

MEETING OF THE PUBLIC TRUST BOARD

Held in public on Thursday 2 September 2021 from 10.30am to 13.30pm
Meeting held virtually via Microsoft Teams

AGENDA

#	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome; apologies and confirmation of quorum	Inform	Steve Field	Verbal	10.30
2.	Declarations of interest	Inform	Steve Field	Enclosure	
3.	Minutes of last meeting	Approve	Steve Field	Enclosure	
4.	Matters arising and action log	Review	Steve Field	Enclosure	10.35
5.	Trust Values and Nolan Principles	Inform	Steve Field	Enclosure	10.40
6.	Chair's Report	Inform	Steve Field	Verbal	10.45
7.	Chief Executive's Report	Inform	David Loughton	Enclosure	10.55
8.	COVID-19 Board Assurance Framework	Assure	Ned Hobbs	Enclosure	11.05
PROVIDE SAFE, HIGH QUALITY CARE					
9.	Quality, Patient Experience and Safety Committee Report	Assure Inform	Pamela Bradbury	Enclosure	11.30
10.	Safe High Quality Care Executive Report (including Board Assurance Framework and performance)	Assure Inform	Manjeet Shehmar Ann-Marie Cannaby Lisa Carroll	Enclosure	11.35
11.	Maternity Update	Assure Inform	Carla Jones-Charles	Enclosure	11.50
12.	Mortality Report Q1 2021/22	Assure	Manjeet Shehmar	Enclosure	12.00
13.	7 Day Services Assurance Report	Assure	Manjeet Shehmar	Enclosure	12.05
14.	Infection Prevention and Control Board Assurance Framework Update	Assure	Amy Walleth Lisa Carroll	Enclosure	12.10
USE RESOURCES WELL					
15.	Performance, Finance and Investment Committee Report	Assure Inform	John Dunn	Enclosure	12.15
16.	Use Resources Well Executive Report (including Board Assurance Framework and performance)	Assure Inform	Ned Hobbs Russell Caldicott	Enclosure	12.20
12.30 – 12.35 COMFORT BREAK					
VALUE OUR COLLEAGUES					
17.	People and Organisational Development Committee Report	Assure Inform	Junior Hemans	Enclosure	12.35
18.	Value Our Colleagues Executive Report (including Board Assurance Framework and performance)	Assure Inform	Catherine Griffiths	Enclosure	12.40
19.	Safe Staffing Report	Assure	Ann-Marie Cannaby /Lisa Carroll	Enclosure	12.55
20.	Medical Revalidation Report	Assure	Manjeet Shehmar	Enclosure	13.00
CARE AT HOME					

#	Agenda Item	Purpose	Lead	Format	Time
21.	Walsall Together Partnership Board Report	Assure Inform	Anne Baines	Enclosure	13.05
22.	Care at Home Executive Report (including Board Assurance Framework and performance)	Assure Inform	Daren Fradgley	Enclosure	13.10
WORK CLOSELY WITH PARTNERS					
23.	Work Closely with Partners Executive Report (including Board Assurance Framework)	Assure Inform	Ned Hobbs	Enclosure	13.15
GOVERNANCE AND WELL LED					
24.	Audit Committee Highlight Report	Assure Inform	Mary Martin	Enclosure	13.20
25.	Board Assurance Framework/Corporate Risk Register	Assure	Jenna Davies	Enclosure	13.25
CLOSING ITEMS					
26.	Any other business	Discuss	Steve Field	Verbal	
27.	Questions from the Public	Discuss	Steve Field	Verbal	
DATE AND TIME OF NEXT MEETING					
Thursday 7 October 2021 at 10.30am					
EXCLUSION OF THE PRESS AND MEMBERS OF THE PUBLIC					
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).					

Lead Presenters

Name of Lead	Position of Lead
Prof Steve Field	Chair of Trust Board
Mr John Dunn	Vice Chair of Trust Board; Chair of Performance, Finance and Investment Committee
Mrs Pamela Bradbury	Non-Executive Director; Chair of Quality, Patient Experience and Safety Committee
Mrs Anne Baines	Non-Executive Director; Chair of Walsall Together Partnership Board
Mr Junior Hemans	Non-Executive Director; Chair of People and Organisational Development Committee
Mrs Mary Martin	Non-Executive Director; Chair of Audit Committee
Prof David Loughton	Interim Chief Executive Officer
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive Officer
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive Officer
Dr Manjeet Shehmar	Interim Medical Director
Mr Russell Caldicott	Director of Finance and Performance
Ms Catherine Griffiths	Director of People and Culture
Mr Ned Hobbs	Chief Operating Officer
Ms Jenna Davies	Director of Governance
Mrs Glenda Augustine	Director of Planning and Improvement
Ms Lisa Carroll	Director of Nursing
Mrs Carla Jones-Charles	Divisional Director of Midwifery, Gynaecology & Sexual Health

MEETING OF THE PRIVATE TRUST BOARD – 2nd September 2021

Declarations of Interest			AGENDA ITEM: 2
Report Author and Job Title:	Keith Wilshire Interim Trust Secretary	Responsible Director:	Steve Field, Trust Board Chair
Action Required	Approve ☐ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The report presents a Register of Directors' interests to reflect the interests of the Trust Board members. The register is available to the public and to the Trust's internal and external auditors, and is published on the Trust's website to ensure both transparency and also compliance with the Information Commissioner's Office Publication Scheme.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	There are no risk implications associated with this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	It'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 ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Register of Directors Interests at August 2021

Name	Position held in Trust	Description of Interest
Professor Steve Field	Chair	Chair: Royal Wolverhampton NHS Trust
		Director: EJC Associates
		Trustee for Charity: Pathway Healthcare for Homeless People
		Trustee: Nishkam Healthcare Trust Birmingham
		Honorary Professor: University of Warwick
		Honorary Professor: University of Birmingham
Mr John Dunn	Vice Chair Non-executive Director	Non-Executive Director, Royal Wolverhampton NHS Trust
Mrs Anne Baines	Non-executive Director	Director/Consultant at Middlefield Two Ltd
		Associate Consultant at Provex Solutions Ltd (no longer an interest as at 25th May 2021)
		Birmingham and Solihull Mental Health Trust (from August 2021)
Ms Pamela Bradbury	Non-executive Director	STP Workforce Bureau (Vaccination Programme)
		Partner, Dr George Solomon is a Non-Executive Director at Dudley Integrated Health and Care Trust
Mr Ben Diamond	Non-executive Director	Director of the Aerial Business Ltd.
		Volunteer at Gracewell of Sutton Coldfield Care Home
		Partner - Registered nurse and General Manager at Gracewell of Sutton Coldfield Care Home
		Volunteer Vaccinator with St John's Ambulance
Mr Junior Hemans	Non-executive Director	Non-executive Director - Royal Wolverhampton NHS Trust
		Visiting Lecturer – University of Wolverhampton
		Director – Libran Enterprises (2011) Ltd
		Chair/Director - Wolverhampton African Caribbean Resource Centre
		Chair - Tuntum Housing Association (Nottingham)
		Company Secretary – The Kairos Experience Ltd.
		Member – Labour Party

Name	Position held in Trust	Description of Interest
		Mentor – Prince's Trust
		Spouse is a therapist at Royal Wolverhampton NHS Trust
Ms Mary Martin	Non-executive Director	Royal Wolverhampton NHS Trust - Non-Executive Director
		Trustee/Director, Non-Executive Member of the Board for the charity - Midlands Art Centre
		LTDT Trustee/Director, Non-Executive - B:Music
		Director - Friday Bridge Management Company Ltd
		Non-Executive Director/Trustee - Extracare Charitable Trust (stood down 21 June 21)
Mr Paul 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 Provex Solutions Ltd.
Mr Rajpal Virdee	Associate Non-executive Director	Lay Member, Employment Tribunal Birmingham
		Vice President of Pelsall Branch Conservative Party Association (from 19 th June 2021)
Mrs Sally Rowe	Associate Non-Executive	Executive Director Children's Services - Walsall MBC
		Trustee of the Association of Directors of Children's Services
Professor David Loughton	Interim Chief Executive	Chief Executive – Royal Wolverhampton NHS Trust
		Health policy advisor to the Labour and Conservative Parties
		Member – Dementia Health and Care Champion Group
		Member of Advisory Board – National Institute for Health Research
		Chair – West Midlands Cancer Alliance
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive	Director of Oaklands Management Company
		Spouse, Helen Willan, is Systems Manager at West Midlands Ambulance Service
		Clinical Adviser NHS 111/Out of Hours
		Non-Executive Director at whg

Name	Position held in Trust	Description of Interest
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive	Chief Nurse – Royal Wolverhampton NHS Trust
		Director – Ann-Marie Cannaby Limited
		Visiting Professor – Staffordshire University
		Honorary Fellow – La Trobe University, Victoria, Australia
		Teaching Fellow – Higher Education Academy
		Member – Royal College of Nursing
		Visiting Professor – Birmingham City University
Mr Russell Caldicott	Director of Finance and Performance	Member of the Executive for the West Midlands Healthcare Financial Management Association (HFMA)
Dr Matthew Lewis	Medical Director	Spouse, Dr Anne Lewis, is a GP and partner at The Oaks Medical Practice (Great Barr) and Blackwood Health Centre (Streetly)
		Director of Dr MJV Lewis Private Practice Ltd.
Dr Manjeet Shehmar	Acting Medical Director	To be confirmed
Ms Catherine Griffiths	Director of People and Culture	Catherine Griffiths Consultancy Ltd
		Chartered Institute of Personnel (CIPD)
Mr Ned Hobbs	Chief Operating Officer	Father – Governor Oxford Health FT
		Sister in Law – Head of Specialist Services St Giles Hospice
Mrs Lisa Carroll	Director of Nursing	To be confirmed
Ms Glenda Augustine	Director of Performance & Improvement	No interests to declare

RECOMMENDATIONS

The Board is asked to note the report

MEETING OF THE PUBLIC TRUST BOARD
HELD ON THURSDAY, 5TH AUGUST 2021 AT 10.30AM
HELD VIRTUALLY VIA MICROSOFT TEAMS

PRESENT

Members

Prof Steve Field CBE	Chair of the Board of Directors
Mr John Dunn	Non-Executive Director; Vice Chair, Board of Directors
Mrs Anne Baines	Non-Executive Director
Mrs Pamela Bradbury	Non-Executive Director
Mr Ben Diamond	Non-Executive Director
Mr Junior Hemans	Non-Executive Director
Ms Mary Martin	Non-Executive Director
Mr Paul Assinder	Associate Non-Executive Director
Mr Rajpal Virdee	Associate Non-Executive Director
Mrs Sally Rowe	Associate Non-Executive Director
Prof David Loughton CBE	Interim Chief Executive
Mr Daren Fradgley	Director of Integration/Deputy Chief Executive
Prof Ann-Marie Cannaby	Interim Chief Nursing Officer/Deputy Chief Executive
Ms Lisa Carroll	Director of Nursing
Dr Manjeet Shehmar	Acting Medical Director
Mr Russell Caldicott	Director of Finance and Performance
Mrs Glenda Augustine	Director of Planning and Improvement

In attendance

Mr Steve Bagley	Digital Communications Manager
Ms Clair Bond	Deputy Director of People and Culture
Mr Kevin Bostock	Advisory Director of Governance, RWT Support Team
Mr Keith Wilshere	Interim Trust Secretary
Mr Mike Sharon	RWT Strategic Advisor to the Board
Mrs Sophie Harris	Interim Senior Executive Assistant

Apologies

Ms Jenna Davies	Director of Governance
Mr Ned Hobbs	Chief Operating Officer
Ms Catherine Griffiths	Director of People and Culture
Ms Sally Evans	Director of Communications and Engagement

114/21	Welcome, Apologies and Confirmation of Quorum
	Prof Field welcomed everyone to the meeting and noted the apologies above. Prof Field welcomed Dr Shehmar in her newly appointed role as Acting Medical Director and Ms Carroll as Director of Nursing and Mr Wilshere as Interim Trust Secretary.
115/21	Declarations of Interest
	No further interests were declared.
116/21	Minutes of Last Meeting
	The minutes of the meeting held on 1 st July 2021 were approved.

