

MEETING OF WALSALL HEALTHCARE NHS TRUST BOARD OF DIRECTORS TO BE HELD IN PUBLIC ON THURSDAY 7 MAY 2020 AT 10:00 VIA MICROSOFT TEAMS AND TELECONFERENCE

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

A G E N D A

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
CHAIR'S BUSINESS					
1.	Apologies for Absence	Information	Chair	Verbal	1000
2.	Quorum and Declarations of Interest	Information	Chair	ENC 1	
3.	Minutes of the Board Meeting Held on 2 nd April 2020	Approval	Chair	ENC 2	
4.	Matters Arising and Action Sheet	Review	Chair	ENC 3	
5.	Chair's Report	Information	Chair	Verbal	1010
6.	Chief Executive's Report	Information	Chief Executive	ENC4	1015
SAFE HIGH QUALITY CARE					
7.	Patient Story – COVID Heroes	Information			1020
8.	Covid-19 Update	Information	Chief Operating Officer/Director of Integration	Verbal	1030
9.	COVID Governance Continuity Plan	Information	Director of Governance	ENC 5	1045
10.	Improvement Programme Update	Information	Chief Executive	ENC 6	1055
11.	Ethics Committee Terms of Reference	Approval	Medical Director	ENC 7	1100
RESOURCES					
12.	Performance Report	Information	All	ENC 8	1105
FOR INFORMATION ONLY					
13.	Monthly Nursing and Midwifery Safer Staffing Report	Discussion	Director of Nursing	ENC 9	1115
14.	Quality, Patient Experience and Safety Committee Highlight Report	Information	Committee Chair	Verbal	1125

ITEM		PURPOSE	BOARD LEAD	FORMAT	TIME
15.	Performance, Finance & Investment Committee Highlight Report	Information	Committee Chair	Verbal	
16.	People & Organisational Development Committee Highlight Report	Information	Committee Chair	Verbal	
17.	Walsall Together Partnership Board Highlight Report	Information	Committee Chair	Verbal	
18.	QUESTIONS FROM THE PUBLIC				
19.	DATE OF NEXT MEETING Public meeting on Thursday 4th June 2020, to be confirmed.				
20.	Exclusion to the Public – To invite the Press and Public to leave the meeting because of the confidential nature of the business about to be transacted (pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960).				

MEETING OF THE PUBLIC TRUST BOARD – 7 th May 2020			
Declarations of Interest			AGENDA ITEM: 2
Report Author and Job Title:	Jenna Davies Director of Governance	Responsible Director:	Danielle Oum Chair
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input type="checkbox"/> Assure <input checked="" type="checkbox"/>		
Executive Summary	<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>		
Recommendation	<p>Members of the Trust Board are asked to:</p> <p>Note the report</p>		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	It's fundamental that staff at the Trust are transparent and adhere to both our local policy and guidance set out by NHS England and declare any appropriate conflicts of interest against the clearly defined rules.		
Strategic Objectives	Safe, high quality care <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 April 2020

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.
		Non-Executive Director – Royal Wolverhampton NHS Trust
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 – Birmingham and Solihull Mental Health Trust.
		Director of PG Consultancy
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd
		Associate Consultant at Provex Solutions Ltd
Ms Pamela Bradbury	Non-executive Director	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

Mr B Diamond	Non-executive Director	Partner - Registered nurse and General Manager at Gracewell of Sutton Coldfield Care Home. Director of The Aerial Business Ltd
Mrs Sally Rowe	Associate Non-executive Director	Executive Director Children's Services, Walsall MBC Trustee – Grandparents Plus, registered charity
Mr P Assinder	Associate Non-executive Director	Chief Executive Officer – Dudley Integrated Health & Care Trust Director of Rodborough Consultancy Ltd. Governor of Solihull College & University Centre Honorary Lecturer, University of Wolverhampton Associate of Provox Solutions Ltd.
Mr R Virdee	Associate Non-executive Director	No Interests to declare.
Mr Richard Beeken	Chief Executive	Spouse, Fiona Beeken is a Midwifery Lecturer at Wolverhampton University. Director – Watery Bank Barns Ltd.
Mr Russell Caldicott	Director of Finance and Performance	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 Wombourne Management Company Clinical Adviser NHS 111/Out of Hours Non-Executive Director at whg
Dr Matthew Lewis	Medical Director	Spouse, Dr Anne Lewis, is a partner in general practice at the Oaks Medical, Great Barr Director of Dr MJV Lewis Private Practice Ltd.
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 Chattered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT Sister in Law – Head of Specialist Services St Giles Hospice
Ms Ann-Marie Riley	Interim Director of Nursing	Deputy Chief Nurse – Nottingham University Hospitals NHS Trust

Report Author: Jenna Davies, Director of Governance
Date of report: May 2020

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 2 APRIL 2020 AT 10:00 a.m. HELD VIRTUALLY VIA TEAMS**

Present:

Ms D Oum	Chair of the Board of Directors
Mr J Dunn	Non-Executive Director
Mr S Heer	Non-Executive Director
Mr P Gayle	Non-Executive Director
Mrs A Baines	Non-Executive Director
Mrs P Bradbury	Non-Executive Director
Mr B Diamond	Non-Executive Director
Mr R Beeken	Chief Executive
Ms AM Riley	Interim Director of Nursing
Dr M Lewis	Medical Director
Mr R Caldicott	Director of Finance
Mr N Hobbs	Chief Operating Officer

In Attendance:

Mr P Assinder	Associate Non-Executive Director
Mr R Virdee	Associate Non-Executive Director
Mr D Fradgley	Director of Strategy & Improvement
Ms J Davies	Director of Governance
Ms C Griffiths	Director of People & Culture
Ms J Wells	Senior Executive EA (Minutes)

Members of the Public 1
Members of Staff 2
Observers

001/20 Apologies for Absence

Apologies were received from Mrs S Rowe, Associate Non-Executive Director.

Ms Oum welcomed Aileen Farrar, Healthwatch and Staffside representatives to the meeting.

002/20 Declarations of Interest and quorum

There were no declarations of interest and the meeting was quorate.

003/20 Minutes of the Board Meeting held in Public on 5th March 2020

The minutes were approved as a true and accurate record.

004/20 Matters Arising and Action Sheet

126/19 – Leadership and Talent Management. Ms Oum asked that reconsideration and reprioritisation be given to risks around colleague wellbeing, safety and engagement at this difficult time. Ms Griffiths updated that a number of health and wellbeing workstreams were underway.

Ms Oum informed that Mr Diamond was the Non-Executive Director Lead for colleague wellbeing. A booklet for staff was being created which signposted a range of support. Ms Oum encouraged proactive approaches to supporting staff.

168/19 - Nurse Establishment Review – Ms Riley advised that work was ongoing and assured that it was continuing despite COVID-19.

179/19 - Patient Story – Work was difficult to progress due to the current COVID-19 climate, though Ms Oum reiterated the importance of staff and patient stories and asked members to reflect upon how progress could be made.

Resolution

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

005/20 Chair's Report

No update was given.

Resolution

The Board received and noted the verbal update.

006/20 Chief Executive's Report

No update was given.

Resolution

The Board received and noted the verbal update.

007/19 COVID-19 Update

Mr Hobbs provided the following update as of the previous day:

- The Trust had 205 confirmed positive COVID-19 patients. 96 of those were current inpatients.
- Total number of patients in critical care was 22.
- Total confirmed number of deaths was 31.
- Staff absence was 752. 553 of those were directly in relation to COVID. The total percentage of staff off work was just below 18%.

ED had been segregated into a zone with respiratory conditions and one without. Patients who required admittance would move to the Acute Medical Unit and Ward 29 which provided a COVID assessment service.

Further inpatient wards who received patients from AMU or Ward 29 with a confirmed or clinical suspicion pending would move to Wards 1, 2 and 3. There were further plans to expand bed base.

Ward 28a was being utilised for surgical patients with COVID. Ward 9 had this week been consolidated to empty Ward 20a.

The strategy was to protect critical, emergency and urgent care services and had ceased routine outpatient and elective surgical based procedures to consolidate staff. Services protected included cancer, non-elective care cohorts and obstetric services.

A Critical Care expansion plan had been developed to manage up to 36 patients on the Intensive Care Unit and could expand beyond into theatre recovery areas, the old Intensive Care Unit and if required, Wards 20a, b and c.

The main risk to delivering the plan was access to ventilator equipment, the supply of oxygen and staff. The risks had been reflected on the Corporate Risk Register.

Mrs Bradbury queried the remainder of patient numbers tested positive who were not an inpatient and asked whether it was assumed that they were now in the community. Mr Hobbs replied that the remaining number had either not required admission or had been admitted, treated and successfully discharged back in to the community.

Mr Gayle queried the number of staff who were absent and asked whether those figures included those isolating as a family member had displayed symptoms. Mr Hobbs informed that the 553 member of staff who were off in relation to COVID included both those who were displaying symptoms themselves and those isolating due to a household member who was or had been symptomatic.

Mr Gayle asked was action was in place for those isolating due to a household member, in order to get them to return to work quicker. Mr Hobbs replied that there was hotel provision for staff that require it in order to stay segregated from household members. Nationally, staff testing was available and a recent pilot had taken place within the Black Country by Sandwell and Dudley, however the Trust was not yet in a position to test staff. Mr Beeken updated that it was anticipated that by the middle to end of the following week, there should be capacity to start testing priority staff.

Mr Dunn asked whether there were any key leaders absent from the Trust.

Mr Hobbs informed that there were or had been members within Director positions, Clinical Directors and Clinical Nursing who have

had to isolate, adding that it was a credit to colleagues who had ably deputised. Daily reviews took place at Tactical Command and no decision making responses had been delayed as a result of sickness or isolation.

Mrs Baines queried whether the figures provided included community services. Mr Hobbs confirmed that they did and were Trust wide.

Mr Diamond asked whether there was training and awareness provided for staff working in new areas.

Mr Hobbs replied that there were staff, particularly within medical staffing who were deployed from other areas to work alongside Critical Care and ED to manage critically unwell patients. Training was taking place for staff from other specialties to work within critical care services which had been well attended and received a positive response. RGNs from Theatres and Critical Care had already been deployed to ITU. Dr Lewis confirmed that ICU training was taking place and had delivered 8 sessions to date. Staff had been supportive, and the Trust was reassured that there were experienced staff available, which emphasised that people in the Trust wanted to help.

Mr Fradgley informed that activity across community teams was rising and also faced similar challenges in relation to staff sickness and isolation. Across 7 place based teams, there were extractions of between 20-35%. Rapid response had seen an 80% extraction rate the previous week. The profile of community sickness was escalating.

A daily conference call had been established with all partners which added value and challenge.

Mr Fradgley added that risks were rising as the day to day activity remained, with long term conditions being the biggest risk.

There had been COVID outbreaks in care homes which could result in a risk with access to acute services.

Hot clinics had been established at the old walk in centre at The Saddlers Centre and community hubs were being opened.

Hollybank, which was a 21-bed unit for stroke patients was due to open on 6th April and thanks were given to the volunteers who had assisted in the move.

Ms Oum recognised and reiterated the value of Walsall Together during the crisis and the advantages of working together.

Mr Virdee queried whether patients in care homes were being looked after by GPs. Mr Fradgley replied that GPs were working alongside integrated teams and a team had been allocated to every care home and had completed risk assessments.

Mr Hobbs cautioned that some patients would wait longer for treatment due to reduced routine services.

Mr Hobbs summarised that the availability of equipment was key such as ventilators and equipment. Oxygen supply in to Ward 2 areas was also required.

Health and wellbeing of staff was a risk and consideration should be given for both the physical and psychological effects. Psychological resource had been deployed to support key areas of the Trust and a request had been made to the Ministry of Defence regarding managing traumatic situations. Dr Lewis cautioned the significance consequence of potential physical illness and infection which should be recognised on the Risk Register.

Mr Heer asked for a review of tolerance levels to be built in and the impact of it on other risks.

Ms Oum agreed and asked Ms Davies to arrange a workshop in order to discuss further.

Ms Davies advised that it was likely that all Trust risks would be impacted upon. There was a need to agree on and develop the Board Assurance Framework and strategic risk that COVID will impact on delivery of strategic priorities over 12 months. Ms Davies was arranging an external consultant to run a workshop session on risk management and the BAF.

**Director of
Governance**

Mrs Bradbury asked what the implications were on non-COVID patients and how resources were being used to support staff who were isolating but not sick. Dr Lewis advised that consideration should be given to how necessary outpatient activity is. The Trust was redesigning the service with a long term view. There were staff who were off sick who would normally attend work due to mild symptoms, self-isolators and staff shielding who may still be available to work still but not on site who could be utilised to contact patients, formulate plans, investigations and review results.

Mr Caldicott cautioned to be mindful of adding expenditure which was a risk due to not yet being sighted on the level of funding the Trust would receive.

Ms Oum asked that the Risk Register was developed to include colleague safety, wellbeing and financial impact.

**Director of
Governance**

Resolution

The Board received and noted the content of the report.

008/20 Performance Report

Mr Caldicott presented the Performance report,

Quality, Patient Experience and Safety Committee

Dr Lewis informed that the current key focus of the committee was the current and future COVID issues and would continue to focus on quality, safety and patient experience.

VTE remained important as did the Mental Capacity Act and discussions around DNAR and CPR were very current.

Ms Oum requested that the Committee and Safeguarding reviewed the plans in place relating to COVID in order to obtain additional assurance.

Ms Riley informed that a risk assessment across safeguarding elements had been undertaken and reviewed weekly what could continue as normal, continue with changes or stepped down. The team also provided updates regarding patients with learning disabilities, dementia and reasonable adjustments in place across all safeguarding functions including the community. Ms Davies, Mrs Bradbury and Ms Riley had arranged a meeting to discuss the focus of the committee.

Mr Beeken referenced midwifery continuity of care and new national standards and advised that he and Mr Caldicott were looking at cost pressure consideration in the financial plan. Ms Riley would provide detail to Board members regarding implications for patients, staff and budget at a future meeting and added that some programmes had been delayed due to COVID.

Mr Gayle noted that there was a deterioration in inpatient areas in relation to sepsis and asked what impact it had and how it would be addressed in the current situation. Dr Lewis updated that the position was to maintain it as an important criteria and manage, escalate and treat as well as possible. However, staffing levels on wards were stretched at the moment both medical and nursing, therefore it would be a challenge to maintain good performance and maintain quality and should be recognised as a potential risk.

Integration

Mr Fradgley had covered much of the update in an earlier agenda item, adding that significant progress had been made with integration, sharing performance and pressures.

Ms Oum gave thanks to the teams, adding that the range of achievements in difficult times was impressive.

People and Organisational Development Committee

Ms Griffiths updated that daily absence reporting figures were being shared. The committee would conduct reviews linked with the staffing hub.

The LiA engagement app was working well and quick actions were being taken.

A Health and Wellbeing Group met weekly. Ms Griffiths would circulate the booklet that had been created for staff.

Wellbeing support had started to show impact on sickness figures prior to COVID and work was continuing to strengthen that approach and will ensure that staff have the ability to recover and recuperate following COVID pressures.

Ms Oum identified that sickness was an area of priority and COVID had underlined that. Priorities would be identified prior to the next committee which would focus on support for staff.

**Director of
People &
Culture**

Pastoral support mechanisms had been put in place for staff on wards and food packs were being delivered twice a day. With effect from 6th April, hot food would be available on site 24 hours a day. Car parking was now free.

From 6th April, a local crèche would be available for staff with the first allocations available to staff in critical areas.

A range of apps for self-care were available nationally and detailed within the staff booklet. Occupational Health hours had been extended and strengthened and using Mind Health and the Listening Centre. On call psychological support was also available for staff as and when needed.

The Trust would continue to build on what people needed and learning from best practice

Mrs Baines advised that there was anxiety from staff regarding PPE and for assurance that there was a clear communication regarding provision and process of what was necessary.

Dr Lewis agreed that staff were concerned. There was a consistent message which followed national guidance which was communicated through the Daily Dose, email and face to face at hand overs. There was enough PPE and in the right places to provide the right protection throughout, which would be adjusted if there were any changes to guidance nationally.

Constitutional Standard

Mr Hobbs emphasised the risks that COVID brought. There were delays in admission for patients on acute medical pathways and placing pressure on Trust performance.

Routine elective care has been consolidated and would therefore expect to 18 week referrals to rise.

Cancer care is being protected.

Diagnostic standards would also be impacted as services such as Radiology and Endoscopy had been consolidated for urgents.

Mr Assinder asked if there was a national understanding that standards won't be met. Mr Beeken informed that key elements were addressed in the letter from Simon Stevens and with the exception of cancer, other standards weren't listed.

Performance, Finance and Investment Committee

Mr Caldicott reported a £10.9m deficit.

Additional revenue of £4m had been secured commissioner partners.

For year 2019-1020, The Trust was heading for a breakeven performance and delivery of the plan which would result in a cash benefit for the Trust. The next committee meeting would receive confirmation of plans.

COVID would have an impact and the Trust would lose clinical income. Further discussion would take place in the Private Trust Board meeting.

An emergency budget had been set for 2021 but the allocation for first 4 months of new year was unknown and would be debated further at the next committee.

Mr Assinder welcomed the achievement of the financial position and gave credit to the work undertaken. Mr Assinder queried the capital spending and if there was an infrastructure implications of delay. Mr Caldicott informed that the question would be raised at a national conference that day and that the capital brief would be issued later on today. Capital resource should be adjusted.

Mr Heer stated that it was a great achievement to hit the financial target and asked to ensure that financial discipline was maintained in these difficult circumstances. The committee would review the degree of tolerance.

Resolution

The Board received and noted the content of the report.

009/20 Monthly Nursing and Midwifery Safer Staffing Report

Ms Riley introduced the paper detailing February data as read. Modelling for critical care was underway, following national guidance. Staffing on each ward had been modelled to ensure continuation of deliver medical and nutritional care.

The staffing hub operated 0800-2200 documenting staff moves, sickness and leave. A rota for out of hours was being drafted.

Resolution

The Board received and noted the content of the report.

010/20 Walsall Together Update

The update had been provided in a previous agenda item.

Resolution

The Board received and noted the content of the report.

011/20 Quality, Patient Experience and Safety Committee Highlight Report

The report was taken as read.

Resolution

The Board received and noted the content of the report.

012/20 Performance, Finance and Investment Committee Highlight Report

The report was taken as read.

Resolution

The Board received and noted the content of the report

013/20 People and Organisational Development Committee Highlight Report

The report was taken as read.

Resolution

The Board received and noted the content of the report.

014/20 Walsall Together Partnership Board Highlight Report

The report was taken as read.

Resolution

The Board received and noted the content of the report.

015/20 Questions from the Public

Aileen Farrar, Healthwatch informed that staff were now working from home. Patient engagement was taking place through the website and social media with the main topic being COVID.

A maternity report had just been completed and would be shared with stakeholders once approved and would provide information to new mums regarding COVID. Healthwatch were happy to support any public messages from the Trust and any volunteers to help within the hospital and local authority.

Ms Oum thanked Ms Farrar for the helpful update and offer of assistance and suggested that she liaised with Ms Riley and expressed interest in the sharing of messages, use of volunteer input and suggestion of getting feedback from women using rust maternity services.

016/18 Date of Next Meeting

The next meeting of the Trust Board held in public would be on Thursday 7th May 2020 at 2:00p.m. at Walsall Healthcare NHS Trust.

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.

