strategy' to the Trust Board. The paper outlines the process followed to develop the strategy and seeks approval for it to be publicised.

Background/Context

The Trust Boards of both organisations previously approved the extensions of the Trust's current strategies to allow time for the development of a single, joint strategy covering both organisations. Alongside this was the request for the Committee in Common to oversee its development.

'Our strategy' has now been finalised with the attached document having been through successive rounds of engagement before being recommended for approval by the Committee in Common.

The process

Analysis of the internal and external environment

The analysis of the internal environment is in the form of a SWOT analysis and is available in the reading room. Undertaken by a working group of staff at deputy director level from across different disciplines within both Trusts, the Strengths, Weaknesses, Opportunities and Threats of each organisation were reviewed. The development of the strategic objectives focuses on how the strengths and opportunities can be maximised whilst addressing the threats and weaknesses.

The analysis of the external environment is in the form of a PESTLE analysis and examined the key factors influencing the Trust from a Political, Economic, Sociologic, Legal and Environmental perspective. This is with a view to the priorities being reflected within the strategic objectives.

Engagement

The Trust commissioned Deloitte to run the engagement for Our Strategy. As part of this, the following engagement activities have been undertaken:

Internal Engagement

- An initial engagement session with the Trust's Committee in Common which took place on 6th April.
- Eight internal engagement sessions (four at each Trust) available for all staff to attend, including options for a drop-in basis. The sessions ran at different times of the day and days to accommodate as many colleagues as possible.

- A session for the Committee in Common.
- A session for the subgroup of the Committee in Common
- Attendance at the Senior Nurses Group.
- A staff survey, for those colleagues who are unable to join the sessions but still wish to contribute their views.
- An internal survey offering colleagues the opportunity to vote on a new vision.

External engagement

- An engagement session with representatives from PLACE teams
- A session with the executive team from the ICS (as was)
- A session with the councils of Wolverhampton and Walsall
- A session with Healthwatch and service user groups across Wolverhampton and Walsall.
- An external survey for PLACE based colleagues in Walsall and Wolverhampton.
- Two public surveys for the wider public to contribute their views (one run by Deloitte and the other by Healthwatch).

The sessions were publicised through Trust Briefs, all user emails, diary invites, social media, peer to peer groups and specific meetings.

The detailed feedback from these sessions is contained within the report “PESTLE analysis and output of engagement activity” within the reading room.

Development of Strategic Options

The results of the engagement were presented back to the sub-group of the Committee in Common. The group agreed to continue the approach currently in Wolverhampton of having a set of strategic aims and supporting objectives. Four strategic aims (The Four Cs) have been devised that focus on what are considered the four priorities from the engagement undertaken. These are supported by more detailed strategic objectives with delivery plans underpinning these.

Completion of strategic narrative

A final draft of ‘Our strategy’ was them developed following completion of the narrative that describes our strategy.

Further engagement with all stakeholders

This final draft has been circulated to a wide variety of stakeholders including the public, colleagues, and system partners. The general consensus was that the strategy was focusing

on the right priorities and there was an appreciation of the engagement opportunities that had been offered.

Next Steps

Assuming approval from the Trust Board, ‘Our Strategy’ will be published publicly and communicated via the associated communications plan. In addition, a strategy oversight group will be set up (as a sub-committee of the Board) to oversee our progress against our strategic objectives.

Recommendation

The Trust Board is recommended to approve ‘Our Strategy’ for publication.

NHS

Our Strategy 2022-2027

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

Contents

Professor Steve Field CBE

Chair of the Board

Professor David Loughton CBE

Chief Executive

Where we are now

This five-year strategy is our first joint strategy for The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT). It reflects the closer working relationship between the two Trusts under the leadership of a joint Chair and Chief Executive. Uniting us is our shared vision to "To deliver exceptional care together to improve the health and wellbeing of our communities."

The strategy covers an extraordinary time in the history of the NHS as it continues to be heavily influenced by the COVID-19 pandemic. As well as continuing to meet the changing demands that COVID-19 places on us, we are also committed to recovering our services – specifically the waiting lists for planned care. The challenge in doing so cannot be underestimated. The physical and mental health of our colleagues continues to be challenged as a result of their tireless efforts throughout the pandemic, there is a national shortage of nurses and doctors and, unfortunately, we do not have the funding available to meet all of our aspirations.

Regrettably, we know that the communities of Wolverhampton and Walsall that we primarily serve often have poorer health outcomes than the nation as a whole and are characterised by some of the highest levels of deprivation. Life expectancy is generally lower and many risk factors associated with poor health (e.g. physical inactivity) are higher. Our challenge is the differing needs that come from the diversity of these communities and the health inequalities that exist. Understanding and implementing plans to address these inequalities remains a key area of focus for us.

Our response to the pandemic has demonstrated to us all the benefits of working together and these opportunities are reflected heavily within this strategy. The new Health and Care Act (2022) set out key changes to reform the delivery and organisation of health services in England. At its heart is the ambition to not only provide healthcare, but to work together with others to improve the health and wellbeing of our communities. As well as working more closely together, our Trusts are also strengthening relationships with other healthcare providers within the Black Country at a PLACE based level.

We have a lot to be proud of and to be excited by. As integrated providers of acute, community and primary care services we have the opportunity to effect change across the entire patient journey. Our hospitals provide a wide range of varied and specialised services that make us attractive to new staff and we have a history of innovation that ranges from the introduction of a Clinical Fellowship Programme to the construction of a solar farm.

At the same time, we aspire to improve further. The pandemic has resulted in increased waiting times and our capacity to reduce these is constrained. We are also seeing a significant increase in patients who need unplanned treatment which, combined with insufficient social care capacity, is causing pressure on the flow through our hospitals.

The following pages outline our strategy for the next five years and how we will realise our strategic ambitions.

Where we want to get to

Strategic Framework

Our strategic framework encompasses the key components of our strategy and the relationship between these are reflected within the diagram below.

Vision

Our vision is to 'To deliver exceptional care together to improve the health and wellbeing of our communities'. Our vision has been updated to reflect the closer working of our organisations and to focus on our core purpose of improving the health and wellbeing of our communities.

A vision is more than a few words – it reflects our aspirations, helps to guide our planning, support our decision making, prioritise our resources and attract new colleagues.

Strategic Aims and Objectives

Our strategy is based around four strategic aims - referred to as the Four Cs.

Care	Excel in the delivery of **Care**
Colleagues	Support our **Colleagues**
Collaboration	Effective **Collaboration**
Communities	Improve the health and wellbeing of our **Communities**

Our strategic aims reflect our four key areas of focus and consider the key influences from the environment within which we operate.

Our aims incorporate feedback from colleagues working for both organisations as well as the public and external stakeholders, e.g. the Integrated Care Board and other providers.

Our strategic aims are underpinned by strategic objectives (detailed later in the document) – these are more specific measures which we use to judge our achievement.

Values

Our values reflect the culture we want to create and inform the behaviours we wish to demonstrate. The two Trusts have their own set of values (shown in the two images below), which were developed and co-produced with our colleagues. Over time we expect to move to a common set of values that covers both Trusts.

WHT Values

RWT Values

Our Values		
Safe and Effective We will work collaboratively to prioritise the safety of all within our care environment.	**Kind and Caring** We will act in the best interest of others at all times.	**Exceeding Expectation** We will grow a reputation for excellence as our norm.

This is an artist's impression of the new £40m Urgent and Emergency Care Centre at Walsall Manor Hospital, being delivered by Tilbury Douglas Construction Limited. The new building will house an Urgent Treatment Centre, Emergency Department for adults and separate Children's ED, co-located Paediatric Assessment Unit, and an Acute Medical Unit with 45 beds. It also makes provision for Frailty and Community Integrated Assessment services. #BuildingOurFuture

How we will get there

Strategic aims and objectives

Our strategic aims and objectives are the means to achieving our vision. We have refreshed these to ensure they remain relevant and fit for purpose. In doing so, we have moved to a single set of strategic aims and objectives across the two Trusts. They comprise a tiered approach with high level, long-term aims that are underpinned by more specific objectives.

Given the breadth of work, detailed delivery plans are used within the organisations to assess the performance and ensure we are delivering our aims and objectives.

Our strategic aims revolve around four Cs – **Care**, **Colleagues**, **Collaboration** and **Communities**. We see these as being the key areas of focus for us over the next five years in the achievement of our vision. These areas have been prioritised following an analysis of the environment with which we are operating in and after discussion with internal and external stakeholders.

The four Cs are interconnected; we must make improvements in all areas if we are to deliver our vision. The graphic to the right outlines our strategic aims and their supporting objectives.

Excel in the delivery of Care

We will deliver exceptional care by putting patients at the heart of everything we do, embedding a culture of learning and continuous improvement.

- We will embed a culture of learning and continuous improvement at all levels of the organisation
- We will prioritise the treatment of cancer patients, focused on improving the outcomes of those diagnosed with the disease
- We will deliver safe and responsive urgent and emergency care in the community and in hospital
- We will deliver the priorities within the National Elective Care Strategy
- We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations

Support our Colleagues

We will be inclusive employers of choice in the Black Country that attract, engage and retain the best colleagues reflecting the diversity of our populations.

- Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff
- Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing
- Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged
- Deliver year on year improvement in Workforce Equality Standard performance

Improve the health of our Communities

We will positively contribute to the health and wellbeing of the communities we serve.

- Develop a strategy to understand and deliver action on health inequalities
- Achieve an agreed, Trust-specific, reduction in the carbon footprint of clinical services by 1st April 2025
- Work together with PLACE based partners to deliver improvements to the health of our immediate communities

Effective Collaboration

We will provide sustainable healthcare services that maximise efficiency by effective collaboration with our partners.

- Work as part of the provider collaborative to improve population health outcomes
- Improve clinical service sustainability by implementing new models of care through the provider collaborative
- Implement technological solutions that improve a patient's experience by preventing admission or reducing time in hospital
- Progress joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes
- Facilitate research that establishes new knowledge and improves the quality of care of patients

What we will do

Excel in the delivery of **Care**

The primary purpose of both Trusts is to provide a high-quality service, free at the point of delivery and available to everyone who needs it. The delivery of high-quality care is the foundation of everything that we do and is what defines us. It is also a moving target as we strive to continuously improve. Our Quality and Safety Enabling Strategy provides further detail on our journey towards providing exceptional, safe and clinically effective care. To meet this ambition, we have identified the following specific objectives:

1. **We will embed a culture of learning and continuous improvement at all levels of the organisations.**
   Utilising the Trusts' Quality Improvement teams, we will embed a culture that is focused on learning and striving for continuous improvement, involving patients in this process. We will support our colleagues by equipping them with the tools to systematically learn, measure and monitor quality at all levels of the organisations.
2. **We will prioritise the treatment of cancer patients, focused on improving the outcomes of those diagnosed with the disease.**
   One of the highest clinical priority groups of patients are those on a cancer pathway. We will continue to prioritise the treatment of cancer patients at a time when the number of patients seen following an urgent suspected cancer referral is at a record high. Working together with other providers in the healthcare system, our ambition is to diagnose more people with cancer at an earlier stage given the positive impact this has on a patient's outcome.
3. **We will deliver the priorities within the National Elective Care Strategy.**
   The pandemic has had a significant impact on the delivery of planned (elective) care and, as a result, on the lives of many patients who are waiting for treatment. Over the next three years, we will work to address the backlogs that have grown during the pandemic and are expected to grow further before reducing. This will focus on treating patients in order of clinical priority, increasing activity, and transforming services.
4. **We will deliver safe and responsive urgent and emergency care in the community and in our hospitals.**
   At the same time as treating patients on planned pathways, we will ensure patients receive safe and timely unplanned care. At a time of significant pressures on unplanned care, we will strive to reduce long waiting times and work with our partnering organisations to improve the flow of patients throughout our hospitals.
5. **We will deliver financial sustainability by focusing investment on the areas that will have the biggest impact on our communities and populations.**
   Finally, appropriate financial investment can support the achievement of exceptional care. We must be realistic on the financial resources available to the NHS and the need to be efficient. Ultimately, we need to ensure we are financially sustainable and will achieve this by focusing our investment on the areas that have the biggest impact on our communities and populations.

Kerry finds her voice

A healthcare worker who was paralysed and left unable to speak says she owes her recovery to the specialist care she received at New Cross Hospital.

Kerry Williams was admitted in February this year. After an MRI and blood tests, doctors diagnosed Guillain-Barré syndrome which is a rare and serious nerve condition.

Kerry, 52, deteriorated rapidly and was admitted onto the Intensive Care Unit (ICCU). She then required a period of support from a ventilator as well as the placement of a tracheostomy and various other medical interventions.

She spent 76 days in ICCU. When she started to regain strength, she was introduced to the Speech And Language Therapy team, which is based on Critical Care.

Emily Davies-Veric, Advanced Practitioner Speech and Language Therapist - Critical Care and Tracheostomy, said: "When we met Kerry she was unable to use her voice.

"Facial weakness meant that Kerry was unable to mouth words. She was essentially, 'locked in' meaning that movement in her eyes was her communication."

Kerry, an assistant stroke practitioner in the community at The Royal Wolverhampton NHS Trust, said: ***"Not being able to talk or communicate was terrifying. I was so grateful to the speech and language team. The staff were first class."***

Treating the whole person

Our Walsall midwives delivered "amazing care" for a mum going through a traumatic birth.

Shauni Sibley, aged 28, had the condition polyhydramnios which is the excessive accumulation of amniotic fluid – the fluid that surrounds the baby in the uterus during pregnancy.

Shauni said maternity services staff were mindful of her mental health - as she suffers from anxiety and depression – as well as her physical health.

She said: "The whole experience was traumatic but the care I received from the doctor and midwife before and after my c-section was amazing. The care I had from the midwives afterwards was brilliant too.

"The level of care I received was extraordinary."

Support our Colleagues

Delivering exceptional care starts with exceptional people. Our People and Organisational Development Enabling Strategy details our plans for supporting our colleagues. We are committed to supporting them to reach their potential and deliver exceptional care. This encompasses our efforts to look after our colleagues, improve the feeling of belonging within the NHS and promote diversity; working differently and growing for the future.

We have outlined our specific objectives to judge our success:

1. **Be in the top quartile for vacancy levels across the organisations, recruiting and retaining staff.**
   The availability of skilled colleagues is arguably the most significant challenge facing the NHS. It is imperative, therefore, that we do all that we can to attract staff to our Trusts and retain them thereafter. We aspire to be in the top quartile of Trusts across the country with the lowest vacancy levels.
2. **Deliver year on year improvements in the percentage of staff who consider the organisation has taken positive action on their health and wellbeing.**
   The focus on colleagues' health and wellbeing is continuing from the height of the pandemic as we recognise the impact this ultimately has on the care we deliver. We will continue to implement actions to improve health and wellbeing from the conversations that take place with our colleagues. As we strive for continuous improvement we expect the NHS Staff Survey to show increasing percentages of staff who consider the organisation has taken positive action.
3. **Improve overall staff engagement, addressing identified areas for improvement where groups are less well engaged.**
   As with health and wellbeing, we recognise the association between the engagement of our colleagues and the care they deliver. We want to create an environment where staff feel empowered and supported to make decisions and deliver change.
4. **Deliver year on year improvement in Workforce Equality Standard performance.**
   It is important that the diversity of the colleagues working within our hospitals reflects the diversity of the communities we serve. The Workforce Equality Standard gives us the ability to review and take action to address inequalities.

Boosting our teams with a successful recruitment drive

We have been giving a warm welcome to hundreds of international nurses who have boosted our teams across both Trusts.

More than 1,000 will have been recruited across the Black Country and West Birmingham by the end of this year - the largest ever such recruitment drive in the Midlands.

Organised through The Royal Wolverhampton NHS Trust, the campaign recruited more than 600 nurses from abroad in 2021, to work in locations across the Black Country and West Birmingham Integrated Care System.

The programme was developed to recruit nurses to help fill growing local demands, and it complements intensive efforts being made across the system to train and recruit more nurses locally. The initiative is called the Clinical Fellowship Programme.

Beatrix Feldman, 31, is a Sister at New Cross Hospital in Wolverhampton. She said: ***"The first few weeks were a bit of a blur, but the support I had from the management team and other colleagues was amazing and I was made to feel at home straight away."***

Fitting tribute to Leon

A new Clinical Suite for intravenous (IV) interventions has been opened in memory of Team Lead Nurse Leon Talbot, to support patients in Walsall's communities.

Leon was a much-loved and well-respected member of staff at Walsall Healthcare NHS Trust, who died last year following a short illness.

He was instrumental in the drive to establish a treatment room where patients, who would normally have to go into hospital for IV Iron Infusions, could be seen safely and much quicker in the community.

Donna Roberts, Deputy Director of Operations/Community Division for Walsall Healthcare NHS Trust, said: "Leon had been working closely with Dr Shelley Raveendran, Consultant in Acute Medicine, to develop a pathway that would allow this to happen.

"We named this new treatment room 'The Leon Talbot Clinical Suite' in his memory."

The Leon Talbot Clinical Suite is located at Hollybank House.

Rob Elson, Leon's partner, said: ***"He would have been so proud for this to happen – he was always talking about ways to keep people out of hospital. It's a lovely, long-lasting legacy."***

The new pathway was developed as part of the work led by the Walsall Together Partnership.

Effective Collaboration

The new Health and Care Act (2022) sets out key changes to the way in which the health and care sector is structured. The key change relates to the way in which organisations work together with a significant emphasis on greater collaboration. It is expected that this collaboration will ultimately lead to an improvement in the care we deliver to our patients by delivering services in a more seamless and impactful fashion.

The new Act dictates three main forms in which Trusts will collaborate:

1. As part of an 'Integrated Care System' (ICS) where a collaboration of hospitals, GPs, social care and others work together to improve local services and make the best use of public money.
2. As part of a 'Provider Collaborative', where providers from across the Black Country will work together to better deliver health services.
3. As part of PLACE teams where town and neighbourhood teams work to improve care within local areas, e.g. Walsall and Wolverhampton.

These are in addition to the closer working that is already taking place between our Trusts.

We have identified five main objectives to measure the success of our collaboration efforts:

1. **Work as part of the provider collaborative to improve population health outcomes.**
   Ultimately, our core purpose is to improve the health of our communities. We strive to increase their life expectancy and reduce the inequalities that we know exist. As an integrated healthcare provider, this work involves our primary care practices and community services.
2. **To improve clinical service sustainability by implementing new models of care through the provider collaborative.**
   Rising demand, combined with a shortage of skilled colleagues in specific specialities has led to clinical services facing challenges to their sustainability. One of the benefits anticipated from working together is an improvement in service sustainability across the Black Country.
3. **Implement technological solutions that improve patients' experience by preventing admission or reducing time in hospital.**
   We know that technology exists that can support a patient to remain in their own home or to make their experience a better one when in hospital. We will focus our efforts on collaborating with providers who are able to support an improvement in our patients' experience and reduce the demand on our hospitals.
4. **Implement further joint working across Wolverhampton and Walsall that leads to a demonstrable improvement in service outcomes.**
   Under a shared leadership, we are committed to make the most of the opportunities of working together. We are confident that some of our individual and collective challenges can be better faced together. A programme of work is already in place and is expected to increase further over the life of this strategy.
5. **Facilitate research that establishes new knowledge and improves the quality of care of patients.**
   Research and Innovation is a core component of Trusts' activity and is key to making advancements in patient care. Clinical research is an essential requirement to improve knowledge and understanding of which treatments work best.

Teamwork to keep children healthy

With a little help from Wolves mascot Wolfie, Dental Health Specialist Caroline Bestwick is on a mission to get Wolverhampton's children smiling and avoid toddlers having their teeth taken out.

Working alongside the City of Wolverhampton Council and Public Health England, Caroline, from The Royal Wolverhampton NHS Trust, is campaigning for better oral health among children to avoid unnecessary tooth extractions.

She is targeting the 3,700 three-year olds across the city and visiting nurseries to distribute free dental packs, as well as talk to parents, staff and the children to educate them about their teeth.

Wolves Foundation is also involved through its Healthy Goals project, which works with pre-school children and their families to promote healthy growth through education and activity sessions.

"We're keen to support Caroline and the team with this initiative and cascade important messages about oral health to the families we work with in the city," said Jade Sutton, Health Officer from the Wolves Foundation.

Caroline said: "Currently, there are more than 150 children on the Special Care Dental Services waiting list for teeth to be extracted under general anaesthetic because of dental decay, which is preventable.

"So, it's about getting the key messages out to all to further help and educate people to make better, healthier choices from the start, for their oral health."

Improve the health and wellbeing of our **Communities**

The population we serve extends further than the patients being treated at our hospitals. In fact, the care that healthcare organisations give only accounts for a small element of a population's health outcomes with other factors such as living and working conditions having a greater impact. We will continue to work closely with colleagues from across our local authorities and the voluntary sector in recognition of this. As two of the largest organisations within our communities, we recognise the positive influence we can bring to bear. We can choose to spend our budget and employ locally, which will positively impact our communities and local economy. We also have a responsibility to manage the environmental impact that our organisations have on the living conditions of the area.

The following three objectives will be used to measure our success:

1. **Develop a strategy to understand and deliver action on health inequalities.**
   There are significant health inequalities within our population which have been both illuminated and exacerbated because of the pandemic. Understanding the reasons these inequalities exist is complex, but an area where we have already made progress. We will develop a strategy to fully understand these inequalities as well as identifying tangible actions that address them, alongside our colleagues in local authorities.
2. **By 1st April 2025, make a reduction in the carbon footprint of clinical services.**
   Climate change poses a major threat to our health. Tackling climate change through reducing harmful carbon emissions will improve health and save lives. In response to the health threat posed by climate change, the NHS became the world's first health service to commit to a target of reaching net-zero carbon emissions by 2040. In support of this, both Trusts will make a reduction in their carbon footprint by 2025.
3. **Work together with PLACE based partners to deliver improvements to the health of our immediate communities.**
   By working with our partners within our communities, we will strive to empower people to live a healthy life for as long as possible through joining up health, care and community support for residents and individual communities.

Shaping our services with Community Connectors

Our Walsall Together Partnership has secured £97,000 of funding to develop a team of up to 20 Community Connectors.

They will help reduce health inequalities and improve outcomes for people in Walsall, working with the borough's most vulnerable communities.

This means our health and wellbeing services will be based on what matters most to people and their community.

Michelle McManus, Director of Transformation for Walsall Together, said: "If we really want to reduce inequalities and remove barriers that prevent people from accessing health, care and wellbeing support, then we really need to be working with our most disadvantaged communities to find out how we can do this."

The Community Connectors programme is part of Core20Plus5, a national NHS England approach to support the reduction of health inequalities.

The connectors will be managed by Healthwatch Walsall.

Walsall Together
Collaborating for happier communities

Simon Fogell, Chief Executive of Engaging Communities Solutions CIC which delivers Healthwatch Walsall, said: "Recruiting Community Connectors from within communities is a great way of making sure that we are reaching those most in need, often living with long standing health inequalities, linking them to appropriate services, learning more about the challenges they face and how we can work as a partnership to address these."

Proud of our solar farm project

Work began last year on our new solar farm which will help to power the whole of New Cross Hospital.

This means we're the first NHS Trust in England to fully utilise and operate its own facility providing renewable energy.

The site is the size of 22 football pitches and around a ten-minute walk from the main hospital in Wednesfield.

It is estimated our solar farm will power the hospital for three quarters of the year – around 288 days of self-generated renewable energy.

This is in addition to existing green energy sources already in use at the hospital, including harnessing heat from a waste incinerator and a combined heat and power system, with most of the imported electricity coming from the solar farm.

The new solar farm will save the Trust around £15 million-£20 million over the next 20 years – around £1 million a year: money which will be put back into frontline healthcare.

Councillor Steve Evans said: "The start of works on this pioneering solar farm in Wolverhampton demonstrates our commitment to climate change which is critical to protect our planet for generations to come.

"Since declaring our Climate Emergency in July 2019, the council has been supporting its partners towards making Wolverhampton zero carbon. I'm pleased to see the council supporting the local hospital in achieving its ambitions to reduce carbon emissions in the city."

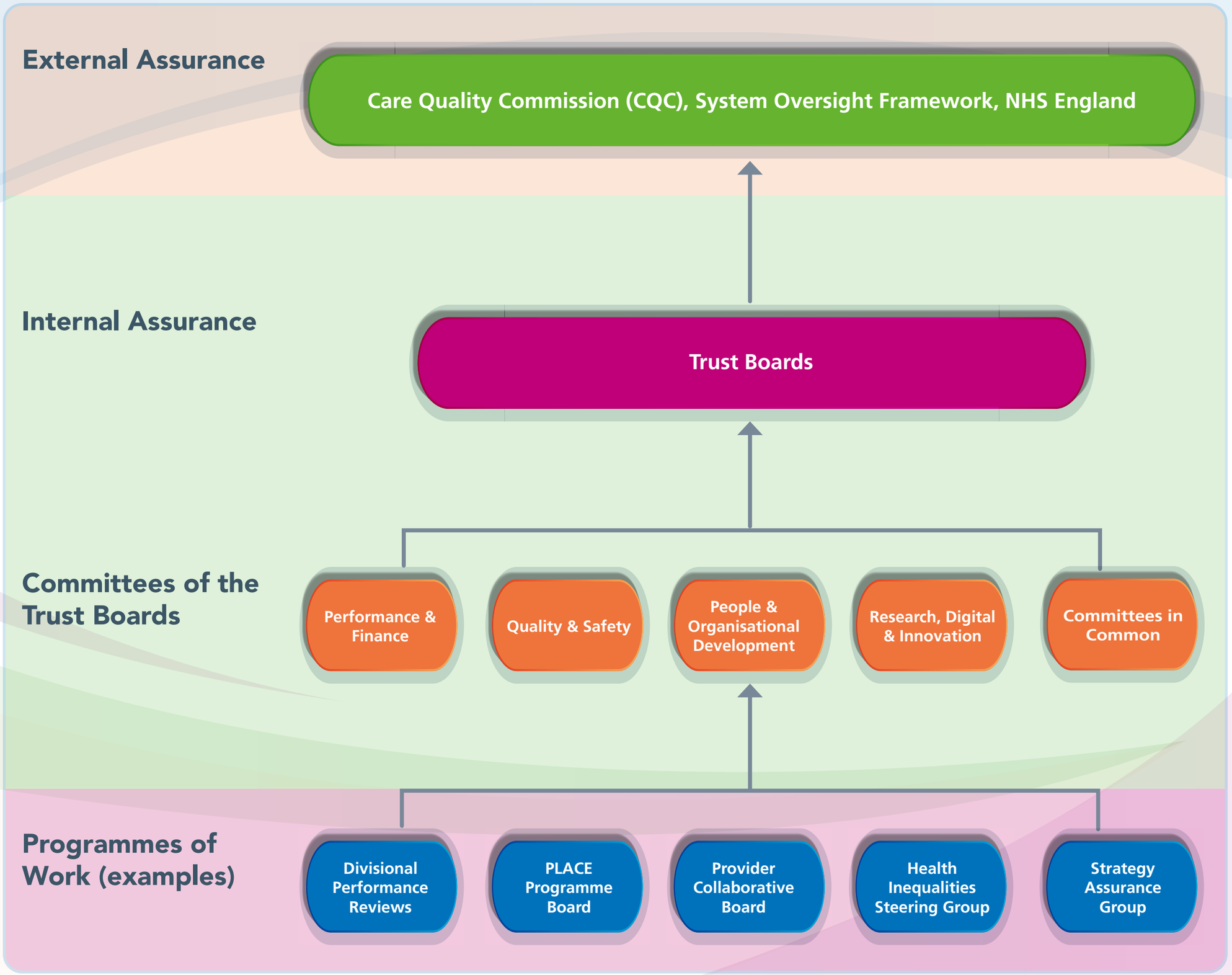
How we will know we have succeeded

Our governance process sets out how we will monitor the delivery of our strategy. Our governance flows from the external mechanisms, such as Care Quality Commission reviews or NHS England's System Oversight Framework, to our internal assurance mechanisms such as our Board, our sub-committees and through to our key programmes.

It will be the role of the sub-committees of our Trust Boards to routinely monitor the achievement of our strategic aims and objectives, reporting into the Trust Boards. On a six-monthly basis, the strategy assurance group will report to the Committee in Common on progress against our strategy.

Strategic Delivery Plans will cover the detail of 'how' strategic objectives are being achieved. These will underpin our strategic aims and objectives and be reported to the sub-committees of the Boards.

The focus of the structure opposite is on the internal governance of the Trusts, reflective of the ownership of 'Our Strategy'. The Trust sits within the Black Country health system which has its own governance structure.



Designed and produced by the Department of Clinical Illustration, The Royal Wolverhampton NHS Trust

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Joint Trust Strategy: Communications Plan to launch 4 Cs

September 2022. V1

Sally Evans
Group Director of Communications and Stakeholder Engagement

Working in partnership
The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

Background

The Trust Boards of both organisations previously approved the extensions of the Trust's current strategies to allow time for the development of a single, joint strategy. Alongside this was the request for the Committee in Common to oversee its development.

'Our strategy' has now been finalised with the attached document having been through successive rounds of engagement before being recommended for approval by the Committee in Common.

The campaign

This is the first large scale piece of work the two Trusts have done since moving into a group model, and sets the strategic direction for the next five years. It is key that our staff, patients, stakeholders and wider communities are clear on our approach and key areas of focus.

This communications plan aims to increase awareness of the joint Trust Strategy revolving around the four Cs – Care, Colleagues, Collaboration and Communities.

The awareness campaign will provide clear and accurate information:

- **STAFF:** informing about new joint strategy, the four Cs, what each of them mean and how their role is linked to each of them as well as understanding the Trusts' direction of travel and embedding them into every day life.

- **PATIENTS / COMMUNITIES:** informing via awareness of our commitment to them, how we will continue to make improvements in all areas by delivering against our strategic aims.

- **STAKEHOLDERS:** informing our key stakeholders how the two Trusts are coming together under a key vision, with a single set of key strategic aims, which have been prioritised following analysis of the environment and engaging with both internal and external stakeholders.

The campaign will launch week commencing 10th October.

Barriers / challenges

For staff:

- Staff may be overwhelmed by information at present and may struggle to absorb the detail
- Not all staff regularly access a computer to see key updates about joint strategy
- Strategy is not a very people friendly word – staff on the engagement exercise thought it sounds "boring and corporate" so will need to work hard with the messaging to get staff to 'buy in'
- Resistance from staff who are not embracing the new collaborative way of working
- Negativity from staff who say "We've seen it all before"
- Some staff can't read

- Some managers are poor communicators and do not cascade information
- Early winter pressures/competing engagement such as UECC work will affect this

Patients / Communities:

- Patients may not understand how the two Trusts are working together
- Communities may not be open to the group model of both organisations
- To the average service user the word strategy doesn't mean anything so there will be a strong focus on the language we use – a clear emphasis will be on promoting the four Cs
- Different languages in different communities or those who are sight impaired – will be developing easy read material and translated versions of content

Analysis / opportunities

- Regular communications and engagement with staff to talk about the strategy, highlighting the four Cs – builds relationship with staff face to face rather than just through digital channels
- Builds stakeholder relationships when describing the vision and strategic aims with key partners
- Demonstrates to our communities that we have listened and value their input into shaping the strategy

Objectives and stakeholders

SMART objectives:

- ✓ By end of October 2022, a series of internal roadshows will have been held with staff promoting the four Cs
- ✓ By December 2022, track digital channels and measure how staff interact with posts related to the four Cs
- ✓ By April 2023, staff will recognise and understand the strategic aims

Key stakeholders

All staff

The messages should land directly with each member of staff, highlighting the single strategy across both organisations and the four Cs, a s The call to action will be to:

- Engaged staff understanding what each of the four Cs means how their role fits within each of the Cs.

Managers (cascading and insight is crucial to success)

Managers will be expected to:

- make sure their teams are aware of the new strategy
- provide opportunities for staff to read and learn more about it

We will utilise down-up communication methods where managers will cascade messages to teams, while simultaneously gaining feedback and suggestions that can be passed back to us so that we can respond / shape the ongoing campaign.

RWT and WHT Executives

Executives will need to be the ambassadors of the joint Strategy, promoting the four Cs at every opportunity. Executives will be given information to support them in doing this.

High level activities

The campaign will be launched October following approval at both Trust Boards.

Due to the nature of the campaign, this will be both digital and paper to maximise the reach.

Earned channels

- **Press releases** to be shared with local media outlets, highlighting the good work going on across both organisations aligning the work to each of the four Cs.

Owned channels

- **News stories** – including showcasing our staff, the care that we provide, and how the collaboration is working
- **Social media graphics** to be shared, both in the closed staff Facebook and across the public social media sites
- **David's Despatch**
- **Screensavers –** a suite of screensavers detailing the four Cs
- **Intranet page** to detail the strategy, the new joint vision and four Cs
- **Public website update –** to highlight the strategy, the new joint vision and four Cs
- **Updates on the 'Reach' app**
- **Email updates via Dose and Trust Brief**
- **Animation**
- **Video clips**

Shared channels

- With enough traction, social media posts (on the public site) should be shared by staff members on their personal profiles and therefore giving us more exposure
- Further exposure will be given if shared by the ICB

Hard copy materials

- A suite of posters
- Pull-ups
- Pens
- Lanyards
- Features in Trust Connect and Trust Talk (the Trust's quarterly newsletters)

Workin

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
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Collaboration Communities

Working in partnership

The Royal Wolverhampton NHS Trust
Walsall Healthcare NHS Trust

Care Colleagues
Collaboration Communities

Face-to-face

- Engagement sessions in key areas across the hospital sites, community settings and primary care
- Team brief sessions (held virtually)

Digital media

- Social media
- Intranet
- Email
- Email signature
- Powerpoint
- Website

External engagement / shared media

- Website
- Press releases
- Stakeholder briefings – i.e. Health and Wellbeing Boards

Examples of activities

- Visible leaders promoting the new vision, four Cs
- Chief Executive push – David's Despatch and Team Brief
- Social media content – linking stories to the four Cs
- Photos / videos of staff promoting their supporting the four Cs
- New vinyl / posters displayed across the organisations
- Suite of templates – used for board and committee papers

Resources and budget

The communications plan will be delivered by utilising existing resources and channels. However, there will be a need for printed materials. To support that there have been clear efforts to negotiate efficient and economic solutions to deliver an impactful launch of 'Our Strategy'.

Utilising existing resources / channels

- Social media use
- The campaign will be led by the Trust's own Campaigns and Project function (based within Communications)

- All photography and videography will be provided by the inhouse and therefore this will incur no extra costs.
- The Digital function will develop our intranet page on our existing content management system (without the need to out-source web design) and the graphic designers in Clinical Illustration will provide artwork for free.
- Engagement sessions will be hosted in Trust spaces and therefore no cost will be incurred

Evaluation

I've suggested some ways we can evaluate our SMART objectives but aside from this:

Metrics:

- Engagement with posts on social media - comments, likes and shares
- Engagement with staff
- Hits on the relevant intranet news post / web pages
- Number of times a press release / new story has been picked up by the media and the wider reach on social media (plus reviewing the comments)
- A poll to be carried out with staff to determine if the messages have landed

It is key to note that this is not just a communications plan to support the week of launch. This will be an ongoing roll-out of the four Cs.

Walsall Healthcare NHS
NHS Trust

Integrated Quality & Performance Report

August 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 92.6%, an increase in compliance from 88.9% in July 2022. Divisional teams continue to report on their performance and improvement plans into Patient Safety Group (PSG). • The prevalence of timely observations in August 2022 was 80.13%. Changes have been made to the thresholds for late observations which has seen a significant drop in compliance. • Falls per 1000 bed days was 3.85 in August 2022 and in line with the previous consistent performance. • The Trust target for Clostridium difficile 2022/23 has been set at 27 cases with 2 C.Diff cases reported for August 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 77.55% by E-sepsis in August 2022. • 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 18 out of the last 19 months. This has been achieved despite continuing to support neighbouring Trusts with a record high 155 out of borough ambulances intelligently conveyed to Walsall in August. • 4-hour Emergency Access Standard performance in August was 74.25% of patients managed within 4 hours of arrival. WHT's national ranking has improved to 30th out of 110 Acute Trusts. • In July 2022, for 62-day Cancer performance the Trust was materially better than the West Midlands average (50%) and better than the national average (61.69%) with 64.4% of our patients treated within 62 days of GP referral • The Trust's 6 Week Wait (DM01) Diagnostics performance is 37th best (July 2022 reporting), out of 122 reporting acute Trusts. Cardiac Physiology and Endoscopy services have both experienced challenges (increased referrals and decreased capacity due to sickness and vacancies in Cardiac Physiology's). The Trust's performance in August 2022 is that 22.64% of patients are waiting over 6 weeks. • The Trust's 18-week RTT performance remains consistent with trajectory with 60.54% of patients waiting under 18 weeks at the end of August 2022, the national ranking position is stable at 68th (out of 122 reporting Trusts) for July 2022. The Trust's 52-week waiting time performance slipped to 8th best in the Midlands (out of 20 Midlands Trusts). The Trust now has 1082 patients waiting in excess of 52-weeks. • 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. Mutual aid has been provided from Royal Wolverhampton Trust and extended to include Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust
WORKFORCE	**FINANCE**
• Aug-22 sickness absence compares favourablely year on year. Long-Term episodes continue to increase, now accounting for 76% as a proportion of all sickness absences. • Mandatory training compliance remains stable just below the 90% target. Compliance remains stable, with Safeguarding Adults Level 3 (80%) and Adult Basic Life Support (70%) competencies key outliners. E-Learning completion rates remain noteably high. • PDR compliance has consolidated at 24 month average levels. PDR compliance remains relatively high amongst clinical and estates colleagues (an 82% average) but continues to decline amongst Admin & Clerical colleagues (72%).	• The Trust enters 2022/23 with clear risks to revenue and capital, income reduced by 57% of Covid-19 resource and an efficiency ask. The 2022/23 financial plan requires the Trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure • The Trust's month 5 Year to Date deficit is £2.506m which is £4.601m adverse to plan, drivers being increased temporary workforce and shortfalls in savings / efficiency delivery. The Integrated Care System for the Black Country reporting a £36m deficit (£27.9m adverse to plan) but all organisations continue to forecast break even at full year. An initial modelling of run rate indicates a risk for the Trust of an £8.7m deficit in year, with a forecast outturn to include mitigations (best/likely/worst) under construction that will be included within a system forecast outturn for the financial year in December 2022, Finance supporting production with Operational and Clinical colleagues and the forecast outturn to be endorsed by Executive, Trust management Committee and then presented to Trust Board at the December 2022 meeting prior to sharing with system partners. • The total capital programme for 2022/23 totals £38.188m. However there remain a £4m gap in funding the programme, with further meetings progressing with regional and system colleagues to identify a route to financing the shortfall.

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	23rd September 2022
Chair of Committee/Group:	Dr Julian Parkes
Date of Report:	23rd September 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• 2 week wait for suspected breast cancer and symptomatic breast pathways continue to challenge. Only 11.8% of patients were seen within the 2 week window in July 2022. Booking times in September are around 3 weeks. Mutual aid from surrounding Trusts and mitigations are being applied • The national shortage of Health Visitors continues to be reflected locally with a 50% vacancy rate and this is affecting service provision • Stage 2 Mental Capacity Act compliance shows a significant fall from 71% to 38.89% and 26.09% in July and August. It is not clear why this is the case and an urgent investigation is taking place. The target in 100% • Prevalence of timely observations is slowly climbing to 77.23% and 80.13% in July and August • Level 3 children's and adult's safeguarding remains below target. Additional training is being provided • Staffing in maternity continues to a challenge with short term illness and rising maternity leave
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• Waiting times for domiciliary phlebotomy have decreased and the routine waiting time is now 4 days but urgent bloods can be done before then. • VTE Compliance is below target at 88.9% and 92.6% but is improving following a series of audits • One hour antibiotic times were achieved in 77.5% in ED and 80% inpatients in August • The 18-week RTT performance remains in line with trajectory, although the number of patients waiting over 52 weeks is not yet reducing. 1082 patients are currently waiting over 52 weeks (8th best in the Midlands out of 20 Trusts) • Falls per 1000 bed days was 5.12 in July and 3.85 in August (June 3.68%) • Maternity Services have declared compliance with 7 out of 10 of CNST safety actions and is on track to complete the remaining actions • Work is being done to identify what data needs to be collected to deliver the CQUIN targets for 2022/23

ASSURE **Positive assurances & highlights of note for the Board/Committee**	• Ambulance hand over times continue to be the best in the West Midlands • 74.25% of patients were managed within 4 hrs in ED, making it 30th out of 109 reporting Trusts in the West Midlands. This is on the background of an 8.3% rise in attendances in August 2022 compared with August 2021 • 64.42% of patients are seen within the 62 day performance target for cancer, which is better than both West Midlands and national performance • Following recruitment into the Paediatric Diabetes Service, the corporate risk associated with this has been de-escalated • Performance remains strong in the Community Based Hospital Avoidance and Step Up bed service • Total number of hospital acquired pressure ulcers has decreased in July and August • A review of those waiting for more than 104 days for definitive cancer treatment has found no evidence of harm • SHMI is 116 but falls to as expected when deaths in the attached Goscote Hospice are excluded
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 • Constitutional Standards and Acute Services Restoration and Recovery • Community Services Report • Safe High Quality Care Oversight report • Maternity Services update • Serious Incident Update • Clinical Audit validation report • Safeguarding update • Mortality and SHMI report • 104 day harm update • CQUINs update • Electronic Discharge Summary update
Matters presented for information or noting	
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of Reference received
Items for Reference Pack	•

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	Aug-22	2	2	27	?	
No.	MRSA - No. of Cases	Aug-22	0	0	0	?	
%	VTE Risk Assessment	Aug-22	92.53%		95.00%	?	
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Adults	Aug-22	77.55%		90.00%	F	H
%	Sepsis - ED - % of patients screened who received antibiotics within 1 hour - E-Sepsis Module - Paeds	Aug-22	20.00%		90.00%	F	
No.	Falls - No. of falls resulting in severe injury or death	Aug-22	0	0	0	?	
Rate	Falls - Rate per 1000 Beddays	Aug-22	3.85	6.10	6.10	?	
Ave	National Never Events	Aug-22	0	0	0	?	
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Hospital Acquired	Aug-22	10				
No.	Serious Incidents (inc cat 3 & 4 pressure ulcers, HCAI's & Falls) - Community Acquired	Aug-22	0				
Rate	Midwife to Birth Ratio	Aug-22	31.5	28	28	?	
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Hospital	Aug-22	8				
No.	Pressure Ulcers (category 2, 3, 4 & Unstageables) - Community	Aug-22	14				

Metric Name: Clostridium Difficile - No. of Cases

MONTH

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

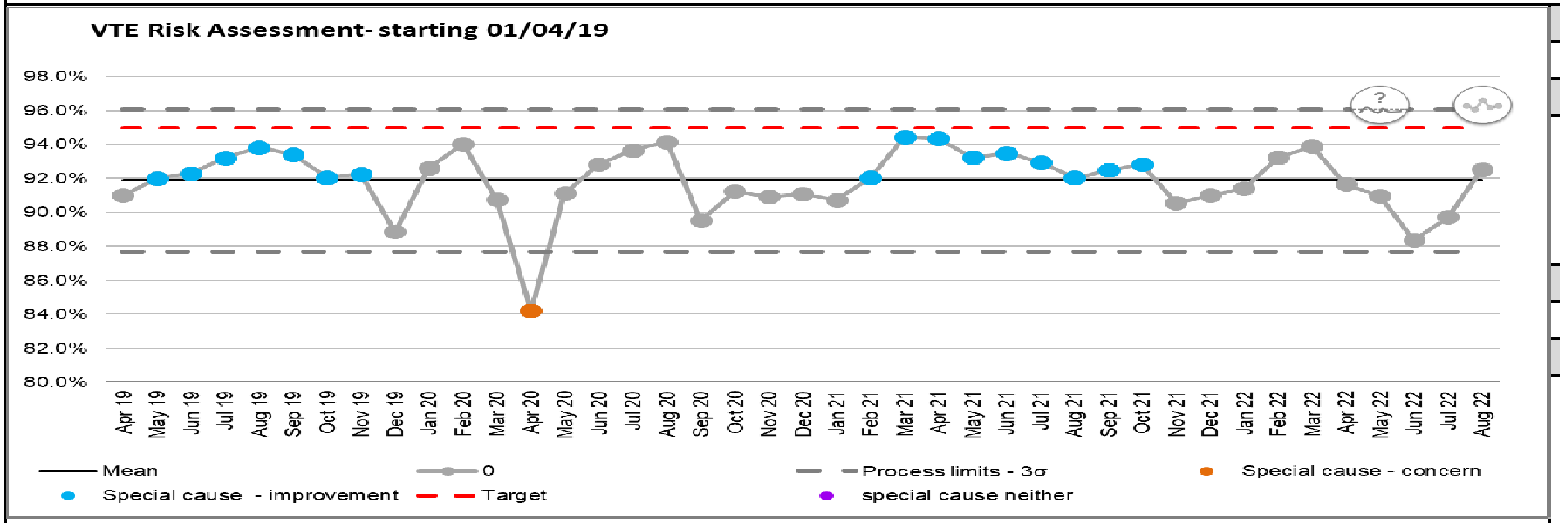
CUMULATIVE

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

Month
Aug-22
Variance Type
Target
27
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.	2 case of C.Diff was reported in August 2022, review of the case has found that the use of antibiotics was justified.	None required	N/A

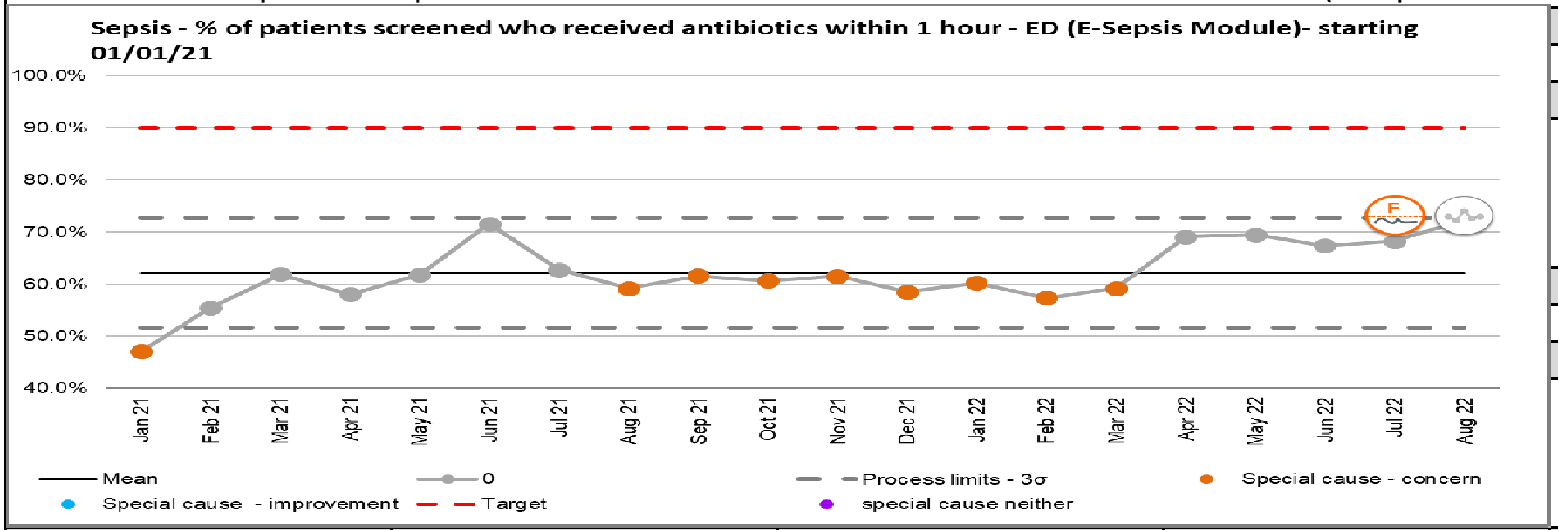
Metric Name: VTE Risk Assessment



Month
Aug-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 target of 95% and within normal variation. Encouraging to see last two months have improved with August at 92.53% which is above the average of 92%.	The timeliness of completing the initial assessments continues to be the main issue. 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) - Adults



Month
Aug-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 (Adults)	The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department in August 2022 was 77.6%. The data shows improving statistical variation and has been above the mean for the last 5 months.	The previously reported concers regarding the accuracy f the E-sepsis data hav been resolved with validation of data from the Sepsis team. Focus on staff training.	The PBI report has been refreshed to focus on the Antibiotics within the hour. Training on vitals to be refreshed. 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
Committee Chair's Assurance Report

Walsall Healthcare NHS Trust

Name of Committee:	**Performance and Finance Committee**
Date(s) of Committee Meetings since last	**Wednesday 31st August 2022**
Chair of Committee:	**Paul Assinder, Non-Executive Director**
Date of Report:	**Wednesday 31st August 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 deficit of £1.6m at month 4, resulting in the Trust being off plan by £2.9m. The report contained a forecast, based on current run rates, that indicates an unmitigated deficit of £8.7m outturn to 31st March 2023. • The ICS has reported a £27m deficit year to date, adverse to plan by c£17m. The performance of the ICS and risk share signed up to by the Trust, introduces further risk to attainment of our financial plan. • The ICS is currently modelling a £100m normalised deficit, the Trust is £15m of this system risk. This will result in resources being constrained for the 2023/24 financial year, and lead to difficulty in endorsement of models of care within available resources for the next financial year. • Cost Improvement Plan schemes increased to £5.8m, against a target of £6.3m. There are a number of red and amber rated schemes. Savings also back phased (delivery largely in the latter half of the financial year). • Agency usage remains above planned levels (Nursing & Medical). • Funded to 104% of 2019/20 elective performance, the Trust is significantly below this funded level. Whilst confirmed there will be no clawback during 2022/23, it is unlikely the Trust will earn further income in year. • The allocation of funding for the 2022/23 national pay award had not been confirmed, prior to confirmation of funds to the Trust this remains a risk. **Capital** • The Trust has yet to secure the funds required to deliver the theatres capital scheme. However, discussion is continuing 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. The current construction industry's prevailing conditions are giving both delays and cost increases, that are requiring careful management and present a real risk to overspend and delay in handover. **Performance Issues** • The Trust continues to have strong ambulance handover. However, mutual aid charging at less than 133%, Histology performance and vacancies in Health Visiting were debated as concerning by members.
ADVISE **Areas that continue to be reported on and / or where some**	**Financial Performance** • Agency costs are reducing month on month owing to successful overseas recruitment drives within Nursing, detailed plans for cessation of Nursing agency have been provided to members.

assurance has been noted / further assurance sought	• Agency targeted reductions have been set at 30% of historic levels by ICS, the reduction for Walsall aligns to the plans put forward. However, the Trust continues to commit resources beyond these planned levels for both Nursing and Medical staffing. **Performance** • Performance remains strong from the Community Division, but concerns were raised in relation to the rise in referrals for patients with complex needs, levels of medically fit for discharge and Health Visiting staffing levels. • The Community Services Division has bid for additional resources for virtual wards. Confirmation of the bids are expected in September 2022. • 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. • Walsall's Community Services have been shortlisted for national exemplar status for discharge practice. • The Committee received the backlog maintenance report that identified £37m worth of maintenance for the Walsall site inclusive of the PFI and non-PFI buildings. The report was prepared by Skanska's surveyors but was being reviewed by the Estates leadership teams. • Concerns continued on the 2 weeks suspected Breast Cancer delays as the targets were not being achieved despite additional effort and mutual support. **Emergency Preparedness Resilience and Response** • The Committee received the self-assessment at 'substantial compliance' and the report and self-assessment was endorsed by members. The overall rating is subject to potential change following review by NHSE/I colleagues.
ASSURE **Positive assurance & highlights of note for the Board / Committee**	**Revenue** • The Trust has now attained all financial performance targets for the past three financial years. **Capital & Cash** • The Trust has delivered two theatres full upgrade's, four ward refurbishments and continues to conclude work on the development to open in year the new Emergency Department • The Trust has a strong cash position moving into the 2022/23 financial year. **Performance** • Performance on the 62-day standard was performing better than the West Midlands and National average. • Diagnostic access remained in the upper quartile but Cardiac Physiology and Endoscopy waiting times were providing challenging.
Recommendation(s) for the Board	Board to note: • The Trust has a deficit of £1.6m and is off plan by £2.9m, driven largely by temporary workforce increased costs, overspends and Cost Improvement Programme shortfalls. • A forecast based on current run rate has been produced, indicating a deficit outturn to 31st March 2023 (without mitigation) totalling £8.7m. • The forecast for the Trust is a deficit position based on current run rate of £8.7m, reducing to £4.5m subject to the pace of agency reduction, delivery of the CIP position and avoiding activity related pressures. • Further risks remain regarding ICS financial position of a £27m deficit (£17m adverse to plan) and the recent pay award funding yet to be

	confirmed. • The capital programme is in risk of breach owing to the Theatres scheme having no confirmed funds and the current economic climate resulting in cost increases and delays to scheme completion
Changes to BAF Risk(s) and 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.
ACTIONS Significant Follow Up	A forecast model is to be produced for next Committee, indicating mitigations following engagement with the Operational teams on future run rate and mitigations to cost overruns, results to be presented to Trust Board.
ACTIVITY SUMMARY Major items discussed including those Approved	• Financial deficit year to date (Trust and system) with impact on this and next financial year budgets • Risk to breach of capital allocations in year • EPRR self-assessment endorsed by members • Backlog maintenance reviewed, low levels of high-risk areas and a provisional value of £37m of backlog works highlighted (under review by the Estates leadership)
Matters presented for information	BAF and CRR relative to committee and business cycle
Future Work Plans	
Items for Reference	Not applicable

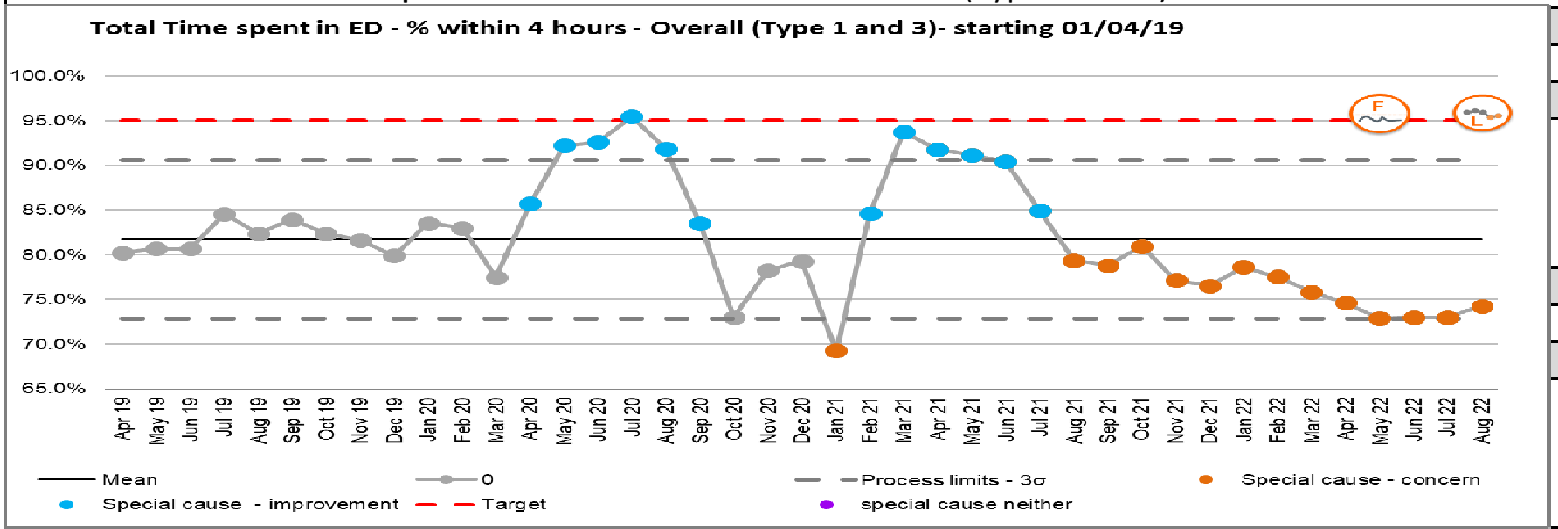
Walsall Healthcare NHS
NHS Trust

P&FC

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
PERFORMANCE, FINANCE & INVESTMENT COMMITTEE							
%	18 weeks Referral to Treatment - % within 18 weeks - Incomplete	Aug-22	60.54%	59.87%	92.00%		
No.	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete	Aug-22	1082	950	0		
%	Ambulance Handover - Percentage of clinical handovers completed within 30 minutes or recorded time of arrival at ED	Aug-22	89.14%		95.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment	Jul-22	75.00%		93.00%		
%	Cancer - 2 week GP referral to 1st outpatient appointment - breast symptoms	Jul-22	11.76%		93.00%		
%	Cancer - 62 day referral to treatment from screening	Jul-22	88.89%		90.00%		
%	Cancer - 62 day referral to treatment of all cancers	Jul-22	64.38%		85.00%		
%	% of Service Users waiting 6 weeks or more from Referral for a Diagnositc Test	Aug-22	22.64%		1.00%		
%	Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)	Aug-22	74.25%	84.00%	95.00%		
%	Locality Teams - % of Hours Demand Unmet	Aug-22	11.42%		20.00%		
Ave	MSFD - Average number of Medically Fit for Discharge Patients in WMH	Aug-22	52		50		
%	Rapid Response - 2 Hour Response Rate	Aug-22	89.50%		95.00%		

		Reporting Period	Actual	Trajectory	2022/23 Target	SPC Assurance	SPC Variation
%	Rapid Response - % Admission Avoidance	Aug-22	90.20%		87.00%		
£	Total Income (£000's)	Aug-22	30700	See Financial Performance for further detail			
£	Total Expenditure (£000's)	Aug-22	31600	See Financial Performance for further detail			
£	Total Temporary Staffing Spend (£000's)	Aug-22	3800	See Financial Performance for further detail			
£	Capital Expenditure Spend (£000's)	Aug-22	2400	See Financial Performance for further detail			

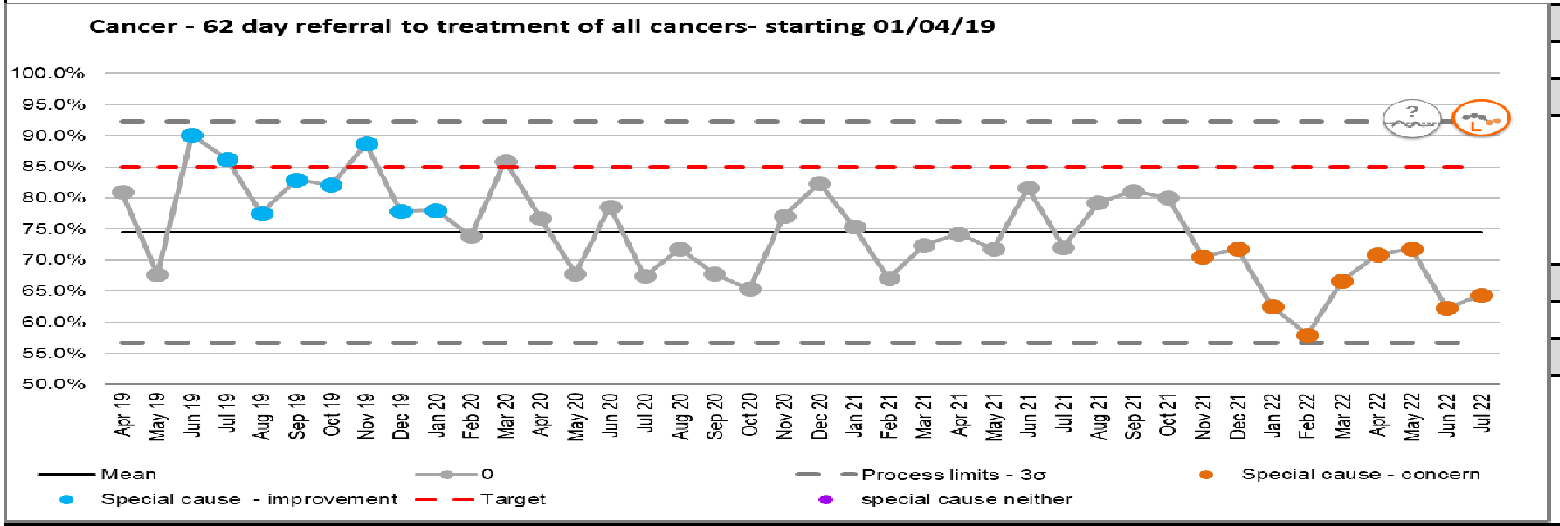
Metric Name: Total Time spent in ED - % within 4 hours - Overall (Type 1 and 3)



Month
Aug-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 (13 data points). August reported performance is 74.25%, an improvement on July 72.9%. Forecast month end performance for September is expected to improve further.	Type 1 attendances decreased to 7,753 albeit this still remains 8.3% higher than August 2021 . The Trust received 155 out of borough ambulances intelligently conveyed to Walsall in August, a record high. Key actions remain focused in the short term on improved management of non-admitted patients.	ED Nursing establishment approved. ED medical workforce business case approved. AEC business case approved. Discharge Lounge business case approved. New Clinical Director for ED and Acute Medicine appointed September 2022.	WHT's national ranking has improved to 30th out of 110 Trusts in August, and is forecast to improve further. The Trust's UEC resilience Winter Plan is before Trust Board for approval in October.

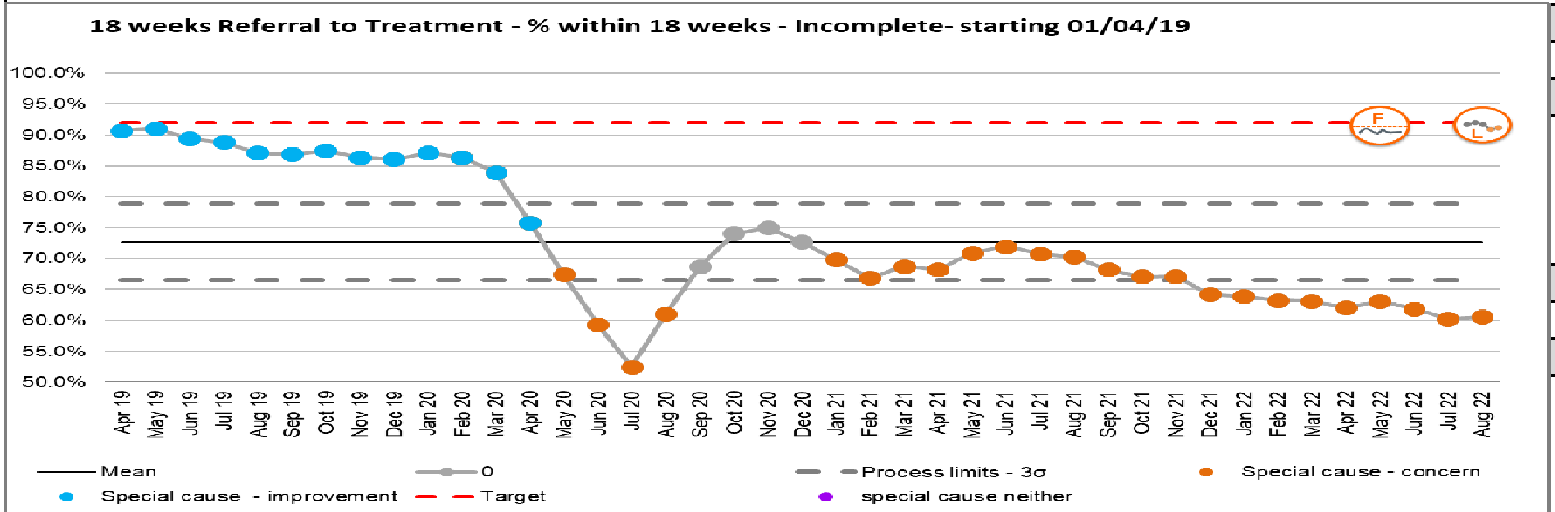
Metric Name: Cancer - 62 day referral to treatment of all cancers



Month
Jul-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	There remains a statistical special cause concern with 9 data points below the average. July's performance shows an improved performance of 64.4% compared to June's 62.2%. Performance was materially better than the West Midlands average (50%) and better than the national average (61.64%) in July.	Urology and breast continue to be challenged. The 2WW GP referred (suspected Cancer) & Breast Symptomatic standards were not achieved, with performance of 75% and 11% respectively impacting the 62 day standard.	Additional oversight of Urology with weekly focused deep dive in place supported by Cancer Manager. Breast mutual aid continues from Trusts across the ICS, and clinic templates have returned to pre-Covid levels following revised IPC guidance.	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. Recruitment for the non-medical posts has commenced in July.

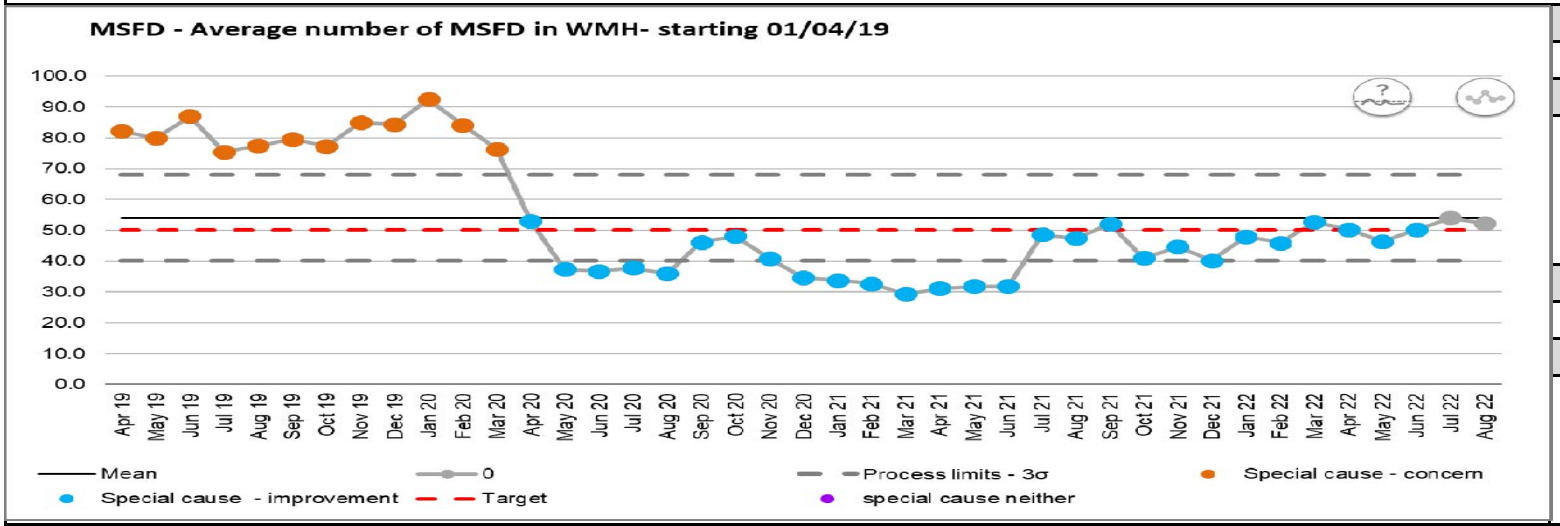
Metric Name: 18 weeks Referral to Treatment - % within 18 weeks - Incomplete



Month
Aug-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 August, performance is sitting just above the anticipated Trust trajectory at 60.54%. There was one 104 week incomplete breaches. The national ranking position is stable at 68th (out of 109 Trusts) for July 2022	Short-term sickness – both within the Anaesthetics and Theatre Departments – alongside heightened emergency and trauma demand has resulted in fewer elective sessions running in August.	Performance meetings now provide scrutiny and oversight – at patient level – to ensure the Trust maintains on a trajectory to remove non-admitted patients waiting in excess of 52 weeks and admitted patients waiting in excess of 78 weeks Validation and review of non-admitted pathways continues	Further to the approved Theatres & Anaesethetics business case, the Theatre Staffing establishment is fully recruited into (posts offered & accepted) at Band 5. Two further Consultant Anaesthetists are starting in September 2022.

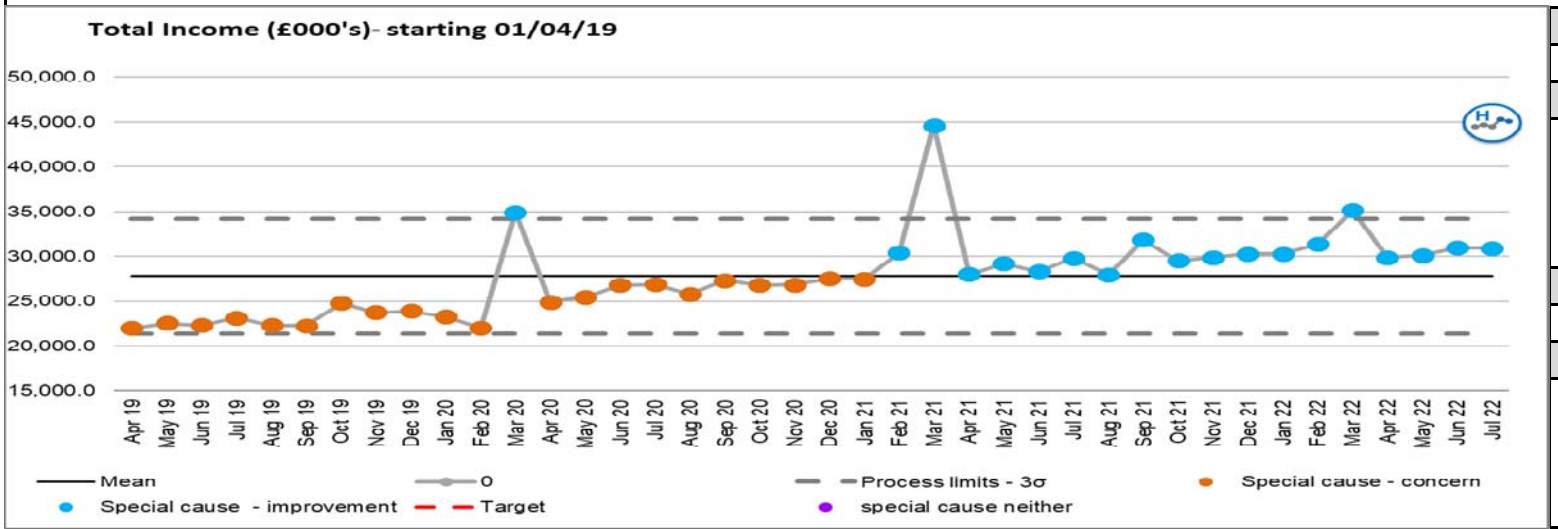
Metric Name: MSFD - Average number of MSFD in WMH



Month
Aug-22
Variance Type
Common Cause - No Significant Change
Target
50
Target Achievement
Variation Indicates Inconsistently Passing and Falling Short of 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 (ICS pathways 1-4)	The Service delivered a strong performance in August with the number of MSFD patients being maintained at just above an average of 50. Despite an unprecedented demand in referrals, the length of stay was maintained at 4.6 days demonstrating good flow through the pathway.	Demand in terms of the Intermediate Care Service remains high. In particular the length of stay position deteriorated during August as a result of the significant increase in patients who were medically fit that needed to be discharged out of the Walsall area.	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 just above 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.

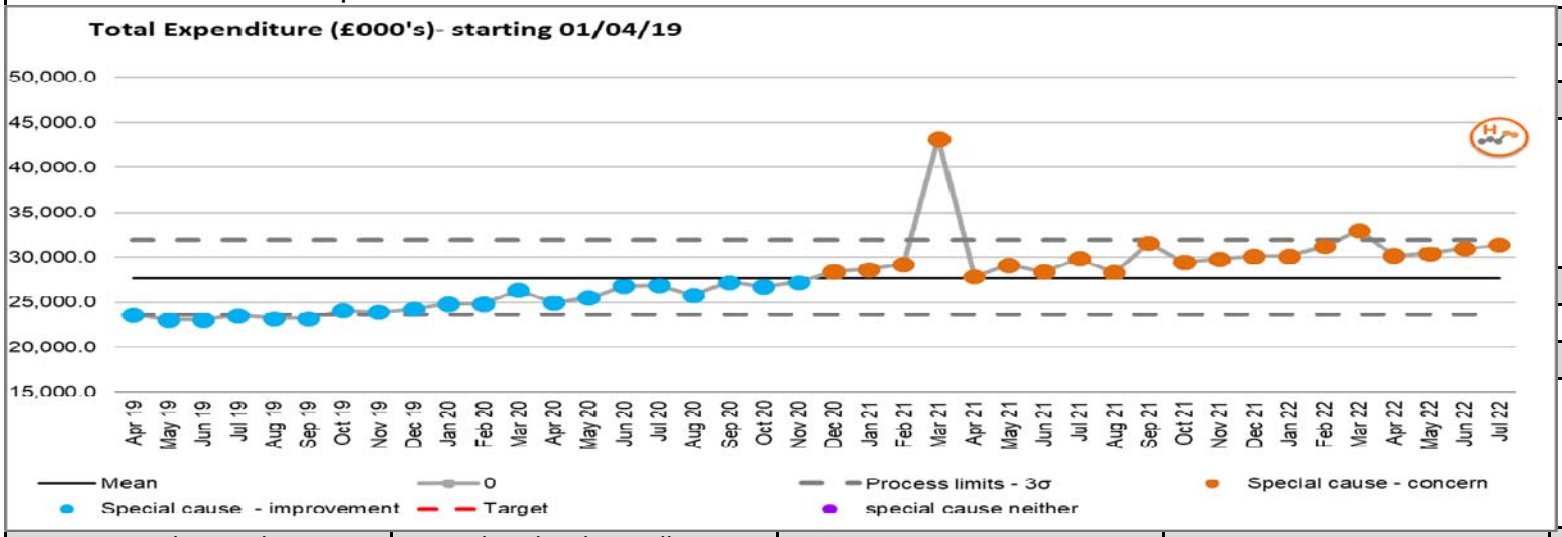
Metric Name: Total Income



Month
Aug-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

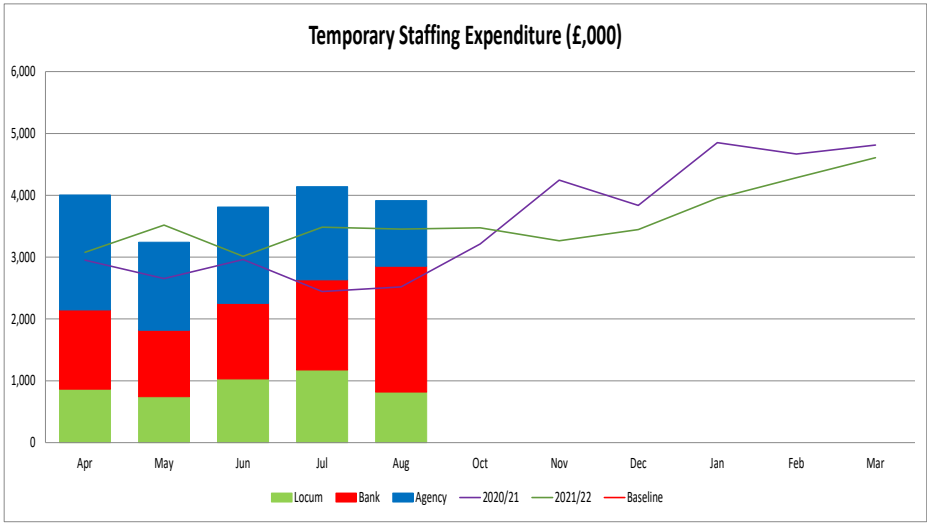


Month
Aug-22
Variance Type
Special Cause of Concerning Nature or Higher Pressure
Target
Target Achievement

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. The Trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure

Financial Performance to August 2022 (Month 05)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Subtotal Income	152,412	152,529	117
Subtotal Pay Expenditure	(97,328)	(100,792)	(3,464)
Subtotal Non Pay Expenditure	(48,312)	(49,607)	(1,295)
Subtotal Finance Costs	(4,756)	(4,756)	(0)
Total Surplus / (Deficit)	2,016	(2,626)	(4,642)
Donated Asset Adjustment	80	120	40
Adjusted Surplus / (Deficit)	2,095	(2,506)	(4,601)



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
- The 2022/23 financial plan requires the trust to move back into more 'normal' business, with a requirement for efficiency attainment, removal of agency usage and cessation (where safe to do so) of COVID designated expenditure
- The Trust submitted a revised financial plan for 2021/22 following release of additional allocations. The Trust financial plan moving from an initial £7.6m deficit to break-even
- In month 5 the Trust reported a £2.506m deficit, which is £4.601m 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.
- The Trust also reported adverse variance to plan and deficit at month 4, so completed a forecast based on current run rates that results in a c£8.7m deficit, presented through Executive, Trust Management Committee (TMC) and members of Performance & Finance Committee (PFC)
- The Integrated Care System (ICS) for the Black Country is also reporting a deficit YTD at £36m. It is clear there is significant financial risk to delivery of financial plans
- The Trust and wider system are to produce forecast outturns at month 6, presenting a best, likely and worst case outturn. The focus being on delivery of efficiencies and cessation on agency usage

Capital

- The approved programme for the year includes the Emergency Department, ward refurbishment and theatres 1-4 upgrades
- Capital expenditure totals £13.4m 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). The Trust is in liaison with the ICS and NHSEI to secure the required funds, bids submitted and a decision on resourcing pending.

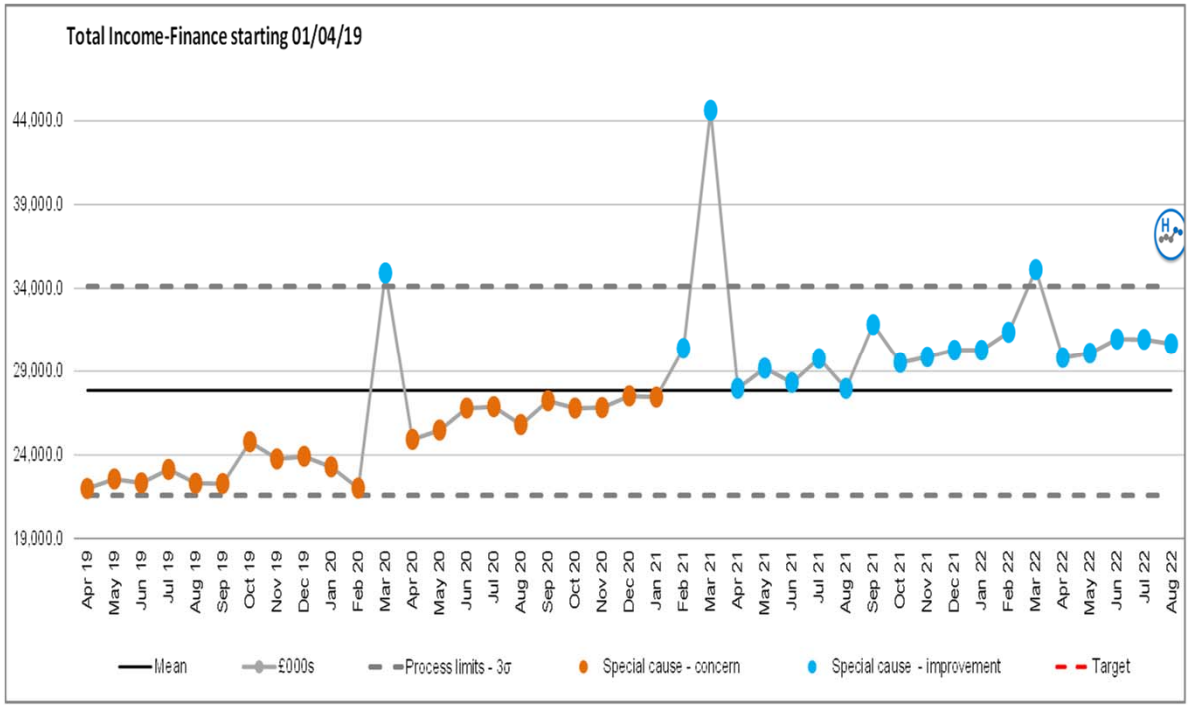
Cash

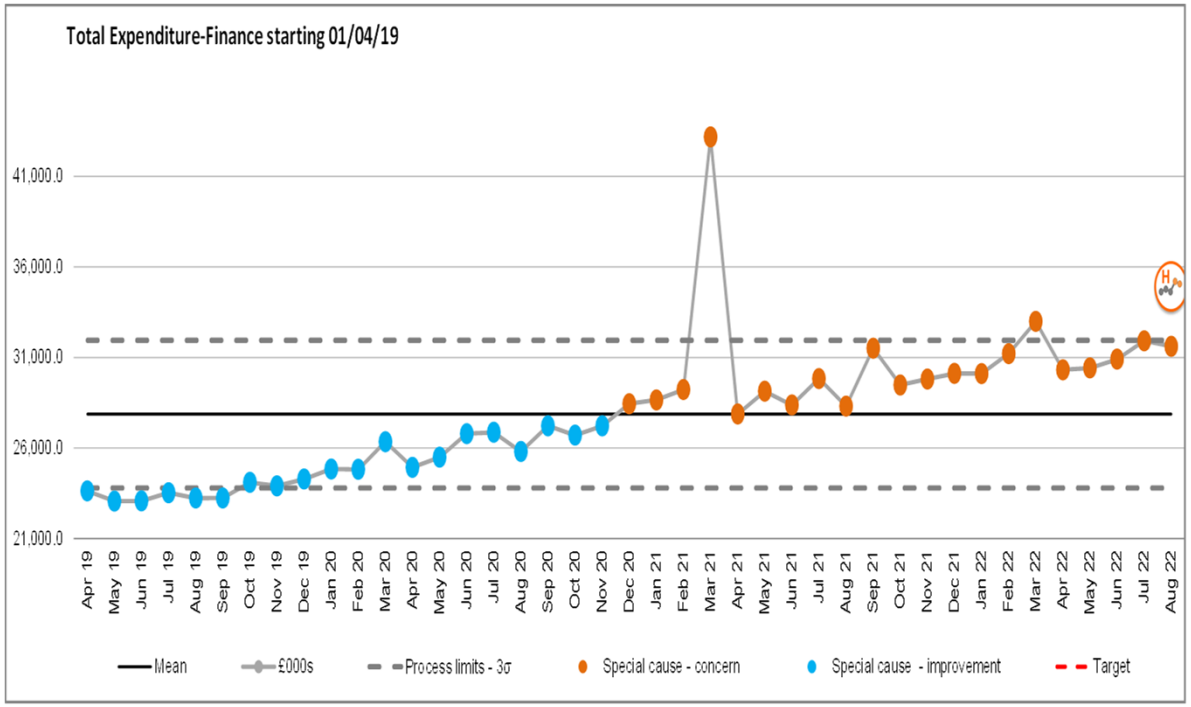
- The Trust continues to have a strong cash position which is sufficient to support a planned revenue deficit plan and the programmed capital expenditure

Efficiency attainment

- The Trust has an annual operational efficiency target of £6.3m, against plans of £5.9m (of which some schemes are rated red) leaving a planning gap of £0.4m.
- YTD performance has been comparable to plans at £1.6m. However, this reflects the program being phased into the later half of the year (delivered equally through the year the target to date would have been £2.62m).

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:	People and Organisational Development Committee
Date(s) of Committee/Group Meetings	Monday 26th September 2022
Chair of Committee/Group:	Junior Hemans (Note: The Committee held on 26th September was chaired by Paul Assinder, Non-Executive Director)
Date of Report:	27th September 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The Trust retention rates, and turnover rates are showing an adverse trend with the 24-month retention rate for the nursing and midwifery workforce at its lowest rate (78%) for 3 years. The People and OD Committee will receive a progress report on this in Q3 2022-2023. • The Trust sickness rates remain above trust target – 5.3% in month August – against target of 4.5%. The committee received a detailed update from the task group on reducing sickness absence, noting the absence rates are showing significant reduction month on month and noting the focus on managing hot-spot areas and on managing long-term sickness absence cases (now accounting for 76% of all absence). The proactive case management between division, HR and OCH is profiled to bring absence back within target by 2022–2023-year The end, with a stretch target of reducing to 3.5%, which is dependent upon further investment in preventative OCH services being in place.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The committee were pleased to note that the Trust's Occupational Health and Wellbeing service achieved SEQOSH accreditation (Safe, Effective, Quality Occupational Health Service) which is a national quality standard, during September 2022, the inspection took place in August 2022. • The committee heard a staff voice story concerning career progression from a specialist Occupational Health nurse, recently employed and supported by the trust to complete a masters' qualification and also being named as the student of the year for her course at university. • The committee approved the annual Medical Revalidation Report for approval at Trust Board. • The committee received a detailed update on workforce metrics Trust wide and from the Womens and Childrens Clinical Support Services and noted the improvement in workforce metrics for the Division and noted the work on retention, supporting work life balance and reducing turnover for hotspot areas such as pharmacy. The committee commissioned a spotlight report which was presented to September committee on healthcare sciences, this demonstrates the demographic profile of the workforce and the importance

	of growing the workforce for the future and investing in career pathways. • The committee approved and noted the OD approach on the Patient First Culture supported by OD framework and noted the joint work taking place with RWT and WHT on developing a behavioural framework to support trust values and the joint strategy due to be launched at Trust Board in October. The behavioural framework will improve colleague experience and continue to develop a patient first culture. This contributes to improving the experience of the Trust as a place to work and a place to be treated. The committee received an update on progress on people metrics and achieving excellence in people management. This shows significant improvement in staff survey outcomes against both national benchmark for trusts like us and against the baseline position for Walsall, which was lowest 20% in 2019. The committee noted improvement in colleagues reporting positively on health and wellbeing support as well as noting a further improvement year on year on WRES indicators. The indicators for culture require further improvement within the Trust and the OD Framework provides a framework for improvement aligned to the new Trust strategy.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• The recruitment to full establishment for nursing and midwifery is on target and the committee were assured by the safer staffing report that the agency reduction plan is on track; most wards have stopped agency use. The committee commended the work and clear ambition to eliminate agency reliance. The nursing and midwifery vacancy rate stood at 12% in August 2022 and 10% in September 2022 however this is due to further increases in establishment following approval of business cases through the investment group during Q1 and Q2. The recruitment plan is on target and the vacancy rate will continue to reduce (the vacancy rate was 1% in May 2022). There were no gaps in the nursing and midwifery establishment at year end March 2022. • The committee received an assurance update on the delivery of the Health and Wellbeing Strategy during its September meeting, noting the significant progress achieved against the domains within the national Health and Wellbeing Framework. • The committee received an update on the work of the Healthy Attendance Project, a central team of HR and OHS practitioners working with divisions to improve attendance at work. The committee reviewed activity in detail and were assured there is a robust plan in place to support the planned improvement in attendance and workforce availability. The committee noted the early reduction in sickness absence in month from baseline 6.76% to 5.35% in month, there has been significant work on reducing long-term absence and the profile for reaching the 4.5% target by financial year end is currently on track. The committee heard about further work and investment case on establishing preventative OCH services to further reduce absence to within the 3.5% target during 2023. • The committee reviewed the exit monitoring data and received a report on retention, which provides detail on hotspot operational areas. The committee reviewed and accepted the onboarding and retention plans including further development of career pathways and noted the report provides assurance on the areas for further focus, particularly increasing options to promote work/life balance. The committee agreed to receive a

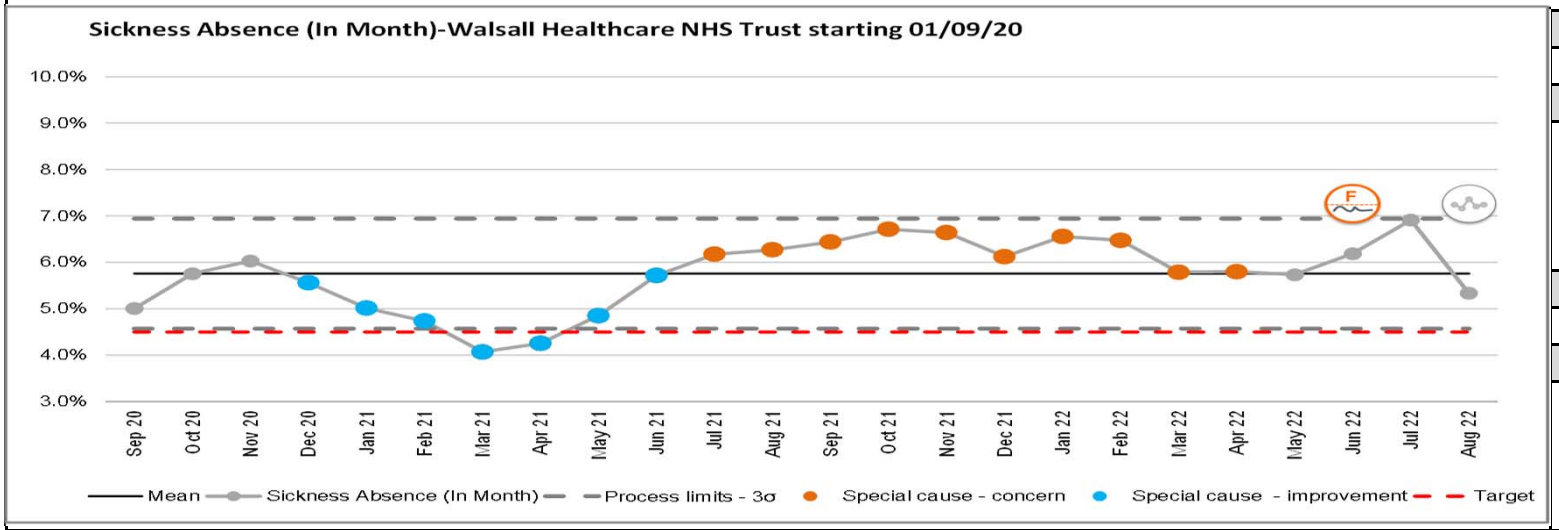
	further focused report.
Recommendation(s) to the Board/Committee	• That members of the Board note the contents of the report.
Changes to BAF Risk(s) & TRR Risk(s) agreed	• BAF S04 – Culture (lack of an Inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care)
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• Preventative healthcare OCH business case to Investment Group. • Further spotlight reports on hot-spot workforce areas to PODC • The Annual Equalities Report collating all actions including WRES, WDES and Pay Equality data to PODC and Trust Board • Program of staff voice (board to ward) to be scheduled to year end.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• Medical Revalidation Report Annual approved by PODC to be received by Trust Board. • Healthy Attendance Project (HAP) – assurance action plan approved PODC
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	1.Staff Story - Occupational Health Succession Planning and Individual Achievement 2.Trust Workforce Metrics and escalation of exception reports 3.Safe Staffing Report 4.Medical Revalidation Report 5.Corporate Risk Register Escalations 6. Healthy Attendance Project Assurance 7. Patient First Culture and OD Approach 8. Board Pledge Assurance Metrics
Matters presented for information or noting	Library and Knowledge Services Delivery Plan Equality Diversity and Inclusion Group Health and Wellbeing Group Joint Negotiating and Consultative Committee Local Negotiating Committee WRES 2022 Indicators
Self-evaluation/ Terms of Reference/ Future Work Plan	• Terms of reference and future work plan are in place. • Meeting evaluation takes place each month – agenda item
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	Aug-22	5.34%		4.50%		
%	PDRs	Aug-22	79.79%		90.00%		
%	Mandatory Training Compliance	Aug-22	89.05%		90.00%		
%	% of RN staffing Vacancies	Jul-22	8.80%				
%	Turnover (Normalised)	Aug-22	11.89%		10.00%		
%	Retention Rates (24 Months)	Aug-22	80.66%		85.00%		
%	Bank & Locum expenditure as % of Paybill	Jul-22	13.04%		6.30%		
%	Agency expenditure as % of Paybill	Jul-22	6.87%		2.75%		

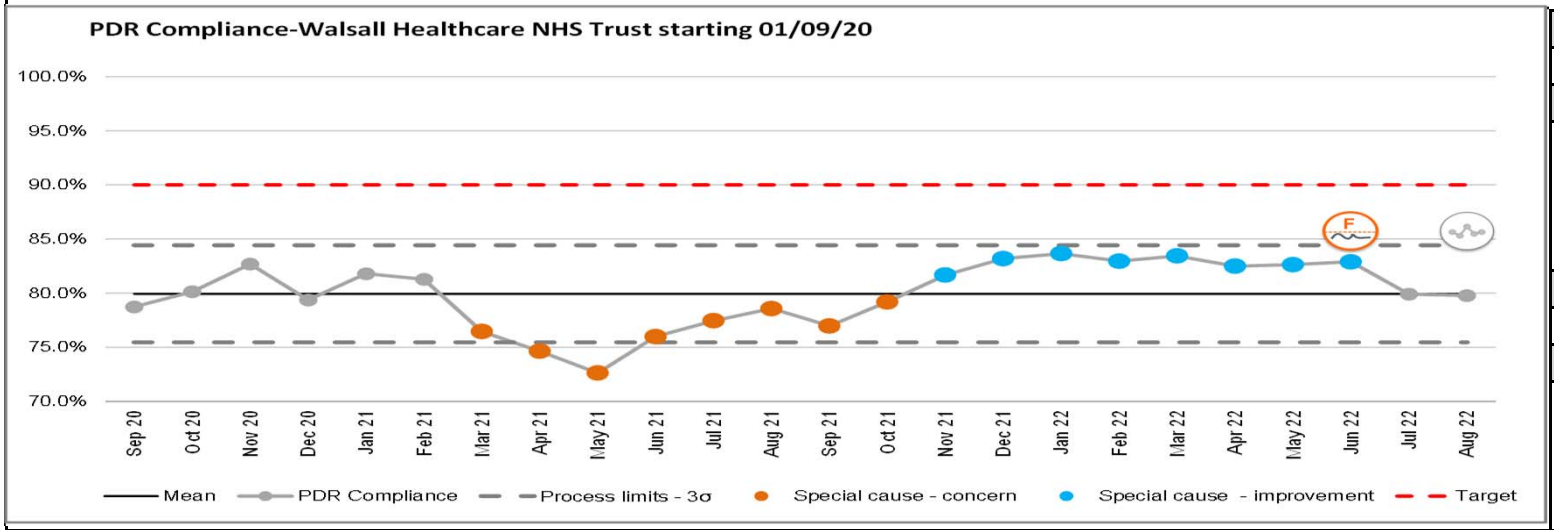
Metric Name: Sickness Absence



Month
Aug-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.	Aug-22 sickness absence compares favourablely year on year.	Long-Term episodes continue to increase, now accounting for 76% as a proportion of all sickness absences.	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.

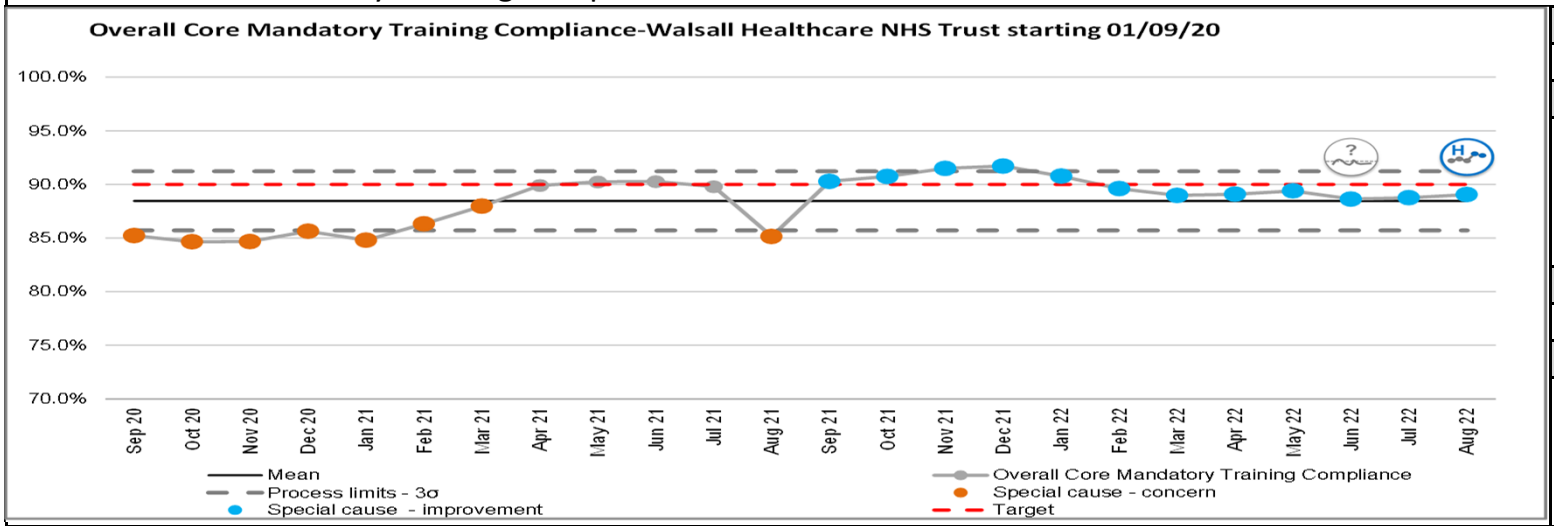
Metric Name: PDRs



Month
Aug-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.	PDR compliance has consolidated at 24 month average levels.	PDR compliance remains relatively high amongst clinical and estates colleagues (an 82% average) but continues to decline amongst Admin & Clerical colleagues (72%).	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
Aug-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.	Compliance remains stable, with Safeguarding Adults Level 3 (80%) and Adult Basic Life Support (70%) competencies key outliners. E-Learning completion rates remain noteably high.	Collobration 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 **October 2022**			
Director of Nursing Report			
Report Author and Job Title:	Lisa Carroll Director of Nursing Christian Ward Associate 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	• 1 case of Clostridium Difficile toxin was reported in July 2022 and 2 cases in August 2022, review of the cases has found justified antibiotic prescribing. Overall performance year to date remains below trajectory. • Safeguarding adults and children's training is achieving the Trust target for all level 1 and level 2 training. • 214 Clinical Fellowship Nurses have commenced employment within the Trust and 195 are registered with the Nursing and Midwifery Council (NMC).		
Advise	• Falls per 1000 bed days was 5.12 and 3.85 during July 2022 and August 2022 respectively (3.54 in June 2022). Weekly falls accountability meetings are continuing, identifying lessons learnt and shared learning. • Issues with Scale 2 usage within NEWS2 have been identified and logged as a corporate risk. An e-Learning package has been uploaded to ESR, implementation plan agreed, and compliance will be monitored. • Tier 2 agency usage is now at its lowest levels since March 2022.		
Alert	• Stage 2 MCA compliance for July and August is reported as 38.89% and 26.09% respectively, this is a considerable fall over a quarter (April 71%). Target is 100%. • The prevalence of timely observations for July and August was 77.23% and 80.13% respectively, the last reported figure was 78.02% in June 2022. • Safeguarding level 3 adults and children's training remains consistently below Trust target, additional training is being made available to improve compliance		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF IPC BAF **208** - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks (Risk Score 16). **2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 20 increased from 16 in month). **2245** - Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level (Risk Score 20). **2325** – Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes (Risk Score 16). **2430** – Risk of harm to children due to fragmented record storage (Risk Score 20). **2439** - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety' (Risk Score 20). **2475** - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services (Risk Score 5). **2540** - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems (Risk Score 12). **2581** – Internal risk for patients awaiting Tier 4 hospital admission (Risk Score 20). **2587** - 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 and treatment of the sepsis 6 (Risk Score 20). **2917** - Inappropriate use of SCALE2 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 – October 2022

Introduction

The following report details the Trust position 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

A Trust wide corporate action plan with responsible executive Directors and identified leads has been established. Divisions maintain action plans for ownership, implementation and embedding of practice at local level. Progress is monitored through the Divisional Governance process and assurance meeting with members of the executive team.

Falls

The number of inpatient falls recorded for July 2022 and August 2022 is 79 and 65 respectively with 57 reported in June 2022.

Hospital falls made up 75 of the July 2022 total and 61 of the August 2022 total.

Community falls made up 4 of the July 2022 total and 4 of the August 2022 total.

The Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days has been achieved continuously for the past rolling 27 months.

Falls per 1000 bed days was 5.12 for July and 3.85 for August 2022 (3.54 in June 2022). There were 3 falls resulting in severe harm and 1 with moderate harm recorded.

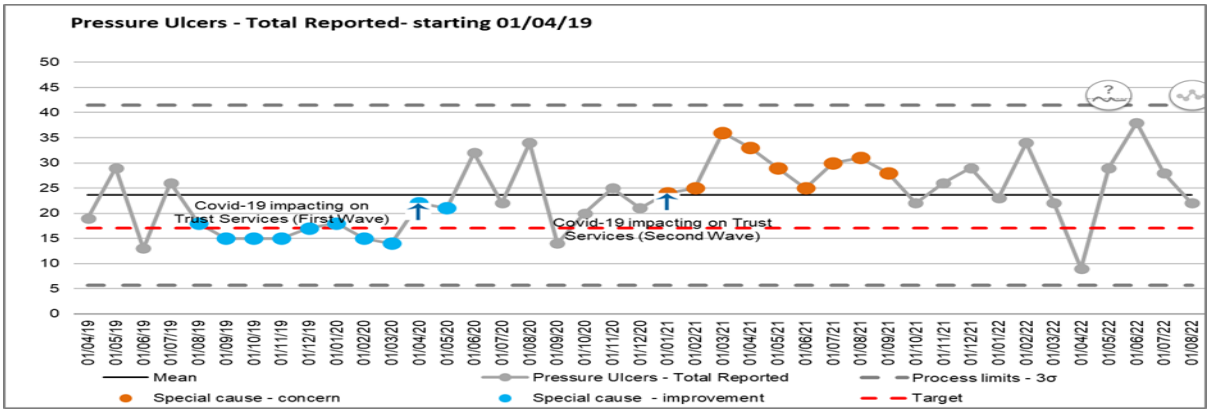
Weekly falls accountability and review meetings are continuing identifying lessons learnt and promoting shared learning.

