

**MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN  
PUBLIC ON THURSDAY 3 OCTOBER 2019 AT 14:00  
IN THE LECTURE SUITE, MLCC, MANOR HOSPITAL, WALSALL**

For access to Board Reports in alternative accessible formats, please contact the  
Director of Governance via 01922 721172 or [jenna.davies@walsallhealthcare.nhs.uk](mailto:jenna.davies@walsallhealthcare.nhs.uk)

## A G E N D A

ITEM	PURPOSE	BOARD LEAD	FORMAT	TIME
1. Patients, Carer and Staff Story	Learning	Director of Nursing	Verbal	1400
<b>CHAIR'S BUSINESS</b>				
2. Apologies for Absence	Information	Chair	Verbal	
3. Quorum and Declarations of Interest	Information	Chair	ENC 1	
4. Minutes of the Board Meeting Held on 5 <sup>th</sup> September 2019	Approval	Chair	ENC 2	1420
5. Matters Arising and Action Sheet	Review	Chair	ENC 3	
6. Chair's Report	Information	Chair	ENC 4	1425
7. Chief Executive's Report	Information	Chief Executive	ENC 5	1430
<b>SAFE HIGH QUALITY CARE</b>				
8. Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 6	1435
9. Improvement Update	Information	Chief Executive	ENC 7	1445
10. Winter Plan	Discussion	Chief Operating Officer	ENC 8	1455
<b>VALUE COLLEAGUES</b>				
11. HR/OD Improvement Update	Information	Director of Culture & People	ENC 9	1510
<b>BREAK – TEA/COFFEE PROVIDED</b>				
<b>RESOURCES</b>				
12. Performance Report	Discussion	Director of Finance & Performance	ENC 10	1520
<b>PARTNERS</b>				
13. Walsall Together Update	Information	Director of	ENC 11	1530

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
			Strategy & Improvement		
<b>GOVERNANCE AND COMPLIANCE</b>					
14.	Health & Safety Policy	Approval	Director of Governance	ENC 12	1535
15.	Risk Management Strategy	Approval	Director of Governance	ENC 13	1540
16.	EPRR Submission	Approval	Chief Operating Officer	ENC 14	1545
17.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	ENC 15	1550
18.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	Verbal	
19.	People & Organisational Development Highlight Report	Information	Committee Chair	ENC 16	
20.	Walsall Together Partnership Board Highlight Report	Information	Committee Chair	ENC 17	
21.	<b>QUESTIONS FROM THE PUBLIC</b>				
22.	<b>DATE OF NEXT MEETING</b> Public meeting on <b>Thursday 7<sup>th</sup> November 2019</b> at 14:00 at the Manor Learning and Conference Centre, Manor Hospital				
23.	<b>Exclusion to the Public</b> – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3 October 2019			
Declarations of Interest			AGENDA ITEM: 4
<b>Report Author and Job Title:</b>	Jo Wells Senior Executive Assistant	<b>Responsible Director:</b>	Danielle Oum Chair
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input checked="" type="checkbox"/>		
<b>Executive Summary</b>	<p>The report presents a Register of Directors' interests to reflect the interests of the Trust Board members.</p> <p>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.</p>		
<b>Recommendation</b>	<p>Members of the Trust Board are asked to:</p> <p>Note the report</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	There are no risk implications associated with this report.		
<b>Resource implications</b>	There are no resource implications associated with this report.		
<b>Legal and Equality and Diversity implications</b>	It's fundamental that staff at the Trust are transparent and adhere to both our local policy and guidance set out by NHS England and declare any appropriate conflicts of interest against the clearly defined rules.		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

Register of Directors Interests at October 2019

Name	Position held in Trust	Description of Interest
Ms Danielle Oum	Chair	Chair: Healthwatch Birmingham
		Committee Member: Healthwatch England
		Chair: Midlands Landlord whg
		Co - Chair, Centre for Health and Social Care, University of Birmingham.
Mr John Dunn	Non-executive Director	No Interests to declare.
Mr Sukhbinder Heer	Non-executive Director	Non-executive Director of Hadley Industries PLC (Manufacturing)
		Partner of Qualitas LLP (Property Consultancy).
		Non-executive Director Birmingham Community NHS Foundation Trust (NHS Entity).
		Non-executive Director Black Country Partnership NHS Foundation Trust
		Chair of Mayfair Capital (Financial Advisory).
		Partner - Unicorn Ascension Fund ( Venture Capital)
Mr Philip Gayle	Non-executive Director	Chief Executive Newservol (charitable organisation – services to mental health provision).
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd
		Associate Consultant at Provex Solutions Ltd
		Clinical Strategy Lead – Worcester Acute Hospitals NHS Trust.
Ms Pamela Bradbury	Non-executive Director	Chair of Healthwatch Dudley
		Consultant with Health Education England
		People Champion – NHS Leadership Academy
		Partner is an Independent Clinical Lead with Sandwell and West Birmingham Clinical Commissioning Group
Mrs Sally Rowe	Associate Non-executive Director	Executive Director Children's Services, Walsall MBC
		Trustee – Grandparents Plus, registered charity
Mr Richard Beeken	Chief Executive	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University.

		Director – Watery Bank Barns Ltd.
Mr Russell Caldicott	Director of Finance and Performance	Chair and Executive Member of the Branch of the West Midlands Healthcare Financial Management Association
Mr Daren Fradgley	Director of Strategy and Improvement	Director of Oaklands Management Company
		Clinical Adviser NHS 111/Out of Hours
Dr Matthew Lewis	Medical Director	Spouse, Dr Anne Lewis, is a partner in general practice at the Oaks Medical, Great Barr
		Director of Dr MJV Lewis Private Practice Ltd.
Dr Karen Dunderdale	Director of Nursing/Deputy CEO	No Interests to declare.
Ms Jenna Davies	Director of Governance	No Interests to declare.
Miss Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy Ltd
		Chartered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT Sister in Law – Head of Specialist Services St Giles Hospice

**Report Author:** Jenna Davies, Director of Governance

**Date of report:** October 2019

## RECOMMENDATIONS

The Board are asked to note the report

**MINUTES OF THE PUBLIC MEETING OF THE BOARD OF DIRECTORS  
WALSALL HEALTHCARE NHS TRUST HELD  
ON THURSDAY 5<sup>TH</sup> SEPTEMBER 2019 AT 2:00 p.m. IN THE LECTURE SUITE, MANOR  
LEARNING & CONFERENCE CENTRE, MANOR HOSPITAL, WALSALL**

**Present:**

Ms D Oum	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director
Mr S Heer	Non-Executive Director
Mrs P Bradbury	Non-Executive Director
Mr R Beeken	Chief Executive
Dr K Dunderdale	Director of Nursing/Deputy Chief Executive
Dr M Lewis	Medical Director
Mr R Caldicott	Director of Finance
Mr N Hobbs	Chief Operating Officer

**In Attendance:**

Ms S Rowe	Associate Non-Executive Director
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Miss J Wells	Senior Executive PA (Minutes)

Members of the Public 1  
Members of Staff 2  
Members of the Press / Media  
Observers 2

**072/19 Patient Story**

The Patient Experience Team introduced a story as told by patient Julie Edwards, who was admitted to the hospital via ambulance following a fall and injuring her leg.

Julie highlighted some of the issues that she experienced:

- A&E removed the balloon splint which then caused discomfort and pain.
- Ward 9 was very cold.
- Julie had to undergo an operation on her leg to insert metal plates. She opted for a spinal tap rather than general anaesthetic. There was no screen erected therefore she could oversee the procedure, which some patients may have been uncomfortable with.
- Julie advised that she would have liked a little more conversation with the surgeon, though she acknowledged that the majority patients would likely be under anaesthetic. She added that in this case, music could've been helpful.
- Julie was given ibuprofen and paracetamol together, which she knew would irritate her acid reflux and make her vomit.

- Sleep deprivation was an issue as the ward was very busy. Julie suggested that consideration should be given to supplying patients with a side room for one night following their operation.
- Julie was left in the toilet for 30 minutes as there was a general lack of staff on the ward and a number of bank nurses.
- It was felt that the discharge may have been a little premature. Julie felt that if she lived on her own, she would have required some help. She was not given any training for self-injectable needles nor opportunity to ask questions.
- Physiotherapy did not have Julie's notes available.

Julie added that some elements of her care were very good:

- The drug regime on an evening was fantastic.
- The physiotherapist found a small lump and referred Julie to A&E to check for a blood clot. Thankfully there was not.
- Julie was making limited progress with her crutches and was referred to Mobility as she lacked confidence following a fall.

Julie thanked the hospital doctors and nurses for aiding her recovery.

Ms Oum observed some really important messages from Julie's story, particularly relating to equipment, discharge and staff explaining why things are being done. Ms Oum asked the Patient Experience Team to pass on her thanks to Julie for sharing her experience.

Dr Dunderdale gave thanks to Julie for articulating her story well, through the eyes of the patient. Dr Dunderdale was disappointed that Julie was left in the toilet for 30 minutes without assistance.

Dr Dunderdale explained that Ward 9 in particular had low nursing fill rates due to significant vacancies and this story reflected the patient experience of that ward at that time. Dr Dunderdale assured that the situation had been rectified. The story would be shared with the Ward 9 team, theatres and ED.

Ms Rowe was surprised to hear that the ward was so cold and asked what had been done in order to address.

Mr Fradgley replied that air handling units was a high priority issue as there was a great temperature variation. A proposal would be presented at Trust Board in the near future.

Mrs Bradbury referenced the discharge, advising that getting patients mobile was best practice for patients in order to aide their recovery and suggested that communications should be issued to encourage patients to do so.

Ms Oum asked whether the lack of training for self-injections was a common issue.

Dr Dunderdale also expressed her surprise on hearing this and would look in to the matter along with the removal of the balloon splint.

**Dr Dunderdale**

Mr Beeken observed a number of issues to collectively think about, concentrating on the fundamentals of care including better documentation, infection control, medicines management, communication privacy and dignity. Mr Beeken asked that the Quality, Patient Experience and Safety Committee give consideration to how to measure, manage and improve.

**QPES**

Dr Lewis stated that there needed to be a way of regularly sharing the feedback with the relevant teams. Work was underway with Ms Davies regarding governance processes within the local teams.

Ms Oum thanked the teams involved throughout Julie's recovery process.

**073/19 Apologies for Absence**

Apologies were received from:

- Mrs A Baines, Non-Executive Director
- Mr P Gayle, Non-Executive Director

Ms Oum gave thanks to Alan Yates, Associate Non-Executive Director who had stepped down due to work pressures.

**074/19 Declarations of Interest and quorum**

There were no additional items to declare.

The meeting was quorate in line with Item 3.11 of the Standing Orders, Reservation and Delegation of powers and Standing Financial Instructions; no business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and members (including at least one member who is also an Officer Member of the Trust and one member who is not) is present.

**075/19 Minutes of the Board Meeting held in Public on 4<sup>th</sup> July 2019**

Mr Beeken informed that 049/19 should read 'a record number of **attendances**'.

Mr Hobbs advised that 051/19 should read '**Paediatric** emergency demand differed'.

Mr Fradgley informed that 055/19 should read '**ICP board**' was now running.



Dr Dunderdale informed that 070/19 should read 'there was **no** intention of replacing CSWs'.

**076/19 Matters Arising and Action Sheet**

Ms Oum observed that action 234/18 was still open and asked for an update. Dr Lewis replied that there would be a review at the Quality, Patient Experience and Safety Committee in September.

010/19 Learning from Deaths – Dr Lewis updated that Dr David Wilson attended the Medical Advisory Committee in August which was well received by clinical directors in the Trust. Unfortunately Dr Wilson was no longer in that job role therefore would not be the opportunity to attend a Board Development session. Ms Oum asked that the session was still conducted, without the assistance Dr Wilson.

032/19 – Performance Report. Mr Fradgley informed that options were within the scope for the new EPR deployment in February the following year and had been built into the plan.

028/19 – Nursing and Safer Staffing Report. Ms Griffiths updated that work was underway and an update was included in the People and Organisational Development Committee. A further update would be provided at Trust Board in October.

049/19 – Chief Executive's Report. Ms Griffiths informed that the item in relation to implications of staff resilience would be discussed at the September People and Organisational Development Committee and an update provided within the highlight report at October Trust Board.

**Resolution**

**The Board received and noted the progress on the action sheet.**

**077/19 Chair's Report**

Ms Oum presented the report which was taken as read.

**Resolution**

**The Board received and noted the Chair's report.**

**078/19 Chief Executive's Report**

Mr Beeken presented the report and highlighted the following key points:

- The Trust was out of special measures and still had a Requires Improvement rating. NHSI had approved a wraparound support to ensure that the Trust continued its journey of improvement.
- There were 3 strands of work to follow which were outlined within the report.
- An initial opinion of establishment of the improvement

programme board as a sub-group of Trust board was sought.

- The new NHSI/E oversight framework had been published and was to be collectively managed with mutual accountability with the STP.

Mr Caldicott referenced a key change with the STP reviewing the financial position, risk of delivery and run risk.

Mr Heer asked whether assurance would be given for the completion of tasks and asked whether the Trust had the right capability, skill set, time and resources. Mr Beeken replied that it would be measured by a systematic and comprehensive improvement programme, though the Trust did not have the right capacity or capability. Walsall Together, if properly managed and invested in would assist and the Trust would look at pooling resources from across the Black Country. Assurance to be delivered through a sub-committee of the board.

Mr Heer queried the timelines and outcomes. Mr Beeken responded that work was underway with a view to starting within the next couple of weeks and a proposal would be shared at October Trust Board.

**Trust Board**

Ms Rowe asked for clarification that this was not a new incentive but a new plan. Mr Beeken responded that was a new plan in terms of terms of the scale, pace and step increases in improvement.

Mr Dunn urged executive colleagues to ensure that the structure beneath the board was fit for purpose to achieve the key objective of getting to understand and encouraged a review. Mr Beeken informed that part of the support package and the undertakings were governance reviews. Ms Griffiths cautioned that there needed to be alignment of governance with quality improvement but the processes should facilitate not stifle.

Ms Oum looked forward to seeing like to seeing much more explicit focus on the work that would make Walsall a great place to work.

### **Resolution**

**The Board received and noted the content of the report.**

## **079/19 Monthly Nursing and Midwifery Safer Staffing Report**

Dr Dunderdale introduced the report which had been reviewed at the Quality, Patient Experience and Safety Committee. The following key points were highlighted:

- There continued to be unfunded capacity driving temporary staffing, though temporary workforce was

- reducing and was less than the previous 3 years.
- There was confidence with the grip and control. Fewer requests for agency were being seen.
- Fill rate for RNs was reported at 91.4% and was monitored by Dr Dunderdale and the wider teams.
- There was assurance that quality measures were in place.
- E-rostering training had commenced. Cohorts on 3 wards go live in October.

Mrs Bradbury asked for assurance that staff were fully engaged in the process. Dr Dunderdale stated that there had been lots of engagement with staff on the 3 wards that were going to act as champions for the remaining wards to offer support when they went live. Formal focus groups were being built in and would include the experiences of staff. The quality elements would be fed back to the Quality, Patient Experience and Safety Committee.

Mr Heer would welcome an update on how the Trust benchmarked against the model hospital. Dr Dunderdale agreed it would be useful but advised that there were quality issues with the data until the electronic system was in place.

Mr Heer questioned whether benchmarking going forward would show a trajectory. Dr Dunderdale replied that the Trust wasn't yet in a position to forward plan trajectory for fill rate.

Mr Hobbs stated that Mr Heer's question could be applied to far more metrics and indicators, in addition to having the ambition to measure against the best.

Ms Oum asked for a review of hard and soft measures of performance to take place at the People and Organisational Development Committee.

PODC

Mr Dunn observed a huge amount of change taking place and asked how using feedback to change approach and its monitoring would be undertaken. Dr Dunderdale responded that KPIs were reviewed every week which included indicators around staff experience and making adjustments on a ward by ward basis. Ward 2 had been invited to attend the Quality, Patient Experience and Safety Committee to present and demonstrate some significant improvements made through no agency usage.

Ms Oum advised that work through the People and Organisational Development Committee would influence the report.

### **Resolution**

**The Board received and noted the content of the report.**

### **080/19 CQC Report**

Ms Davies updated that the organisation was inspected during February, which included an inspection against the use of

resources framework. The outcome was published in July. The overall rating for the Trust had not changed but the report was much more positive.

Moving forward, the Trust was developing the Patient Care Improvement Plan and was making improvements recommended by the CQC.

Ms Oum stated there was a credit to staff and the Trust continued on its improvement journey. The Board appreciated moving out of special measures.

### **Resolution**

**The Board received and noted the content of the review.**

## **081/19 Performance Report**

Mr Caldicott introduced the report.

### **Quality, Patient Experience and Safety Committee**

Dr Dunderdale updated that the report was balanced, detailing a number of successes. Safeguarding training had achieved for a number of months.

An area of concern for the committee was complaints. New indicators for complaints had been introduced to monitor completion within timeframes. Falls and pressure ulcers had started to plateau. An external review would be commissioned. VTE continued to be a stubborn area.

Ms Oum asked that analysis of potential differences in occurrences of pressure ulcers between diverse communities was considered within the pressure ulcer review.

**QPES**

Mr Heer observed that the midwife to birth ratios and caesareans appeared to be rising. Dr Dunderdale informed that the subcommittee would review the charts to look at one month variations for areas of concern.

### **Walsall Together Committee**

Mr Fradgley reported that single point of access was running but was challenging Rapid Response. Rapid Response has had to close referrals 3 times to date, which was an early indication that more manpower was required. Mr Fradgley noted that there was variability within numbers and medical outliers across the whole stroke pathway. An end to end pathway review was underway to see what was causing challenges.

Ms Oum highlighted the great news regarding diabetic patients in Walsall.

Mr Beeken asked whether Histopathology had seen improvements. Mr Fradgley responded that there had been an improvement in performance though there were concerns within the logistical chain, which had been raised earlier that day during the Board walk.

### **People and Organisational Development Committee**

Ms Griffiths reported that retention formed part of the direct report programme work with NHSI. Steps were being taken to move towards an electronic system to exit data. Sickness was still a concern of impact on retention.

A health and social care event was being organised to reach out to communities.

There was some system work to do in regard to mandatory training. Reviewing the ESR process and how training was delivered to staff was taking place. Ms Oum asked whether assurance could be given that the improvements could be sustained. Ms Griffiths replied that would need to be a review. There was lots of effort being put in to make the process easier for managers and was confident that system issues could be resolved.

Ms Oum encouraged all members to attend the upcoming leadership conference.

### **Performance, Finance and Investment Committee**

Mr Hobbs updated that type 1 emergency attendances had increased by 7.5% in comparison to the previous year. This sign of growth would be considered in the planning cycle for next year. The increase did have an impact upon performance in July.

Mr Hobbs noted that the teams in Elective Care had made a lot of effort in improving 18 week RTT performance, though deterioration had been seen for the last 2 months. Mr Hobbs cautioned that performance may deteriorate further before it improves.

There were speciality specific challenges such as pain management, where demand was higher than capacity. An update would be provided to the Performance, Finance and Investment Committee next month.

Ms Oum queried whether it was anticipated that issues would be resolved internally or through an acute collaboration process. Mr Hobbs informed that there was an internal plan in place for Radiology. The Pathology service would include other partners. Pain management should be managed internally once a

consultant has been recruited.

Cancer 62 day target delivered above standard in July and there was confidence that it would continue in August. 2 week wait for all cancer delivered with the exception of breast. The number of referrals from Wolverhampton was steadily increasing and would put pressure on performance.

Diagnostics was on track to deliver July and August.

Mr Caldicott informed that the Trust had attained a £3.3m deficit as per plan.

Savings performance was on plan. Temporary workforce reductions were seen in July, though further work needed to be done to close gaps. There remained a risk with birth numbers.

A run rate risk remained which could rise to an £8m deficit. Further discussion would take place during Private Trust Board.

**Resolution:**

**The Board received and noted the content of the report.**

**082/19 Review of the Winter Plan for 18/19**

Mr Hobbs presented the Review of the Winter Plan which had been reviewed at the Quality, Patient Experience and Safety Committee, Performance, Finance and Investment Committee and People and Organisational Development Committee.

In summary, the excellent planning completed last year resulted in good evidence of a better quality of service, improved performance against emergency access and KPIs.

It was noted that costs were in excess of the £1m budgeted.

Lessons learnt were included within the report and were being built in to the 19/20 planning process.

Mrs Bradbury asked that patient experience was included in the report.

Ms Oum agreed and asked for it to be explicitly factored in when planning for this winter.

Mr Hobbs informed that it was the most comprehensive plan he had seen and agreed that patient and staff experience would strengthen it even further.

Mr Heer asked when the finances would be available. Mr Beeken responded that they would be available in October.

**Resolution:**

**The Board received and noted the content of the report.**

### **083/19 Walsall Together Update**

Mr Fradgley presented the update, and highlighted the following

- A Section 75 skeleton had commenced and a board briefing was being created to be shared at the end of September. The final draft for consideration would be presented in February.
  - After 3 years of planning, the East localities, Social Care and HQ teams were together. A joint management proposal would be considered over the coming weeks.
1. Concerns with delivery of the programme plan and slippage relate to the designs with GPs, intermediate care service and the stroke rehab pathway. Programme plans can be shared with Board members if required.

Mr Heer referenced resources and capability, asking whether more could have been done if the resources were available. Mr Heer would like to see where progress should be and how it can be achieved.

**Resolution:**

**The Board received and noted the content of the report.**

### **084/19 Alliance Agreement**

Mr Fradgley drew attention to the revised Terms of Reference which included quoracy and decision making. The Terms of Reference were presented for approval at all constituent bodies. The title had been updated along with the membership, making all partners members and the inclusion of Housing as a core partnership. Mr Fradgley sought formal adoption of the Terms of Reference from the board.

The Terms of Reference were agreed.

Ms Oum clarified that the agreement was the overarching set of principles.

Mr Dunn referenced paragraph 2, advising that he would like to see more information relating to scope and the strategic direction. Mr Dunn noted that there was a lack of specifics.

Mr Fradgley advised that the agreement was non-legally binding and was more of a behavioural framework.

Ms Rowe informed that it was written in such a way to enable flexibility and in order to move forward faster.

**Resolution:**

**The Board:**

- **Received and noted the content of the report.**
- **Approved the Terms of Reference.**

**085/19 Medical Revalidation Annual Organisational Audit**

Dr Lewis presented the audit for approval, in capacity of his role of Responsible Officer and highlighted the key points:

- 87% of doctors due for revalidation were recommended compared to 55% in the previous year.
- Appraisal figures were lower than the previous year, though overall there had been a shift in appraisal performance which was thanks to the newly appointed lead appraiser. 17 new appraisers had been trained, giving a ratio of 4:1.

Ms Oum reiterated the importance of the improvement and that doctors are supported.

The Audit was approved.

**Resolution:**

**The Board:**

- **Received and noted the content of the report.**
- **The Medical Revalidation Annual Organisation Audit was approved.**

**086/19 Annual Infection Prevention & Control Report**

Louise Fox, Matron for Infection Control and Steve Jones, Microbiologist attended the meeting to present the report alongside Dr Dunderdale.

The report was more robust than previous years and there were a number of items in terms of a forward plan that would be included. The report would be reviewed on a monthly basis at the Infection Prevention and Control Committee.

The Trust was compliant in 6 of the criteria and near compliant in the remaining 4. Compliance had been reviewed at the Quality, Patient Experience and Safety Committee.

Ms Oum thanked the team for the helpful overview, adding that she was pleased with the progress being made.

Mr Beeken observed that the report did not articulate a description of where the Trust continued to have risks or issues. Mr Jones acknowledged that efforts needed to be continuously reviewed along with CPE awareness, C-diff antibiotic use and PPE use in the community.

Ms Fox added that practice was being done differently, giving better overview to the Trust.



Mr Heer would welcome an assessment of resilience to future outbreaks.

Dr Dunderdale replied that there was a recent CPE outbreak that was dealt with swiftly. Immediate actions were taken and there was good engagement. Structures were in place to respond quickly.

Ms Oum referenced the containment of outbreaks demonstrated the good work done to date.

The Annual Infection Prevention and Control Report was approved.

**Resolution:**

**The Board**

- **Received and noted the content of the report.**
- **Approved the Annual Infection Prevention and Control Report.**

**087/19 Quality, Patient Experience and Safety Committee Highlight Report**

The report was taken as read.

Dr Dunderdale updated that assurance had been received that the organisation had key mechanisms in place in light of the Gosport report.

**Resolution**

**The Board received and noted the content of the report.**

**088/19 People and Organisational Development Committee Highlight Report**

The report was taken as read.

**Resolution**

**The Board received and noted the content of the report.**

**089/19 Integrated Care Partnership Committee Highlight Report**

The report was taken as read.

**Resolution**

**The Board received and noted the content of the report.**

**090/19 Audit Committee Highlight report**

The report was taken as read.

**Resolution**

**The Board received and noted the content of the report.**

**091/19 Questions from the Public**

Jane Wilson, Unison representative, referenced Walsall Together

and good practice, however lots of the staff did not fully understand what it was. Ms Wilson suggested that sharing the good points would assist with the transition.

**092/18 Date of Next Meeting**

The next meeting of the Trust Board held in public would be on Thursday 3<sup>rd</sup> October 2019 at 2:00p.m. in the Lecture Suite, Manor Learning and Conference Centre, Manor Hospital, Walsall.

**Resolution:**

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

DRAFT

## Action log

Updated from Trust Board Meeting: July 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
234/18		Improvement Update	Dr Lewis to review the underlying evidence in relation to mental health capacity act. Feedback to be reviewed at the Quality, Patient Experience and Safety Committee.	Medical Director/QPES	04/09/2019	On the agenda for QPES in May. This has been deferred to September	Delayed
027/19		Chief Executive's Report	Clarity in the cause of high A&E attendance needed to be sought and a plan created including mitigations.	Chief Operating Officer	04/07/2019	Detailed report scheduled August PFIC. Meeting deferred so now scheduled September PFIC	Open
028/19		Nursing & Safer Staffing Report	Bank implementation plan to be presented at the next Trust Board meeting.	Director of Culture & People	07/09/2019	Inlcuded within the update on the agenda	Open
051/19		ED Review	Annual review of staffing establishment to be reviewed at Trust Board in October	Director of Nursing	07/11/2019	On track	Open
051/19		ED Review	QPES and PODC to review the findings of the Ann Casey report.	Director of Nursing/Director of People & Culture	04/10/2019	the Trust are still awaiting for the outcome of the Ann Casey review	Open
072/19	06/09/19	Patient Story	Dr Dunderdale would review why the patient's split was removed and the lack of training in relation to self-injections. Fundamentals of care to be reviewed at QPES.	Director of Nursing	07/11/2019	On track	Open
079/19	06/09/19	Nursing & Safer Staffing Report	A review of hard and soft measures of performance to take place at the People and Organisational Development Committee.	Director of Nursing/Director of People & Culture	07/11/2019	on track	Open
081/19	06/09/19	Performance Report	QPES to review the rise in birth ratios and caesareans	Director of Nursing	07/11/2019	On the agenda for October	Open

Complete

Open

Delayed (1 meeting)

## Action log

Updated from Trust Board Meeting: July 2019

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
Overdue (14+ days)							

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3 <sup>rd</sup> October 2019			
Chair's Report		AGENDA ITEM: 6	
<b>Report Author and Job Title:</b>	Danielle Oum, Chair	<b>Responsible Director:</b>	Danielle Oum, Chair
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>This is a regular paper providing oversight of Chair and Non-Executive Director (NED) activities relating to the Well-Led framework.</p> <p>The paper includes details of key activities undertaken since the last Board meeting including NED development and resourcing; governance developments; service visits and NED visibility; and external meetings with partners and other stakeholders.</p>		
<b>Recommendation</b>	<p>Members of the Trust Board are asked to:</p> <p>Note the report</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	There are no risk implications associated with this report.		
<b>Resource implications</b>	There are no resource implications associated with this report.		
<b>Legal and Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper.		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

**Chair's Update**

**PRIORITY OBJECTIVES FOR 2019/20**

**1. Continue our journey on patient safety and clinical quality through a comprehensive improvement programme**

As I reported last month, we are incredibly proud with our improved CQC ratings, especially with the improved rating of outstanding for caring. I would like to once again extend my thanks and the thanks of the Board to all staff within the organisation. The Improved rating has resulted in the Trust being removed from special measures, this is a real boast not only for the organisation, but also to the people of Walsall, and the confidence that the people of Walsall can place in the organisation.

We are currently working with colleagues at NHSi to identify the support the organisation requires to continue to drive continuous improvement and reach outstanding by 2022. The support will focus on leadership, building capacity to deliver our improvement programme, and also strengthening Governance.

Along with Richard Beeken, I joined a call with the Chief Executive, NHS Providers to discuss regulatory processes and feedback from being exited from special measures.

**2. Improve our financial health through our robust improvement programme**

I participated in a Financial Cabinet meeting, which was formed with Board Colleagues to oversee progress in relation to delivery of the 2019/20 financial plan. We are starting to see improved oversight and accountability throughout the organisation in relation to the delivery of financial improvement and again I would like to recognise staff who are working differently to deliver against the financial plan.

At the last private session the Board we discussed our Long Term Financial Plan, which will form part of the wider STP financial plan. This is an important step forward nationally, regionally and locally, which will enable further collaboration, foster innovation and support clinical pathway improvements across the Black Country.

**3. Develop the culture of the organisation to ensure mature decision making and clinical leadership**

As part of our Board day in September, the Board took part in a development session with NHSi focusing on making data count. The session focused on how we can use our data to inform our decision making, and more importantly drive improvement. We have committed to use the learning from this event to improve our reporting through the Board and its sub Committees.

**4. Develop the clinical service strategy focused on service integration in Walsall & in collaboration with other Trusts**

This month I stepped in for a colleague and chaired the Walsall Together Board. I was involved very early on in the development of the Walsall Together vision and ambition, chairing this Board gave me the opportunity to see the vision and ambition really come to life, at the start of every meeting we hear a patient story, and this month we heard a story from a

patient who has had her quality of life improved thanks for Multi-Disciplinary working, and she explained how she felt the MDT team had placed her at the centre of her own care, and really tailored a care plan for her. This story really exemplified the importance of partnership working and the benefits to the people of Walsall. The opportunity to make a positive difference to a wider community was evident throughout the conversations, with the various partners coming together from various sectors with a common purpose.

Also this month I was invited to attend a knife crime awareness session hosted by the Trust in Partnership with James Brindley Foundation, with the aim of giving frontline health and social care staff, and organisations to work more closely together and influence young people to make positive choices. It was a privilege to meet and hear from James parents, and how his death has influenced the family to raise awareness of both the impact of knife crime and the collective part we can all play in influencing young people away from such behaviour.

## 5. Meetings

I visited Northumbria Healthcare NHS Foundation Trust with Healthwatch England Committee members and learnt about the Trust's approach to patient voice.

I participated an NHS Diversity Partners event with our Director of People and Culture and explored best practice in promoting inclusion for colleagues with a disability.

I attended a seminar on the NHSE Healthy Towns initiative at the National Housing Federation Conference and reflected on ways that collaborations between Health and Housing can promote health and well being and reduce health inequalities

I attended the NHSI Regional Talent Board which works to develop a pool of executive directors, reducing dependence on recruitment agencies

## RECOMMENDATIONS

The Board are asked to note the content of the report

MEETING OF THE PUBLIC TRUST BOARD – Thursday 3rd October 2019			
Chief Executive's Report			<b>AGENDA ITEM: 7</b>
<b>Report Author and Job Title:</b>	Richard Beeken, Chief Executive Officer	<b>Responsible Director:</b>	Chief Executive Officer
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>The purpose of the report is to provide the Board with my appraisal of the high level, critical activities which the organisation or I have been engaged in during the past month, set against the organisation's strategic objectives.</p> <p>The report also sets out to the Board, the significant level of guidance, instruction and best practice adoption we received during September 2019 and assures the Board through an allocation of the actions required, to the relevant executive director.</p>		
<b>Recommendation</b>	<p>Members of the Trust Board are asked to:</p> <p>Note the report and discuss the content</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>This report outlines the activities undertaken by the chief Executive officer aligned to each of the organisation's strategic objectives. This report provides assurance around the mitigation of a number of our strategic risks and also provides context in which the Board can triangulate information.</p>		
<b>Resource implications</b>	There are no resource implications associated with this report		
<b>Legal and Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper.		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



## Chief Executive's report

### 1. PURPOSE OF REPORT

The purpose of the report is to provide the Board with my appraisal of the high level, critical activities which the organisation or I have been engaged in during the past month, set against the organisation's strategic objectives.

The report also sets out to the Board the significant level of guidance, instruction and best practice adoption we received during June 2019 and assures the Board through an allocation of the actions required, to the relevant executive director.

### 2. BACKGROUND

The Trust has, through its sign off of the 2019/20 Annual Plan, reaffirmed its strategic objectives. These will drive the bulk of our action as a wider leadership team and organisation:

- Provide safe, high quality care across all our services
- Use resources well to ensure we are sustainable
- Care for patients at home wherever we can
- Work closely with partners in Walsall and surrounding areas
- Value our colleagues so they recommend us as a place to work

### 3. DETAILS

#### 3.1. Provide safe, high quality care across all our services

On 24<sup>th</sup> of September, the executive team of the Trust, together with colleagues from the CCG as well as NHSI/E regional team members and CQC, are holding a "Quality Stocktake Meeting". In the previous CQC inspection regime, a "Quality Summit" would be held for any Trust placed in special measures or about to exit special measures. Such forums also included the majority of the Trust Board and a wider cross section of arm's length bodies. The quality stocktake meeting is intended to be a much lower key event, aimed at marking our exit from special measures and ensuring that there is wider system ownership and sign up to the Trust's post-special measures intentions as well as the support package from NHSE/I. At the meeting, I intend to ensure that the agenda covers not just quality related matters and our formal response to the "must do's" and "should do's" from the CQC report, but also to impress upon the wider system that only through a

systematic approach to organisational development and service improvement, will we achieve the ambition of being an outstanding rated Trust by 2022.

With effect from October, I take on the SRO role for urgent and emergency care for the Black Country & West Birmingham STP. Given the increasing emphasis by NHSE/I on STPs becoming integrated care systems (ICSs) and plan for delivery of the long term plan objectives collectively and through mutual accountability, this is a role which proves to be challenging, yet could achieve progress on this high priority agenda. I intend to focus my attentions on ensuring we achieve a standardised and best practice approach to winter planning and resilience for the coming winter, a standardised and best practice approach to ambulatory emergency care, managing “stranded” patients and inter-emergency department standard operating procedures. An increased focus on delivering the urgent care related benefits of place based integration will also be required. This will add to the previous dominance of NHS 111 and blue light service commissioning and delivery within the STP.

## 3.2 Use Resources Well

On 26<sup>th</sup> September, the STP health partners hold their regular, monthly session. The most pressing and important agenda item for that meeting will be a presentation on how our collective, long term plan submission is coming together. Intended as a collective description of how the STP will achieve clinical, workforce and financial sustainability over the next five years, it runs the risk at present of being merely an aggregation of individual organisational ambition and plans, some of which may not appropriately deviate from the national planning assumptions.

As a Trust, we are keen to lead the way on ensuring that the submission we make is reflective of current realities and indeed, the reality of investment that will be required, both capital and revenue, if those ambitions are to be delivered. An excellent session with our internal finance cabinet allowed us to debate and then agree to submit a long term financial plan which sets out a growth in emergency activity which is greater than current national planning assumptions and an investment profile, for Walsall Together, organisational development and 7 day service standards, which may challenge the ability of the STP to guarantee financial balance for each component year of the 5 year plan.

### 3.3 Partners

This month, I have participated in the stakeholder panels for the appointment of the Chair role for Dudley & Walsall Mental Health Trust and Black Country Partnership FT, as well as the joint accountable officer role for the Black Country CCGs. These are organisations with whom we have critical partnership relationships. It wasn't always the case that we would have been involved in such appointments in the past, so this is a measure of the collective leadership we are all engaged in now.

This month, we have also held a constructive meeting between the chairs and CEOs of the Black Country acute hospital providers. During the meeting, we reaffirmed our commitment to working together on clinical service integration in Dermatology and Urology, as well as agreeing the need to accelerate the pace of the work on forming a Black Country locum medical and nursing bank. Our leadership role collectively in the STP, was also discussed.

### 3.4 Valuing colleagues

On 10<sup>th</sup> October, I will be spending half a day with our operating theatres team, learning about the improvements they have made on safety and productivity over the last 12 months and also hearing about the concerns and frustrations they still have. I will meet the theatres matron, take part in a free ranging discussion at their team meeting and shadow one of our ODPs during a morning list. Front line staff in the team requested this of me, as there are still concerns about staff morale and uncertainties about the future, which they wish to share.

On 24<sup>th</sup> October, the Trust holds its annual leadership conference. Last year's event was a special occasion, given the inspirational and thought provoking speeches we had as well as the formal launch of the organisation's new values. This year's event will be on values based leadership and will feature keynote addresses from well known health commentator, Roy Lilley and NHS providers CEO, Chris Hopson. Following the leadership diagnostic for our "top 100" leaders, the event will formally launch the talent management programme also.

## 4. RECOMMENDATIONS

Board members are asked to note the report and discuss the content.

**Richard Beeken**  
**Chief Executive**  
23/9/19

## NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system since July have been sent to Executive Directors for review and decision on whether any actions are required for follow up or consideration by Board Committees.

No	Document	Guidance/ Report/ Consultation	Lead
1.1	<p><b>Reducing single-use plastics in the NHS</b></p> <p>All NHS organisations are now being asked to remove single-use plastics from their catering services and reduce NHS waste by over 100 million plastic items by 2021.</p>	<p>Action</p> <p>PFIC Committee</p>	<p>Chief Operating Officer</p>
1.2	<p><b>Revised friends and family test guidance</b></p> <p>NHSi/NHSE have published revised guidance on the Friends and Family test. The changes announced mean that, from next April:</p> <p>All providers will use a new FFT mandatory question and six new response options</p> <p>The Guidance has removed mandatory timescales where some services are currently required to seek feedback from users within a specific period, which affects A &amp; E services, inpatients and maternity, to allow more local flexibility and enable people to give feedback at any time, in line with other services.</p>	<p>Action</p> <p>Quality, Patient Experience and Safety Committee</p>	<p>Director of Nursing</p>
1.3	<p><b>The NHS's recommendations to Government and Parliament for an NHS Bill</b></p> <p>An NHS Bill should be introduced in the next session of Parliament. Its purpose should be to free up different parts of the NHS to work together and with partners more easily. Once</p>	<p>Information</p>	<p>Director of Governance</p>

	enacted, it would speed implementation of the 10- year NHS Long Term Plan.		
<b>1.4</b>	<p>The role and remuneration of chairs and non-executive directors in NHS trusts and foundation trusts</p> <p>There has been a long standing issue within the NHS in relation to the levels of remuneration paid to FT Non-Executive Directors and Non-Executive Directors working with NHS Trusts. the guidance aims to address the remuneration gap</p>	<p><b>Action</b></p> <p><b>Private Board</b></p>	<p><b>Director of Governance</b></p>

MEETING OF THE PUBLIC TRUST BOARD - 3 <sup>rd</sup> October 2019			
Monthly Nurse Staffing Report – August 2019 Data			<b>AGENDA ITEM:</b> <b>8</b>
<b>Report Author and Job Title:</b>	Angie Davies Deputy Director of Nursing	<b>Responsible Director:</b>	Dr Karen Dunderdale Director of Nursing
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input checked="" type="checkbox"/>		
<b>Executive Summary</b>	<p>The total temporary staffing usage is showing an improving position of reduced usage with a reducing amount of variability.</p> <p>A number of process actions have been strengthened to ensure grip and control remains around request of temporary staffing.</p> <p>The RN fill rate average for August 2019 overall was 92.45%.</p>		
<b>Recommendation</b>	The Board is requested to note the contents of the report and make recommendations as needed.		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>BAF Objective No 5: Establish a substantive workforce that reduces our expenditure on agency staff.</p> <p>Corporate Risk No 11: Failure to assure safe nurse staffing levels.</p>		
<b>Resource implications</b>	None		
<b>Legal and Equality and Diversity implications</b>	None		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

## MONTHLY NURSE STAFFING AND WORKFORCE REPORT

This is the monthly report to the Trust Board in accordance with the requirements of the updated National Quality Board (NQB) Safe Sustainable and Productive Staffing Guidance (July 2016) and the National Institute for Health and Care Excellence (NICE) guidance issued in July 2014.

The Trust is committed to providing safe, effective, caring, responsive and well led care that meets the needs of our patients. It is recognised that decisions in relation to safe clinical staffing require a triangulated approach which consider Care Hours per Patient Day (CHPPD) together with staffing data, acuity, patient outcomes and clinical judgement. This report provides evidence that processes are in place to record and manage Nursing and Midwifery staffing levels across all settings and that any concerns around safe staffing are reviewed and processes put in place to ensure delivery of safe care.

### 1.SHIFT FILL RATES

The RN fill rate average for August overall was 92.45% which splits in to the following day and night average:

- 90.37% for day shifts
- 95.31% for night shifts

To date there has been no correlation between incidents and staffing levels.

### 2.TEMPORARY STAFFING

#### 2.1 Total Temporary Staffing Use

Since October 2018 a number of key changes have been embedded leading to a reduction in the use of agency nurses and an increase in the use of bank nurses.

Chart 1

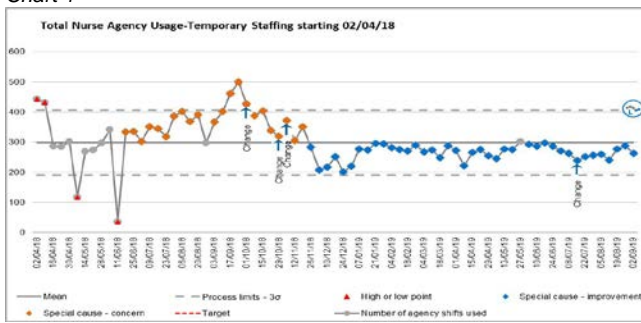


Chart 2

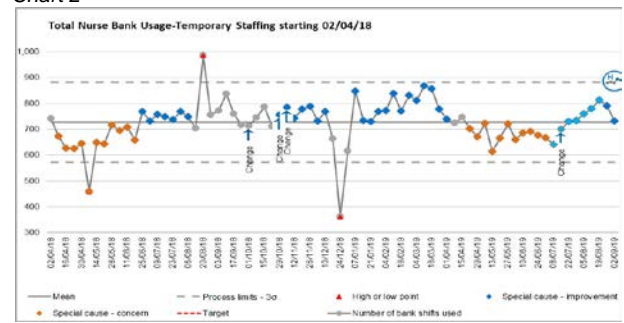


Chart 1 demonstrates a greater level of control and reduced variance with the use of RN Agency. The commencement of the Nursing Workforce Transformation programme and some schemes of work from that programme are evidenced on the chart. Schemes of work include agency check in and twice daily approval meetings for shift escalation.

Chart 2 demonstrates the rise in bank bookings which is considered a positive effect. Achieving at least 75% of temporary staffing fill with bank helps contribute to a reduction in agency use.

Chart 3

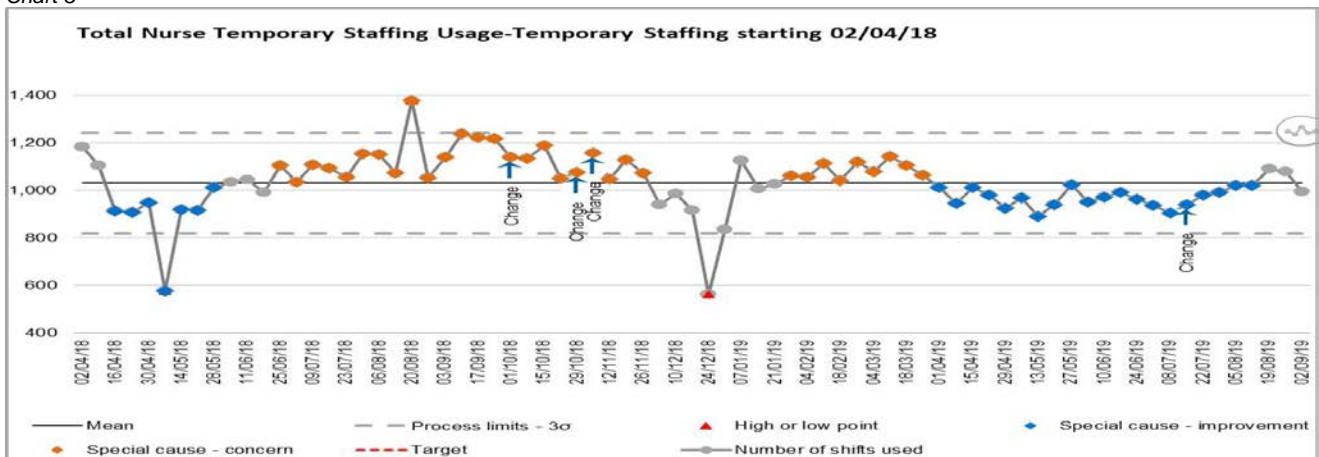


Chart 3 shows overall temporary staffing use has now a greater level of control with a reduced amount of variance demonstrating the value of the Workforce Transformation programme initiatives.

## 2.2 Agency Use

The top four reasons for Agency staff use within this financial year, which include unfunded capacity are shown below in Charts 4 - 7:



Chart 4

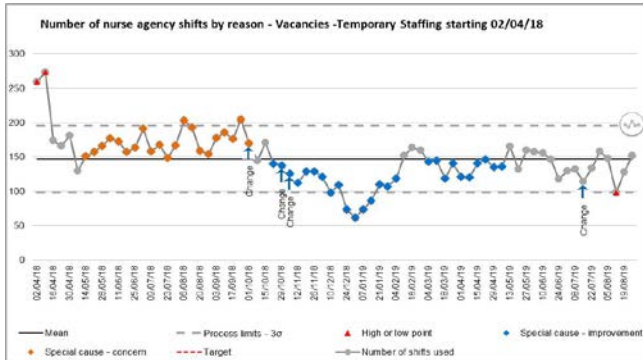


Chart 5

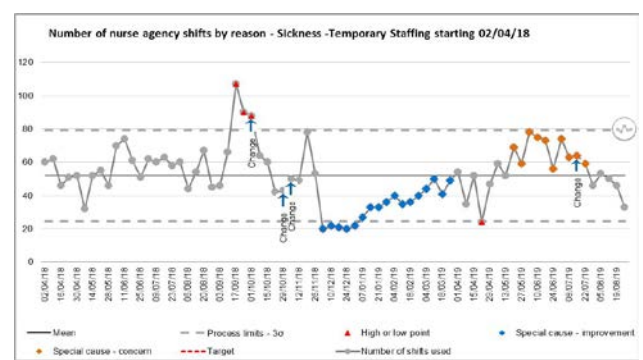


Chart 6

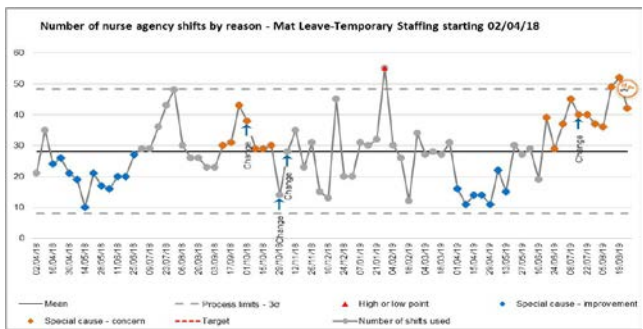
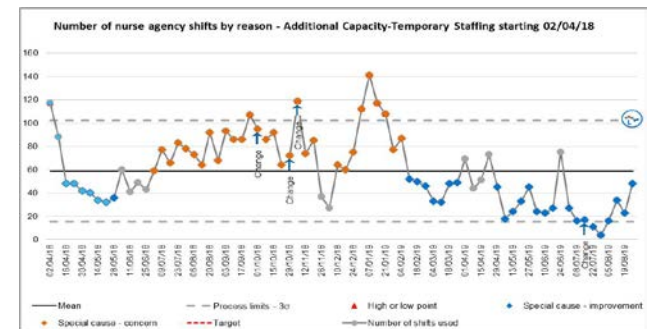


Chart 7



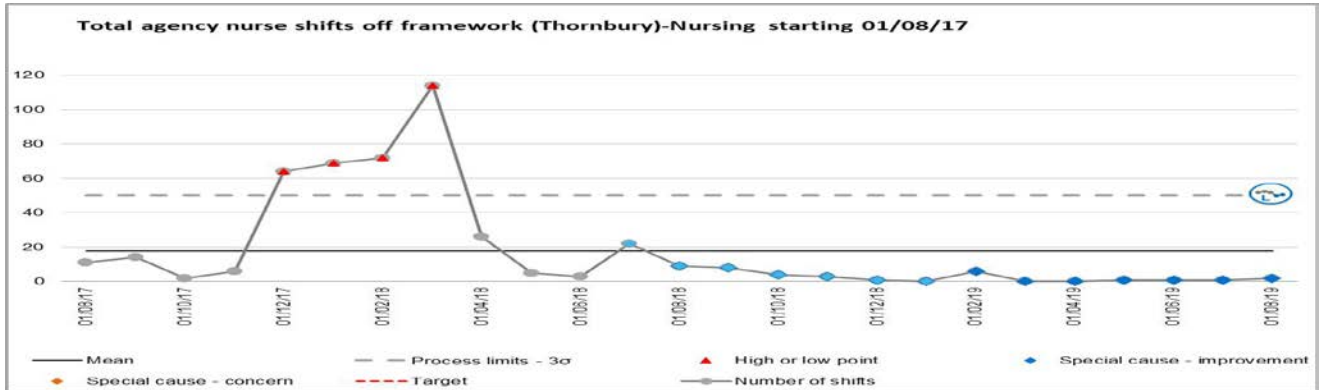
The Workforce Transformation programme is undertaking a weekly appraisal of vacancy figures by ward to facilitate easier cross referencing of current vacancies and Matrons align all requests for temporary staffing to their current vacancy position at twice daily staffing meetings.