Action log

Updated from Trust Board Meeting: March 2020

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
168/19	06/02/20	Nurse Establishment Review	Categories of the report to be clarified at PODC	Director of Nursing	05/03/2020	The report was received at PODC in February in line with the action. The report will be considered again once the Director of Nursing starts with the Trust.	Complete
179/19	05/03/20	Patient Story	QPES to gain assurance that the Trust has the necessary processes in place to meet the needs to those requiring reasonable adjustments and also gain assurance how well engage and supported engagement is with patient groups to improve patient experience	Medical Director	04/06/2020	The recent focus on COVID has prevented detailed work on patients with learning disability. We remain mindful of the need to protect the rights of all patients with appropriate safeguards.	Open
179/19	05/03/20	Patient Story	DoN to share best practice in terms of NUH approach and what may be adopted by the Trust	Director of Nursing	04/06/2020	Shared decision making principles form part of the Care Excellence Programme. The team will scope ways to engage with the public during current COVID restrictions	Open
183/19	05/03/20	Action Log	BAF/CRR to each Committee in March and Board agenda in April	Director of Governance	04/06/2020	The BAF and CRR has been reviewed and will be approved via the relevant committees and Board in the May Board Cycle	Open

Action log

Updated from Trust Board Meeting: March 2020

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
183/19	05/03/20	Safer Staffing	Staffing report will be reviewed and amended in line with the actions previously requested by the Board: A review of hard and soft measures of performance to take place at the People and Organisational Development Committee.	Director of People and Culture/ Director of Nursing	02/07/2020	The hard and soft measures for workforce are scoped. The workforce metrics are all impacted by the current CV19 situation and workforce analysis is focussed on supporting resourcing for the next 12 weeks update on progress to PODC in July.	Open
			People and Organisational Development Committee to undertake a deep dive of Impact and profile of the Nursing workforce model		02/07/2020	This work is impacted by directing resources to the current CV19 situation and progress update is planned for PODC in July	Open
			People and Organisational Development Committee to review the sickness absence target, review the effectiveness of the current interventions and trajectory to improve sickness absence. PODC to recommend to the Board a sickness absence target and trajectory		02/07/2020	The sickness absence level had stabilised and absence in January and February 2020 was over 0.5% down on the previous year. PODC has discussed the target and trajectory - an improvement target has been set within the workplace metrics of Valuing Colleagues.	Open

Action log

Updated from Trust Board Meeting: March 2020

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
190/19	05/03/20	Freedom to Speak up	POD to gain assurance and review a report SI/ HR case Management/FTSU with a process for ongoing monitoring	Director of People & Culture	04/06/2020	The work with NHSi is supporting the Trust with putting systems and processes in place to include this within PODC and Trust Board reporting. There will be a board development session week commencing 11th May 2020.	Open
190/19	05/03/20	Freedom to Speak up	DoN to ensure and provide assurance through QPES that the processes and ongoing reporting of the safe staffing report links with patient safety incidents	Director of Nursing	04/06/2020	Report is being reviewed and developed.	Open
191/19	05/03/20	Performance Report	QPES to review and gain assurance relating to the cancer access standards, the delays in histopathology and the impact this has in terms of quality of care, harm and patient experience	Medical Director	02/07/2020	Standards are being reviewed but the item has been deferred due to the current COVID-19 restrictions.	Open
007/19	02/04/20	COVID-19 Update	Board workshop to be arranged in order to discuss tolerance of risk	Director of Governance	07/05/2020	A number of facilitated Board workshops have been set up during May with a conclusion session planned after the June Board Meeting. Further information to be circulated to Board Members WC 4.5.20	Complete
007/19	02/04/20	COVID-19 Update	Risk Register to be developed to include colleague safety, wellbeing and financial impact of COVID-19	Director of Governance	04/06/2020	A Covid Risk Register was presented to Board in April. A COVID BAF risk has been developed and will be presented to the Board in June	Open

Action log

Updated from Trust Board Meeting: March 2020

Ref:	Date	Agenda Item	Action Notes	Who	Due Date	Progress / Comments	Status
008/19	02/04/20	Performance Report	Health and Wellbeing booklets created for staff to be circulated to Board members.	Director of People & Culture	07/05/2020	The Health and Wellbeing Booklet has been circulated to Board Members with a copy of the Screensaver used throughout April. The Booklet is on the intranet and 4,000 copies have been distributed to staff.	Complete

Complete

Open

Delayed (1 meeting)

Overdue (14+ days)

MEETING OF THE PUBLIC TRUST BOARD – Thursday 7 th May 2020			
Chief Executive's Report			AGENDA ITEM: 6
Report Author and Job Title:	Richard Beeken, Chief Executive Officer	Responsible Director:	Chief Executive Officer
Action Required	Approve <input type="checkbox"/> Discuss <input checked="" type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	<p>The purpose of the report is to provide the Board with my appraisal of the high level, critical activities which the organisation has or will engage with in the immediate future, set against the organisation's strategic objectives. In this report, I particularly focus on our COVID-19 response, tactically and strategically, through the lens of our 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 April 2020 and assures the Board through an allocation of the actions required, to the relevant executive director.</p>		
Recommendation	<p>Members of the Trust Board are asked to:</p> <p>Note the report and discuss the content</p>		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	<p>This report outlines the actions set 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>		
Resource implications	<p>There are significant resource implications associated with our COVID-19 response. These include additional expenditure on temporary staffing, consumables, personal protective equipment and specialist advice. These costs are all coded accurately and scrutinised by the PFIC.</p>		
Legal and Equality and Diversity implications	<p>There are no legal or equality & diversity implications directly linked to this paper, however there is clear evidence that the BAME population are disproportionately affected by COVID-19 and as such, particular care and attention needs to be taken both in understanding co-morbidity and ethnicity risk factors in those working with or being treated for COVID-19 and also to ensure that risk assessment of BAME staff being deployed to COVID areas of the Trust, is effectively done.</p>		

Strategic Objectives	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"/>	



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 has or will engage with in the immediate future, set against the organisation's strategic objectives. In this report, I particularly focus on our COVID-19 response, tactically and strategically, through the lens of our strategic objectives.

The report also sets out to the Board the significant level of guidance, instruction and best practice adoption we received during April 2020 and assures the Board through an allocation of the actions required, to the relevant executive director.

2. BACKGROUND

The Trust has, through its revised corporate strategy and initial work to develop its 2020/21 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

The Trust has responded well, in large part, to the COVID challenge from a quality and safety perspective. By virtue of being the borough with the highest COVID incidence rate per 100,000 population and because the Black Country system has the highest incidence rate nationally, we were tested fairly early on with regard to the correct admission pathways and effective cohorting and segregation. The latest changes expected by the national team which came into effect on 25/4, demand that every non-elective admission, be they symptomatic or not, is tested for COVID. Our teams have responded swiftly to this latest challenge.

We have been concerned in Walsall and ultimately, across the Black Country, about the community death rate from COVID, which in crude terms, is of similar number, even if it has tracked at a different rate. Walsall as a system and as a partnership, has been praised by

CCG leads and public health colleagues, for our swift response to this issue. In particular, the immediate deployment of significant additional resources from both community services, infection control and elderly care, as part of a care home intervention team, has been highlighted as excellent practice. The early outputs of this work do seem to be reducing the risks in the homes in focus, but we await more longitudinal evidence before drawing further conclusions.

Other community based risks are also at the forefront of our minds at present. The significant reduction in emergency department attendances and non-elective admissions points towards the very real risk of non-COVID exacerbations of chronic conditions being in significant number in the community. Not all of these can or will be managed by primary care or our community teams and therefore we have been and continue to be, quite open and forthright in our communication to the public regarding the fact that we have the capacity and the safe systems in place to manage them if they are acutely unwell. We do not want people to be suffering alone or in distress because they feel they shouldn't or mustn't access our services.

The operational and public health risks that I have described above need effective oversight and as such, we have:

- Established swift interventions in care homes to manage that risk
- Re-established our patient safety group and risk management group to ensure the incidents declared are appropriately investigated and managed
- Stepped up the quality assurance process via the Director of Nursing to ensure the fundamentals of care are delivered during this exceptional period
- Decided to work jointly with CCG colleagues and public health on a retrospective review of community deaths to determine whether there is any learning from positive or negative aspects

Looking to the future, we have already initiated a series of interventions that are all designed at maximising the once in a managerial generation opportunity that COVID has brought us, from a service redesign perspective. Linked to explicit requests from the national and regional teams around “restoration and recovery” of key services and standards, we are:

- Reviewing radical ideas for outpatient redesign, including a new partnership with primary care providers in certain specialities and pathways
- Reviewing the opportunity to integrate urgent and emergency care between the ED, acute medicine, frailty service and our community multi-agency teams in Walsall Together. The concept of an integrated ambulatory emergency care, frailty and intermediate care “step up” model is gathering pace and planning for this is underway

- Using benchmarking information on clinical best practice to change inpatient and elective management

All of the above work will be managed through the Improvement Programme architecture. There will be a need to ensure that at all times, we protect a safe amount of capacity for a potential second COVID “peak” and there is an expectation that this planning work is also done across the Black Country system, to maximise cross-organisational opportunities.

3.2 Valuing our colleagues

Effective communication and staff engagement is critical during unprecedented times like this. Also vital, is to acknowledge the unique pressures this is placing on clinical and support staff and the often psychological distress that it can cause. New stresses and uncharted territory is also being experienced by managers, leaders and supervisors, in the face of rapidly changing national and local guidance and the increases in staff absence.

From a communication perspective, we are undertaking a weekly Team Brief, a weekly Care Group leaders briefing, intensively communicating guidance and best practice daily, regularly updating our intranet FAQs section on COVID and, critically, we have been able to significantly increase executive director presence in wards and departments. That said, there is always more we can do and as such, we are now seeking to introduce a “push notification” approach to key communications to all staff and making that as much as possible, communicated by the face and voice of a senior leader, as opposed to written information.

We have been highlighted in the Health Service Journal for the utilisation of the Listening into Action staff engagement app during the COVID crisis. Over 300 staff now have used this app to raise concerns, make suggestions and ask questions. Hundreds of responses to those questions have been shared, again on a “push notification” basis.

From a staff health and wellbeing perspective, a comprehensive and systematic offer has been developed in four tiers of support. This has been publicised both electronically and in written staff health and wellbeing booklets, distributed across acute and community services. This has been received well thus far and there has been good feedback from colleagues about how the psychological support offer has been matched to specific areas with the greatest need. This was no better demonstrated than during the immediate aftermath of the death of Areema Nasreen, one of our nursing colleagues, from COVID-19.

There is strong evidence that COVID-19 is affecting the BAME population, both patients and staff, disproportionately. Our equality, diversity and inclusion group is examining this issue and in the meantime, we are amending our individual risk assessment process regarding staff deployment, to ensure these factors are taken into account by managers prospectively.

3.3 Partners

The Black Country system has cooperated effectively so far on the COVID response. Initially, daily teleconferences took place between all the CEOs, facilitated by the CCG leadership team, which have proven effective at ensuring that practice is standardised and ideas shared, where appropriate. Mutual aid between Trusts on PPE and equipment has been arranged when required, without fuss or significant bureaucratic delay.

Now, the system is turning its attention to restoration and recovery planning. Helpfully, the CCG leadership are wanting each borough (“place”) to develop its restoration plans based on its own evidence and local circumstances and partnerships. The system involvement will then come on testing those plans out, standardising practice where appropriate and brokering additional capacity, within and outwith the system, should it be required. Regional team scrutiny will be significant on this, but there is no evidence thus far that it will be intrusive or slow down progress.

3.4 Resources

I would like to put on record my thanks to the Board for swiftly and pragmatically, agreeing the changes to financial governance and delegated limits that have allowed the executive team to move quickly on key tactical and strategic decisions with the commitment of resources, both pay and non-pay. Our finance team have kept a strong audit trail of that expenditure, such that the top-up reimbursement of COVID expenditure is accurate and timely. As a result, with the exception of the regional team rejection of our mobile x-ray machine request, there has been no delay to the provision of staff or PPE/equipment and staff feedback about this has, in general, been positive.

The restoration and recovery planning will have, inevitably, a necessary financial planning element. Once plans have been developed regarding restart, redesign and recovery of backlogs, these will need extensive financial modelling, within a contractual context and financial framework which is not yet fully known or understood. At present, we are being told to await guidance shortly which is likely to set out the protection of current, run rate based budgets and income for Trusts, but this isn’t guaranteed. However, what is almost certain, is that the era of payment by results is over and as a result, we have the opportunity to redesign services, significantly expand the Walsall Together integration capacity and work with the acute hospital, without a fear of diluting our financial position as much as before. These are exciting times for us in the NHS and care sector and we must seize this opportunity as it won’t come round again for some time.

3.5 Care at home

Our Walsall Together partnership has stood up well to the COVID-19 crisis. Key elements of the resilient and impressive approach taken include:

- Risk stratification and dynamic workload scheduling done by community nursing teams, to protect the most vulnerable
- Enhanced care home support team, delivered by WHT, in an arena which is usually the preserve of public health and local authority intervention. Matching need to professional expertise pragmatically has been the order of the day here
- The development of a real time dashboard of indicators, from care home risks, to disease prevalence by locality, to workforce risks and availability, have allowed our community teams to be responsive and nimble
- The regular use of the local authority tactical command hub to deploy additional, multi-agency resources to particular logistical or practical problems
- A twice weekly, multi-agency Walsall Together tactical command forum
- The deployment of Walsall Housing Group maintenance staff to assist with preparing HollyBank House to receive the community stroke rehabilitation inpatient service

The impressive work of our partnership has been evident in the teleconferences and STP wide forums and has been noted as advanced in its approach and impressive in its deployment.

3.3 RECOMMENDATIONS

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

Richard Beeken
Chief Executive
27/04/2020

NEW NATIONAL GUIDANCE, REPORTS AND CONSULTATIONS

The following guidance and policy actions, which have been received from the wider regulatory and policy system since April 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>ICO's regulatory approach during the coronavirus public health emergency</p> <p>ICO guidance on its approach to its enforcement of legislation during Covid-19</p>	<p>Guidance</p> <p>PFIC</p>	<p>Director of Governance</p>
1.2	<p>Checklist for accepting gifts or donations</p> <p>During the Covid-19 pandemic NHS organisations are being offered unprecedented levels of donations and gifts. This guidance provides advice to NHS Trusts</p>	<p>Guidance</p> <p>Audit Committee</p>	<p>Director of Governance</p>
1.3	<p>Guidance on handling donations and loans of medical equipment to hospitals in response to the COVID-19 pandemic</p>	<p>Guidance</p> <p>Audit Committee</p>	<p>Director of Governance</p>
1.4	<p>Financial accounting and reporting updates</p> <p>Changes have been made to the year-end timetable and arrangements owing to Covid- 19.</p>	<p>Guidance</p> <p>Audit Committee</p>	<p>Director of Finance</p>
1.5	<p>COVID-19: interim guidance on DBS and other recruitment checks</p> <p>CQC interim guidance on DBS and other recruitment checks, for providers recruiting staff and volunteers to health and social care services in response to coronavirus (COVID-19).</p>	<p>Guidance</p> <p>POD Committee</p>	<p>Director of People and Culture</p>
1.6	<p>COVID-19: infection prevention and control (IPC)</p>	<p>Guidance</p> <p>QPES Committee</p>	<p>Medical Director</p>

MEETING OF THE PUBLIC TRUST BOARD – 7 th MAY 2020			
Governance Continuity Plan			AGENDA ITEM: 9
Report Author and Job Title:	Jenna Davies Director of Governance	Responsible Director:	Jenna Davies Director of Governance
Action Required	Approve <input checked="" type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input checked="" type="checkbox"/>		
Executive Summary	<p>In response to COVID-19, a level 4 national incident was declared. The Trust, as a first responder has a legal obligation to establish Emergency Preparedness, Resilience & Response (EPRR) framework, which includes an incident command structure (Board Briefing 17.3.20), which enables robust and effective decision making throughout the organisation in relation to COVID-19.</p> <p>As an NHS Trust, the board needs to be able to deliver prudent and effective leadership and effective oversight of the trust's Strategy and Performance to ensure it is operating in the best interests of patients and staff.</p> <p>Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective and the right outcomes are delivered. In the NHS this means delivering safe, effective services in a caring and compassionate environment in a way that is responsive to the changing needs of patients and service users.</p> <p>Good corporate governance is dynamic and is the means by which quality governance is overseen. Robust corporate and quality governance arrangements complement and reinforce one another. Individuals working in clinical teams providing NHS services are at the front line of ensuring quality of care to patients. However, it is the board of directors that takes final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care. Effective governance therefore requires that boards pay as much attention to quality of care and quality governance as they do to the financial health of their organisation.</p> <p>In light of the boards duties highlighted above and in order to ensure robust governance processes during the Covid – 19 incident, the Trust Board at its meeting in April approved changes to both the Corporate Governance and the financial governance of the organisation</p>		

	<p>The initial governance continuity plan was approved at the Board in private session in April. At the meeting the Board approved the recommendations in both the Corporate Governance and the Financial Governance proposals. The Board requested the updates to the continuity plan;</p> <ul style="list-style-type: none"> • Delegated limits to reflect the agreement at board • Both the corporate governance and financial proposals to brought together into one continuity plan • Reflective of the Committee cycle of business review <p>The updated continuity plan was reviewed by the Performance, Finance and Investment Committee (for financial governance and pro-forma) on 29 April, and Audit Committee (for governance process) on 21 April.</p>	
Recommendation	Members of the Trust Board are asked to review and approve the revised governance continuity plan.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	In order to mitigate the impact of the COVID-19 outbreak this paper provides assurance that governance will be maintained, and the process for ensuring Non-Executive Director oversight of the risks to the organisation.	
Resource implications	The Financial implications are outlined in the paper	
Legal and Equality and Diversity implications	<p>Legal implications are outlined within the paper</p> <p>Making provision for virtual meetings increases the accessibility of the Trust for those who struggle to visit the Trust in person; however, they increase the risk of excluding sections of our community without internet access or requisite technology.</p>	
Strategic Objectives	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"/>	

GOVERNANCE CONTINUITY COVID 19

1. Situation

A coronavirus is a type of virus. As a group, coronaviruses are common across the world. COVID-19 is a new strain of coronavirus first identified in Wuhan City, China in January 2020. The incubation period of COVID-19 is between 2 to 14 days. This means that if a person remains well 14 days after contact with someone with confirmed coronavirus, they have not been infected.

The government have implemented a four point action plan, with the latest national guidance was released on 16th March 2020 which includes;

- COVID-19: guidance for households with possible coronavirus infection
- COVID-19: guidance for employees, employers and businesses
- COVID-19 guidance for mass gatherings

2. Background

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. This virus is referred to as SARS-CoV-2, and the associated disease as COVID-19.

In response to COVID-19, a level 4 national incident was declared. The Trust, as a first responder has a legal obligation to establish Emergency Preparedness, Resilience & Response (EPRR) framework, which includes an incident command structure (Board Briefing 17.3.20), which enables robust and effective decision making throughout the organisation in relation to COVID-19. This structure considers all aspects of operational, quality, people and financial planning and processes.

The initial governance continuity plan was agreed at the Board in private session in April. At the meeting the Board approved the recommendations in both the Corporate Governance and the Financial Governance proposals. Audit Committee retrospectively considered and approved the proposals at its Committee meeting in April.

3. Corporate Governance

To support the incident management structures, it was agreed to reduce the decision and governance making processes within the organisation for business as usual and routine business. Revising the structures will enable us to focus on supporting the critical delivery of the response to COVID-19.

The revised governance structure which has been agreed removes all meetings, other than care group, divisional and the bi weekly Trust Management Board. Therefore Trust Management Board will temporarily expand its Terms of Reference to receive all divisional escalations, including Quality, Patient Experience, Finance, and risk oversight.

Further to the above decision we have also agreed to maintain the following critical groups; (However this will remain under review by strategic command group)

- **Emergency Department Building group**; This group has been identified as a priority due to decisions which will need to be made to ensure progress in the ED build is not impacted at this stage.
- **Staff Health and Wellbeing Group**; this group will oversee the support to staff to ensure our staff remains healthy and able to attend work during COVID 19. It will also oversee specific interventions for staff in critical areas such as ward 29 and ITU.
- **EPR Programme Board** – will continue until/unless decision made by strategic command to revise scope of the programme or defer its implementation

The Director of Governance has led a review of the current cycle of business for each Committee, with each Committee chair, and executive lead. Each Committee has agreed agendas for the next 3 months which will include the following standard items;

- Risk Management- Each Committee will have a standard agenda item on new and emerging risks, as well as the Board Assurance Framework and Corporate Risk Register
- Covid 19 update- for each Committee a Covid update based on the Committee Terms of Reference will be presented for assurance and escalation of immediate issues or risks
- Improvement Programme- Each Committee will continue to receive progress updates on the overall improvement programme, and where appropriate restoration plans.

The Committees will continue to seek assurance for immediate issues or concerns aligned to their Terms of Reference.

Aligned to the national guidance, all Committee and Board Meetings for the next three months will be conducted virtually via Microsoft teams (Appendix 1). Virtual meetings, subject to quoracy, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

Where it is not possible to convene a meeting via video conference, decision items may be

- circulated to voting members of the body for comment and approval, or:
- taken by Chair's action, in liaison with the Chief Executive and Lead Executive Director for the matter concerned.

In each case, the Trust Secretary will collate responses and ensure that the resulting decision is communicated, and reported to the next formal meeting for information.

As a public body we must transact our Business in accordance with the Public Bodies (Admission to Meetings) Act 1960, which states we must enable members of the public to attend our Public Trust Board. Owing to the national guidance as part of the overall 'social distancing' strategy to protect staff and patients, the public, we are recommending that whilst we still conduct the public elements of our Public Trust Board meeting, we do as part of our Private Board. We will publish a statement on our website and also publish the papers of the meeting and ask for written questions in advance of the meeting. We will also invite our local Healthwatch to participate via conference call for the public elements of the meeting to ensure public oversight.

In addition to the formal governance arrangements, we have also put in place an informal progress to ensure Non-Executives have oversight of the Trusts Covid Response;

- Weekly NED call, daily Sit reps,
- weekly C-19 finance paper,
- weekly C-19 Chief Operating Officer (hospital & Community) paper

As the outbreak continues, and as we shift towards restoration and recovery, we have agreed;

- Fortnightly COO C-19 (hospital) paper,
- weekly C-19 Community (Walsall Together) paper,
- daily Sit reps,
- weekly C-19 finance paper weekly NED call and;
- Weekly CEO /Dep CEO-NED restoration and recovery call

We have developed a Governance Contingency plan which as the outbreak continues and as national guidance changes it may be necessary to further reduce meetings (Appendix 2). Therefore the contingency plan sets out how decisions could be made in the absence of a quorum if required.