Tissue Viability

The total number of Trust acquired pressure ulcers in July and August 2022 (28 and 22 respectively) demonstrates a reduction in pressure ulcer incidents in hospital and community with the run rate now below the mean. Lessons continue to be learnt using the RCA process.

The new hybrid mattress contract has been awarded to Direct Healthcare this is linked to Risk 1856 on the Risk Register.

The inpatient risk assessment document and intervention chart has been implemented from mid-July 2022 and will be subject to review in the initial stages of implementation.



Venous Thromboembolism (VTE)

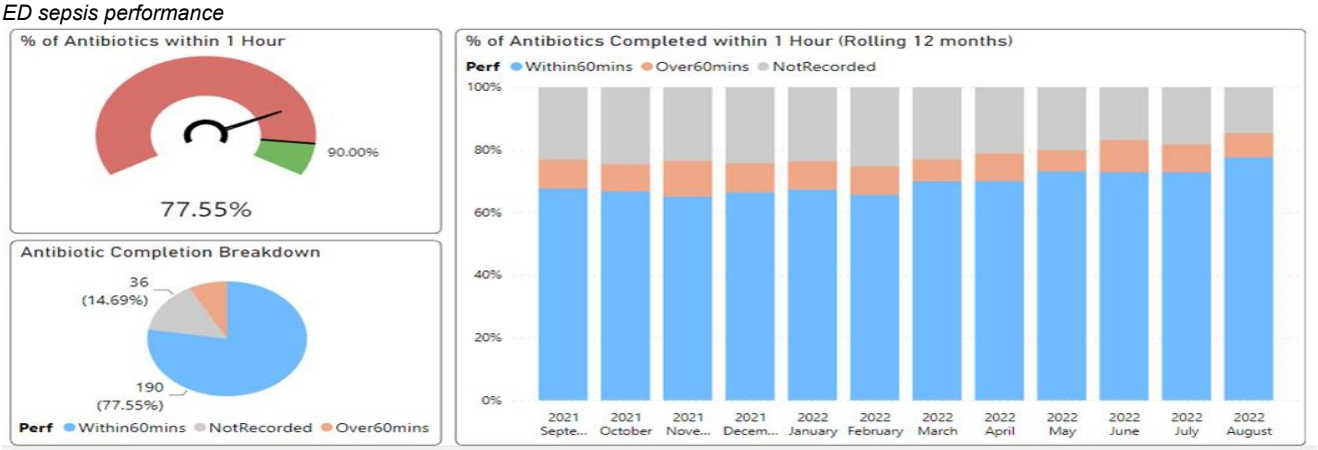
VTE compliance for August 2022 was 92.6% which shows an increase in compliance compared to July 2022 (88.90%). Although this is an increase from the previous months it continues to be below the 95% target for compliance.

Sepsis

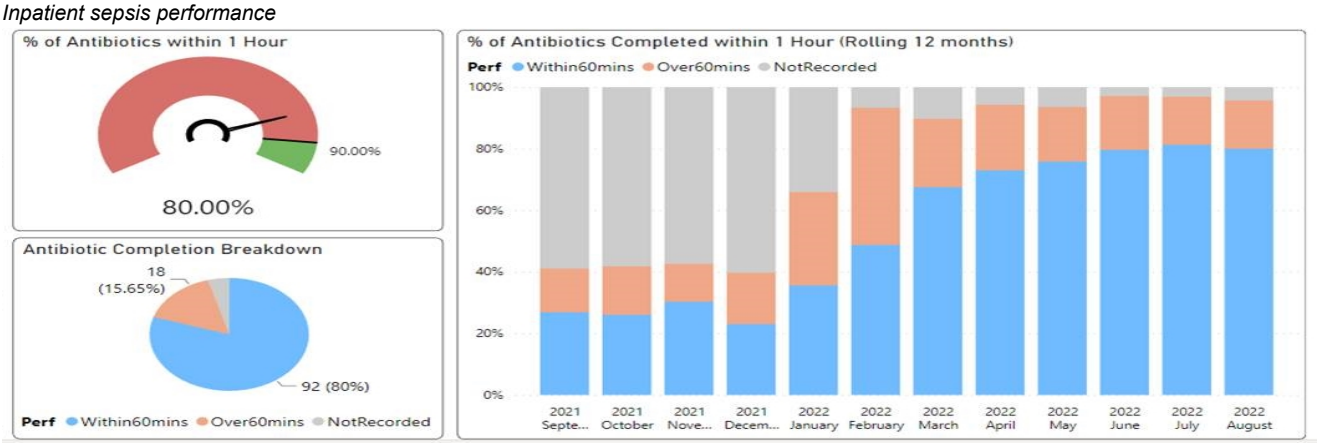
A Trust wide deteriorating patient group is established and reviews the management of sepsis and actions being taken to improve compliance and practice.

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 sepsis performance



Inpatient sepsis performance



Surgical Site Infections (SSIs)

The Trust reported two SSIs in August 2022 and RCA meetings took place in September 2022 with good MDT involvement.

The Trust has appointed a nurse to lead on Surgical Site infection avoidance and management and an action plan is in place. This is monitored by the patient Safety Group.

Clostridium difficile (C. diff)

The National Trust trajectory for 2022/23 is 27.

1 acute toxin has been identified in July 2022; a review has identified that antibiotics were justified.
2 acute toxin cases were identified in August 2022; both cases on review were found to be unavoidable with antibiotics justified

C.d*iff* 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	1	2							
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Actual cumulative total	0	1	5	6	8							

Percentage of observations undertaken within timeframe

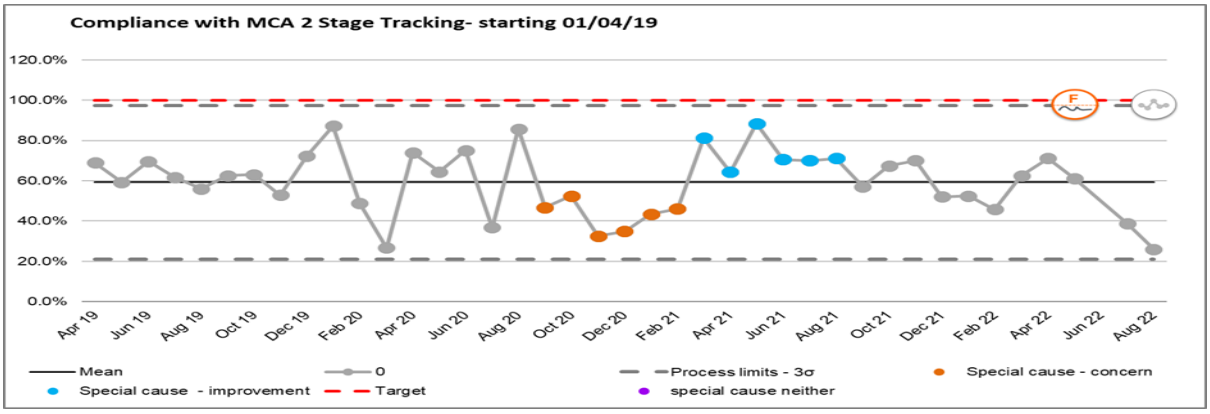
As reported in August 2022 changes have been made to the threshold of late observations, and how late observations are classified. The previous threshold of 33% has been reduced to 10% for all observations at a frequency of greater than 1 hour. The 33% threshold remains in place for observations that 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 July 2022 was 77.23% and continued to improve in August 2022 to 80.13%

Mental Capacity Assessment (MCA)

June's MCA compliance was not reported due to a lack of capacity to conduct the audit. MCA compliance for July and August is 38.89% and 26.09% respectively. A significant fall from the last compliance figure reported in the last 3 months



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.
Additonal training is being provided to allow more opportunity to complete this training.

The Safegurading business case has been recruited to and senior nursesa re joining the team in September and October 2022.

Safe Staffing

Vacancy position

There have been establishment changes following approval of business cases for ED, Ambulatory Care and Winter Planning this resulting in a significant increase in the vacancy position which was reported in June 2022 as 12.3%. The RN and Midwifery vacancy rate for July 2022 has decreased to just under 10%.

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

Recruitment

214 Nurses have arrived in the Trust on the Clinical Fellowship Programme, 195 of these are now registered with the NMC.

Five Nursing Associates are expected to qualify in September 2022. Nine Trainee Nursing Associates commenced the programme in September 2021 and will be expected to qualify in November 2023.

Nine Nursing Associates are expected to commence the NA to RN programme with Birmingham City University in in September 2022.

Thirty-five student nurses have accepted posts within the Trust and are expected to commence in post in September 2022.

Temporary staffing

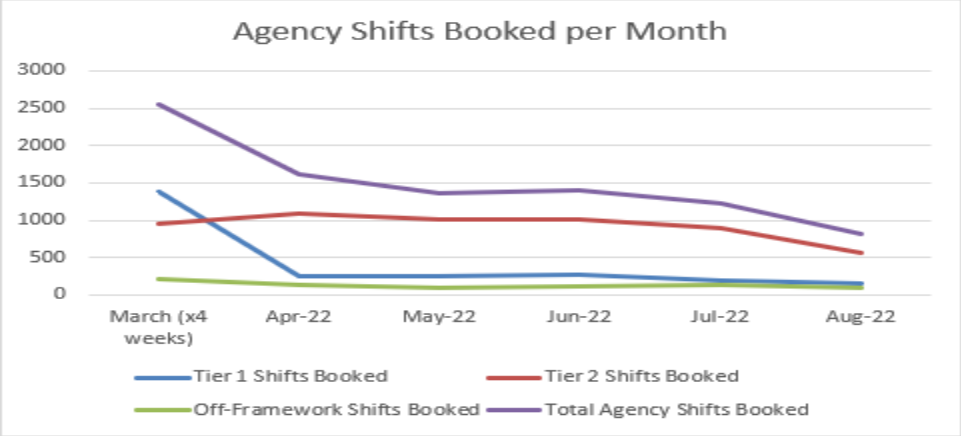
A total of 974.35 hours of Off-Framework was used during August 2022 (July 2022 was 1320.92 hours)

The highest use areas for off framework agency staff are ED using 356.10 hours and Endoscopy using 348.75 hours.

During August 2022, Tier 2 bookings are at the lowest levels since March 2022.

At the end of August 2022 there are 16 departments where agency is no longer in use at any Tier.

Agency Cap Performance



Staffing hub

The Virtual Staffing meetings are embedded and 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.

Through the safe staffing meetings 1041 hours of RN and 677 hours of CSW were re-deployed across the Trust during August 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 August 2022 there were 121 open Red Flags, a decrease of 61 open red flags recorded compared to July (182).

84% of Red Flags are reported during the day, 16% at night. The majority of Red Flags continue to be recorded on weekdays and not weekends (72%).

60% (73) of Red Flags were recorded for the reason of 1 to 1 not covered, a decrease of 2% since July.

Red Flags are cross referenced with dates of incidents raised in the Trusts incident management system on the same date. Cross referencing does not confirm a correlation between Red Flag and incident reported.

A review was undertaken to examine if there were falls with harm recorded on wards and dates that had a Red Flag raised for 1:1 not available. Based upon July and August 2022 activity there were 15 incidents reported of a fall with harm (all low or no harm) on a shift where a Red Flag was raised for 1:1 not covered. The falls recorded did not involve the patients requiring the 1:1.

Acute Medical Unit (AMU) Board Update

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 in now completed and on Allocate (Job Planning Module).
- AMU consultant post readvertised with enhanced offer to attract suitable candidates.
- Prioritisation of Patient in AMU audit remains at 100% (4 months at 100%).
- Matron for AMU will commence in September 2022.
- Guardian of Safe Working Appointed.
- Rota cover continues to improve, the new rota included 28 medics (previously 18).
- Temporary Worker (Medic and Nursing) IT access process improving with the provision of logins and passwords to support staff and ensure data security.
- Mandatory Training is on track for Nursing and Medics.
- Comprehensive Induction pack and Junior Handbook complete
- Governance structure in place with the Ward Manager and Care Group Governance Facilitator to review the themes and trends of incidents.
- Dashboard data is still being validated and will be presented to the Project Board in September.
- Workshops planned for September and October to address behaviours noted from Behaviours and Culture Group.

Clinical Systems Framework (CSF)

Development of the CSF is ongoing with staff engagement being the focus of the last two months. Engagement has been through a survey monkey and visits to clinical areas to gain staff views. These views will be collated and incorporated into a draft document for further consultation. A final draft is expected in December 2022 with the aim of launching in January 2023.

Health Education England National Education and Training Survey

Health Education England wrote to the Trust in September 2022 following concerns raised in the November 2021 survey. In the September 2022 letter HEE confIrmed that based on positive findings and the robust actions in place the Trust has been removed from the HEE Quality Improvement Register and the programme will be monitored through standard quality processes.

End of Report

MEETING OF THE TRUST BOARD, IN PUBLIC– 5TH OCTOBER 2022			
Hospital Mortality Report (June - August 2022)			
Report Author and Job Title:	Mr Salman Mirza, Deputy Chief Medical Officer Lorraine Moseley, Business Manager, Medical Directorate	**Responsible Director:**	Dr Manjeet Shehmar, Chief Medical Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☒ Inform ☒ Assure ☒ The reporting methodology for SHMI has been reviewed, see Section 6 for detail. The Committee is asked to approve amendment to the content of this report.		
Assure	• The most recent published SHMI value for the 12 month rolling period (published September 2022) June 2021 to May 2022 is 116, this is on an upward trend and is above the 90% upper limit range as a red Trust. • The Trust is now ranked 95th out of 122 Trusts across the country.		
Advise	• The medical examiner team reviewed 100% of the eligible total inpatient deaths for the months June, July and August • Community ME pilot is progressing with 6 Walsall GP Practices' deaths being reviewed		
Alert	• There are currently 18 SJRs outstanding (compared to 27 at the last report) and these will be followed up by the Learning from Deaths Administrator and highlighted at Mortality Surveillance Group by the Deputy Chief Medical Officer.		
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	None		
Legal and/or Equality and Diversity implications	• The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. • National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic Objectives (highlight which Trust	Safe, high-quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	

Strategic objective this report aims to support)	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

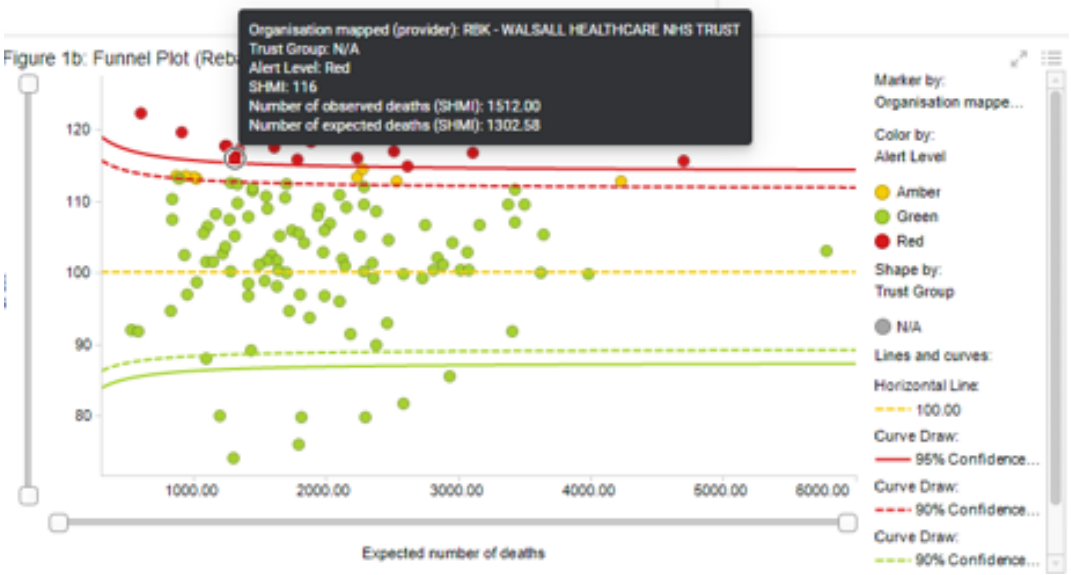
1.1 Activity levels over this period is as follows:

	Admissions	Hosp Deaths	Total Discharges	Covid Deaths
Apr-22	8201	101	7350	21
May-22	7873	103	7850	14
June-22	7595	93	7360	8

1.2 SHMI (Inpatient deaths plus 30 days post discharge)

The most recent published SHMI value for the 12 month rolling period (published September 2022) June 2021 to May 2022 is 116, this is on an upward trend and is above the 90% upper limit range as a red Trust. However, this figure includes Goscote Hospital (see section 7 - NHS Digital reporting separates Manor Hospital and Goscote to identify acute SHMI).

The Trust is now ranked 95th 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
June 2021 - May 2022	116.08	2.84

Please note that SHMI has been rebased resulting in lower outcomes for the Trust than previously reported.

SHMI in comparison with neighbouring Trusts

Trust	June 2021 - May 2022
Walsall Healthcare NHS Trust	116.08
The Royal Wolverhampton NHS Trust	101.36
The Dudley Group NHS Foundation Trust	115.84
Sandwell And West Birmingham Hospitals NHS Trust	110.77

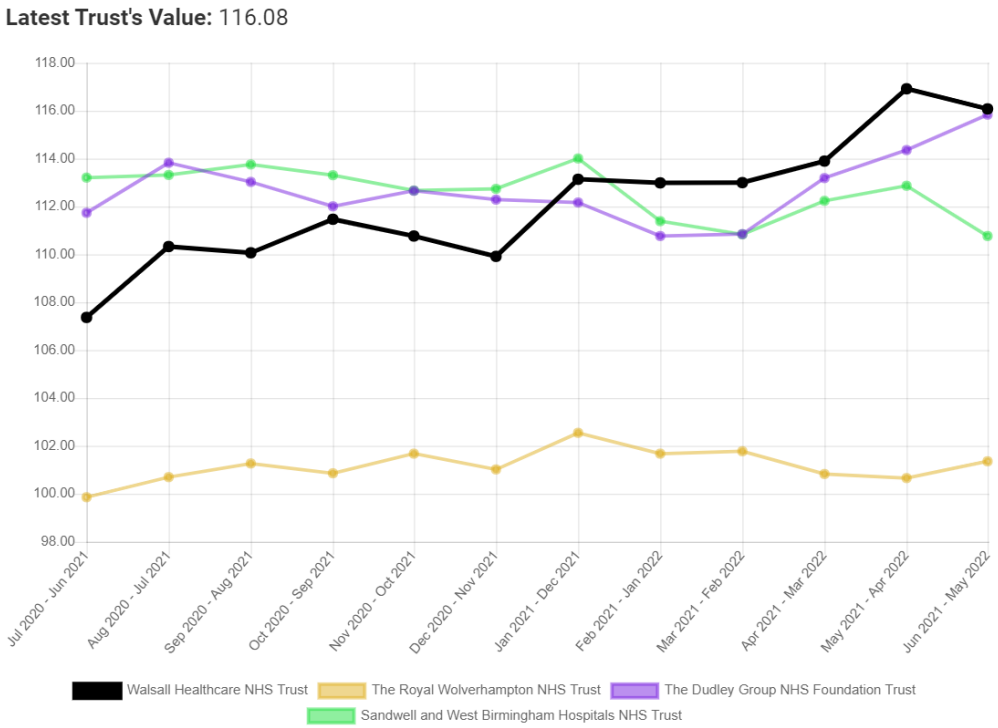
Recent discussions with NHS Digital have identified that SHMI is available as reporting by site rather than Trust, therefore separating Trust SHMI value from palliative care (see section 7 for further detail). The SHMI breakdown is as follows:

Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	
Manor Hospital	62295	1275	1305	0.98	As expected SHMI
Hollybank House	105		15		
Walsall Hospice	205	125			

NHS digital have confirmed that the SHMI for Walsall Manor Hospital is within the expected range. We are working with NHS Digital around agreed reporting.

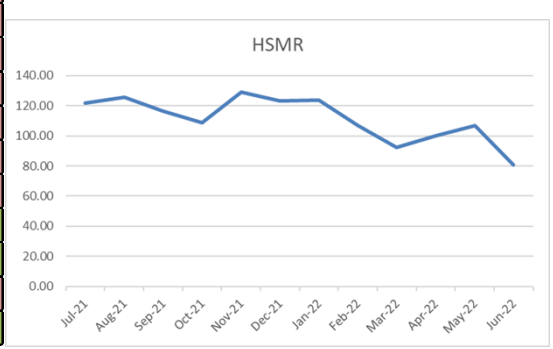
2. HMSR

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



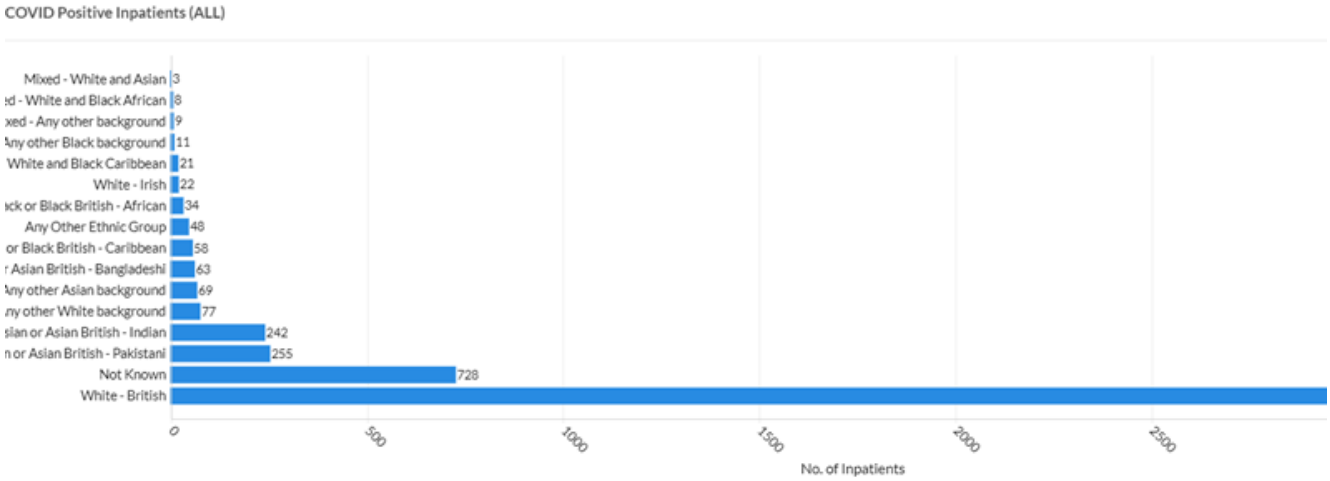
The following table includes the expected HMSR level to June. It shows a continued decrease in HMSR.

	HSMR
Jul-21	122.02
Aug-21	125.46
Sep-21	116.44
Oct-21	108.84
Nov-21	129.24
Dec-21	123.45
Jan-22	123.89
Feb-22	107.04
Mar-22	92.45
Apr-22	99.89
May-22	106.80
Jun-22	80.88



3. Covid 19 inpatient/ethnicity

The graph below shows ethnicity for all covid positive inpatients. This report is being modified and will be updated for the next report to show number of covid deaths by ethnicity.



4. Alerts

The Trust has received the following HMSR/SHMI alerts during this period:

	Indicator Name	Period	Value	
HSMR	59 - Deficiency and other anemia	Jan-22	5.65	
SHMI	59 - Deficiency and other anemia	April 2021 - March 2022	193.54	
	19 - Cancer of bronchus; lung	April 2021 - March 2022	146.83	
	24 - Cancer of breast	April 2021 - March 2022	407.27	
	29 - Cancer of prostate	April 2021 - March 2022	325.98	

This is also the subject of an SMHI alert and will be the subject of a deep dive and subsequently reported.

3. Specialty Learning / Feedback

The Child Death Report will be included in the next report to this Group.

Intensive Care

The team reported on 3 SJRs undertaken and the outcomes. All three were judged as Good Care and no issues highlighted. However, the team recognised that additional training in specific areas was needed:

- Improve compliance for Respect Form and MCA
- Improvement to completion of daily sedation documentation

Good practice was identified:

- Daily review by ENT team
- Good communication with families
- Recognition of complications and appropriate escalation
- LocSSips completed

Lung Cancer

The update from the interim lung cancer lead included a review of the HMSR alert notified by HED.

Alerts - a deep dive into patient level data identified that there were no concerns and deaths were expected. 50% of the deaths occurred in patients on a palliative care pathway.

There are challenges to the service:

- 44% achieved the recommended three day turnaround for pathological subtyping
- 37% achieved molecular diagnostics within 10 days
- Limited onsite access to endobronchial ultrasound, local anaesthetic thoracoscopy, positron emission tomography and computed tomography

Recent quality improvement programmes have led to the following:

- New rapid access suspect referral process
- New pathways to identify potential malignancies on imaging
- Appointment of lung nodule tracker and cancer navigation post
- Agreed business case to strengthen respiratory team
- Streamlining and clarifying function of lung cancer MDT
- Trust-wide cancer Power BI dashboard

National Audit for Care at the End of Life

Results of the NACEL Audit 2021 were presented to the Mortality Surveillance Group.

What did we do well?

- Board member responsible for EoL care
- Rapid discharge home to die policy and procedures
- Learning from deaths in place
- Care plan to support 5 priorities of care for the dying person
- 7 day service with access to telephone advice 24/7
- Ward staff feel supported
- Evidence of good practice in relation to CPR discussions

Recommendations:

- Implementation of Acute Based Gold Standard Framework
- Review of current staffing levels in acute palliative care
- Offer communication skills training - difficult conversations

Cardiology

Cardiology presented an overview of audit of deaths within the speciality and no issues in care were highlighted.

Good practice:

- Cardiology outreach service
- Early and effective use of investigations
- MDT
- Involvement of palliative care team, early recognition of the dying patient and increased use of RESPECT forms
- Respecting patient and family's wishes

Support need identified:

- Non invasive imaging
- Staffing levels
- IT improvements, eg PACS, Echo
- Equipment - cardiac CT reporting station

4. Deaths reviewed by the Medical Examiner Service

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

June 2022 – 100%
July 2022 – 100%
August 2022 - 100%
Number of GP deaths reviewed by medical examiners - 12.

The pilot scheme to review community deaths is now in place and has been running for 3 months. 6 GP practices have signed up with others being invited to join. The trajectory is to have all 54 GP practices taking part by March 2023 to go live with the statutory requirement in April 2023.

GPs are providing a 3 month summary of the deceased's treatment, scanned through to the medical examiner team. Once the process is statutory there will be a legal requirement for GPs to allow medical examiners access to their electronic patient records. A data sharing agreement is currently being drafted for agreement by the PCNs to be in place by 1st April 2023.

No issues have been highlighted with the process to date, however numbers of community deaths are relatively low and additional GP practices are being actively sought.

Recruitment is progressing with 2 part time MEOs to start in October. Advertisement for ME has been published. This will bring the medical examiner team to full capacity before the winter period.

5. Mortality Reviews - Structured Judgement Reviews (SJRs)

5.1 There are currently 18 SJRs outstanding (compared to 27 at the last reporting period) and these will be followed up by the Learning from Deaths Administrator. This figure has reduced from the previous report. The Trust

Mortality Lead highlighted the backlog at the August Mortality Surveillance Group meeting and Divisions are to provide a trajectory for completion of all outstanding SJRs.

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

5.3 1 LeDeR review was identified in June, no others for this period

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%

Any case which scored 3a or below has an incident filed which is then reviewed in line with the Trust Incident Reporting, Learning and Management Policy with the appropriate level of investigation.

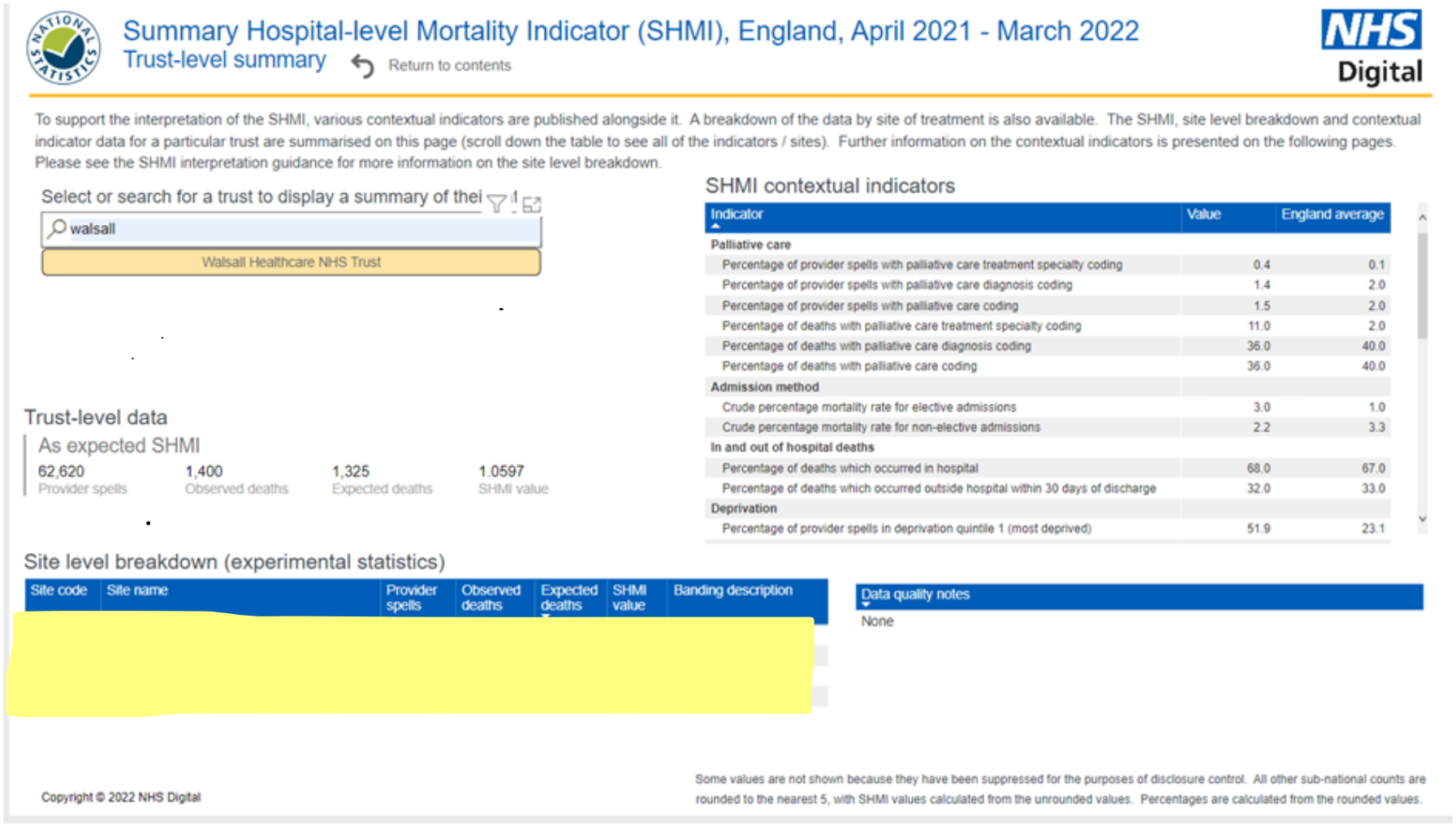
6. **Future reporting**

The mortality team recently met with NHS Digital on 25th 'August 2022 to discuss SHMI reporting available on the NHS Digital platform. As the Trust is aware, SHMI is inflated by the inclusion of palliative care patients at Goscote Hospital. The NHS Digital report identifies the main hospital site and palliative care separately with SHMI for each site. This will provide assurance that the Trust is not an outlier and that SHMI levels are within expected range. The data is clearly presented and provides easy access to other Trusts' data to benchmark.

NHS Digital continuously improve this suite of reporting and it is publicly available through their website.

In order to improve the quality of reporting, Mortality Surveillance Group proposes that the Trust move to the NHS Digital platform to report on SHMI and implement HED data for deep dives. For example, when we have alerts, patient level data from HED can be provided to the relevant speciality for investigation. The reports can be found at http://bit.ly/shmi-vis-apr21mar22

Examples of the reports available through NHS Digital are included as figures 1-3 below. NHS Digital data is updated around 1 month in arrears to HED data.



Summary Hospital-level Mortality Indicator (SHMI), England, April 2021 - March 2022

Trust-level summary Return to contents

NHS Digital

To support the interpretation of the SHMI, various contextual indicators are published alongside it. A breakdown of the data by site of treatment is also available. The SHMI, site level breakdown and contextual indicator data for a particular trust are summarised on this page (scroll down the table to see all of the indicators / sites). Further information on the contextual indicators is presented on the following pages. Please see the SHMI interpretation guidance for more information on the site level breakdown.

Select or search for a trust to display a summary of thei

walsall

Walsall Healthcare NHS Trust

Trust-level data

As expected SHMI

62,620	1,400	1,325	1.0597
Provider spells	Observed deaths	Expected deaths	SHMI value

SHMI contextual indicators

Indicator	Value	England average
Palliative care		
Percentage of provider spells with palliative care treatment specialty coding	0.4	0.1
Percentage of provider spells with palliative care diagnosis coding	1.4	2.0
Percentage of provider spells with palliative care coding	1.5	2.0
Percentage of deaths with palliative care treatment specialty coding	11.0	2.0
Percentage of deaths with palliative care diagnosis coding	36.0	40.0
Percentage of deaths with palliative care coding	36.0	40.0
Admission method		
Crude percentage mortality rate for elective admissions	3.0	1.0
Crude percentage mortality rate for non-elective admissions	2.2	3.3
In and out of hospital deaths		
Percentage of deaths which occurred in hospital	68.0	67.0
Percentage of deaths which occurred outside hospital within 30 days of discharge	32.0	33.0
Deprivation		
Percentage of provider spells in deprivation quintile 1 (most deprived)	51.9	23.1

Site level breakdown (experimental statistics)

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description

Data quality notes
None

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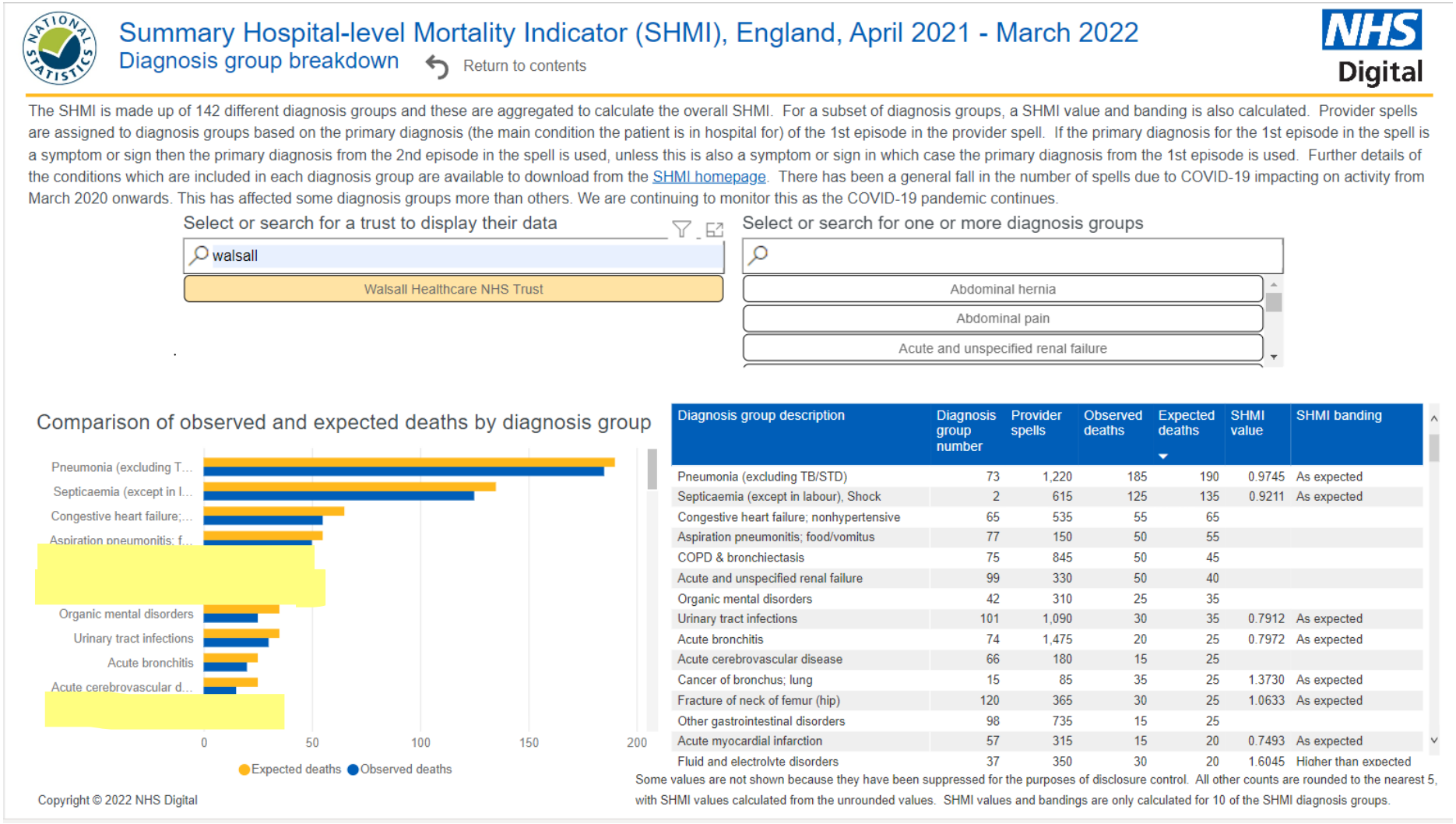
Some values are not shown because they have been suppressed for the purposes of disclosure control. All other sub-national counts are rounded to the nearest 5, with SHMI values calculated from the unrounded values. Percentages are calculated from the rounded values.

Figure 1: Data above shows that the SHMI for the Manor Hospital site is within expected range. Data for palliative care is recorded separately, this gives assurance that the Trust is not an outlier in relation to SHMI

Figure 2: Top causes of death



Summary Hospital-level Mortality Indicator (SHMI), England, April 2021 - March 2022
Diagnosis group breakdown
Return to contents
NHS Digital

The SHMI is made up of 142 different diagnosis groups and these are aggregated to calculate the overall SHMI. For a subset of diagnosis groups, a SHMI value and banding is also calculated. Provider spells are assigned to diagnosis groups based on the primary diagnosis (the main condition the patient is in hospital for) of the 1st episode in the provider spell. If the primary diagnosis for the 1st episode in the spell is a symptom or sign then the primary diagnosis from the 2nd episode in the spell is used, unless this is also a symptom or sign in which case the primary diagnosis from the 1st episode is used. Further details of the conditions which are included in each diagnosis group are available to download from the SHMI homepage. There has been a general fall in the number of spells due to COVID-19 impacting on activity from March 2020 onwards. This has affected some diagnosis groups more than others. We are continuing to monitor this as the COVID-19 pandemic continues.

Select or search for a trust to display their data
walsall
Walsall Healthcare NHS Trust

Select or search for one or more diagnosis groups
Abdominal hernia
Abdominal pain
Acute and unspecified renal failure

Comparison of observed and expected deaths by diagnosis group

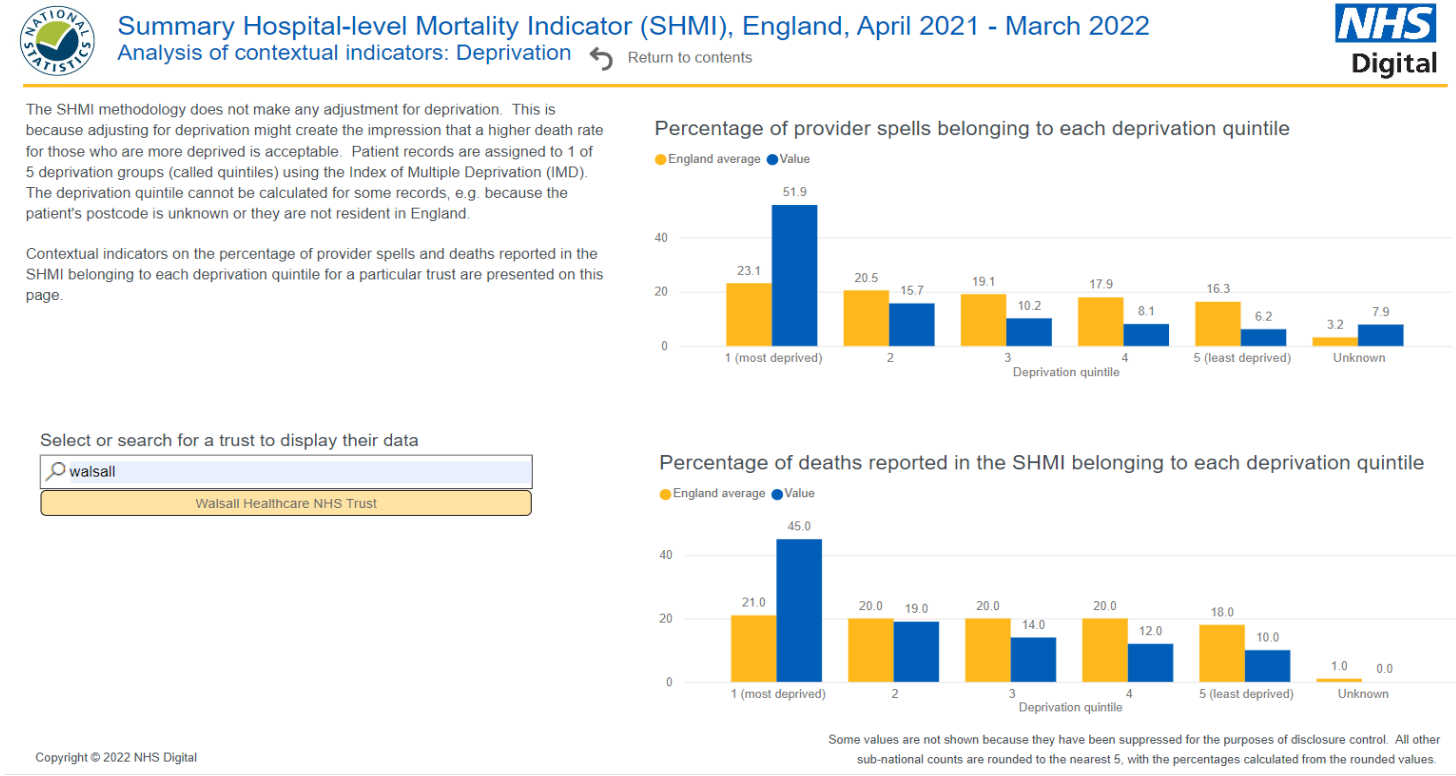
Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	SHMI banding
Pneumonia (excluding TB/STD)	73	1,220	185	190	0.9745	As expected
Septicaemia (except in labour), Shock	2	615	125	135	0.9211	As expected
Congestive heart failure; nonhypertensive	65	535	55	65		
Aspiration pneumonitis; food/vomitus	77	150	50	55		
COPD & bronchiectasis	75	845	50	45		
Acute and unspecified renal failure	99	330	50	40		
Organic mental disorders	42	310	25	35		
Urinary tract infections	101	1,090	30	35	0.7912	As expected
Acute bronchitis	74	1,475	20	25	0.7972	As expected
Acute cerebrovascular disease	66	180	15	25		
Cancer of bronchus; lung	15	85	35	25	1.3730	As expected
Fracture of neck of femur (hip)	120	365	30	25	1.0633	As expected
Other gastrointestinal disorders	98	735	15	25		
Acute myocardial infarction	57	315	15	20	0.7493	As expected
Fluid and electrolyte disorders	37	350	30	20	1.6045	Higher than expected

Some values are not shown because they have been suppressed for the purposes of disclosure control. All other counts are rounded to the nearest 5, with SHMI values calculated from the unrounded values. SHMI values and bandings are only calculated for 10 of the SHMI diagnosis groups.

This clearly indicates where observed deaths have exceeded expected deaths and areas the Trust should investigate, not necessarily the top cause of death. It can be clearly seen there are 3 areas where further investigation is needed, this would not be visible on current HED data. ***NHS Digital reporting provides assurance across the top 10 causes of death (reported monthly to Mortality Surveillance Group) as it identifies whether the number of deaths is within the expected range (this is not available in HED). We can then clearly identify areas of concern and investigate***. For example, pneumonia has been the highest cause of death within the Trust for some time, however NHS Digital reporting indicates that this is within the expected range.

Figure 3: Deprivation

Although SHMI is not adjusted for deprivation, NHS Digital use the 5 deprivation groups to report on percentage of provider spells and deaths in each deprivation quintile.



MEETING OF TRUST EXECUTIVE BOARD 5th October 2022			
Goscote Hospice Update			
Report Author and Job Title:	Sindy Dhallu Professional Lead – Palliative & End of Life Care Sally Killian - Community General Manager	**Responsible Director:**	Matthew Dodd -Director of Integration
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	The service transferred over to Walsall Healthcare Trust in October 2020 and access to hospice care for Walsall residents has increased, both in the numbers of people being admitted and when they are able to be admitted		
Advise	The model of care at Goscote Hospice is constantly being reviewed and developed		
Alert	There are ongoing discussions related to quality developments in the hospice, particularly around seven-day senior clinical cover.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There is a risk regarding the funding of the hospice which currently sits on the Trust risk register (No. 2963). There are ongoing discussions with Walsall Place based commissioners and WHT.		
Resource implications	Development of a seven-day medical / ACP model for Specialist Palliative Care.		
Legal and/or Equality and Diversity implications	Engagement event undertaken with the public to rename the hospice to gain a wider resonance across diverse communities within Walsall		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☒		

GOSCOTE HOSPICE

1. PURPOSE OF REPORT

To update the Trust Board on the changes that have occurred since the hospice transferred to Walsall Healthcare from the charitable organisation St Giles Hospice.

2. BACKGROUND

In 2020, the management of the hospice at Goscote transferred from St Giles Hospice to Walsall Healthcare Trust. As part of this transfer there was an expectation from commissioners that WHT would develop the range of palliative care services for people in Walsall by integrating existing community responses with the in-patient facility.

Walsall Healthcare reopened the hospice as an NHS provider on the 5th October 2020, under the leadership of the Palliative & End of Life Care Service. This was undertaken in the middle of the pandemic with the concomitant impacts on patient care and staff availability.

3.0 DETAILS

During the past 2 years the Palliative & End of Life Care Service has stabilised the hospice provision and has introduced some new roles and service developments.

3.1 Stabilisation of the Service

- ***Transfer and Integration:*** of St Giles Hospice staff to Walsall Healthcare.
- ***Nursing vacancies:*** The service inherited some vacancies which have all now been filled. In addition, numbers and roles have been expanded (for example with the introduction of the first ACP roles in Palliative and End of Life Care in an NHS organisation).
- ***Medical vacancies:*** A substantive Consultant in Palliative Medicine has been recruited across the Community and the Hospice, along with additional Speciality Doctors and a new FY3 role.
- ***Contracts:*** Several contracts were novated to support the hospice function including out of hours medical provision (non-specialist Palliative Care), while other contracts such as catering, needed to be established with new providers.
- ***Training:*** A training needs analysis of all nursing staff has been undertaken and any identified gaps have been addressed. This has enabled the introduction of further skills to enhance the service
- ***Governance:*** All processes regarding risk management, health & safety and IPC have been aligned with Trust practice

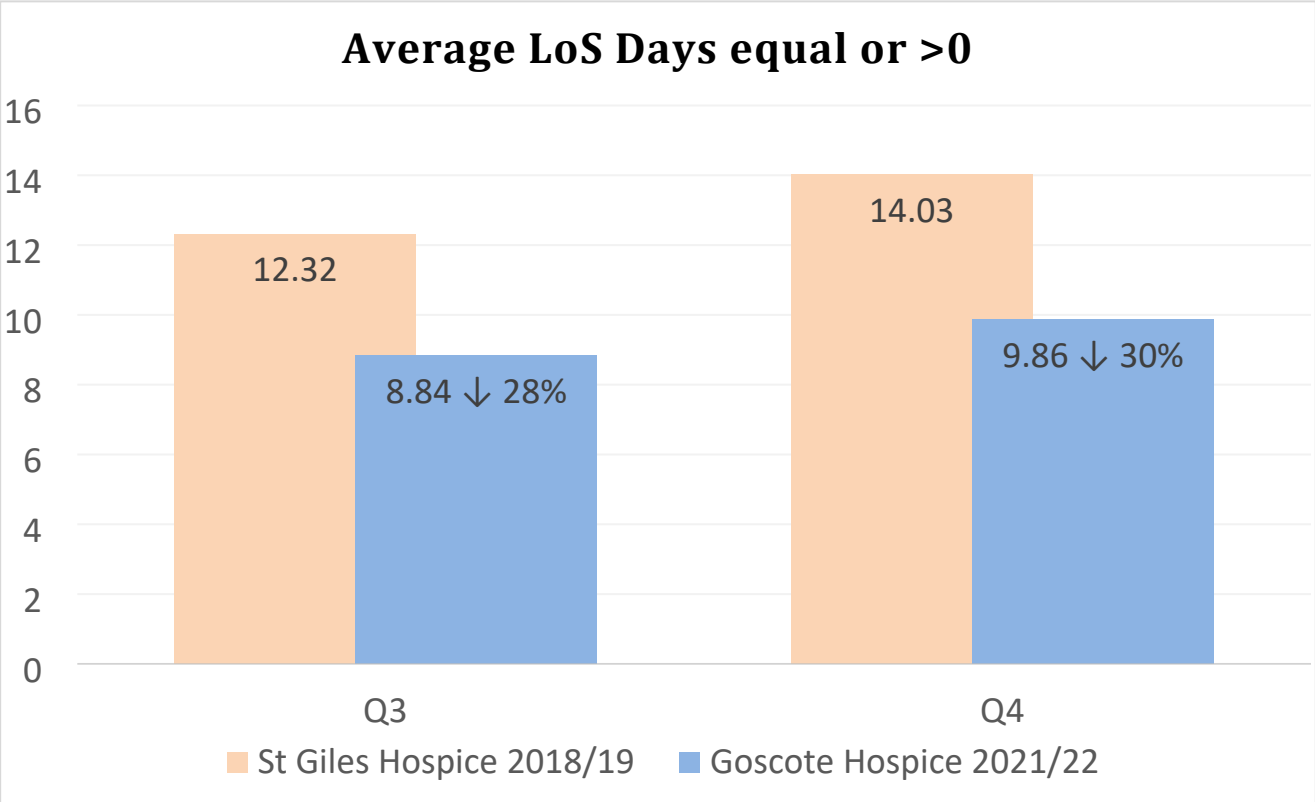
3.2 Service Improvements

Enhanced Model of Care: The St Giles Walsall Hospice focused on a nurse-led model, admitting patients at end of life without complex needs. The Palliative & End of Life Care Service has expanded this model by targeting investment into the senior

clinical team at the hospice. This has increased admissions, discharges, and levels of complexity of patient that can be admitted into Goscote Hospice.

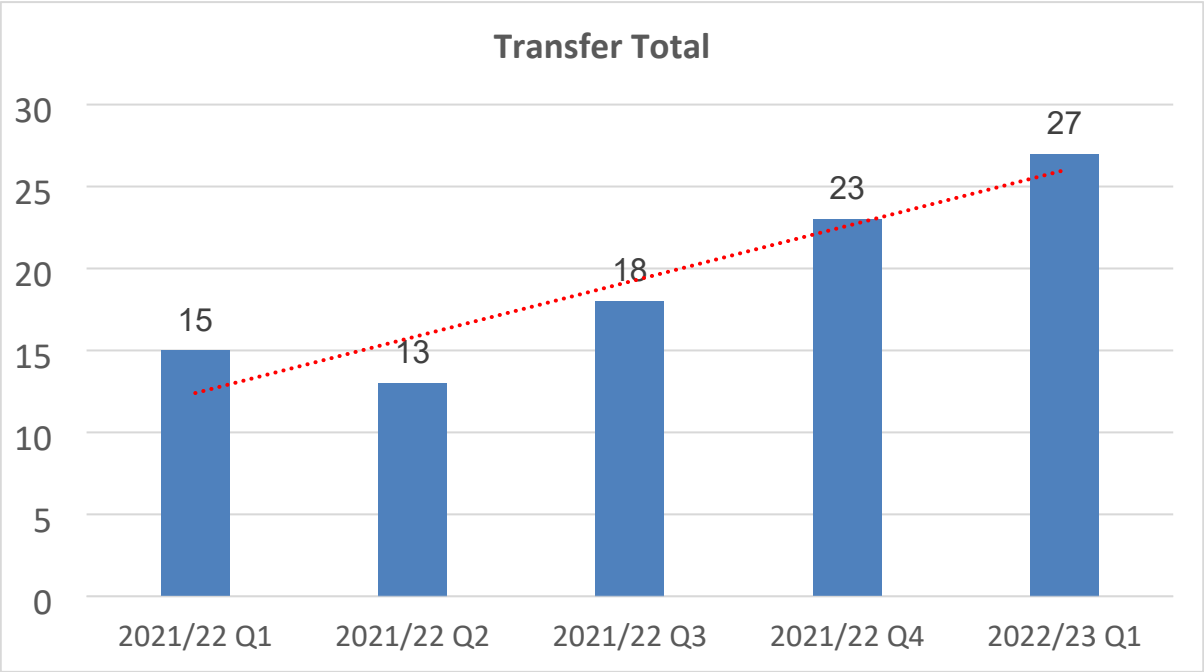
This has had the following impact:

- **Length of Stay**[1]
  The length of stay has reduced for patients in Goscote Hospice compared to St Giles Walsall Hospice. Goscote Hospice aims to stabilise patients' symptoms and discharge them to their preferred place of care / death, if this is not the hospice.

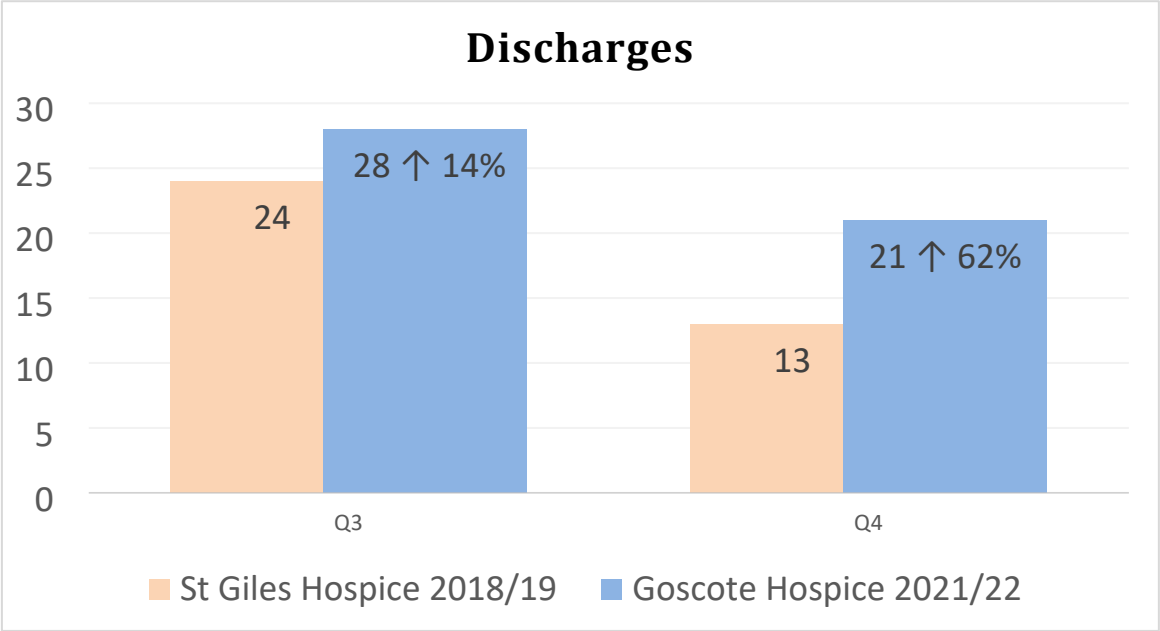


- **Impact on Palliative Care Pathways in Walsall Manor Hospital**
  The graph below shows the number of transfers from Walsall Manor Hospital to Goscote Hospice from April 2021 until June 2022. There was an increase of 80% in transfers from the hospital during 2022/23 Quarter 1, compared to the previous year.

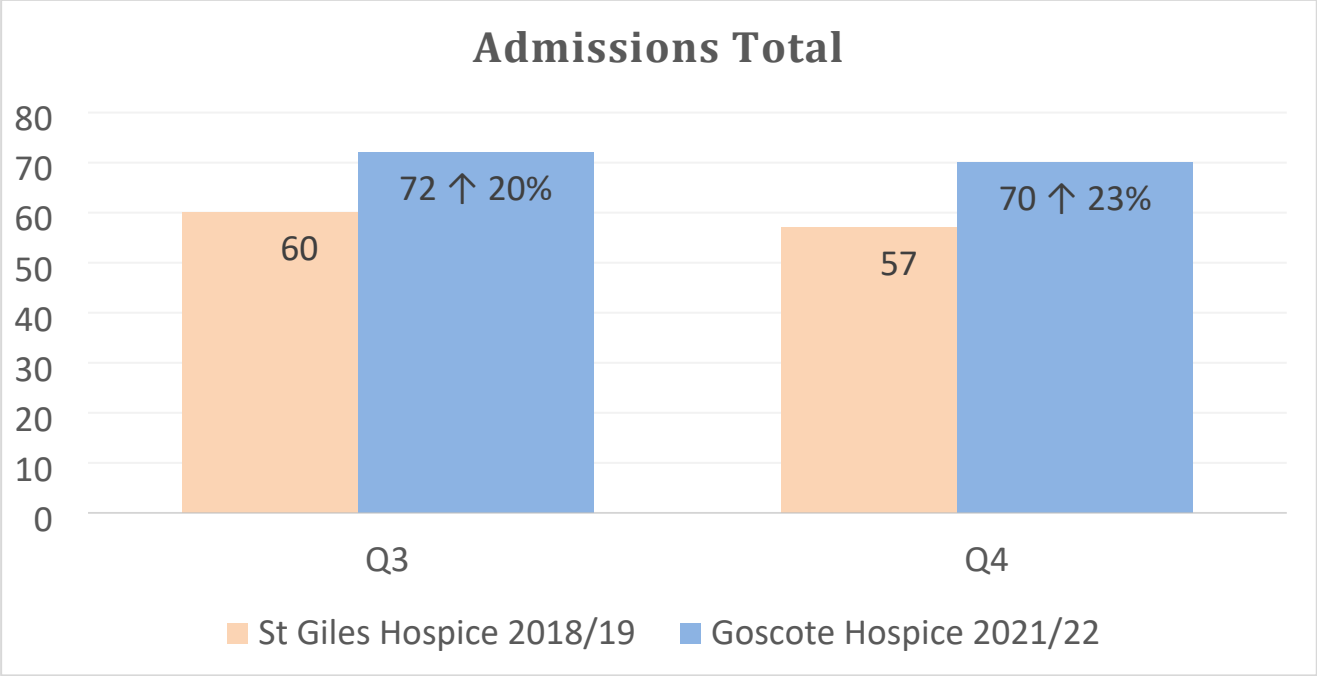
[1] Comparative data Q3 & 4 for 2018/19 and 2021/22 to exclude Covid impact



- **New Model of Care**
  Discharges: More symptomatic patients are now supported within the hospice and their symptoms stabilised to be cared for at home. Discharges to other preferred places of care or death increased by 62% during Quarter 4, 2021/2022 compared to Q4, 2018/19 under St Giles.



Admissions: St Giles hospice limited admissions to one admission a day due to their medical staffing availability. With the enhanced medical cover, Goscote Hospice can take more admissions per day to ensure patients' preferred place of care / death is achieved.



- **Expanding the range of recipients of Palliative Care: Focus on traditionally low users of these services**

  Working with social prescribers: The outreach team is now working alongside the social prescribers to support in the delivery of targeted interventions. These targeted interventions support those who are socially vulnerable to maintain themselves in community settings by decreasing social burden. The team are training the wider Palliative Care Teams to increase their understanding of social prescribing, with the aim of ensuring robust referral routes and greater use of this service.

  Deprivation and Mortality project: The outreach team is now focused on further interventions in the local community:

  - Increase community service-led activities to promote Palliative Care Services (significantly reduced during pandemic).
  - Provide 'prevent cancer' education.
  - Continue working with low performing GPs to improve the uptake of screening.
  - Provide easy-to-read information.
  - Host live demonstrations of using screening kits.

  Asian Women's Group for Breast Cancer support: A support group was established to support patients from an ethnic minority. This has been very successful and will now be used as a driver for other initiatives to improve access for groups that are low users of Palliative Care.

- **Staffing**
  Culture change: There has been a significant culture change for staff that transferred over into WHT. Staff have communicated there has been a tangible

change in the patients being admitted. Staff have been supported throughout these changes and there is a further event planned in October to involve them in changing the model of care.
Recruitment: The service has started to attract staff from neighbouring hospices. It is reported that Walsall is an attractive place to work with the integrated Acute, Community and Hospice model.
Staff skill set: Staff skills are continually reviewed and followed up with training to ensure that they can care for the increasing acuity of the patients being admitted.

- **Governance**
  Increased incident reporting: In line with developments across the Trust, there has been a focus on encouraging the reporting of incidents so that lessons can be learnt and processes improved.
  Increased audit participation: The hospice has been able to align with audits undertaken on the acute site and ensure joint learning and seamless care for patients.
  Member of Hospice UK: This allows the service to balance the needs and developments of hospices in the UK with the requirements of an NHS organisation.
  User Experience: The service is implementing a specialist system to understand user experience that has been developed within other hospices. This involves using a suite of outcome measures which includes symptom management.

3. FUTURE PLANS FOR THE DEVELOPMENT OF THE SERVICE

- To move towards a 7-day medical / ACP model to support weekend admissions and discharges. This will support patient flow from the Acute Trust and Community Services.
- To negotiate with the ICB regarding the funding for Goscote Hospice to further expand the range of interventions.
- To scope the feasibility of funding for a Hospice at Home service.
- A virtual ward is being developed to enable fast-track Palliative care patients to be transferred from the hospital seamlessly.
- Increase in pharmacy provision to support Community Palliative Care.

4. RECOMMENDATIONS

- The board to note the improvements undertaken as part of Goscote Hospice transfer
- The board to support the ongoing changes to the model of care and the work towards facilitating 7-day admissions

MEETING OF THE PUBLIC TRUST BOARD **Wednesday 5th October 2022**			
Annual Report Spiritual, Pastoral and Religious Care (SPaRC) 2021-2022			
Report Author and Job Title:	Garry Perry Associate Director – Patient Relations and Experience	**Responsible Director:**	Lisa Carroll Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	The enclosed report details the activity by encounter type and belief of the Chaplaincy team in addition to detailing the work of the Bereavement team throughout the year 2021-2022		
Recommendation	Committee is requested to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Annual Report – Spiritual, Pastoral and Religious Care (SPaRC) 2021-2022

1. PURPOSE OF REPORT

The purpose of the report is to report the activity and associated work of the Spiritual, Pastoral and Religious Care Team in the year 2021-2021.

2. BACKGROUND

As the introduction in the attached report advises, following the onset of Covid-19 unexpected opportunities were afforded by our response to the pandemic. The move to provide and have available different means of access, the provision of faith resources such as the Quran cubes and Sikh radios have been welcomed. The SPaRC team are now embedded within the Patient Experience structure - adding value to our ability to engage and support an enhanced offer to patients, carers, staff, and others wherever the ask.

During 2021/2022 we also begun to explore different ways of working, developing our existing internal and external relationships. We are optimistic and excited about the future and following the appointment of a new Head of Spiritual, Pastoral and Religious Care across both Wolverhampton and Walsall we will build on the working partnership with the Royal Wolverhampton NHS Trust, as we search to align practices and lead a service that is committed to caring for the spiritual, pastoral, and religious needs of patients, staff, and relatives of all faiths (and of none).

3. DETAILS

Please see enclosed report.

4. RECOMMENDATIONS

Note the contents of the annual report.

APPENDICES
Annual Report 2021-2022

Walsall Healthcare NHS
NHS Trust

Patient Relations
& Experience

Spiritual, Pastoral and Religious Care

Annual Report: 2021 - 2022

GARRY PERRY, ASSOCIATE DIRECTOR

PATIENT RELATIONS AND EXPERIENCE

Introduction

Caring for the pastoral, spiritual and religious needs of patients and caregivers contributes positively to patient and staff experience.

In the past year the Chaplaincy team have demonstrated that the vital work they do is as much about 'Spiritual' care and not narrowly 'Religious' care – a perception that some have traditionally held.

Following the onset of Covid-19 unexpected opportunities were afforded by our response to the pandemic. The move to provide and have available different means of access, the provision of faith resources such as the Quran cubes and Sikh radios have been welcomed.

The team are now embedded within the Patient Experience structure - adding value to our ability to engage and support an enhanced offer to patients, carers, staff, and others wherever the ask. In the past year the team was strengthened following the recruitment of two new Chaplains in Reverend Edd Stock, Anglican Chaplain and Shyam Singh, Sikh Chaplain. We also welcomed back chaplaincy volunteers whose support is invaluable.

During 2021/2022 we also begun to explore different ways of working, developing our existing internal and external relationships. We are optimistic and excited about the future and following the appointment of a new Head of Spiritual, Pastoral and Religious Care across both Wolverhampton and Walsall we will build on the working partnership with the Royal Wolverhampton NHS Trust, as we search to align practices and lead a service that is committed to caring for the spiritual, pastoral, and religious needs of patients, staff, and relatives of all faiths (and of none).

Garry Perry
Associate Director
Patient Relations and Experience

Reverend Linford Davis, Head of Spiritual, Pastoral and Religious Care (SPaRC)

Reverend Linford Davis was appointed to this brand-new role, overseeing the multi-faith chaplaincy teams at both Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust. Linford, who lives in Wolverhampton, said he was proud to be joining the NHS following a period in the justice sector, which he described as “challenging at times, but extremely rewarding.” He said: “Religious, spiritual and pastoral care is often about healing the wounds you can’t see.”

In 2016, aged just 23, he was one of the youngest chaplains in the UK when he was appointed as a chaplain to work within a West Midlands prison, which held 2,100 male inmates. Linford’s commitment to his role and his support and encouragement for colleagues was recognised and he was promoted to a managerial role.

“I joined the prison initially in 2014 in a role which supported prisoners with independent living and life skills, but the managing chaplain heard I was of faith, and had undergone my ministerial training. He asked if I would be interested in joining the chaplaincy team and this kick-started my chaplaincy career where I would support prisoners in all manner of ways.” he said. “I grew up in a Christian family with parents who are faith leaders. Their example of selfless service inspired me greatly and, as I developed a personal faith, I wanted to reach out to those that are separated and isolated; those who are marginalised and on the fringes of society.

“My personal belief is God does not use superheroes but empowers ordinary people to care for others in an extraordinary way. In my role I can inspire people, and challenge perceptions – helping in that moment and hopefully, in my new role, beyond the hospital doors and into the rest of their life.” The teams of chaplains across the Trusts offer support in all situations to staff, patients and their families from all backgrounds.

Linford added: “We offer support to anyone associated with the trust, to reconnect with the things in life that help them to make sense of what is happening, or which can help with recovery (if receiving care or treatment. We make no assumptions and pass no judgement. You do not need to be of faith either, we try to connect first on a human-to-human level, which can consist of a simple conversation or times of reflection."

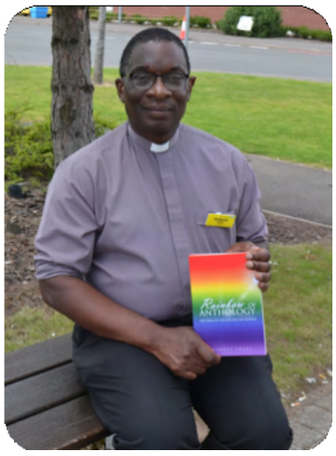
The Walsall Healthcare Chaplaincy Team

Reverend Joe fielder – Team Leader, Chaplaincy, Spiritual Care & Bereavement

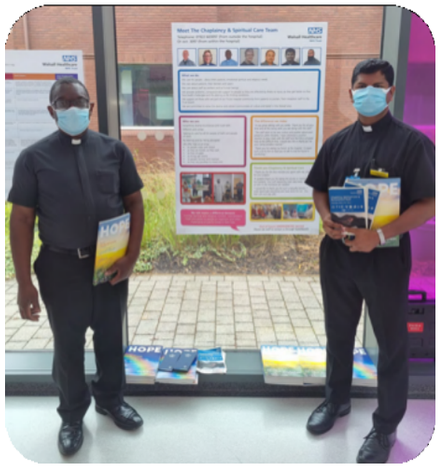
Consolidating the team.

As a team we have been through a time of change, growth and development, we are proud of the changes that we have seen in service delivery, particularly those that have led to a reinforcement of the value of chaplaincy and spiritual care; those that have enabled better communication, better use of time such as using service re-design to develop our "Baby Notes" and raised the profile of chaplaincy and spiritual support.

We are glad for the growing sense of collaboration amongst the Chaplaincy Spiritual Care team. The addition of Edd Stock, Shyam Singh and Nasima Bhayat have strengthened us as a team and deepened our diversity and skill set to meet the needs of our local faith's communities and cultures, within the Trust and outside. Through joint working on some projects, we have strengthened ourselves as a team.



Significant changes in the past year have included Rev Anthony Swaby moving to be based part time at the Palliative Care Centre over 4 days, which has increased the sense of 'chaplaincy spiritual care 'presence there, and enabled more regular contact with patients, families, and staff. Alongside this Ahmed Salloo our Muslim chaplain and Edd Stock having opportunities to grow in leadership and some aspects of line management responsibility.



Faith Matters

Patient Experience Week - July 2021

We were active participants in marking Patient Experience week in July 2021. We produced posters to help people understand the scope of our work, and to be able to recognise team members. We staffed an information table and joined in various ‘trolley trips’ to take information about services directly onto wards. Faith profiles were produced which are now included in the Trust end of life blossom boxes and a larger information guide is available that explains what might be required or desired by patients and their relatives.

All faiths hold human life to be sacred, therefore when that life is endangered any religious observance which interferes with assistance may need to be overruled. However, it is always important to respect the beliefs of the individual, and to keep them fully informed.

Faith/Culture & Language	Dress	Diet	Physical Contact	Medical Treatment	Dying	Death Customs	Organ Donation & Post Mortem
Baha'i Mainly English, also Arabic & Farsi	No special dress code.	Baha'is do not normally drink alcohol, but may take it if medically prescribed.	Unlikely to object to be touched or treated by members of the opposite sex.	No special requirements.	No special requirements, but a family member or friend may read the Baha'i scriptures. They believe in an after-life.	The body is washed or wrapped in white silk/cotton & special ring is placed on the finger of those aged 15 upwards. The body should not be embalmed and should be buried in a durable coffin within an hour's travel time from place of death. A special prayer for the dead is said.	Donations are permitted. Post Mortems are acceptable if necessary.
Buddhist English, Cantonese, Hakka, Japanese, Thai, Tibetan, Sinhalese	No special dress code for lay Buddhists.	Often vegetarian or vegan. Salads, rice, vegetables & fruit are usually acceptable.	May be touched by person of either sex for comfort, treatment, and medical examinations.	No special requirements.	May wish to maintain a clear mind when dying. May want to have quiet, or time with another Buddhist chanting sacred texts. Non- Buddhists should treat the person mindfully. They believe in reincarnation.	The body may be handled by non-Buddhists. Many believe that the soul does not immediately leave the body after death so it is important to treat the corpse as a person not an object. It should be moved as little as possible.	These are personal decisions (unless legally required). See previous section.
Christian There are many different denominations with different requirements – please ask.	Most have no special dress code, except for clergy and members of religious orders. Some women cover their heads.	Generally all foods are permissible. Some follow Jewish customs, some are vegetarian. Some do not use alcohol & other stimulants.	Most have no objection to being touched by members of the opposite sex.	Some may decline conventional medical treatments. Some have special procedures regarding blood transfusions.	Some appreciate quiet, some value prayers or scripture being read. Some require Holy Communion and/or the Sacrament of the Sick. They believe in the resurrection.	Choice of cremation or burial is personal.	There is strong support for organ donation in line with teaching on self-sacrifice and compassion. There is no religious objection to Post Mortems.
Hindu English, Bengali, Gujerati, Hindi, Punjabi, Tamil	Modesty and decency are essential.	Hindus do not eat beef. Some are strict vegetarians and also avoid fish, eggs and animal fat. Salad, rice, vegetables, yoghurt, milk products & fruit are acceptable.	Some prefer to be comforted and treated by someone of the same sex.	Generally no special requirements. Some prefer Ayurvedic medicine.	Most would want prayer with a mala (prayer beads). Some may prefer the company of someone of the same sex. They believe in reincarnation.	The body should be undressed and washed, preferably by someone of the same sex. Jewellery and religious items should not be removed. The body should be placed with head facing north (feet south), arms placed to the side and legs straightened.	There is strong support for organ donation. If PMs are unavoidable they are permitted, all organs should be returned to the body before the funeral.
Humanist English or any other language	No special requirements.	No particular requirements. Some are vegetarian or vegan.	No specific restrictions on physical contact.	No special requirements.	They prefer to have family or close friends with them. They may object to prayers being said or reassurances given based on belief in God or after-life.	No specific requirements. Many request a non-religious ceremony.	These are personal decisions unless legally required.
Jehovah's Witness English or any other language	No special requirements.	They do not eat food containing blood eg sausages. Some may be vegetarian.	No specific restrictions.	Blood donations are strictly prohibited, though some minor blood components & non-blood volume expanders are allowed – on admission special forms should be signed.w	There are no special rituals or requirements.	There are no special rituals or requirements.	Organ donations are allowed as long as no blood is transferred. Post mortems are allowed if necessary.
Jewish English, Hebrew and Yiddish	Some keep their heads covered at all times. Some men wear black and have side-locks and beards. Most have no strict dress code though women and girls generally dress modestly.	Pork and shellfish are forbidden. Fish must have fins and scales. Red meat and poultry must be kosher. Milk and meat are usually kept and eaten separately. Vegetarian food is acceptable. Alcohol is usually acceptable. Kosher food is available.	For some it is usually unacceptable to be touched by someone not a close family member. However, the need to save life always takes precedence.	All laws normally applying to the Sabbath or festivals are overruled for the purposes of saving life or safeguarding health.	It is usual for a companion to remain with a dying Jewish patient until death, sometimes until the Burial Society comes for them. If they have no family/friend accompanying them contact the on-call chaplain. The dying person should not be touched or moved more than is necessary. He or she may wish to recite the Shema (The Lord our God is One…) Most believe in an after-life.	The Jewish Chaplain should be notified on death so that the appropriate Burial Society can be contacted. (If unavailable contact the on-call chaplain). When a person dies the eyes should be closed and the jaws tied. The body should be covered in a plain white sheet, arms by the side with palms facing upwards. If the family is not present it is permissible to remove jewellery.	In principle organ donation is supported, but each case must be considered individually. Post mortems are only allowed if legally necessary.
Mormon Latter-Day Saints English and any other language	Some wear white one or two piece underclothing (endowment) which is considered sacred. This should not be removed except in times of emergency or incapacity.	Coffee, tea, alcohol, cola and tobacco are forbidden. Alcohol and caffeine as part of prescribed medication is permissible. If medically fit enough they fast for one 24 hour period a month.	No specific restrains.	Generally no special requirements. Blood transfusions are acceptable.	Most would request prayers from their own minister.	An endowed member should be buried wearing the special undergarments. Generally cremation is not encouraged, but it is the family's decision.	Organ donations are permissible and there is no objection to post mortems.
Muslim English, Arabic, Bengali, Dari, Farsi, Gujarati, Punjabi, Pushto, Turkish, Urdu & many others	Some Muslim women and girls wear a head covering. All are expected to dress modestly. Both men and women may choose to wear clothes that reflect their cultural background.	Pork and alcohol are forbidden. Meat must be halal. Kosher food is usually acceptable, as are vegetarian meals and fresh fruit.	Most prefer to be treated by someone of the same sex, but either is permissible.	Blood transfusions are acceptable. In the case of other interventions such as organ transplants the family's views should be sought but most accept.	The dying person's face should be turned towards Mecca (south-east). They need to say or hear "There is no God but The God, and Mohammad is his prophet." in Arabic. (If no one else is available you may say it for them in English). They believe in an after-life, and that illness & death should be faced in a spirit of acceptance of Allah's (God's) will.	The body should be laid on a clean surface and covered in a plain cloth with the head on the right shoulder and facing Mecca. The bodies of men and women should be handled by someone of the same sex and placed in a designated area, men and women separated. Next of kin usually make arrangements for burial which takes place as soon as possible.	Most will accept and donate organs. If post mortems are unavoidable they are permitted, all organs should be returned to the body before the funeral.
Pagan Mainly English	Ritual jewellery is common and holds deep significance. Some wear a special ring the removal of which would cause distress.	Most eat meat and drink alcohol, but some are vegetarian or vegan.	No specific restrains.	There are no particular requirements but alternative treatments may be preferred.	Most believe in reincarnation.	The emphasis in funerals is on joyfulness for the departed in their passing to new life.	There are no formal objections to either.
Sikh English, Hindi, Punjabi, Swahili, Urdu	Initiated Sikhs wear 5 K symbols: Kesh (uncut hair), Kangha (comb), Kara (steel bangle), Kirpan (short dagger) and Kachhera (shorts). Most men wear a turban, women cover their heads.	Many are vegetarians or vegan and do not eat eggs. Those who do eat meat will generally avoid beef. Salads, rice, dahl, vegetables and fruit are acceptable. Tobacco, alcohol and drugs are forbidden.	Most prefer to be treated by someone of the same sex, but either is permissible.	Some prefer Ayurvedic medicine. In general cutting or removing any body hair should be avoided. If it is necessary it mustn't be thrown away but given to another Sikh to dispose of.	The dying person may want access to Sikh scriptures. They believe in reincarnation.	The 5 Ks should be left on the body. Deliberate expressions of grief are discouraged. The dead are cremated.	Organ donation and post mortems are permitted.
Spiritualist English and any other language	There are no special requirements.	There are no special requirements.	No specific restrains.	While accepting conventional treatments some may request a Healer for Laying on of Hands and prayer.	Acceptance and a peaceful mind are possibly important as the state of mind is believed to influence the transition to the spirit realms. Friends who have passed on will meet them and welcome them.		Organ donation and post mortems are permitted.

Patient & Staff Engagement

Chaplaincy in practice

We took some time as a team to reflect on and discuss the development of Chaplaincy practices. We have produced a standard operating practice enabling us to review the scope of our work, to identify what is good and best practice and to consider how our work could better express our Trust values, and to also identify the potential for other areas of work and our own development. We aim through practice to bring a level of a consistency in practice, and act as a training guide for new team members and a benchmark for good professional practice.

Getting "out there"

As a chaplaincy team the vast bulk of our work is "out there" – either on wards, or on corridors or whichever place people stop us to ask us for support. This was brought powerfully home to me when on a visit to the Spar to buy some milk for the morning coffee; a person stopped me by the milk fridge and said "You may not remember me, but can I say 'Thankyou' "It turned out that when we had last spoken, he had had been an in-patient, seriously ill with Covid and feeling very isolated and fearful.

Chaplaincy support had helped him find a source of spiritual strength and comfort and had provided a level of practical support in helping him communicate with his wife and family that had made a great deal to him as he slowly recovered. To see him standing up, able to speak, and in such better place of health was a huge encouragement. Other team members have similar stories of pastoral encounters where their "little thing" of pastoral care has meant a "great thing to people". So, whilst as chaplains we must and should respond to specific referrals, we also endeavour to have a regular mechanism of visiting every area, ward, and department to say "Hello" and "How are you?" and especially to staff to provide them with an easily accessible form of pastoral care and support

Patient & Staff Engagement

Staff support - Schwartz Rounds

Chaplaincy team lead Joe Fielder has been part of the Schwartz Rounds steering panel, since arriving at the Trust.

These focused times for reflection enables staff as individuals or as small groups from wards or departments have an opportunity to hear panellists describe and reflect on experiences from clinical, acute or community care which have impacted them.

They have often proved to be a means of processing difficult experiences constructively and gaining a better perspective.

Topics have ranged from “The patient I can never forget” to the experiences of international nurses, to dealing with sudden and exceptional trauma. Joe in the last year has completed his training as a Schwartz Round facilitator and will be chairing these in the future.

The presence of Chaplaincy and Spiritual care team members at these Rounds highlights the important role this department has in meeting the health and well being needs of the wider staff community.

Patient & Staff Engagement

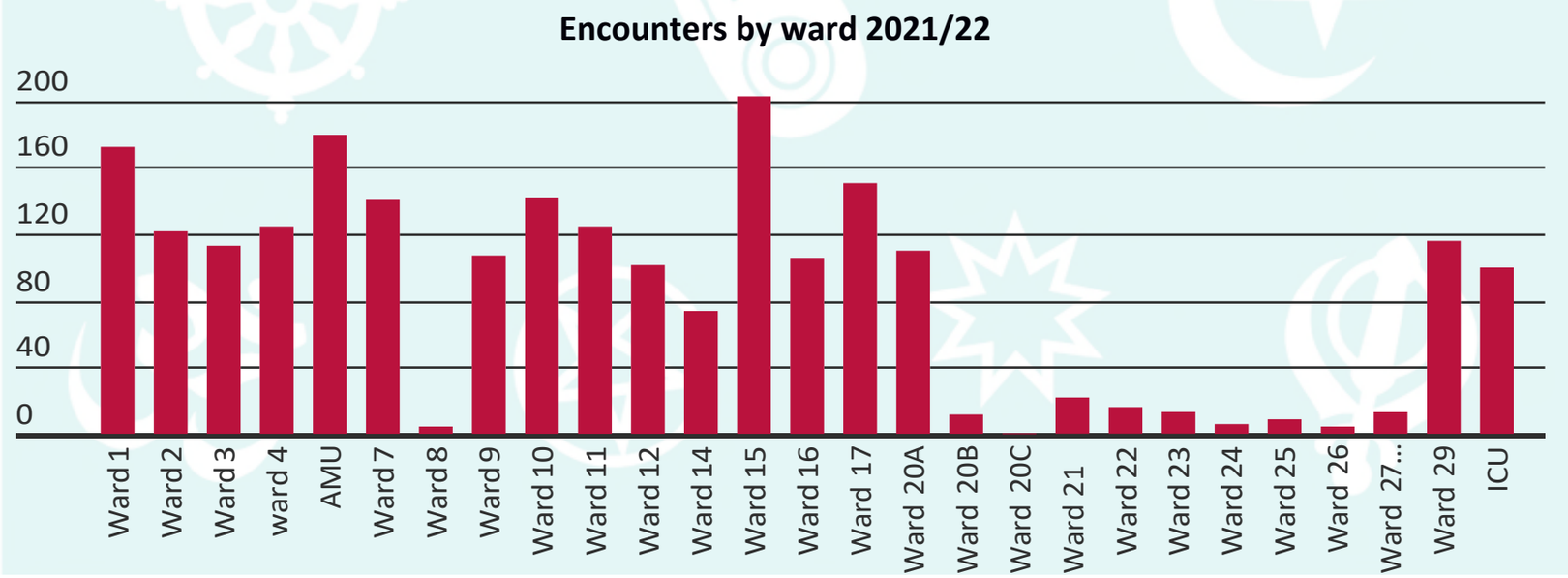
Re-introducing Volunteers

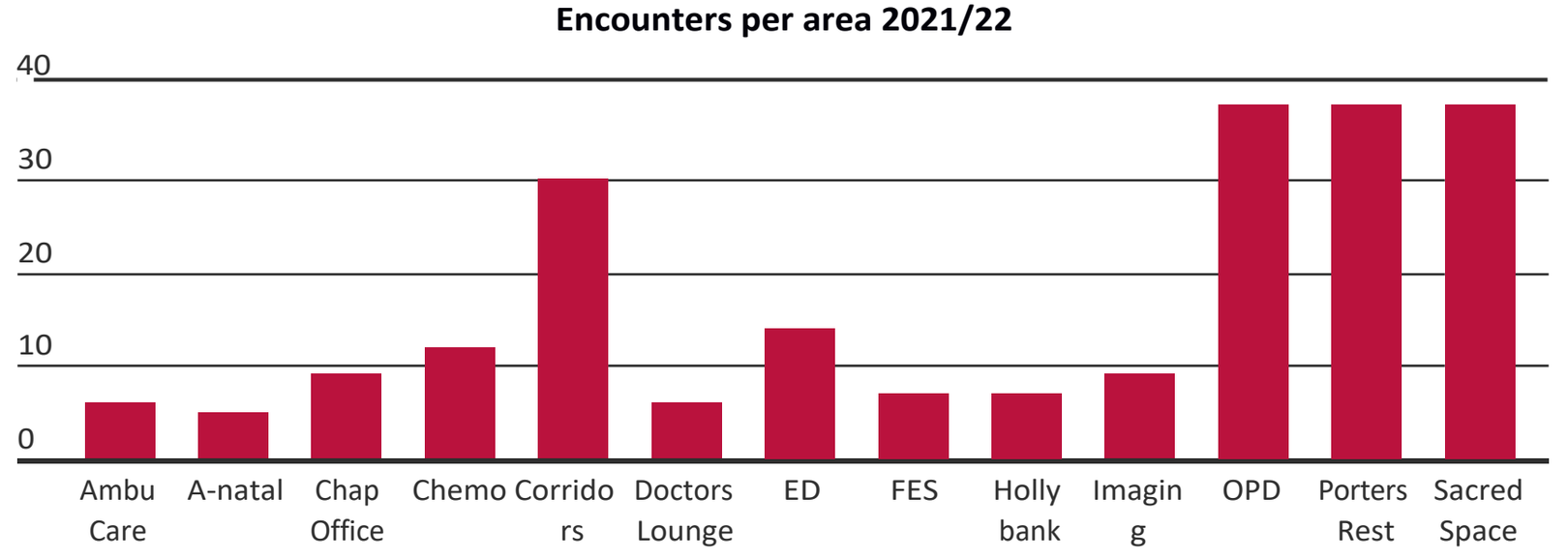
Reverend Edd Stock has taken the lead on re-introducing and recruiting chaplaincy volunteers to pastoral visiting. One of the knock-on effects of the Covid lockdowns was the cessation of chaplaincy volunteers visiting. But in 2021/22 we successfully relaunched the chaplaincy volunteer's programme.

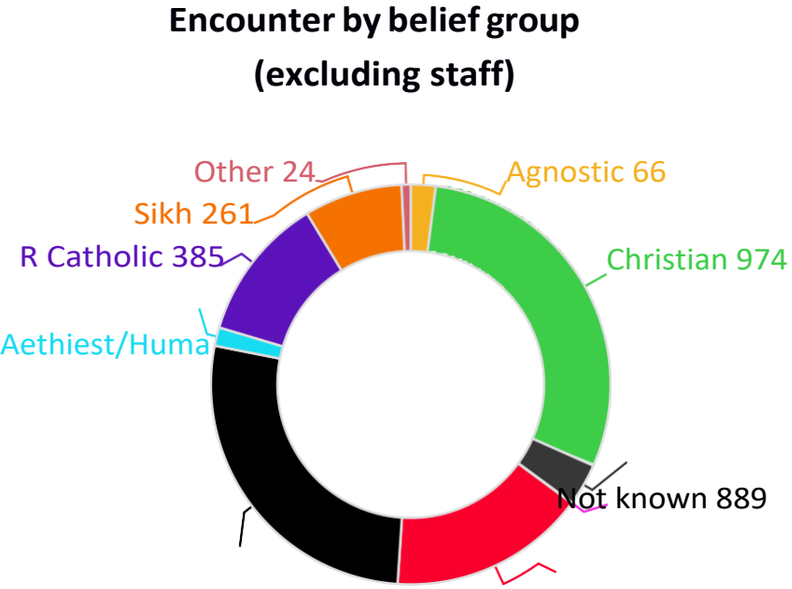
Some previous volunteers have been able to re-join the team, and we have advertised for volunteers through local faith and belief networks. We are really pleased to start to see very able and 'life-experienced' local people join our new look volunteer team with its slightly different approach. Volunteers are now allocated a ward to enable better week in week out continuity of contact with staff, as well as provide a regular face on the wards for patients. Chaplaincy volunteers are now recruited as part of the wider Trust Voluntary Services and our recruitment, training and induction is aligned with them. We look forward to the numbers of volunteers growing over the coming year.

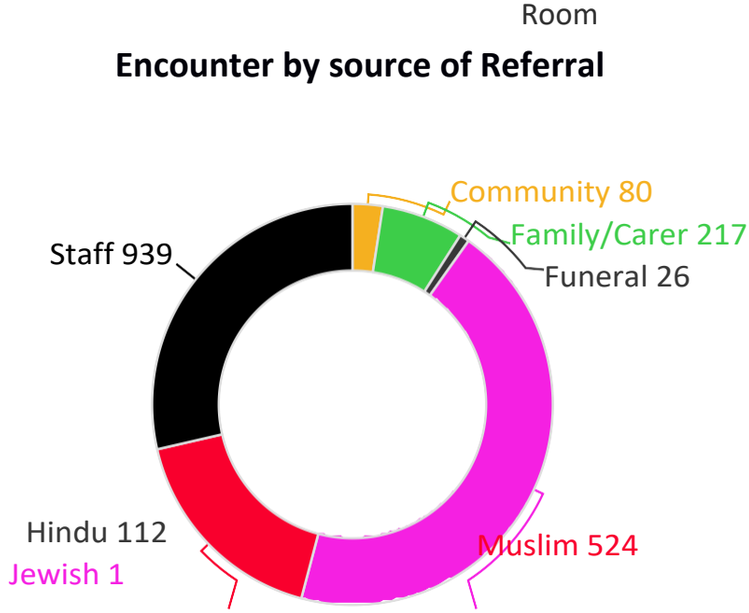
Patient & Staff Engagement

Patient & Staff Engagement







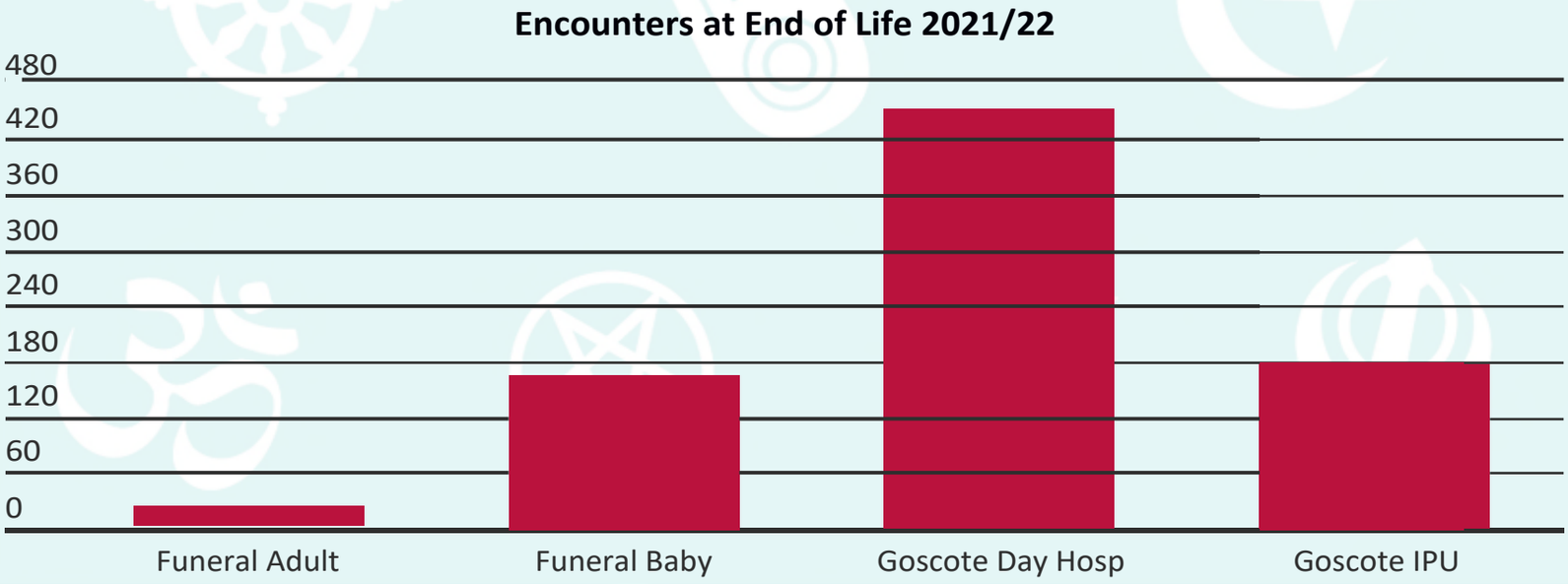


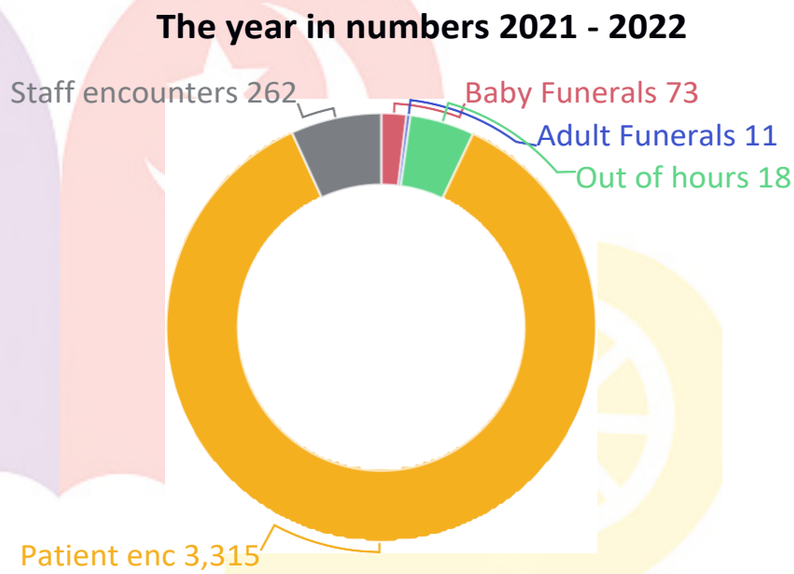
Ongoing support 56

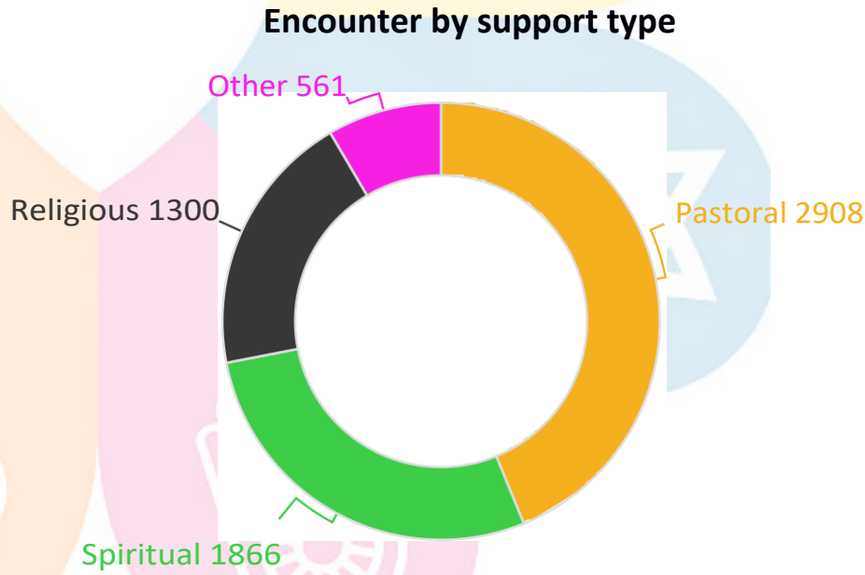
General visiting 145

Patient & Staff Engagement

Patient & Staff Engagement







Patient & Staff Engagement

Bereavement

Our bereavement co-ordinator, Tim Mortimer returned from his secondment at the vaccination centre in June 2022. The team moved office location to a new base situated next to the Mortuary along with the Medical Examiner function. This has enabled greater partnership working and made for a more effective service, particularly relating to death certificate queries. This team is often unseen and yet deals with some of the most distressed relatives / carers at some of their lowest points in life. The team strive to deliver a service that is built on the core value of compassion, handling situations with professionalism and sensitivity.

The team work closely with Trust Chaplains in the arrangement of contract funerals for adults with no next of kin or where families have no means to pay for funerals. 11 contract funerals were arranged in the past year which meant the deceased was laid to rest with dignity. 73 baby funerals were also arranged in conjunction with the Trust bereavement midwife and families dealing with the loss of a child.

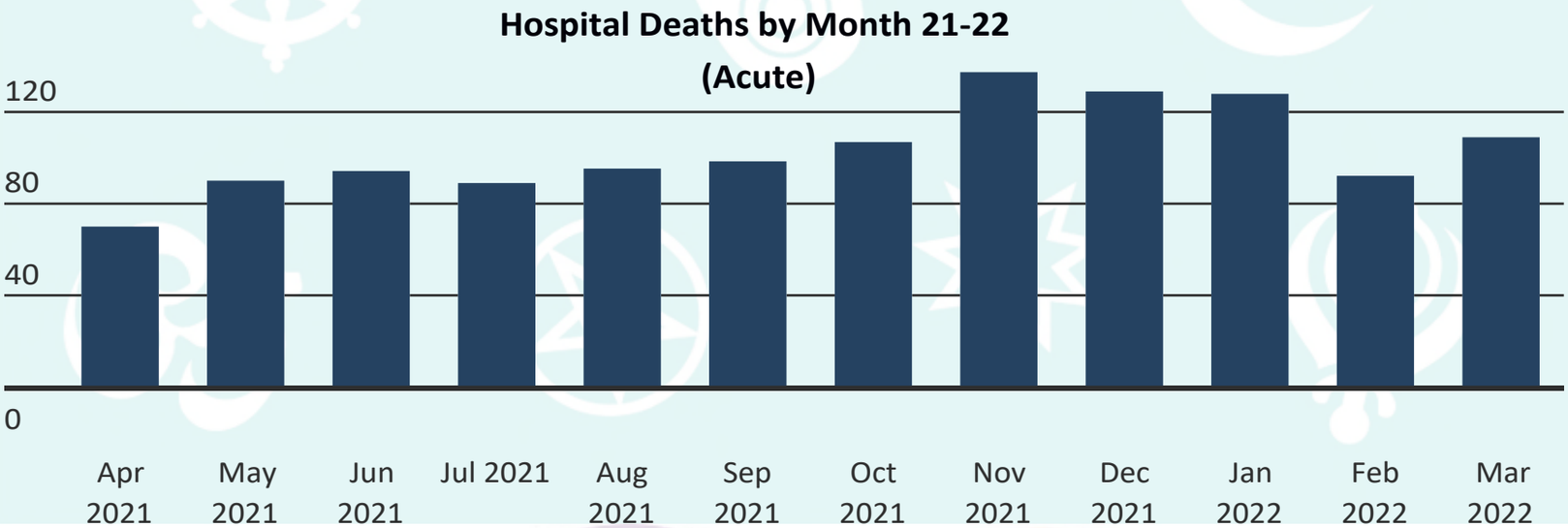
Service developments have included a new bereavement handbook and this information is also available on the Trust website. Following Covid, there has been a return to death certificates being completed and death registered in-person. The can and do assist with booking these appointments. Death certificates have to bee completed within a 5 working day timeframe unless there is a referral to the coroner for clarity over the cause of death. The Coroner and his team are another key contact for the bereavement team who work closely with them, and families during this process.

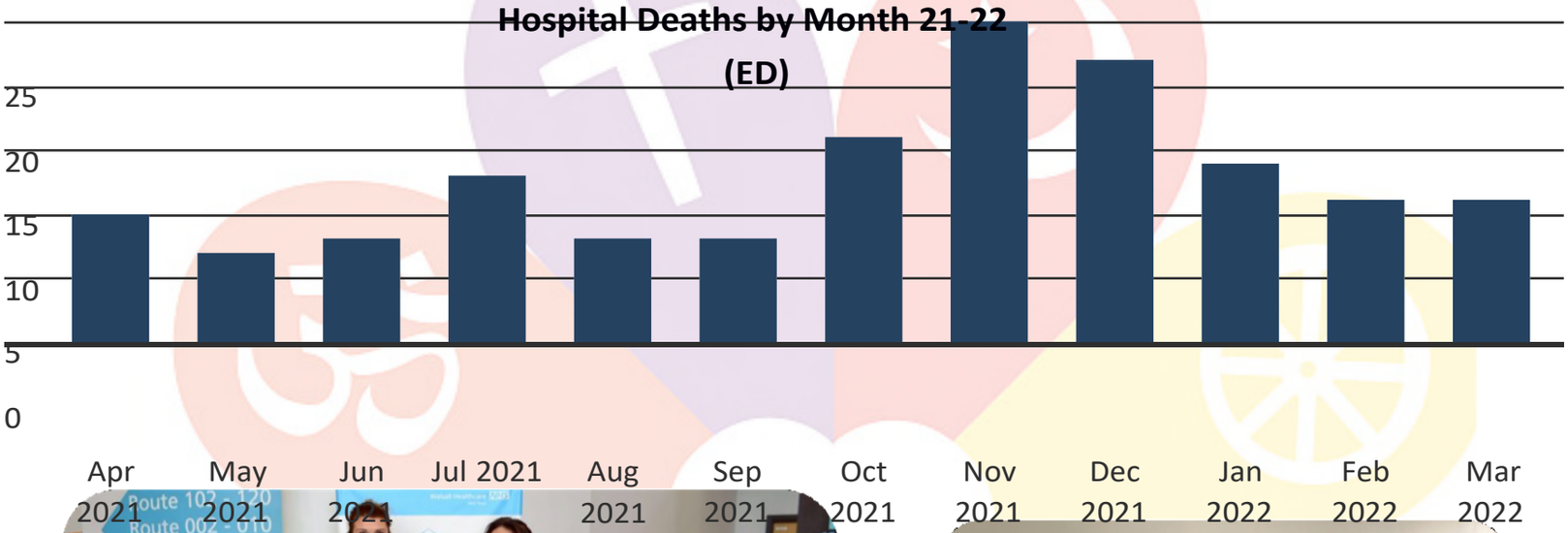
The team now also receive administrative support from Cathryn Smith, Chaplaincy Administrator, who contacts GP's within 48 hours of a patient's death. This allows the GP surgery to update Careflow / Fusion to ensure accurate records are kept.