Since these extra actions have been put in place there has been less weekly variation in the vacancy use.

Sickness cover with temporary staffing has showed less variation.

Chart 8 shows an improved position on use of Thornbury nurse shifts which led to the removal of both Tier 3 and Tier 4 usage.

Chart 8



## 5.0 RECOMMENDATIONS

The Board is requested to note the report and make recommendations as necessary.

## 6.0 CONCLUSIONS

The report is presented to reflect the on-going nursing workforce transformation and will continue to reflect the progress being made and the improvements in grip and control across temporary staffing enhanced by workforce developments and agreed safe establishments according to national guidance and best practice.

MEETING OF THE PUBLIC TRUST BOARD – 3 <sup>rd</sup> October 2019			
Improvement Programme Update			<b>AGENDA ITEM:</b> <b>9</b>
<b>Report Author and Job Title:</b>	Dr Karen Dunderdale, Director of Nursing & Deputy CEO	<b>Responsible Director:</b>	Richard Beeken, CEO
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input checked="" type="checkbox"/>		
<b>Executive Summary</b>	<p>The Improvement Programme underpins the delivery of the Trust's Vision, Values and Strategy, this paper provides the Board with an update on the progress being made</p> <p>The Improvement programme is in the final planning stages, and the task and finish group which was established to support the development improvement programme and the development of the programme infrastructure has recommended the establishment of an improvement programme board.</p> <p>At the last meeting of the Board we discussed the establishment of the programme board, and the intention for this to be a sub-committee of our the Trust Board, however whilst the programme is still in its infancy stages the executive have agreed that the improvement programme board be established as an executive board with regular reporting to the Trust Board.</p>		
<b>Recommendation</b>	<p>Members of the Trust Board are asked to:</p> <p>Note the progress made to date</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>The Improvement programme underpins the delivery of strategy and once fully established will act as a mitigation and an internal control mechanism against all the current Board Assurance Framework Risks.</p>		
<b>Resource implications</b>	<p>There are no resource implications associated with this report. However there are resource implications associated with the delivery of the improvement programme and a business case will be developed and submitted via the proper governance structures.</p>		

<b>Legal and Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper. However equality and diversity impact assessments will be undertaken as part of the development of the PIDs for each workstream.	
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

# Improvement Programme Structure



# Improvement programme: 2019 - 2022



# Safe, High Quality Care

## Workstream Structure

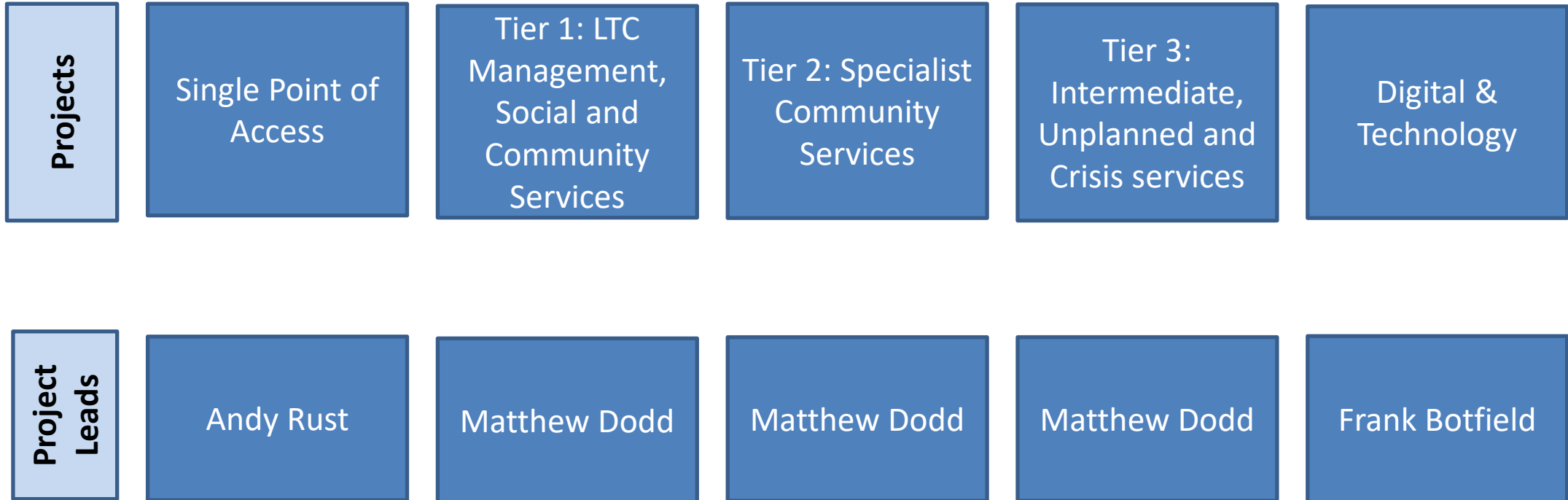
Dr Mathew Lewis, Medical Director & Dr Karen Dunderdale, Director of Nursing

Projects	VTE Assessment and Prophylaxis	Reducing Falls on Wards	Improving Documentation	Reducing Length of Stay	Improving Infection Control	Patient, Public and Staff Engagement
Project Leads	Uzo Ibechikwu & Jo Adams	Angie Davies & Lisa Stanley	Pilot Project Ward 16	Delreita Ohai and Medicine ToT	Jo Taylor	Louise Mabley

# Care At Home

## Workstream Structure

Daren Fradgley, Interim Walsall Together Director

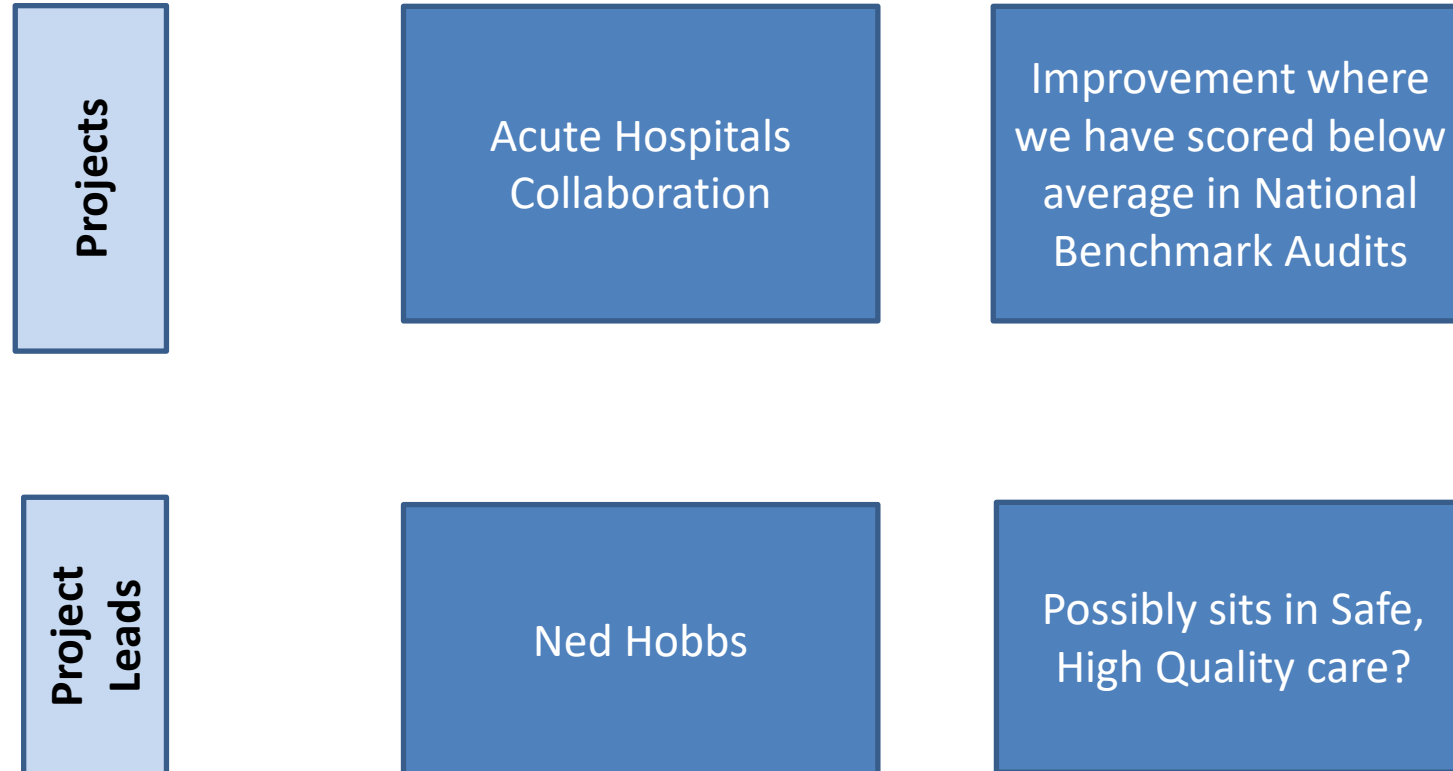




# Partners

## Workstream Structure

Ned Hobbs, Chief Operating Officer



# Valuing Colleagues

## Workstream Structure

Catherine Griffiths, Director of People & Culture

Projects	Leadership, Culture and OD	Workforce Sustainability & redesign	Managing Staff Wellbeing
Project Leads	Marsha Belle	Claire Bond	Michala Dytor
Project Areas	<ul style="list-style-type: none"> <li>• Coaching and Mentoring</li> <li>• Quality Improvement Culture</li> <li>• Talent Management</li> <li>• Career Development</li> <li>• Leadership &amp; Management Development</li> <li>• Counter Cultural issues</li> </ul>	<ul style="list-style-type: none"> <li>• Sustainability Review</li> <li>• New Roles Group</li> <li>• Workforce Plan</li> <li>• Organisation Design Model</li> </ul>	<ul style="list-style-type: none"> <li>• Sickness Absence Policy</li> <li>• Staff Health and Wellbeing Strategy</li> <li>• Just Culture</li> </ul>

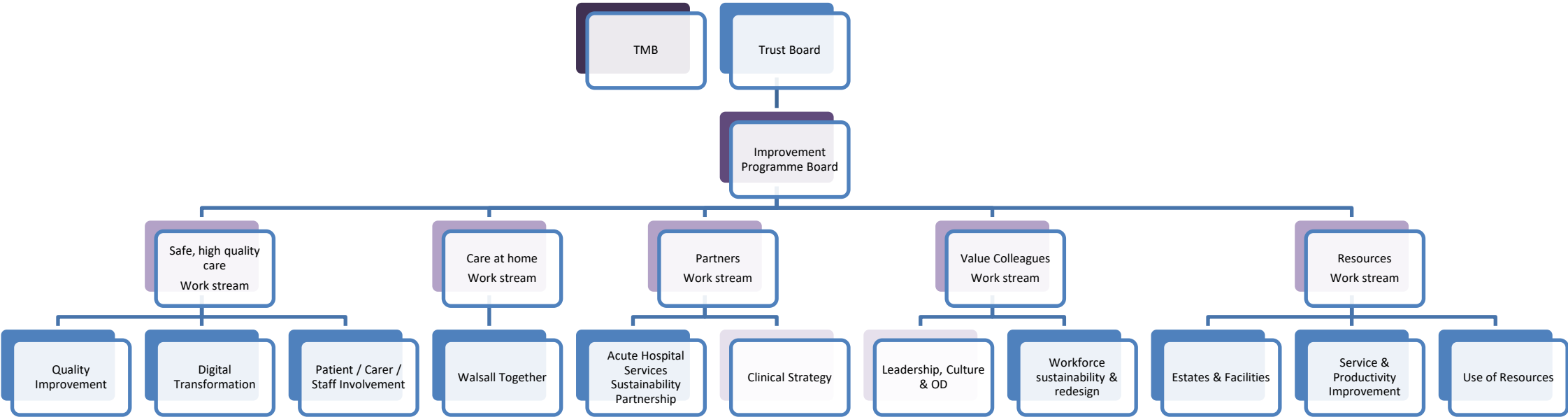
# Use of Resources

## Workstream Structure

Ned Hobbs, Chief Operating Officer

Projects	Ambulatory Emergency Care	Diagnostic Clinical Pathways	Technology / Innovation to improve Productivity	Ensure Estates used to maximum efficiency	Surgical Ambition for repatriation, GIRFT recommendations and Theatre Utilisation	Resource Management
Project Leads	Medicine / Surgery / WCCSS ToT	Alan Deacon/ Kate Salmon	TBA	Jane Longden	Surgery ToT	Deputy Director Finance

# Governance Arrangements



# Governance

- Each Division will develop a Divisional Improvement plan aligned to the priorities in the Improvement Programme Strategy
- The Divisional Improvement Plan will be monitored monthly through the Improvement Programme Board
- Each ward or department will have a local clinical and operational improvement lead responsible for quality
- Each Division will support their clinical and operational leaders to design and deliver their local improvement plans



MEETING OF THE PUBLIC TRUST BOARD – 3 <sup>RD</sup> OCTOBER 2019			
Arrangements for Winter 2019/20			<b>AGENDA ITEM: 10</b>
<b>Report Author and Job Title:</b>	Adam Townsend Ian Billington	<b>Responsible Director:</b>	Ned Hobbs – Chief Operating Officer
<b>Action Required</b>	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>To ensure the health economy delivers a safe, effective service over the winter period, a significant piece of diagnostic, improvement and forecasting work has been undertaken, led by the Urgent and Emergency Care Operational Group, which sets out the expected demand on services during the winter months, a set of mitigations (improvements) to that increased demand, and management approaches along with detailed forecasting of operational and financial requirements.</p> <p>The plan in this document sets out, in detail, how the health and social care partners in Walsall are preparing for the additional peaks in demand from November 2019 through to March 2020. It builds on the winter planning of 2018/19 and demonstrates how the learning from the previous year has translated into a set of improvement workstreams which aim to further reduce bed demand on the trust.</p> <p>This document sets out:</p> <ul style="list-style-type: none"> <li>- The approach taken to winter planning</li> <li>- The agreed operational and financial plan for winter including details of interventions</li> <li>- Clinical and operational operating principles and standards</li> <li>- Operational, Clinical and financial governance and reporting structures</li> <li>- Specific protocols for opening capacity areas</li> <li>- External reporting methodologies and requirements</li> </ul>		
<b>Recommendation</b>	<p>Members of the Performance, Finance and Investment Committee are asked to:</p> <p>Approve the interventions contained within the Winter Plan</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>Risk 208 - Total time spent in ED</p> <p>BAF 002 – Failure to achieve financial plans as agreed by the Board and communicated to NHSI.</p>		

<b>Resource implications</b>	The plan outlined within this document has been costed as follows:	
		<b>Forecast Spend 19/20 £'000</b>
	<b>Inpatient Capacity to Service Winter Activity</b>	<b>466</b>
	<b>Festive Period</b>	<b>159</b>
	<b>Additional Support Requested</b>	<b>947</b>
	<b>Subtotal Winter Interventions</b>	<b>1,572</b>
	<b>Inpatient Capacity to Service Increased Admissions</b>	<b>732</b>
	<b>GRAND TOTAL</b>	<b>2,305</b>
	<p>This represents a decrease in planned spend on Winter-specific Interventions compared to the previous year's spend.</p> <p>The Financial Plan for 2019/20 contains provision for £1.05m for additional capacity over the winter period. The plan detailed here proposes Winter Interventions in excess of this provision of £526k, with a further £732k spend relating to Inpatient capacity to service increased admissions, giving a total variance to plan of £1.3m.</p> <p>The implications of this have been discussed in Financial Cabinet and will be built into the Trust's forecast for the remainder of the 2019/20 financial year.</p>	
<b>Legal and Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper.	
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

# ARRANGEMENTS FOR WINTER 2019/20

**Active Period**  
1st November 2019 to  
31st March 2020

**Version 1.3**

Executive Lead

Ned Hobbs  
Chief Operating Officer

Contributing Authors  
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## 1.0 Foreword

As a Community Trust with a District General Hospital, providing high quality emergency care is not only one of our core duties, but is something we can and want to excel at. Since joining the Trust this Summer, I have been humbled by the incredibly hard work of staff working across the emergency and acute care pathway both in the hospital, in community services, and in the wider health economy.

We have used the Summer period to be thinking ahead to Winter, where traditionally emergency care services face even greater pressure. This pressure is not typically as a result of increased ED attendances, or even particularly increased emergency admissions, but tends to be as a result of patients being more acutely unwell and thus staying in hospital longer, and/or influenza or norovirus outbreaks placing additional pressure on the inpatient bed base, and in turn on the ability for us to admit patients from ED.

Accordingly, the Winter Plan for 19/20 has two central strategies within it to help us to best manage our emergency demand:

1. A focus on increasing access to clinical decision-making, diagnostics and associated interventions (e.g. Therapy or Endoscopy) that supports patients to progress against their clinical management plan, get better quicker, and home sooner. This reduces pressure on our inpatient bed base, whilst simultaneously improving quality of care.
2. A targeted focus on the Festive period, running from late December to early January. Last year our bed occupancy rose very steeply over this period. Not because we admitted any more patients, but because we discharged far fewer patients over the Christmas and New Year period. Consequently a central thrust of this year's plan is to run the weekend and bank holiday days as close to a normal working day as possible to maximise the number of patients that can be safely discharged home over this period.

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 Emergency Department which is not right for the following reasons:

- a) Firstly, if I or my loved one was a patient, I would not want to wait longer than I need to.
- b) Secondly, there is increasing evidence that patients who stay in the Emergency Department for prolonged periods of time are associated with worse clinical outcomes, including mortality. In short, prolonged time in an Emergency Department can be harmful.
- c) Thirdly, once the Emergency Department becomes overcrowded with patients staying a long period of time, cubicle space becomes very limited, placing new undifferentiated patients at risk and making it a very challenging environment for staff to work in.

Thank you to all colleagues who have played a part in developing this plan, and who will contribute additional time to managing our patients over the Winter. 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. If we work closely together as a team, and deliver the commitments contained within this document, I am confident we can deliver safe, timely emergency care and a good working experience for our staff.

Ned Hobbs  
Chief Operating Officer, Walsall Healthcare NHS Trust

## 2.0 Executive Brief

The health economy in Walsall, including all the relevant partners, prepares for peaks in demand throughout the year. Contingency arrangements for unscheduled and planned care activity is required.

During the winter period, however, a number of pressures will be prevalent which will have an impact on our ability to manage demand and capacity. These include:

- Increased demand for non-elective care.
- Higher rate of admissions to hospital.
- More acutely unwell patients
- More patients waiting to be discharged from hospital and requiring subsequent care packages to support discharge.
- Decreased workforce resilience (festive holidays and sickness absence).
- Requirement to balance the elective programme with management of unplanned care demand.
- Need to provide additional health and social care capacity in acute hospital and community settings.

The Health Economy A&E Delivery Board member organisations have been tasked to ensure robust arrangements are in place for the winter. This ensures inappropriate admissions are avoided and patients are discharged home or closer to home, in a safe and timely manner. Operational responsibility for delivering the winter arrangements sits with the relevant operational leads, including the Chief Officers of the organisational partners.

The Urgent and Emergency Care Operational Group, sets out the expected demand on services during the winter months, a set of mitigations (improvements) to that increased demand, and detailed forecasting of operational and financial requirements.

The plan in this document sets out how the health and social care partners in Walsall are preparing for the additional peaks in demand from November 2019 through to March 2020. It builds on the winter planning of 2018/19 and demonstrates how the learning from the previous year has translated into a set of improvement workstreams which aim to further reduce bed demand on the Trust, despite the continuing rise in both Emergency Department demand and subsequent numbers of admitted patients.

The planned improvements from the workstreams have been used to build a model of how we expect inpatient demand to arrive on a weekly basis, and the subsequent number of acute hospital beds we will need to have open to safely manage inpatient demand.

*The ambition and expectation of this plan is that the system will mitigate and manage the expected 3.6% growth in bed demand through the winter period (3792 bed days or 20 beds) to a point where we are planning to deliver the coming winter period without the requirement for increased G&A bed capacity year on year and within a financial envelope of Winter-specific interventions that is no greater than last year.*

2.1 This document sets out:

- The purpose of this document, its target audience and how it should be used along with any and all associated supporting documentation (as appendices)
- The approach taken to winter planning
- The agreed operational and financial plan for winter including details of interventions

- Clinical and operational operating principles and standards
- Operational, Clinical and financial governance and reporting structures
- Specific protocols for opening capacity areas
- External reporting methodologies and requirements (Unify2, SitRep etc)

The After Action Review of Winter 2018/19 highlighted a number of issues relating to the way in which capacity areas were opened during last winter, some of which were recurrent issues from the prior year. Whilst the Winter 2018/19 was amongst the safest delivered in recent years, a significant amount of the residual risk of harm centred around the opening and management of additional capacity ward areas. This being the case it has been agreed that the opening extra capacity checklist must be completed to inform any opening.

The plan, once complete will pass through a robust assurance process both within the Trust and externally through Urgent & Emergency Care Operational Group and A&E Delivery Board. Once adopted by these groups and boards the document will be published on appropriate intranet areas within all relevant organisations.

### **3.0 Purpose of this document**

3.1 The purpose of this Winter Plan document is to:

- Inform all relevant organisations and individuals of the way in which the system intends to manage winter demand over 2019/20
- Provide a collective overview of actions that will support operational resilience at Walsall Healthcare NHS Trust over the winter period (1st November 2019 to 31 March 2020)
- Hold information on the approach taken to building the winter plan
- Collate historical data, learning from past winter periods and knowledge of the current position that has been used in the development of these arrangements within the appendices
- Provide 'organisational memory' of what was agreed, how and why.
- Provide a platform to monitor demand and performance variance as a means to understand variance in subsequent performance and operational pressures

3.2 The winter plan should be read by:

- Members of A&E Delivery Board and the Urgent & Emergency Care Operational Group
- 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

There is a significant volume of work that has been undertaken by this group to compile the winter plan. Inclusion of all this documentation within the body of the document would make it cumbersome and difficult to be used as an operational reference document as intended.

This being the case the relevant documentation has been collated in the accompanying appendices which accompanies the main text of the document.

- 3.3 This document should be read in conjunction with the following documents, plans and arrangements:

The appendix to this document

Walsall A&E Delivery Board Improvement Plan

Escalation policy – Full Hospital Protocol (2016)

Major Incident Plan (May 2019)

Local business continuity arrangements

Severe Weather Plan

Walsall Council Severe Weather Partnership

#### **4.0 Approach to planning for winter**

- 4.1 The over-arching methodology for winter planning is grounded in a PDSA approach.

- Plan - In partnership with senior operational representatives of the health system create a document setting out the way in which we will approach managing winter pressure.
- Do - Deliver the plan as described/prescribed
- Study - Measure delivery against the plan. Identify deviations and agree improvements
- Act - improve the plan based on recommendations from the study phase

- 4.2 This process has been completed using the 18/19 winter plan as a starting point and a full After Action Review of the implementation of the plan – See Appendix.

The After Action Review generated a set of recommendations for further improvement which drove a set of improvement workstreams which were agreed and sponsored by the Chief Officers of the A&E Delivery Board. This improvement work and its associated expected benefit were offset against the forecast and expected growth in demand for unplanned care during 19/20 and a forecast of expected demand was created which forms the basis of the capacity and demand plan for 19/20. The Winter Plan 18/19 After Action Review (including recommendations), Improvement Programme, benefits calculations and subsequent forecast of demand can all be reviewed in the appendices to this document.

The approach to delivering a safe robust winter period consists of 3 key elements:

- A full review of the previous winter plan and assessment of its success
- Pre-emptive improvement work which builds on learning from the previous year to design and implement changes which reduce the burden of winter demand
- Pro-active, robust actions and interventions during the winter period which ensure the system is resilient to winter pressure and assists in the management of escalated pressure when necessary.

## Review of Winter 18/19

To understand and agree the approach to managing the winter period it was critical that a group undertook a deep analysis of the actual way demand and capacity was managed through the winter period.

This was achieved through the undertaking of a full 'After Action Review'. The After Action Review delivered a full, detailed analysis of how the winter was delivered, a thematic review of what worked and what did not and an analysis of all quality and safety metrics associated with delivery of non-elective care during the winter period.

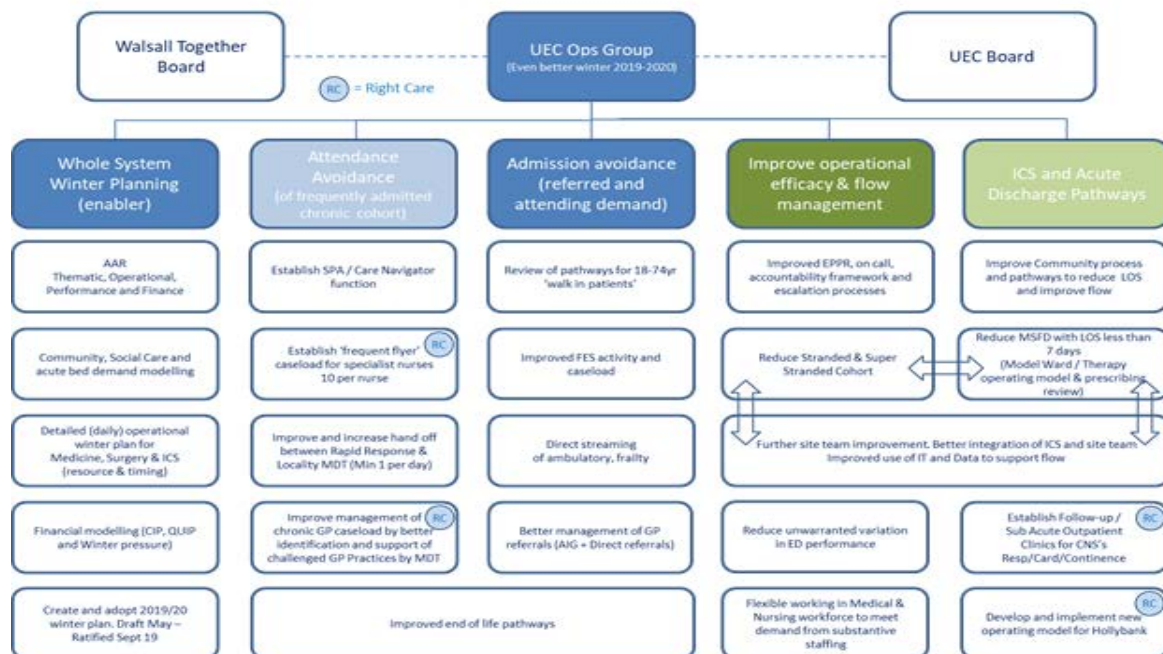
Recommendations were considered by the system leads and operational managers and a set of improvements for the coming year was agreed. These projects and workstreams became the mechanism for implementation of the recommendations through pre-emptive mitigation and pro-active management.

The Review of Winter 2018/19 was presented at Performance Finance & Investment Committee; Quality, Patient Experience & Safety Committee; People & Organisational Development Committee; and was received at Trust Board in September 2019.

### Pre-emptive mitigation of demand

The pre-emptive element consists of a number of identified workstreams and projects which address the recommendations made in the After Action Review. The following diagram illustrates the workstreams and projects identified for implementation during the period March 2019 - October 2019 along with the workstream sponsors and owners.

## Confirmed workstreams and projects



## Pro Active management

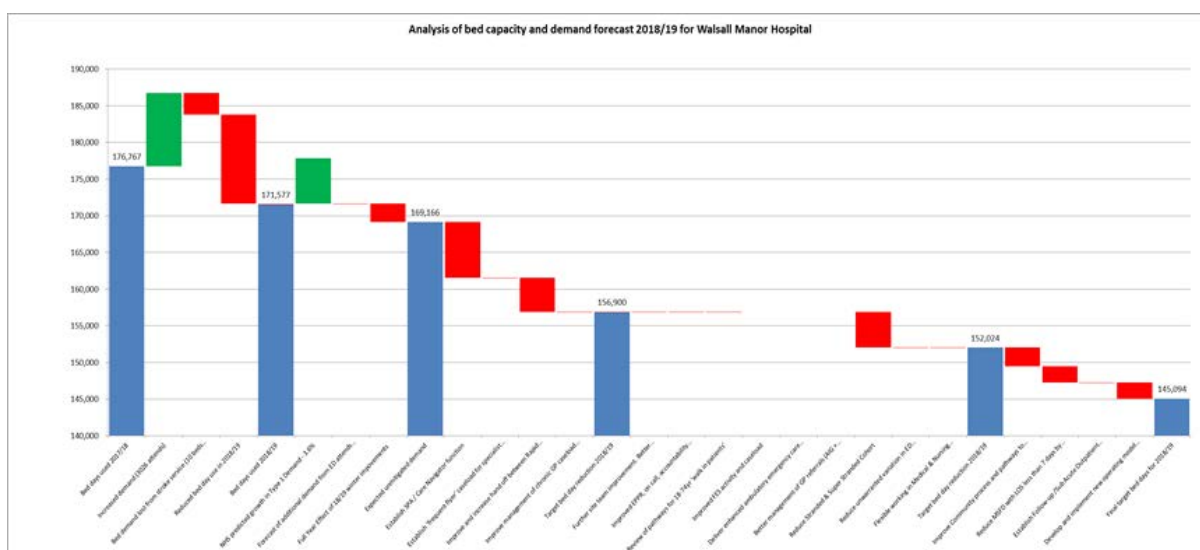
Pro-active management can be described as an activity which is aimed at reducing inpatient bed demand in real time, such as increased senior medical resources at key times of the week / day. In addition to these interventions it was separately recognised that during the winter period 2018/19 the primary driver for opening capacity beds at the beginning of January was not actually increased demand (through emergency admissions) but the cumulative impact of low levels of discharges in the preceding 15 days of the festive period. In this period the Trust was exposed to 6 weekend days and 3 bank holidays, all of which had significantly lower discharge rates than 'normal' working days.

To mitigate this risk in the coming winter period a number of significant changes have been implemented to move the number of safe discharges during the weekend and bank holiday days closer to the average of a normal working day.

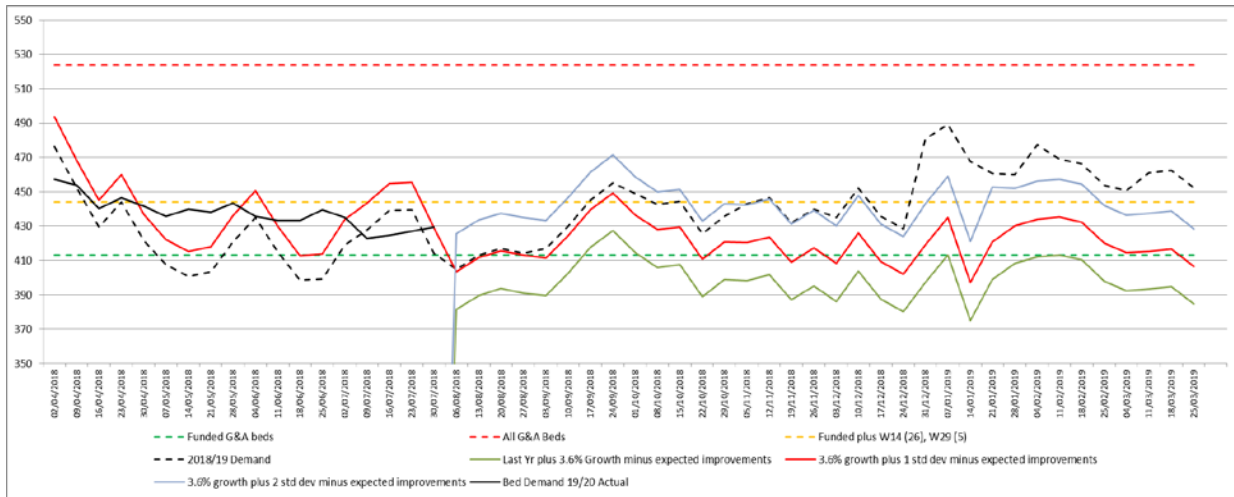
## Calculating the expected impact of planned interventions

The expected benefits of these two separate approaches were subject to scrutiny and are evidence based.

After the expected benefit calculations were completed (in a currency of bed day reductions). This benefit was then used to demonstrate, at project level, the expected impact on demand that each project (and workstream) was committing to deliver. This was articulated in a 'waterfall' visualisation which showed historic levels of bed day activity plus forecasted growth minus benefit improvements giving a forecast of annual bed demand for the coming year

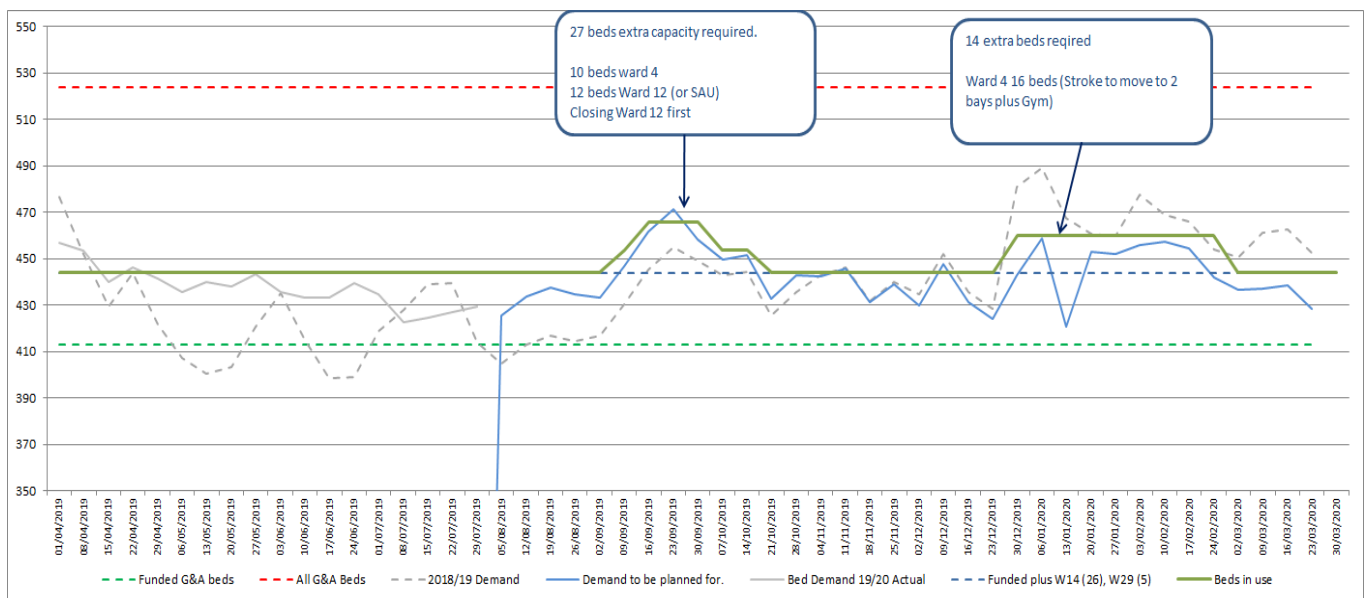


The benefit of these collective actions – including both pre-emptive and pro-active benefits – have created a new forecast for the overall bed demand required to operate safely over the winter period. We have used this to generate a graphical representation of the way in which bed demand is predicted to increase and fall over the period. In turn this model was 'stress tested' by modelling the expected demand to 1 and 2 standard deviations to replicate the expected pressure if demand increased or planned mitigations failed to deliver the expected benefit. Critically this projection includes the phased realisation of benefits from the improvement work as it moves to full year effect.



This modelled demand was then used to inform and agree a viable and deliverable operational plan for managing acute bed stock through the winter period and, more specifically, identify times when the Acute Trust would need to consider opening additional inpatient capacity to safely manage demand.

As at 18<sup>th</sup> Sept 19 this is the current forecast of demand and the two occasions on which the Acute Trust is expecting to open demand



This forecast demand has then been used to drive detailed operational, fully costed models for delivery. These detailed plans are set out in the Detailed Winter Plan in the next chapter

## 5.0 Detailed Winter Plan

Plan for the period 1<sup>st</sup> November to 31<sup>st</sup> March

The following summary documents are extracted from the larger document 'Winter Plan Costings' which is appended to this document. It sets out the interventions, along with costs and the expected number of beds in use on a weekly basis for the period, both are fully costed



## Winter initiatives

The following document shows the planned interventions, along with costs, which aim to reduce inpatient demand 'in the moment'. They typically add resources into existing pathways to make them more robust or able to deliver services over longer periods (into the evening or at weekends for example)

Description	Notes	Nov	Dec	Jan	Feb	Mar	Total
Weekdays			20	22	20	22	84
Saturdays			4	4	5	4	17
Sundays			5	4	4	5	18
Bank Holidays			2	1	0	0	3
<b>Total Check</b>			<b>31</b>	<b>31</b>	<b>29</b>	<b>31</b>	<b>122</b>
Junior Dr Saturday ward round cover	3 Drs for Modular, 4 Drs to cover 7,15,16,17		11,200	11,200	14,000	11,200	47,600
	Less amount already included in festive fortnight		-5,600	-5,600			-11,200
ED Acute Physician	17:00-22:00 weekdays 14:00 - 21:00 weekends and Bank Holidays		21,000	20,000	19,000	20,000	80,000
	Less amount already included in festive fortnight		-7,500	-10,000			-17,500
AEC Extended Opening (Reg, Jnr, ANP)	Weekdays: 20:00-22:00 (2 hours)		15,179	15,869	13,799	15,179	60,027
	Saturday: 16:00-22:00 (6 hours)		10,012	10,012	12,515	10,012	42,551
	Sunday: 16:00-22:00 (6 hours)		12,806	10,245	10,245	12,806	46,101
	Less amount already included in festive fortnight		-6,979	-12,317			-19,296
Consultant Ward 2 cover weekends	1 consultants for 4 hours each Saturday		3,000	3,000	3,750	3,000	12,750
Junior Dr Sunday for EDS and Clerking	1 Dr, 8 hours shift each Sunday		2,000	1,600	1,600	2,000	7,200
Additional A&E Consultant to facilitate consultant cover from 8am and until 10pm	08:00-14:00 Saturday and Sunday		6,750	6,000	6,750	6,750	26,250
ED middle grade shifts	Weekdays: 2 additional shifts 14:00-00:00 and 22:00-08:00		34,972	38,469	34,972	38,469	146,882
	Weekends: 2 additional shifts 14:00-00:00 and 18:00-04:00		19,235	15,737	15,737	15,737	66,447
ED Junior/ACP shifts	Weekdays: 18:00-04:00 Weekends: 16:00-02:00						0
Boarding Nurse in ED	Band 5 for 12 hours		11,245	11,099	10,333	11,099	43,776
Transfer team in ED	10 hours per day of Band 2 Porter and CSW (Bank rate)		11,085	10,664	9,950	10,664	42,363
Extend RATS	Extend from 7pm to 10pm 1 RN and 1 CSW		4,697	4,626	4,304	4,626	18,253
RATs Admin support	Band 2 to support above (10am-10pm)		6,605	6,348	5,924	6,348	25,224
Increase progress chaser hours	Band 3 increase by 3 hours per day		2,007	1,975	1,837	1,975	7,794
Phlebotomist in ED	Band 2 10:00-02:00		9,192	8,887	8,283	8,887	35,248
<b>GRAND TOTAL</b>		<b>0</b>	<b>160,905</b>	<b>147,814</b>	<b>172,998</b>	<b>178,752</b>	<b>660,470</b>

## Festive Period interventions

This document summarises the detailed planned interventions as set out in the winter plan regarding pro-active management. It shows a number of interventions that aim to increase discharges through the festive period thus reducing overall bed demand in a period which, typically, has marked the commencement of opening capacity

	Expenditure area	£	Dec	Jan	Assumptions
MLTC	Inpatient Ward Medical cover	53,900	28,450	25,450	7 Consultants, 6 hours per day 7 juniors, 8 hours per day
	AEC Extended opening	19,296	6,979	12,317	Assume extend weekdays by 2 hours and Wkend and BH by 6 hours
	Consultant Acute Physician ED	17,500	7,500	10,000	17:00-21:00 weekdays and 14:00 - 22:00 wkends and BH
	Consultant Orthogeriatrician	3,500	2,000	1,500	4 hours each Sunday and BH - Saturdays already covered
	Inpatient Endoscopy weekends and BHs	13,855	7,587	6,268	Based on a 4 hour list on each Weekend and Bank Holiday day
	Extend FES Medical Cover to weekend	11,000	6,000	5,000	Saturday and Sunday cover as per weekday (9-5)
	<b>Total</b>	<b>108,051</b>	<b>52,516</b>	<b>55,535</b>	
WCCSS	CT and Ultrasound Provision	7,377	3,689	3,689	Based on AFC rates for CT and proposed bank rate of £45/hr for US
	MRI provision	6,000	4,000	2,000	Awaiting pricing from InHealth, assumed £2k per bank holiday day until this is provided
	Pharmacy	18,000	8,250	9,750	2 WTE Band 6, 1 WTE Band 7, 1 WTE Band 5, 1 WTE ATO
	<b>Total</b>	<b>31,377</b>	<b>15,939</b>	<b>15,439</b>	
Community	Therapy Ward cover	10,155	5,409	4,746	Assumes 1 Physio, 1 OT, 2 CSWs each Saturday, Sunday and bank holiday (Funded by BCF?)
	Specialist Care Group	1,896	1,264	632	1 Band 7 Matron each Saturday, Sunday and Bank Holiday
	Intermediate Care	3,377	1,223	2,154	1 Band 4 and 1 Band 6 each Saturday, Sunday and Bank Holiday excluding Xmas day
	DISCO/IDT Cover	4,416	3,584	832	5x Band 4 Discos 9am-5pm (Funded by BCF?)
	<b>Total</b>	<b>19,844</b>	<b>11,480</b>	<b>8,364</b>	
<b>GRAND TOTAL</b>		<b>159,272</b>	<b>79,935</b>	<b>79,338</b>	

### Opening of additional capacity to meet unmitigated inpatient demand

Despite the other interventions detailed above the estimated demand will still, at times, outstrip our 'standard' non elective bed base. This is demonstrated in the graphical representation of the plan and in this document the planned opening and, critically, closing dates of the capacity areas has been modelled into a financial plan.

*N.B.*

*Whilst we have identified a period during September where we believe demand will require additional capacity to be opened, we are also aware that the exact timing and size of this peak is much more unpredictable than the rise in demand in the post Christmas period. This being the case we will review the levels of demand dynamically over the period September and October and only open capacity areas at a time it is agreed the expected rise in demand is being seen. Also worthy of note is that the need for more additional beds in the September period than January is due to the timing of expected improvements with many workstreams not delivering benefit until October 19 and the main contributor, reduction in Length Of Stay, contributing on an exponential basis until March 2020.*

	Sep	Sep	Sep	Oct	Oct	Oct	Oct	Oct	Nov	Nov	Nov	Nov	Dec	Dec	Dec	Dec	Jan	Jan	Jan	Jan	Jan	Feb	Feb	Feb	Feb
<b>Week Commencing</b>	<b>09-Sep</b>	<b>16-Sep</b>	<b>23-Sep</b>	<b>30-Sep</b>	<b>07-Oct</b>	<b>14-Oct</b>	<b>21-Oct</b>	<b>28-Oct</b>	<b>04-Nov</b>	<b>11-Nov</b>	<b>18-Nov</b>	<b>25-Nov</b>	<b>02-Dec</b>	<b>09-Dec</b>	<b>16-Dec</b>	<b>23-Dec</b>	<b>30-Dec</b>	<b>06-Jan</b>	<b>13-Jan</b>	<b>20-Jan</b>	<b>27-Jan</b>	<b>03-Feb</b>	<b>10-Feb</b>	<b>17-Feb</b>	<b>24-Feb</b>
<b>Capacity Beds Open:</b>																									
Ward 14	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28
Ward 4	10	10	10	10	10	10										16	16	16	16	16	16	16	16	16	16
Ward 12 (ASU)		9	9	9																					
<b>Total</b>	<b>38</b>	<b>47</b>	<b>47</b>	<b>47</b>	<b>38</b>	<b>38</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>28</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>44</b>	<b>28</b>
<b>Ward 14</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>31,706</b>	<b>30,424</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>
<b>Ward 4</b>	<b>6,879</b>	<b>6,879</b>	<b>6,879</b>	<b>6,879</b>	<b>6,879</b>	<b>6,879</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>28,194</b>	<b>27,411</b>	<b>26,628</b>	<b>26,628</b>	<b>26,628</b>	<b>26,628</b>	<b>26,628</b>	<b>26,628</b>	<b>26,628</b>	<b>0</b>
<b>Ward 12</b>	<b>0</b>	<b>27,545</b>	<b>27,545</b>	<b>27,545</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total</b>	<b>36,022</b>	<b>63,567</b>	<b>63,567</b>	<b>63,567</b>	<b>36,022</b>	<b>36,022</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>29,143</b>	<b>59,900</b>	<b>57,836</b>	<b>55,771</b>	<b>55,771</b>	<b>55,771</b>	<b>55,771</b>	<b>55,771</b>	<b>55,771</b>	<b>55,771</b>	<b>29,143</b>
<b>Estates</b>																									
<b>Soft FM</b>																									
Ward 14	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9	2997.9
Ward 4	1070.7	1070.7	1070.7	1070.7	1070.7	1070.7	0	0	0	0	0	0	0	0	0	1713.1	1713.1	1713.1	1713.1	1713.1	1713.1	1713.1	1713.1	1713.1	0
Ward 12 (ASU)	0	1070.7	1070.7	1070.7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>Provisions</b>																									
<b>Estates Total</b>	<b>4068.5</b>	<b>5139.2</b>	<b>5139.2</b>	<b>5139.2</b>	<b>4068.5</b>	<b>4068.5</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>2997.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>4710.9</b>	<b>2997.9</b>

The summary of these costs is as follows:

		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	Actual spend 18/19	Variance from Last Year	Notes
Inpatient Capacity to Service Increased Admissions	MLTC - Ward 14	90,229	143,714	116,972	119,535	144,996	116,972	0	732,417	690,000	42,417	28 Beds MFFD
<b>Subtotal Capacity for Increased Admissions</b>		<b>90,229</b>	<b>143,714</b>	<b>116,972</b>	<b>119,535</b>	<b>144,996</b>	<b>116,972</b>	<b>0</b>	<b>732,417</b>	<b>690,000</b>	<b>42,417</b>	
Inpatient Capacity to Service Winter Activity	MLTC - Ward 4	20,639	20,639	0	32,004	130,115	79,885	0	283,282	234,000	49,282	10 Beds Sep-Oct then 16 beds Dec-Feb (Inc. Gyn)
	MLTC - Ward 8	53,661	28,973	0	0	0	0	0	82,634		82,634	10 Beds
	Estates	14,347	19,272	11,991	13,704	23,555	17,131	0	100,000	128,000	-28,000	
<b>Subtotal</b>		<b>88,647</b>	<b>68,884</b>	<b>11,991</b>	<b>45,708</b>	<b>153,670</b>	<b>97,016</b>	<b>0</b>	<b>465,916</b>			
Festive Period	MLTC				52,516	55,535			108,051		108,051	
	WCCSS				15,939	15,439			31,378		31,378	
	Community				11,480	8,364			19,844		19,844	
<b>Subtotal</b>		<b>0</b>	<b>0</b>	<b>0</b>	<b>79,935</b>	<b>79,338</b>	<b>0</b>	<b>0</b>	<b>159,273</b>			
Additional Support Requested	MLTC			0	160,905	147,814	172,998	178,752	660,470	476,000	184,470	<a href="#">See tab</a>
	Surgery			20,118	27,882	27,882	19,414	0	95,295	78,000	17,295	SACU Open Overnight
	WCCSS			47,800	47,800	47,800	47,800	0	191,200	256,000	-64,800	<a href="#">See tab</a>
<b>Subtotal</b>		<b>0</b>	<b>0</b>	<b>67,918</b>	<b>236,587</b>	<b>223,495</b>	<b>240,212</b>	<b>178,752</b>	<b>946,965</b>			
<b>Subtotal Winter Interventions</b>		<b>88,647</b>	<b>68,884</b>	<b>79,909</b>	<b>362,230</b>	<b>456,503</b>	<b>337,228</b>	<b>178,752</b>	<b>1,572,154</b>	<b>1,172,000</b>	<b>400,154</b>	
<b>GRAND TOTAL</b>		<b>178,876</b>	<b>212,599</b>	<b>196,881</b>	<b>481,765</b>	<b>601,499</b>	<b>454,199</b>	<b>178,752</b>	<b>2,304,571</b>	<b>1,862,000</b>	<b>442,571</b>	

<b>Funding Available:</b>												
Winter Reserve												1,000,000
SAU Winter Capacity Funding												78,000
BCF Funding												14,571
<b>Less:</b>												
AT (winter planning) - assumed at full year, full cost - query whether this is shared?												-25,712
August Bank Holiday												-20,175
<b>Funding Available</b>												<b>1,046,684</b>
Winter Plan Deficit												-525,470
Cost to service additional admissions												-732,417
<b>Total budgetary cost pressure</b>												<b>-1,257,887</b>

## 5.1 Intermediate Care Pathways

Finally the planned interventions in the intermediate care pathway and the distribution of winter monies allocated through the Better Care Fund are set out here.