3.1 Financial Decision Making

In order to support incident command structure, we have reviewed our financial governance processes and we are recommending the following changes to our current processes for COVID 19 expenditure;

- Suspension of discretionary spend panel (COVID-19)
- Temporary (4 months, 31st July 2020) changes to Standing Financial Instructions to include;
 - Increase in spending limits to the Incident Commander of the Acute Hospital (Ned Hobbs), and the Incident Commander of the Community (Daren Fradgley) to approve spend aligned to the national definitions to £150,000 currently £25,000).
 - Increase in spending limits to the Chief Executive Officer to approve spend aligned to the national definitions of up to £300,000 (£75,000)

All procurement processes, as laid out in SFIs will remain in place.

Normal consultancy approval and agency reporting requirements

Financial control and stewardship of public funds will remain critical during our response to COVID-19, and we will need to ensure we are complying with our legal obligations. Therefore through the incident command process will be monitoring all expenditure associated with COVID;

- Tactical Command- Senior Financial lead attendance at each meeting to capture all costs/financial impact of each decision
- Strategic Command- Review the COVID financial budget report. Director of Finance to ensure that the financial impact of decisions taken at Strategic level are captured.
- Each week a report listing the decisions taken within the above forums (with narrative under each of the headings within the proforma) will be supplied to board members
- PFIC to receive a monthly COVID Finance report
- Audit Committee will retain oversight of financial governance, specifically relating to procurement, and single source wavers.

In order to provide assurance both to the Board and the national teams, we will apply the following process to ensure COVID expenditure is appropriate;

- The monthly commitment of resources and schemes enacted then reviewed in a formal report to PFIC
- All schemes endorsed will then be presented monthly within Private Board papers for oversight and transparency

However any the above changes to **will not** apply to;

- Business as usual expenditure or non COVID-19 expenditure
- Recurrent spend or enable the organisation to commit to recurrent spend without following our current SFI processes.

There is a national mandate for each organisation to claim the additional costs from the national fund, on a monthly basis, alongside regular monthly financial reports.

4. Recommendation

The Board is asked is approve the updated Governance Continuity plan

Appendix 1; Managing Meetings attended remotely

1. General

- Participants using mobile phone to dial in should ensure that once engaged in the meeting their mobiles are turned to 'mute' to prevent any unwanted noise, unless it is necessary for emergency reasons.
- Participants should also ensure they are in a sound free environment for the duration of the meeting.

2. Engaging in the meeting

- Instructions will be provided to every participant
- It can be the case that there is a slight delay for all participants to join the call; participants are asked to hold the call until the Chair commences the meeting.

3. Chair to open the meeting

- The Chair will open the meeting and ask each participant to state their name, and position. This is important for meeting records and to determine whether the meeting is quorate.
- If the meeting is not quorate at that point, the Chair will:
 - a) Ask the Trust Secretary for advice as to any anticipated late attenders; then
 - b) Consider delay of up to 10 minutes, then
 - c) Dependant on numbers attending, progress with any matters on the agenda that do not require approval.

4. Taking each item on the agenda

- The Chair will introduce each item, and speaker.
- No one other than the speaker can contribute until the speaker has concluded.
- At that point the Chair will ask whether anyone wishes to raise a question.
- Each participant wishing to raise a question must first state their name. They must not ask any questions until indicated to do so by the Chair.
- The Chair will then invite each of those participants to raise their query in full; no-one other than the participant raising the question should comment.
- The Chair will respond and /or direct someone to respond

5. Presenting papers and presentations

- Introduce the paper clearly – be clear at the start what the aim of your paper/presentation
- Ensure the paper or presentation has page numbers on before circulation
- Refer to those page numbers clearly as you move through the presentation / paper – so the listeners can follow easily the document and where you are at in it

6. Voting

- For each item requiring approval:
- The Chair will read the recommendation

- He will then ask each participant who is eligible to vote to state their name followed by:
 - “Yes”: if they approve;
 - “No”: if they don’t approve; or
 - “Abstain”: if they choose not to vote.No other comments are to be made.
- The Chair will declare the result of the vote.

7. End of meeting

- The Chair will declare the end of the meeting

8. Video Conferencing – in addition to the above

- Mute audio but not video otherwise the Chair may think you have left the meeting.
- Ensure your technology works correctly and that you have the video, audio and papers viewing capabilities you might need.
- Wear work-appropriate clothing and be in a place with the minimum disturbance.
- Frame the camera correctly and have the right light – if you sit in front of a brightly lit window, all others will see of you is a silhouette.
- Look into the camera and reduce any potential distractions.
- Be courteous – give way or let the Chair invite you to speak by name.
- Close down properly. Don’t forget you might still be seen and heard after the call has finished.

Appendix 2- Governance Continuity Plan- Board and Board Sub Committees

- 1) The Terms of Reference and Membership, including quorum arrangements, for the Board and its Committees will be temporarily suspended as of xxx, until further notice.
- 2) During this period, if meetings are to be held, then this will be done through the use of telephone / digital technology.
- 3) The primary focus of communication with the Board will be the organisation's response to Covid 19, including the safety of patients and the wellbeing of staff.
- 4) Whilst some effort will be made to continue aspects of 'business as usual' activity, based upon the existing business cycles / forward agenda:
 - 4a) All matters for approval will be either:
 - Deferred if not urgent or
 - Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
 - Discussed via telephone / digital technology with the decision recorded by Trust Secretary (or nominated representative) or
 - Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action
 - 4b) In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors
- 5) It is likely that those responsible for preparing assurance papers for Committees and the Board will not be in a position to do so. Therefore:
 - 5a) All matters for information or assurance will be either:
 - Put on hold until further notice or
 - Circulated via email
- 6) For ad hoc items agreed by the Executive Directors as requiring a decision by the Board:
 - Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
 - Discussed via telephone / digital technology with the decision recorded by Trust Secretary or
 - Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors

The Business Cycles will be reviewed and updated by the Trust Secretary, to maintain an accurate record of items considered / approved or deferred



Safe, high quality care



Care at home



Partners



Value colleagues



Resources



Respect
Compassion
Professionalism
Teamwork

MEETING OF THE PUBLIC TRUST BOARD – 7 th May 2020			
WHT Improvement Programme Update			AGENDA ITEM: 10
Report Author and Job Title:	Dave Dingwall Improvement Advisor	Responsible Director:	Richard Beeken
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input type="checkbox"/>		
Executive Summary	<p>This paper updates Board Members on progress, risks and issues associated with the WHT Improvement Programme. Whilst the last weeks have been challenging for all, the organisation has continued to reinforce its commitment to planning for the future and implementing the actions critical to achieve its ambition of having Outstanding rated services. In summary:</p> <ol style="list-style-type: none"> 1. Work continues on development and mobilising a set of comprehensive programme plans around 6 workstreams 2. A phased introduction of the proposed improvement support team structure has been implemented with key WHT staff taking on Improvement lead roles on each workstream 3. Informal monitoring and governance of the programme has continued through Exec team, weekly Exec Lead reviews and recent SRO led Workstream Reviews. <p>Progress in all areas continues (with exception of Acute Collaboration / Integration agenda as paused due to Covid-19), although pace has understandably been impacted by key staff availability and effect of organisation having to rapidly create remote working capabilities and then staff familiarising themselves with how to do that. There is a strong sense that the organisation has found a 'rhythm' again, and with horizons starting to lift, momentum has started to build again. With key successes already achieved, much work continues and we need to be prepared to 'pivot' and respond to future events as they unfold.</p>		
Recommendation	Trust Board members are asked to note the contents of this paper.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This paper outlines the progress in relation to the development of the WHT Improvement programme and provides assurance to the board on contribution to the mitigation of the risks in relation to all BAF risks i.e. BAF001 to BAF06 inclusive.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	The WHT Improvement Programme Plan will include an EDI assessment overall and individual assessments for each project.		

Strategic Objectives	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"/>	





Walsall Healthcare NHS Trust

Improvement Programme Status Update

Author: Dave Dingwall

Date: 7th May 2020

*"Look up at the stars and not down at your feet.
Try to make sense of what you see and wonder
about what makes the universe exist. Be curious."*

Stephen Hawking

Programme Development Summary



Purpose of this paper - The purpose of this report is to provide members of the Trust Board with a progress update on the development and mobilization of the WHT Improvement Programme.

The Trust has remained committed to continuing development work associated with the programme (wherever possible) even throughout the challenge of the Covid-19 pandemic. The Executive team has remained engaged and although some key resources have been realigned to deliver operational priorities, development of our programme has continued, if at a pace which has understandably been slower than that originally planned.

Summary status of 3 key focus areas of work being undertaken:

1. Development and mobilisation of Strategic Workstream plans:

Short and Medium-term plans are maturing, actions relevant to supporting Covid-19 response mobilised and delivering e.g. C-19 clinical documentation / guidelines and Outpatients service transformation. As the horizon is starting to lift, teams are starting to define the 'new normal' to be returned to i.e. learning from and retaining improvements from C-19 response actions and the longer-term improvements required to achieve Outstanding rated services

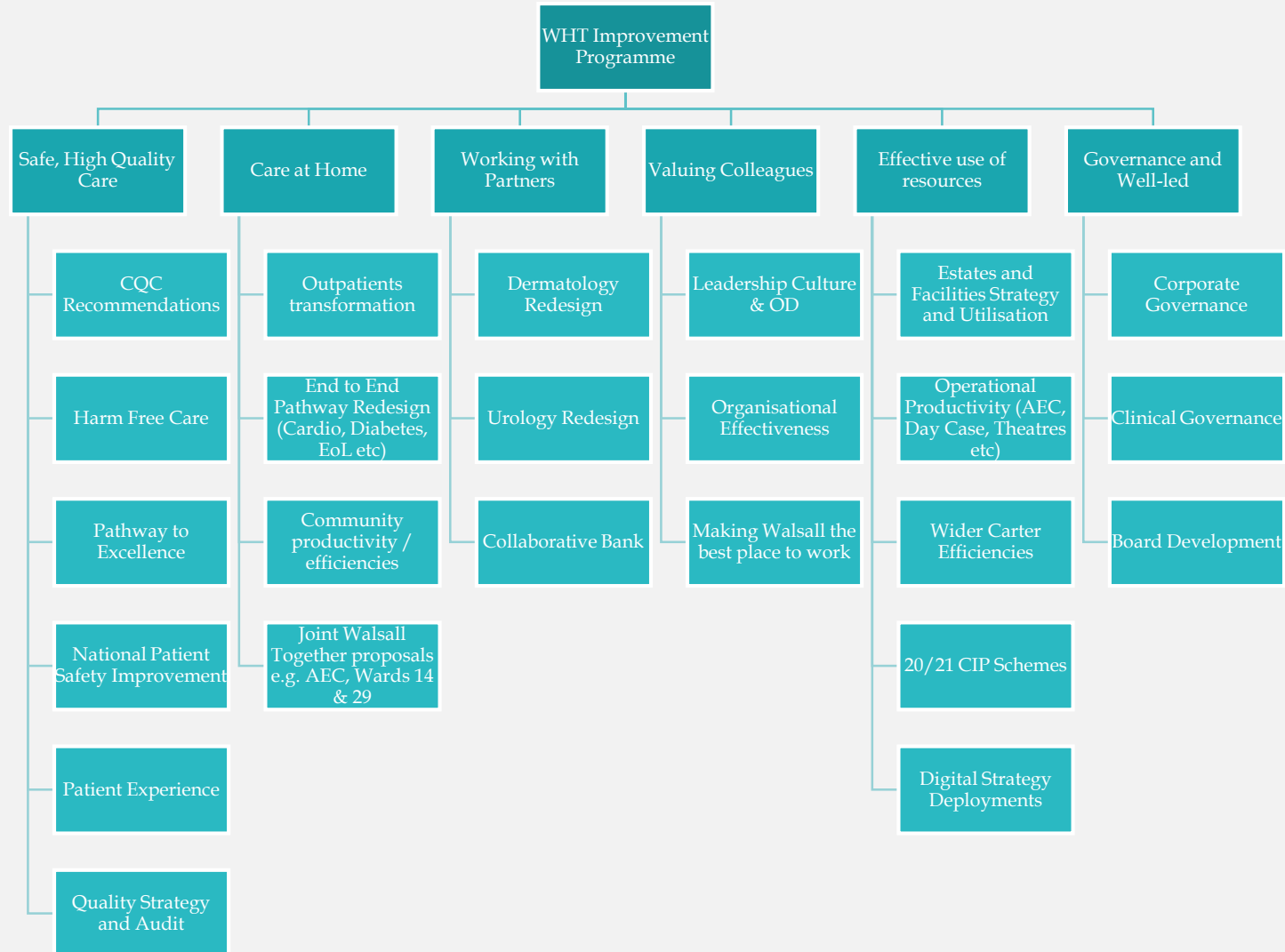
2. Mobilising an internal Improvement Support Function:

Existing WHT service improvement resources (QI Academy and others) have been realigned to assume Improvement Lead roles for each workstream and are providing hands-on support to plan development and priority implementation. The Trust has to date been unable to realign the PMO resources to support the Programme development, however actions are being undertaken to ensure this happened in the coming weeks as the level of detailed planning work required across the workstreams has created the need for that to happen sooner rather than later. Finally, the new Director of Planning and Improvement role has been confirmed, job description and person specs are in final review with Executives and is to go out to advert shortly.

3. Mobilising a model of Programme Governance aligned to wider Trust Governance plans:

The Improvement Programme Board was one of many meetings deemed to be 'non-essential' in the Trust's initial response plan to Covid-19 and as such formal programme governance has been stood down, however ongoing review of programme development and implementation progress monitoring has continued through weekly updates to Exec Team, weekly drumbeat calls with each Exec Lead in relation to their workstream status and recent Workstream reviews led by Programme SRO and Dave Dingwall. Progress reports have also been provided to John Dunn as the NED lead for the Programme weekly 1:1 reviews are scheduled going forward. Work is also underway to establish a phased reintroduction of priority governance models which is expected to include Improvement Programme monitoring and assurance. This work is being developed as part of the new Governance and Well-Led Improvement Workstream which is also developing our plans to address the feedback and recommendations in these areas from CQC and the recent NHSE/I review.

High-level programme work breakdown structure



Workstream Development Status Summary



Core Workstreams	SRO	Core Team	Drum-beat	Long List	Priorities	Plan	Resources	Mobilised	Comments
Safe, High Quality Care	Green	Green	Green	Green	Green	Yellow	Green	Yellow	Long-list defined and action ownership split between Nursing and Medical Directorates. Covid-19 and CQC mandatory action priorities being supported. Teams engaged in developing and mobilising longer term planning e.g. Nursing 'Pathway to Excellence' programme.
Care at Home (i.e. interface with Walsall Together)	Green	Green	Green	Yellow	Green	Yellow	Green	Green	Recent contract discussions providing opportunity to fast-track certain Walsall Together plans on Tiers 2 & 4 of the WT COM. Joint Outpatients transformation programme now mobilised.
Working with Partners (Acute collaboration / integration)	Green	Green	Red	Green	Green	Red	Red	Red	Suspension of all activities planned during Covid-19.
Valuing Colleagues	Green	Green	Green	Green	Green	Yellow	Green	Yellow	Directorate workshops held to draft initial delivery planning against the OD framework identify 3 sub-streams of activity and a set of common and enabling actions required. Further work to complete planning scheduled, priority actions continue to be implemented as part of Trusts Covid-19 response plan, with some 'fast tracking' delivery of a number of previously proposed actions.
Effective use of Resources	Green	Green	Yellow	Green	Green	Yellow	Yellow	Yellow	Large productivity improvement portfolio, progress has (understandably) been impacted as clinical teams have been orientated to Covid-19 response and as such have been unable to engage significantly in service redesign around benchmarks and best practice. Currently reenergising this workstream as part of WHT Covid recovery planning e.g. plans for maximising day case use
Governance & Well-led	Green	Green	Green	Green	Green	Yellow	Yellow	Yellow	Additional workstream established to address CQC Well-Led recommendations and following recent NHSE/I Governance review outcomes. Planning development underway on Corporate and Clinical Governance improvement - NED engagement sessions proposed on NHSE/I maturity matrix and PID generation.

Highlight key successes and work underway



- Introduction of new single clerking document to remove need for multiple clerking when patient transitions for ED to AMU to Wards
- Creation of a Covid-19 reference site on Intranet for front line teams to access latest clinical guidelines, e-learning and standard operating procedures
- Development of an Adult Deteriorating Patient Care Bundle underway to address key issues highlighted by CQC as requiring Mandatory action e.g. NEWS, SEPSIS, VTE etc
- Outpatients transformation – standardising organisational approach to the triaging of cancelled activity and backlogs, confirmation of urgent activity to be recommenced and identification and mobilisation of new service models to meet demand as Outpatient service models are restarted e.g. Community led pathways, virtual clinics etc
- Significant programme of work mobilised around Health and Well-being of staff as part of the Covid-19 response plan which the organisations needs and wants to retain going forward
- Massive digital transition in organisation, enabled by availability of national funding and support, leading to enhanced virtual clinic capabilities / capacity, laptop roll-out to support remote working, creating of an interim Virtual Desktop solution to enable remote workers to access the systems they require, MS Teams roll-out to enable meetings and governance to continue
- To name but a few! – the organisations commitment to continuing progress on their Improvement Programme journey during this crisis should be applauded. There remains much work yet to be done, and as we are not yet fully clear on what the 'new normal' will look like, we need to continue to be prepared to pivot and respond to events as they unfold.

Key Programme Issues / Risks



Risk / Issue	Description	Impact	Mitigations
Issue	Availability of key staff to participate in, or lead, improvement projects	A number of key staff remain orientated towards managing and implementing Covid-19 response their ability to input into to shaping programme priorities is fragmented.	<ul style="list-style-type: none"> • Improvement Programme co-ordination continues mostly remotely • Various communication streams being used to engage e.g. WhatsApp • Focus on developing improvement 'work packages' which can be undertaken by staff working remotely
Issue	Transition of PMO resource to Improvement Support Function delayed.	Current resources unable to provide the level of detailed planning development support, delaying progress.	<ul style="list-style-type: none"> • Meetings scheduled during w/c 27th April to confirm transition plan and develop business case for VERTO roll-out
Risk	Long-term effect of Covid-19 leaves future model of health and care provision uncertain	Could fast-track wider system reconfiguration, changing role of WHT and possibly the services it would deliver	<ul style="list-style-type: none"> • Continue service redesign planning around best practice implementation and pursuit of upper decile levels of service quality, patient experience, staff satisfaction and wellbeing and operational performance. • Continue joint planning and implementation with Walsall Together on wider Walsall based redesign opportunities. • Continue engagement in wider Black Country discussions around hospital group options.

ETHICS COMMITTEE (Time limited for Covid 19 Pandemic)

TERMS OF REFERENCE: 20 03 2020

AUTHOR: Dr Manjeet Shehmar, Deputy Medical Director

Executive Sponsor: Dr Matthew Lewis, Executive Medical Director

RATIFIED BY THE TRUST BOARD ON: NEXT REVIEW DUE:

1. CONSTITUTION

- 1.1 The Trust Quality, Patient Experience and Safety Committee (QPES) hereby resolves to establish a time limited Committee of the Board of Directors to be known as the Covid 19 Ethics Committee (The Committee).
- 1.1.1 The Committee has delegated authority from the Trust Quality Executive in respect of the functions and powers set out in these Terms of Reference.
- 1.2 The Committee has authority to investigate any matter within its Terms of Reference and to obtain such information as it may require from any Partner, officer or employee

2. PURPOSE

- 2.1 The Committee is commissioned by QPES to check that decisions made by Clinicians and the Trust (Tactical and Strategic Management Team Covid 19) are ethically sound.
- 2.2. The Committee will critically and collectively appraise the ethical implications of relevant clinical and operational decisions, and their inherent risks or issues. These decisions, risks or issues may include those related to clinical care and treatment; resource management; governance (such as quality and safety); significant and unexpected events and their consequences, especially in emergency planning situations.
- 2.3 The Committee will provide reassurance to the Trust Quality Executive that ethics and integrity are embedded within the Trust and that the Tactical and Strategic Incident Management Team are following due process.
- 2.4 The Committee is responsible for keeping key relevant ethical risks under review and monitoring mitigation activities and controls.
- 2.5 The Committee will offer a collective independent and unbiased opinion and will discharge its responsibilities by:
 - Promoting the highest standards of ethical conduct in all its dealings
 - Promoting compliance with statutory requirements
 - Ensuring compliance with organisational values
 - Identifying good practices and opportunities for improvement.
- 2.6 Opinion from the Ethics Committee Changes supports the Covid Fast Learning Group, which ratifies Covid clinical pathways and policies.

3. ETHICAL PRINCIPLES

3.1 The Royal College of Physicians suggest that although distributive justice is the most cited ethical principle during a pandemic, fairness is a better way of understanding the ethical problems the workforce will face¹. The Covid-19 Ethics Committee will adopt the framework described by the RCP to guide advice and recommendations:

Accountability	Measures are needed to ensure that ethical decision-making is sustained throughout the crisis, ideally nationally.
Inclusivity	Decisions should be taken with stakeholders and their views in mind.
Transparency	Decisions should be publicly defensible.
Reasonableness	Decisions should be based on evidence, principles and values that stakeholders can agree are relevant to health needs, and these decisions should be made by credible and accountable members of staff.
Responsiveness	Flexibility in a pandemic is key. There should be opportunities to revisit and revise decisions as new information emerges throughout the crisis.