Patient & Staff Engagement

Patient & Staff Engagement

Bereavement





Meeting of the Quality, Patient Experience & Safety Committee Friday 23rd September 2022			
Divisional Director of Midwifery Report			
Report Author and Job Title:	Carla Jones-Charles – Divisional 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		
Advise	• Maternity service has confirmed compliance with 7 of 10 CNST safety actions and on track to achieve the remaining 3 actions.		
Alert	• Staffing pressures continue, driven by short term sickness and rising maternity leave. This is being managed using the staffing escalation policy.		
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 ☐		

Divisional Director of Midwifery Report

1. PURPOSE OF REPORT

The purpose of the report is to provide a monthly update to assure the Quality and Patient Experience and Safety (QPES) Committee of the following items;

- Resource
- 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 Aug 2022. The service has continued its active recruitment. Maternity leave has increased to 7.4%. Sickness management continues.
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	19.3%	1.2%	7.4%	11.4%	1.6%	2.0%	42.9%
		Unregistered Nurses	12.9%	1.4%		10.9%	2.3%		27.5%

2.2. 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.

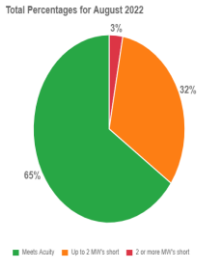
Table 2. Birth Activity July 2021-March 2022

Month	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22
No: Births	313	317	294	311	298	287	331	284	300	285	288	312

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 Aug was 65%. Graph 5 acuity for Aug 2022, graph 6 outlines that 78% of the time there were no red flags and the main action taken was to delay the induction of labour. Actions taken were related to delay in activity, graph 8. The delivery suite team leader remained supernumerary.

Graph 5



Graph 6

Graph 7

Number & % of Red Flags Recorded
From 01/08/2022 to 31/08/2022

RF1	Delayed or cancelled time critical activity	28	90%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	3%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	2	6%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Delivery Suite Co-ordinator is not supernumerary	0	0%
	Total	31	

Graph 8

Number & % of Management Actions Taken
From 01/08/2022 to 31/08/2022

MA1	Rideploy staff internally	43	61%
MA2	Redeploy from community	2	3%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	5	7%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist midwife working clinically	1	1%
MA7	Manager/Matron working clinically	2	3%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call MW	0	0%
MA10	Escalate to Manager on call	17	24%
MA11	Maternity Unit on Divert	0	0%
	Total	70	

2.5 CNST

The unit continues to work towards demonstrating full CNST compliance. A paper has been prepared for board declaring compliance with 7 out of the 10 safety actions and on track for full compliance for the remaining 3 safety actions. The evidence information will be shared and discussed with the Director of Nursing. The following are the actions that are completed –

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard.
Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units programme.
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard.
Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two.
Safety action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.
Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 5 December 2022

The following 3 are on track for compliance-

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard.
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard.
Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4.

In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4.

3.0 Culture

The unit has commissioned a culture review and has a planned away day for delivery suite team leaders and consultant staff as part of promoting and continuing team working.

The unit has received feedback from junior doctors expressing the need for greater senior support. An action plan has been developed and implemented to ensure that they continue to feel supported.

The national survey on junior doctors demonstrates that none of the indicators are below the national average and in one element, demonstrates that the department scored significantly above the national average – "junior doctors felt support to attend regional and national meetings".

Key:

Complete	On Track	Some Slippage with deadline	Missed target

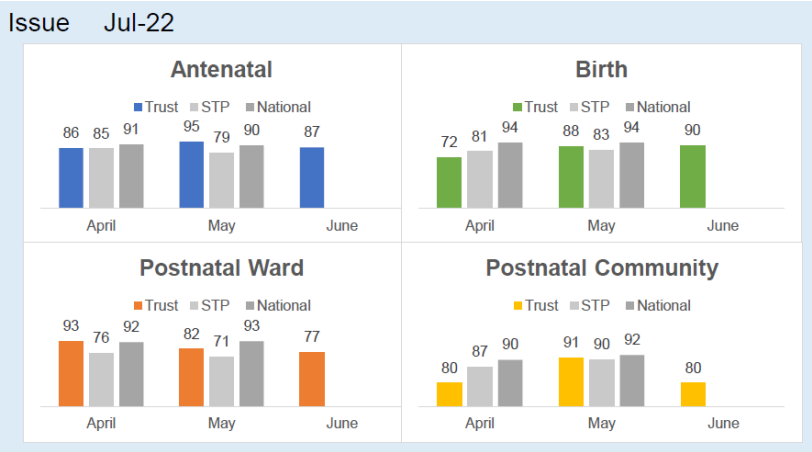
NHS Trust

Action plan in response to junior doctors concerns

Issue highlighted	Action	Person Responsible	Deadline	Update
Patients not reviewed on Ward 23 by senior gynaecologist	Email to consultant team to emphasise importance of reviewing their own patients	Paul Woollett	August 2022	
	Discuss at consultant meeting	Paul Woollett	June 2022	Completed 24th June 2022
	Gynae lead to audit the reviews of patients on ward 23	Amr Farag	November 2022	
Patients arriving on ward 23 with no prior referral and/or not appropriate for in-patient gynaecology ward	Gynae lead to discuss with ED CD	Amr Farag	September 2022	Discussions are already under way regarding new referral pathway
	Promotion of civility and understanding across teams	Paul Woollett	August 2022	Conversations with ED staff have been undertaken to understand the pressures they are under, and communicated this to the juniors at the August induction, with the aim of promoting civility and understanding across the teams
	Joint simulation in ED resus between ED staff and O&G team	Paul Woollett	August 2022	Joint simulation planned in ED resus between ED staff and O&G team on the 19th August – will help promote teamworking
SHO/FY1 doctors working alone on ward 23	Email consultant team to raise awareness on this issue and request as much support as possible	Paul Woollett	August 2022	Complete

Issue highlighted	Action	Person Responsible	Deadline	Update
	Discuss at consultant meeting	Paul Woollett	June 2022	Completed 24th June 2022
	Advise junior doctors to ensure the consultant on-call is aware if they are struggling with workload	Paul Woollett	August 2022	Complete - There were situations where the junior was not coping, but this had not been escalated to the consultant on-call
	Introduce a "back-up consultant" on the weekly rota	Paul Woollett	August 2022	Name of consultant who is on-site and not patient-facing – can be contacted if on-call team not available and junior doctor requiring immediate support
	Expectations, Escalation and Resilience" talk during departmental induction in August 2022	Paul Woollett	August 2022	Promoted wellbeing and peer support Emphasised the importance of communicating effectively to the senior members of the team if struggling
	Gynae lead to liaise with AMU to develop a live board that shows the activity in GAU/EPAU and can be accessed remotely. This will enable the consultant on-call to recognise increased activity	Amr Farag	March 2023	
Undermining behaviour by individuals within the team	College tutor, clinical director and clinical supervisor to provide to feedback the individuals	Paul Woollett Vinita Gurung	August 2022	Complete
	Ensure individual no longer manages the rota	Paul Woollett	August 2022	Complete

4.0 Engagement with Women and Families
FFT responses



The service continues to work with the patient experience team to achieve consistency for all our patients and respond to concerns to ensure that women receive high quality care.

The feedback is in line with the data across the STP.

	Antenatal			Birth		
	Q4	Q1	Change	Q4	Q1	Change
Recommendation Score	84	89	5	78	83	5
Response Rate	8.7	15.6	6.9	15.7	19.4	3.7

	Postnatal Ward			Postnatal Community		
	Q4	Q1	Change	Q4	Q1	Change
Recommendation Score	84	84	0	79	84	5
Response Rate	11.3	11.8	0.5	6.9	11.3	4.4

Mystery Patient feedback for Q1

Mystery Patient Feedback

Feedback received on a roling 3 month basis

Question	Rating
Courtesy of the staff rating	9.6
Environment and hospital facilities rating	9.2
Treated with respect and dignity?	10
Involvement in decisions about your care and treatment?	10

I felt really safe and was pleased with how much support I had from the midwife's & delivery midwife's

Our Midwife was amazing. She delivered our baby with her student nurse who was also exceptional. explained everything she was doing in detail which during labour was extremely reassuring. We Couldn't have asked for two better midwives.

Making sure my birthing partner was given food when they stayed over.

During the night shift Friday to Saturday morning all we could hear was extremely loud talking and laughing which kept us awake all night

5.0 Serious incidents

There was one new Si in during July. This was a patient booked with WHT but having antenatal care at SWBH. This lady booked for care late at 17 weeks of pregnancy and was not assessed for smoking. She was seen at WHT at 19 weeks and assessed as high risk and a plan of care was made for serial growth scans from 32 weeks of pregnancy. The patient attended at 20 weeks and 4 days with a history of reduced movements and the baby had sadly passed away. The initial review found that there was a missed

opportunity in the community as well as the plan for scans should have commenced at 28 weeks which may have made a difference to the outcome. the investigation will encompass the care at SWBH.

6.0 RECOMMENDATIONS

The service is requested support for the progress of the maternity refurbishment plans. Members of the Committee are asked to review and note the contents of this report.

MEETING OF THE TRUST BOARD – IN PUBLIC **Wednesday 5th October 2022**			
WHT Safeguarding Update Report Q1 (April – June 2022)			
Report Author and Job Title:	Fiona Pickford Head of Safeguarding	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• The Safeguarding Business Case was agreed in February 2022, allowing for the expansion of the Safeguarding Team. The recruitment to posts will conclude in Q3. • Substantial work has been undertaken regarding the completion of actions outlined in the WHT Safeguarding Development Plan. • Progress has continued in respect of WHT Safeguarding Case Review work (as a result of WHT internal practice review group which oversees the partnership DHR, SAR and CSPR work). • WHT participated in Walsall Partnership assurance audits in respect of Section 11 (Children Act 2004) and Care Act 2004. The feedback from the partnership was that WHT had good governance arrangements overall. • The learning disability agenda within the Trust is being scoped via collaboration work across RWT and WHT. A full report is due at the end of 2022. There are plans to have a 'one service model' across WHT and RWT. • DBS compliance reporting has commenced as part of the requirements of the safeguarding dashboard. A working group is meeting across WHT and RWT to oversee this work. • DoLS applications have increased due to the significant work undertaken by the safeguarding team during this period (ward support work)		
Advise	• Significant staff shortages (in the safeguarding children and maternity team) have had an impact on contributing to Walsall Partnership work during Q1. This has been included on the risk register. • The expansion to the safeguarding team is being progressed, and posts are expected to be recruited to by end of 2022. • There are difficulties in securing office space for the safeguarding team at Walsall Manor Hospital. This has been escalated to WHT Directors. • Safeguarding Children activity is buoyant. Children's MASH and Domestic Violence activity remains consistently challenging throughout this quarter due to the complexity of cases being discussed. During Q1 and Q2, the CCG are reviewing the funding framework around the working model in MASH as a result of activity and following the publication of a national serious case review (Arthur and Star).		

Alert	Safeguarding Training Level 3 (adults and children) compliance has shown a slight variation during this period, as a result there will be an overall review of the delivery of this programme during 2022. Additional Training sessions have been provided during May, June and July.	
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 costs associated with the expansion of the safeguarding service, as highlighted in the business case.	
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 ☒	

Safeguarding Update Report Q4 (Jan – March 2022]

1. PURPOSE OF REPORT

The purpose of the report is to provide information and evidence of the Trust's continued commitment to good safeguarding measures. It refers to the attached standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021 – 2022 and is aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Walsall Safeguarding Partnership.

2. DETAILS

The key points from the report include:

- The Safeguarding DASHBOARD has been submitted monthly to the CCG following scrutiny at the Trust Safeguarding Group. Additional work is in progress during Q2 to complete outstanding areas of reporting on the DASHBOARD template.
- The Safeguarding Midwife (who commenced in post April 2022) has worked significantly to address maternity safeguarding supervision compliance.
- It is noted that from April to June, safeguarding training compliance has fluctuated across the levels. This has been escalated to Divisions for their attention. Additional level 3 training sessions have since been provided over May, June and July. The safeguarding service is currently reviewing the training delivery model to allow staff across WHT and RWT to access each other's training.
- The compliance for staff accessing supervision has varied due to staff shortages within the Trust. Additional group supervision sessions have been delivered and continue to be offered to ensure staff are speedily compliant. Compliance will be monitored at the Trust SG Group.
- The safeguarding team have continued to provide a visible presence across the Trust to support staff and teams. There is additional safeguarding adult support required for the community teams, this will be planned following the recruitment to new members of staff in the adult service during Q3.
- WHT have attended all CCG and LA partnership meetings.
- Progress has been noted in completion of actions aligned to the Safeguarding Development Plan. There is further work to be progressed in regard to audit (in particular oversight of the Child Protection Information System known as CP-IS in ED). There is additional work to be progressed with safeguarding oversight of incidents, by team attending divisional governance meetings and this work will continue during Q2/Q3.
- WHT internal CSPR/SAR/DHR/LeDeR Group formed in December 2021 continues to meet on a bi-monthly basis to review and update all actions aligned to the organisation. Many outstanding actions have now been addressed.
- The number of MASH checks completed by the safeguarding children team has remained consistently high and complex in nature. It is noted that there has been more than 20% increase in activity overall.
- The number of DoLS applications submitted during Q1 was 112 which is an increase from 93 submitted in Q4. The safeguarding adult team have provided robust ward

support during this period which has clearly impacted on the number of applications being progressed.

- 27 concerns were received via an external source during Q4. The key themes cited were poor discharge (12), care and treatment issues (6), pressure ulcer damage (5), bruising (3) and a cannula left in a patient arm on discharge. 21 met the criteria for S42 enquiry.
- During Q4/Q1, WHT participated in Walsall Partnership assurance audits in respect of Section 11 (Children Act 2004) and Care Act 2004. The feedback from the partnership during Q4 was that WHT had good governance arrangements overall.
- WHT have secured funding (from the Walsall Partnership) for a Band 7 practitioner to work in ED to raise awareness of domestic violence.
- WHT and RWT are working in collaboration to respond to the LPS consultation

Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs)

This Q1 2022/2023 report seeks to provide information and evidence of the Trust's continued commitment to good safeguarding measures. It refers to the standards outlined in the Black Country and West Birmingham STP Safeguarding Assurance Framework for Commissioned Services (Safeguarding Children and Safeguarding Adults with Care and Support Needs) 2021-2022 and is aligned to national and local safeguarding standards including the requirements from CQC, NHS Learning Disability Standards and Wolverhampton Safeguarding Together Partnership.

1 a. 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 SABs priorities, and in regular monitoring meetings with commissioners.
b. Health providers are required to demonstrate that there is a Board Level Executive Director who holds accountability within the organisation for safeguarding (including Children and Young People in Care) and Prevent in line with Intercollegiate Documents and National Guidance

c. Health providers are required to demonstrate that the organisation complies fully with information requests and safeguarding informatics returns to NHSE/I and Commissioning organisations.

Annual Submission

Q1 Update:

Annual report completed and presented to Trust in July 2022. Data provided accordingly.

d. 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 Counter-Terrorism and Security Act 2015, and to assure themselves, regulators and their commissioner that these are working. These arrangements include:

- Safe recruitment practices (to include safe recruitment standards – DBS) and arrangements for dealing with allegations against people who work with adults, children or vulnerable children 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.
- Demonstrate that the organisation is managing allegations against staff in line with Safeguarding Partnerships and Safeguarding Adult Boards (this must include reference to risk assessments and clear process when protection thresholds in the local authority are not met). This includes referrals to the Local Authority Designated Officer for concerns around children's safeguarding and referrals relating to persons in position of trust in relation to adults. This must also include review of Prevent concerns around staff.
- Identification of a Named Doctor and Named Nurse (and a Named Midwife if the organisation provides maternity services) for safeguarding children and adults. In the case of out of hours services, ambulance trusts and independent providers, this could be a named professionals from any relevant health or social care background.
- Evidence that there is a safeguarding team in place in accordance with specifications set out in the Intercollegiate Documents for Adults (2018), Children (2019) and Working Together (2018).

- 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.
- Information sharing (including Duty of Candour) in line with local, regional and national requirements.
- Policies, arrangements and records to ensure consent to care and treatment is obtained in line with legislation and guidance including the MCA 2005 and Children Acts 1989/2004.
- Demonstrate that safer recruitment standards are monitored by the Executive Director and action taken where they fall short of expectations (i.e., charity visitors, volunteers, celebrities and agencies are monitored by the Executive Director and are consistent with their own HR internal policies).
- Demonstrate how the organisation manages requests for access from volunteers, paid/unpaid charity fundraisers, celebrities and 'friends' of the organisation and has a policy in place to reflect this.
- Demonstrate that there are systems in place to report unsafe practice to external professional bodies (i.e., Police, DBS, NMC, GMC).
- Demonstrate that the organisation has a policy regarding internet and social media use which addresses safeguarding.

Annual Submission

Q1 Update

- There will be a review of all safeguarding policies undertaken in Q1/Q2. Full data has been provided within the Safeguarding Department Annual Report (July 22). WHT and RWT are working collaboratively to complete outstanding policy work.
- The safeguarding team have expanded to include a Deputy Head of Safeguarding (commencing 3rd October 2022) and a new Safeguarding Adult Team Lead (commencing 12th September 2022). The outstanding post cited within the previous business case (the Safeguarding Business Support Manager) job description is currently being reviewed. It is expected that this job will be out for advert in September 2022.

- During Q4/Q1, there was a request for WHT to provide assurance against the DBS recording process (evidence of compliance required for the monthly safeguarding dashboard). This was escalated to the Director of Nursing and HR. Further joint work across WHT and RWT commenced during Q1, and the reporting of the DBS for new starters has since improved. There is ongoing work to review the staff groups aligned to the standard and enhanced element of this work.
- During Q1, partnership funding has been agreed to recruit to a Domestic Violence practitioner in ED, to raise the profile and act as a resource for vulnerable victims who present within the department. It is expected that this post will be recruited to during Q3.

Actions:

- To complete the recruitment of outstanding posts.
- To work collaboratively with RWT to ensure all policies are updated.

2 a. Health providers must ensure the effective training of all staff commensurate with their role and in accordance with intercollegiate competencies relating to:

- Safeguarding Adults
- Safeguarding Children
- Children and Young People in Care
- Prevent
- Domestic Violence
- MCA and DOLS
- Learning Disabilities

b. Health Providers must have a safeguarding training strategy and compliance percentage in line with the safeguarding performance framework. This must cover requirements for all staff, volunteers and external contractors.

Q1 Update

- The current WHT Safeguarding Training staff level groups were reviewed during Q4 to ensure that competencies required for healthcare staff remain in line with the Intercollegiate Document for Children (2019) and Adults (2018). This will continue every six months. The WHT/RWT training package content is currently under review (regarding eLearning and face to face delivery options) with both safeguarding services considering the content and ability to let staff access both training programmes.
- All safeguarding training compliance is reported monthly at the Trust Safeguarding Group (for each Division) and via the Safeguarding Dashboard (**see attached**).
- Safeguarding Children Level 1 and 2 compliance remains consistent with over 96% and 92% recorded over the quarter. Level 3 figures show a slight increase

from 84.3% in April to 86.06% in June. Training remains via e learning for Level 1 & 2 and via Microsoft Teams for Level 3.

- During Q1, Safeguarding Adult Level 1 and 2 compliances remained consistent with over 94.1% for Level 1 and 96.7% for Level 2. It was noted that Adult Level 3 training compliance was reduced to 83.4%, and as a result 2 additional training sessions were created to support with non-attendance.
- To support the Divisions with attendance opportunities, further training sessions have now been created during July and August too.
- Attendance at the Mental Capacity Act training has increased slightly over the period. This training remains on an electronic platform and will be reviewed at the end of Q3 to ensure it includes any additional information regarding the forthcoming Liberty Protection Safeguard processes due to be launched during 2024.
- The Safeguarding Team training compliance has varied. Adult Level 4 training (Named Nurses) is 100%, whereas 75% for children (6 out of 8) due to significant staff sickness.
- The Safeguarding Team has continued to provide bespoke training for ward and community staff as required. Additional support and/or bespoke training is required for the community services and will commence when the adult team expand with new staff in post. A particular focus will be on case escalation and referral process to the local authority.
- Learning Disability Training has been included within the Level 3 Adult training programme. The Trust is awaiting further guidance on the plan to roll out the Oliver McGowan LD national training programme. This is expected to be mandatory across health trusts from 2023 (to be confirmed).
- Domestic Violence Training is included in both Adult and Children Safeguarding Level 3. Additional training has been offered to WHT staff during Q1 via the Walsall Partnership DV team.
- The attendance at Prevent Training has been excellent during Q1 at over 95% predominantly.
- WHT Board training is currently being scoped for delivery on 3rd November 2022.

Actions:

- Safeguarding Training compliance will continue to be monitored during Q2 and additional training dates will be provided as necessary to meet the needs of the Trust.

3. a. Safeguarding Named Doctor/Nurse/Midwife/Named Professionals/Safeguarding Specialists should have access to advice and support and a minimum of quarterly safeguarding supervision with Designated Professionals.

b. Professionals supervising staff or working on a day to day basis with adults, children and families should have child and adult safeguarding

supervision available to them, appropriate to their role and responsibility in order to promote good standards of practice.

During Q1, the Safeguarding Team specialists, including Named Doctors have been offered or have had access to safeguarding supervision (except for 2 members of staff who were off due to sickness). The new Named Safeguarding Midwife has also been offered external supervision during this period. It is noted that for most safeguarding professionals this supervision is provided externally by the CCG or other external experts.

Total number of children community Staff/midwives identified to receive supervision within Q1	**Q1 Compliance**
Health Visitors:	**72%**
School Nurses:	**22%**
Community Midwives	**100%**

Health Visitor and School Nurse supervision compliance had previously varied (during Q3 and Q4) but due to significant staffing shortages in Q1, has remained low at 72% and 22%. All outstanding supervision has been a key priority, and staff have been offered follow up supervision during Q2.

Due to significant staff sickness, midwives were unable to access or attend supervision at the end of Q4/beginning of Q1. There has been a focus on delivering supervision to midwives during May and June and as a result the compliance has increased to 100%.

Over Q1, the Safeguarding Service has had additional support (from 0-19 service) with the delivery of supervision to community staff. This model will continue over Q2 until staff have been recruited into the safeguarding team. To note, that staff have been recruited to in July 2022. Expected to take up posts in November 2022.

Throughout Quarter 1 ED and acute paediatrics have had access to Monthly Drop-In safeguarding supervision sessions. The Safeguarding Children Team have also undertaken floor walks which provides opportunistic case reflection and discussions. Floor walks to Ward 21 increased during May due to an increase in safeguarding cases and respective activity in the department.

General support is also provided to all key areas within the Trust including Maternity, Children Ward, Sexual Health, and community services. The Safeguarding Team plan to provide safeguarding children supervision to Sexual Health Services and allied professionals in the future.

Supervision training has been completed in Q4/Q1 by WHT staff as part of a commissioned training event by Richard Swann (National Safeguarding Supervision Expert). Further safeguarding supervision training is being scoped via NSPCC (for refresher training purposes) during Q3 2022.

Actions:

- To monitor supervision compliance and ensure outstanding supervision is completed.

4 a. 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, SAB's , Community Safety Partnerships Terms of Reference and templates. Resulting organisational action plans must be addressed as agreed by the Safeguarding Partnerships/SAB's and DHR Standing Panels.

b. 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.

During Q1, WHT have attended all respective safeguarding case review groups across the region. This covers work aligned to Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Learning Disability Reviews (LeDeR) and Domestic Homicide Reviews (DHR).

The WHT internal CSPR/SAR/DHR/LeDeR Group was formed in December 2021 and continues to meet on a bi-monthly basis to review and update all actions aligned to the organisation. This is currently chaired by Deputy Head of Safeguarding at RWT and will be reviewed in Q3 to consider transferring the role to the new WHT Deputy Head of Safeguarding who comes into post on 3rd October 2022.

Three referrals have been submitted to Walsall 'Practice Review Group' during 2022 known as SAR 7, 8. 9. The referrals have generated chronology responses and are being progressed into a Walsall partnership action plan. One review has concluded, the others are in progress.

A CSPR referral was made to Walsall Practice Review Group during Q3, however after an in-depth review this was accepted as a SAR, due to the potential learning being adult focused. It was proposed that this fit the criteria for a joint SAR with Walsall and Wolverhampton and agreed at One Panel (Wolverhampton) and PRG (Walsall) in Q1.

To note that during Q1 the national review into the murders of Arthur Labinjo-Hughes and Star Hobson was published and findings disseminated across Walsall Partnership. The initial reaction for safeguarding boards is to review MASH and partnership arrangements. An action for WHT is to participate in a planned review of Walsall MASH as commissioned by Black Country and West Birmingham ICB.

During Q1, 5 notifications were made by the Trust as part of the 'Learning from the lives and deaths' programme. There are no outstanding actions for the Trust, but work continues to ensure the sustainability of previous actions. The Trust is represented at the regional LeDeR Strategic Group.

Actions:

- To review and commence action planning against safeguarding cases during Q2
- To attend Walsall Practice Review Group (PRG)
- To attend internal PRG and share learning, and update action plans.
- To participate in the review of MASH arrangements as commissioned by ICB

4 c. Health providers are required to demonstrate that recommendations and learning from all types of learning reviews and enquiries are distributed to relevant staff and there is evidence of practice change.

During Q1 WHT has ensured that learning from all types of 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.

Single agency action plans have also been discussed and updated at:

- The WHT Emergency Department Informal Safeguarding Meetings (Children). These will be bi-monthly from June 2022
- The Trust Safeguarding Group
- Divisional Governance meetings (Safeguarding and Trust wide)
- Matrons and Heads of Nursing meeting from Q1
- Practice Review Group
- WHT internal CSPR/SAR/DHR Meeting
- Operational Meetings (Safeguarding Children, CYPiC, Learning Disability and Safeguarding Adults)

Learning from reviews is embedded within the safeguarding supervision process across the service.

The WHT internal practice review group have completed most of the actions that were outstanding. This group meets on a bi-monthly basis (see plan).

5. a. Health providers are required to provide evidence that staff are aware of the importance of listening to children, young people and adults with care and support needs.
b. Evidence that the organisation ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding.

Annual Submission

Data provided within the Safeguarding Department Annual Report (presented July 22)

6. Health providers are required to provide evidence that patient assessment processes within the organisation identify appropriate risk and need, and result in an appropriate response; including where the criteria for statutory enquiries are not met.

Safeguarding Adults Activity

- 112 DoLS applications were submitted during Q1 (April = 34, May = 41, June = 37) which is an increase on the 93 submitted in Q4 and 79 submitted during Q3. To note that the safeguarding team have provided regular ward support in completion of applications and offered bespoke training regarding mental capacity assessment processes throughout Q1.
- No Prevent referrals have been made during Q4. This is not unexpected, as Walsall has a low level of activity.
- All Prevent returns (to NHSE) have been completed in required reporting timeframe.
- 27 concerns were received via an external source during Q1, (2 concerns were subsequently withdrawn). The key themes cited were in relation to poor discharge (12), care and treatment (6), pressure ulcer anomalies (5), bruising (3) and a cannula left in a patient arm on discharge (1).
- During Q1, WHT were asked to look at the impact of the forthcoming implementation of Liberty Protection Safeguards (LPS) with RWT. As part of this work, WHT will be looking at scoping a range of opportunities to contribute to this work stream which Walsall CCG will lead on across the Black Country.
- The safeguarding team continue to offer support, training and guidance on the Mental Capacity Act, assessing mental capacity, and completing DoLS. WHT Safeguarding Adult Team undertake a monthly audit regarding RESPECT and MCA compliance. The outcome of this is reported to each Division. The focus remains on raising awareness of appropriate documentation and ensuring that relatives are informed of the process and outcome of decision making.
- During Q1, it was agreed that RWT would provide the Trust with a LD specialist (for 2 days per week) to scope the current service and work with service areas to identify any future requirements and provide a gap analysis and future work plan. The progress has been reported to Trust Safeguarding Group on a monthly basis. The business case will be prepared and presented at the end of 2022.

Safeguarding Children Activity

- During Q1, it was noted that there continued to be significant staff shortages due to sickness, maternity leave, and vacancy factors. This prompted the service previously (during Q4) to be placed on the Trust Risk Register. This has resolved slightly with the return of staff, and the temporary placement of 2 staff from 0-19 service to assist with safeguarding supervision.
- The Safeguarding Children Team have provided support via face to face ‘floor walks’ to Ward 21, ED, Maternity and Fracture Clinic. The Flow Chart for Safeguarding Children Floor Walks was updated and circulated to key areas.

- Safeguarding Children Supervision has been offered to the Health Visiting, Maternity and School Nursing Teams by a mixture of remote and face to face sessions. This has remained a key priority although attendance has reduced due to team shortages overall.
- Group Supervision has also been offered to Ward 21, Maternity and ED. Attendance has been difficult due to operational pressures.
- During Q1 the MASH checks and Strategy Meetings remained consistently high. There was a total of 1910 MASH checks completed (50% increase in quarter), 115 MARAC Cases discussed (involving 162 children checks). The overall activity for domestic abuse information sharing (DA Triage) has increased each month too. Activity will be raised at the partnership MASH meeting to be held in September.
- It is also noted that advice calls received by the safeguarding team during Q1 was 74 overall. This is a reduction from 107 (in Q4) and 84 (during Q3). This may have been a result of the team increasing their floor walks.
- During Q1 the Safeguarding Children Team supported staff with 23 statements for court proceedings (down slightly from 40 during Q4). 35% of the statements completed were generated from the health visiting service.
- Virtual Safeguarding Children Level 3 training and face to face training has been delivered to all staff.

7. 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.

- WHT participated in Walsall Partnership assurance audits in respect of Section 11 of the Children Act 2004, and Care Act 2004 during 2021. The feedback from the Walsall Partnership was that WHT had good governance arrangements overall. Positive feedback referred to effective governance, training, service engagement and working within the 'Think Family' model.
- During Q1, in advance of the planned Joint Targetted Area Inspection (JTAI planned for 2022) WHT completed a self-assessment tool regarding exploitation. It was highlighted that additional support for vulnerable children and adults within ED would be beneficial, and as a result partnership funding will create a role to support this work.
- Throughout Q1, WHT, Walsall Local Authority and Walsall CCG met to conclude the actions that were highlighted in the 'safeguarding development plan'. The work has progressed significantly in relation to these concerns (raised during 2021) and most of the actions completed. (Attached). 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 for Q1) of compliance with the Child Protection Information Sharing System (CP-IS) has been delayed until July 2022.
- The safeguarding team continued to undertake the Trust audit around RESECT 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. The process for undertaking RESPECT audits is to be reviewed during Q3.

Action:

- For WHT to participate in WSP multi-agency audit programme planned for Q2/3

8. Health providers are required to provide evidence and assurance that they are responding to National Reports and Inquiries.
During Q1, the WHT Safeguarding Team commenced collaborative work with RWT and Black Country & West Birmingham CCG/ICB regarding the response to, and implementation of the LPS national report. During Q1, WHT participated in the national SEND inspection process within Walsall. An action following this process is to review the LD provision within the Trust and to include a review of the Autism provision. WHT are currently scoping the LD service and presenting findings/gap analysis and action plan by Q4. There are no outstanding CQC actions noted following the previous inspection. During Q2/Q3, there is an expected JTAI inspection in Walsall which WHT will be supporting and contributing to.

9	a. Health providers are required to demonstrate they have effective arrangements for engaging and working in partnership with other agencies. b. Health providers are required to demonstrate that they actively engage with all aspects of the work of the local safeguarding partnerships, strategic groups

and sub groups (including Channel, MAPPA, MARAC, CSP, CJB and Modern Slavery Partnerships)
During Q1 the Safeguarding team have attended all requested partnership and safeguarding meetings with Walsall Local Authority (LA), CCG/ICB and all care planning operational meetings. This includes MARAC and Practice Review Group (PRG) WHT have submitted the completed monthly CCG/ICB dashboard. (Attached). There is further planned work (with CCG/ICB) to review the assurance framework documentation and safeguarding dashboard in anticipation of the revised National Safeguarding Assurance Standards due to be published in September 2022

3. RECOMMENDATIONS

The committee is asked to receive the report for assurance.

Walsall Healthcare NHS
NHS Trust

Safeguarding Development Plan – August 2022

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
1	**Safeguarding Service & Team Resource**	To carry out a review of the current resources within the Safeguarding Team (Adults, Children and LAC) to ensure there is the capacity to promote good professional practice, support the local safeguarding system and processes, provide advice and expertise for fellow professionals, and ensure safeguarding supervision and training is in place.	**Dec 21** (for business case approval) **August 22** (To conclude recruitment process) Head of Safeguarding	**<u>05.08.22 Update:</u>** **Deputy Head of Safeguarding commencing in post on Monday 3rd October.** **Safeguarding Adult Lead commencing in post on Monday 12th September.** **Band 6 (Safeguarding Adult posts) recruitment completed.** **Band 5 Business Support manager post in recruitment stage.** ***Vacant Children NN posts and SG Team admin team posts have been advertised*. Interviews completed.** **<u>06.05.22 Update:</u>** Band 8b (Deputy Head of Safeguarding) post interview set for 26.5.22. Band 6 (Safeguarding Adult Nurse x 2) post interview set for 13.5.22 Band 7 (Named Nurse) post in recruitment stage Band 5 (Safeguarding Business Manager) awaiting job matching Band 4 (Admin Team Lead) recruited to and will commence in post on 16.5.22. Named Midwife for Safeguarding commenced in post 25.4.22 **<u>11.04.22 Update</u>**: Posts out on Trac and recruitment expected from August onwards following expected notice periods. Additional space to be sought at Walsall Manor Hospital.	Amber Evidence: (*Minutes with Outcome of finance meeting January 2022*) Staff in post

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				2.3.22 Update: Business case concluded and full funding agreed. Plan to commence recruitment week commencing 7.3.22 **1.2.22 Update:** Awaiting outcome of business case which has been sent to WHT Senior Team for their consideration in February 2022. **29.12.21 Update:** Outcome of business case as evidence for completing action **23.12.21 Update:** Business case to be presented in January (to new WHT finance group). Additional room space to be sourced c/o Space Utilisation Meeting in January too. **17.11.21 Update;** Business case completed. Funding in review. Decision date to be confirmed. **29.10.21 Update:** In process**.** **12.10.21 Update:** In process, meeting with finance 14.10.21 **10.09.21 Update:** In process – Awaiting confirmation of current service budgets to provide the immediate funding of posts. **31.08.21 Update**: Business Case to be progressed via WHT C&C processes. **19.08.21 Update**: HOS Meeting with accountant on Friday 27th August. **05.08.21 Update:** Initial Business Case (part 1) for SG Team in progress. Meeting to be confirmed (requested) with	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				WHT Corporate Accountant and AMC to consider initial funding for 4 posts (1 x Band 8b, 2 x Band 6's and 1 x Band 5). Part 2 of Business Case to be drafted in Q3/Q4.	
2	**Safeguarding Supervision Process (Adults & Children)**	**a)** Safeguarding Team to develop a Specific Safeguarding Supervision Policy (Children and Adult Policy) **b)** Safeguarding Adult and Children Supervision Training to be delivered during August/September. *(Safeguarding champions to attend training)* Safeguarding Adult Supervision Policy to be developed during Q3.	**August 2022** Head of Safeguarding and Team Leads	**05.08.22 Update:** **Supervision policy to be tabled at new WHT Policy Group during Q2 following review by RWT staff. Safeguarding children supervision is already in place. Reported monthly/quarterly** **29.12.21** Update from Group In process during Q4 **23.12.21 Update:** WHT Policy Group (new process) to receive the updated policy Feb. Additional EIA paperwork to be completed. *Wendy James contacted by FP for review of process*. **17.11.21 Update:** Discussion with Community Division (Kelly Geffin) to potentially adopt this (base) as a pilot site in Q4. **Update 29.10.21** Safeguarding adults' team currently reviewing the policy and will forward to Head of safeguarding. Scoping also being undertaken with other Trusts to benchmark what their process is for delivery of adult safeguarding supervision. **12.10.21 Update:** Policy to be presented to WHT Group end of October. Training delivered (safeguarding supervision). **20/08/21 Update:** Policy is in draft and has been forwarded to the safeguarding children and adult leads for comments. Comments to be completed by	Amber Evidence: (*Copy of Supervision Policy*)

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				23/08/21. Thereafter the policy will be forwarded to WHT Policy Group for ratification. **05/08/21 Update**: Policy is in draft	
3.	**Safeguarding and SUI Processes within WHT**	**Further work required during 2022 to understand the process with regard to the development of the terms of reference to ensure that any safeguarding elements are identified and addressed.** Attendance at SUI – Falls, PU meeting Provide safeguarding oversight on safeguarding incidents as appropriate.	**Dec 21** Director of Nursing	**05.08.22 Update:** **Meetings commenced (with governance) to review the process within these service areas via respective (Falls/PU meetings) and how reporting up through to safeguarding is robust. Further work to be progressed with (RWT inclusion) during Q1 and Q2. Work has also commenced with the 'record of advice proforma' providing information to caller/receiver. This will be audited (with RWT team in Q4).** **2.3.22 Update:** Meeting convened to discuss this work with MA end of March 22 **1.2.22 Update:** Raised by HOS to Deputy Director of Governance (MA) about establishing a process going forward. 'Consider SG as part of the SI/STEIS process. Construction of enquiry and Safeguarding Sign off'. **23.12.21 Update:** SG Team have oversight of SI on a weekly basis. Further work regarding review of referral/form to be considered in 2022**.** **22.10.21 update** The Safeguarding Service Team are supporting the falls team with the 'falls 'cluster review-safeguarding over sight has been provided. Membership at the SI, falls and PU meetings.	Amber

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				Head of Safeguarding and Safeguarding Adult Lead have met with CCG to discuss and review SI process. **12.10.21 Update:** Safeguarding Team are now in attendance at SUI meetings. (Cluster meetings). **05.08.21 Update:** Internal WHT process to be confirmed.	
4	**Safeguarding Audit:** **Child Protection Information System (**CPIS) To ensure that this process is embedded across the Trust.	• Current CP-IS SOP requires improvement • Current SG Children Policy needs to be updated to reflect CP-IS. • Audit to be undertaken to ensure practitioners are using CP-IS during Q1.	**August 22** Head of Safeguarding	**05.08.22:** **Joint meeting to be set up with ED/SG following initial meeting 03.06.22. CP-IS audit programmed for end of Q2 with help from ED and SG Children Team input.** **11.4.22 Update**: FP and RV to progress CP-IS audit. For update at Trust Group in June as joint work with ED and Named Nurses halted in April due to unforeseen staff sickness. **23.12.21 Update**: To commence audit in Q4. Discussion with SG and ED leads in February to review as part of wider support to ED service. **17.11.21 Update:** Audit outstanding. To commence in Q4. **12.10.21 Update**: Work to commence to review process in Q3. All respective staff (ED) will have access to NHS smartcard (to access system) and have received training on CP-IS process. All midwives will have access to CP-IS as well.	Amber Evidence: *Audit findings & action plan*.
5	**Safeguarding Risk: HV and School Nurse Records**	• To add to the Corporate Risk Register	**Nov 21** *changed to*	**05.08.22 Update:** **0-19 service to update Trust SG Group**	Amber

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
	Current HV Records are not a formal Trust commissioned patient information system (PIS). The system being used is 'informal' due to delay in introduction of electronic records. Currently using Microsoft Word documents which record all HV contacts and interactions. HVs send their typed record to the team administrator who converts it to a PDF and uploads onto a secure electronic drive. Main issues are: lack of chronology of events, MASH health information is not complete, Records have no care plan, and practitioners are responsible for uploading their own word document.	• For Trust to progress with development of new IT platform for records in 2022.	**June 22** Head of Safeguarding & 0-19 Lead	**05.06.22 Update:** In progress. **11.4.22 Update:** Continues to be progressed and completion date expected June 2022 (tbc). SG Team have read only access to caseload for MASH checking purposes**.** **2.3.22 Update:** Update from service requested by HOS. Advised it is in process still. **17.11.21 Update:** Work in process – timescales for completion extended. This group to receive confirmation of progress from service division. **12.10.21 Update:** In process **10.09.21 Update:** Work in progress across the Trust to complete the transfer of 'paper records' to electronic platform. Timescale within 12 weeks. **28.08.21 Update:** Significant work in place to resolve issue. Placed on TRR. Plan to resolve within 12 weeks. 05.08.21 Update: Head of safeguarding and Children Lead to meet 11.8.21 Added to CRR. Work commenced to transfer records from paper to electronic platform. Estimated time 12 weeks.	
6	**Learning Disability Service Within WHT** confirmation of role of LD service within Trust, and review of LD Strategy/Standards**.**	To review the current model of service provided by LD team (via BCHT) to include posts, training, autism & LD Strategy.	May 22 **Nov 22** Head of Safeguarding	**<u>05.08.22 Update:</u>** **Report prepared and presented to Trust Group in July 22. Further work in place to scope the commissioning aspect of the service from CCG/LA. Anticipated business case/service scope to be drafted by end of Q3/Q4. Included in**	Amber

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
	Gap analysis to be undertaken to establish areas for escalation/improvement**.**	• Additional resource required during scoping of service (from May 2022)		**SG Annual Report and discussed briefly at Trust Board on 3rd August 22.** **<u>06.05.22 Update:</u>** EW (LD Team Lead Band 7 from RWT) working at WHT from May 22 for 2 days per week on site to scope service with LD nurses from BCPFT. Focus will be on standards, strategy, team & flagging. Role to support the LeDeR process. Report on progress Q2. **<u>11.4.22 Update</u>** Service discussion in progress. For update to Trust Group in May <u>1.2.22 Update</u>: HOS to meet with BCPFT LD Community Lead to clarify KPI's and service spec. **23.12.21 update:** HoS to meet with the LD nursing team to discuss the service and achievements towards any identified KPi's. WHT have enrolled on NHSI Improvement Standards with an end date for Feb 2022. Data regarding processes currently being collated by service leads within the Trust. LD nurses supporting with service user feedback questionnaires (requirement is 100), link for staff to complete on line staff version has been circulated. **22.10.21 update** BCHCT have appointed into the 0.5wte vacancy. Current provision therefore 1.0WTE Trust has supported BCHCT re- 'changing our lives 'audit. Will await final report. Audit was commissioned by Black Country and west Birmingham CCG.	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
				Trust has enrolled on NHSI LD and autism improvement standards self-assessment process. Communication plan to be developed to ensure staff aware of the Trust participation. Audit supporting the process **12.10.21 Update:** LD service provision discussed at WHT Board 7.10.21. Service to be scoped and paper to go to Board in March 2022. **10.09.21 Update:** Initial scope of current LD provision for WHT (from BCHFT) has identified gaps – (limited resourcing and subsequent oversight of LD patients within the Trust). For further review with WHT Chief Nurse in Q3. **05.08.21 Update**: Full review of LD service and provision to commence September 2021. Initial meeting with LD lead from BCHFT arranged 31.8.21.	
7	**Children placed on Adult Ward areas for scheduled or unscheduled care.** WHT to have awareness of children placed in adult areas for training and oversight purposes.	To commence recording number of children placed in adult ward areas to consider paediatric oversight, training and legal/documentation position.	**March 22** Head of Safeguarding	**06.05.22 Update:** **Data is now available and will be included in the children report to Trust Group each month. Numbers per month, and ward area data to be shared.** **12.04.22 Update:** Monthly data now available. Trust SG Group to discuss at April meeting. 2.3.22 Update: Data requested from business support service. **23.12.21 Update:** Data collection to commence from February 22	May 22
8	**May 2022** **Safeguarding Policy Work**	Review of all related WHT safeguarding policies to ensure: • Updated	**July 22**	**05.08.22 Update:** Review progress and update on a monthly basis	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
	A review of Safeguarding Policies to be undertaken during Q1.	• Relevant • That any outstanding policies are written	***Review Dec 22*** Head of Safeguarding	**<u>08.07.22 Up0date</u>**: **06.05.2022 Update**: SG Policy tracker to be drafted and presented at Trust Group in June/July 2022. Policy leads to be confirmed for updating respective documents that are outstanding. Support from RWT and WHT staff to ensure this work is completed.	
9	**<u>May 2022</u>** **Liberty Protection Safeguards known as LPS (from Oct 2023 tbc)** WHT to be fully prepared for the forthcoming changes within legislation and implications for practice	Review of national (and local) documentation around the intended introduction of LPS and the impact and implications for WHT. • There should be WHT attendance at relevant national and local LPS events. • WHT to attend the Black Country STP LPS Group and feedback to SG Group • Identify a Trust 'Lead' for LPS • Set up a Trust Group with relevant stakeholders to support this work	**Dec 2022** SG Adult Lead	**<u>05.08.22 Update:</u>** **See below** **<u>08.07.22 Update:</u>** **Joint work undertaken as planned. Audit findings to be presented at next Trust Group by RWT adult lead (who conducted the audit in June).** **05.06.2022 Update:** Joint work in process with RWT re response to national report (due July). Audit to be undertaken in June across RWT to review all case records to establish that MCA and DoLS process is robust as part of the feedback required to establish workload generated from the ?LPS due to commence end of 2023/24. **06.05.2022 Update:** Work has commenced. National report/paper released in April. (paper presented at Trust Group in April 22). NHSE National Group is meeting (WHT in attendance) and Black Country STP Group meeting to be attended in May. RWT/WHT Safeguarding Adult Team LPS 'away day' organised. Further updates will be prepared for TSG.	

	Issue	Action required	Timescale & Identified Lead	Progress Update	Evidence/RAG rating
10	**<u>June 2022</u>** **Walsall Partnership Safeguarding Board & Groups** Review of WHT attendance (at groups) to be undertaken in Q2.	Review Walsall Partnership (Safeguarding Adult/Children) Committees and Groups to ensure appropriate attendance.	**Oct 2022** Head of Safeguarding	**05.06.2022 Update:** **Liaison with Walsall Partnership re current groups/committees has commenced.**	

Rag RATE	Description
	Not started yet, or Delayed
	In Process/Progress
	Completed Action

Safeguarding Dashboard

Achieving target	Populated by P&I
Within 1% of achieving target	Populated by Service
> 1% of target	

Rag rating tolerances internally set

Ref	Area	Quality Requirement	Target	Frequency		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	Jul-22	Aug-22	Narrative
LQSG01	SG	Level 1 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 1 Safeguarding Children competence (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1056	1087	1070	1079	1075	1089	1088	1107	1095	1116	1108	1117	1111	1091	1094	
					D	1118	1126	1102	1104	1104	1120	1123	1145	1141	1163	1154	1167	1154	1146	1153	
					%	94.45%	96.54%	97.10%	97.74%	97.37%	97.23%	96.88%	96.68%	95.97%	95.96%	96.01%	95.72%	96.27%	95.20%	94.88%	
LQSG02	SG	Level 2 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 2 Safeguarding Children competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1654	1658	1682	1694	1704	1783	1787	1816	1821	1891	1903	1944	1934	1930	1995	
					D	1818	1809	1834	1846	1837	1927	1940	1976	1988	2041	2045	2080	2097	2073	2135	
					%	90.98%	91.65%	91.71%	91.77%	92.76%	92.53%	92.11%	91.90%	91.60%	92.65%	93.06%	93.46%	92.23%	93.10%	93.44%	
LQSG03	SG	Level 3 training for Safeguarding Children. As set out in Safeguarding Children & Young. People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date. Level 3 Safeguarding Children competence. (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	880	911	885	909	920	955	943	922	903	927	932	959	957	931	957	
					D	1057	1062	1041	1042	1052	1083	1068	1078	1063	1108	1105	1126	1112	1094	1142	
					%	83.25%	85.78%	85.01%	87.24%	87.45%	88.18%	88.30%	85.53%	84.95%	83.66%	84.34%	85.17%	86.06%	85.10%	83.80%	
LQSG04	SG	Level 4 training for Safeguarding Children . As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 4 Safeguarding Children competence**	100%	Recorded Monthly Reported Quarterly	N															6	
					D															8	Exception: Staff sickness and training opportunities.
					%															75.00%	
LQSG05	SG	Safeguarding Children training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. **As set out in Safeguarding Children & Young People roles and competencies for health care staff - Intercollegiate Document.**	100%	Reported Annually																	
LQSG06	SG	Level 1 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 1 Safeguarding Adults competence (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1050	1061	1054	1061	1056	1078	1066	1084	1068	1083	1109	1094	1072	1062	1083	
					D	1118	1123	1102	1103	1102	1119	1119	1138	1135	1153	1179	1158	1139	1129	1144	
					%	93.92%	94.48%	95.64%	96.19%	95.83%	96.34%	95.26%	95.25%	94.10%	93.93%	94.06%	94.47%	94.12%	94.07%	94.67%	
LQSG07	SG	Level 2 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 2 Safeguarding Adults competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	969	951	945	923	929	929	928	945	952	979	989	1012	1035	1025	1054	
					D	1014	1002	989	966	973	964	970	1000	1008	1026	1024	1042	1070	1059	1083	
					%	95.56%	94.91%	95.55%	95.55%	95.48%	96.37%	95.67%	94.50%	94.44%	95.42%	96.58%	97.12%	96.73%	96.79%	97.32%	
LQSG08	SG	Level 3 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 3 Safeguarding Adults competence (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1622	1653	1613	1625	1653	1692	1684	1699	1732	1764	1790	1847	1798	1731	1753	
					D	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	2133	2174	2156	2126	2205	
					%	88.06%	89.06%	85.66%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	83.92%	84.96%	83.40%	81.42%	79.50%	
LQSG09	SG	Level 4 training for Safeguarding Adults. As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document. **Percentage of eligible staff that have up to date Level 4 Safeguarding Adults competence**	100%	Recorded Monthly Reported Quarterly	N															2	
					D															2	
					%															100.00%	
LQSG10	SG	Safeguarding Adults training for Board Level for Chief Executive Officers, Trust and Health Board Executive and Non-Executive Directors/members. **As set out in Safeguarding Adults roles and competencies for health care staff - Intercollegiate Document.**	100%	Reported Annually																	
LQSG11	SG	Basic Prevent Awareness Training (level 1&2) as defined in NHS England – Prevent Training and Competencies Framework (2015). **Percentage of staff with up to date PREVENT competence. (YTD per month)**	95%	Recorded Monthly Reported Quarterly	N	1845	1853	1854	1844	1834	1857	1852	1892	1901	1940	1949	1981	1990	1978	2021	
					D	1988	1968	1954	1941	1933	1942	1948	1994	2004	2039	2040	2063	2074	2059	2095	
					%	92.81%	94.16%	94.88%	95.00%	94.88%	95.62%	95.07%	94.88%	94.86%	95.14%	95.54%	96.03%	95.95%	96.07%	96.47%	
LQSG12	SG	Prevent Awareness Training (level 3,4 & 5) WRAP training as defined in NHS England – **Prevent Training and Competencies Framework (2015). Percentage of staff with up to date competencies. (YTD per month)**	85%	Recorded Monthly Reported Quarterly	N	1846	1833	1853	1903	1922	2029	2012	2036	2019	2091	2096	2148	2140	2115	2182	
					D	1983	1980	1999	2055	2061	2188	2182	2204	2188	2272	2264	2308	2290	2253	2335	
					%	93.09%	92.58%	92.70%	92.60%	93.26%	92.73%	92.21%	92.38%	92.28%	92.03%	92.58%	93.07%	93.45%	93.87%	93.45%	
LQSG13	SG	Statutory Organisational Prevent Leads to demonstrate criteria met to achieve competency levels as defined in NHS England – **Prevent Training and Competencies Framework (2015).. • Attendance at a minimum of 2 NHSE regional Prevent forums each financial year (4 take place). • Evidence of face to face meetings with the channel coordinator and CTU officers. • Participate in local or regional multi-agency Prevent forums/Boards when required**	100%	Recorded Monthly Reported Quarterly	N																1	
					D															1	
					%															100.00%	
LQSG14	SG	**Learning Disabilities Awareness Training**	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly	N	1622	1653	1613	1625	1653	1692	1684	1699	1732	1764	1790	1847	1798	1731	1753	
					D	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	2133	2174	2156	2126	2205	
					%	88.06%	89.06%	85.66%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	83.92%	84.96%	83.40%	81.42%	79.50%	
					Traj.																

Safeguarding Dashboard

Achieving target	Populated by P&I
Within 1% of achieving target	Populated by Service
> 1% of target	

Rag rating tolerances internally set

Ref	Area	Quality Requirement	Target	Frequency		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	Jul-22	Aug-22	Narrative
LQSG15	SG	Domestic Abuse Awareness Training	95% (Trajectory to be agreed)	Recorded Monthly Reported Quarterly	N	1622	1653	885	1625	1653	1692	1684	1699	1732	1764	1790	1847	1798	1731	1753	
					D	1842	1856	1883	1918	1921	2049	2044	2062	2051	2134	2133	2174	2156	2126	2205	
					%	88.06%	89.06%	47.00%	84.72%	86.05%	82.58%	82.39%	82.40%	84.45%	82.66%	83.92%	84.96%	83.40%	81.42%	79.50%	
					Traj.																
LQSG16	SG	Mental Capacity Act *(Previously Mental Capacity Act/DoLS (LPS) Training - split April 2022)*	95%	Recorded Monthly Reported Quarterly	N	5068	4981	4963	5023	5104	5359	5251	5321	5393	5595	2814	2837	2848	2759	2881	
					D	5318	5254	5282	5349	5392	5706	5617	5709	5762	5909	2986	2989	3025	2950	3082	
					%	95.30%	94.80%	93.96%	93.91%	94.66%	93.92%	93.48%	93.20%	93.60%	94.69%	94.24%	94.91%	94.15%	93.53%	93.48%	
LQSG16	SG	DoLS (LPS) Training	95%	Recorded Monthly Reported Quarterly	N											2807	2830	2841	2754	2877	
					D											2981	2984	3020	2945	3077	
					%											94.16%	94.84%	94.07%	93.51%	93.50%	
LQSG17	SG	DBS Compliance – new staff (within the last 3 months)	100%	Recorded Monthly Reported 6 monthly	N											199	175	147	124	4405	
					D											219	191	165	164	4790	
					%											90.87%	91.62%	89.09%	75.61%	91.96%	
LQSG18	SG	DBS Compliance – existing staff	100%	Recorded Monthly Reported 6 monthly	N	2484	2495	2576	2621	2688	2751	2783	2869	2946	2932	4258	4290	4377	4365	223	
					D	3658	3693	3760	3810	3891	3992	4015	4134	4229	3727	4706	4706	4739	4747	274	
					%	67.91%	67.56%	68.51%	68.79%	69.08%	68.91%	69.32%	69.40%	69.66%	78.67%	90.48%	91.16%	92.36%	91.95%	81.39%	
IRSG01	SG	Percentage compliance with provider protocol for child protection supervision for frontline staff (individual or group)		Reported Quarterly	Health Visitine	45.00%	Q2 - 69%			Q3 - 95%											Reported quarterly April July/October/January
					CNN	33.30%	Under review			Under review											
					SHA	43.20%	Q2 - 86%			Q3 - 100%											
					Paeds Nurse	17.80%	Under review			Under review											
					TPT	100.00%	100.00%			100.00%											
					NNSG	85.70%	Q2 - 75%			Q3 - 50%											
					NNLAC	100.00%	100.00%			100.00%											
					CMW	14.28%	Q2 - 83%			Q3 - 93%											
IRSG02	SG	Percentage compliance with provider protocol for adult protection supervision for frontline staff (individual or group)		Reported Quarterly	N																Group Supervision to commence during Q3
					D																
					%																
IRSG03	SG	Percentage compliance for safeguarding supervision for Named Professionals/Specialist roles within Safeguarding		Reported Quarterly	%	85.70%	Q2 - 75%			Q3 - 50%											Reported quarterly
IRSG04	SG	Number of referrals made for PREVENT		Monthly		1	0	0	0	0	0	0	0	0	0	0				0	No referrals
IRSG05	SG	Compliance with quarterly CCG/provider meetings, either 1:1 or Safeguarding Forum -		Monthly – Reported Quarterly			Yes													Yes	
IRSG06	SG	100% Compliance with Submitting Safeguarding Reporting Framework to CCG	100%	Monthly	N	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Shared with CCG at CQRM monthly
IRSG07	SG	100% Compliance with Prevent Returns (NHS Digital – Strategic Data Collection Service)	100%	Quarterly	N	Yes	Yes			Yes			Yes			Yes					Next return due in October
IRSG07	SG	Numbers of DoL's/LPS referrals.		Monthly – Reported Quarterly	N	31	25	36	17	30	36	27	22	37	31	34				41	0 referrals for LPS as awaiting further legislation.
IRSG07	SG	Number of DoL's/LPS authorised. Number of LPS completed under the Vital Act. Number of DoL's/LPS which have objections		Monthly – Reported Quarterly	N	0	0	0	0	0	0	0	0	0	0	0				NA	0 LPS objections

MEETING OF THE TRUST BOARD Wednesday 5th October 2022			
Risk Management Report covering Bi-Monthly 2, June and July 2022/23			**AGENDA ITEM: 21**
Report Author and Job Title:	Vicky Haddock - Head of Risk Management and Compliance	**Responsible Director:**	Kevin Bostock - Group 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 Board 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 the 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 and Compliance to review their risks that sit on the corporate level element of the Trust's 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. • 21 of the 25 Corporate Risks have a current **High** rated risk score, 15-25 (an increase from 18 of the 23 in Bi-Monthly 1, April and May 2022/23).		

Alert	• Some of the BAF and CRR are passed their target completion dates, see below. These have been discussed with the Lead Director at their Corporate Confirm and Challenge meetings with support offered to enable the actions to be completed at the earliest opportunity.
	• Of the eight identified Board Assurance Framework Strategic Objective, there are:
	  ○ Six actions overdue their target completion dates (down from 14 in Bi-Monthly 1, April and May 2022/23).
	• Of the 25 Corporate Risks, there are:
	  ○ 11 actions overdue (an increase from four in Bi-Monthly 1, April and May 2022/23),
	  ○ One risk had no progress narrative provided within the specified review timescales (down from two in Bi-Monthly 1, April and May 2022/23),
	  ○ There remain no risks without any documented controls,
	  ○ There remains one risk with vague assurance details,
	  ○ There remain no risks without any documented SMART actions.
	• The Trust Board is asked to:
	  ○ Review and discuss the report.		

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 Board with a status update in relation to; 1) the Board Assurance Framework (BAF) Strategic Objectives (SO) and those risks that site on the corporate level of the Trust's 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
- 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 and Compliance to review their risks that sit on the corporate level element of the Trust's 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 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 closed.

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 Trust Board in Appendix 1 - 8.

3.1.2 BAF Movement

The table below shows the movement of the BAF risk documents from Bi-Monthly-1 (April and May 2022/23 financial year) to Bi-Monthly 2 (June and July 2022/23 financial year):

Summary Risk Title	SO Under Threat	Change in Current Risk Score						
		2021/22				2022/23		Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	Bi-M2	
BAF SO 01 - Safe, High-Quality Care	Safe, high quality care	15 High	25 High	25 High	20 High	20 High	20 High	↔
BAF SO 02 - Care at Home	Care at home	9 Moderate	12 Moderate	16 High	16 High	12 Moderate	12 Moderate	↔
BAF SO 03 - Working with Partners	Partners	6 Low	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	12 Moderate	↔
04b - Organisational Effectiveness		20 High	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	↔
04c - Making Walsall & BC BPTW		20 High	16 High	16 High	12 Moderate	12 Moderate	12 Moderate	↔
BAF SO 05 - Use Resources Well	Resources	15 High	15 High	15 High	15 High	15 High	20 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	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** (Bi-Monthly-3, August and September) and risk review details over the last bi-monthly review** (Bi-Monthly-2, June and July), 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 second 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 remained the same for the second 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 of risk reduction being confirmed in the third 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 second 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 second 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 third 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 second 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 third 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 second 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 third 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 increased in the second bi-monthly period of 2022/23 financial year, from a 15 High (Severity 5 x Likelihood 3) to a **20 High** (Severity 5 x Likelihood 4).
  - **Forecasted Risk Score Movement for the next bi-monthly Review** - Is expected to remain the same.
  - **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 remained the same for the second bi-monthly period of 2022/23 financial year, as 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 November 2022.

3.2 Corporate level of the Trust's risk register (CRR)

There are currently 25 risks that sit on the corporate level of the Trust's 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-M2'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 (RMEG) meeting.

3.2.1 Current Risks

Details of the 25 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 ↔ • 2394 * • 2430 ↔ • 2439 ↔ • 2581 ↔ • 2601 ↔ • 2664 ↔ • 2917 ↔	25:
Likely 4	4:	8:	12:	16: • 208 ↔ • 2072 ↑ • 2081 ↔ • 2082 ↔ • 2325 ↔ • 2737 ↔ • 2002 * • 3012 *	20: • 2370 ↔
Possible 3	3:	6:	9: • 2587 ↔	12: • 2489 ↔ • 2540 ↔	15: • 665 ↔ • 1005 ↔ • 2066 ↔
Unlikely 2	2:	4:	6:	8:	10: • 2464 ↔
Rare 1	1:	2:	3:	4:	5: • 2475 ↓LRR
	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 Bi-Monthly-1 (April and May 2022/23 financial year) to Bi-Monthly 2 (June and July 2022/23 financial year):

Risk ID	Risk Title	Quarterly Change in Current Risk Score						
		2021/22				2022/23		Change Direction
		Q1	Q2	Q3	Q4	Bi-M1	Bi-M2	
1528	*Potential delay in patient care and patient results.*				20 High	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	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	20 High	↔
2394	*Reduced Capacity in Health Visiting due to Recruitment and Retention Challenges.*						20 High	New risk
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	20 High	↔
2439	*Unable to provide specialist care, treatment or meet social care requirements for complex CAMHS patients.*	20 High	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	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	20 High	↔
2664	*Patient Safety and Training Issues in Medicine /ED.*		20 High	20 High	20 High	20 High	20 High	↔
2917	*In appropriate use of SCALE2 within NEWS2.*				20 High	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 12th 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, and we have an agreed solution.
    - **Risk Review** - Supplier demos now completed - options being finalised for DAG sign off before submission to Digital Transformation Board.

- **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 21st 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 September 2022 to a 12 Moderate (Severity 4 x Likelihood 3).
    - **Risk Review** - There has been a recruitment delay international nurses which has resulted in a time shift from July to October 2022. This is being worked through with the lead from RWT.

- **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 11th consecutive month (since August 2021), despite it being previously expected to reduce to a 15 High (Severity 5 x Likelihood 3). The risk deliverable date has been amended further from 29/07/2022 to 30/11/2022 to reflect this.
    - **Forecasted Risk Score Movement for next month** - Is expected to remain the same, with the reduced trajectory now expected by the end of November 2022 to a 15 High (Severity 5 x Likelihood 3).

- **Risk Review** - Updated action to reflect production of Joint HWB Strategy and draft version of the partnership Population Health & Inequalities Strategy. Final version of the strategy expected in November.

➢ **Risk ID 2394** - *Reduced Capacity in Health Visiting due to Recruitment and Retention Challenges.*
- **Risk Description** - *Risk of not receiving safe and quality care to children and families, as a result of the service has a significant vacancy rate across Health Visitors and is struggling to retain staff and recruit new staff into post.*
  - **Current Risk Score Movement** - New escalation, set as a **20 High** (Severity 4 x Likelihood 5).
  - **Forecasted Risk Score Movement for next month** - Is expected to remain the same, with the trajectory reduction being confirmed in October 2022.
  - **Risk Review** - The service needing exec support and oversight of how the Division and service are mitigating the risk and addressing the issues within the service.

➢ **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 13th consecutive month (since June 2021), despite it being previously expected to reduce to an 8 Moderate (Severity 4 x Likelihood 2). The risk deliverable date has been amended further from 30/06/2022 to 31/08/2022 to reflect this, due to the project experiencing further unexpected technical and supplier resource issues, that have delayed the ingestion of the records. In addition to resource issues in the service which has meant the QAing has taken longer than initially expected.
  - **Forecasted Risk Score Movement for next month** - Is expected to reduce to an 8 Moderate (Severity 4 x Likelihood 2).
  - **Risk Review** - The risk trajectory was expected to decrease at the end of July 2022 to its Target Risk Score following completion of Quality Assurance of ingested Legacy and Electronic records which was due to cease at the end of July subject to approval by Information Governance Team. Meeting held with the service regarding incident 164219. Working through the process with the service, it became apparent when responding to a lateral check, the service is required to read all records held for that child. To support this process the EDM Project Manager, Adam Colcough, demonstrated how to use collection functionality in MediViewer to build Child Protection Plan reports which can then be shared with external stakeholders. It was confirmed staff received training on this functionality and the EDM Project Manager would arrange for refresher training to be issued. Small volumes of records subjected to QA has been escalated to project executive, along with the lack of resource to undertake QA from the end of July. Decision required to whether additional resources are made available or accept QA. Meeting scheduled 3rd August to confirm decision. Timescale for the ingestion of the loose filing is not yet known due to delays on the supplier side. It is anticipated a date will be confirmed first week of August. Action 8869 due date extended to mid-August to reflect this.

➢ **Risk ID 2439** - *Unable to provide specialist care, treatment or meet social care requirements for complex CAMHS patients.*
- **Risk Description** - *Risk of potential physical, emotional, and psychological harm to CYP, staff, and/or public. That could result in harm to patients as well as reputational and financial harm to the Trust.*
  - **Current Risk Score Movement** - Has remained the same this month as a **20 High** (Severity 4 x Likelihood 5) for the 16th 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** - Following discussion with the CMO and Lead Nurse for MH, a new version of the risk has been created with an updated risk title and description. There has been continued admissions for CYP in Mental Health crisis, there has been continued incident reports relating to acts of violence and aggression within the division. There are continued incidents relating to CYP absconding from the department, the paediatric ward awaits a repair and upgrade to the doors. We continue to work in collaboration with the Mental Health Trust to develop and improve CYP crisis pathways and access to timely care and treatment. Risk title and description improved. The target date for delivering actions 9 (7925) and 10 (9975), are now overdue as of 31/07/2022. Confirmation on the actions progress to be provided as to whether these actions have been delivered or if extensions are required.

- **Risk ID 2581** - *Internal risk for CYP patients awaiting Tier-4-Beds hospital admission*.
  - **Risk Description** - *An increase in CYP in crisis within paediatrics which results in a failure to manage patient safety and offer optimum care*.
    - **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 November 2021).
    - **Forecasted Risk Score Movement for next month** - Has not been clarified, risk score reduction trajectory to be confirmed.
    - **Risk Review** - Following discussion with the CMO and Lead Nurse for MH, a new version of the risk has been created with an updated risk title and description. Risk remains the same. Rapid Tranquilisation Policy is currently going through ratification, presented at MMG with a couple of queries remain outstanding. This is expected to be completed for the next risk review meeting. Risk title and description improved. The target date for delivering action 2 (6855), is overdue as of 30/06/2022. Confirmation on the action progress to be provided as to whether the action have been delivered or if an extension is required.

- **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 9th consecutive month (since October 2021).
    - **Forecasted Risk Score Movement for next month** - Is not expected to change, with the risk score reduction trajectory to be confirmed.
    - **Risk Review** - The Trust had previously reported a lack of assurance regarding the sepsis data reported electronically. The revised reports and validation from the Sepsis Team and Deteriorating Patient Group has resulted in assurance regarding the accuracy of data.

- **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 10th consecutive month (since September 2021).
    - **Forecasted Risk Score Movement for next month** - Is not expected to change, with the risk score reduction trajectory expected by the end of September 2022.
    - **Risk Review** - No response back from HEE around the improvement plan submitted. The risk is split into two parts: 1) the clinical divisional concerns surrounding patient safety, and 2) the concerns surrounding non-patient safety items. The improvement plan is progressing according to timescales: 1) the two clinical divisional concerns highlighted continue to be monitored through AMU Assurance Board, and 2) the ten non-patient safety concerns continue to be monitored through MEG, with the two amber items discussed with CMO at the MWG meeting in June, and to be discussed at the meeting on 20th July 2022. Awaiting formal feedback from HEE, not yet received.

- **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 4th consecutive month (since March 2022).
    - **Forecasted Risk Score Movement for next month** - It is expected to remain the same, with the reduced risk reduction trajectory being confirmed in Bi-Monthly 3 of 2022/23 financial year.
    - **Risk Review** - RCP NEWS2 e-Learning package live on ESR, workforce intelligence requested to provide regular figures of compliance by division. FORCE have produced a specific e-learning package covering SCALE2 in detail. Also, to be added to ESR.

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's risk register (CRR) reports will be presented to provide assurance and mitigation where appropriate.

The Head of Risk Management and Compliance will provide expert support to risk owners and assessors in further reviewing and updating risks, 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 Group (RMEG) meeting, where all Executive Directors have the opportunity to discuss and challenge their peers BAF SO's and CRR risks.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the BAF SO's and CRR risks documented 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's risk register Dashboard - June
*Appendix 10 - Corporate level of the Trust's risk register Dashboard - July*****

****July data extracted on 08/09/2022, after the business cycle.

Latest Board/Committee/Group - 22/07/2022
Version V11.03

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					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 2021~~ 31 December 2022
Consequence:	4	4					4		Consequence:	5	
Risk Level:	**20 High**	**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~~ 31/12/2022	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. 25.07.2022 Posts recruited to, mental health act administrators in post. Work continues in conjunction with the mental health trust to ensure patients have timely mental health reviews in line with CORE24.	
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. 25.07.2022 Deputy DoN for quality post is vacant, recruitment in progress.	

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	**Complete** - 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. 25.07.2022 Maternity services re-visited on 13.12.2021 and report received May 2022. Significant assurance gained.	
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~~ 30/09/2022	03.11.2021 Deputy DoN with portfolio for Patent Voice will lead this work from 08.11.2021 25.07.2022 Patient experience enabling strategy out to public consultation.	
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 - 27/07/2022
Version V11.2

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.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• Risks in this area relate to Walsall Together partnership risks. • Risks relating to Community Services are updated through the divisional structure. Where relevant, equivalent risks are recorded here, and reframed to reflect the risk to the wider system. • Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together. • 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)	2022/23 Bi-Monthly 2 (June & July)	2022/23 Bi-Monthly 3 (Aug & Sept)	2022/23 Bi-Monthly 4 (Oct & Nov)	2022/23 Bi-Monthly 5 (Dec & Jan)	2022/23 Bi-Monthly 6 (Feb & March)	2021/22 Q4	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3	3					4	• Whilst the partnership response to 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					4		Consequence:	3	
Risk Level:	**12 Moderate**	**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~~ Nov 22	**In Progress** - The partnership Plan is progressing and at final draft stage. However, delays in the Data & Intelligence workstream within the Place Development Programme are likely to impact on finalising the partnership approach to Population Health Management, utilising intelligence jointly across NHS and Public Health teams. Since the previous report, the Joint Health & Wellbeing Strategy has been published by the HWB Board, confirming the strategic priorities for Walsall. A timeline for consultation on the draft Plan has been agreed by partners and joint working groups have now been established. 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.	

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 becoming a formal place-based partnership under the Health & Social Care legislation.	Director of Integration	Sept 22	**In Progress** - As part of the development of place-based partnerships and integrated care systems. A draft governance model for Walsall has been developed and is progressing through the partnership governance process for approval before any relevant governing body approvals, including the ICB.	
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 (£1m for Walsall non-recurrent for 2022/23 but with potential for recurrency) and public health/prevention.	Director of Integration	Aug 22	**Complete** - Confirmation of the funding envelopes for virtual wards and health inequalities for Walsall is now known and has been built into 2022/23 transformation plans.	

Latest Board/Committee/Group - 29/06/2022
Version V11.02

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					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					3		Consequence:	3	
Risk Level:	**6 Low**	**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	July 2022	**IN PROGRESS**	

Latest Board/Committee/Group - 28/06/2022
Version V11.01

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					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					4		Consequence:	4	
Risk Level:	**12 Moderate**	**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 31/08/2022	**In Progress** - Templates and guidance circulated. New Senior Leaders are being actively supported to complete exercise by the end of August 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~~ 30/06/2022	**Complete** - Updated policy now completed. Action now to conduct Training and Development on the HR Framework Policy.	
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~~ 31/08/2022	**In Progress** - Draft model agreed in principle with trade unions supported by draft toolkit and procedure. Consultation has taken place. Policy still to go through Policy Group.	
13.	Roll out Cultural Competency Training for 100 clinical leaders and embed via internal training knowledge and capacity.	Catherine Griffiths	30/09/2022	**In Progress** - Provider commissioned and funding secured. Cohorts planned for Q2. On going evaluation of training effectiveness.	

Latest Board/Committee/Group - 28/06/2022
Version V11.01

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: • **2072** - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency (Risk Score = 16).
	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					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 risk gaps in control.	Likelihood:	2	30 September 2022
Consequence:	4	4					4		Consequence:	4	
Risk Level:	**12 Moderate**	**12 Moderate**					**12 Moderate**		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	**In Progress** - As of June 2022, there are 212 international nurses in place within the Trust.	
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~~ 31/05/2022	**Complete** - Reports developed. Pilot 3 completed by end of April as planned and currently establishing a monthly workforce intelligence report.	
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~~ 31/08/2022	**In Progress** - 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. Investment Case for a sustainable structure to be agreed by the Medical Director, with an aim to complete by end of August 2022.	
7	Report detailing all risks and issues relating to the medical staffing function to be provided to PODC	Catherine Griffiths	31/12/2021	**Complete** - Diagnostic report presented to CMO and DP&C by Interim Head of Medical Staffing (30 December). Proposal agreed and updates to be provided to Executive Committee and Medical Workforce Group.	
8	Completion of Operational Workforce Planning 2022-2023	Catherine Griffiths	31/10/2021	**Complete** - First draft completed and reviewed by PODC.	
9	Official Launch of formal partnership with Walsall Housing Group to support local people into healthcare careers to be completed.	Catherine Griffiths	~~31/08/2021~~ 31/10/2021	**Complete** - Manager's briefings to be completed and post appointed to provide pastoral support for new healthcare workers.	

10	Update report to PODC re Anchor Institute and employment models to include overview of system work streams to be presented in August 2021.	Catherine Griffiths	31/08/2021	**Complete**.	
11	Work with Acute Provider Collaboration to identify hard to recruit roles and staff groups.	Catherine Griffiths	30/09/2021	**Completed** - WHCT paper re recruitment hotspots.	
12	Identify opportunities to work collaboratively across RWT and WHCT to support recruitment and retention of people	Catherine Griffiths	31/10/2021	**Complete** - Ongoing. Joint paper developed - oversight provided by Joint HR Working Group. Next meeting arranged for 29 November 2021.	
13	Consideration of case to align WLI rates between Walsall and RWT	Catherine Griffiths	31/08/2021	**Complete** - Acute Collaborative paper outlining options to be considered by Executive Team.	
14	Scoping of collaborative bank model between RWT and WHCT	Catherine Griffiths	31/08/2021	**Complete** - Outline paper to identify opportunity and what would be required to formalise collaborative approach due for joint HRD consideration. Progress towards Acute collaborative bank continues. Outline paper completed and submitted.	

Latest Board/Committee/Group - 28/06/2022
Version V11.02

Walsall Healthcare NHS Trust

Risk Summary

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

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **2072** - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff) and undermines financial efficiency (Risk Score = 16). • **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					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					4		Consequence:	4	
Risk Level:	**12 Moderate**	**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	**Complete** - Reported and approved at PODC in May 2022.	
3.	Business Case for 22/23 HWB funding to complement HWB strategy and support ambitious and innovative interventions.	Catherine Griffiths	~~31/03/2022~~ 31/07/2022	**In Progress** - Update to HWB Strategy Group on 6 December 2021. Went to Investment Group on 14th July, the Extraordinary Investment Group on 29th July.	
4.	Achieve Occupational Health accreditation	Catherine Griffiths	~~31/03/2022~~ 31/08/2022	**In Progress** - All milestones ahead or on track. Reviewed at HWB Strategy Group 04.01.22. Evidence submitted, waiting a date for formal review / assessment confirmed in August 2022.	
5.	Update interim Home Working Procedure and develop into flexible working strategy for the Trust.	Kevin Bostock	~~30/11/2021~~ 31/07/2022	**Complete** - This has now been added into the Flexible Working Policy.	
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 - 29/06/2022
Version V11.02

Walsall Healthcare NHS Trust

Risk Summary

BAF Strategic Objective Reference & Summary Tile:	**BAF SO 05 - Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly.**
Risk Description:	The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.
Lead Director:	Chief Operating Officer.
Lead Committee:	Performance, Finance, & Investment Committee.

Links to Corporate Risk Register:	Title:	Current Risk Score Movement:
	• **208** - Failure to achieve 4-hour 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).	**Likelihood = 4 Consequence = 5 = 20 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	4					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: • Adverse variants to 2022/23 financial plan in Q1. • 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 resulted in deficit for the Trust and the STP, prior to additional STP allocation. Evidence of planning uncertainty: • 22/23 financial planning guidance issued 24/12/21 by NHSEI. Draft plans submitted April 2022 • Final plan submitted June 2022.	Likelihood:	2	~~31 March 2022~~ 31 March 2023
Consequence:	5	5					5		Consequence:	5	
Risk Level:	**15 High**	**20 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** - Trust £7.6 million deficit plan (STP £48 million deficit) plan endorsed by Board.	
6.	Revision to Financial Plan 2022/23	R. Caldicott	June 2022	**Complete** - Trust plan breakeven for 2022/23 with the STP/ICS also submitting a balance programme. The plan recommended for endorsement by Executive and endorsed at Performance and Finance Committee under powers delegated by the Board.	
7.	Operational Delivery	R. Caldicott	~~April 2022~~ September 2022	**In Progress** - Assessment being undertaken in conjunction with the Director of Nursing of reduction in agency and through Divisional Performance Reviews holding officers to account on financial run rate.	
8.	Development of 2022/23 Efficiency Programme	N. Hobbs	~~April 2022~~ September 2022	**In Progress** - 88% of stretch CIP target (£6.3m) identified as of the end of June 2022.	

Latest Board/Committee/Group - 28/06/2022
Version V11.01

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	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	Likelihood:	2	30 Sep 2022
Consequence:	3	3					3		Consequence:	3	
Risk Level:	**9 Moderate**	**9 Moderate**					**12 Moderate**		Risk Level:	**6 Low**	

								year. • Covid-19 has exposed existing significant health inequalities in the population the Trust serves. Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust. • Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20, with further analysis presented to QPES 28/01/21 confirming 21 probable or definite nosocomial deaths from Covid in Wave 1. • Planning assumptions for a second wave of Covid-19 cases assumed a peak at half the level of the April 2020 peak. In 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

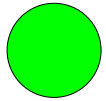
- With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables.
- Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough.
- 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.	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.	

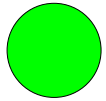
Walsall Healthcare Risk Register

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		10/07/2022	15/07/2022
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		24/07/2022	29/07/2022
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

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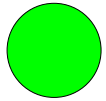
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
01/05/2022	Identification and implementation of MFA solution for VPN and VDI connectivity		Richard Pearson			26/07/2022	31/07/2022
24/03/2022	OS build upgrade programme to build 21H2 to be undertaken		Richard Pearson			26/08/2022	31/08/2022
04/05/2022	Confirm Divisional Business continuity plans are in place, available and uptodate		Mark Hart			26/08/2022	31/08/2022
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

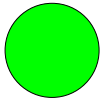
Walsall Healthcare Risk Register

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	

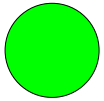
Walsall Healthcare Risk Register

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	

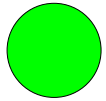
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					skills between NHS employers.	development offer under development. Director of Education and Training across RWT and WHCT to support of quality medical education and development. Managers framework launched 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	26/07/2022	31/07/2022
01/03/2022	WHCT & RWT to establish joint medical bank.	Clair Bond	26/07/2022	31/07/2022
30/06/2022	An investment case has been developed and is due to be considered by the Investment Group in July 2022.	Marsha Belle	31/07/2022	05/08/2022
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond	25/09/2022	30/09/2022
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

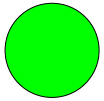
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	Operational expenditure incurred during the current financial year exceeds income allocations and/or the financial plan agreed with the ICS, which results in the Trust 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	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
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	**Closed**	26/06/2022	01/07/2022

Walsall Healthcare Risk Register

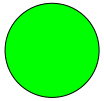
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Future Financial Sustainability	There is a risk that the Trust does not break-even in line with its statutory duty. Incurring expenditure beyond a break-even position could cause the regulator to reduce 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		26/10/2022	31/10/2022
01/12/2021	To ensure the investment Group is successful	Dan Mortiboys		26/10/2022	31/10/2022
24/06/2022	NHS nationally has asked Trusts to review financial sustainability. Locally Internal Audit will review the outcomes of this and this will be reported through Board Committee structure. This may then lead to further actions	Russell Caldicott		25/09/2022	30/09/2022
19/12/2021	Establishment of a group to set and monitor an efficiency programme	Ned Hobbs	**Closed**	26/03/2022	31/03/2022
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	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

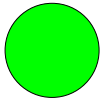
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2245	Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.	There is a high level of maternity leave within the maternity team, currently totalling 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

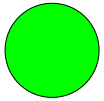
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2325	Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing 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	

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		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
2394	Reduced Capacity in Health Visiting due to Recruitment and Retention Challenges.	Risk of not receiving safe and quality care to children and families, as a result of the service has a significant vacancy rate across Health Visitors and is struggling to retain staff and recruit new staff into post. This is significantly impacting on: * Ability to deliver against contract - eg., ability to deliver mandated contacts * Ability to fully participate in partnership working and developments * Impacting on staff morale and stress levels * Impacting on Quality and safety of care delivered	Kelly Geffen	20	• Process • Health Visitor recruitment is on a rolling recruitment with NHS jobs to ensure adequate staff are recruited and leavers are replaced.	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Process in place to prioritise work: - suspended well baby clinics - moved to parent led contact for some mandated parent contacts for universal children - have centralised allocation of work rather than team based - have reviewed staffing capacity and allocated workload accordingly - suspended south locality team due to no clinical team leader and have merged into remaining teams - daily clinical team leader huddles as oversight and monitoring of workload	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Introduction of emotional health and behaviour pathway to reduce 1-1 work and move work to group work. This will provide more evidenced based approach (stepped care model) and reduce resource intensity to release clinician time.	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Process has been established - worksheets established, manually updated with: - children due for assessments - scheduled appointments - monitoring of DNA's	• Monitored in the daily service huddle and overseen by Deputy Professional Lead and the Care Group Support Manager. • N/A	

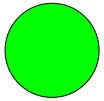
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
10/01/2022	Rolling programme of recruitment agreed by Division	Sallyann Sutton	25/09/2023	30/09/2023
10/01/2022	To create 0-19 team for delivery of SENDi agenda, and improve skill mix and expertise within the team. Creation of CTL role - with HR for matching and then to explore options for new roles drawing from different skill sets might improve pool for recruitment of new staff.	Sallyann Sutton	26/12/2022	31/12/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
10/01/2022		To develop procedures and process to monitor demand at service level, improve allocation of work and management of caseload. Includes introducing daily CTL huddles to monitor flow and allocation of work service wide and introduce prioritisation process.	Sallyann Sutton		25/06/2022		30/06/2022
06/05/2022		Business change to explore if the HV service can move to a digital/automated allocation system.	Sallyann Sutton		27/08/2022		01/09/2022
01/06/2022		To set up a monthly Task and finish group to address the issues identified in the service. Membership to include Director of Nursing, Director of People & Culture, Acting Director of Integration and members of the Community Division and the Health Visiting Service.	Matthew Dodd		26/12/2022		31/12/2022

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.					

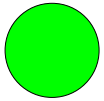
Action Plan

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			24/07/2022		29/07/2022
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

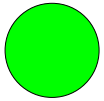
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2439	Unable to provide specialist care, treatment or meet social care requirements for complex CAMHS patients.	Risk of potential physical, emotional, and psychological harm to CYP, staff, and/or public. That could result in harm to patients as well as reputational and financial harm to the Trust.	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

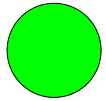
Walsall Healthcare Risk Register

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

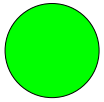
Walsall Healthcare Risk Register

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	5	• 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.	
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	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	• Terms of Reference agreed. Outputs monitored via PODC on a	

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

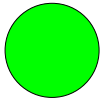
Action Plan

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	26/07/2022	31/07/2022
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	Tamsin Radford	26/08/2022	31/08/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
	request						
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
21/06/2022	A series of workshops to define anti-racism and anti-discrimination will take place and a joint anti-racist & anti-discrimination statement will be developed for RWT & WHCT.		Marsha Belle			26/08/2022	31/08/2022
21/06/2022	The ICS resource packs will be launched in the Trust		Sabrina Richards			26/07/2022	31/07/2022
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	

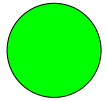
Walsall Healthcare Risk Register

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	26/10/2022	31/10/2022
12/07/2021	Delivery of Level 3 Safeguarding adults training	Lisa Carroll	26/10/2022	31/10/2022
12/07/2021	revise training to reinforce emerging themes from concerns raised continue to develop safeguarding briefings as necessary	Lisa Carroll	26/10/2022	31/10/2022

Walsall Healthcare Risk Register

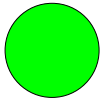
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2581	Internal risk for CYP patients awaiting Tier-4-Beds hospital admission.	An increase in CYP in crisis within paediatrics which results in a failure to manage patient safety and offer optimum care.	Jodie 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.	
					• Policy	• Staff access the MH team within the	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• 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.	trust for support and guidance. • N/A	
					• Policy • To have a ratified rapid tranquilisation policy for children/young people.	• TBC • N/A	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
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	25/09/2022	30/09/2022

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	

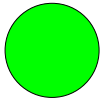
Action Plan

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

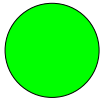
Walsall Healthcare Risk Register

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.	Amy Blakemore	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 05.07.22The Trust had previously reported a lack of assurance regarding the sepsis data reported electronically. The revised reports and validation from the sepsis team and deteriorating patient group has resulted in assurance regarding the accuracy of data.	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		27/08/2022	01/09/2022
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.	

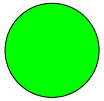
Action Plan

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	

Walsall Healthcare Risk Register

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		

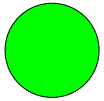
Walsall Healthcare Risk Register

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
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
01/11/2021	Funding for pyxis machine across all sites where medication is stored.	Gary Fletcher	**Closed**	25/06/2022	30/06/2022

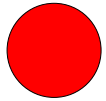
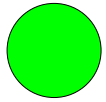
Walsall Healthcare Risk Register

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 Risk Register

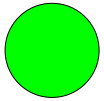
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2977	Risk of harm to children due to fragmented record storage and clinicians not having access to the full contemporaneous record across all children's pathways	0 - 19 electronic and paper records created by Community Paediatric Consultants, Children's Safeguarding, Teenage Pregnancy Team, HIPs, Paediatric SALT, Paediatric Occupational Therapy, Child Development Centre, Team Around the Child teams, Community Children Nursing, Haemoglobinopathy and Children's Audiology are held locally within the individual teams. This prevents a clinician having access to the full child record.		20			
3002	Unable to provide expert specialist care consistently for complex adults suffering mental health illness	Risk of potential physical, emotional, and psychological harm to patients, staff, and/or public, due to the unavailability of specialist services that would manage the behaviors and mental health symptoms. That could result in harm to	Jodie Kirby	16	• Process • Internal escalation process to WHT MH Team for staff to escalate concerns, incidents or risks.	• Bank is utilised to ensure the service is covered to be able to support the growing MH need. • We are engaging with the MH Trust transformational work to improve MH service delivery within WHT.	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		patients as well as reputational and financial harm to the Trust.					

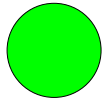
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
21/06/2022	There will be a series of senior and executive meetings which commence 23.6.22. The meetings are to agree escalation and transformational service plans.	Manjeet Shehmar	26/08/2022	31/08/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
3012	360 whole practice appraisals and medical governance	Two external reviews (Grant Thornton and NHSE) highlighted a number of information and governance issues erelated to appraisals, including lack of process for gathering information relating to clinicians to support appraisals. No robust recording of complaints and incidents; out of date policies; lack of process for obtaining MPITs and the need for training new appraisers	Manjeet Shehmar	1 6	• Policy • Appraisal policy out of date	• Policy with LNC for approval at next meeting, Once approved to go to Policies Group and published on intranet •	
					• Process • Currently no robust process for collating accurate complaints and incident reporting in relation to clinicians	• Process being reviewed by Governance •	
					• Process • Audits highlighted no register of private practices in place	• Revalidation team have contacted all clinicians and requested confirmation of all work undertaken outside of Walsall Healthcare Trust and a register is now kept • Revalidation team have contacted all clinicians and requested confirmation of all work undertaken outside of Walsall Healthcare Trust and a register is now kept	
					• Process • MPITs not requested from previous employers. This task previously sat within Recruitment but a change in management has resulted in MPITs being overlooked and not requested. Revalidation team to pick this up	• Revalidation team have taken on this task and have had training on TRAC to enable them to start working on this aspect. A "look back" exercise on new clinicians over the last 12 months will be undertaken to ensure all records are now available •	

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'	

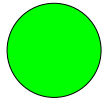
Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
01/07/2022	Recruit to all vacant posts contained within the ED Medical, Nursing & AEC Business Case.	Rob Ankcorn		31/10/2022	05/11/2022
03/08/2022	Recruit to vacant CD post for ED & Acute.	Rob Ankcorn		11/09/2022	16/09/2022
03/08/2022	Implementation programme for the introduction of a Emergency Decisions Unit to manage emergency clinical conditions with expected extended LOS in ED is in situ supported by the QA Team	Rob Ankcorn		25/09/2022	30/09/2022
03/08/2022	Run medical component of department in parallel after sufficient recruitment.	Rob Ankcorn		26/10/2022	31/10/2022
01/09/2022	Trial an EDU for 12 set pathways for one week in the month of September.	Rob Ankcorn		25/09/2022	30/09/2022
01/09/2022	Escalate with Surgery & Women's instances where junior medical teams are not accepting handover for direct streaming.	Rob Ankcorn		25/09/2022	30/09/2022
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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances		Review Status
11/04/2022	To run a PDSA with a senior decision maker working in Triage.		Rob Ankcorn			**Closed**	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			**Closed**	10/07/2022	15/07/2022
06/06/2022	ED to send Senior Clinical Rep to Operational Meetings three times a day		Rob Ankcorn			**Closed**	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			**Closed**	11/07/2022	16/07/2022
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			**Closed**	24/07/2022	29/07/2022

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	• •	

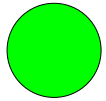
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
18/07/2022	In light of an increase in phishing attempts the trust will be implementing MFA on NHS.net accounts in financial, procurement and exec authority roles	Richard Pearson	26/08/2022	31/08/2022
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

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			06/09/2022	11/09/2022
24/03/2022	OS build upgrade programme to build 21H2 to be undertaken		Richard Pearson			25/09/2022	30/09/2022
04/05/2022	Confirm Divisional Business continuity plans are in place, available and uptodate		Mark Hart			26/08/2022	31/08/2022
01/04/2022	Implementation of Vulnerability scanning solution		Richard Pearson			25/09/2022	30/09/2022
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
01/11/2021	E-mail migration to be completed to Office 365 and upgrade of Office 2010 suite to O365 version		Richard Pearson		**Closed**	26/07/2022	31/07/2022

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	27/10/2022	01/11/2022
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 due to lab results electronic alerts	Risk of harm due to a lack of robust electronic alerts for when pathology, histology, radiology, microbiology and endoscopy, reports are available to view, which may lead to a delay in patient care and potentially unnecessary follow up appointments	Mark Harrison	8	• • 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	
					• Process • Users to select the email notification and inputting of a valid email address into the splash screen within the Fusion application.	• No incident reported to the service desk • N/A	
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	Caroline Whyte	20	• 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	

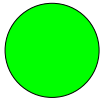
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		poor staff morale caused by suboptimal staffing levels _Increased reliance on temporary staffing which has a potential negative impact both financially and to the ward/department skill mix **See Risk Assessment attached for full details**					

Action Plan

Start Date	*Action Details / Description*	*Owner*		*Reminder Date*	*Target Date*
26/03/2020	On-going international and national recruitment. Establishment reviews have increased the numbers of vacancies.	Lisa Carroll		26/01/2023	31/01/2023
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		26/01/2023	31/01/2023
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
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	**Closed**	26/10/2022	31/10/2022

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	16	• 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	

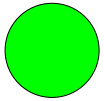
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					skills between NHS employers.	development offer under development. Director of Education and Training across RWT and WHCT to support of quality medical education and development. Managers framework launched 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*
30/06/2022	An investment case has been developed and is due to be considered by the Investment Group in July 2022.	Marsha Belle	25/11/2022	30/11/2022
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.	Clair Bond	25/09/2022	30/09/2022
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	25/09/2022	30/09/2022

Walsall Healthcare Risk Register

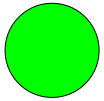
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	Operational expenditure incurred during the current financial year exceeds income allocations and/or the financial plan agreed with the ICS, which results in the Trust 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
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
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	**Closed**	26/06/2022	01/07/2022
25/05/2022	The trust runs an Investment Group to manage investment within affordable levels	Roseanne Crossey	**Closed**	/ /	26/05/2022

Walsall Healthcare Risk Register

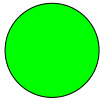
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Future Financial Sustainability	There is a risk that the Trust does not break-even in line with its statutory duty. Incurring expenditure beyond a break-even position could cause the regulator to reduce 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		26/10/2022	31/10/2022
01/12/2021	To ensure the investment Group is successful	Dan Mortiboys		26/10/2022	31/10/2022
24/06/2022	NHS nationally has asked Trusts to review financial sustainability. Locally Internal Audit will review the outcomes of this and this will be reported through Board Committee structure. This may then lead to further actions	Russell Caldicott		25/09/2022	30/09/2022
19/12/2021	Establishment of a group to set and monitor an efficiency programme	Ned Hobbs	**Closed**	26/03/2022	31/03/2022
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	**Closed**	25/04/2022	30/04/2022

Walsall Healthcare Risk Register

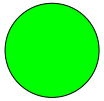
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2245	Risk of suboptimal care and potential harm to patients from available midwives being below agreed establishment level.	There is a high level of maternity leave within the maternity team, currently totalling 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		25/11/2022	30/11/2022
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		25/11/2022	30/11/2022
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	Risk of patient safety by the possibility of incomplete medical records that fail to document the patient's complete clinical journey	Mark Harrison	16	• Process • Access Fusion for diagnostic/ clinical overiew	• Calls monitored via the service desk • N/A	
					• Process • Incident reporting notes if unable to be located within a timely manner	• > Creating a temp set of notes and are reintegrated once they have been received back into the records library with the main set of notes. > A reinstatement of a register is being implemented to record the the creation of the temp notes and also recording the last location. • N/A	
					• 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	• Night staff create incidents to reflect a missing file Creating effective reporting of incident raised and presented to IGSG • N/A	
					• Policy • Staff to following the heath records policies located on the Trusts intranet.	• Staff engagement will be either attending the library and inserting the loose filling or requesting daily the records (limited to a maximum of 10 records) • N/A	

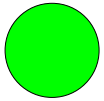
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/09/2022	Medicine division to investigate why policies are not being followed effectively and ensure staff are following policies.	Rob Ankcorn	26/12/2022	31/12/2022
01/09/2022	Surgery division to investigate why policies are not being followed effectively and ensure staff are following policies.	William Roberts	26/12/2022	31/12/2022
01/09/2022	Women's & Children's division to investigate why policies are not being followed effectively and ensure staff are following policies.	Delreita Ohai	26/12/2022	31/12/2022
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	26/12/2022	31/12/2022
10/09/2021	Implementation of EDM (Electronic Document Management system) to digitise current	Mark Harrison	26/08/2023	31/08/2023

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
	paper records. This will remove the need for paper health records to be utilised.						
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			26/12/2022	31/12/2022
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 implementation.		Mark Harrison			26/12/2022	31/12/2022
27/03/2022	Review demand and capacity for HRL tasks.		Mark Harrison		**Closed**	26/07/2022	31/07/2022

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 Strategy, 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 strategy 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		25/11/2022	30/11/2022
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
2394	Reduced Capacity in Health Visiting due to Recruitment and Retention Challenges.	Risk of not receiving safe and quality care to children and families, as a result of the service has a significant vacancy rate across Health Visitors and is struggling to retain staff and recruit new staff into post. This is significantly impacting on: * Ability to deliver against contract - eg., ability to deliver mandated contacts * Ability to fully participate in partnership working and developments * Impacting on staff morale and stress levels * Impacting on Quality and safety of care delivered	Kelly Geffen	20	• Process • Health Visitor recruitment is on a rolling recruitment with NHS jobs to ensure adequate staff are recruited and leavers are replaced.	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Process in place to prioritise work: - suspended well baby clinics - moved to parent led contact for some mandated parent contacts for universal children - have centralised allocation of work rather than team based - have reviewed staffing capacity and allocated workload accordingly - suspended south locality team due to no clinical team leader and have merged into remaining teams - daily clinical team leader huddles as oversight and monitoring of workload	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Introduction of emotional health and behaviour pathway to reduce 1-1 work and move work to group work. This will provide more evidenced based approach (stepped care model) and reduce resource intensity to release clinician time.	• Reported at monthly care group meetings and also added to Divisional Quality Board escalation papers monthly. It is also reported to the newly formed monthly Task and Finish Group which is led by Exec Directors. • N/A	
					• Process • Process has been established - worksheets established, manually updated with: - children due for assessments - scheduled appointments - monitoring of DNA's	• Monitored in the daily service huddle and overseen by Deputy Professional Lead and the Care Group Support Manager. • N/A	

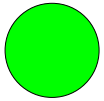
Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
10/01/2022	Rolling programme of recruitment agreed by Division	Sallyann Sutton	25/09/2023	30/09/2023
10/01/2022	To create 0-19 team for delivery of SENDi agenda, and improve skill mix and expertise within the team. Creation of CTL role - with HR for matching and then to explore options for new roles drawing from different skill sets might improve pool for recruitment of new staff.	Sallyann Sutton	26/12/2022	31/12/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
06/05/2022	Business change to explore if the HV service can move to a digital/automated allocation system.		Sallyann Sutton			27/08/2022	01/09/2022

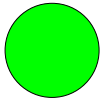
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2430	Fragmented Trust Health Records related to Health Visiting and School Nursing.	Risk of harm to CYP seen by the Health Visiting and School Nursing Services, as a result of fragmented Health Records held across multiple storage sites and over numerous shared drives. That could consequently lead to; suboptimal care and delivery, deletion of health record notes, and clinicians' full access to Child Health Records being impeded.	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	

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	13/09/2022	18/09/2022

Walsall Healthcare Risk Register

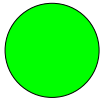
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2439	Unable to provide specialist care, treatment or meet social care requirements for complex CAMHS patients.	Risk of potential physical, emotional, and psychological harm to CYP, staff, and/or public. That could result in harm to patients as well as reputational and financial harm to the Trust.	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*
11/07/2022	Paediatric Matron to upload action plan to this risk.	Charlotte Yale	25/09/2022	30/09/2022
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	25/09/2022	30/09/2022

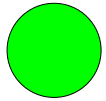
Walsall Healthcare Risk Register

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	15/09/2022	20/09/2022
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.	Paul Richardson	25/09/2022	30/09/2022
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	25/09/2022	30/09/2022

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	

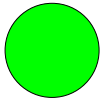
Walsall Healthcare Risk Register

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		25/09/2022	30/09/2022
01/12/2021	To develop a strategic approach to dispute resolution.	Clair Bond		25/09/2022	30/09/2022
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		25/11/2022	30/11/2022
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		25/11/2022	30/11/2022
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
21/06/2022	The ICS resource packs will be launched in the Trust	Sabrina Richards	**Closed**	26/07/2022	31/07/2022
21/06/2022	A series of workshops to define anti-racism and anti-discrimination will take place and a joint anti-racist & anti-discrimination statement will be developed for RWT & WHCT.	Sabrina Richards	**Closed**	15/09/2022	20/09/2022

Walsall Healthcare Risk Register

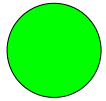
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2540	Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems	There is a risk of avoidable harm going undetected to patients, public and staff as 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	

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	26/10/2022	31/10/2022
12/07/2021	Delivery of Level 3 Safeguarding adults training	Lisa Carroll	26/10/2022	31/10/2022
12/07/2021	revise training to reinforce emerging themes from concerns raised continue to develop safeguarding briefings as necessary	Lisa Carroll	26/10/2022	31/10/2022

Walsall Healthcare Risk Register

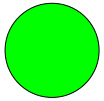
Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2581	Internal risk for CYP patients awaiting Tier-4-Beds hospital admission.	An increase in CYP in crisis within paediatrics which results in a failure to manage patient safety and offer optimum care.	Jodie 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.	
					• Policy	• Staff access the MH team within the	

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• 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.	trust for support and guidance. • N/A	
					• Policy • To have a ratified rapid tranquilisation policy for children/young people.	• TBC • N/A	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
17/02/2022	For a rapid tranquilisation policy to be ratified and available for use within paediatrics.	Raghu Krishnamurthy	25/09/2022	30/09/2022
12/07/2021	For staff to have mental health act training and de-escalation training (IKON)	Charlotte Yale	25/09/2022	30/09/2022
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	25/09/2022	30/09/2022

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	

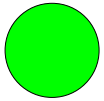
Action Plan

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		26/01/2023	31/01/2023
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	**Closed**	25/09/2022	30/09/2022

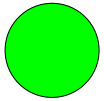
Walsall Healthcare Risk Register

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.	Amy Blakemore	20	• Policy • National Early Warning Score within the Management of the Deteriorating Patient Policy V1.000.	• Vital Pack electronic patient system Management of the Deteriorating Patient Policy V1.000. • Management of the Deteriorating Patient Policy V1.000.	
					• Training • Vital Pack Training, ALS, ILS, BLS, and E-Sepsis Training.	• > 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.	
					• Process • E-Sepsis Module EPR	• > 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 05.07.22The Trust had previously reported a lack of assurance regarding the sepsis data reported electronically. The revised reports and validation from the sepsis team and deteriorating patient group has resulted in assurance regarding the accuracy of data.	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	26/12/2022	31/12/2022

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	Patient Safety and Training Issues in Medicine / ED Potential Consequences: -Patient safety incidents -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.	Nuhu Usman	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 Education and Training (non patient safety) 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 Education and Training (non patient safety) concerns 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 Education and Training (non patient safety) concerns which form part of the 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 (non patient safety issues) improvement plan to HEE.this element of the risk now sits on risk number 3031	• Documented improvement plan, with progress and action narrative against applicable items.this element of the risk now sits on risk number 3031 • Action log is maintained in line with HEE progress report. this element of the risk now sits on risk number 3031	

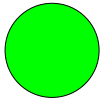
Walsall Healthcare Risk Register

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*
08/08/2022	Formally review risk 2664 at next AMU assurance board and update risk rating of 2664 accordingly	Nuhu Usman		06/09/2022	11/09/2022
01/11/2021	Continued work of the improvement plan.(This work is now transfered to risk 3031 and this action closed on 2664)	Louise Nickell	**Closed**	08/01/2023	13/01/2023

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		

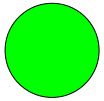
Walsall Healthcare Risk Register

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*
01/11/2021	Funding approval for electronic controlled drug management system. Scope funding for new software.	Gary Fletcher		30/11/2022	05/12/2022
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
01/11/2021	Funding for pyxis machine across all sites where medication is stored.	Gary Fletcher	**Closed**	25/06/2022	30/06/2022
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	**Closed**	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	**Closed**	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	**Closed**	26/07/2022	31/07/2022

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. E-learning package now available on ESR. Compliance figures to be reported monthly.	Lorna Kelly		26/10/2022	31/10/2022
23/03/2022	Scope further training in the use of SCALE2 within NEWS2 for all clinical staff	Lorna Kelly	**Closed**	26/08/2022	31/08/2022

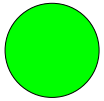
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
3002	Unable to deliver consistent specialist mental health care to complex patients admitted to WHT.	Risk of potential physical, emotional, and psychological harm to patients, staff, and/or public, due to the unavailability of specialist services that would manage the behaviours and mental health symptoms. That could result in harm to patients as well as reputational and financial harm to the Trust.	Jodie Kirby	16	• Process • Internal escalation process to WHT MH Team for staff to escalate concerns, incidents or risks.	• Bank is utilised to ensure the service is covered to be able to support the growing MH need. • We are engaging with the MH Trust transformational work to improve MH service delivery within WHT.	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
21/06/2022	There will be a series of senior and executive meetings which commence 23.6.22. The meetings are to agree escalation and transformational service plans.	Manjeet Shehmar	25/09/2022	30/09/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
3012	360 whole practice appraisals and medical governance	Two external reviews (Grant Thornton and NHSE) highlighted a number of information and governance issues related to appraisals, including lack of process for gathering information relating to clinicians to support appraisals. No robust recording of complaints and incidents; out of date policies; lack of process for obtaining MPITs and the need for training new appraisers	Mark Read	16	• Policy • Appraisal policy out of date	• Policy with LNC for approval at next meeting, Once approved to go to Policies Group and published on intranet • TBC	
					• Process • Currently no robust process for collating accurate complaints and incident reporting in relation to clinicians	• Process being reviewed by Governance • TBC	
					• Process • Audits highlighted no register of private practices in place	• Revalidation team have contacted all clinicians and requested confirmation of all work undertaken outside of Walsall Healthcare Trust and a register is now kept • Revalidation team have contacted all clinicians and requested confirmation of all work undertaken outside of Walsall Healthcare Trust and a register is now kept	
					• Process • MPITs not requested from previous employers. This task previously sat within Recruitment but a change in management has resulted in MPITs being overlooked and not requested. Revalidation team to pick this up	• Revalidation team have taken on this task and have had training on TRAC to enable them to start working on this aspect. A "look back" exercise on new clinicians over the last 12 months will be undertaken to ensure all records are now available • TBC	

Action Plan

Start Date	*Action Details / Description*	*Owner*	*Reminder Date*	*Target Date*
01/07/2022	Updated Appraisal Policy to be approved. Email to Chair LNC for amendments - no response. Chasing email to be sent with deadline	Mark Read	26/10/2022	31/10/2022
01/08/2022	Register to be kept by Revalidation team. Details requested from clinicians	Mark Read	26/12/2022	31/12/2022
01/07/2022	Revalidation team to take over the responsibility for requesting MPITS. Look back exercise for last 12 months to ensure all MPITS up to date	Mark Read	26/12/2022	31/12/2022

MEETING OF THE PUBLIC TRUST BOARD Wednesday 5th October 2022			
Health and Safety Annual Report - April 2021 to March 2022			
Report Author and Job Title:	Simone Smith Head of Health and Safety	**Responsible Director:**	Kevin Bostock – Director of Assurance
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☐ Assure ☐		
Assure	The purpose of this report is to provide the Trust Board with a summary of principal activity and performance relating to the promotion and management of health and safety for Walsall Healthcare NHS Trust for the period 1st April 2021 to 31st March 2022. This includes: • Continued, quorate Health and Safety Committee convention, with 5 meetings held during this reporting period. • Reviewed, updated, and agreed Terms of Reference reflective of local governance arrangements enabling full consultation with Health and Safety Union Representatives, Divisional Representatives and Specialist Advisors. • Reviewed and published health and safety resources, supporting managers in assessing, prioritizing and managing risks. • Continual policy review and refresh in line with changes to local arrangements, national guidance and legislation. • Robust Fit Testing arrangements and internally accredited Fit2Fit trainer means we have been able to increase testing provision, performance and train staff as testers.		
Advise	• Following sustained focus on Covid-19 safety arrangements over the past 2-years, restoration plans developed to restore and improve compliance against HSG65. • Increased incident reporting compared with previous year. Health and Safety incident increase of 11% compared to 2020/21, with Violence and Aggression increasing by 22%. • Slips/ Trips/ Falls; Manual Handling (inc. load handling), Occupational disease (Dermatitis) and struck by an object are the most frequently causes of RIDDOR reportable incidents and incapacitation of an employee in excess of 7-days.		
Alert	• Currently, there is no electronic system to capture H&S proactive risk assessment performance. Work is underway to evaluate systems available including Datix as a solution moving forward. • Compliance against the Health and Safety toolkit remains low organisationally with the exception of Community services. • Manual Handling, Slips/ Trips/ Falls are triangulated in Incident, RIDDOR and Claims data.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	• BAF SO 04b - Organisational Effectiveness, • BAF SO 04c - Making Walsall and the Black Country the Best Place to Work.	
Resource implications	There is no resource implications associated with this report.	
Legal and/or Equality and Diversity implications	Breaches of statutory legal duties can result in enforcement notice, including improvement, prohibition notices and prosecution. There are no equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Walsall Healthcare NHS Trust
Health and Safety - Annual Report 2021/22

Contents:

EXECUTIVE SUMMARY

Health and safety is an integral, and important part of everyone's duties. The Trust's commitment to Health and Safety therefore ranks equally with all other aims, objectives, and activities. All organisations have a legal duty to put suitable arrangements in place to manage health and safety.