117/21	Matters Arising and Action Log
	The Board received the action log and updates were noted. Mr Assinder congratulated Prof Loughton, Prof Cannaby and the executive team on the recruitment of 90 additional nurses and the progress toward a full nursing establishment. Prof Loughton thanked Mr Assinder for his support and highlighted that there was a significant amount of work to implement 260 nurses before the end of October and this was not without its risks in relation to the education, training and mentorship required. He advised that Mr Caldicott and Prof Cannaby were working together in a review of the nursing establishments to ensure a robust case was in place. Prof Cannaby said she was seeking to be able to discharge her professional accountability during this process. Prof Loughton agreed with this and the need for a robust case given the deficit position of the Trust.
118/21	Standing Orders/Standing Financial Instructions
	Mr Caldicott introduced the updated Standing Orders, Standing Financial Instructions and Scheme of Delegation endorsed by the Executive Team, Trust Management Board and Audit Committee. He summarised the main changes included revised delegated financial limits as previously approved by the Board, the inclusion of the Senior Independent Director role and recognition of the auditor panel as well as some changes to the terminology used in the document. Resolved: The revised Standing Orders/Standing Financial Instructions were approved.
CLOSING ITEMS	
119/21	Any Other Business
	There was no other business.
120/21	Questions from Public
	There were no questions from the public.
	The next meeting will take place on Thursday 3 rd September 2021.
	Prof. Field read the declaration of exclusion.

Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
042/20	04 June 2020	BAF and CRR	The BAF will continue to remain on the Board agenda each month until further notice.	Director of Governance	Monthly	Will remain open action for the agenda for foreseeable future	Open
063/21 (a)	06 May 2021	Acute Care Collaboration	A discussion to take place at the Walsall Together Partnership Board on how the acute care collaboration will address health inequalities and support the communications through place.	Director of Integration/Deputy CEO	02 September 2021	<i>Update for the September meeting:</i> Discussion held at the previous WTPB meeting about the Population Health and Inequalities Strategy for the partnership which encompassed aspects of the acute care collaboration.	Complete
066/21 (a)	06 May 2021	Patient Story (mental health)	Details of the planning in place for mental health training to come to the People and Organisational Development Committee and Mr Hemans to report back to Board.	Medical Director Chair of PODC	02 September 2021	<i>Update for the September meeting:</i> E-learning training packages have been developed including training for ligature cutters and restraint. Details will be circulated through trust communications and an update will be presented through a mental health update paper to QPES in September.	Complete
092/21 (a)	01 July 2021	COVID-19 BAF	Confirmation that the national strategy document on Long-Covid has been taken into account in the Long-Covid pathways	Director of Integration/Deputy CEO	02 September 2021	<i>Update for the September meeting:</i> The Long Covid service and pathways has been developed in line with the national strategy document and continues to be reviewed against current and future guidance.	Complete
092/21(b)	01 July 2021	COVID-19 BAF	It was noted that the previous waves of COVID-19 saw a rise in early births and C-Section rates. Given the rise in COVID-19 cases in the borough, the current impact of this on pregnant women to be included in September report.	Chief Operating Officer	02 September 2021	<i>Update for the September meeting:</i> Impact of Covid-19 on Maternity specifically incorporated into the Covid-19 Board Assurance Framework Risk Assessment. Across April-July 2021, the Trust has had 18 Obstetric women who have tested positive for Covid-19 during their inpatient admission, of which 2 have gone on to require Critical Care. None of those women had been vaccinated at the point of their inpatient episode.	Complete
	01 July 2021	AOB (memorial/reflection garden)	Proposal for event to honour staff – possibly a tree planting – to come to September meeting.	Director of Communications and Engagement	02 September 2021	Verbal update to be provided at the September meeting.	Open

The Seven Principles of Public Life 'Nolan principles'

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

1. Selflessness

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

2. Integrity

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

3. Objectivity

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

4. Accountability

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

5. Openness

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

6. Honesty

Holders of public office should be truthful.

7. Leadership

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

Our Vision, Objectives & Values



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

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

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

Our Objectives: Underpinning the vision

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

- 

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

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

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

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

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



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

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

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

MEETING OF THE PUBLIC TRUST BOARD			
Thursday 2 nd September 2021			
Interim Chief Executive Officer's Report			AGENDA ITEM: 7
Report Author and Job Title:	Prof David Loughton, Interim Chief Executive Officer	Responsible Director:	Prof David Loughton, Interim Chief Executive Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	The paper includes details of key activities undertaken since the last Trust Board meeting.		
Recommendation	Members of the Trust Board are asked to note the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	None in this report.		
Resource implications	There are no resource implications associated with this report.		
Legal and Equality and Diversity implications	None in this report.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

INTERIM CHIEF EXECUTIVE OFFICER'S REPORT – SEPTEMBER 2021

1.0	<u>Review</u>
	This report indicates my involvement in local, regional and national meetings of significance and interest to the Board.
2.0	<u>Consultants</u>
	The following consultants were appointed this month: <u>Dermatology</u> Dr Viktoria Eleftheriadou Dr Noha Elshimy Dr Seema Garg <u>Palliative Care</u> Dr Lucia Birch <u>Obstetrics and Gynaecology</u> Dr Archana Hatti Dr Caroline MacMahon
3.0	<u>Policies and Strategies</u>
	The following policies were approved this month: • Hand Hygiene and Personal Protective Equipment policy
4.0	<u>Visits and Events</u>
	• Since the last Board meeting I have undertaken a range of duties, meetings and contacts locally and nationally including: • Since Friday 27 March 2020 I have participated in weekly virtual calls with Chief Executives, led by Dale Bywater, Regional Director – Midlands – NHS Improvement/ England • Since Monday 3 August 2020 I have participated in weekly calls with the Black Country and West Birmingham Strategic Transformation Partnership (STP) on the co-ordination of a collective Birmingham and the Black Country restoration and recovery plan and COVID-19 regional update • 23 June 2021 – participated in a virtual Regional Cancer Board • 24 June 2021 – site visit to Women's and Children's services and chaired a Senior Managers Virtual Briefing and participated in a Regional NHS System Transformation and Restoration (STaR) Board meeting • 25 June 2021 – met with Eddie Hughes MP

	• 12 July May 2021 – participated in a virtual Trust Management Board (TMB) • 15 July 2021 – chaired a Senior Managers virtual Briefing and met with Jane Wilson and Pat Usher, Freedom to Speak Up Guardians • 16 July 2021 – met virtually with Eddie Hughes MP and Wendy Morton MP • 19 July 2021 – met virtually with Dr Helen Paterson, Chief Executive – Walsall Council • 20 July 2021 – participated in a virtual Health and Well Being Board • 22 July 2021 - participated in a virtual Joint Negotiating Committee (JNC) • 23 July 2021 – participated in a national Cancer Alliances Leadership Forum • 26 July 2021 – Prof Steve Field CBE, Chairman and myself virtually met with Cllr Mike Bird – Leader and Dr Helen Paterson, Chief Executive – Walsall Council and virtual met with Mandy Poonia, Chair and Aileen Farrer, Manager – Healthwatch • 27 July – chaired the virtual West Midlands Cancer Alliance Board • 5 August 2021 – site visit to Medicine Departmental Service areas and virtually met with Dr Helen Paterson, Chief Executive – Walsall Council • 6 August 2021 - participated in a virtual Joint Liaison Committee meeting with the Privately Funded Initiative (PFI) Provider – Skanska and participated in a virtual Annual General Meeting (AGM) Healthwatch • 10 August 2021 - participated in a virtual Trust Management Board (TMB) • 12 August 2021 – site visit within the Patient Experience Department, met with Joan Dyer, Cultural Ambassador and chaired a Senior Managers virtual Briefing • 17 August 2021 - met with Jane Wilson and Pat Usher, Freedom to Speak Up Guardians and undertook a site visit of the Imaging Department • 19 August 2021 – participated in a welcome of all the international nurses • 20 August 2021 – virtually met with Eddie Hughes MP and Wendy Morton MP
5.0	<u>Board Matters</u>
	There are no Board Matters to report on this month.

MEETING OF THE PUBLIC TRUST BOARD – 2 ND SEPTEMBER 2021			
Quality, Patient Experience and Safety Committee (QPES) Highlight Report			AGENDA ITEM: 9
Report Author and Job Title:	Mrs Pam Bradbury, Non-Executive Director	Responsible Director:	Mrs Pam Bradbury, Non-Executive Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the key messages from the Quality, Patient Experience and Safety Committee meeting held on 26th August 2021. Of note are: - The committee were updated on restoration and recovery. Elective and day case activity restored to 92% YTD of 2019 activity, as of first cut July 2021. 6 Week Wait (DM01) Diagnostics performance is now the 2nd best (June 2021 reporting) in the country, out of 122 reporting general acute Trusts. The Trust is now meeting the constitutional standard of less than 1% of patients waiting over 6 weeks for the 2nd consecutive month since the onset of the pandemic, 16 months ago. - The Trust has received NHSEI guidance predicting a Paediatric Respiratory Syncytial Virus season that is 20-50% higher than usual. Which is likely to place significant pressure on children's emergency care, and affect the Trust's ability to manage children within 4 hours of arrival to ED. A surge plan has been developed. - Due to the number of Covid-19 positive patients on Critical Care it is unlikely that the Trust will reinstate the 7th elective operating theatre during August 2021 - The community service update reported that The Care Navigation Centre continued to operate as an escalation point for clinical deterioration in the community and were able to provide a full schedule of ward rounds within the homes. - The numbers of patients who are medically stable for discharge remained low, while new services such as the Integrated Assessment Hub continued to have a positive impact in reducing numbers of admissions to Walsall Manor Hospital - There is a shortage of domiciliary care services available, provision is usually via private providers who have reported shortages of staff. This is likely to impact the number of people being admitted to care homes rather than discharge home. - The safe high-quality care reported the weekly CQC Steering Group continues to meet to ensure oversight, progress against and evidence of changes made, embedding in practice and closure of all CQC actions from inspections. - The back log of Out-of-date policies continues to raise concerns but significant improvement continues to be made in this area. - The committee has requested monthly updates on progress being		

	made to deal with SI's previously reported to Trust Board. Although there is still much work to be done in this area the committee were reassured of the progress being made. • A review of the nursing workforce was presented for information and assurance that the methodology being used was robust and will be adopted as the review tool for future biannual reviews. • The maternity update reported consistently lower levels of staff than required, although 1.1 in labour was maintained the triage area could not always be staffed by 2 members as recommended and the transition ward was temporarily closed, recruitment is taking place which should rectify this position. • 2 Serious incidents were reported in July and are going through the process of investigation. • The committee (as requested by Audit Committee) received an update on the electronic discharge summary programme of work as there has been a delay in this being progressed due to the demands on the digital team. A clinical risk paper has been requested and will be presented at QPES in September. • Dr Lewis presented as AOB that there is a National shortage of BD blood tubes and although the Trust do not use these types of tubes there is going to be increased demand on the provider used at WHT and therefore the request is to reduce blood tube usage by 25%, a communication plan is in place. The situation is likely to last until end of September. • The committee was not assured about the process for updating policies and procedures as 76/284 are currently out of date (with a further 32 due for review in the next 3 months). It was not possible to confirm that policies which are clinically significant are being prioritised for review. It was noted that the Policy for the Development and Review of Policies, Guidelines, Procedures and Protocols was last approved in 2016. It was reported that further assistance on the management of policies had been identified from RWT. • There was assurance around the management of sepsis in ED, with manual audits demonstrating 95.45% compliance with the delivery of antibiotics within 1 hour; further work is taking place to identify why this level of performance is not yet reflected in the data generated by the eSepsis tool. • However, in patient wards were only able to show data demonstrated through eSepsis which indicates 36.36% compliance; there is no comparable manual audit data so assurance was not possible. A Clinical Lead for Sepsis has recently been appointed, who will work with the ED and Sepsis Teams to understand this performance. A Sepsis Improvement Workshop has been set up in Medicine and Long Term Conditions on 7th September. The next meeting of the Committee will take place on 30th September 2021
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.