3.2 The Ethics Committee will also consider the NHS Constitution as a basis for discussions.

- Equal access to service and treatment irrespective of gender, race, disability, age, sexual orientation, religion or belief.
- High standards of excellence and professionalism
- Reflect the needs and preferences of service users
- Collaborative working across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population
- Best value for taxpayers' money and the most effective, fair and sustainable use of finite resources
- Accountability to the public, communities and patients that we serve

4. MEMBERSHIP

4.1 Membership of the Committee is as follows:

- Deputy Medical Director (Chair)
- Director of Nursing
- Senior Medical and Nursing Staff
- Safeguarding representative

¹ RCP (March 2020) Ethical Dimensions of COVID-19 for front-line staff

- Allied Health Professional
- Junior doctor representative
- Chaplaincy representative
- Non-Executive Director
- Legal Services Manager
- Director of Governance
- Ethics Academic Representative from an external body
- Legal representative
- Other members will be co-opted as required in any agreed situation.

5. ATTENDEES

- 5.1 The Committee may invite individuals to attend from time to time on a regular or ad hoc basis for specific items on the agenda.

6. ATTENDANCE

- 6.1 It is expected that each member attends a minimum of 75% of meetings and performance will be reported for each member in terms of attendance at the end of each financial year.

7. QUORUM

- 7.1 The Committee has no decision making authority unless there are present:
- Three clinicians and
 - Chair and or nominated Deputy Chair and
 - Either the Director of Governance or the Legal Services Manager.

8. FREQUENCY OF MEETINGS

- 8.1 The Committee is a time limited group and will meet as appropriate during the Incident Management process.
- 8.2 The Committee will make decisions using technology such as Skype, telephone conference, Microsoft Teams and email.

9. CHANGES TO TERMS OF REFERENCE

- 9.1 Changes to the terms of reference including changes to the Chair or membership of the Committee are a matter reserved to the Trust Board.

10. CONSULTATION TO COMMITTEE

- 10.1 The Committee will be commissioned to consider questions posed by the Executive Sponsor (Medical Director) on behalf of the Trust, using the Covid Ethics Committee Referral Form (Appendix a).

11. ESTABLISHMENT OF SUB GROUPS

- 11.1 The Committee may establish sub groups made up wholly or partly of members of the Committee to support its work. The subgroup will be commissioned by the Executive Sponsor as required to consider urgent

issues, which require consideration in a matter of hours. The urgent issues may involve individual patient care.

11.2 The urgent subcommittee will be chaired by a core member of the Covid Ethics Committee and two other senior members. The whole Committee and the Board will be informed via a time-bound process through the Trust's governance reporting process.

11.2 The terms of reference of such sub group will be approved by the Committee and reviewed at least annually. The Committee may delegate work to the sub group in accordance with the agreed terms of reference. The Chair of each sub group will be expected to provide a Chair's report to the Committee.

12. ADMINISTRATIVE ARRANGEMENTS

12.1 The Chair of the Committee will agree the agenda for each meeting with the Executive Lead (Medical Director). The Committee shall be supported administratively by the Executive PA whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the committee on pertinent issues/areas
- Enabling the development and training of Committee members

12.2 All papers presented to the Committee should be prefaced by a summary of key issues and clear recommendations setting out what is required of the Committee.

13. REPORTING TO THE TRUST BOARD

13.1 The Chair of the Committee will provide a highlight report to QPES outlining key opinions with regard to quality and safety issues, key recommendations and items discussed.

14. REVIEW

14.1 The terms of reference of the Committee shall be reviewed by the Trust Quality Executive once the Covid 19 incident is stood down.

15. DUTIES

15.1 Provide a collective oversight of the culture of integrity of the decisions made by the Strategic Covid Management Team.

15.2 The Committee will anticipate ethical challenges facing the Trust and the correct response. It will advise and influence changes in policy.

15.3 Ensure that there is effective communications strategy for the ethics programme relating to the Incident Management Team reinforcing ethical values and good practice in the Trust.

- 15.4 Provide oversight of the policies and procedures adopted by the Trust in relation to the Covid 19 Incident Management Team.
- 15.5 Monitor the Trust's overall compliance with such policies including any adverse findings in respect of ethical compliance.
- 15.6 When considering ethical matters the Committee will have due regard for matters of significant public interest or which may have a wider potential reputational impact on the Trust and will raise such matters as necessary.
- 15.7 Consider and maintain oversight of the adequacy of the processes for ensuring ethical considerations are taken into account in all third party relationships.

16. BOARD ASSURANCE FRAMEWORK

- 16.1 To review the status of the top-level strategic risks owned by the Committee by reviewing the actions being taken to mitigate risks.
- 16.2 To ensure that the gaps in control and gaps in assurance for strategic risks are reported appropriately to the Committee by the Lead Executive.

17. LEGAL AND EQUALITY AND DIVERSITY IMPLICATIONS

- 17.1 To ensure that the Covid 19 Ethics Committee acts in a way which is fair, equitable and non-discriminatory by employing best practice guidance and facilitating equal access.
- 17.2 To ensure that all committee members views are taken in account fairly and equally.
- 17.3 To consider any legal requirements of the Trust, gain appropriate advice and apply in practice where necessary.

Performance Report

April 2020

(March 2020 Results)

Author: Performance & Information team

Lead Director: Russell Caldicott – Director of Finance and Performance

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Quality, Patient Experience and Safety Committee

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Quality, Patient Experience and Safety Committee – Highlight Page

Executive Lead: Medical Director: Dr Matthew Lewis / Non-Executive Director Lead and Chair of Q&S Committee: Pamela Bradbury

Key Areas of Success

- A number of standardised Proformas and training materials have been developed for the consistent management of Covid-19 patients in ED, the wards and ICU. A standard clerking booklet covers assessment, treatment, escalation and ceiling of care plans. Training has been provided on CPR in Covid-19 patients, proning, respiratory management and ICU care. All training materials are regularly updated and available on the Covid-19 intranet page.
- A staffing hub has been established (0800-2000 each day) which oversees safe staffing
- Family Liaison service set up to support families whilst they are unable to visit their loved ones
- Digital devices now available to support patients keeping in touch with their family and friends
- Weekly safeguarding position statement and daily reviews of all patients with dementia or learning disability
- All information requested by the CQC to process our application to add the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital has now been submitted. Draft SLA with BCHFT has been developed and awaiting full sign off.

Key Areas of Concern

- A new consent form which incorporates MCA assessment has been approved by MAC and will be implemented for all procedures which require formal consent.
- VTE assessment performance for February (up to 28/2/20) has fallen to 90.75%. This has been due to focus on Covid-19 pathways. A VTE assessment reminder is included on the Covid-19 clerking booklet, however we still rely on staff then completing the assessment on VitalPac. Moving forward, the Medical Directorate will reinstate an audit of the VTE stickers from ED to know the true VTE assessment performance and Covid-19 pathways are now focussing on the associated VTE risk.
- Matrons audits did not take place in March – these audits are now being conducted via the corporate nursing team
- Single sex breaches seen on Ward 9 and Ward 12 as we contain COVID cases. Patient letter developed and to be given to every patient who unfortunately experiences mixed sex accommodation.



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

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
SAFE, HIGH QUALITY CARE											
no..	HSMR (HED) nationally published in arrears		109.36					111.62	100.00		N
no..	SHMI (HED) nationally published in arrears		110.08						100.00		BP
no	MRSA - No. of Cases	0	0	0	2	1	0	4	0	2	N
no	Clostridium Difficile - No. of cases	2	3	6	2	4	5	36	26	19	N
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Hospital Acquired per 1,000 beddays	0.65	0.73	0.93	0.92	0.58	0.73				
no	Pressure Ulcers (category 2, 3, 4 & Unstageables) Community Acquired per 10,000 CCG Population	0.21	0.17	0.14	0.17	0.17	0.10				
no..	Falls - Rate per 1000 Beddays	3.91	3.92	3.91	4.67	4.81	5.32		6.63		BP
no	Falls - No. of falls resulting in severe injury or death	1	1	2	2	1	1	21	0	13	BP
%..	VTE Risk Assessment	92.06%	92.26%	88.87%	92.61%	94.04%	90.75%	92.22%	95.00%	94.90%	N
no	National Never Events	0	0	0	1	0	0	1	0	17	N
no..	Midwife to Birth Ratio	1:27.6	1:28.2	1:33.3	1:30.7	1:28.1	1:31.9		1:28	1:28.1	N
%..	C-Section Rates	33.11%	29.11%	30.06%	30.36%	30.58%	29.55%	30.16%	30.00%	28.46%	BP
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.87%	11.96%	12.13%	12.72%	11.21%			10.00%	10.73%	L
%..	Electronic Discharges Summaries (EDS) completed within 48 hours	85.75%	85.42%	82.24%	82.57%	82.93%	83.52%	84.59%	100.00%	84.47%	N/L
%..	Compliance with MCA 2 Stage Tracking	63.04%	52.86%	72.34%	87.23%	48.72%		63.77%	100.00%	62.44%	BP
%..	Friends and Family Test - Inpatient (% Recommended)	94.00%	94.00%	95.00%	96.00%	94.00%	95.00%		96.00%		N
%..	PREVENT Training - Level 1 & 2 Compliance	91.47%	90.52%	89.99%	89.01%	89.99%			85.00%		L
%..	PREVENT Training - Level 3 Compliance	88.39%	88.26%	88.33%	75.25%	78.36%			85.00%		L
%..	Adult Safeguarding Training - Level 1 Compliance	95.34%	95.83%	94.89%	95.63%	96.45%			95.00%		L
%..	Adult Safeguarding Training - Level 2 Compliance	87.33%	86.12%	84.50%	82.14%	83.37%			85.00%		L
%..	Adult Safeguarding Training - Level 3 Compliance	85.79%	85.20%	86.00%	55.76%	59.32%			85.00%		L
%..	Children's Safeguarding Training - Level 1 Compliance	89.82%	90.53%	89.12%	87.49%	88.94%			95.00%		L
%..	Children's Safeguarding Training - Level 2 Compliance	88.80%	88.63%	86.95%	84.51%	86.63%			85.00%		L
%..	Children's Safeguarding Training - Level 3 Compliance	85.45%	86.13%	85.28%	80.53%	80.76%			85.00%		L



People and Organisational Development Committee

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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 Discussion & Progress

Workforce Availability

The increase in workforce availability reflects data validations initiatives carried out during April, which has provided greater assurance about the availability of colleagues. A revised position was achieved and will be maintained by;

- Gathering improved intelligence regarding the status of colleagues shielding for 14+ days.
- Greater understanding and record-keeping concerning colleagues who are remote working.
- Proactive engagement with colleagues who are available for redeployment or remote working duties.
- Compassionate Health & Well-being communication with all colleagues unavailable due to sickness absence.

The departmental rate of compliance with daily COVID absence returns is 86%.

- Non-compliant departments are relatively small, with an average of 5 colleagues per team.
- People & Culture colleagues liaise with and chase non-compliant areas daily.

500+ enquiries/follow-up calls were made during the week-commencing 13 April 2020, leading to the closure of 200+ absences.

- 132 new absence cases were reported during this period, offsetting some of the reduction in absence rates this might have created.

We are better able to differentiate between colleagues able to work remotely whilst self-isolating, and those who are unavailable.

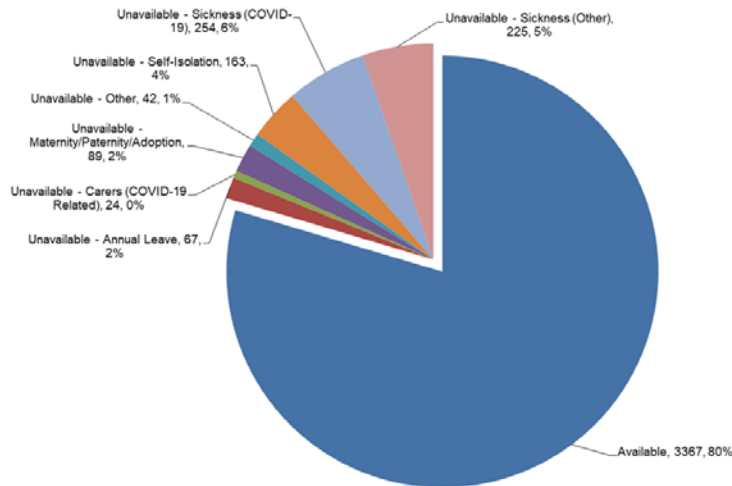
- There are currently 112 colleagues identified as remote working.
- Workforce Intelligence colleagues liaise with managers to improve this dataset daily.



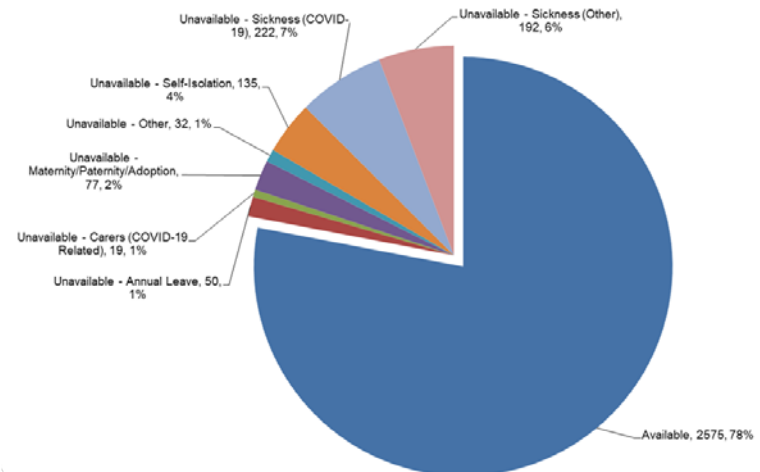
People and Organisational Development Committee

Category	Description	Redeployment Priority	Applicable Colleagues
Category A	Staff Required to work on-site	3	Clinical, Estates & Ancillary Colleagues
Category B	Staff whose job enables them to and can work from home	2	Admin & Clerical (Corporate Areas)
Category C	Staff whose job role has not been identified in a) or b) above and will be asked to stay at home in the first instance	1	Admin & Clerical (Non-Corporate Areas)

Workforce Availability 23/04/2020 - Overall



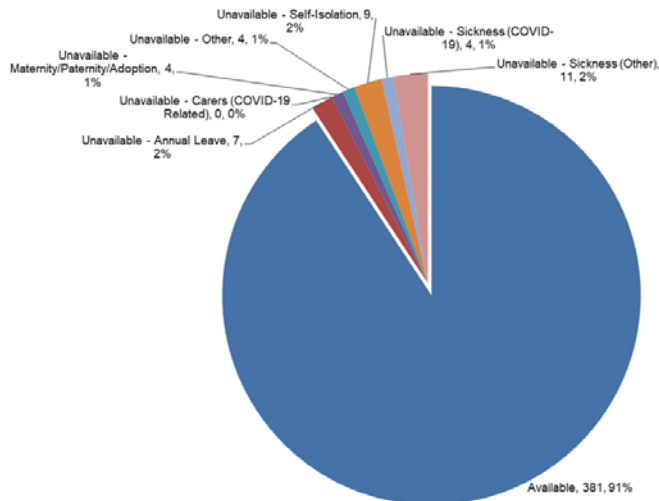
Workforce Availability 23/04/2020 - Category A Colleagues



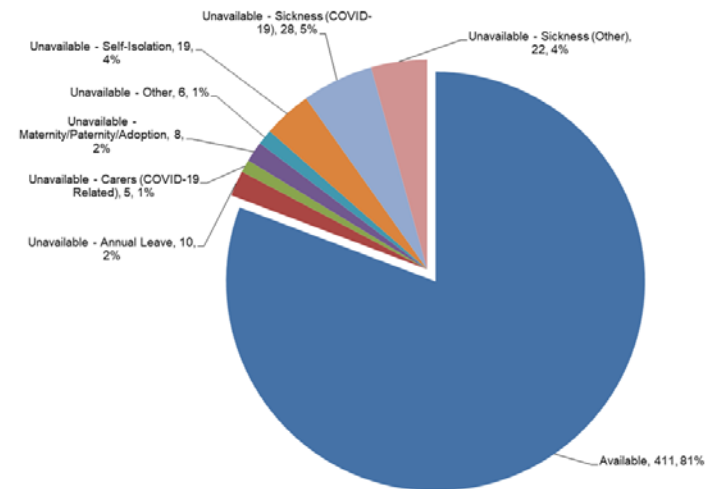
People and Organisational Development Committee

Category	Description	Redeployment Priority	Applicable Colleagues
Category A	Staff Required to work on-site	3	Clinical, Estates & Ancillary Colleagues
Category B	Staff whose job enables them to and can work from home	2	Admin & Clerical (Corporate Areas)
Category C	Staff whose job role has not been identified in a) or b) above and will be asked to stay at home in the first instance	1	Admin & Clerical (Non-Corporate Areas)

Workforce Availability 23/04/2020 - Category B Colleagues



Workforce Availability 23/04/2020 - Category C Colleagues



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

- The management of COVID-19 as a level 4 national incident has resulted in a profound impact on emergency, cancer, diagnostic and elective care. The Trust's first positive COVID-19 patient was confirmed on 6th March 2020. The public anxiety over COVID-19 has seen a significant drop in Type 1 ED attendances which are 19.5% down on last year. The Emergency Department has separated into two halves – one treating suspected COVID-19 patients and one treating non-COVID-19 patients. The Department has adjusted to the new clinical processes and a higher acuity patient cohort rapidly which has detrimentally impacted on the 4 Hour Emergency Access Standard.
- The Trust has achieved the control total advised by NHSE/I for 2019/20 of a £0.3m deficit, including central funding of Provider Sustainability & Financial Recovery Funds (PSF & FRF). This is an improvement on the re-forecast undertaken in year, and in part was delivered through working in conjunction with local commissioners within the Strategic Transformation Partnership to maximise clinical income. It is likely the Trust could see this position improve further with receipt of additional central funds (PSF).

Key Areas of Concern

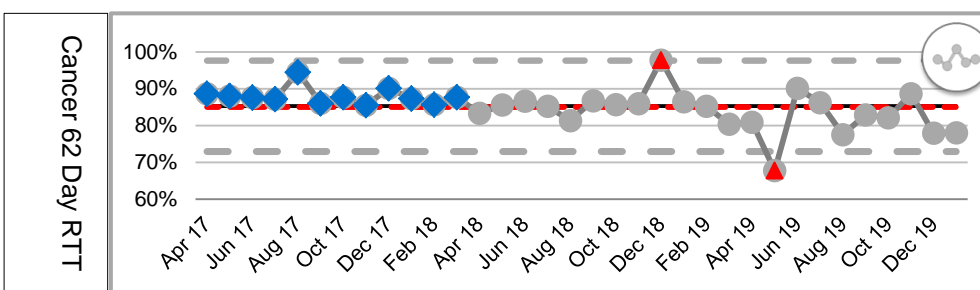
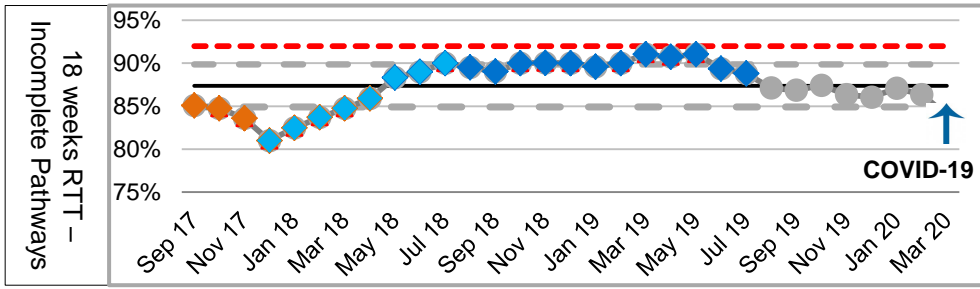
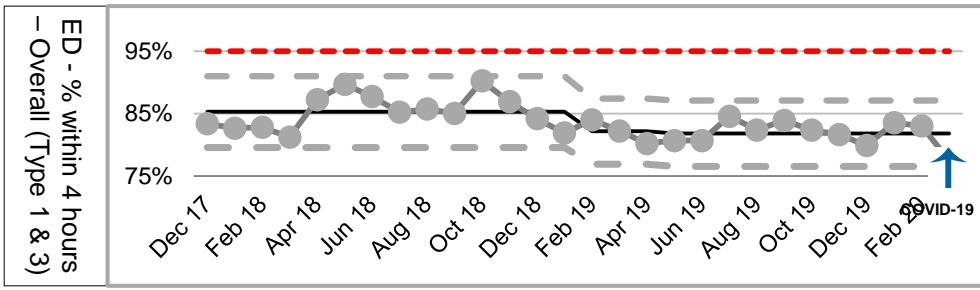
- The NHS declared a level 4 national incident in response to COVID-19, with the resultant operational planning process for 2020/21 suspended. The Trust is to receive a block allocation of income for the initial four months of 2020/21. If these funds are insufficient for the Trust to breakeven because of Covid 19 expenditure, there is a process to claim further income. The Trust has revised governance arrangements at this time to manage Covid-19 but must remain vigilant on financial control to ensure expenditure incurred falls within national definitions, so as to ensure income received to off-set these costs continues to be secured.
- RTT and Diagnostics performance in March (at 83.93%, 2.93% respectively) deteriorated as a result of ceasing routine elective surgery, and significantly reducing routine outpatient activity to free clinical staff up to support COVID-19 Critical Care expansion plans and strengthened emergency care. RTT performance will continue to deteriorate until the full elective programme is restarted.
- Agreement in full remains outstanding in regards to income recognition within the accounts reported with both Walsall and Staffordshire commissioners for 2019/20
- The Royal Institute of Chartered Surveyors (RICS) have published guidance to valuers, that any valuations generated for year end accounting purposes will be subject to material uncertainty and physical verification of assets and stocks is not possible under current social distancing. This is an issue for all NHS organisations.