<b>Winter spend 2019</b>	<b>Budget Allocated</b>	<b>Start Date</b>	<b>End Date</b>	<b>Lead</b>
<b>Title of Scheme</b>				
Intermediate Care Service model winter demand - Re-ablement hours to support discharges	<b>£277,120</b>	01/11/2019	31/03/2020	<b>Kerrie Allward</b>
Intermediate Care Service model winter demand - Discharge to Assess beds/Discharge home to assess hours	<b>£867,682</b>	01/11/2019	31/03/2020	<b>Kerrie Allward</b>
Additional short term winter scheme – Additional Discharge Coordinator/ facilitator to support flow for social care MH cases	<b>£20,000</b>	01/10/2019	31/03/2020	<b>Natalie Borman</b>
Additional short term winter scheme – Funding to support deep cleans, furniture moves and associated expenses	<b>£1,400</b>	01/10/2019	31/03/2020	<b>Claire Hammonds</b>
Additional short term winter scheme – To implement PJ Paralysis challenge in the acute hospital through an MDT approach	<b>£50,000</b>	01/11/2019	31/03/2020	<b>Claire Hammonds</b>
Additional short term winter scheme – Block contract for community care packages	<b>£80,000</b>	01/10/2019	31/03/2020	<b>Carol Parkes</b>
Additional short term winter scheme – Re-ablement training to further develop 6 re-ablement providers	<b>£20,000</b>	01/10/2019	31/03/2020	<b>Carol Parkes</b>
Winter capacity support – Contingency/ 7 day working over Christmas and New Year Bank Holiday period	<b>£115,623</b>	01/12/2019	31/03/2020	<b>Matthew Dodd</b>
<b>TOTAL</b>	<b>£1,431,825</b>			

## 6.0 Risk Log

Whilst the authors and contributors to this plan are confident in its methodology and assumptions they also recognise that some of its actions assume an availability of additional staff resource, both nursing and clinical, the absolute volumes of which continue to be tested to their limit within the entire health economy both locally and nationally. Equally, whilst we have planned for, and mitigated against expected public health events such as influenza, c-difficile, norovirus et al we have not experienced a significant, major event in recent years. Finally there are specific events and or incidents which should not be planned for but do need to be recognised within the plan.

In accordance with best practice the Winter Plan, as presented, has an associated Risk Register which will be updated throughout the Winter and appended to this document electronically. It will be reviewed as part of the governance process and form part of the AAR framework. The current identified risks (as at 23/9/19) are as follows:

Risk Level	Number	Title	Description	Mitigation	Risk Score	Next Review
Corporate	1909	Management of Outbreaks	The Trust has have planned for and mitigated against expected public health events such as influenza, c-difficile, norovirus et al we have not experienced a significant, major event in recent years. Our expectations of the plain is that we can manage an expected level of outbreak consistent with the previous 3 years	Outbreak Procedure Escalation Policy Infection Control Committee	2	30/10/19
Corporate	1910	Staffing for delivery of the Winter Plan	Actions assume an availability of additional staff resource both nursing and medical. The absolute volumes of which continue to be tested to their limit within the entire health economy both locally and nationally.	Winter Plan 2019/20 Fully costed Winter Plan Rigorous overview and scrutiny at operational, tactical and strategic level	9	30/10/19

\*Exerts from the Safeguard Risk Register as at 30/09/19.

## 7.0 Measures of Success

Whilst the Winter Plan's overall priority is to ensure the building blocks are in place to deliver a safe and effective winter there are a number of statutory and operational metrics by which the Winter Plan must be judged. These will be:

- The Acute Trust will achieve 4hr performance in line with its committed trajectory agreed with NHS Improvement:

Forecast Out-tum		Y1 M01	Y1 M02	Y1 M03	Y1 M04	Y1 M05	Y1 M06	Y1 M07	Y1 M08	Y1 M09	Y1 M10	Y1 M11	Y1 M12	
31/03/2019		30/04/2019	31/05/2019	30/06/2019	31/07/2019	31/08/2019	30/09/2019	31/10/2019	30/11/2019	31/12/2019	31/01/2020	29/02/2020	31/03/2020	
March 2019		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	
Accident and Emergency		84.1%	85.0%	89.0%	87.0%	84.0%	85.0%	83.0%	92.0%	88.0%	84.0%	81.0%	84.0%	86.0%
Accident and Emergency - Performance % (92% standard)														

- The Trust will achieve 100% performance against the 12-hour decision to admit standard
- The number of incidents that directly relate to patient harm, as set out in the After Action Review of Winter 18/19, will reduce Year on Year
- The Trust will achieve a target of there being no serious incidents associated with the delivery of the Winter Plan.

## 8.0 Operational and Clinical principles & standards

8.1 This section sets out a series of key mandatory operational and clinical principles and standards, applicable to all areas, which will assist patient flow during the winter period whilst maintaining service quality and patient experience.

### 8.2 Emergency department

The Emergency Department should primarily be accessed for serious and life threatening conditions and therefore all patients will spend as little time as possible within the Emergency Department and in any event will not spend more than 4-hours waiting wherever possible.

- All patients will undergo triage within 15 minutes of attending ED.
- All patients in Emergency Department requiring assessment or admission will be 'pulled' into the appropriate short stay areas or speciality bed within the 4-hour waiting time.
- All patients will be assessed where required by an appropriate decision maker working to a service agreed care pathway.

8.3 All specialities will review all emergency patients daily – 7 days a week – and continue a multi professional Board and Ward round approach to be completed each morning based on clinical need.

8.4 The comprehensive Board Rounds (9am) will ensure early identification of definite and potential discharges ensuring communication to the Bed Bureau in a timely manner.



8.5 The Trust, in accordance with national best practice, which is recognised by the appropriate Royal Colleges, will embrace the principles of SAFER as a mechanism for optimising Patient Flow:

- Senior Review (**S**) – All patients will have a senior review before midday.
- All patients (**A**) – Will have expected discharge date and clinical criteria for discharge.
- Flow (**F**) – Commencing at the earliest opportunity, first patients by 10am.
- Early discharge (**E**) – 33% of patients discharged before midday.
- Review (**R**) – Multi-disciplinary team reviews of patients with extended length of stay.

8.6 The afternoon Board Rounds will focus the identification of definite discharges for the following morning with patients moving by 10am.

8.7 Re-ablement will be offered where appropriate to allow considered decisions about long-term care.

8.8 All appropriate patients will be discharged via the Discharge Lounge 5 days per week. These patients will be, wherever clinically appropriate, moved to discharge lounge between 10am and 2pm. Wherever possible a 'golden patient' will be identified daily, in advance by each ward with the aim being to move this patient to the discharge lounge no later than 10 am the following day

8.9 Specialities will provide appropriate in-reach to admission areas to:

- a. Provide specialist support in inpatient management
- b. Ensure appropriate patients are identified and rapidly moved to speciality wards
- c. Discharge/early supported discharge is expedited by specialist opinion/community management

## **9.0 Operational model for opening and closing capacity**

Although a significant amount of work has been undertaken to mitigate bed demand the forecast still shows that we will experience times of pressure during the winter months that will require us to open additional capacity. Equally our modelling predicts times when we can reasonably de-escalate these capacity areas as demand reduces. The opening of additional capacity areas carries significant financial, operational and clinical risk so it is critical to the success of the winter plan that, at the point a capacity area needs to be opened it is done in as effective and safe way as possible. Equally de-escalating capacity areas quickly mitigates risk across the whole hospital which might otherwise remain if the capacity areas remain open, staffed but underutilised.

A fundamental and guiding principle of the operational approach to managing demand is that it is far safer, in the face of variable demand which will most likely continue to outstrip the bed base on multiple weeks over a longer period, to open a capacity area and staff it with a significant and relatively substantive staff group. On this basis the plan has called for an extended period of 9 weeks where we open a capacity area even though forecast demand does not necessarily consistently require it.

Furthermore whilst we expect this capacity to be required the exact opening, and subsequent closing date are subject to ongoing review based on demand.

Opening additional planned capacity, will only be undertaken with prior approval of the Chief Operating Officer and/or Director On-Call.

Care must be taken to ensure all patients meet appropriate criteria for admittance to additional capacity areas and consideration given to the maintenance of good care provision

The need to open capacity areas will be kept under constant review in terms of capacity and demand. Opening of additional capacity beds will not be taken as a last minute decision, but reviewed formally by capacity team and site manager throughout the day and night. The Divisional Director for MLTC or Surgery will approve the plan to open such areas following agreement with senior medical, nursing & managerial colleagues.

**Considerations when opening additional capacity:**

- i. Not just the current but the following 3 days requirement for the space
- ii. The number of beds required and available
- iii. The suitability of patients
  - 1. IVs, CDs
  - 2. Planned discharge for the following day is preferred to acutely ill patients
- ii. Nurse staffing
- iii. Medical cover (how will each patient be seen)
- iv. Equipment, medical gases

All such decisions must include senior nursing and managerial contribution.

**Additional beds on wards:**

The full hospital protocol (June 2016) provides for an additional bed to be placed on wards in situations where the Trust would otherwise be at Level 4 escalation. Wards suitable to accept an additional patient will be agreed with the relevant Divisional Director of Nursing based on safe staffing and environmental considerations.

N.B. The way in which capacity areas were opened last year was a major cause of concern (see AAR document in appendix). This being the case it will now be mandatory practice to implement and fully record the opening extra capacity checklist as recommended by the After Action Review.

For clarity and to remove any ambiguity the checklist is detailed in the appendix.

## **10.0 Operational, Clinical and financial governance arrangements**

10.1 Three governance levels exist that ensure our clinical operating principles and standards are maintained, and quality as well as patient safety standards are not compromised throughout the winter period. The three levels are Strategic, Tactical and Operational. Each of these levels is well established and embedded within the arrangements of the Trust.

### **10.2 Operational Governance**

In addition to the 3 x daily bed meetings and Friday 'Weekend Cabinet' Meeting the Weekly Operational Group (chaired by the Chief Operating Officer) will review the prior week's adherence to plan. The Weekly Operational Group will be every Wednesday and the discussion will be informed by the Week by Week Report. This process ensures that the Trust will adhere to the principles of PDSA methodology and the Trust becomes an organisation with a memory. The meeting will highlight any required adjustments to the plan based on information and insight from the following pro forma:

## Winter by Week Report for Week Ending

Review of Previous Week										Next Week Forecast									
4hr performance		Mon	Tues	Wed	Thu	Fri	Sat	Sun	Totals	4hr performance		Mon	Tues	Wed	Thu	Fri	Sat	Sun	Total
Attendances	Forecast	242	230	220	225	228	198	203	1546	Attendances									
	Actual								0	Med Admissions	Forecast	238	228	225	224	225	198	199	1538
	Variance	242	230	220	225	228	198	203	1546	Ambulances	109	102	108	104	104	96	101		
	Cummulative	242	471	691	916	1144	1343	1546	1546	Bed Base	352	352	352	352	352	352	352		
Ambulances	Forecast	109	99	104	100	102	95	97	#REF!	Staffing	RAG								
	Actual								0	Elective Activity	Y/N								
	Variance	109	99	104	100	102	95	97	706	Leadership	TOT in Work	AT/KR/							
	Cummulative	109	208	312	412	514	609	706	706		Beds Med								
Forecast								0	Beds Sur										
Actual								0	Man. On Call		AT/KR/								
Discharges	Variance	0	0	0	0	0	0	0	0	Exec on Call									
	Cummulative	0	0	0	0	0	0	0	0	RAG									
	Forecast								706	Risk									
	Actual								0	Mitigation									
Ambulances	Variance	109	99	104	100	102	95	97	706	Owner									
	Cummulative	109	208	312	412	514	609	706	706	Due									
	Forecast								706	Complete									
	Actual								0										
Bed Base	Predicted	384	384	384	384	384	384	384	321	Issue									
	Actual								#DIV/0!	Mitigation									
Escalation Level																			
Inf Control	Beds Closed									Issue									
	Beds re-opened									Mitigation									
ICS Discharges	Planned									Owner									
	Actual									Due									
ICS Narrative										Complete									
Elective Admissions	Planned									MLT C TOT narrative									
	Actual																		
Trauma & Emergency Admissions	Planned									Exec Feedback									
	Actual																		
Surgery Narrative																			

### Tactical Review

Delivery of the winter plan will be a standing agenda item on the Trust Management Board agenda which is held bi-weekly

The Board will receive updates on:

- i. Proposed plans for Winter
- ii. Monitoring the monthly feedback on progress against the plan
- iii. Risk mitigations to be put in place
- iv. Overall performance against the standards and criteria identified with the plan

### Strategic Review

In line with reporting of the constitutional standards the winter plan will be strategically reviewed at Performance, Finance & Investment Committee. The operational and tactical reviews generated above will drive the narrative that supports the document but the winter plan will not be reported separately to avoid duplication of existing Performance, Finance & Investment Committee reports.

The focus of discussion at each of the above meeting will be the development of actions and plans to recover the expected trajectory and Trust position if required.

## 11.0 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 SITREPs 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.

## 10.0 Appendix

### **After Action Review 2018/2019 (Winter)**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/winter-18-19-review-trust-board-v2-aar.pptx>

### **Bed demand model including workstream benefit assumptions**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/bed-demand-model-including-workstream-benefit-assumptions.docx>

### **Costings**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/winter-plan-costings-v9.xlsx>

### **Walsall A&E Delivery Board Improvement Plan**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/walsall-urgent-and-emergency-care-improvement-plan---september-2019.docx>

### **ICS – September 2019**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/enc-6c-ae-delivery-board-ics-update-september-2019-v2.pptx>

### **LOS – September 2019**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/enc-6b.2-reducing-los-slide-04.09.19.pptx>

### **Medicine – September 2019**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/enc-6b.1-ae-delivery-board-medicine-revised-slides-03-09-19.pptx>

### **Attendance Avoidance – September 2019**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/enc-6a,-aa-work-stream-update-ae-delivery-op-gp-sept-2019.pptx>

### **Escalation policy – (2018)**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/escalation-policy-as-at-021118-inc-raci-and-flow.docx>

### **Major Incident Plan (May 2019)**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/110059-major-incident-plan-june-2019.pdf>

### **Tactical & Strategic Commander - business continuity arrangements**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/tactical-commander-pack-v1-as-at-030918-3.docx>

### **Severe Weather Plan**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/severe-weather-plan---assumptions-and-expectations.docx>

### **Opening extra capacity checklist**

<http://themanor.xwalsall.nhs.uk/Data/Sites/1/userfiles/858/final-extra-capacity-checklist-mar-18.docx>

### **Outbreak Procedure**

<http://themanor.xwalsall.nhs.uk/SharedFiles/Download.aspx?pageid=2030&fileid=9054&mid=4041>

<b>MEETING OF THE PUBLIC TRUST BOARD 3<sup>rd</sup> OCTOBER 2019</b>			
UPDATE ON TRUST HR AND OD WORKSTREAM – VALUING COLLEAGUES IMPROVEMENT PROGRAMME			<b>AGENDA ITEM: 9</b>
<b>Report Author and Job Title:</b>	Catherine Griffiths – Director of People and Culture	<b>Responsible Director:</b>	Catherine Griffiths – Director of People and Culture
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>The purpose of this report is to provide members of the Trust Board with an update on the Trust’s HR and OD work-stream. This work is part of the implementation plan for Valuing Colleagues within the Trust Improvement Programme which aims to achieve a CQC outstanding rating for the Trust by 2022.</p> <p>Improving staff experience and staff engagement will improve advocacy rates for the Trust and thereby the reputation of the Trust by increasing the number of staff who recommend the Trust as a place to work and a place to be treated. There are well evidenced links between staff experience and patient experience and outcomes, and the HR and OD work-stream aims to improve both measures with its focus on valuing colleagues.</p> <p>The HR and OD Work-stream covers a number of delivery elements as the foundation for achieving year on year improvement in the staff engagement indicator within the National Staff Survey. The current engagement score for the Trust is 6.7 against an average engagement score of 7.0 and a best engagement score of 7.4 nationally for Trusts similar to this Trust. In addition, the percentage of staff recommending the Trust for a place to be treated stands at 53% (compared with an all England score of 81%). The percentage of staff recommending the Trust as a place to work stands at 49% (compared with an all England score of 66%). The delivery elements of the HR and OD work-stream are as follows:</p> <ol style="list-style-type: none"> <li>1. Values and Behavioural Framework – The extent to which these are integrated within the Trust and integrated into all people management practices. This report contains an update.</li> <li>2. Trust Board Pledge – this report contains an update on the work taking place to improve the equality,</li> </ol>		

diversity and inclusion outcomes as expressed within the Board Pledge and Trust equality objectives.

3. Staff Voice and Temperature Check - The Trust as a place to work and a place to be treated. This report contains an update on the first Trust Pulse Survey completed in the Summer and provides a summary of the results and provides themes for improvement.
4. Retention – this report provides information on the Trust’s progress on plans to improve retention as part of NHSI’s cohort 5 – Direct Intervention on Retention programme.
5. Leadership and Management Development – this report provides an update on the NHS Leadership Academy Diagnostic on capacity and capability and provides an update on next steps.
6. Just Culture – This report provides an update on the work planned on developing a Just Culture and ensuring the Quality Improvement methodology becomes the ‘way we do things here’ so the Trust becomes a learning organisation.
7. Talent Management, Career Development and Succession Planning – This report provides an update on the milestones for a focused approach to performance and appraisal.
8. Communication and Engagement – this report provides a brief update on emerging work aimed at raising The Trust’s profile and brand as an employer. It provides an update on plans to bring together a single Organisation Development and Leadership Plan and plans to ensure the internal engagement plan involves staff and provides feedback. “you said, we did”
9. Health and Wellbeing – this report provides a brief update on the approach to promoting physical health, mental health, spiritual health, financial health and family life.

<p><b>Recommendation</b></p>	<p>Members of the Trust Board are asked to:</p> <ol style="list-style-type: none"> <li>1. Note the report and progress made and note the work of this element of the improvement programme will be contained within an Organisation Development Action plan, the delivery of which will be monitored at PODC each quarter and at Trust Board bi-annually.</li> <li>2. Note and approve the planned elements of work in support of the Improvement programme for Valuing Colleagues.</li> <li>3. Note the Trust target to match best national performance by 2022 :</li> </ol> <p>Staff engagement to match best in class target score 7.4, Improved Friends and Family Scores that reach the all England average – [recommendation as a place to work and recommendation as a place to be treated]</p>
<p><b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b></p>	<p>The work programme described within this report will provide positive assurance to the committee on the following BAF risks:</p> <p><i>Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.</i></p> <p><i>National staff shortages amongst a number of professions impacts on the Trust's ability to provide safe and high quality care, and impacts on the morale and robustness of the Trust's current workforce.</i></p>
<p><b>Resource implications</b></p>	<p>There are currently no cost implications associated with following this programme of work, all resource will be re-aligned through existing budgets.</p> <p>There are no savings associated with improved people metrics the targets above will result in lower turnover and improved retention and consequently reduction in temporary and agency workforce; however it is too early to quantify these, consideration will be given within the operational plan 2019-2020.</p>



<b>Legal and Equality and Diversity implications</b>	The OD Action Plan is not complete therefore it is not sufficient to determine and evidence any equality and diversity impacts currently. This is being addressed through completing an equality impact assessment on all elements of the programme and all data supporting it. Any implications evidenced will be reported within the quarterly progress report to People and OD Committee and escalated to Trust Board through the PODC highlight report.	
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>
	Partners <input type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input type="checkbox"/>	

**Valuing Colleagues Improvement Programme – HR and OD Workstream****1. PURPOSE OF REPORT**

The purpose of this report is to provide members of the Trust Board with an update on the Trust's HR and OD work-stream. This work is part of the implementation plan for Valuing Colleagues within the Trust Improvement Programme which aims to achieve a CQC outstanding rating for the Trust by 2022. The Trust Board is asked to note the Organisation Development interventions planned and provide approval to the trajectory for improvement identified, which are to reach the Trust target for a staff engagement score of 7.4 which matches best performance nationally, and to achieve this by 2022. The Committee are asked to note that an Equality Impact Assessment will be required on Organisation Development Action Plan.

**2. BACKGROUND**

Improving staff experience and increasing the number of staff who will recommend the Trust as a place to work supports the Trust's aim of becoming an employer of choice as a major employer within Walsall community. This programme supports achievement of the Trust's equality and inclusion objectives over the life of the Equality, Diversity and Inclusion Strategic Framework, with the benefit of improving patient experience and outcomes through having inclusive employment policies and an employment framework that improves staff engagement levels and staff morale. The Trust approach to staff wellbeing complements these aims to ensure the Trust attracts, develops and retains its workforce.

The HR and Organisation Development work-stream covers a number of delivery elements as the foundation for achieving improvements in the staff engagement score for the Trust and to improving the staff recommendation of the Trust as a place to work and a place to be treated. The Trust is currently below the national average for similar Trusts on its staff engagement score and below the national average for staff recommending the Trust as a place to work and a place to be treated. This report proposes setting a target to exceed the national average for the Friends and Family Test and to match best performance for staff engagement score and metrics by 2022.

### 3. PROGRESS UPDATE ON HR AND OD

The HR and OD delivery elements and progress update are as follows:

1. The Trust Values and Behavioural Framework and evaluation of how this work has embedded within the Trust over the last two years. The original focus groups on values took place in 2017 resulting in a significant programme of staff engagement. An evaluation of how well embedded the Trust values are now took place through a series of staff engagement workshops during Summer 2019 and the People and Organisation Development Committee reviewed and considered these results during their September meeting. In addition, a dedicated Board Development session has been scheduled for October 2019. The themes and priorities coming from this qualitative and detailed work is being considered with other qualitative and quantitative data available and will be drawn together in an Organisation Development Action Plan that supports the improvement culture within the Trust with the aim of being rated an outstanding provider by 2022.
2. Staff Voice and the Trust Pulse Survey takes a temperature check on staff morale and staff experience within the Trust in between the results of the annual National Staff Survey. This report contains an update on the first Trust Pulse Survey completed during summer 2019 and the People and Organisation Development Committee reviewed and considered these results during their September meeting. In addition, a dedicated Board Development session has been scheduled for October 2019. The themes and priorities coming from this qualitative and detailed work are being considered with other qualitative and quantitative data available. This will be drawn together in an Organisation Development Action Plan that supports the improvement culture within the Trust with the aim of being rated an outstanding provider by 2022.
3. Leadership and Management Development – The NHS Leadership Academy diagnostic questionnaire took the form of a detailed discussion over 90 minutes with the 100 most senior leaders within the Trust as a temperature check on culture, behaviour, challenges, leadership morale and leadership development needs. The interviews were completed over the summer period and a summary report is complete and is scheduled for discussion at the People and Organisation Development Committee in October. The Executive Team discussed the report and themes in September 2019 and further discussion is scheduled with the Leadership Academy to form the Leadership and Management Development Strategy within the Trust.

4. The Trust Board Pledge – contains the Trust approach to achieving and developing an inclusive culture where staff are confident to speak up and can work within a Trust with zero tolerance to bullying and violence. The People and OD Committee reviewed the draft Annual Equalities Report and the objectives and outcomes contained within the Equality, Diversity and Inclusion Strategy, this will be finalised for wider input and community consultation before publication on the Trust website. The Freedom to Speak up Guardians present a quarterly report to People and Organisation Development Committee, bi-annual reports to Trust Board and will now present information and themes from the concerns being raised through the Trust Accountability Framework and monthly Performance Review meetings to ensure the divisions are fully involved in developing the approach to speaking up. The Trust Equality, Diversity and Inclusion Group extended its membership and a ‘Walsall for All’ partnership officer is helping the Trust to build more effective links out to the community. The group recently recommended the adoption of the NHS Rainbow Badges which aims to give a positive message of inclusion and means staff members can make a pledge to be someone who is a friendly ear for LGBT+ people; this was supported and ratified at People and OD Committee. There is a communication plan including events in place for Black History month and for FTSU month the plans were supported and ratified at the People and OD Committee. The EDI Group are working on establishing self-managed staff networks which will be part of an Inclusion Network reporting to EDIG, a request for support with a small budget for rooms and refreshments for meeting out of hours has been agreed and put in place. There has been significant work completed over the summer period on establishing the ‘red’ card system for any patients who are verbally or physically abusive to staff and legal processes are being followed. A dedicated Board Development session is being planned for January 2020 on achieving the Trust Board Pledge; an appointment has been made to the Talent, Resourcing and Inclusion Lead officer who will join the Trust in December 2019 to provide further focus and leadership capacity.

5. Valuing Colleagues Retention – NHSI launched a national programme in 2016 to support Trusts with staff retention challenges [NHSI Direct Support Retention Programme]. The first four cohorts were consisted of outliers in terms of performance on agency use, retention and turnover. Walsall Healthcare NHS Trust has been selected as a partner for Cohort 5, which has been identified as a group of Trusts who are currently at the well performing end of the performance spectrum on the criterion above. Despite this national benchmark however, the Trust is not meeting the current internal targets for retention. The national retention partners programme is an intervention over 4 months and will complement the work commissioned by the People and OD committee to provide assurance to Trust Board that the BAF risk of high reliance on temporary workforce are being mitigated and exit data identifies any themes of concern.

NHSI Direct Support Retention Programme involves:

The baseline report for the Trust is attached at Appendix One for further information, this focuses mainly on nursing and midwifery data currently.

Exit Monitoring Intelligence and Capturing Intention to Leave.

The People and Organisation Development Committee commissioned work on Exit monitoring during its July meeting for report back in December. This work is focused on process improvement. The key features are as follows:

- ✓ The introduction of 'Stay Conversations' that aim to identify intention to leave and seeks to identify reasons and whether these can be addressed to retain staff.
- ✓ The introduction of an enhanced Exit Questionnaire which encourages a more qualitative response and identifies changes required to improve staff experience of working within the Trust.
- ✓ The introduction of electronic resignation process which allows for an earlier indication of intention to leave and triggers an electronic exit questionnaire and the ability to book a face to face exit interview before leaving, this will be launched in December 2019.

### Recent Leavers and 'Share your Story'

The People and Organisation Development Committee commissioned work on Exit monitoring during its July meeting for report back in December. This work is focused on staff engagement and understanding the 'real' reasons people leave, the human stories behind the statistical data. The work is scheduled for October and November ready for reporting in December 2019 The key features are as follows:

- ✓ An analysis of data over the last 12 months to identify leavers and any trends and patterns evident including an equality impact assessment on leaver data.
  - ✓ A letter out to all leavers (following due diligence checks) to establish contact and identify any staff who might want to return.
- 
6. Just Culture – The work on developing a framework of employee relations policy, training and guidance to support a 'Just organisational culture' has started. Staff side are working in partnership with the Trust in order to ensure the approach is one where staff are supported and developed at work. The approach will be co-produced with multi-disciplinary operational teams, a focus on improvement and ensuring the Quality Improvement methodology becomes the 'way we do things here' so the Trust becomes an organisation that learns through human factors and appreciative inquiry.
  7. Talent Management, Career Development and Succession Planning – the milestones for a focused approach to performance and quality appraisal based will be launched at the Leadership Conference in October 2019.
  8. Communication and Engagement – there is an emerging approach to raising the Trust's profile and brand as an employer and ensuring the approach to widening participation is integral. An internal communications and engagement plan involves staff and provides feedback on actions taken "you said, we did"

9. Health and Wellbeing – the approach to caring for our staff is developing and the Health and Wellbeing steering group members will report to People and OD Committee in November on improvements made and outcomes identified, the action plan for Health and Wellbeing covers the following domains:

- ✓ Physical Health
- ✓ Mental Health
- ✓ Spiritual Health
- ✓ Financial Health
- ✓ Family Life

#### 4. RECOMMENDATIONS

Members of the Trust Board are asked to:

1. Note the report
2. Approve the planned work-streams and HR and OD actions in support of the Improvement programme.
3. Note the Trust target for staff engagement and Friends and Family Test and note the trajectory for achieving target.
4. Agree to receive updates bi-annually in October and April.

#### APPENDICES

One - Retention Direct Support Programme Data Pack Walsall Healthcare NHS Trust

# Retention Direct Support Programme Data Pack

**Walsall Healthcare NHS Trust**

NHS England and NHS Improvement





## Introduction

**Purpose:** This data pack provides your turnover position, reasons for leaving data and age profile of your staff. This pack provides comparative data between trusts within your region/sector, as well as comparisons with trusts in your cohort of the programme and those in your STP.

We acknowledge that many trusts use other platforms for exploring reasons for leaving in more detail. This pack is designed to be a helpful supplementary resource to add to your trust's current information sources.

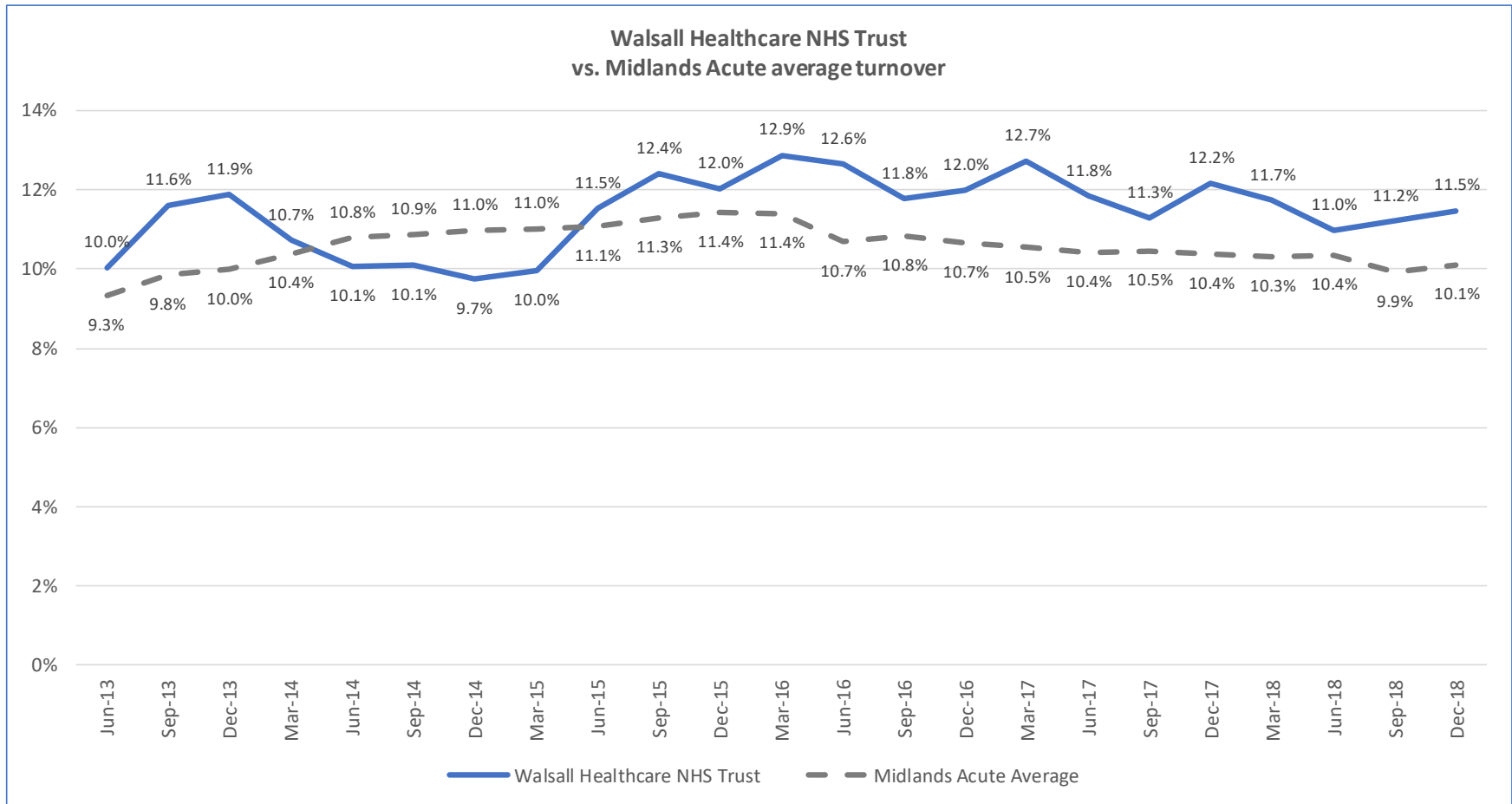
This pack, unless otherwise stated, shows data on registered nursing staff.

Below details some useful information in respect of the data available in the pack:

- Trust turnover trend with peer comparisons
  - Regional/Sector group turnover comparison – an acute trust in the North will be compared against acute trusts in the North
- The turnover metric tracks staff in post at a point in time and assesses whether those individuals are still employed by the trust 12 months later. It includes all staff that leave your organisation - it will not include inter-organisational transfers/promotions.
- We update the 12 month rolling average data once a quarter.
- The turnover metric excludes any leavers with “reason for leaving” category as “employee transfer”. This should cover TUPE, however is naturally dependent on the trust coding accordingly.
- The data uses information from trust's Electronic Staff Records.

## Trust turnover trend with region/sector comparison

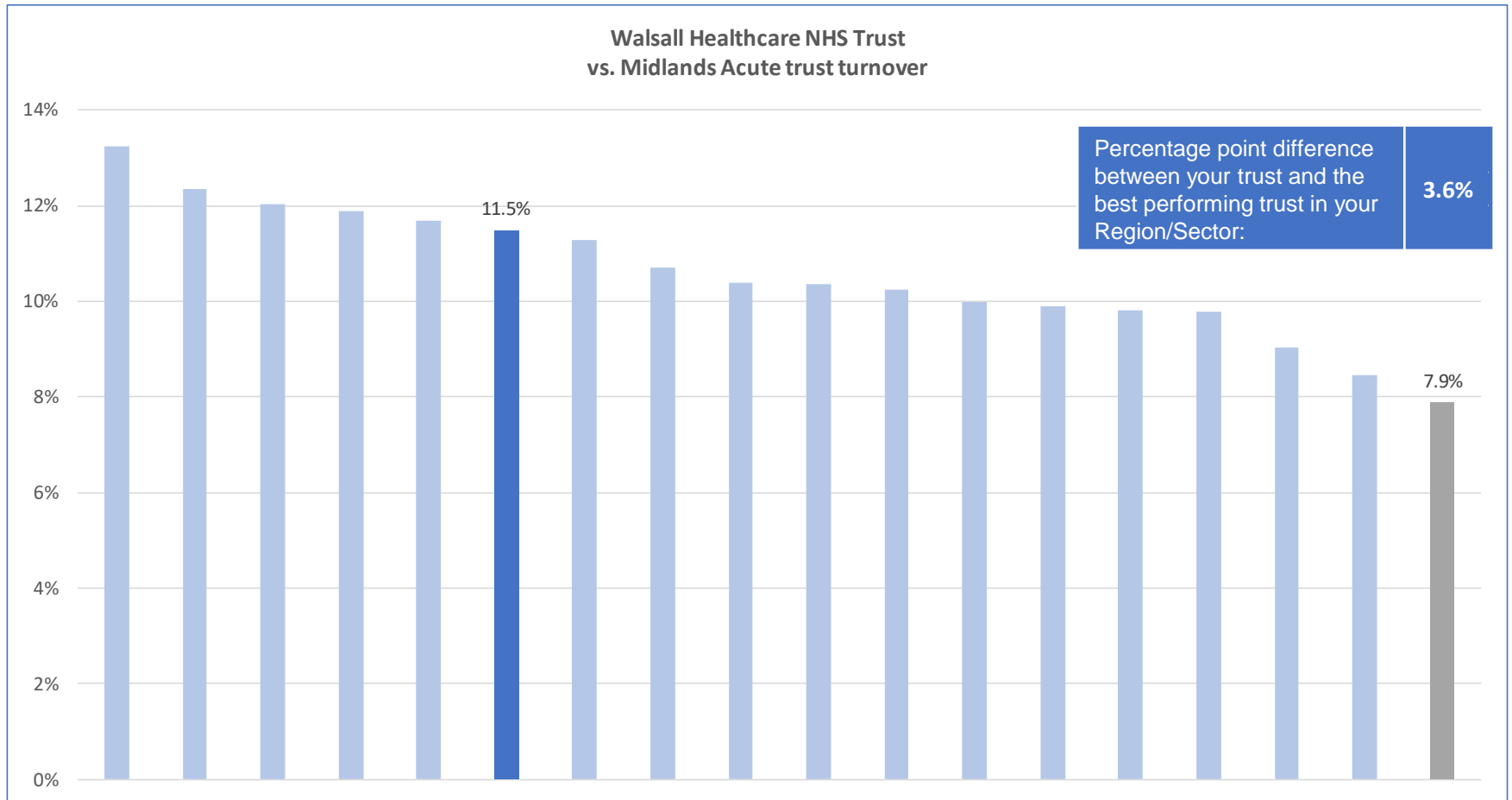
This chart tracks your turnover over time and allows you to compare against other trusts in your region and sector.



The chart details quarterly turnover rate for Registered Nurses and Midwifery staff at your trust and your region/sector average.

## Trust turnover comparison with region/sector trusts – latest position

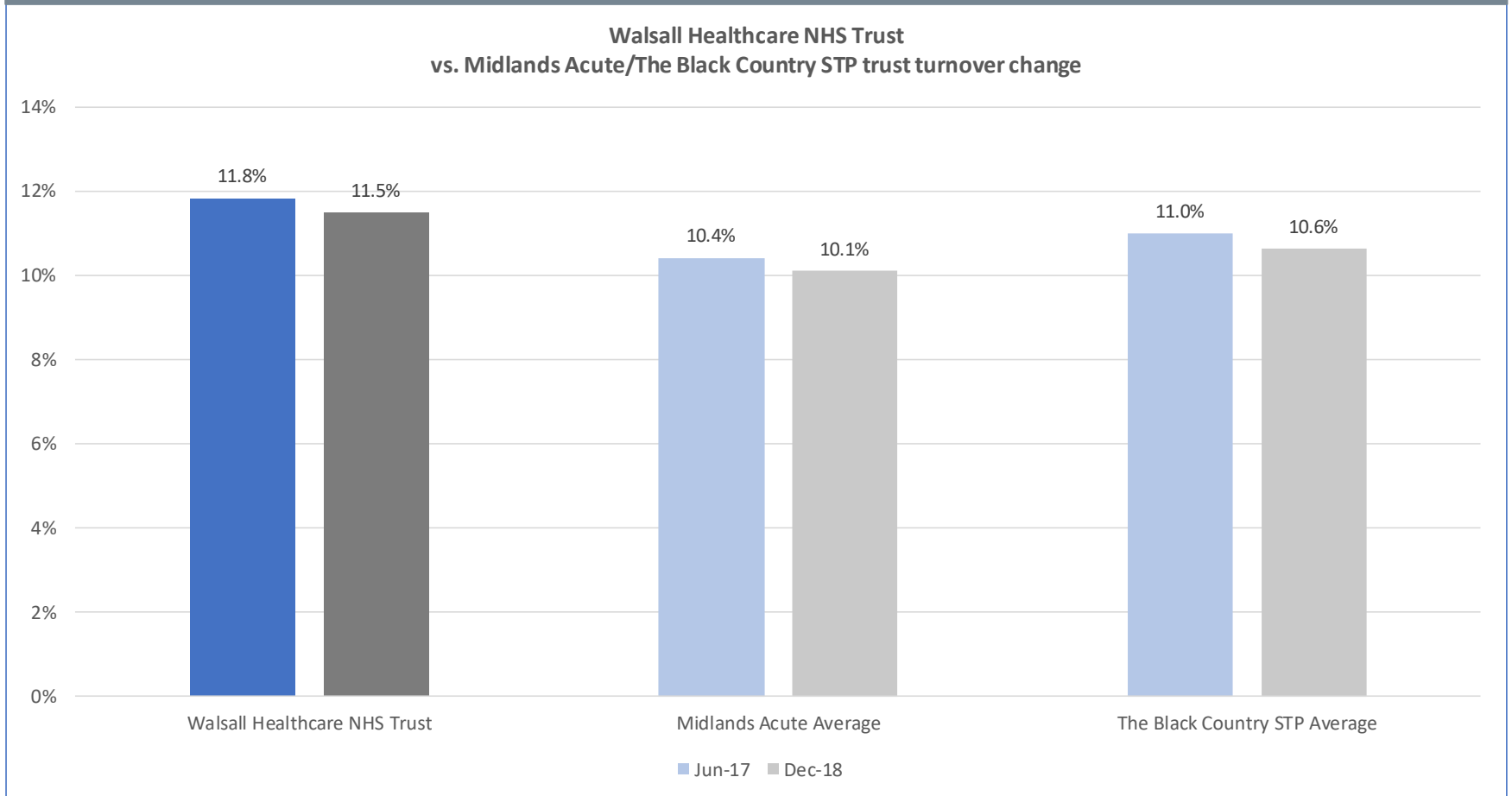
This chart enables you to see your relative position on turnover vs. other trusts in your region/sector.



The chart illustrates your trust turnover for Registered Nurses and Midwifery staff in December 2018, compared to trusts in your region/sector. Trusts are ranked in order from highest to lowest turnover rates in December 2018. Your trust is highlighted in a darker blue; the trust with the lowest turnover in your region/sector is highlighted in grey.

## Trust turnover % point change comparison with region/sector and STP

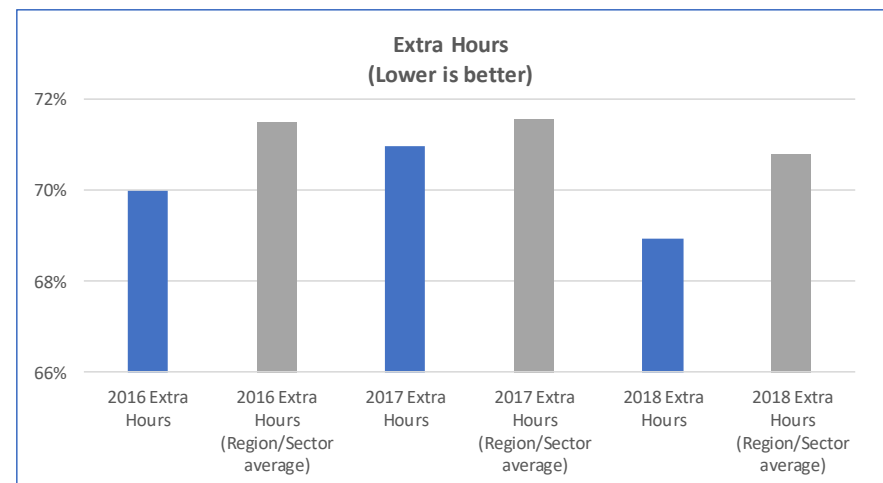
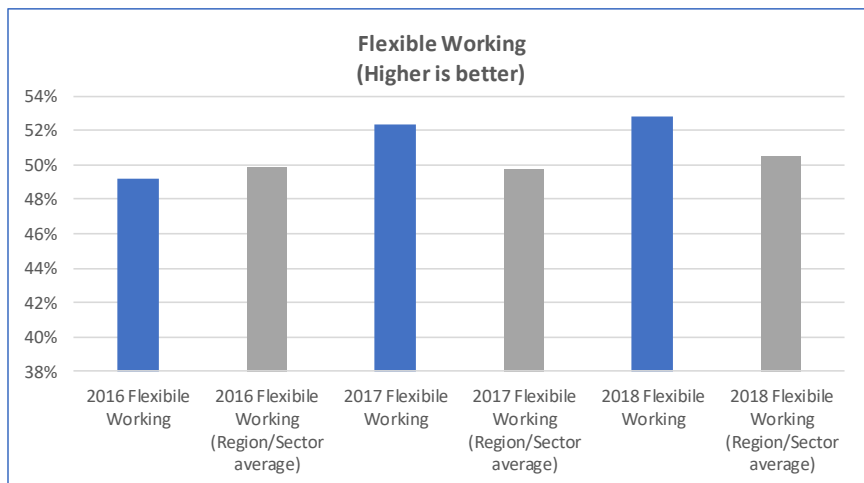
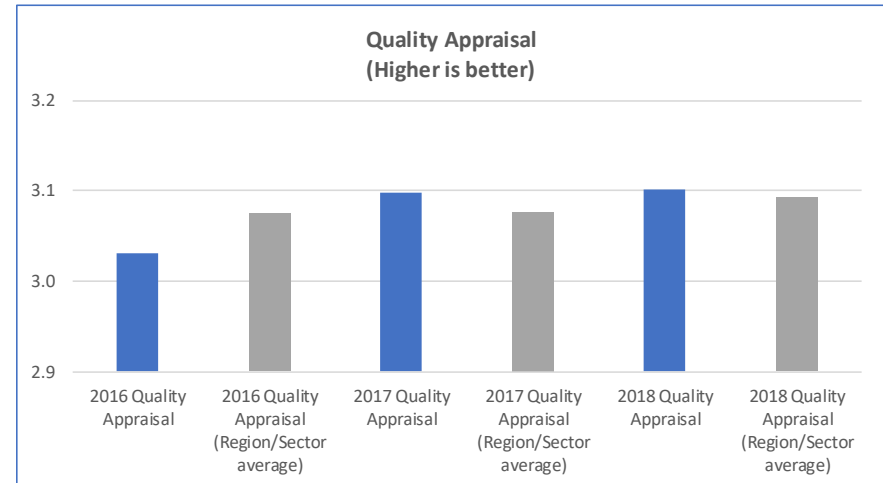
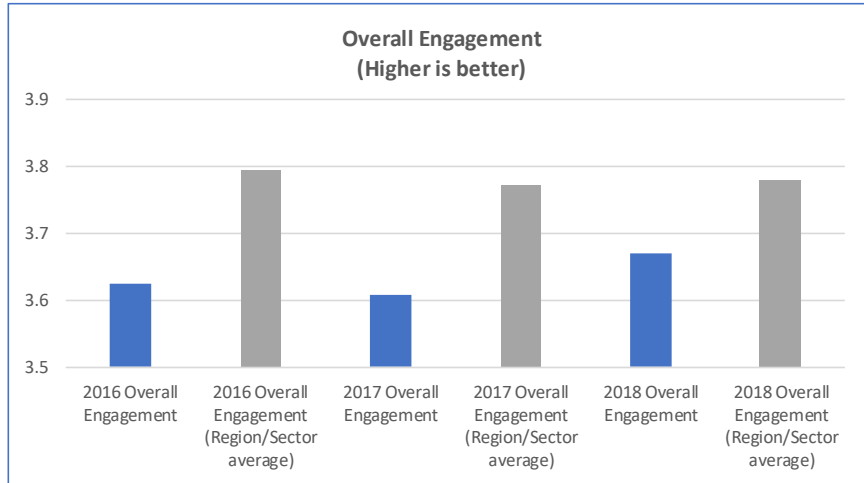
This chart shows how your turnover has changed since the start of the programme (June 2017) and how this compares with your STP and region/sector.



The chart illustrates changes in your trust turnover for Registered Nurses and Midwifery staff compared to aggregated figures for trusts in your region/sector and your primary STP. Your trust is highlighted in a darker shade.

## Staff experience and engagement – All staff

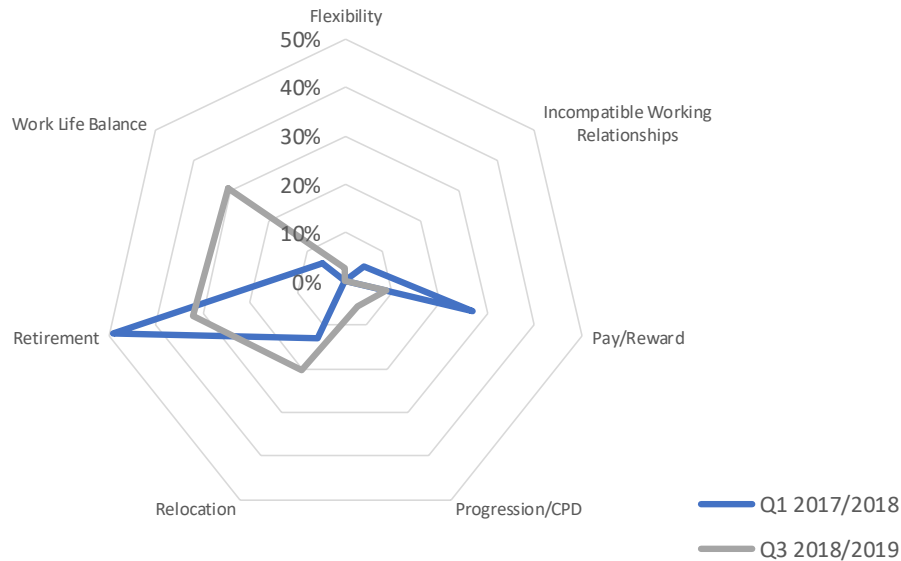
These charts show how key retention-related staff survey findings compare with your region/sector. Data compares results from the 2016, 2017 and 2018 staff survey.



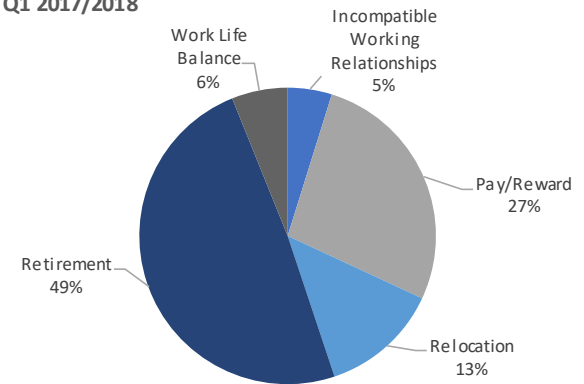
The charts illustrate staff survey findings from 2016-2018 for all staff in your trust vs. region/sector averages. The charts show: overall engagement, flexible working, working extra hours and whether staff deem their appraisal to be a quality appraisal. The factors link to key drivers of retention.