During 2021/22, the Trust has focused on restoring, recovering, and resetting many of its core services, particularly those impacted by the Covid-19 pandemic. Equally, the past 12 months has seen a refocus and realignment of core health and safety management arrangements, whilst continuing to adhere to the restrictions brought about by Covid-19. This has provided opportunities to reimagine delivery of our key priorities utilising innovative ways of working, primarily advanced during 2020/21. Digital solutions such as the implementation of Microsoft Teams and the roll-out of I.T. equipment, has enabled the continued dissemination of some aspects of health and safety training, virtual meetings, policy consultation and specialist advice.

The Health and Safety Committee acts as the main mechanism for consultation on work related health and safety matters. However, during the pandemic, the Trust adopted a Control & Command reporting structure to ensure timely decision making and necessary actions were taken in terms of emerging risks associated with the pandemic. As such, for the duration of the pandemic, a representative from the Health and Safety Team has attended (at times daily) multidisciplinary-team meetings, with representation from unions supporting staff-side, to offer specialist health and safety advice and support. The Health and Safety Committee has now been re-established with new chairpersonship, reviewed, and agreed terms of reference, representatives and meetings scheduled for the new financial year 2022/23.

Clear, well-articulated policy documents are essential for the implementation of organisational health and safety structures and arrangements. The Health and Safety Team have continued to review existing policy documents over the last 12 months including the Trust overarching Health and Safety Policy which has recently been approved. The team have commenced an 18-month plan to review all Health and Safety policies and convert these into practical, easy-read procedures.

The Trust uses a range both reactive and proactive measures to monitor health and safety performance. The Managers Health and Safety Toolkit is a checklist designed to assist managers in identifying any deficiencies in health and safety management arrangements and a process for proactively developing actions to mitigate risks identified. We have taken the opportunity over the last 12 months, to review and update this tool to include some additional guidance and templates including a COSHH Microbiological agents risk assessment tool, an annual fire safety briefing template, a sharps guided risk assessment tool, Personal Protective Equipment (PPE)/ Respiratory Protective Equipment (RPE) Standing Operating Procedure (SOP), COVID-19 environmental and individual risk assessment templates and associated SOP.

Despite the challenges associated with Fit Testing prior to, and during, the pandemic, the Trust had delivered a much-improved position. In September 2021, our RPE Facilitator achieved Fit2Fit accreditation meaning not only are we able to provide Fit Testing, but we are also able to deliver Qualitative Face Fit Tester Training in-house.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 1995 (amended 2013) requires employers to report certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work' to the Health Safety Executive (HSE). The Trust reported 46 RIDDOR incidents over the last 12 months.

Predominantly these relate to lifting and handling and slips trips and falls, resulting in absence from work in excess of 7 days.

Moving into the next 12 months, the Health and Safety team will focus on maturing and embedding the safety management system, reducing preventable harm from incidents associated with violence & aggression, sharps, load handling and slips, trips, falls and engaging with divisional representatives to steer the health and safety agenda locally. To support these objectives, we will provide enhanced health and safety training for managers and directors and reinvigorate our programme of audit to monitor compliance against health and safety legislation and internal policy.

1. PURPOSE OF REPORT

The purpose of this report is to provide the Trust Board with a summary of principal activity and performance relating to the promotion and management of health and safety for Walsall Healthcare NHS Trust for the period 1st April 2021 to 31st March 2022. In addition, this report highlights key health and safety priorities, to be delivered throughout the current financial year 2022/23.

The aim of the report is to provide the Trust Board with **assurance** there are suitably effective systems and processes in place to ensure WHT executes it's statutory responsibilities in line with Health and Safety legislation. Where complete assurance cannot be provided, the report will **advise** the Board on action planned and taken to mitigate any enduring risk. For issues or risks identified as having no assurance, this will be clearly **identified** within the report.

2. BACKGROUND & CONTEXT

All organisations have a legal duty to put in place suitable arrangements to manage health and safety. The Health and Safety at Work etc. Act 1974 is the primary piece of legislation covering occupational health and safety in the UK. This Act defines the general duties for employers and employees to protect both themselves and other service users from significant or avoidable harm. A positive safety culture should be recognised as being a part of the everyday process of conducting business and/or providing a service, and an integral part of workplace behaviours and attitudes.

In particular, the act requires organisations to provide and maintain:

- A Health and Safety Policy
- A system to manage and control risks in connection with the use, handling storage and transport of articles and substances
- A safe and secure working environment, including provision and maintenance of access to and egress from premises
- Safe and suitable plant, work equipment and systems of work that are without risks
- Information, instruction, training and supervision as necessary
- Adequate welfare facilities

It is advocated that Health and Safety arrangements used by the Trust are aligned with the principles and guidance issued by the Health and Safety Executive (HSG65) which is represented by four key components of health and safety management: 'Plan, Do, Check, Act'. Health and safety objectives have been aligned to these four components with an associated Improvement Plan. Notwithstanding, a comprehensive legislative framework exists, within which the main duties placed on employers are defined and enforced.

The Health and Safety Executive (HSE) are the regulatory body with responsibility for enforcing health and safety legislation and this is often enforced in healthcare by the Care Quality Commission (CQC) through a Memorandum of Understanding with the HSE. The HSE also fulfils a major role in producing advice on health and safety issues, and practical guidance on the interpretation and application of the provisions of the legislative framework.

Regardless of the size, industry or nature of an organisation, the key aspects to effectively managing for health and safety are:

- leadership and management (including appropriate and effective processes)
- a trained/skilled workforce
- an environment in which people are trusted and involved

The HSE provides guidance to support organisations of all sizes to effectively manage health and safety based on the principles of 'Plan, Do, Check, Act.' (PDCA). This is described in detail within the HSE's 'Managing for Health and Safety Guidance' (HSG65). The key components of the PDCA framework that is being applied within WHT are summarised, as follows:

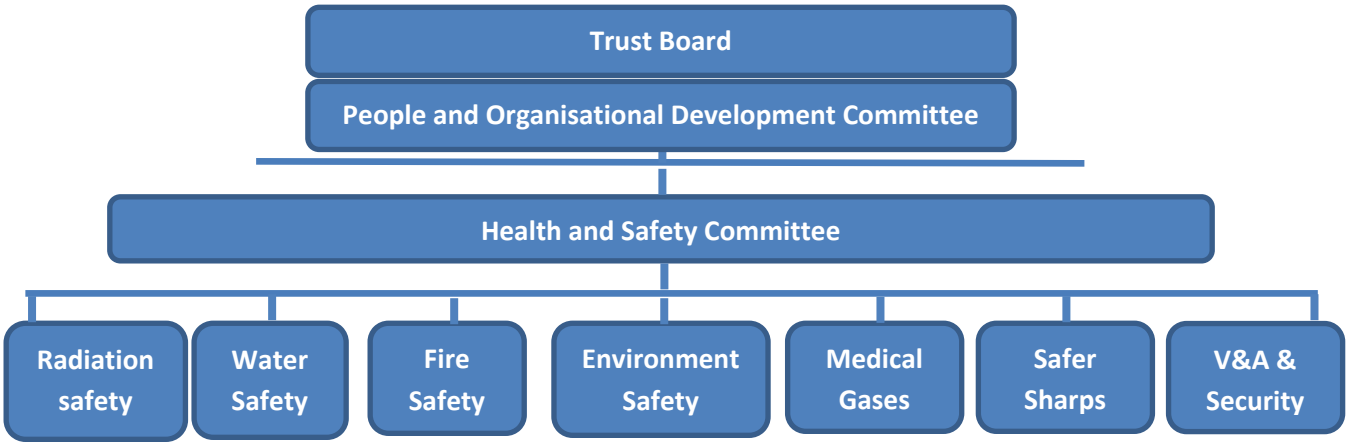
- Plan - determine policy, plan for implementation
- Do - profile health and safety risks; organise for health and safety management; implement the plan
- Check - measure performance; investigate accidents and incidents
- Act - review performance; apply learning

Walsall Healthcare NHS Trust (WHT) accepts this framework to be fundamental in the delivery of safe services for staff, patients, carers and visitors. Health and Safety law places specific duties on organisations. Employers, directors, managers and employees, can be held personally liable when these duties are breached, and members of the board have both collective and individual responsibility for health and safety.

Each section of this report will review the suitability of Health and Safety management arrangements for controlling risk, within WHT based on *Managing for Health and Safety* (HSG65). This will include an evaluation of contributions from specialist advisors and safety-sub-groups reporting into the Health and Safety Committee.

Whilst not included under the Management of Health and Safety at Work Regulations 1999; fire safety remains an essential requirement to ensure the H&S of people present on our sites. The Regulatory Reform (Fire Safety) Order 2005 (RRO) became law in 2006 and covers all fire legislation, alongside the RRO are the Firecode suite of documents and the building regulations. Together these documents form the basis of all fire safety on site and within community premises, including fire safety training and emergency evacuation. Responsibility currently remains with the Fire Safety Advisor under the Chief Operating Officer as Executive Director with delegated responsibility for fire and overall remit for Estates and Facilities. The Trust Fire Adviser has submitted the Annual Fire Safety report and this will be presented to the Trust Board as a separate report. This report will present a summary of key aspects of fire safety performance.

3. Health and Safety Committee and Governance Arrangements



The Health and Safety Committee, (HSC), is constituted under the requirements of Section 2(7) of the Health and Safety at Work etc. Act (1974). Its purpose is to consult with employees on matters of health, safety and welfare in accordance with the Safety Representatives and Safety Committees Regulations (1977) and the associated Code of Practice and Guidance, the Management of Health and Safety at Work Regulations (1999) and the Health and Safety (Consultation with Employees) Regulations 1996.

The Committee has an overarching responsibility for corporate leadership and risk management of health and safety matters appertaining to WHT. The primary role of the Committee is to promote the health, safety, security and welfare of all the employees of the Trust, service users, visitors and any others who may be affected by the Trust's activities and to promote of consultation and co-operation between management and staff. The Group Director of Assurance Chairs the Health and Safety Committee, being the Director with delegated responsibility for health and safety, specifically providing strategic leadership within Walsall Healthcare NHS Trust.

The Health and Safety Committee acts as the main mechanism for consultation on work related health and safety matters. During the first wave of the pandemic, the Trust adopted a Tactical Command & Control reporting structure to ensure timely decision making and necessary actions were taken in terms of emerging risks associated with COVID-19. For the duration of the pandemic, a representative from the Health and Safety Team attended (at times daily) multidisciplinary-team meetings, with representation from unions supporting staff-side, to offer specialist health and safety advice and support.

As such, the Health and Safety Committee did not convene in its formal constitution during 2020/21. Although an initial meeting took place in April 2021, the continuation of this meeting was frustrated by a lack of chairpersonship, wider committee representation and sickness absence. During Quarter 2, plans were put in place; divisional and specialist representation was predominantly secured, the Advisory Director of Governance (subsequently Group Director of Assurance) was appointed as chairperson and meetings convened for the remainder of the year and the year ahead. As such the Committee convened via MS Teams on 6 occasions during 2021/22, updating and agreeing Terms of Reference on 30th November 2021. Quoracy was achieved at all meetings following representation from divisional representatives and specialist advisors. Meeting minutes and actions were taken and disseminated by the Governance Administrator.

Divisional Quality Meetings

Health and Safety Divisional proactive and reactive principal activity report data is provided to each of the 4 clinical divisions on a quarterly basis. A Health and Safety Team representative attends these meetings in the second month of each financial quarter to present and advise on lessons learnt and remedial action required. The report has been updated to include Trust oversight in the main body of the document with Division-specific data contained within the appendices. This allows divisions to view performance data across the Trust and the 4 clinical divisions.

Divisional Health & Safety Assurance Reports

Divisional Health and Safety representatives prepare assurance reports to be presented at Health & Safety Committee. This report is intended to provide the committee with assurance of actions taken to improve compliance within the division in terms of the H&S management arrangements including, risk assessing, training, participation in audit, review, and management of incidents etc.

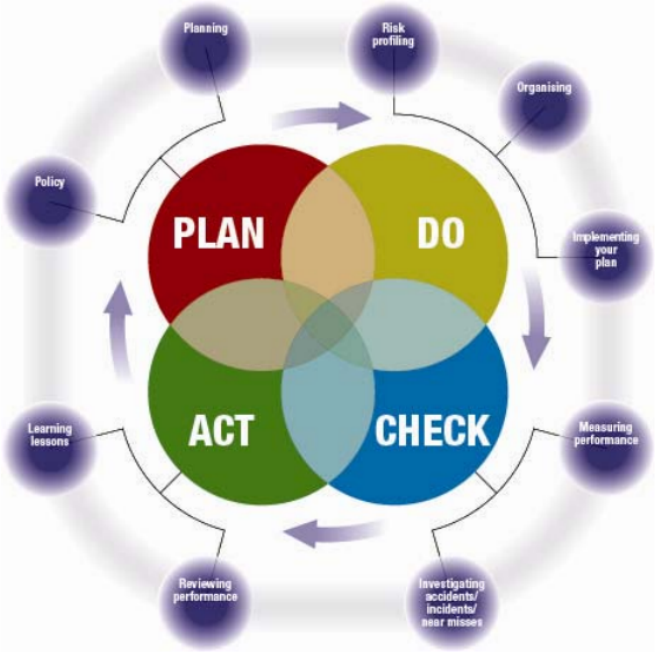
People and Organisational Development Committee

The Health and Safety Committee is accountable to the People and Organisational Development Committee (PODC) which is in turn, as a sub-committee, responsible to the Trust Board. The Health and Safety Committee can at any time take Health and Safety matters directly to the Chief Executive Officer, as accountable officer, and also to the Trust Board. Scheduled reports are provided by the Head of Health and Safety to PODC quarterly and a summary report annually.

Trust Board

The Trust Board is responsible for demonstrating the commitment of the Trust to all matters relating to health and safety and for leading the health and safety agenda. The Trust Board receive reports from PODC via the same schedule described above.

4. Health and Safety Management System - HSG65



Source - HSE

PLAN - Health and Safety Policy

A review of the Trust's overarching Health and Safety Policy was undertaken during the third quarter of 2021/22.
The policy was:

- Consulted on, and agreed by the Health and Safety Committee on 30th November 2021
- Reviewed and agreed at Policy Management Core Group on 8th March 2021,
- Ratified by Trust Management Committee on 29th March 2022

Amendments to the reviewed document include additional clarity in terms of governance reporting structures including re-status of the forum as a 'committee' as opposed to a 'group'. The Director with delegated responsibility was refreshed and updated and additional information added to clearly define the Health and Safety Coordinator Role (Formerly referred to as 'champions'). The risk management policy and strategy section were further developed to reflect documents in place now that were not previously in existence.

In addition to the overarching Health and Safety Policy, the Health and Safety Team have reviewed and updated a number of policy documents during quarters 3 and 4, these include:

- **Water Safety Policy** – Consulted and agreed at Health and Safety Committee on 30th November 2021 – Ratified on 26th April 2022
- **Slips/ Trips/ Falls (Non-clinical) Policy** - Consulted and agreed at Health and Safety Committee on 24th January 2022 – Ratified on 25th May 2022
- **Laser Ultraviolet and Hazardous Light Source Safety Policy** - Consulted and agreed virtually by the Radiation Safety Group on 16th December 2021, at Health and Safety Committee on 24th January 2022 – Ratified on 25th May 2022
- **Work Equipment Policy** - Consulted and agreed at Health and Safety Committee on 24th January 2022 – Awaiting Ratification

The Health and Safety Team will continue to review and update topic-specific health and safety policies, procedures and Standard Operating Procedures (SOP's) throughout the current financial year.

DO – Assess Risk/ Plan for Implementation

The completion of risk assessments is a statutory requirement under the Management of Health and Safety at Work Regulations 1999. Assessing risks helps identify what could cause harm in the workplace, how or what could be harmed, and the likelihood this is to happen. This enables managers to identify and prioritise their biggest health and safety risks and focus efforts on putting suitable and proportionate safety measures in place to mitigate the risk of harm.

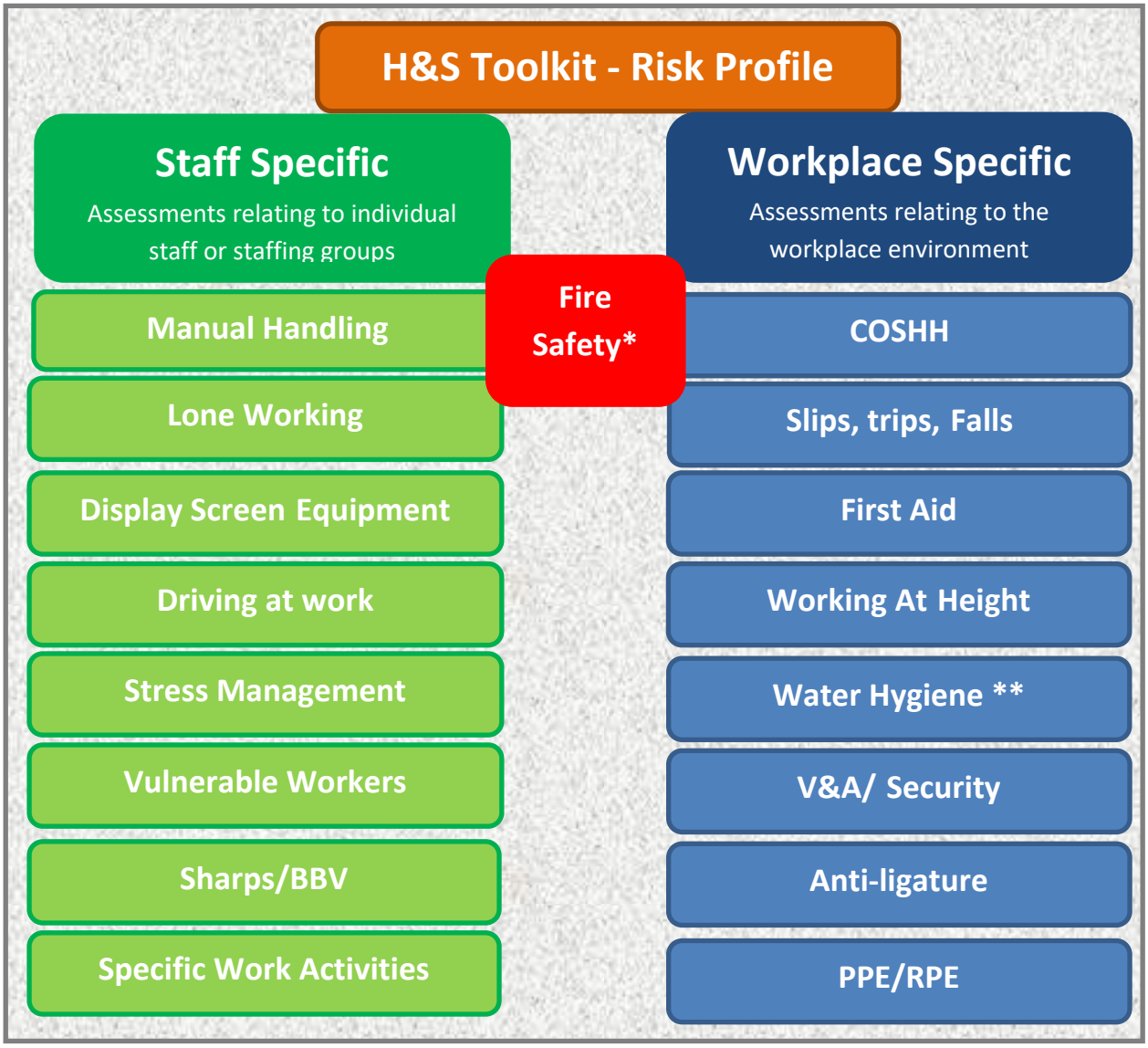
To support the risk assessment programme, the Health and Safety Team continues to provide advice and guidance in the implementation of statutory risk assessments through utilisation of the Health and Safety Toolkit. The Toolkit is intended as a health and safety 'one-stop' resource to guide managers through assessing and managing their relevant statutory responsibilities.

The Health and Safety Toolkit has been in place for over 5 years at Walsall Healthcare

NHS Trust. Essentially this comprises of a proforma containing 21 sub-sections covering relevant aspects of Health and Safety Law and local policy, at times, specifically relevant to healthcare work and environment. During this reporting period, the toolkit has been reviewed and updated to include some additional guidance and templates including a COSHH Microbiological agents risk assessment tool, the annual fire safety briefing template, a sharps guided risk assessment tool, the PPE/RPE SOP, COVID-19 environmental and individual risk assessment templates and SOP.

In June 2020, we procured an additional module to the Ulysees Risk Management system, to capture Toolkit compliance electronically. We were subsequently unable to implement this system due to the Trust decision in 2021, to move to a new risk management system; Datix. This continues to remain one of our key priorities, primarily to convert the toolkit into an electronic Health and Safety Database, capable of recording compliance and providing summary data for the purpose of assurance against regulatory activity.

DO - Develop Risk Profile - Walsall Health and Safety Risk Profile



Note: * Completed by the Trust Fire Advisor
** Specialist Estates staff, engineers and contractors, complete the required risk assessments associated with the maintenance and operation of the estate i.e., asbestos, electrical works, lifts, waste and water

DO - Organise and Communicate

During 2021/22, the Health and Safety team adhered to COVID-19 restrictions, which remained in place from the previous financial year. As a result, the team continued to employ innovative ways to link in with staff and managers to provide technical advice and guidance which ordinarily would have occurred face to face. This included the use of MS Teams but also reviewing video footage, still images, and drawings.

Workplace COVID-19 Guidance for Staff Members and Managers.

Throughout the COVID-19 Pandemic, Walsall Healthcare NHS Trust ("Trust") has taken steps as required by Government COVID-19 regulations to protect our patients, colleagues and the local community in the fight against the coronavirus infection. COVID-19 Safety arrangements remained in place in the Trust as they did in all NHS healthcare organisations during 2021/22 including *after* the Governments relaxing of general restrictions for the wider public on 19th July 2021 ('Freedom Day'). Corporate Command continued to review national advice and convert into practical workplace guidance.

Many of the usual operating policies, processes, systems and rules that enable the delivery of patient services and support our staff members in the workplace were adapted and regularly reviewed in response to national guidance and requirements to ensure a safe working environment. The Trust, provided information in terms of the continued efforts to protect the workforce and patients; by:

- Continuing to encourage colleagues to access COVID-19 vaccines and boosters.
- Encouraging all colleagues to access regular asymptomatic testing via twice weekly lateral flow testing (order your kits here)
- Ensuring clear workplace guidance and processes are in place to maintain safe working environments.
- In exceptional circumstances, supporting frontline colleagues to attend work rather than self-isolate with testing mitigations.
- Retaining emergency command protocols to support strategic and operational decision making.

As of 31st March 2022, the Trust had issued version 7 of the Workplace COVID-19 Guidance for Staff Members and Managers.

Sharps and Needlestick Incident Reporting

Collaborative work between the Infection Prevention & Control, Occupational Health and Health and Safety Teams, identified substandard levels compliance with incident reporting, specifically with regards to sharps/ needlestick incidents. The issue was highlighted during times of increased pressure and demand on the service. The main disparity being between actual numbers of staff attending occupational health following an injury of this type, versus actual reported incident data. As a result, targeted communications were developed and shared across the Trust to reinforce the risks associated with use of sharps, safe use and disposal, incident reporting and escalation. **Appendix 2** demonstrates reporting variance.

Timely Reporting of Injuries, Diseases and Dangerous Occurrence

In November 2021, the Communications team supported with the delivery of a safety message reminding all managers of the importance to report work related accidents/incidents, including near misses, on the Trust incident management system. This followed several incidents highlighted to the team outside of the usual incident

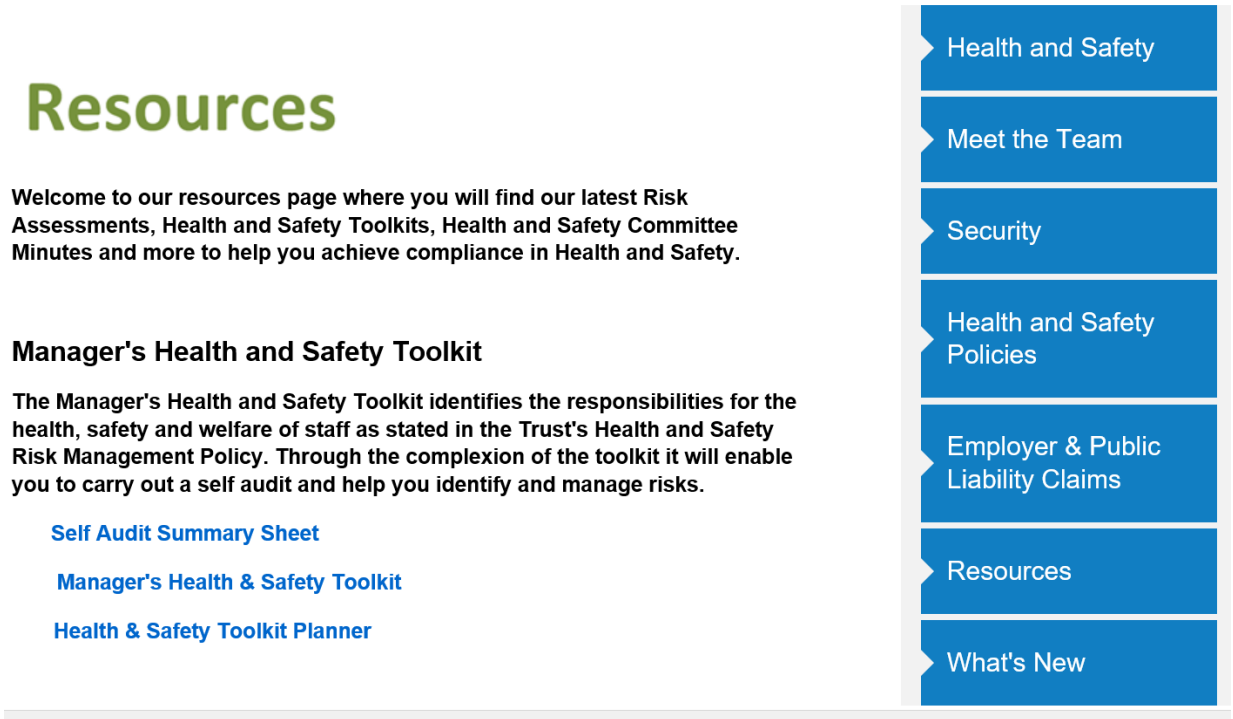
reporting system resulting in RIDDOR reporting latency. All workplace H&S incidents reported are monitored by the Health & Safety Team who liaise with relevant managers in an effort to prevent reoccurrences. In addition to this, the Health and Safety Team, on behalf of the Trust, report any **RIDDOR** reportable incidents to the **Health and Safety Executive**. Under these Regulations an accident is a separate, identifiable, unintended incident, which causes physical injury and includes acts of non-consensual violence to people at work. Strict reporting timescales are in place, breaching these Regulations is a criminal offence and can lead to enforcement action.

The Incident Reporting and Management Policy has been reviewed during this reporting period with input from the Health and Safety Team, specifically the provision of a section clearly outlining RIDDOR responsibilities.

Resources

During this reporting period, Health and Safety resources have been reviewed and updated to further support staff in addressing their local safety risks. The Health and Safety team understand the difficulties that manager's face due to the vast number of competing priorities that must be managed within any one department. The Health and Safety Planner has been developed as a 'tool', to assist managers plan and prioritise their health and safety arrangements. The planner organises all risk assessments, workplace inspections and more into a monthly schedule. This tool is flexible and can be adapted to the specific departmental risks. This assists managers in planning effective implementation and completion of local health and safety arrangements, and thereafter, used to continually monitor and review health and safety progress. **See Appendix 5.**

Resources are held on the Health and Safety 'Team Pages' on the Trust intranet site. There are over 40 resources ranging from guided risk assessment tools, posters, Standard Operating Procedures (SOP's) to inspection tools, checklists, links to committee minutes and helpful videos.



In Quarter 1 and during the 3rd and 4th quarter of 2021/22; the team reviewed and updated the following resources:

- Generic (Blank) Risk Assessment Template (version 4)

- H&S Planner (Version 3)
- Managers H&S Toolkit (Version 4)
- Public Liability Insurance Certificate 2022-2023
- Health & Safety for Managers Training Flyer 2022-2023

The following new additions have also been made available:

- DSE & COSHH for Assessors Training Flyer
- DSE Assessors report to manager's template
- Self-assessment checklist for Homeworking
- Working from Heights Risk Assessment Template (Version 1)
- Ladder, Stepladders; Inspection checklist
- Healthy Back at Work Video

Divisional Health and Safety Activity

Each clinical division received a quarterly report during this reporting period. Reports include a summary of principle activity from both a Trust and Divisional perspective. Each report contains details of proactive and reactive performance including, Health and Safety Toolkit monitoring, Audit progress, policy review, training compliance (including Fit Testing), trust wide & divisional incident activity with comparators and claims data.

Training and Competence

Mandatory Health and Safety training is available for staff to complete by eLearning on induction to the Trust. Non-clinical staff renew their compliance bi-annually whilst clinical staff undertake annually. Compliance for mandatory training as of 31st March 2022 reported at 87.12% with overall Corporate Update Training at 90.70 %. Load Handling compliance as of year-end demonstrated positive engagement at 93.46%. Action plans remain in place to increase compliance with mandatory training as per Trust policy. Promotion of training, flexibility in accessing online training and regular compliance reporting are ways in which compliance is encouraged.

Additional Health and Safety Training was provided throughout 2021/22, predominantly delivered via MS Teams; this includes:

Table 1 – Health and Safety Training

Training Course Description	No of Sessions
DSE Risk Assessment for Assessors (2-hour)	5
COSHH Risk Assessment for Assessors (2-hour)	6
Health and Safety Risk Assessment (Half-day) (Face-to-face)	3
Health and Safety Toolkit Awareness Sessions (1-hour)	31
Fit-Test Training	10
Health and Safety for Managers (Full-Day, Face-to-face)	-
Health and Safety for Coordinator's (2-hours, 8- Modules)	-
IOSH for Directors (1 Day via MS Teams – External Provider)	-

Health and Safety for Managers is a full-day course. Due to Covid-19 restrictions remaining in place, specifically social distancing, these sessions were not delivered, although they have now recommenced and scheduled for the current financial year.

The Health and Safety Co-ordinator (HSC) course is a bespoke programme, specifically designed to develop a network of champions across the organisation that have enhanced skills to support the Trust in the delivery of its strategic vision; to value our colleagues

and provide safe, high-quality care across all of our services. 2 full Cohorts of training have been delivered within the Trust prior to the pandemic. Unfortunately, the third Cohort was cancelled in March 2020 as a result of the initial impact of Covid-19 on face-to-face training. At present, this course remains suspended due to temporary reduced capacity within the health and safety team.

At the end of March 2022, funds were approved to source IOSH for Directors. This course will be delivered virtually during 2022/23 providing Executives and Directors with an understanding of the moral, legal and business case for proactive safety, health and risk management, and of strategic safety and health management and its integration into holistic business management systems and procedures.

The Core Objectives being;

- Describe the legal, moral and financial role of operational directors, and senior executives
- Understand responsibilities, liabilities and accountabilities, both personal and organisational
- Explain the importance of integrating safety and health at top-management level
- Illustrate how to plan the direction for safety and health
- Explain the value of an efficient safety and health management system
- Describe the importance of reviewing and continually improving management systems
- Explain the positive impact and improvement that an organisation's leaders can have on its performance
- Describe the importance of setting key performance indicators and targets

The Health and Safety Team

The full team establishment comprises of the following members:

- Head of Health and Safety
- Health and Safety Officer (X2)
- Health and Safety Skills Trainer/ Officer

At the beginning of 2020 a Health and Safety Officer post became vacant and attempts to recruit were unsuccessful. Due to retirement and return, the Health and Safety skills Trainer post reduced from 1 Whole Time Equivalent (WTE) to 0.6 WTE. In quarter 2 of the same year, a fixed term Respiratory Protective Equipment (RPE) Coordinator post was created and approved at Tactical Command albeit not funded from Covid-19 funds. As such, the vacant Health and Safety Officer budget line has continued to fund the RPE post throughout 2021/22.

In terms of combined experience, the Health and Safety Team hold approximately 100-years' worth of public sector experience, at least 70-years of which specifically pertains to safety and regulatory governance. Qualifications held by the team include National Examination Board in Occupational Safety & Health (NEBOSH) Certificate & Diploma, Chartered Member of the Institution of Occupational Safety and Health (CMIOSH), BA (Hons) Law and Social Policy, Preparing to Teach in the Lifelong Learning Sector (PTLLS) and more recently, in September 2021, our RPE Facilitator achieved Fit2Fit

accreditation meaning we can deliver Qualitative Face Fit Test Training internally.

CHECK - Measure Performance

Ongoing restrictions brought about by COVID-19, continued throughout 2021/22. As a result, non-essential face-to-face Health and Safety audits remained largely paused. Despite, restrictions, onsite activity continued where it was deemed necessary, to attend community or hospital departments to provide specialist advice and support. A summary of this activity is captured below:

Table-2 - Health and Safety Intervention Monitoring

Health and Safety Activity	Number of *planned* interventions
Display Screen Equipment Assessments	44
Covid-19 Environmental Safety Inspections	23
Lifting/ Handling Assessment Advice	12
Workplace Inspections	9
Advising on environment/ Space/ pre- and post-move checks/ / COSHH assessments/ equipment	10
Trust EPRR Exercise	2
Advising on new ED build	2

Note: The above figures detail only those interventions that were booked and planned and does not cover reactive requests.

Health and Safety Toolkit - Self-Audit Monitoring

Self-audit monitoring continued within the Trust. The Self Audit Summary process **(Appendix 3)** provides a visual summary in terms of compliance against each of the health and safety topics identified within the toolkit. Previously, the requirement for self-audit summary submission expected returns, 6-monthly.

During the reporting period 2021/22, 106 self-audits have been reviewed and resubmitted. The Divisional breakdown is illustrated below:

Table-3 – Divisional Self-Audit Performance

Medicine and Long-Term Conditions	Community	Surgery	Women's, Children's, and Clinical Support Services
19	43	14	24

This financial year, priority work will be undertaken to return to pre-pandemic activity and more focused attention on corporate areas such as; Estates and Facilities, Digital Services, Governance and other key infrastructure functions.

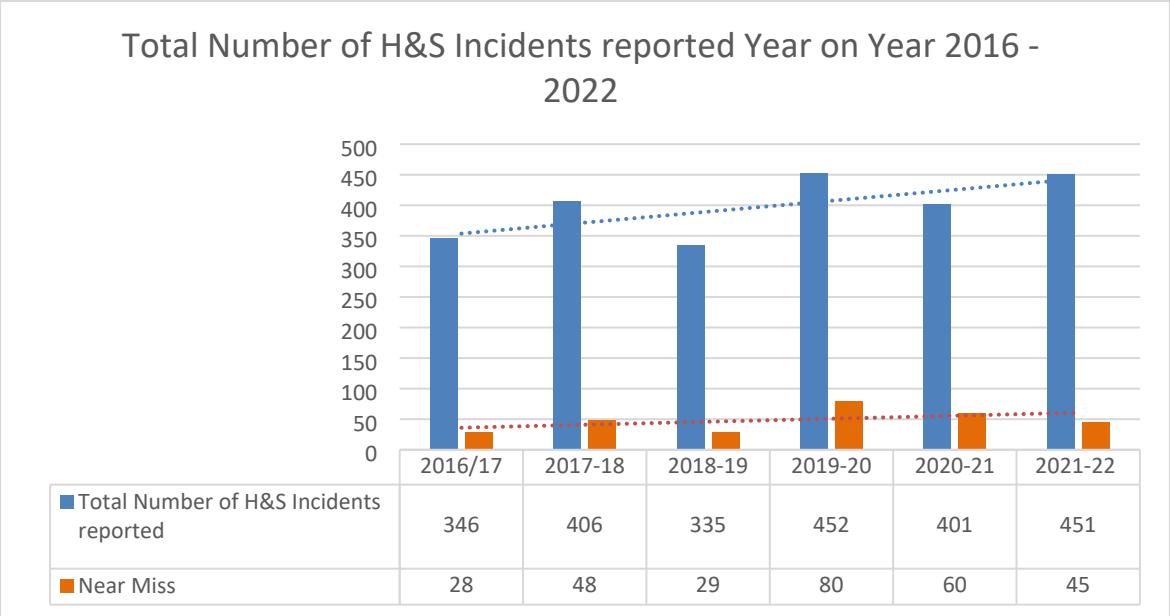
The Health and Safety Committee have agreed that evidence of ongoing proactive monitoring warrants more frequent self-audit submissions to demonstrate continual review and progress. As such, from 1st April 2022, the Self Audit Summary compliance will be expected on at least a quarterly basis. Compliance against this will be monitored through the Health and Safety Committee which will also convene on a quarterly basis during 2022/23.

Incident Reporting and Investigation

Health and safety investigations form an essential part of the monitoring process. Findings from incident investigations can help identify why existing risk control measures failed, form the basis of action to prevent an incident from happening again, and improve overall risk management.

During 2021/22, the total number of Health and Safety incidents reported in the Trust, increased compared with the previous year. During the pandemic overall incident reporting decreased for all incident categories including Patient Safety. It is not uncommon to see patterns of decreased reporting activity at times of excessive organisational pressure, such as during winter and summer months. The sustained pressure experienced during the first wave of the pandemic is reflected in the figures below. Whilst as a Trust our primary objective is to decrease harm associated with incidents and accidents; incident reporting is actively encouraged as part of our open learning culture. Increased near miss reporting is indicative of a positive learning culture, i.e., incidents are reported even though harm was prevented. These incidents provide beneficial insight into patterns of behaviour and allow early intervention to prevent harm being realised. Interestingly, figures demonstrate positive performance following a trust-wide campaign in 2019 and through the into 2020/21, albeit figures have decreased for this reporting period.

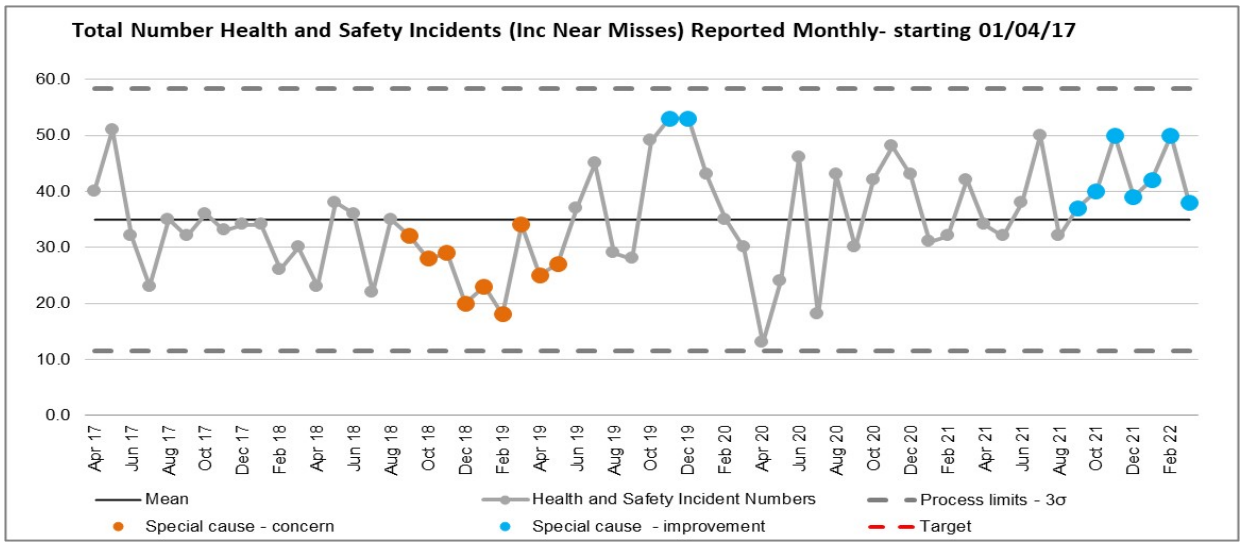
Chart 1 – Total Number of Health and Safety Incidents (excluding Violence and Aggression) Year on Year



	2016/17	2017-18	2018-19	2019-20	2020-21	2021-22
Total Number of H&S Incidents reported	346	406	335	452	401	451
Near Miss	28	48	29	80	60	45

The Statistical Process Control (SPC) Chart below demonstrate, an overall increase in Health and Safety incident reporting from 2019/20.

Chart 2 - Statistical Process Control (SPC) Chart – Monthly Incident Performance (2017 – 2022)



Health and Safety combined with Violence and Aggression figures, illustrate a similar picture. Reduced onsite footfall due to visiting restrictions, are likely to have impacted positively on the reduction of violence and aggression during 2020/21. As restrictions have been relaxed over recent months, incidents have increased, however figures overall are on a downward trend. Table 4 demonstrates year on year performance and percentage difference in reporting behaviour.

Chart 3 – Combined Health and Safety and Violence and Aggression Figures – Year on Year

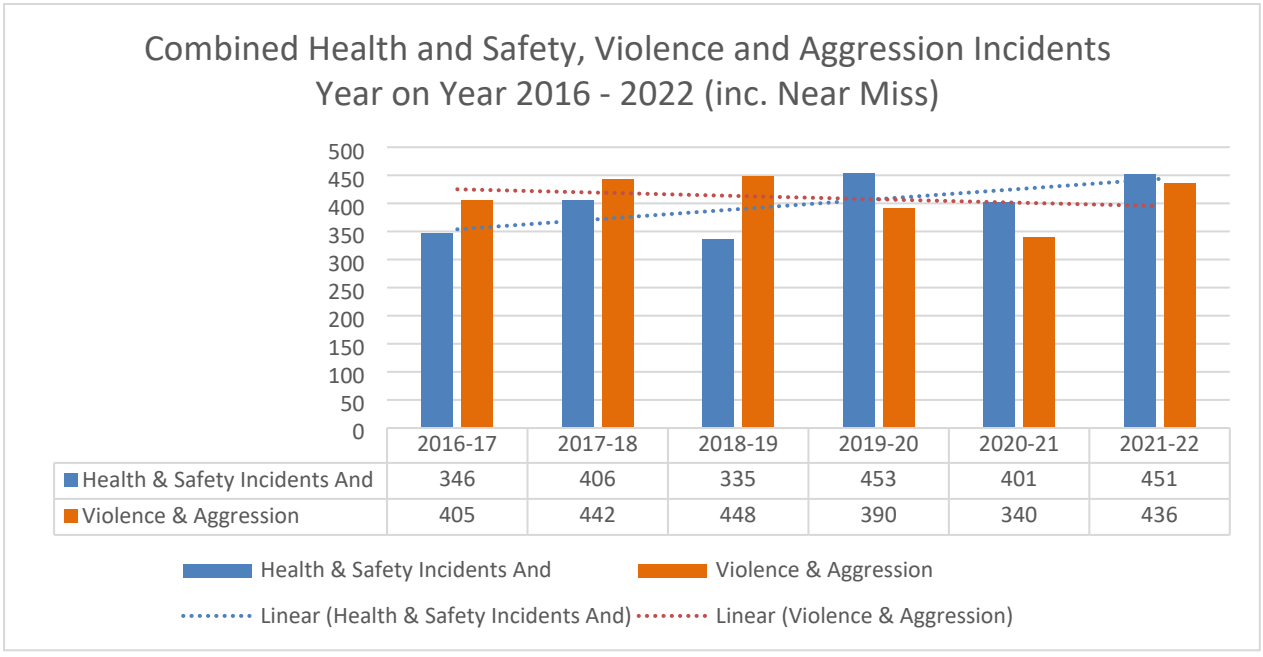


Table-4 – Year on Year Incident Performance

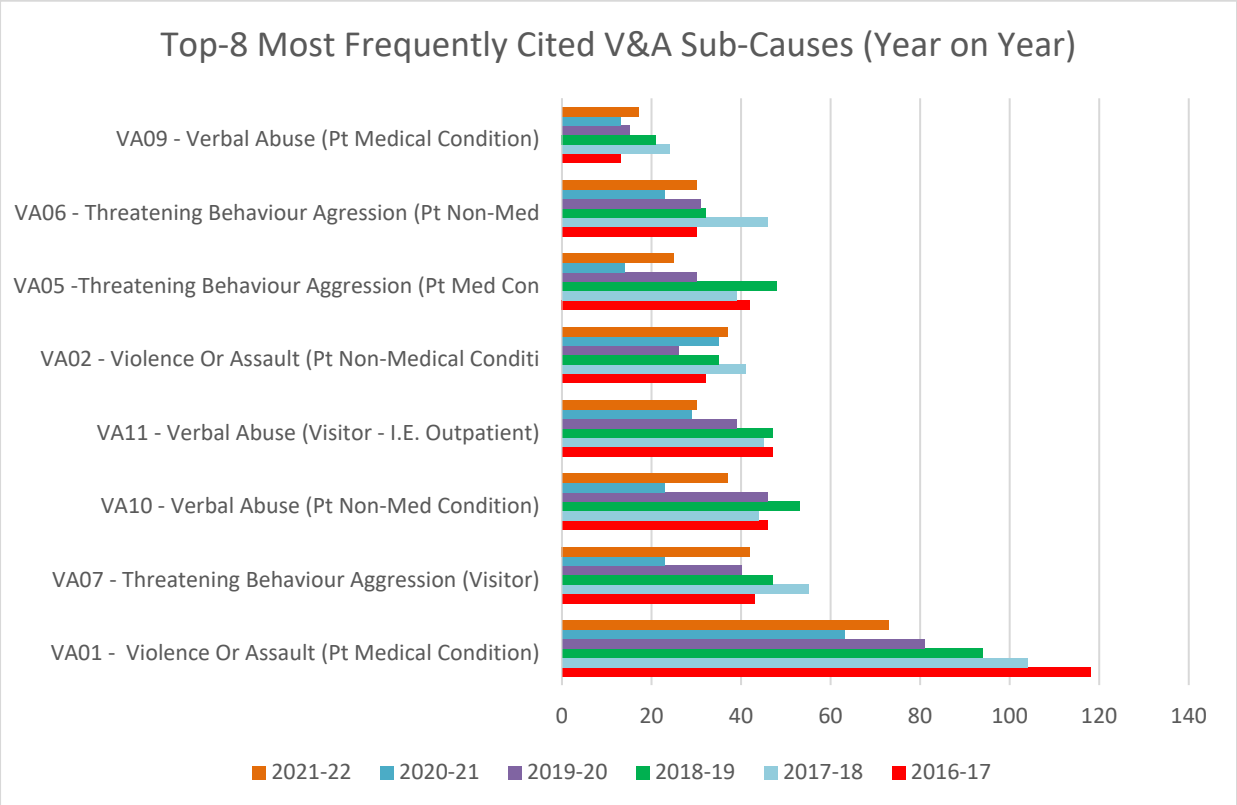
Year on Year Incident Performance	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Health & Safety Incidents	346	406	335	453	401	451
Year on Year % Difference	-	+15%	-17%	+26%	-11%	+11%
Violence & Aggression	405	442	448	390	340	436

Year on Year % Difference	-	+8%	+1%	-13%	-13%	+22%
Grand Total	**751**	**848**	**783**	**843**	**741**	**887**
Total Year on Year % Difference	-	+11%	-8%	+7%	-12%	+16%

Most Frequently Cited Incidents

Appendix 1 and Chart 4 below, illustrate most frequently sited causes of incidents. Sharps, Manual Handling and Slips/ Trips/ Falls feature as our most frequently cited incidents. In addition to this, Violence and Aggression equate to comparable levels with violence perpetrated by patients with a medical condition being almost double that of incidents occurring where there is no clinical contributing factor. Incident investigation is essential in determining learning outcomes and reducing further incidence. Health and Safety practitioners, and other specialist advisors including Security, Occupational Health, Ergonomist and Fire safety Advisor also liaise with staff to undertake suitable investigation of incidents, which in turn promotes learning. In isolation, this data simply outlines the most common causal factors for incidents reported within the Trust. However, triangulated with RIDDOR and Employer and Public Liability claims data, demonstrates potential weaknesses in our safety system.

Chart 4 – Top 8 Most Sited Violence and Aggression Sub-causes



RIDDOR Reporting

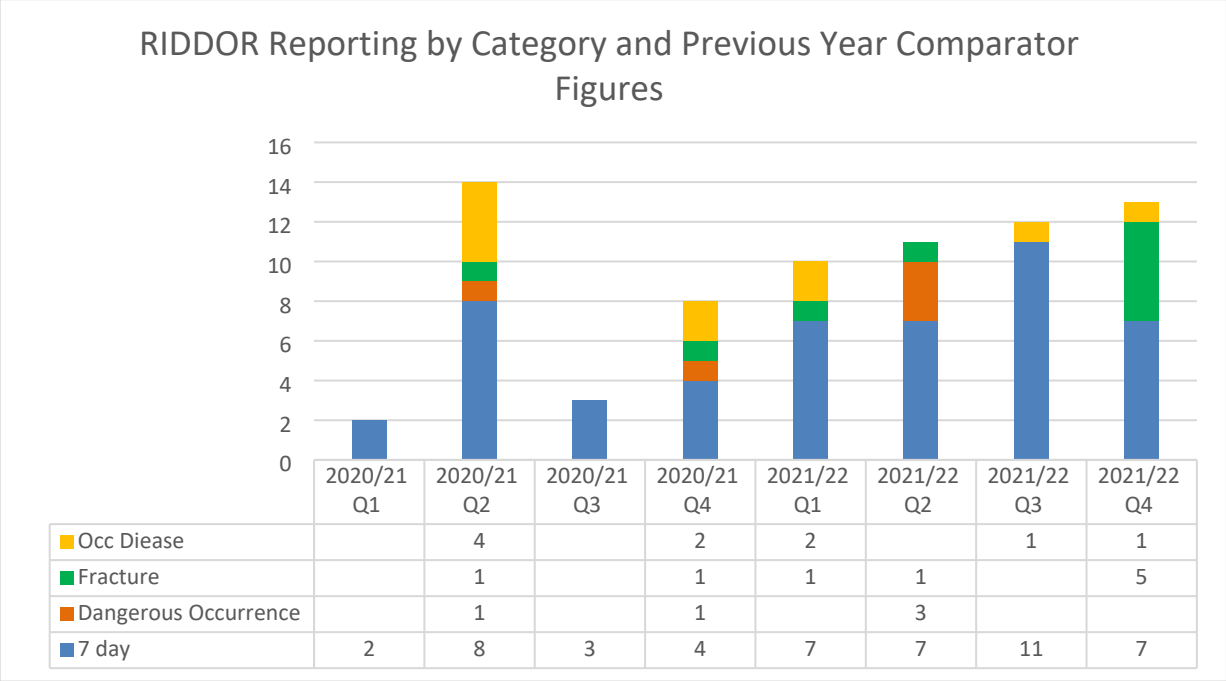
Cumulatively, and in order, Slips/ Trips/ Falls; Manual Handling (inc. load handling), Occupational disease (Dermatitis) and struck by an object are the most frequent causes of RIDDOR reportable incidents and incapacitation of an employee in excess of 7-days. Slips/ Trips/ Falls contributed to 75% of RIDDOR 7-day incapacitation[1] whilst all Manual/

[1] Over-seven-day incapacitation of a worker. Accidents must be reported where they result in an employee or self-employed person being away from work, or unable to perform their normal work duties, for more than seven consecutive days as the result of their injury.

load handling resulted in RIDDOR 7-day incapacitation. With regards to occupational disease, all relate to staff who developed workplace dermatitis as a result of prolonged mask wearing and hand hygiene, during the pandemic, resulting in sensitivity to hand wash/ gel. Although additional correspondence was received from the Health and Safety Executive (HSE), they were satisfied with our internal processes for managing risks associated with workplace dermatitis, such as:

- Cases diagnosed by a consultant dermatologist and reported to our Consultant in Occupational Health and Wellbeing
- Newly developed formal skin surveillance procedure however, Occupational Health have been implementing the clinical principles of this procedure for a number of years, having also introduced direct Dermatology referrals
- Annual skin monitoring for contact dermatitis document has been implemented annually as part of the appraisal process
- Occupational health and wellbeing undertake annual health surveillance for staff working with dermatological hazards such as theatre staff, HSDU staff, etc

Chart 5 – RIDDOR Reporting by Category



Employer and Public Liability Claims

During the period April 2021 to March 2022 the Trust received a total of 22 Employer & Public Liability Claims. This demonstrates a 45% increase from the previous period April 2020 to March 2021, where a total of 12 Employer & Public Liability Claims were received.

Incident Category	Claims Received April 2020 / March 2021	Claims Received April 2021 / March 2022
Manual Handling Patient	1	2
Manual Handling Load	2	3
Slips Trips & Falls	3	3
Physical Assault	2	3
Body Part Impacting with Object	2	5
Burn / Scald	0	1

Needle Stick Injury	1	2
Operative Procedures	0	1
Work Related Stress	1	1
Covid 19 Exposure	0	1

The Total amount paid out in Claims for the period April 2020 to March 2021 was:
£ 72,128.25

The Total amount paid out in Claims for the period April 2021 to March 2022 was:
£ 569,508.33

Incident Category	**Claims Settled – Paid Out April 2020 / March 2021**	**Claims Settled - Paid Out * April 2021 / March 2022**
Manual Handling Patient	£19,699.50	£394,827.44
Manual Handling Load	£8,485.25	£89,075.39
Slips, Trips & Falls	£25,992.50	£37,231.00
Physical Assault	£0	£0
Body Part Impacting with Object	£12,893.00	£40,998.50
Burn / Scald	£0	£0
Needle Stick Injury	£5,058.00	£7,376.00
Operative Procedures	£0	£0
Work Related Stress	£0	£0
Covid 19 Exposure	£0	£0

NOTE: *Please note however that this is not the Total amount that the Trust has paid out in Employer & Public Liability Claims.

Employer Liability Claims have an excess of £10,00.00 and Public Liability Claims have an excess of £3,000.00.

On investigation it is found that most Claims are successful due to the following contributing factors:

- Shortage of Staff
- Inadequate / out-of-date training
- Lack of Risk Assessments/ failure to share assessments with Staff
- Needle Sticks / Sharps inappropriately disposed
- Lack of/ unavailable appropriate work equipment

National Patient Safety Alerts

All Health and Safety related alerts issued during 2021/22 were responded to within timescale. NatPSA/2021/009/NHSPS – was reviewed and a formal risk assessment undertaken, supported by Infection Prevention and Control colleagues and disseminated to relevant departments.

Reference	**Alert Title**	**Originated By**	**Issue Date**	**Status**	**Response**

NatPSA/2022/002/MHRA	UPDATED 25/05/22: Philips Health Systems V60, V60 Plus and V680 ventilators â€“ potential unexpected s ...	National Patient Safety Alert - MHRA	29-Mar-22	Issued	Action Completed
NatPSA/2021/009/NHSPS	Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) ...	National Patient Safety Alert - NHS England & NHS Improvement	25-Aug-21	Issued	Action Completed
NatPSA/2021/005/MHRA	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particle ...	National Patient Safety Alert - MHRA	23-Jun-21	Issued	Action Not Required

ACT - Review Performance

On review of overall performance, a significant amount of work has taken place over the past 12 months. Despite restrictions brought about by Covid-19, the promotion of a positive health and safety culture has continued. Engagement with divisional teams and individual departments has been positive, policy review and development has continued, more so during the last 2-quarters of the financial year and into the current year. Training provision, particularly, face-to-face training has returned for managers with IOSH for Executives and Directors funded. Incidents have continued to increase, which provides additional intelligence to support our priority focus moving forward but demonstrates a positive culture of open reporting. Incident intelligence triangulated with RIDDOR and claims data, provides a clear picture of gaps in our safety management system.

Moving forward into 2022/23, our primary focus will continue to reinforce the importance of proactive safety management. Improved Health and Safety toolkit compliance is essential to ensure managers assess risk in their respective areas, implement sufficient safety arrangements and share findings with their teams. We appreciate the importance of providing staff and managers with suitable information and instruction to fully understand their legal obligations, coupled with delivery IOSH

for Executives and Directors, who can then steer the health and safety agenda; this should only serve to improve the safety culture of the organisation.

Health and Safety Restoration Plan 2021/22 Performance Review

2021/22 Restoration Priority	Objective	Progress at year end
There needs to be defined processes for H&S incidents requiring investigation including RIDDOR and Serious incidents.	Incident investigation policy needs to detail processes for managing incidents of a health and safety nature, so staff are clear in terms of roles and responsibilities including external reporting arrangements.	Section added into Interim Incident Reporting, Learning and Management Policy and approved on 5th April 2022
Implementation of audit actions and monitoring of compliance managed locally. Organisational oversight is required.	Development of a clear programme of audit/ inspection, monitoring, implementation of control measures and shared learning from good practice in addition to non-compliance. Implementing a planned audit/ inspection forward plan will reinforce expectation to participate in the H&S management	Audit SOP developed describing process for undertaking audits. Suite of documents to support the SOP including overall rating of compliance, actions plan, formal letter. Face-to-face audits remained paused during the last 12 months due to COVID-19 restrictions, however these will recommence in the current financial year. An audit forward plan will be agreed in the current year during quarters 1&2
Lack of awareness of the importance of legal requirements to deliver health and safety in line with current legislation.	Increase knowledge and skills in terms of H&S requirements to enable staff, managers and leaders to execute their responsibilities in line with current legislation	COSHH & DSE for assessors delivered via MS Teams. Managers face-to-face training not delivered due to COVID-19 restrictions. Training will recommence in the current financial year including IOSH for Executives and Directors.
Poor compliance with proactive H&S risk assessment. Risk assessments poorly articulated	Improved understanding of H&S requirements and risk management processes	In Excess of 30 Toolkit Sessions have been provided to support managers in their completion of the health and safety toolkit. The corporate Head of Risk is developing a TNA to be delivered throughout 2022/23
Lack of organisation overview re application of health and safety risk management arrangements.	Proactive monitoring of compliance specifically relating to assessment of H&S hazards and subsequent risk.	An additional Ulysses module for monitoring H&S compliance was procured in 2020. This is no longer a viable option due to the decision to move to Datix risk management system. Work is underway to find a suitable system for facilitating compliance capture.
No coherent direction to the overall health and safety management system across the board	Influence and steer health and safety agenda across the organisation and at executive/ Board level	Director of Assurance is chairperson and delegated executive for Health and Safety. IOSH for Executives and Directors will be provided

		during 2022/23 to support senior leaders in understanding strategic health and safety and encourage leadership steer.
Insufficient staff consultation re Health and Safety matters	Improve consultation to ensure staff have 'their say' on workplace health and safety matters	The Health and Safety Committee has convened on 6 occasions during 2021/22. All meetings were quorate. Policy review have consulted with all parties either virtually or face-to-face.
Current reporting arrangements do not provide sufficient comparative information to determine improved direction of travel regarding H&S risk management compliance	Divisional (and other) groups will have the necessary information to agree processes to improve performance against expected KPI's	Reports now include trust wide and divisional data. This is provided quarterly to all divisional boards. KPI's will be agreed over the course of quarters 1 and 2 for reporting into divisional boards and assurance coming back to H&S Committee
Progress and monitoring of H&S alerts has been inconsistent historically leading to a lack of scrutiny to determine effectual response and action required.	The H&S Committee will ensure that all alerts are reviewed and an agreed and planned response to necessary action is taken.	Safety alerts added as a standing agenda Item.

5. Key Stakeholder Safety Activity and Performance

Fit Testing Activity

During the first wave of the pandemic, Fit Testing provision was largely delivered by staff who were displaced from their substantive roles due to services being paused, such as medical educators and some specialist roles. As restoration plans opened services back up during the summer of 2020, most of the Fit testing resource diminished. Despite best efforts to establish a monthly rota to ensure equitable Fit Test provision, availability of staff to support this effort was difficult, due to increased activity in clinical wards/ departments and inability to free-up testers.

Consequently, during August 2020, a decision was made to provide additional Fit Test Training from an accredited Fit2Fit external provider and also to recruit a Fixed Term RPE Facilitator to coordinate internal arrangements for Fit Testing, allocation and monitoring of other RPE including reusable pieces of equipment.

Additional training was provided in September 2020 to increase Fit Testing capacity, however almost 50% of staff booked onto the course failed to attend. The RPE Facilitator was recruited late October 2020 with Fit Testing provision increased to 2 x Half Days and 1 x Full Day. It was at this time that NHS organisations were informed of the reduced availability of 3M FFP3 respirator masks; specifically the **3M-9330** that we have been largely using within the Trust. These were substituted with Handanhy **HY-9330** which required staff to be re-tested as per INDG47:

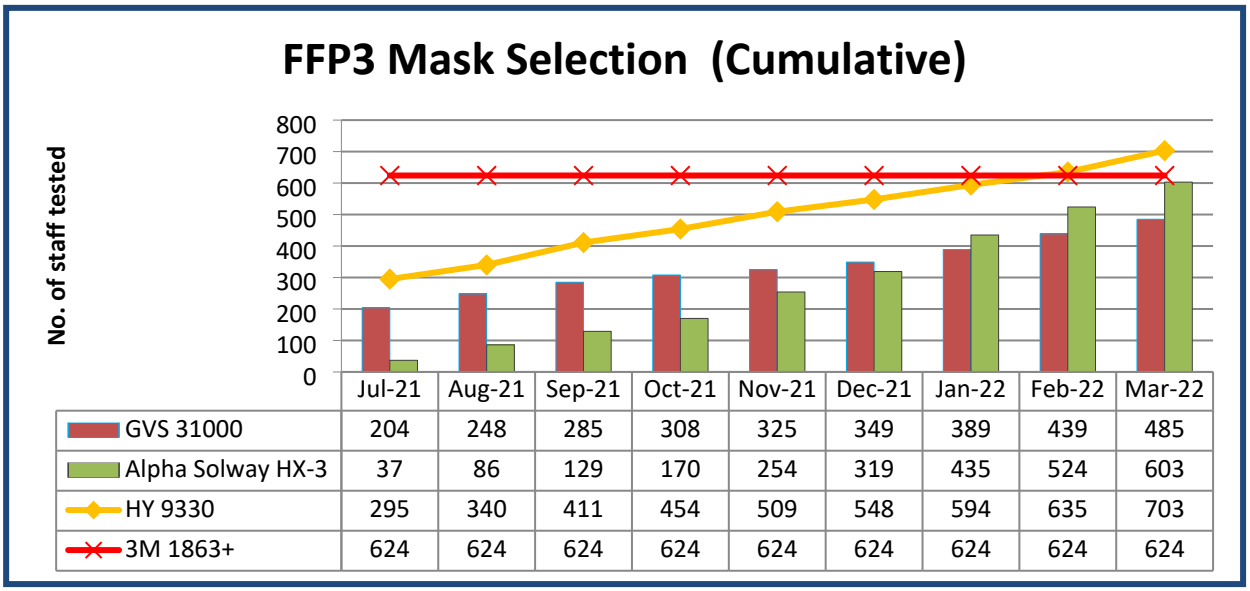
*'A fit test should be repeated whenever there is a change to the RPE **type, size, model or material** or whenever there is a change to the circumstances of the wearer that could alter the fit of the RPE; for example':*

- weight loss or gain
- substantial dental work
- any facial changes (scars, moles, effects of ageing etc) around the face
- seal area
- facial piercings
- introduction or change in other head-worn personal protective equipment (PPE)

Multiple communications were sent via the Daily Dose newsletter to appraise the organisation of the requirements to Fit Test and escalations to the Executive Team. Although the initial warning 3M-9330 would be withdrawn, steady supplies continued and remain available to date.

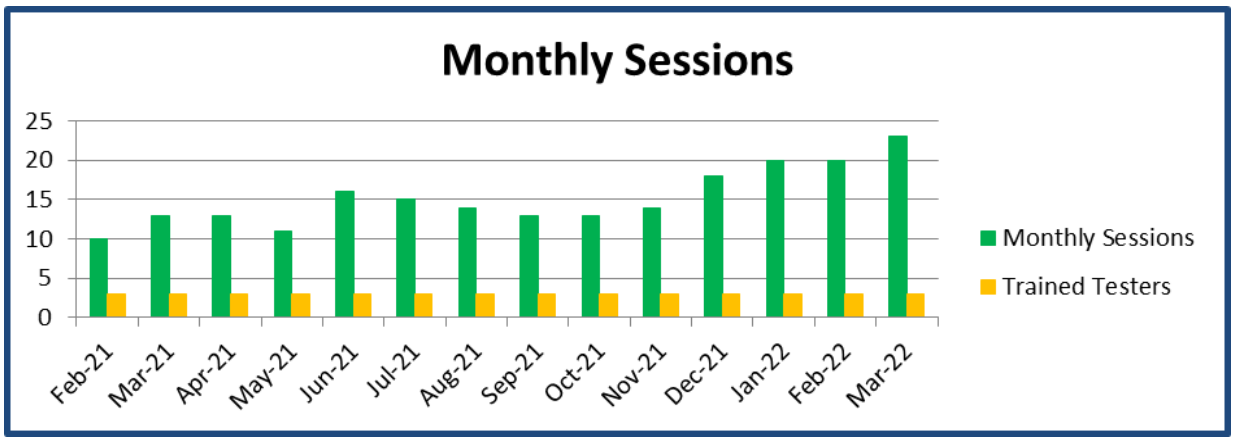
In January 2021, the Trust responded to the offer of support from an external resource of Fit testers coordinated by NHSEI. As such from February 2021, we were able to triple provision at arranged sessions in the MLTC whilst also arranging satellite sessions outside ED, ITU, and Theatres albeit the uptake was poor.

UK manufacturing of FFP3, meant that we were able to evaluate and adopt new masks. The more FFP3 masks available at the selection phase increases the chances of a user having success to a particular respirator, in April-21, the Alpha Solway HX-3was introduced to our increasing pool of respirators. Over the course of 2021-22 the number of masks added to our pool has further increased, meaning we have greater likelihood of successfully achieving face fitting for our staff.



	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
GVS 31000	204	248	285	308	325	349	389	439	485
Alpha Solway HX-3	37	86	129	170	254	319	435	524	603
HY 9330	295	340	411	454	509	548	594	635	703
3M 1863+	624	624	624	624	624	624	624	624	624

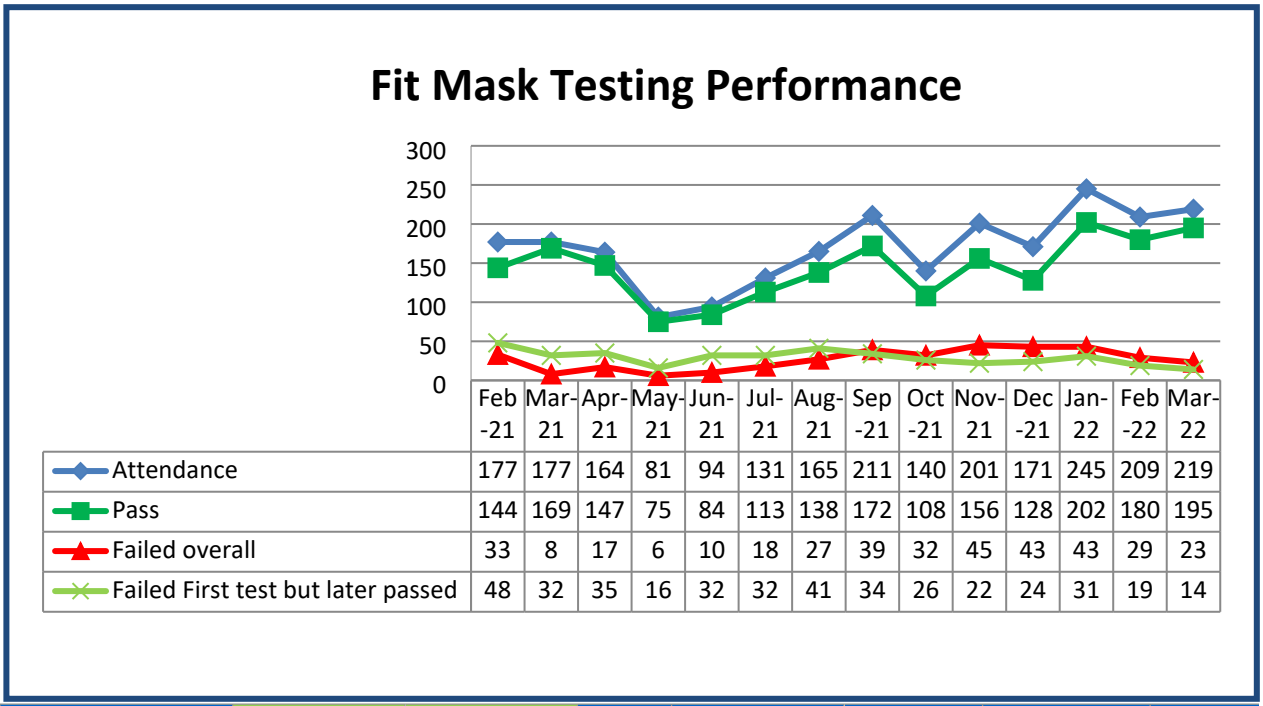
Between May and July-21 attendance to face fit testing sessions reduced dramatically, frustrated by sickness absence and annual leave. An action plan was developed to increase Fit Testing uptake. In August-21 we launched a pre-book system to allow staff to book on sessions as opposed to 'dropping-in', reducing wait time for users from 1-2 hours to just 30 minutes. To promote the use of the bookings system and increase attendance to sessions from Sep-21 all non-compliant staff are mail-merged bi-weekly inviting them to book and complete training along with QR codes being placed in all clinical areas this includes staff only tested to one mask type.



A lag in reporting from time-of-test to recording on ESR was on average 10-14 days, meaning our true figures were at least a fortnight behind. A decision to utilise MS Teams to capture tests undertaken and this then fed into ESR; reduced the lag to a matter of minutes. April-July-21 – 252 monthly slots increasing in Aug-Nov-21 – 384. With the sharp rise in omicron in Dec-21 we increased testing to five days per week with a total of 560 monthly slots.

In September 2021, our RPE Facilitator achieved Fit2Fit accreditation meaning we are able to deliver Qualitative Face Fit Test Training. A training pack has been developed and 10 sessions delivered, with 23 trained as 'Testers'. The RPE lead has continued to work relentlessly to implement the Department of Health and Social Care resilience principles to ensure staff are tested on more than one respirator, ensure there are multiple respirators available, monitor stock, input testing compliance into ESR and continually monitor. Bi-weekly reports are disseminated to managers to monitor local compliance and staff are provided with a Fit Testing Passport providing clear information about the process and the mask(s) tested on. (Appendix 4)

As of year-end, overall Trust compliance on one type of mask is 76% and two mask types is 25%.



	Feb -21	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
Attendance	177	177	164	81	94	131	165	211	140	201	171	245	209	219
Pass	144	169	147	75	84	113	138	172	108	156	128	202	180	195
Failed overall	33	8	17	6	10	18	27	39	32	45	43	43	29	23
Failed First test but later passed	48	32	35	16	32	32	41	34	26	22	24	31	19	14

Division	Compliant In Two or More Masks	Compliant In One Mask Only	HY 9330	GVS31000	Alpha Solway HX-3	3M 1863/9330	Force 8

Trust Overall	**25%**	**76%**	**28%**	**19%**	**17%**	**29%**	**8%**

Occupational Health Activity

The Occupational Health & Wellbeing Service aims to improve and maintain the health, safety and wellbeing of Walsall Healthcare NHS Trust employees; guided by the objectives and values of the organisation. Staff Health and Wellbeing are integral to improving performance and reducing sickness absence within the Trust. The OHS offers a confidential and independent service that is available to all staff.

Despite challenges, the following activities were delivered this past year:

- Provision of various clinics delivering the following to prospective and existing staff: new starter screening assessments/clearances, staff vaccinations, health surveillance, self-referrals (mental health, physiotherapy, skin/face mask problems, sharps/splash injuries, suspected rashes, diarrhoea/vomiting) and supporting sickness absence management referrals
- Providing case management advice to line managers and Human Resources
- Work in partnership with Human Resources to encourage management use of Trust stress checklist in line with Stress Policy and Attendance Policy
- Work in partnership with Infection Prevention and Control (IPC) to reduce cross infection risks to staff, i.e., outbreak management/contact tracing
- Collect, monitor and distribute monthly inoculation data for IPC and H&S Stress/Mental Health Interventions
- Provision of in-house Counsellor/Psychotherapist for specialist face to face counselling intervention; specifically for staff who are experiencing acute and significant mental health problems
- Provision of EAP 24-hour telephone helpline and face to face counselling service to proactively support staff who are experiencing mainly personal problems, to support staff to remain healthy at work
- When warranted, encourage managerial use of Trust stress risk assessment tool in line with Prevention and Management of Stress Policy and Attendance Policy
- Provision of urgent counselling and bespoke team bereavement counselling to support staff mental wellbeing following critical situations in the work environment, such as sudden colleague bereavements, etc.
- Provision of bespoke Team Stress Management sessions for Teams where stress concerns have been raised

Physiotherapy Musculoskeletal Interventions

- Designated in-house occupational health Physiotherapist for fast-track referrals, management referrals and functional assessments
- Early intervention physiotherapy to aid individual recovery from acute musculoskeletal problems/conditions with emphasis to help employees remain fit for work
- Proactive intervention to assist employees with chronic underlying musculoskeletal conditions

Improvements/Innovations

- Safe Effective Quality Occupational Health Service accreditation improvements – national standards to improve practice
- Development of OH internal clinical and administrative procedures
- Development of OH internal clinical audits

- Expediting staff hospital referrals, where possible, to Specialist Consultant and investigations
- Expediting staff skin referrals to Dermatology Service
- Updating of OH confidential database

Challenges

- Delivery of ongoing quality improvements with reduced staff capacity
- Maintaining KPIs
- Delay in the installation of the confidential OH web database system

Summary

Staff Health and Wellbeing are integral to improving performance within the Trust. A robust evidence-based employee health and wellbeing service is key to helping employees to maintain good health and productivity at work. Integral to this are work-based interventions and innovations to help maintain safety, prevent and reduce sickness absence levels within the organisation.

Manual Handling Activity

Our key objective was to achieve the KPI target of 90% for people handlers, with 1430 refresher spaces, 430 spaces for inductions using BI data to prioritise targeted support to staff groups with high musculoskeletal injuries.

Notable success during this reporting period include:

- Pivotal in a pilot between West Midlands Ambulance Service and the Rapid Response Team to reduce waiting times of people who had fallen in the community, thus increasing ambulance availability, in the delivery of training for the Rapid Response Team for non- trauma post fall rescue package, including the use of an Emergency Lifting Cushion
- Introduction of disposable slings and slide sheets to all wards, with training delivered to 348 people handlers and 12 super users across the Trust
- Completion of intranet pages, with managers guidance for reducing musculoskeletal disorders, occupational health, and incident reporting
- Evaluations score 4/4 with excellent feedback given
- Ergonomist Lead became an Executive Director of the National Back Exchange and was invited and accepted to be on the NBE Professional Affairs Committee

Known risks

- KPI not met and stands at 80.14%. Weekly emails are sent to managers informing of booking/spaces. 20 bespoke sessions were requested and completed, totalling 139 people handlers
- Audits of equipment, including monthly usage and ordering reports received from supplier show improvement, but require further improvement
- Flat Lift Kits (FLKs) -Four FLKs were purchased by staff who have now left the trust from charitable funds. The SPHT monitor the kits, but do not own them
- Currently 1 x FLK is missing a vital part and the power source and jack is in need of repair. This information has been taken to the Falls Steering Group

Plans

To further explore musculoskeletal health needs using the HSE Body mapping tool in a risk reduction exercise, raising awareness of the importance of incident reporting and identifying trends that require further investigation.

Fire Safety Group

The COVID-19 pandemic has required WHT to alter many aspects of how we conduct routine business and this, in turn, has impacted on fire risk management. The pandemic has presented many fire safety challenges, and fire risk factors previously never encountered before by Nursing Staff, Hospital Management Teams, Fire Safety Advisors and Maintenance Teams. In particular, the number of high dependency patients requiring to be in areas not specifically designed for the treatment and care of this profile of patient, along with the unprecedented level of oxygen being administered on a continual basis. Although the pandemic has presented challenging circumstances for WHT Board and its staff, who have been required to work under exceedingly difficult circumstances, it was important that managers and staff did not assume that these challenging circumstances excused them from their legal duties as detailed under the Fire Safety (Reform) Order 2005. Although the legal obligations remain unchanged and undiminished, the nature of life and how NHS does its business has changed so significantly that new and previous issues not considered to be a risk are emerging and identified as matters of concern.

To meet the challenges these risks present, new fire safety guidance and procedures have been developed and existing guidance and procedures will need to be reviewed to ensure they remain 'fit for purpose.' Careful consideration and good management are required with regards to how we manage and balance the risks of fire, along with the other risks the pandemic continues to present, as often the measures to mitigate and control both can conflict and have a detrimental impact on each other. It is essential that fire safety arrangements are reviewed on a regular basis and where significant changes to working routines, processes, or adaptations to buildings are made, the necessary additional control measures should be implemented. Of the many aspects that required to be considered relative to additional fire risk through the pandemic, increased storage of equipment and materials, including more frequent deliveries and undesignated areas being used to accommodate storage, has been, and continues to be a particular challenge. Social distancing control measures needed to be reviewed to ensure they did not adversely affect fire safety measures, including obstructing means of escape routes, obscuring emergency exit signage, or affecting the performance of fire alarm and detection systems.

Royal Wolverhampton & Walsall Healthcare Partnership Initiatives

Over the last year a partnership working relationship has been developed between the Fire Safety Team at New Cross Hospital and the Fire Advisor at the Manor Hospital which is now well established and continues to develop and bring forward joint initiatives to improve the overall level of fire safety for staff, patients, and visitors in all Trust premises. During reporting period 2021/22 the team have worked collaboratively to overcome any challenges relating to the COVID 19 pandemic. To develop a Fire Safety management structure

In addition, the Fire Safety Team, during 2022 will continue to:

- Develop a Fire Risk Assessment Management Programme
- Review the Fire Risk Assessment format
- Review both Trust's Fire Policy to develop a coordinated policy
- Develop Fire Warden Training programmes
- Review Fire Training requirements
- Provide information and assistance for Fire Advisors when completing their operational risk assessments for Trust buildings

The Fire Safety Advisor continues to prioritise his workload across fire safety management now with the support of the Fire Safety Team from New Cross Hospital to play an active role in maintaining compliance in all premises owned or occupied by the

Trust's. During 2022 the strategic approach to fire safety will be that all primary fire risk assessments were conducted, and a programme of reviews put in place to ensure compliance with the significant findings and action plans, which form part of the initial risk assessment process. Work recommended to mitigate the risk of fire will be added to action plans and those plans monitored by the Fire Safety Review Group.

Fire training continues to be challenging in relation to numbers attending and a more focused approach will be required to improve compliance in this essential area. The Trust has achieved an unacceptable level of 69% staff trained across all services.

In relation to unwanted fire calls, there has been a slight increase in the number of false alarms occurring on the main hospital site, a total of 60 activations over the 12 months

Much of the Trust retained estate is becoming increasingly more mature as the years pass and this will require a comprehensive auditing process to assess its sustainability and calculate the fire risks that will be arising due to the age and use of the building and its services. An effective backlog maintenance programme has been developed over the year to refurbish wards fire compartmentalisation, fire alarm panels and fire door replacement, this a vital element in reducing this risk.

The overall fire safety strategy for the Trust sites is progressing well, with some major investment on fire safety issues this year to reduce the fire risks and improve patient safety. However, this investment in the buildings and patient safety requires constant monitoring and regular capital funding to avoid the estate falling below the fire/patient safety standards required.

Overall, the report reflects that a high standard of fire safety has continued to be maintained throughout all Trust premises over the last 12 months, despite the challenges faced with Covid 19.

Radiation Safety Group

The Trust Medical Physics Expert & Trust Laser Safety Officer produced an annual report to the Radiation Safety Group, identifying matters of assurance and compliance with recommendations arising from audit and quality assessments. A summary of the report is detailed below:

Staff Dose Monitoring

Results obtained from staff members at the Trust showed all results were well below the level at which staff should be classified. Learning was identified, specifically latency in returning dosemeters.

Patient Dosimetry - Patient dosimetry required by IR(ME)R could not be captured for all modalities as a result of inconsistencies in data entry to CRIS by users. An audit on regulatory compliance was planned for spring-summer 2021, however, a resurgence of COVID and staff shortages delayed this. The solution via dose-watch remains pending.

Equipment Replacement

A new CT has been designed and installed in Imaging A, and the DTC fluoroscopy unit is due for replacement. There are a number of pieces of equipment which require upgrading due to age.

Reportable Radiation Incidents update / action plans

One incident was externally reportable during this period. Key learning identified a lack of adherence to local procedures by radiography staff, for example, filing images incorrectly. Training sessions are being established for new radiographers.

Equipment Quality Assurance

The quality assurance programme has largely been kept up to date during Covid-19, although, access to equipment for Quality Assurance (QA) has presented some challenges, in particular, the cardiac catheterisation lab and pacing were significantly late in being surveyed.

Reporting monitor QA was not completed due to issues coordinating access to the equipment. Self-assessment audit has taken place in x-ray and nuclear medicine, which was mostly rated with a RAG of green with some actions required.

Priorities for this new financial year 2022/23

Development of an effective equipment replacement program.

- Complete the setup of the Dose Watch system to enable effective patient dosimetry and dose optimisation as required by IR(ME)R. The setup should be completed across modalities and also a system established to ensure its effective use going forwards
- Image Optimisation Groups within each modality. These groups can look at the problems, identify the people and agree on the activity and meeting cycle
- Nuclear Medicine staff should be classified under IRR17 due to the potential for an accident
- The radiation risk assessment should be updated accordingly to outline potential dose rates and therefore the reasoning behind the classification
- Radon risk assessment must be undertaken, and this is likely to involve radon measurements as the Manor Hospital sits within a 3-5% radon affected area, this is likely to require radon measurements. A specialist contractor should be used for this
- Encourage the use of the Clinical Imaging board taxonomy coding system for all incidents and identify trends

Local Security Management Specialist Activity

LSMS - Community Buildings Review

The Trust is currently undertaking a review in respect of the security of Community Buildings in both the security of the building itself incorporating entry and egress as well as opening up the areas and lockdown at the end of a working day.

The building review is being undertaken by the Community Division supported by Estates & Facilities and the Local Security Management Specialist. The benchmark initially has been to identify the buildings we currently occupy, the services within the same and whether we own the freehold; have a lease or occupy a building owned by NHS Property Services. This will then dictate the approach in respect of funding and responsibility to ensure that the risks outlined relating to building and staff security are mitigated. A paper is being drafted at present by the Community Division with some recommendations from January 22.

Mortuary Security

Following an incident communicated nationally which has been widely publicised about an NHS staff member committing indecent acts within a mortuary, the Trust has reviewed all entry and egress points within this area.

The main issues following a review related to the audit trail as to who enters this area and there was insufficient coverage in regard to CCTV within the corridors or any of the main rooms. The Trust has now installed CCTV cameras within the main body fridge areas and the post-mortem areas with CCTV recording being streamed locally into a secure room housing the monitors and hard drive. In addition to this, all the additional swipe access works are planned for January with the final fire protection works being completed in early February. This will ensure a secure area for staff and give the public and Trust assurance that security is robust within this area.

Additional CCTV around site
Walsall Healthcare NHS Trust is now a "No-Smoking Site", and a lot of work is being done in regard to ensuring both the enforcement of this principle in respect of patients/visitors and staff members. However, there is a significant problem in regard to staff members smoking on site and some of the incidents have been in close proximity to stores with flammable materials and substances contained therein. The Trust has now therefore reviewed the locations in respect of regular smoking activity and will be installing CCTV to monitor those areas by the Security Team. Individuals identified will be referred to HR to review under current policy processes.

Liquid Oxygen Resilience
The Covid-19 pandemic has been unprecedented for the country and the NHS in particular. The obvious effect of this pandemic has been the significant number of hospital admissions since its first identified cases in January 2020 and the subsequent need for additional oxygen supplies for patients. The main source of oxygen on site is contained in two liquid oxygen tanks whereby there is a 10-day main supply and a 2 day backup supply. NHSE/I previously confirmed that due to the precious nature of the supply, all compounds containing liquid oxygen should have CCTV monitoring them from the main security room. This was completed for the two main cylinders and now the Trust installed a further two cylinders for resilience in February/March 2022 to reinforce the current resilience on site. A new camera will be installed simultaneously which will have a dual role of monitoring the liquid oxygen cylinders and the clinical waste at the same time. The latter will ensure strict Environment Agency compliance is maintained by the Trust and its waste contractor.

Aggression/Clinical Judgement
Each Incident reported by acute and community staff in regard to persistent offenders where they aggressively and inappropriately continue to contact staff members in respect of their discharge from the service is monitored because the frequency has increased. Staff are advised to focus on offering everything within their remit but once an individual disagrees with a clinical professional judgement and becomes abusive, a staged process involving the consultant or head of service writing to them has been implemented and conveyed to staff. An option of the patient pursuing alternative treatment or alternative healthcare providers has also been implemented.

Alerts – identify higher risk individuals
Following a review of the risks posed to staff both in the main Acute Hospital and within the Community, the LSMS now puts alerts onto the FUSION system to allow community staff to risk assess each visit with a new or existing patient and therefore reinforce their current lone working procedures which involves the use of: -

- Mobile phones
- GPS alarms – call centre support then Police support depending on incident
- Local personal Alarms
- WhatsApp checking systems

- Line manager responsibility of staff locations

Training
The security contractor has been recognised, in year, for a national award by NAHS (National Association for Healthcare Security) at Hull NHS Trust.

Following the acknowledgement of this award, Walsall Healthcare NHS Trust has asked the contractor to produce a draft plan for this site based on the success achieved at Hull NHS Trust. This plan will be based upon the following: -

- Developing a formal plan for a much more customer-focused service, for example by making themselves more available to patients/staff though 24/7 staffed offices on both hospital sites
- Working with clinical staff to design and deliver safe, appropriate escalation procedures (the 'Enhanced Care' model) for patients with challenging behaviours
- Reduce direct calls to the Police by utilising the security team in the first instance.
- Invest in the professional development of team members through the delivery of extra training such as customer service, ICT, physical intervention and NHS core skills
- Monthly improvement scheme for security staff to provide improvement ideas based on their frontline experience.
- Focus on the motivation and personal value managers both within the Trust and the Security Contractor place on their members of staff by building authentic personal and professional relationships.

Water Safety Group

Within the last 12 months the water safety Group has worked on the following:

L8Guard
In September we commenced with a staged roll-out of L8guard across the trust:

- L8guard is a web-based software system that enables you to fully manage low-use water outlet flushing regimes across your entire estate.it reduces the administration overheads of processing low-use water outlet risk assessments whilst providing up-to-the minute statistical information and analysis
- It replaces the Trusts current paper based systems such as log-books, L8guard provides an initiative-taking instant audit trail helping to ensure ACOP L8, HTM 04-01 and HSG 274 compliance

As of July 2022; 75% of the trust is on this system.

Water in General
At this time, we are working with Skanska to make sure all water issues are actioned correctly and efficiently. We are also looking at all our current water assets and making sure that the technology we have on site is being used to its maximum capacity. Reports on problem areas are being written and will be forwarded to all the relevant managers to advise on what action the Trust needs to take.

Augmented Care Areas
The group have reviewed the current areas and found that areas that should be classed as Augmented Care Areas were not. After a full group discussion and a piece, a work from the director and deputy director of nursing and director of IPC a new list was drawn

up and approved by the group. We are now going through Variation with Skanska to get these areas set up on a new testing regime.

Testing regimes
Earlier on in the year it was highlighted that we need to check what our water testing regime was. This was gone through in the group and also with our microbiologist to make sure we are testing to the correct level. This piece of work was undertaken before it was highlighted that we needed to add more areas as Augmented care Areas.

Water Risk Assessments
The group have been reviewing the progress of the remedial works which was highlighted on the current water risk assessment. They have also asked all the relevant questions appertaining to the system of monitoring the work undertaken by the contractors in completing this work.

Isolations and routine maintenance
Any water isolations (for whatever reason unless in an emergency) have been brought before the group for their authorisation for it to take place. Any existing 28a jobs concerning water have also been brought to the group for information and approval if required. Skanska, our PFI partners also produce a report which shows where they are with the routine maintenance and PPM'S.

Water testing and Results
Each month Skanska present information to the group about what outlets have been tested and the results of these. If we have any failure these are acted on straight away by Skanska and key members of the group are informed of this. A full report is then presented at the next Water Safety group.

Environmental Control Group
The newly established, Environmental Control Group exists to receive, review, scrutinise, challenge and respond to or escalate data and information across the activities of Estates and Facilities that supports Walsall Healthcare NHS Trust to deliver its strategic objectives in relation to compliance with the Hygiene Code of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015).

The group was established in the latter half of 2021/22, however, has already addressed some key issues:

Peracetic acid spillages –fire and chemical response teams attended site on 2 occasions in response to incidents occurring within a relative short timescale of one another. The estates team devised a new SOP in terms of appropriate storage and removal of said chemical from the endoscopy department. We have undertaken spill kit training with the Endoscopy team and the waste team now have a portable and static spill kit. The team and key facilities workers within the area were asked to sign off the SOP to confirm they have read and understood it.

A summary of key activity is highlighted below:

- The group prompted the purchase of a new mortuary trolley – old one was defunct and required replacement
- 2 master-movers have been purchased to improve safety in the transportation of cages across site taking strain and load weight off the operators.

- New gas cylinder trolleys have been purchased to further enhance safe movement of medical gases across site
- Increased volumes of PPE have been regularly purchased throughout the year to further support housekeeping, porters, caterers and waste porters
- Review of portering SOPs is currently underway along with relevant risk assessments
- HACPP is being undertaken by the catering team ensuring our food safety procedures and the management of food is safe and controlled
- Compactors are regularly serviced with any faults or repairs being reported to the team. Risk assessments are appropriate and UpToDate
- Cluttered corridors present risks to health and safety so plans to rectify clutter have been put in place with a campaign through a new poster called 'keep our corridors clean'
- Space utilisation group – looks at available space onsite and any relevant requests for new space. Health and safety plays a big part especially if more staff begin to return to the work place post COVID19 restrictions
- COSHH is kept UpToDate especially when new cleaning products are introduced
- Hydrogen Peroxide Vapour is monitored prior to entering rooms following HPV
- An increase in incident reporting from the facilities team is a positive shift in culture
- Appropriate use of PPE is regularly reinforced as well as great support from our IPC colleagues
- Inappropriate disposal of sharps incidents are on the rise and facilities are looking for Sharpsmart to undertake additional audits and support any necessary training if and where identified there is a need. Waste posters and bin label audits were circulated at IPCC and Environmental control group
- Cleanliness standards are high considering workforce gaps. Housekeeping recruitment plans are in place to mass recruit
- Escalator falls – these continue to pose a risk to patients and visitors, particularly those with mobility issues. The Health and Safety team along with Estates and Skanska are reviewing the layout of the main atrium and signage to encourage patients and visitors to utilise the safest mode of travel when on the hospital site

Medical Gases Group

The Medical Gases Group meets on a quarterly basis and is chaired by the Director of Pharmacy. During the last 12-months the group have focused on several key issues:

Vacuum-Insulated Evaporator (VIE) replacement – Initial works have commenced, with a view to completion in September 2022. E&F have received the RAMS (Risk Assessment Method Statement) form BOC. The current VIE will continue to operate until the cutover. Whilst there was some corrosion to the outer skin of the current VIE at inspection in January 2022, assurances have been provided by BOC that the corrosion does not represent a risk, but the VIE will need to be replaced at some point. This will not be an issue when the new VIE is commissioned.

Training for nurses acting as Designated Nursing Officers is an identified gap, however training has now been arranged for 14th September 2022. This training will be aimed at all nurses at Matron level and will deem them competent to authorise any shutdown to the piped gas system to a clinical area if requested by an engineer.

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, estates colleagues have since 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 and other medical gases known to be abusable.

“Greener NHS” – WHT is success story with regards to nitrous oxide and desflurane usage, with the Trust cited as one of the lower-users in the country.

The Trust lead for EPRR reported to the group that the Trust are assessed from an EPRR perspective on 80 core standards. This is an annual check which takes place in August. Last year’s deep dive into medical gases demonstrated that the Trust are in a good position, mainly through the work of the Group.

The Authorised Engineers report was submitted in March 2022. The primary issue for resolution is around the demarcation of the MRI facility for piped gases between ‘In Health’ and ‘Skanska’. This is a contractual issue which is being addressed.

6. Conclusion:

The past 12-months have been hugely busy. Restoring services following the global pandemic has proved challenging specifically integrating the demands that have arisen over the past 2-years into something we regard as business as usual. However, our aim last year was not simply to restore our health and safety arrangements to a pre-pandemic state, but rather to improve to a more effective and engaged model. Most importantly, we were able to re-establish our Health and Safety Group as a Committee and to ensure requirements under the Safety Representatives and Safety Committees Regulations 1977 (as amended) and the Health and Safety (Consultation with Employees) Regulations 1996 (as amended) are executed effectively. As part of the reestablishment of the Health and Safety Committee, we have secured Executive Directorship as Chairperson, with Divisional Directors in attendance representing their respective divisional teams. Managing safety in healthcare is extremely complex posing significant risks to our staff, visitors etc. We feel leadership of this group should be sufficiently senior to demonstrate the organisations commitment to health and safety matters, and the complexity of its business. As such, our model for committee members includes:

- Management representatives who have the authority to give proper consideration to views and recommendations
- Employee representatives, either appointed by a trade union, elected by our workforce, or a combination of both, who have knowledge of the work of those they represent
- Representatives of others in the workplace such as contractors (SKANSKA)
- Co-opted workers and others included because of their specific competences including health and safety advisers, and other specialist advisors such as Occupational Health, Manual Handling, Security etc

Moving into the next 12 months, the focus will be on maturing and embedding the safety management system within the Trust. This will include a focus on health and safety training at all levels to ensure our workforce has the necessary knowledge and competence to execute statutory responsibilities effectively. From a competent workforce, as a Trust we will then focus on addressing gaps in our safety system to reduce preventable harm from incidents associated with violence & aggression, sharps, load handling and slips, trips, falls and engaging with divisional representatives to steer the health and safety agenda locally. To monitor the efficacy of our safety arrangements, we will reinvigorate our programme of audit to monitor compliance against health and safety legislation, internal policy and agreed priorities.