Key Actions Taken

- PFIC endorsed the compilation of an emergency budget for the initial four months of 2020/21, the budget approved on the 29 April 2020
- A bi-weekly report on Clinical income and temporary workforce expenditure was produced bi-weekly during quarter 4, 2019/20 (presented to Executive and PFIC)
- Chair, Chief Executive Officer and Director of Finance escalation within the STP leadership was undertaken and the Trust secured additional income of £4m at close of the financial year, which enabled delivery of the original rather than the re-forecast plan. The Trust continues to meet with local commissioners to obtain agreement in full for the income recognised within the 2019/20 financial accounts.
- Re-forecast run rates were used to assess Divisional performance in monthly performance meetings following the Trust re-forecasting, when combined with the additional clinical income from commissioners this contributed to delivery of the original financial plan 2019/20.



Performance, Finance and Investment Committee



Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

March saw 5675 Type 1 attendances which was 19.5% down on last year. The response to Covid-19 has seen the Emergency Department separated into two halves – one treating suspected Covid patients and one treating non-Covid patients. The Department has adjusted to new processes and a higher acuity patient cohort rapidly which have impacted on the 4 Hour Emergency Access Standard. The Trust's EAS performance in March deteriorated to 77.5%, this has seen improvement through the first half of April to standing at 85.24 % week ending the 19.04.2020.

RTT

The RTT performance deteriorated (by 2.82% from previous month and by 3.55% from last year) during March due to the ceasing of elective inpatients and a reduction in formal outpatient activity. This was due to the emergency measures put in place to deal with Covid-19.

In March there was a reduction of 35.97% (934 to 598) in elective cases from last year. Outpatient attendances saw a reduction of 17.08% from last year.

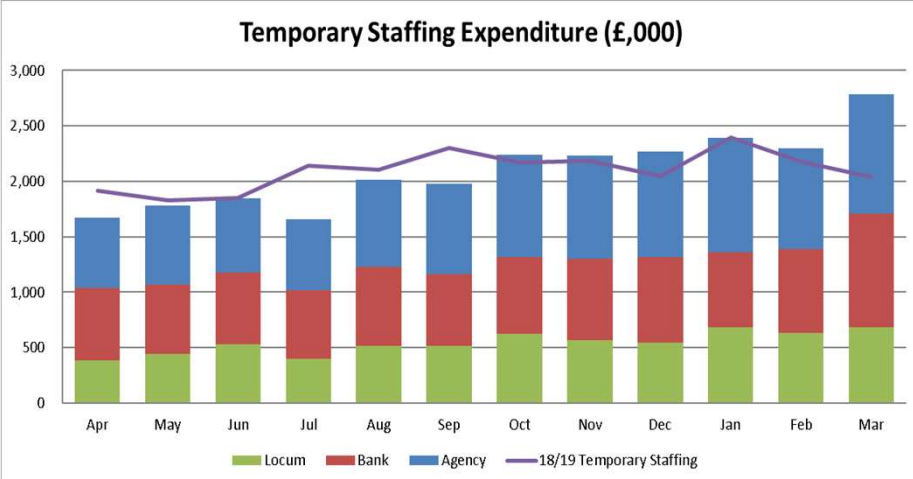
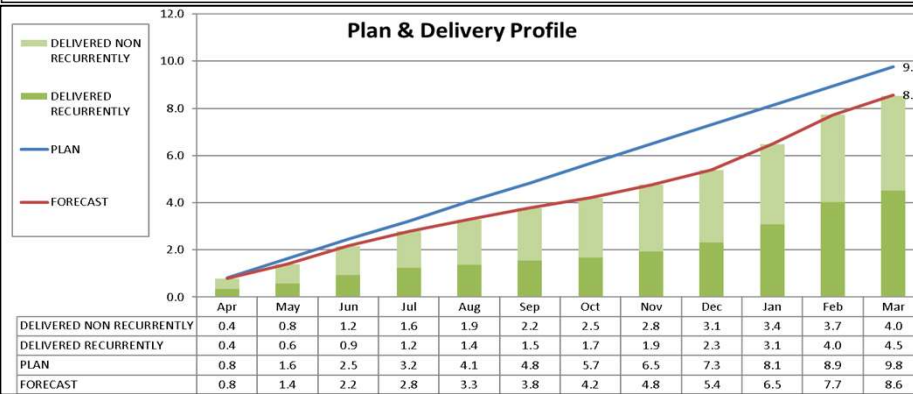
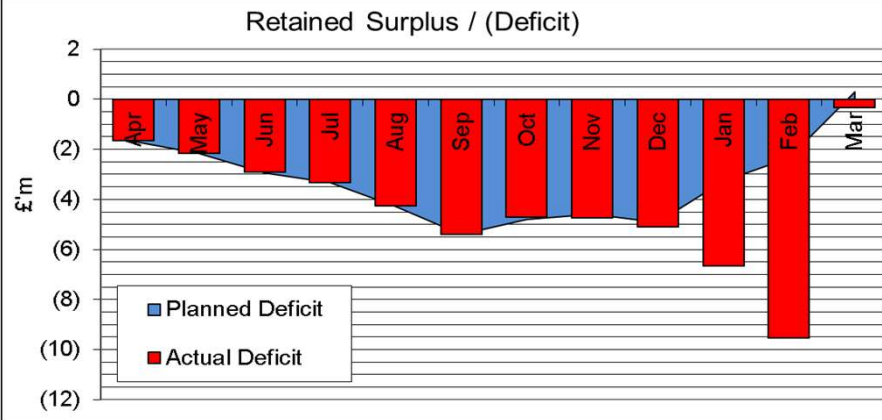
Cancer

The Trust failed to achieve the constitutional measure for 62 day RTT with a performance of 73.8%. Work continues across a number of tumour sites to improve the 62 day RTT performance with a focus on reducing the front end of the pathway.

The Trust achieved the 62 day consultant upgrade with a performance of 86.6%. Due to Covid-19 a number of surgical treatments are being carried out by Spire Little Aston using our own surgical Consultants.

Chemotherapy continues to be administered. However, patients are declining offers of treatment which will impact on performance.

DRAFT - Financial Performance to March 2020 (Month 12)



Financial Performance

- Trust draft financial performance at month 12 of a £0.33m deficit, against a revised control total of £0.34m deficit (including receipt of £17m PSF/FRF). The Trust has also received additional funding of £2.2m to support the Covid-19 effort.
- Overspending on pay is reflective of the use of temporary workforce costs. This has been mainly seen in MLTC supporting capacity and Covid-19.
- Temporary Staffing increased to £2.8m in March due to additional staffing and enhanced rates supporting Covid-19.
- Improved Elective performance (pre covid-19) combined with enhanced income from other providers and Commissioner support has delivered income significantly above plan. There remains a shortfall in births.

CIP Delivery

- The Trust's Cost Improvement Programme requirement is £8.5m (£10.5m stretch).
- The CIP has delivered £8.5m YTD, but remained below the stretch target of £10.5m, with £4.0m of the total delivered non-recurrently

Cash

- The Trust's planned cash holding in accordance with borrowing requirements is £1m. Actual cash holding was £9m due to retention of Q3 FRF/PSF (previously loaned in advance of receipt) and late receipt of PDC to support Digital Aspiration

Financial Performance - Period ended 31st March 2020

Description	Annual Budget	Budget to Date	Actual to Date	Variance
	£'000	£'000	£'000	£'000
Income				
CCGs	214,312	214,312	216,804	2,492
NHS England	20,260	20,260	21,190	930
Local Authorities	8,981	8,981	9,261	280
DoH and Social Care	18,380	18,380	18,545	165
NHS Trusts/FTs	1,008	1,008	1,685	678
Non NHS Clinical Revenue (RTA Etc)	1,060	1,060	1,062	2
Education and Training Income	6,920	6,920	7,821	901
Other Operating Income (Incl Non Rec)	9,055	9,055	10,364	1,308
Total Income	279,975	279,975	286,731	6,756
Expenditure				
Employee Benefits Expense	(177,510)	(177,510)	(180,824)	(3,313)
Drug Expense	(17,725)	(17,725)	(18,422)	(697)
Clinical Supplies	(16,398)	(16,398)	(18,433)	(2,035)
Non Clinical Supplies	(18,396)	(18,396)	(18,920)	(524)
PFI Operating Expenses	(5,362)	(5,362)	(5,222)	141
Other Operating Expense	(27,781)	(27,781)	(28,197)	(416)
Sub - Total Operating Expenses	(263,173)	(263,173)	(270,018)	(6,845)
Earnings before Interest & Depreciation	16,802	16,802	16,713	(89)
Interest expense on Working Capital	51	51	86	35
Interest Expense on Loans and leases	(10,387)	(10,387)	(10,960)	(573)
Depreciation and Amortisation	(6,466)	(6,466)	(6,140)	326
PDC Dividend	0	0	0	0
Losses/Gains on Asset Disposals	0	0	0	0
Sub-Total Non Operating Exps	(16,802)	(16,802)	(17,013)	(211)
Total Expenses	(279,975)	(279,975)	(287,031)	(7,056)
Less Prior Year PSF			(165)	(165)
RETAINED SURPLUS/(DEFICIT) PLAN	0	0	(465)	(465)
Adjustment for Gains on Donated Assets			132	132
Adjusted Financial Performance (Control Total)	0	0	(333)	(333)

**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 (Latest Month Provisional)
%..	Cancer - 62 day referral to treatment of all cancers (Latest Month Provisional)
%..	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)

Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
82.35%	81.66%	79.87%	83.54%	83.00%	77.49%
61.44%	55.78%	58.30%	64.22%	66.13%	55.93%
19	28	77	28	14	30
73.73%	72.96%	75.13%	72.40%	85.82%	95.28%
82.08%	88.68%	77.91%	78.00%	73.81%	83.12%
87.43%	86.33%	86.05%	87.08%	86.35%	83.93%
0	0	0	0	0	0
0.19%	0.21%	0.84%	0.14%	0.39%	2.43%
11	10	11	9	9	9
6.84%	7.52%	7.76%	8.15%	7.26%	7.55%
10.16%	10.24%	10.95%	10.30%	9.51%	11.56%
87.23%	84.57%	84.46%	80.19%	85.88%	74.71%
3.58%	3.61%	4.39%	4.48%	3.95%	
77	85	82	93	84	76
8.00	11.00	8.00	7.00	8.00	8.00
£76	£11	£6	£3	£7	£333
£76	£11	£6	£3	£7	£613
£5,700	£5,400	£6,100	£6,900	£8,900	£8,500
£4,200	£4,800	£5,400	£6,500	£7,500	£8,500
£11,200	£13,100	£15,000	£16,800	£18,600	£20,300
£13,200	£14,400	£17,700	£20,100	£22,400	£25,200
£4,500	£4,700	£5,400	£5,900	£6,500	£8,200
£2,900	£3,300	£3,300	£3,400	£5,300	£11,500

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
81.77%	95.00%	85.90%	N
61.45%	100.00%	72.20%	BP
312	0	155	N
84.05%	93.00%	93.59%	N
80.73%	85.00%	85.35%	N
	92.00%		N
0	0	1	N
1.63%	1.00%	0.32%	N
9	0	9	L
7.61%	7.00%	7.43%	BP
10.44%	8.00%	10.44%	L
	75.00%		L
	2.50%	3.46%	L
£333		£-27,669	L
£613		£-17,038	L
£8,500		£15,500	L
£8,500		£11,100	L
£20,300		£19,400	L
£25,200		£25,200	L
£8,200		£12,200	L
£11,500		£13,100	L



Walsall Together performance pack

April 2020: March 2020 Performances

Caring for Walsall together



Safe, high quality care



Care at home



Partners



Value colleagues



Resources



Respect
Compassion
Professionalism
Teamwork

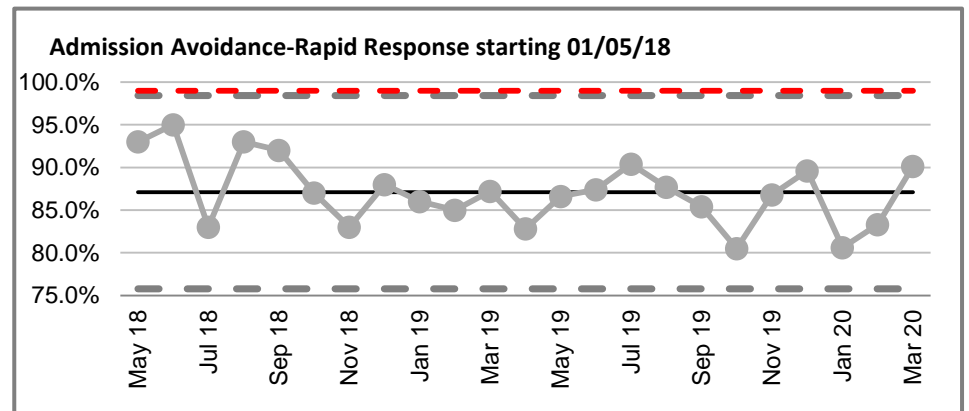
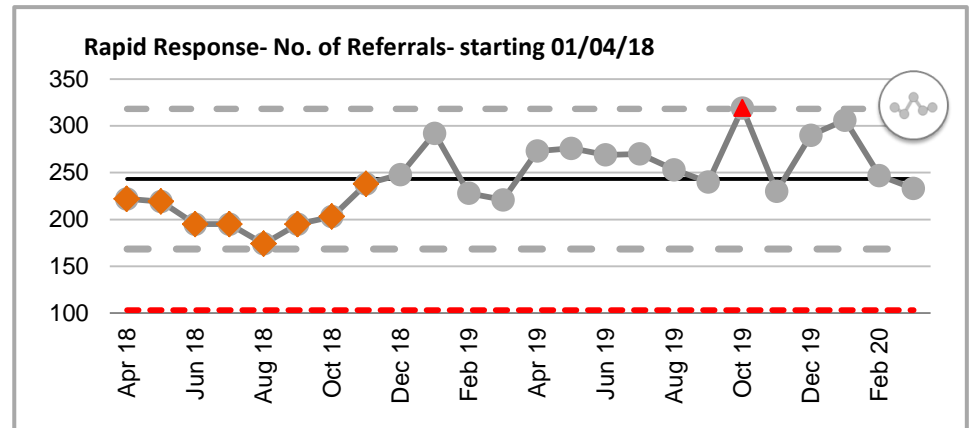
Referrals to Rapid Response

The committee is asked to note that whilst the first part of the month of March was normal in relation to Rapid Response and referrals were tracking within accepted levels, these have now fallen away and the second part of the month contributed to the down turn in activity.

The main swing has been those from GP's whom as the main contributor to activity in this area have halved their referrals due to the model changes in primary care in relation to Covid-19.

Whilst in normal circumstances this would release significant capacity back into the system this has in reality helped to offset the staff sickness due to isolation and potential infection.

Moving forward, the team is acting as a credible reserve to the care home response team whilst protecting the remaining rapid response activity.



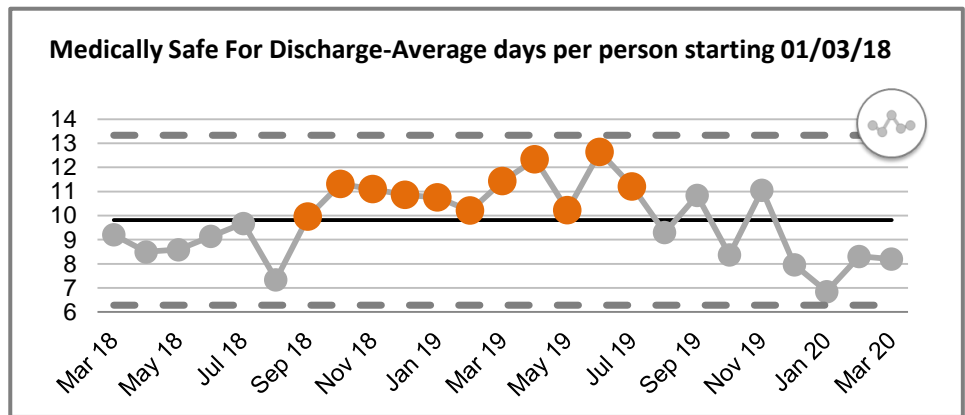
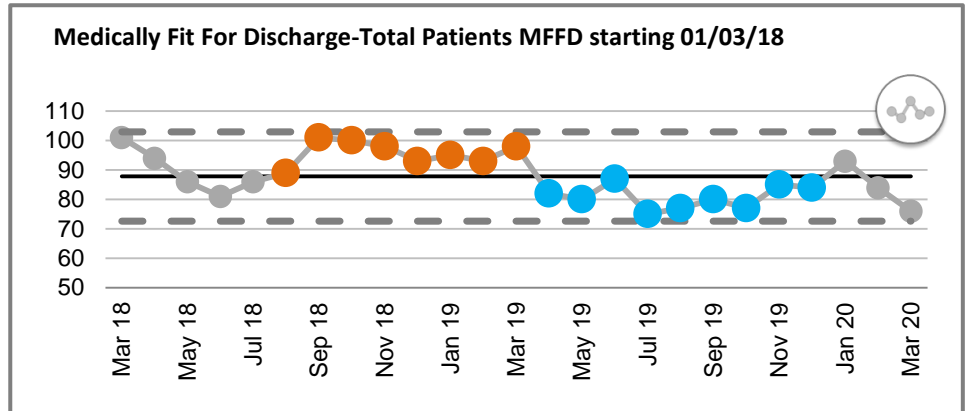
Medically Safe for Discharge

Performance in this area remains strong and is further enhanced by the Covid response.

Outturn from March tracks the planned trajectory for recovery post winter period both in terms of absolute numbers but also on length of stay data. In reality this results in less beds being used but also for a shorter period enhancing further this performance.

Since the close of March substantial improvements have been made in this area with LOS data halved again and a further reduction in the absolute number of patients at any one time on this pathway. The Covid actions are now being embedded to ensure continued performance at the new levels which will be reported in April's data pack.

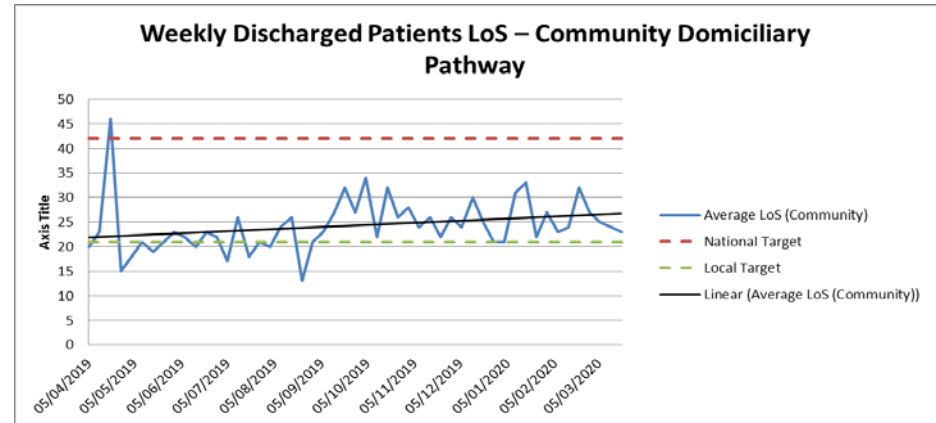
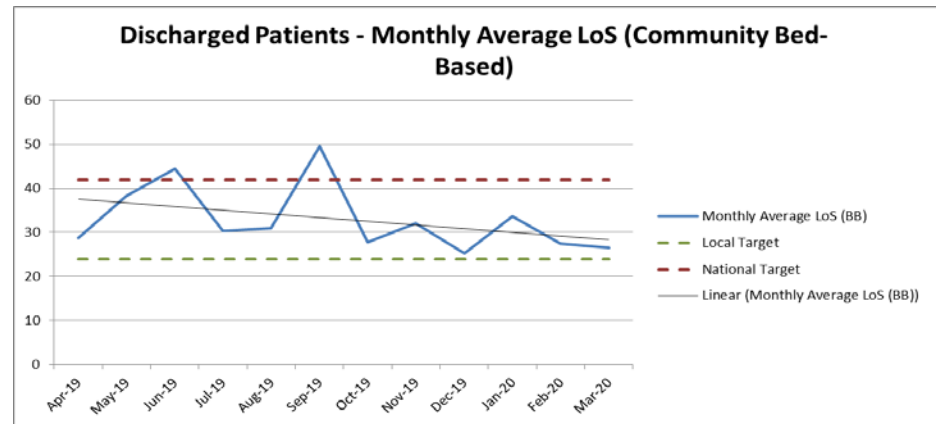
In contrast, the associated risk to care home infections and poor staffing in domiciliary care providers due to Covid has challenged the performance in this area and is currently being managed actively.