## Changes in leaver reasons

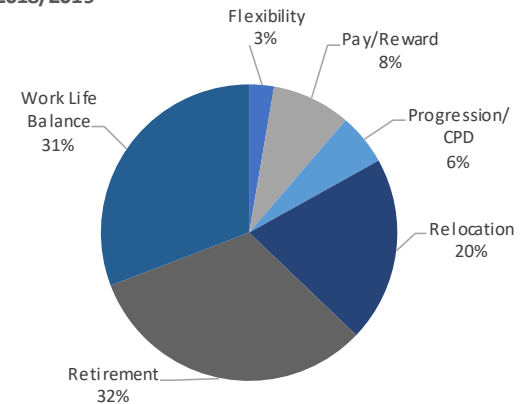
These charts show ESR reasons for leaving have changed since the start of the programme. This will hopefully be helpful in assessing the impact of your initiatives and evaluating your plans.



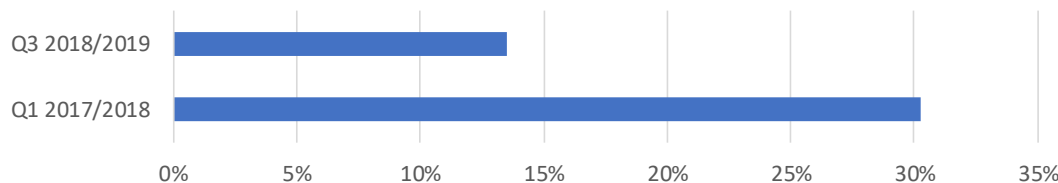
Q1 2017/2018



Q3 2018/2019



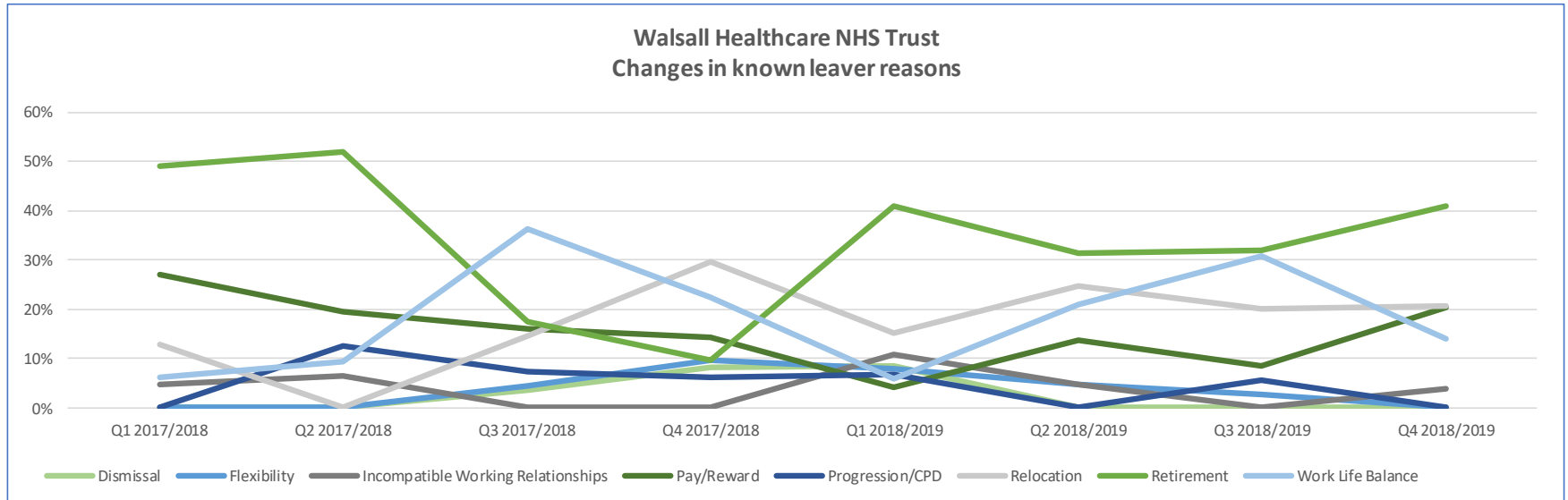
Unknown leaver reasons



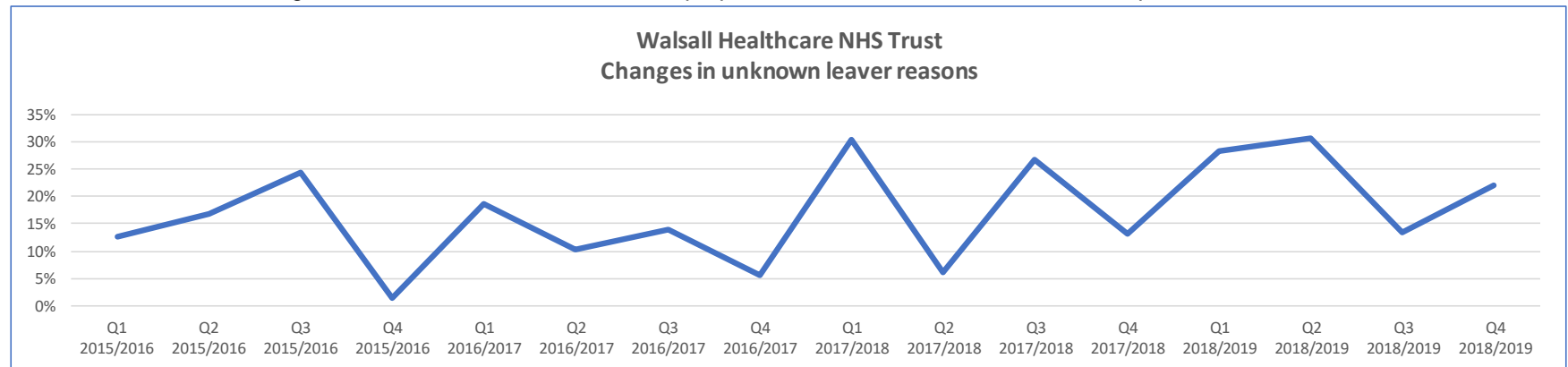
The charts detail shifts in reasons for leaving your trust amongst Registered Nurses and Midwifery staff between Q1 2017/2018 and Q3 2018/2019 (these do not include “Unknown” as a reason for leaving). The Unknown Leaver Reason chart details the proportion of voluntary leavers recorded as “Unknown” in Q1 2017/2018 and Q3 2018/2019.

## Changes in leaver reasons

These charts show ESR reasons for leaving have changed over time.



The chart details the changes in leaver reasons over time, as a proportion of known leaver reasons, from April 2017 to March 2019.

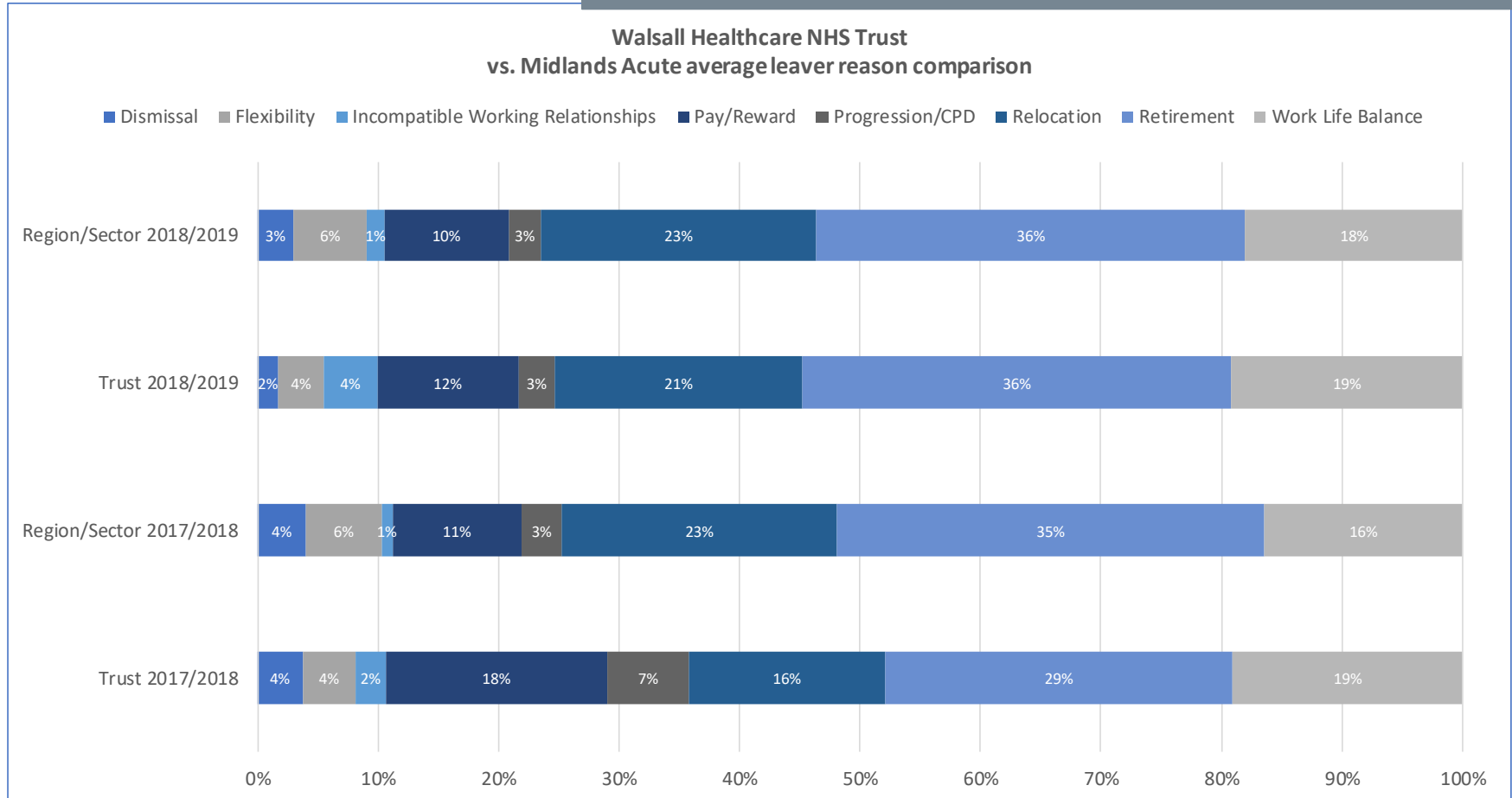


The chart details the changes in unknown leaver reasons over time, as a proportion of known and unknown leaver reasons, from April 2015 to March 2019.

# Trust reasons for leaving profile comparison with region/sector average

## reason for leaving profile (WTE)

This chart shows how the reasons for leaving vary compared to other trusts in your region/sector. It might be helpful when thinking about which initiatives to prioritise.



The chart details the leaver reasons profile of Registered Nurses and Midwifery staff leaving your trust compared to the region/sector leaver reasons profile in 2017/2018 and 2018/2019.



## Trust vs. national leaver reasons against age profile

This chart shows how reasons for leaving vary by age group. As an example, 21.8% of Registered Nursing and Midwifery staff aged 50-54 leave your trust for Relocation vs. 16.1% nationally. Where your colour varies from the national picture then this may be worth exploring.

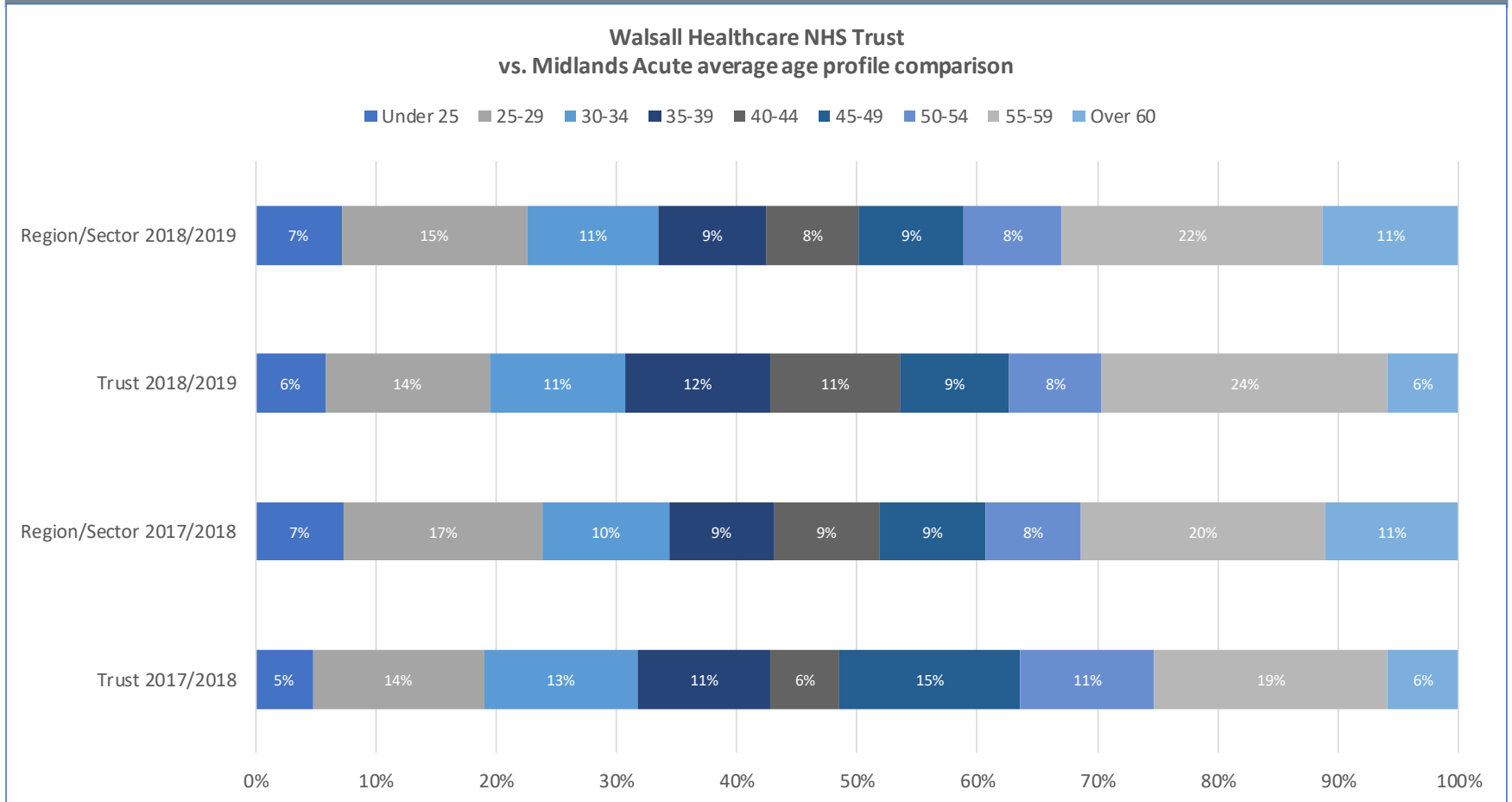


		Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	Over 60	Grand Total
Retirement	Trust	0.0%	0.0%	5.9%	3.4%	0.0%	0.0%	0.0%	79.0%	94.4%	27.1%
	National	0.0%	0.0%	0.1%	0.2%	0.4%	1.1%	9.2%	74.8%	80.4%	21.9%
Unknown	Trust	33.6%	28.4%	16.7%	29.2%	44.6%	50.7%	16.8%	10.0%	5.6%	23.9%
	National	26.2%	22.2%	22.1%	23.1%	26.5%	26.4%	23.8%	7.6%	7.1%	19.4%
Relocation	Trust	55.2%	36.3%	18.2%	7.9%	4.0%	22.2%	21.8%	2.5%	0.0%	15.6%
	National	40.7%	41.2%	31.2%	23.5%	20.2%	18.2%	16.1%	3.8%	1.6%	21.8%
Work Life Balance	Trust	0.0%	21.1%	25.8%	41.0%	20.1%	9.9%	6.7%	2.5%	0.0%	14.6%
	National	16.7%	15.2%	18.2%	21.3%	20.0%	20.1%	18.0%	5.4%	5.4%	14.7%
Pay/Reward	Trust	11.2%	4.9%	23.1%	0.0%	19.0%	17.2%	16.8%	2.0%	0.0%	9.0%
	National	7.4%	11.6%	15.8%	16.4%	18.0%	19.6%	15.9%	3.0%	1.1%	11.4%
Incompatible Working Relationships	Trust	0.0%	0.0%	7.9%	9.9%	6.2%	0.0%	0.0%	2.5%	0.0%	3.3%
	National	0.4%	0.5%	0.9%	1.1%	1.4%	1.9%	1.9%	0.6%	0.3%	0.9%
Flexibility	Trust	0.0%	0.0%	2.4%	0.0%	6.1%	0.0%	21.2%	1.5%	0.0%	2.9%
	National	2.2%	3.8%	6.2%	8.8%	6.8%	5.6%	5.3%	2.0%	2.1%	4.5%
Progression/CPD	Trust	0.0%	4.5%	0.0%	8.6%	0.0%	0.0%	8.4%	0.0%	0.0%	2.3%
	National	5.9%	4.5%	4.1%	4.0%	3.9%	3.8%	3.8%	0.8%	0.2%	3.3%
Dismissal	Trust	0.0%	4.9%	0.0%	0.0%	0.0%	0.0%	8.4%	0.0%	0.0%	1.3%
	National	0.6%	0.9%	1.4%	1.6%	2.7%	3.3%	6.0%	2.0%	1.9%	2.1%

The RAG rated heat map details 2018/2019 reasons for leaving within each age bracket for Registered Nurses and Midwifery staff in your trust. Red represents the higher percentages in leaver reasons where green represents the lower percentages in leaver reasons

## Trust age band leaver profile comparison with region/sector

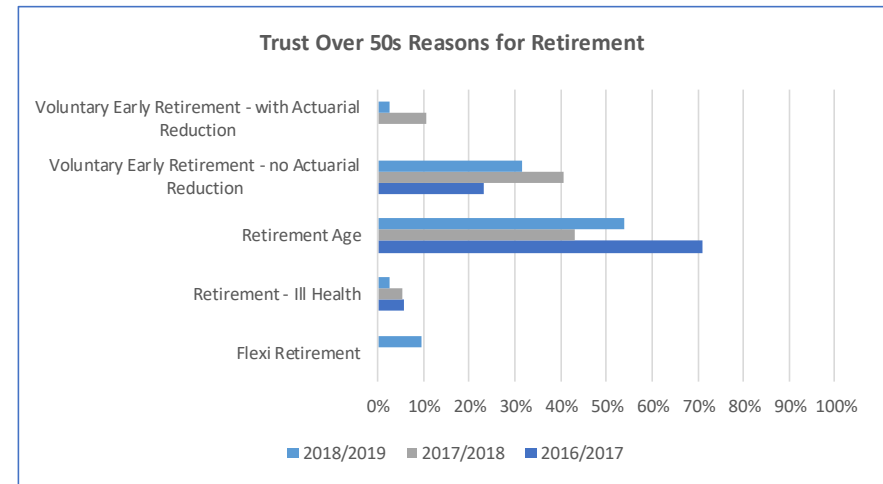
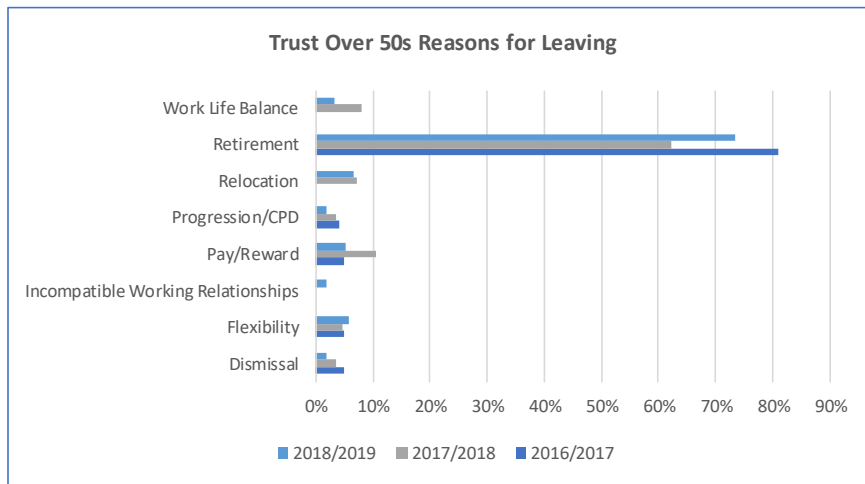
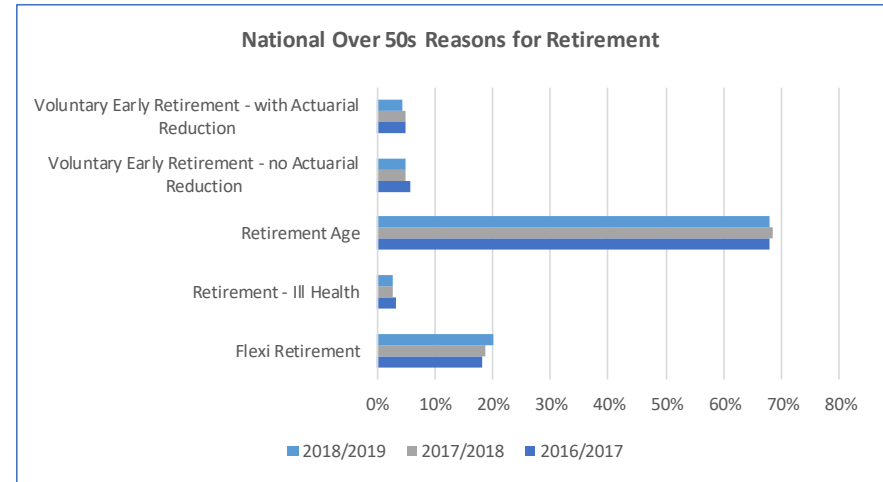
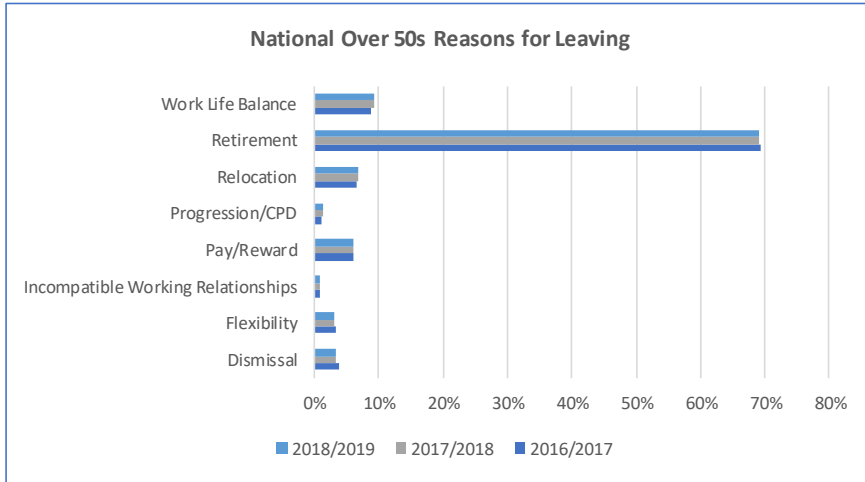
This chart shows how the age profile of leavers varies compared to other trusts in your region/sector. It might be helpful when thinking about which initiatives to prioritise given your staff demographics.



The chart details the age profile of Registered Nurses and Midwifery staff leaving your trust compared to the region/sector age profile in 2017/2018 and 2018/2019.

## Trust vs. national over 50s leaver reasons profile

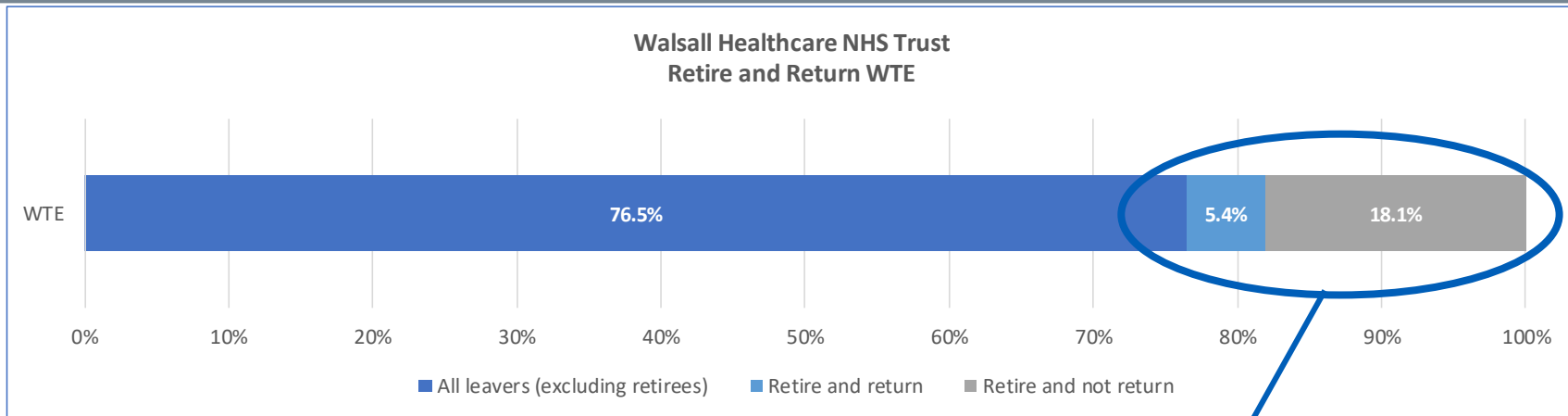
These charts show why staff over 50 are leaving your organisation and how this compares to the national picture. It also shows the type of retirement and how this compares nationally. It might be helpful when thinking about possible interventions for experienced staff and in assessing whether there is scope for boosting retire and returns.



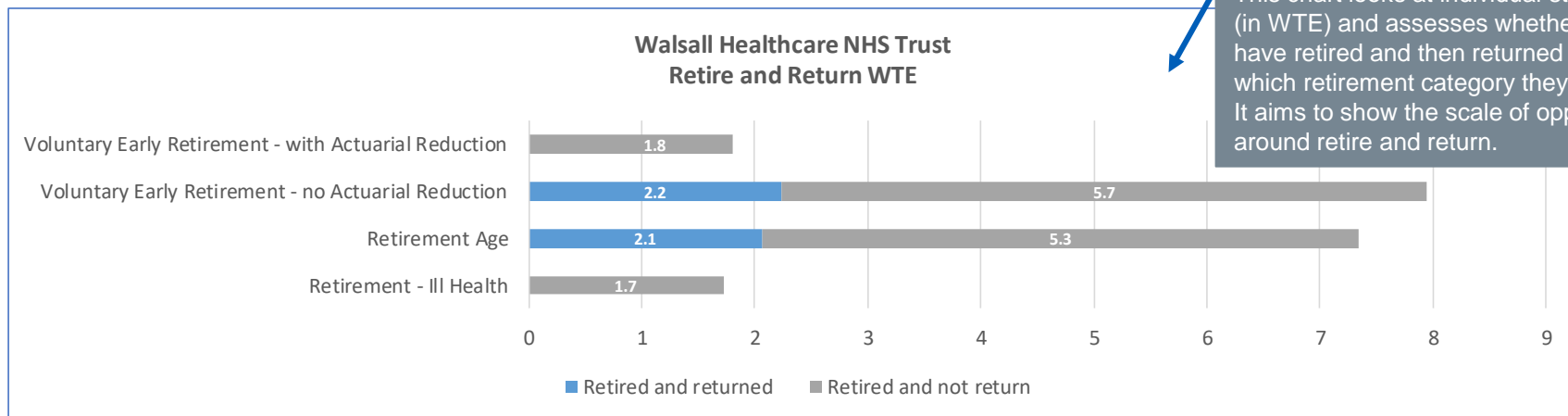
The charts on the left illustrate the Registered Nursing and Midwifery reasons for leaving nationally and from your trust across 3 financial years. The charts on the right look deeper into the Retirement reasons for Registered Nursing and Midwifery staff leaving nationally and from your trust.

## Retire and return volumes (WTE)

This chart looks at your total leavers and assess the proportion of those who retired and how many returned as a percentage of all leavers. The method of calculating has been tested with several trusts but you may have more accurate local information



The above chart shows the break down of Registered Nursing and Midwifery staff leaving your trust in 2017/2018, by all leavers (excluding retirees), those who retired and did not return and those who retired and subsequently returned to your trust.

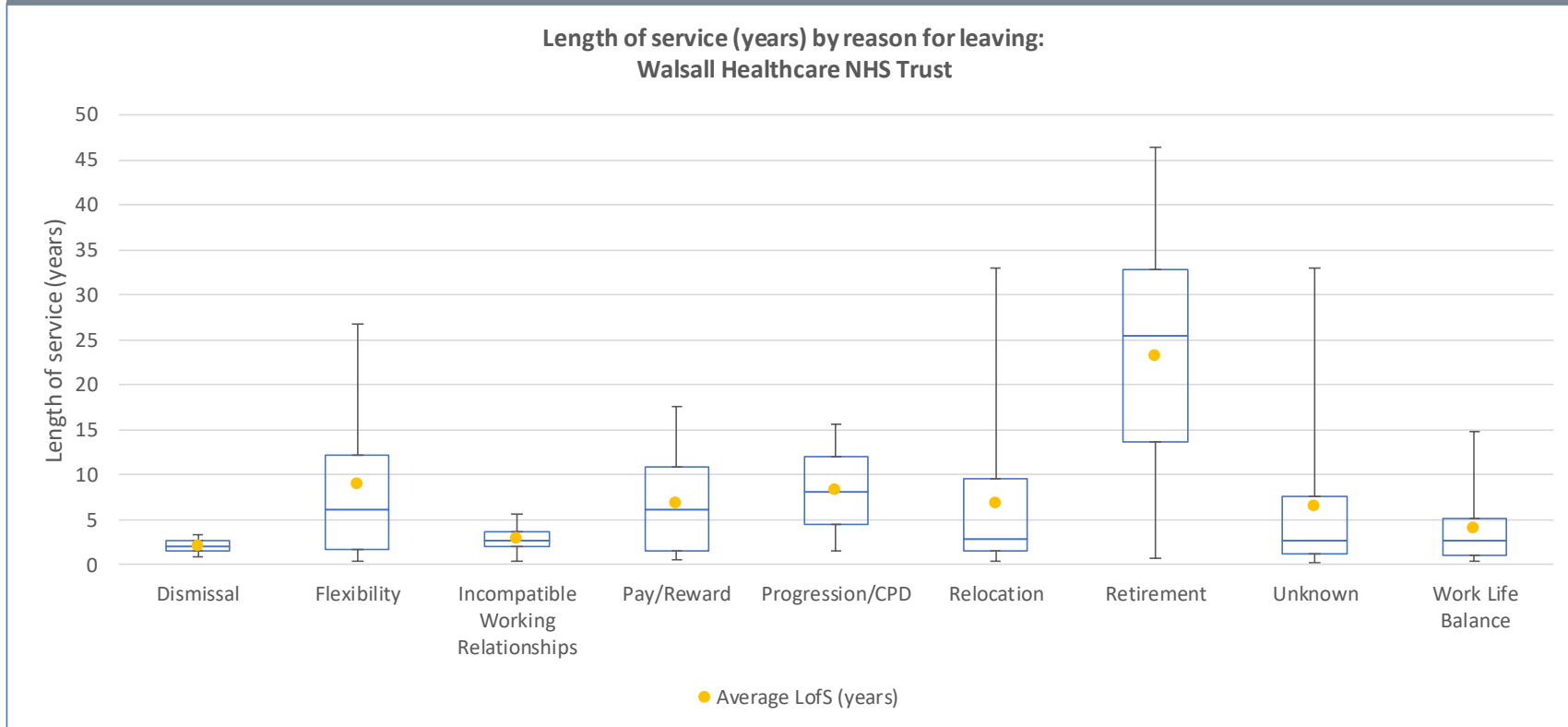


This chart looks at individual staff data (in WTE) and assesses whether they have retired and then returned and which retirement category they fall into. It aims to show the scale of opportunity around retire and return.

The above chart shows the reasons for Registered Nursing and Midwifery staff retiring from your trust in 2017/2018, broken down by those by retired and did not return and those who retired and subsequently returned to your trust.

## Length of Service by Reason for Leaving

The box and whisker plots show the length of stay ranges for each leaver reason within your trust. Each plot shows the max, min, average and interquartile range of the lengths of stay by year. The chart shows for example that staff leaving for work life balance tend to leave sooner after joining the organisation. Staff who leave for flexibility reasons have on average been in the organisation for almost 9 years before leaving.



LofS (years)	Dismissal	Flexibility	Incompatible Working Relationships	Pay/Reward	Progression/CPD	Relocation	Retirement	Unknown	Work Life Balance	All
Average	2.08	8.95	2.88	6.71	8.32	6.76	23.19	6.37	3.91	10.53
Min	0.83	0.33	0.41	0.50	1.50	0.34	0.75	0.25	0.33	0.25
Max	3.33	26.77	5.67	17.52	15.60	33.02	46.45	33.02	14.84	46.45

The chart illustrates lengths of service (years) of Registered Nursing and Midwifery staff by reason for leaving who left all trusts in 2018/2019. The table outlines the average, minimum and maximum lengths of service (years) by reason for leaving.

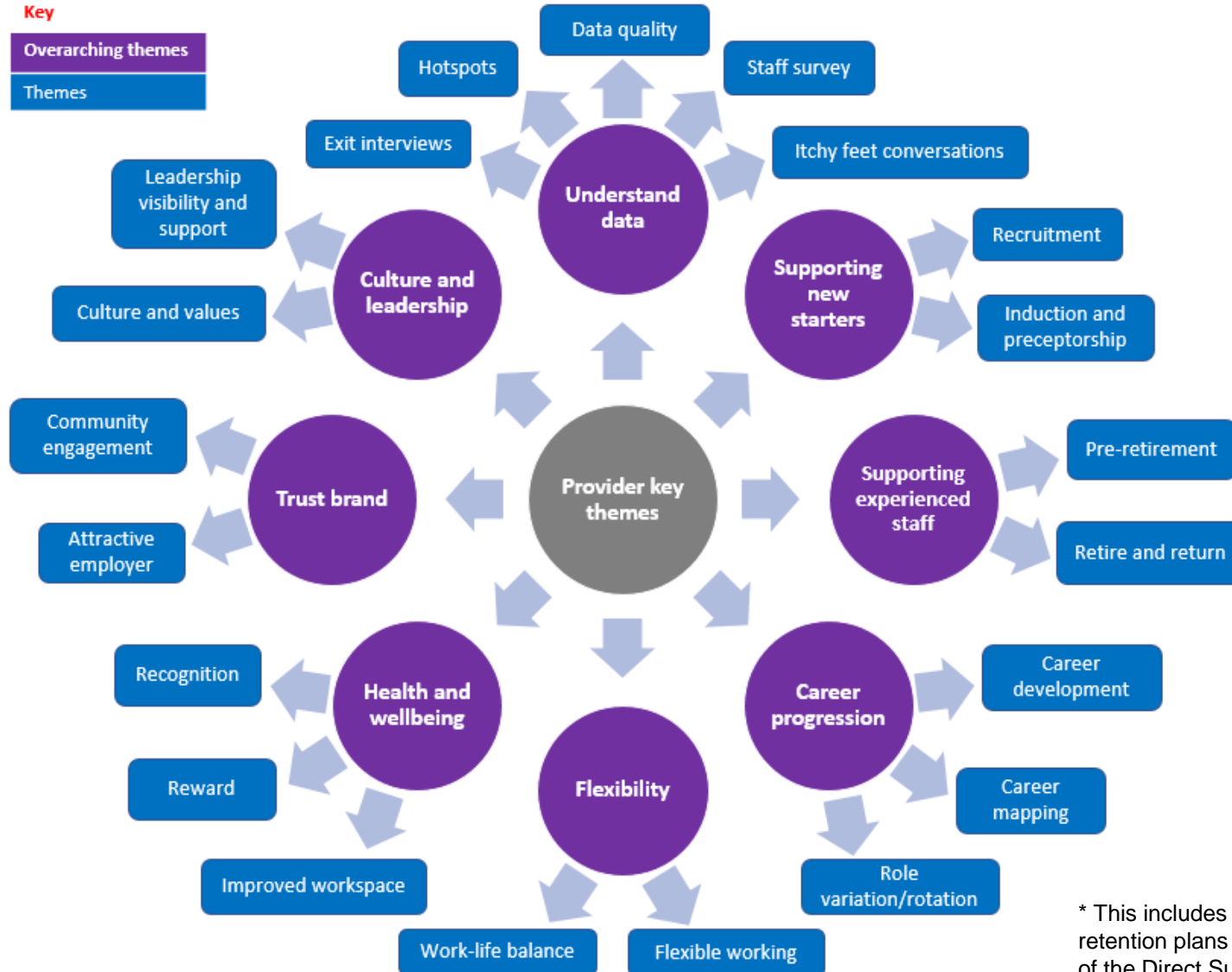
## Thematic review of key themes from Cohort 2 and 3 retention plans

- **Purpose** – To summarise the key themes of focus as highlighted by NHS trusts in cohorts 2 - 3 of the NHS Improvement Retention Direct Support Programme. The themes represent collectively the key challenges, priorities and solutions in retaining staff.
- **Method** – As part of the programme trusts were asked to submit retention improvement plans. Plans were analysed and grouped into themes. Information extracted from the plans was based on the key areas of focus for each trust.
- **Results** – Analysis revealed the following areas of focus for the plans:
  - Career progression
  - Understanding data
  - Supporting and retaining new starters
  - Trust brand and marketing
  - Supporting the experience workforce
  - Flexibility
  - Staff health and wellbeing
  - Culture and leadership

Trusts tended to focus on 3-5 of these areas depending on what their data diagnostic and staff engagement revealed as the key issues in the trust.

For a full map of these themes please see the thematic map on the next page. These are consistent with information NHS Improvement provided in the trust-specific data packs at the outset of the Direct Support Programme. Full report attached to enclosing email.

# Key areas of focus in trust retention plans\*



\* This includes a review of trusts retention plans from cohorts 2 and 3 of the Direct Support Programme.

## Annex 1 – ESR leaving reason definition

Leaver reviews in slide five are categorised as below:

ESR Leaving Reason Categorisation
<b>Dismissal:</b> Dismissal – Capability, Dismissal – Conduct, Dismissal – Some Other Substantial Reason, Dismissal – Statutory Reason
<b>Incompatible Working Relationships:</b> Voluntary Resignation – Incompatible Working Relationships
<b>Flexibility:</b> Voluntary Resignation – Child Dependants, Voluntary Resignation – Health, Voluntary Resignation – Adult Dependants
<b>Pay/Reward:</b> Voluntary Resignation – Better Reward Package, Voluntary Resignation – Promotion
<b>Progression/CPD:</b> Voluntary Resignation – Lack of Opportunities, Voluntary Resignation – To undertake further education or training
<b>Relocation:</b> Voluntary Resignation – Relocation
<b>Retirement:</b> Retirement – Ill Health, Flexi Retirement, Retirement Age, Voluntary Early Retirement – no Actuarial Reduction, Voluntary Early Retirement – with Actuarial Reduction
<b>Work Life Balance:</b> Voluntary Resignation – Work Life Balance
<b>Unknown:</b> Voluntary Resignation – Other/Not Known



## Annex 2 – Definitions and supporting information

**Data source:** ESR Data Warehouse – substantive staff.

**Turnover:** Includes staff that leave the NHS and those individuals moving on to be employed at another NHS organisation i.e. includes churn between trusts. This will not include inter-organisational transfers. Further details on definitions of reasons for leaving and ESR data extract and filters can be found in the Annex.

**Exclusions in turnover data:** Any leaver record coded within the period with a “reason for leaving” category as “employee transfer”. This should cover TUPE however is naturally dependent on the trust coding accordingly.

**Inclusions in turnover data:** All other leaver records i.e. voluntary leavers for any reason and regardless of new role destination including retirements. Fixed term contracts are also included in the data.

**Additional information:**

- Leaver reasons information based on financial year (April-March)
- The ESR “Staff Group” field has been utilised to identify the respective staff group turnover rates
- Leaving reasons are as interpreted from trust leaving/transfer processes and as recorded from trust internal processes
- Length of stay has been calculated using an individuals latest hire date and end date (as years)

# Performance Report

**September 2019**  
**(August 2019 Results)**

Author: Performance & Information team  
Lead Director: Russell Caldicott – Director of Finance and Performance

Caring for Walsall together



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# Quality, Patient Experience and Safety Committee

Caring for Walsall together



## Quality, Patient Experience and Safety Committee – Highlight Page

Executive Lead: Director of Nursing: Karen Dunderdale / Non-Executive Director Lead and Chair of Q&S Committee: Anne Baines

### Key Areas of Success

- There were no reported MSA breaches in August. However, there remains a risk of breaches occurring on the wards in the West Wing due to the ward layout and availability of bathroom facilities, this has been escalated to the corporate risk register and is reviewed daily by the matrons
- Safeguarding Adults and safeguarding Children's level 2 and level 3 target were achieved and continues to maintain compliance over the last 4 months.

### Key Areas of Concern

- The total number of C.diff cases reported in August was 1 case against a target of no more than 26 in 2019-2020, this means the Trust is currently 1 case above trajectory at this point in the year with 12 cases overall since April 2019.
- Performance for the MCA stage 2 training declined in August and remains below the Trust target. The Medical Director is leading a specific piece of work in this regard.
- The number of complaints responded to within 30 days decreased in August to 26% and is well below the 80% target. This will be a focus for the next committee
- There number of falls is cause for concern and an external review of our processes and actions has been commissioned.

### Key Focus for Next Committee

- The number of complaints responded to within 30 days decreased in August to 26% and is well below the 80% target. This will be a focus for the next committee
- Falls will be a focus for the next committee meeting

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Safe, high  
quality care



Care at home



Partners



Value  
colleagues



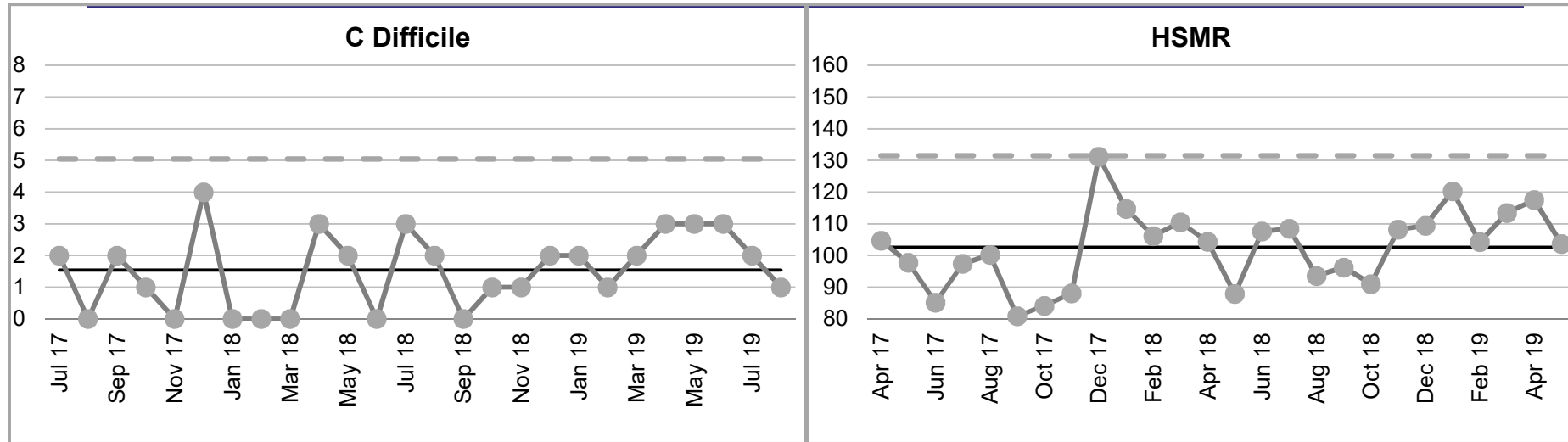
Resources



Respect  
Compassion  
Professionalism  
Teamwork

## Quality, Patient Experience and Safety Committee

SPC Key: — Mean    — Process limits - 3σ    ▲ High or low point    ◆ Special cause - improvement  
 ◆ Special cause - concern    - - - Target    ● 0



**Narrative (supplied by Director of Nursing)**

In August there was 1 C Diff case attributed to the Trust.

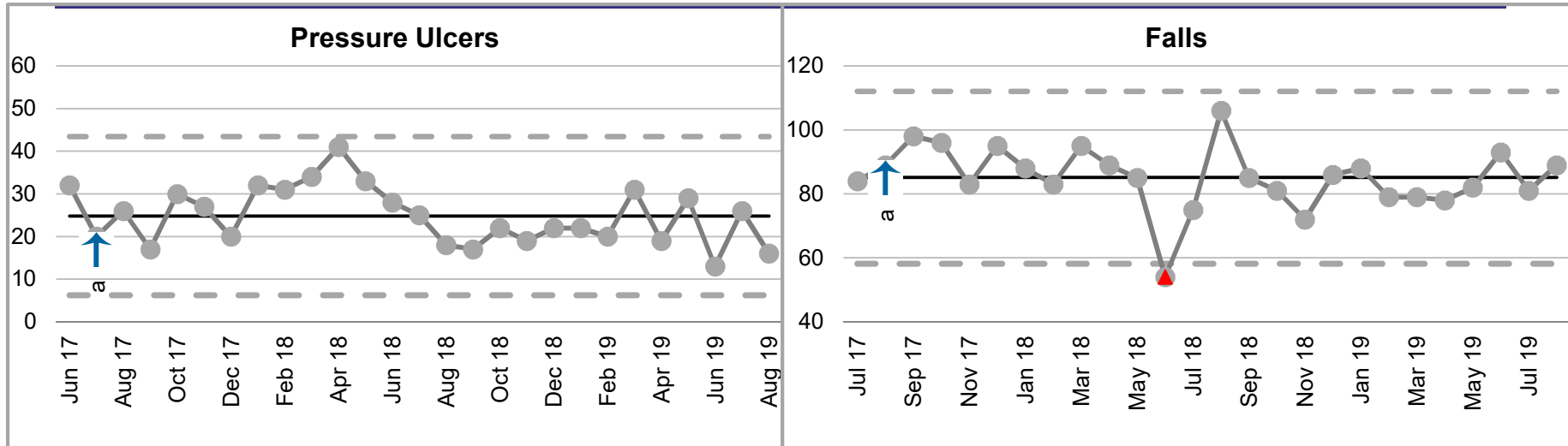
The Trust has had a total of 12 cases YTD against a target of 26 cases for the year this is 1 case over the trajectory for this point in the year.

**Narrative (Supplied by Medical Director)**

- HSMR for May 2019 is 103.69 (year to date 110.83). SHMI for February 2019 is 107.28 (109.92 year to date). Alerts identified potential concerns for Acute/Unspecified renal failure, Respiratory failure, # Neck of femur and Pneumonia, prompting further actions.
- Extensive advice and support has been sought to improve the processes and reporting of mortality in the trust. A broad paper outlining the actions has been submitted to QPES.
- The Medical Examiner process is expected to start in November.

## Quality, Patient Experience and Safety Committee

SPC Key: — Mean, — Process limits - 3σ, ▲ High or low point, ◆ Special cause - improvement, ◆ Special cause - concern, - - - Target, ● 0



**Narrative (supplied by Director of Nursing)**

Across the Trust in August 2019 there was a total of 16 acquired pressure ulcers reported for the hospital and community compared to 26 reported in the previous month; a significant decrease. RCAs are currently being undertaken on these pressure ulcers.

**Narrative (supplied by Director of Nursing)**

The number of falls increased again in August 2019 with 89 falls reported, an increase from the 81 falls reported in July 2019. In August 2019 the ratio of falls per 1000 bed days increased to 6.18 from the 5.01 ratio reported in July 2019. In August 2019 the Divisional Director of Nursing for Medicine introduced a Trust wide weekly Falls Project Working Group with support from the Corporate Team, to address the number of falls and ways of working using the PSDA methodology.

**QUALITY, PATIENT EXPERIENCE AND SAFETY  
COMMITTEE  
2019-2020**

SAFE, HIGH QUALITY CARE	
no..	HSMR (HED) nationally published in arrears
no..	SHMI (HED) nationally published in arrears
no	MRSA - No. of Cases
no	Clostridium Difficile - No. of cases
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population
no..	Falls - Rate per 1000 Beddays
no	Falls - No. of falls resulting in severe injury or death
%..	VTE Risk Assessment
no	National Never Events
no..	Midwife to Birth Ratio
%..	C-Section Rates
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)
%..	Electronic Discharges Summaries (EDS) completed within 48 hours
%..	Compliance with MCA 2 Stage Tracking
%..	Friends and Family Test - Inpatient (% Recommended)
%..	PREVENT Training - Level 1 & 2 Compliance
%..	PREVENT Training - Level 3 Compliance
%..	Adult Safeguarding Training - Level 1 Compliance
%..	Adult Safeguarding Training - Level 2 Compliance
%..	Adult Safeguarding Training - Level 3 Compliance
%..	Children's Safeguarding Training - Level 1 Compliance
%..	Children's Safeguarding Training - Level 2 Compliance
%..	Children's Safeguarding Training - Level 3 Compliance

Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
113.74	117.55	103.69			
0	0	0	0	0	0
2	3	3	3	2	1
1.09	0.82	0.93	0.56	0.80	0.78
0.55	0.31	0.59	0.21	0.55	0.14
4.82	5.02	5.17	6.05	5.01	6.18
0	4	1	0	0	4
91.94%	91.01%	92.02%	92.29%	93.20%	93.83%
0	0	0	0	0	0
1:28.1	1:24.2	1:26.9	1:27.3	1:31.5	1:27.5
26.33%	29.20%	27.55%	28.01%	34.77%	33.45%
11.56%	11.12%	12.22%	10.13%	11.21%	
83.65%	85.23%	85.72%	85.04%	83.65%	85.49%
66.67%	68.97%	59.26%	69.57%	61.76%	56.00%
95.00%	96.00%	96.00%	96.00%	96.00%	93.00%
93.62%	93.72%	92.69%	93.28%	92.73%	91.94%
88.65%	89.12%	85.74%	84.92%	85.11%	85.69%
96.27%	97.04%	96.21%	96.32%	96.65%	96.56%
92.23%	92.67%	92.85%	93.10%	91.61%	90.04%
89.50%	89.16%	84.75%	85.68%	87.37%	87.05%
95.48%	95.37%	95.08%	95.45%	94.26%	93.68%
83.42%	83.38%	85.12%	89.64%	90.89%	89.91%
90.81%	88.98%	90.37%	89.96%	90.24%	89.46%

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
	100.00		N
	100.00		BP
0	0	2	N
12	26	19	N
	6.63		BP
9	0	13	BP
92.49%	95.00%	94.90%	N
0	0	17	N
	1:28	1:28.1	N
30.72%	30.00%	28.46%	BP
	10.00%	10.73%	L
85.03%	100.00%	84.47%	N/L
63.30%	100.00%	62.44%	BP
	96.00%		N
	85.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	85.00%		L





# Integration

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## Integration – Highlight Page

Executive Lead: Director of Strategy & Improvement: Daren Fradgley / Non-Executive Director Lead: TBC

### Key Areas of Success

#### **SPA (Single Point of Access):**

There has been a positive response from the Community Nurses delivering the SPA in terms of support from other community teams.