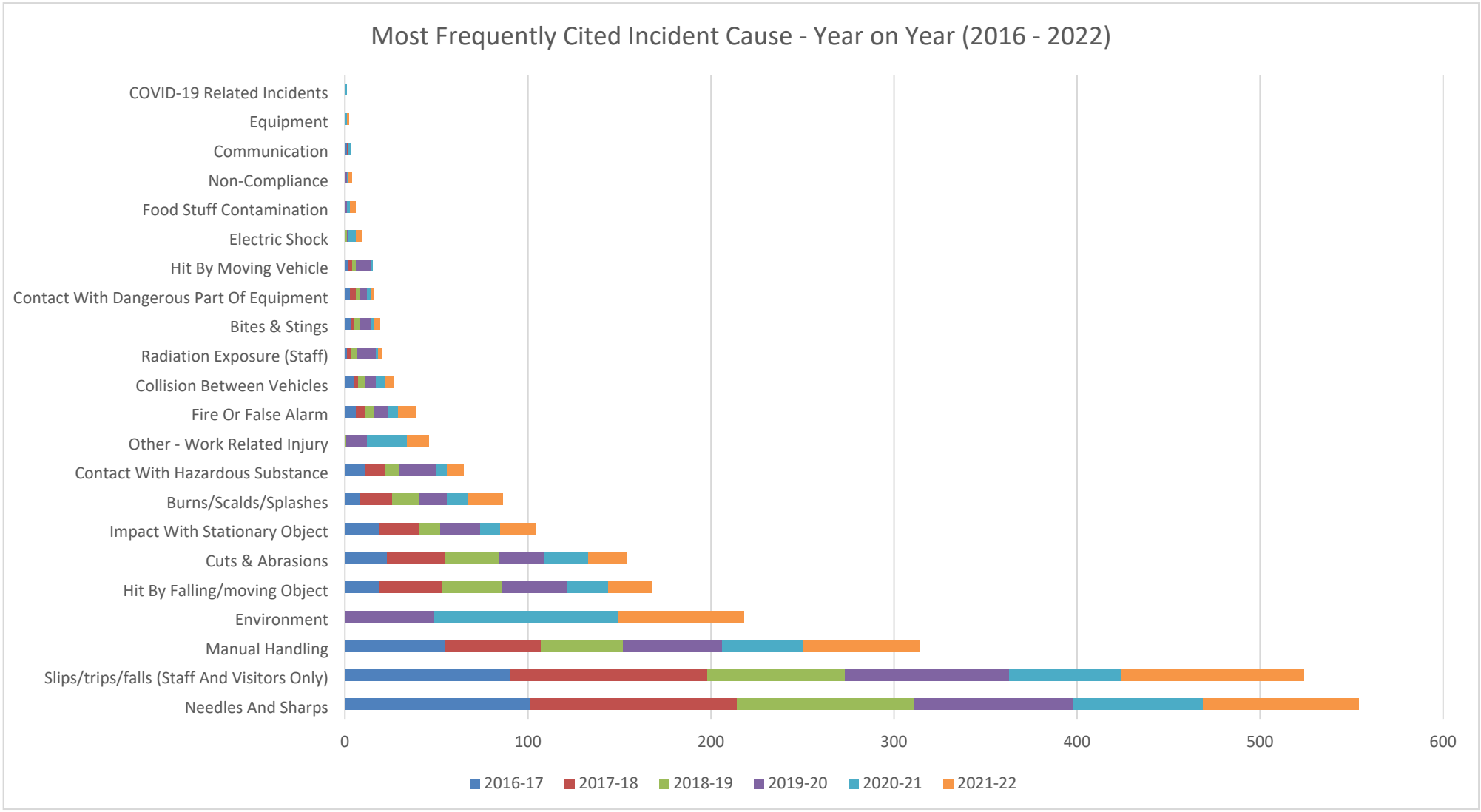
7. Current Year Priorities

2021/22 Restoration Priority	Lat Years Objective	Progress at year end	2022/23 Objective
There needs to be defined processes for H&S incidents requiring investigation including RIDDOR and Serious incidents.	Incident investigation policy needs to detail processes for managing incidents of a health and safety nature, so staff are clear in terms of roles and responsibilities including external reporting arrangements.	Section added into Interim Incident Reporting, Learning and Management Policy and approved on 5th April 2022	All moderate and RIDDOR reportable incidents will be subject to an investigation utilising 'concise' documentation form the incident reporting policy. Utilise divisional safety huddles to escalate incidents requiring divisional review and investigation.
Implementation of audit actions and monitoring of compliance managed locally. Organisational oversight is required.	Development of a clear programme of audit/ inspection, monitoring, implementation of control measures and shared learning from good practice in addition to non-compliance. Implementing a planned audit/ inspection forward plan will reinforce expectation to participate in the H&S management	Audit SOP developed describing process for undertaking audits. Suite of documents to support the SOP including overall rating of compliance, actions plan, formal letter. Face-to-face audits remained paused during the last 12 months due to COVID-19 restrictions, however these will recommence in the current financial year. An audit forward plan will be agreed in the current year during quarters 1&2	Develop and implement a face-to-face audit forward plan for 2022/23 and 2023/24. *Capacity to deliver the full programme is co-dependent on H&S Team establishment and recruitment to 1 x WTE
Lack of awareness of the importance of legal requirements to deliver health and safety in line with current legislation.	Increase knowledge and skills in terms of H&S requirements to enable staff, managers and leaders to execute their responsibilities in line with current legislation	COSHH & DSE for assessors delivered via MS Teams. Managers face-to-face training not delivered due to COVID-19 restrictions. Training will recommence in the current financial year including IOSH for Executives and Directors.	Deliver health and safety training for managers and mandated within the Managers Framework. External providers to deliver 3 x virtual IOSH for Directors and Executives with non-clinical designations being prioritised in the first cohorts.
Poor compliance with proactive H&S risk assessment. Risk assessments poorly articulated	Improved understanding of H&S requirements and risk management processes	In Excess of 30 Toolkit Sessions have been provided to support managers in their completion of the health and safety toolkit.	Risk assessment/ management training to be delivered to staff through the Risk Management Strategy TNA.

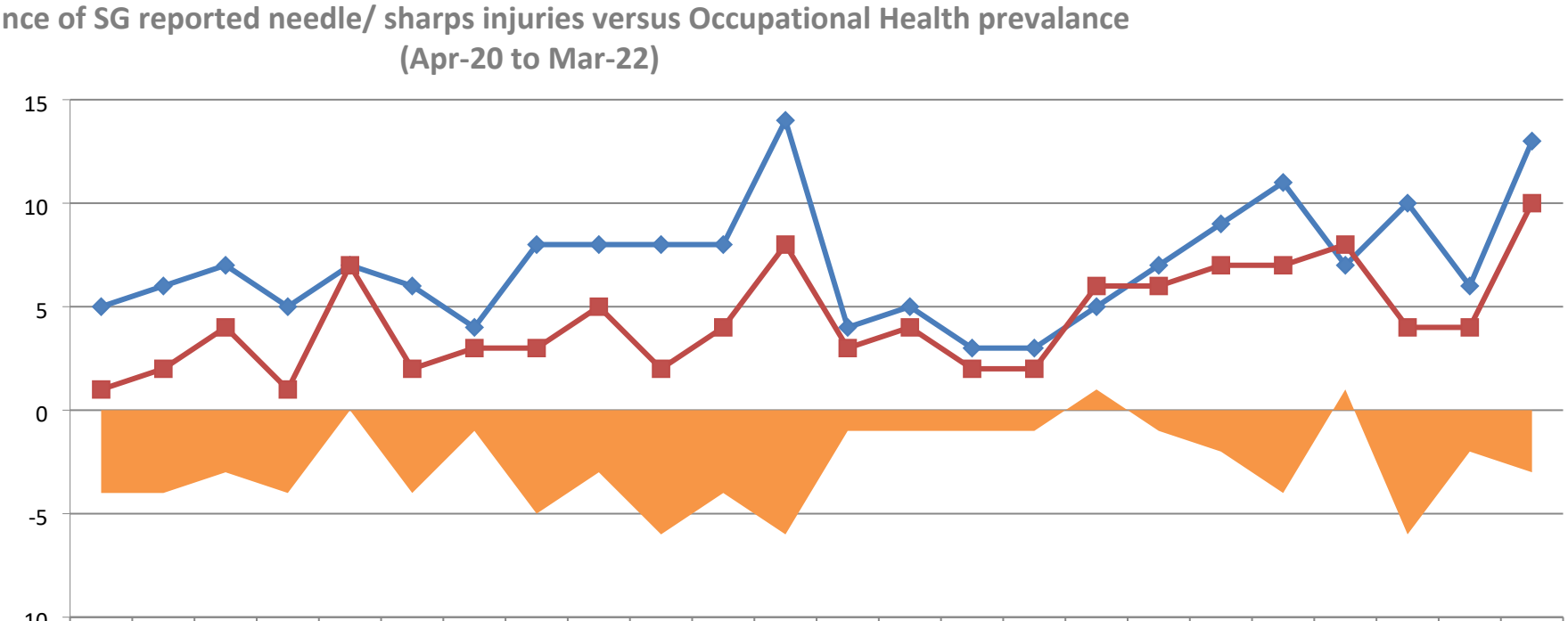
		The corporate Head of Risk is developing a TNA to be delivered throughout 2022/23	
Lack of organisation overview re application of health and safety risk management arrangements.	Proactive monitoring of compliance specifically relating to assessment of H&S hazards and subsequent risk.	An additional Ulysses module for monitoring H&S compliance was procured in 2020. This is no longer a viable option due to the decision to move to Datix risk management system. Work is underway to find a suitable system for facilitating compliance capture.	Identify a suitable off-the-shelf system to monitor proactive H&S compliance, or develop a local solution to enable front end input and rear-end extraction of data.
No coherent direction to the overall health and safety management system across the board	Influence and steer health and safety agenda across the organisation and at executive/ Board level	Director of Assurance is chairperson and delegated executive for Health and Safety. IOSH for Executives and Directors will be provided during 2022/23 to support senior leaders in understanding strategic health and safety and encourage leadership steer.	Further mature relationships between divisional H&S representatives through development of clear KPI's for monitoring through performance review. Introduce director health and safety 'walkabouts' to highlight and address safety matters locally. Establish 'toolkit-talks' and Estates and Facilities and H&S 'walkabouts'.
Insufficient staff consultation re Health and Safety matters	Improve consultation to ensure staff have 'their say' on workplace health and safety matters	The Health and Safety Committee has convened on 6 occasions during 2021/22. All meetings were quorate. Policy review have consulted with all parties either virtually or face-to-face.	Review representation from corporate teams to ensure there is adequate representation and consultation across the whole Trust.
Current reporting arrangements do not provide sufficient comparative information to determine improved direction of travel regarding H&S risk management compliance	Divisional (and other) groups will have the necessary information to agree processes to improve performance against expected KPI's	Reports now include trust wide and divisional data. This is provided quarterly to all divisional boards. KPI's will be agreed over the course of quarters 1 and 2 for reporting into divisional boards and assurance coming back to H&S Committee	Develop clear KPI's for all divisions including corporate infrastructure teams for monitoring thought performance models.
Progress and monitoring of H&S alerts has been inconsistent historically leading to a lack of scrutiny to determine effectual response and action required.	The H&S Committee will ensure that all alerts are reviewed and an agreed and planned response to necessary action is taken.	Safety alerts added as a standing agenda Item.	Complete and Close

New Priority	New Objective
A strategy for management of perpetrated violence and aggression needs to be developed, agreed and implemented to ensure all staff understand their role in mitigating and managing the output of incidents to ensure all staff feel safe when working in both acute and community.	Review and rewrite the Trust Violence and aggression policy to include models for managing intentional and non-intentional acts of violence and also staff-on-staff incidents of aggression and lack of professional respect. Establish a consultative working forum to develop policy and process. Work alongside multidisciplinary colleagues to develop robust and inclusive processes. Provide training and access to post incident support mechanisms.
Improve investigation of al health and safety incidents to ensure adequate post incident support is provided and illicit learning outcomes; specifically, for RIDDOR and moderate and above incident	Utilise current incident reporting policy and infrastructure for escalating incidents for investigation and further review. Improve H&S scrutiny of incidents to ensure classifications and harm levels are accurate and amended where they are not. Review incident and sickness absence data to identify hotspots and agree mitigation plans.
Incident reporting has increased; we need to understand whether the Trust is an outlier in terms of its incident reporting, types of incidents per populous and also external reporting to the HSE	Work alongside external organisations to review systems, processes and benchmark incident data against WTE's.

8. Appendix 1


Most Frequently Cited Incident Cause - Year on Year (2016 - 2022)
COVID-19 Related Incidents
Equipment
Communication
Non-Compliance
Food Stuff Contamination
Electric Shock
Hit By Moving Vehicle
Contact With Dangerous Part Of Equipment
Bites & Stings
Radiation Exposure (Staff)
Collision Between Vehicles
Fire Or False Alarm
Other - Work Related Injury
Contact With Hazardous Substance
Burns/Scalds/Splashes
Impact With Stationary Object
Cuts & Abrasions
Hit By Falling/moving Object
Environment
Manual Handling
Slips/trips/falls (Staff And Visitors Only)
Needles And Sharps
0
100
200
300
400
500
600
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22

9. Appendix 2



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Variance	-4	-4	-3	-4	0	-4	-1	-5	-3	-6	-4	-6	-1	-1	-1	-1	1	-1	-2	-4	1	-6	-2	-3
Occ Health Total	5	6	7	5	7	6	4	8	8	8	8	14	4	5	3	3	5	7	9	11	7	10	6	13
Safeguard Incident Report	1	2	4	1	7	2	3	3	5	2	4	8	3	4	2	2	6	6	7	7	8	4	4	10

10. Appendix 3

Managers Self Audit Summary Sheet

Red	Non Compliant
Amber	Working towards compliant
Green	Compliant

DIVISION:
DEPARTMENT:
YOUR NAME:
JOB TITLE:
DATE:

Self-Audit Summary Sheet

Topic area	Qu.	R	A	G	N/A	Need help? Y/N
Risk Ass'ment	1					
	1a					
	1b					
Slip Trip & Falls	2					
Lone working	3					
COSHH	4					
	4a					
	4b					
	4c					
Moving/Handling	5					
	5a					
	5b					
	5c					
	5d					
DSE/VDU	6					
Security	7					
V & Aggression	8					
	8a					
Stress	9					
Vulnerable Workers	10					
H&S Training	11					
Incident Report	12					
Workplace	13					
	13a					
	13b					

Topic area	Qu.	R	A	G	N/A	Need help? Y/N
	13c					
Work equipment	14					
	14a					
	14b					
	14c					
	14d					
	14e					
PPE	15					
	15a					
	15b					
	15c					
	15d					
Drv. & Vehicle	16					
	16a					
	16b					
Fire Safety	17					
	17a					
	17b					
	17c					
	17d					
	17e					
	17f					
	17g					
	17h					
	17i					

Topic area	Qu.	R	A	G	N/A	Need help? Y/N
	17j					
	17k					
	17l					
	17m					
	17n					
	17o					
	17p					
First aid	18					
	18a					
	18b					
Water hyg.	19					
Work at height	20					
Coordination & sharing information	21					

11. Appendix 4

Walsall Healthcare NHS Trust Fit Test Passport

Repeat tests

When should I be retested on my respirator?

- Every 2 years
- Any weight change Plus or minus 10%
- When something could potential affect the seal such as a broken nose, scars, moles, serious dental work, effects of aging, piercings or any medical intervention to your face.
- If the respirator's make, model or material changes in any way or if the respirator is no longer available to use.
- Use the QR code to book a repeat test

Declaration:

I have read and understand the information in this leaflet. I also understand that it is my responsibility to complete a fit check when donning an FFP3 respirator every time I wear one.

I understand that I must be clean shaven where the mask seals for it to work effectively.

Any questions or queries email:

mathew.fellows@walsallhealthcare.nhs.uk

NHS
Walsall Healthcare
NHS Trust

Fit Testing Passport

What is respiratory protective equipment?

Respiratory Protective Equipment, or RPE, is designed to protect the wearer from a variety of airborne hazards, including dust, vapours, gas, fumes and mist. FFP3 respirators are designed to protect against the inhalation of airborne infectious agents.

Why am I being fit tested?

The wearing of FFP3 respirators has become common place in reducing the risk of transmission of Covid-19 specifically in AGP environments. Tight-fitting respirators (such as disposable FFP3 masks and reusable half masks) rely on having a good seal with the wearer's face. A face fit test should be carried out by a competent person in accordance with HSE requirements to ensure the respiratory protective equipment (RPE) can adequately seal to your face.

When should I use an FFP3 respirator?

- FFP3 masks are required when caring for a patient who's undergoing an Aerosol Generating Procedure (AGP) or when you are working in close proximity to AGP's.
- Podiatry Procedures - FFP3 respirators would provide an adequate level of protection from the microbial matter contained in nail dust.

Is the fit testing procedure safe?

The fit testing methods used in Walsall Healthcare are safe and are approved methods as per Health and Safety Executive guidance.

Will I need to be fit tested again?

- You are required to fit mask test on 2 types of FFP3 respirator.
- This will be a two yearly requirement. You may need to be tested again within the two year period on the same type of mask, if there's a significant change to your face (See reverse)

Fit checking the mask?

Each time you wear an FFP3 respirator; Cover the front of the respirator with both hands, being careful not to disturb the position of the mask. Exhale sharply (you shouldn't feel any air leaking from the seals)

00415 06/22

Caring for Walsall together

Fit Test Record

Name:		
Date of Test:		
Respirator Model Type 1:		
Respirator Model Type 2:		
Fit Test protocol used: HSE INDG 479		
Qualitative (Hood) ☐ **Quantitative (PortaCount)** ☐		
Test result:	**Pass** ☐	**Fail** ☐

HY 9330 ☐ **Alpha Solway HX-3** ☐

GVS 31000 ☐ **3M 1863+** ☐ **Honeywell 3207** ☐

Trained Tester Name:	
Trained Tester Signature:	

What should I use?

When to use an FFP3 Respirator: Aerosol Precautions

Close patient contact

- While undertaking or in close proximity to an AGP)

PPE to be worn

- FFP3 Respirator mask
- Long sleeved disposable apron
- Gloves
- Eye protection

When to use a surgical face mask: Droplet precautions

Close patient contact

- Within 2 metres of patient
- When walking down corridors

PPE to be worn

- Blue surgical face mask
- Standard Apron
- Gloves
- Eye protection/Visor

Current AGP Guidance

Intubation, Extubation, Tracheotomy / Tracheostomy, Manual ventilation, Open suctioning, Bronchoscopy, C-PAP, Bi-PAP, Surgery and post-mortem procedures in which high-speed devices are used, High-frequency oscillating ventilation (HFOV), High-flow Nasal Oxygen (HFNO) (NOT standard Nasal Specs), Induction of sputum, Some dental procedures (e.g. high speed drilling), Upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract, Chest compressions. (not limited too)

For your safety - You should not wear FFP3 respirators that you're not tested on, as you can't be sure the mask fits correctly. Any FFP3 mask you wish to wear you should get fit tested on first.

FFP3 Fit Testing Certificate (1.1 Edition) Mar 2022 Review Mar 2024

12. Appendix 5

Health and Safety Annual Planner

HEALTH AND SAFETY PLANNER *-The Health and Safety Department understands the difficulties that manager's face due to a vast amount of competing demands and workloads, that must be managed within any one department. Therefore, a new Health and Safety Planner has been created as a 'tool', to help managers plan their health and safety arrangements. The planner organises all risk assessments, workplace inspections and more into monthly schedules. It is important to remember that this tool is flexible, and can be adapted to the risks of the department. Therefore risks that take precedence over others or a lack of risk assessments of such subjects below must be completed first. This tool will help manager's plan for its effective implementation and completion of health and safety arrangements, and thereafter can be used to continually monitor and review health and safety progress.*

SCHEDULE	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC
RISK ASSESSMENT TO COMPLETE/ REVIEW	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject	Pick a subject
RISK REGISTER	FOLLOWING RISK ASSESSMENT COMPLETION, SHOULD ANY RISKS BE ADDED/ UPDATED ON DEPARTMENTAL RISK REGISTER?											
WORKPLACE INSPECTIONS			COMPLETE WORKPLACE INSPECTION*			COMPLETE WORKPLACE INSPECTION*			COMPLETE WORKPLACE INSPECTION*			COMPLETE WORKPLACE INSPECTION*
	* Please note the frequency of the workplace inspection is determined by the level of risk in the department. The frequency can be as often as weekly or a minimum of quarterly.											
REVIEW MANAGERS H&S TOOLKIT (SUBMIT A SELF-AUDIT SUMMARY SHEET TO THE H&S TEAM)		1/4 SUBMIT SELF-AUDIT SUMMARY SHEET TO HEALTH AND SAFETY TEAM			1/4 SUBMIT SELF-AUDIT SUMMARY SHEET TO THE HEALTH AND SAFETY TEAM			1/4 SUBMIT SELF-AUDIT SUMMARY SHEET TO HEALTH AND SAFETY TEAM			1/4 SUBMIT SELF-AUDIT SUMMARY SHEET TO HEALTH AND SAFETY TEAM	
INCIDENT REPORTING	WEEKLY CHECK ON SAFEGUARD. ARE THERE ANY OUTSTANDING ACTIONS, INVESTIGATIONS OR TRENDS IN THE DEPARTMENT?											
STAFF ABSENCE	IS STAFF ABSENCE RELATED TO ANY WORK RELATED RISK? IS A RISK ASSESSMENT OR FURTHER ACTION REQUIRED?											
TRAINING	REVIEW ALL MANDATORY TRAINING. ARE TEAM MEMBERS UP TO DATE?											
QUARTERLY FIRE SAFETY AUDIT - APPENDIX B	¼ FIRE SAFETY AUDIT			¼ FIRE SAFETY AUDIT			¼ FIRE SAFETY AUDIT			¼ FIRE SAFETY AUDIT		
FIRE WARDEN CHECKS	MONTHLY FIRE WARDEN CHECKS- APPENDIX D											
PREVENTING AND MANAGING ARSON AUDIT - APPENDIX C	ANNUAL PREVENTING AND MANAGING ARSON AUDIT - APPENDIX C											
DANGEROUS SUBSTANCES AND EXPLOSIVE ATMOSPHERES - APPENDIX E	ANNUAL DANGEROUS SUBSTANCES AND EXPLOSIVE ATMOSPHERES - APPENDIX E											
PERSONAL EMERGENCY EVACUATION PLANS	DOES A MEMBER OF YOUR TEAM REQUIRE A PEEP?											

TRUST BOARD MEETING 5 OCTOBER 2022			
Infection Prevention and Control Q2 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.
Recommendation & Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Assure	• 0 Acute Acquired MRSA bacteraemias to report for Quarter 2 (at time of report 27.09.22) • Elements of the IPC BAF have been updated to reflect new risks in quarter 2 • The NHSE review in August 2022 achieved a "Green" rating from a previous "Amber" rating		
Advise	• There were 3 acute Trust acquired C.difficile toxin cases to report during July and August 2022 • There were 2 acute Trust acquired MSSA bacteraemias to report for Quarter 2 (at time of report 27.09.22) • In response to the changing approach to the COVID-19 pandemic the local guidance has been updated to reflect the management of all respiratory tract infections.		
Alert	• 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.		
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 ☐		

Walsall Healthcare NHS Trust

Board Assurance Framework Summary

Action	Required action	Q3	Q4	Q1 22/23	Q2 22/23 current current	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	6	6	→
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	12	8	6	8	↑
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	4	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	8	6	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	3	6	6	9	↑
7	Provide or secure adequate isolation facilities	20*	20	12	9	↓
8	Secure adequate access to laboratory support as appropriate	12	8	6	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	8	6	8	8	→

Details of updates captured in IPC BAF

Changes to COVID-19 guidance

The Infection Prevention Team and Consultant Microbiologist updated the latest respiratory pathway manual in Quarter 2. This manual has been positively received and the latest version is due to be presented at the National Infection Prevention Society conference in October 2022. 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. In September 2022, the Head of Infection Prevention and Infection Prevention Doctor led question and answer sessions open to all Trust staff to support adaptation of updated guidance to local departments.

Infection Prevention in the healthcare environment

A revisit from NHSE on Infection Prevention and Control took place in August 2022; this noted significant improvements in the overall healthcare environment and included a walk around the new building site for the emergency care centre. The overall Trust rating for infection prevention is now "green", with a sustainability visit to be scheduled in six to nine months' time.

Air disinfector units installed across the Trust remain in place as an infection prevention measure to improve indoor air quality. An audit of the units in September 2022 demonstrated a few units that were switched off and multiple units that needed the pre-filters cleaned. There is variation in maintenance of the units and this has been escalated with facilities to ensure these are being routinely maintained.

Staff members responding to symptoms of a respiratory tract infection

On 6th September 2022, updated infection prevention guidance was launched at the Trust which stopped the requirement for routine asymptomatic testing of staff members via lateral flow devices. The Trust standard operating procedure for staff remains that in the event of developing any symptoms of a respiratory tract infection, to undertake a lateral flow test prior to coming into work and isolate from work if positive. An outbreak in September 2022 identified staff members who attended work with mild cold-like symptoms who were later identified as COVID-19 positive. The Trust has circulated communications to reiterate measures still required to prevent transmission of infection in the workplace. The COVID-19 team will come to an end in October 2022, therefore still will be advised to seek advice via their line manager, via Trust SOPs and further advice through Occupational Health.

Ability to isolate patients

The Manor Hospital now has nine Bioquell isolation pods installed to improve available segregation facilities. Changes in COVID-19 guidance and increased availability of segregation facilities has reduced the incidence of "failure to isolate" reports. It is anticipated that as the winter season approaches that demand for isolation requirements for infection prevention reasons will increase again, but increased facilities will support with appropriate prioritisation between the Infection Prevention team and clinical teams.

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. During July and August there were a total of 3 acute acquired C.difficile cases. Learning is shared at Infection Prevention and Control Committee and divisional quality meetings.

2022/23	April	May	June	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	1	2							
Cumulative YTD projected	2	4	6	8	10	12	14	16	19	22	24	27
Acute Cumulative actual	0	1	5	6	8							

MRSA Bacteraemia

There have been 0 MRSA bacteraemias to report for Quarter 2 at time of report (27.09.22)

MSSA Bacteraemia

There have been 2 MSSA acute acquired bacteraemias to report for Quarter 2 at time of report (27.09.22). Both cases have been deemed unavoidable during further investigation.

Gram-negative Bacteraemias

National target for E.coli bacteraemias at the Trust are 50 for the year. 6 acute acquired cases were reported in during July and August 2022. This can be associated with seasonality; increased risk of E.coli associated infections during hotter months of the year.

National target for Klebsiella bacteraemias at the Trust is 27 for the year. 1 acute acquired case was reported during July and August 2022.

National target for Pseudomonas bacteraemias at the Trust is 10 for the year. 1 acute acquired case was reported during July and August 2022; this case had already presented to hospital with a Pseudomonas urinary infection and clinical staff responded accordingly to sepsis pathway on day 3 of admission. No issues identified during the review.

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. A business case is currently being prepared for the introduction of a mouth care team with an aim to reduce the incidence of hospital acquired pneumonia, the most prevalent health care associated infection at the Trust.

Carbapenemase producing Enterobacteriaceae (CPE)

0 cases of acute acquired CPE to report for Quarter 2 at time of report (27.09.22).

Outbreaks and Incidents

COVID-19: During July-August 2022, there were 32 bay closures due to COVID-19 (3 in August, 29 in July). 1 ward was closed in July due to a COVID-19 outbreak. In July-August 2022 there have been a total of 42 cases of COVID-19 that meet the health care acquired definition. Each case is reviewed by the IPC team as well as a review of compliance to COVID-19 guidance in the ward setting. At time of report (27.09.22) there have been 5 COVID-19 outbreaks reported during September, affecting Wards 15, 16, 17, 1 and Palliative Care Centre.

Suspected Norovirus: 0 bays were closed during quarter 2 due to suspected Norovirus. All were negative and promptly reopened.

Influenza A: 1 bay closure due to confirmed Influenza in July; no further cases identified following this case and the bay reopened.

End of Report.

MEETING OF THE TRUST BOARD 5th October 2022			
Medicines Management Report			
Report Author and Job Title:	Gary Fletcher Director of Pharmacy	**Responsible Director:**	Manjeet Shehmar Medical Director
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Assure	• 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 CD 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. • Controlled Drug record keeping is also being monitored closely and electronic solutions to replace the current paper systems is being considered.		
Alert	• 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	Resources will be required for purchase of electronic drug storage units and Controlled Drug management software, if supported in principle by TMC. Business cases to follow if supported.		
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 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 completed on 14th September.
- 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 aany 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.

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

TMC 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.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE Public Trust Board **October 2022**			
Biannual Skill Mix Review			
Report Author and Job Title:	Gaynor Farmer Senior Nurse Workforce	**Responsible Director:**	Lisa Carroll Director of Nursing
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☒ Inform ☐ Assure ☐		
Assure	• The Biannual skill mix review has been undertaken in June 2022 utilising the Safer Nursing Care Tool and professional judgement in line with nationally recognised best practice		
Advise	• Following the skill mix review the Director of Nursing recommends an increase in the establishments on ward 7 and 17. • The recommended total increase in staffing is 3.66 WTE band 5 RNs and 5.28 Band 2 CSWs		
Alert	• Nil to alert		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Safe High Quality Care BAF **2066** – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels (Risk Score 20 increased from 16 in month).		
Resource implications	• An increase in staffing of 3.66 WTE band 5 RNs and 5.28 Band 2 CSWs		
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 TRUST BIANNUAL SKILL MIX REVIEW

DATA COLLECTION JUNE 2022

Author: Gaynor Farmer Senior Nurse for Workforce

Responsible Director: Lisa Carroll Director of Nursing

INTRODUCTION

To deliver safe quality patient care it is essential wards have optimal Nurse staffing levels. It has been acknowledged that one of the contributory factors linking failures in care and patient safety were inadequate staffing levels (Francis 2013). In July 2016 the National Quality Board published 'Supporting NHS providers to deliver the right staff with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'. This safe staffing improvement resource provided updated expectations for nursing and midwifery care staffing**.** The Developing Workforce Safeguards published by *NHS Improvement* in October 2018 will assess Trusts compliance with a more triangulated approach to Nurse staffing planning in accordance with the National Quality Board guidance for all clinical staff. This document recommends a combination of evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skill are in the right place and time.

To demonstrate the Trust's commitment to the above requirement a twice-yearly Adult Inpatient, Acute Assessment units and Paediatric inpatient skill mix review is completed.

Walsall Healthcare NHS Trust (WHT) uses the 'Safer Nursing Care Tool' (SNCT). The SNCT is a simple-to-use, evidence based digital tool that calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward and it is linked to nurse sensitive outcome indicators.

The SNCT, which was developed by Professor Dame Hilary Chapman and Katherine Fenton OBE, has been rigorously validated using a substantial database over a number of years and is now widely used by NHS trusts. The development of the SNCT has been supported and endorsed for use by NHS England and NHS Improvement. The SNCT now includes different staff multipliers for Acute Assessment Units, Acute Inpatient and Children and Young People's Wards, and very recently released one for Emergency Departments.

This tool enables the measurement of both acuity and dependency which can be applied to patients whose care can be delivered within acute adult, paediatric or acute assessment settings (appendix 1). A multiplier for calculating establishments will suggest nursing whole time equivalents (WTE) required to provide a safe and appropriate standard of care for each of the five levels of acuity and dependency identified by SNCT. Also measured are Nurse Sensitive Indicators (NSIs); these are quality indicators, which can be influenced by nursing establishments and skill mix (appendix 2).

Acuity and dependency data was collected in January 2022 and June 2022 for the recommended 20 days (Mon-Fri) from:

- Fifteen adult inpatient ward areas
- One Community area

This review has taken place during January 2022 and June 2022. January 2022 was a time that the Trust was still experiencing activities related to the omicron variant of the Covid-19 pandemic.

You will note that the review does not provide data for the following areas of additional capacity that are not open for the entire year

- Ward 14 Medical Winter Ward (maximum 28 beds) and Ward 9 Surgical Winter Ward (maximum 26 beds) – these two areas opened to support the Trust through winter demands. Some of the staffing has been redeployed from other areas and there has been reliance upon Temporary Staffing for the remaining shifts.

The review does not include Ward 21 (paediatric ward) and the Paediatric Assessment Unit. Paediatrics are developing a business case separate to this process as currently the budget is combined across in patient and assessment areas.

The Acute Medical Unit (AMU) and the Emergency Department are not included as both areas have had business cases approved during May and June 2022 and these are now being recruited to.

In undertaking a skill mix review it is essential that the acuity/dependency data is triangulated against professional judgement and Nurse Sensitive Indicators (Falls, Pressure Ulcers, Medication Incidents, Complaints and Healthcare Associated Infections).

- Ward layout/facilities: the configuration of wards and facilities affect the nursing time available to deliver care to patients, and this can be reflected in staffing establishments through professional judgement. For example, wards with a high proportion of single rooms might make adequate surveillance of vulnerable patients more difficult. This is particularly pertinent around Covid-19 with donning and doffing requirements and where isolation has reduced staff-patient visibility.
- Escort duties: consideration needs to be given if this role is likely to affect the numbers of staff required. A local data collection and analysis exercise is undertaken to determine a percentage to be added to the establishment to ensure staffing remains responsive to daily patient care needs if this is considered to have a significant impact on the ward activity
- Shift patterns: the type of shift patterns (long day versus short day) in use may affect the overall establishment required to ensure shift-to-shift staffing levels. These are monitored to understand the impact and effect on staff and patients

RESULTS

OCCUPANCY, ACUITY AND DEPENDENCY

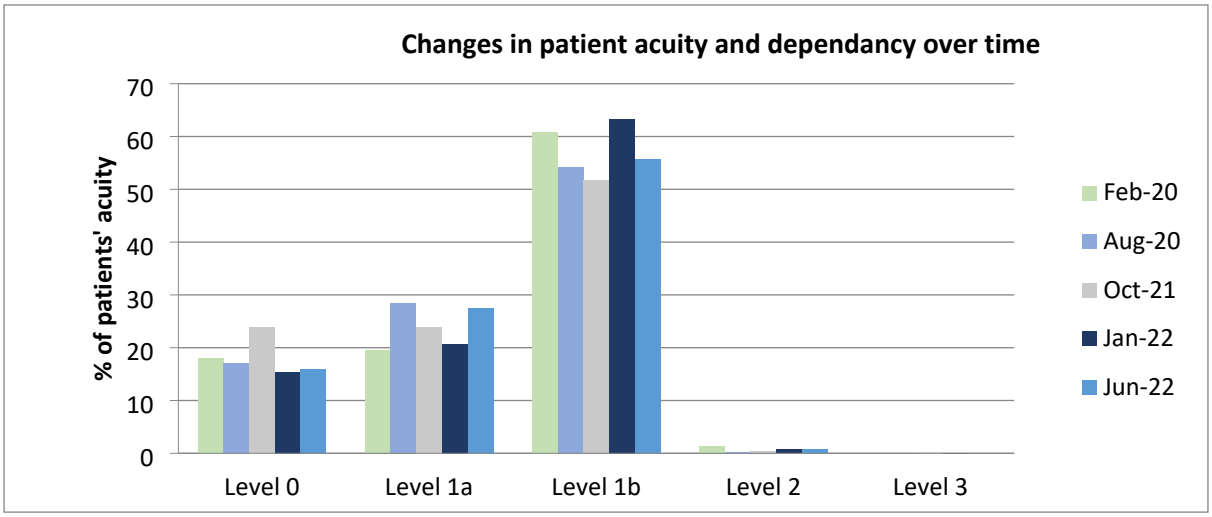
The data in Table 1 below summarises that 8179 acuity scores were collected using the SNCT daily in June 2022. 15.9% of patients were scored at level 0, 27.5% at 1a and 55.8% of patients were scored as level 1b (stable but have a higher dependency on nursing support). Level 2 totalled 0.8% and represent patients on acute medical wards and one surgical ward. There were no recorded level 3 patients on wards prior to transfer to an ICCU or another Level 3 facility.

Table 1 (Acuity Scores collected by Level)

		Feb-20	Aug- 20	Oct-21	Jan-22	Jun-22
No of Scores	Multiplier	8494	6781	7447	7351	8179
Level 0 (requires hospitalisation)	0.99	18.1%	17.1%	23.9%	15.3%	15.9%
Level 1a (acutely ill patients who unstable)	1.38	19.5%	28.4%	23.9%	20.6%	27.5%
Level 1b (stable patients who are heavily dependent on nursing care)	1.72	60.9%	54.2%	51.6%	63.2%	55.8%
Level 2 (require expertise provided in designated beds or Level 2 facility)	1.97	1.3%	0.2%	0.3%	0.6%	0.8%
Level 3 (require advanced respiratory support or therapeutic support of multiple organs).	5.96	0	0	0	0	0

Chart 1 below shows that acuity score at 1b is predominantly the highest proportion of scores and that level 0 has the least number of patients in each data collection. Since the October 2021 data collection there has been an elevation in level 1b patients', but it is worth recognising the data collection for January 2022 is within the winter period where typically more patients are in hospital with higher acuity and dependency because of chronic illness. June 2022 data saw 1b levels decrease more in line with previous collection.

Chart 1 – changes in acuity (last 5 SNCT reviews)



From September 2021 there was an E-learning Tool available that had been designed to enhance knowledge around acuity recording. A competency assessment was attached to that. There have been 195 responses to the E-learning, staff can attempt multiple times. The number of Band 6 and above staff that are fully competent is 64 across our in-patient areas. A recommendation for education following this report is that the E-learning will be mandated for band 6, 7 and 8 for the in-patient areas and further work will be undertaken to ensure a wider understanding amongst all registered nurses and midwives.

NURSE SENSITIVE INDICATORS (NSI) BY AREA

Table 2 demonstrates rates of falls, pressure ulcers, medicine related incidents, number of complaints and infections during January and June 2022 (the previous 2 reviews). For falls, the 8 areas highlighted as amber had a falls incident rate in month greater than the national average (6.68)

Within Table 2 wards with an asterix highlight where data indicates an establishment uplift of greater than 10% is required. There is limited correlation between uplift request and NSI by area. In January 2022 two areas showed a high NSI score and a 10% or greater change to establishments. In June 2022 this was shown in one area.

i. Ward 1- SNCT 56.4 WTE, Professional Judgement 52.87, current establishment 47.5
ii. Ward 4- SNCT 43.0 WTE, Professional Judgement 41.41, current establishment 30.91. The data collection is based on 28 beds. Just prior to the January 2022 SNCT data collection the medical division had a business case approved to establish ward 4 as a 28 bedded ward (until this point it had a substantive establishment for 22 beds), with the agreement that should there be a requirement to increase capacity this will be established using winter monies. At the time of writing this report the budgeted establishment for ward 4 has not be adjusted to reflect the increase from 22 to 28 beds and the division have not closed the winter capacity beds and ward 4 remains open to 34 beds. Ward 4s substantive staffing is being predicated on 28 beds for this review.
iii. Ward 17-SNCT 39.3 WTE, Professional Judgement 41.41, current establishment 34.90
iv. Ward 10- SNCT 39.5 WTE, Professional Judgement 38.81, current establishment 33.43
v. Ward 11- SNCT 34.4 WTE, Professional Judgement 38.81, current establishment 34.51
vi. Ward 12- SNCT 41.4 WTE, Professional judgement 38.81, current establishment 22.01

Wards 11 and 12 were historically managed as one ward (ASU) with a single budget. Following a reconfiguration over a year ago ward 11 became a complex surgical ward and ward 12 the emergency surgical ward. At the point of this change being made the budgets and establishments were split. The decision on allocation of the budget between the two wards was not based on the acuity or dependency of patients or any other nurse sensitive indicators.

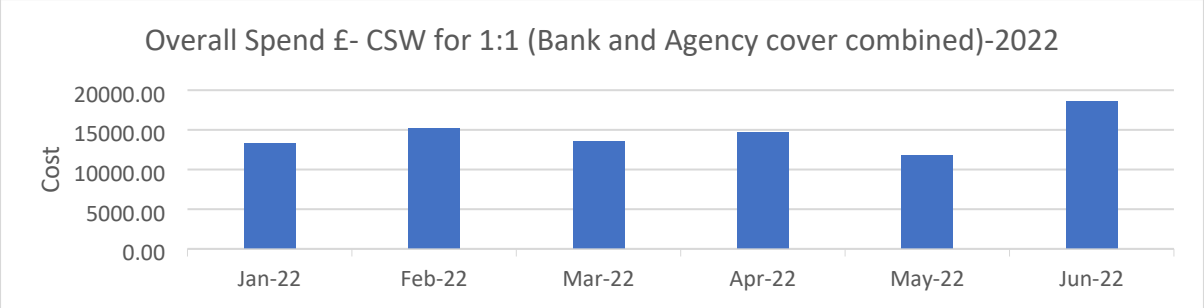
Table 2 – Nurse Sensitive Indicators by Area – January 2022 and June 22

		Jan-22	Jun-22	Jan-22	Jun-22	Jan-22	Jun-22	Jan-22	Jun-22	Jan-22	Jun-22	Jan-22	Jun-22
Jun-22	Ward	Falls per 1000	Falls per 1000	Pressure Ulcers	Pressure Ulcers	Medication Errors	Medication Errors	Complaints	Complaints	C-Diff	C-Diff	MRSA	MRSA
MLTC	1*	7.74	4.79	0	1	2	1	0	0	0	0	0	0
	2	1.15	4.34	0	1	1	1	0	0	0	0	0	0
	3	5.78	7.73	0	0	3	0	0	0	0	0	0	0
	4*	9.51	4.02	2.85	4	2	4	1	0	0	0	0	0
	7	3.14	1.5	1.57	3	1	3	0	0	0	0	0	0
	15	12.69	2.38	2.82	1	0	1	0	1	0	0	0	0
	16	1.44	1.34	1.44	2	0	2	1	0	1	0	0	0
	17*	9.51	0	0	3	0	3	0	0	1	0	0	0
	29	11.46	2.96	1.91	1	4	1	0	2	0	0	0	0
SURGERY	10*	2.71	6.34	1.36	0	0	0	1	0	1	0	0	0
	11*	1.33	1.36	0	1	10	1	2	1	0	2	0	0
	12*	1.37	4.02	0	3	1	3	0	0	0	0	0	0
	20A	5.48	8.51	0	0	0	0	1	1	0	0	0	0
WCCCS	23	0	0	0	0	1	0	0	0	0	0	0	0
COMMUNITY	Hollybank	0	8.88	0	0	0	0	0	1	0	0	0	0

AMBER= high falls rate/ *= establishment uplift requested of 10% higher than budget

Chart 2 demonstrates the current cost of 1:1 cover via Bank and Agency CSW to help mitigate some of the falls and care issues for those patient's requiring supervision. Total 6-month cost is £86,926

Chart 2- Cost of CSW cover for 1:1's



ESTABLISHMENTS

Applying the SNCT multipliers (described in Table 1) to the data collected, the differential between funded establishments and required establishments are calculated inclusive of 21% uplift (to provide direct comparison). This model is based on establishment and not actual nursing staff in post (contracted)

The skill mix review undertaken previously in January 2022 was at the height of the Omicron variant of COVID-19 and this had a significant impact on the number of unwell patients with COVID-19 within the hospital. Data was collected again in June 2022.

In January 2022 and June 2022 the review indicated the need for an increase in RN and CSWs of more than 10% in 6 wards.

Table 3 provides the full suite of data calculated (June 22)

Division	Ward	WTE- Professional Judgement Jun22	WTE- SNCT Acuity Tool Jun 22	Areas that breach 10% SNCT threshold (highlighted)	CHPPD	WTE-Total budgeted required post skill mix review	% change from current budget	REG- Difference required from Current to Required budget (%)	CSW- Difference required from Current to Required budget (%)	Total difference required from Current to Required budget (WTE)
MLTC	Ward 1	55.47	56.4		8.2	52.87	10.16	0.00	5.37	5.37
	Ward 2	47.5	39.8		7.7	47.50	0.00	0.00	0.00	0.00
	Ward 3	52.87	51.6		7.3	50.18	5.34	0.00	2.68	2.68
	Ward 4	41.41	43			41.41	25.36	7.40	3.10	10.50
	Ward 7	36.22	29.8		6.7	36.22	7.70	2.43	0.36	2.79
	Ward 15	40	44.2		6.6	40.00	0.00	0.00	0.00	0.00
	Ward 16	38.77	37.9		7.3	38.77	-0.85	-0.33	0.00	-0.33
	Ward 17	41.41	39.9		7.3	41.41	15.72	1.23	5.28	6.51
	Ward 29	59.08	48.5		6.9	50.30	0.00	0.00	0.00	0.00
					Divisional Total	398.66		10.73	16.79	27.52
SURGERY	Ward 10	38.81	39.5		6.9	38.81	13.86	2.35	3.03	5.38
	Ward 11	38.81	34.4		6.3	38.81	11.08	1.27	3.03	4.30
	Ward 12	38.81	41.4		7.2	38.81	43.29	8.80	8.00	16.80
	Ward 20a*	47.87	17.2		8.7	47.87	0.00	0.00	0.00	0.00
					Divisional Total	164.30		12.42	14.06	26.48
		20.7			11.					

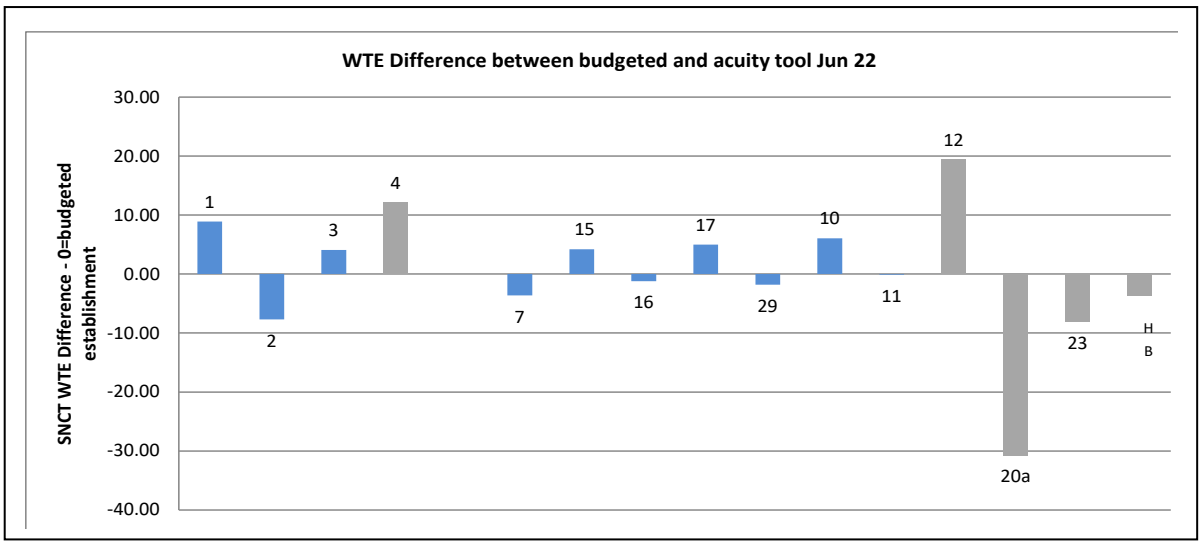
- ***Highlighted in yellow are areas requesting a change of more than 10% from current budget.***
- ***Highlighted in grey are areas where current budget and SNCT are more than 10% different.***
- **** = area with 16 or less beds where SNCT is not considered valid or the preferred tool for this area***

The skills mix reviews undertaken in January and June 2022 indicate a requirement for an increase in RN and CSW establishments from that indicated in the June 2021 review and approved by the Trust board in October 2021 of 24.29 WTE registered staff and 31.14 WTE CSWs.

Chart 3 demonstrates WTE demand from the review.

Exceptions are highlighted in grey; Wards 20a, 23 and Hollybank are in exception and low SNCT results have been received due to the SNCT not being accurate or appropriate as an establishment review methodology in departments of 16 beds or less. Wards 4 and 12 are an exception due to the previous budget not being aligned to this departments current service provision.

Chart 3 – WTE Difference between Budgeted Establishment and SNCT -June 22



**** Positive figure= SNCT recommends higher than current budget***

It is accepted that being within 10% of SNCT in terms of WTE is within tolerance and further consideration is given to those areas outside of 10% (in Chart 4 demonstrated by the red threshold line). Despite the following areas being within the SNCT 10% accepted tolerance, the professional judgement discussion indicates some changes to establishment based upon clinical care. Skill mix review meetings took place between the Director of Nursing, Head of Nursing for Workforce, Head of Nursing for Division and Corporate Lead Nurse for Workforce.

Ward 3 is identified as having a high number of patients requiring 1:1 care and patients at high risk of falls. Where this has been identified, the Director of Nursing is working with the Divisional Director of nursing and Quality Team to review the approach and find appropriate solutions to providing safe care to patients who have care needs that would traditionally be identified as requiring 1:1 care across the Trust

Ward 7- Currently one of the Registered Nurses on duty at night holds a cardiac arrest call bleep. This means that they are required to attend any cardiac arrest call across the Trust and can be absent from the ward for a considerable length of time. When this occurs, staffing levels are reduced on the ward to 2 RNs. There remains a clinical need for a member of Coronary Care staff to attend all cardiac arrests at night.

Chart 4-% difference between current budget and acuity tool June 22

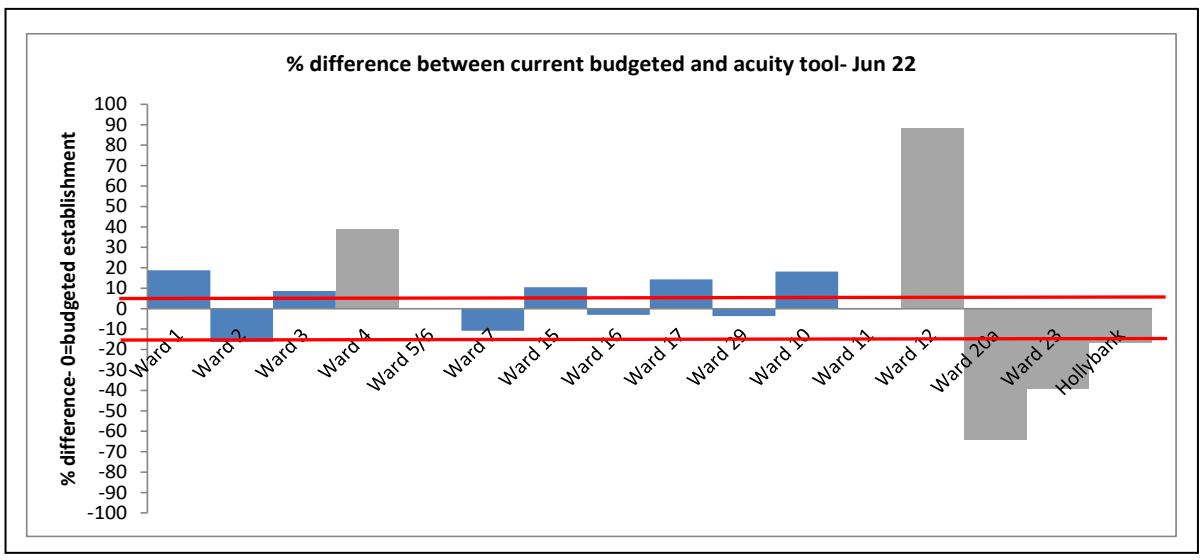
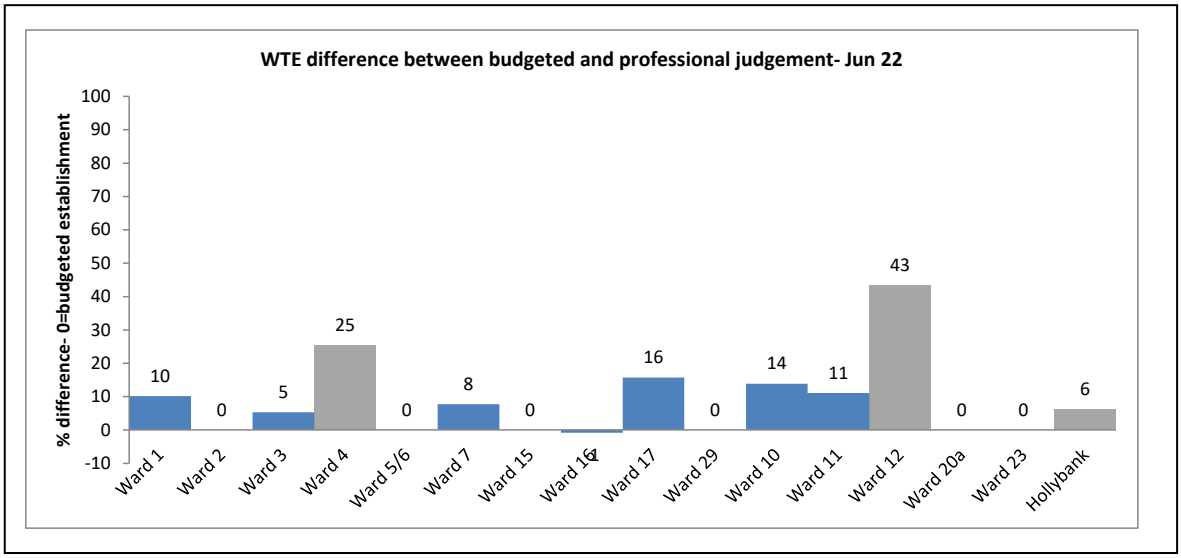


Chart 5 shows the variation between the current budgeted establishment and professional judgement.

Graph 5 - % variation from current establishment to professional judgement June 22



ANALYSIS

It is essential that decisions to change to staffing requirements are based on a thematic analysis over time rather than a single point measurement unless:

i. One measurement has changed significantly and is support by other triangulated data.
ii. Activity and/or acuity has been altered significantly (change of speciality/bed base change).

In this case other triangulated evidence is summarised in each individual departments' summary.

The skill mix review was concluded by the Director of Nursing, Head of Nursing for Workforce, Corporate Lead Nurse for Workforce and appropriate Divisional Head of Nursing for each division.

Over the page is table 4 which is demonstrates budgeted establishments and required establishments.

- Highlighted in yellow are areas requesting a change of more than 10% within this review.
- Highlighted in grey are areas that fall out of the SNCT 10% parameters.

Table 4- Department breakdown June 22

									20/21 Budgeted WTE								June 22 Requested change after Professional Judgement											
Division	Ward	WTE- Professional Judgement Jun22	WTE- SNCT Acuity Tool Jun 22	Areas that breach 10% SNCT threshold	CHPPD	Number of Funded Beds	Occupancy		Band7	Band 6	Band 5	Band 4	Band 3	Band 2	WTE- Total Budgeted 21/22		Band 7	Band 6	Band 5	Band 4	Band 3	band 2	WTE-Total budgeted required post skill mix review	% change from current budget	Ratio (Reg%) (B6/B5/B4)	WTE per bed	REG- Difference required from Current to Required budget (%)	CSW- Difference required from Current to Required budget (%)
MLTC	Ward 1	55.47	56.4		8.2	34	98%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	18.9	3.00	0.00	25.97	52.87	10.16	48.99%	2.03	0.00	5.37
	Ward 2	47.5	39.8		7.7	34	93%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	18.9	3.00	0.00	20.6	47.50	0.00	54.53%	1.83	0.00	0.00
	Ward 3	52.87	51.6		7.3	34	90%		1.00	4.00	18.90	3.00	0.00	20.60	47.50		1.00	4.00	18.9	3.00	0.00	23.28	50.18	5.34	51.61%	1.93	0.00	2.68
	Ward 4	41.41	43			28	96%		1.00	2.52	9.71	0.00	0.00	17.68	30.91		1.00	2.52	14.11	3.00	0.00	20.78	41.41	25.36	47.40%	1.59	7.40	3.10
	Ward 7	36.22	29.8		6.7	23	91%		1.00	7.56	12.24	0.00	0.00	12.63	33.43		1.00	7.56	14.67	0.00	0.00	12.99	36.22	7.70	61.37%	1.39	2.43	0.36
	Ward 15	40	44.2		6.6	28	97%		1.00	4.00	15.00	2.00	0.00	18.00	40.00		1.00	4.00	15	2.00	0.00	18	40.00	0.00	52.50%	1.54	0.00	0.00
	Ward 16	38.77	37.9		7.3	25	99%		1.00	3.00	15.00	3.00	0.00	17.10	39.10		1.00	3.00	15.67	2.00	0.00	17.10	38.77	-0.85	53.31%	1.49	-0.33	0.00
	Ward 17	41.41	39.9		7.3	25	100%		1.00	5.20	12.80	3.00	0.00	12.90	34.90		1.00	5.20	14.03	3.00	0.00	18.18	41.41	15.72	53.68%	1.59	1.23	5.28
	Ward 29	59.08	48.5		6.9	36	96%		1.00	4.00	19.70	5.00	0.00	20.60	50.30		1.00	4.00	19.7	5.00	0.00	20.6	50.30	0.00	57.06%	1.93	0.00	0.00
						Divisional Total			9.00	38.28	141.15	22.00	0.00	160.71	371.14		9.00	38.28	149.88	24.00	0.00	177.50	398.66				10.73	16.79
SURGERY	Ward 10	38.81	39.5		6.9	27	100%		1.00	2.52	9.82	4.94	0.00	15.15	33.43		1.00	2.52	12.17	4.94	0.00	18.18	38.81	13.86	50.58%	1.49	2.35	3.03
	Ward 11	38.81	34.4		6.3	25	100%		1.00	2.60	14.76	1.00	0.00	15.15	34.51		1.00	2.60	16.03	1.00	0.00	18.18	38.81	11.08	50.58%	1.49	1.27	3.03
	Ward 12	38.81	41.4		7.2	27	94%		1.00	2.00	10.43	1.00	0.00	7.58	22.01		1.00	2.00	19.23	1.00	0.00	15.58	38.81	43.29	57.28%	1.49	8.80	8.00
	Ward 20a*	47.87	17.2		8.7	16	95%		1.00	4.32	21.34	1.00	0.00	20.21	47.87		1.00	4.32	21.34	1.00	0.00	20.21	47.87	0.00	55.69%	1.84	0.00	0.00
						Divisional Total			4.00	11.44	56.35	7.94	0.00	58.09	137.82		4.00	11.44	68.77	7.94	0.00	72.15	164.30				12.42	14.06
WOMENS	Ward 23*	20.71	12.6		11.3	12	68%		1.00	1.00	11.13	0.00	0.00	7.58	20.71		1.00	1.00	11.13	0.00	0.00	7.58	20.71	0.00	58.57%	0.80	0.00	0.00
						Divisional Total			1.00	1.00	11.13	0.00	0.00	7.58	20.71		1.00	1.00	11.13	0.00	0.00	7.58	20.71				0.00	0.00
COMMUNITY	Hollybank*	23.23	18.2			12	90%		1.00	3.52	7.18	0.00	0.00	10.10	21.80		1.00	3.52	8.32	0.00	0.00	10.39	23.23	6.16	50.97%	0.89	1.14	0.29
						Divisional Total			1.00	3.52	7.18	0	0	10.10	21.80		1.00	3.52	8.32	0	0	10.39	23.23				1.14	0.29
																									TOTAL REQUEST		24.29	31.14

DIVISION OF MEDICINE AND LONG TERM CONDITIONS

WARD 1- Acute Older People

Ward 1 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout.

The nurse sensitive indicators for June 2022 are: 4.79 falls per 1000 bed days, 1 pressure ulcer, 1 medication error reported and no HCAI Incidents. Occupancy in June 2022 was 98%. There were 5 DOLS applications, 53 uses of cohort bays on days and 34 occasions where a 1:1 CSW was required.

This Establishment Review indicates the need for an increase of 2 CSW to the night shift which will result in staffing of:

Shift	RN	CSW
Day	6	5
Night	4	5

To facilitate the staffing numbers indicated in the review this requires an increase in the band 2 establishment:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	18.9	3.0	0.00	25.97	52.87
Total WTE difference required	0	0	0	0	0	5.37	5.37

Recommendation: The Nurse sensitive indicators are good – recommend no change to substantive staffing; continue to use temporary bank workforce for additional 1:1s as required and review approach to management of patients who traditionally require 1:1 care (learning the lessons from ward 2) – review in January 2023

WARD 2 –Combined medically fit/Acute Older People

Ward 2 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout and 1 side room also has limited visibility.

The nurse sensitive indicators for June 2022 are: 4.34 falls per 1000 bed days, with 1 pressure ulcer, 1 medication error reported and no HCAI Incidents. Occupancy in June 2022 was 93%. There was 1 DOLS applications, 65 uses of cohort bays on days and 17 occasions where a 1:1 CSW was required.

This Establishment Review indicates no change to the current budgeted establishment which will result in staffing of:

Shift	RN	CSW
Day	6	5
Night	4	3

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time. Review in January 2023.

WARD 3- Combined Medically Fit/ Acute Older People

Ward 3 is a 34 bedded unit based in the Modular block of the Main hospital and has 4 Side rooms. Bay 3 has limited visibility due to the ward layout.

The nurse sensitive indicators for June 2022 are: 7.73 falls per 1000 bed days, 0 pressure ulcers, 3 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was90%. There were 0 DOLS applications, 20 uses of cohort bays on days and 26 occasions where a 1:1 CSW was required.

This Establishment Review indicates the need for an increase of 1 CSW to the night shift which will result in staffing of:

Shift	RN	CSW
Day	6	5
Night	4	4

To facilitate the staffing numbers indicated in the review requires an increase in Band 2 establishment:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	18.9	3.0	0.00	20.6	47.5
Required WTE	1.00	4.0	18.9	3.0	0.00	23.38	50.28
Total WTE difference required	0	0	0	0	0	3.32	3.32

Recommendation: The nurse sensitive indicators demonstrate an increase in falls with other indicators being good. Recommend no change to substantive staffing; continue to use temporary bank workforce for additional 1:1s as required and review approach to management of patients who traditionally require 1:1 care (learning the lessons from ward 2) – review in January 2023

WARD 4- Combined Medically Fit/ Acute Older People

The current budgeted ward 4 is for 22 beds. In December 2021 the Trust approved a case which was presented by the division to substantively establish ward 4 as a 28 bedded ward. At the time of undertaking this skill mix review the budget has not been adjusted to reflect an establishment for 28 beds.

There is potential for the ward to increase capacity by 6 beds funded through winter monies. Throughout winter 2021/22 these additional beds were open. At the time of writing this report the ward remains open to 34 beds.

As the ward should be funded for 28 beds the SNCT data reported for June 2022 has been based upon this.

The ward has not previously included band 4 Nursing Associates within its establishment and the Division are keen to include the development of this within their workforce on Ward 4.

The nurse sensitive indicators for June 2022 are: 4.02 falls per 1000 bed days, 4 pressure ulcers, 4 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 96%. There was 1 DOLS applications, 58 uses of cohort bays on days and 36 occasions where a 1:1 CSW was required.

This Establishment Review indicates the need for Ward 4, a 28 bedded unit to be funded for staffing of:

Shift	RN	CSW
Day	5	5
Night	3	3

To facilitate the staffing numbers indicated in the review the budget should be aligned to reflect the 28 beds approved in the business case in December 2021. The skill mix should be adjusted to introduce the band 4 Nursing Associate role and there is a requirement to increase the band 2 establishment.

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE (aligns to staffing for 22beds)	1.00	2.52	9.71	0.00	0.00	17.68	30.91
Establishment agreed in Dec 2021 Business Case for 28 beds	1.00	2.52	17.28	0.00	0.00	12.63	33.53
Required WTE	1.00	2.52	14.11	3.00	0.00	20.78	41.41
Total WTE difference required	0	0	4.4	3.00	0	3.10	10.5

Recommendations: The nurse sensitive indicators demonstrate a reduction in falls since January 2022 whilst seeing an increase in pressure ulcers and medication incidents. Recommend align the budgeted establishment to that approved in December 2021 for 28 beds with change to skill mix by moving 3 WTE RN posts from the band 5 to band 4 Nursing associate posts. No change to the substantive band 2 staffing; continue to use temporary bank workforce for additional 1:1s as required and review approach to management of patients who traditionally require 1:1 care (learning the lessons from ward 2) – review in January 2023

WARD 5/6-AMU- Acute Medical Care

Ward 5/6 – AMU is a 45 bedded unit based in the West Wing of the Main hospital consisting of 2 wards, ward 5 has 3 bays with 6 beds, 1 bay of 3 beds and 3 side rooms, ward 6 has 3 bays of 6 beds and 3 side rooms.

The establishment review is requesting no change to the budgeted establishment as a separate business case has been approved in June 2022.

Recommendation: This establishment review indicates no change to the budgeted establishment for AMU as a separate business case has been approved.

WARD 7- Cardiology

Ward 7 is a 23 bedded unit based in the West Wing of the Main hospital site and has 5 monitored Coronary Care beds. The department has 3 side rooms of which 2 are not directly visible at the Nurses Station.

A significant requirement for this department is that they are required to attend out of hours cardiac arrest calls. Current Staffing for 3 RN on duty at night results in 2 RNs being left in the department when staff attend to cardiac arrest calls out of hours.

The division have reviewed the requirement for the need for and RN to attend cardiac arrests out of hours and it has been identified that this clinical requirement remains.

The nurse sensitive indicators for June 2022 are: 1.5 falls per 1000 bed days, with 3 pressure ulcers, 3 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 91%. There were no DOLS applications, 2 uses of cohort bays on days and 10 occasions where a 1:1 CSW was required during June 22.

This Establishment Review indicates the need for an increase of 1 RN to the night which will result in staffing of:

Shift	RN	CSW
Day	5	3
Night	4	2

To facilitate the staffing numbers required to support a member of staff attending cardiac arrests across the Trust at night, requires an increase of 2.43 band 5 RNs.

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	7.56	12.24	0.00	0.00	12.63	33.43
Required WTE	1.00	7.56	14.67	0.00	0.00	12.99	36.22
Total WTE difference required	0	0	2.43	0	0	0.36	2.79

Recommendations: Nurse sensitive indicators are good. Recommend increasing the band 5 RN workforce by 2.43 WTE to provide safe staffing at night.

WARD 15-General Medicine/ Diabetes/ Haematology

Ward 15 is a 28 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms.

The nurse sensitive indicators for June 2022 are: 2.38 falls per 1000 bed days, 1 pressure ulcer, 1 medication error reported and no HCAI Incidents. Occupancy in June 2022 was 97%. There were no DOLS applications, 36 uses of cohort bays on days and 11 occasions where a 1:1 CSW was required.

This Establishment Review indicates no change to the current budgeted establishment which will result in staffing of:

Shift	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Required WTE	1.00	4.0	15.0	2.00	0.00	18.0	40.0
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: no further action at this time. Review January 2023

WARD 16- Gastroenterology

Ward 16 is a 25 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms. This ward caters for Gastroenterology and general medical patients.

The nurse sensitive indicators for June 2022 are: 1.34 falls per 1000 bed days, 2 pressure ulcers, 2 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 99%. There were no DOLS applications, 41 uses of cohort bays on days and 24 occasions where a 1:1 CSW was required.

This Establishment Review indicates the need for movement of Band 4 funds to Band 5 but no change to the current staffing levels which will remain at:

Shift Mon-Fri	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers requested, the budgeted establishment will require the move of 1 WTE Band 4 to the Band 5 establishment:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	3.0	15.0	3.0	0.00	17.0	39.10
Required WTE	1.00	3.0	15.67	2.0	0.00	17.0	38.77
Total WTE difference required	0	0	0.67	-1.0	0	0	-0.33

Recommendation: Nurse sensitive indicators are good. Recommend no change to current establishment. Division to review band 4 Nursing Associate roles to ensure working within full scope. Review January 2023

WARD 17- Respiratory

Ward 17 is a 25 bedded unit based in the West Wing of the Main hospital site and has 4 side rooms, 3 of which have limited visibility from the Nurses Station.

The nurse sensitive indicators for June 2022 are: 0 falls per 1000 bed days, 3 pressure ulcers, 3 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 100%. There were no DOLS applications, 4 uses of cohort bays on days and 7 occasions where a 1:1 CSW was required.

A recent temporary request for uplift to staffing, which was supported by the Director of Nursing has improved quality indicators and staff morale within the department- 3 senior staff left at the end of 2021 citing stress and work-related activities as a reason for departure. Data from the department demonstrates an improvement with outcomes since the temporary change to the skill mix.

In the January 2022 review it was identified there was a need to increase the band 5 RN and band 2 CSW establishments. The recommendation at the time was to confirm and validate the figures in June 2022.

This Establishment Review indicates the need for an increase of 1 RN for the day shift and 1 CSW for the 24-hour period, which will result in staffing of:

Shift	RN	CSW
Day	5	4
Night	4	3

To facilitate the staffing indicated in the review requires an increase in band 5 RN and band 2 CSWs

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	5.20	12.80	3.00	0.00	12.90	34.90
Required WTE	1.00	5.20	14.03	3.00	0.00	18.18	41.41
Total WTE difference required	0	0	1.23	0	0	5.28	6.51

Recommendation: Nurse sensitive indicators have improved since the temporary uplift in staffing. Recommend substantively increasing establishment by 1.23 WTE Band 5 RNs and 5.28 WTE CSWs

WARD 29- Acute Medical

Ward 29 is a 36 bedded unit based in the Modular block of the Main hospital and has 6 side rooms. The client group is acute short stay medicine.

The nurse sensitive indicators for June 2022 are: 2.96 falls per 1000 bed days, 1 pressure ulcer, 1 medication error reported and no HCAI Incidents. Occupancy in June 2022 was 96%. There were no DOLS applications, 18 uses of cohort bays on days and 26 occasions where a 1:1 CSW was required.

This Establishment Review indicates no change to the current budgeted establishment and staffing numbers will remain as:

Shift	RN	CSW
Day	6	4
Night	5	4

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.0	19.7	5.0	0.00	20.6	50.3
Required WTE	1.00	4.0	19.7	5.0	0.00	20.6	50.3
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time. Review in January 2023.

DIVISION OF SURGERY

WARD 10- Trauma

Ward 10 is a 27 bedded unit based in the West Wing of the Main hospital site and has 3 side rooms.

Ward 10 is the Trauma ward within the hospital accepting admissions for fractured neck of femur as part of their cohort.

The nurse sensitive indicators for this area are: 6.34 falls per 1000 bed days, 0 pressure ulcers, 0 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 100%. There were no DOLS applications, 8 uses of cohort bays on days and 14 occasions where a 1:1 CSW was required.

At the establishment review in June 2021 and the subsequent paper approved by Trust board ward 10 required 5 RNs and 4 CSWs during the day and 3 RNs and 3 CSWs at night. However, it has been identified that the budgets were not adjusted appropriately following the June 2021 review and therefore an adjustment of 2.35 RNs and 3,03 CSWs is required to reflect the previously agreed establishments. This was reported following the January 2022 establishment review and remains outstanding.

This Establishment Review of June 2022 indicates no change to the establishment and staffing numbers previously agreed in June 2021 and will remain as:

Shift	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers requested the budgeted establishment is requested to remain as:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.52	9.82	4.94	0.00	15.15	33.43
Required WTE	1.00	2.52	12.17	4.94	0.00	18.18	38.81
Total WTE difference required	0	0	2.35	0	0	3.03	5.38

Recommendation: No change from the establishment agreed in June 2021. Further review in January 2023.

WARD 11- Complex Surgery

Ward 11 is a 25 bedded unit based in the West Wing of the Main hospital site and has 3 side rooms with limited visibility to 2 side rooms.

The nurse sensitive indicators for June 2022 are: 1.36 falls per 1000 bed days, 1 pressure ulcer, 1 medication error reported and 2 cases of C-Difficile. Occupancy in June 2022 was 100%. There were no DOLS applications, no use of cohort bays on days and 1 occasion where a 1:1 CSW was required.

This Establishment Review indicates an increase of 1 RN to the day shift and 1 CSW to the night shift which will result in staffing of:

Shift	RN	CSW
Day	5	4
Night	3	3

To facilitate the staffing numbers indicated, the WTE Change requested for this department is:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.60	14.76	1.00	0.00	15.15	34.51
Required WTE	1.00	2.60	16.03	1.00	0.00	18.18	38.81
Total WTE difference required	0	0	1.27	0	0	3.03	4.30

Recommendation: The nurse sensitive indicators are within range. Recommend no change to current establishment. Review January 2023

Ward 12-Emergency Surgery

Ward 12 is a 27 bedded unit based in the West Wing of the Main hospital site and 3 side rooms with limited visibility to 2 side rooms. Ward 12 is the emergency surgical admission route for the Trust. The assessment area SNCT measures have been used for this department.

The nurse sensitive indicators for June 2022 are: 4.02 falls per 1000 bed days, 3 pressure ulcers, 3 medication errors reported and no HCAI Incidents. Occupancy in June 22 was 94%. There were no DOLS applications, 9 uses of cohort bays on days and 11 occasions where a 1:1 CSW was required.

Wards 11 and 12 were historically managed as one ward (ASU) with a single budget. Following a reconfiguration over a year ago ward 11 became a complex surgical ward and ward 12 the emergency surgical ward. At the point of this change being made the budgets and establishments were split. The decision on allocation of the budget between the two wards was not based on the acuity or dependency of patients or any other nurse sensitive indicators.

Ward 12 is currently staffed to 5 RNs and 4 CSWs during the day and 4 RNs and 2 CSWs at night. This was approved at the June 2021 review and there is no change required following this establishment review. The current budget following the split from ward 11 does not align

to the approved safe staffing levels, with a deficit on the budget lines on 8.80 WTE Band 5 RNs and 8 WTE band 2 CSWs and this needs resolving. This was reported following the January 2022 review and remains outstanding.

This Establishment Review indicates staffing to remain as:

Shift	RN	CSW
Day	5	4
Night	4	2

To facilitate the staffing numbers indicated the budget will need to be aligned to:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	2.00	10.43	1.00	0.00	7.58	22.01
Required WTE	1.00	2.00	19.23	1.00	0.00	15.58	38.81
Total WTE difference required	0	0	8.80	0	0	8.0	17.8

Recommendation: No change to current staffing levels. Review in January 2023.

Ward 20a-Elective Surgery

Ward 20a plus 20b is a 28 bedded unit based in the Main hospital, but the layout of the area means there is an expansive floor area of cover. Ward 20a has 16 beds with 8 side rooms. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department.

The combined department has a bay of 4 Enhanced Recovery beds which are in use as per national guidelines to support patients who may otherwise require Intensive Care support. Since the reintroduction of elective activity as part of the post pandemic elective recovery plans the department has been used to its full potential and is influencing positive outcomes for surgical recovery. A separate business case will be developed to support the future of enhanced recovery.

The nurse sensitive indicators for June 2022 are: 8.51 falls per 1000 bed days, 0 pressure ulcers, 0 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 95%. There were no DOLS applications, no use of cohort bays on days and 9 occasions where a 1:1 CSW was required.

This Establishment Review indicates staffing to remain as:

Ward 20a			Enhanced recovery		
Shift	RN	CSW	Shift	RN	CSW
Day	4	4	Day	1	1
Night	3	2	Night	1	1

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	4.32	21.34	1.00	0.00	20.21	47.87
Required WTE	1.00	4.32	21.34	1.00	0.00	20.21	47.87

Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time. Review in January 2023.

DIVISION OF WOMENS AND CHILDRENS

WARD 23-Gynaecology

Ward 23 is an 8 bedded unit based in the Main hospital site and this area delivers gynaecological care. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department. The department also support the Gynaecology Assessment Unit with CSW cover at weekends.

The nurse sensitive indicators for June 2022 are: 0 falls per 1000 bed days, 0 pressure ulcers, 0 medication errors reported and no HCAI Incidents. Occupancy in June 22 was 68%. There were no DOLS applications, no uses of cohort bays on days and no occasions where a 1:1 CSW was required.

This Establishment Review indicates no change to the establishment and staffing to remain as:

Shift	RN	CSW
Day	2	1
Night	2	1

To facilitate the staffing numbers requested the budgeted establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Required WTE	1.00	1.00	11.13	0.00	0.00	7.58	20.71
Total WTE difference required	0	0	0	0	0	0	0

Recommendation: No further action at this time. Review in January 2023.

DIVISION OF COMMUNITY

Hollybank House - Stroke Rehabilitation

Hollybank is a 12 bedded unit based off site in Willenhall. There is limited visibility of all bays from the main desk due to the unit layout. Though the SNCT has been used to measure in this department, its use is not recommended as a tool of choice due to the low number of beds in the ward. Professional Judgement weighs heavily in the decision making for this department.

The nurse sensitive indicators for June 2022 are: 8.88 falls per 1000 bed days, 0 pressure ulcers, 0 medication errors reported and no HCAI Incidents. Occupancy in June 2022 was 90%. There were no DOLS applications, no uses of cohort bays on days and no occasions where a 1:1 CSW was required.

This Establishment Review indicates no change to the establishment and staffing remains as:

Shift	RN	CSW
Day	3	2
Night	2	2

It has been identified through the establishment review process that the budget for the required establishment was not aligned when the stroke unit was moved from MLTC to the community division and this needs addressing separately.

To facilitate the staffing numbers requested the establishment is requested to remain at:

	Band 7	Band 6	Band 5	Band 4	Band 3	Band 2	Total Budgeted WTE
Current WTE	1.00	3.52	7.18	0.00	0.00	10.10	21.80
Required WTE	1.00	3.52	8.32	0.00	0.00	10.39	23.23
Total WTE difference required	0	0	1.14	0	0	0.29	1.43

Recommendation: No further change at this time. Review January 2023

Recommendations to Trust Board following completion of the skill mix review in June 2022

The skill mix review was undertaken in June 2022 when the Trust was still experiencing the impact of Covid-19 and seeing increases in the number of people attending the Emergency Department requiring admission and increased bed occupancy. Skill mix reviews are undertaken every six months and the next review will take place in January 2023.

The Director of Nursing recommends the following:

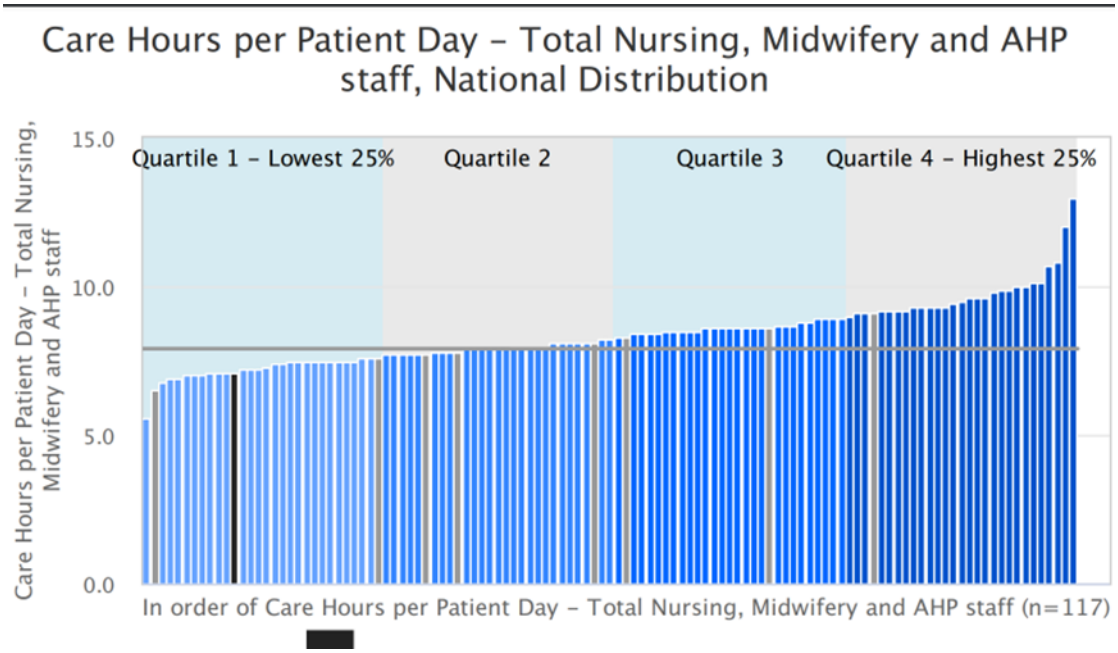
- Increase the establishments on ward 7 and 17 as indicated in this paper. This will see a total increase of 3.66 WTE band 5 RNs and 5.28 Band 2 CSWs

TRUST CARE HOURS PER PATIENT DAY (CHPPD).

An additional part of the skill mix review has been to use data available on the Model hospital to benchmark the Trust position with CHPPD (graph 4) . No updated chart was available in Model Hospital

Graph 4 shows the most recent Model Hospital position (Dec21) of the Trust CHPPD both nationally and with peers, the Trust value is 7.1 against a national value of 8.2 or peer median of 7.9

Graph 4 – Care Hours per Patient Day – Total Nursing/Midwifery and AHP staff



APPENDIX 1

Levels of acuity and dependency

Level 0: Patient requires hospitalisation. Needs met by provision of normal ward cares.

•Elective medical or surgical admission

•May have underlying medical condition requiring on-going treatment

•Patients awaiting discharge

•Post-operative / post-procedure care - observations recorded half hourly initially then 4-hourly

•Regular observations 2 - 4 hourly

•**Early Warning Score** is within normal threshold.

•ECG monitoring

•Fluid management

•Oxygen therapy less than 35%

•Patient controlled analgesia

•Nerve block

•Single chest drain

•Confused patients not at risk

•Patients requiring assistance with some activities of daily living, require the assistance of one person to mobilise, or experiences occasional incontinence

Level 1a: Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate

Increased level of observations and therapeutic interventions

•Early Warning Score - trigger point reached and requiring escalation.

•Post-operative care following complex surgery

•Emergency admissions requiring immediate therapeutic intervention.

•Instability requiring continual observation / invasive monitoring

•Oxygen therapy greater than 35% + / - chest physiotherapy 2 - 6 hourly

•Arterial blood gas analysis - intermittent

•Post 24 hours following insertion of tracheostomy, central lines, epidural or multiple chest or extra ventricular drains

•Severe infection or sepsis

Level 1b: Patients who are in a STABLE condition but are dependent on nursing care to meet most or all the activities of daily living.

•Complex wound management requiring more than one nurse or takes more than one hour to complete.

•VAC therapy where ward-based nurses undertake the treatment

•Patients with Spinal Instability / Spinal Cord Injury

•Mobility or repositioning difficulties requiring the assistance of two people

•Complex Intravenous Drug Regimes - (including those requiring prolonged preparatory / administration / post-administration care)

•Patient and / or carers requiring enhanced psychological support owing to poor disease prognosis or clinical outcome

•Patients on End-of-Life Care Pathway

•Confused patients who are at risk or requiring constant supervision

•Requires assistance with most or all activities of daily living

•Potential for self-harm and requires constant observation

•Facilitating a complex discharge where this is the responsibility of the ward-based nurse

Level 2: May be managed within clearly identified, designated beds, resources with the required expertise and staffing level OR may require transfer to a dedicated Level 2 facility / •Deteriorating / compromised single organ system

•Post-operative optimisation (pre-op invasive monitoring) / extended post-op care.

•Patients requiring non-invasive ventilation / respiratory support; CPAP / BiPAP in acute respiratory failure

•First 24 hours following tracheostomy insertion

•Requires a range of therapeutic interventions including:

•Greater than 50% oxygen continuously

•Continuous cardiac monitoring and invasive pressure monitoring

•Drug Infusions requiring more intensive monitoring e.g., vasoactive drugs (amiodarone, inotropes, GTN) or potassium, magnesium

•Pain management - intrathecal analgesia

•CNS depression of airway and protective reflexes

•Invasive neurological monitoring unit

Level 3: Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

•Monitoring and supportive therapy for compromised / collapse of two or more organ / systems

•Respiratory or CNS depression / compromise requires mechanical / invasive ventilation

•Invasive monitoring, vasoactive drugs, treatment of hypovolaemia / haemorrhage / sepsis or neuro protection.

APPENDIX 2

Nurse Sensitive Indicators

Formal complaints

Registered complaints about nursing/midwifery care/staff in the following three areas:

- Communication
- Clinical care
- Attitude

Medication Errors

Actual medication errors where nursing was the primary cause

Infection

Incidence rates of MRSA bacteraemia and Clostridium Difficile

Slips, trips and falls

Number of slips, trips and falls

Pressure Ulcers

Prevalence of pressure ulcers developed in hospital

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h. The Safer Nursing Care Tool The Shelford Group – 2013 http://shelfordgroup.org/resource/chief-nurses/safer-nursing-care-tool http://shelfordgroup.org/library/documents/SNCT A4 pdf

i. Developing Workforce Safeguards – 2018 NHSI.

Health Education England

Lisa Carroll
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14th September 2022

Dear Lisa,

Re: Training in Adult Nursing at Walsall Healthcare NHS Trust.

Further to the recent action plan which was submitted by the Trust in response to the November 2021 National Education and Training Survey (NETS) results for Adult Nursing at Walsall Healthcare NHS Trust, we write to you to confirm that based on the positive findings and the robust actions in place which have been shared with Health Education England (HEE), this item has been reduced from Intensive Support Framework Category 2 to ISF Category 1, and removed from the HEE Quality Improvement Register.

The programme will continue to be monitored through the HEE Regional Clinical Nursing Team and standard quality processes in line with HEE's Quality Framework and Strategy.

If you have any questions in the meantime, please do not hesitate to contact us via the Quality mailbox on quality.me@hee.nhs.uk.

I would like to thank you for your continuing engagement with our quality processes.

Yours sincerely,

Dr Russell Smith
Postgraduate Dean, West Midlands

cc. Carol Love-Mecrow, Regional Head of Nursing & Midwifery

MEETING OF THE TRUST BOARD – in Public – 5 October 2022			
Complex Case Review Update Brief			
Report Author and Job Title:	Dr Manjeet Shehmar Chief Medical Officer	**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 Complex Case Assurance Group agreed a proposal option to operationally manage a patient review and recall. • Patient letters have been posted • A helpline and email address has been set up for patients, staff and others who may have concerns • Trust communication has been shared • Training has been provided to helpline staff		
Advise	• A Complex Case Assurance Group this group was created to advise and monitor the complex patient review and recall, offers support, and will escalate concerns to the Trust Board as and when required. • There has been a media release via BBC news naming the Consultant surgeon. The Trust has provided interview for the report which included patient stories both from WHCT and the Private Sector. Staff have been briefed and signposted to support • NHSE, CQC, CCG and the Spire are working collaboratively via the Assurance Group. • A new risk will be set up to represent this programme of work.		
Alert	• Up to 600 patients will need review of notes and a project team will need to be set up to manage and deliver this. • Clinics will need to be set up for those patients who need further review as well as referral pathways for treatment both at WHCT and externally at other relevant centres.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high-quality care		
Resource implications	The recall project will require circa £XXX of resource.		
Legal and/or Equality and Diversity implications	There are no legal or equality & diversity implications associated with this brief		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Complex Case Review Update -Brief

1. PURPOSE OF REPORT

The purpose of the brief is to provide the Trust Board with an update of the progress made since last Trust Board report.

2. BACKGROUND

WHT formed a Complex Case Assurance Group which is supported by a Complex Case working group. Since approval of the governance structure of the complex case recall project, the group have identified key milestones to progress next steps.

There was a media release by BBC on Monday 26th September which included patient stories both from WHCT and the Spire Private Hospital at Little Aston. The media release named the surgeon as Mr Mian Munawer Shah. WHCT CEO and CMO were interviewed for this release and Mr Shah was contacted for his comments via his legal representative. Mr Shah's Trust mentor and wellbeing support has also been in contact with him to offer support.

3. DETAILS

A proposal of the next steps to recall the patients who have been treated under the care of Mr Shah Orthopaedic Consultant was agreed by the Complex Case Assurance Group.

An external clinical lead with expertise in patient review and recall has been recruited. Based the findings and recommendations of all reviews and investigations so far and surgery procedure codes, patient selection has been agreed. Patients who had upper limb procedures, in particular shoulder surgery were found to be most at risk of complications and harm. Patients who had lower limb surgery and those under the age of 18 were found to be lowest at risk. The following procedures have been identified for review:

- Latarjet
- Shoulder replacement
- Replacement of humeral head
- Elbow replacement
- All hand and wrist fusion surgery

The review and recall process has identified up to 600 patients who have had upper limb surgery performed by Mr Shah. The review will be performed in cohorts of 3 year blocks working back in time to 2010. There is an assumption that the likelihood of problems from surgery will have been identified the further back the surgery was undertaken. The year 2010 has been chosen because this is when activity data shows Mr Shah started to perform these types of surgeries. The aim of the review and recall is to address any clinical needs the patients may have and to recognise learning. The

process of medical records review will be undertaken by four external consultants with speciality in peer review and upper limb surgery. Approval from the relevant professional societies has been requested. A clinical harms framework for how the patients would be triaged has been agreed based on NHS Harm Levels. The notes reviews will determine which patients need to come back to clinic if they need a telephone review or just reassurance. All patients will have a letter to communicate all findings of the review of their case. A project group and staffing for clinics needs to be supported. NHSE have approved the methodology via the Assurance Group. The review will be continually evaluated and we will make sure that if any other patients need to be included that this will be done and communicated with patients.

Progress on patient review and recall

- Letters to patients have been posted on Monday 27th September
- A press release statement has been issued and available on the Trust Website
- A helpline phone number and email has been set up
- Staff briefing has been delivered through a teams meeting to the staff who have worked with Mr Shah or in the trauma and orthopaedic team. This was delivered by the CMO, CEO, Director for Communications and supported by the Director for People & Culture.
- Training has been provided to the helpline staff
- A log of all calls and themes will be made and form part of the review project for analysis and address
- A new risk will be added to the Trust Risk Register around the patient review and recall programme.

Financial requirements

Trust Board are asked to note that the resource implications to support this project are circa £659,459.

4. RECOMMENDATIONS

Trust Board are asked to note this report.

Trust Board/Committee/Group Chairs Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Charitable Funds Committee
Date(s) of Committee/Group Meetings	12th September 2022
Chair of Committee/Group:	Paul Assinder
Date of Report:	27th September 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• The Charity is, in part, reliant upon its portfolio of investments to generate income. With the recent conflict in Ukraine and subsequent economic sanctions, coupled with more interventionist economic measures instituted by the UK Government, the international markets and thus our portfolio, will be subject to volatility in the coming months. • The Charity employs professional Investment Managers to advise upon the ethical investment of surplus funds. The value of the investments held by Brewin Dolphin on our behalf as at 30th June 2022 was £694,000. • The overall movement in the book value of investment during the past 12 months was a reduction of c11%. However, the Fund had a yield of c2.5% (£17,000).

ADVISE
Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought
	One of the principal roles of the Charitable Funds Committee is to scrutinise the spending bids against the Charitable fund to ensure these comply with the objects of the Charity.
	
	• The Committee scutinised bids approved by Fund Managers (under £5,000) under delegated authority during Q1 (April to June) of £9,516.
	
	• The Committee considered and approved three bids for expenditure above £5,000 but below £100,000:
	  • Long Service Awards £12,614
	  • An End of Life Training Package £33,432
	  • Equipment for a staff catering outlet at the Manor £20,114
	
	• There were no bids for expenditure over £100,000 – for referral to the Full Board.

ASSURE
Positive assurances & highlights of note for the Board/Committee
	• The Charity's excellent fundraising activity programme continues to be successful and popular. For the June – August Quarter, of note are:
	  • The Big Tea and NHS 74th Birthday activities
	  • The incredibly generous bequest of £130,000 from the estate of a former patient, Mr Patel.
	  • The inclusion of Well Wishers as a prime Mayor's Charity for 2022/23 and a visit from the Mayor.
	
	• Future activities to note are:

	• 8th October Football Match at Silverdale FC • 14th October Boxing Evening at Rushall Club • Quiz Evening at the Bell Inn Walsall • For the period 1st April to 30th June 2022, the Charity Fund increased by £3,000 and stood at £1,197,000 at the period end. Current future spending commitments are £152,286, against this fund.
Recommendation(s) to the Board/Committee	The Board of Trustees is asked to note this report
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)**	None
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	None
ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	Not Applicable
Matters presented for information or noting	None
Self-evaluation/ Terms of Reference/ Future Work Plan	**Well Wishers Events Programme 2022** • Boxing Event 14th October Rushall Labour Club • Make a Will Fortnight November (TBC) Enoch Evans • Quiz November (TBC) The Bell, Walsall • Trust got Talent & Christmas Party 16th December Rushall Labour Club • Christmas Celebrations 2nd December onwards Manor site
Items for Reference Pack	

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD **5th October 2022**			
Walsall Together Partnership Board Highlight Report			
Report Author and Job Title:	Rachael Gallagher, Personal assistant, Walsall Together	**Responsible Director:**	Patrick Vernon, Chair, Walsall Together
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☐		
Assure	• Pressures experienced across discharge pathways, as a result of increased numbers of out of area patients, are being addressed through partnership working with neighbouring places in the Black Country and Staffordshire • A revised implementation timeline for the Integrated Shared Care Record is in development, following delays across the Black Country. The Board was assured on the rationale for the delays and expects an updated timeline by the end of November.		
Advise	• The Walsall Together Partnership Board met on Wednesday 21st September 2022, chaired by Professor Patrick Vernon		
Alert	• The Board a new risk would be added to the partnership risk register relating to the delays to several areas of non-recurrent funding from the ICB and the potential impact on developing robust plans for Winter. • The board approved a high-level model for development of Place Based Governance arrangements in line with the Health & Care Act 2022 and Integration white paper. Further details are contained in the Care at Home report.		
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	None		
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 ☐		

Walsall Together Partnership Board
Highlight Report
September 2022

1. PURPOSE OF REPORT

This report provides an overview of the key items discussed at the Walsall Together Partnership Board at its meeting on Wednesday 21st September 2022.

The Chair of the meeting was Professor Patrick Vernon.

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. The Walsall Together Partnership Board is a sub-committee of the Walsall Healthcare Trust Board.

3. BOARD HIGHLIGHTS

The following sections provide a summary of the key agenda items discussed.

3.1. Operational Update:
August has seen an increased delay in discharges for out of areas patients. The issue is being addressed and connections have been made with neighbouring Trusts to address the issue. The funding of virtual wards is another area to highlight within the report.

3.2. Cost of Living:
A comprehensive report was shared with board members on the cost-of-living crisis drafted by the Resilient Communities Steering Group. The paper detailed areas and schemes that the partnership can link into for little or no funding and additional schemes where funding was requested. The paper highlighted the high levels of deprivation within the borough and how to date government interventions will have little impact for the residents and communities.

The paper included priorities and principles with support and dignity at the heart of the suggestions. A recommendation to board was made to approve the following schemes, Food clubs, Growing healthy in Walsall, Library of things and warm hubs. The board had an in-depth conversation on the proposal, and it was agreed to provide residents with coordinated communications of where and what support is available, to explore the flexibility of local funding across partners to support the schemes and therefore the paper was approved by the board.

3.3. User Story: The Board were presented with a user story from a couple from Darlaston who between them have established 2 support groups for the community. Those groups are an amputee support group and a diabetes group. The couple shared their personal experiences of dealing with amputation, diabetes and the lack of support available from statutory services. The group works with amputees and their families

providing practical and emotional support and have an ambition of extending their reach with the help of the partnership. A request was made to help with sharing and promoting their groups within GP surgeries, help upgrading their website, and potentially help creating a signposting directory. The board agreed to help where possible and agreed that an agenda item to explore diabetes is required.

3.4. Transformation Report:
The board received assurance that the transformation programme is making progress and that there are no new risks to report and of the 2 outstanding programmes in exception there will be a detailed update on the Shared Care Record.

3.5. Shared Care Record Update:
Board was given an update on the delays to the implementation of the Shared Care Record. Colleagues from the ICB were in attendance to explain the delays. Several components are required to ensure the legal implications are addressed and successful execution of the plan. Walsall are ahead of neighbouring localities and have completed all their sign up and members requested a revised timeline of implementation. The board were reassured that implementation is very close and updates will be given as soon as available.

3.6. Communications Brief:
The monthly communication brief was approved for circulation subject to the addition of including an update on the cost-of-living crisis.

3.7. Place Based Governance:
Board was presented with an update on the place-based government arrangements. After discussions with board members recommendations was finalised and the final draft was presented for approval of the board. The board approve for the model to be taken to the ICB board for their approval.

3.8. Items for Escalation:
The Board discussed the delays to several areas of non-recurrent funding from the ICB and the potential impact on developing robust plans for Winter. It was agreed that a new risk would be added to the partnership risk register and discussed at the Walsall Healthcare Risk Management Executive in October.

4. RECOMMENDATIONS

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

MEETING OF THE WALSALL HEALTHCARE TRUST BOARD – Wednesday 5th October 2022			
Care at Home Report			
Report Author and Job Title:	Michelle McManus, Director of Transformation & Place Development	**Responsible Director:**	Matthew Dodd, Director of Integration
Recommendation & Action Required	**Members of the Trust Board are asked to:** **Approve** ☐ **Discuss** ☐ **Inform** ☒ **Assure** ☒		
Assure	• ***Service pressures:*** continue to impact on Community Services with mitigating actions having been implemented. Demand on locality teams increased in month but they were able to meet 89% of demand. • ***Avoiding Hospital Admissions:*** Services such as the Integrated Assessment Hub, Care Navigation Centre and Rapid Response continued to have a positive impact in reducing numbers of admissions to Walsall Manor Hospital. The CNC received 1,207 calls in August which were from patients and care professionals seeing advice & care rather than attending Walsall Manor Hospital		
Advise	• ***Health Visiting:*** A prioritisation & recovery plan was submitted to the Walsall Safeguarding Board in August and recommendations were made around assessment of risk and timescales. • ***Walsall Together:*** The Walsall Together Partnership Board and Walsall Joint Commissioning Committee have agreed a high-level model for place-based governance		
Alert	• ***Medically Stable for Discharge:*** The number of patients in Walsall Manor Hospital who live outside Walsall and who require complex discharge support increased during July and August. The Trust service does not directly manage the whole pathway for these placements and is dependent on the response by the resident authority. This has contributed to greater pressure on the hospital system and ambulance turnaround times • ***System Pressure Funding:*** Community's ability to fully prepare for anticipated system pressures is becoming a risk, due to delays in the ICB confirming investment for out of hospital activity this winter		
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

October 2022

1. PURPOSE OF REPORT

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

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 6,421 hours of care, while the Care Navigation Centre saw a sustained high level of demand with 1,207 calls.

3.2 Capacity:
Locality Teams: The Locality Community Teams met 89% of the demand in August, 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.

Health Visiting: The service is experiencing operational difficulties as Health Visitor numbers are at c50% of their established work force. A prioritisation & recovery plan was submitted to the Walsall Safeguarding Board in August and recommendations were

made around assessment of risk and timescales. Further work is now planned jointly with Public Health and the Director of Walsall Right for Children Early Help and Partnerships.

Discharge & Step-Up Pathways: The number of people at Walsall Manor Hospital who were medically stable for discharge increased from 50 in June to 55 in July and 52 in August. The number of patients in Walsall Manor Hospital who live outside Walsall and who require complex discharge support increased during July and August. The Trust service does not directly manage the whole pathway for these placements and is dependent on the response by the resident authority. This has contributed to greater pressure on the hospital system and ambulance turnaround times. The matter has been escalated to the ICB and the Trust Director of Integration has been asked to lead a system-wide response.

Systems Pressure Plan: The Partnership awaits decisions around funding for out of hospital developments from the Service Development Fund, Ageing Well allocation and Community Services investment budget. The Partnership's capacity to fully prepare for anticipated system pressures this winter is becoming a risk, due to these delays.

4. RISK REGISTER

The overall risk score on the Care at Home Board Assurance Framework (BAF) remains at level 12. The BAF remains under review by the partnership and in parallel to the review of the Trust Strategy. It will also be reviewed in the context of the risks identified regarding funding to support winter pressures.

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.

5. PLACE-BASED PARTNERSHIP DEVELOPMENT

The Walsall Together Partnership Board and Walsall Joint Commissioning Committee have agreed a high-level model for place-based governance, in alignment with the original direction of travel outlined in the Walsall Together business case; the Health & Care Act 2022; and the policy white paper *Health and social care integration: joining up care for people, places and populations* (February 2022). These proposals build on existing arrangements and seek to increase the level of collaboration on both strategic planning and delivery of integrated health and care.

Building on existing joint commissioning arrangements, we are requesting formal delegation of responsibilities from the Integrated Care Board (ICB) and the Council (Cabinet/HWB) to a newly established Place Integrated Commissioning Committee (PICC), for services agreed to be in scope for 'control' ('control' defined as shaping service models, managing delivery, and redistributing system-allocated resource) at place.

The Health & Wellbeing Board will set the medium to long-term ambition and priorities for health and wellbeing in the Borough, also feeding into the Black Country Integrated Care Partnership strategy. The PICC will translate the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy into an Outcomes Framework.

Statutory commissioning responsibilities will be retained by the Place Integrated Commissioning Committee (PICC), which will be separate to the Walsall Together partnership. Legally, the PICC will need to report into the ICB for NHS expenditure and the Cabinet for the Council elements. However, greater collaboration on several processes traditionally associated with and undertaken solely by commissioning will be formally transferred to the Walsall Together partnership, to increase the level of collaboration across all partners including providers.

Inherent in the development programme is the recognition that moving to a more collaborative model brings some risks regarding how to manage conflicts of interest and to ensure transparency. While these risks are not unique to collaborative models, they demand careful management and formal structures to support collaborative service planning. This involves building mutual understanding between local commissioner and provider leaders, a process which takes time but is essential. Developing shared views and understanding among senior leaders goes alongside a wider process of change for operational staff that focuses on supporting them to work more effectively with colleagues in other local organisations. Within Walsall, 'System Leadership' (focussed on leading across local organisational/sector boundaries) is a workstream in our Place Development Programme. The scope will include Walsall Together partners and wider commissioning teams to ensure we role-model the collaborative values that have delivered benefits to date.