Intermediate Care Services – Community Pathways

Performance continues to be strong in the length of stay in community pathways. However the next big step change is required is through additional therapy support that is requested as part of the Walsall Together investment case.

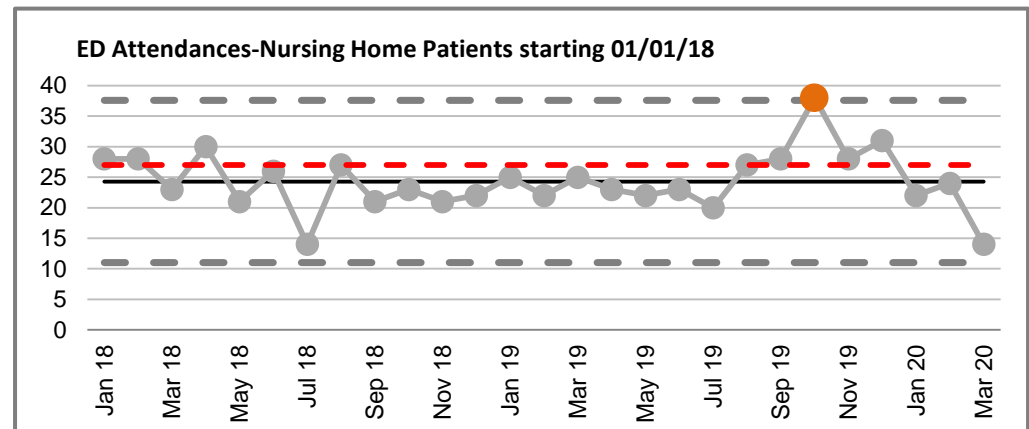
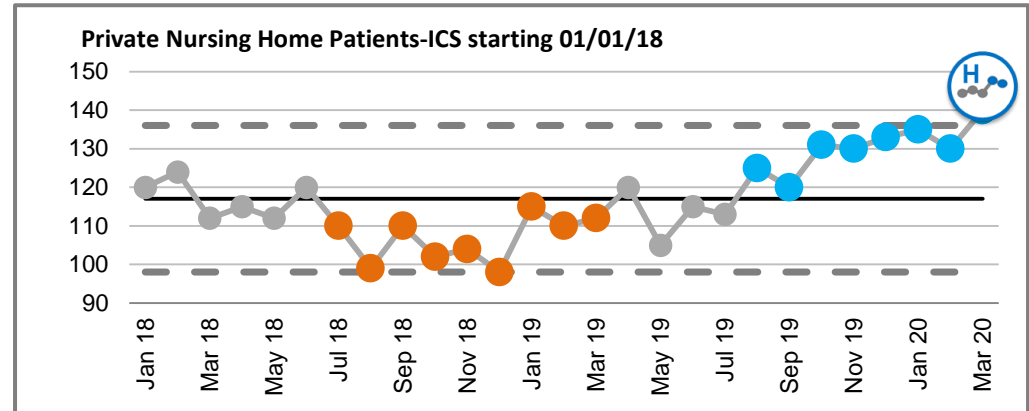
Discharges to Domiciliary Care remain strong. However further work is ongoing to understand the LOS growth albeit slow. Additional therapy support in this area is also required and being designed as we speak.



Patients case managed in private nursing homes- Care at Home

Support to nursing homes continues to increase month and month with more community resource being profiled to this area as planned as part of the Walsall Together partnership.

This activity has been complimented by the Covid response with more patients being supported in the community. As a result the teams are now looking to expand operations to care homes and from next month reporting will commence in this area to the committee. It should be noted from the outset that this area is not currently funded beyond that of Covid operations and will be presented to the committee as a future operational opportunity.



**INTEGRATION
2019-2020**

		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
SAFE, HIGH QUALITY CARE							
%..	% of Emergency Readmissions within 30 Days of a discharge from hospital (one month in arrears)	10.87%	11.96%	12.13%	12.72%	11.21%	
no	Rapid Response Team - Total Referrals	319	230	290	306	247	233
no	Rapid Response Team - MDT Interventions potentially avoiding attendance or admission	257	198	260	245	185	210
%	Rapid Response Team - % of patients referred requiring a 2 hour response who are subsequently seen within 2 hours	65.30%	70.67%	79.17%	70.77%	60.66%	41.18%
CARE AT HOME							
%..	ED Reattenders within 7 days	6.84%	7.52%	7.76%	8.15%	7.26%	7.55%
RESOURCES							
no	Average Number of Medically Fit Patients relating to Social Care - Walsall only (Mon&Thurs)	30	39	40	36	35	33
no	Average Number of Medically Fit Patients - Trust (Mon&Thurs)	25	30	24	33	26	23
PARTNERS							
Rate	Occupied Beddays per Locality - Rate per 1000 GP Population (GP Caseload)	33.64	36.71	37.55	38.42	36.75	39.66
no	Nursing Contacts per Locality - Total	19494	17990	18755	19599	17396	16044
Rate	Emergency Readmissions per Locality - Rate per 1000 GP Population (GP Caseload)	2.08	2.02	2.03	2.31	2.07	1.96

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
11.60%	10.00%	10.73%	L
			L
			L
			L
7.61%	7.00%	7.43%	BP
			L
222967		205571	L
			L

19/20 YTD Actual	19/20 Target	18/19 Outturn	Key
11.60%	10.00%	10.73%	L
			L
			L
			L
7.61%	7.00%	7.43%	BP
			L
222967		205571	L
			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
H DU – 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 – 7 th May 2020			
Director of Nursing Oversight Report- April 2020			AGENDA ITEM: 13
Report Author and Job Title:	Angie Davies Deputy Director of Nursing	Responsible Director:	Ann-Marie Riley Interim Director of Nursing
Action Required	Approve <input type="checkbox"/> Discuss <input type="checkbox"/> Inform <input checked="" type="checkbox"/> Assure <input checked="" type="checkbox"/>		
Executive Summary	<p>Quality indicators continue to show an overall stable position, although some improvement work has paused due to redeployment of key staff.</p> <p>There has been a 2.3% improvement in year in the nursing vacancy position.</p> <p>Overall staffing level assurance can be provided due to the introduction of a new staffing hub the details of which are in the report. Skill mix is noted to be potentially affected due to staff absence, high reliance on temporary staffing and continual redeployment of staff and this inevitably will impact on consistency and timeliness of the quality of care delivered.</p> <p>Critical care staffing has been re-modelled in line with national guidance and has taken a significant amount of additional multi-professional resource to maintain safety.</p> <p>A new rapid response quality review process has been introduced to proactively review areas of concern as required.</p> <p>There have been single sex accommodation breaches in order to safely cohort COVID-19 cases on AMU and ward 9.</p> <p>Due to the step down of usual audit and governance processes the quality audit assurance data is more limited for March. The report does however highlight 4 ward areas of concern and gives updates of initiatives to mitigate risk caused by the COVID-19 crisis across acute and community services.</p> <p>Antenatal and postnatal care is being maintained in line with national guidance and we have been able to maintain our immunisation clinics for neonates.</p> <p>There is close co-ordination and oversight of community response across the system through a daily Walsall Together tactical, multi-agency strategic command.</p> <p>We have developed ‘Haven’ rooms for staff to relax, talk, join mindfulness sessions and access support</p> <p>We have developed a family liaison service to support both staff and relatives/carers who are not able to visit the hospital</p> <p>We have robust oversight of safeguarding activities during this challenging time</p>		

Recommendation	The Committee is requested to note the contents of the report and make recommendations as needed.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF risk 001- Failure to deliver fundamental standards of care, which may result in harm to patients	
Resource implications	None	
Legal and Equality and Diversity implications	None	
Strategic Objectives	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"/>	

DR



Director of Nursing Oversight Report**1.0 Executive Summary**

This monthly report is in a new format that combines the previous Safe Nurse Staffing Report and the Quality Report.

- The report provides a summary of principles that underpin the application and management of staffing levels and redeployment of staff to ensure patient needs are met, during the COVID19 period.
- There has been a 2.3% improvement in year in the nursing vacancy position.
- Overall staffing level assurance can be provided due to the introduction of a new staffing hub the details of which are in the report.
- Critical care staffing has been re-modelled in line with national guidance and has taken a significant amount of additional multi-professional resource to maintain safety.
- A new rapid response quality review process has been introduced to proactively review areas of concern as required.
- There have been single sex accommodation breaches in order to safely cohort COVID-19 cases.
- Due to the step down of usual audit and governance processes the quality audit assurance data is more limited for March. The report does however highlight 4 ward areas of concern and gives updates of initiatives to mitigate risk caused by the COVID-19 crisis across acute and community services.
- Antenatal and postnatal care is being maintained in line with national guidance and we have been able to maintain our immunisation clinics for neonates.
- There is close co-ordination and oversight of community response across the system through a daily Walsall Together tactical, multi-agency command.
- Hollybank House opened on 6th April as the Community Stroke rehabilitation Unit.
- The report highlights how we are supporting patients, carers and staff currently
- The report provides assurance in regards to safeguarding activities.

2.0 Staffing Update.**2.1 Vacancy Position**

Across both Hospital and community nursing services there are 114 Registered Nurse (RN) staff vacancies (of which 1.5wte is community RN vacancies) and 5 Clinical Support Worker (CSW) vacancies. The RN vacancy level is at 9.2% for with improvements seen in year from a position of around 11.5%.

2.2 Nursing and Midwifery Absence

The usual nursing absence data is unavailable at the time of report writing and will be presented fully next month. The most up to date nursing and midwifery absence figures via the COVID-19 dashboard are as follows (as of 20th April):

- 128 (COVID-19)
 - 17 Carer (COVID-19 related)
 - 42 High risk
 - 48 Household symptoms
 - 70 other sickness
- (Total 305)

Staffing gaps created by these absences are managed on a day to day basis via a new staffing hub which operates 08.00-20.00hrs each day (see Appendix 1). All shifts are prioritised alongside patient acuity, so use a risk based approach to covering the impact of staff absence, and staff deployment, to ensure areas have the most appropriate staffing possible to meet patient need.

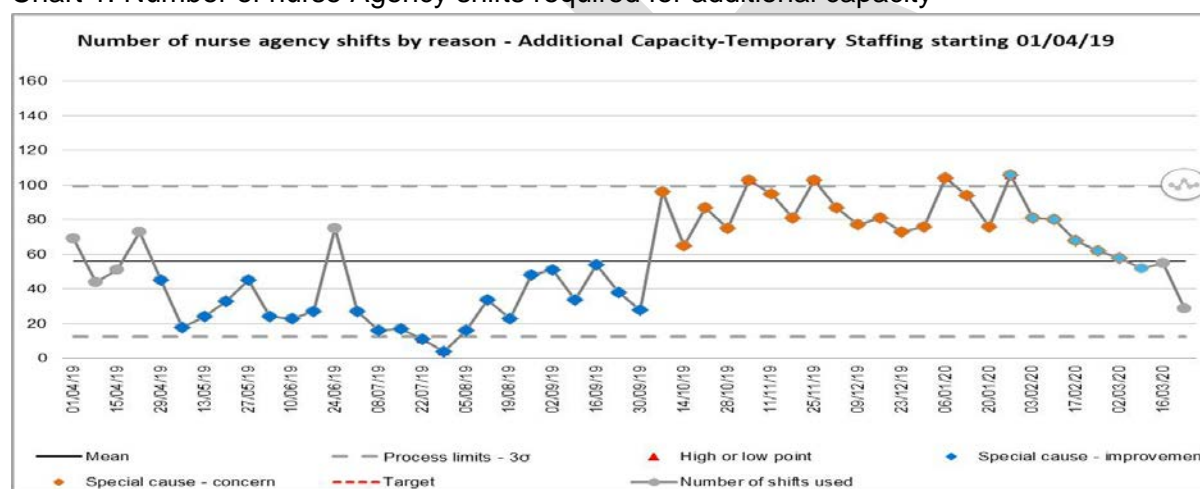
2.3 NHSi Agency Cap Performance

During March, RN agency use continued to be reported to NHSi on a weekly basis; including the use of 'off framework' agencies. Nurse agency use has breached the price cap for circa 150 shifts per week. Off framework use increased towards the end of March to assist COVID-19 management, rising to 25 shifts in a week at the end of March.

2.4 Temporary Staffing Analysis

The temporary staffing usage in March showed usual variation between 250 and 300 shifts per week. For the majority of March bank staff bookings were around 800 shifts per week. From week commencing 30th March bank shifts started to reduce and this can be attributed to COVID-19 absences. The number of nurse agency bookings for reason of 'vacancy' continued to reduce during the month of March, following the trend previously reported. For the booking reason of sickness there has been an increase in requests for nurse agency cover since the 9th March predominantly due to COVID-19. Maternity leave nurse agency requests amounted to between 5 and 15 shifts per week, which is not included in funded headroom and therefore is a cost pressure to ward areas. RN agency bookings for the reason of extra capacity have remained on a downward trend since beginning of February with a steep downturn during March as plans for COVID19 management were enacted (as seen in Chart 1).

Chart 1: Number of nurse Agency shifts required for additional capacity



During March, 'COVID19 backfill' was created as a reason for booking temporary staff across the Trust and within nursing backfill we have seen a steep increase in bookings for this reason to coincide with the pandemic. Week of 9th March had 60 nurse agency shift bookings and by 23rd March there were 120 bookings to support both wards and ICU. ICU requirements increased demand as we planned ICU staffing in line with national guidance to support the critical care response to COVID-19.

Nursing and Finance are working collaboratively to undertake detailed analysis so we are able to rationalise the increase temporary staffing expenditure in light of closing capacity and redeploying staff in response to COVID-19. The output of that analysis will be reported in May.

2.5 Staffing Fill Rates

NHSI usually receive a monthly submission which details RN and CSW fill rates across inpatient areas. NHSI have suspended the reporting of staff fill rates for the month of March due to COVID-19. From the 24th March onwards, the Staffing Hub has recorded daily % fill rates and, as demonstrated in Table 1 below, the range of fill rates for Day and Night are variable. Overall fill rate has obviously been affected by absence figures and a high reliance on temporary staffing and redeployment of staff to cover gaps has also impacted skill mix. This has impacted care delivery in areas such as timely observations, timely medication delivery, timely assistance with meals and fundamental care delivery. Assurance can be given that the staffing hub team assess acuity and occupancy to support staff deployment decisions to ensure staffing levels are able to meet patient needs.

Table 1: Fill rates via staffing hub

	Day	Night
RN	85 – 92 %	79 – 91 %
CSW	80 – 90 %	88 – 92 %

2.6 Areas of concern

There are currently four areas of concern across the ward areas as identified below in Table 2. A rapid response quality review process has been introduced to ensure we have a proactive response to concerns and are assured that there are no immediate patient quality of care concerns.

Table 2: Areas of concern

Ward	Cause of Concern	Action/mitigation
1	Ability to consistently ensure safe staffing on night shifts	Oversight via staffing hub, Div DON and Dep DON. Whilst we have mitigated risk to date the area remains under review.
2	Whistleblowing in regards to care delivery and staff conduct	Urgent quality review underway which will be reported to QPES next month. Safeguarding procedures being followed. No immediate patient safety concerns
11	Ongoing concerns following ward reconfiguration last year	Quality review to be undertaken which will be reported to QPES next month. No immediate patient safety concerns
29	high sickness and reliance on temporary staffing or redeployed staff	Oversight via staffing hub, ward senior nurses have agreed defined responsibilities and roles to ensure smooth running of the ward with continual support for the staff working on ward 29. Div DON has weekly meetings with the senior nursing team including Ward Manager via Microsoft teams

In order to manage the cohort requirements of COVID-19 cases we have needed to mix sex accommodation. Data is collated each day so any breaches of single sex accommodation are captured. Patients affected are given a letter to explain the rationale and to date the Interim Director of Nursing is not aware of any complaints received in relation to this. The patient involvement team will be proactively seeking feedback from patients who are nursed in a mixed sex bay.

2.7 Maternity update

There are 23.42wte registered Midwife (RM) vacancies at present with plans to recruit into 4.00wte. There is currently 17.7% RM sickness, 5wte RM redeployed to support the Trust, and a further 8wte RM on maternity leave. Despite these gaps, antenatal and postnatal care is being maintained in line with national guidance. The National Maternity Transformation Programme has paused and there is little formal LMS work currently.

In response to Covid-19, the service has implemented several virtual clinics which has presented an opportunity to review how some services are delivered which will inform future service provision. Teams have been able to maintain our immunisation clinic for the neonates and the work with the GP surgeries and 'Walsall together' has started to build the foundations for excellent partnership working for implementation of 'Better Births'.

2.8 Update from Community services

RAG scoring has been developed to enable teams to identify the priorities within their caseloads for that day, thereby allowing teams to be clear about what can be delivered in the light of staffing availability. To date, only 0-4 visits per day have been cancelled. The teams are also reviewing the impact of any visits that have either been cancelled or where the patients have declined the service. No concerns have been raised to date.

Care Home triage and clinical decision support tools have been introduced so patients can be assessed remotely and a clinical response determined by it. A Care Home Ceiling of Care form has been introduced across the BCWB STP which is being rolled out at pace (more than 60% of all residents have now had an individualised discussion around DNARCPR and a Ceiling of Care plan). Hospital transfers are taking place as required.

Hollybank House opened on 6th April as the Community Stroke rehabilitation Unit.

3.0 Quality and Safety Update

Several quality indicators have received a high level of focused attention from the corporate nursing quality team working with the ward teams over recent months including ward cleanliness and hand hygiene, falls risk and falls reduction, reduction of pressure ulcers, record keeping and documentation standards. Some of this work has paused during March due to COVID19 redeployments.

A schedule of work has been developed as part of the Improvement Programme workstream "Safe, High Quality Care" which includes:

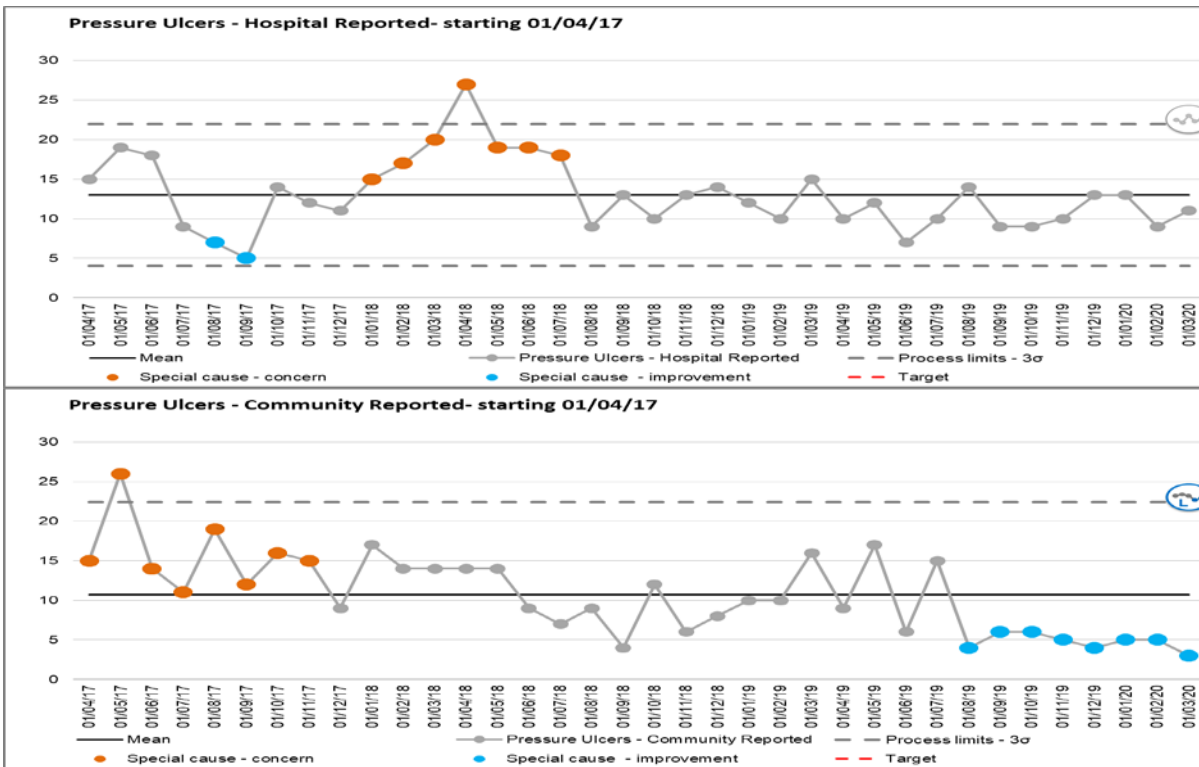
- Development of a Harm Free Care Strategy
- Launch of Care Excellence Programme
- Development and Introduction of Ward Accreditation
- Commencement of Pathway to Excellence Programme

3.1 Harm Free Care

3.1.1 Pressure Ulcers

Charts 2 and 3 below shows the number of pressure ulcers reported in the Trust since April 2019 split between hospital and community attributable. The previously reported improvements remain consistent across both settings.