During August, access to the Rapid Response Team was closed 3 times due to being unable to meet the increase in new referrals, an additional nurse was recruited to the team during the month to support. The 4<sup>th</sup> ACP comes into post on the 1<sup>st</sup> October 2019. There will be a detailed analysis of the pilot in November.

**Stroke unit:** continues to have mixed occupancy of medical outliers and stroke rehab patients. Currently 8 beds occupied by stroke patients and 18 medical patients. Average occupancy rate for Aug is 6 (33.4%) stroke patients. The key challenge for staff is ensuring the appropriate and timely transfer of patients to the unit, there have been a number of incidences recently where the transfer of care protocol has not been followed by RWT, resulting in late or no notification of transfer and some patients deemed not suitable for rehabilitation. Meeting scheduled in October with the Therapy Manager at RWT to address the discharge process issues. Ideally, an in-reach service model for the stroke team would greatly assist with eliminating these problems and ensure that patients are transferred to the correct stroke care pathway.

**Clinical Intervention Team :** Pilot Project for 24 hr IV antibiotic infusion/ administration in the community in progress with launch dates predicted for October, the Team currently provide daily or twice daily therapy, this enhanced model will support care at home for patients who currently need IV therapy greater than twice daily for conditions such as bacterial endocarditis, osteomyelitis.

### Key Actions Taken

**Quality and assurance team for care homes** to be launched within Q2 2019/ 20. Health led posts out to advert, Interviews planned for Early October.

### Points to Note

The development of new integrated dashboard will be available covering all services in scope for Walsall Together. The new dashboard will be available for November board meeting.

Caring for Walsall together



Safe, high  
quality care



Care at home



Partners



Value  
colleagues

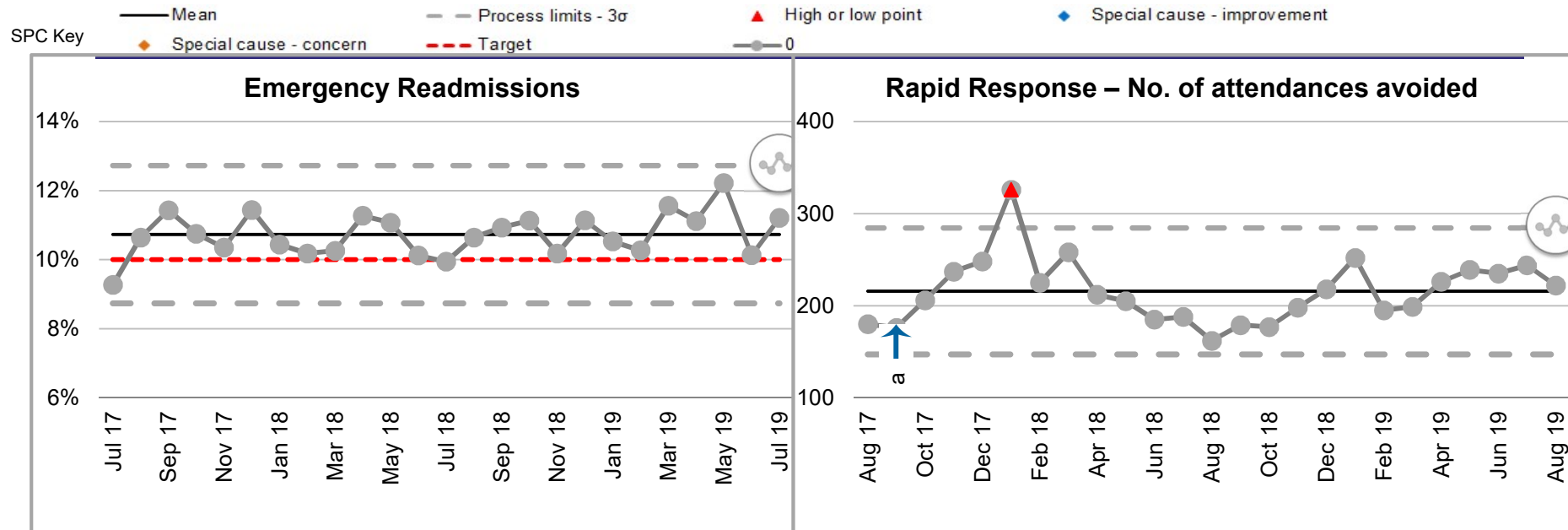


Resources



Respect  
Compassion  
Professionalism  
Teamwork

## Integration



**Narrative (supplied by Director of Strategy & Improvement)**

Service delivery improvement plans (SDIP) investment have been approved, recruitment and service redesign is progressing with the aim of having all schemes in place by Q3 2019.

Proactive budget management has provided further opportunity to recruit to additional pharmacist capacity to support redesign of medication directives and enhanced management of discharge medication and additional therapy support.

Adult Community Divisional structure under review as additional services are transferred to Division i.e. Therapies and Integrated Equipment loans.

Plans to change from 4 Care Groups to 4 Localities groups and 2 Care Groups for Urgent Intermediate Care and Palliative care.

Partners under Walsall Together Alliance have moved to Blakenall Village which will enhance our interdisciplinary partnership between health and social care providers. East 1 and East 2 place based health and social care locality teams have also moved to Blakenall Village.

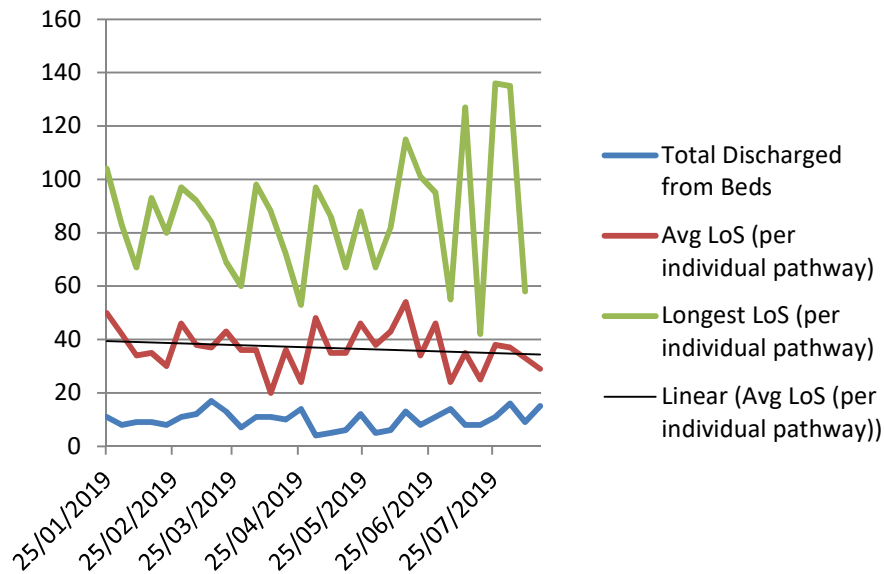
Transformation funding initiatives in Diabetes services are beginning to demonstrate outcomes including a 37% reduction in patients requiring limb Amputations when comparing 2017 and 2018 and a 15% increase in patients receiving multidisciplinary support.

recurrent funding for MDT coordinator approved and out to recruitment.

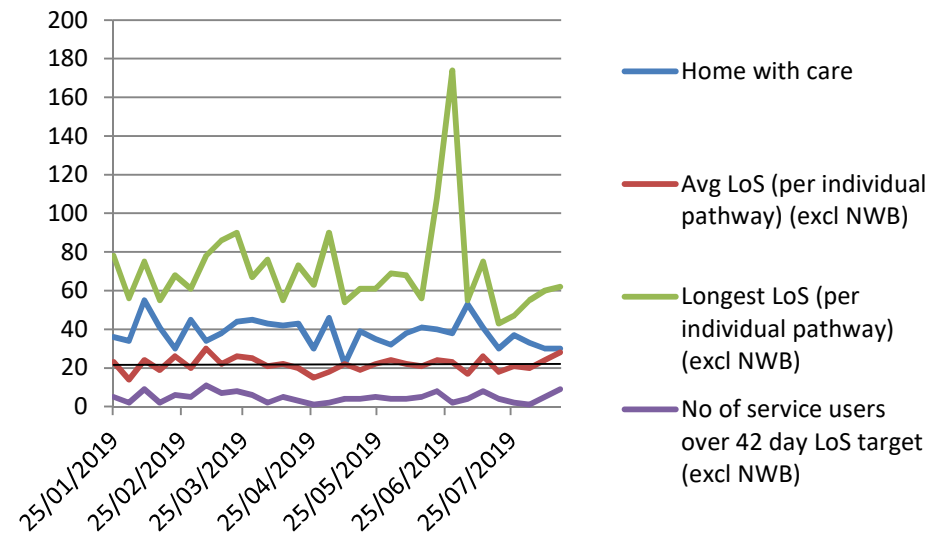
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# Community Pathways: ALOS of Discharged Patients



- This relates to much smaller numbers than those actually on pathways and is a subset of all discharges
- The trend line for ALOS on discharge from beds shows a gradual reduction
- The ALOS of discharge from home with care was 21 days in July and 24 days in the first half of August



**INTEGRATION  
2019-2020**

<b>SAFE, HIGH QUALITY CARE</b>	
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)
no	Rapid Response Team - Total Referrals
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours
<b>CARE AT HOME</b>	
%..	ED Reattenders within 7 days
<b>RESOURCES</b>	
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only (Mon&Thurs)
no	Average Number of Medically Fit Patients - Trust (Mon&Thurs)
<b>PARTNERS</b>	
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)
no	Nursing Contacts per Locality - Total
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)
no	No. of patients on stroke pathway in partnership with Wolverhampton (one month in arrears)

Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
11.56%	11.12%	12.22%	10.13%	11.21%	
221	273	276	269	270	253
199	226	239	235	244	222
91.04%	71.08%	66.28%	63.44%	72.73%	73.10%
7.13%	7.18%	7.79%	7.89%	7.84%	8.37%
36	36	31	35	31	34
40	25	30	32	25	24
37.49	37.88	36.26	35.94	37.25	33.03
18784	18619	19182	18447	19638	19370
1.90	2.16	2.03	2.09	2.30	2.07
10	3	4	6	7	

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
11.18%	10.00%	10.73%	L
			L
			L
			L
7.82%	7.00%	7.43%	BP
			L
95256		205571	L
			L
			L



# People and Organisational Development Committee

Caring for Walsall together



Safe, high  
quality care



Care at home



Partners



Value  
colleagues



Resources



Respect  
Compassion  
Professionalism  
Teamwork

## People and Organisational Development Committee – Highlight Page

Executive Lead: Director of People and Culture: Catherine Griffiths / Non-Executive Director Lead and Chair of POD Committee: Philip Gayle

### Key Areas of Success

- The Health & Wellbeing Team have taken an holistic approach to sickness prevention and management. This has included working with local partners, such as Samaritans and Pure Gym, to offer specialist consultation/advice for colleagues whilst also offering incentives for colleagues wanting to lead a balanced lifestyle
- The Trust is part of a national cohort focused on retention best practice, and will implement innovative means of gathering intelligence which will inform the package offered to current and prospective colleagues
- Learning and Development continued to review the infrastructure supporting training completion, including capacity and demand modelling to ensuring sufficient classroom sessions are available to meet the compliance gap

### Key Areas of Concern

- Retention – There is a continued decline in the retention of support to clinical colleagues
- Sickness Absence – There has been a 40% spike in Musculo-skeletal related illnesses
- Mandatory Training – Clinical Update & Safeguarding compliance rates are not improving at a consistent rate
- Appraisals – Compliance amongst corporate based colleagues is low, averaging 63%

### Key Actions Taken

- The Workforce Intelligence have drafted a project, to commence in Jan 2020, which will see the rollout of self-service KPI reporting for all line managers next year
- The Health & Wellbeing Team have put in place interventions regarding hypertension, referring high risk colleagues to GP or Outpatient service
- The POD Committee have agreed to revise the sickness target, with a view to achieving Model Hospital parity by 2021
- The Governance Team are reviewing Information Governance training & reporting, to ensure the Trust is compliant by Mar 2020
- E-Learning content is being reviewed, to ensure it is fit for purpose; with alternatives to the current platform under-review

### Key Focus for Next Committee

- Retention – Is the Trust an employer of choice for local residents
- Sickness Absence – A reduction trajectory, in line with target of achieving upper quartile status (Model Hospital) by 2021

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Care at home



Partners



Value  
colleagues



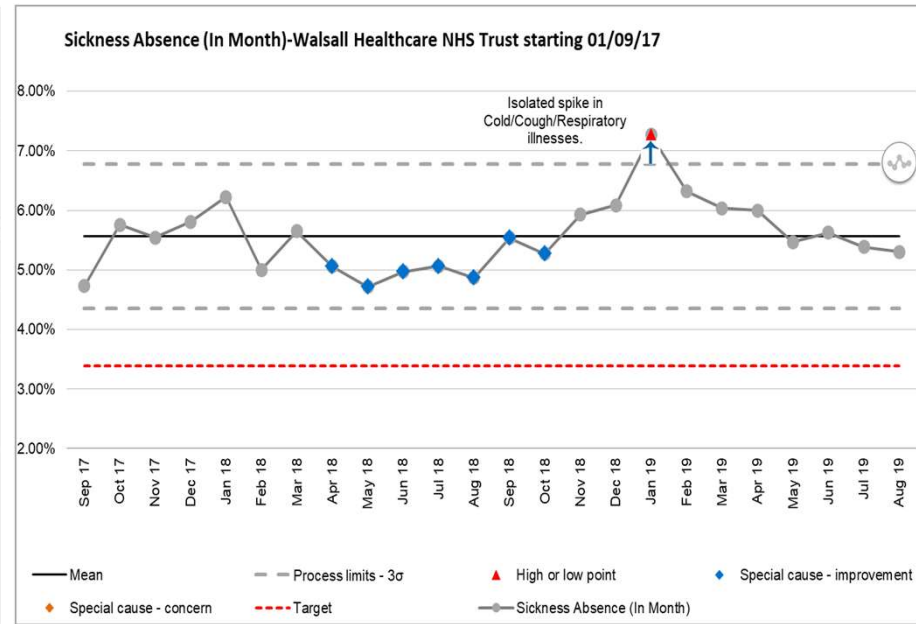
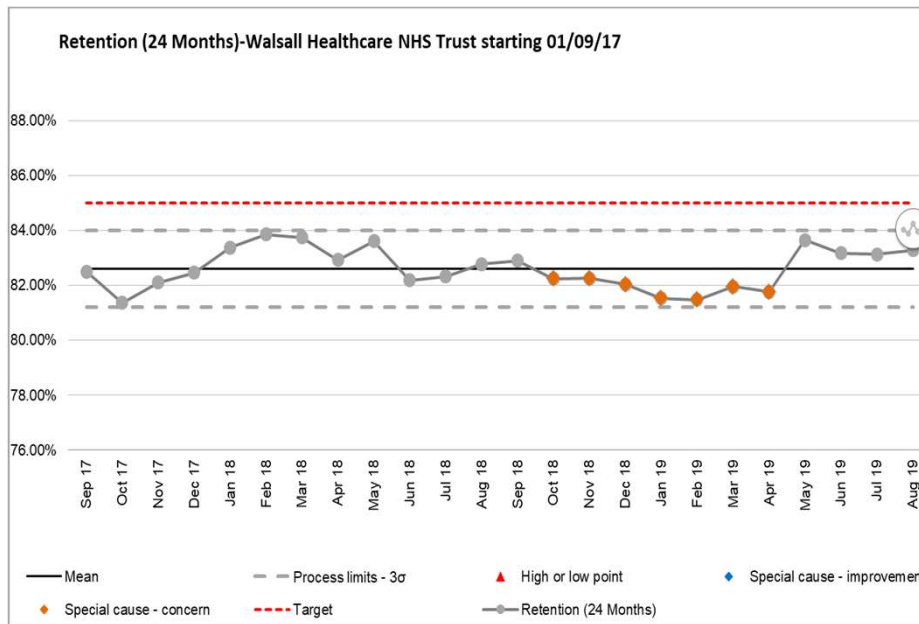
Resources



Respect  
Compassion  
Professionalism  
Teamwork

## People and Organisational Development Committee

— Mean      — Process limits - 3σ      ▲ High or low point      ◆ Special cause - improvement  
◆ Special cause - concern      --- Target      ○ 0

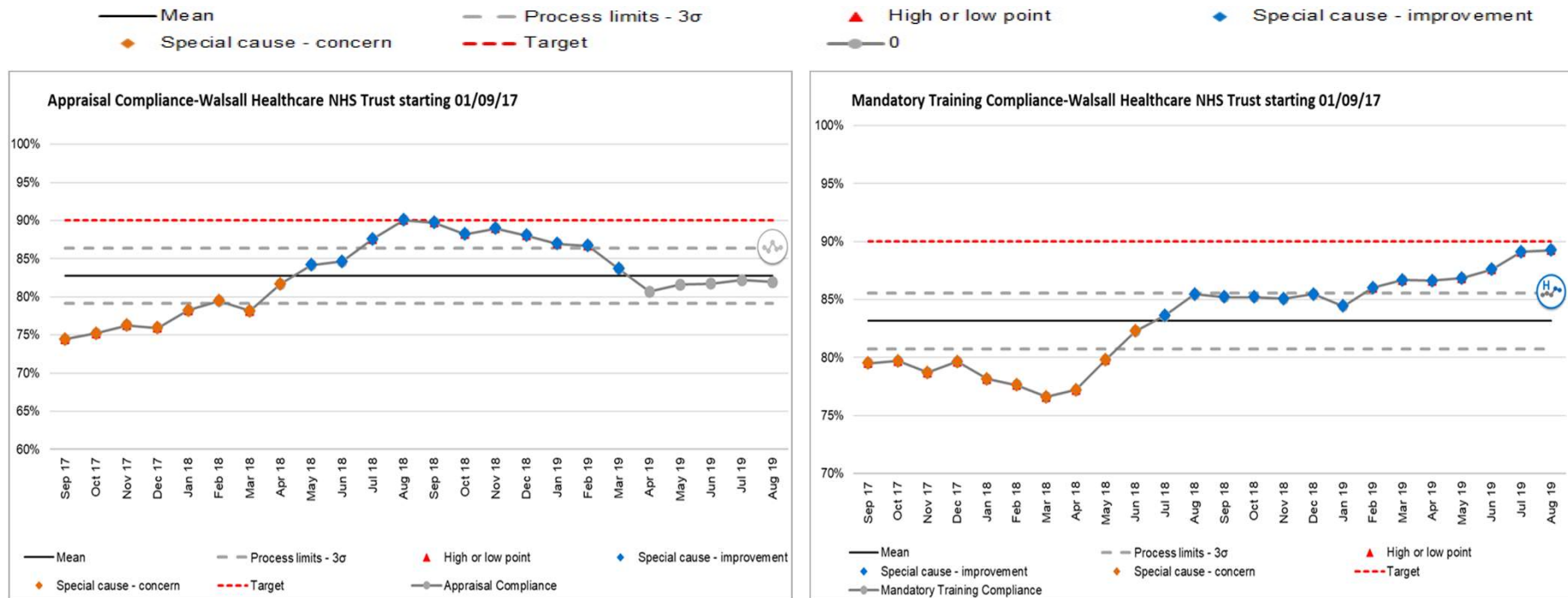


Caring for Walsall together





## People and Organisational Development Committee



Caring for Walsall together



**PEOPLE AND ORGANISATIONAL  
DEVELOPMENT COMMITTEE  
2019-2020**



SAFE, HIGH QUALITY CARE	
%..	% of RN staffing Vacancies
%..	Mandatory Training Compliance
%..	PREVENT Training - Level 1 & 2 Compliance
%..	PREVENT Training - Level 3 Compliance
%..	Adult Safeguarding Training - Level 1 Compliance
%..	Adult Safeguarding Training - Level 2 Compliance
%..	Adult Safeguarding Training - Level 3 Compliance
%..	Children's Safeguarding Training - Level 1 Compliance
%..	Children's Safeguarding Training - Level 2 Compliance
%..	Children's Safeguarding Training - Level 3 Compliance
VALUE COLLEAGUES	
%..	Sickness Absence
%..	PDRs
RESOURCES	
%..	Bank & Locum expenditure as % of Paybill
%..	Agency expenditure as % of Paybill
no	Staff in post (Budgeted Establishment FTE)
%..	Turnover (Normalised)

Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
8.44%	8.52%	9.65%	10.84%	11.28%	
86.67%	86.62%	86.84%	87.60%	89.09%	89.25%
93.62%	93.72%	92.69%	93.28%	92.73%	91.94%
88.65%	89.12%	85.74%	84.92%	85.11%	85.69%
96.27%	97.04%	96.21%	96.32%	96.65%	96.56%
92.23%	92.67%	92.85%	93.10%	91.61%	90.04%
89.50%	89.16%	84.75%	85.68%	87.37%	87.05%
95.48%	95.37%	95.08%	95.45%	94.26%	93.68%
83.42%	83.38%	85.12%	89.64%	90.89%	89.91%
90.81%	88.98%	90.37%	89.96%	90.24%	89.46%
6.04%	6.00%	5.47%	5.63%	5.38%	5.30%
83.66%	80.67%	81.60%	81.73%	82.20%	81.93%
9.12%	4.61%	7.37%	7.96%	6.97%	8.26%
4.46%	2.76%	4.83%	4.49%	4.41%	5.29%
3981	3871	3905	4022	4033	3978
11.58%	11.65%	11.92%	11.68%	11.07%	11.04%

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
			BP
	90.00%	86.67%	L
	85.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	85.00%		L
	95.00%		L
	85.00%		L
	85.00%		L
	3.39%	6.04%	L
	90.00%	83.66%	L
	6.30%	9.14%	L
	2.75%	4.90%	L
			L
	10.00%		

# Performance, Finance and Investment Committee

Caring for Walsall together



## Performance, Finance and Investment Committee – Highlight Page

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

### Key Areas of Success

- August saw continued improvement in EAS performance compared to the Q1 mean, but did not meet the submitted trajectory (85%) due to worsened performance in the final week of August. The percentage of service users waiting 6 weeks or more from referral for a diagnostics test delivered performance of 0.22% in August, achieving the 1% national target for the second consecutive month.
- Trust has attained plan at a £4.3m deficit at month 5, though has an operational deficit of £1.68m year to date that requires recovery later in the financial year
- Cost Improvement Programme delivery remains on plan (though is not attaining the stretch targets)

### Key Areas of Concern

- As forecast 2WW suspected cancer and Breast Symptomatic standards failed as a result of managing Breast demand from RWT. 18 weeks referral to treatment in August delivered performance of 87.11% which is now 3 consecutive months of deteriorating performance.
- August saw continued high ED attendances, with Type 1 attendances having risen by 8.2% March-August 2019 compared to the same 6 months in 2018. Despite significant interventions over the bank holiday weekend, exit flow from the department was challenging. This is most likely associated with the number of MFFD patients rising steeply to 95 during the last week of the month.
- The Trust has attained a £1.68m operational deficit to plan at month 4 (attaining plan through a movement in reserves). The Trust will need to mitigate the adverse operational deficit through continued focus being placed upon improvements within medically stable, closure of additional capacity, reductions in sickness and reducing temporary workforce, alongside grip and control measures and supporting the Medical and Long Terms Conditions (MLTC) Division to control cost overruns
- The financial plan indicated a run rate risk of £0.5m per month (approximately £6m per annum) and in the early months of the financial year this risk has only partially been mitigated, and with additional emergency admissions requiring additional capacity and introducing further costs the risk to delivery of the outturn remains at £6m (£8m deficit with lost quarter 4 Provider Sustainability Funding)

### Key Actions Taken

- ED Medical workforce review near completion which will produce a rota matching staffing to peak times of demand. Nursing workforce review undertaken and presented to JNC (Aug). RTT; 120 pain referrals transferred to another provider, ENT substantive consultant commences in September.
- Implementation of the Executive led measures to improve run rate, with further reviews on-going to assure full mitigation of the £0.5m monthly run rate risk (improved patient flow, reduction in medically stable/stranded patient, improved sickness absence management examples). Escalation of financial performance at Divisional Performance Reviews, to ensure attainment of productivity (theatres/outpatients) Obstetric activity and MLTC Division recovery plans.
- The Trust Board forming the Financial Cabinet to endorse Executive recommendations for run rate improvements to mitigate this financial risk to the 2019/20 financial plan, performance to be monitored through PFIC and a forecast produced to monitor and provide mitigation to the risk to delivery of the financial plan

### Key Focus for Next Committee

- Review of the forecast run rate to actual delivery (to include winter expenditure plans) and a review of productivity and length of stay improved performance impacts

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Safe, high quality care



Care at home



Partners



Value colleagues



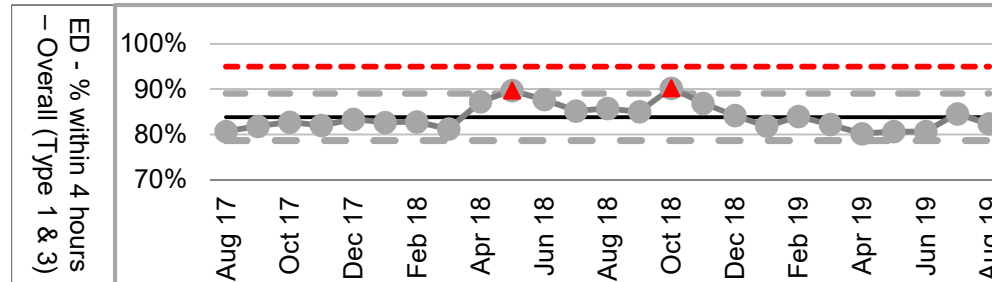
Resources



Respect  
Compassion  
Professionalism  
Teamwork

## Performance, Finance and Investment Committee

SPC Key — Mean — Process limits - 3σ ▲ High or low point ◆ Special cause - improvement  
◆ Special cause - concern - - - Target — 0



### Narrative (supplied by Chief Operating Officer)

#### Emergency/Urgent Care

The Trust delivered 8 consecutive weeks of 4-hour EAS performance above the Q1 mean performance between 30/6/19 and 18/8/19, representing a statistically significant improvement. August saw continued high ED attendances, with Type 1 attendances having risen by 8.2% March-August 2019 compared to the same 6 months in 2018.

#### RTT

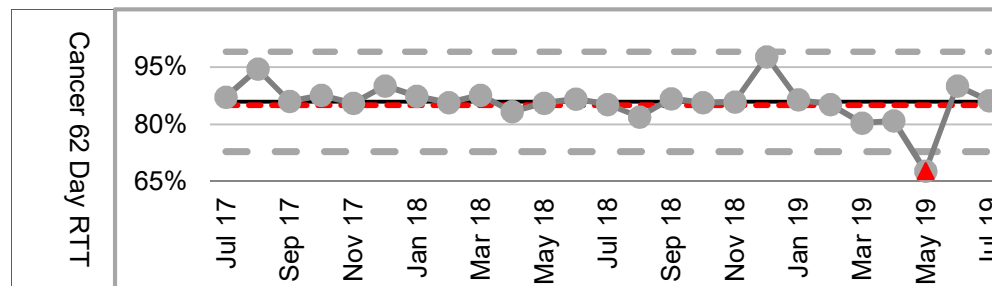
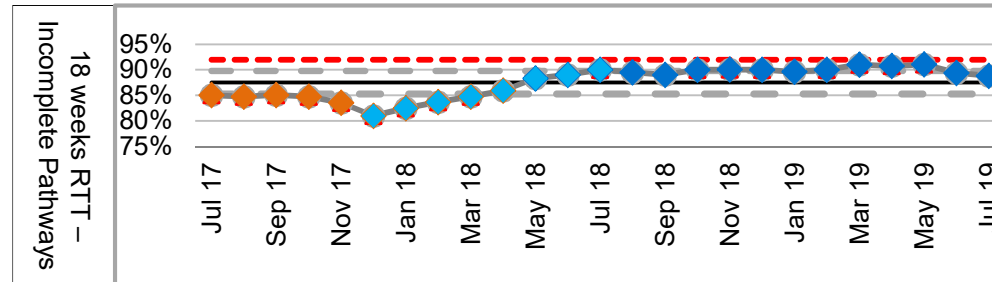
The Trust RTT incomplete pathway performance for August was 87.11% . The deteriorating position for the RTT is attributable to Respiratory, Dermatology Services predominately in MLTC and two services in Surgery (ENT, and Ophthalmology). Pain Management experienced an increase in long waiting patients, but were able to stabilise numbers waiting > 18 weeks.

Actions are in place to reduce long waits in Pain Management and bring deteriorating services back in line to meet the Trust Trajectory.

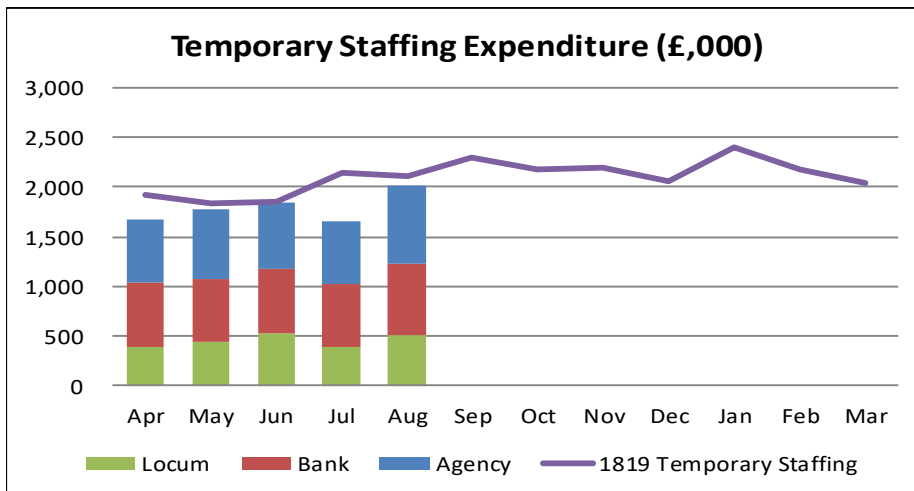
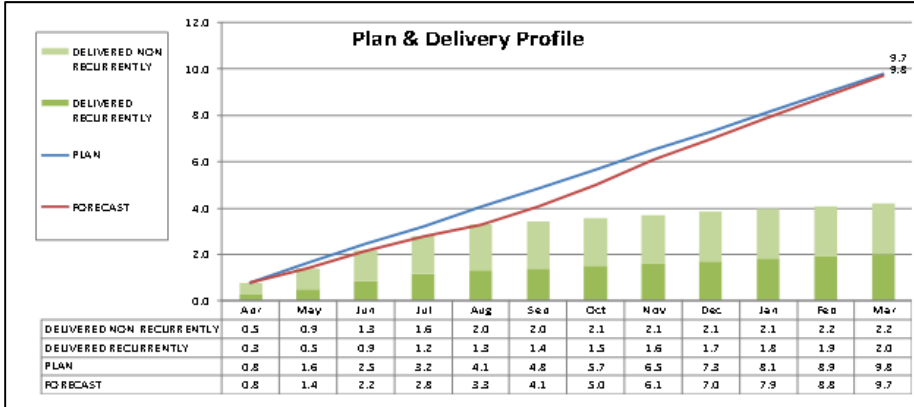
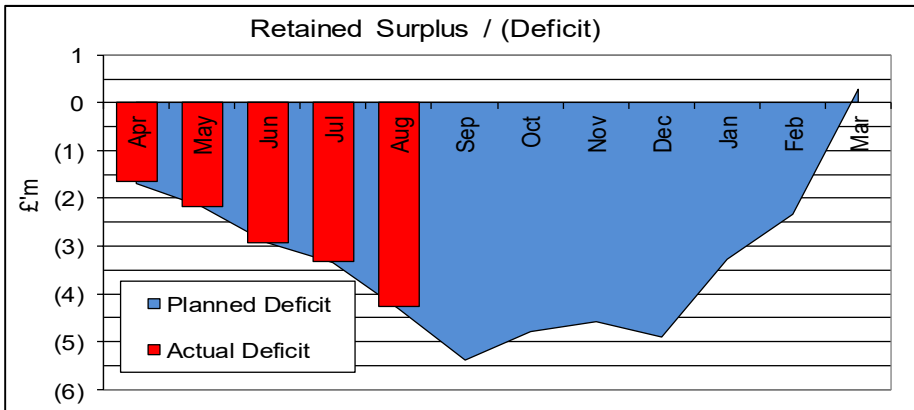
#### Cancer

The Trust achieved the constitutional measure for 62 day RTT with a performance of 86.2% and 62 day RTT consultant upgrade performance of 85.1%. The Trust failed to achieved the constitutional measures for 62 day RTT screening. 7 referrals received, 1 patient breached which was a complex case that needed a further biopsy before treatment could be given. Diagnostic waiting times, reporting times and histopathology remain a challenge.

July saw the highest month of suspected cancer 2ww referrals (all tumour sites ) on record. Increasing Breast referrals from RWT are highly likely to result not only in non-compliance of Breast Symptomatic 2WW standard, but also of Trust suspected cancer 2WW standard. The Trust has agreed to further increased Diversions from RWT from 9th September onwards.



## Financial Performance to August 2019 (Month 5)



## Financial Performance

- Trust has attained the planned deficit of £4.3m. However, has an operational deficit of £1.68m mitigated following a movement in reserves.
- Overspending on pay is reflective of the cost overruns within MLTC (sickness and servicing of unfunded capacity in part driven by increased demand)
- MLTC remains in escalation for financial performance as part of the Trust's Accountability Framework following the Divisional Review.
- The Executive have endorsed improved run rate measures (endorsed at Extra-ordinary Trust Board) to mitigate run rate risks and further reviews are ongoing to assure full mitigation of the £0.5m monthly run rate risk (a further 1% reduction in run rate targeted from Divisions).
- Income is below plan (against commissioners clinical income contracts) largely as a consequence of reduced births and Emergency Department depth of coding.

## CIP Delivery

- The Trust's Annual Cost Improvement Programme requirement is £8.5m (£10.5m stretch).
- The CIP has delivered £3.3m YTD, which broadly on plan but under the stretch target of £4.1m, an under achievement of £0.8m YTD. In addition, £2m of the total is delivered non-recurrently and focus is being placed on attainment of sustainable improvements using model hospital and other relevant benchmark data.

## Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. The actual cash holding for the month is £1.1m.
- Failure to deliver mitigating actions will result in increased spending, as such will place additional pressure on management of cash flow.

## Financial Performance - Period ended 31st August 2019

Description	Annual Budget	Budget to Date	Actual to Date	Variance
	£'000	£'000	£'000	£'000
<b>Income</b>				
CCGs	211,354	88,335	87,789	(546)
NHS England	18,255	7,637	7,828	191
Local Authorities	8,874	3,720	3,766	45
DoH and Social Care	18,380	5,392	5,392	0
NHS Trusts/FTs	1,008	413	479	66
Non NHS Clinical Revenue (RTA Etc)	1,060	442	480	38
Education and Training Income	6,887	2,863	2,878	15
Other Operating Income (Incl Non Rec)	7,563	3,441	3,646	205
<b>Total Income</b>	<b>273,380</b>	<b>112,243</b>	<b>112,258</b>	<b>15</b>
<b>Expenditure</b>				
Employee Benefits Expense	(178,001)	(73,444)	(74,111)	(667)
Drug Expense	(10,360)	(7,390)	(7,541)	(151)
Clinical Supplies	(15,354)	(6,772)	(7,202)	(431)
Non Clinical Supplies	(17,766)	(7,615)	(7,610)	5
PFI Operating Expenses	(5,444)	(2,268)	(2,318)	(49)
Other Operating Expense	(29,618)	(12,037)	(10,764)	1,273
<b>Sub - Total Operating Expenses</b>	<b>(256,544)</b>	<b>(109,525)</b>	<b>(109,546)</b>	<b>(21)</b>
<b>Earnings before Interest &amp; Depreciation</b>	<b>16,836</b>	<b>2,718</b>	<b>2,711</b>	<b>(6)</b>
Interest expense on Working Capital	51	21	34	13
Interest Expense on Loans and leases	(10,387)	(4,327)	(4,486)	(158)
Depreciation and Amortisation	(6,500)	(2,708)	(2,521)	188
PDC Dividend	0	0	0	0
Losses/Gains on Asset Disposals	0	0	0	0
<b>Sub-Total Non Operating Exps</b>	<b>(16,836)</b>	<b>(7,015)</b>	<b>(6,973)</b>	<b>42</b>
<b>Total Expenses</b>	<b>(273,380)</b>	<b>(116,540)</b>	<b>(116,519)</b>	<b>21</b>
<b>RETAINED SURPLUS/(DEFICIT)</b>	<b>0</b>	<b>(4,297)</b>	<b>(4,262)</b>	<b>35</b>

## Use of Resources Ratings (M5)

Finance and use of resources rating	03AUDITPY	03PLANYTD	03ACTYTD	03PLANCY	03FOTCY
	<i>i</i>				
	Audited PY	Plan	Actual	Plan	Forecast
	31/03/2019	31/08/2019	31/08/2019	31/03/2020	31/03/2020
	Year ending	YTD	YTD	Year ending	Year ending
Number	Number	Number	Number	Number	
Capital service cover rating	4	4	4	4	4
Liquidity rating	4	4	4	4	4
I&E margin rating	4	4	4	2	2
I&E margin: distance from financial plan	4		1		1
Agency rating	3	1	3	1	1

### CASHFLOW STATEMENT

Statement of Cash Flows for the month ending August 2019

Year to date  
Movement

	£'000
<b>Cash Flows from Operating Activities</b>	
Adjusted Operating Surplus/(Deficit)	354
Depreciation and Amortisation	2,521
Donated Assets Received credited to revenue but non-cash	0
(Increase)/Decrease in Trade and Other Receivables	(8,054)
Increase/(Decrease) in Trade and Other Payables	(5,647)
Increase/(Decrease) in Stock	(10)
Increase/(Decrease) in Provisions	1,714
Interest Paid	(4,485)
<b>Net Cash Inflow/(Outflow) from Operating Activities</b>	<b>(13,607)</b>
<b>Cash Flows from Investing Activities</b>	
Interest received	35
(Payments) for Property, Plant and Equipment	(2,667)
<b>Net Cash Inflow/(Outflow) from Investing Activities</b>	<b>(2,632)</b>
<b>Net Cash Inflow/(Outflow) before Financing</b>	<b>(16,239)</b>
Cash Flows from Financing Activities	13,106
<b>Net Increase/(Decrease) in Cash</b>	<b>(3,133)</b>
<b>Cash at the Beginning of the Year 2018/19</b>	<b>4,186</b>
<b>Cash at the End of the August</b>	<b>1,053</b>

### STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month  
ending August 2019

Balance  
as at  
31/03/19

Balance as  
at 31/08/19

Year to  
date  
Movement

	£000	£000	£000
<b>Non-Current Assets</b>			
<b>Total Non-Current Assets</b>	<b>141,208</b>	<b>141,142</b>	<b>(66)</b>
<b>Current Assets</b>			
Receivables & pre-payments less than one Year	16,532	23,964	7,432
Cash (Citi and Other)	4,186	1,053	(3,133)
Inventories	2,362	2,372	10
<b>Total Current Assets</b>	<b>23,080</b>	<b>27,389</b>	<b>4,309</b>
<b>Current Liabilities</b>			
NHS & Trade Payables less than one year	(29,461)	(22,355)	7,106
Other Liabilities	(1,445)	(1,978)	(533)
Borrowings less than one year	(15,590)	(15,015)	575
Provisions less than one year	(117)	(1,831)	(1,714)
<b>Total Current Liabilities</b>	<b>(46,613)</b>	<b>(41,179)</b>	<b>5,434</b>
<b>Net Current Assets less Liabilities</b>	<b>(23,533)</b>	<b>(13,790)</b>	<b>9,743</b>
<b>Non-current liabilities</b>			
Borrowings greater than one year	(202,939)	(216,245)	(13,306)
<b>Total Assets less Total Liabilities</b>	<b>(85,264)</b>	<b>(88,893)</b>	<b>(3,629)</b>
<b>FINANCED BY TAXPAYERS' EQUITY composition :</b>			
PDC	64,190	64,823	633
Revaluation	15,925	15,925	-
Income and Expenditure	(165,379)	(165,379)	-
In Year Income & Expenditure	-	(4,262)	(4,262)
<b>Total TAXPAYERS' EQUITY</b>	<b>(85,264)</b>	<b>(88,893)</b>	<b>(3,629)</b>

**PERFORMANCE, FINANCE  
AND INVESTMENT COMMITTEE**  
**2019-2020**

SAFE, HIGH QUALITY CARE	
%..	Total time spent in ED - % within 4 hours - Overall (Type 1 and 3)
%..	Ambulance Handover - Percentage of clinical handovers completed within 15 minutes of recorded time of arrival at ED
no	Ambulance Handover - No. of Handovers completed over 60mins
%..	Cancer - 2 week GP referral to 1st outpatient appointment
%..	Cancer - 62 day referral to treatment of all cancers
%..	18 weeks Referral to Treatment - % within 18 weeks - Incomplete
no	18 weeks Referral to Treatment - No. of patients waiting over 52 weeks - Incomplete
0	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test
no	No. of Open Contract Performance Notices
CARE AT HOME	
%..	ED Reattenders within 7 days
RESOURCES	
%..	Outpatient DNA Rate (Hospital and Community)
%..	Theatre Utilisation - Touch Time Utilisation (%)
%..	Delayed transfers of care (one month in arrears)
no	Average Number of Medically Fit Patients (Mon&Thurs)
no	Average LoS for Medically Fit Patients (from point they become Medically Fit) (Mon&Thurs)
£	Surplus or Deficit (year to date) (000's)
£	Variance from plan (year to date) (000's)
£	CIP Plan (YTD) (000s)
£	CIP Delivery (YTD) (000s)
£	Temporary Workforce Plan (YTD) (000s)
£	Temporary Workforce Delivery (YTD) (000s)
£	Capital Spend Plan (YTD) (000s)
£	Capital Spend Delivery (YTD) (000s)

Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
82.21%	80.22%	80.68%	80.68%	84.57%	82.38%
65.43%	62.49%	66.92%	60.93%	63.65%	62.49%
22	35	16	21	5	12
87.38%	82.46%	94.48%	95.61%	90.81%	85.27%
80.37%	80.90%	67.71%	90.10%	86.21%	81.05%
91.02%	90.72%	91.04%	89.37%	88.83%	87.11%
0	0	0	0	0	0
0.12%	3.15%	6.50%	4.13%	0.33%	0.22%
9	10	11	11	11	11
7.13%	7.18%	7.79%	7.89%	7.84%	8.37%
9.94%	10.63%	10.35%	9.93%	10.57%	11.34%
92.73%	89.54%	86.70%	86.99%	86.94%	85.57%
2.86%	3.51%	2.65%	3.27%	3.45%	
99	85	80	87	75	77
11.35	12.34	10.46	12.57	11.23	9.51
£-27,669	£45	£3	£4	£14	£35
£-17,038	£45	£3	£4	£14	£35
£15,500	£900	£1,600	£2,500	£3,200	£3,300
£11,100	£800	£1,400	£2,200	£2,800	£3,300
£19,400	£1,300	£2,700	£4,200	£6,000	£7,600
£25,200	£1,700	£3,500	£5,300	£6,900	£8,900
£12,200	£500	£800	£1,600	£2,400	£3,200
£13,100	£700	£1,200	£1,300	£1,700	£2,000

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
81.70%	95.00%	85.90%	N
63.29%	100.00%	72.20%	BP
89	0	155	N
89.78%	93.00%	93.59%	N
80.87%	85.00%	85.35%	N
	92.00%		N
0	0	1	N
3.00%	1.00%	0.32%	N
11	0	9	L
7.82%	7.00%	7.43%	BP
10.56%	8.00%	10.44%	L
	75.00%		L
	2.50%	3.46%	L
£35		£-27,669	L
£35		£-17,038	L
£3,300		£15,500	L
£3,300		£11,100	L
£7,600		£19,400	L
£8,900		£25,200	L
£3,200		£12,200	L
£2,000		£13,100	L





# Glossary



# Glossary

## A

ACP – Advanced Clinical Practitioners  
AEC – Ambulatory Emergency Care  
AHP – Allied Health Professional

Always Event® - those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system

AMU – Acute Medical Unit  
AP – Annual Plan

## B

BCA – Black Country Alliance  
BR – Board Report

## C

CCG/WCCG – Walsall Clinical Commissioning Group  
CGM – Care Group Managers  
CHC – Continuing Healthcare  
CIP – Cost Improvement Plan  
COPD – Chronic Obstructive Pulmonary Disease  
CPN – Contract Performance Notice  
CQN – Contract Query Notice  
CQR – Clinical Quality Review  
CQUIN – Commissioning for Quality and Innovation  
CSW – Clinical Support Worker

## D

D&V – Diarrhoea and Vomiting  
DDN – Divisional Director of Nursing  
DoC – Duty of Candour  
DQ – Data Quality  
DQT – Divisional Quality Team  
DST – Decision Support Tool  
DWMHPT – Dudley and Walsall Mental Health Partnership NHS Trust

## E

EACU – Emergency Ambulatory Care Unit  
ECIST – Emergency Care Intensive Support Team  
ED – Emergency Department  
EDS – Electronic Discharge Summaries  
EPAU – Early Pregnancy Assessment Unit  
ESR – Electronic Staff Record  
EWS – Early Warning Score

## F

FEP – Frail Elderly Pathway  
FES – Frail Elderly Service

## G

GAU – Gynaecology Assessment Unit  
GP – General Practitioner

## H

HALO – Hospital Ambulance Liaison Officer

HAT – Hospital Acquired Thrombosis  
HCAI – Healthcare Associated Infection  
HDU – High Dependency Unit  
HED – Healthcare Evaluation Data  
HofE – Heart of England NHS Foundation Trust  
HR – Human Resources  
HSCIC – Health & Social Care Information Centre  
HSMR – Hospital Standardised Mortality Ratio

## I

ICS – Intermediate Care Service  
ICT – Intermediate Care Team  
IP – Inpatient  
IST – Intensive Support Team  
IT – Information Technology  
ITU – Intensive Care Unit  
IVM – Interactive Voice Message

## K

KPI – Key Performance Indicator

## L

L&D – Learning and Development  
LAC – Looked After Children  
LCA – Local Capping Applies  
LeDeR – Learning Disabilities Mortality Review  
LiA – Listening into Action  
LTS – Long Term Sickness  
LoS – Length of Stay

## M

MD – Medical Director  
MDT – Multi Disciplinary Team  
MFS – Morse Fall Scale  
MHRA – Medicines and Healthcare products Regulatory Agency  
MLTC – Medicine & Long Term Conditions  
MRSA – Methicillin-Resistant Staphylococcus Aureus  
MSG – Medicines Safety Group  
MSO – Medication Safety Officer



# Glossary

M cont

MST – Medicines Safety Thermometer

MUST – Malnutrition Universal Screening Tool

N

NAIF – National Audit of Inpatient Falls

NCEPOD – National Confidential Enquiry into Patient Outcome and Death

NHS – National Health Service

NHSE – NHS England

NHSI – NHS Improvement

NHSIP – NHS Improvement Plan

NOF – Neck of Femur

NPSAS – National Patient Safety Alerting System

NTDA/TDA – National Trust Development Authority

O

OD – Organisational Development

OH – Occupational Health

ORMIS – Operating Room Management Information System

P

PE – Patient Experience

PEG – Patient Experience Group

PFIC – Performance, Finance & Investment Committee

PICO – Problem, Intervention, Comparative Treatment, Outcome

PTL – Patient Tracking List

PU – Pressure Ulcers

R

RAP – Remedial Action Plan

RATT – Rapid Assessment Treatment Team

RCA – Root Cause Analysis

RCN – Royal College of Nursing

RCP – Royal College of Physicians

RMC – Risk Management Committee

RTT – Referral to Treatment

RWT – The Royal Wolverhampton NHS Trust

S

SAFER – Senior review - All patients will have an expected discharge date - Flow of patients - Early discharge – Review

SAU – Surgical Assessment Unit

SDS – Swift Discharge Suite

SHMI – Summary Hospital Mortality Indicator

SINAP – Stroke Improvement National Audit Programme

SNAG – Senior Nurse Advisory Group

SRG – Strategic Resilience Group

S cont

SSU – Short Stay Unit

STP – Sustainability and Transformation Plans

STS – Short Term Sickness

SWBH – Sandwell and West Birmingham Hospitals NHS Trust

T

TACC – Theatres and Critical Care

T&O – Trauma & Orthopaedics

TCE – Trust Clinical Executive

TDA/NTDA – Trust Development Authority

TQE – Trust Quality Executive

TSC – Trust Safety Committee

TVN – Tissue Viability Nurse

TV – Tissue Viability

U

UCC – Urgent Care Centre

UCP – Urgent Care Provider

UHB – University Hospitals Birmingham NHS Foundation Trust

UTI – Urinary Tract Infection

V

VAF – Vacancy Approval Form

VIP – Visual Infusion Phlebitis

VTE – Venous Thromboembolism

W

WCCG/CCG – Walsall Clinical Commissioning Group

WCCSS – Women’s, Children’s & Clinical Support Services

WHT – Walsall Healthcare NHS Trust

WiC – Walk in Centre

WLI – Waiting List Initiatives

WMAS – West Midlands Ambulance Service

WTE – Whole Time Equivalent

N – National / L – Local / BP – Best Practice

Green	Performance is on track against target or trajectory
Amber	Performance is within agreed tolerances of target or trajectory
Red	Performance not achieving against target or trajectory or outside agreed tolerances



MEETING OF THE PUBLIC TRUST BOARD – Thursday 3 <sup>rd</sup> October 2019			
Walsall Together Report			<b>AGENDA ITEM: 13</b>
<b>Report Author and Job Title:</b>	Michelle McManus Walsall Together Programme Manager	<b>Responsible Director:</b>	Daren Fradgley Executive Director of Walsall Together
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>This paper updates the Board Members on the key Walsall Together work undertaken this month:</p> <ul style="list-style-type: none"> <li>• Progress on the governance arrangements</li> <li>• Primary Care Network (PCN) engagement</li> <li>• Communications update</li> <li>• System reporting</li> <li>• Programme resource constraints</li> <li>• IT &amp; Digital progress</li> <li>• STP Alignment</li> <li>• Programme Delivery Report</li> </ul> <p>To provide assurance on delivery of the transformation, the programme office produces a suite of documents to the WTP Board on a monthly basis. A number of exception reports were presented to the WTP Board in September which are outlined in section 9 of this report together with an over dashboard attached</p>		
<b>Recommendation</b>	Board members to NOTE and discuss the contents of this paper.		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>This paper outlines the progress in relation to the Walsall Together programme of work and provides assurance to the board to mitigate the risks in relation to the following BAF risks:</p> <p>BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will not be able to deliver a sustainable integrated care model;</p> <p>BAF004 Failure to progress the delivery of the Walsall Integrated model for health and social care.</p>		
<b>Resource implications</b>	There are no new resource implications associated with this report.		
<b>Legal and Equality and Diversity implications</b>	The Walsall Together Programme Plan will include an EDI assessment overall and individual assessments for each project.		
<b>Strategic Objectives</b> (highlight which Trust	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	

Strategic objective this report aims to support)	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	



**WALSALL TOGETHER REPORT**  
**OCTOBER 2019**

## 1. PURPOSE OF REPORT

This report provides the board with an update on the Care at Home strategic objective which is coordinated by Walsall Together.