This current iteration of governance proposals is seeking agreement in principle to establish the key governance groups identified in the model described above. There remains a substantial amount of detail to work through in the coming months. This work will include a review of the governance between Walsall Healthcare Trust Board and the Walsall Together Partnership; key executives from Walsall Healthcare are engaged in this process.

6. RECOMMENDATIONS

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

APPENDICES

Appendix 1: Operational Performance Report for August 2022: Walsall Together

Walsall Together

Walsall Together Partnership Operational Update: September 2022

Matthew Dodd
Director of Integration

Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0

Tier	Activity	Thresholds			Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jun-22	Jun-22
Tier 0: Resilient Communities											
Social Prescribing	whg - No. referrrals received				47	43	33	32	33	35	34
	Primary Care - % referrrals received East 1	<0.4%		>=0.4%							
	Primary Care - % referrrals received East 2	<0.4%		>=0.4%							
	Primary Care - % referrrals received North	<0.4%		>=0.4%							
	Primary Care - % referrrals received South 1	<0.4%		>=0.4%							
	Primary Care - % referrrals received South 2	<0.4%		>=0.4%							
	Primary Care - % referrrals received West 1	<0.4%		>=0.4%							
	Primary Care - % referrrals received West 2	<0.4%		>=0.4%							

	Activity in-month	Thresholds			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	Jul-22	Aug-22
Workforce: Anchor institutions	No. staff employed by whg via scheme									68	No data receieved	75	79	86	96	96	100	108	98
	% whg customer's									38%	No data receieved	37%	37%	38%	39%	38%	38%	38%	38%

[Emergent] Score Card for WT Tiers – Tiers 1

Walsall Together

Tier	Activity in-month	Thresholds			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	Jul-22	Aug-22
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services																			
Community Services	Hours delivered by Locality teams	<5525	5525-6500	>6500	5576	6574.25	5945.25	5769.75	6038	6127	7015.75	6228.5	5210.5	5713.5	5495.25	6452.75	5871.5	5638	5688.25
	Hours cancelled by Locality teams	>1350	1147-1350	<1147	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	950.00	733.25
	% of hours demand unmet	>23%	20%-23%	<20%	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%	14.4%	11.4%
Multidisciplinary Team(MDT)	No. MDTs held	<20	20-24	>24	27	25	26	26	22	26	24	26	23	25	25	26	28	27	27
	No. referrrals received	<100	100-200	>200	37	26	26	34	26	30	27	25	24	22	19	30	39	25	29
	No. cases reviewed	<100	100-200	>200	40	90	96	92	88	120	103	108	89	117	83	102	142	129	107
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).				2.9%	2.9%	3.1%	3.1%	3.2%	3.4%	3.3%	3.3%	3.3%	3.6%	3.8%	4.0%	3.9%	4.0%	4.0%
	1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).				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%	85.5%	85.8%
	2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	<9.1		>= 9.1	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	3.6	5.4
	2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	<671.8		>= 671.8	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	172.3	221.8
	2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	<85%		>=85%	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%	82.2%	77.7%
	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				550	553	617	661	695	738	724	831	718	930	905	939	989	1063	1012
	Care and Support Assessments and 3 Conversations Completed - Total				343	346	341	346	287	313	292	296	429	316	280	327	358	285	355
	Monthly Adult contacts completed by Team				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	1,148	1,172
	Total Initial & Subsequent Reviews Completed				334	327	268	290	290	268	249	288	304	372	265	241	267	288	

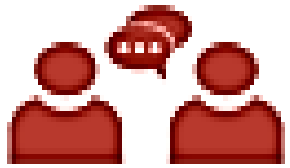
[Emergent] Score Card for WT Tiers – Tier 2/3

Walsall Together

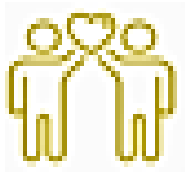
Tier	Activity in-month	Thresholds			Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Tier 2: Specialist Community Services																			
ASC Safeguarding Concerns	Concerns received				307	315	258	286	316	297	265	291	336	323	284	381	354	322	388
	Concerns progressing to s42 eqnuiry				83	88	66	81	87	79	83	73	91	79	76	61	65	56	45
	% of concerns progressing to s42 enquiry				27%	28%	26%	28%	28%	27%	31%	25%	27%	24%	27%	16%	18%	17%	12%
	Safeguarding cases in progress				15	36	20	17	35	31	7	34	86	63	80	84	129	97	120
Tier	**Activity in-month**	**Thresholds**			**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**	**Jul-22**	**Aug-22**
Tier 3: Intermediate Care, Unplanned Care & Crisis Services																			
Care Navigation Centre	Calls received	<435	435-512	>512	747	821	840	869	925	861	1094	1225	1170	1338	1278	1270	1307	1323	1207
Rapid Response Team	Referrals received	<160	160-247	>247	304	301	334	227	230	264	268	260	254	294	281	294	242	277	245
	% admission avoidance	<73%	73%-87%	>87%	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%	90.0%	90.2%
Medically Stable For Discharge	Average number of MSFD in WMH	>57.5	50- 57.5	<50	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	54.10	52.10
	Average number of days MSFD	>5.75	5.0 - 5.75	<5.0	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	4.0	4.6
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	N/A	N/A	N/A	N/A	N/A	35	34	32	26	28	28	27	25	27	26
	Domiciliary Pathways - Average service users				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	203.5	204.4
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	N/A	N/A	N/A	N/A	N/A	33	50	43	38	37	54	48	48	47	48
	Bed-based Pathways - Average beds in use				N/A	N/A	N/A	N/A	N/A	86.5	68.5	74	82.5	90	75	82	81	78	81
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	90	80	72	113	84	94	85	158	168	162	210	193	224	219	157
	Prevent Readmission	35<	35-50	>50	63	60	62	20	43	33	32	41	37	27	20	19	10	5	9
	Early Supported Discharge	40<	40-54	>54	43	48	47	26	35	29	65	35	44	45	29	31	48	85	49
	Assisted Discharge	35<	35-50	>50	63	103	61	42	54	42	75	54	40	35	56	68	76	44	74

Tier 0 Resilient whg The H Factor Social Prescribing Programme .

20 Referrals received



83 Clever Conversations



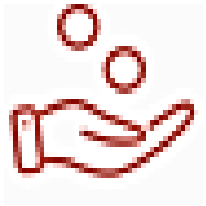
13 sign up to the Social Prescribing programme

13 Co – production of a WOOP Plan

(Wish Outcome Obstacle Plan)

7 Completed of a WOOP Plan

5 Referrals into training and education



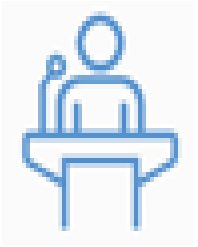
7 Referral Money Advice

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

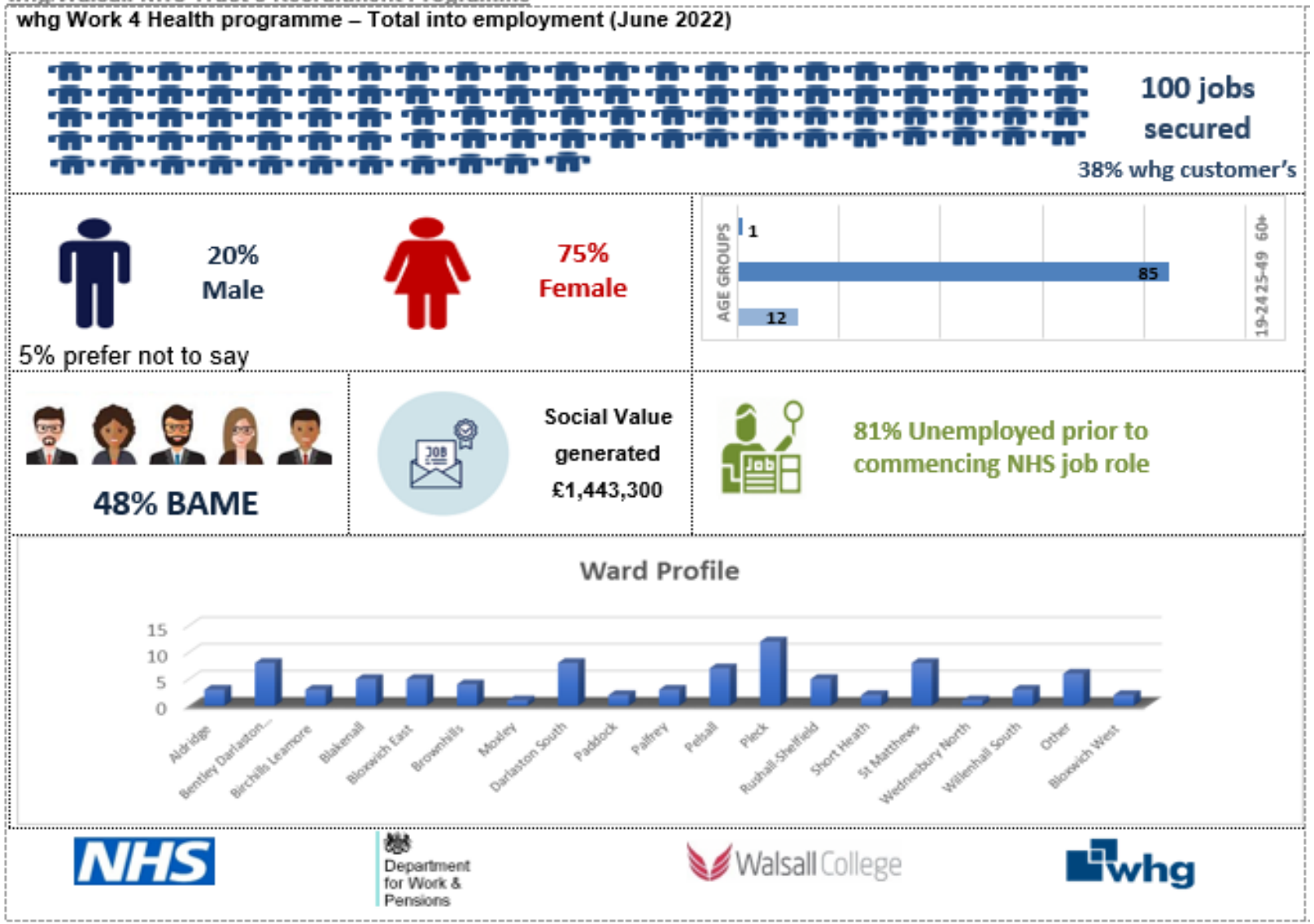
2 Referral Money Advice

2 Referrals into training and education

TIER 2 Workforce Development Work 4 Health

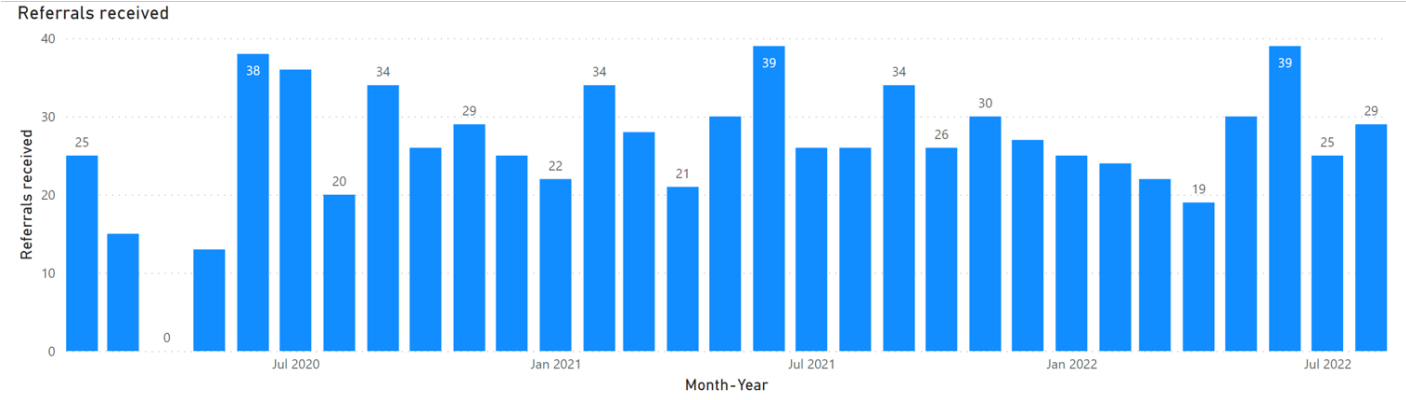
Walsall Together

whg/Walsall NHS Trust's Recruitment Programme



Tier 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 August 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

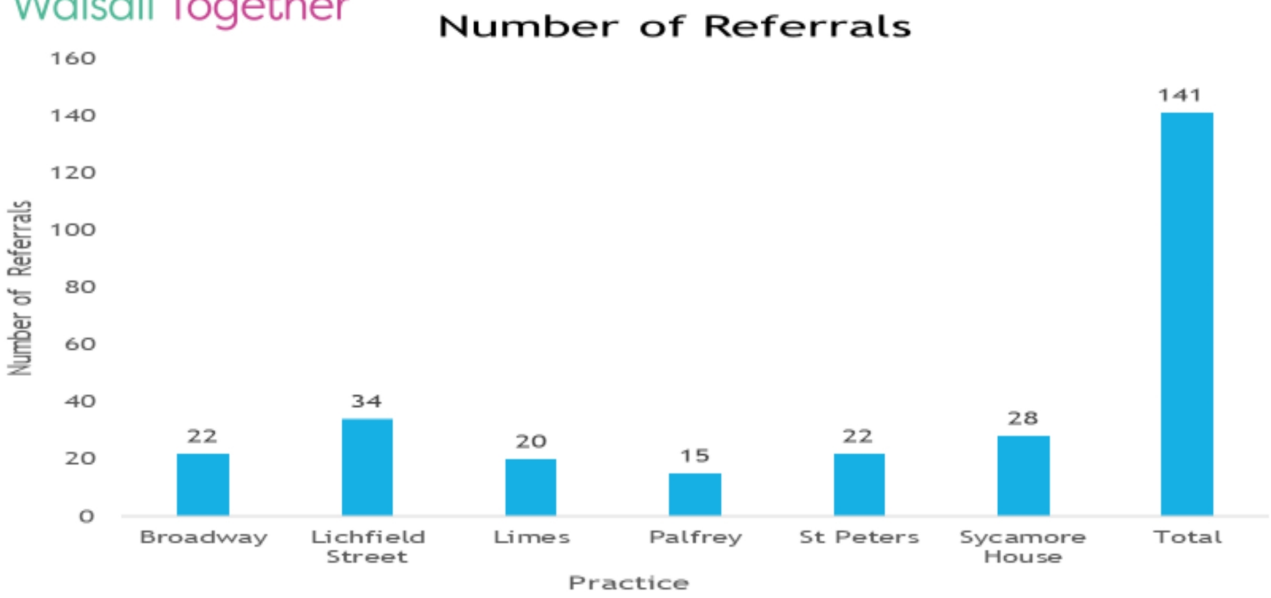
Tier 1: Primary Care Network(PCN) – Additional Roles Reimbursement Scheme (ARRS)

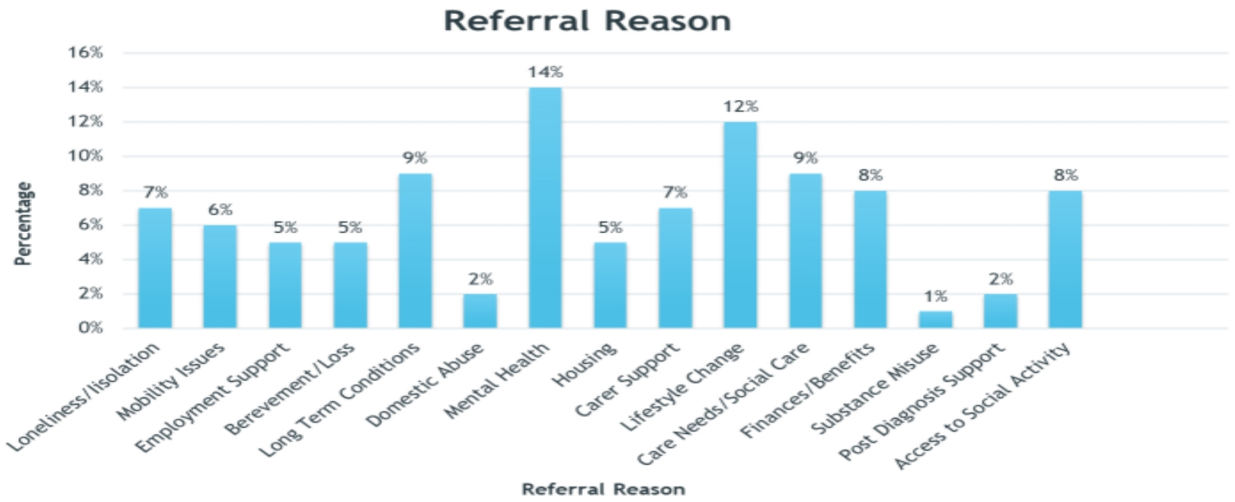
- Currently 3 projects involving PCN ARRS and WT.
  - First Contact Practitioner (FCP) - **x1 WTE in South 2 and 0.33 WTE starting in North via WHT , West , East & South 1 have sourced their own FCPs.**
  - First Contact Mental Health Practitioner - **x4 currently in place in South 2 , West 1 & 2 and 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 September 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

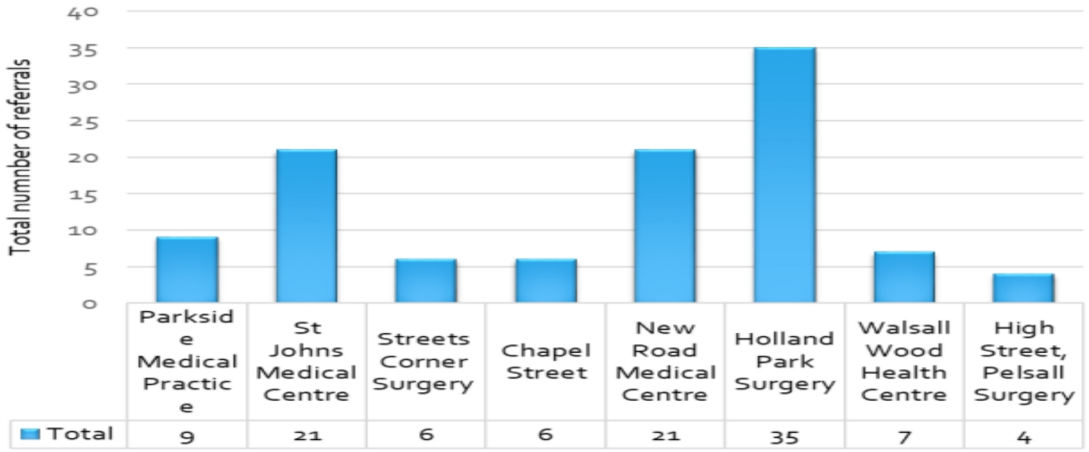


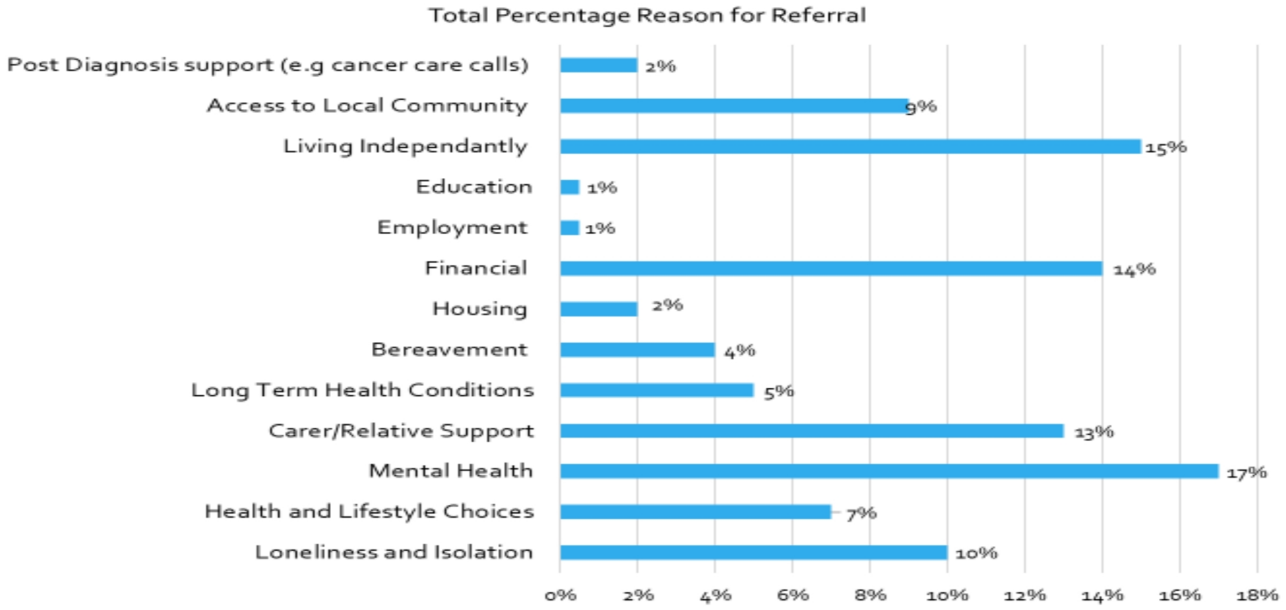


Last updated on July 2022

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

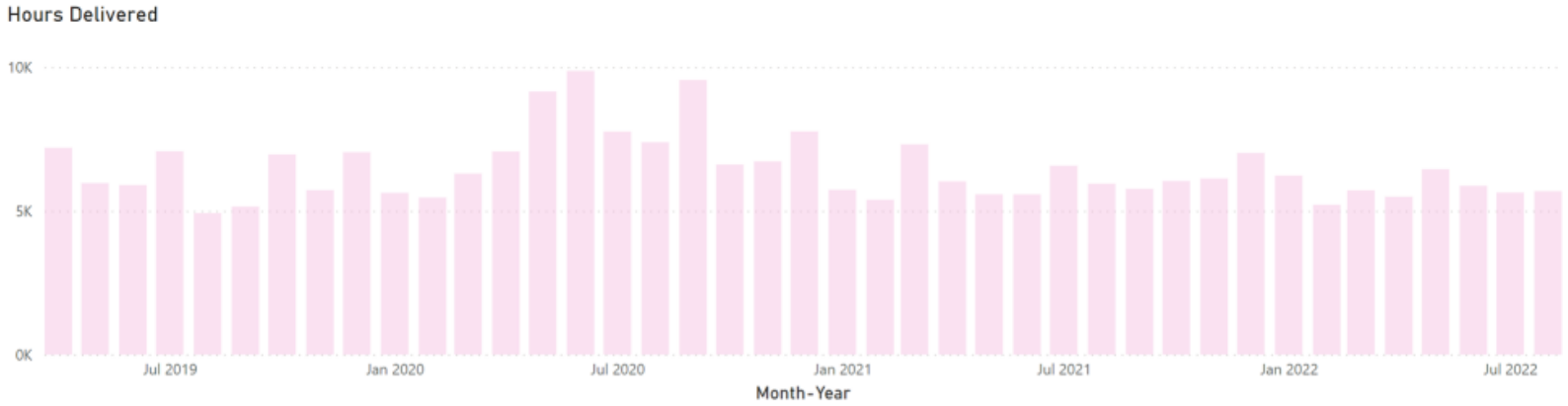


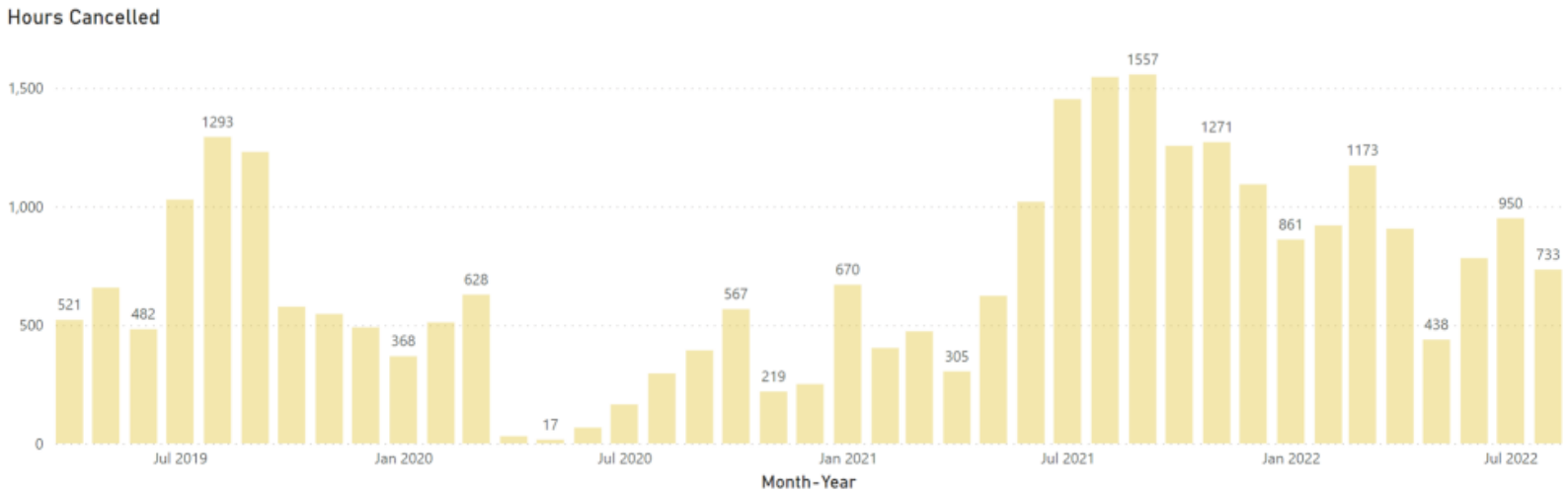


Last updated on July 2022

Tier 1:

Community Nursing Capacity and Demand: In July 2022, Locality District Nursing Teams delivered slightly less hours than the previous month.





The Locality Teams delivered over 5,500 hours

Sickness absence increased during July impacting on the hours that the team were able to deliver.

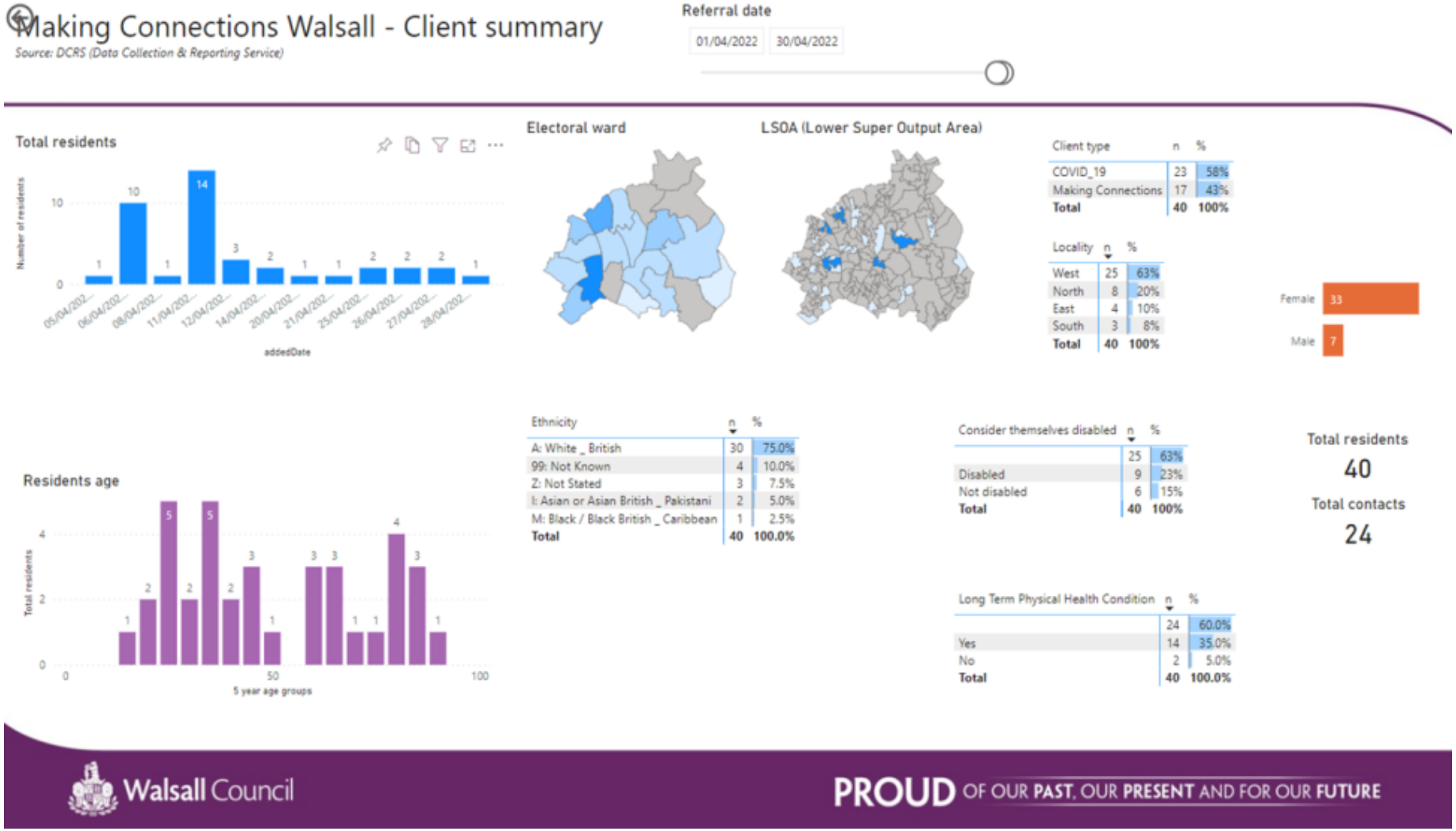
Complexity of patients remains an issue and impacts on service delivery. During June, the Locality teams continued to see significant levels of complexity which included Palliative patients requiring syringe pumps and also complex social issues due to the late palliative diagnosis.

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.

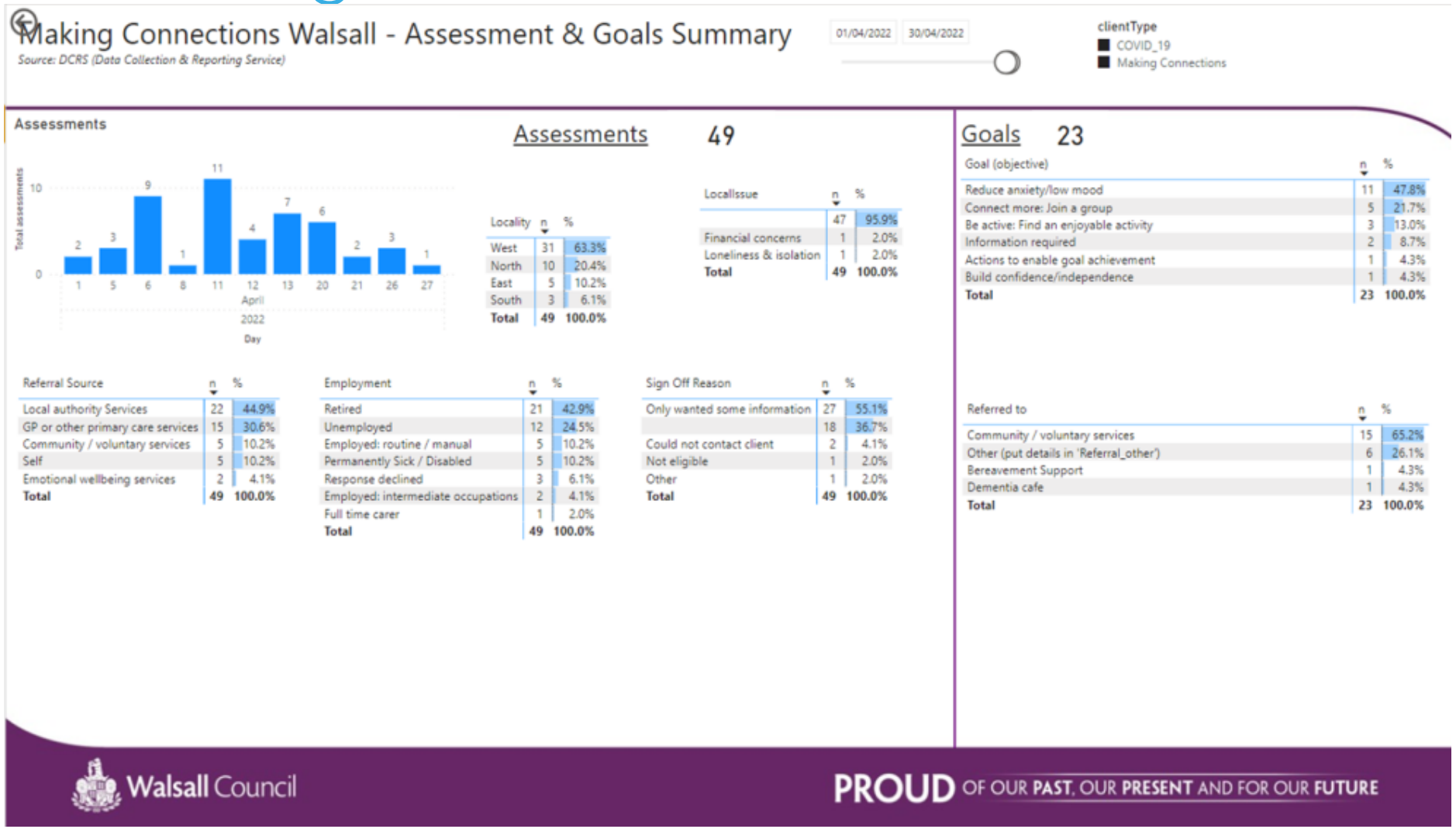
Last updated on August 2022

Tier 1: Making Connections Walsall



Last updated on July 2022

Tier 1: Making Connections Walsall



Last updated on July 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

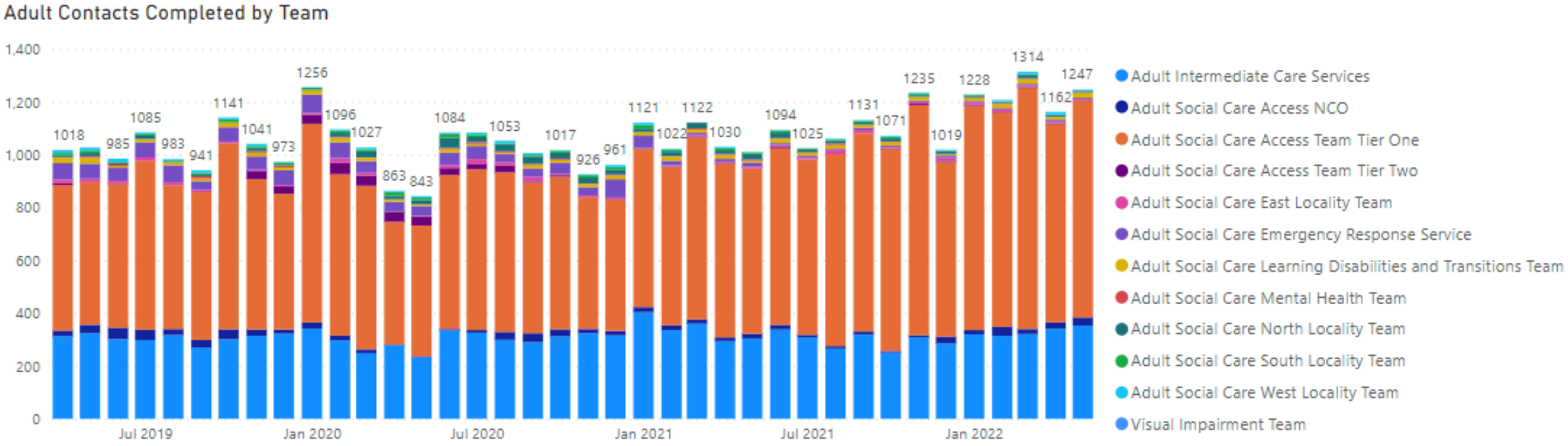
Last updated on August 2022

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
- Number of referrals picking up again and coming through to the service

Last updated on August 2022

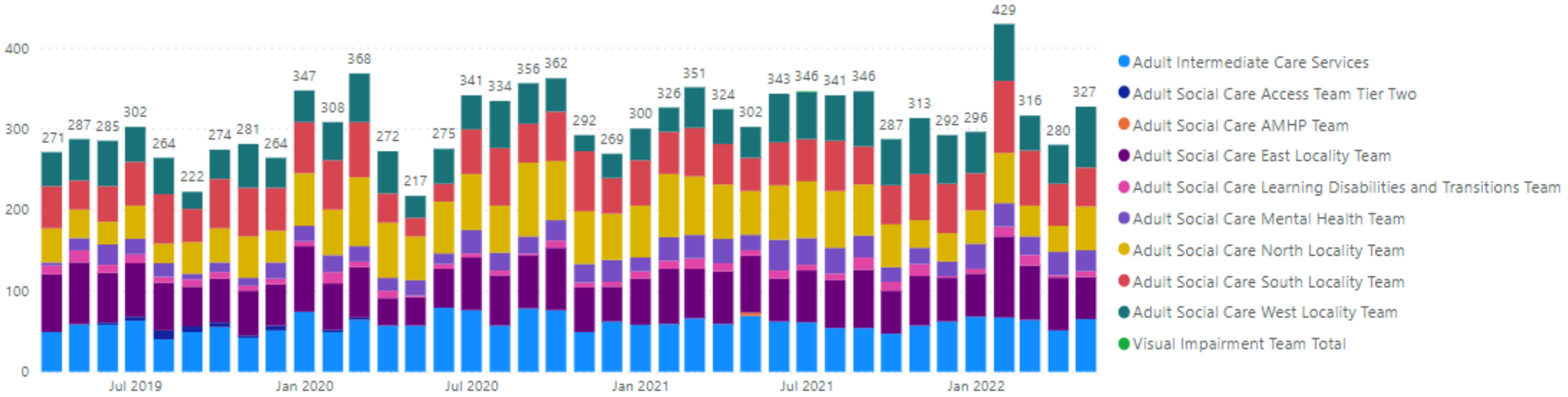
Tier 1:
Adult Social Care



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.

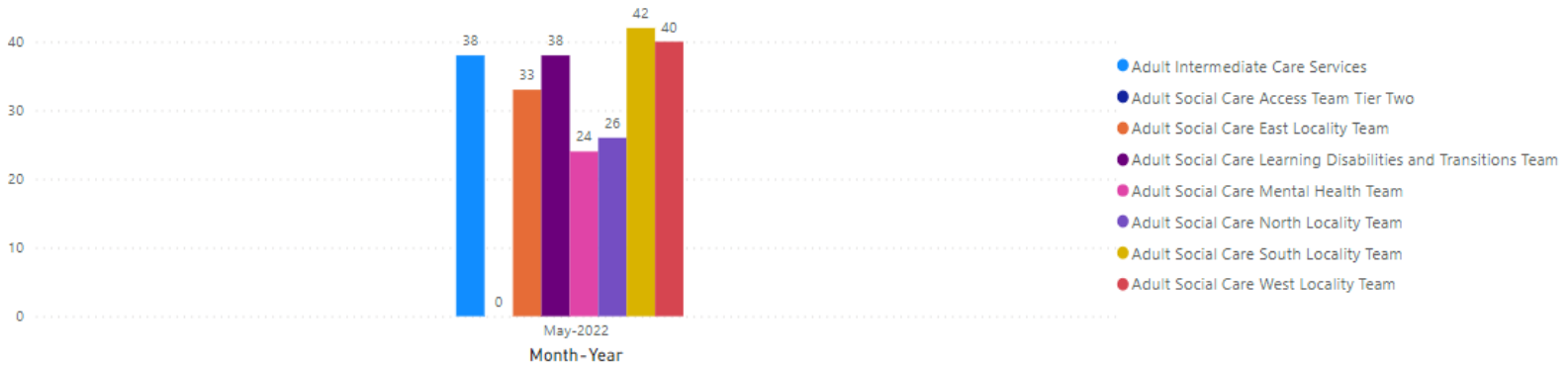
Last updated on July 2022

Care and Support Assessments and 3 conversations completed

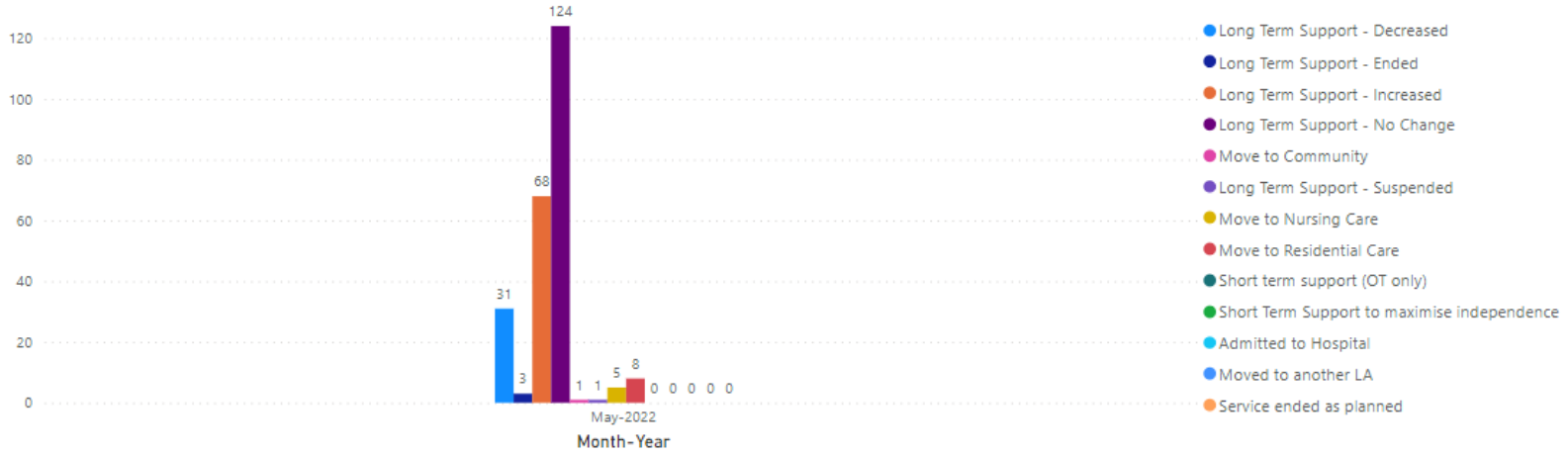


Last updated on July 2022

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
Jul-22	
Aug-22	

Last updated on July 2022

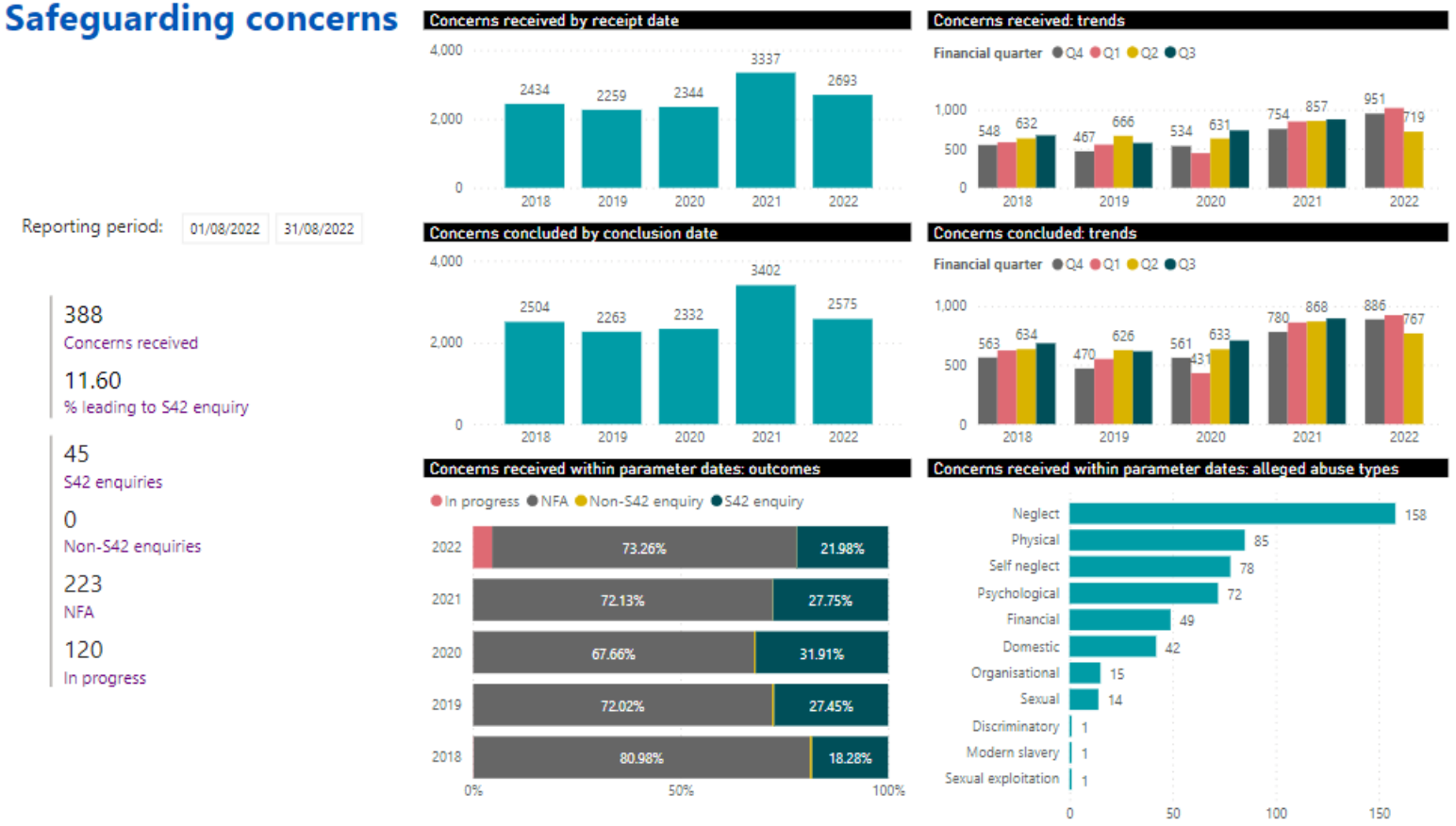
Tier 2:
Adult Social Care

ASC have received 388 concerns which is a increase of 32 cases on the previous month.

The number of cases progressing to a s42 enquiry is higher than on the previous period.

There are currently 45 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. This approach has caused a reduction.

Neglect & Psychological abuse remain the two highest categories of alleged abuse in this period.



Last updated on August 2022

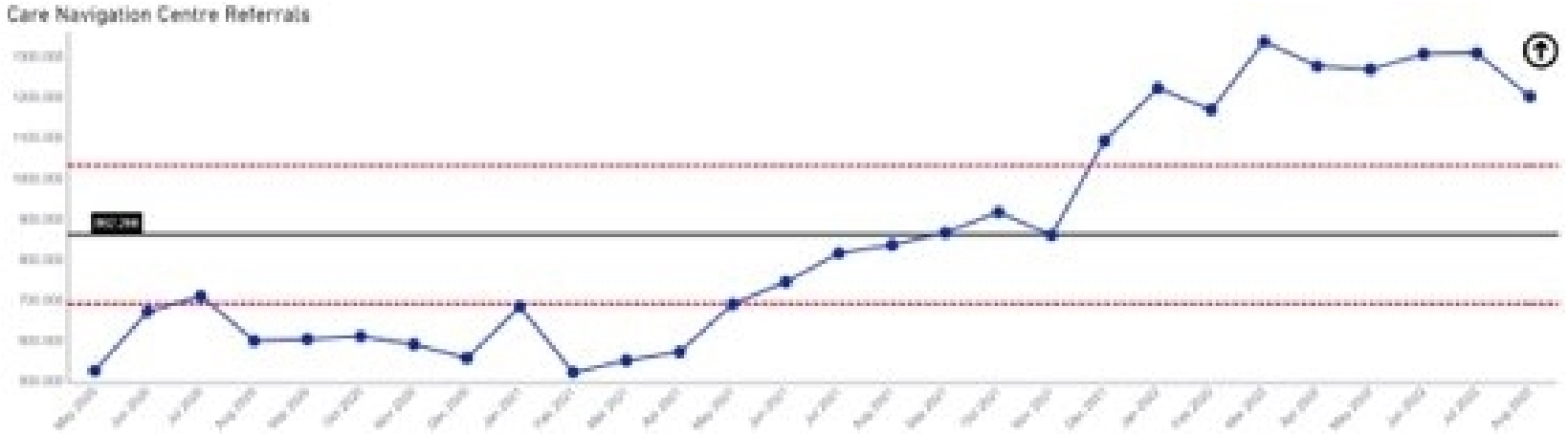
Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2022/23

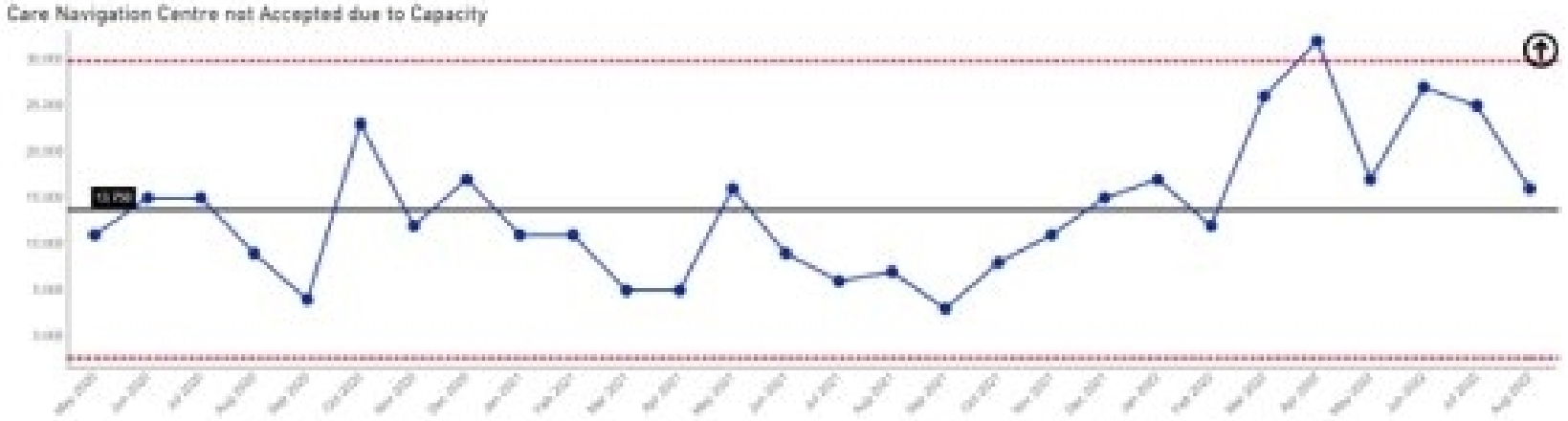
Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	21/22 Result	April 22/23 Data	May 22/23 Data	June Q1 Data	July 22/23 Data	Aug 22/23 Data	Sept Q2 Data	Oct 22/23 Data	Nov 22/23 Data	Dec Q3 Data	Jan 22/23 Data	Feb 22/23 Data	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	2197	2230									
	AACM	1895	1951	1954	2045	2100	2188	2183	2187	2181	2198	2197	2230									
	Jennie Pugh	**91.3%**	**97.3%**	**98.4%**	**99.7%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**								**100.0%**	
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	22	22								12	
	AACM	551	585	587	596	574	573	576	527	531	538	545	549									
	Jeanette Knapper	**1.1%**	**1.7%**	**0.2%**	**1.2%**	**2.4%**	**3.3%**	**3.6%**	**3.8%**	**4.0%**	**3.9%**	**4.0%**	**4.0%**									
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	466	471									
	AACM	551	585	587	596	574	573	576	527	531	538	545	549									
	Jeanette Knapper	**85.8%**	**85.0%**	**86.0%**	**84.2%**	**86.1%**	**85.3%**	**85.1%**	**85.6%**	**85.7%**	**85.7%**	**85.5%**	**85.8%**								**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	6	9								15	
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500	167,500	167,500									
	Jennie Pugh	**4.4**	**6.8**	**13.4**	**6.0**	**14.5**	**10.8**	**11.9**	**0.6**	**0.6**	**1.8**	**3.6**	**5.4**								**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	87	112								300	
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500	50,500	50,500									
	Jennie Pugh	**565.3**	**628.6**	**624.8**	**655.9**	**603.6**	**615.8**	**562.4**	**47.5**	**108.9**	**140.6**	**172.3**	**221.8**									
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	79	93	106	96	111	115									
	Provider Services	317	130	266	73	91	125	103	110	122	121	135	148									
	TBC	**80.1%**	**86.9%**	**82.7%**	**75.3%**	**83.5%**	**75.2%**	**78.1%**	**84.6%**	**86.9%**	**79.3%**	**82.2%**	**77.7%**								**82.0%**	

Last updated on August 2022

Tier 3:

Care Navigation Centre (CNC): Received a high number of referrals in July 2022.





The CNC continued to receive a high level of referrals in July 2022.

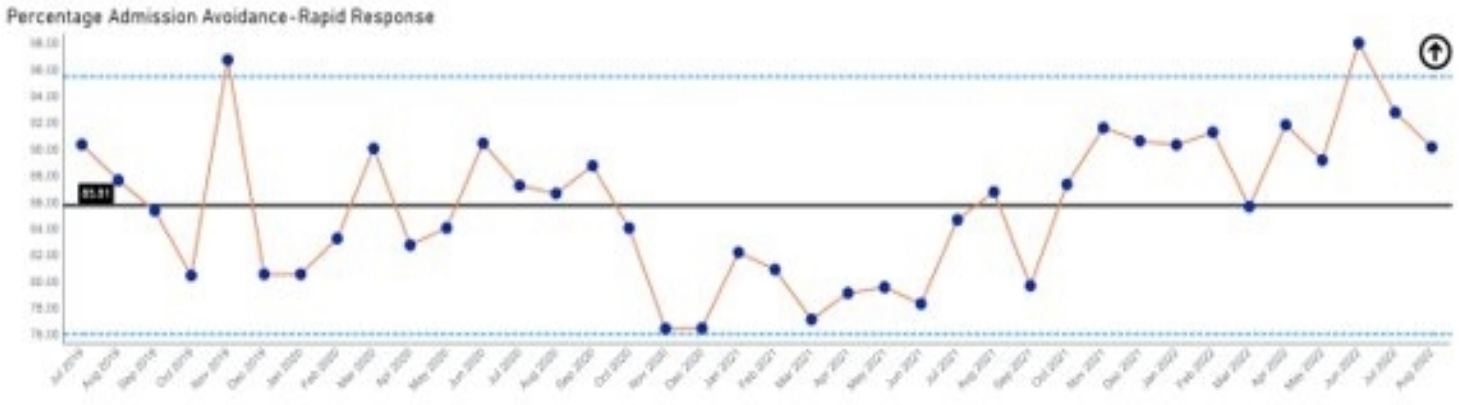
The expansion of capacity that has been embedded has enabled the CNC to receive greater call volumes and disposition more patients into Community pathways avoiding pressure on GP's, ED and hospital admissions.

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. A direct push model from the WMAS CAD has been implemented so that more patients can be diverted into Community Services

Last updated : August 2022

Tier 3: Rapid Response
The high levels of admission avoidance are being maintained

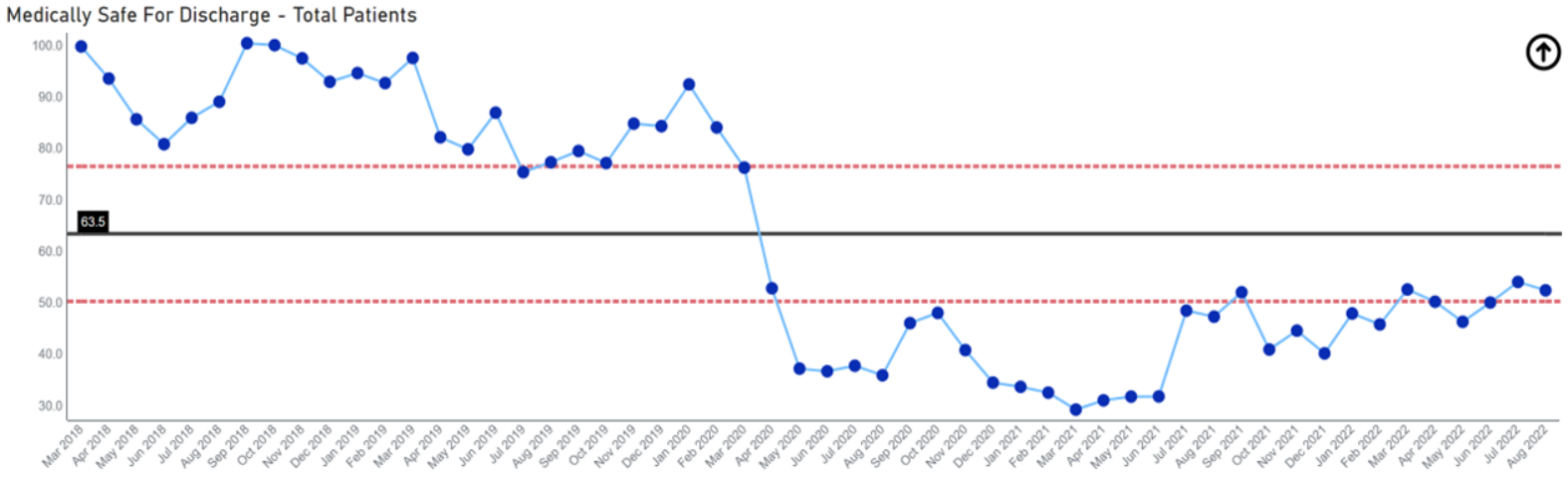


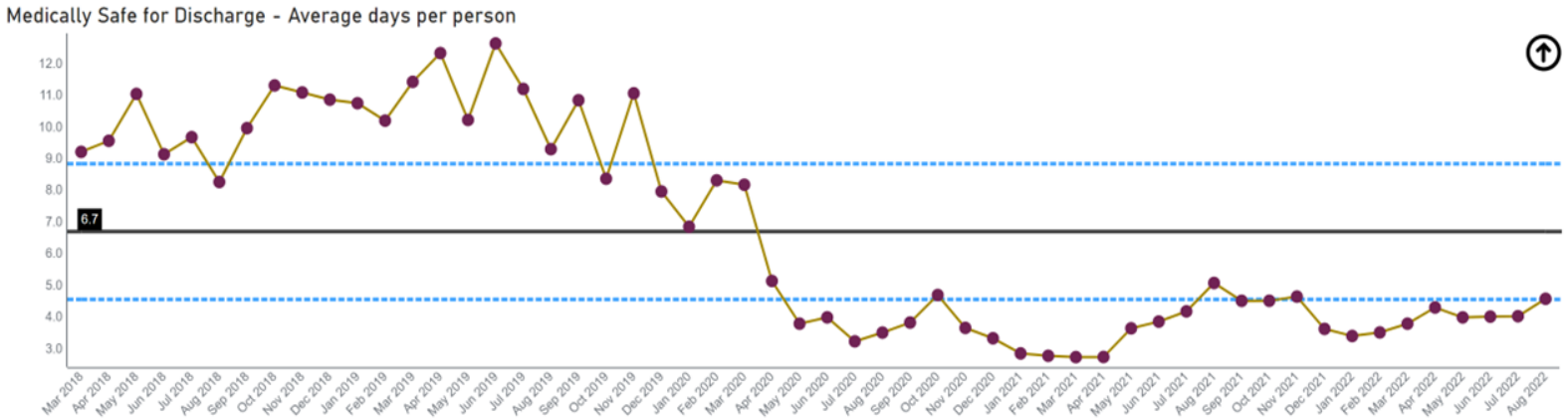
Rapid Response is visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non –clinical calls as a 3 month pilot with 6 identified conditions). This has not led to a significant level of referrals to date and is being managed within the present capacity 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 Aug 2022

Tier 3: Medically Stable for Discharge (MSFD): the numbers of patients averaged 55 patients during July 2022





The number of patients on the MSFD list averaged 55 patients during July 2022. This was due to high demand for the service. Despite the high numbers of patients, the average length of stay was maintained at 3.5 days.

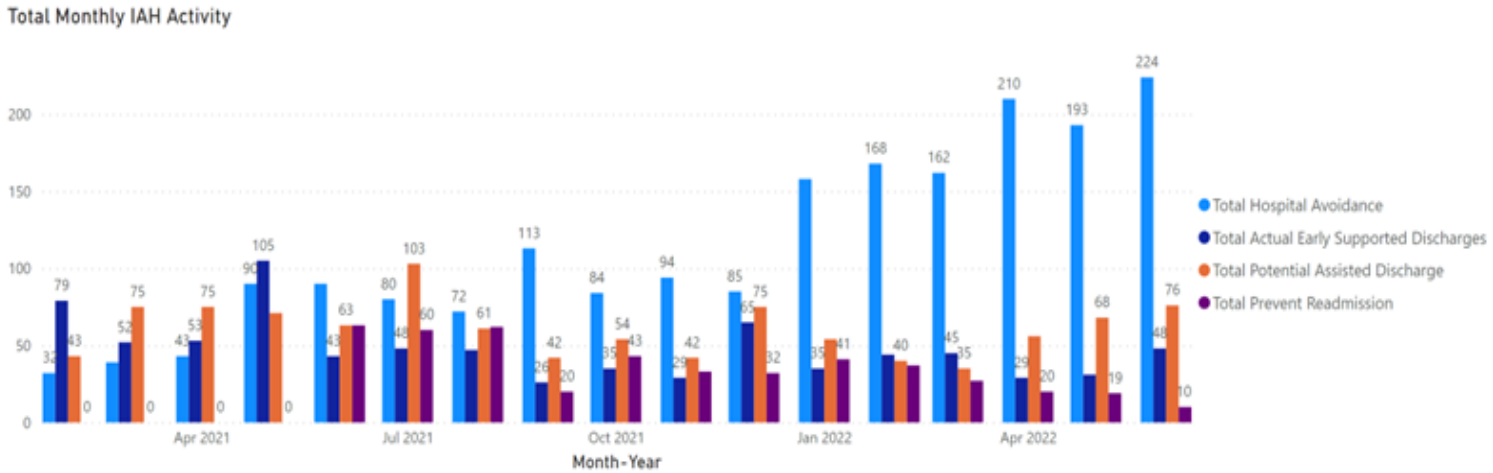
Work continues to make efficiencies in the discharge and ICS pathways to ensure that there are minimal delays for patients.

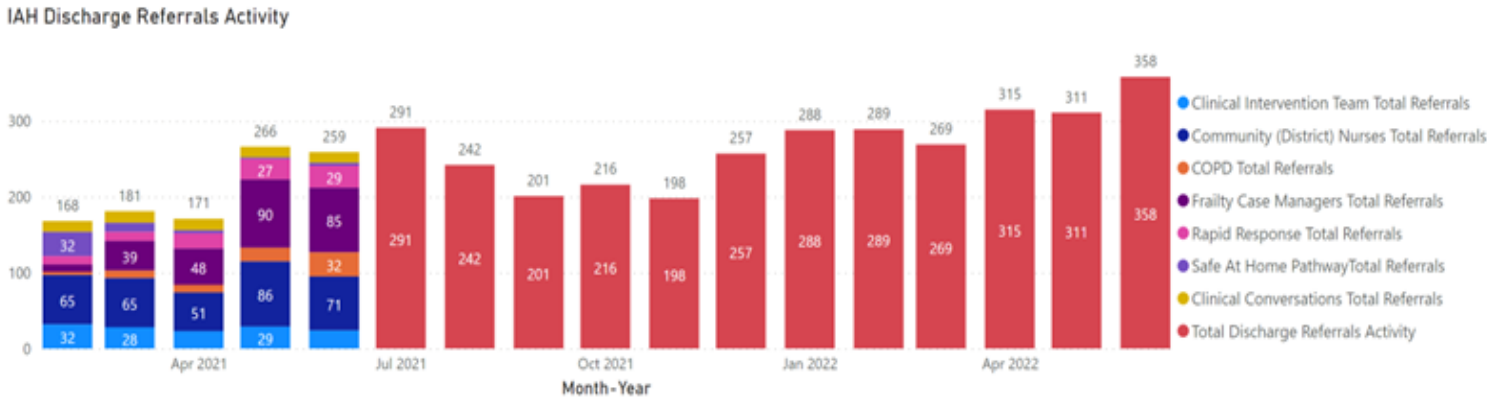
Patients continue to be placed on an interim basis into care home beds while continuing to seek a package of care to enable them to be cared for in their own home. Further work is being completed to reduce the number of patients in beds through expediting their discharge to home.

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 : Aug 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 Aug 2022

MEETING OF THE TRUST BOARD **Wednesday 5th October 2022**			
Annual Emergency Preparedness, Resilience and Response (EPRR) Assurance Report 2022-23			
Report Author and Job Title:	Mark Hart Head of EPRR	**Responsible Director:**	Ned Hobbs Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	It is a mandatory requirement for all organisations that receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. Trust Boards should be updated at the start of the annual process and again at the mid-point on progress made against the Action Plan. A more detailed assurance process is in place this year; 3 yearly review of core standards by NHS England has added additional standards and required tauter evidence. Furthermore, ICBs are given a formal assurance responsibility. They will review our Self-Assessment documentation 19 September 2022. Walsall Healthcare is self-assessed as "Substantial Compliance" with an associated Action Plan set out, which will be integrated into the annual EPRR work programme monitored by the EPRR Steering Group. A rigorous internal process after a consolidated improvement and proactive training and exercise EPRR surge in last 12 months has shaped this submission. The report highlights significant improvements, whilst meeting the response remit managing the covid-19 pandemic locally and sets a firm direction for the period ahead. Committee should note that, due to the thresholds set as part of the EPRR Core Standards submission, if the ICB or NHSEI moderate more standards to partial rather than full compliance it could result in the overall Trust assessment moving from "Substantial Compliance" to "Partial Compliance".		
Recommendation	Members of the Board are asked to: • **Approve** our response to the Annual EPRR assurance process and note ICB challenge session in mid-September; • **Note** our approach for the next 12 months.		

Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The EPRR work programme mitigates a number of corporate, divisional and departmental risks across the Trust as well as setting a course of implementing outstanding preparedness and response policies, plans, arrangements and culture.	
Resource implications	There are no resource implications associated with this report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☒
	Resources ☒	

Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance 2022 - 2023

1. PURPOSE OF REPORT

The purpose of the report is to inform and assure that the Trust has professionally completed the annual assurance of EPRR required by NHS EI and offer an update that will set tone for the next 12 months.

2. BACKGROUND

It is a mandatory requirement for all organisations that receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. Last year due to the national response to covid-19, it was recognised that the regular process would be excessive, so a slightly modified framework was established and completed by the Trust. This year NHS England has returned to the full mechanism and has conducted a "3 yearly review" to strengthen further the framework and assurance process. In particular, Integrated Care Boards (ICB) will have an important responsibility to assure the local process.

NHS England directed an enhanced process that was communicated by letter on 29 July 2022. The assurance process is split into the following areas:

- Stage 1: Self Assessment. Each organisation is asked to rate their compliance via a self-assessment against the relevant individual core standards. See section below for compliance levels and overall assurance rating.

- Stage 1: Self Assessment Deep Dive. Following the publication of the updated national "Evacuation and shelter guidance for the NHS in England" and recent work driven by heightened risk associated with reinforced autoclaved aerated concrete (RAAC), the 2022/23 EPRR annual deep dive will focus on local evacuation and shelter arrangements. The outcome more widely will be used to identify area of good practice and further development for future guidance.

- Stage 1: Organisational Assurance Rating. The Trust is to set an organisational rating based on the full self-assessment. The outcome of the deep dive is not included.

- Stage 1: Develop Action Plans. Each Trust based in response to the activities of the EPRR annual assurance process should develop an Action Plan and place them within their annual EPRR work programmes for the period ahead.

- Stage 1: Submission. Submit self-assessment against the 2022-23 core standards including a deep dive and report findings to:

- NHS EI Regional Head of EPRR and Black Country ICB EPRR Lead by 7 September 2022
- Trust Board when, most convenient but before 30 December 2022 and agreed by the ICB

- Stage 2: Local Assurance. ICB colleagues will review our self-assessment 19 September 2022. ICB should provide NHS Midlands an overview report outlining the level of preparedness, risks and areas of good practice of all organisations in their geography.

- Stage 3: Regional Assurance.

- Stage 4: National Assurance.

3. OUTCOMES

The Head of EPRR co-ordinated our annual process under the auspices of the EPRR Steering Group and completed the main actions by mid-August 2022. The key outcomes are set out below.

Self Assessment

Head of EPRR submitted the Departmental self-assessment, rating the compliance for each standard to EPRR Steering Group on 8 August for initial scrutiny and then a separate challenge with the Accountable Emergency Officer (AEO) as part of a more robust and outstanding best practice process. The self-assessment included a deep dive on evacuation and shelter arrangements, which has been a planning focus since national guidance changed in late 2021.

Compliance level	Compliance definition
Fully compliant	Fully compliant with the core standard.
Partially compliant	Not compliant with the core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Not compliant	Not compliant with the core standard. The organisation's EPRR work programme shows compliance will **not** be reached within the next 12 months.

Table 1 Core Standards Compliance levels

The final submission to regional NHS England and Black Country ICB EPRR Leads is at Appendix 1.

- *Appendix 1 - Walsall Healthcare Final Core Standards Self-Assessment 2022-23.*

Organisational Rating

The overall EPRR assurance rating is based on the percentage of core standards the organisation assesses itself as being "fully compliant" with and is explained in detail in the Table below:

Overall EPRR assurance rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Table 2 Core Standards Organisational Ratings and Criterial

The EPRR Function, EPRR Steering Group and AEO all assess Walsall Healthcare as "Substantial Compliance".

Action Plan

As required and following the process, 6 core and 4 deep dive standards rated "partially compliant" in the completed self-assessment are placed in an Action Plan, reported accordingly and will be integrated into the EPRR annual work programme from October 2022. The new annual work programme is in draft and will be submitted to the EPRR Steering Group 10 October for approval. The Action Plan devised was reported to Regional NHS and ICB EPRR Leaders as required.

Reporting

The AEO submitted the final report to the Regional Head of EPRR and ICS Leaders on 23 August, which included the Self-Assessment and associated Action Plan; a copy of this report is at Appendix 2.

- *Appendix 2 - Walsall Healthcare Annual EPRR Assurance 2022-23 Report*

It is expected that ICB will review and scrutinise our self-assessment 19 September 2022.

4. Detail

Summary of each core standard category is set out below:

Governance

Whilst in good shape previously, this is very strong and robust within the Trust. Supported by refreshed and approved Business Continuity and EPRR Policies and a proven governance regime, the EPRR Department is in a very good place. Draft EPRR business case should allow a revised structure and budget for the EPRR Department to be agreed (allocated within the prioritised Executive Team business cases for 2022/23), that builds on lessons from the pandemic and sets the Trust with a firm capacity to meet future challenges and collaborative working in the medium term.

Duty to Risk Assess

Strong, robust and transparent. Risk assessment and management leads all preparedness/resilience activity; used extensively to guide regular Covid-19 Contingency Plan development, winter resilience planning and preparation to meet remit for the Commonwealth Games. Further work with external Walsall Resilience Forum colleagues to share and understand the local risks and hazards across Walsall Borough is maturing, for example Queen Relay Baton Event planning.

Duty to Maintain Plans

Considerable effort made over last 12 months to update key plans; Mass Casualty Incident Plan, Trust Evacuation and Shelter Framework Plan, Trust Mass Countermeasures Framework Plan as well as reviewing Emergency Mortuary Arrangements and Protected Individual Plan. Updates have embedded wider lessons from our covid-19 response, improved operational response arrangements and learning from a number of bold targeted exercises and training sessions. More staff have ownership of these plans as a result.

Refinements are required with the new Trust Evacuation and Shelter Plan to operationalise the high-risk requirement, which is a priority in the EPRR Work Programme in next 12 months.

Command and Control

Building on real and relentless incident response activity over the last 18 months, particularly but not exclusively from covid-19, our practices are in very good shape. However, training in more basic incident responses such as fire and floods will require a re-focus, as soon as other operational challenges allow staff the time to complete more traditional training and individual/collective exercising. Whilst Manager and Director on

Call training has continued some operational training has been postponed/cancelled as limited staff have been released/available.

Robust command and control arrangements, resilient Incident Co-ordination Centres and improving resources/tools and familiarity by staff is a positive.

Training and Exercising

Two significant live exercises and over 10 tabletop exercises have been completed in the last 12 months; this planned surged training and exercising approach for staff after dominated so much by covid-19 response only has undoubtedly improved our capability. Whilst this has widened staff EPRR training, the staff turnover and priority in recovery, elective and emergency care has limited dedicated and traditional training sessions. There remains more to do to ensure training particularly for operational responders is placed on a more consistent footing.

Response

Our Incident Co-ordination Centre options and arrangements have improved, offering more resilience to manage concurrent incidents, which was proven again and during our posture during Commonwealth Games period.

As highlighted above all response to planned risks/events (covid-19, Urgent and Emergency Care regional pressures, Commonwealth Games, extreme weather) and sudden incidents have all concluded with positive response outcomes. Our record under EPRR Level 3 is excellent, our preparedness and “heightened readiness” posture during the Commonwealth Games, whilst only receiving two patients, was robust and well poised.

Again a number of real operational incidents including chemical spills, IT disruptions, armed police presence in ED, fire alarms have all assured that our general response is valid, timely and effective, with debrief reports and learning all submitted to the EPRR Steering Group and recommendations managed through the Trust EPRR Improvement Programme.

Warning and Informing

Excellent support and output from the small communications team continues to be valuable. Close and collaborative working with RWT has stretched resource and increased training remit. A new dedicated Communications Incident Plan is drafted and will be matured and tested in the autumn by both Trusts.

Co-operation

Strong and mature collaborative working in place across Trust Divisions and Departments, with our local partners (mass vaccination programme), Borough

emergency service colleagues and local/regional NHS colleagues through restored partnership forums.

Business Continuity

As an EPRR Steering Group priority previously and despite the covid-19 response, further progress has been made and a clear policy led arrangement, with internal assurance, planning, testing and improvement established and building. With the foundations now well set, this work will guide and improve future preparedness and resilience thinking, resourcing and culture.

CBRN

Significant energy in this domain has resulted in a stronger capability, which has matured steadily in the last 12 months. Live CBRN exercise in March 2022 was a key element of CBRN preparedness and response. Good learning has improved procedures and confidence, but a more consistent training pathway needs to be maintained. Loss of lead trainer is unfortunate; arrangements in place to train more educators in the autumn with WMAS support.

5. SUMMARY

Whilst attention has remained focused on the covid-19 pandemic, another complex winter, regional UEC pressures and readiness to support Commonwealth Games preparedness for all Divisions and frontline teams day in day out, EPRR departmental core activities have remained guided by a pragmatic and ambitious work programme building on learning and setting excellence.

Improvements continue in all domains whilst in tandem Trust has managed an extraordinary response remit. This challenge has not diminished and the next 8 months ahead appear to be equally demanding with a different set of challenges and associated risks. The EPRR function, whilst growing and embedding deeper is in a good state to support the leadership in the year ahead. And the longer term process to build a resilient organisation, agile and robust to meet core business and any incident/emergency or disruption in parallel continues.

6. RECOMMENDATIONS

Trust Board:

- **Approve** our response to the Annual EPRR assurance process and note ICB challenge session in mid-September;
- **Note** our approach for the next 12 months.

Appendix:

1 Walsall Healthcare Final Core Standards Self-Assessment 2022-23.
2 Walsall Healthcare Annual EPRR Assurance 2022-23 Report to NHS Midlands and ICB EPRR Leads.

Walsall Healthcare NHS
NHS Trust

NHS England Midlands EPRR
Cardinal Square
10 Nottingham Road
DERBY
DE1 3QT

Tel: 01922 656206
Email: ned.hobbs1@nhs.net
Website: www.walsallhealthcare.nhs.uk

23 August 2022

EPRR Annual Assurance 2022 - 2023

References:

A. NHS England, Director of EPRR letter dated 29 July 2022 (EPRR Annual Assurance Process for 2022/23).

B. NHS England Midlands, Regional Head of EPRR letter dated 29 July 2022 (EPRR Annual Assurance 2022-2023).

C. NHS England, Emergency preparedness, resilience and response annual assurance guidance, Version 3.0, 29 July 2022.

D. NHS England, NHS core standards for emergency preparedness, resilience and response guidance, Version 6.0, 29 July 2022.

As requested at References A and B, this letter submits Walsall Healthcare NHS Trust's self-assessment against the revised core standards.

Reference A from the National Director of EPRR, set out the start of the EPRR assurance process and the initial actions for organisations to take as part of NHS England's statutory duty to seek formal assurance of both its own and the NHS in England's EPRR readiness.

Reference B from the Regional Head of EPRR set out requirement for submissions, self-assessment, an action plan and deadline for return.

Walsall Healthcare Rating is assessed as "Substantial Compliance"; the full self-assessment is at Appendix 1 and subsequent Action Plan is at Annex A. The details

have been scrutinised and challenged by our EPRR Steering Group on 8 August 2022 and by myself, the Accountable Emergency Officer separately on 12 August 2022.

Thereafter the self-assessment and an accompanying report will be presented to our Trust Board on 5 October 2022, following scrutiny at the Performance & Finance Committee of the Board on 31 August 2022.

Building on significant learning over the last 12-24 months, operating in an ambitious local EPRR culture and a sharpening all our EPRR processes and tools to strengthen preparedness and resilience, the refreshed annual core standards detail and process is welcomed. Significant work over the last 12 months, embedding NHS Midlands advice, closer Black Country collaboration and seeing sector best practice further afield have all supported a strengthened EPRR function at the Trust. A focused and tailored EPRR Work Programme is already in draft for commencing again this October.

In sum, the Trust has utilised the full depth of our EPRR capability to continually respond to the covid-19 pandemic and recovery process over the last 12 months – with both elements ongoing. In tandem, the maintenance of priority preparedness and resilience activities to meet concurrent challenges, providing operational management assurance and ensure we are ready for the next threat has been maintained. In addition, planning for the Commonwealth Games offered opportunities to test core standards further in practice, and the Trust has seen a significant increase in EPRR exercising over the last 18 months. Lastly, we remain operating in a complex environment; restoring and delivering elective and emergency care, monitoring RSV, monkeypox and other infectious disease levels, caring for covid-19 patients and playing a key part in mitigating a highly pressured regional Urgent and Emergency Care system. Winter planning for 2022-23 is already facing uncertainty in potential further risks (including industrial action) and requires considerable planning and underpinning EPRR capability. This continues to be an extraordinary period, where the value of EPRR capacity and capability is paramount.

Yours sincerely,

Ned Hobbs
Chief Operating Officer
Accountable Emergency Officer

Copy:

Ash Canavan, Regional Head of EPRR
Nick Hardwick, Director of Performance
Mark Brassington, Director of Performance and Improvement

Jason Evans, Associate Director and EPRR Lead, Black Country and West Midlands Integrated Care System
Mark Hart, Head of EPRR, Walsall Healthcare NHS Trust

Annex:

A. Walsall Healthcare EPRR Action Plan

Appendix:

1. Walsall Healthcare Completed Self-Assessment including “deep dive” 2022-23

Walsall Healthcare NHS
NHS Trust

Annex A – Walsall Healthcare EPRR Action Plan

Standard	Detail	Organisational Evidence	Action to be taken	Lead	Timescale
15 Duty to maintain plans, Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Full review of Mass Casualty Incident Plan completed in light of Commonwealth Games readiness, adoption of WHO Mass Casualty Management principles and new ED/AMU build due to open Autumn 2022. Mass Casualty Incident Plan and supporting action cards updated for Commonwealth Games and will be tested via Exercise PROTECTOR in November 2022. The Trust has conducted a number of divisional Mass Casualty Exercises in the last 6 months to refine divisional processes which include Exercise HEALY, Exercise ROSEMARY BANK and Exercise KOLUMBO. Mass casualty patient identification system in place. **EPRR/00 Policies & Plans/14 Mass Casualty Incident Plan** **EPRR/Exercises/202206 Exercise HEALY** **EPRR/Exercises/202202 Exercise ROSEMARY BANK** **EPRR/Exercises/202207 Exercise KOLUMBO**	Refreshed Plan to EPRR Steering Group Sep 22. Exercise PROTECTOR in New ED.AMU Build	Head of EPRR/ ED Resilience Working Group / Exercise PROTECTOR Planning Team	Sep 22 Dec-22
21 Command and control, Trained On Call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Key out of hours staff training in place with regular Director on Call, Acute Manager on Call and Community Manager on Call in place. These are supplemented with bespoke sessions (Commonwealth Games Briefings) and participation in both live and tabletop exercises. Training needs analysis completed. Regular ICC Information Officers training in place and annual refresh of staff induction pack in place. Operational Command Team	Ensure more robust training to operational response teams and their availability improves	Head of EPRR / Divisional Leaders	Feb 23 / Jun 23

		training has been limited due to operational pressures on Trust staff and recognised as a priority to re-establish a more regular programme once operational tempo allows. **EPRR/Training/01 MOC etc** **EPRR/Training/ 2021**			
24 Training and exercising, Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Key out of hours staff training in place with regular Director on Call, Acute Manager on Call and Community Manager on Call in place. These are supplemented with bespoke sessions (Commonwealth Games Briefings) and participation in both live and tabletop exercises. Training needs analysis completed. Regular ICC Information Officers training in place and annual refresh of staff induction pack in place. Operational Command Team training has been limited due to operational pressures on Trust staff and recognised as a priority to reestablish a more regular programme once operational tempo allows. **EPRR/Training**	Prioritise and focus training for operational command teams	Head of EPRR / Divisional and Departmental Leaders	Jul 23
34 Warning and informing, Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Communications team incident management has been integrated across all core EPRR plans. Short dedicated Incident Communications Plan developed and will be tested and linked with RWT in full in the next 6 months. **EPRR/00 Policies & Plans/15 Incident Comms Plan**	Draft new Incident Plan as a Standalone document with RWT	Head of EPRR, Head of Comms	Oct 22
50 Business Continuity, BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any	Whilst BC Policy and BCMS established with supporting templates, workshops and exercises, some Departments and parts of some Divisions are less mature due covid-19 response, operational temp, UEC pressures, recovery and elective priorities. Not all Divisions can measure	Embed full process across all Divisions	Head of EPRR / Divisional Directors of Operations	Feb 23

	corrective action are annually reported to the board.	performance. Trust board receives Report twice in a year to update on business continuity progress.			
64 CBRN, HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Change of personnel in last 9 months has reduced our training expertise. Awaiting dates for training course for Band 7 EPRR lead and 2 Band 6 educators.	Confirm places and attend on Training course with WMAS	ED EPRR Lead	Dec 22
Deep Dive: **Evacuation and Shelter, Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	Shelter and Evac procedure updated July 2022 (V 2.2) Section 10. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Formalise use and identification of external shelter locations/options	Head of EPRR	Mar 23
Deep Dive: **Evacuation and Shelter, Partnership Working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Shelter and Evac procedure updated July 2022 (V 2.2). See Sections 9, 10 and Annex L. No real planning or exercising completed with external partners.	Engage local partners in Trust Shelter and Evacuation Framework Plan details	Head of EPRR	Jun 23
Deep Dive: **Evacuation and Shelter, Equality and Heath Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Shelter and Evacuation Framework Plan mentions this in Section 10. To be undertaken	Undertake Equality and Health Inequalities Impact Assessment of updated Plan	Head of EPRR	Jun 23
Deep Dive:	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the	Updated to reflect revised national guidance, Oct 21. Framework Plan in place to reflect new guidance and local practices. Workshop programme planned autumn with key	Training approach agreed and will be delivery 2022/23	Head of EPRR	Jun 23

Evacuation and Shelter, Exercising	case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	Divisions separately with a Table Top Exercise planned Q2/3 2022-23 as set in draft EPRR Work Programme that commences Oct 22			

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Ned Hobbs, Chief Operating Officer since June 2019	Fully compliant				
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Trust has an EPRR policy and BCMS policy in place that covers resource, business continuity, training and exercising. It also covers assurance, process, EPRR standards and responsibilities. **EPPR/00 Policies & Plans/30 Policies/EPRR Policy**	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	EPRR Steering Group meets monthly, reporting to Trust Management Committee, Performance Finance & Investment Committee through to Trust Board. Board receives 2 formal EPRR reports annually and others by exception. Additional two Trust reports submitted for CWG. **EPRR/00 Core Standards/Core Standards 2021/Annual Assurance/Mid Point** **EPRR/00 Events/Commonwealth Games 2022/08 Papers** Further record on Trust website with Public Trust Board record, minutes, Papers etc	Fully compliant				
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Annual EPRR Work Programme developed every September and approved by EPRR Steering Group. Sets out work programme across core standard areas on a quarterly basis. Managed and delivered by Head of EPRR and monitored monthly as a standard agenda item at EPRR Steering Group **EPRR/00 EPRR Work Programme**	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Revised EPRR structure following review agreed. EPRR function has dedicated budget within corporate division. New structure and financial arrangements completing new business case process. Resilience leads identified across all Divisions and key Departments, that support local championing and delivery. In addition to enhance the EPRR function resource, volunteer ICC Information Officers remain a core part of the Trust structure.	Fully compliant				
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Robust debrief, learning and improvement planning process and culture in place. EPRR Improvement Plan assured monthly by EPRR Steering Group. Debriefs and lessons shared quarterly with NHSEI Midlands and key partners as required. **EPRR/00 Structured Debrief and Improvement Planning**	Fully compliant				
Domain 2 - Duty to risk assess											
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Regular Risk Assessment established by EPRR and shared for assurance monthly with EPRR Steering Group. Risk assessment leads all EPRR planning and response activity such as Commonwealth Games (Separate Trust Risk Register). Various exercises (Exercise KEMP and ORCA Risk Register), and Monkeypox Outbreak (IPC Risk Assessment). Working with Walsall Resilience Forum to improve multi agency Risk Assessment. **EPRR/00 Risk**	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Risk Management in place using Trust Wide Risk Management Safeguard System and briefed for assurance monthly at EPRR Steering Group. **Safeguard Risk Management/Head of EPRR log in** **EPRR/00 Risk**	Fully compliant				
Domain 3 - Duty to maintain Plans											

9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements <u>Evidence</u> • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	EPRR Function fully integrated and lead all internal planning through dedicated Working Groups or short term Task and Finish Groups. All collaborative activity set out and reported monthly to EPRR Steering Group. Recent examples include ED Resilence Working Group (EPRR arrangements in new ED/AMU new build), Trust Commonwealth Games Working Group and Heatwave Plan Task and Finish Group. **EPRR/00 ED Resilience Programme/ED Resilience Working Group** **EPRR/00 Events/Commonwealth Games 2022/05 TCWGWG** Furthermore EPRR lead collaborative approach to all exercise planning for example Exercise ORCA had a dedicated cross Trust planning team. **EPRR/Exercises/202203 Exercise ORCA/01 Planning** EPRR team links with external partners including Walsall Council (Covid 19 response, local emergency mortuary arrangements and Queen's Relay Baton planning). Other external examples include CT and security planning (West Midlands Police) and fire response (West Midlands Fire Service). Lastly EPRR function works closely with Black Country Trust EPRR colleagues (monthly meeting) and in particular very closely with Royal Wolverhampton NHS Trust. EPRR function attends regional HEPOG and LHRP meetings.	Fully compliant
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has adequate plans, and arrangements in place to respond to business continuity, critictical and major incidents. Continuous response to Covid 19 and some critical incidents has reinforced and offered confidence in arrangements. Opertaional Response Working Group has updated our Trust Response Plan, following Exercise KEMP and refining opeartional command and control arrangements. A full review and exercising of mass casualty incident has taken place and the Trust has adopted WHO mass casualty management principles. Ten Trust members have attended bespoke WHO mass casualty three day programmes and plans have been exercised and are being further refined. **EPRR/00 Policies & Plans/10 Response Plan** **EPRR/00 Policies & Plans/Mass casualty Incident Plan** **EPRR/On Call Arrangements/03 Weekend Plan** **EPRR/On Call Arrangements/Tactical Pack**	Fully compliant
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	EPRR Function co-ordinates and distributes all warnings and alerts with a Trust wide process in place. Annual programme in place to promote, raise awareness, embed and debrief both Heatwave Plan and Severe Weather Plan as appropriate throughout the year. **EPRR/00 Polices & Plans/12 Severe Weather/Heatwave** **EPRR/00 Policies & Plans/12 Severe Weather/Severe Weather** **EPRR/00 Structured Debrief and Improvement Planning** EPRR Function part of Trust Sustainability Group and contributes significantly to Adapation plan. Regular engagement with local partners; Water Company, UKHSA and Environment Agency on extreme events.	Fully compliant
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	Trust IPC Team regularly review outbreak management and Infectious Disease Plan and procedures. Whilst focus remains with Covid 19, Trust has managed Monkeypox and prepared a full Commonwealth Games Infectious Disease Manual for clinicians as an Appendix to the Trust Commonwealth Games Operational Plan. **EPRR/00 Policies & Plans/07 Outbreak/Outbreak Management Policy** **EPRR/00 Events/Commonwealth Games 2022/05 TCWGWG/Operational Plan/IPC Infectious Diseases Manual** All staff have individual fit mask testing and are tested on several FFP3 masks. This programme is led by dedicated individuals co-ordinated by Health and Safety Lead with support from IPC team.	Fully compliant
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Pandemic Flu Plan in place **EPPR/00 Policies & Plans/08 Pandemic Influenza** Over the last 18 months, 5 versions of the Trust Covid 19 Contingency Plans has evolved and remains active. Debriefs have taken place regulary and inform each version of the contingent plan. **EPPR/00 Policies & Plans/02 Flu including Covid-19** Await National and Regional guidance on further reducing Covid 19 response and for Trust to revise its existing Pandemic Plan.	Fully compliant

14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Full review conducted in light of Commonwealth Games readiness which resulted in major update of Trust Plan. Revised plan considers a range of operational solutions to match a wide range of planning assumptions. A new plan includes arrangements for administration, recpetion and distribution of mass prophylaxis and mass vaccination. Large operational option builds on successful hospital hub Covid 19 mass vaccination plan and delivery. EPRR Steering Group approved new Trust Mass Countermeasures Framework Plan in July 2022. EPRR have reported some operational risks to ICB and NHSEI Midlands and continue to refine operational readiness through awareness and training. **EPPR/00 Policies & Plans/14 Mass Countermeasures Plan**	Fully compliant			
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Full review of Mass Casualty Incident Plan completed in light of Commonwealth Games readiness, adoption of WHO Mass Casualty Management principles and new ED/AMU build due to open Autumn 2022. Mass Casualty Incident Plan and supporting action cards updated for Commonwealth Games and will be tested via Exercise PROTECTOR in November 2022. The Trust has conducted a number of divisional Mass Casualty Exercises in the last 6 months to refine divisional processes which include Exercise HEALY, Exercise ROSEMARY BANK and Exercise KOLUMBO. Mass casualty patient identification system in place. **EPRR/00 Policies & Plans/14 Mass Casualty Incident Plan** **EPRR/Exercises/202206 Exercise HEALY** **EPRR/Exercises/202202 Exercise ROSEMARY BANK** **EPRR/Exercises/202207 Exercise KOLUMBO**	Partially compliant	Refreshed Plan to EPRR Steering Group Sep 22. Exercise PROTECTOR in New ED.AMU Build	Head of EPRR/ ED Resilience Working Group / Exercise PROTECTOR Planning Team	Sep 22, Dec 22
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Following revised National Guidance in October 2021, Trust has reviewed its Evacuation and Shelter arrangements. EPRR Steering Group have approved revised Trust Shelter and Evacuation Framework Plan which requires dedicated awareness and operationalising which is programmed in the revised EPRR Work Programme 2022/23. Plan has been reviewed by external consultant to ensure it covers all direction given in National Guidance and EPRR function has peer reviewed with sector best practice in other trusts. **EPRR/00 Policies & Plans/04 Evacuation & Shelter Plan**	Fully compliant			
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Plan in place (July 2021), which was updated following 2 incidents in 2021 and at its 2 yearly review point. Awareness training programme including table top exercises remain ongoing in EPRR Work Programme. **EPRR/00 Policies & Plans/11 Security Plans**	Fully compliant			
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plan refreshed and approved by EPRR Steering Group September 2021. Tabletop exercise conducted November 2021. Refreshed and briefed as part of Commonwealth Games Readiness Programme. PIP Working Group occasionally gather to raise awareness of planned VIP visits to Trust site or community locations. **EPRR/00 Policies & Plans/09 Protected Individual Plan**	Fully compliant			
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust has robust and proven resilience arrangements in place that adequately supported Trust response to covid-19 and the overlap with 2 winters. Trust working closely with Walsall Council to update Local Emergency Mortuary Arrangements Plan which now includes an option for Manor site if HM Coroner wishes to do so. Updated Walsall Council Plan in final draft and being agreed with both Trust management (EPRR Steering Group September 2022) and relevant regional and local emergency services and partner organisations. Trust Mortuary Resilience Plan being further revised to reflect improvements to capability and arrangements with local partners. A Trust Mortuary Working Group meets on a quarterly basis and oversees planning and associated awareness training.	Fully compliant			
Domain 4 - Command and control										
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Alerting, activation and notification arrangements in place and regularly tested. Arrangements also exist for out of hours including a Weekend and Bank Holiday SOP. Further work underway to improve resilience of switchboard capability, alerting communication to staff and building staff resilience out of hours.	Fully compliant			
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Key out of hours staff training in place with regular Director on Call, Acute Manager on Call and Community Manager on Call in place. These are supplemented with bespoke sessions (Commonwealth Games Briefings) and participation in both live and table top exercises. Training needs analysis completed. Regular ICC Information Officers training in place and annual refresh of staff induction pack in place. Operational Command Team training has been limited due to operational pressures on Trust staff and recognised as a priority to re-establish a more regular programme once operational tempo allows. **EPRR/Training/01 MOC etc** **EPRR/Training/ 2021**	Partially compliant	Ensure more robust training to operational response teams and their availability improves	Head of EPRR/Divisional Leaders	Jun-23
Domain 5 - Training and exercising										

22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	As above regular training programme in place although has been limited over the last 12 months due to Covid 19 and operational tempo. All training events and exercises are recorded along with training materials and pack. **EPRR/Training** **EPPR/Exercises** EPRR team have completed diploma (RSPH Level 4 Award in Health Emergency Preparedness, Resilience and Response) and await opportunity for the next . EPRR team and ICC Information Officers uses Public Health England online training packages on a regular basis and individuals have attended some Public Health England courses.	Fully compliant		
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Trust has completed 2 communications test exercises, at least one table top exercise, at least one live exercise and one command post exercise in the last 12 months. All exercises include planning, operations order (if applicable), joining instructions, training materials/delivery pack, lessons and report. All key reccommendations have transferred to EPRR Improvement Plan which is reviewed monthly via EPRR Steering Group. Key exercises include: **EPRR/Exercises/Exercise KEMP** **EPRR/Exercises/Exercise AXIAL** **EPRR/Exercises/Exercise ADAMS (12&3)** **EPRR/Exercises/Exercise WINTERPOINT** **EPRR/Exercises/Exercise PATTON** **EPRR/Exercises/202203 Exercise ORCA** **EPRR/Exercises/202206 Exercise HEALY** **EPRR/Exercises/202202 Exercise ROSEMARY BANK** **EPRR/Exercises/202207 KOLUMBO**	Fully compliant		
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Key out of hours staff training in place with regular Director on Call, Acute Manager on Call and Community Manager on Call in place. These are supplemented with bespoke sessions (Commonwealth Games Briefings) and participation in both live and table top exercises. Training needs analysis completed. Regular ICC Information Officers training in place and annual refresh of staff induction pack in place. Operational Command Team training has been limited due to operational pressures on Trust staff and recognised as a priority to resestablish a more regular programme once operational tempo allows. **EPRR/Training**	Partially compliant	Training for operational command teams	Head of EPRR	Jul-23
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Annual updates made to Trustwide Staff Induction Programme which for most of last year has been conducted virtually.	Fully compliant		
Domain 6 - Response									
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Trust has a Main ICC, Alternative ICC (currently Covid 19 Command Centre), Standby ICC and a Strategic Command Centre. Main ICC capability refreshed and dedicated tactical training and exercising within main ICC completed. Standby ICC activated to co-ordinate a number of business continuity and a critical incident successfully. Alternative ICC operating since March 2020.	Fully compliant		
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	All plans kept on Trust IT infastructure. For bespoke operations (Commonwealth Games) key plans and documents are shared on dedicated teams channels. Hard copies available at main and alternative ICCs. Currently Trust Intranet is being replaced and EPRR function will place all relevant documents on new system when installed 2023. **Emergency Planning/EPRR/00 Policies & Plans**	Fully compliant		
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	New divisional business continuity plans as well as key enabling business continuity plans (estates & facilities, IT & digital services) completed. Procurement, HR and finance business continuity plans ongoing. Formal rolling programme of operational business continuity plans in place and monitored by EPRR Steering Group monthly and by Divisional Quality Boards. All incidents debriefed **EPRR/Business Continuity** **EPRR/00 Policies & Plans/10 Response Plan** **EPRR/00 Structured Debrief and Improvement Planning**	Fully compliant		

29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	Nil attendance to NHS loggist training over the last 12 months. ICC Information Officers support Tactical Command with information management requirements (key events, current situation, strategic aim and focus points and action log). More training required to ensure Operational and Tactical Commanders mantain own decision log.	Fully compliant			
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Arrangements in place and regularly used. ICC Information Officer cadre fully trained and have conducted Sitreps internally and externally extensively. EPRR function have completed various sitreps including SBAR form During incidents over the last 12 months. **EPRR/Incidents**	Fully compliant			
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	**EPRR/00 Policies & Plans/05 Major Incident Plan**	Fully compliant			
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	**EPRR/00 Policies & Plans/01 CBRNE**	Fully compliant			
Domain 7 - Warning and informing										
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Communications team have extensive tools to communicate with patients, visitors and the public and have used regularly in the last 12 months. Internal communication includes email, snap comms and alerts but better wider cascading of information to all staff continues to be improved. New Reach App in operation since late August 2021 which EPRR utilises.	Fully compliant			
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Communications team incident management has been integrated across all core EPRR plans. Short dedicated Incident Communicatons Plan developed and will be refined in full in the next 6 months. **EPRR/00 Policies & Plans/15 Incident Comms Plan**	Partially compliant	Draft new Incident Plan as a Stand alone document with RWT	Head of EPRR/Comms	Oct-22
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Communications team fully integrated into EPRR arrangements and support training, exercises and incidents. Well established and mature contact list in place with key partner organisations and local stakeholders utilised on a weekly basis. Robust communications with communications teams across local NHS providers and NHS Regional team in place as well as strong relationships with our partners.	Fully compliant			
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Communications team have sound arrangements to support all incidents and emergencies at tactical and strategic levels. Dedicated spokespersons identified and have regularly spoken to press/media. Further media training planned for Executives 2022/23.	Fully compliant			
Domain 8 - Cooperation										
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Regular attendance and contribution since restarted by AEO or his delegated representative. **EPRR/00 LHRP & HEPOG**	Fully compliant			
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	EPRR function is represented at twice yearly Walsall Resilience Forum chaired by Walsall Council. Local partners regularly liaise, plan and share information in a number of regular activities (Exercise KEMP, Exercise ORCA, liaison with CTSA, Casualty Bureau and DVI training, fire alarm response policy changes, Queen's Baton relay). EPRR/Walsall Resilience Group During Covid 19 EPRR function attended some LRF meetings in order to appreciate wider risks, planning and response activity. **Head of EPRR/inbox/LRF**	Fully compliant			
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Trust again efficiently integrated military personnel through MACA arrangements January to February 2022. Covid 19 response continued to highlight significant regional mutual aid support in terms of stores, equipment and clinical transfers. Trust worked closely with Re-Act charity to support porter resilience over the winter and are planning to do the same this winter. Furthermore Trust worked with local partners and volunteers to enhance mutual aid during extreme heat and heat wave level 4 period. Draft MOU with RWT in place to improve and deepen local mutual aid arrangements between 2 partnership Trusts. Mutual Aid arrangements including MACA set out in Trust Response Plan.	Fully compliant			

40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	Fully implemented during Covid 19. Close working with ICB has developed to understand improved local risk assessment, planning and response. ICS lead (both Black Country and Brimingham & Solihull) for Commonwealth Games preparedness and assurance highlighted early cross boundary working.	Not applicable
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	Fully implemented during Covid 19. Close working in preparation for Commonwealth Games conducted. **EPRR/00 Events/Commonwealth Games 2022** Close working with Walsall Council Public Health not just Covid 19 but wider health emergencies including Monkeypox. EPRR function attend regular Health Protection Forum Meetings led by Director of Public Health **Head of EPRR/Inbox/Regional/Walsall Health Protection**	Not applicable
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas	Regular attendance and contribution since restarted by AEO or his delegated representative. **EPRR/00 LHRP&HEPOG**	Not applicable
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	EPRR function regularly liaises with Trust FOI cell, Caldicott Guardian, Safeguarding Lead and Governance Team on regulatory matters to ensure EPRR remains compliant. EPPR function contributes annually to Data Protection and Security Toolkit compliance and remains compliant as assessed by Head of Information Governance & Data Protection Officer.	Fully compliant
Domain 9 - Business Continuity							
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Business Continuity Policy in place covering key components. Although reviewed every 2 years, the policy is actively checked/refreshed annually. Updated again in Mar 22 (Version 2.0) via EPRR Steering Group **EPRR/Business Continuity/00 Master Programme from 2020/Policy**	Fully compliant
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	BCMS Policy includes scope, aim and objectives, requirement, responsibilities, assurance, response, training and exercising. Awareness training has gradually built with increased number of BC Workshops and exercises underway and planned in the next 12 months. **EPRR/Business Continuity/00 Master Programme from 2020/Policy**	Fully compliant
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Documemented and Briefing Pack developed setting out BCMS with focus on risk assessment, BIA and operatonal BCP. New Templates designed in 2020/21 form basis of updated process, which is utilised by all Divisions/Departments **EPRR/Business Continuity/00 Master Programme from 2020/BIA BCP Templates** **EPRR/Business Continuity/00 Master Programme from 2020Presentations**	Fully compliant
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Documemented and Briefing Pack developed setting out BCMS with focus on risk assessment, BIA and operatonal BCP. New Templates designed in 2020/21 form basis of updated process, which is utilised by all Divisions/Departments New templates follow ISO 22301 principles and the NHS Toolkit. External Consultant utilised to cross reference when Template designed. Template has two versions - one for clinical and the other non clinical areas. This programme continues with associated Divisional and Departmental resilient leads, associated workshops and EPRR expertise. Dynamic activation of numerous OPERATIONAL business continuity plans has taken place over the last 12 months which has significantly improved Trust wide understanding and application of business continuity. **EPRR/Business Continuity/00 Master Programme from 2020/BIA BCP Templates** **EPRR/Business Continuity/00 Master Programme from 2020Presentations**	Fully compliant

48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Regular testing and exercising outside of operational activation due real incidents continues. EPRR Function offers bespoke awareness sessions; by Care Group, Department or 121 including BC Surgery for Community Teams. At least two exercises conducted: Exercise AXIAL (IT & Digital services), Business Continuity Awareness Table Top Exercise, Sep 21, **EPRR/Exercises/202108 Exercise AXIAL** Exercise ADAMS (Community Division) Resilience training and Exercise, Oct 21, **EPRR/Exercise/202110 Exercise ADAMS** Exercise WINTER POINT (Walsall Council, Walsall Together Partnership and Walsall Healthcare) winter preparedness and resilience exercise, Dec 21, **EPRR/Exercises/202112 Exercise WINTERS POINT** and **Head of EPRR/Inbox/Exercise Winterpoint** Winter Covid-19 and Resilience Plan Debriefing Exercises (Trust wide reviewing of winter resilience), Apr 22 **EPRR/Winter Planning/Winter Plan 2021-22/Lessons**	Fully compliant			
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Statement of Compliance completed. EPRR work closely with Information Governance and Data Protection Officer and all training and exercise requirement under DPST conducted.	Fully compliant			
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	Whilst BC Policy and BCMS established with supporting templates, workshops and exercises, some Departments and parts of some Divisions are less mature due covid-19 response, operational temp, UEC pressures, recovery and elective priorities. Not all Divisions can measure performance. Trust board receives Report twice in a year to update on business continuity progress.	Partially compliant	Embed full process across all Divisions	Head of EPRR/Divisional Directors	Feb-23
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	BC audits currently being undertaken by Head of EPRR with support from External Contractor. This has strengthened policy plans and arrangements whilst internal audit arrangements return to a healthier position after Covid 19. Governance teams aware of EPRR process and supportive; they are undergoing a significant transformation change programme and business continuity/emergency preparedness is already part of their regulatory check..	Fully compliant			
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Updated EPRR Improvement Plan includes lessons and learning from business continuity incidents. All activation of plans are followed by debrief sessions. Currently many departments are refreshing own business continuity plans based on Covid 19 learning as well as new templates and means of crtically thinking about resilience in their area of responsibility. Business Continuity performance a Standing Agenda Item at EPRR Steering Group. **EPRR/00 EPRR Steering Group** **EPRR/00 Structured Debrief and Improvement Planning**	Fully compliant			
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	This was again reviewed at the start of Covid 19 and learning continues to be built in to appropriate business continuity plans. Procurement lead process with Framework and other businesses.	Fully compliant			
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning		Not applicable			
Domain 10 - CBRN										
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	National Support - Chemical, biological, radiological and nuclear incidents; clinical management and health protectrion, Page 23 Trust Mass Countermeasures Framework Plan/NHS England Guidance for Requesting and Receipt of Countermeasures	Fully compliant			
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	CBRN/HAZMAT plan in place (March 2017) and initial review delayed due to Covid 19. Plan reviewed December 2021 to reflect National guidance, local changes and feedback from WMAS CBRNE audit. Exercise ORCA (live CBRNE exercise) conducted March 2022 which further validated plan. Currently amending to reflect additional learning and umpire comments. Planned for EPRR Steering Group approval (version 2.0) in September.	Fully compliant			

57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	ED risk assessment updated June 2021 and remains valid.	Fully compliant			
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	New decontamination shelter purchased by the organisation which was tested in Exercise ORCA (live CBRNE exercise in March 2022). Old decontamination shelter continues to be used for training purposes. Significant training sessions held prior to the exercise with list of staff trained and security staff trained logged, which allowed catchup in training programme. New ED/AMU Build due to open November 2022 which has a dedicated decontamination shower room which can take 2 people or stretcher patient for decontamination.	Fully compliant			
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Full internal audit completed spring 2022 including WMAS visit in Autumn 2021. Local checks in place with dedicated ED team and checked occasionally by EPRR team to ensure accurate and safe process in place.	Fully compliant			
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	Uplift in PRPS suits received in last 12 months and have been stored safely and logged. There is adeqaute supply of suits to deal with a CBRNE incident, including supply of old suits which are used for training purposes These are checked regularly to ensure they remain in date. Maintenance checks have been carried out by Respirex July 2022 and next checks are planned for 2023.	Fully compliant			
61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	Routine inspections and audits in place. EPRR provide level of assurance for ED staff who maintain and conduct equipment checks. Head of EPRR manages PRPS suit inventory and maintenance schedule.	Fully compliant			
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	Routine maintenance in place (led by dedicated CSW in ED) including support from Estates & Facilities and external bodies (WMAS, Private Sector Companies).	Fully compliant			
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	Any suits that are used then get recycled as training suits for training staff. Any damaged or unrequired suits are collected by WMAS.	Fully compliant			
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	Change of personnel in last 9 months has reduced our training expertise. Awaiting dates for training course for Band 7 EPRR lead and 2 band 6 educators.	Partially compliant	Confirm places and attend on Training course with WMAS	ED EPRR Lead	Dec-22
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Since March 2022 training has reduced due to changes in specialist staff in ED. Full training has taken place and proven during exercise ORCA in March 2022. There has been a temporary gap in training over the summer. Once new band 6 educators are in place a regular training schedule will recommence EPRR training passports to be launched Autumn 2022 to coincide with the new ED/AMU building.	Fully compliant			
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	Regular training programme in place up to March 2022. Training has reduced due to changes in specialist staff in ED. New staff need to attend specialist course.	Fully compliant			
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Regular training programme in place and records kept. Full live exercising for a number of staff took place in Exercise ORCA in March 2022. Number of operational lessons were identified and refinements are being made to ED CBRNE SOP and in latest version of Trust CBRNE plan. Recognised CBRNE training programme with supporting documentation and training suits in place.	Fully compliant			
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		All staff have individual fit mask testing and are tested on several FFP3 masks. All training recorded on ESR. This programme is led by dedicated individuals co-ordinated by Health and Safety Lead with support from IPC/key individuals in Depts.	Fully compliant			

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Evacuation and Shelter											
Domain: Evacuation and Shelter											
DD1	**Evacuation and Shelter**	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	https://www.england.nhs.uk/publication/shelter-and-evacuation-guidance-for-the-nhs-in-england/	Y	Trust Shelter and Evacuation Framework Plan updated twice in last 12 months to reflect national guidance and further operational planning. Now updated July 2022 (V 2.2) **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD2	**Evacuation and Shelter**	**Activation**	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2) See Sections 6, 7 and Annex K. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD3	**Evacuation and Shelter**	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2) See Sections 8, 9 and 10. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD4	**Evacuation and Shelter**	**Evacuation patient triage**	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2) Sections 8, 9, 10 and Annex B. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD5	**Evacuation and Shelter**	**Patient movement**	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2) - see Sections 8, 9 and 10. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD6	**Evacuation and Shelter**	**Patient transportation**	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2). See Sections 8, 9, 10, Annex B and Annex H. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD7	**Evacuation and Shelter**	**Patient dispersal and tracking**	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2). There are several references to Staff Tracking including form in Annex B. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Fully compliant				
DD8	**Evacuation and Shelter**	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	Shelter and Evacuation Framework Plan updated July 2022 (V 2.2). There are references in the plan to receive internal patients displaced by a local Trust incident. More work required to identify external shelter locations in extremis. Have stood up arrangements in last 12 months to recieve additional atients from neighbouring Trust.	Fully compliant				
DD9	**Evacuation and Shelter**	**Community Evacuation**	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	Shelter and Evac procedure updated July 2022 (V 2.2) Section 10. **EPRR/00 Policies & Plans/04 Shelter and Evac**	Partially compliant	Formalise use and identification of external shelter locations/options	Head of EPRR	Mar-23	
DD10	**Evacuation and Shelter**	**Partnership working**	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	Shelter and Evac procedure updated July 2022 (V 2.2). See Sections 9, 10 and Annex L. No real planning or exercising completed with external partners.	Partially compliant	Engage local partners in Trust Shelter and Evacuation Framework Plan details	Head of EPRR	Jun-23	
DD11	**Evacuation and Shelter**	**Communications- Warning and informing**	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	Communication planning covered separately. In extremis this would be a siginifiacant challenge	Fully compliant				

DD12	**Evacuation and Shelter**	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Y	Shelter and Evacuation Framework Plan mentions this in Section 10. To be undertaken	Non compliant	Undertake Equality and Health Inequalities Impact Assessment of updated Plan	Head of EPRR	Jun-23
DD13	**Evacuation and Shelter**	**Exercising**	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.	Y	Updated to reflect revised national guidance, Oct 21. Framework Plan in place to reflect new guidance and local practices. Workshop programme planned autumn with key Divisions separately with a Table Top Exercise planned Q2/3 2022-23 as set in draft EPRR Work Programme that commences Oct 22	Partially compliant	Training approach agreed and will be delivery 2022/23	Head of EPRR	Jun-23

MEETING OF THE Walsall Healthcare NHS Trust Board – Wednesday 5th October 2022			
Update from the Black Country Acute Collaboration Board			
Report Author and Job Title:	Simon Evans, Group Chief Strategy Officer	**Responsible Director:**	Simon Evans, Group Chief Strategy Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☒ Discuss ☐ Inform ☒ Assure ☐ Following discussions held at the Provider Collaboration Board over recent months, the Board is asked to: • Approve the report including next steps regarding configuration		
Assure	• The proposals contained within the reports have been considered by The Chief Executive and Chair and previously shared for discussion with Non-Executive Directors via the Committee in Common		
Advise	• The Provider Collaboration programme is working with colleagues across the ICB to agree the revised 'Target Operating Model' for all groups across the ICS		
Alert	• Further discussions regarding potential delegation of decision making are being worked through, recommendations regarding what this looks like will be presented back to the Board for consideration.		
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 is a commitment from all organisations to commit resources in terms of time for key roles. As a minimum this includes the roles identified so far: CEO, Chair, CSO, Director of Nursing and Director of Communications.		
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 ☒		

Black Country Provider Collaborative

Report to the Sovereign Boards of the BCPC

Subject: Strengthening Collaboration across the Black Country

Date: 18th July 2022

Report from: Black Country Provider Collaboration Board

1. PURPOSE

1.1 To share with Board members of the four sovereign Trusts the output of recent discussions on strengthening collaboration and obtain approval from each sovereign Board on the recommendations made by the Black Country Provider Collaborative Board.