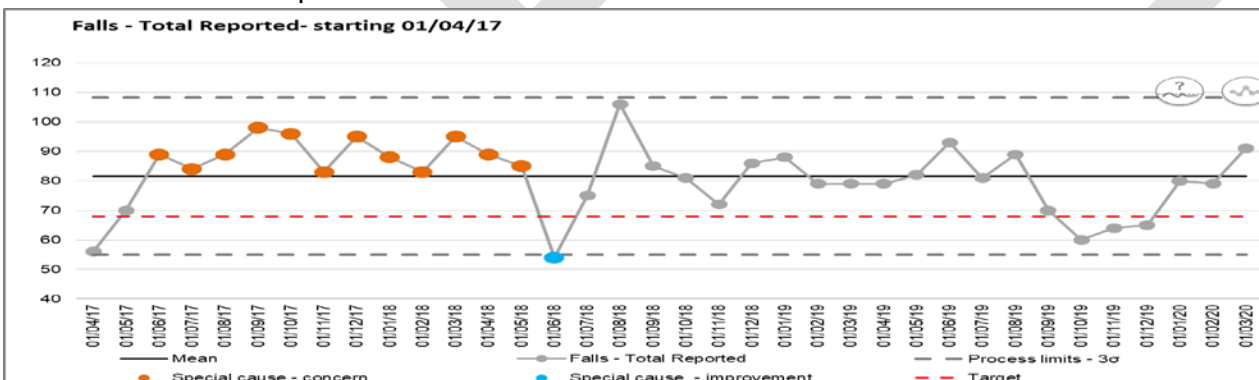
Charts 2 and 3



3.1.2 Falls

The number of patient falls has increased in month, as can be seen in Chart 4 below, and the ward based work to sustain the previous improvements made is ongoing, although redeployment of key staff means that the support from the corporate nursing quality team and focus on falls reduction has decreased in month. Staffing levels have not been highlighted as a contributing factor in relation to falls.

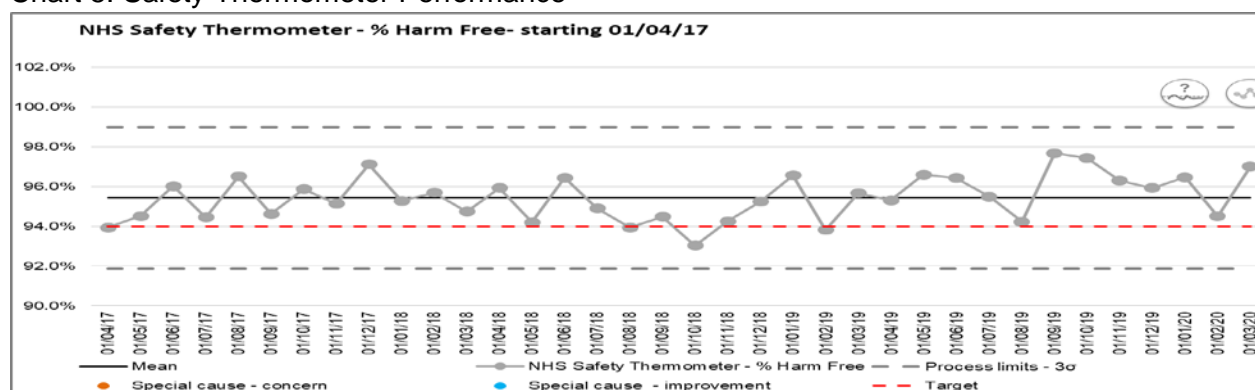
Chart 4: Number of Reported Falls



3.1.3 NHS Safety Thermometer

There has been an improvement in the harm free % in March compared to recent months as can be seen in Chart 5. QPES is asked to note that the NHS Safety Thermometer will no longer be collected from April 2020. There are plans nationally to replace this but no further information is available at this time.

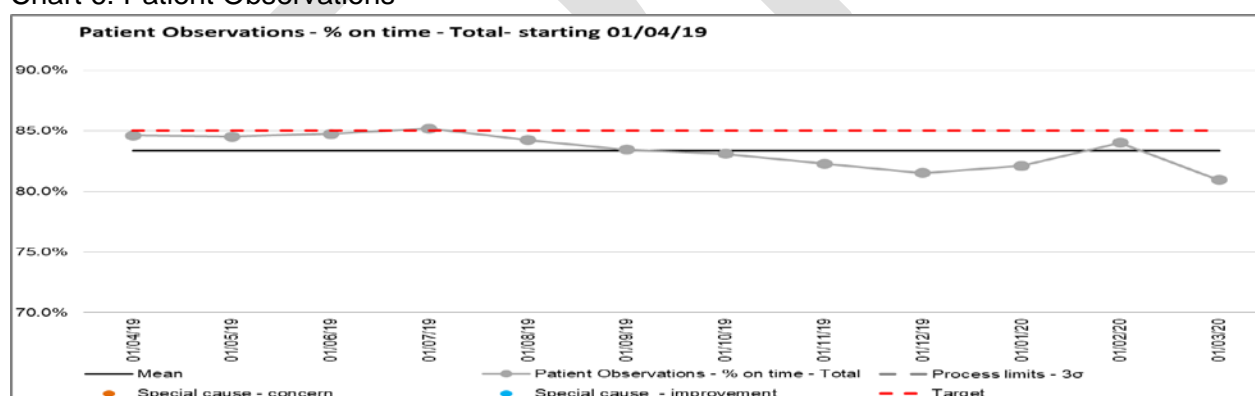
Chart 5: Safety Thermometer Performance



3.1.4 Patient Observations

The percentage of observations completed on time has decreased in March as can be seen in Chart 6 and is most likely been affected by staff absence, additional reliance on temporary staffing and redeployment of staff across wards. The improvement work started in the previous month to implement changes to enable clinical observations to be recorded on time has paused during March due to COVID19 redeployment. This will be recommenced as soon as is practicable. In the meantime, related equipment issues have been addressed through the purchase of 100 Vitalpacs devices for use across the wards and a new process regarding a standardised approach to storage and supply will be introduced when the devices arrive.

Chart 6: Patient Observations



4.0 Patient, carer and staff experience

4.1 FFT Results

Over the last quarter around 92% of patients who used our hospital and community services said they would recommend us to their friends and family if they needed similar care or treatment. This

recommendation score is based on over 11,600 Friends and Family Test (FFT) surveys completed by our patients and service users.

The positive FFT recommendation score for Emergency Department (ED) showed an increase of 9% in March 2020 (pandemic impact month) compared to the previous month (reaching 83%). All the other areas did not show any significant changes to their scores. Charts 7 and 8 below show average FFT results for positive recommendation scores (%) for inpatients, emergency department, maternity services, outpatients and community services during 2019-2020.

Chart 7: FFT results

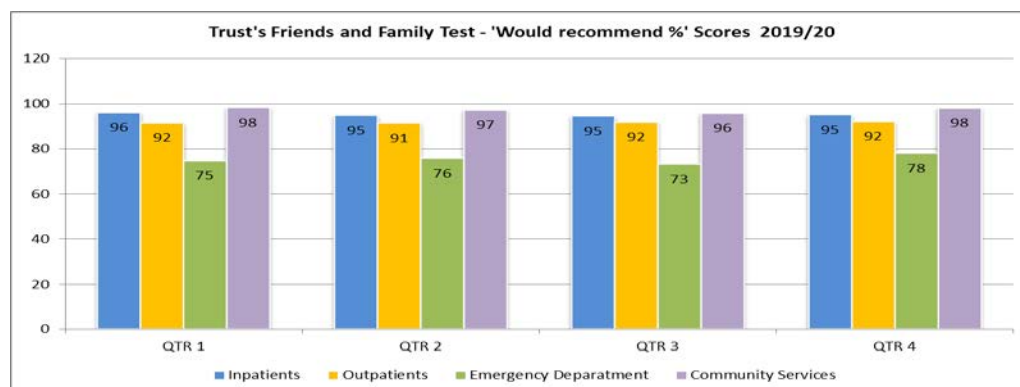
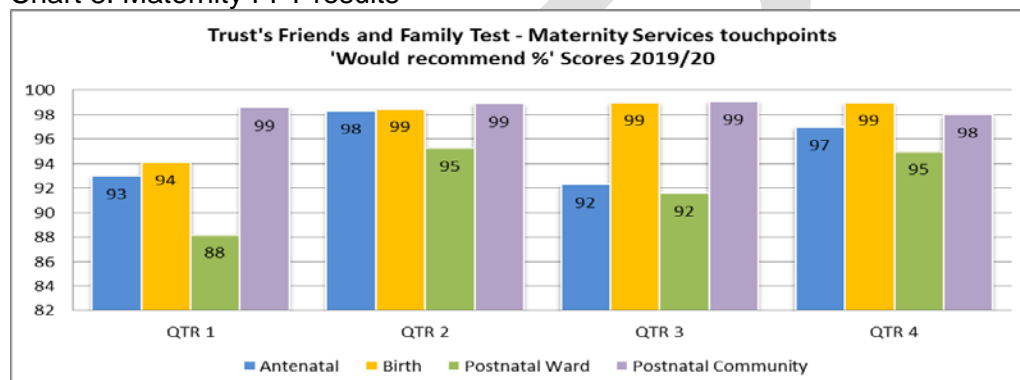


Chart 8: Maternity FFT results



Themes generated from over 9000 feedback comments, patients positively commented the most about staff attitude, implementation of care and our healthcare environment. The themes which need more attention were staff attitude, waiting times and environment.

4.2 Covid-19 Pandemic response

On advice from NHSI/E, all feedback activity relating to FFT and national surveys has been suspended from late March 2020. There are plans to restart non-direct feedback methods such as texts, calls and patient and staff experience stories in May/June 2020. Key areas of work include:

- Established a process for keeping in contact with our existing 300 volunteers where all receive regular personal phone calls.
- Established a Fast Tract Process for volunteer recruitment
- Recruitment and placement has been progressing at fast pace with 14 new volunteers already placed and a further 33 currently being processed due to start imminently.
- Response Volunteers are supporting the Trust in a number of ways, for example:

- Daily 'Food Runs' - delivering refreshments to staff who struggle to get away from the wards. This provision is also extended to our community nursing colleagues where volunteer drivers are delivering refreshments to community sites.
- Collection of IT equipment from wards and cleaning prior to delivery to IT Department.
- Other roles and functions being introduced to support the frontline are Porter support commencing on 20th April and supporting the Patient Transfer Team.
- Haven rooms have been jointly created with the Staff Hub and other teams to provide a calm and safe space for colleagues. The rooms will cover the hospital and community sites supporting staff emotional and mental health wellbeing.
- Facilitating 'virtual' patient and family interaction using Facetime and other applications to lessen the stress caused by restriction on hospital visiting. Mental health and LD teams will also support this initiative.

4.3 Complaints

Upon receipt of national guidance there has been a pause in the complaints process and this has now been in place since March 27. There are some exceptions highlighted below in Table 3 below details our response to each of these as follows:

Table 3: Expected COVID exceptions

<p>All providers should ensure that patients and the public are still able to raise concerns or make a complaint, but that the expectation of an investigation and response in the near future is managed.</p> <p>All providers would continue to acknowledge complaints, log them on their respective systems, triage them for any immediate issues of patient safety, practitioner performance or safeguarding and take immediate action where necessary. All complaints would then remain open until further notice, unless an informal resolution could be achieved, or the complainant chooses to withdraw their complaint.</p>	<p>Only interim staffing changes made. The availability of the process remains.</p> <p>We have written/contacted all current and ongoing complainants advising of the current timeframe difficulties – all acknowledgement letters amended to reflect the current</p>
<p>In secondary care where PALS offices still operate, they could still provide support by email and telephone and this should be encouraged for patients and the public to engage with the organisation</p>	<p>On-site staffing presence in place – contact via telephone/email maintained.</p>
<p>We would advise the system that consideration should be given to complainants who, at the time of the "pause", have already waited excessively long for their response (specifically those who have waited six months or more) these should be reviewed to ascertain if and how these can be resolved to the complainant's satisfaction</p>	<p>We are continuing to review these complaints and initiate a response where information is available</p> <p>We have some support from clinical staff that are on desk based duties due to underlying conditions/risk factors. This is also assisting us in investigating and reviewing complaints.</p>

4.4 Family Liaison Service

The service went live at the beginning of April and has 7 day cover. It offers the following to relatives of patients admitted with COVID-19.

- Speak with individuals and find out more about their relative and family.
- Listen to any worries or concerns they may have and work with them to find the different ways we may be able to help.
- Speak with other hospital staff and professionals on their behalf, and with their permission. These could include doctors and nursing staff and people involved in the care of the relative
- Direct individuals to other external teams and/or organisations that may be able to help them.
- Discuss any worries individuals may have about others in their family
- Help to arrange for an appropriate person to speak with individuals if they have any specific medical worries regarding the treatment their loved one is receiving/received

Contact forms have also been introduced so that patients/relatives can send messages to each other pending digital support for those with limited or no access to telephones/IPads.

4.7: Parliamentary & Health Service Ombudsman (PHSO) – cases 2019/2020

Two PHSO investigations remain ongoing which are detailed in Table 4 below.

Table 4: Outstanding PHSO cases

Case reference	Period of care complained about	Reason	Status
18000	March, August and September 2017	Complaint that there was no holistic approach to patient's condition – inadequate care planning	Remains an ongoing investigation
21601	August 2018	Relative is concerned that patient did not receive the best care and attention whilst an inpatient; delay in review by doctor, Warfarin stopped and lack of communication.	Ongoing investigation

5.0 Safeguarding

The Trust is expected to uphold its statutory and mandatory duties in respect of safeguarding during the COVID-19 crisis and the Director of Nursing can provides assurance that the current Trust safeguarding arrangements are robust overall.

5.1 Mental Health

There are occasions when the Trust is required to provide health care to patients who are detained subject to the Mental Health Act 1983 (as amended by the Mental Health Act 2007). The Care Quality Commission (CQC) registration process for health and adult social care requires that any hospital using the Act to detain patients must be specifically registered to do so.

The Trust is currently submitting an application to CQC to include in its regulated activity the assessment or medical treatment for persons detained under the Mental Health Act. In order to support this development a Mental Health Act Administration policy has been drafted. The Trust is also in the process of agreeing a service level agreement (SLA) with Black Country Healthcare NHS Foundation Trust (BCHFT), our local NHS provider of mental health services.

The SLA will formally set out the arrangements for the oversight and monitoring by BCHFT of the Trust's compliance with MHA and its Code of Practice (CoP); the Associate Hospital Manager function as set out in the MHA and CoP will be contracted from BCPT as part of the SLA.

In order to develop its mental health function and better assure the organisation, the Trust will:

- Establish a Mental Health Steering Group comprising key internal and external members, including CCG Commissioners (ToR have been drafted); the Group will advise on and monitor the use of the MHA;
- Provide quarterly reports to QPES in respect of all detentions of patients subject to the MHA to Trust inpatient units; the reports will highlight whether the principles of the Act have been applied correctly and patient rights upheld;
- Provide training to Trust staff – a training needs analysis has been developed;
- Develop effective processes and procedures to assist staff in using the MHA;
- Ensure that staff have access to statutory forms, leaflets and key MH documents – a MHA page has been created on the Trust intranet – see link below.

<http://themanor.xwalsall.nhs.uk/mental-health-act.aspx>

The Interim Director of Nursing can offer the following assurances:

- Full assurance that the staffing levels are closely monitored and no areas have been identified as unsafe but partial assurance regarding skill mix due to the numbers of temporary and redeployed staff.
- Unable to provide assurance that the current reported CHPPD data is correct. We are not reporting all areas that should be included and work is required to provide assurance that ward and specialty level data is correctly aligned within the Model Hospital dataset.
- Partial assurance that quality of care is being maintained to the Trust's usual standard. We are seeing delays in observations, increased fall rates, redeployment of staff to unfamiliar areas and patients being nursed in mixed sex accommodation.
- Full assurance that WHT community service provision is currently being safely managed.
- Full assurance that Children's services are currently being safely managed and there are no current areas of concern.
- Full assurance that we are currently maintaining safeguarding services in line with national guidance.

Appendix 1: Staffing Hub

The Staffing Hub (8am - 8pm) has daily oversight of the demand for and supply of nurse staffing to ensure that all areas have nursing staffing levels appropriate to the acuity of the patients and the bed capacity. This includes a twice daily staffing meeting where patient acuity is discussed; staffing levels are agreed against the required establishment and bed capacity. A 4 day forward view is also managed.

Critical Care patient acuity and capacity is managed in line with national guidance.

Dedicated daily administrative support for the new critical care roster has been provided through the PMO team. The roster is created up to 72 hours in advance and managed daily due to the daily changing picture

All nursing rosters are now created on a 2 week block for the COVID19 period. The rosters are centrally managed through the corporate E-Roster team, who have oversight of changes, requirements and redeployments.

Identification of red and amber clinical areas - for priority support and help and to be sighted on for reasons around acuity of patients /staffing issues / bed capacity / professional judgement around quality and safety etc.

Day and night shift fill rates for registrants and CSW is captured

Community staffing in community teams and HollyBank Stroke Unit is reported daily with discussion around mitigation and plans for staffing at HollyBank.

Redeployment of staff across all areas is captured twice daily in the staffing plan.

Twice daily situational report (sit rep) are provided following the staffing meetings to the Director of Nursing / Director of People / EPRR .

Medical staffing availability is reported into the staffing Hub and feedback regarding RED wards / patient acuity is provided back to the medical staffing team to ensure all clinical staff are aware of the areas of priority.

Community Risk – Covid19

Daren Fradgley

Director of Integration / Deputy CEO

Caring for Walsall together



Demand and operational model changes

- Attendances to the Emergency Department have dropped on a daily basis by over 50% on some days
- Attendances through the Urgent Treatment Centre has reduced by 50% on some days
- Access to GP face to face appointments have been suspended in all but the very urgent cases. Urgent care and non covid appointments are still available
- Routine outpatient and long term condition management has changed from face to face to digital and telephone reviews
- Community demand for patients known to the locality teams is starting to increase.
- Deaths in community and care homes are on the rise. Significantly so in care homes



Impact for Walsall Together Services?

- **Identifying & Dealing with Unmet need:** either through people not presenting or face to face services being changed
- **Dealing with increased demand for community services:** acuity changes in referrals to Rapid Response and locality teams
- **Realigning the workforce:** in the face of staff absence and shielding
- **Standardising PPE across the borough:** ensuring that all agencies are synchronised
- **Care Home requirements:** changing needs of residents and infrastructure supporting care homes



Managing the Risks: Joint Working - Walsall Together

- **Daily review of caseloads:** within each locality (Adult Community Nursing & Adult Social Care) to share intelligence and agree joint plans where required
- **Daily Operational Command:** Adult Community Nursing and Adult Social Care senior managers identify & resolve immediate pressures
- **Daily Tactical Command:** Walsall Together partners plus others agree any inter-agency responses
- Ongoing risk identification and resolution through the above structures
- Work has commenced with **Health Watch** to ensure that the public voice is maintained throughout the crisis and Health Watch have been invited to join the partnership calls once per week.