Risk in the BAF or Trust Risk Register	This report aligns to BAF risk S01 for safe high quality care and COVID-19 BAF risk S06.	
Resource implications	There are no new resource implications associated with this report.	
Legal, Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☐	

MEETING OF THE PUBLIC TRUST BOARD - Thursday 2 nd September 2021			
Safe High-Quality Care Oversight Report – August 2021			AGENDA ITEM: 10
Report Author and Job Title:	Lisa Carroll Director of Nursing Manjeet Shehmar Medical Director Caroline Whyte – Interim Deputy Director of Nursing	Responsible Director:	Manjeet Shehmar Medical Director Lisa Carroll Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	- The paper highlights key additions to the Board Assurance Framework and identifies actions associated with gaps in assurance or control. - The Clinical Guidelines Group continues to monitor updates to guidelines. In the last month, 4 guidelines were updated and uploaded. 76 guidelines remain out of date; this is a significant improvement from March 2021 when 106 guidelines were out of date. - A weekly CQC Steering Group continues to meet to ensure oversight, progress against and evidence of changes made, embedding in practice and closure of all CQC actions from inspections. - Corporate risk 2066; Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels remains at a score of 15. - VTE compliance for July is 92.99% Work continues as per the plan outlined in this report last month and Divisional teams are now reporting on their performance and plans to Patient Safety Group (PSG). - The prevalence of timely observations is 88.26% and consistently is remaining above trust target. Seventeen clinical areas achieved in excess of 85% trust target. - Falls per 1000 bed days was 4.78 in July 2021 and remains significantly below the national average of 6.1 as recognised as the Royal College Physicians. There has been one severe harm fall in July 2021. This is due for presentation at serious incident committee. - Safeguarding adults and children's training is achieving trust target for all level 1 and level 2 training. Level 3 adult and children's training remains below trust target.		
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?	208 - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks. (Risk Score = 12). 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). 2398 - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12). 2437 - Service wide impact as a result of the risk of CYP are being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Internal factors). (Risk Score = 20). 2439 - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Risk Score = 20). 2475 - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services. (Risk Score = 25). 2540 - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems. (Risk Score = 16).	
Resource implications		
Legal and Equality, Diversity and inclusion implications	COVID-19 has impacted disproportionately on people who are men, from low socioeconomic backgrounds and from BAME backgrounds. Our local population is subject to multiple inequalities which affect quality of life, health and mortality.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

Safe High-Quality Care Oversight Report – July 2021

1. Board Assurance Framework (BAF)

Our strategic objective is to deliver excellent quality of care as measured by an outstanding CQC rating by 2022. The BAF has been reviewed in June and additional actions highlighted that mitigate gaps in assurance and/or controls.

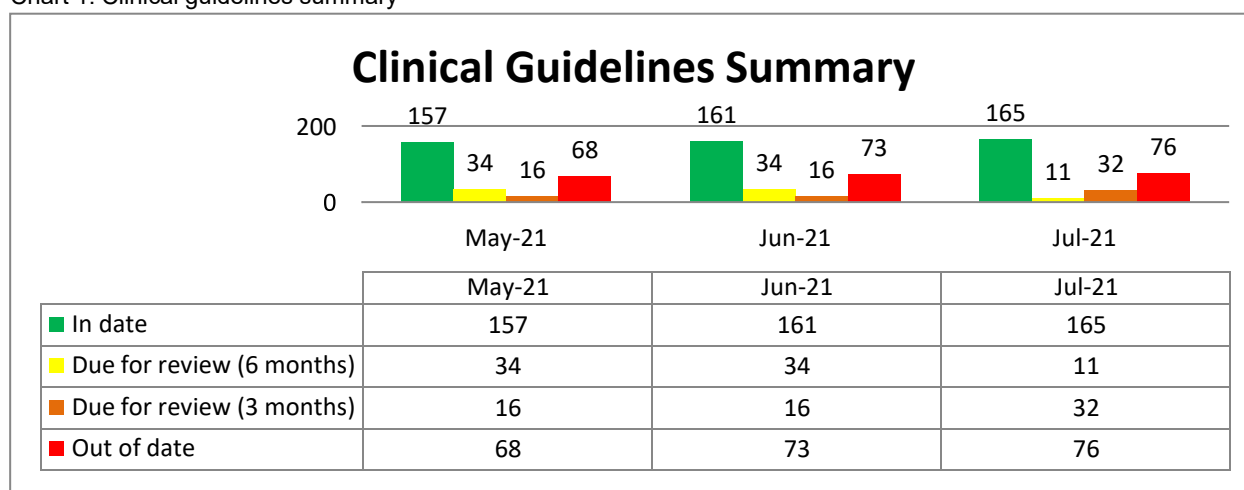
The BAF for Safe, High Quality Care appear at Appendix 1 and the corporate risk register at Appendix 2. The Trust continues to have a low-risk appetite for compromising quality and safety of patient care.

2. Gaps in Assurance

Clinical Policies, Procedures and Scopes of Practice

The Clinical Guidelines Group continues to monitor updates to guidelines. In the last month, 4 guidelines were updated and uploaded. Care groups have also been asked for plans to address any guidelines due to go out of date within the next 6 months. The table shows that 75% of all Trust clinical guidelines are now in date. This is a significant improvement from March 2021 when 106 guidelines were out of date (Chart 1).

Chart 1: Clinical guidelines summary



CQC action plan update

A weekly CQC Steering Group continues to meet to ensure oversight, progress against and evidence of changes made, embedding in practice and closure of all CQC actions from inspections. A revised action plan with links to the evidence of compliance is currently being collated by a project co-ordinator to ensure all actions have been addressed. The monthly CQC action plan oversight group attended by all divisions has been re-established with commitment from divisions to attend and provide details and evidence of progress and assurance gained.

CQC Unannounced Inspections

Medicine and Long-Term Conditions

The CQC conducted an unannounced inspection across 5 medical wards on Tuesday 9 March 2021. A Section 29a warning notice and requirement notices were served on the Trust on the 31 March 2021 and the final CQC report was published 19 May 2021. On the 30 June 2021 the Trust submitted to the CQC a response to the Section 29a and requirement notices detailing the actions taken by the Trust to address the issues raised. The CQC are required to re-visit the Trust at some point after the 30 June 2021 to gain assurance that the required actions have been taken and that changes are embedded.

Maternity services

The CQC conducted an unannounced inspection of maternity services on the 28 July 2021. Initial feedback on the day, whilst highlighting some good practice, raised concerns regarding staffing and support for teams under pressure, triage, cleanliness and the environment and medication storage. Immediate action has been taken to address immediate concerns and a more detailed action plan is under development. The final report will be shared once it is available.

GIRFT

The summary report below illustrates the performance of specialties against their implementation plan. Local actions are progressing well with many specialties having completed all recommendations.

For note: there have been a number of national reports issued and the recommendations have been added to the relevant speciality implementation plan. There are several specialties that have not yet had a meeting with GIRFT following publication of the national reports which explains 0% progress.

Two meetings with the GIRFT team took place during July. The Dermatology and Lung cancer teams reported progress to the regional GIRFT representatives.

In addition, several regional events were held attended by Trust staff. A Midlands Elective Delivery Programme Regional Learning Event supporting the restoration and recovery of elective services took place on 7 July. Introduction to the Urology HVLC pathways and examples of success took place on 13 July and Introduction to the Gynaecology HVLC pathways and examples of success was held on 29 July.

Speciality	RAG	Action Progress	National Recommendations Progress
Acute and General Medicine	Green	95%	
Breast Surgery	Green	76%	0%
Dermatology	Green	100%	0%
Diabetes	Green	97%	60%
Ear, Nose and Throat	Green	100%	0%
Endocrinology	Green	100%	0%
Gastroenterology	Green	100%	3%
General Surgery	Green	97%	4%
Geriatric Medicine	Green	100%	
Gynaecology and Maternity	Green	100%	
Hospital Dentistry	Green	100%	
Imaging and Radiology	Green	100%	
Ophthalmology	Green	100%	0%
Orthopaedic Surgery	Green	96%	84%
Paediatric Surgery	Green	100%	
Respiratory	Green	100%	0%
Spinal Surgery	Green	67%	4%
Urology	Green	85%	77%
Vascular	Green	100%	3%

Delivery of consistently high standards of care

Falls

For the year 2021-2022 the average falls per month currently stands at 58. The average has increased from June to July from 52. Falls reported for July are 77 (Chart 2), an increase from 51 in June. Falls per 1000 bed days has increased but remains within normal variation and under the national average of 6.1 per 1000 bed days (Chart 3).

A Falls Steering Group is attended by all divisions where assurance regarding actions from investigations and embedding of lessons learnt is sought. The Trust Falls and Deconditioning Prevention Strategy is currently being developed and will be supported by an e-learning training package for staff.

There has been 1 fall with severe and 1 fall with moderate harm recorded in July 2021. The severe harm incident has been deemed reportable as a Serious Incident (SI) and is currently being investigated.

The Trust has identified 12 falls that have not previously been investigated and have been identified as potential SI's, despite being discussed at SI group. A cluster review to identify themes and individual RCAs are being undertaken and once complete Duty of Candour will be undertaken where identified as required. Actions have been put in place to ensure more robust tracking of falls SI's.

Chart 2: Total Falls

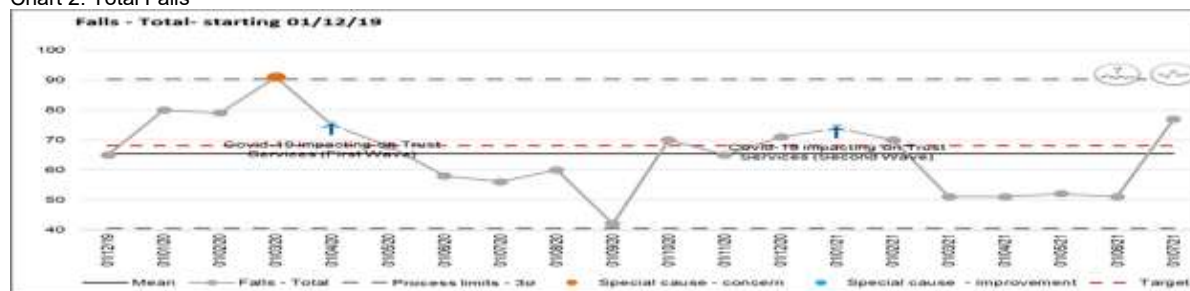
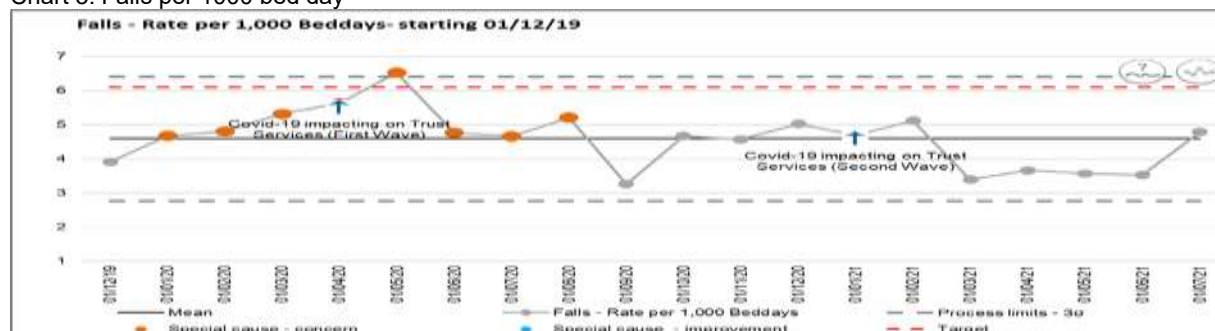