## 2. GOVERNANCE ARRANGEMENTS

A Highlight Report from the Walsall Together Partnership (WTP) Board is included in the Committee section of the Board papers.

The Clinical Operating Model (COM) Group met for the second time on 6<sup>th</sup> September 19 and was well attended. The Group has agreed:

- Terms of Reference (to be ratified by the WTP Board on 9<sup>th</sup> October); and
- Key Lines of Enquiry that present a framework of conversation to support getting the pathway work up and running.
- The end to end pathway design will be based on the following 6 areas
  - Cardiac Care
  - Respiratory Care
  - Diabetes Care
  - End of Life Care
  - Mental Health Outpatient provision
  - 0 – 19 years Pathway

## 3. PCN ENGAGEMENT

The Executive Director of Walsall Together has written to the PCN Clinical Directors to offer support and to formally requesting engagement in Walsall Together. This letter followed one issued by the CCG outlining supportive funding to get engagement going. In response, Dr Abdalla has confirmed their intention to engage in the following three areas requested:

- Local leadership contacts in each of the 7 places across the borough including GP support to MDTs.
- Attendance and participation in the Walsall Together governance and decision-making process including representation at SMT and Board;
- Clinical leadership across the end to end pathways and also digital programme including shared care records and population health management.

SMT is considering a proposal to make use of this resource across the Walsall Together programme which will be confirmed by the end of September.

#### 4. COMMUNICATIONS

Plans are now underway to establish a communications lead within the programme team as outlined within the business case and leadership funding. It has become apparent over the last few months that key communication opportunities with our own staff are being missed and more importantly, early successes are not being shared as openly as initially planned to encourage further engagement and promote system confidence.

To compliment this appointment, regular updates will be produced from each of the work streams to highlight process and advertise ways for clinicians to engage in the program. The post holder will also be tasked with linking with the communication teams of all the providers to establish a regular rhythm in part publications. It is hoped that a recruitment process can be completed in early October for appointment in the coming months.

#### 5. SYSTEM REPORTING

There has been good engagement from the Data Leads across partner organisations. However, there remains an issue in the release of information from organisations to produce a consolidated dashboard for the operational services in scope (System Performance Dashboard). As a result, the progress we were expecting to have made in August has not materialised. SMT members have been tasked to resolve this issue.

The mapping process relating to the previously published Walsall Together Outcomes Framework is progressing well with CCG teams. This is now being shared with Local Authority Commissioners to undertake the next stage of the work but again has not progressed as quickly as expected.

NHS Improvement has offered support in helping the production of a system-wide operational dashboard using their newly published "Making Data Count" framework. It is anticipated that work on this will commence in September with drafts of this work being confirmed at next month's board. It should be noted that this work will complement the outcomes framework with operational metrics rather than replace them.

#### 6. PROGRAMME RESOURCE CONSTRAINTS

Whilst progress continues it is apparent, we are starting to witness some early constraints to greater progress. As a result, a quick diagnostic has been undertaken and the following areas have been identified as potential resource constraints.

The Programme Team are struggling to service the commencement of so many workstreams all at the same time. This will start to ease over the next few months as plans start to get approved but it is a live pressure at the minute.

The key operational leaders servicing the workstreams are limited and duplicated in most of the projects.

Providers have become used to making do with what they have and therefore have constrained their thinking. We are not therefore realising the big change ideas on first pass that we were hoping to achieve.

In response, the following have been recorded on the risk log with the appropriate mitigations.

The programme team and operational teams are being expanded with additional support from a variety of sources within the current funding envelope to ensure that progress can still be made. In addition, the challenge is now being placed on the teams to think of bigger and bolder ways of establishing the levels of integration required as outlined in the business case. Funding proposals are being scheduled to coincide with the planning round where possible, but the board must consider a reasonable figure (to be determined) in next year's plan to service system changing business cases and developments.

If the mitigations do not appear to be successful, then SMT will be coordinating the prioritisation and making recommendations to the Board in due course.

## 7. IT & DIGITAL

On the back of the EPR Programme comes the development of the Integrated Shared Record across all partners. This group is going to be closely aligned to the current EPR Programme Board. This will be clinically-led with lessons and evidence from other implementations in the country. An engagement programme is being developed and will be released in October.

## 8. STP ALIGNMENT

The Executive Director of Walsall Together attended a session on place-based care organised by the STP to share learning from other parts of the Black Country. Following on from this, through successful petitioning, the STP has now formally allocated a 'Place' workstream that will enable continual learning and sharing of best practice. Walsall Together will be taking a key role in this workstream.



## 9. DELIVERY OF THE TRANSFORMATION

To provide assurance on delivery of the transformation, the programme office now produces a suite of documents to the WTP Board on a monthly basis. This includes:

Document	Detail
<b>Programme Structure and RAG Ratings for Horizon 1</b>	A high-level view of all live projects, their associated RAG ratings and any necessary exception reporting.
<b>Programme Status Report</b>	A high level status summary of every project within the programme.
<b>Individual Workstream/ Project Reports</b>	When relevant within the agreed governance processes, individual Workstream and Project level documentation will be presented to the WTP Board for assurance and approval.

The following exception reporting was presented to the WTP Board in August against 'amber' (defined as off track but recoverable) and 'red' (defined as off track, intervention required) projects:

Within Tiers 0 and 1, the following project is currently 'amber' rated:

- Estates accommodation for place based teams (PBTs) and scoping for H&WB hubs as per the Business Case offering

There are 2 separate risks associated with this project: a) the short-term challenge of securing suitable premises to enable co-location of PBTs; b) the long-term ability to deliver the full business case offering. Mitigation has been identified to address the short-term challenges and solutions for co-location of all PBTs have been identified. The long-term challenge around development of 4 H&WB hubs has been included in the proposed strategic risks.

The ICS Improvement Plan is 'amber' rated due to the risks associated with achieving the commissioned model (therapies establishment and funding).

The Stroke/Neuro Rehab Pathways project was 'red' rated due to challenges around the financial model; intervention was required in respect of the costs associated with catering, cleaning and medical cover. However, since the WTP Board, the Outline Business Case has been revised and is going through the WHT governance process. The project group has been re-established and will now focus on implementation of a 12-bedded model to be delivered from Holly Bank House.

The Communications and Workforce & OD enabling workstreams are both 'amber' rated following discussions with the SMT regarding their significance in the context of delivering the programme and the level of resource allocated to these areas to date. Mitigation has been identified: resource has been allocated from the Programme Office to mobilise these workstreams and ensure adequate focus is given during the next reporting period

The following workstream/project documentation has been approved by the WTP Board:

- Workstream Plan for Tier 1 – Integrated Primary, Long-term Condition Management, Social and Community Services;
- Workstream Plan for Tier 4 – Acute and Emergency Services;
- Mobilisation Project Brief;
- Highlight Report for the Exemplar Ward.

The following pipeline projects were approved by the Board for initiation and further scoping:

- Falls prevention;
- Quality in Care Homes;
- WHT community outpatients

## 10. RECOMMENDATIONS

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

Appendix: - Programme Overview Dashboard

# Walsall Together Programme Overview - Horizon 1

Date Updated: 26th September 19

Walsall Together Ambition	Outcomes Impact		Walsall Together Partnership (WTP)
Improve the health and wellbeing outcomes of the Walsall population	<b>A healthy population</b>	Living longer lives; living healthy, happy, fulfilling lives; the best possible start in life; greater equality in health outcomes across Walsall	Walsall Healthcare NHS Trust (WHT)
Increase the quality of care provided	<b>Accessible, coordinated and responsive care</b>	Good experience of care; health & care services that work together; access to right care, right place, right time; best care for people with long-term and complex needs; best possible end of life care	Walsall Council (Social Care and Public Health) Dudley & Walsall Mental Health NHS Trust Walsall Clinical Commissioning Group
Provide long term financial sustainability for the system	<b>Strong, active communities</b>	People feel in control of health and wellbeing; people actively engaged in communities; families and friends providing informal care well-supported; making a difference to the wider aspects of daily life	One Walsall (Council for Voluntary Services) Walsall Housing Group (rep the housing sector)

## Clinical Operating Model (COM)

	<b>Single Point of Access</b>	Care access, navigation and coordination including clinical triage
	<b>Tier 0 (T0)</b>	Resilient Communities - an integrated prevention and early intervention offer to all Walsall citizens
	<b>Tier 1 (T1)</b>	Primary Care at scale and integrated health and care teams working through a hub and spoke model across each locality
	<b>Tier 2 (T2)</b>	Outpatients and diagnostic services delivered from locality based Health & Wellbeing Centres (H&WB) or the home
	<b>Tier 3 (T3)</b>	Network of specialist care delivered from Health & Wellbeing (H&WB) Centres preventing unnecessary hospital admissions and facilitating timely discharge from hospital
	<b>Tier 4 (T4)</b>	Access to high quality acute hospital services for patients when they need specialist intervention provided a) locally and b) at a Black Country, regional or national level where necessary
	<b>Digital (DIG)</b>	Integrated health and care record, data reporting & business intelligence, population health management
<b>Enablers</b>		Communications, Estates, Patient & Public Engagement, Workforce & Organisational Development

Governance		Key Programme Risks	Mitigation	RAG
<b>WTP Board</b>	Decision making and strategic direction including devliery of the Business Case. Responsibility for oversight of service integration.	Suitable premises to deliver 4 H&WB centres	Space Use Group, Local Est Forum, One Public Estate	Red
<b>Senior Man Team</b>	Proivde assurance to WTP Board. Responsible for delivery of system integration and transformation as per the COM	Funding to provide the Bus Case estates model	Rev how estates £ is released and moved around	Yellow
<b>COM Group</b>	Provide clinical and professional input to the work of Walsall Together	Partner Engagement at all staff levels	Comms group in place. Recruitment of Lead post.	Yellow
<b>WTPO</b>	Drive the programme forwards and manage relationships through to delivery	Primary Care Network engagement and alignment	PCN funding agreed. Engagement in progress.	Yellow
<b>Projects</b>	Delivery of the integration and realisation of programme benefits	Ability to invest in prevention/pump priming	Commissioner reps in governance	Yellow
		Resource capacity to delivery the transformation	Review of priorities. Recruitment to prog office	Yellow
		Organisational culture re integrated working	Org Dev plan at 3 levels: Board, SMT and operational	Yellow

Latest Update: key actions completed and key priorities for the next period			Milestones
<b>Gov</b>	Initial session and 'Place' workstream established within the Black Country Sustainability & Transformation Plan/Partnership (STP) - enable learning from across the Black Country		Sep-19
	Alliance Agreement approved at partner Governing Bodies		Oct-19
	Scoping for Horizon 2 including childrens and Public Health		Oct-19
<b>SPA</b>	Workshop with key stakeholders across the system to review wider SPA.		Aug-19
	Evaluation of pilot SPA (launched Jun). Pilot fully engaged WMAS - improved relations, referral protocols and referral confidence. Has contributed to ambulance non-conveyance.		Sep-19
<b>Tier 0</b>	Further workshop re wider SPA defining in/out of scope and specific actions.		Oct-19
	Workshop 1 undertaken with key stakeholders - define context, concept, vision		Aug-19
<b>Tier 1</b>	Second workshop to agree vision, set priorities & timelines, to inform commissioning/investment requirements. Proposals to WTP Board October 2019.		Sep-19
	GPs have been identified across the four Localities to lead the MDT's		Aug-19
<b>Tier 3</b>	Appointment to MDT Coordinator role undertaken, with the view for the successful candidate to be in post in Oct-19		Sep-19
	Short term solutions re estate issues for all PBT have been identified		Aug-19
	East locality team for Health and Social Care is now co-located in Blakenall Village		Aug-19
<b>Tier 4</b>	ICS end-to-end patient process mapping commenced (weekly review meetings)		Sep-19
	Establishment of Steering Group for the Patient Mobilisation project and initial engagement undertaken with senior nursing colleagues at WHT to secure support for implementation		Aug-19
	Approval of the outline business case for the transfer of stroke services from Manor Hospital to Holly Bank House (community inpatient facility)		Sep-19
<b>Workforce</b>	Exemplar Ward rollout to Ward 14 at Manor Hospital		Oct-19
	Funding secured from Skills for Care and Better Care Fund to deliver Strengths Based Practice training to health and social care workforce		Aug-19
<b>PPE</b>	WT Patient Engagement Lead appointed and induction in progress (attendance at SMT, SMT sub-group for PPE and COM)		Aug-19
<b>PPE</b>	First draft patient and public engagement strategy for review by SMT (in development)		Oct-19

MEETING OF THE PUBLIC TRUST BOARD – 3 <sup>rd</sup> October 2019			
Health and Safety Policy (Including Organisational Requirements)			<b>AGENDA ITEM:</b> 14
<b>Report Author and Job Title:</b>	Simone Smith Head of Health and Safety	<b>Responsible Director:</b>	Jenna Davies
<b>Action Required</b>	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	This Policy has been produced in accordance with the requirements of Section 2(3) of the Health & Safety at Work Act and applies to Walsall Healthcare NHS Trust in its entirety. The significantly updated and reworded policy sets out the responsibilities and arrangements in place within Walsall Healthcare NHS Trust in order to realise its Health and Safety commitments. It applies to all Trust employees, agency/ temporary/ locum staff, contractors, visitors and others who may be affected by its undertaking.		
<b>Recommendation</b>	Members of the Trust Board are asked to receive this policy and approve its content.		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p>1060 - No high level Health and Safety training provision to support Executive &amp; Divisional leadership teams to adequately execute expected statutory Health and Safety requirements.</p> <p>1083 - Lack of suitably trained staff in Health and Safety (H&amp;S) theory and practice to support ward and Departmental Managers in the execution of their legal H&amp;S responsibilities.</p>		
<b>Resource implications</b>	There are no resource implications associated with this report		
<b>Legal and Equality and Diversity implications</b>	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.		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input type="checkbox"/>		



Walsall Healthcare NHS Trust - Health and Safety Policy	
Document Title	
Health and Safety Policy (Including Organisational Arrangements)	
Document Description	
Document Type	Corporate Policy
Service Application	Trust Wide
Version	2
Lead Author(s)	
Name	Job Title
Simone Smith	Head of Health and Safety

Executive Director / Director / Manager			
If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date below:			
Name	Jenna Davies	Date	
Signature			

Change History		
Version	Date	Comments
1.1	1 <sup>st</sup> Jan 2011	This is the first draft of the Trust policy for the new integrated service
1.2	27 <sup>th</sup> May 2011	Circulated to existing members of Health and Safety Committee and corporate management team members, all divisional directors, directors, Nicky Kaur for wider consultation. Alan Lakin, Project Co, SFS, and Julian Rainsford KPIs and audit and monitoring arrangement revised. Governance arrangements clarified and community services included.
1.3	22 Nov 2011	Policy reviewed by Head of Health and Safety Non Clinical. Insert monitoring and control table page 34, insert generic risk assessment page 52 and insert Equality Impact Assessment page 61
1.4	8 Jan 2015	Change of policy title. Add para 5.11 to include the newly formed NHS Property Services. Distributed to Quality Teams and H&S Committee for approval.
2.0	9 <sup>th</sup> September 2018	Policy content significantly revised; re-written and reformatted to include; <ul style="list-style-type: none"> <li>Change of policy title – ‘Risk Management’</li> </ul>

		<p>removed</p> <ul style="list-style-type: none"> <li>• Roles and responsibilities re-written</li> <li>• Director with responsibility for H&amp;S amended</li> <li>• Updated Statement of intent</li> <li>• Updated Objectives</li> <li>• Shortened more concise 'Scope'</li> <li>• Roles and responsibilities re-written</li> <li>• Arrangements for H&amp;S Management separated into appendices for ease of access.</li> <li>• Assurance structure amended to reflect risk management committee.</li> <li>• Former appendices removed; Terms of Reference, Inspection, Checklist and Risk Assessment Template</li> <li>• Equality Impact Assessment Undertaken</li> </ul>
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Links with External Standards	
NHSLA	3.1, 3.2, 3.4, 3.6, 3.7 and 3.8
CQC	Outcome 11
Health and Safety at Work Etc. Act 1974	
Management of Health and Safety at Work Regulations 1999	
Managing for Health and Safety (HSG65)	
Key Dates	DATE
Ratification Date	Trust Management Board – April 2015 Minute Number – 42/15
Review Date	April 2019

Executive Summary Sheet		
Document Title:	Health and Safety Policy (Including Organisational Arrangements)	
<b>Please Tick ( <input type="checkbox"/> ) as appropriate</b>	This is a new document within the Trust	
	This is a revised Document within the Trust	X
<b>What is the purpose of this document?</b>		
This policy sets out the responsibilities and arrangements in place within Walsall Healthcare NHS Trust in order to realise its Health and Safety commitments. It applies to all Trust employees, agency/temporary/locum staff, contractors, visitors		

and others who may be affected by its undertaking

**What key Issues does this document explore?**

1. The Trust accepts its humane, economic and legal responsibilities in respect of the management of health & safety risks arising from its activities that may affect staff, patients and others.
2. This policy outlines the Trust arrangements in connection with these responsibilities. Local controls are created from these arrangements as appropriate.
3. This policy also sets out the arrangements to ensure appropriate consultation with Trades Union and Employee safety representatives (Health & Safety Committee)

**Who is this document aimed at?**

All the Trusts employees and partners as well as contractors and visitors.

**This document is essential reading for the following staff groups :**

- All staff involved in activities connected with this issue
- Leaders, Managers and Supervisors

**Staff groups should be aware of the policy for reference purposes:**

- Trade union safety representatives
- Employee representatives

**What other policies, guidance and directives should this document be read in conjunction with?**

In conjunction with the Trusts core business objectives as well as all the other health and safety policies and procedures as well as statutory inspections e.g. HSE, CQC, NHS and NHS Resolutions

**How and when will this document be reviewed?**

The document will be reviewed and monitored by the Head of Health and Safety at least 2-yearly or before if required.

**CONTRIBUTION LIST**

**Key individuals involved in developing the document**

<b>Name</b>	<b>Designation</b>
Simone Smith	Head of Health and Safety
Dora Elkington	Health and Safety Officer
Amanda Gristwood	Health and Safety Adviser
David Kempson	Health and Safety Officer
Roy Dobson	Trust Fire Adviser



## Circulated to the following for consultation

Name/Committee/Group	Designation
Health & Safety Committee	Trust's Corporate Committee
Quality and Safety Committee	Trust Board Members and Senior Directors
Intranet	Wider Public and Staff Consultation
Division of Surgery	For Information
Division of Women's, Children's and Support services	For Information
Division of Medicine and Long Term Conditions	For Information
Corporate Services	For Information

## Version Control Summary

### Significant or Substantive Changes from Previous Version

A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Author
1.1	1/1/11	Reviewed and revised by the Head of Health and Safety	Dipak T Chauhan
1.2	27 <sup>th</sup> May 2011	Amended with comments received from Health and safety team, and Lincoln Dawkin Richard Kirby and Sue Wakeman	Dipak T Chauhan
	9 <sup>th</sup> May 2011	Amended with comments from HSC meeting	
Version	Date	Comments on Changes	Author
1.3	22 Nov 2011	Policy reviewed by Head of Health and Safety Non Clinical. Insert monitoring and control table in line with NHSLA standards page 34. Insert generic risk assessment page 52	Carlton Brooks
1.4	8 Jan 2015	Change of policy title. Add para 4.12 to include the newly formed NHS Property Services.	Carl Measey
2.0	9 <sup>th</sup> Sept 2018	Full Review and re-write	Simone Smith

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## Walsall Healthcare NHS Trust

### Chief Executives Health and Safety Policy Statement of Intent

This statement identifies the commitment of Walsall Healthcare NHS Trust to provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust's undertaking.

Health, Safety and Wellbeing is the responsibility of all Employees, and for the avoidance of any doubt any reference to Staff in this policy and subsequent arrangements will include; Directors, Care Group Managers, Matrons / Heads of Department, Managers, Agency Staff, Locums, Volunteers and any individual carrying out work on behalf of or in connection with the Trust. Health, Safety and Wellbeing is an integral and important part of everyone's duties. The Trust's commitment to Health, Safety and Wellbeing therefore ranks equally with all other aims, objectives and activities.

The Health and Safety Policy establishes both general and specific arrangements relating to the Trust's undertaking and extends to all premises, buildings, areas and activities throughout the Trust.

Advice on how to access the policy in full is made available to all employees at induction and subsequent training where relevant. The Trust ensures that all employees are fully aware of their legal obligations to take reasonable care for their own Health and Safety and that of any persons who may be affected by their acts or omissions at work. All employees are legally required to co-operate with their employer in Health and Safety matters. A summary of which will be provided in the induction pack as a leaflet.

Walsall Healthcare NHS Trust recognises and accepts that it is responsible for complying with Health and Safety legislation and ensuring the Health Safety and Welfare of its employees and others who may be affected by the Trusts business. Through information, instruction and training, the Trust seeks to provide and maintain, risk management so far as is reasonably practicable, by implementation of this Policy and associated Arrangements and commits to providing;

- Roles, responsibilities and accountabilities for all staff, at all levels within the Trust which are clearly defined and understood in order to secure corporate and individual compliance with relevant legislation.
- A positive Health and Safety culture and a Health and Safety Management System that ensures Health and Safety at work.
- Systems of work, plant and equipment that are safe and without risks to health.
- Arrangements for the use, handling, storage and transport of substances and articles that are made safe and without risks.
- Information, instruction, training and supervision that is necessary to ensure adequate Health and Safety at work.

- Places of work, access and egress, which are made safe to a level of risk which is as low as reasonably practicable to health.
- A working environment that is made safe and without risks to health together with adequate arrangements for welfare at work.
- Adequate resources to facilitate the undertaking of this policy.
- Information, training and supervision regarding Health, Safety and Wellbeing, so that everyone is aware of their accountabilities and responsibilities.
- Systems for identifying and assessing all hazards and risks associated with their activities and putting in place adequate control measures.

Whilst the Chief Executive Officer accepts full responsibility for ownership of this policy, all employees have a personal responsibility to ensure a proactive approach to Health and Safety matters that impact on the Trust. The Board of Directors have identified a lead Director with specific responsibility for health, safety and welfare, and a competent Head of Health and Safety to whom reference should be made in the event of any difficulties in the implementation of this Health and Safety policy and procedures.

<b>Chief Executive</b>	<b>Date</b>

<b>Non-Executive Director</b>	<b>Date</b>

<b>Director of Governance</b>	<b>Date</b>

## **1 Introduction:**

- 1.1 This Policy has been produced in accordance with the requirements of Section 2(3) of the Health & Safety at Work Act and applies to Walsall Healthcare NHS Trust in its entirety. It will be reviewed periodically or where it is believed to be no longer valid, with any amendments brought to the attention of all employees.
- 1.2 This policy contains details of roles and responsibilities for the management of Health and Safety throughout the Trust and is supported by other more detailed policies, procedures, and guidance documents which should be read in conjunction with it.
- 1.3 The policy has been compiled to provide guidance to Managers both clinical and non-clinical and Employees on the arrangements for managing Health, Safety & Welfare throughout the trust. Whilst comprehensive, the document is not exhaustive and as such all employees are required to take reasonable care of their own Health and Safety and that of others who may be affected by their acts or omissions, i.e. service users and visitors.
- 1.4 Where employees identify potential risks during their work or risks that are not covered by this document, they are to bring them to the attention of their Line Manager directly or via their Health and Safety Representative and/or the Health and Safety Department
- 1.5 The Policy 'Statement of Intent', signed by the Chief Executive, the Non-Executive Director and Corporate Director Responsible for Health and Safety sets out the Trust's commitment towards Health and Safety.
- 1.6 This policy sets out the Organisation and Responsibilities required to implement the Health and Safety Statement of Intent
- 1.7 This policy must be read in conjunction with the Trust's Arrangements for 'Managing Health and Safety', Procedures and Guidance.
- 1.8 The Arrangement - Managing Health and Safety sets out the Trust's systems for managing Health and Safety and is based on the Health and Safety Executive (HSE) guidance document HSG 65 'Managing for Health & Safety', which the Trust has adopted. Managers must read and implement this Arrangement.
- 1.9 The Arrangement - Risk Assessment sets out the Trust's procedure for undertaking a risk assessment and is vital to ensuring the management of Health and Safety.
- 1.10 The Arrangements known as 'Procedures' have been developed to support this Policy; they reflect the requirements set out in various Health and Safety Regulations and other statutory provisions. These are key to the development of management systems and the controls required to manage the risks

identified by the risk assessment process. Managers and Staff must read and implement procedures that are applicable to their role.

- 1.11 This Policy and its Arrangements i.e. Procedures, can be found on the Corporate Health and Safety Intranet Site where other Health and Safety information can be found pertinent to the Trust.

## **2 Scope**

This policy applies to all statutory employees of Walsall Healthcare NHS Trust, contractors, seconded staff, voluntary placements and agency staff.

## **3 Objectives**

The primary objectives of this policy are to ensure:

- The Trust complies with the provisions of the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and all other relevant Health and Safety legislation and regulations pertaining to Occupational Health and Safety and risk management.
- There are systems in place for identifying, assessing and either eliminating or adequately controlling significant risks to staff, patients and visitors.
- The Trust has access to competent health and safety advice.
- All staff members are consulted on decisions and changes related to health and safety, through duly appointed safety representatives or directly by managers.
- That the buildings, grounds and facilities within the Trust are, so far as is reasonably practicable, safe for staff, patients and visitors. The Trust will comply with the relevant external standards e.g. NHSLA and CQC as well as other statutory requirements.
- Policies, procedures and safe systems of work are in place and are adequate to ensure, so far as is reasonably practicable, the health safety and welfare of all staff patients and visitors.
- All equipment etc. provided in the Trust for use by staff is suitable, fit for the intended use, in good condition and is well maintained.
- All substances provided in the Trust for use by staff, or to which staff might be exposed too, are evaluated, safe to use, adequately stored and disposed of in a safe manner.
- That staff are competent and receive sufficient instruction, information and training to be able to work without endangering their own safety or that of colleagues, patients or other people.
- That safety management is part of the day to day management of the Trust.
- That there are systems in place to learn from accidents and near misses.
- That achieving an improvement in safety standards is one of the objectives of all service developments or changes.

#### **4 Roles and Responsibilities - The Trust Board**

- 4.1 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.

#### **5 Chief Executive Officer**

- 5.1 The Chief Executive has overall responsibility for all matters involving Health and Safety in the Trust. This responsibility includes ensuring that all safety matters are seen as an important priority for the Trust and addressed through comprehensive policies and procedures that are effectively implemented and appropriately resourced within the overall financial position of the Trust.
- 5.2 The Chief Executive must ensure the Trust Management Team follow their responsibilities detailed within this Health and Safety Policy and Arrangements, holding them to account if they do not.
- 5.3 Provide leadership to ensure that Health and Safety is effectively managed within the Trust.
- 5.4 Ensure the decisions the Trust's Management Team make take into account this Health and Safety Policy and any applicable statutory provisions.
- 5.5 Be informed of, and alert too, relevant Health and Safety risk management issues.
- 5.6 Ensure a Health and Safety Strategy is in place for the ongoing development of Health and Safety management systems.
- 5.7 The Chief Executive will ensure that appropriate financial resources are made available to support this Policy based upon sound risk management principles.
- 5.8 The Chief Executive is assisted at Board level by a Non-Executive Director with specific responsibility for ensuring that the aims and objectives of the Trust's Health and Safety Policy are implemented throughout the Trust.
- 5.9 In addition, each member of the Trust Board has an individual role in providing health and safety leadership and ensuring that all board decisions reflect the intentions outlined in the Health and Safety Policy 'Statement of Intent'.
- 5.10 Has responsibility for Health and Safety throughout the Trust and is responsible for managing Health and Safety and monitoring compliance, NHS directives and Trust Policies and Arrangements. The Chief Executive will achieve this by:
- Ensuring this policy is implemented in every operational area throughout the Trust.
  - Ensuring arrangements are in place to enable the effective planning, organisation, control, monitoring and review of Health and Safety in every operational area of the Trust
  - Appointing a Director to act on their behalf with regard to Health and Safety, to ensure adequate infrastructure is in place across the Trust, so far as is reasonably practicable to ensure the health, safety and welfare of all employees and others affected by the Trusts' undertakings.
  - Ensuring active channels of communications for consultation with employees are formed, by establishing and maintaining, appropriate Health and Safety committees, groups, forums and structures.



- Ensuring Health and Safety is regarded with equal importance as any other core business of the Trust.
- Ensuring that, adequate resources are allocated to meet the Trust's commitment to Health, Safety and Welfare.
- The Chief Executives Health and Safety Policy Statement of Intent endorses these responsibilities and commitments.

## **6 Role of Non-Executive Directors**

- 6.1** The Trust Board forms the collective strategic and operational leadership of Walsall Healthcare NHS Trust. Representation on the Board includes Executive Directors and also independent Non-Executive Directors from outside the organisation.
- 6.2** Membership of the Health and Safety Committee includes a Non-Executive Director who will:
- Independently challenge decisions, actions taken and progress made on matters relating to the management of health and safety.
  - Provide assurance to the Trust Board that the aims and objectives of the Health and Safety Committee are being met.
  -

## **7 Director of Governance (Director with responsibility for Health and Safety)**

- 7.1** The **Director of Governance** is the lead director for Health and Safety within the Trust.
- 7.2** Their key responsibilities include the provision of strategic leadership on Health and Safety matters for the Trust
- 7.3** Ensure that the operation of the Health and Safety management system provides effective planning, organisation, control, monitoring and review of Health and Safety within the Trust.
- 7.4** Be kept informed about any significant Health and Safety risks and failures, and of the outcome of any investigations into their causes through the Trust's reporting arrangements.
- 7.5** Under the Corporate Manslaughter and Corporate Homicide Act, Health and Safety legislation means 'any statutory provision dealing with Health and Safety matters' i.e. Pedestrian and vehicle transport, food safety, workplace safety, infection control, etc. and other legislation enforced by the Health & Safety Executive.
- 7.6** It is therefore vital that the Trust keeps its Health and Safety management systems under review, in particular, the way in which its activities are managed or organised by senior management.
- 7.7** In support of the Chief Executive, the Director of Governance shall ensure that they establish a Trust Health and Safety Committee, the Terms of Reference (TOR) for which are to be approved by the Trust Board.
- 7.8** The Director Responsible will be fully conversant and comply with the TORs of the Health and Safety Committee.
- 7.9** The Director of Governance will arrange a review of compliance with the Terms of Reference (appendix 1) annually. This will include an audit of:
- The number of meetings held;

- The reasons any meetings have been cancelled;
- Attendance by members and the frequency of deputising arrangements; and
- By reviewing the extent to which reporting has complied with the requirements of the Committee.

**7.10** Be kept informed of changes in the relevant statutory provisions and assess the implications of such changes with regard to Health and Safety.

**7.11** The Director of Governance will chair the Trusts corporate Health and Safety Committee and has the following specific responsibilities to ensure:

- That the Trust has a Health and Safety Policy which gives a clear unequivocal commitment to safety and sets out the framework for improving Health and Safety compliance performance and reducing accidents, illness and financial loss in regard to safety, to a minimum.
- That there is a clear communication plan in place to enable the Policy to be brought to the attention of all staff, including contractors and has the support of the Joint Negotiating Committee (JNC).
- That the objectives of the Policy are fully understood and implemented by all Directors, Senior Managers, Managers, and department leads.
- That rigorous monitoring procedures are in place at all levels of the organisation, to facilitate the effective implementation of the Policy.
- The Trust corporate health and safety committee review the Policy every 2 years or sooner if there are any significant legislative or organisational changes identified by the Head of Health and Safety.
- The Trust Corporate Health & Safety Committee draws up a robust plan to ensure integration of health and safety matters into the Trusts corporate objectives and assurance framework and that this is supported by an annual action plan of priorities for approval and assurance purposes by the Trust Board.
- That an Annual Report on the Health and Safety Performance of the Trust is provided to the Trust Board and for the Trusts Annual Report.
- That the corporate Health and Safety Committee provides regular reports to the Quality and Safety Committee on all matters relating to health and safety.

## **8 Executive and Divisional Directors**

- 8.1** Provide leadership on Health and Safety matters for their Divisions / Business Units.
- 8.2** Ensure that the operation of the Health and Safety management system provides effective planning, organisation, control, monitoring and review of Health and Safety within the Divisions/ Business Unit.
- 8.3** Appoint a Senior Manager(s) to become the 'Health and Safety lead' for each Division / Department in their portfolio.
- 8.4** Ensure Health and Safety is regarded with equal importance as any other core business of the Trust.
- 8.5** Ensure Senior Managers, follow their responsibilities detailed within this Health and Safety Policy and its Arrangements, holding them to account if they do not.

- 8.6 Ensure Senior Managers are competent to perform their role.
- 8.7 Provide support and cooperation to the trusts Health and Safety Manager.
- 8.8 Promote a positive health and safety culture and provide representation for employees.
- 8.9 Hold meetings where appropriate to address H&S issues or concerns.

## **9. Senior Managers/ Matrons/ Care Group Managers**

- 9.1 Ensure that the operation of the Health and Safety management system provides effective planning, organisation, control, monitoring and review of Health and Safety within the Division(s).
- 9.2 Prepare, implementing and maintaining Divisional Health and Safety arrangements aimed at complying with the requirements of this Health and Safety policy and arrangements, at Divisional / Departmental level where required.
- 9.3 Ensure Managers, follow their responsibilities detailed within this Health and Safety Policy, and its Arrangements, holding them to account if they do not.
- 9.4 Ensure employees within their authority are competent to perform their role.
- 9.5 Provide support and cooperation to the trusts Health and Safety manager.
- 9.6 Holding Consultative Group meetings where appropriate to address Health and Safety issues or concerns
- 9.7 Encourage the nomination of Health and Safety 'Champions' are identified to promote a positive health and safety culture for every service within their control. Ensuring they are aware of their duties, have sufficient ability, resources and training to be able to carry the role out properly (In any premises where there are employees of more than one Division / Department, the relevant Senior Managers must liaise and co-ordinate in identifying champions).

## **10 Ward/ Department Managers/ Team Leaders/ Supervisors**

- 10.1 Ensure arrangements are in place to enable the effective planning, organisation, control, monitoring and review of preventative and protective measures within their area of responsibility.
- 10.2 Inform their Senior Management of any breaches of the Health and Safety Policy and Arrangements.
- 10.3 Provide support and cooperation to the Trust's Health and Safety Manager.
- 10.4 Ensure employees, within their authority are competent to perform their role.
- 10.5 Hold Consultative Group meetings where appropriate to address H&S issues or concerns.
- 10.6 Managing property assets and services in compliance with Health and Safety legislation, the Equalities Act and Compliance Standards, where this is a part of their remit.
- 10.7 Ensure compliance with all statutory workplace inspections managed either directly or via Estate Services or other service providers. Liaise with Estate Services or the appropriate service provider (e.g. NHS Property Services) and building occupants to establish where the lines of responsibility lie for the management of property assets and services (note: there may be a crossover of duties between the Health and Safety Champions and Manager(s) so these two roles must liaise with each other).
- 10.8 Ensure that electronic records of statutory servicing, maintenance and testing for WHT Premises are accessed periodically to check accuracy (note: this may be a delegated responsibility to Estate Services, where this has been

delegated, the Manager must ensure Estate Services are undertaking checking accuracy)

- 10.9** Support the Director(s) and Senior Managers responsible for managing Health & Safety.
- 10.10** Managers (clinical and non-clinical) shall, within their area of responsibility ensure that day to day work activities under their control are carried out with full regard to good Health and Safety management and in compliance with this policy and Arrangements. In particular within their area of responsibility shall ensure:
- 10.11** The Statement of Intent contained within this policy is brought to the attention of all employees within their area of responsibility.
- 10.12** Employees are made aware of their Health and Safety Responsibilities as determined by this policy, arrangements and respective roles.
- 10.13** They monitor the health and safety performance of their area on a suitable basis (dependant on the risks) but no longer than annually and take such steps as may be necessary to improve the performance
- 10.14** They develop an appropriate risk register in accordance with the Trust's Risk Management Strategy (or where it is believed to be no longer valid, whichever is the sooner). The register is to be kept, maintained and made available to the Trust's Health & Safety Forum.
- 10.16** Promote and encourage consultation and communication on matters of Health and Safety.
- 10.17** Ensure that employees are provided with such health surveillance as is appropriate with regard to risks to their Health & Safety.
- 10.18** Arrange for the assessment of employees' capabilities, in particular their specific training needs and provide appropriate training to ensure they can perform their work without risk to themselves or others.
- 10.19** Appoint and / or Elect or allow be appointing and / or electing employee Health and Safety Champions/ Representative(s), First Aider(s) and Fire Warden(s). Ensuring that there is sufficient numbers and resources, to assist them to discharge their duties.
- 10.20** Ensure employees, especially part time or temporary receive comprehensible and relevant information on:
- Any risks to their health & safety
  - Protective and preventative measures
  - Emergency procedures
  - The identity of individuals nominated to assist them with Health and Safety matters and Emergencies.
  - Report, using the Trust's internal reporting system "Ulysses", the details of any incidents, dangerous occurrences or cases of disease.
  - Making suitable and sufficient assessments of risks to the Health and Safety of employees and others, recording the significant findings and ensure the adequacy of preventative and protective measures
  - Reviewing, if necessary, revising risk assessments at regular intervals to ensure the continuing adequacy of preventative and protective measures
  - Recommending improvements or remedial action(s) arising from; reviews, or the findings of any investigations into the cause of incidents / accidents or dangerous occurrences.

## **11.0 Employees;**

- 11.1 Carry out their duties in line with the Health and Safety Policy and Arrangements.
- 11.2 Take reasonable care for the Health and Safety of themselves and of other persons who may be affected by their acts or omissions.
- 11.3 Co-operate with the Trust to ensure that any relevant statutory provisions are complied with.
- 11.4 Not to intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare.
- 11.5 Report all accidents, incidents and / or near misses to their immediate line manager.
- 11.6 Report any unsafe work situation or equipment defects to their immediate line manager.
- 11.7 Use any equipment or substance provided in accordance with any training or instruction given.
- 11.8 Participate in Health and Safety reviews and reporting arrangements.
- 11.9 Inform the Health and Safety Representative(s)/ 'Champion(s)', and Line Manager(s) without delay, of any work situation which they consider represents a serious or immediate danger to the Health and Safety of themselves or others.
- 11.10 Inform the Health and Safety Representative(s)/ Health and Safety 'Champion(s)', and Line Manager(s) of any matter they reasonably consider represents a shortcoming in the Health and Safety arrangements, even when no immediate danger exists.
- 11.11 Familiarise themselves with all the trusts emergency arrangements and procedures relevant to them.
- 11.12 Make themselves familiar with those work arrangements in place for reasons of Health and Safety, which are relevant to their work. Those who visit other sites shall themselves familiarise with the local Health and Safety arrangements and requirements of those locations and activities and act responsibly.
- 11.13 Make themselves aware of arrangements particularly at non Trust controlled premises,
- 11.14 Attend mandatory and statutory training sessions and other training, as directed by their Line Manager. Employees must bring to the attention of their line manager any outstanding training requirements needed to ensure they can carry out their work activities in a safe and competent manner. A member of staff should carry out no work activity if they are not trained or competent to complete the task safely.

## **12 Trust Head of Health and Safety**

- 12.1 Supporting the Director Responsible for Health and Safety to ensure the Trust is meeting its legal and moral obligations with regard to the Health, Safety and Wellbeing of its employees and those affected by the Trust's activities.
- 12.2 Advising the Trust on Health and Safety objectives and ensure objectives are planned and implemented.

- 12.3** Ensuring that the strategic direction for Health and Safety is developed and communicated to all and performance is regularly monitored and reviewed.
- 12.4** Providing leadership for Health and Safety across the Trust, working with and co-ordinating Health and Safety teams and advisors and providing support to Directors and Senior Managers.
- 12.5** The Trust Head of Health and Safety shall, as part of their duties:
- Ensure that Managers and employees are aware of their Health and Safety responsibilities as determined by this policy.
  - Review and amend policies and arrangements on a regular basis or on the introduction of new legislation, whichever is the sooner.
  - Keep informed of changes in the relevant statutory provisions and assess the implications of such changes for the Trust.
  - Monitor the Health and Safety performance of the Trust and its service providers, taking such steps as may be necessary to improve safety performance.
  - Recommend improvements or remedial action to the Trust's Board and Health and Safety
  - Forum arising from reviews or findings of investigations into the cause of incidents / accidents or dangerous occurrences;
  - Promote interest in and enthusiasm for Health and Safety throughout the Trust.
  - Review the details of incidents / accidents, dangerous occurrences and cases of disease reported to the Health and Safety Executive.
  - Assist managers in providing employees with adequate information, instruction and training as may be necessary to perform their work without risk to themselves or others;
  - Advise and assist Employee Health and Safety 'Champion(s)'

### **13 Health and Safety Team**

- 13.1** Ensure that the Trust is aware of its responsibilities and requirements to comply with relevant statutory provisions and codes of practice.
- 13.2** Provide competent Health and Safety advice to all areas of the trust in line with policies and arrangements.
- 13.3** Create and maintain the Trust's Health and Safety Policy and Arrangements.
- 13.4** Monitor compliance with this Policy and Arrangements, advising and reporting on areas of Health and Safety management that are lacking, inconsistent or not in accordance with good practice.
- 13.5** Advise and support Divisions, Care Groups and Departments where necessary on production of risk assessments and localised policies and arrangements.
- 13.6** Identify Health and Safety training requirements in coordination with the Leadership, Education and Development Department.
- 13.7** Develop and deliver training on matters relating to health and safety, including induction, mandatory training and (in collaboration, with other providers where necessary) bespoke sessions to support staff at all levels of the organisation.
- 13.8** Carry out and support Senior Managers in the Trust to carry out Incident / accident investigations and implementing and monitor corrective actions.
- 13.9** Attend Divisional, Care Groups and Departmental Safety forums

- 13.10 Groups where appropriate to address Health and Safety issues or concerns Liaise regularly with the Trust's trade unions in regard to Health and Safety matters.
- 13.11 Assist the Trust in liaising with enforcement authorities.
- 13.12 Keeping abreast of, and bring to the attention of the Trust any relevant legislation changes.
- 13.13 Provide, assist and support, reporting to the Health and Safety forum / committee(s) on trends identified from incident / accident reporting, inspections, audits and any general observations based on enquiries.
- 13.14 Issue periodic Health and Safety bulletins on changes to legislation, updates to the Health and Safety Policies and Arrangements, training/briefing sessions, and results from incident / accident investigations, audits and inspections.

#### **14 The Occupational Health and Wellbeing Service;**

The Trust has an agreement with Occupational Health and Wellbeing to ensure their responsibilities include:

- 14.1 Offering a comprehensive, specialist advisory service to management and employees within the Trust, on all matters relating to Health and Wellbeing
- 14.2 Providing health surveillance activities to enable the Trust to meet its statutory obligations
- 14.3 Creating the necessary conditions to improve awareness throughout the Trust and of the need to promote and maintain employee health, as well as ensuring the physical and mental well-being of employees.
- 14.4 As part the agreement, the Occupational Health and Wellbeing Service Provider shall where required and in conjunction with the relevant Manager and Human Resource Department:
- 14.5 Undertake Work Health Assessments for new employees to identify susceptible individuals who may be likely to be at excessive risk of developing work-related disease from hazards / hazardous agents present in the workplace and to ensure as far as possible, that the prospective employee does not represent a risk to others and that the employee is physically and psychologically capable of carrying out the work role.
- 14.6 Ensure assessments consider relevant current or previous illness, e.g. serious communicable diseases i.e. blood borne viruses (tuberculosis, hepatitis B, hepatitis C and HIV) and offer protection against pathogens in the workplace thereby reducing the risk of healthcare worker-to–Service User- transmission of infection.
- 14.7 Ensure assessments made, take into account the relevant workplace risk assessments, the requirements of the Equality Act and will consider reasonable adjustments that may be required and recommendations made, to ensure that employees can work regardless of physical impairment, mental illness or learning disabilities where it is safe to do so.
- 14.8 Provide advice to managers / employees in relation to reasonable adjustments required by the Equality Act;
- 14.9 Provide health surveillance programmes to employees who may be exposed to hazardous substances at work, to ensure that any change in health are detected at an early stage.
- 14.10 Ensure that vulnerable group's i.e. pregnant workers, new mothers, receive health surveillance throughout their pregnancy where identified through risk

assessment and ensure that workplace activities do not affect the health of the mother or her baby.

- 14.11 Undertake assessment following occupational injury i.e. inoculation, contamination, sharps (bites, cuts, scratches, splashes), etc. provide support, advice and recommendation as to the appropriate treatment.
- 14.12 Support employees and managers to create a healthy work environment where the health and wellbeing of employees is highly valued and encourages and supports employees to maintain and adopt healthy lifestyles.

## 15 Radiation Protection Advisor

The Trust, with the Health and Safety Executive, formally appoints the Radiation Protection Advisor (RPA) as required by Ionising Radiation Regulations. The RPA is the competent person and has the responsibility for advising on compliance with statutory requirements concerning the use of ionising radiation. In particular;

- 15.1 Providing advice on all aspects of radiation protection
- 15.2 Carrying out periodic audits of work places where necessary
- 15.3 Acting as the Competent Person in relation to radiation monitoring equipment
- 15.4 Appointing Radiation Protection Supervisors for service areas working with ionising radiation
- 15.5 Assisting with the provision of appropriate training for staff
- 15.6 Being a resource to the Trust for ensuring compliance with the necessary statutory instruments, policies and arrangements
- 15.7 Ensuring there are policies and arrangements in place for all clinical and non-clinical elements of ionising radiation protection.
- 15.8 Within each Imaging Department, the Lead Radiographer, Senior Employees and Radiation
- 15.9 Protection Supervisors are responsible for ensuring compliance with this Policy, arrangements and the requirements of legislation and guidance pertaining to the use of ionising radiation.

## 16 Infection Prevention and Control Lead Nurse

The Trust has nominated and appointed a Lead Nurse for infection prevention and control

(IP&C), who is responsible for;

- 16.1 Implementing the strategic and operational management of the Infection Control Team and the operational management of infection prevention and control across the organisation Ensuring IP&C advice is available to protect the health, safety and welfare of all employees.
- 16.2 Ensuring policies and arrangements in place for all clinical and non-clinical elements of infection prevention and control coincide with health and safety regulation.
- 16.3 Provide guidance and advice as required on decontamination of medical devices and the environment.
- 16.4 Work alongside the health and safety team and in conjunction with clinical colleagues to support the effective safe management of sharps as per Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- 16.5 Participate in, and support, the collection and review of surveillance data.