Risk management of locality work – Adult Community Services

- All the case work for the locality teams has been risk rated.
- This risk rating follows national policy for Covid response with the risk grid also being approved through the Trust Ethics committee.
- All cases loads are profiled as Red (must not cancel), Amber (urgent and must prioritise) or Green (Can be conducted virtually if required)
- Elective activity such as podiatry and wheelchair services have been suspended and staff redeployed – this is under constant review
- Additional staffing has been placed into locality teams to cover off sickness and Covid isolation gaps through the reprioritisation of the school nursing teams
- This is reviewed daily by each locality at 09.00 hrs and resources redeployed across the borough dependent on demand

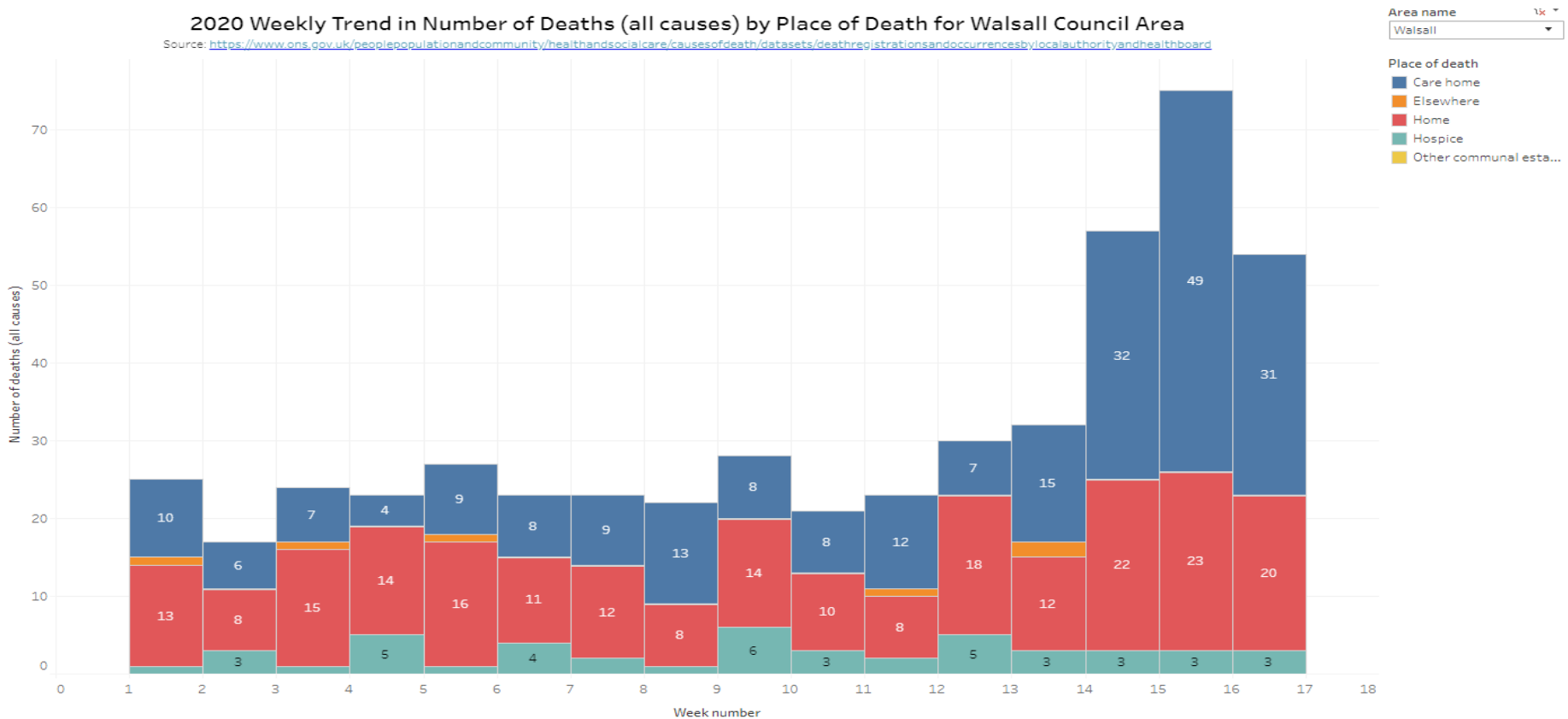


Risks: Community Death Data

The below chart shows the validated community death data from ONS up to the week ending 19th April 2020. (care home yearly average = 6 per week)

2020 Weekly Trend in Number of Deaths (all causes) by Place of Death for Walsall Council Area

Source: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard>

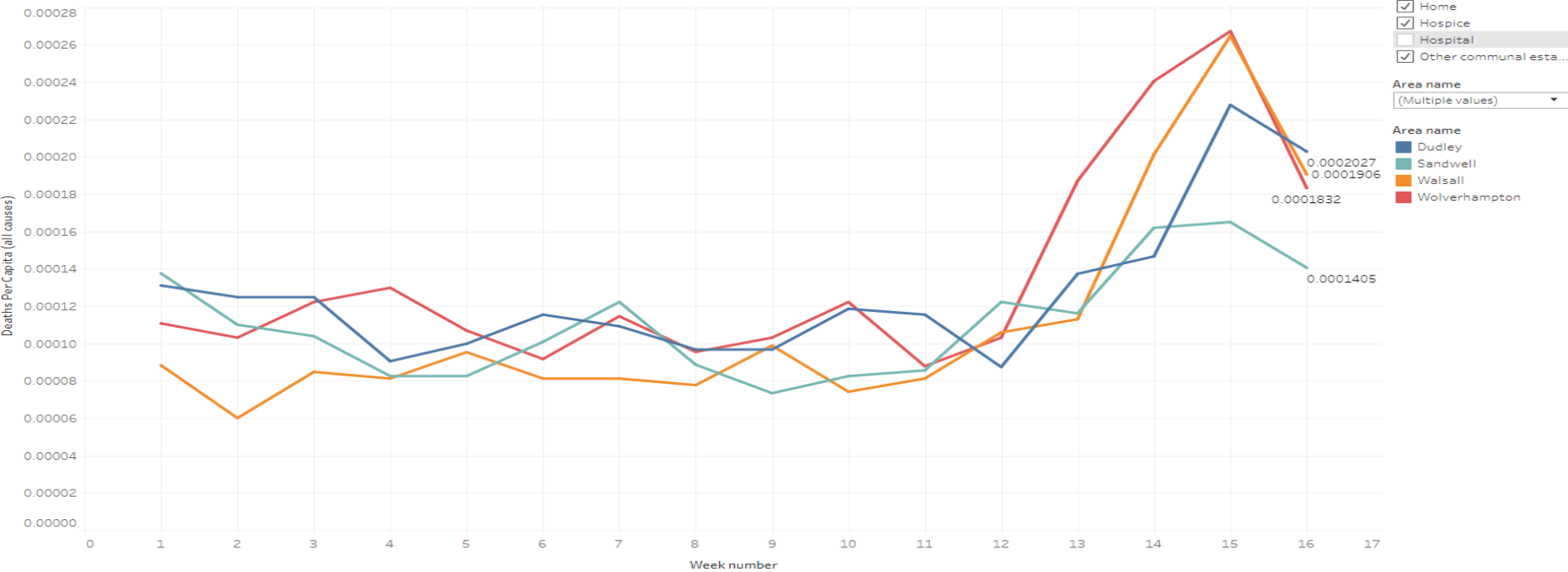


Community death data in the Black Country

It is noted from this slide the Black Country Deaths are showing the same profile. Sandwell's number is missing the West Birmingham profile

2020 Total Weekly Deaths Per Capita (all causes) Where Place of Death = Care home, Elsewhere, Home and 2 more, for Dudley, Sandwell, Walsall and 1 more Council Areas

Source: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard>



Identifying Growing Risks

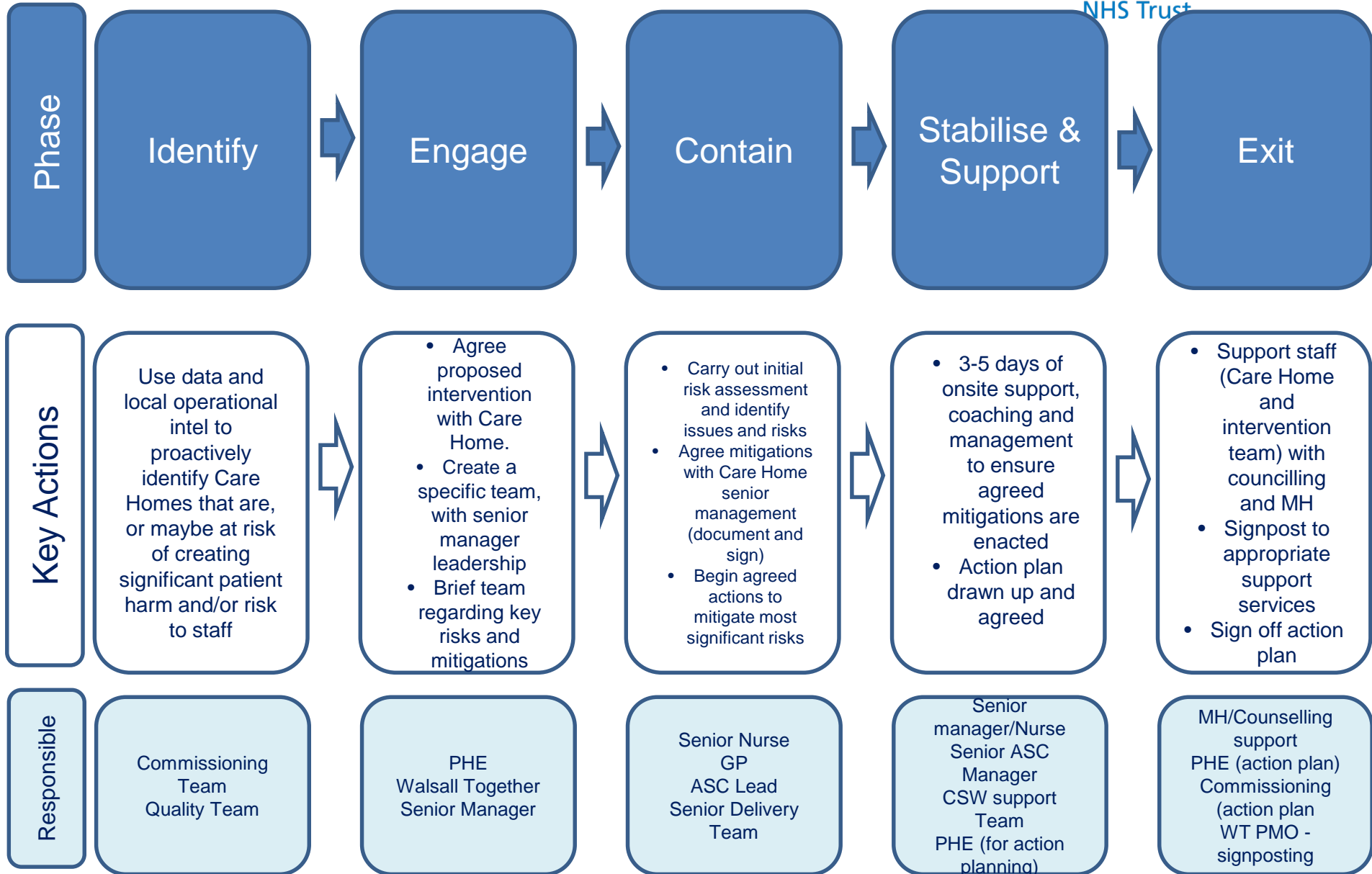
- Walsall Together daily call monitors the data from all the data sources and looks for risks that have not yet been identified. It was on this call that it was identified that the community death rate was increasing before the Covid monitoring systems nationally picked it up.
- Immediate action for the identified risks are discussed and agreed on this call and placed into operation through the relevant partners.
- Demand and capacity is monitored across Walsall and escalation plans are in place if demand begins to out balance capacity in the locality and intermediate care teams



Response to emergent risks in Care Homes

- The Trust has in conjunction with partners set up a dedicated operational team to support care homes in crisis
- The profiling of this team is reviewed daily and is targeted based on the presenting risk
- The team includes Medical, Nursing, Social Care and Volunteers to provide immediate support to care homes.
- In addition support from infection prevention team is being provided to control future outbreaks.
- Data and intelligence from these and normal locality oversight is coordinated daily and reviewed to ensure that enough resource is targeted in the right areas.
- The following slide shows the 5 phases of intervention of the team





Enhanced Care Home Support Team

- The model of care for this team has been signed off by Walsall Together Partners
- Ceiling of care plans that have been approved by the BC&WB STP are now being rolled out across the care homes. These are discussed and agreed with family and patients with capacity before being required. These documents are consistent with RESPECT, frailty scores and DNA CPR planning.
- Adult Community Services have undertaken 469 advanced care plans / DNACPR in Nursing Homes and 384 in Residential Homes within the borough
- A primary care led mortality review is now underway and is looking to establish any avoidable causation in care homes that can be removed.
- The same review is underway from IPC issues given rapid outbreaks in many care homes
- Coordination of the Walsall care home response is shared with the STP to ensure that best practice is shared and deployed



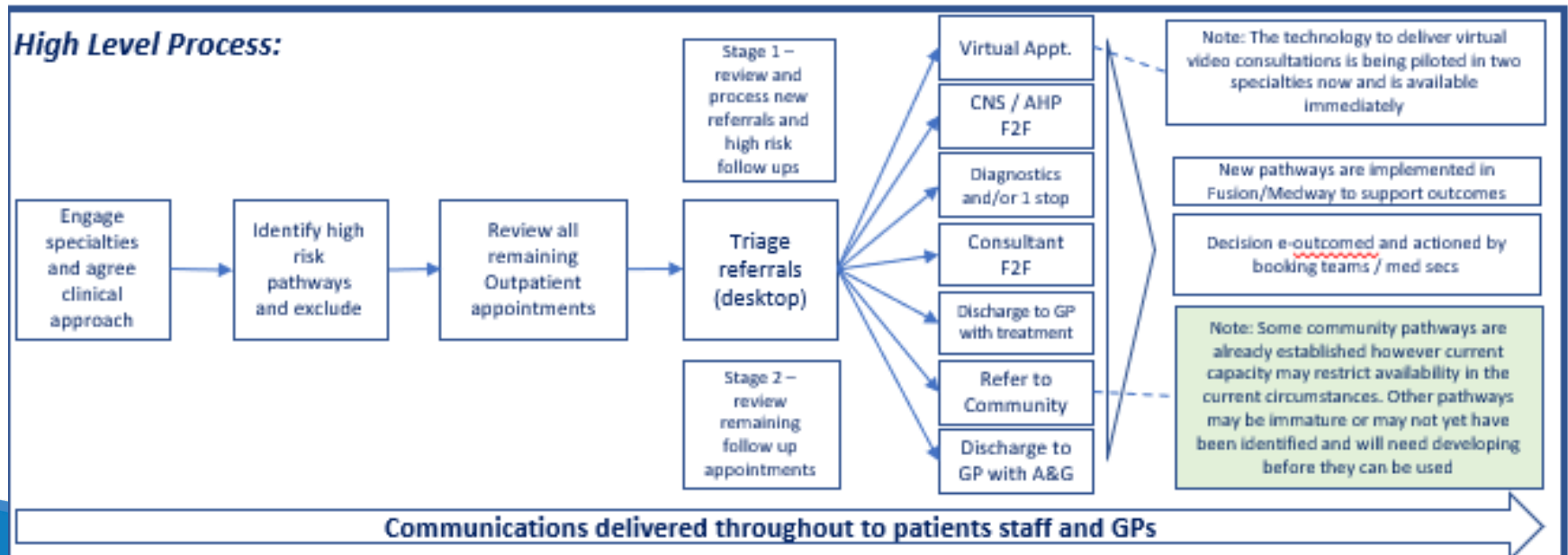
Managing Risk: Social isolation

- One Walsall inline with the resilient communities tier of the Walsall Together partnership have been coordinating a community support response
- The teams which are based around the four localities are supporting isolated and shielded members of the public with food parcels and a befriending service.
- This work is now also coordinated with West Midlands Police who are responding to community issues around social isolation and public safety
- West Midlands Fire Service are connected through the making connections hubs which act as the single point of contact for socially isolated members of the public during the covid response



Managing Risk: Outpatients

- Accepting that patients with long term conditions have an increased risk of deterioration in the community a large scale outpatients redesign programme is underway.
- This is being coordinated with an immediate focus on risk and clinical safety whilst taking every opportunity to re design pathways through community where appropriate.



Residual Risks: Domiciliary Care

- To date the Domiciliary market has remained fairly stable with some early support from the local authority
- However over recent weeks the staffing in this market has started to fall away due to illness, isolation of families and the continued lock down which was expected - mitigation plans for relocation of social care staff has held firm to date
- The concern that this market will start to present additional problems is growing.
- In addition the provision of private agencies personally commissioned by families lacks connection with the local authority and associated risk of poor PPE compliance is of growing concern.
- Over the next week the Walsall Together team will be reviewing this risk and coming up with a response plan



LIST OF ACRONYMS/ABBREVIATIONS

ACRONYM / ABBREVIATION	DESCRIPTION
A&E or ED	Emergency Department
AMU	Acute Medical Unit
AC	Audit Commission
ACO	Accountable Care Organisation
ACP	Advanced Care Plan
ACS	Accountable Care System
AfC	Agenda for Change
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAU	Business As Usual
BCM	Business Change Management
BCWB STP	Black Country & West Birmingham Sustainability and Transformation Partnership
BCWB UEC Board	Black Country & West Birmingham Urgent & Emergency Care Board
BMD	British Medical Association
CAMHS	Child and Adolescent Mental Health Services
CAS	Central Alerting System
CCG	Community Commissioning Group
CCN	Change Control Notice
CCU	Coronary Care Unit
CD	Controlled Drugs
CDS	Commissioning Data Set
CHIS	Child Health Information System
CIO	Chief Information Officer
CIP	Cost Improvement Programme
CLIPS	Complaints, Litigation, Incidents, PALS and Safeguarding
CNST	Clinical Negligence Scheme for Trusts
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disorder
COT	College of Occupational Therapists
CP	Child Protection
CPP	Child Protection Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRL	Capital Resource Limit
CRS	Care Records Service
CYP	Children & Young People
DBS	Disclosure and Barring Service
DD	Divisional Director
DDO	Divisional Director of Operations
DH or DoH	Department of Health
DN	District Nursing
DNA	Did Not Attend
DOC	Duty of Candour
DOLS	Deprivation of Liberty Safeguards
DPA	Data Protection Act
DQ	Data Quality

LIST OF ACRONYMS/ABBREVIATIONS

DTOC	Delayed Transfer of Care
E&D	Equality and Diversity
EOLC/EOL	End of Life Care / End of Life
EPR	Electronic Patient Record
EPRR	Emergency Preparedness, Resilience and Response
EPS	Electronic Prescription Service
ESR	Electronic Staff Record
FAQ	Frequently Asked Questions
FBC	Full Business Case
FOI	Freedom of Information
FTSU	Freedom to Speak Up
GIRFT	Getting It Right First Time
GMC	General Medical Council
GP	General Practitioner
GUM	Genito-Urinary Medicine
HASU	Hyper Acute Stroke Unit
HCA	Health Care Assistant
HCAI	Healthcare Associated Infection
HDD	Historical Due Diligence
HEE	Health Education England
HFMA	Healthcare Financial Management Association
HOT	Heads of Terms
HPV	Human Papilloma Virus
HR	Human Resources
HSE	Health and Safety Executive
HSJ	Health Service Journal
HWB	Health and Well-Being Board
I&E	Income and Expenditure
ICAS	Independent Complaints Advocacy Service
IG	Information Governance
IM&T	Information Management and Technology
Integra	Trust's Procurement Software supported by Capita partners
IPC	Infection Prevention and Control
JDF	Junior Doctors Forum
JNCC	Joint Negotiation and Consultative Committee
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicator
KSF	Knowledge and Skills Framework
LA	Local Authority
LNC	Local Negotiating Committee
LOS	Length of Stay
LTC	Long Term Conditions
LTFM	Long Term Financial Model
LTP	Long Term Plan
MFFD	Medically Fit for Discharge
MLCC	Manor Learning and Conference Centre
MLTC	Medicine & Long Term Conditions
MOU	Memorandum of Understanding
MSG	Mortality Surveillance Group
NAO	National Audit Office

LIST OF ACRONYMS/ABBREVIATIONS

NED	Non-executive Director
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NHSLA	National Health Service Litigation Authority
NICE	National Institute of Clinical Excellence
NIGB	National Information Governance Board
NMC	Nursing and Midwifery Council
NRLS	National Reporting and Learning System
NTDA	NHS Trust Development Authority
OD	Organisational Development
OJEU	Official Journal of the European Union
OOA	Out of Area
OOH	Out of Hospital agenda or Out of Hours
ORSA	Organisational Readiness Self-Assessment
OSC	(Local Authority) Overview and Scrutiny Committee
OT	Occupational Therapist/Therapy
PALS	Patient Advice and Liaison Service
PFI	Private Finance Initiative
PID	Patient Identifiable Data
PID	Project Initiation Document
PFIC	Performance, Finance & Investment Committee
PLACE	Patient Led Assessment of the Care Environment
PMO	Project Management Office/Officer
PO	Purchase Order
PODC	People and Organisational Development Committee
PPE	Personal Protective Equipment
PSF	Provider Sustainability Funding
PTS	Patient Transport Service
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QPES	Quality, Patient Experience and Safety Committee
QSIR	Quality Service Improvement Redesign
R&D	Research and Development
RAG	Red Amber Green Assessment Rating
RCA	Root Cause Analysis
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RTT	Referral to Treatment
SDIP	Service Development Improvement Plan
SJR	Structured Judgement Review
SI	Serious Incident
SIRO	Senior Information Responsible Officer
SLA	Service Level Agreement
SLAM	Starters, Leavers and Movers
SLR	Service Line Reporting
SLT or SaLT	Speech and Language Therapy
SOP	Standard Operating Procedure
SPC	Statistical Process Control
SRO	Senior Responsible Officer

LIST OF ACRONYMS/ABBREVIATIONS

STEIS	Strategic Executive Information System
STP	Sustainability and Transformation Partnership
SUS	Secondary Uses Service
TMB	Trust Management Board
TOMS	Therapy Outcome Measures
TUPE	Transfer of Undertakings (Protection of Employment Regulations 1981)
UCC	Urgent Care Centre
VFM	Value for Money
VSM	Very Senior Managers
WCCSS	Women's Children's & Clinical Support Services
WIC	Walk-in Centre
WT	Walsall Together
WTE	Whole Time Equivalent
VTE	Venus Thromboembolism