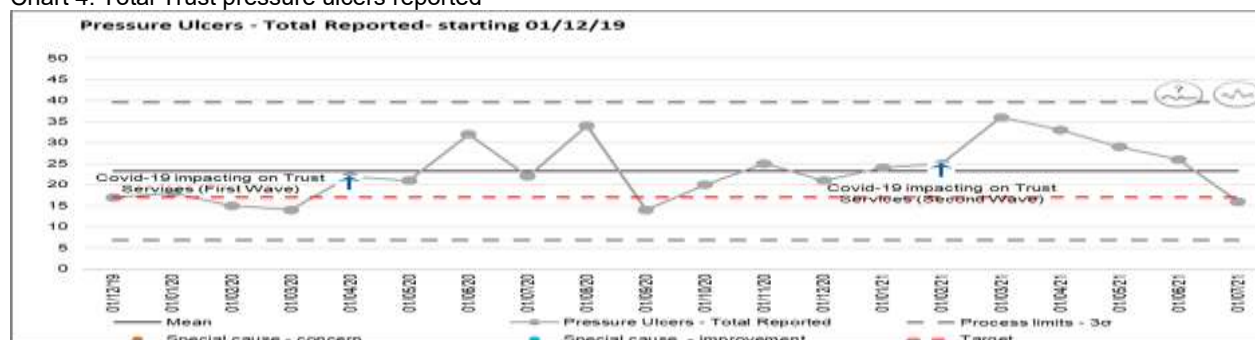
Chart 3: Falls per 1000 bed day



Tissue Viability

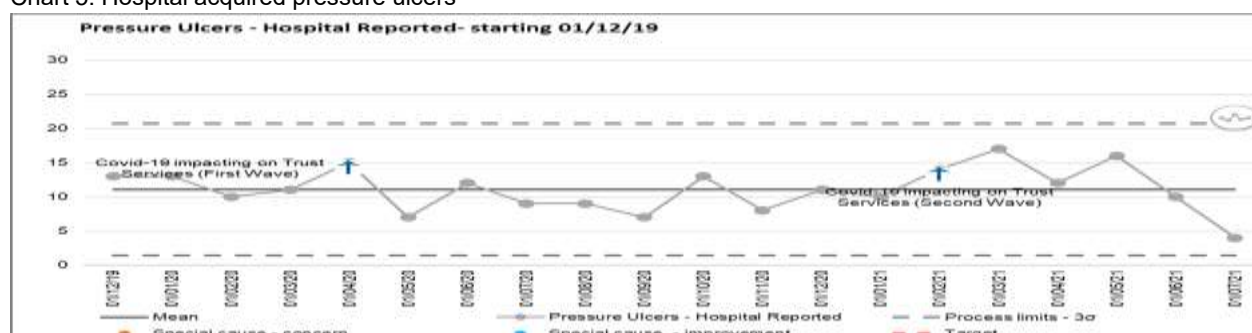
There has been a sustained reduction in Trust acquired pressure ulcers with 12 being reported in July 2021 (Chart 4). The main categories of pressure ulcers reported across the Trust are unstageable (8); category 2 (2); deep tissue injury (1). All pressure ulcers of stage 3 and above and those that are unstageable have a Root Cause Analysis (RCA) completed as to whether any Serious Incident (SI) criteria are met.

Chart 4: Total Trust pressure ulcers reported



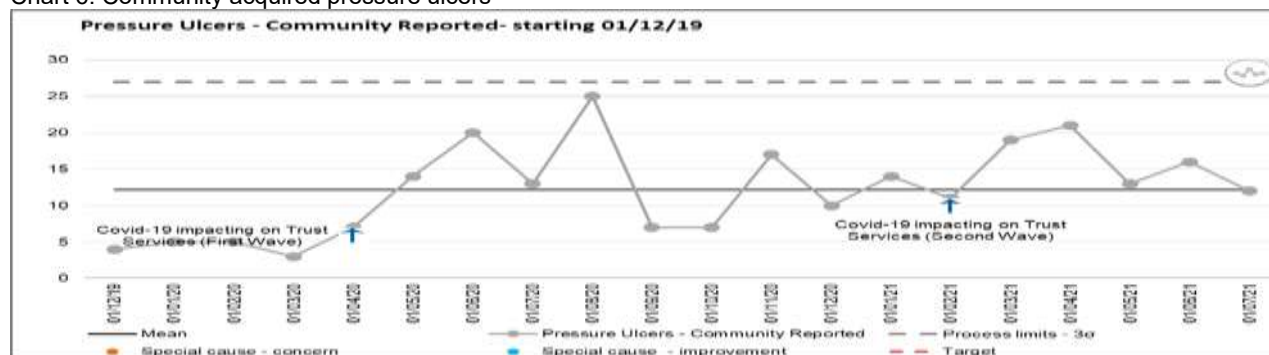
The total number of hospital acquired pressure ulcers has decreased and remains with normal variation (Chart 5).

Chart 5: Hospital acquired pressure ulcers



A total of 13 pressure ulcers were reported across Community services. Of these 6 were reported as a category 2, 1 as a category 3 and 5 were reported as unstageable.

Chart 6: Community acquired pressure ulcers



Actions being taken:

- The tissue viability team have designed an e-learning package on the fundamentals of pressure ulcer prevention and management we are waiting for feedback and launch date from the FORCE team.
- Tissue viability team have, in collaboration with the research team engaged in a research project – Venous 6 Looking at compression therapy
- Training has been given to Walsall Gosport Palliative Care Centre on pressure ulcer management and prevention, with the intention to expand training to wound care.
- Teaching will commence in August to community nursing teams. The aim is to update knowledge on wound care, dressing selection, pressure ulcer grading and management.

Mouth care

A point prevalence study of health care associated infections has been undertaken. This highlights that work is required to reduce Hospital Acquired Pneumonia (HAP) including mouth care matters.

A business case is being developed to recruit a dental nurse/mouth care matters practitioner to focus on a work stream with an ambition to reduce incidence of HAP.

Poster submitted this month for the QI awards regarding mouth care and the involvement of the palliative care team. This poster won an award for the most viewed poster

Mouth care gels are now standard within ICU for critically ill patients.

Nutrition and Hydration

The Speech and Language Team (SALT) are working with pharmacy to ensure only patients prescribed thickeners receive them. Work is underway to ensure thickeners are only prescribed on the PRN section of the drug chart only to those patients assessed by SALT.

A number of mealtime initiatives are being rolled across more wards. There is a plan to implement mealtime iPads and the Trust is working with RWT regarding menu planning and catering options.

Continence

Training covering all aspects of continence and catheterisation is established through the FORCE team. Training sessions are held in a combination of face to face and e-Learning. The Quality team support the assessment of practical competencies for the staff that have completed theory training and are facilitating 'train the trainer' sessions.

A Continence Ambition is currently undergoing consultation prior to submission for ratification by the Trust. This is expected to report into QPES in September 2021.

Venous Thromboembolism (VTE)

VTE compliance for July 2021 was 92.99% (Chart 7), which is again under the 95% target for compliance.

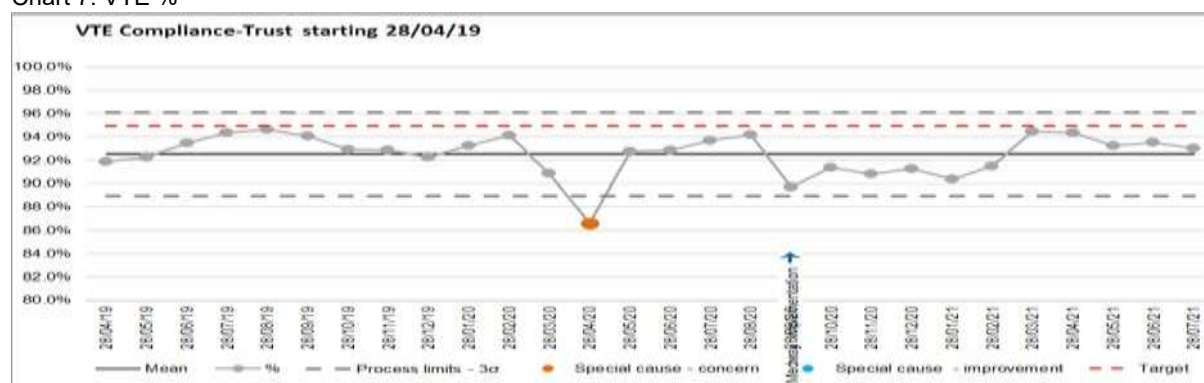
In order to fully understand the issues leading to low compliance, audits are being carried out in the Surgical and Medicine and Long-Term Condition Divisions. The results are expected in the next few weeks. This will provide information to support action plans to improve compliance.

Divisional compliance is outlined below (Table 1).

Table 1: Divisional VTE compliance

	Apr-21	May-21	Jun-21	July 21
Medicine and Long term Conditions	90.99%	88.06%	90.44%	88.70%
Surgery	93.52%	93.98%	91.52%	92.42%
Womens Childrens and Clinical Support	98.37%	96.77%	98.41%	97.37%

Chart 7: VTE %



Sepsis

A Trust sepsis team has been agreed and being recruited to. The Trust Clinical Lead for sepsis was appointed in July 2021.

The percentage of adult patients screened who received antibiotics within 1 hour within the Emergency Department was 95.45% by manual audit and 71.54% by E-sepsis in July 2021. The inpatient adult E-sepsis compliance for July 2021 was 36.36%. A meeting was held with the clinical teams, System C, informatics and IT to understand the discrepancy between manual and E-sepsis data. Both data and functionality issues were identified by following patient pathways. The team are now working through these in a task and finish group. The Divisions continue to monitor their performance and report to patient safety group.

104-day harms

The patients who have waited longer than 104 days for assessment, diagnosis and treatment following GP referral or Consultant upgrade are monitored closely and regular updates provided via the Trust Cancer Team to Patient Safety Group.

In June 2021, one patient was identified who was having symptoms of upper gastrointestinal issues was managed on day 111. Harm evaluation still in progress. July validation currently in progress.

Safer Surgery

The WHO checklist for safer surgery is now electronic on Bluespider. June's audit shows 100% compliance for completion of WHO for safer surgery checklist, July's data is currently being collated.

Mortality

The monthly Hospital Standardised Mortality Rate (HSMR) for May 2021 was 109.85 (Chart 8) and the monthly Summary Hospital Mortality Indicator (SHMI) for April 2021 was 81.11 (Chart 9). The HSMR has risen in month from 83.24 and work has commenced in Acute Medical Unit (AMU) with coding to improve capture of co-morbidities which increase the expectation of death so reduce the HSMR. The SHMI continues to fall. There were no deaths from fractured neck of femur in July 2021.