2. BACKGROUND

2.1 Our environment is changing and has recently seen the establishment of Integrated Care Systems/ Partnership/ and Board (ICS, ICB & ICP) underpinned by Provider Collaboratives, Place Based Partnerships, Primary Care Networks and more in the new architecture (see appendix A for summary overview).

2.2 The Black Country Provider Collaborative (BCPC) sits as part of the delivery infrastructure of the ICS and the four Acute providers have been working collaboratively on a range of quality and service improvement initiatives since late 2020.

2.3 In building better relationships and trust between the four partners, it is anticipated that the opportunities presented for us to innovate and build on through best practice models in addition to addressing those collective issues (e.g. CQC ratings) with which we are dissatisfied, aligned with our focus on quality and service improvement, will begin to have a natural impact that will lead to questions of form, and whether the existing arrangements (of four independent organisations) remain a 'fit for purpose' vehicle as we move forward.

2.4 Against this context the regulator (NHSE) are paying close attention to the emergent 'target operating models' of the ICB and in turn the PC so that it can understand the implications for service change providing guidance, support, and approval whilst ensuring a level of assurance that is compliant with the NHSE *'Assurance for managing service change'*.

2.5 This interest has led to more frequent inquiries to key leaders within the Black Country Acute care sector on what the vision for a possible 'end-state' for acute care across the Black Country may be, and any short-term steps that may be taken to support the journey and ambition.

2.6 Under normal circumstances, determining form may not be the optimal course to pursue, with 'form' emanating from an understanding of the key drivers for change, current operating model, vision for the future, and the development of a target operating model amongst other processes.

2.7 However, the issue of 'future form' has taken on a level of importance which necessitated the development of a *Discussion Paper* (for the Provider Collaborative Board) focused

solely on this issue, that would in turn be a key foundational component of our forthcoming work on a '*Case for Change'*.

2.8 In short, this *Discussion Paper* described:

a. The background to the establishment of the Black Country Provider Collaborative
b. The positive journey and progressive work that has been undertaken since its establishment in late 2020
c. The recent governance refresh that has been undertaken to ensure it remains current
d. The context behind refreshing the 'case for change' soon
e. Some suggestions on possible options for future form
f. An insight into some key drivers, opportunities, and options for a way forward
g. Recommendations for consideration
h. An outline of a range of imminent engagement activities should the Programme Board deem it necessary.

2.9 Key extracts of this 'Discussion Paper' are provided in Appendix B.

3. PROPOSED WAY FORWARD

3.1 At their recent meeting on the 28th June the Provider Collaborative Board discussed and reviewed the range of issues presented within the paper by the BCPC Senior Responsible Officer (SRO). Amongst the key discussion points were:

- An acknowledgement of the progressive journey that the 4 partners have taken since late 2020.
- Analysis of the Provider Collaborative policy agenda as part of the emerging healthcare architecture with integration and collaboration central facets.
- The recognition of the range of drivers within the healthcare environment that are influencing and shaping the provision of care and how health care provision is optimally organised for the future.
- The important role that acute care will drive to deliver improvements in unwarranted variation, inequalities in health outcomes, access to services and experience.
- The positive focus on Clinical Service Improvement through the Clinical Networks, which will support delivery of access times, opportunities to 'level up', and pursue opportunities for specialisation and consolidation.

3.2 Against this context several options on a vision for 'future acute care form in the Black Country' were presented, discussed, and considered. These included (descriptions of each provided in Appendix B, section 2):

Short to medium term aspirations

a. Consolidating around existing statutory arrangements
b. North & South Black Country system model (retaining Trust Boards)
c. Shared Chair with existing statutory arrangements (retaining Trust Boards)
d. Single Hospital system – across multiple sites
    i. Site Group Model
    ii. Service Group Model

Longer term possible aspirations

e. Black Country system Acute, Mental Health & Learning Disabilities care provider
f. Black Country ACO / Integrated Health organisation

g. Black Country Integrated Health & Social Care Board

3.3 The discussion paper proposed the following:

i. that the BCPC should work towards developing an agreed model that could be implemented over the next 36 months, and possibly focus on Option (b) '***North & South Black Country system model***' in the first instance.

ii. At an appropriate time, in maximising the opportunities afforded by the new Health & Care Act, a longer-term end-state vision for consideration may be that of option (f) an ***'Black Country ACO / Integrated Health Board'*** which could incorporate all types of health providers enabling a more integrated system.

3.4 Discussion by the Black Country Provider Collaboration Board concluded with the following key Agreements:

a. It was agreed that with the current Chair of Dudley due to step down in the summer, a single Chair for DGFT and SWBH would be pursued. This has now been confirmed with Sir David Nicholson being appointed as of the 1st September 2022.

b. It was agreed that a subsequent step would be to work towards a single unified Chair for the Acute sector in the Black Country at the appropriate time, and in establishing this arrangement that 'anchor organisations' at Place would most likely have a 'Deputy Chair' in Group Model arrangement, a model that is being explored and adopted in many places around the country (see Appendix B, section 3.7).

c. It was agreed that this approach would be articulated in a short paper for presenting to all Board members of the four Acute Providers simultaneously in private prior to presentation at a public board meetings.

d. It was agreed that an engagement plan would be urgently developed, to ensure good communications and engagement with all stakeholders.

3.5 It should be recognised that no changes to Trust Board sovereignty are being proposed, and with 'Place Based Partnerships' being a key vehicle for local delivery, Trusts will retain a very strong local focus in the future healthcare delivery and provision model.

3.6 This is something that we are actively working on with our colleagues in the ICB as part of the work on a future 'target operating model' and will be further expanded upon in our forthcoming work on a 'Case for Change'.

4. RECOMMENDATIONS

4.1 Sovereign Trust Boards are asked to:

a. Note the circumstances which have led to key discussions and this report

b. Receive and note the contents of this report as identified in 3.4 (c) above.

c. Discuss and review at the next sovereign Trust Board, the approach proposed by the Black Country Provider Collaborative Board, outlined at 3.4 and confirm / provide support for this proposal to the Black Country Provider Collaborative SRO and Programme Director

5. CONTACT DETAILS

Diane Wake
SRO BCPC & DGFT CEO
D.Wake@nhs.net

Sohaib Khalid
BCPC Programme Director
Sohaib.khalid4@nhs.net

MEETING OF THE Trust Board – 05 October 2022			
Sustainability Report			**AGENDA ITEM:**
Report Author and Job Title:	Janet Smith Head of Sustainability	**Responsible Director:**	Simon Evans Group 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	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 and to seek approval for the use of the Sustainability Impact Assessment Tool for business development, investment, and procurement decisions.

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 for 2022/23, 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 June 2022, the proportion of desflurane used in surgery is at 0.0% (Attachment 1). 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 ensure that the level of use remains within the national target.

b) ***Waste management and recycling*** – There is a strong demand from staff for the implementation of better waste management and recycling within the Trust. The result of the ongoing waste management review will inform the type of waste management and recycling system that will be implemented to satisfy the demand.

c) ***Greening Services Scheme*** – Infection Prevention is implementing a scheme to reduce usage of gloves in clinical practice. This will reduce the volume of gloves going into the waste stream and realise financial savings.

d) ***Travel and Transport*** –Patients and visitors to the Trust will enjoy 25% discount on day tickets 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.

NHS Midlands priority deliverables for 2022/23

NHS Midlands Greener Delivery Board released the priority deliverables for 2022/23. The focus are travel & transport, medicines, estates and facilities, supply chain and workforce & leadership. Key deliverables for the Trust are:

a. By March 2023, 5% of Trust fleet are Ultra-Low Emissions (ULEV) and Zero Emissions Vehicle (ZEV).
b. By March 2024, 90% of the Trust owned and leased fleet are Low Emissions Vehicle.
c. Reducing desflurane used in surgery to less than 5% by March 2023.
d. Reducing the emissions associated with nitrous oxide
e. 25% reduction in all non-salbutamol inhalers prescribed.
f. Reduce the mean life-cycle carbon intensity of salbutamol inhalers prescribed to 13.4kg C02e by increase prescribing of less carbon intensive MDIs.
g. Reducing the C02e impact of inhalers by 50% in 2028.
h. Ensure all new builds and retrofits over £15m are compliant with the Net Zero Hospital Buildings Standards.
i. All new NHS procurements include a minimum of 10% net zero and social value weighting from April 2022.
j. Implement a walking aids reuse scheme by March 2023
k. 50% reduction in printing and office paper use by 2025.

BCWB ICS Sustainability Impact Assessment

The Black Country and West Birmingham ICS has agreed a single sustainability impact assessment tool (Attachment 2) to assist its member organisations to measure the sustainability impact of business development, investment, and procurement decisions. Each Trust is expected to implement the tool.

Funding opportunities

1. SBRI Healthcare Competition 22: Delivering Net Zero NHS: Clinical Innovation Competition
2. Innovate UK KTN - Net Zero Heat Programme

Action priorities of the next 6 months are the following:

1. Update Green Plan carbon reduction targets and action plan based on the result of the carbon footprinting exercise.
2. Recruit clinical and non-clinical services in "Greening Services Scheme".

3. 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.
4. Mid-year review of the Green Plan.
5. 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, approve the use of the sustainability Impact Assessment, the priorities for the next 6 months, the funding opportunities, and the resource implication for planned initiatives.

Audit Committee
Chair Assurance Report

Walsall Healthcare NHS Trust

Name of Committee/Group:	Audit Committee
Date(s) of Committee/Group Meetings	2nd September 2022 – Virtual meeting
Chair of Committee/Group:	Mary Martin
Date of Report:	28th September 2022

ALERT **Matters of concerns, gaps in assurance or key risks to escalate to the Board/Committee**	• At the end of June, the Trust was targeted by a Mandate Fraud. Local Counter Fraud services were alerted and have carried out internal training and are working with the NHS Counter Fraud Authority.
ADVISE **Areas that continue to be reported on and/or where some assurance has been noted/further assurance sought**	• The committee received a presentation on the CQC action plan and around Medicines Management and the Respect Audit. Good progress is being made on implementing the recommendations. • The committee received a report on the Security services. These are now being managed across both WHT and RWT by the same team and the WHT provider is now being held to account to deliver the contracted service. A full report will be prepared for the December meeting. The services are due for retender in the next twelve months and the intention is to tender for both Trusts at the same time.
ASSURE **Positive assurances & highlights of note for the Board/Committee**	• RSM have six internal audits in progress which are on timetable and should be complete by the next meeting. • The timetable for the 2022/23 External Annual Audit is in place.
Recommendation(s) to the Board/Committee	• Recommendation of the Standing Orders, Reservations and Delegations of Powers & Standing Financial Instruction Policy for endorsement at Private Board
Changes to BAF Risk(s) & TRR Risk(s) agreed	• A new Board Assurance Framework template is being developed and will be introduced along with the revised Strategic Objectives. A consultation process is in progress.
ACTIONS **Significant follow up action commissioned (including discussions with other Board Committees, Groups, changes to Work Plan)**	• The Mandate Fraud will be further debated at Private Board. • An update on the IT road map to support areas where there are paper systems which do not help the Trust manage risk is due in December. • External Audit and Internal Audit recommendations implementation are being tracked during 2022/23.
ACTIVITY SUMMARY **Presentations/Reports of note received including those Approved**	• RSM presented their IT infrastructure report. There were 1 high, 3 medium and 4 low recommendations all due for completion by 31 March 2023. These will be tracked along with all other Internal Audit recommendations • A verbal update on Cyber Security was received. A full paper will come to the December meeting. • An update on staff email access was received. The staff without email access has now been reduced to 465.

ACTIVITY SUMMARY **Major agenda items discussed including those Approved**	• Counter Fraud progress report was discussed • Single Tender action report was presented • The review of Losses and Payments was presented.
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 5th October 2022**			
Urgent & Emergency Care Resilience – Winter Plan 2022/23			
Report Author and Job Title:	Rob Ankcorn, Director of Operations (MLTC)	**Responsible Director:**	Ned Hobbs Chief Operating Officer
Recommendation & Action Required	Members of the Committee are asked to: Approve ☒ Discuss ☐ Inform ☐ Assure ☐ Members are asked to note the investments made to date within Urgent & Emergency Care of £2.4m and recommend utilisation of the remaining winter funds of £2.2m (£1.6m the balance of the £4m uncommitted and further system allocation of £0.6m) schemes contained within option 1 of this report. Members are further asked to note the preferred solution is option 2 and the Executive are seeking further resources that will enable enhanced investment beyond option 1 upon securing further resources.		
Assure	The Winter of 2021/22 was an incredibly difficult period for Urgent & Emergency Care in the West Midlands region. The pressures of increased hospital occupancy levels, above average staff absence and Winter-specific illness and acuity led to challenged Urgency & Emergency Care performance across the Black Country Integrated Care System. Last year's Winter Plan heavily mitigated these pressures and enabled Walsall Healthcare NHS Trust to deliver a higher quality of care than would otherwise been achieved. Together, the trust delivered the best ambulance handover times in the West Midlands for each month between October 2021 – March 2022 and placed in the top quartile nationally for Emergency Access Standard performance between November 2021 – February 2022. This was testament to the planning and execution of every Division, Department, and colleague in the Trust. Winter 2022/23 presents a different set of challenges which will be equally if not more challenging than the preceding one. We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This is set against the context of unprecedented national pressures for Emergency Care currently too. So far, 2022/2023 has seen the worst national Emergency Access Standard Performance on record with a quarter of patients waiting over 4 hours to be admitted or discharged from Emergency Departments every month so far. The number of patients spending over 12 hours awaiting an admission has increased more than thirty-fold and ambulance response times have deteriorated to their worst ever levels. In addition, developments in the wider economy are also placing increased importance on effective Winter Planning. The 'Cost of Living Crisis' is increasing poverty and hardship for the most financially		

	vulnerable. The Institute of Health Equity led by Public Health Professor Sir Michael Marmot claims the increased financial hardship will have a direct negative impact on both Physical and Mental Health which will likely increase the demand for health services. Given Walsall is the 25th most deprived English Local Authority out of 317, this will have a disproportionate effect on Communities the Trust serves. As an anchor institution for the Borough of Walsall with a commitment to reducing health inequality, it is crucial the Trust factors this into the Winter Plan. With this challenging context in mind, the 3 central tenets of the Winter Plan are as follows: 1. A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than simply opening more hospital inpatient beds. 2. Following the success of our targeted approach to managing the Festive period over the last three years, the same approach will be adopted for 2022/23 running from Saturday 17th December 2022 to Sunday 8th January 2023. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated. 3. A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions. This has resulted in part of the Winter Plan allocation being diverted to fund substantive rather than temporary interventions such as increased clinical decision making in ED, service expansion of Ambulatory Emergency Care and extending operational hours of the Discharge Lounge.
Advise	Getting this right is really important, and is a whole hospital, whole Trust, and whole health economy responsibility. It is important because if we don't get it right, patients will spend excessive time in the ED and will be at increased risk of contracting covid-19, influenza, RSV or other infections under our care. We know prolonged duration of stay in the ED for admitted patients is directly associated with an increased mortality rate of approximately 0.75% per additional hour in ED. We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, the pan-West Midlands Stat-stress study highlighted that staff working along the

	emergency care pathway in ED, wards and Critical Care were 40-50% more likely to report symptoms suggestive of Post-Traumatic Stress Disorder during the Covid-19 pandemic. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. Importantly, and directly to support staff experience and wellbeing, we have taken a conscious decision to shift the balance of the Winter Plan financial allocation from non-recurrent temporary interventions towards approved recurrent business cases to ensure substantive staff can be recruited to strengthen emergency care services and staffing resilience. This has played a part in contributing to the approval of the following business cases, all of which will support a safer Winter (and indeed all year round), in addition to ED and AMU nurse establishment reviews: - ED medical workforce (including doctors, ACPs and ENPs) - Ambulatory Emergency Care - Discharge Lounge hours extension - Therapy provision to surgical wards
Alert	In addition to the £2.4m investment made in year for substantive workforce within Urgent and Emergency Care (ED Medics, Ambulatory Emergency Care, Discharge Lounge and Therapies), this paper outlines further additional measures and investment for Winter Plan, the three options for the Board being. 1. Option 1 – (£2.4m plus a further £2.17m) This option sets a core set of Winter Interventions designed to mitigate the pressure on UEC. However, the option heavily curtails most large interventions in place from November-February which is a risk given the sustained pressures seen historically within the month of March. In addition, it excludes further interventions such as weekend provision of the Acute Frailty Unit and increases in portering staff to assist with urgent transfers of patients. This option would deliver limited resilience for UEC pathways compared to the further options and thus contains greater risk to maintaining safe UEC services and maintaining staff wellbeing along the UEC pathway. 2. Option 2 – (£2.4m plus a further £2.79m) This option enables the key interventions to run for the duration of Winter to align the Trust's response with past experience of Winter pressure. This option would deliver satisfactory resilience for UEC pathways, but contain some risk in the event of a Winter with more significant adverse scenario factors such as higher levels of Covid, Influenza or Norovirus or more significant risk in the social care setting due to the cost of living crisis.

<table>
<tr><td></td><td>
3. Option 3 – (£2.4m plus a further £3.45m) This option is the broadest set of interventions and includes expanded Community IV interventions, expanded Frailty Case Managers, additional beds for Women's services and increased operational support for managing Capacity & Flow. This option would deliver the greatest resilience for UEC pathways.

Combining the financial and non-financial risk factors, Option 2 is the preferred option. This option will mitigate risk satisfactorily in the most likely scenario for this Winter, but will not provide enough resilience to manage more significant Winter adverse scenario factors, such as:
- Significant increase in MSFD patients
- Significant further increase in out of borough intelligently conveyed ambulances
- High influenza prevalence combining with significant Covid-19 resurgence and/or high norovirus prevalence.

However, due to timing of Committee and Board, option 2 is not yet fully resourced, and thus the recommendation within the resource implications below is in two phases.
</td></tr>
<tr><td>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</td><td>Risk 208 - Total time spent in ED
BAF S01 – Safe, High Quality Care
BAF S06 – Use of Resources</td></tr>
<tr><td>Resource implications</td><td>
The Trust identified £4m within the 2022/23 financial plans for winter, with the Trust making investments from this pot of resource within Urgent & Emergency Care of £2.4m, as detailed within the below table:

<table>
<tr><th>Ref</th><th>Description</th><th>Amount £m's</th></tr>
<tr><td colspan="3">Funding to support winter initiatives</td></tr>
<tr><td>1</td><td>Financial Plan 2022/23</td><td>4.0</td></tr>
<tr><td>2</td><td>Further system allocation (further pressures)</td><td>0.6</td></tr>
<tr><td colspan="2">TOTAL FUNDING FOR WINTER</td><td>4.6</td></tr>
<tr><td colspan="3">Expenditure committed to support winter substantively in 2022/23</td></tr>
<tr><td>3</td><td>Emergency Department Medical Staffing</td><td>(0.7)</td></tr>
<tr><td>4</td><td>Ambulatory Emergency Care (AEC) & AMU</td><td>(1.0)</td></tr>
<tr><td>5</td><td>Discharge Lounge</td><td>(0.4)</td></tr>
<tr><td>6</td><td>General Surgery</td><td>(0.2)</td></tr>
<tr><td>7</td><td>Surgical Therapies</td><td>(0.2)</td></tr>
<tr><td colspan="2">TOTAL EXPENDITURE ALREADY UTILISED</td><td>(2.4)</td></tr>
<tr><td colspan="2">FUNDS AVAILABLE FOR WINTER INITIATIVES
(This represents the £1.6m remaining from the plan plus the additional £0.6m further system allocation received in year).</td><td>2.2</td></tr>
</table>

The Trust has made commitments of £2.4m against schemes to support
</td></tr>
</table>

Urgent and Emergency Care through substantive appointments already made, with further latitude to invest in schemes totalling £2.2m.

Scheme	Option 1 £m's	Option 2 £m's	Option 3 £m's
Committed	(2.4)	(2.4)	(2.4)
Further ask	(2.2)	(2.8)	(3.4)
TOTAL	(4.6)	(5.2)	(5.8)
Funding	4.6	4.6	4.6
Surplus / (shortfall)	**nil**	**(0.6)**	**(1.2)**

The only affordable option is option 1, this results in £4.6m of investment through substantive and non-recurrent measures for 2022/23. The funds increased from the residual pot of £1.6m to £2.2m following further system allocations to support expected demand.

Phase 1:
The Board is asked to approve Option 1 which is the only option fully resourced at an incremental cost of £2.2m, investment in winter for 2022/23 total equating to £4.6m.

Phase 2:
Board Members are asked to note Option 1 may not offer satisfactory resilience within UEC services this Winter, with Option 2 preferred if it can be adequately resourced. The Trust is seeking additional funds from a combination of funding streams, as detailed below:

- £0.3m via charging other systems for out of ICS MSFD delays
- £0.3m via Service Development Funds directly for Community
- £0.35m further allocation from the Black Country ICS Winter fund

The Executive Team will continue to pursue the above funding streams, and assess the additional scheme benefits versus financial risk of option 2, and may recommend further investment.

This recommendation has been endorsed at Investment Group (26/09/22), Trust Management Committee (27/09/22) and Performance & Finance Committee (28/09/22).

Legal and/or Equality and Diversity implications	There is clear evidence that greater deprivation is associated with a higher likelihood of utilising Emergency Department services, meaning longer Emergency Access Standard waiting times will disproportionately affect the more deprived parts of the community we serve.	
Strategic Objectives	Safe, high-quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

Walsall Healthcare NHS
NHS Trust

Urgent & Emergency Care Resilience: Winter Plan 2022/23

Active Period
1st October 2022 to
31st March 2023

Version 3

Executive Lead

Ned Hobbs
Chief Operating Officer

Contributing Authors
Rob Ankcorn, Divisional Director of Operations, Medicine Division

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

Section

1.0 Foreword

The Winter of 2021/22 was an incredibly difficult period for Urgent & Emergency Care in the West Midlands region. The pressures of increased hospital occupancy levels, above average staff absence and Winter-specific illness and acuity led to challenged Urgency & Emergency Care performance across the Black Country Integrated Care System. Last year's Winter Plan heavily mitigated these pressures and enabled Walsall Healthcare NHS Trust to deliver a higher quality of care than would otherwise been achieved. Together, the trust delivered the best ambulance handover times in the West Midlands for each month between October 2021 – March 2022 and placed in the top quartile nationally for Emergency Access Standard performance between November 2021 – February 2022. This was testament to the planning and execution of every Division, Department, and colleague in the Trust.

Winter 2022/23 presents a different set of challenges which will be equally if not more challenging than the preceding one. We know that traditionally emergency care services face greater pressure during the winter months as a result of patients being more acutely unwell and thus staying in hospital longer. This is set against the context of unprecedented national pressures for Emergency Care. So far, 2022/2023 has seen the worst national Emergency Access Standard Performance on record with a quarter of patients waiting over 4 hours to be admitted or discharged from Emergency Departments every month so far. The number of patients spending over 12 hours awaiting an admission has increased more than thirty-fold and ambulance response times at a national level have deteriorated to their worst ever levels.

In addition, developments in the wider economy are also placing increased importance on effective Winter Planning. The 'Cost of Living Crisis' is increasing poverty and hardship for the most financially vulnerable. The Institute of Health Equity led by Public Health Professor Sir Michael Marmot claims the increased financial hardship will have a direct negative impact on both Physical and Mental Health[1] which will likely increase the demand for health services. Given Walsall is the 25th most deprived English Local Authority out of 317[2], this will have a disproportionate effect on Communities the Trust serves. As an anchor institution for the Borough of Walsall with a commitment to reducing health inequality, it is crucial the Trust factors this into the Winter Plan.

With this challenging context in mind, the 3 central tenets of the Winter Plan are as follows:

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

2. Following the success of our targeted approach to managing the Festive period over the last three years, the same approach will be adopted for 2022/23 running from Saturday 17th December 2022 to Sunday 8th January 2023. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this

[1] https://www.instituteofhealthequity.org/in-the-news/press-releases-and-briefings-/fuel-poverty-cold-homes-and-health-inequalities-press

[2] https://www.walsallintelligence.org.uk/home/demographics/deprivation/

period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

3. A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions. This has resulted in part of the Winter Plan allocation being diverted to fund substantive rather than temporary interventions such as increased clinical decision making in ED, service expansion of Ambulatory Emergency Care and extending operational hours of the Discharge Lounge.

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

We also know that emergency care services are high pressure environments, with a greater burnout rate for staff. In addition, recent research published in the British Medical Journal[3], highlights that clinicians working in emergency care specialties are at heightened risk of burnout due to sustained pressure. This Winter Plan seeks to improve the resilience of the Trust's emergency care pathways for the benefit of the patients we serve, and also crucially to protect the wellbeing of hard-working staff working in highly challenging environments. Importantly, and directly to support staff experience and wellbeing, we have taken a conscious decision to shift the balance of the Winter Plan financial allocation from non-recurrent temporary interventions towards approved recurrent business cases to ensure substantive staff can be recruited to strengthen emergency care services. This has played a part in contributing to the approval of the following business cases, all of which will support a safer Winter (and indeed all year round), in addition to ED and AMU nurse establishment reviews:

- ED medical workforce (including doctors, ACPs and ENPs)
- Ambulatory Emergency Care expansion
- Discharge Lounge hours extension
- Therapy provision to surgical wards
- New Acute Gall Bladder pathway as part of the General Surgery business case

Thank you to all colleagues who played their part in delivering as safe a Winter as possible last year and thank you to all colleagues who have been involved in developing this plan. Just about every specialty or department in the Trust has a role to play to ensure we manage Winter as well and as safely as we can, and it is our collective responsibility to ensure that we do just that.

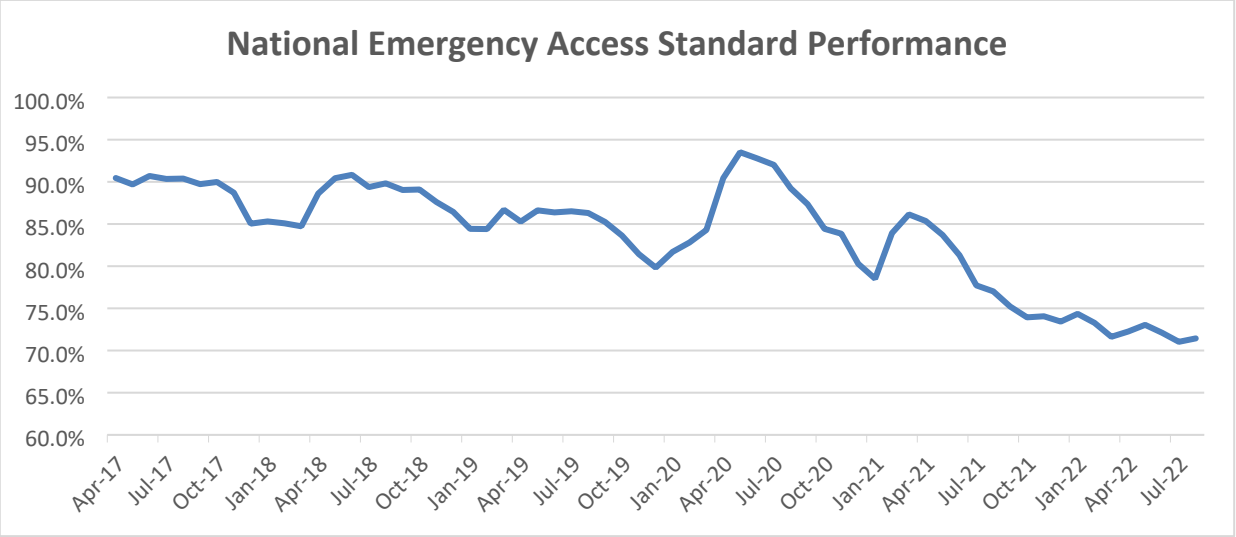
Ned Hobbs
Chief Operating Officer
Walsall Healthcare Trust

3. Weigl, M (2022), *Physician burnout undermines safe healthcare*, British Medical Journal; 2022, 378

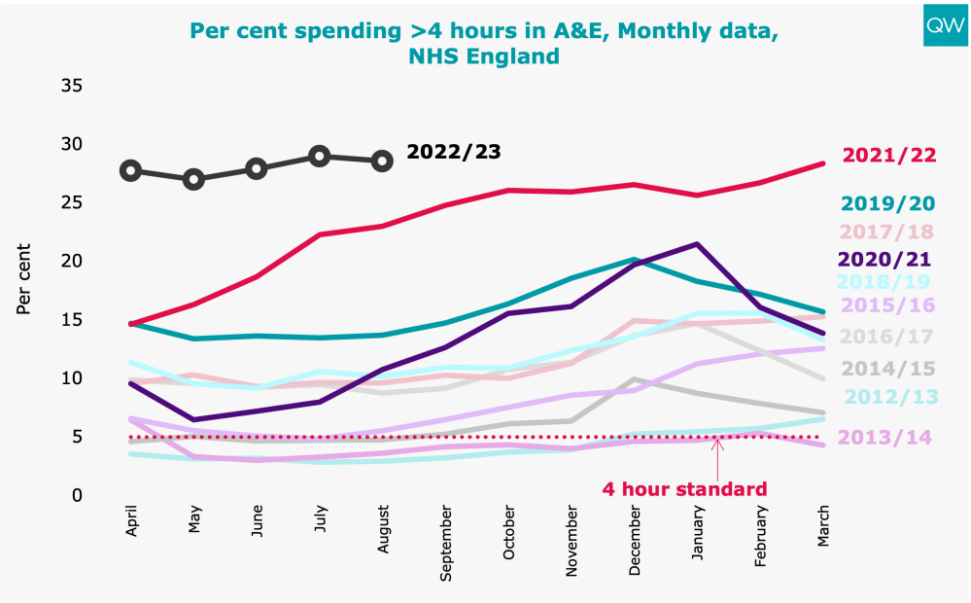
2.0 Executive Brief

Last year's Winter plan anticipated that the winter of 2021/22 would be the most challenging yet. Given the unprecedented challenges facing Urgent & Emergency Care services so far this year, high non-elective demand, more acutely unwell patients due to undiagnosed or delayed diagnosis of conditions, and significant challenges in the provision of domiciliary social care, this winter is set to be even more difficult. The country enters this Winter with the Urgent and Emergency Care system in the most perilous position it has ever faced[4], and thus the importance of a resilient Winter Plan is arguably even greater than in previous years.

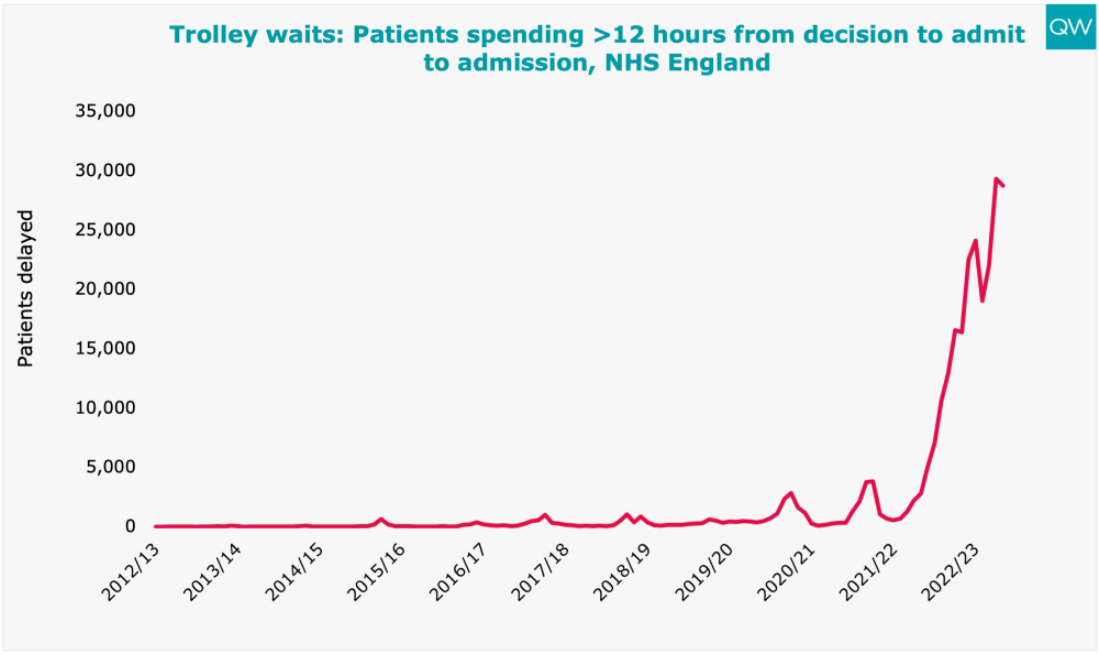
The Urgent and Emergency Care system in England has huge risks within it currently. As a proxy for the level of overcrowding in Emergency Departments, and the level of Exit Block (delayed admission for patients needing admitting from ED into the hospital), the country is delivering the worst 4-hour Emergency Access Standard performance on record currently:



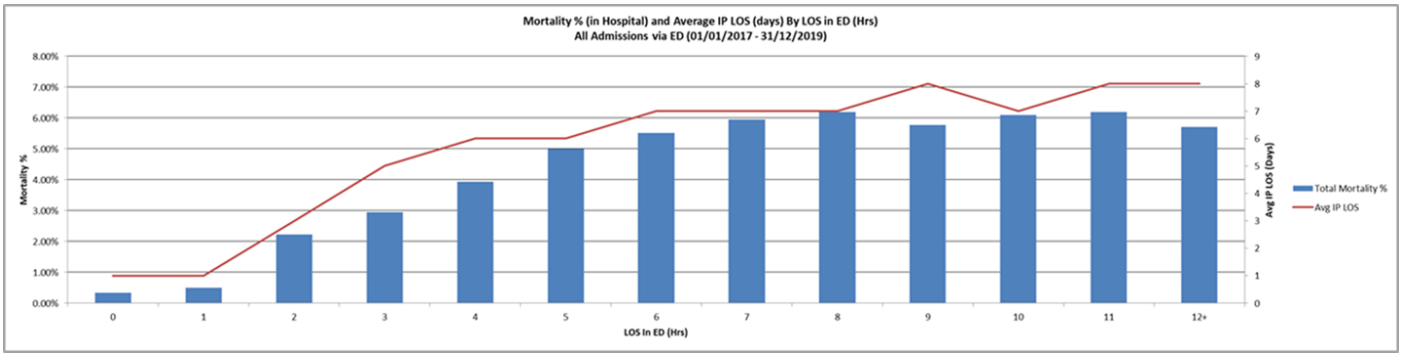
Moreover, as can be seen by the following charts the pressures experienced over Summer 2022, and into Autumn 2022 are unprecedented:



[4] https://www.nuffieldtrust.org.uk/qualitywatch/nhs-performance-summary#ambulance-response-times



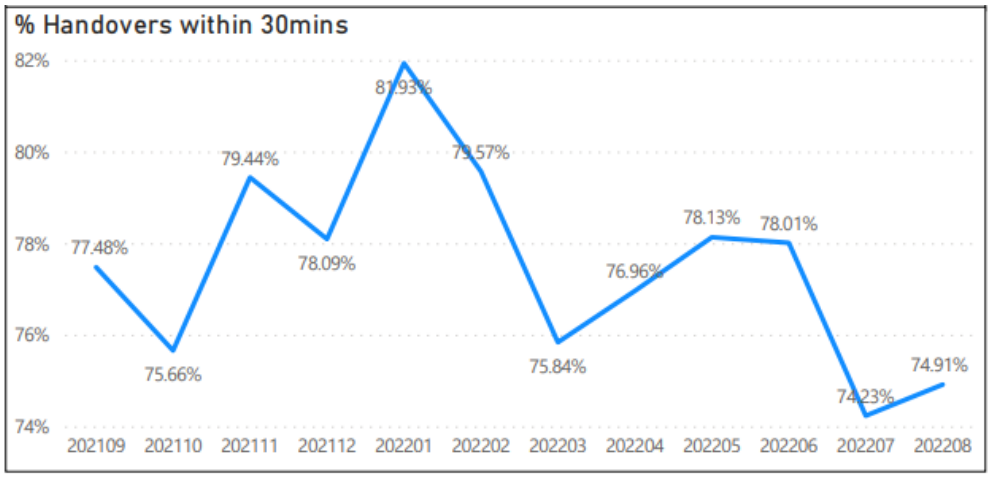
The 4-hour Emergency Access Standard is a relatively blunt measurement. However, we know that each additional hour patients spend in the Emergency Department prior to admission to hospital, is associated with an approximately 0.75% increased risk of death, and with increased inpatient length of stay once admitted too:



The risks are not currently just within hospitals. Indeed some of the greatest risks are for patients in the community needing an emergency ambulance to attend to them[5] . West Midlands Ambulance Service is currently experiencing the worst ambulance handover delays at Emergency Departments on record, meaning crews are unable to be released to get to the next 999 call. Again, the delays are not only unprecedented, but indeed grossly unprecedented for Summer/Autumn period, causing significant concern for the Winter ahead:

[5] College of Paramedics and Royal College of Emergency Medicine (2021*), Increased ambulance handover delays threatening patient safety, RCEM and College of Paramedics warn* https://www.rcem.ac.uk/RCEM/News/News_2021/Increased_ambulance_handover_delays_threatening_patient_safety__RCEM_and_College_of_Paramedics_warn.aspx

West Midlands Ambulance Service handovers within 30 minutes:



This year's Winter Plan explicitly seeks to address the CQC's recommendations contained in People FIRST, the specialist support tool to reset standards of care in Emergency Medicine, published September 2022.

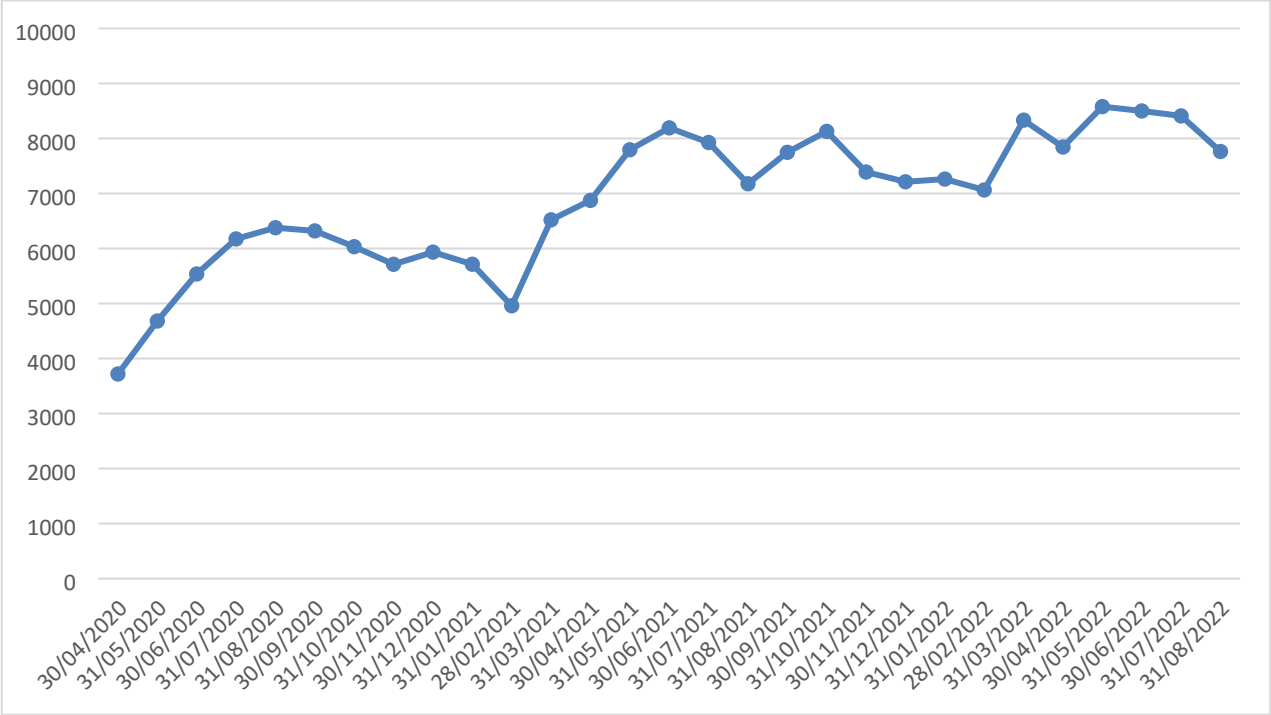
Our staff have continued to work tirelessly throughout this year. Whilst Spring and Summer often brings a less pressured time for the NHS, regrettably this year the heightened pressure has been a constant. This resulted in a greater need for timely treatment, optimised lengths of stay and discharges early in the day. Staff are tired and nervous about the Winter ahead and we need to ensure the Health & Well-being offerings continue throughout the coming Winter and that our Winter Plan is as resilient as it can be to both provide the best possible patient care, and the best possible working environment for staff. Importantly, and directly to support staff experience and wellbeing, we have taken a conscious decision to shift the balance of the Winter Plan financial allocation from non-recurrent temporary interventions that often rely on our own staff undertaking more shifts, towards approved recurrent business cases to ensure substantive staff can be recruited to strengthen emergency care services. This has played a part in contributing to the approval of the following business cases, all of which will support a safer Winter (and indeed all year round), in addition to ED and AMU nurse establishment reviews:

- ED medical workforce (including doctors, ACPs and ENPs)
- Ambulatory Emergency Care
- Discharge Lounge hours extension
- Therapy provision to surgical wards

A full review of the 2021/22 Winter plan was undertaken across all Divisions and departments, and once more the key themes, areas of good practice, improvement and successful interventions were identified and captured (see s.4.0) with the shift from temporary/non-recurrent interventions to recurrent substantive investments a key priority from this review.

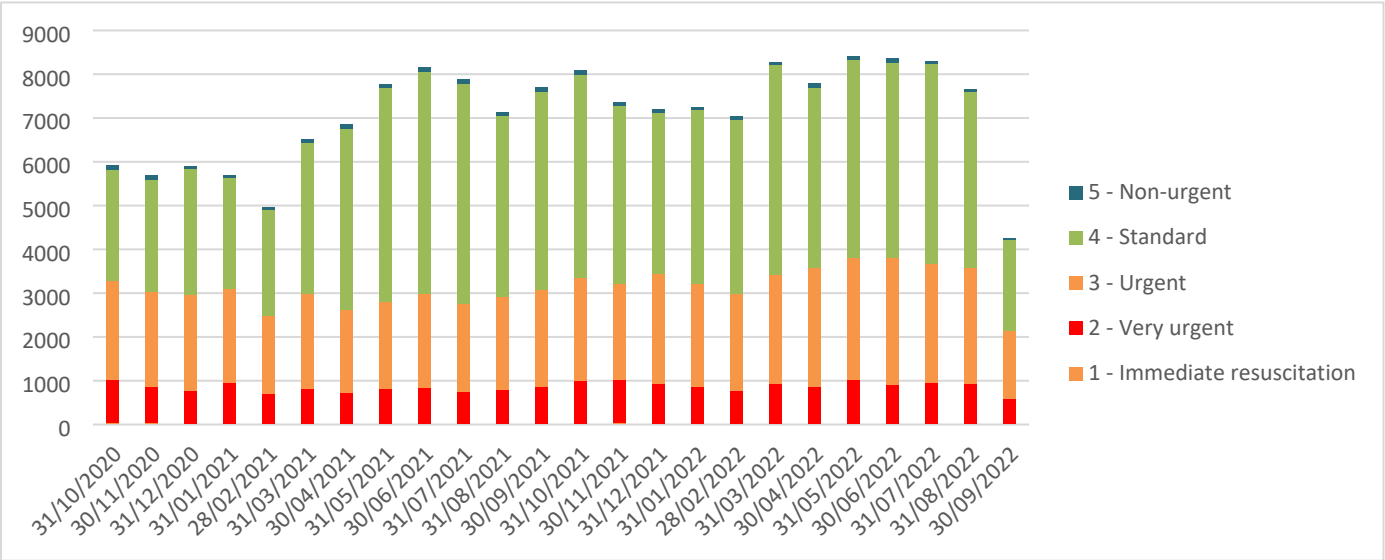
Walsall Healthcare NHS Trust Key Metrics

ED Type 1 attendances



The increase in demand has been particularly seen in the Type 4 categories (lower acuity), possibly due in part to patient's difficulties in accessing primary care and 111 services.

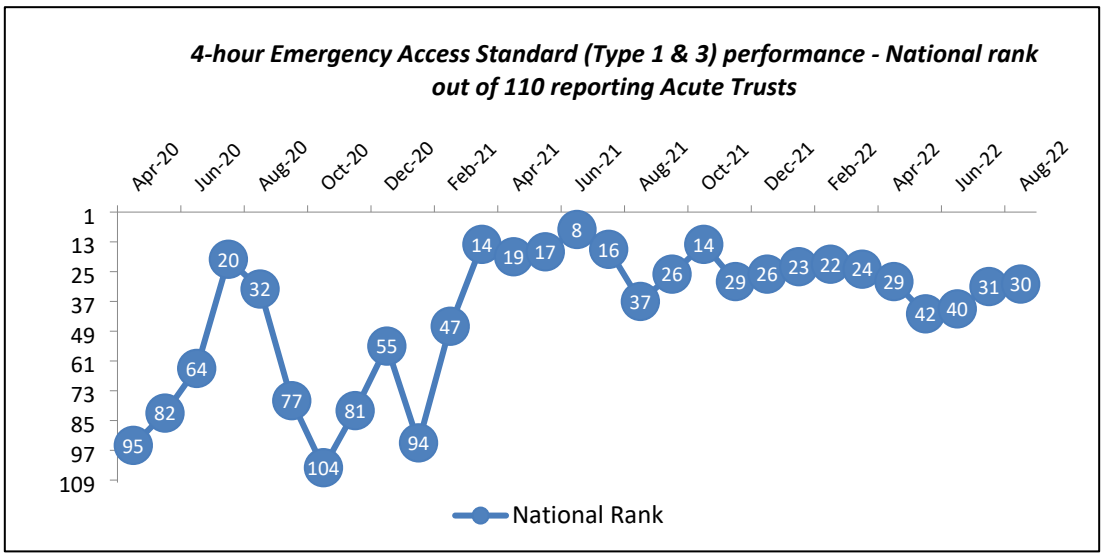
Type 1 Attendances by Triage category (September 2022 part month only)



Despite our own pressures, WHT has continued to support neighbouring Trusts at times of extremis by accepting ambulances intelligently conveyed by West Midlands Ambulance Service, and by accepting requests for ambulance diverts where possible and this was acknowledged in the recent Association for Ambulance Chief Executives national Ambulance Leadership Forum conference on

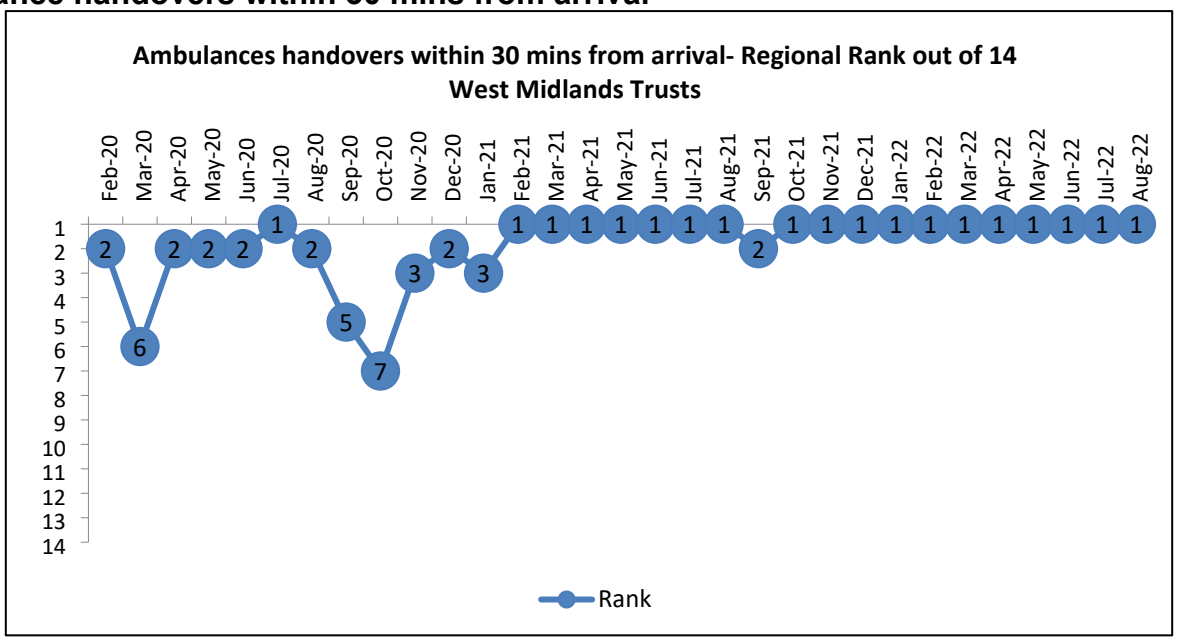
ambulance service performance. Despite these pressures over the past months, the Trust has continued to achieve above performance in the upper third nationally.

Emergency access standard performance – Types 1&3 national ranking



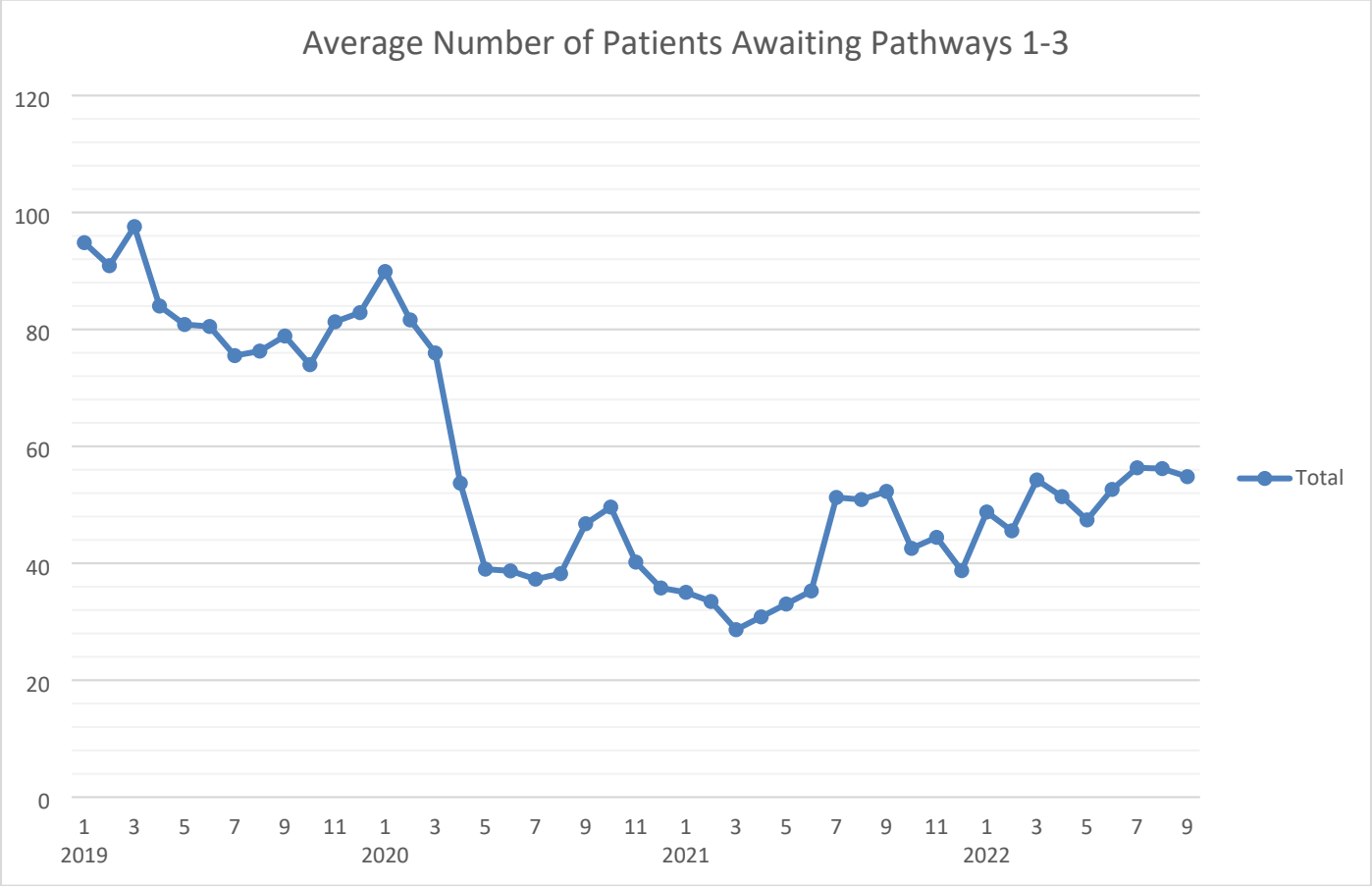
The Trust continues to rank number 1 in the West Midlands for the 11th consecutive month for ambulance handovers within 30 minutes of arrival.

Ambulance handovers within 30 mins from arrival



The Trust's ability to maintain flow throughout the hospital and thus avoiding exit block from ED has been greatly enhanced by the hard work of our Community colleagues and the management of our medically stable for discharge (MSFD) patients. Whilst numbers of MFFD patients remain much lower than the pre-covid average, they have exceeded the planning assumption of 50 for the past four months.

Medically Stable Patients Awaiting Pathways 1-3



This plan continues to build on the learning from previous years with many enhancements to the interventions that have worked so well to date, spanning acute and community health and social care.

The plan is subject to the following Governance approval process:

- Trust Management Committee (27/09/22)
- Performance & Finance Committee (28/9/22)
- Trust Board (05/10/22)
- Black Country Urgent & Emergency Care Board (07/10/22)

3.0 Purpose of this document

3.1 The purpose of this Urgent & Emergency Care Resilience Winter Plan is to:

- Inform all relevant organisations and individuals of the way in which the system intends to manage Urgent and Emergency Care demand and provide resilience over the winter 2022/23
- Hold information on the approach taken to building the winter plan

3.2 The plan should be read by:

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

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

- The appendices to this document
- Emergency Department Covid Escalation Policy
- Escalation policy – Full Hospital Protocol (2016)
- Covid-19 Contingency Plan (Version 3.3 June 2021)
- RSV Surge Plan (August 2021 and ongoing)
- Major Incident Plan (May 2019)
- Divisional, Enabling Departments and local Business Continuity arrangements
- Severe Weather Plan
- Walsall Council Severe Weather Partnership
- Walsall Council Local Covid-19 Outbreak Plan

4.0 Approach to planning for winter 2022/23

4.1 In previous years a formal 'After Action Review' has taken place with a final report presented to a number of committees and to Trust Board. This year Winter Plan reflections and lessons learned workshops were developed, co-ordinated and reported upon by the Head of EPRR. A detailed database of reflections, new ideas, areas that succeeded and interventions/arrangements that can be improved upon were documented. This report was shared to all Divisions and key departments and formed a strong foundation to fine tune arrangements for the winter ahead. Supplemented by strong and consistent datasets, both offered planners an excellent starting point for 2022/23 and were shared before and briefed at the initial planning meeting. The Winter 2021/22 review is included as an Appendix.

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

- A strategic focus on interventions that improve quality of care and result in reduction in overnight hospital admissions, including an increase in same day emergency care (SDEC) services, interventions to get people better sooner (reducing inpatient length of

stay), and interventions through the Walsall Together Partnership to avoid admissions, rather than simply opening more hospital inpatient beds.

- Following the success of our targeted approach to managing the Festive period over the last three years, the same approach will be adopted for 2022/23 running from Saturday 17th December 2022 to Sunday 8th January 2023. Operational services over the key weekends and bank holidays will run as close to a normal working day as possible, in order to maximise the number of safe patient discharges. Historically bed occupancy rises steeply over this period as fewer patients are discharged over Christmas and the New Year period, and it is this risk which must be mitigated.

- A strategic focus on the recruitment and use of substantive workforce, rather than reliance on temporary bank, agency and locum workforce to fulfil planned interventions.

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

5.0 Winter plan modelling methodology

The following methodology was used to calculate the expected impact/benefits of the planned interventions to produce a winter bed model at an ICS Level.

Approach

- Combination of WMAS and ECDS data utilised.
- Model set to flow daily simulation.
- Emergency admissions flowed through diagnostic grouping to allow for differentiated length of stay calculations for the winter effect on bed usage.

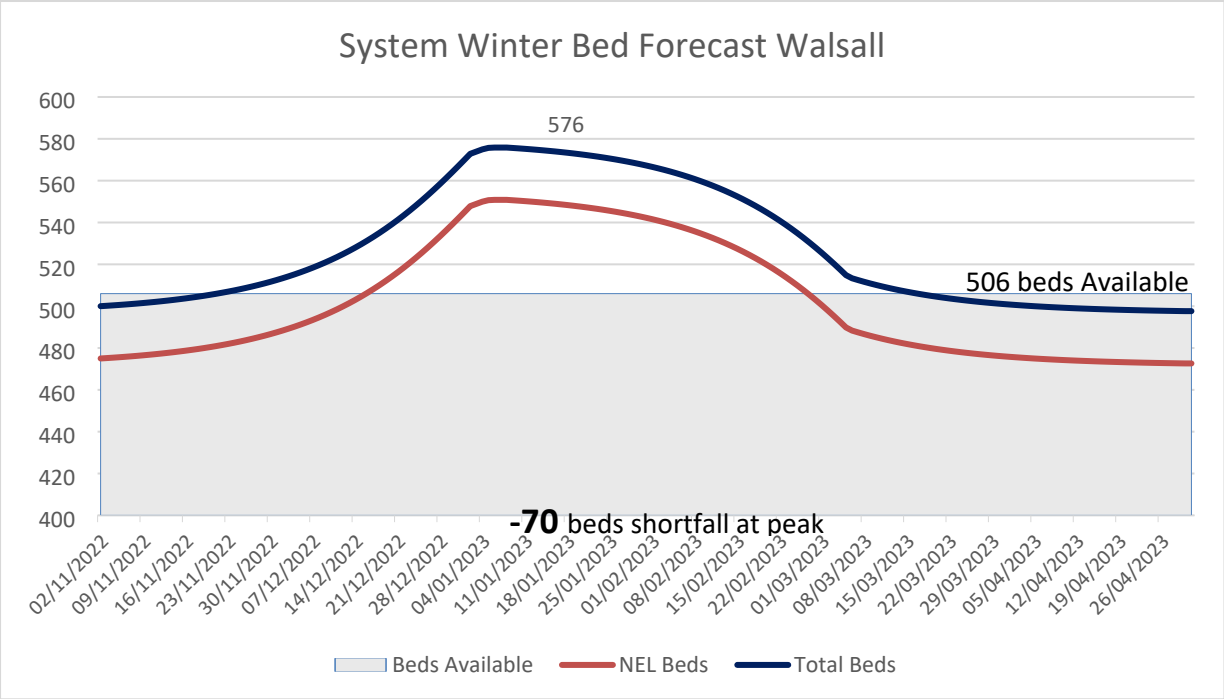
Parameters

- Covid: Based on Covid hospitalisations in the January and April 2022 increases nationally. An SDM epidemiological model was incorporated into Beds model and generated likely hospitalisations. Although this estimate differed slightly by Trust (due to serving different population sizes; the peak estimate was 4-6 admissions per day at peak.
- Weather: Based on research that estimates a 0.8% increase in emergency admissions for every 1C below the 5C threshold, combined with average numbers of days likely to fall below the threshold.

- Infections other than COVID: Based on research that estimates a 3.6% increase in admissions due to infections such as Flu and Pneumonia in the Winter Period.
- Intelligent Conveyancing: Based on most recent 12 months data and seasonal changes.

6.0 Modelling

- The Trust has a G&A bed base of 506 beds.
- At the peak of winter pressures including predicted COVID, a combination of other infections such as Flu and Pneumonia, adverse winter weather and intelligent ambulance conveyancing suggests a requirement of 576 beds.
- Resulting in a forecast unmitigated bed deficit of -70 beds.
- Therefore demand would require 114% of the available bed base.



The ICS model assumed the region would mitigate the shortfall in bed-based care with an expansion of virtual wards, reduced numbers of MFFD patients awaiting the start of pathways 1-3, increased number of patients accessing Same Day Emergency Care and expanded provision of Urgent Community Response services. From this modelling, the Trust successfully bid for funding for an additional 12 beds over Winter which took Medicine's Winter ward beds up from 22 to 34 to provide greater resilience.

	Bed above plan	Virtual Ward	Improved MFFD	SDEC	UCR	Unfunded Additional Beds	Balance	Cost in 000s
SYSTEM	371	-181	-55	-29	-13	-72	-21	3677
SWBH	108	-40	-14	-6	-3	-24	-21	1190
RWT	106	-59	-15	-10	-4	-10	-8	603
WHT	70	-42	-8	-5	-2	-12	-1	595
DGFT	87	-40	-18	-8	-4	-26	9	1289
Rational		2:1 Ratio of average VW Winter bed plan (Please see VW for provider detail)	Improved MFFD at 15% of 18/07/2022			At risk those in amber require agreement from Trusts		

7. Detailed plans & summary costings

This section of the paper identifies the financial resources available to support the winter plan and further outlines costs associated with prioritised schemes for the 2022/23 financial year.

7. 1 Financial summary

The Trust identified £4m within the 2022/23 financial plans for winter, with the Trust securing further resource from the system (£0.6m) to support increased expectation of emergency pressures in 2022/23 (investments from this pot of resource within Urgent & Emergency Care of £2.4m already committed) as denoted by the below table:

Ref	Description	Amount £m's
Funding to support winter initiatives		
1	Financial Plan 2022/23	4.0
2	Further system allocation (further pressures)	0.6
TOTAL FUNDING FOR WINTER		**4.6**
Expenditure committed to support winter substantively in 2022/23		
3	Emergency Department Medical Staffing	(0.7)
4	Ambulatory Emergency Care (AEC) & AMU	(1.0)
5	Discharge Lounge	(0.4)
6	General Surgery	(0.2)
7	Surgical Therapies	(0.2)
TOTAL EXPENDITURE ALREADY UTILISED		**(2.4)**
FUNDS AVAILABLE FOR WINTER INITIATIVES (This represents the £1.6m remaining from the plan plus the additional £0.6m further system allocation received in year).		**2.2**

The Trust has made commitments of £2.4m against schemes to support Urgent and Emergency Care through substantive appointments already made, with further latitude to invest in schemes totalling £2.2m.

7.1.1 Summary by Planned Further Winter Expenditure

The Trust has developed further plans to maintain care throughout the winter period (details supplied within the financial appendix) with the summary of the schemes and costs by Division listed below:

Winter Initiative by Division	Plan 1	Plan 2	Plan 3
Comm	£ 355,070	£ 648,758	£ 970,580
Corporate	£ 130,411	£ 130,411	£ 160,609
Estates	£ 210,465	£ 263,466	£ 288,610
MLTC	£ 898,412	£ 1,058,198	£ 1,130,780
Surgery	£ 291,181	£ 308,236	£ 361,537
WCCSS	£ 291,595	£ 379,697	£ 542,681
Total	**£ 2,177,134**	**£ 2,788,765**	**£ 3,454,797**

7.1.2 Assessment of affordability of additional schemes proposed for Winter

Scheme	Option 1 £m's	Option 2 £m's	Option 3 £m's
Approved already	(2.4)	(2.4)	(2.4)
Further requested schemes	(2.2)	(2.8)	(3.4)
TOTAL SCHEMES	(4.6)	(5.2)	(5.8)
Available Funding	4.6	4.6	4.6
Surplus / (shortfall)	**nil**	**(0.6)**	**(1.2)**

The only affordable option is option 1, this results in £4.6m of investment through substantive and non-recurrent measures for 2022/23. The funds increased from the residual pot of £1.6m to £2.2m following further system allocations to support expected demand.

7.1.3 Summary and Financial Recommendations

The Committee/Board is asked to recommend the Board approve Option 1 which is the only option fully resourced at an incremental cost of £2.2m, investment in winter for 2022/23 in total equating to £4.6m.

Members are asked to note Option 1 may not offer alone satisfactory resilience within UEC services this Winter, with Option 2 preferred if it can be adequately resourced. The Trust is seeking additional funds from a combination of funding streams, as detailed below:

- £0.3m via charging other systems for out of ICS MSFD delays
- £0.3m via Service Development Funds directly for Community
- £0.35m further allocation from the Black Country ICS Winter fund

The Executive Team will assess the additional scheme benefits verse financial risk of option 2 and may recommend further investment upon securing further resources as detailed above.

The detailed financial modelling for the options is contained within the below embedded / attached spreadsheet.

Winter Plan Costings 2223v7.xlsx

7.2 Division of Medicine

The Division has received substantial support from the Winter Plan Funds in order to recurrently invest in the ED Medical Workforce and expand Ambulatory Emergency Care. The Division's Winter Plan is therefore completely pared back this year with only Festive Period Ward Rounds and the Division's Winter Ward in response to the Bed Modelling included in Option 1.

The Division has diverted funds away from temporary medic spend in order to recruit more junior doctors substantively. This has enabled a more comprehensive General Internal Medicine Rota which puts in place medical support on all wards over the weekends and on weekday evenings. It also has more Junior Doctors on the Medical Take to enable faster diagnosis and treatment.

The Division has strengthened ED Medical Decision making and ED Nursing capacity in response to the unprecedented levels of activity seen during 2022 and the projections for the future. Paired with the more resilient nursing levels on the Acute Medical Unit, the Division enters Winter 22/23 more resilient than before.

Intervention	Expected benefit	Option
Inpatient Ward Weekend Medical cover	Progressing patients care plans over the weekend to ensure timely, quality care and increased discharges over the weekend; to improve flow. Sunday ward rounds will be in place over the festive period.	1
Extend FES Cover	Extending weekday hours and providing additional medical and nursing support over the weekend to ensure frail, elderly patients are seen and treated by specialists with the aim of avoiding unnecessary admissions and treated as same day emergencies. Relieving pressure in ED.	2
Medical winter ward capacity – 34 beds	Additional inpatient winter ward capacity to reduce exit block from ED due to lack of bed capacity. Contributes towards achieving 4-hour EAS standard which is a proxy for safe, timely care; patients should not be in ED any longer than necessary; it is well known it has an adverse impact on patient care. • 28 beds on Ward 14 • 12 general medical beds on Ward 4	1 (Curtailed) 2 (Full)

7.3 Division of Surgery

The Surgical Division have utilised some Winter Funding to support recurrent investment in Business Cases that more sustainable support additional emergency pressures. The Division will be introducing an Emergency Surgical Day Unit from December 2022; the Unit will remove patients requiring preparation and recovery from emergency surgery from attending the Surgical Ambulatory Care Unit, thus releasing capacity to assess urgent and emergency patients in a safe and timely manner. Furthermore, the Division have recruited two new Consultant General Surgeons, which will – from February 2023 – will a 2nd Consultant to be available from 0800 – 1200, Monday – Friday. Their input will provide Consultant led emergency surgery whilst the on-call Surgeon can conduct a Consultant-led ward round, supporting timely decision making for emergency inpatients. The Division are also reviewing the impact of new pathways for Acute Back Pain and Emergency Laparoscopy Cholecystectomy, with a view to limit admissions.

Intervention	Expected benefit	Option
Additional trauma capacity	No waits for non-elective Trauma surgery >24 hours. Aim to protect ring-fenced elective beds (and thus avoid a period without elective operating), unless additional ward-based staff are required for issues related to Covid-19. [NB: these sessions may come as a replacement of elective sessions for Anaesthetists and Surgeons]	1
Consultant Orthogeriatrician providing additional ward rounds	Provision of timely review of patients over the festive period to progress patients care plans and providing quality of care.	1
Additional Emergency Theatre capacity – introduction of 2nd Emergency Theatre lists both before and after Bank Holidays	As above	1
Ward 9 (12 beds) Additional capacity	Additional non-elective bed capacity within the acute zone of the hospital.	1 (Curtailed) 2 (Full)

7.4 Community Division

The following interventions have been derived to enhance the support for admission avoidance and complex discharge teams in order to ensure sufficient capacity to dela with increased demand through the Winter period.

Intervention	Description	Option

Clinical Intervention Team	Additional capacity for existing team to ensure that more patients can be discharged earlier into the CIT pathways and supported at home. The additional staffing will also enable greater capacity for patients to step up into pathways rather than be admitted. Ut will also support AEC for Antibiotics including cellulitis (step up and step down) IV Furosemide for HF patients – re-launch of pathway to enhance VW step down capability.	3
Frailty Case management	Additional capacity to existing team to support step up and step down but also longer term risk stratification and case management. Expansion in the numbers of complex patients that can be managed with Community Nursing Teams to support more patients at home and prevent admissions.	3
Intermediate Care Service	Additional capacity for Hospital Hub team and for the Community team to enable them to process an increasing volume of patients that require supported discharge into their preferred place of care. Ensures that Team can managed increased demand for referrals processing these efficiently to ensure that there are no delays to discharge both from hospital and from beds in the Community that provide vital capacity for discharge.	1
Enhanced Case Managers in Care homes	Extension of operational hours of 8am to 8pm, 7 days a week to respond to more unplanned responses taking diversion of caseload from RRT OOH preventing conveyances to hospital Extension of the operational hours will enable a more effective urgent Community response to residents in Care Homes ensuring timely interventions and prevention of admission.	3
Integrated Community Equipment Stores	Extension of the operation hours to 8am to 8pm, 5 days per week in order to provide greater capacity for equipment deliveries to support complex discharges from hospital. Increased capacity for deliveries and recycling of equipment to managed the increase in demand and prevent delayed discharge.	1 (Curtailed) 2 (Full)
Integrated Community Equipment Stores	In addition to the extension of hours, ICES requires an increased stock of frequently provided equipment to ensure sufficient supply through the Winter period. Assists prevent delays to discharge as a result of equipment availability.	1 (Curtailed) 2 (Full)

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

Paediatrics and Neonates

Intervention	Description	Option
PAU/Ward 21 Emergency/INP floor model	Additional Paediatric Consultant and Junior Medical Cover. Additional Registered Nurse and Clinical Support Worker capacity. Improved quality of care to increased number of children attending the hospital during the winter period. Focus on interventions to support increase in SDEC and reduced length of stay, with reliance on an increased substantive workforce.	1 (Curtailed) 2 (Full)

Gynaecology

Intervention	Description	Option
Ward 23	Increase staffing to flex gynae bed-base to provide additional 5 beds for Division of Surgery. Reduce impact on transfers from ED, therefore contributing to reduced waiting times in ED for patients.	3
GAU/EPAU	Additional (Nurse-led) scanning during weekends Support avoidance of admissions through SDEC.	3

Clinical Support Services & Pharmacy

Intervention	Description	Option
Pharmacy	Extended opening hours to 7pm on weekdays Support timely discharges for our patients and reduced inpatient length of stay	1
Pathology	Additional Norovirus/Flu/COVID testing Maximise the number of safe patient discharges; reduced length of stay and admission avoidance	1
Phlebotomy	Additional phlebotomists to support inpatients Maximise the number of inpatient discharges	2

Imaging: CT/Ultrasound/Sonography	Additional provision across the modalities Support avoidance of admissions through the delivery of SDEC	1
Imaging	Surgical nurse to support service Reduced inpatient length of stay	3
Imaging Festive Period	Provision of MRI/CT and Ultrasound during 2-week festive period. Maximise the number of safe patient discharges; reduced length of stay and admission avoidance.	1

7.6 Corporate Services

Initiative	Description	Option
Operations centre will increase capacity coordinator cover through the twilight period, and add in trainee Clinical Site Practitioners to the twilight period,	Additional operational site support provides more robust management of the site, particularly during times of peak pressure. Increasing resilience during the Twilight period is as a direct result of feedback and review of last year's plan.	1
Infection, Prevention and Control	Strengthened evening and weekend IPC on-call cover to optimally manage the predictable increased prevalence of seasonal viruses including RSV, norovirus and influenza, as well as COVID-19.	1
Staff Flu & Covid Programme	Funding to operate the Staff Flu & Covid Programme between October – January.	1

8.0 Risks

Winter Plan Risks

Risk (an uncertain future event that could affect the outcome)	Risk Rating	Mitigation (what steps can be taken to reduce adverse effects)
Increase in Covid inpatients to a level like Wave 3	12	Change in IPC rules with benefit of less disruption to normal hospital functioning. Point of Care testing in Emergency Portals.

		Covid & Flu Staff Vaccination Campaign
Staff Sickness increases to unsustainable levels	8	Accelorate recruitment with the International Nurse Recruitment campaign and strengthen the Staff Bank by collaborating with NX.
MFFD list far surpasses 50 patients.	8	Walsall Together to monitor closely and quickly implement solutions to blockages in care.

Corporate Risks Affected by Winter

Risk Title	Current risk score	Risk description
Risk 208 Failure to achieve 4-hour emergency access standard resulting in patient safety, experience and performance risks.	16	Despite improvement in the Trust's national ranking for EAS performance, there remains a delay in patients being assessed in ED which will result in failure to achieve consistent wait to be seen times, time to treatment which will impact upon failure to achieve 4 hour EAS. This will lead to poor patient experience and risk of adverse clinical outcomes including mortality.

8.1 Command and Control.

Tactical Command will lead the Trust wide response to the winter UEC pressures and covid-19 challenges. Battle rhythm will be set by forecasted trends and the need to respond early to appropriate indicators and triggers set in various plans. Divisional leaders will ensure operational arrangements dovetail into the acute hospital Tactical Command tempo.

Thrice daily Site Safety Meetings will remain managing daily operational matters and will flex and enhance membership and tempo to meet the challenges as they present.

9.0 External Reporting

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

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

The additional Covid-19 reporting requirements are as follows:

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

10.0 Appendices

Winter Plan phased interventions and costings

Winter Plan Costings 2223v7.xlsx

Severe Weather Plan

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

Winter Plan 2021/22 Reflections & Debrief

UEC and Covid-19 Resilience Winter Pl

Winter 2021/22 Metrics

Appendix 1 - Winter 2021-22 Meti

ICS Winter Bed Modelling

BC Beds Forecast V6.pptx

ED Covid Escalation Policy

WMH ED Escalation 24th Nov.pptx

MEETING OF THE PEOPLE AND ORGANISATION DEVELOPMENT COMMITTEE 26th September 2022			
Trust Board Pledge Update			
Report Author and Job Title:	Clair Bond – Deputy Director of People and Culture	**Responsible Director:**	Catherine Griffiths – Chief People Officer
Recommendation & Action Required	Members of the Trust Board are asked to: Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Assure	• Performance against The Trust Board Pledge metrics has been reviewed and are summarised within this report • An update against planned actions reported to the Committee in March 2022 has been provided •		
Advise	• The people metrics are monitored annually to monitor and review progress. • The Trust Board Pledge seeks to contribute to creating a healthy organisational culture in which colleagues feel valued and will advocate for the Trust as a place to work and a place to be treated.		
Alert	• The culture remains an issue with the staff survey still demonstrating bullying and harassment as above the national average.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	The BAF and Corporate Risk Register both highlight culture and staff experience including discrimination as a risk. The Trust Board Pledge sets an expectation for improved performance. The report shows where the risks have been mitigated and where further action is required.		
Resource implications	There is no resource implication associated with this report.		
Legal and/or Equality and Diversity implications	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 and to improve staff experience by eliminating bullying and harassment within the workforce and create a health organisation culture where staff will advocate for the trust as a place to work and a place to be treated		
Strategic Objectives	Safe, high-quality care ☐	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☐		

Introduction

The Trust Board updated its pledge to In August 2020 and following the Race Code accreditation as follows:

"***To demonstrate through our actions that we listen and support people. We will be an anti-racist and anti-discrimination organisation that treats people equally, fairly, and inclusively, with zero tolerance of bullying. We uphold and role model the Trust values chosen by you".***

The updates made to the pledge makes a clear statement to our service users, staff and the public of our intolerance to racism and commitment to stamping it out, operating with a culture of respect and inclusion.

The People and Organisational Committee are charged on behalf of Trust Board to seek assurance and regular review of progress towards meeting the Trust Board Pledge

This paper provides a year-to-date overview of progress against the people metrics that have been agreed by the Committee to monitor in respect of understanding the impact of interventions aimed at improving the experience of staff in the workplace. The Committee last received an update in March 2022 looking back at data from 2021/22 and including metrics from the 2021 NHS National Staff Survey which were made available in February 2021.

Background

In the previous report to the Committee (March 2022); several planned actions were outlined as next steps following achievement of Race Code accreditation. The Race Code is Reporting Action Composition Education) Equality Code Quality Mark, known as the RACE Code which supports organisations to improve race equality and to tackle discrimination within the workplace. The assessment framework is designed to challenge managers to identify ways in which they could improve diversity and race equality within their services – ensuring staff and service-users feel both valued and understood.

Assessment

The agreed measures received by the Committee in March 2022 are provided below. A majority of these indicators are available on an annual basis and therefore an update is not available, although where possible a year-to-date assessment has been provided.

Measure	2019	2020	2021	2022/23 (April to August 2022)
1. Employee Engagement Score (NSS indicator)	6.6	6.7	6.6	n/a
2. % of staff saying the organisation takes a positive interest in their health and	26.5%	26%	52% (benchmark average	n/a

wellbeing (NSS indicator) This indicator has been reframed win the 2021 NSS to "My organisation takes action on health and well-being" (Q11a)			56.4%)	
3. No of SA days taken as a result of bullying and harassment.	4.64 days	3.77 days	3.68	n/a
4. Reduction in voluntary turnover rates.	82%	82.7%	81.7%	80.4%
5. Reduction of B&H and Grievance case work relating to behaviours.	32 cases (August 2019-2020)	37 cases (Sept 2020 – March 2021	34 cases (April 2021 to March 2022)	8 cases April to August 2022
6. Increased BAME representation in B7 and above roles *(excluding medical staff)*	Total 18.81% B7 9.5% B8a + 4.6%	Total 19.17% B7 9.7% B8a + 4.7%	Total 23% B7 22% B8a + 25%	Up to July 22 B7 22% B8a + 25%

The data is limited presented provides an indication that in the impact of interventions which have taken place or are ongoing continues to sustain the improvements that have been demonstrated since August 2020. The outcome of the actions and interventions have taken place between April and August 2022 and are those which are planned throughout 2022/23, as listed below are intended to continue to build on progress and improving the experience of colleagues in the workplace:

- A Race Code action plan has been completed jointly with The Royal Wolverhampton NHS Trust (RWT) and received by the Committee in Common.
- A joint commission has been made to work with an independent provider to undertake engagement across both Trusts to work with staff to co-design a joint anti racist statement. These workshops are planned for November 2022.
- A Board development session will take place in January 2023 using the feedback and outcomes from the workshops with a view to agreeing the joint to vision statement.
- A high level engagement plan and survey which will be made available for all staff to complete and contribute to this work will be available for PODC to note in October.
- The planned culture competency workshops have been completed over July and August with one further session taking place in September. The sessions support healthcare workers to gain knowledge and understanding of the issues around culture and health; and how this might influence health care outcomes. Over 50 staff have attended the workshops and interest has been generated for a number of staff to become trained on how to deliver the workshops. Once completed, this will

enable sustainability of the approach and a plan to provide the education to all healthcare workers will be developed.

- The Trust as submitted its 2022 WRES and WDES data (August 2022) and is awaiting formal, validated confirmation of our performance indicators. An initial assessment suggests continued incremental improvement from a WRES perspective.
- An Ethnicity Pay Gap analysis report has been completed the detail of which will be shared with a future PODC for discussion.
- The appointment Staff Networks and EDI Development Manager is continuing to work and strengthen staff networks, in particular a new chair has now been appointed to lead the LGBTQ plus network.
- The Raising Concerns Policy has been reviewed and updated.
- Robust plans are in place for Black History Month and Freedom to Speak Ip month in October 2022.
- A training programme focusing on civility and respect in the workplace and speaking up has been piloted with AMU Band 6 nurses in September. Based on feedback the programme will be updated to support the roll out of the Dispute Resolution Policy later in the year.
- A toolkit developed by the ICS sharing awareness of the impact of micro aggressions has been shard with managers encouraging them to review and discuss within teams.

Recommendation.

The Committee are asked to note the contents of this report.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE TRUST BOARD **5th October 2022**			
People Culture – Towards Excellence in People Management			
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 improvement work on the people culture had an evidenced impact on outcomes shown within this report, there is further work scoped to focus on culture and behaviours. • The People and Patient First Culture framework aimed at improving staff experience and staff advocacy measures. • There is a scoped OD program to improve the measures relating to staff experience and advocacy for the trust as a place to work and be treated.		
Advise	• There is a monthly review of all people metrics embedded within the performance and quality review governance. • There is good divisional engagement with improving the people culture and people management and staff experience.		
Alert	• There is still a significant way to go to improve staff advocacy scores to meet national levels and this will be monitored through regular pulse surveys and the national staff survey.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Assurance on progress with reaching the outcomes within the NHS People plan and mitigating the risks on the BAF and Corporate Risk Register.		
Resource implications	There are no direct resource implications associated with this report as work will continue; however, failure to fund improvement work is likely to impact on future progress		
Legal and/or Equality and Diversity implications	There are legal or equality & diversity implications associated with this paper since the national staff survey results demonstrate differential experience from groups with protected characteristics.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high-quality care ☐	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☒		

Walsall HealthCare NHS Trust

Towards Excellence in People Management

Progress September 2022:

The Valuing our Colleagues workstream of the Improve Plan has delivered on many of its workstream objectives with evidence of change and engagement in EDI, Health & Wellbeing and Learning & Development – systems (PDR & Career Conversations) and access to SMT. The 2021 NHS Staff Survey Results demonstrate improved position against national average for the People Promise themes, moving the Trust from lowest 20% of scores for Acute and Community benchmark to within the 40 to 60% range for all but one indicator (We are compassionate and inclusive). There have been gains in:

- Staff receiving respect from colleagues at work 2021 66% up by 1% from 2020. Benchmark average 69.7%. *(Q7c) We are a team; team working.*

- 70% of respondents believe their line manager encourages them at work compared to 67% in 2020. *(Q9a) We are a team; line management.*

- More staff feeling secure to raise concerns about unsafe clinical practice. 2021: 70.1% v 2020: 67.4%. (Q17a) *We each have a voice that counts; raising concerns*.

- 67.1% of staff responded that their immediate line manager takes a positive interest in their health and well-being, above the benchmark average of 66.3% in 2021. *(Q9d) We are a team; Line management.*

However, the key staff advocacy indicators have fallen back to pre-pandemic levels and remain within the lowest 20% of trusts like us. This impacts patient care and the factors within this include:

- *(Q3i) We are safe and healthy. Negative reduction of 7%*
  Just 23% of respondents feel there are enough staff at the organization to enable them to do their job properly. The benchmark average of 26% has reduced by 10% compared to 2020.

- In all questions relating to bullying and harassment (Q14a,b,c) the Trusts responses are above the benchmark average which remains relatively static compared to 2020.

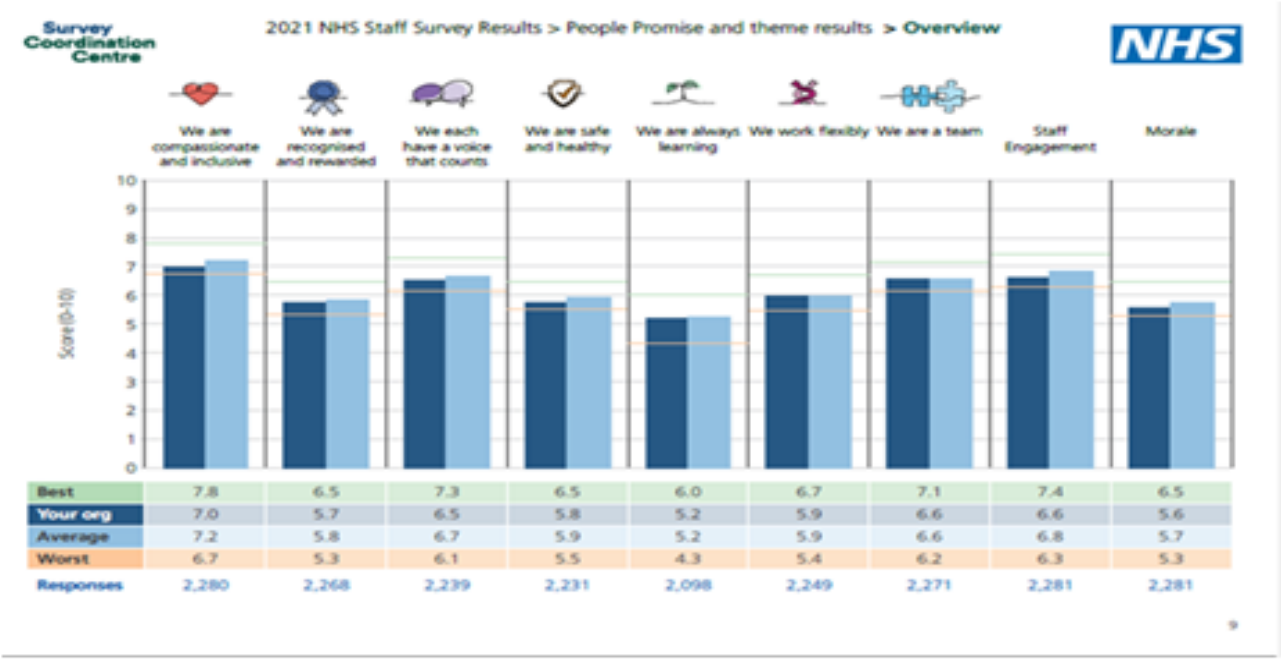
- Less staff are advocating for the Trust; staff recommending WHCT as a place to work has decreased from 52% to 48% and staff recommending WHCT as a place to be treated has decreased from 53% to 47%. Whilst this follows a national downward trend, the 2021 results are more aligned to pre pandemic results received in 2019 and a significant distance from the average sector benchmark

Staff experience across the trust is not consistent the culture requires continued Organisation Development input to create a healthy organisational culture with patient experience and outcomes at the centre.

The national picture highlights similar issues and concerns [Reference: NHS Confederation – On the Day Briefing March 2022]. The culture of an organisation is the single biggest contributing factor to patient outcomes and experience. It is imperative the culture is compassionate, inclusive, open/honest, learning and able to listen, hear and act on patient voice. WHT faces the same cultural challenges evident in the national results; except at WHT elements of poor culture are entrenched, with informal power networks and discrimination present, hence further structured input is required to increase the momentum and pace of change.

Walsall Healthcare NHS
NHS Trust

2021 Results by Themes



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.0	5.7	6.5	5.8	5.2	5.9	6.6	6.6	5.6
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,280	2,268	2,239	2,231	2,098	2,249	2,271	2,281	2,281

Walsall Healthcare NHS
NHS Trust

Divisional Overview – Need for consistency

This overview highlights the variability in the theme scores across the different divisions. Whilst this variability can in part be attributed to the difference in size and complexity of the division and the impact that Covid-19 will have had on the experience of colleagues working within the divisions, there is no difference in terms of the required ownership of results and accountability for improvement by divisional leadership teams. It should be noted that the Communication Team have reported under the CEO Department for 2021. Medical Directorate received too few responses to provide analysis against the ten themes.

	Trust	Benchmark Average	Best	Worst	Community	MLTC	Surgery	WICCSS	E&F	CEO (incl Comms)	Transformation & Strategy	Finance	Governance	Informatics	Medical Directorate	Nursing Directorate	Operations	P&C
Response Rate (%)	53%	46%			57%	42%	44%	54%	57%	68%	75%	83%	77%	62%	64%	74%	65%	84%
We are compassionate & inclusive	7	7.2	7.8	6.7	7.2	6.5	7	7.2	6.9	7.4	7.3	7.1	6.5	6.2	7.8	7.3	7.5	7
We are recognised & rewarded	5.7	5.8	6.5	5.3	6	5.1	5.7	5.9	5.2	7.1	6.8	6.4	5.6	4.9	7.5	6.4	6.5	6
We each have a voice that counts	6.5	6.7	7.3	6.1	6.7	6.1	6.6	6.7	6	6.8	6.7	6.6	6.2	5.6	7.5	6.9	7.2	6.5
We are safe and healthy	5.8	5.9	6.5	5.5	6	4.8	5.8	5.8	6.1	6.6	7	6.4	5.3	5.6	6.9	6	5.7	5.9
We are always learning	5.2	5.2	6	4.3	5.3	4.9	5.4	5.4	4.4	5.3	5.9	5.3	3.3	3.8	6.6	5.3	6.1	5.4
We work flexibly	6	5.9	6.7	5.4	6.1	5.3	6.1	5.8	5.4	6.8	8.2	7	6.5	6	7.6	7	6.4	6.5
We are a team	6.6	6.6	7.1	6.2	6.9	6.1	6.6	6.8	5.5	7	7.1	7.1	5.9	5.9	7.9	7.2	7.3	6.9
Staff Engagement	6.6	6.8	7.4	6.3	6.7	6.2	6.7	6.8	6.3	7.3	7	6.6	6.5	5.7	7.5	6.8	7.5	6.5
Morale	5.6	5.7	6.5	5.3	5.7	4.9	5.8	5.6	5.7	6.2	6.2	5.9	5	4.9	6.8	5.9	6.5	5.4

0.3 below Trust score | 0.2 below Trust score | Equal to Trust score | Up to 0.2 above Trust score | 0.3 & above Trust score | Equal to or above national best score | Equal to or below national worst score

Many of the objectives of the Value our Colleagues improvement programme have moved into 'business as usual' and there is still an important change yet to be felt in terms of cultural transformation, which will be reflected in the advocacy indicators of the annual staff survey – recommend as a place to work and recommend as a place to receive care. The National Staff Survey for 2022 will launch week commencing 3rd October 2022.

Cultural change takes investment of both time and money to create the capacity and capability of creating the momentum for change. Continuity and commitment will build on the foundations being put in place through attention to the basics, confidence in policy, process and relationships.