- 16.6 Participate in Health and Safety and Infection Control service reviews for new builds, service developments and refurbishment projects.
- 16.7 In the event of an outbreak, to work in collaboration with the regional Health Protection Unit in the management, investigation and containment of the outbreak, whether deemed a minor or major incident

### **17 Electrical Biomedical Engineering (EBME)**

The EBME Manager is appointed by the trust to advise, support and guide the trust in order to set out long term objectives for the management of medical devices; including strategic replacement, development and equipment procurement.

- 17.1 The EBME manager is responsible for;
- 17.2 Ensuring there are policies and arrangements in place for all elements of medical devices.
- 17.3 Coordinating medical device safety and management arrangements across the trust to ensure relevant statutory requirements are met.
- 17.4 Being the key point of contact for all medical devices related queries, providing advice and support to managers and employees.
- 17.5 Providing the Trust with assurance of safe device use and management
- 17.6 Work towards and maintaining standards in line with national guidelines and industry standards, including the Health and Social Care Act, Health Technical Memorandums and NHSLA.

### **18 Moving and Handling Lead**

The Moving and Handling Lead is responsible for providing professional advice, guidance and training on reducing manual handling risks to employees and patients and will ensure:

- 18.1 There are policies and arrangements in place for all elements of manual handling.
- 18.2 Coordination of manual handling and arrangements across the trust to ensure relevant statutory requirements are met.
- 18.3 Develop, design, deliver and evaluate moving and handling training programmes which incorporate relevant evidence based practice and statutory requirements.
- 18.4 Managers and employees are provided with support and advice
- 18.5 Incident reports relating manual handling are reviewed and investigated accordingly. This will include assisting managers to investigate accidents / incidents involving manual handling.
- 18.6 Advice is provided on moving and handling issues relating to the design, refurbishment, lease or purchase of buildings, furniture or equipment.

### **19 Fire Safety Manager (FSM)**

The Fire Safety Manager is responsible for providing competent advice, support, guidance and training on fire safety risks to employees and with regards to the trust premises, ensuring compliance with the Regulatory Reform (Fire Safety) Order across the trust, in particular;

- 19.1 There are policies and arrangements in place for all elements of fire safety.
- 19.2 Coordination in relation to the fire safety policy and arrangements to ensure relevant statutory requirements are met.
- 19.3 Providing support and advice to all employees on fire safety matters

- 19.4** Ensuring suitable and sufficient fire emergency arrangements are in place.
- 19.5** Development and delivery of an effective training programme in all aspects of fire safety.
- 19.6** Monitoring fire safety compliance and reducing fire safety risks.
- 19.7** The role of the Fire Safety Advisor is to:
  - Ensure that suitable advice is available to Project Team/s on plans for new buildings or major refurbishment to existing buildings.
  - Coordinate and carry out Fire Risk Assessment Reports for all Trust premises.
  - Offer competent fire safety advice and guidance to local managers and remedial action to address fire safety issues.
  - Coordinate and manage delivery of suitable Fire Safety Training to all Trust staff.
  - Monitor, manage and coordinate investigation of fires and false alarms and give advice or work with managers to reduce the number of such incidents.
  - Investigate fire incidents, where appropriate, and submit a report to the appropriate manager, Director or Chief Executive, together with an action plan.
  - To ensure that the Trust meets its statutory requirements in regard to fire management and report to the Director with lead responsibility for Fire safety on all Trusts premises.
  - Establish and service the Fire Safety Review group and provide regular reports to the corporate health and safety committee as a standing item and via formal quarterly reports.

## **20 Security Manager (SM)**

The Security Manager is the appointed Local Security Management Specialist (LSMS) and will undertake the duties of an LSMS in accordance with Secretary of State Directions to health bodies on measures to tackle violence and general security management measures. This includes:

- 20.1** Ensuring that all NHS security management work is carried out within a professional and ethical framework developed and provided by the NHS Security Management Specialist (SMS).
- 20.2** Ensuring that an inclusive approach to security management is taken, involving both internal and external stakeholders where appropriate and necessary.
- 20.3** Lead on day-to-day security management work, to tackle violence against staff and professionals in accordance with the Trust's and national framework and guidance.
- 20.4** Ensure appropriate steps are taken to create a pro-security culture throughout the Trust ensuring that any security incidents or breaches that occur are detected and reported.
- 20.5** Attend necessary meetings and ensure appropriate links are made with the Trust's risk management process, including the Trust's health and safety infrastructure, so that security-related issues are an integral part of that process
- 20.6** Participate in the Trust's induction programme for new staff and develop and deliver security awareness sessions for stakeholders

- 20.7** Ensure lessons learnt from security incidents and breaches are fed into risk analysis, both locally and nationally, so that appropriate preventative measures can be developed.
- 20.8** Local Security Management Specialist (LSMS)  
The LSMS is a specialist advisor providing advice and guidance on managing risks associated with security and violence and aggression.

The LSMS will:

- Establish clear corporate objectives to implement the Directives NHS Protect.
- Lead on day-to-day work in the Trust to tackle violence against all staff and others in accordance with the NHS Security Management Service's (NHS SMS) national framework and guidance.
- Attend the Trust's corporate health and safety committee meetings so that security related issues are an integral part of Trust's risk management strategy.
- Ensure that suitable and sufficient training is provided to all staff groups in line with the NHS Protects' Security Management Standards.
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- Ensure appropriate steps are taken to create a pro-security culture within the Trust and among contractors and where security incidents/ breaches occur they are detected and reported.
- Ensure security incidents/breaches are investigated in a fair, objective and professional manner so that the appropriate sanctions are applied and measures are put in place to prevent recurrence.
- Formulate security alerts, monitor, disseminate and manage national alerts.
- Produce crime reduction and security surveys and report for the corporate Health & Safety Committee on findings, based on prioritised risk ratings and relevant to specific areas.
- Ensure strong links are built with the Area Security Management Specialist.
- Consider cases not progressed by the police or Crown Prosecution Service and where appropriate, work with the NHS SMS Legal Protection Unit, in order to seek redress, where appropriate.
- Support all managers in establishing suitable links with the police to ensure that security, violence and aggression issues to NHS staff are proactively managed.

## **21 Learning and Development Manager**

The Trusts Learning and Development Manager is responsible for the following:

- 21.1** Providing a suitable Trust induction, in consultation with Head of Health and Safety, to all new staff prior to them commencing employment. This includes volunteers.
- 21.2** Ensuring that mandatory updates are available for all staff (responsibility for ensuring attendance rests with the line manager)
- 21.3** Ensuring that a training prospectus, including all health and safety related training is produced on an annual basis, identifying mandatory and essential health and safety related training and the staff groups to whom each session is targeted
- 21.4** Maintaining a training attendance database.

21.5 Highlighting non-attendance at training sessions to the appropriate manager

## 22 Staff Safety Representatives

22.1 The Trust acknowledges the right of recognised unions and professional associations to appoint health and safety representatives to represent their members regarding health and safety related matters. In addition, the Trust will also recognise nominated non-union appointed staff representatives within the Trust in accordance with the:

- Safety Representatives and Committees Regulations 1977 (as amended)
- Health and Safety (Consultation with Employees) Regulations 1996 (as amended)

22.2 The Trust will consult with such representatives with a view to developing and maintaining arrangements which will enable the Trust and staff to co-operate fully and effectively in the promotion of health and safety.

22.3 The Trust will provide facilities, support and assistance so that health and safety representatives may reasonably carry out their role, including allowing reasonable access to appropriate training to ensure competency.

22.4 The functions of the staff health and safety representatives are:

- To investigate health and safety concerns brought to their attention, potential hazards and dangerous occurrences and the causes of incidents.
- To make representation to appropriate managers on the above matters and on general health and safety matters.
- To carry out local health and safety inspections, if they have not inspected in the last three months, where there has been a substantial change in the condition of work and after a notifiable incident, illness or dangerous occurrence.
- To actively participate in the Health and Safety Committee meetings.
- To represent staff in consultation with Health and Safety Executive inspectors and other enforcing authorities

## 23 Contractors / Service Providers / Suppliers (CSPS)

23.1 All CSPSs employed directly or indirectly by the Trust must undertake their work in a safe manner. This work must be undertaken in accordance with statutory health and safety requirements and the Trust's policies and procedures.

23.2 CSPSs must fully co-operate with this Policy and any subsequent arrangements which may be appropriate or necessary.

23.3 CSPSs must ensure that;

- They and other self-employed persons (engaged on Trust business) assess and document the risks of their work and undertakings and make provision to protect themselves and others in respect of their own work activities.
- That they are competent and authorised to carry out the required work and they have the supporting documentation to evidence this through risk assessments, safety plans and/or method statements, permits to work, etc.

- That all their employees (and sub-contractors) are appropriately informed, instructed and trained in health, safety and welfare related matters pertaining to their own and Trust work activities
- That reasonable steps are taken to ensure co-operation and communication between all contractors and Trust staff and other relevant persons
- That they report significant accidents and incidents to the Trust when undertaking their work and incidents that fall within Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) which occur as a result of the contractor's undertakings
- That they provide safe access to and from their workplace for their own staff and all others affected by their undertakings and put in place provisions to deal with a fire and do nothing to compromise the fire systems and procedures already in place within the Trust

## **24 Project Co – Privately Funded Initiative [PFI] Partners**

- 24.1** Project Co (Walsall Hospital Company (WHC)) is an entity made up of a private sector consortium. This consortium is typically formed for the specific purpose of providing the PFI. It is owned by a number of private sector investors. The consortium's funding will be used to build the facility and to undertake maintenance and capital replacement during the life-cycle of the contract.
- 24.2** Project Co (Pco) will monitor the service level agreement with out-sourced suppliers for hard facilities management (FM) e.g. Skanska Facilities Service (SFS). They will:
- 24.3** Ensure that the Project Agreement and service delivery is adhered to and proactively managed.
- 24.4** Assure the Trusts corporate health and safety committee around health and safety performance by providing regular reports on health and safety related matters to the committee
- 24.5** Ensure that any risks identified are clearly communicated and shared with the Trust. Subsequent risk control strategies are identified, implemented, monitored and again, communicated to the Trust.
- 24.6** Adhere to the Trusts policies and procedures – in particular the Risk Management Policy and Risk Management Strategy Policy and other health and safety related policies.
- 24.7** That incidents are reported in line with the Trusts policies and procedures.
- 24.8** Provide Walsall Healthcare NHS Trust with written evidence that all matters related to health, safety, security and fire are carefully considered as part of all projects and commensurate with the type and scale of the project.
- 24.9** In particular they will ensure that in consultation with the Trusts Estates & Facilities Department and in compliance with the Project Agreement, clear Key Performance Indicators (KPIs) are agreed and these are monitored through the monthly Hard FM meetings and other groups i.e. Fire Safety Group; Medical Gases Committee; Water Safety Group. The health & safety issues flowing from these groups should be reported to the Trust's Health & Safety Committee
- 24.10** Ensure that contractors are aware of Trust policies and procedures and will comply with the relevant sections – Pco & Skanska
- 24.11** Ensure that contractors provide method statements showing how work will be carried out safely and in compliance with legal requirements – Pco & Skanska
- 24.12** Ensure that contractors comply with the requirements of the Trust permit to work system – Pco & Skanska

- 24.13 Require contractors not working to the necessary safety standard to, either make changes, stop work or leave the site, depending upon the degree of risk and previous performance on the project. This responsibility may be delegated to the manager or engineer overseeing that project - Skanska
- 24.14 Ensure that there is a robust system in place for reporting and rectifying reported defects to the Trust estate, including the fabric, fixtures and fittings of buildings, ground and access routes and plant and equipment – Pco & Skanska
- 24.15 Ensure that maintenance and repair of plant and equipment is carried out according to manufacturer’s instructions - Skanska
- 24.16 Provide engineering advice to managers and directors on suitability of facilities plant or equipment. This will include identifying equipment as obsolete or beyond economic repair and making recommendations for replacement - Skanska
- 24.17 Ensure that there is a system in place for planned preventative maintenance of plant and equipment
- 24.18 Ensure that there is maintenance history held for relevant pieces of plant and equipment (this will include medical equipment and other safety critical equipment) - Skanska
- 24.19 Ensure that the Trust and or the contractor maintains a register of all aspects of asbestos, Legionella and other Planned preventative maintenance issues that can be monitored and managed has an asbestos register as required by the relevant regulations and that the information contained in this is available to engineers and contractors required to work in areas where there is asbestos containing material.
- 24.20 Ensure that suitable contractual arrangements are in place to ensure robust risk management in regard to hard facilities management or any other such contracted services e.g. waste management, catering, laundering etc.
- 24.21 Ensure that suitable and sufficient measures are in place and managed and monitored by the competent person in regard to Construction Design and Management (CDM) regulations.
- 24.22 Ensure that the Project Agreement, detailing contractual obligations are adhered too and monitored on a regular basis in regard to health and safety matter.

## **25 Skanska Facilities Services**

- 25.1 The responsibilities for management of contractors will be met by the General Manager of SFS, as detailed under the Project Agreement. In addition the General Manager has the following site specific responsibilities.
- 25.2 Ensuring that where projects fall under the requirements of the CDM Regulations, the Trust complies with its duties as client under those regulations including the duty to appoint a competent designer, planning supervisor and main contractor.
- 25.3 Ensuring compliance with both statutory and legal requirements in regard to hard FM.
- 25.4 Ensuring that the specification for the project includes elimination or reduction of future health and safety risks for users of the facility so far as is possible within the scope of the project.
- 25.5 Ensuring that robust systems are in place and make them available for proactive monitoring by the Trust
- 25.6 Ensuring that all works subcontracted is actively monitored and that risk assessments, method statements and systems of works are verified before

works commence and are available to the Health and Safety Team if requested.

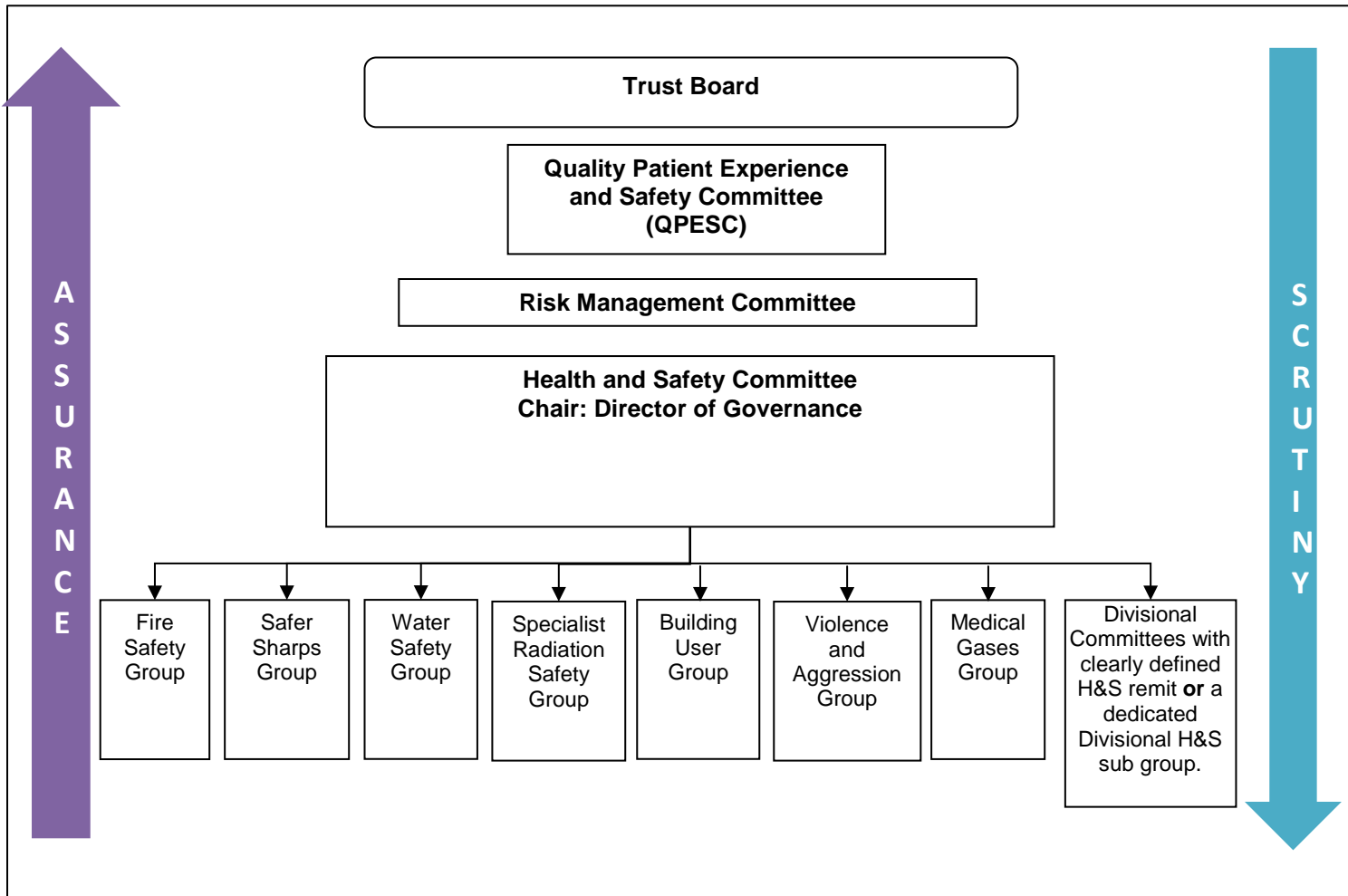
- 25.7** Ensuring that they provide the health and safety team sufficient notice if any significant works that impact on health and safety issues are to be undertaken.
- 25.8** Ensuring that systems are in place for maintenance and monitoring as required by statutory or legislative requirements and available to the Trust on request e.g. Asbestos register, legionella etc.
- 25.9** Ensuring that they have incident reporting systems in place and that this information is actively shared at via the corporate health and safety committee. Where serious incidents are involved these should be reported to the Director of Estates and Facilities immediately and also the Head of Health and Safety. Learning and reports of investigations must be shared with the corporate Health and Safety Committee.
- 25.10** Ensure that they adhere to all Trust safety policies and put in place a system of risk assessing work that may impact on people safety and the integrity of the Trust buildings.

## **26 Training Requirements**

- 26.1** The training of all staff is an essential element of any successful health and safety risk management.
- 26.2** The information, instruction and training of employees is seen as a fundamental part of providing a safe working environment. Training should be provided at the start of employment (induction) and then on a regular basis through employment. This continual training programme is to ensure high standards of safety are maintained for the benefit of staff and the general public.
- 26.3** Where health and safety training is required by legislation, it is termed statutory/ mandatory in Trust documentation.
- 26.4** Other elements of health and safety training are considered to be essential and vary from one service to another depending on the risks to staff.
- 26.5** Training is organised at two levels: at a Trust-wide level for all staff to access and then at a local, more job specific level. Health and safety training locally will include, for example, use of work equipment, managing safely, DSE assessor training, emergency procedures, COSHH, use of personal protective equipment etc.
- 26.6** Training should, where possible, involve practical instruction where the trainer demonstrates or explains how to carry out a particular procedure. To support training employees should be provided with written information to be used as a reference at a future date.
- 26.7** All training provided to staff should be recorded and evidence kept that training has taken place for legal as well as audit purposes.
- 26.8** All training information/ records should be reported to the Learning and Development Team to populate the ESR records of employees. This information should then be available to both the health and safety team and all managers to facilitate training requirements and also audit purposes.
- 26.9** Training needs will be identified by undertaking a training needs analysis or via change in statutory requirements or from the process of risk management. The identification and coordination of this will be undertaken jointly by the Head of Learning and Development and the Head of Health and Safety.

## 27 Audit & Assurance Arrangements

The monitoring and audit of all the performance indicators will be organised and managed by the Head of Health and Safety, unless otherwise stated. The reporting structure for assurance and scrutiny is detailed below:



Health and Safety Report will be presented to the Health and Safety Committee and Quality and Safety Board. It will summarise the Trust's Health and Safety performance against this Policy and subsequent procedures, including:

- An assessment of the organisations Health and Safety culture and how this is changing over time.
- Performance against industry indicators and assessment of the significant risks facing the organisation and how these are being managed
- Benchmarking activity internally and externally
- Use of proactive and reactive monitoring tools by departments
- Compliance with training standards relating to Health and Safety



- The Health and Safety Report will make recommendations for the ongoing development and improvement of Health and Safety and processes in order to achieve a positive Health and Safety culture and vision.
- The effectiveness and suitability of the Health and Safety Management processes and systems will be evaluated against the following:
- Findings and recommendations from internal and external audit reports.
- External reviews

Learning from audits will be shared with the Trust Board and all the divisions via the corporate health and safety committee as the overarching committee responsible for ensuring sound risk management associated with health and safety. Learning can be both local and organisational and as such information from inspections, audits, and other sources will be shared either at a local level via the Divisional quality committee or with the management team at a local level. Otherwise the learning will be shared via the corporate health and safety committee to inform the whole organisation.

### 27.1.1 Monitoring

Monitoring Process	Requirements
Who	Health and Safety Team
Standards Monitored	HASAWA 1974; Management of Health and Safety at Work Regulations 1999; H&S Regulations, Guidance Notes and Approved Codes of Practice HSG 65: Plan-Check- Act- Do
When	Rolling programme
How	<ul style="list-style-type: none"> <li>• Safety Culture Survey Outcomes and Action Progress</li> <li>• Proactive Risk assessment and timely remedial action</li> <li>• Mandatory Training compliance</li> <li>• Non-mandated health and safety training uptake</li> <li>• Incident reporting activity, action and outcomes</li> <li>• Consultation and effective stakeholder involvement</li> <li>• Audit and inspection</li> <li>• Compliance and attendance at health and safety committee.</li> </ul>
Monitored by	Health and Safety Department Quality and Safety Committee
Presented to	Health and Safety Committee
Completion/Exception reported to	Quality and Safety Committee, providing data on compliance and shortfalls

## 28 Definitions and Abbreviations

For the purpose of this document the following definitions will be used:

<b>Risk Assessment</b>	The process of identifying and evaluating risks for the purpose of determining whether existing controls are adequate and prioritising possible additional controls.
<b>Health and Safety at Work Act 1974 (HASAWA)</b>	The underpinning piece of health and safety legislation in the UK. It is goal setting rather than prescriptive in that it specifies what employers and other duty holders are expected to do, but does not specify how this is to be achieved.
<b>Management of Health and Safety at Work Regulations 1999 (MHSWR)</b>	Supplementary regulations, arising from the 1992 European Framework Directive. These regulations establish that employers are required to carry out risk assessments and appoint competent persons for the provision of health and safety advice. These regulations are also goal setting.
<b>Medicines and Healthcare Products Regulatory Agency (MHRA)</b>	Agency responsible for ensuring medicines and medical equipment are safe. The MHRA issues safety notices to NHS organisations that are required to take the action specified in the notice in order to ensure patient safety. Each NHS organisation is required to appoint a Liaison Officer.
<b>Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)</b>	Statutory requirement setting out the duty of employers to report certain serious types of incidents or ill health of employees to the Health and Safety Executive (HSE).
<b>Conflict Resolution Training (CRT)</b>	A training program designed to give trainees skills in avoiding or reducing the risk of violence or aggression. The training concentrates on managing situations to avoid escalation to the point at which violence might occur rather than reacting to violence.
<b>Root Cause Analysis (RCA)</b>	An incident investigation technique designed to identify underlying causes and organisational management failures that may have given rise to an incident.
<b>Corporate Homicide/ Manslaughter</b>	A new offence where an organisation to which this section applies is guilty of an offence if the way in which its activities are managed or organised: a, causes a person's death, and b, amount to a gross breach of a relevant duty of care owed by the organisation to the deceased.

<b>QSC</b>	Quality and Safety Committee
<b>CMG</b>	Corporate Management Group
<b>TMB</b>	Trust Management Board
<b>SFS</b>	Skanska Facilities Services
<b>WHC</b>	Walsall Hospital Company
<b>ISO</b>	International Standards Organisation
<b>SMD</b>	Security Management Director
<b>NED</b>	Non-Executive Director

## 29. References

1. Health and Safety at Work etc. Act 1974 The Stationery Office ISBN 978 0105437741
2. Management of Health and Safety at Work Regulations 1992 SI 1992 No 2051 HMSO ISBN 011250516, HMSO.
3. Workplace (Health Safety and Welfare) Regulations 1992. Approved Code of Practice and Guidance L24 HSE Books 1992 ISBN 978 0 7176 1413 5, HMSO
4. HSG 65, Successful Health and Safety Management, HMSO
5. Corporate Manslaughter and Corporate Homicide Act 2007, HMSO
6. Safety Offences Act 2008, HMSO
7. The Reporting of Injuries Diseases and Dangerous Occurrence Regulations (1995)
8. Safety Representatives and Safety Committees Regulations (1977).
9. 5 Steps to Risk Assessment INDG163 (HSE Books; 1994)
10. Human Factors in Industrial Safety HSG48 (HSE Books; 1994)

## 30. Related Policies

The following (but not exhaustive) strategies, policies and procedures support this policy and should be referred to when reading this policy.

- Risk Management Strategy
- Incident Reporting, Learning and Management Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Display Screen Equipment Policy
- Fire Safety Policy
- Slips Trips and Falls Policy
- Laser Policy
- Working at Height Policy
- Work Equipment Policy
- Driving at Work Policy
- Lockdown Policy
- First Aid Policy
- Safer Moving and Handling Policy
- Personal (PPE) Protective Equipment
- Management of Violence and Aggression Policy
- Security Policy (as of Nov 2014 this policy was in development)
- CCTV Policy
- Infection Control Policies
- Lone Working Policy
- Prevention and Management of Violence and Aggression
- Claims Handling Policy and Procedure
- Whistle Blowing Policy

**(This is not an exhaustive list)**

## Organisational Health and Safety Arrangements

### All Divisional Directors will:

1. Ensure that local health and safety issues are formally raised and managed at a local level by identifying a suitable forum for all health and safety matters to be raised, discussed and managed within each division. This may mean creating a divisional health and safety sub group or using a significant existing forum for this. Where health and safety issues are to be serviced in an existing committee they must ensure that all staff and management are made aware.
2. That health and safety is a standing item in one of their committee's e.g. quality committee. This does not preclude divisional directors from having a dedicated local health and safety arrangements.
3. This type of arrangement will ensure that all health and safety issues are captured, managed and addressed at a local level. Where this is not possible the risks identified, if significant, and in line with the Risk Management Strategy Policy will be escalated to the corporate Health and Safety Committee:

### Matters which should be considered in this forum are:

- a. Inspections undertaken by unit/department/ward managers
  - b. Risk identified and numbers of actions outstanding
  - c. Incident reporting and monitoring and learning
  - d. Claims reporting, monitoring and learning.
  - e. Ensure that managers have local competent advice and support in undertaking duties under the health and safety legislation.
4. At divisional level these forums will ensure the operational implementation of health and safety objectives and action plans throughout the division and Trust wide. The Group will be chaired by a senior divisional/speciality manager who will ensure quarterly reports are presented to the Corporate Health & Safety Committee regarding progress made.
  5. They will have representation from health and safety team and health and safety key workers/champions. The group will be chaired by a senior manager sitting on the corporate HSC.
  6. Relevant specialist Groups will be established. The Groups will be suitably constituted to reflect senior members from clinical, support services and technical leads

There will be a subgroup for each of the following areas:

- Specialist Radiation and Laser Group
- Path Lab Health and Safety Group: (to address issues concerning laboratory staff. Alternatively, link in with family health and diagnostic to create a divisional health and safety sub group).
- Safer Sharps Group
- Safe Water Management Group: This group already exists and feeding through the corporate health and safety committee will ensure that the work of the groups feeds through to the Trust board.
- Fire Safety Review Group: This group would specifically address issues around fire safety management in the Trust and again feed through the corporate health and safety committee to assure the trust board around fire safety compliance.
- ? Violence and Aggression

- ? Building User Group

## 7. Procedures and Arrangements for Management of Health and Safety

### 7.1 Policies

All Trust policies will be revised and laid out according to a Trust standard format. This format should ensure consistency of approach and ease of use. Each policy will include policy aim, objectives, roles and responsibilities, procedures, arrangements in place or methods of achieving the objectives, evidence or references that support the policy and arrangements for monitoring and review.

As the statutory requirement the corporate committee will take the responsibility for agreeing all health and safety policies. However, all policies will have gone through the policy group to ensure that they comply with the Trust Policy on Policy guidelines.

### 7.2 Review of Health and Safety Policies (Proactive)

This policy and all subsidiary health and safety policies will be subject to regular review on a 2 yearly basis by the policy lead. In some instances the policy may require more frequent reviews. However, any review will follow the Trusts guidance on Policy procedural document. As part of this review, the following questions will be considered:

- Was the policy effectively disseminated?
- Was it fully implemented?
- Did it meet the stated objectives?
- Have there been any revised legislation, guidance or standards released requiring a revision?
- Are changes to the appended tools necessary

Based on the review, each policy might be revised. The policy will then be circulated for consultation and comments and possibly revised again prior to final review by Trust Policies and Procedures group and ratification according to guidance in the Policy on Policy document.

### 7.1 Risk Management Strategy

The Trust has in place a risk management strategy. This document includes the Trust policy for identifying, assessing, recording and eliminating, controlling or accepting risk. This includes clinical, health and safety related, financial information related and corporate risks.

This strategy sets out roles and responsibilities for risk assessment and the compiling of a risk register within the Trust. It also includes a clear scoring system that allows disparate risks to be compared and contrasted.

### 7.2 Incident Reporting, Root Cause Analysis and Claims Handling Policies

The Trust has in place; incident reporting, root cause analysis and claims handling policies. Each of these policies sets out a single Trust wide approach to its respective topic. This means that there is a consistent approach within the Trust to the management of all incidents and claims whether clinical or non-clinical in origin

and whether involving staff patients or visitors. In addition the Trust has a single incident report form and a single incident database.

The incident reporting, learning and management policy is particularly relevant to the Trust Health and Safety Policy and all staff members should be familiar with their roles in terms of incident reporting and external reporting of RIDDOR incidents to the HSE.

The Root Cause Analysis policy although mostly applied to serious clinical incidents, details techniques also relevant to non-clinical incidents and will be used in the event of serious health and safety related incidents.

### **7.1 Subsidiary Health and Safety Policies**

There are a number of subsidiary health and safety policies, dealing with the management of specific risk areas. The policies are listed at para 11. Each Trust manager should have access to an up to date set of policies (normally held on the Trust intranet) and that they make themselves familiar with new or revised policies as appropriate.

In view of the wide ranging requirements of the Health and Safety at Work etc. Act 1974 and subsequent regulations and approved codes of practice and guidance issued under that act, the Trust will issue individual policies and procedures reflecting those requirements.

The policies will be developed and approved by the Trust corporate health and safety committee and ratified for implementation by the Trust Board. Service Directors will be responsible for issuing and implementing policies and procedures within their service areas.

The health and safety team will ensure that the most current copies are made available to all staff via the Trust's intranet. Managers will ensure that copies of all relevant policies and procedures are made available freely to all employees and others wishing to view them.

The Trust's corporate health and safety committee will be responsible for maintaining an up to date schedule of health and safety policies and procedures and will be responsible for monitoring and reviewing policies taking into account changes in statutory requirements and operational practice.

There are a range of policies and the most current copy can be found on the Trust's intranet. Printed copies of any policy should not be considered to be current.

### **7.1 Local Departmental/Service Policies & Procedures**

In some instances and at a local level, procedures (safe systems of work) may be developed for activities/tasks/treatments undertaken within that area. These are detailed documents for which new staff will require training.

Each manager or department head is responsible for implementing safe systems of work within their own work or service. This is to be based on suitable and sufficient risk assessments.

All policies and procedures relating to health and safety will be supported by the Trust's Head of Health and Safety.

All service/department documented health and safety information, policies; safe systems of work (procedures/guidelines) must be drawn to the attention of, and made available to all employees working in the department. Arrangements must be made for the procedures to be continually audited and regularly reviewed and updated when work practices change, such as following an incident/accident.

All locally developed policies, procedures or guidance must be developed in consultation with the Trust Health, Safety and Security Committee and in line with the corporate guidelines for policies and procedures.

## **8. Management Responsibilities**

Walsall Healthcare NHS Trust considers that health and safety is an integral part of managing any service within the Trust and that responsibility for safety is a line management function, cascaded from the Chief Executive through Directors and senior managers to all managers and supervisors and front line staff.

## **9. Specialist Advice and Support**

Line managers have access to specialist occupational health and safety or related advice and support from various departments and specialist staff.

Specialist advisors will make recommendations and assist in implementing them effectively is asked for assistance, but will not carry out risk assessments on a manager's behalf or be able to allocate resources or to action which circumvents the business planning process. In the event that a specialist advisor identifies a risk that has not been adequately assessed or addressed, he or she will be required to bring it to the attention of the next tier of management if the manager on the ground is unable or unwilling to do this.

Where individual staff members request assistance from the health and safety department, they will normally be referred to their line manager. Under certain circumstances, it is however appropriate for the health and safety department to get directly involved following a request from a staff member. These include the following:

- There is ongoing or immediate danger and it is not possible to involve the manager straightaway.
- The staff member has raised the issue with the manager but had no or inadequate response.
- The staff member is genuinely of the opinion that they will be discriminated against if they raise the health and safety issue with their manager.
- The issue is one which has previously been considered and reported as resolved.
- The issue is one that is already being investigated by the health and safety department or has been raised with the Trust corporate health and safety committee.



- The issue fits into an ongoing objective for the health and safety department.

## **10. Assurance and Scrutiny Structure**

The Trust Risk Management Structure is set out in the Trust Risk Management Strategy Policy

The corporate health and safety committee will feed into the Quality and Safety committee which feeds directly into Trust Board. This structure is reflected in the diagram at ss. 27.

Health and Safety Minutes will be presented to the Quality and Safety Committee as its Governing Committee.

## **11. Risk Assessment & Process**

The key component of safety and risk management within the Trust is the use of risk proactive assessments.

The process of identifying risks and carrying out general risk assessments is detailed in the Trust Risk Management Strategy. Risk assessment is the process whereby hazards are systematically identified, recorded, assessed and controlled on a continual basis.

The 'Risk Management Strategy outlines the framework that Groups must follow to ensure local arrangements for risk assessment align with the organisational management structure of the Trust. In particular, this involves:

Assessment of all significant risks to staff, patients, visitors and others who may be affected by our undertaking

- Local decision-making with regard to effective risk controls
- Registering and reviewing risks at Group and Corporate levels
- Allocation of responsibilities in connection with the above.

There are a number of guided risk assessment tools available in the Trust for the assessment of health and safety risks. These are contained within the Health and Safety Toolkit.

### **11.1 Risk Prioritisation**

All identified risks will be graded using the risk assessment matrix in the Risk Management Policy Strategy. Risks should be managed both locally and corporately as defined in this strategy policy.

### **11.2 Incident Reporting**

All untoward incidents and near misses including clinical non-clinical, security related and information related occurrences must be reported. The Trust has in place incident report system which is identified the Incident Reporting Policy.

For details of the arrangements in place for incident reporting, refer to the Trust incident reporting.

All incidents will be investigated by managers as set out in the policy and for serious incidents a more detailed investigation or root cause analysis, facilitated by the Head of Safety will be carried out.

Incidents falling under the criteria as RIDDOR will be reported to the HSE by the Health and Safety team or Occupational Health Department.

All reported health and safety incidents, including near misses, are recorded on a database, and trends etc. used when planning for health and safety. The corporate Health and Safety

Committee will receive quarterly health and safety performance reports including non-clinical incident statistics.

Contractors will ensure that they provide regular reports to the corporate health and safety committee and this will be monitored by the health and safety committee.

## **12. Planning For Safety**

The Trust will ensure that it is constantly identifying ways in which safety management can be improved, via proactive and reactive means. 'Proactive' includes inspections, audits and specialist advisors bringing to the attention of the Trust Board any changes in statutory requirements. 'Reactive' includes learning from incidents, claims or other surveys and feedback.

The process will be managed by the corporate health and safety committee ensuring that there is a plan and programme of work for health and safety and that issues are also proactive considered as part of the Trusts wider strategic objectives.

## **13. Strategic Goals and Objectives**

On an annual basis the Trust will set its key objectives. These will primarily address clinical service performance and service developments. Achievement of such objective will also lead to planned improvements in patient or staff safety.

### **13.1 Health and Safety Department Project Plan and Annual Health and Safety Plan**

The corporate health and safety committee will ensure that an annual health and safety plan is agreed and approved by the Trust Board

### **13.2 Local Objective**

Responsible Directors and will ensure that the Trust objectives are cascaded down to form care group and departmental objectives.

### **13.3 Capital Projects**

The Estates and Facilities Director will ensure that the Trust capital developments will lead to more suitable and safer facilities by ensuring that safety issues are addressed from project inception to completion.

## **14 Risk Register**

The Director of Governance will ensure that as part of the Trust risk assessment system, risk treatment plans must be prepared. In some cases, additional controls cannot be implemented immediately. In these cases, the risk may be accepted for a specified time period, or a partial solution implemented and a plan drawn up to address the underlying risk in the future.

#### **15 Business Planning**

The Finance Director will ensure that identifying risks to be addressed is an integral part of the Trust business planning process.

#### **16. Serious incidents or in response to incident trends.**

The Head of Health and Safety, as part of the incident investigation process or for more serious incidents, a full root cause analysis, recommendations or action plans are prepared in order to reduce the risk of similar incidents occurring in future.

#### **17. Safety Inspections and Audits (Proactive Monitoring)**

Senior managers/ Heads of Department/Clinical Managers are responsible for ensuring the on-going inspection of their workplaces, taking into account that higher risks will need more detailed and frequent inspection. Any hazards identified must be included within the department risk assessment and risk register, unless the hazard can be removed and is unlikely to re-occur. It is recommended that staff-side representatives are involved in these inspections.

The Health and Safety Team will ensure that there is an audit plan that is agreed by the corporate health and safety committee. The planned annual and ad hoc inspections will capture areas of good and bad practice and advise managers on action that needs to be taken as a result of any findings. Divisions too will ensure that they monitor that all their care groups have completed the inspections and acted on the actions.

The Head of Health and Safety will identify and undertake a planned programme of audits throughout the year. The primary purpose of this audit will be to confirm that suitable and sufficient risk assessments have been completed, that a plan has been devised to identify any action that needs to be taken following assessment and that a local risk register exists.

Any significant findings identified during fire and security inspections and audits, undertaken will be reported via the corporate health and safety committee and appropriate operational committee.

Learning from audits and inspection will be shared with all divisions via the corporate health and safety committee as well as by engagement with divisional committees responsible for health and safety.

#### **18. Performance Review/Reporting Health and Safety Performance (Proactive Monitoring)**

It is the responsibility of senior managers/Heads of Department and clinical managers to report on health and safety performance through the corporate health and safety committee. The corporate health and safety committee will

monitor performance against corporate and local objectives. Exception reports may be made directly to the Trust Board should there be an area of significant concern.

Performance review should be continuous with the specific aim of correcting risk management failures and ensuring workplace processes are in place to manage risk & safety. Performance monitoring will assess improvements in the workplace, work practices and the physical environment, the effectiveness of local and Trust-wide plans, and the results of any audits of systems and processes.

### **19. Health Surveillance (Proactive Monitoring)**

The Head of Occupational Health will ensure that health surveillance programmes in accordance with national guidelines and health and safety regulations. The need for health surveillance will be identified during the risk assessment process and in relevant policies (e.g. Infection Control). Occupational Health Manager will provide quarterly reports on all occupational injuries reported by staff.

### **20. Staff/Patient Surveys & Involvement (Proactive Monitoring)**

Staff and patient surveys are undertaken annually and represent a key element of the assessing performance management processes through the collection of information about risk and safety data. The Trust may choose to undertake ad hoc surveys or focus groups as part of the assessment or management process. This process can capture useful data to guide and fine tune health and safety risk management.

### **21. Incident/Ill-Health Monitoring (Reactive Monitoring)**

The Health and Safety Team and Occupational Health Team will maintain statistical information on incidents and ill-health occurring within the organisation, respectively. The departments will liaise on a regular basis to ensure that relevant information is shared and discussed. An analysis of trends relating to both incidents and ill-health will be provided to the corporate health and safety Committee.

Walsall Hospital Company/ NHS Walsall and Contractors (SFS, Norlands etc.) will provide regular reports on health and safety matters to the corporate health and safety committee to include their incident reports, investigation and trends. In addition they will ensure that all serious incidents are investigated and the findings reported to the corporate health and safety committee.

### **22. Key Indicators**

Key indicators can be used to measure the Trust's compliance against health & safety requirements and to identify any areas where management is inadequate, as well as measuring achievement of local and Trust-wide objectives and action plans. Indicators will include data on sickness rates, accidents, incidents, and analysis of underlying causes and trends and features; the number of departments with active risk assessments, action plans & registers; the number of staff trained in different aspects of health & safety; complaints and litigation.

### **23. Health and Safety Audits/Inspections (Proactive)**

The enclosed health and safety inspection checklist should be utilised by managers to ensure that they are carrying out generic assessments in their areas. This checklist will also identify if other specific assessments need to be undertaken. Inspections should be reviewed by the manager at least quarterly. The Health and Safety Team will audit these inspections on an annual basis as part of the assurance process and for preparing reports for the corporate health and safety committee. All inspections and risk assessments (specific risk assessment e.g. COSHH, DSE, manual handling) should be recorded and kept in the health and safety file located in the department/ward. Other audits undertaken by the health and safety team will include those around:

- Trends in incidents and near misses
- Serious incidents in the Trust or elsewhere
- HSE priorities
- Areas of public concern
- Reported ill health due to industrial injury
- Non clinical claims
- Estates related safety alerts management

Audits may be carried out by the Trust Health and Safety Department or by other departments including Infection Control, Occupational Health and Human Resources or Internal Audit.

### **24. Training and Information**

The Trust provides health & safety training and information for staff and others (e.g. contractors, visitors) where necessary and to the appropriate standard and formal corporate and local systems will be used in its delivery.

In broad terms, this will comprise information on:

- Relevant hazards and risks
- Controls in place to manage risks effectively
- Risk assessment procedure
- Incident reporting procedure
- Emergency procedures (e.g. fire, first-aid)

The intended audience will dictate the appropriateness and degree of content.

#### **Provision for general health & safety training for staff:**

- Corporate induction in line with the induction, statutory, mandatory & risk management training policy
- Corporate refresher in line with the induction, statutory, mandatory & risk management training policy

- Local induction via host ward/department General health & safety for others:
- Contractors' induction via Estates Department on arrival at site
- Visitors' induction via host ward/department as necessary
- Job-specific for Staff (e.g. Fire Safety, First-aid, Conflict Resolution etc.):

As appropriate and refreshed according to relevant policy and/or risk assessment  
It is recommended that all managers complete corporately-provided training in connection with Risk Assessment and Incidents

## Appendix 2 - Checklist for the Review and Approval of Procedural Documents

To be completed and attached to any procedural document that requires ratification

	<b>Title of document being reviewed:</b>	<b>Yes/No</b>	<b>Comments</b>
<b>1.</b>	<b>Title</b>		
	Is the title clear and unambiguous? It should not start with the word policy.	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
<b>2.</b>	<b>Rationale</b>		
	Are reasons for development of the document stated? This should be in the purpose section.	YES	
<b>3.</b>	<b>Development Process</b>		
	Does the policy adhere to the Trust policy format?	YES	
	Is the method described in brief? This should be in the introduction or purpose.	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	
<b>4.</b>	<b>Content</b>		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
	Are all terms clearly explained/defined?	YES	
<b>5.</b>	<b>Evidence Base</b>		
	Has a comprehensive literature search been conducted to identify best evidence to inform the policy?	YES	
	Have the literature search results been evaluated and key documents identified?	YES	
	Have the key documents been critically appraised?	YES	
	Are key documents cited within the policy?	YES	
	Are cited documents referenced?	YES	

	Title of document being reviewed:	Yes/No	Comments
<b>6.</b>	<b>Approval</b>		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	YES	
	For Trust wide policies has the appropriate Executive lead approved the policy?	YES	
<b>7.</b>	<b>Dissemination and Implementation</b>		
	Is there an outline/plan to identify how this will be done?	YES	
	Does the plan include the necessary training/support to ensure compliance?	YES	
<b>8.</b>	<b>Document Control</b>		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
<b>9.</b>	<b>Process to Monitor Compliance and Effectiveness</b>		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
	Is there a plan to review or audit compliance with the document?	YES	
<b>10.</b>	<b>Review Date</b>		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
<b>11.</b>	<b>Overall Responsibility for the Document</b>		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the documentation?	YES	

**Reviewer**

If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date it and forward to the Compliance and Risk Department for ratification.

Name	Simone Smith	Date	
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Signature	S Smith	Approving Committee/s	Health and Safety Committee
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**Lead Manager (Local Policies) / Director (Trust Wide Policies)**

If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date it and forward to the Compliance and Risk Department for ratification.

Name		Date	
Signature		Approving Committee/s	

**Ratification Committee Approval**

Quality Board minute number:  
PPG minute number:  
**TMB minute number:**

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

## Service Overview & Improvement Action Plan: Equality Analysis Form

<p><b>Title:</b> Health and Safety Policy (Including Organisational Arrangements)</p>	<p><b>What are the intended outcomes of this work?</b> This policy sets out the responsibilities and arrangements in place within Walsall Healthcare NHS Trust in order to realise its Health and Safety commitments. It applies to all Trust employees, agency/temporary/locum staff, contractors, visitors and others who may be affected by its undertaking.</p> <ul style="list-style-type: none"> <li>• The Trust accepts its humane, economic and legal responsibilities in respect of the management of health &amp; safety risks arising from its activities that may affect staff, patients and others.</li> <li>• This policy outlines the Trust arrangements in connection with these responsibilities. Local controls are created from these arrangements as appropriate.</li> <li>• Section 4 of this policy points to more specific arrangements for particular risk topics and risk management systems.</li> <li>• This policy also sets out the arrangements to ensure appropriate consultation with Trades Union and Employee safety representatives (Health &amp; Safety Committee)</li> </ul>
<p><b>Who will be affected?</b> All the Trusts employees and partners as well as contractors and visitors.</p>	<p><b>Evidence:</b></p> <ul style="list-style-type: none"> <li>• Risk Management Strategy</li> <li>• Incident Reporting, Learning and Management Policy</li> <li>• Control of Substances Hazardous to Health (COSHH) Policy</li> <li>• Display Screen Equipment Policy</li> <li>• Fire Safety Policy</li> <li>• Slips Trips and Falls Policy</li> <li>• Laser Policy</li> <li>• Working at Height Policy</li> <li>• Work Equipment Policy</li> <li>• Driving at Work Policy</li> <li>• Lockdown Policy</li> <li>• First Aid Policy</li> <li>• Safer Moving and Handling Policy</li> <li>• Personal (PPE) Protective Equipment</li> <li>• Management of Violence and Aggression Policy</li> <li>• Security Policy (as of Nov 2014 this policy was in development)</li> <li>• CCTV Policy</li> <li>• Infection Control Policies</li> <li>• Lone Working Policy</li> <li>• Prevention and Management of Violence and Aggression</li> </ul>

	<ul style="list-style-type: none"> <li>• Claims Handling Policy and Procedure</li> <li>• Whistle Blowing Policy</li> </ul>
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ANALYSIS SUMMARY: considering the above evidence, please summarise the impact of the work based on the Public Sector equality duty outcomes against the 9 Protected characteristics			
<i>Public Sector Duty</i>	<b>Eliminate discrimination, harassment and victimisation</b>	<b>Advance equality of opportunity</b>	<b>Promote good relations between groups</b>
<i>Protected Characteristics (highlight as appropriate)</i>			
AGE / DISABILITY/ RACE	There is no opportunity for discrimination, harassment or victimisation if this policy is followed	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.
SEX (Gender)/ GENDER REASSIGNMENT	There is no opportunity for discrimination, harassment or victimisation if this policy is followed	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.
RELIGION or BELIEF/ SEXUAL ORIENTATION	There is no opportunity for discrimination, harassment or victimisation if this policy is followed	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons affected by the Trust 's undertaking in line with Health and Safety legislation.
PREGNANCY & MATERNITY	There is no opportunity for discrimination, harassment or victimisation if this policy is followed	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons	Policy is designed to ensure the Trust provide and maintain a working environment and systems of work that are, so far as is reasonably practicable, safe for employees, service users, visitors and other persons

		affected by the Trust 's undertaking in line with Health and Safety legislation.	affected by the Trust 's undertaking in line with Health and Safety legislation.
MARRIAGE & CIVIL PARTNERSHIP	There is no opportunity for discrimination, harassment or victimisation if this policy is followed	<i>Not applicable at present</i>	<i>Not applicable at present</i>
<b>What is the overall impact?</b>			
If this policy is followed, there is no adverse impact on any patient group			
<b>Any action required on the impact on equalities? –</b>			
Policy is designed to ensure that there is no impact – if it is followed.			
<b>Name of person completing analysis</b>	<i>Simone Smith</i>	<b>Date completed</b>	<i>30.11.18</i>
<b>Name of responsible Director</b>	<i>Jenna Davies</i>		
<b>Signature</b>			

MEETING OF THE PUBLIC TRUST BOARD - 3 <sup>rd</sup> October 2019			
Risk Management Strategy		<b>AGENDA ITEM:</b> <b>15</b>	
<b>Report Author and Job Title:</b>	Simone Smith	<b>Responsible Director:</b>	Jenna Davies
<b>Action Required</b>	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>The aim of this strategy is to strengthen the existing risk management framework and further embed risk management at divisional and local level. An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services. The business of healthcare is, by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Walsall Healthcare NHS Trust's Board of Directors with assurance that services are delivered safely, effectively and in line with corporate strategic objectives.</p> <p>The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.</p>		
<b>Recommendation</b>	Members of the Trust Board are asked to receive this strategy and approve its content.		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	Fundamental to the aims of this strategy is ensuring greater ownership of risk at all level of the organisation regardless of source, and ensure appropriate escalation of risks through the organisation to the Board.		
<b>Resource implications</b>	There are no resource implications associated with this report		
<b>Legal and Equality and Diversity implications</b>	Robust risk management systems ensure that the Trust meets the legal requirements of the Health & Safety at Work etc., Act (1974), the Management of Health & Safety at Work Regulations (1999) and the Civil Contingencies Act (2004).		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		



Document Title	
Risk Management Strategy 2019 - 2020	
Document Description	
Document Type	Corporate Strategy
Service Application	Trust Wide
Version	1
Lead Author(s)	
Name	Job Title
Ruth Barnard	Acting Risk Manager
Simone Smith	Head of Health and Safety

### Executive Director / Director / Manager

If you are assured that the correct procedure has been followed for the consultation of this policy, sign and date below:

Name	Jenna Davies	Date	
Signature			

### Change History

Version	Date	Comments
1.0	August 2019	New Strategy

### Links with External Standards

NHSLA	3.1, 3.2, 3.4, 3.6, 3.7 and 3.8
CQC	Outcome 11
Health and Safety at Work Act 1974	
Management of Health and Safety at Work Regulations 1999	
Key Dates	DATE
Ratification Date	
Review Date	August 2021

## Executive Summary Sheet

Document Title:	Risk Management Strategy	
<b>Please Tick (<input type="checkbox"/>) as appropriate</b>	This is a new document within the Trust	X
	This is a revised Document within the Trust	
<b>What is the purpose of this document?</b>		
The Trust aim, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This strategy will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.		
<b>What key Issues does this document explore?</b>		
<ol style="list-style-type: none"> <li>1. Embed risk management at all levels of the organisation</li> <li>2. Create a culture which supports risk management</li> <li>3. Provide the tools and training to support risk management</li> <li>4. Embed the Trust's risk appetite in decision making</li> <li>5. Measure the impact of implementation</li> </ol>		
<b>Who is this document aimed at?</b>		
This strategy applies to all Trust staff, agency staff and contractors, engaged on Trust business in respect of any aspect of that work. It is recognized that actions contain inherent risks.		
<b>What other policies, guidance and directives should this document be read in conjunction with?</b>		
<ul style="list-style-type: none"> <li>• Risk Management Policy</li> <li>• BAF SOP</li> <li>• Incident Management Policy</li> <li>• Investigations, Analysis and Improvement Policy</li> <li>• Information Asset Risk review (now within Information Asset Owners &amp; Administrators Handbook)</li> <li>• Information Security Risk Review Guidance</li> <li>• Management of Legal Claims Policy</li> <li>• Risk Scoring Matrix</li> </ul>		
<b>How and when will this document be reviewed?</b>		
The document will be reviewed and monitored by the Risk Management Group at least 2-yearly or before if required.		