Chart 8: HSMR data

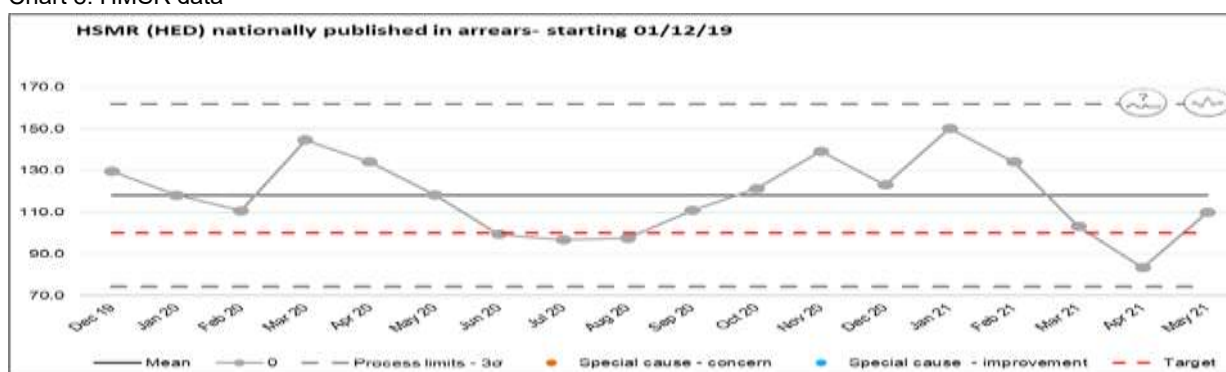
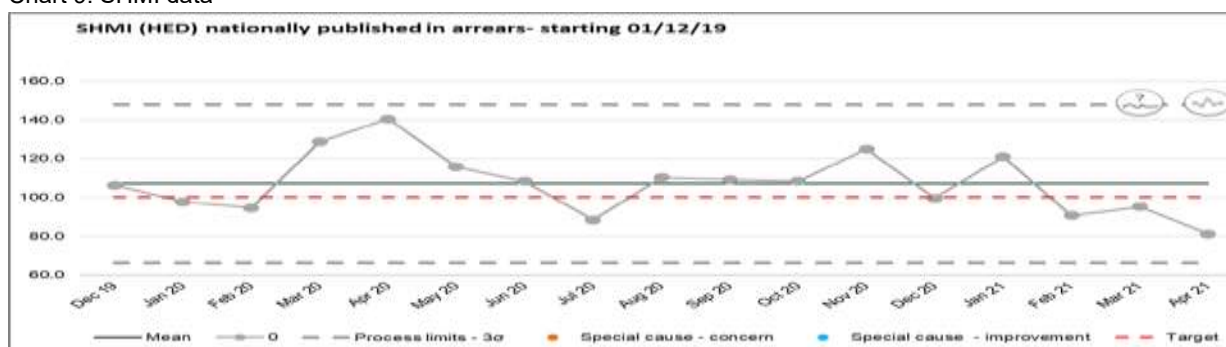


Chart 9: SHMI data



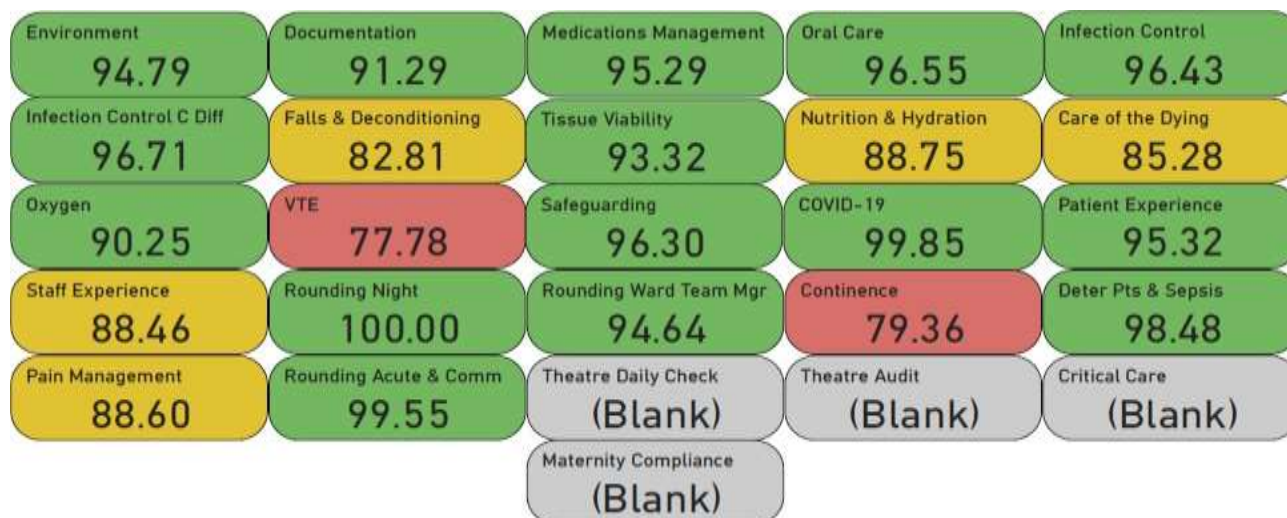
Perfect Ward

Nursing and clinical practice audits, led by matrons, are recorded and reported through the Perfect Ward system. Audit data is available at ward, divisional and a corporate level. Work is planned with RWT to align audits and ensure the audit questions are designed to measure the appropriate elements of clinical practice and ensure action planning and changes to practice are made where required and embedded in practice.

Areas of reduced compliance for July 2021 Perfect Ward data continue to be falls, continence and VTE. Steering groups are in place with actions being taken and progress monitored to enable the committee and Trust to be assured that patients are receiving harm free care (Chart 10).

A plan is currently being developed to ensure the results of audits are available in a standardised format on all wards and are reviewed and action taken at ward and department meetings. The blank results indicate audits not currently within the schedule.

Chart 10: Trust wide perfect ward audit results



3. Performance Report

The full performance dashboard is included at appendix 3. Key areas to the report are as follows:

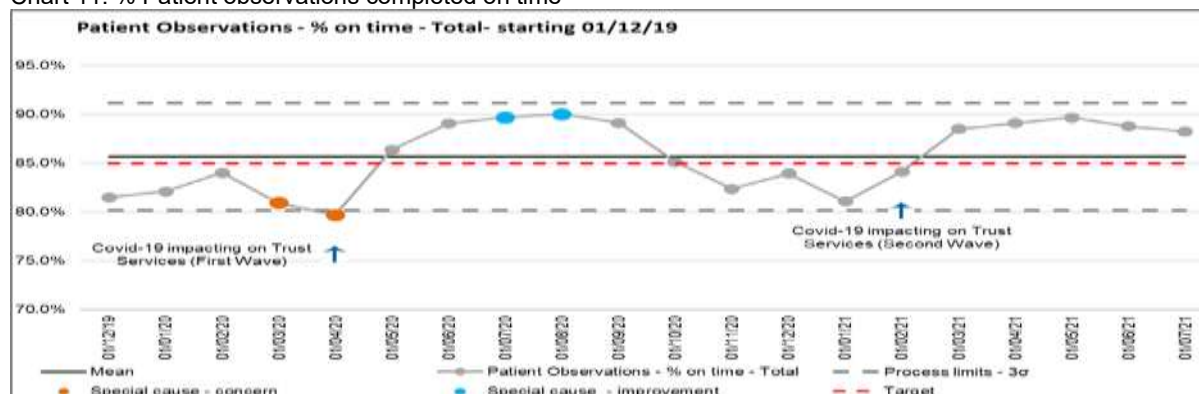
Clostridium difficile (C. diff)

Two cases of *Clostridium difficile* were identified in July 2021, which was a decrease from the 5 reported in June 2021. This takes the Trusts cumulative total for the year 2021/2022 to date to 11. In August 2021 the Trust were informed that the nationally set maximum number of cases allowed in the standard acute contract of *C. diff* is 33; The Trust has an internal maximum threshold of 29 cases. All alert organisms are reported to and monitored through the Infection Prevention and Control (IPC) committee

Percentage of observations undertaken within timeframe

The prevalence of timely observations has decreased slightly to 88.26% in month from 88.79% in June 2021 but remains above the Trust target of 85% for the fourth month running and within normal variation (Chart 11).

Chart 11: % Patient observations completed on time



21 clinical areas reported into this metric in July 2021 (a reduction from 23 in June, due to Medway issues within the Paediatric areas) of which 17 clinical areas achieved the 85% target. Areas not achieving the 85% target (3 clinical areas, table 2) have had communication via their Divisional Directors of Nursing and Matrons and improvement plans have been developed. These are monitored through the Nursing, Midwifery and Allied Health Professionals Forum and assurance to the Patient Safety Group

Mental Capacity Assessment

Audit for July 2021 shows that 70% of patients who lacked capacity had a stage 2 assessment undertaken. Discussion with patient's relatives or attorney has decreased to 54.67% (June 65.45%) of cases audited (Chart 12).

Chart 12: Audit of ReSPECT form

Qu1 Respect form filled in front of notes



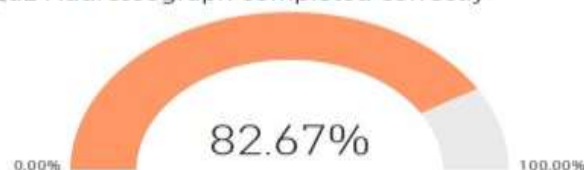
Qu3 Did patient have capacity?



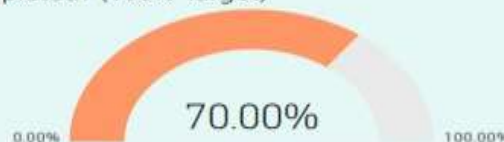
Qu5 Respect form with reasons for decision documented



Qu2 Addressograph completed correctly



Qu4 If patient lacked capacity, was a 2 stage test completed? (100% Target)



Qu6 Respect discussion with patient's relatives/attorney



Safeguarding, Prevent, DoLS, MCA and Dementia Awareness Training

Safeguarding Adult and childrens levels 1 and 2 training remain above trust target. Level 3 training remains under target for both adults and children (Charts 13,14,15,16,17 & 18).

A review of ESR has been undertaken to ensure only staff required to undertake level 3 training in line with the Intercollegiate Guidance have this recorded on their record.

Divisions have been requested to share their plan for achieving compliance with level 3 training at the September Safeguarding Committee.