Reflecting on what has been achieved so far, through the workstream and the opportunities that closer working with RWT creates, is described below:

Valuing our People Workstream

What have we done?	**What's the outcome?**
Improving colleague experience	
• Investing in Leadership Development (FLM & Leo)	Reinforcing leadership behaviours and competencies
• Introduced Schwartz Rounds	Creates safe space for sharing experiences
• Embedding Employee Voice Groups	Improves engagement - staff voices heard
• Enhanced Health & Wellbeing Team & offer	Valuing and caring for staff
• Increased ownership at Div level of Staff Survey	Focus on local challenges and feedback
• Improving physical environment	Better, safer care – improves value & quality
• Increasing recruitment at all levels	Permanent recruitment and safer staffing levels
• Housekeeping on systems & processes (Trac, ESR)	Improving credibility and accuracy of data
• Tackling 'hot-spot' people management issues	Facing the issues and seeking solutions
• Establishing a safe, open & supportive place to work	Civility & Respect, FTSU, Compassionate Conversations
• Improved PDR process	Increased accessibility, introduced talent management

Appreciative Inquiry work – identifying team and leadership behaviours that create and build a positive, successful service from work with specialities requires further investment, it creates a safe psychological space for improvement and learning by listening, hearing and empowering all to make a step change in patient experience and outcomes.

Improving People process & structure through collaboration

What's the plan?	**Progress to date:**
• Collaborative working to align services	Recruitment & onboarding (Medical Staffing)
• Aim to have aligned policies and procedures	WHT adopting Dispute Resolution Process
• Collaborative Bank (Joint Medical Bank)	Target met to implement soft launch from 01.09.22
• Shared behaviours to support values	CiC agreed approach in June 2022, work started 1.11.22
• Aligned Learning Management Systems	WHT adopting RWT system from 01.09.22
• Single model of leadership development	Discussions – needs to reflect maturity of each Trust
• Workforce Intelligence & Analytics	Interim group role, WHT shortlisted for HPMA Award
• Development of HRBP Model	Potential to establish shared HR Advisory Service

Moving forward

To accelerate change, build on the Valuing our Colleagues Workstream of the Improvement Programme and organisational development needed at the Trust, clear focus and priority needs to be placed on how to move the dial for patient care and staff experience. A structured and measurable programme of work needs to be approved and resourced, starting in WHT with the most challenges services in terms of staff experience (MLTC in Phase 1) and (Estates and Facilities), moving through the organisation and sharing best practice with RWT. The overarching aim is to minimise variation of behaviour, experience and practice across both organisations; and to embed shared values and cultural norms that reflect excellent people management skills to drive excellent patient care. This work has been started by the Committee in Common.

Progressing Towards Excellence (excellent people management skills, drives excellent patient care)

Initial Objective :- ***WHT is a place where local people want to work and are proud to recommend for its quality of patient care. Staff report that patient care is WHT's highest priority.***

The further development of the organisational culture has been scoped as outlined below and the framework for Patient First Culture and the OD approach supporting are outlined in the appendices and have been approved by the Committee. The detail below highlights the next level of detail in scope for delivery outcomes.

Patient centredness (Team around the Patient)

NHS People Plan Four Pillars

Looking after our people	Belonging in the NHS	Growing for the future	New ways of working and delivering care

A modern Contract of Employment
• Recognising the local workforce needs
• Acknowledging the generational expectations moving forward
• Flexible and mobile – expectation of rotating across Trusts
• PDRs seen as constructive and developmental
  ○ Shared clear objectives
  ○ Line of sight to the patient – what can I do to improve patient care and experience
• Shared learning environment
  ○ Buddy Matrons across the Trusts
  ○ Safe Forums to share experiences – wicked issues forums
  ○ Consolidate Learning
	Creating a great place to work
	• EDI
	• FTSU
	• Behaviours – Civility & Respect
	• Employee experience
	  ○ Regular pulse and focus groups to check and challenge – why do you stay, what needs to be different, what can you do?
	• Reward and recognition
		• Establish functional career pathways
		• Local community as the recruitment pool
		• Supported opportunities to develop at and across all levels
		• Build stronger relationships within the community – social care utilising the apprenticeship levy
			• Using business intelligence to inform workforce planning and decisions
			• Cleanse job descriptions and align with national standards
			(Nursing project likely to be part of programme of work to provide one nursing service across both Trusts)
			• Create job families
			• Pay modelling – linked to career pathways

Matters and Making it Better – learning from mistakes ○ Incivility costs Lives (governance processes/speaking up/raising concerns			

Culture and Behaviour

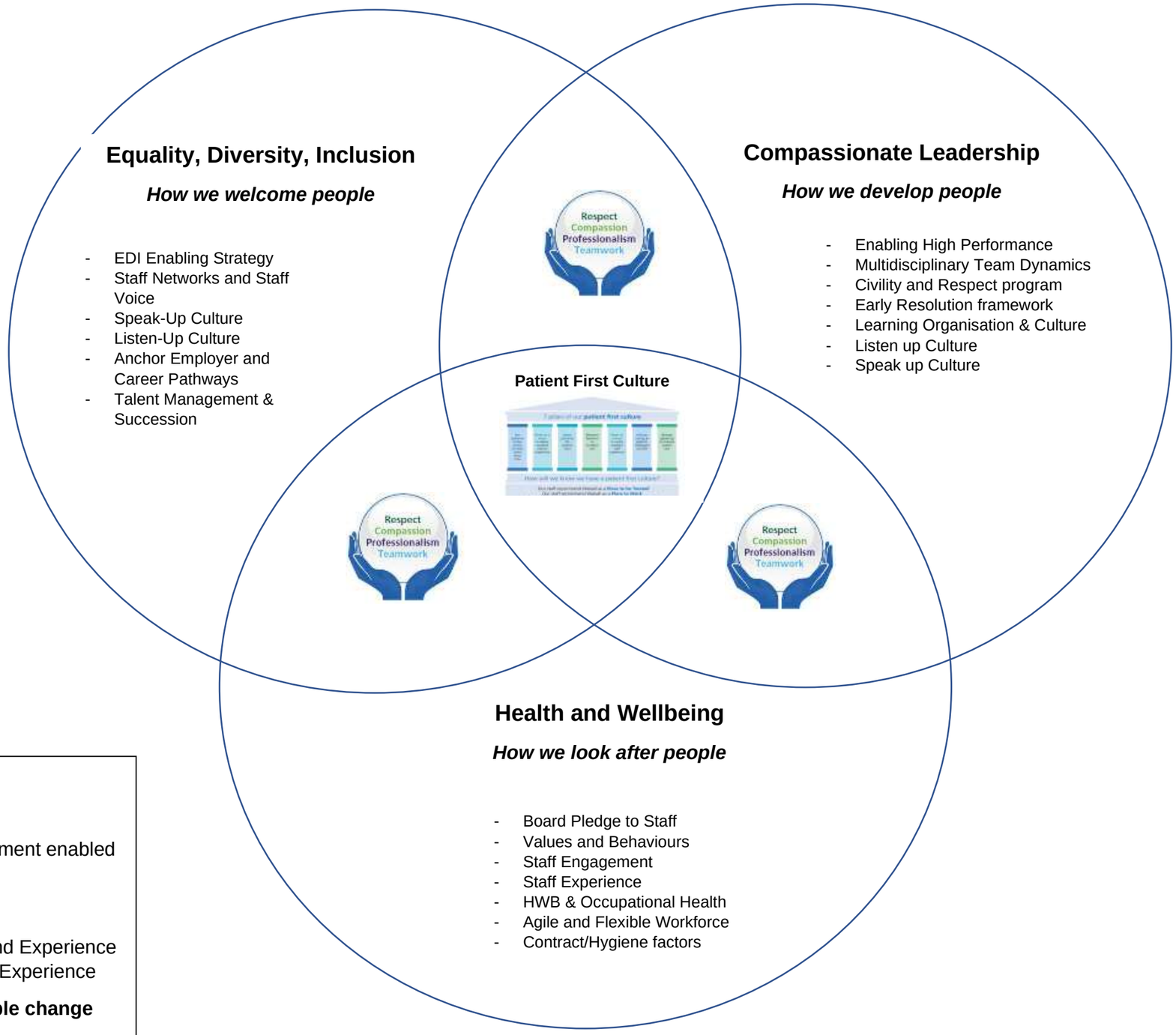
Leadership Development

- Clear transparent accountability & behavioural framework
  - Focus on outcomes of values (valued embedded)
  - Shared with RWT – focus on embedding values
- Reinforcing responsibility and accountability - patient centric
  - Clarity of what's my role and clear expectations
- A range of development programmes identified for leaders and managers embedding the basics
  - Shared developmental offer across both Trusts
  - Embed what good looks like (improvement journey in Pharmacy)
  - How to have challenging/supportive conversations
- Creating and maintaining a safe and healthy working environment
  - Attitude and behaviour – calling out unchallenged inappropriate behaviour
  - Being supported to make a difference
- Fair and transparent decisions making
  - Flexible working

Patient centredness (Team around the Patient)

Appendix One

Patient First Culture – Organisational Development Approach



Dependencies:

Clinically Led

- Quality Improvement enabled
- Action enabled

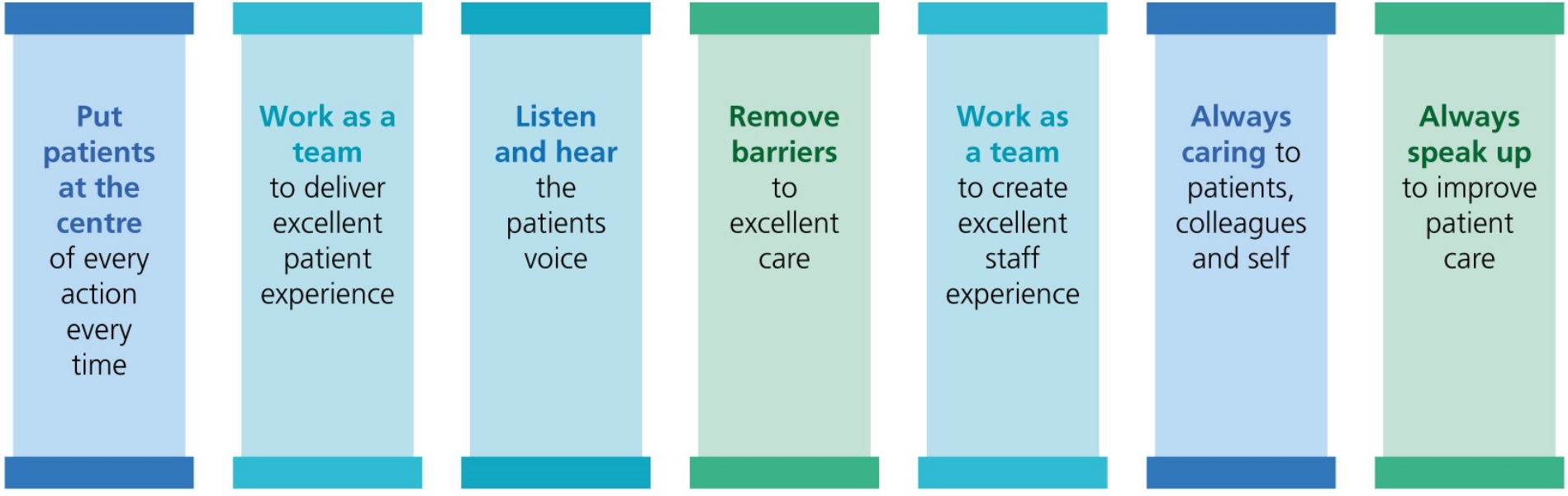
Co-Produced

- Patient Voice and Experience
- Staff Voice and Experience

Corporate Services enable change

- Investment: Patient First - OD Business Case
- People First

7 pillars of our **patient first culture**



How will we know we have a patient first culture?

Our staff recommend Walsall as a **Place to be Treated**
Our staff recommend Walsall as a **Place to Work**
Our staff report that patient care is the **Trust's highest priority**

Walsall Healthcare NHS
NHS Trust

MEETING OF THE QUALITY, PATIENT EXPERIENCE & SAFETY COMMITTEE HELD ON FRIDAY 22nd JULY 2022 AT 11.30 AM HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Prof L Toner	Associate Non-Executive Director (Chair)
Mr K Bostock	Director of Assurance
Mr M Dodd	Interim Director of Integration
Mr N Hobbs	Chief Operating Officer
Mrs O Muflahi	Associate Non-Executive Director
Dr M Shehmar	Chief Medical Officer
Mr R Virdee	Associate Non-Executive Director

In attendance

Dr A Garg	Clinical Lead ICU (observing)
Mrs C King-Stephens	MLU Manager
Mr G Perry	Associate Director, Patient Relations & Experience
Mrs V Pickford	Community Lead, Maternity
Mr A Rice	Patient Experience & Voluntary Services Manager
Mrs J Toor	Senior Exec PA (observing)
Mrs C Whyte	Deputy Director of Nursing (deputising for Director of Nursing)
Mr K Wilshere	Company Secretary
Mrs A Hill	Executive Assistant (minutes)

Apologies

Mrs L Carroll	Director of Nursing
Mrs C Jones-Charles	Divisional Director of Midwifery
Dr J Parkes	Non-Executive Director (Chair)

257/22	**Welcome and Introductions**
	Professor Toner welcomed everyone to the meeting and introductions were made.
258/22	**Apologies for Absence**
	Apologies for absence, as listed above, were noted.
259/22	**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.
260/22	**Minutes of Previous Meeting**
	The minutes from the 24th June 2022 meeting were agreed as a true record.
261/22	**Items for Redaction**
	There were no items for redaction and minutes were approved for publication.

262/22	**Matters Arising & Action Log**
	221/22 – postcode information has now been included in the Community Services report and is being discussed and included in the health inequalities strategy that is under development. Action closed. 222/22 - Community falls are now included in the SHQC report – action closed. 223/22 - July update - ethnic breakdown in the Maternity Services update still needs to be in line with census categories. Update to be given at September meeting that data has been amended. 224/22 - Discussions are taking place to align as much as possible the cycle of business and ToR for both WHT QPES and RWT QGAC by October and the committees that feed into them. Action closed. 242/22 - Discussions are taking place with Paediatric Community Teams and WCCSS regarding Paediatric long covid services and update will be bought to September meeting. 243/22 – VTE Thrombosis Group report each month how many HATS (hospital acquired thrombosis) and number of harms and will present this each month in an SPC chart for QPES. Audits have been initiated within the divisions to look at the patients who did not have the VTE assessment recorded electronically to pull the notes to ensure the correct clinical decisions were made. Report will be bought back to September meeting. 248/22 – The mortality summit paper relating to health inequalities has been circulated to committee for information – action closed. 253/22 – clarity was given on the three items requested from QPES was that they were not for formal risk escalation but for informed discussion between the Chief Executive and the NEDS to create some evolving structure. 253/22 – Mr Wilshere will investigate with IBABS whether there was a server problem which caused come corruption of reports when uploading and will discuss outside of the meeting and monitor the situation.
263/22	**Patient Story**
	Patient story was viewed prior to the meeting. Mr Rice advised that this story was from Maureen and Margaret who are well established volunteers who embody what volunteering is all about and have a wealth of experience. Both volunteers gain a lot from their volunteering, and they enjoy participating in the work they do and feel that it would impact on their own health and happiness if they didn't have this opportunity to give something back. Dr Shehmar advised that with the Covid pandemic and other work carried out relating to loneliness, it has become clearer that community initiatives are important to counteract this and whilst the Trust received real value from the volunteers, it is also important to provide these opportunities within the community. Mr Rice advised that the Volunteer Co-ordinator working in partnership with Manor Farm, is focussing on targeting those lonely and isolated patients to support them whilst they are in hospital and assist them to access support services when they return home. Mr Virdee asked if the volunteer services are linked in with other community services that can assist with discharged patients who are lonely and isolated. Mr Rice advised that Patient Services are linking in via volunteers and carer co-ordinators to community groups to explore this provision.

	Mrs Whyte advised that one of these volunteers had spoken to her in the atrium and had some good ideas around the management of wheelchairs and she will speak to Patient Experience to take some of her ideas forward. Mrs Muflahi advised that volunteering often leads to other opportunities arising for individuals and they add much value to the work of the Trust and she receives enquiries from young people wishing to participate. Mr Rice advised there are discussions around youth volunteering and moving the volunteering programme forward and development for the future and needs to link in with the current recruitment processes. Volunteer Awards this year will be held on the evening of 6th October and invites will be going out shortly.
264/22	**Covid-19, Acute Services Access/Restoration & Recovery Update**
	Waiting times for definitive treatment for patients with a confirmed cancer diagnosis are now significantly better than the West Midlands and National average. Cancer pathways still need further work on access to and outcomes of treatment. Confirmation is given that the recovery of MRI and non-obstetric ultrasound diagnostic waiting times has been completed and both services have returned to within six week booking. However, there are challenges in cardiac physiology and endoscopy diagnostics. Cardiac physiology is a very small service and recovery time will be longer and it is anticipated that it will be around October before waiting times are back in line. There has been improvement in access to suspected breast cancer appointments and waiting times have reduced in recent months. However, there is still fragility in the service recovery and booking times are currently around three weeks. Mutual aid continues with Black Country Partners and improvement in staffing levels should help to improve waiting times in the coming months. Mr Virdee asked if it was possible to have postcode data in the same format as the ethnicity data for RTT PTL & 42-week analysis. Also, what caused the increase in 18 week waiting list from May to June? Does WHT have any evidence that there are any patients accessing out of area treatment for breast cancer appointments? Mr Hobbs advised that in the appendices to the report there is a breakdown of patients waiting for over a year for treatment by their ethnicity group and area via quintile. Overall waiting list growth is not a single month problem but growth in the overall waiting lists is a national issue. Most clinically urgent patients and patients waiting the longest are prioritised, but capacity is still not currently meeting demand. Mr Hobbs will check if there is any evidence of any patients going outside of the Black Country for breast cancer treatment and report back to committee. Mrs Muflahi asked if the breast care practitioner that commenced in April is the breast care navigator and if there are intentions to have two breast care navigators in light of the backlog of treatment? Mr Hobbs advised that they are separate roles, and the breast care practitioner is a nurse specialist who will provide direct clinical care. There are care navigators in the majority of cancer tumour site services who work closely with CNSs to co-ordinate care for patients, ensuring any delays or blockages in progression of patient care is escalated and managed

	with the relevant service. He advised that he thinks there is one BCN in the service but will confirm.
265/22	**Community Services Report**
	There is sustained high activity within the localities with planned and unplanned care and this has been impacted by staffing shortages, but the division has managed to maintain the composite core service. There is a trend of increased activity through complex discharges and there is a 15% increase in discharge referrals per week. The Trust is currently holding the length of stay of patients who medically stable but the numbers are creeping up. Had a visit by the national discharge team who have picked out Walsall as an exemplar of good practice with the same day emergency care and out of hospital work and it is acknowledged that there is more work to do with admission avoidance and early supported discharge. Significant progress has been made with recruitment into Paediatric Diabetes Service to mitigate the risks within the service and the corporate risk has now been de-escalated. The Phlebotomy Service has set a trajectory to reduce the patient numbers and length of wait down to ensure all routine referrals are seen within 4 days of receipt and this has been sustained through the month of June and the wait is now in line with what their GP would offer. There is still work to be done with Primary Care on investigating why the number of patients referred to Phlebotomy is increasing and ensure only those patients who are domiciliary-bound are referred. A prioritisation plan has been developed to address issues within the Walsall Health Visiting Service with support from RWT and discussions with the Local Authority and Commissioners and this is going to Safeguarding Board for agreement and assurance to enable a graduated return to full service as the actions being taken on recruitment are completed. Mrs Muflahi asked if the Long Covid referral data for children being referred from WHT is being collected and that it would be helpful for future planning and resources. Mr Dodds advised that this is an adult only service at the moment and children are being referred to the Birmingham Children's Hospital. Work would have to be done with the Paediatric Team and GPs to access this data. Mrs Whyte suggested it may be useful to approach the Paediatric Service in Children's Outpatients for the number of referrals received to this service. Mrs Muflahi enquired about the psychology vacancy in Paediatric Diabetes and the lack of psychology for children who are struggling to come to terms with their long-term conditions and asked if they are referred to the CAMHS service. Mr Dodd's advised that they would not be referred to the CAMHS service as this is for acute psychological issues rather than long term and would not fit the criteria. They may be referred to the IAP service (improving access to psychological therapies) but this is a generic service rather than a paediatric speciality. Mrs Whyte confirmed that CAMHS are not taking referrals for longer term conditions as the service is currently experiencing problems with acute referrals for paediatrics. Mrs Muflahi asked for some assurance next month in the absence of recruitment to the psychology vacancy that psychological interventions are being put in place for children with diabetes and their long-term care.

	Action – Mr Dodds to provide assurance in September report that paediatric psychological interventions are being put in place in the light of psychology vacancy for children with diabetes long term care. Mr Hobbs endorsed the increasing referral demand in intermediate care services as inevitably the increasing demand on emergency and urgent care pathways in the acute setting will translate into more impact on community care resources. The business case for increased therapists in the acute surgical wards was approved 2-3 months ago but performance is still not where the Trust would like. Mr Dodd's advised that recruitment has now taken place and there are only 4 vacancies not filled, so once the recruitment checks have been completed this should show through in the performance figures. Mr Wilshere stated that the situation with psychological services is both a national and international issue and needs to be taken into context and the IAP service is not designed for this sort of intervention. Professor Toner added that there was a service piloted equivalent to a CPN in schools that would manage issues at this level as an intervention and avoid escalation, but this service is now not funded. Mr Virdee stated that the integrated assessment hub is working well and is reflected in the admissions to ED. Mr Dodds advised that Community Services is adult focused, but work is ongoing with Walsall Together and Children's Services to look at early intervention for mental health services in the community to reduce the need for acute admission. He also advised that there is also ongoing work with prevention via BMI support, smoking support and links with cardiology and respiratory services to address health inequalities and patients not fit enough to access surgical interventions. Mrs Muflahi added that there is national work taking place regarding integrating community psychiatric nurses into primary care and the Royal College of GP's has issued information in relation to community mental health support in GP surgeries. Dr Shehmar advised that there is a Mental Health Steering Group led by the Community Mental Health Team in the Integrated Care Board and it is important that the Trust links in with this. Professor Toner asked how the Trust is upskilling staff to look after more complex patients within the community. Mr Dodds advised that there is work ongoing regarding unplanned care to increase medical support and resource within the community. Dr Shehmar advised that the Trust have started an initiative with GP consortiums and training is taking place for a GP with special interests who is working with the community team. Professor Toner asked if there are figures available for when patients are transferred into care homes on a temporary basis until the package of care is put in place and go home rather than remain in long term care. Mr Dodds advised these figures are available and will include in next report. **Action – Mr Dodds to include figures of how many patients return home from temporary care home when awaiting their package of care.**
266/22	**Safe High Quality Care Oversight Report**
	The number of patient falls recorded in June was 57 which was a slight decrease from May. The number of falls in the community was 6 falls across Goscote Hospice and Hollybank Stroke Rehabilitation. The Trust is consistently below the

	Royal College of Physicians average performance of 6.63 falls per 1000 occupied bed days with the Trust being 3.54 during June and no moderate or severe harm falls were recorded. Retrospective data on community falls is included in the report. There has been a marked increase in the number of hospital acquired pressure ulcers developed in both community and acute settings in June and a similar trend has been seen at RWT. There are mitigating actions being undertaken in the change over to hybrid mattresses so that all mattresses will be pressure relieving and also the introduction of a risk assessment tool, Purpose T, which commenced in July. The Tissue Viability Team are investigating the increase to see if further actions need to be taken. The Deteriorating Patient Group (DPG) has now met, and the terms of reference have been ratified. The corporate risk remains in relation to patients being inappropriately put on Scale 2 within NEWS2 national early warning system. Now have the Royal College of Physicians eLearning package for staff to undertake and a roll out plan is in development. Changes have now been made to the thresholds of late observations and how late observations are classified. Prior to this there was a marked decrease in performance and after changes were made performance did drop, but there is now a very slight improvement to the percentage of observations taken within timescale. There has been similar performance observed at RWT. Discussions have taken place in the Matrons and Ward Managers Forums as to how to make improvements, for instance when a patient is off the ward and not available to have their observations carried out. Mr Hobbs asked if there has been any analysis carried out relating to pressure ulcers with prolonged waiting times for ambulance responses, particularly for patients who have fallen in the community, being a contributory factor. Mrs Whyte advised that there is a larger piece of work being carried out which is likely to be multi-factorial, particularly with more complex patients being admitted currently and that maybe a contributory factor. The Tissue Viability team are working on this in conjunction with the team at RWT. Professor Toner asked if there is information available in the categories of the pressure ulcers being reported and Mrs Whyte advised that they are mainly category 2 as category 3 and above are reported as Serious Incidents and category data can be included in the report in future. Professor Toner asked if the trial of Purpose T will be across the whole Trust and Mrs Whyte advised that this will be commence initially in the modular ward areas but as the new patient assessment booklet is disseminated this will then be across the whole of the Trust. Mr Virdee asked if the Trust is able to monitor patients who fall in the hospital and are discharged for any falls that occur at home. He was concerned that the 1:1 support figure had increased and asked the reason for this. Also, if the Trust is now receiving the appropriate level of support from the Mental Health Trust now. Mrs Whyte advised that the increase in 1:1 increase can be for variable and is mainly patients who are at high risk of falls or have mental health requirements that require 1:1 support. Dr Shehmar advised that the Trust now have a Mental Health Team whose role it is to support and liaise with the Community MH Trust, but patient care is provided by the Community MH Trust. This is being discussed at Exec level and any

	incidents where support is not being received are being incident reported and these are slowly reducing. Mr Dodd advised that there was a commissioned service for putting in preventative measures for patients at high risk of falls, but this was decommissioned 18 months ago and there is no current funding. Community have a falls service which when advised of a patient fall will assess and put in a package of care. One of the areas for expansion that has been identified for admission avoidance is find people who are vulnerable and frail who have been admitted to hospital and on discharge pick up and carry out a comprehensive geriatric assessment, identify needs and put in package of care. Currently bidding through service development funds to find funding for more staff to look at point of discharge. Mr Bostock added that there is now a service move in place to bring all providers, social care, acute, mental health, ambulance and community onto a single incident reporting and oversight system in the next two to three years which will provide a better patient journey and learning. Mrs Muflahi added that whilst support staff in any role are pivotal to the support to the service, it must be clear that their role is to support clinical staff rather than role substitution. Mrs Whyte advised that as an organisation WHT were a pilot site for nursing associates and there are some very established nursing associates in the workforce, and they work within their framework of competencies and are registered with the NMC, and workload is closely monitored. Professor Toner advised that Dr Parkes had asked in his absence to raise concerns regarding Sepsis, VTE and Safeguarding Level 3 training. Mrs Whyte advised that there has been little improvement on the Safeguarding Level 3 training compliance, divisions bring their plans to Safeguarding Committee and Divisional Performance Reviews, but they need to keep a closer eye on the staff who are about to go out of date and have a more focused oversight. Dr Shehmar advised that VTE is low this month and this was discussed at Patient Safety Group. There are two areas of concern being Surgery and Medicine and the divisional directors have commenced an audit of the cases to investigate further. Dr Shehmar also advised that Sepsis was discussed at Patient Safety Group and manual data is available for ED and the Care Group have advised that performance is higher than the electronic data available on the audit. It has been noted that antibiotics within an hour figure is improving and there should be verified data available to share with Committee next month. Mrs Muflahi advised that she attended a maternity safety walk and VTE compliance was discussed. There are some prescribing advice differences between Badgernet and VTE SOP and this is being raised in MDT meetings and will be picked up outside of the meeting. Dr Shehmar advised that the Deputy Chief Medical Officer has now started a group for Clinical Engagement to look at clinical guidelines and this has been identified as a common issue across RWT and WHT and a joint piece of work is taking place to address this. The 104 day harms paper was presented last month as a separate report with more detail and Committee agreed that it would be useful to have this as a separate agenda item to each QPES meeting in future.

	Dr Shehmar gave an update on the AMU improvement action plan. The Trust is currently still awaiting a response from Health Education England (HEE) but the Trust is on track with all the actions in the improvement plan. A substantial business case has been approved for 15 doctors on the junior doctor rota which will be 11 new doctors on the rota which will make a difference to supervision and the provision of service, and it is planned to phase some of these doctor slots into ACP slots once recruited and trained. The cultural and listening work is going well with the external coach and all consultants and junior doctors have been offered one to one coaching sessions and suggestions from the junior doctor's sessions are being taken forward to the joint clinical forum.
267/22	**Maternity Services Update**
	Committee was given assurance that 100% of women received 1:1 care in labour. The Maternity 15 steps programme took place on 7th July which used an observational approach for service review. Positive feedback was received, and an action plan was developed for areas that require strengthening such as streamlining patient information, visible information on staff uniforms to enable better identification, signboard improvements and estates improvements. The Maternity Service is working with staff to support areas that require strengthening as highlighted in the Staff Survey. Feedback from this included comments that immediate line managing encourages staff and they feel trusted to do their jobs and their manager cares about their concerns and top three areas of improvement were that there were not enough staff and the Trust is addressing this in recruiting nationally and internationally; the teams do not meet often enough and regular monthly meetings have been reintroduced and staff are being made aware of the health and wellbeing sessions available to them to help deal with work related stress. There continues to be staffing pressures within the division due to staff absences and there has been a rise in absence due to Covid and D&V. The division continues to use the escalation policy and business continuity plan and recruitment continues to take place. The Ockenden business case has been submitted for approval. In June there were 285 births and acuity for June was 81% against a target of 85%. 81% of the time no action was required and 19% of the time actions included redeployment of staff. There were no red flag events 91% of the time and 8 red flag events in total, where actions were needed in relation to delay in induction of labour procedures and the delivery suite team leader remained supernumerary. Mrs Muflahi advised that the feedback correlates with the themes emerging at the maternity safety walkabouts and there has been a noticeable difference in the proactive approaches of all staff within the division. Dr Shehmar advised that she has been made aware of some issues raised by junior doctors within the division and asked that the report is more holistic in future and takes into account the whole of the service. There have been issues raised from FY doctors around supervision and seeing emergency patients and these have been discussed within the care group and an action plan is being produced to address these issues. These will be tracked through Medical Education Group and PODC but also needs to be included in this report in future.

	Action – Issues raised by junior doctors to be included in the report in future to ensure this is a holistic report and takes into account the whole of the service.
268/22	**Serious Incident Progress Report Update**
	The SI and Incident Report has been written by a different author this month and it has been identified there is an inaccuracy in it around duty of candour reporting with an inconsistency in the divisional reporting which will need to be amended. The pattern of incidents and serious incidents is fairly stable and an increase has been seen in the last 12 months due to the improvement in transparency of culture within the Trust. There has been one serious incident reported to the commissioners and the occurrence of SI's is starting to become less frequent with better learning patterns and recurrence of similar themes. Committee are advised that there has been a never event in July which will be recorded in next month's report but was significant enough to mention this month. The style of this report will be changing with the style of content being aligned across both WHT and RWT. Dr Shehmar advised that the alert on the Stage 2 of the Statutory Duty of Candour for Surgery is related to the cluster around shoulder surgery and this stage 2 duty of candour letter has now gone out. Mr Bostock advised that the information contained in the report is not accurate and this will be rectified in the next report. Mr Virdee expressed concern that the Violence and Aggression incidents figure stands at 33. Mr Bostock advised that any form of conflict gets reported into the system and more detail can be given if required. Improvements are being made in this area working with the Mental Health Team, Security and operational teams.
269/22	**CQC Action Plan Update**
	The CQC Action Plan paper is included in the papers, an audit has been carried out and there are improvements but there are still areas that need focus, mainly corporate visibility and the strength of corporate assurance at board and committee level and work is ongoing in these areas.
270/22	**Safeguarding Annual Report**
	Safeguarding Annual Report was included in the papers for information on progress. Any queries to be sent to Mrs Whyte for escalation with the Safeguarding Lead.
271/22	**Patient Experience Update**
	The report reflects the traditional aspects of patient experience and patient voice and the plans that have been put in place from feedback received are starting to make a difference. Complaint response times have dipped slightly and there has been an increase in the volume of written complaints mainly due to the Covid backlog. Feedback is increasing as there are now more avenues for access such as Friends and Family, surveys, concerns, complaints and Mystery Shopper and bedside collection of data giving real time feedback. The Mystery Shopper scheme goes directly to ward managers and monitoring of feedback is available and linked to the national survey using the same scoring matrix.

	The key focus this quarter is the maternity engagement work across both WHT and RWT which is based on the 15 steps observational tool and carried out via a booklet given to patients for feedback. Liaison is taking place with the Maternity Voices Partnership (MVP) and BAME communities with patient experience engagement, volunteer recruitment and opportunities for people to get involved. Currently linking in with We Are Walsall to develop a vision for the future of the Borough, particularly with new and expectant families. Real success story is the Friends and Family Test nudge messaging which was switched on in May as a trial to see if it made a difference to collection rates for feedback and improved the recommendation scores. Maternity services are now in top quartile nationally for collection rates and this is translating into the recommendation scores with the provider, Health Care Comms wanting to do a case study on WHT. This system has also improved the response rates in inpatient areas. The Patient Involvement Partners (PIP's) are continuing to engage and are assisting with the Patient Experience Enabling Strategy and vision to have a patient and public engagement hub. A partnership has commenced with 'Blessed to Bless' which is a charity that helps feed the homeless and those that are struggling financially, and they are supporting the Trust with the Hospital to Home Discharge Programme based with the Discharge Lounge supporting vulnerable patients leaving hospital with no support network in place and are lonely or isolated by delivering food parcels and referring through to the network for ongoing support and links in with community hubs.
272/22	**Committee Review of Annual Priorities**
	No discussion took place.
273/22	**Maternity Ethnicity Findings**
	Mrs Carol King-Stephens, the Equality, Diversity and Inclusion Midwife at WHT presented the Walsall Maternity Ethnicity Findings report. The report looks at January – March data and identified a gap in information being pulled through from the Careflow system, particularly NOK and Ethnicity data for patients attending the ante natal clinic. This temporary issue is being addressed by the company who supply Careflow. Mrs King-Stephens presented the findings of her report: - Perinatal MH referrals for Jan – March showed that no patients were referred for support from the Bangladeshi community and very low referrals for Indian and Pakistani patients. ATAIN data for admission to the neonatal unit at term and showed 2.7% of white patient's babies were referred to neonatal unit which was low compared to Pakistani and Indian ladies at 25% and Black African and Black Caribbean 12.5% more likely to be admitted to neonatal unit. Postcode information showed that in the WS1 area of Walsall, babies were more likely to be admitted to the neonatal unit.

	Diabetes information showed that a higher proportion of Black Asian and Ethnic Minorities had gestational diabetes and it was concerning to note that all the diabetes information was in English. Triage admission data showed that Black and Asian women are attending triage. Caesarean section data showed that Black and Asian women were more likely to have a caesarean section in the Robson 10 categories 1, 2 and 5. Service user feedback was included in the report with some service users feeling unheard but mostly good care received overall. Student midwife feedback received highlighted that their training did teach about the MBRRACE report but there was a lack of training related to darker skin women and higher risk factors for stillborn/higher morbidity and mortality rates. The report recommends that there is a need to have a Black, Asian and Ethnic Minority Continuity of Care Team to be based in the community and work is ongoing to develop this with the LMNS (Local Maternity and Neonatal System). The research has shown that service users from Black and Asian Groups would benefit from having more time in appropriate settings to discuss their care and this would improve outcomes. Develop information into different languages so that leaflets are produced in different languages and also information contained on Badgernet and digital platforms such as video. Talk to students in the university regarding decolonisation and unconscious bias and this should assist with the gap in education for student midwives. Mental health support referrals have been made to talking therapy and birth trauma clinics, particularly post covid. Working with the Diabetes team to ensure referrals are made into the NHS Diabetes prevention programme for those patients who have had gestational diabetes. Professor Toner thanked Mrs King-Stephens for her comprehensive report and advised that she will ensure that she takes these findings to her university to incorporate into their training. Dr Shehmar suggested that Mrs King-Stephens links with the Patient Experience team who have a national system, EIDO, that translates patient information into different languages to see if this can help and also the issue with the Badgernet system needs to be further investigated as this is a national maternity programme and provides information to patients which should be available in different languages. She also suggested it may be useful to look at some of the clinical outcomes for patients to see whether there is any link in difficulties in obtaining information in different languages or different cultural issues having an impact on a higher rate of admission and should this affect the advice and antenatal care that the Trust is giving to certain ethnic backgrounds. This ethnic data is not presented in the perinatal mortality reports and would be useful to be included, particularly as WHT are an outlier for perinatal mortality rate. Mr Dodds advised he would like to arrange meeting with to look at access to resources and support for this service and how to build this into the services the Trust offers.
274/22	**NHSEI Undertakings**
	Discussed in 268/22 above.

275/22	**Exception Reports from Sub Groups**
	No exception reports were received for discussion.
276/22	**Any Other Business**
	There was no any other business for discussion.
277/22	**Matters for Escalation to the Trust Board**
	Chair will escalate Sepsis, VTE, Safeguarding Level 3 Training, two-week wait in Breast Cancer and Never Event via the Chair's report for Trust Board.
278/22	**Reflections on the Meeting**
	Meeting finished at 1.55 pm
279/22	**Date of Next Meeting**
	Friday 23rd September 2022 at 11.30 am

Walsall Healthcare NHS
NHS Trust

MEETING OF THE PERFORMANCE AND FINANCE COMMITTEE HELD ON WEDNESDAY 27th JULY 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 M Dodd	Interim Director of Transformation

In Attendance

Dr M Shehmar	Chief Medical Officer
Miss B Edwards	Executive Assistant **(Minutes)**
Mr N Joy-Johnson	Director of Procurement **(For Item 60/22)**
Ms D Ohai	Divisional Director of Operations (WCCSS)

Apologies

Mrs D Brathwaite	Non-Executive Director
Mr N Hobbs	Chief Operating Officer
Mrs L Carroll	Director of Nursing
Mr D Mortiboys	Operational Director of Finance
Mr S Evans	Interim Chief Strategy Officer

56/22	**Chair's welcome; apologies and confirmation of quorum**
	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. Mr Assinder welcomed Mrs Ohai, Divisional Director of Women's, Children's and Clinical Support Services, to the meeting in Mr Hobbs capacity.
57/22	**Declarations of interest**
	There were no declarations of interest raised.
58/22	**Minutes of last meeting held on Wednesday 29th June 2022**
	Following a minor amendment, the minutes were approved. However, Mrs Martin requested matters contained in the minutes be listed as action items: - Ms Griffiths invited to October's Committee to update on sickness - PFI update to be brought to the November 2022 Committee - Mr Hobbs / Mrs Ohai to update on funding arrangements for mutual aid provided to UHB &UHL trusts On the third point, Mr Caldicott confirmed the mutual aid income arrangements had not been agreed. Mrs Martin was concerned that work may have commenced without the funding being agreed and requested

	escalation. Mrs Ohai raised that she would investigate and to confirm the process and would update members. Mrs Martin requested clarification as to why two reports were not on the agenda but are contained within the business cycle. Mr Caldicott noted that the Digital Strategy Update had been deferred, in agreement with the Chair, to the next Committee meeting and the Emergency Preparedness Resilience and Response item was covered last month. Mrs Martin questioned the absence of the Board Assurance Framework and Corporate Risk Register (BAF and CRR), and Mr Caldicott noted the Trust cycle had changed, owing to presentation bi-monthly of CRR & BAF moving forwards (also agreed with the Chair). Mrs Martin was concerned that this would fall out of the Trust Board cycle and Mr Caldicott requested Miss Edwards to speak to Mr Bostock and Mr Wilshere. Mr Caldicott advised the underlying financial position would be reported on a monthly basis and would be included within the finance report at the August 2022 Committee, following a further piece of work being undertaken at system level after the revised plan submission at the end of June 2022. **Action:** - **Miss Edwards to speak to Mr Wilshere and Mr Bostock regarding the BAF and CRR business cycle in relation to fitting in with the Trust Board cycle.** - **Miss Edwards to confirm if EPRR requires inclusion within the next Committee agenda.** - **Mrs Ohai / Mr Hobbs to provide members with an update on treatment of patients under mutual aid at the next meeting or before.**
59/22	**Matters arising and action log**
	The action log was reviewed and updates provided. Mr Caldicott agreed to speak to Mr Hobbs regarding action **26/22, Estates Strategy,** and his agreement to circulate the backlog maintenance log. Mr Assinder requested it was added to the August 22 agenda. **Action:** - **Miss Edwards to include Estate's backlog maintenance log on to the next agenda.**
60/22	**Procurement Report**
	Mr Joy-Johnson joined the meeting. Mr Joy-Johnson presented to members and highlighted the 2022/23 total forecast had bottom line savings at £1.267m when inflationary cost avoidance is included (noting this excluded the Black Country Pathology savings). A strong position was reported with 207 schemes forecast to achieve £194k on cost reduction savings. Members noted there was on

	going risk in relation to the workforce supply chain resilience and inflation with pressures which were being monitored closely. Mr Joy-Johnson advised a new category concept had been implemented and recently had introduced a new pathology cell to leverage spend and expertise across both pathology networks supported by ISPD. It was advised the Midlands Partnership Trust and the Black Country Alliance were participating in category cell meetings and was the first time both ICS's were fully represented from Procurement perspectives. **Dr Shehmar joined the meeting at 15:23**. Members were informed there had been an introduction of the electronic expenditure approval request system at RWT that went live in July 2022 and was running well but would continue to be monitored for a few months before being signed off as successful. It was advised, following the sign off, Walsall would be the next to go live. Mr Joy-Johnson raised that there were significant challenges in relation to workforce in the ISPD but stated this was across all industries in all sectors. Mr Joy-Johnson advising supply chain resilience was challenging and work was on going with national and regional colleagues. It was advised mutual aid was on going and the key success factor was around the clinical procurement colleagues that have supported with product substitution working with clinicians. Mr Joy-Johnson highlighted to members the 2022/23 position had been protected by legacy contracts resulting in inflation increasing to 2% by the end of this year. It was raised as an ongoing challenge but was not just an NHS issue. Mr Dodd questioned the strategy for dealing with inflationary pressure and if the resource was trying to mitigate the cost pressures or was there something different to refresh the strategy to deal with coming down the line. Mr Joy-Johnson expressed it had been seen for the last 12 months and the strategy was to do everything possible such as collaboration, increase leverage, product substitution, global and UK sourcing. Mrs Martin stated she was looking for assurance the Trust was working with the ISPD on finding people opportunities in relation to workforce and if the apprenticeship route had been explored. Mrs Martin requested assurance on disrupted products and to confirm if there was any impact on patient care. Mr Joy-Johnson advised he was working with Mr Caldicott and Mr Mortiboys and highlighted the procurement community had an increase of 30% in procurement professionals over the last 12months but this had been driven by the Commission environment. It was confirmed there were 7 apprentices within the ISPD for long term resilience.

	Mr Joy-Johnson advised there was always a risk on supply chain resilience but assured there had not been anything reported yet. It was highlighted the key was to ensure the divisions and clinicians were aware of any potential risks to engage support as soon as possible. Mr Joy-Johnson expressed the priority was and will always be to keep the hospital running with savings being a key focus. Mr Assinder questioned the £1.2m of benefits and what proportion would go into the CIP programme (this year's efficiency programme) and how will it be reflected in budgets. Mr Joy-Johnson advised the savings transacted will form part of the divisional dashboards. Mr Caldicott advised the savings model had been built into the CIP but there was a difference in the value compared to the tracker from the procurement model. There was an opportunity for a further c£300k savings in terms of budget extractable benefits but these were not taken out until the contracts had been awarded. Mr Caldicott advised of £300k in the CIP pipeline but there was risk to this, as well as to attainment, of negated inflation and cost avoidance. Mr Assinder thanked Mr Joy-Johnson and his teams for their ongoing work. Mr Joy-Johnson passed on his thanks to the divisional teams and colleagues' support.
61/22	**Financial Reports Month 3**
	Mr Caldicott presented to members. It was highlighted the Trust was £1.5m adverse to plan due to 4 different areas. Agency cost was highlighted as a key driver, due to there not being the expected reduction in agency at the scale that had been planned. Members noted there was a CIP shortfall in delivery but also an enhanced risk as the plan has a phased approach that would see targeted delivery increase in the later quarters of the financial year. Emergency demand continued to be high and resulted in the continued use of extra capacity areas. Mr Caldicott advised the Executive team noted investments made into emergency care would support the flow of patients and close the capacity areas. Mr Caldicott advised that he and Mr Hobbs were having conversations with the ICS about the management of the increased levels of emergency demand and how it was being felt across the rest of the ICS. Mr Caldicott advised he felt the Trust's swift ambulance handover was attracting an increased level of demand. Elective Recovery was highlighted as another driver, with the risk the Trust would not achieve the 104% elective threshold to earn additional income. It was noted this was a system risk and there had been comments in relation to the resource being recycled and put back into the

	system, this being highlighted as a system risk. The Trust has achieved 88% and was in a similar position to other organisations. Mr Caldicott stated from an STP perspective, there was a £21m deficit, with £10m adverse to plan. However, it was noted some ICS providers assumed the elective recovery would occur (as performance was below the 104% funded levels) restating the adverse variance to £8m. It was highlighted £6.5m was for Sandwell & West Birmingham, a key risk for the system. Mr Caldicott advised it will be important to focus upon future financial periods and the normalised position, combined with forecast exit run rate, but stated the normalised position was still being debated within the system regarding income allocations being recurrent. However, members were informed there was a c£100m normalised ICS deficit position and further work had been undertaken. Mr Caldicott stated the normalised position indicates next year looked to be challenging. Members were informed that in relation to the pay award there was 2% contained within the allocation base in the original allocations to ICS's. However, the pay award determined by an independent body resulted in on average a 4.5% pay award. It was highlighted there was an extra 2.5% assumed to be absorbed from notified baseline allocations. HM Treasury will not sanction any further allocations to the NHS, so the shortfall would be made up through a 'reprioritisation' of existing allocated funds (innovation and digital being an example where cuts will be facilitated). Mr Caldicott advised that the capital programme was £38m. It was noted the new Emergency Department build would conclude by October 2022 (a 4-week delay). However, the theatres programme of £4m for 2022/23 had not been secured, so there was risk to overspending the capital allocation. Mr Caldicott advised the cash position was healthy but summarised with there being risk on both revenue and capital. Mr Assinder noted the YTD deficit of £600k and with the Trust off plan by £1.5m and questioned the forecast outturn. Mr Caldicott stated there was a surplus plan because resources would be committed as the Trust enters the winter period, but current run rates indicating the deficit could total c£6m for the year. Mrs Martin stated that the pay award had not yet been costed and questioned what this meant for the Trust. Mr Caldicott advised the team were working up the costings whilst waiting for the formal written documentation for each band to get the costed position, raising there was a risk element in working the cost back through on an allocation model and through the ICS as the 'reprioritised' income received may not off-set the full local cost of pay award implementation.

	Mrs Martin stated that previous rules had been applied where funding was only received for staff that were in post at the start of the financial year and expressed concern following the large recruitment drive that could leave some staff uncovered. Mr Caldicott assured Mrs Martin that the allocation was on a fair share based on income allocation, not head count. Mrs Martin questioned the current agency cap and the Trust's performance within the first 3 months. Mr Caldicott confirmed there was not a cap in force and the centre had advised a target of a 30% reduction in agency expenditure, with the basis either being 2022/23 plan or 2021/22 outturn (with confirmation to be received for month 4 reporting from NHSEI). Mrs Martin stated Sandwell and West Birmingham's financial performance was concerning from an ICS point of view and questioned if it had disclosed what was causing the variation in the early stages of the financial year. Mr Caldicott advised they were a high consumer of temporary workforce and agency costs appeared high compared to the system (including the use of Thornberry). Members noted the group of Chief Financial Officers had requested clarification on outturn forecast and how this would impact the Trust in relation to the risk share, which is a substantial risk. Mr Assinder questioned the Executive Team's level of confidence against the agency reduction plan. Mr Caldicott advised he was raising this regularly in different forums but at Trust Management Committee there was a real push to reduce agency workforce and see significant reductions in usage from a nursing perspective within ED. Mr Caldicott expressed there was a balance as recently there had been an increase in emergency demand and business cases had been approved to support this. Dr Shehmar stated medical agency was tracked through medical workforce monthly meetings. Dr Shehmar added she was increasing substantive positions through the clinical fellowship scheme, with 80 doctors being recruited in the last year with 50 in post but the remaining agency by exception had not been switched off due to difficult recruit areas or to bridge a substantive staff member joining. Mrs Martin highlighted the total number of agency hours was decreasing but costing remained high and questioned if the bank rates had been increased in response to sickness and other pressures. Mr Caldicott advised the agency usage was more focused in high-cost areas such as ED and Critical care which was driving a premium. Agency reduction was seen across the ward base, tier 1 and tier 2 being removed but higher cost base was being driven further from the enhanced establishment.

	It was advised that Professor Loughton was looking to increase the bank rate through the month of August 2022 to attempt to offset some of the risk. Dr Shehmar stated she agreed with Mr Caldicott in relation to the areas that are difficult to recruit to are more senior tiers and require more experience. Members were informed there was a process implemented for approval for higher agency spends.
62/22	**Restoration and Recovery**
	Acute Mrs Ohai presented to members. It was highlighted the Trust's recovery was progressing well. It was noted that cancer waiting times remained better than the West Midlands and National averages. It was highlighted the Trust had performed well in the number of patients that have to wait longer than 6 weeks for a diagnostic test but there had been a dip in performance, but work was underway to recover that position. Improvement had been seen on MRI with patients waiting less than 6 weeks. Concerns were raised around sickness, and it was reported there was spikes of increased activity in echocardiograph but the Trust remained within the top 20 nationally. Further concern was highlighted around 2 weeks wait for patients with suspected breast cancer. It was noted mutual aid to supporters from Wolverhampton that had been extended to include Dudley and Sandwell. Mr Assinder raised that there did not seem to be an improvement on the 800+, 52-week waiters and requested assurance what was being done to reduce the 52-week waiters. Mrs Ohai expressed the concerns were shared but there was plans in place in terms of trajectories for service to improve and a reduction has started to be displayed. Mrs Ohai added additional support was being given out to Leicester but advised Mr Hobbs held fortnightly meetings with the Division to work through plans and to gain assurance. Mr Assinder questioned if there was a trajectory and requested for it to be included within the next report. Mrs Martin raised concern there was a steady decline in the Trust National ranking for 18-week RTT benchmarking. Mrs Ohai agreed and added the primary focus was ensuring the Trust had the resources for patients to have their review, resulting in some patients waiting longer. Mrs Ohai confirmed there was a lot of work ongoing in relation to reviewing and prioritising patients through the process. Members were informed that nationally the Trust performance was declining but was in line with the Trust's trajectory. Mrs Ohai agreed to share the trajectory with members to provide clarity in terms of progress planning and work towards improvements. **Action:** - **Mr Hobbs to include the trajectory plan for the 52-week waiters within the next R&R report at the August 22 Committee.** - **Mr Hobbs / Mrs Ohai to share 18-week RTT trajectory with members.**

63/22	Performance Constitutional Standards Report
	Community Mr Dodd presented to members. Members were informed high levels of activity have been maintained throughout June 2022. There had been general growth in demand at the Acute site and the Community site. The Community site was seeing an increase in referrals for complex discharges having increased from 15% to 20% since April 2022. Mr Dodd advised the team were dealing with the same average length of stay but the numbers were starting to increase. Mr Dodd stated there was a range of processes to try and mitigate demand, but pressures continued to grow. Mr Dodd added he was planning to put a bid in to increase the hospital team due to the delays and the hospital side rather than moving into community capacity. Mr Dodd informed members the Community had been cited as a National Exemplar of good practice and have put in a bid to become an exemplar model site. It was confirmed the team have been shortlisted and was now at National selection level. Mr Dodd informed members a bid for £1.2m that have been approved but there had been no official announcement yet. Mr Dodd highlighted at the last meeting the Psychology Children's diabetes best practice tariff would be resolved by the end of the month. It was confirmed the recruitment of the psychologist post had fallen through but added majority of the service issues had been resolved so the risk had been de-escalated on the Corporate Risk Register. Mr Caldicott stated it was right for the Investment Group to review the Community Investment Model to provide oversight and assurance over the receipt of non-recurrent resources in development of community-based care provision. Mr Dodd stated it would be difficult to battle at a system level for growth for ambulance services to be deflected towards community services. Mr Assinder agreed and added this was around the benefits realisation analysis work and demonstrating he admission of alliance work that is done. Mr Dodd added he was having discussions with the strategy unit to try and frame up an evaluation model to enable the Trust to gain a bit of resource from the centre. Acute Mrs Ohai advised members the Trust continued to have the best ambulance handover in the West Midlands and remained as one of the top performing organisations despite having the highest record of type 1 activity in June 2022. The Trust ranked 4 out of 40 nationally for 4-hour turnaround time. Mrs Martin expressed there was a lot of overlap between the Restoration and Recovery report and the Constitutional Standards report and questioned if the reports could be aligned. Members were informed that

	the Board of Directors across 2 Trusts committed to having a review of how we report to align and get more consistency. Mrs Ohai agreed to update Mr Hobbs regarding meeting with Ms Gwen Nuttall in relation to the performance reporting taken to the Committee's equivalent. **Action** - **Mrs Ohai to speak to Mr Hobbs in relation to aligning the performance reporting across both Walsall and Wolverhampton sites.**
64/22	**Efficiency Programme**
	Mr Caldicott presented to members. Currently identified plans totals £5.5m compared to the £6.3m target. Some 50% of the programme is risk rated as green with 20% being amber but further work was on going. It was noted this position would not provide assurance at this time to members. Mr Assinder questioned if there was a clear view of what the cash releasing element of this Programme was. Mr Caldicott advised it was all cost releasing, due to income being largely blocked during the current financial year. The Trust will not earn ERF but there was an opportunity to earn more moving forward and would be through the mutual aid case but was subject to receipt of confirmation of the increased tariff price. Mr Assinder questioned if there were any initiatives across the ICS the Trust could benefit from. Mr Caldicott stated digital would prove a good opportunity for the organisation to move away completely from paper based medical records. However, it was added the digital innovation funds were curtailed which had provided some pressures in terms of how we deliver the medical records business case with the PAS provider and system C.
65/22	**The Ockenden 2 Report – Consultant Staffing**
	Mrs Ohai presented this business case to members. It was highlighted a gap analysis had been performed to ensure the Trust was compliant with the 15 actions in Ockenden. We are partially complaint. Members were informed that the business case presented today was for the obstetric consultant element only. It was noted the case would provide 6.15 WTE staff in total - that would be 4.19 consultant posts and their respective administration support. **Dr Shehmar left the meeting at 16:29** Mr Assinder questioned the requirement for the administration support. Mrs Ohai advised it was to provide each consultant with a basic level of support to prevent other roles picking up administration tasks. Mr Caldicott advised there was no funding allocated for this case but expressed it was deemed to be a significant safety risk for the Trust and was put before members for consideration on that basis. It was advised the Trust would seek additional funds for Ockenden 2 from the ICS to be able to allocate the funding against the posts, if this funding is not secured

	then this case would form a first call for investment in 2023/24, noting if funds could not be secured then this would further enhance the normalised deficit position. Mrs Martin expressed she was not sure of the difference between the options. Mrs Ohai expressed the case was only proportion to meet the requirement, the complete business case ready but due to time scales a case on just on Obstetric Medical element. Mrs Martin expressed concern in relation to the timeline and certainty on the rest of the case. Mrs Ohai confirmed the case would be progressing to Investment Group. Mr Caldicott stated the medical workforce elements had taken priority owing to recruitment timeframes and what was expected to be a significant demand on the medical workforce. The separate case for a further c£3m subject to review by the wider ICS. Members were informed the second case was substantial but there was a lot of conversations going on but would need to be endorsed by the ICS due to the level of investment in the staffing group. Mrs Martin expressed the Board needed to be made aware of the £3m. **Resolution:** **The Ockenden Consultants Business Case was approved but was not covered within the financial plan and place pressures on normalised position moving forwards.**
66/22	**General Surgery Medical Workforce**
	Mr Caldicott advised members the emergency care rota that was currently not compliant and had been supported through Executive team and TMC. The second part of the case was for patients that attend for gall bladder surgery that are diagnosed and sent away to come back for elective care procedures. Due to time delay, this has resulted in the deterioration of patients conditions. Mr Caldicott advised the secondary aspect came with a level of potential income around increased volume. It was noted Mr Hobbs had committed a level of the winter programme as well as annual cancer funding resulting in the case being fully resourced. Mr Caldicott further advised members that the £4m winter funding allocation had been utilised for several cases to support recurrent establishment increases, with the residual sum now c£1.6m. Whilst the Trust has bid for additional funds in order to support the previously endorsed cases the winter plan would need to work within this reduced financial ceiling. **Resolution:** **The General Surgery Medical Workforce was approved.**
67/22	**Emergency Department Build Update**

	Mr Caldicott informed members the construction timeline and contractual handover was 28th September 2022 but with the 8-week delay that brought the date to the end of November 22. Mr Caldicott stated that Mr Watson had managed to reduce the delay to 4 weeks, so the opening of the department would be in November 22. Mr Caldicott expressed that there was still construction industry risk.
68/22	**Annual Cycle of Business**
	Members noted the Annual Cycle of Business.
69/22	**Any other business**
	There was no other business discussed.
70/22	**Matters for escalation to the Trust Board**
	The following items were agreed to be included within the Committee highlight report to Trust Board. - The declining financial position and where the Trust was heading for the remainder of the year and the deterioration of the ICS Financial performance during quarter 1 (risks centring upon agency and cost improvement program) - Concerns were highlighted in relation to the 52 & 18-week waiters, with a request that trajectories are shared at the next meeting. - Community Services have been shortlisted for the National Exemplar Status. - The Ockenden Consultants business case was approved with the concerns regarding the cost implications not offset by an income source. - The Surgery Medical Workforce business case was approved and was fully funded. - Progress on the ED development and the revised handover date of 28th October 2022. - The Theatres case capital scheme remains without a funding source in 2022/23 and 2023/24
72/22	**Date of next meeting: Wednesday 31st August 2022 at 15:00**

Walsall Healthcare NHS Trust

MEETING OF THE PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE

HELD ON MONDAY 25TH DAY OF JULY 2022 AT 13:30
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Present

Mr Junior Hemans (Chair)	Non- Executive Director
Mr Paul Assinder	Non-Executive Director
Mrs Dawn Brathwaite	Non-Executive Director
Ms Catherine Griffiths	Chief People Officer
Mr Kevin Bostock	Director of Assurance
Mr Keith Wilshere	Company Secretary – Walsall and Royal Wolverhampton NHS Trusts
Ms Shabina Raza	Freedom to Speak Up Guardian
Ms Caroline Whyte	Deputy Director of Nursing
Mrs Jane Wilson	Joint Staff Side Lead
Mrs Kelly Geffen	Divisional Director of Nursing -
Mrs Sabrina Richards	Equality, Diversity and Inclusion Lead
Mrs Jaswinder Toor	Senior Executive Assistant
Mr Brad Allen (Minutes)	Executive Personal Assistant

Apologies

Ms Maria Arthur	Deputy Director of Assurance
Mrs Lisa Carroll	Director of Nursing
Mrs Patricia Usher	Joint Staff Side Representative
Ms Clair Bond	Deputy Chief People Officer

49/22	**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.
50/22	**Declarations of Interest**
	Mrs Raza raised one declaration of interest for the committee to note a member of her family holds a Freedom to Speak Up Guardian position at The Royal Wolverhampton NHS Trust.

51/22	**Minutes of Previous Meeting – June 2022**
	Committee **resolved** to approve the minutes of the meeting that took place on Monday 27th June 2022 as a true and accurate record of discussions and decisions that took place.
52/22	**Matters arising and Action Log**
	The Action Log was reviewed and updated by action owners as necessary by utilising the iBabs service.
53/22	**Integrated Care Systems Update**
	Mr Hemans advised committee that discussions had been held with Ms Griffiths to provide members with a monthly update on improvements to cultural elements within the Integrated Care System. Ms Griffiths stated that a workstream on education, apprenticeships and Health and Wellbeing is in place, the workstream on growing for the future has a particular focus on filling vacancies and improving retention levels within the system. Ms Griffiths then referred to recruitment initiatives undertaken with external partners at place level to improve staffing figures and retention across the Black Country system. Ms Griffiths then advised members that the ambition is to look at hybrid roles that combine both Healthcare and Health and Social Care to support with capacity and demand. Ms Griffiths then went on to refer members to efforts being made to improve overall retention metrics within the system and for individual Trusts. She advised that Flex for the Future is a national scheme which support with this initiative and with improving retention through agile and flexible working approaches. Mr Assinder expressed his support for the Trust's focus to improving retention figures and advised that teams review exit interview processes utilised by the private sector to improve expertise when trying to retain staff. Ms Griffiths responded to Mr Assinder's points and advised that monitoring projects had taken place to review reasons for people leaving the organisation and summarised that work-life balance is increasingly featuring as a prominent reason for their departure. To tackle this, Ms Griffiths assured Mr Assinder that the case to be submitted to the Investment Group to support the Resourcing Team to also work on processes to retain staff. Mrs Brathwaite stressed the need for the Trust to publicise what the Trust is doing to support colleagues with their work-life balance requests, as well as overall improvements to staffing figures to separate ourselves from the overall picture within the national headlines.

	Ms Griffiths agreed with Mr Assinder and Mrs Brathwaite's points and confirmed that conversations would take place with the Communications Team to pull together a press release to not only reflect these new initiatives, but also the Trust's improved position with staffing levels. Mrs Wilson referred members to a recent slideshow presented at the Joint Negotiating and Consultative Committee that outlined details of exit interview data and suggested it be circulated to members for their reference. **ACTION:** **Committee Secretary to circulate presentation for information.** Mr Hemans suggested a join Board Development Day be scheduled to review flexible working options for staff and advised he would host conversations with the Trust Secretary. Mr Hemans requested that Integrated Care Systems be added to the beginning of all future agendas for discussion. There were no further comments from members.
54/22	**Divisional Workforce Metrics – Community Division**
	Ms Geffen introduced the paper and gave members an overview of all Divisional Key Performance Indicators and detailed any mitigating measures to support in areas that require improvement. Mr Hemans queried whether the Division was experiencing increased requests for flexible working following previous discussions held around turnover. Ms Geffen responded to Mr Hemans to advise an increase had been experienced and that each request is reviewed individually to ensure fairness. She advised although every effort is made to support requests, in some cases, requests may be declined due to service requirements. She did, however, assure committee that a review of adaptions is taking place moving forward and gave examples. Ms Geffen also summarised the demographic of these requests, of which the majority were staff members seeking flexibility to support with childcare needs. Mr Assinder referred committee to sickness levels outlined in the report and raised concern with the overall figure of 6%, with stress and anxiety being the main reason for absence. Ms Geffen assured Mr Assinder that every effort is being made to support staff with their return to work and advised that the stress and anxiety levels outlined in the report were predominantly home related.

	Mr Assinder went on to question whether Mental Health First Aiders were in position within the Division to support staff with any needs. Ms Geffen confirmed that a number of Mental Health First Aid staff were in place and have proven incredibly beneficial. There were no comments or questions from members, therefore the paper **noted.**
55/22	**Staff Story – Community Division's Cultural Elements**
	Ms Geffen introduced the report and gave a breakdown of employer relations figures for the Division and advised committee of the thirteen active cases that remain open, as well as five Management of Change cases that have recently been undertaken. Ms Geffen then went on the briefly outline details to established forums in place within the Division to identify and develop talent, as well as promote the Equality, Diversity and Inclusion strategy. Ms Geffen advised committee of recent efforts made to promote and improve Health and Wellbeing elements within the Division, in which a total of thirty-four managers had participated in dedicated training sessions. Ms Geffen then updated member on the Division's National Staff Survey results, of which teams had achieved an overall response rate of 57%, which has given Managers a greater understanding of where to focus their efforts in terms of improvement. Following this, a communications Action Plan has been developed to support one-to-one conversations with staff and their teams. Ms Geffen then went on to update the committee on the recent transfer of the Therapies department. Concerns had been raised around staffing numbers within the Health Visiting Team, however, a task and finish group has been established to implement mitigatory measures to decrease risk factors within the teams. Ms Geffen briefly updated members on training opportunities offered to staff to support the promotion of freedom to speak up. She advised that all Professional Leads in the Division hold conversations with staff to provide them with the opportunity to raise any concerns and discuss any development opportunities. Ms Geffen then updated members on the recent recognition of the Rapid Response Team of whom have been awarded with 'Placement of the Year' with personal thank you letters and visits being sent to all staff from the Divisional Team of Three. Mr Hemans queried the progressions being made within the recently established Community Forum.

	Ms Geffen advised that the group had not yet met but will be meeting to discuss action plans ahead of winter pressures. Ms Whyte expressed her support for the efforts made within the Community Division and stated that changing the mindset of staff was key to creating a positive working environment. Ms Whyte emphasised the need to celebrate the positive news stories that arise within teams and that they be shared amongst wider teams for reference. Ms Richards referred to the recently established Annual Staff Awards Programme and suggested that the success stories mentioned be submitted to the panel for consideration. There were no further comments from members, therefore the report was **noted.**
56/22	**Safe Staffing**
	Ms Whyte introduced the report as read and began by providing members with a brief overview of areas to highlight for their reference. These were: • An increase in the vacancy rate to 11% from 4% had been experienced, but following a series of recruitment days, figures are expected to improve in the coming months as staff commence employment at the Trust. • A Business Case has been developed to increase staffing within the Recruitment Team to ensure staff can join the Trust in a timely manner and to ensure that audit and compliance and improvement wor. • The largest amount of vacancies are in the Emergency Department, but plans are outlines in the recruitment plan to mitigate this. • A total of two-hundred and twelve Nurses have been recruited, with one hundred and seventy now being registered with the Nursing and Midwifery Council. Pastoral support for these staff is being provided by the Force Team. • Agency usage increased slightly during the month of June due to staffing pressures and high attendance rates within the Emergency Department. Agency usage was required to ensure safe practice.

	• Additional lists have been developed in Endoscopy to decrease backlogs. This has resulted in a need for additional agency staffing, thus meaning agency usage has increased. • An Agency deactivation programme has been developed, which has seen a downwards trend on agency usage and tier 2 staffing usage. Different wards will be switched off in terms of agency usage, however it was reported that this has been a challenge due to increased covid cases amongst the workforces. Mr Assinder emphasised the importance of deactivation of agency usage plan being implemented as soon as possible to have a positive impact on patient care. He then queried an update as to how Ms Whyte thought the plan to be deliverable. Ms Whyte replied to Mr Assinder to state at present, she wasn't able to confirm how deliverable the scheme would be. She advised that discussions had been held to withdraw agency earlier than anticipated, however it was deemed a delay due the current capacity issues the Trust is experiencing. Mr Assinder queried whether the Trust had plans to increase bank payment rates. Ms Whyte clarified that the Chief Executive was soon to make an announcement to increase Bank rates by £5 per hour for a period of six weeks to support with capacity issues. There were no further comments from members, therefore the paper was **noted.**
57/22	Freedom to Speak Up – Annual Report
	Ms Raza introduced the report as read and began by providing members with a brief overview of the highlights detailed within the paper. They were as follows: • A total of 110 concerns were raised within the last financial year, with one third of these being related behaviours and harassment. • Policy and Procedural issues were also reported to be high, with concerns raised by staff around lack of managerial support/understanding, with staff feeling like their concerns aren't being followed up.

	• Following a review of Freedom to Speak Up accessibility, it was noted that both Band 3 and Band 8t staff members were least likely to raise concerns. As a result of this, a review will take place to identify barriers and implement mitigating measures. • It has been noted that, on a national level, members of the Black and Minority Ethnic were least likely to raise concerns. • The Division of Medicine and Long-Term conditions has been identified as the main area for concerns raised, however it was noted by committee that it size in terms of workforce would be a contributing factor. Mr Hemans emphasised the importance of ensuring all concerns raised during the exit interview process are captured, investigated, and dealt with. He then raised concerns around the figures specified within the Medicine and Long-Term conditions Division and queried what could be done to encourage Management teams to undertake additional Freedom to Speak up Training. Mrs Richards thanked Ms Raza for her report and referred members to the data outlined within the report. She raised concern that numbers specified did not correlate with Human Resources casework. Mrs Wilson stated that 42% of concerns were reported to be coming from members of the Black and Minority Ethnic community and queried whether there were similarities between the concerns raised from White members of staff. She advised it would be useful to compare data to identify caseloads. Mr Hemans stressed the need for this to be added to the agenda for discussion at future Trust Board meetings to move forward. There were no further comments from members, therefore the report was **noted.**
58/22	**Staff in Difficulty Report**
	Ms Griffiths introduced the report as read and provided an overview of key themes for the reference of members. She advised that the report would provide assurance to staff members that the Trust is dealing with employment relations cases to ensure their swift closure. Ms Griffiths then advised committee that the Trust is currently dealing with approximately ten cases per month and that the report showcases progress made with tribunal cases.

	Ms Griffiths advised that an increase in grievances has been noticed including collective grievances: one related to pay and the other relating to re-location of staff. Ms Griffiths noted that many staff members are under a lot of pressure due to staffing issues and demand for services , but constant establishment review ensures the staffing models support staff in line with the Trust's values. Mr Hemans stated that conversations had been held with Ms Griffiths and others to look at various ways in which we can tackle long-term sickness absence figures, and that a more effective approach will be explored as statistics are released. Mrs Wilson referred members to the age brackets in which issues are broken down in to and queried whether there may some training issues that may need to be looked in to in the age bracket of 41-50. Ms Griffiths assured Mrs Wilson that a review in this would take place to ensure necessary professional development is offered to members of staff as required. There were no further comments from members, therefore the paper was **noted.**
60/22	**Revised Terms of Reference**
	Mr Hemans introduced the revised Terms of Reference as read. Committee **resolved** to approve the revised Terms of Reference as set out.
61/22	**Items for Information**
	It was **resolved** by members that each paper included within this section be noted. There were no additional comments from members.
62/22	**Escalations to the Trust Board**
	It was **resolved** that the following escalations be made to the Trust board for reference/further intervention: - Staff retention and joint board development session to be arranged. - Encouraging and empowering Managers to deliver effective services. - Agency usage figures. - Freedom to Speak Up Report, with focus to bullying and harassment cases, as well as the need for focus to age profiling and training issues.

	- Good news stories from community.
63/22	**Any other Business**
	There were no additional items of business raised by members for discussion.
64/22	**Date and Time of the Next Meeting**
	Monday 29th August 2022 – 13:30 – Via Microsoft Teams.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE AUDIT COMMITTEE HELD ON MONDAY 20TH JUNE 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
Mr J Parkes	Non-Executive Director

In attendance

Mr K Bostock	Director of Assurance
Mr R Caldicott	Chief Financial Officer
Miss R Edwards	Executive Assistant
Mr D Mortiboys	Operational Director of Finance
Mrs A Ward	Executive Assistant
Mr K Wilshere	Company Secretary
Ms L Fanning	External Audit – Mazars
Mr M Surridge	External Audit - Mazars
Mrs E Mayne	Internal Audit – Grant Thornton
Mrs M Wren	Internal Audit – Grant Thornton
Mr M Gennard	Internal Audit – RSM
Mr A Hussain	Internal Audit – RSM
Ms E Simms	Local Counter Fraud – RSM

26/22	**Welcome and Introductions**
	Mrs Martin welcomed everyone to the meeting.
27/22	**Apologies for Absence**
	Apologies for absence, were recorded as listed above.
28/22	**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.
29/22	**Minutes of Previous Meeting**
	The minutes of the previous meeting held on 9th May 2022, were agreed as a true record.
30/22	**Matters Arising & Action Log**
	The action log was discussed and updated.

Item 137. Mr Wilshere provided an update around Conflicts of Interest confirming that the new system had been launched in April and 725 declarations had already been made. Reminders will be sent out to all staff over the next few months with confirmation provided that the site was live on the publicly accessible system and reports provided to Audit Committee on a six monthly basis. Mr Wilshere advised that there were approximately 1600 staff on the Electronic Staff Record that had no email address and work was being undertaken with People & Culture Department to try to address. A discussion took place regarding not being able to contact all staff and staff not being able to access systems within the organisation, Mr Bostock advised that he had discussed with the Director of People & Culture with regard to providing a plan for resolution. Mr Hemans queried whether the issue was lack of equipment, Mr Wilshere responded that it was a mixture:

- Staff not having equipment
- Staff not having regular equipment
- Staff not needing IT equipment to do their job
- Suspension of email accounts if not actively used

Mr Parkes queried whether the migration to NHS mail would improve access, Mr Wilshere advised that he felt the effect would be neutral. Following discussion Mrs Martin confirmed that this was a major item which was in process and agreed that the action should be closed with a new action point to find out from People & Culture and IT how the issues of email addresses was to be resolved. Action for Miss Griffiths and Mr Stringer to provide an update to Audit Committee.

Mr Wilshere advised that there were two further items that needed to be undertaken in relation to Declarations of Interest: Cross checks with ABPI register regarding gifts and hospitality received from the pharmaceutical industry. Further work to be undertaken with Procurement and Accounts regarding business interests with Counter Fraud colleagues, Ms Sims confirmed that the work was in the programme.

Action: Update to be provided to the September Audit Committee by Miss Griffiths and Mr Stringer in relation to resolving interactions with staff members that do not have email addresses

Item 271. Mrs Martin confirmed that the request was that Audit Committee reserved the right to request a deep dive into any losses and special payments if necessary and requested that anacronyms were not used within the reports. Action to be closed.

Item 269. Confirmation was provided that the Security Report was on the agenda for Quality Patient Experience & Safety Committee, action to be closed.

Item 272. Mr Mortiboys confirmed that the payments were in relation to legal settlements related to discrimination in the workplace. Action to be closed.

Item 274. Action to be closed.

Item 278. Mrs Martin advised that the Board Assurance Framework should be a standing item on the agenda, Mr Bostock advised that he was still awaiting the report from Internal Audit and had checked the Audit Committee business cycle

	regarding reporting. Mrs Martin requested that moving forward a report would be required at each meeting, the business cycle to be updated. Mr Wilshere advised that the Trust had received external assistance to review the Board Assurance Framework and there was a plan to move to a revised set of strategic risks which would be presented to the Trust Board with a move to a new reporting template and strategic objectives. Mr Bostock confirmed that a review of the risk registers had been undertaken and the new Board Assurance Framework and Risk Registers would be available from 1st September 2022. Mrs Martin advised that in the interim it was important to articulate the Board Assurance Framework risks and provide a holding statement to the Trust Board in August. **Action: Board Assurance Framework and Corporate Risk Register reports to be received at each Audit Committee. Business Cycle to be updated – Mr Bostock, Mrs Ward**
31/22	**Policies Under Review**
	Mr Wilshere provided an update regarding the work being undertaken to ensure that all polices and guidelines are compliant, advising that all policies will be transferred to Inphase and would be managed through that database. Currently approximately 50% of policies were noted as in date which was an improved position, the position with guidelines, however, had decreased to 52% since the start of the financial year. For assurance the policy as described in the Policies and Procedures Guide is now being rigorously applied and it was noted that it was taking time for parts of the organisation to become used to the rigorous adherence to the policy. Mrs Martin asked for numbers of policies in the organisation, Mr Wilshere responded that there were between 260 – 270 policies, 285 – 295 guidelines and 200 – 300 local policies and procedures, all information regarding policies is being shared with the Clinical Commissioning Group on a regular basis. Mr Bostock confirmed that the biggest constraint to improving compliance was being able to free up clinical time to write and review. Confirmation was provided that the CCG had offered to provide clinical personnel to speed up the process, however, some of the content would be organizationally specific and therefore an external person would not be able to help. Mr Assinder expressed his concern about the quantity of out of date policies and guidelines suggesting that this should be highlighted to Quality, Patient Experience & Safety Committee to ensure that the Trust Board were aware. Mr Wilshere assured that any polices or guidelines that were beyond their review date were being risk assessed to ensure that they could remain in place beyond their review date and be extended where there was no risk identified. Following discussion Mrs Martin confirmed that she would include the information regarding policies in the Chairman's report and ensure that the Trust Board were sighted on the clinical risk assessment.
32/22	**Items for Escalation from Board Committee Chairs**
	Items for Escalation to the Trust Board were highlighted as follows: Quality Patient Experience & Safety Committee – Mr Parkes advised that the Committee were sighted on several items and he would draw attention to these as the meeting progressed. People & Organisational Development Committee – Nothing to bring forward

	Performance Committee – To review the Internal Audit plan around the robustness of the waiting list management plans. Trust Management Committee – Nothing to bring forward.
33/22	**Internal Audit – Head of Internal Audit Opinion - GT**
	Mrs Mayne presented the report, which was taken as read. The summary of recommendations and standards was highlighted along with the levels of assurance. Mrs Mayne advised that three core reviews had been undertaken to inform opinion, two reviews had significant assurance with improvement required and one partial assurance with some improvement required. Confirmation was provided that the Trust had directed reviews at areas of risk and Mrs Mayne advised that a positive working relationship had been forged with the organisation during their tenure. The overall Head of Internal Audit Opinion was partial assurance with some improvement required and Mrs Mayne drew attention to risk management and the Board Assurance Framework which had been a work in progress for the three years that Grant Thornton had been working with the organisation. Mrs Mayne advised that it was important for the work to be completed, noting that there was more confidence at corporate level, however, there was a need to ensure that the confidence spread to the extremities of the organisation. The recommendations within the report were highlighted and Mrs Mayne confirmed good engagement at corporate level, with a need to ensure ownership throughout the organisation. Mr Assinder thanked Mrs Mayne for the comprehensive report advising that the partial assurance outcome was disappointing and queried how the organisation would move from partial to full assurance, along with asking if the Executive team had a route map of the way forward. Mr Bostock advised that staff with operational control had been operating under a low bar and the governance team had been working really hard to bring the bar up by reviewing actions to improve standards. Mr Caldicott confirmed that partial assurance was disappointing as there had been some good results for the Internal Audit work on infection control and the staff survey and he felt that the organisation was making progress. He further noted that with the follow up work around internal audit recommendations and improvements now being followed up promptly, there would be more improvements through the new financial year. Mr Hemans expressed his concern around the sustainability of improvements to the Board Assurance Framework and risk management. He was particularly concerned about the staff survey results when 1600 members of staff did not have digital access. Mrs Martin confirmed that there was an urgent need to be able to contact all staff and requested that the Director of People & Culture be asked to attend Audit Committee in September, which would show that Audit Committee are taking the report seriously. Mrs Martin confirmed that her Audit Report to the Trust Board would detail the lack of a green opinion and the requirement for additional focus. Mr Assinder requested that a clear message was given from the Non-Executives to the Trust Board that partial assurance and lack of progress is

	not acceptable, with a clear request for a roadmap moving forward to monitor progress.
34/22	**Internal Audit – Final CQC Improvement Plan - GT**
	Mrs Mayne presented the report advising that she felt the outcome was positive. Significant assurance against compliance, oversight and reporting, partial assurance with some improvement required around evidence and significant assurance with some improvement required against sustainability. Mr Bostock advised that when he joined the organisation, he found that there was little knowledge of a self-assessment programme against CQC standards and had now introduced a programme which was in its early stages that would move the organisation in the right direction. A discussion took place regarding the outcome of the report and how the Executive should respond to move the programme forward and to ensure buy in with Mrs Martin confirming from the discussion that a team of people should be invited to the September meeting led by Ms Cannaby to do a 10-15 minute presentation on 'What Good Looks Like' around objective three and Ms Carroll to provide an update around objective four. Further Ms Cannaby, Ms Carroll and Mr Bostock to provide an update around the processes for the work, this would be followed up by a further presentation 6 – 8 months later. **Action: Presentation to be received at the September meeting on 'What Good Looks Like' Objectives 3 and 4 Ms Cannaby and Ms Carroll to present – MM/AW**
35/22	**Internal Audit – Board Assurance Framework - GT**
	Mrs Wren presented the report, which was taken as read. Four objectives were agreed and the older recommendations had been reviewed. The detailed conclusion was partial assurance with improvement required and positive changes noted around closing down risk register actions. Recommendations made were 13 medium risk and 1 low risk. Mr Bostock confirmed that a lot of work and resources had been put into the re-structuring of the team and the technology to support the work over the last six months noting that some of the actions had been paused because there would be a change to implementation moving forward. Mrs Martin requested further updates at each Audit Committee regarding the work being undertaken. Mrs Martin and Mr Caldicott thanked Grant Thornton and the team for their work over the last three years. **Action: Updates to be provided to each meeting – RSM**
36/22	**Internal Audit Plan – RSM**
	Mr Hussain presented the Internal Audit plan for 2022/23 advising the plan would include: • Data quality • Sepsis • Effective rostering • Agency cap • Cyber security • Waiting lists and Covid-19 recovery • Financial Controls

	• Board Assurance Framework Mr Hussain advised that NHSE/I had asked for a review of financial sustainability, the scope for which had been discussed with Mr Caldicott and Mr Mortiboys and would focus on key financial controls and the efficiency programme. Areas of work that did not make the final cut were listed in the report with the proviso that some of these would be listed in the three year strategy. Mr Caldicott queried how the financial sustainability of the NHS would look when the review was undertaken, Mr Hussain advised that he would prefer to defer until the work was completed. Mr Parkes expressed his concern that VTE was not part of the current workplan and deferred for another year as a variation in results was being reported through Quality, Patient Experience & Safety Committee with the mitigation that the organisation was not seeing a high number of patients with blood clots. Mr Parkes also raised concern around servicing of equipment and controlled drugs which would not be audited at all. Mr Caldicott expressed the view that these items should be part of the clinical audit programme which would provide assurance to Quality, Patient Experience & Safety Committee. Mrs Martin asked about the process for appointing a lead for Clinical Audit, Mr Bostock confirmed that an advert for a Band 8A collaborative post across both organisations would be going out this week, with confirmation provided that there was an clinical audit lead in post and medicines management had been requested to be included in the forward plan. It was agreed that Mr Parkes to confirm the audits through Quality Patient Experience & Safety Committee and to the next Audit Committee. Mrs Martin asked if there would be any reports for the September meeting that would require the Executive lead to be present, confirmation was provided that IT reviews of the Infrastructure report would be received, Mr Stringer to be asked to attend. Further confirmation was provided that scoping had been planned for the Temporary Staffing and Rostering reports. **Action: VTE, Servicing of Medical Equipment and Controlled Drugs audit to be included in the Clinical Audit Plan and monitored through QPES. – Mr Parkes**
37/22	**Local Counter Fraud – RSM**
	Ms Sims presented the report advising that there had been a positive first quarter. Ms Sims advised that she had noted the information regarding the number of staff without an email address and confirmed that she would use as many different ways as possible to communicate across the organisation. Confirmation was provided that Counter Fraud Training had been provided to Divisional Directors and Clinical Directors at Medical Advisory Committee. Open cases were listed in the report and it was noted that case 3 and 5 were linked as they were part of the handover from Grant Thornton. Ms Sims advised that she felt bank time sheets were an area of risk due to being paper documents. She noted an incident when a bank member had received the whole set of paperwork back after authorisation giving the potential opportunity to amend the contents. She was proposing to change the Counter Fraud plan to undertake a deeper dive into rostering rather than ID Identification. Mrs Martin queried with Mr Caldicott the control process for time sheets, Mr Caldicott advised that bank time sheets were in triplicate with the back copy being for the staff member and the other two pages going to the bank office. Mrs Martin requested that moving forward issues such as this were raised immediately with the Executive Director and not left for the next Committee. Mrs Martin asked if a

	decision regarding the proposed change in the Counter Fraud plan could be made today, Mr Caldicott advised that he would take a view and discuss with the Chair of Audit Committee and then email Audit Committee members on whether there is a recommendation for a change in the programme. Mrs Martin asked about the unavailability of the national database, Ms Sims confirmed that the national database was now back in working order and that was the reason for having two cases that were linked. A discussion took place regarding target dates for concluding the work, Ms Sims advised that target dates were difficult and would like to manage expectations within the updates and confirmed she would include next steps in the report moving forward. Members expressed the view that they would have liked to have seen a joint statement from the Executive Lead and Grant Thornton regarding the position at the handover of the portfolio. Ms Sims confirmed that the case highlighted dating back to 2018 was only reported in July 2021. Mr Caldicott confirmed that regular meetings were set up with Counter Fraud to ensure that all matters are brought forward. **Action: Mr Caldicott to review the request for a change to the Local Counter Fraud Plan and report back to the Chair of Audit Committee following by a report to members.**
38/22	**External Audit – Annual Audit Report**
	Mr Surridge confirmed that the Annual Audit Report and arrangements for Governance Statement had been finalised with the 2022 audit closed and certificate issued to submit with the Annual Report. Mr Surridge confirmed that the audit report concluded that there was a positive direction of travel in the Trust arrangements since last year. It was recognised that there were system wide financial sustainability issues and challenges across the NHS, however, what the Trust was doing with the plan for next year was considered to be full and appropriate. External Audit reviewed governance, including risk management which had been concluded as adequate, also looked at economy efficiency management, workforce and in the previous year there was a significant weakness concluded, however, there was enough evidence to say that there had been improvement. The work was not yet finished with focus needed on embedding of staff engagement. A review was undertaken of clinical performance outcomes from the CQC reports, noting that there were arrangements for an improvement plan with actions in place, this was rated as a significant weakness as there is work to be undertaken before the CQC rating would be improved. The report was an improving result for the organisation with no new matters being brought forward. Clinical performance is matter of fact and a review of the accounting code may influence how this is reported moving forward as it was not designed for long standing issues, therefore expecting that there would be a refresh of the code for next year. Mr Surridge confirmed that Mazars did not use a rating system, however, felt that the report was partial assurance due to areas that need additional work within the existing framework. Mrs Martin drew attention to page 28 of the report around a Section 30 referral which was confirmed for discussion with the financial statement, Mrs Martin also advised that there were no fees listed on the page, Mr Surridge advised that the notification regarding fees needed to be removed with a final version to be issued on 21st June.

	Mrs Martin highlighted the one new recommendation that was raised on page 21 of the report and asked what the outcome of the discussion with the Executive lead had been and what had been agreed about implementation, Mr Surridge confirmed that Mazars would follow up throughout the year, but no formal response was required. Conversations with the Executive team had been held during March, there was a recognition of the need to move forward and the result depending on having sufficient clinical buy in, which remained the concern. Confirmation was provided that this was discussed with the Director and Deputy Director of People & Culture, Mrs Martin felt that this was quite unusual in an External Audit Report and queried with Mr Caldicott how this should be taken forward. Mr Caldicott confirmed previously External Audit recommendations had been taken into the Internal Audit plan to keep the focus and provide visibility and would suggest doing the same with this recommendation, allocated to the Director of People & Culture. Mr Hemans confirmed that he would discuss taking this forward with Miss Griffiths. **Action: External Audit Recommendations to be included in the Internal Audit Plan to ensure they are followed up – Mr Caldicott** **PPE revaluations recommendation allocated to the Director of People & Culture – Miss Griffiths, Mr Hemans to discuss further**
39/22	**External Audit – Financial Statement**
	Mr Surridge presented the financial statement advising that there had been increasing challenges around the reporting cycle with competing priorities from NHSE/I, creating a lot of pressure on the organisation. There was concern that there would be no improvement for next year due to the new reporting requirements. Mr Surridge advised that section two of the report sets out the work that is to be completed, which was confirmed as finalised with no change in the risk assessment or audit strategy. Confirmation was provided that the team had spent a lot of time looking at accruals at year end. He stated that a full valuation of land and buildings would need to take place next year. Mr Surridge confirmed that a clean set of accounts had been provided with: • Opinion issued • Clean opinion of financial statement • Ongoing value for money • No concerns raised • Statutory requirements for the Annual Report and Annual Governance statement completed A discussion took place regarding the section 30 referral with Mr Surridge advising that if the Trust takes an action that in this case would breach the break even duty then the Auditors are required to make the referral even if a later plan reverses the action. Mrs Martin queried why the referral had been made prior to the Audit Committee taking place with Mr Surridge confirming that the section 30 was triggered by the April plan. Concern was also expressed that although there is now a revised financial plan this does not go back to the Secretary of State and therefore the section 30 referral is still in the system, Mr Surridge expressed the view that the detail demonstrated that the legislation was not quite in the same place as the situation currently in the NHS. Mr Assinder advised that he felt the Trust Board would take a very serious view of the section 30 referral, advising that consideration needed to be given to the

	communication issued and what Mazars should be asked to issue. Mr Assinder queried whether the interpretation had been adopted across the auditing companies or was it a Mazars policy. Mr Surridge confirmed that the issue of section 30 referrals had been raised with the Audit Group at the National Audit Office and suggested that reference could be made in the 21/22 Annual Report that the Section 30 referral referred to the April financial plan and a revised plan was published in June, which would reflect the change publicly. Further concern was raised that if the referrals are not carried out across the auditing sector then Walsall could be seen as an outlier and members were at a loss to understand why the referral could not be rescinded. Mr Surridge agreed to look at following up with further information regarding the final plan and confirmed that the section 30 referrals were agreed with the ICS. Members agreed following discussion that the Annual Report would be updated to include the information about section 30 and that Mazars would research rescinding the letter following complex changes that had been made to the funding and the fact that the legislation had not yet caught up. **Action: Review of whether the Section 30 information could be updated and/or rescinded with the Secretary of State through National Audit Office – Mr Surridge** **Annual report to be updated to reflect the Section 30 referral and the new financial plan that was now agreed – Mr Caldicott/Mr Wilshere**
40/22	**Annual Report and Accounts**
	Mr Caldicott presented the reports which were taken as read advising that the accounts could be submitted with no changes made to the draft position and there had been a very positive conclusion to the audit. Mr Bostock advised that in the remuneration report there were some wrongly entered figures and start dates, it was agreed that Mr Bostock would liaise with Mr Mortiboys to rectify. Action: **Letter of Representation**: Mrs Martin advised that the Audit Committee had not been sighted on the content of the letter of representation confirming that she was used to having papers on the following: • Post balance sheet events • Going concern • Application of accounting policies Mr Caldicott advised that going concern estimates were contained within the report notes for the accounts and audited by Mazars. Never normally included any other papers but would be happy to do so if required moving forward. Mr Caldicott confirmed that the accounting notes were included for visibility and referenced, there is a need to sign off the letter of representation with assurance provided that there was nothing further to be added to the accounts. **Action: Members approved the Letter of Representation to be signed off. Audit opinion to be signed off with a date of 21st June.**
41/22	**Any Other Business**
	Mrs Martin requested that the Annual Workplan be included on each Committee agenda further advising that she would review the workplan following the meeting. **Action: Annual Workplan to be a standing agenda item and to be reviewed post Audit Committee – Mrs Martin/Mr Wilshere/Mrs Ward**

42/22	**Matters for Escalation to Trust Board**
	Mrs Martin highlighted the following items that she would be escalating to Trust Board: • The number of policies and guidelines that were out of date to ensure the Trust Board were sighted on the clinical risk to the organisation • The number of staff that did not have an email address • Continue to underline the work on the Board Assurance Framework and the Corporate Risk Register • Summarise the Head of Internal Audit Opinion and External Audit Reports and how these are to be monitored • Concern around bank time sheets
43/22	**Reflections on meeting**
	Meeting closed at 11.20 a.m.
44/22	**Date & Time of Next Meeting**
	Friday 2nd September 2022 at 1.30 pm.

Walsall Healthcare NHS
NHS Trust

MEETING OF THE CHARITABLE FUNDS COMMITTEE HELD ON FRIDAY 8TH JULY 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
Mr Rajpal Virdee	Non-Executive Director

In attendance

Mr T Baker	Chief Financial Accountant
Mr D Mortiboys	Operational Director of Finance
Mrs A Ward	Executive Assistant
Mrs G Westley	Fundraising Manager

Apologies

Mr Keith Wilshere	Company Secretary

01/22	**Welcome and Introductions**
	Mr Assinder welcomed everyone to the meeting, especially Mr Virdee as Non-Executive Director newly appointed to the Charitable Funds Committee.
02/22	**Apologies for Absence**
	Apologies for absence, were noted as listed above.
03/22	**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.
04/22	**Minutes of Previous Meeting**
	The minutes of the previous meeting held on 14th March 2022 were agreed as a true record.
05/22	**Matters Arising & Action Log**
	The action log was discussed and updated. 200. NHS Charities – report to be received at the September meeting. 79 & 199. Mr Assinder confirmed that he had been able to meet with Mr Ian Burrows from Brewin Dolphin on 27th June advising that the Investment Company had a good understanding of the portfolio and the risks associated with the current market turmoil. Confirmation was provided that the portfolio was relatively prudent and was well placed to come through the crisis with the advice to leave the investment as it was. Mr Caldicott highlighted that there would be expected volatility in the short term, with the hope that the markets would commence some form of recovery in the medium term. Mr Caldicott also advised that there was no

large expenditure to warrant changing anything with the portfolio. Members noted the risk and confirmed the action could be closed.

74. Mrs Westley advised of the concerns raised following the meeting with the company supplying the kiosks back in January around money donated going to the company who would then release to the Charity. Further discussion had been held around marketing opportunities to offset the cost of the machines. Mr Caldicott outlined his concerns and apologised for the delay in taking the work forward which had been due to the year end accounts work. Mr Caldicott agreed to bring a paper to the September meeting regarding moving forward with charitable giving by card on site. Concerns noted were:

- Costs £1,000's per year
- Paying for an interactive screen
- Technology issues of interaction between the screen and the card machine
- Security and access controls around the Trust bank account and the person making the donation.

Further discussion took place regarding advertising revenues and having a collaborative advertising policy. Mrs Evans confirmed that Royal Wolverhampton NHS Trust would be going ahead with the kiosks if these were approved at Walsall. Mr Assinder requested that the paper that was to be received at the September meeting included a clear decision and plan.

196. Mr Mortiboys advised that the amalgamation of small funds was a piece of work that needed completion. Mr Assinder requested that this work was completed within the next six months.

198. Jubilee Celebrations took place across the organisation. Action to be closed.

197. Mr Assinder provided the background to the concerns regarding the League of Friends Charity, Mr Bostock confirmed that a meeting had been held to review the governance around transferring the funds confirming that there was a process set out by the Charity Commission to enable transfer of funds to take place. 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 and wanted some recognition around what they had bought. Dr Shehmar and Mr Caldicott had met with the League of Friends to discuss the purchase of a quantity of pharmacy cabinets and therefore advised that it would not be appropriate to suggest to the League of Friends that they transfer their funds to Well Wishers, it would be preferable to continue to work with them to utilise their funds and recognise the sensitive importance behind the scenes. Members agreed with this approach and Mr Assinder requested that it remain an agenda item for further feedback.

Action: League of Friends Update to be a standing agenda item, Mr Caldicott to provide a verbal report.

NHS Charities Money: Mr Assinder discussed the formal enquiry that had been announced into the Charity that was set up by the family of Captain Sir Tom Moore did not include in its scope the £38m that was raised for the NHS. Confirmation was provided that Walsall Healthcare Charity benefitted from £200,000 of this money and Mr Assinder advised that it was important that anyone who had concerns was informed that the investigation did not extend to the NHS.

06/22	**Fundraising Strategy**
	Mrs Evans confirmed that the amendments requested had been made to the Strategy and once approved would be subject to formal design and artwork that reflected the collaboration between the two hospitals. Mr Assinder expressed the view that Mrs Westley had been brilliant bringing the charity through a very difficult period confirming that it was important to recognise the work undertaken, noting that Well Wishers continued to be a really strong brand that was in a very good position. Mr Virdee advised that Well Wishers was the Mayor of Walsall's chosen charity for the year and suggested that there was still a lot of good will for the NHS. Concern was expressed that in the short-term fund raising in the current economic climate would be difficult, Mrs Evans confirmed that she would be working on the non-financial key performance indicators with Mrs Westley. Mr Assinder advised that there needed to be some commitment to outcomes but would be happy for these to be agreed outside of the strategy. Members approved the Strategy which would go forward to Trust Board in August.
07/22	**Business Case to Support Fundraising**
	Mrs Evans presented the business case with the financial element included, Mr Assinder queried whether the Executive team were supportive of the role, Mrs Evans and Mr Bostock both confirmed that there was support from the Executive. Mr Mortiboys confirmed that the financial element had been reviewed in terms of managing the risk to the Charity, advising that they had benchmarked for every £1 spent could the Charity raise £2 and considered what the organisation would do if there was not sufficient money raised to cover the post. A discussion took place regarding how the individual would be employed with confirmation provided that the person would be a Trust employee with a charge back to the Charity, Mr Bostock confirmed that he would support the business case advising that in order to increase the funds there needed to be additional resources to undertake the work. Members noted that it would be crucial to ensure that the right person was in the role with a review of the role in 18 months – 2 years' time. Mrs Evans advised that if the key performance indicators were right both financial and non-financial they would help to monitor the effectiveness of the role. Preference was for a permanent role, noting that it would take 3 – 4 months to recruit. Mr Caldicott advised of his approval with a clear view that the role should be evaluated appropriately. Members approved the Business Case with evaluation in two year's time.
08/22	**Fundraising Update**
	Mrs Westley presented the report, highlighting that it was an exciting time for the charity as local businesses wished to be involved with the view to really making a difference. The new role would be working on the day to day running of the Charity. Areas to highlight: • Mayor of Walsall's chosen charity • Mayor will be visiting Walsall Hospice and Hollybank House • Two new business on board Vibrant Network

	Starbucks Confirmation was provided that the Charity were supporting four end of life families through the Hospice. Tilbury Douglas would be doing another event and some gardening work. Mrs Evans advised that support was needed from the Executive Team and Non-Executive Directors both for events and the fostering of relationships with local business, noting that previously a business breakfast had been discussed but did not take place due to Covid-19. Mrs Westley advised that there would be some requests for funds coming through: • Stroke Rehabilitation – rehabilitation garden, quote received of £50,000 with a request that the charity pay half of the cost • Paediatric play room - £20,000 • Meeting to be held with the family, the legacy would be for the new build A & E • Breast feeding rooms • ENT rooms • Patient Experience • Volunteer Recognition Award Mr Assinder advised that all were very worthy causes, requesting that the normal process was followed for approval, Mr Caldicott advised that some of the areas listed had funds assigned to them and therefore these could be accessed first, such as Paediatrics who had more than £20k available. Mr Caldicott confirmed that he would be more than happy to see the bids come through for approval. Confirmation was provided that Mrs Westley had reminded fund managers of the need for them to use their charity funds through a series of roadshows. Mr Virdee queried whether it was possible for the charity to assist staff who were struggling, confirmation was provided that this was not possible with Mrs Evans confirming that there was support for staff in different ways. Mr Caldicott reminded members that it was important to note the support that the charity was providing in relation to health and wellbeing
09/22	**Marketing Pack**
	The marketing pack was deferred during Covid-19, to be re-launched at the breakfast meeting with local business, when this was arranged.
10/22	**Chapel Refurbishment**
	Mr Caldicott advised that there had been a detailed review undertaken with a plan agreed for £250,000 through the Trust and discussion ongoing in relation to improving the bathrooms. A lead person had been identified to take the project forward with the tender process expected to commence within 4 – 8 weeks. It was noted that significant increases in costs had occurred and there may be further decisions to be made moving forward.
11/22	**Performance of Investments**
	Mr Mortiboys presented the report advising that the portfolio reduced by £16,000 during 2021-22, appendix to be circulated following the meeting. Confirmation was provided that a meeting had been held with Brewin-Dolphin who had a planned approach to the portfolio, which remained in good shape. Members noted that the performance of the portfolio had been reasonably good considering the turmoil in the markets. Mr Virdee queried the rules and regulations around investing, Mr Mortiboys advised the process for instructing Brewin Dolphin to take over the portfolio in line with the investment policy and how the portfolio is

	weighted, cash funds, equities, moving away from individual enterprises to manage the risk and ensure security. **Action: Mr Mortiboys to circulate the Investment detail appendix**
12/22	**Quarterly Review of Expenditure Below £5k**
	Mr Mortiboys presented the report advising that £18,600 had been authorised by Fund Manager during the last quarter. Members noted the content of the report and approved the spending as detailed. Mrs Westley queried whether Fund Managers had received monthly statements, Mr Baker confirmed that statements were in the process of being finalised with confirmation that if any fund manager needed further information they could contact Mr Baker for further detail. Mr Assinder requested that an email be circulated to all urgently advising when fund statements would be available. **Action: Mr Baker to circulate an email to all fund managers advising when the fund statements would be available**.
13/22	**Quarterly Review of Income & Expenditure**
	Mr Mortiboys presented the report advising that there was just over £1m available in total with a strong recovery noted. Mr Mortiboys advised that there was still some NHS Charity money available and a detailed financial statement would be provided to the September meeting, once the funding for the staff vouchers had been confirmed and also the amalgamation of funds commenced. Mr Assinder noted that there were some specific balances and suggested that these should be moved along. **Action: Mr Mortiboys to provide a detailed financial statement to the September meeting for Income & Expenditure**
14/22	**Property Bequest**
	Mr Mortiboys advised that the funds from the sale of the property were still awaited, a request had been made by the Solicitor for the organisation to agree to the way the funds had been manged. Mr Mortiboys advised that he would like to resolve during July, Mr Caldicott advised that the organisation was not in a position to assess the management of the Estate and advised that there needed to be a formal letter sent to Enoch Evans stating the Trust position. **Action: Mr Caldicott & Mr Mortiboys to send a formal letter to Enoch Evans stating the Trust position in relation to the property bequest and requesting the transfer of funds**.
15/22	**Any Other business**
	Mr Virdee asked about the relationship that the charity had with Royal Wolverhampton Trust, Mr Assinder confirmed that there were two local separate charities with a clear line between them financially. Mrs Evans discussed the collaborative working that had taken place with Mrs Westley meeting with the Charity Manager at Royal Wolverhampton Trust to look at what events could be undertaken together and to have economy of scale for staff events, along with the possibility of joint appeals.
16/22	**Matters for Escalation to Trust Board**
	Mr Assinder confirmed that there were no items for escalation to the Trust Board.

17/22	**Reflections on the Meeting**
	Members reflected on the meeting with Mr Virdee advising that he had enjoyed his first meeting and was hoping to make connections within the charity. Mr Caldicott expressed the view that the charity was stabilised and there was a lot to look forward to. The meeting closed at 11.37 a.m.
18/22	**Date & Time of Next Meeting**
	Monday 12th September 2022 at 10.00 a.m.