### CONTRIBUTION LIST

#### Key individuals involved in developing the document

Name	Designation
Ruth Barnard	Acting Risk Manager
Simone Smith	Head of Health and Safety
Christopher Rawlings	Head of Governance
Sharon Thomas	Corporate Governance Manager



### Circulated to the following for consultation

Name/Committee/Group	Designation
Risk Management Group	Trust's Corporate Committee
Trust Management Board	Executive Directors
Quality and Safety Committee	Trust Board Members and Senior Directors
Intranet	Wider Public and Staff consultation
Division of Surgery	Various
Division of Women's, Children's and Support services	Various
Division of Medicine and Long Term Conditions	Various
Division of Adult Community	Various
Corporate Services	Various

### Version Control Summary

#### Significant or Substantive Changes from Previous Version

A new version number will be allocated for every review even if the review brought about no changes. This will ensure that the process of reviewing the document has been tracked. The comments on changes should summarise the main areas/reasons for change.

When a document is reviewed the changes should using the tracking tool in order to clearly show areas of change for the consultation process.

Version	Date	Comments on Changes	Author

# Risk Management Strategy



**2019 – 2021**

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## 1. Introduction

An understanding of the risks that face NHS Trusts is crucial to the delivery of healthcare services. The business of healthcare is, by its nature, a high-risk activity and the process of risk management is an essential control mechanism. Effective risk management processes are central to providing Walsall Healthcare NHS Trust's Board of Directors with assurance that services are delivered safely, effectively and in line with corporate strategic objectives.

The Trust Board recognises that complete risk control and/or avoidance is impossible, but that risks can be minimised by making sound judgments from a range of fully identified and assessed options.

The Trust's aim, therefore, is to promote a risk awareness culture in which all risks are identified, assessed, understood and proactively managed. This will promote a way of working that ensures risk management is embedded in the Trust's culture and becomes an integral part of the Trust's objectives, plans, practices and management systems.

This strategy applies to all Trust staff, agency staff and contractors, engaged on Trust business in respect of any aspect of that work. It is recognized that actions contain inherent risks.

## 2. Statement of Intent

The Trust Board is committed to leading the organisation forward to deliver a high quality, sustainable service, achieving excellent results and making the very best use of public funds.

The Board recognises that to deliver these objectives there is a need for robust systems and processes to support continuous improvement, enabling staff to integrate risk management into their daily activities wherever possible and supporting better decision making through a good understanding of risks and their likely impact.

This can only be achieved through an 'open and just' culture where risk management is everyone's business and where risks, accidents, mistakes and 'near misses' are identified promptly and acted upon in a positive and constructive way. Staff are, therefore, encouraged and supported to share best practice in a way that creates a culture of learning and a drive to reduce future risk: these are cornerstones of building safer, effective, and efficient care for the future.

The Trust uses a web based risk management system, Safeguard, for the recording, management and reporting of incidents and risks at Department, Care-group, Divisional, Corporate and Strategic levels.

This Risk Management Strategy is underpinned by a suite of policies including the Risk Management Policy guiding staff on the day to day delivery of effective risk management processes. [Insert Link to Risk Management Policy](#)

## 3. Whose Responsibility is Risk Management?

The success of the risk management programme is dependent on defined and demonstrated support and leadership offered by the Trust Board as a whole.

However, the day-to-day management of risk is the responsibility of everyone in our organisation at every level, and the identification and management of risks requires the active engagement and involvement of staff at all levels. Our staff are best placed to understand the

risks relevant to their areas of work and must be enabled to manage these risks, within a structured risk management framework.

#### 4. Aims and Objectives

The aim of this strategy is to strengthen the existing risk management framework, further embed risk management at divisional and local level, and ensure appropriate escalation of the risks through the organisation to the Board. In addition, greater local level ownership of risk, enhanced clarity regarding roles and responsibilities for risk management and strengthened governance arrangements will support delivery of improved risk management. The strategy is supported with an implementation plan, with objectives to support the achievement of the aims, as outlined below. Both the strategy and implementation plan will be monitored by the Quality Patient Experience and Safety Committee.

The key objectives of the Risk Management Strategy are to:

- i. **Embed risk management at all levels of the organisation**
- ii. **Create a culture which supports risk management**
- iii. **Provide the tools and training to support risk management**
- iv. **Embed the Trust's risk appetite in decision making**
- v. **Measure the impact of implementation**



## **I. Embed risk management at all levels of the organisation**

*Walsall Healthcare NHS Trust is an integrated acute and community provider. Our overall aim is to improve the health, wellbeing and independence of the people we serve by providing safe and high-quality care. Our aim is to support the delivery of the organisational objectives through effective management of risks across all Trust's functions and activities through effective risk management processes, measurement, analysis and organisational learning. Fundamental to the aims of this strategy is ensuring greater ownership of risk at all level of the organisation from department to the Board.*

### **What we will do:**

- We will continue to strengthen risk registers at Divisional, Care Group and Department level, supported by clear criteria and timeframes for escalation of risks.
- Roles and responsibilities for risk identification, assessment, management and monitoring will be clarified and clearly articulated in the Risk Management Policy and the Trust's revised governance reporting structure.
- The escalation of risks between the different levels of the organisation, from 'ward to board' will be mandated and clearly evidenced on Safeguard to support the risk pathway.
- All Wards and Departments will identify, assess and monitor risks as they arise or are anticipated in accordance with the Risk Management Policy.
- Care Groups will maintain Risk Registers, which comprise of all risks escalated from departmental Risk Registers in that Care Group, plus other risks identified as relevant to the Care Group as a whole.
- Care Group Risk Registers will be owned by, and reviewed at, Care Group Governance Group meetings.
- Risks will be regularly reviewed and monitored based on the current risk score to ensure the risk remains current and accurately reflects the status and progress of the associated mitigating actions.

### **How we will achieve this:**

- Each Division will have a Risk Register which reflects the risks it faces (as a whole), plus, Care Group and Department level risks which require management and oversight, in accordance with the Trust Risk Appetite (Appendix 1). Divisional Risk Registers will be owned at, and reviewed by, Divisional Board meetings.
- Corporate Functions (Human Resources, Finance, Estates, Facilities, Integrated Governance, Nursing and Medical Director, & Digital Technology), will also be required to develop and maintain Divisional Risk Registers which reflect the risks relevant to their services which are not incorporated into any of the other Risk Registers identified in the clinical divisions above. The Corporate Division Risk Registers will be owned by the Divisional Management teams and reviewed at Quality & Performance meetings.
- The Corporate Risk Register will be comprised of all risks on the Divisional and Corporate Directorate Risk Registers which score 15 and above, plus other risks which are identified as likely to affect the organisation as a whole or as best managed at a corporate level. Divisional and Corporate Functions Risk Register risks may be amalgamated on the Corporate Risk Register where appropriate for effective oversight and/or management.

- Lower scoring risks which occur across the Divisions or Corporate Functions may also appear on the Corporate Risk Register if they are unlikely to be managed effectively if they are not addressed at a corporate level.
- Regular review and maintenance of the Corporate Risk Register will be undertaken at the Trust Risk Management Group and escalated to sub-committees of the Board for assurance.

## II. Create a culture which supports risk management

*A key component of an effective and mature risk management framework is a culture of knowledge and understanding of risk management and leadership. This means that roles and responsibilities need to be clearly defined so that risk management is 'owned' by appropriate members of staff, and that all staff are encouraged to be more risk-aware through promotion of openness and support for local management of risk where possible. It also means visible and supportive leadership from the Board in ensuring effective systems and processes for the management and escalation of risks.*

### What we will do:

- Ensure the Trust has board level leadership for risk management and a clear committee structure that supports the aggregation and escalation of risk through the Audit Committee. We have already identified and strengthened the leadership within the risk management framework by aligning the management of operational and strategic risk under a Director (Director of Governance) and ensuring Non-Executive level input and challenge at Audit Committee.
- The Risk Management Group will review each Division's risk register on a quarterly basis and care group risks annually, to ensure that risks are being managed effectively and that lessons and risk information are being shared across the organisation. These reviews will also inform the organisations decisions in respect of the recommendation of Corporate Risk Register to the Board for adoption.
- Urgent risks identified and escalation by a Division outside of its scheduled reporting timescale will be brought to the attention of the Risk Management Group as a separate agenda item, and if necessary, can be escalated to the Board by the Group at any point.
- Divisional Risk Registers will also be used by the Executive team to inform discussion at Divisional Board meetings to ensure that risk is considered collectively and holistically, along with financial and operational performance. These meetings will be the mechanism by which Divisional Management Teams are held to account for the management of all aspects of the division, including the management of divisional risks.

Other Board committees play a role in risk management, as outlined in **Appendix 2**.

### How we will achieve this:

- Develop a reporting structure to ensure there is a continued interface between the Corporate Risk Register and Board Assurance Framework (BAF). The BAF is a tool via which risks to the achievement of the Trust's strategic objectives are managed and reported to the Board. Risks recorded on the Corporate Risk Register may also appear on the BAF if they have the potential

to compromise delivery of corporate strategic objectives. Not every high scoring item of the Corporate Risk Register will appear on the BAF, and not all BAF entries will appear on the Corporate Risk Register, which is a tool for the management of operational risk.

The Director of Governance/ Trust Secretary produces the BAF and oversees the relationship between the BAF and the Corporate Risk Register.

- Risk management will be at the heart of board level discussion. To enhance the maturity of existing conversations at board level, one of the aims of this strategy is to create a clear link between assurance, risk management, corporate governance and regulation. Using the agreed risk appetite matrix, the Board can set out a framework within which all risk should be considered, linking objectives, business planning and risk appetite. This will also help to develop an approach that engenders risk forecasting.
- The Board will receive a quarterly Corporate Risk Register for consideration and adoption, as recommended by Audit Committee. The Board will also receive a quarterly Board Assurance Framework, proposed by the Director of Governance. The Board will use both documents to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources.

To this end, each adopted iteration of both the Corporate Risk Register and the BAF will be sent by the Board to;

- Performance Finance and Investment Committee (PFIC) to inform financial decision making and budget setting
- Audit Committee to inform the planning of audit activity and provide assurance that there are suitable arrangements in place to effectively manage risk at Board level.
- People and Organisational Development (POD) Committee to inform human resources and training and development decisions

### **III. Provide the tools and training to support risk management**

*In order to develop a culture for risk management and to ensure successful implementation of this strategy, there needs to be a targeted training programme for staff to supplement existing training provision.*

#### **What we will do:**

- Non-Executive Directors (NEDS) will have a training and awareness raising session on risk management once a year as part of the board development programme, and risk, governance and quality feature in a number of leadership development programmes.
- Executive & Divisional Directors will undertake a risk management system masterclass to equip them with the skills to review, add, amend and notify risks to maintain the fluidity of the live register
- Staff with responsibility for managing/ leading a team will have an enhanced level of training to enable effective identification, assessment and management of risk.
- All staff, regardless of role, will undertake a basic level of risk training to enable identification of potential risk and methods for escalation to a manager for action.

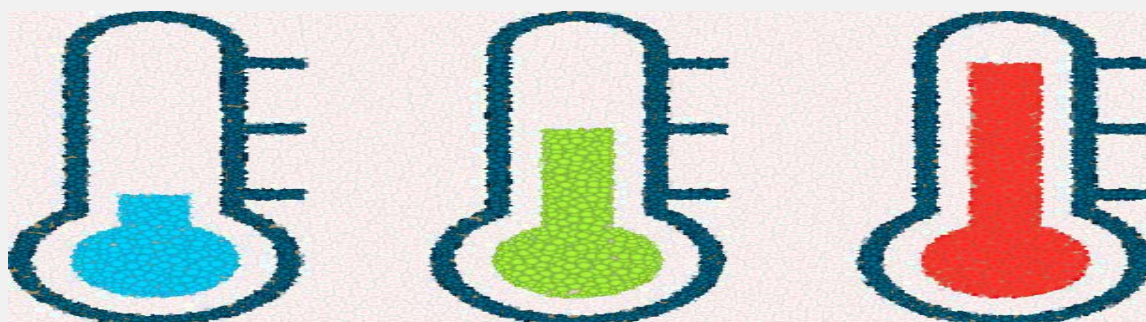


### How we will achieve this:

- We will review the existing training programme and training materials to ensure appropriate knowledge and skills in risk management at different levels of the organisation.
- We will develop a more structured risk management training programme to increase staff knowledge and understanding of risk management for specific staff groups. That training will help to embed a consistent language of risk management, including concepts such as controls, mitigations, assurances and target risk. This will enhance the quality of conversation and consistency of approach.
- Management of risk at Operational levels will be supported by Divisional Quality Governance Advisors. We aim to further standardise, develop and support these roles to ensure the delivery of this strategy. We will also create local ownership of risk management through involvement of staff in designing the tools to manage risk and training programmes.
- Increasing transparency of the Divisional, Care Group and Corporate Functions risk registers will support all risk management activity, and will be achieved by utilising the risk register module within the Safeguard Risk Management System. This will allow for ease of transference of risks and enable incidents, claims and complaints to be linked to specific identified risks.

## IV. Embed the trust's risk appetite in decision making

*Considered, well measured risk taking is encouraged in order to support innovation, research & development within authorised and defined limits. The priority is to mitigate those risks that impact on safety, and reduce our financial, operational and reputational risks. The Trust acknowledges that some of its activities may, unless properly controlled, create organisational risks, and/or risks to staff, patients and others.*



### What we will do:

- The Trust will make all efforts to eliminate risk or ensure that risks are contained and controlled so that they are as low as reasonably practical.
- It is not always possible to reduce or mitigate an identified risk completely and it may be necessary to make judgments about achieving the correct balance between benefit and risk. A balance must be struck between the costs of managing a risk and the benefits to be gained.
- A decision will be made regarding the level at which a risk would be deemed tolerable. A risk is considered acceptable when there are adequate control measures in place and the risk has been

managed as far as is considered to be reasonably practicable. Tolerated risks should be brought to the attention of Risk Management Group through Divisional risk registers or the Corporate Risk Register on an annual basis.

- Where a risk has been reduced to the point where the cost of further controls to reduce the risk outweigh the benefit they may provide, it may not be considered reasonably practicable to implement those controls. However, such position must be fully demonstrated before it can be accepted. Risks requiring a cost benefit analysis must be discussed at the Risk Management Group and Audit Committee for wider debate and decision on 'acceptability'

#### **RISK APPETITE**

*Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.*

*Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take.*

*The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.*

*Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.*

*The Trust's risk appetite is expressed in two key ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.*

## **V. Measure the impact of implementation of the risk management strategy/policy**

*There is a need to measure the impact of the strategy, to measure its effectiveness in developing the maturity of the Trust's risk management framework. We will therefore review the strategy on an annual basis and its implementation plan on a quarterly basis, via the Quality & Performance Committee.*

#### **What we will do:**

- In order to measure the impact of implementation of this strategy, we will complete an annual risk maturity assessment to evaluate performance and progress in:
  - developing and maintaining effective risk management capability, and

- assessing the impact on delivering effective risk handling and required/planned outcomes.

Amongst the measures we will use to measure the impact of the implementation of the strategy are:

- Audit of Committee minutes to show risk is discussed
- Audit of risk review dates to ensure timely review
- Audit of whether risk scores change at appropriate rates and how quickly risks appear on, and are removed from, risk registers
- The extent to which risk is cited in decision making at divisional and corporate levels
- Audit of incidents and complaints to identify whether
  - they feed through into risk registers
  - the identification and management of a risk leads to a decrease in associated incident and complaints
- Audit of whether learning about / from risks is shared across divisions and specialties

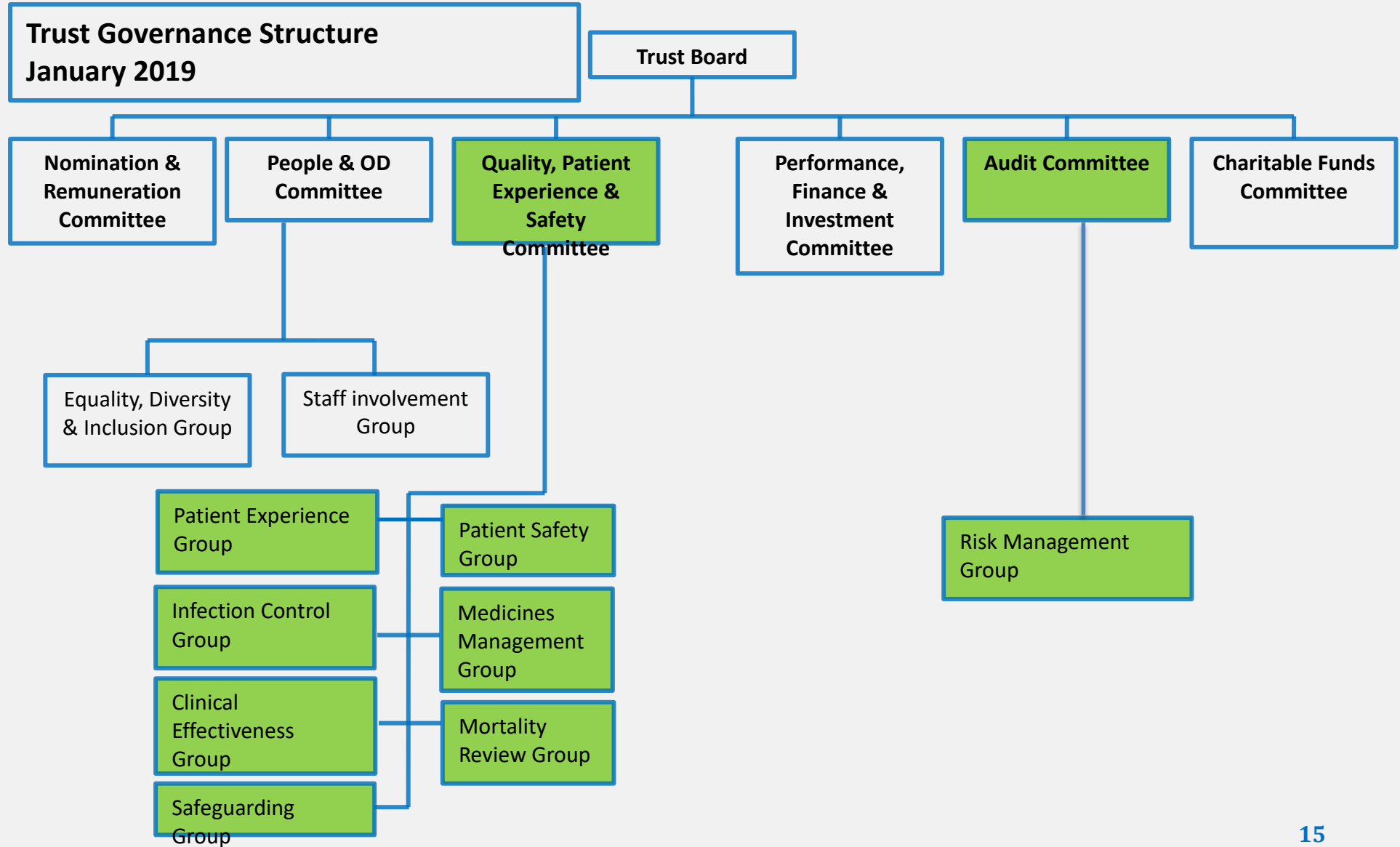
### **How we will achieve this:**

Tools to measure implementation of the strategy may vary from year to year to reflect other audit and governance activity in hand.



 <p>Provide Safe, high quality care across all our services</p>	<p><i>Continue our journey on patient safety and clinical quality through a comprehensive improvement programme</i></p>	<p>The Trust is committed to delivering high quality services provided to patients and we will accept a low appetite for taking risks that will compromise quality, patient safety or affect the experience of our service users</p>
 <p>Use resources well to ensure we are sustainable</p>	<p><i>Improve our financial health through our robust improvement programme</i></p>	<p>The Trust is prepared to accept a low risk appetite on finance where this would impact on patient safety.</p> <p>The Trust will accept a low appetite for enhancing quality or patient safety beyond safe levels to the detriment of its financial stability.</p> <p>The Trust will ensure all decisions taken are aligned to our principle of ensuring good use of resources.</p>
 <p>Work closely with partners in Walsall and surrounding areas</p>  <p>Care at home</p>	<p><i>Develop the clinical service strategy focused on service integration in Walsall &amp; in collaboration with other Trusts</i></p>	<p>The Trust is prepared to accept a high-risk appetite on the development of integrated pathways across partner organisations to deliver sustainability. It has a moderate risk appetite on development of technology driven improvements and on sustainability to deliver the Trust vision.</p>
 <p>Value our colleagues so they recommend us as a place to work</p>	<p><i>Develop the culture of the organisation to ensure mature decision making and clinical leadership</i></p>	<p>The Trust aspires to having a low risk appetite for any behaviours or actions that damage or compromise our Trust values. Specifically working to reduce the current areas of risk such as bullying and harassment, improving inclusion, staff engagement and experience and confidence to speak up.</p> <p>The Trust aims to reduce the current levels of risk to patient and staff experience by reducing the resourcing risks in the Trust and risks to staff health and wellbeing. To foster a healthy organisational culture where Colleagues feel valued and recommend us as a place to work and a place for treatment.</p> <p>The Trust will have a moderate risk appetite for risks associated with building new workforce models for future service sustainability reasons.</p>

Board Committee Structure with a role in Risk Management



<b>MEETING OF THE PUBLIC TRUST BOARD – 3<sup>rd</sup> October 2019</b>			
To provide the Board with an overview of the Core Standards submission of compliance in Emergency Preparedness, Resilience and Response reported to NHS England and to gain the Boards approval for the submission			<b>AGENDA ITEM:</b> <b>16</b>
<b>Report Author and Job Title:</b>	Ian Billington, Head of Emergency Planning, Resilience and Response	<b>Responsible Director:</b>	Ned Hobbs Chief Operating Officer
<b>Action Required</b>	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>This report contains;</p> <ul style="list-style-type: none"> <li>• Description of Emergency Preparedness, Resilience and Response Core Standards self-assessment process and timelines</li> <li>• Last year (2017 submission), the Trust was partially compliant</li> <li>• This year's position is Partially Compliant</li> <li>• Remedial actions incorporated alongside specific standards, with timetable</li> </ul>		
<b>Recommendation</b>	<p>Members of the Trust Board are asked to:</p> <p>Approve the submission of the 2019 EPRR Core Standards self-assessment return.</p> <p>Receive an update report on the actions identified to ensure compliance with the Core Standards and provide assurance to the Trust Board that the Trust is meeting its requirements as outlined in the Civil Contingency Act 2004.</p>		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers?</b>	Evacuation & Shelter Plan (1107) Severe Weather (647) Training (1577)		
<b>Resource implications</b>			
<b>Legal and Equality and Diversity implications</b>	Civil Contingencies Act (2004)		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input checked="" type="checkbox"/>		

**Emergency Preparedness, Resilience and Response (EPRR) Core Standards  
Self-Assessment Submission 2019**

**1. PURPOSE OF REPORT**

The purpose of the report is to gain approval of the EPRR Core Standards 2019 self-assessment return. Each year NHS England is committed to operating an assurance process across the country, this is known as the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR). NHS England EPRR teams and Local Health Resilience Partnerships (LHRP) are asked to conduct the assurance process during 2019/20 as outlined below:

August

- Submit self-assessment against core standards in August 2019 to NHS England and lead CCG

September

- Local health Resilience Partnership (LHRP) to receive an overview of results and an initial draft of the LHRP co-chair's statement of assurance.
- Clinical Commissioning Groups (CCGs) during September, will lead the local evaluation of Trust submissions and provide an evaluation to LHRPs.

October

- LHRP co-chairs to meet with CCG leads, NHS England and NHS Improvement to discuss results. Depending on the findings, organisations may be required to submit further evidence for evaluation during October.
- 31st October: Deadline for LHRP co-chair statements of assurance and submission of evidence to regional offices of NHS England.

November

- LHRPs to receive a copy of minutes of the public Board meeting (providers) / Governing Bodies receiving the EPRR Core Standards self-assessment report.

**2. BACKGROUND**

It is a mandatory requirement for all organisations who receive NHS funding to carry out a self-assessment against the NHS England Core Standards for EPRR. Further, all organisations participating in the 2019 assurance process will ensure their Boards are sighted on the level of compliance achieved, the results of the self-assessment and the action/work plan for the forthcoming period.

The 2019 Core Standards compliance levels have been simplified from the previous year. The Trust achieved substantial compliance last year. This year the Trust is reporting Partial Compliance with the variation due to weighting changes. The Trust is also pleased to identify no areas of non-compliance as opposed to 2018. The Trust is in a good position to make further progress in the areas where full compliance has not been achieved; these areas are identifiable through completion of the Core Standards 2019.

### 3. DETAILS

#### 2019 Submission

- Results of the self-assessment against the NHS England Core Standards for EPRR
- A resulting action/work plan stemming from the self-assessment

Organisations must state overall whether they believe they are fully compliant, partially compliant or non-compliant with the NHS England Core Standards for EPRR. The definitions of which are included below:

Compliance level	Evaluation and testing Conclusion
Full Compliance	Fully Compliant with Core Standards
Partial Compliance	Not compliant with Core Standard. The organisations EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months
Not Compliant	Not compliant with Core Standards. In line with the organisation’s EPRR work programme, compliance will not be reached within the next 12 months

\* Should an Organisation be non-compliant the LHRP will regularly monitor progress throughout the year until it has attained an agreed level of compliance.

The results of the self-assessment and peer review have led to a conclusion that the Trust has achieved **Partial Compliance** against the Core Standards. The tabular breakdown on the Trust performance is included below:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	13	1	0
Command and Control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and Informing	3	2	1	0
Cooperation	4	4	0	0
Business Continuity	9	5	4	0



<b>CBRN</b>	14	6	8	0
<b>Total</b>	64	55	11	3

This is because of the number of standards where a plan is in place but work is not yet complete and does not, at this stage, meet the Fully Compliant requirements. The Local Health Resilience Forums will agree a final rating in due course as outlined above.

In those areas where full compliance was not achieved there has been progress made since April 2018. Some of the progress was delayed while a Head of EPRR was recruited to the vacancy. The Trust is now well positioned to progress with the areas of evacuation and exercises. One of the key differences with last year is the additional prominence given to Business Continuity arrangements which the organisation aims to acknowledge by developing a new distinct Business Continuity policy by 2020.

#### 4. RECOMMENDATIONS

The provider peer review process has recognised the Trust’s position in relation to Emergency Preparedness, Resilience and Response Core Standards.

An action plan is in place to improve the rating to Fully Compliant. The action plan as extracted direct from the Core Standards submission is included within this report. This action plan will be monitored via the monthly EPRR meeting which is chaired by the Accountable Executive Officer (the Chief Operating Officer) for EPRR.

There is further work to do. Actions are detailed below, and progress will be monitored as we continue to work with the West Midlands EPRR network towards Full Compliance.

The Board is asked to support the submission of the 2019 Core Standards return self-assessment of Partially Compliant.

The Board is asked to receive an update report during the 4<sup>th</sup> quarter of 2019 on the actions identified being completed to ensure compliance with the Core Standards and provide assurance to the Trust Board that the Trust is meeting its requirements as outlined in the CCA 2004.

Appendix A – Action Plan generated through completion of the EPRR Core Standards 2019

Domain	Standard	Action to be taken	Lead	Timescale	Comments
Duty to maintain plans	Protected individuals	Existing policy document requires a review and new release	Head of Communications	Nov-19	Emailed Communications Manager and the Head of Communications for an update on the policy position.
Warning and informing	Media strategy	Current Strategy requires a review and update.	Head of Communications	Oct-19	Emailed Communications Manager and the Head of Communications for an update on the policy position. Progress to be monitored and reported at the EPRR Steering Group.
Business Continuity	Business Impact Assessment	The BIA data needs to be reviewed and updated. The BIA Approach also needs to be reviewed.	Head of EPRR	Mar-20	Communications with colleagues from within the LHRF/LHRP to identify the system that would work best for Walsall Healthcare.
Business Continuity	Business Continuity Plans	The Business Continuity Plan need to be reviewed and updated.	Head of EPRR	Mar-20	Communications with colleagues from within the LHRF/LHRP to identify the system that would work best for Walsall Healthcare.
Business Continuity	BCMS monitoring and evaluation	This will be covered in the review of Business Continuity	Head of EPRR	Mar-20	Communications with colleagues from within the LHRF/LHRP to identify the system that would work best for Walsall Healthcare.
Business Continuity	BCMS continuous improvement process	This will be covered in the review of Business Continuity	-Head of EPRR	Mar-20	Communications with colleagues from within the LHRF/LHRP to identify the system that would work best for Walsall Healthcare.
CBRN	Decontamination capability availability 24/7		CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.



CBRN	PRPS availability	Conversations are ongoing of supply in relation to the required number of new Generation 2 Suits	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.
CBRN	Equipment checks	Confirmation and situation report to be received by the EPRR Steering Group,	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.
CBRN	Equipment Preventative Programme of Maintenance	Confirmation and situation report to be received by the EPRR Steering Group,	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.
CBRN	HAZMAT / CBRN training lead	Evidence of continued CPD records	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.
CBRN	Training programme	Confirmation and situation report to be received by the EPRR Steering Group,	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.
CBRN	HAZMAT / CBRN trained trainers	Requirement to increase the number of trainers, plan to be included in the CBRNe report which will be received by the EPRR Steering Group,	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made. CBRN Lead registered for train the trainer in November hosted by the HART Team.
CBRN	Staff training - decontamination	Evidence of training records. Include within the situation report	CBRNe Lead Nurse	Oct-19	Met with CBRN Lead (23/09) and received verbal assurance that substantial advances have been made.

<b>MEETING OF THE PUBLIC TRUST BOARD – 3<sup>rd</sup> OCTOBER 2019</b>			
Quality, Patient Experience and Safety Committee Highlight Report			<b>AGENDA ITEM: 17</b>
<b>Report Author and Job Title:</b>	Karen Dunderdale Director of Nursing	<b>Responsible Director:</b>	Phil Gayle- Non Executive Director.
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	This report provides highlights from the Quality Patient Experience & Safety committee.		
<b>Items for escalation</b>	The committee endorsed the winter plan and the ED outline business case  The committee also approved the Risk Management Strategy		
<b>Recommendation</b>	Members of the Trust Board are asked to NOTE the business of the Highlight Report.		
<b>Risk in the BAF or Trust Risk Register</b>	None		
<b>Resource implications</b>	There are no new resource implications associated with this report.		
<b>Legal, Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper		
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>	
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>	
	Resources <input type="checkbox"/>		

Quality Patient Experience & Safety Committee: September 2019  
 Highlight Report to the Trust Board

<b>Report for Trust Board meeting on:</b>	3 October 2019
<b>Report From:</b>	26 September 2019
<b>Highlight Report:</b>	
<p><b><u>Hospital Acquired Infections</u></b></p> <p>At the date of the committee meeting there has been a total of 12 hospital acquired C. Diff infections and 0 MRSA bacteraemia to August 2019.</p> <p><b><u>Winter Plan</u></b></p> <p>The committee focused on the quality elements of the plan. The committee supported the approach and interventions in the plan. The committee asked for both staff and patient experience to be proactively collected and acted on as part of winter which will be built into the evaluation</p> <p><b><u>ED Outline business case</u></b></p> <p>The committee considered the quality and patient experience elements of the case. Key risks discussed by the committee were related to the model and culture. The committee fully endorse the OBC.</p> <p><b><u>Risk Management Strategy</u></b></p> <p>The committee received and approved the Risk Management strategy</p>	
<b>Action Required by the Trust Board:</b>	
<p>The Trust Board is asked to note the report and support any further action required.</p> <p><b>Philip Gayle, Non-Executive Director and Dr Karen Dunderdale, Director of Nursing/Deputy Chief Executive</b></p> <p><b>September 2019</b></p>	

MEETING OF THE PUBLIC TRUST BOARD – 3 <sup>rd</sup> October 2019			
People and Organisational Development Committee Highlight Report			<b>AGENDA ITEM: 19</b>
<b>Report Author and Job Title:</b>	Catherine Griffiths, Director of People and Culture	<b>Responsible Director:</b>	Philip Gayle, Non-Executive Director
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>This report details Board Assurance and the Annual Cycle of Business and to:</p> <ol style="list-style-type: none"> <li>1. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care.</li> <li>2. The processes adopted to support optimum employee performance in line with the Trust values.</li> <li>3. The delivery of the Trust’s legal and regulatory duties in relation to its employees.</li> <li>4. The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.</li> </ol>		
<b>Recommendation</b>	Members of the Trust Board are asked to note the content of the report for information.		
<b>Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline</b>	<p><b>BAF Risks:</b> The work programme described within this report will provide positive assurance to the committee on the following BAF risks:</p> <p><i>Lack of an inclusive and open culture impacts on staff engagement, staff morale and patient care.</i></p> <p><i>National staff shortages amongst a number of professions impacts on the Trust’s ability to provide safe and high quality care, and</i></p>		

	<i>impacts on the morale and robustness of the Trust's current workforce.</i>	
<b>Resource implications</b>	There are no specific resource implications associated with this report, however the annual cycle of committee business is scheduled to provide oversight and seek assurance on behalf of the Trust Board that people resources are managed within the Trust in a way that is sustainable and that supports the financial health of the Trust.	
<b>Legal and Equality and Diversity implications</b>	The Board Assurance Framework reports to People and Organisational Development Committee to identify current implications. The annual cycle of committee business is scheduled to provide oversight and seek assurance on behalf of the Trust Board that legal, equality and diversity implications are considered and effectively managed within the Trust in a way that promotes inclusion and supports the Equality Objectives contained within the Trust Equality, Diversity and Inclusion Strategy.	
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input type="checkbox"/>
	Partners <input type="checkbox"/>	Value colleagues <input checked="" type="checkbox"/>
	Resources <input checked="" type="checkbox"/>	

**People and Organisational Development Committee Highlight Report.**

**1. PURPOSE OF REPORT**

The purpose of this report is to inform the Board of key issues discussed at People and Organisation Development Committee and of key actions identified.

**2. BACKGROUND**

The People and Organisation Development Committee is a sub-committee of Trust Board and has an annual programme of business that is developed to provide assurance to the Trust Board on:

5. The delivery of the People Strategy which supports employees in the provision and delivery of high quality, safe patient care.
6. The processes adopted to support optimum employee performance in line with the Trust values.
7. The delivery of the Trust's legal and regulatory duties in relation to its employees.
8. The management of Trust risks related to human resource risks and issues that may jeopardise the Trusts ability to deliver its objectives – these are captured on the Board Assurance Framework and Corporate Risk Register.

**3. DETAILS**

**Director of Nursing Safer Staffing Updates**

The reports on Safer Staffing presented by the Deputy CEO and Director of Nursing Dr Karen Dunderdale were discussed, welcomed and approved by the People and Organisation Committee as follows:

- ✓ New Roles and Roles Development Group
- ✓ Terms of Reference for ACP Task and Finish Group
- ✓ Preparing for Winter Staffing Plan for utilisation of internal corporate registered nurses [Option One approved as recommended]



### **Freedom to Speak Up – Update Report (Quarterly)**

The Trust Freedom to Speak Up Guardians Ms Shabina Raza and Ms Kim Sterling attended to report on the improvements that had taken place on the FTSU Action plan – and to highlight the areas causing concern. Bullying is a significant issue feedback and ownership within the Trust could be improved. The committee discussed accountability and approved the FTSU statistics being part of the accountability framework in order that the Divisions can support speaking up and review the performance of their division as well as trends at the monthly Performance Review Meetings. The committee reviewed the letter sent to Trusts about supporting FTSU guardians and noted a start has been made on this, further improvement required. It was noted the Trust would be accessing national support from the National Guardian Office in order to further develop the approach. The quarterly figures were noted and received by the committee. The report was received.

### **The Workforce Performance Data and Metrics**

Mr Cox-Smith presented the workforce metric report and the committee commented that the SPC charts had improved the analysis of workforce trends and welcomed the ongoing work in this regard. Mr Cox-Smith focused on the improvement interventions taken on retention, mandatory training, sickness and appraisals and it was agreed that the Model Hospital target for sickness at 3.85% would be adopted and further information on the trajectory for achievement received by committee. The approach was commended, however the need to make the use of SPC charts consistent across the Trust noted. The report was accepted and noted that the highlights will be included within the Trust Board Performance Report.

### **Update on Trust Retention NHSI – Valuing Colleagues**

Ms Griffiths updated committee on the NHSI Direct Support Retention Programme, and updated committee on the programme. Walsall Healthcare NHS Trust has been selected as a partner for Cohort 5, which has been identified as a group of Trusts who are currently at the well performing end of retention and turnover. The national retention partners programme is an intervention over 4 months and will complement the work commissioned by the People and OD committee to provide assurance to Trust Board that the BAF risk of high reliance on temporary workforce are being mitigated and exit data identifies any themes of concern. The committee received the report and noted the Baseline benchmark report.

### **HR and OD Progress Update**

Mr Simon Johnson provided an update to the committee on the OD work taking place with the evaluation of the values and behavioural framework. Mr Johnson updated the committee on the themes and observations from the focus groups in 2019 and compared the position

found in 2017. He highlighted significant improvements and also areas still requiring improvement. Committee noted a Trust Board Development session had been arranged to further discuss and plan following on from this work. Ms Griffiths presented the Trust Pulse Survey results and informed the committee that this was the first in-house Pulse Survey designed as a temperature check in between the annual national staff survey. Committee noted that many of the themes align and that there is room for improvement on the FFT results and staff engagement score and approved the recommendations on targets and trajectory for improvement.

### **Annual Equalities Report**

Mr Sebastian Cox-Smith and Ms Marsha Belle presented the draft Annual Equalities Report, committee discussed the report and suggested further updates to reflect the Walsall Together partnership, to include the equality objectives and national metrics on equalities. Committee agreed following update the report should be available for public and community consultation prior to it being published on the Trust website and agreed the production of the Annual Equalities Report must be authentic and inclusive and take the time to be so. The committee noted and supported the work and decisions of the Equality, Diversity and Inclusion Group and approved decisions made.

### **Sub-committees and groups of People and OD Committee**

The committee received the minutes of JNCC and agreed to receive the minutes of the Health and Wellbeing Steering Group and Equality, Diversity and Inclusion Group.

### **Matters to bring to the attention of the Board**

#### **4. RECOMMENDATIONS**

The recommendation to Board is to note the content of the report for information.

MEETING OF THE PUBLIC TRUST BOARD – 3 <sup>rd</sup> October 2019			
Walsall Together Partnership (WTP) Board Highlight Report			<b>AGENDA ITEM: 20</b>
<b>Report Author and Job Title:</b>		<b>Responsible Director:</b>	Daren Fradgley Interim Executive Director of Walsall
<b>Action Required</b>	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
<b>Executive Summary</b>	<p>This report provides the key messages from the Walsall Together Partnership (WTP) Board August 2019:</p> <ul style="list-style-type: none"> <li>• Patient story from Goscote, which demonstrated significant positive impacts on the patients confidence and ability to carry out daily tasks, which supported the patient to be able to commence a job at a local charity shop.</li> <li>• The Directors report outlined the following updates; <ul style="list-style-type: none"> <li>○ PCN and GP Engagement is progressing</li> <li>○ Communication and engagement</li> <li>○ System Performance Dashboard consolidation remained a challenge due to the requirement of releasing information from organisations</li> <li>○ Programme resource constraints were acknowledged with a plan to address</li> <li>○ Quality Framework proposal to be considered at October 2019 SMT</li> </ul> </li> <li>• Programme overviews were received and supported by the WTP Board.</li> <li>• WTP Board agreed a people focused approach for Section 75.</li> <li>• Ms Davies agreed to work with Governance Leads and organise a workshop with SMT to address the Risk Management Proposal reviewed by WTP Board.</li> <li>• WTP Board received and noted updates from the SMT action log.</li> </ul>		

<b>Items for escalation</b>	No items for escalation were highlighted at this meeting.
<b>Recommendation</b>	Members of the Trust Board are asked to NOTE the business of the Highlight Report.

<b>Risk in the BAF or Trust Risk Register</b>	This paper provides assurance to the board to mitigate the risks in relation to the following BAF risks:  BAF003 If the Trust does not agree a suitable alliance approach with the Local Health Economy partners it will not be able to deliver a sustainable integrated care model;	
<b>Resource implications</b>	There are no new resource implications associated with this report.	
<b>Legal, Equality and Diversity implications</b>	There are no legal or equality & diversity implications associated with this paper	
<b>Strategic Objectives</b>	Safe, high quality care <input checked="" type="checkbox"/>	Care at home <input checked="" type="checkbox"/>
	Partners <input checked="" type="checkbox"/>	Value colleagues <input type="checkbox"/>
	Resources <input type="checkbox"/>	

**WALSALL TOGETHER PARTNERSHIP BOARD HIGHLIGHT REPORT**  
**SEPTEMBER 2019**

## 1. INTRODUCTION

The Walsall Together Partnership (WTP) Board, formally Integrated Care Partnership Board, met in September 2019. The WTP Board will continue to meet monthly in line with the Terms of Reference. These have now been approved by the Trust and the CCG. Approval is pending for Dudley and Walsall Mental Health Partnership NHS Trust and Walsall Council. These were scheduled for the October governance cycle.

This report provides an overview of the key items discussed at the meeting held in September 2019.

## 2. BACKGROUND

The WTP Board has been established to oversee the integration and transformation of in scope services. The Board is responsible for decision making and strategic direction in the context of the Walsall Together Business Plan.

## 3. DETAIL

### 3.1. Attendance, Apologies and Quorum

The Board was chaired by Ms Danielle Oum, Trust Chair, Walsall Healthcare NHS Trust. The meeting was not quorate but the Chair agreed the meeting would go ahead and items for agreement would be discussed and endorsed, as appropriate. Apologies were received from:

- **Mrs Anne Bains, Non-Executive Director, Walsall Healthcare NHS Trust**
- **Mr Richard Beeken, Chief Executive, Walsall Healthcare NHS Trust**
- **Ms Paula Furnival, Executive Director for Adult Social Care, Walsall Council**
- **Mr Paul Tulley, Director of Commissioning, NHS Walsall Clinical Commissioning Group**

### 3.2. Minutes of last meeting and matters arising

Members agreed the minutes from the previous meeting. No matters arising were escalated therefore the Chair confirmed she was happy to proceed with the agenda items.

### 3.3. Patient Story

Comments were received and noted. WTP Board members acknowledged the positive story and how the support provided enabled the patients to improve their confidence and therefore lifestyle. Members acknowledged the support being provided for patients when they wished to seek employment and the links with other services to ensure patients received full support and guidance when no longer a patient.

### 3.4. Walsall Together Director Report

A report from the Interim Executive Director of Walsall Together were received, outlining the subjects named above. The report was taken as read and members were asked for any comments or queries.

Members discussed the importance of ensuring there was a reference point for communications, to ensure the same message was disseminated across all the partnership. It was agreed for a core set of communications to be outlined for approval at a future Walsall Together Partnership Board, which would be the template for all communications moving forward, once agreed with all partners.

A discussion was held regarding the delay with the outcomes frame work. Mr Fradgley commented that there were lessons learned from the approach taken, to ensure moving forward colleagues periodically checked the same understanding was at the centre of work undertaken. Ms Oum suggested consideration was given to taking a whole oversight academic perspective approach, to ensure focused oversight was maintained.

### 3.5. Programme Overview

#### **Programme structure, RAG & status report**

A report outlining the programme structure including RAG rating and status update was received by WTP Board. WTP Board members thanked Mrs McManus for the report provided and agreed that it was a very positive, centralised report, for partners to reference when disseminating messages to colleagues.

Board Members requested an update on strengths based practice for the next meeting, including a summary of SMT focus items, action summaries and future aims.

#### **Workstream plan: Tier 1 & 4**

WTP Board members endorsed plans for tiers 1 and 4.

Challenges were received regarding workstream plans appearing to have an Acute Healthcare focus and were acknowledged. Mr Fradgley commented that it was important to include this workstream within Walsall Together as it was part of the operating model outlined in the business case. The terms of reference for the board include oversight of operational services in scope of which the whole therapy

pathway was one such service. It was noted however that greater narrative to the links to other partners and system wide benefits needed to be strengthened. Mr Fradgley agreed to discuss with SMT members and ensure that future documents represented system ambitions and in this case would also link with the Mental Health Partnership Trust.

### **Pipeline: Community Outpatient Clinics, Falls, Quality & Care Homes**

Pipeline ideas for Community Outpatient Clinics, Falls and Quality & Care Homes was presented to the WTP Board by Mr Dodd.

Mr Fradgley advised that this item was for the Boards awareness at this stage, as active conversations were taking place to scope for Winter 2019. Mrs Allward confirmed that recruitment processes were underway, to appoint to vacancies in Autumn 2019.

Mr Fradgley confirmed that proposals for Pipelines were to be discussed at SMT with recommendations then presented to the Board.

Challenge on the scope of Community Outpatient partners was discussed and how this could broaden to a wider Primary Network Conversation rather than just a single GP provider.

### **3.6. Housing Representation**

The WTP Board welcomed colleagues from housing partners and accepted the report circulated as read. No comments or queries were raised with regards to this report.

### **3.7. Section 75 briefing**

WTP Board received a report on section 75 briefing and updates were noted. In this case the section 75 would be between Walsall Council and Walsall Healthcare. WTP Board recognised that colleagues had recently been through a section 75 process at Dudley and Walsall Mental Health Partnership Trust and Mr Axcell outlined that change with this specific team should be planned carefully. Ms Oum recognised the importance of a people focused approach to Section 75, to ensure the feelings of colleagues were listened to and understood.

### **3.8. Clinical Operating Model (COM) Group**

WTP Board received a report on COM Group, which was taken as read and supported by WTP Board members.

Mr Axcell stated that the Terms of Reference were missing some of the partners names which were confirmed and appeared to be an incomplete version. Mr Fradgley agreed to take these points and resolve them with the group.

Mr Fradgley confirmed that there were 6 workstreams in progress and these would be added as a chart to the TOR.

### 3.9. Risk Management Proposal

The Risk Management Proposal received Ms Davies agreed to work with Governance Leads and organise a workshop with SMT to address this item. Members agreed a deadline of December 2019 for this action.

### 3.10. SMT Action Log

The Interim Walsall Together Director presented the SMT action log which was shared with members ahead of the meeting.

Ms Davies queried progress with communications and engagement plans for Public Health Watch. Mr Fradgley confirmed that Mr Boys and Mrs McManus were leading on this and Health Watch had been commissioned to support. Mr Boys added that long term planning was being discussed separately to engagement to ensure focus on short term and long term aims.

### 3.11. Matters for escalation

No items were raised for escalation to the Trust Board.

## 4. RECOMMENDATION

The Board is recommended to NOTE the content of the report for information and to formally approve the decisions made.