Chart 13: Safeguarding children level 1

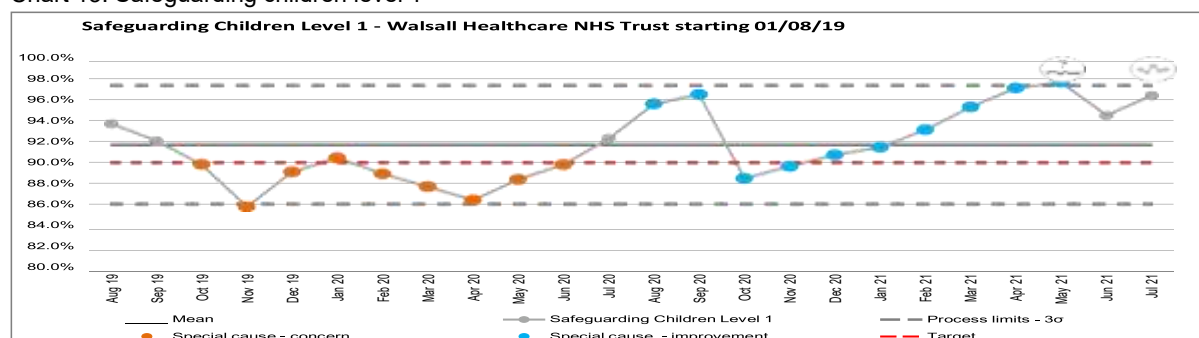


Chart 14: Safeguarding children level 2

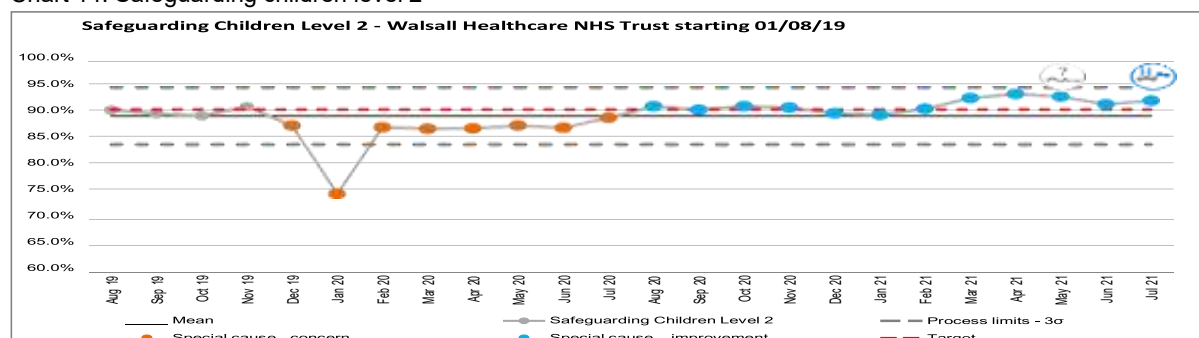


Chart 15: Safeguarding children level 3

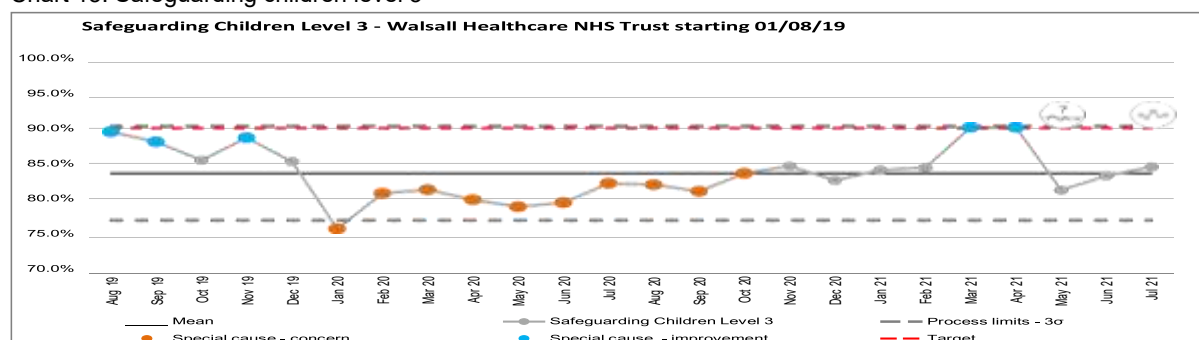


Chart 16: Safeguarding adults level 1

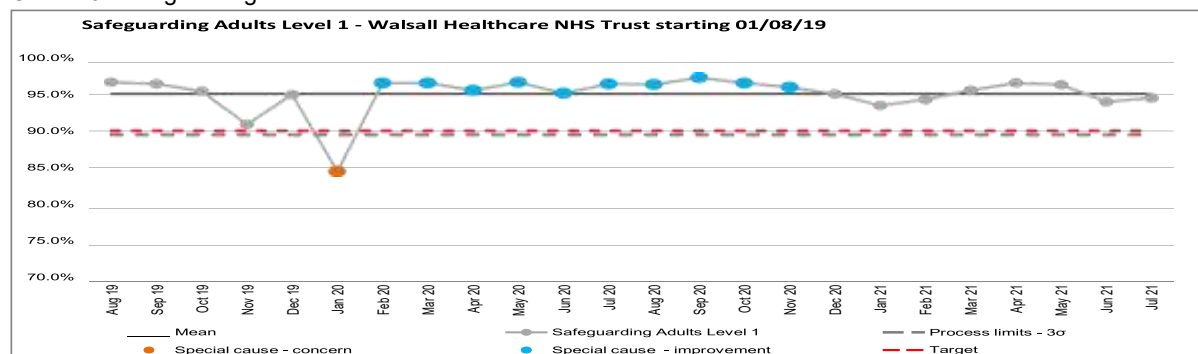


Chart 17: Safeguarding adults level 2

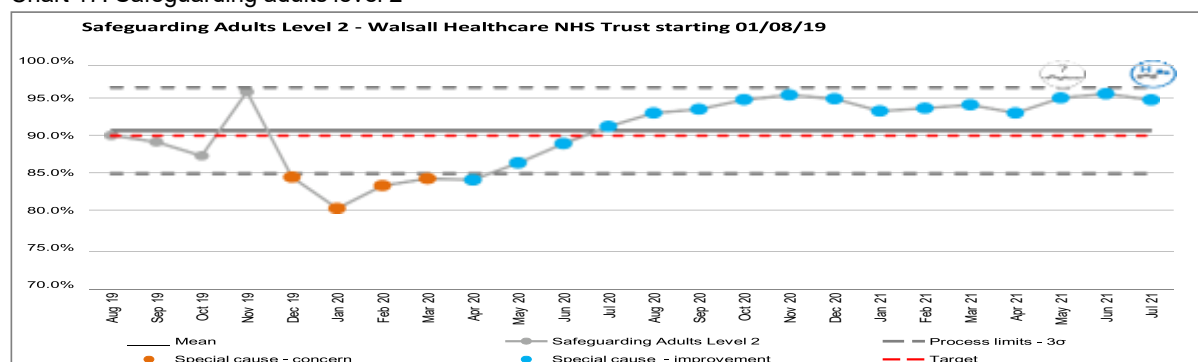
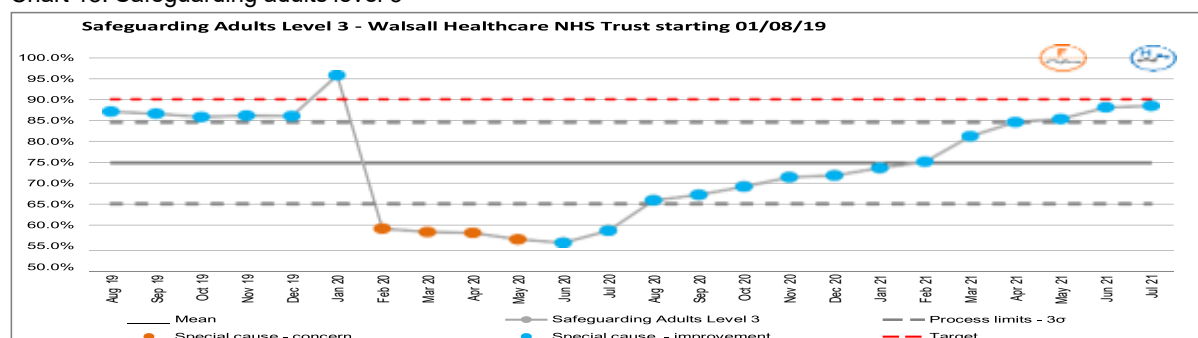


Chart 18: Safeguarding adults level 3



4. Care Excellence

Safe Staffing

125 international nurses will join our teams across the Trust before the end of December 2021. The first two cohorts are working in the Trust and are currently undertaking / preparing for their OSCEs. Two more cohorts arrive in August 2021.

Establishment reviews have been undertaken across all wards and a business case is currently being prepared to support changes to establishments based on the Safer Nursing Care Tool and professional judgment in line with nationally recognised best practice for this process.

The Trust introduced the Safe Care system for reporting patient acuity and the care hours per patient day required and those available. The Safe Care system utilises red flags recommended by NICE to

capture when there is an actual or potential risk of harm to patients. Wards can place alerts which can be remotely reviewed, and the actions taken to mitigate the risks can be documented.

Red flags

Nursing areas have use of the Safecare system which can report Red Flags- recommended by NHSi. Red Flag events are shift by shift alerts which warn when nurses in charge must act immediately to ensure they have enough staff to meet the needs of patients – these include patients not being provided with basic care such as pain relief, vital signs not assessed, unplanned missed medications and a shortfall of >8hrs or 25% of RN time compared to actual requirement for the shift (NICE 2014).

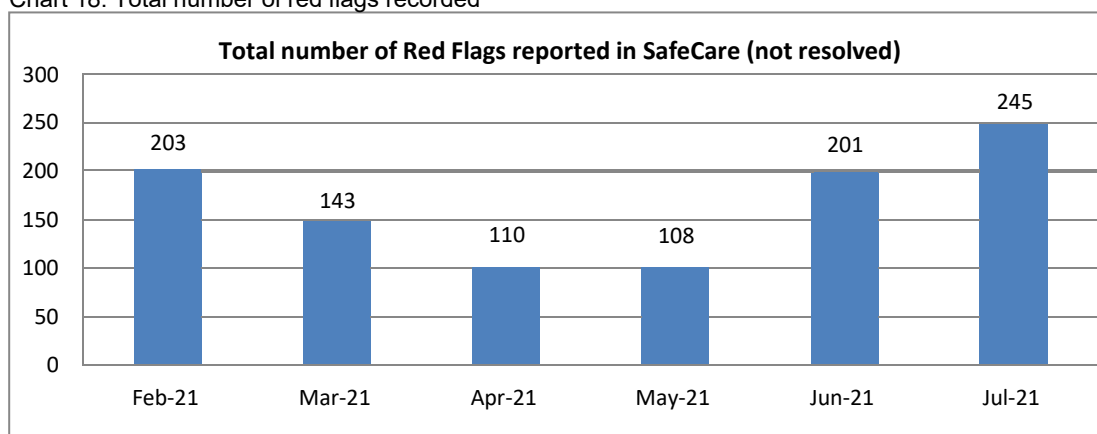
In July 2021:

- There were 245 open Red Flags which is 44 more than June.
- The majority of Red Flags continue to be recorded on weekdays (72%).
- 30% of Red Flags were recorded for the reason of 1 to 1 not covered, 19% recorded for 50% or more of RN duty is temporary staffing, this flag was removed on the 26th July 2021 in order for only the national red flags to be used. 88 red flags were resolved and closed for July, a decrease of 40 closed flags compared to June, these are reported separately to the total figures.

The 3 Red Flags with the highest number of reports were

- Patients require 1-1, needs not met = 73
- 50 or more of RN is temporary staffing = 45
- Increase in Acuity = 33

Chart 18: Total number of red flags recorded



Work continues to cross reference Red Flag dates with any incidents that were raised in Safeguard on the same date. Whilst it is evident that there is some correlation to dates, a robust approach to examining the impact of Red Flags is suggested as an inclusion in local RCA investigations into incidents where there is patient harm. Cross referencing in this report does not confirm a correlation between Red Flag and incident reported. Communication has taken place with ward teams to ensure incidents are reported are when red flags cannot be closed or mitigated.

The increase in red flags in ward areas for July correlates with pressures through the organisation with staffing due to higher levels of sickness and absence. All red flags are reviewed in the matron

morning staffing meeting and actions taken to mitigate risk, ie. Use of cohorted bays where 1 to 1 supervision cannot be provided.

5. Divisional escalations from Patient Safety Group

Medicine and Long-Term Conditions (MLTC)

- Trainees raised concerns in relation to the poor behaviours of some of the staff within the AMU, having repercussions on their ability to work effectively together, particularly from some members of the team. A review of these concerns is due to commence in the next few weeks.

Women's, Children & Clinical Support Services

- Consultant radiologist staffing - An unprecedented sickness absence coupled with unfilled vacancies has impacted the Imaging Department service provision i.e. reporting, ultrasound, interventional procedures, MDT cover. Division is working closely with colleagues from The Royal Wolverhampton NHS Trust on mutual aid to support. Additional image reporting is being outsourced where appropriate to manage patient backlog.
- Critical Trust system support infrastructure for PACS / Clinical Systems Management Team under resourced. Ongoing issues with operationalisation of the recently replaced PACS system across services. Weekly meetings with GE Healthcare (Supplier) now scheduled to ensure issues are managed going forward.
- Maternity staffing remains amber / red due to a high level of maternity leave and there is a joint plan underway to recruit with RWT. Mitigation is via the maternity escalation policy, use of bank and agency staff with oversight via daily staffing huddle. An enhanced bank rate for midwives has been agreed until the end of September 2021.

Surgery and Critical care

- Surgery is working alongside the WCCSS division to plan for a surge in paediatric respiratory patients.
- All elective theatres reinstated alongside weekend operating.
- Less than 14 days breast appointment are being maintained.
- Urology stent register - Weekly monitoring/validation of the stent register continues with Urology medical staff (Clinical Nurse Specialist in absence of medical staff).

Community

- Community recruitment day took place on Saturday 24 July 2021. 12 full time community nurses recruited, including 4 full time health Visitors which will get the service to full establishment by October 2021.
- A focus on the recognition of sepsis is taking place within community services which includes, how to identify deterioration & sepsis. An associated action plan is being worked through with the teams.

End of Report

Appendices

Appendix 1

Safe High-Quality Care BAF

Appendix 2

Corporate risk register

Appendix 3

Performance Dashboard

Risk Summary																												
BAF Strategic Objective Reference & Summary Tile:		BAF SO 01 - Safe, High Quality Care; We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.																										
Risk Description:		The Trust fails to deliver excellence in care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.																										
Lead Director:		Director of Nursing/Medical Director.																										
Lead Committee:		Quality, Patient Experience & Safety Committee.																										
Links to Corporate Risk Register:	Title:																										Current Risk Score Movement:	
	208 - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks. (Risk Score = 12). 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). 2398 - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12). 2437 - Service wide impact as a result of the risk of CYP are being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Internal factors). (Risk Score = 20). 2439 - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Risk Score = 20). 2475 - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services. (Risk Score = 25). 2540 - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems. (Risk Score = 16).																										Likelihood = 5 Consequence = 5 = 25 High ↑	
																											Forecasted Risk Score Movement for Q2:	
																											Likelihood = 5 Consequence = 5 = 25 High ↔	
Risk Appetite																												
Status:	Averse	Averse					Cautious					Balanced					Open					Hungry						
Appetite Score:	< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25		
Tolerate Score:	< 9																											
Risk Scoring																												
Quarter:	Q1 2021/22	Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:						
Likelihood:	3					3		- Risk score increased in line with worst case scenario SHQC risk, Mental Health Act (ID 2475) with a risk score of 25. - The Trust's Quality Strategy is evolving to address the emerging priorities from reviews of systems, process and services.										Likelihood:		2		31 December 2021						
Consequence:	5					5												Consequence:		5								
Risk Level:	15 High					15 High												Risk Level:		10 Moderate								

				• A review of the process for ensuring lessons learnt from incidents and patient feedback is embedded in practice is under way. • A CQC Assurance Oversight Group has been established to ensure compliance with all CQC must and should do actions. • The Trust is an early adopter site for the new patient complaint standards and will be rolling these out with additional support from the national team over the coming months. • A number of clinical guidelines policies and procedures are out of date. The Trust has a clear plan for reviewing and updating these. • Potential to breach statutory requirements under the Mental Health Act due to inconsistent knowledge and application of Trust Policy. • Evidence that safeguarding training is not embedded in practice with staff not recognising potential or actual abuse, reporting and escalating in a consistent manner. • Substantive staffing levels are below those agreed in establishment reviews to deliver safe, high quality care resulting in high usage of temporary staff.		

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	• Clinical audit programme & monitoring. Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels. • Central staffing hub co-ordinating nurse staffing numbers in line with acuity and activity arrangements with staff re-deployed across clinical units and divisions as required to maintain safe staffing levels • Safety Alert process in place and assured through QPES. • Perfect Ward app allows local oversight of key performance metrics. • Freedom to speak up process in place, reporting to the People and organisational development	• Patient Experience group in place. • Governance and quality standards managed and monitored through the governance structures of the organisation, performance reviews and the CCG/CQC. • Learning from death framework supporting local mortality review. • Faculty of Research and Clinical Education (FORCE) established to promote research and professional development in the trust.	• CQC Inspection Programme. • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM). • External Performance review meetings in place with NHSEI/CQC/CCG.

	- committee. - Covid-19 SJR undertaken for all deaths process of assurance for lessons learnt developed. - CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital. - Weekly CQC Action Plan oversight meeting in place. - Improvement programme in place to oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality Care. - Support to safeguarding team in place from RWT - Safeguarding Committee meetings increased to monthly - International Registered Nurse recruitment underway with 200 recruits expected by the end of 2021		
Gaps in Controls:	- Performance targets not being met for all activities, including complaints, Mental Capacity Act compliance and VTE assessments. - Out of date clinical policies, guidelines and procedures. - Training performance not meeting set targets. - Quality Impact Assessment process requires embedding within the trust. - Sepsis audit frequency and performance. - CQC rating of 'Requires Improvement' in 2019; Medicine rated as 'Inadequate' in May 2021 report. - NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required. - Dementia screening performance. - Failure to demonstrate compliance with terms of the Mental Health Act.		
Assurance:	Process in place through ward, business unit and divisional reviews and sub-committees of QPES to confirm and challenge and gain assurance with overarching report and assurance at QPES.	- Patient priorities for 2021 identified which aim to improve patient experience. Assurance of impact via patient feedback. - Learning Matters Newsletter published monthly - Fortnightly assurance meeting with CQC and CQRM meeting with CCG.	- NHSEI and CCG reviews of IPC practice in ED and Maternity have not highlighted any immediate concerns. - NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of social distancing, Patient/Staff screening and PPE Guidance. - Quality Review 6 monthly reviews in place with NHSEI/CQC.
Gaps in Assurance:	- Some CQC 'MUST' and 'SHOULD' do actions remain outstanding. - Inconsistent evidence, both through quality governance structures and performance reviews, of practice having changed as a result of learning from adverse events. - Lack of assurance regarding equality, diversity and inclusion and actions to reduced inequalities.		

- Lack of evidence of risk assessments and quality impact assessments relating to staffing contingency planning and/or activity changes.
- Lack of robust strategic approach to ensuring effective patient/public engagement and involvement.
- Lack of clinical engagement and leadership oversight of the Quality Governance agenda.
- Lack of assurance regarding dementia screening data collection process.
- Lack of assurance internally and externally regarding staff ability to recognise, report and escalate safeguarding concerns

Future Opportunities

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

Future Risks

- Ongoing impact of Covid-19 plus additional significant time pressured programmes of work such as COVID vaccination, staff testing, etc. Communications across the organisation to share programme objectives.
- Performance targets not being met for all activities, including Mental Capacity Act and VTE.
- Sepsis audit frequency and performance.
- NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required.

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Define action plan for addressing lack of assurance around provision of services in line with requirements of Mental Health Act	Medical Director	01/10/2021	Risk included on corporate risk register in May 2021. Action plan in place. 14/07/2021 - Business case in development to ensure adequate resource to Mental Health team. To be presented to PFIC July 2021. If approved recruitment will take approx. 3 months. Due date re-aligned to reflect this process	
2.	Develop a Clinical Audit Strategy and Policy	Director of Governance	01/08/2021		
3.	Oversight of progress to address out of date policies and procedures will be strengthened via the Clinical Effectiveness Group which be reflected in the revised terms of reference	Medical Director	01/04/2021	Complete - Terms of reference agreed through Clinical	
4.	NHSEI re-inspection of cleanliness and IPC practice in maternity services	Director of Nursing	31/06/2021	NHSEI IPC inspection is booked for 22.06.2021. Report expected end of w/c 12.7.2021. Feedback on the day very positive with no significant concerns. Review undertaken and report received	
5.	Further develop processes to provide assurance that lessons learnt from adverse events	Medical Director/ Director of Nursing	03/09/2021	Scoping of new ward performance boards continues.	

6.	Development of Patient Engagement and Involvement Strategy	Patient Experience Lead / Lead for Patient Involvement	30/09/2021	Work ongoing.	

7.	Review of dementia screening data collection process. Initial deep dive completed. Scoping of improvement options commence April 2021	Director of Nursing	30/09/2021	Scoping of improvement options complete; documentation options still under consideration. Collaboration with RWT to review resources, share best practice and where possible align documentation and process. 14.07.2021 - Monthly audit in place and demonstrates improved compliance with dementia screening. Work is underway to review documentation across WHT and RWT to align. Due date re-aligned to reflect this work	
8.	Develop Maternity Services BAF	Interim Director of Nursing	30/12/2021	Ongoing review.	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels	Substantive staffing levels are below the agree safe staffing levels for wards and departments leading to the potential for avoidable harm Lack of skilled registered nurses/midwives on a shift by shift basis leading to: _Poor patient experience leading to increase in complaints, increase in PALS referrals _Increase in episodes of harm, including falls, pressure ulcers, deconditioning, dehydration and malnourishment, loss of continent function; potential increase in incidents/SI's _Increased stress and poor staff morale caused by suboptimal staffing levels _Increased reliance on temporary staffing which has a potential negative impact both financially and to the ward/department skill mix	Caroline Whyte	15	- Development of two staffing hubs manned by the Nursing Team - one for general areas and one for Critical Care. These hubs will oversee the deployment of staff across all Professional Groups. 17/6/20 the staffing hub is no longer required as the staffing position is currently stable. If COVID demand increases then the hub will be reinstated 20/10/20 - staffing hub for nursing reinstated 13/07/2021 - staffing hub remains in place - Community Teams reviewing and adjusting caseloads as required. Roster sign off reduced to two weeks for the next three months. Use of bank/agency to cover short term gaps. Block booking in place for Critical Care. - Deployment of Corporate Nurses at times of high pressure. 17/6/20 - Roster sign off timelines returned to normal, critical care bookings no longer required to previous level as ITU capacity remains stable - Increased use of Volunteers and Administration roles to complete tasks to free up Registered Nurses to deliver direct patient care. 17/6/20 Volunteer support no longer required to initial levels **See Risk	- Daily reviews of staffing levels by Ward, - Monitoring of the number of patient harm incidents reported. - Monitoring of the number of complaints, whistle blowing and freedom to speak up concerns raised. 6 Monthly review and annual management board sign off of Nursing/Midwifery establishments to ensure appropriate planned staffing levels. - Daily review of staffing numbers by ward and moving staff to support areas of short staffing. - Identification of essential training required to maintain competence and	

Walsall Healthcare Risk Register

safety (COVID-19). Use of bank/agency staff to support essential training. 17/6/20 - training completed at height of COVID demand -not currently Assessment attached	• Overview of compliance levels at Performance Meetings. Rapid response to falls in levels of essential role based training.	required



Walsall Healthcare Risk Register

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

Action Plan				
Start Date	Action Details / Description	Owner	Reminder Date	Target Date
26/03/2020	Continued proactive recruitment strategy 16/3/21 international recruitment process in progress with first recruits expected April 2021; corporate nursing working collaboratively with HR to ensure we are continually reviewing our retention plans with the aim that we achieve as close to zero vacancies for RNs and CSWs by Q4	Lisa Carroll	26/12/2021	31/12/2021
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly. 16/3/21 -The hub is well established and the staffing meetings will continue post COVID. The risk regarding temporary staffing usage is predicted to reduce as the international nurses join establishments. Additional capacity areas have closed reducing the staffing demand - areas closed are Wards 10 and 14 and additional beds on Ward 4 have also closed	Caroline Whyte	26/12/2021	31/12/2021
01/06/2021	Establishment review in conjunction with RWT commenced 1/6/21	Lisa Carroll	26/07/2021	31/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2475	The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.	The Trusts inability as a Mental Health (MH) provider to comply with its legal & moral responsibilities of the MH provider status, as well upholding the MHA Code of Practice, has the potential for: > Individuals who require mental health services to; o Not be effectively or safely treated which could ultimately lead to a lack of appropriate admission for individuals in need of urgent care/an increase in avoidable harm, o Not have their civil rights upheld as patients may be detained illegally (due to no section/appropriate beds), > Staff; o To face verbal abusive, physical violence, & aggression, resulting in emotional distress &/or physical injuries, o To treat individuals unlawfully without such	Jodie Kirby	25	• Staffing Resource - To ensure that MH services within the Trust meet our strategic objectives. 3 year MH Strategy underdevelopment to include longer term strategic objectives. This includes the identification of additional MH trained resource required. knowledge, due to		

Walsall Healthcare Risk Register

Standard MH Training - To ensure that all policy & processes

changes have been captured, so that training material is up to date & reflects the current processes.

A review of the Standard MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover changes made. Evidence of this is stored [location] of the actions taken.

Standard MH Training Reporting - To ensure all staff have accessed the Standard MH Training & that they go through refresher training schedules at least yearly.

On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all staff required to complete the Standard MH Training within each relevant ward, against the

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken. • Local Reporting - To ensure daily MH admissions are recorded & reported accurately. On a daily basis when the Matrons conduct their ward visits, they record if anybody have been detained or admitted under the MHA. Where records identify this finding, this data is passed to MH Reporting Administrator/Manager [job title TBC] [Further detail required - To understand where we have patients on a 5-2 or a 17 leave. Who, what, when, how, why, exceptions, evidence]. • External Reporting - To ensure quarterly MH admissions are recorded & reported accurately. On a quarterly basis the MH Reporting Administrator/Manager [job title TBC] will conduct validation checks to ensure that the MH admissions recorded across the Trust mirrors up with [further detail required - To manage & monitoring the MH data for audit purposes to be sent to CQC quarterly. Who, what, when, how, why, exceptions, evidence].		
Action Plan							
Start Date	Action Details / Description				Owner	Reminder Date	Target Date
08/02/2021	The SLA agreement needs to be within the 1 hour response time for MH patients, at present due to insufficient staffing levels within MHLS.				Matthew Lewis	25/07/2021	30/07/2021
08/06/2021	JK has escalated to Exec level and discussed options to collate the information. To have an agreed and embedded process for reporting and auditing all the Mental Health Act detentions that happen within WHT.				Jodie Kirby	22/08/2021	27/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
31/05/2021	Lead Nurse for Mental Health and the OPMHLT are developing mental health act awareness training and this will be rolled out over a period of several weeks. This will be for staff at all levels across the trust . Training dates will commence from June 2021.		Jodie Kirby			26/08/2021	31/08/2021
12/05/2021	Lead Nurse for Mental Health will review the policy and escalate to exec level the difficulties in access to the MHA administrator - for joint update of the policy.		Jodie Kirby			25/07/2021	30/07/2021
	Plan to work with RWT to review MHA policy.						
08/06/2021	To complete a review of the MHA SLA and governance process that WHT are responsible for .		Jodie Kirby			15/07/2021	20/07/2021
	To feedback to the Executive lead for mental health the suggested staffing / resource required to ensure the MHA code of practice is adhered to and the MHA law is upheld.						
22/06/2021	To Review the increase in CAMHS/LD admissions and identify the risks . Lead for Mental Health to devise and action plan and a GAP analysis to the Executive Lead for mental health to support an action plan for safe practice.		Jodie Kirby			01/08/2021	06/08/2021
04/07/2021	WHT must have access to ligature cutters, training and process/ policy to support staff in the event that ligature cutters would be required.		Jodie Kirby			25/07/2021	30/07/2021
08/06/2021	It was agreed through the patient safety group that funding would be provided for appropriate training for security and staff.		Jodie Kirby			25/08/2021	30/08/2021
08/06/2021	A full review of all Mental Health Policies and an action plan to be completed with trajectory of when the policies will be completed .		Jodie Kirby			Closed 24/07/2021	29/07/2021
25/05/2021	To update the incident report system safeguard to enable Mental Health incidents to be coded correctly, this will allow WHT to generate reports and have a clear picture of MH incidents trust wide.		Jodie Kirby			Closed 22/07/2021	27/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2587	Not having sufficient staffing levels available to support the release for fit testing in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19).	The Trust does not have sufficient staffing levels available to fully support the necessary capacity of required staff that are undertaking aerosol-generating procedures (AGP) or present within the area where AGP's are taking place, for the release of fit testing in a timely manner (30 minutes if they pass first time, 60 minutes+ for retests). This leads to an increase of staff being at harm to substances (e.g. COVID-19), due to not having availability to be fit tested for sufficient respiratory protective equipment (RPE; disposable FFP3 respirators, reusable FFP3's, PAPR devices) on at least two different masks (ideally three following updated resilience principles & performance measures from the DHSC), that would reduce the dependency on one mask & reduce the	Lisa Carroll	20			

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		risk of skin damage & other conditions linked to extended PPE use, whilst allowing users to build familiarities with several types of RPE. > Patients & Staff Risk - Of developing disease as a result of inhalation of harmful substances, disease spread, associated illness, skin damage &/or other conditions, mortality. > Trust Risk - Of depleted staffing numbers as a result of high sickness absence & associated reliance on bank/agency staff. Failure to meet COSHH requirements & DHSC performance measures resulting in Regulatory scrutiny & punitive action. Increased risk of liability claims & dissatisfaction as a result of failing to adequately protect staff/patient health.					
Action Plan							
	Start Date	Action Details / Description		Owner		Reminder Date	Target Date

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
16/07/2021		Develop an implementation plan to increase the number of masks an individual is fit tested too & ensure the different masks are available to the user to wear interchangeably.			Ann-Marie Cannaby	/ /	16/07/2021
16/07/2021		Support a fit testing solution plan to enable all existing staff & new staff who will be users of FFP3s, to be released for fit testing.			Ann-Marie Cannaby	/ /	16/07/2021

Clinical Quality and Key Performance Review - Monthly Report

National Key Performance Indicators 1																		Method of Measure	Consequence of Breach	Sanctioned Applied
E.B.3	RTT Waits within 18 weeks from Referral for Incomplete Pathways		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	Where the number of Service Users waiting more than 18 weeks at the end of the month exceeds the tolerance permitted by the threshold, £300 in respect of each such Service User above that threshold	Monthly	
	Total	Month %	52.50%	61.06%	68.66%	74.03%	74.97%	72.69%	69.82%	66.82%	68.72%	68.24%	70.89%	71.91%		92%				
	CARDIOLOGY	Month %	99.75%	100.00%	98.82%	93.77%	97.51%	97.47%	93.02%	94.25%	96.46%	98.89%	99.70%	100.00%		92%				
	CARDIOTHORACIC SURGERY	Month %			100.00%	100.00%	100.00%	88.89%	94.44%	100.00%	76.47%	92.31%	77.78%	90.00%		92%				
	DERMATOLOGY	Month %	51.64%	56.04%	60.02%	51.70%	68.57%	70.75%	69.29%	66.07%	72.07%	70.94%	74.81%	90.30%		92%				
	ENT	Month %	49.23%	55.47%	61.83%	67.12%	66.81%	62.16%	60.50%	55.76%	58.20%	59.20%	62.83%	64.18%		92%				
	GASTROENTEROLOGY	Month %	91.44%	96.63%	96.65%	92.78%	95.39%	88.22%	83.14%	84.62%	87.37%	87.39%	91.73%	93.38%		92%				
	GENERAL MEDICINE	Month %	86.67%	100.00%	94.65%	94.48%	66.67%	100.00%				90.11%	97.37%	97.32%		92%				
	GENERAL SURGERY	Month %	45.62%	56.18%	59.84%	61.63%	58.11%	49.52%	44.95%	39.17%	40.38%	41.71%	45.48%	46.69%		92%				
	GERIATRIC MEDICINE	Month %	100.00%	97.40%	98.89%	97.93%	93.71%	88.44%	91.67%	88.75%	91.97%	90.11%	97.37%	97.32%		92%				
	GYNAECOLOGY	Month %	77.41%	86.88%	92.10%	91.59%	92.21%	92.34%	89.64%	86.01%	83.31%	82.18%	82.42%	81.36%		92%				
	NEUROLOGY	Month %	92.99%	94.15%	99.44%	97.19%	96.60%	92.95%	84.92%	75.00%	75.00%	76.97%	84.03%	82.86%		92%				
	OPHTHALMOLOGY	Month %	30.61%	43.05%	57.95%	75.63%	78.19%	74.31%	68.52%	68.99%	70.39%	67.73%	71.21%	72.43%		92%				
	ORAL SURGERY	Month %	24.13%	47.31%	39.76%	51.10%	51.19%	51.56%	55.73%	60.45%	65.90%	67.82%	69.04%	66.05%		92%				
	Other Nec	Month %	69.18%	77.83%	84.31%	87.29%	87.08%	85.59%	82.89%	81.70%	81.99%					92%				
	PLASTIC SURGERY	Month %	56.52%	79.41%	76.74%	87.67%	89.33%	79.57%	78.85%	59.48%	57.14%	63.20%	64.49%	59.38%		92%				
	PODIATRIC SURGERY	Month %			100.00%	100.00%	100.00%					83.33%	83.33%	80.00%		92%				
	RESPIRATORY MEDICINE	Month %	67.80%	84.05%	81.27%	81.30%	93.30%	87.61%	86.60%	78.41%	81.28%	79.14%	78.83%	77.84%		92%				
	RHEUMATOLOGY	Month %	81.32%	82.12%	88.92%	87.61%	84.99%	78.56%	75.83%	69.04%	65.62%	57.01%	57.85%	55.90%		92%				
	THORACIC SURGERY	Month %	57.14%	100.00%												92%				
	TRAUMA AND ORTHOPAEDICS	Month %	26.26%	39.29%	50.63%	63.33%	65.19%	61.54%	57.15%	50.93%	54.40%	51.21%	54.88%	57.93%		92%				
	UROLOGY	Month %	46.58%	54.67%	58.31%	62.36%	59.95%	59.70%	59.09%	55.55%	54.63%	52.61%	54.88%	56.49%		92%				
	RTT Waits - PTL Waiting List		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly	
	Total		Month Num	12598	13458	15066	17931	18822	19683	19693	20122	20970	21121	21989	22349					
	18 Weeks RTT - PTL Forecast		Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021		21/22 YTD	Annual Target				
	Total		Month Num		13523	13935	14130	14415	19438	18761	18029	17397	20300	19900	19500					
E.B.4	% of Service Users waiting 6 weeks or more from Referral for a Diagnostic Test		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	Where the number of Service Users waiting 6 weeks or more at the end of the month exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Monthly	
	Total	Month %	16.32%	18.24%	14.70%	12.35%	17.92%	15.53%	4.87%	1.45%	1.12%	1.72%	1.04%	0.96%		1.00%				
E.B.5	A&E Attendances Admitted, Transferred or Discharged within 4 hours of Arrival		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	Where the number of Service Users in the month not admitted, transferred or discharged within 4 hours exceeds the tolerance permitted by the threshold, £120 in respect of each such Service User above that threshold. To the extent that the number of such Service Users exceeds 15% of A&E attendances in the relevant month, no further consequence will be applied in respect of the month	Monthly	
	Total	Month %	95.43%	91.88%	83.50%	73.00%	78.27%	79.29%	69.28%	84.60%	93.72%	91.78%	91.18%	90.42%		95.00%				
		Cumulative %	92.17%	92.09%	93.50%	87.59%	86.39%	85.77%	85.57%	83.97%	85.07%	91.78%	90.79%	91.09%		95.00%				

Clinical Quality and Key Performance Review - Monthly Report

National Key Performance Indicators 2																	Method of Measure	Consequence of Breach	Sanctioned Applied
E.B.6	Cancer Suspected seen within 2 weeks of referral for First OP Appt		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(42/615)	(55/786)	(51/642)	(112/834)	(147/829)	(201/875)	(208/945)	(177/713)	(160/782)	(276/1051)	(188/865)	(234/913)			
			Month %		93.17%	93.00%	92.06%	86.57%	82.27%	77.03%	77.99%	75.18%	79.54%	73.74%	76.27%	74.37%	76.27%	93.00%	
E.B.7	Cancer Not Suspected Breast Symptoms seen within 2 weeks of referral for First OP Appt		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than two months during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(3/33)	(3/46)	(6/37)	(12/44)	(4/23)	(21/37)	(47/65)	(25/48)	(31/73)	(39/55)	(55/68)	(46/67)			
			Month %		90.91%	93.48%	83.76%	72.73%	82.61%	43.24%	27.69%	47.92%	57.53%	29.09%	19.12%	31.34%	25.19%	93.00%	
E.B.8	Cancer within 31 days from Diagnosis to First treatment		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(3/51)	(1/60)	(0/53)	(6/79)	(2/80)	(2/83)	(0/77)	(0/69)	(2/88)	(0/76)	(1/57)	(1/81)			
			Month %		94.12%	98.33%	100.00%	92.41%	97.50%	97.59%	100.00%	100.00%	97.73%	100.00%	98.25%	98.77%	98.55%	96.00%	
E.B.9	Cancer Subsequent Treatment within 31 days for Surgery		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(0/15)	(0/12)	(0/4)	(1/10)	(1/7)	(0/7)	(0/10)	(0/14)	(0/9)	(0/17)	(0/13)	(0/9)			
			Month %		100.00%	100.00%	100.00%	90.00%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	94.00%	
E.B.10	Cancer Subsequent Treatment within 31 days for Anti Cancer Drug Regimen		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than 31 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(1/20)	(0/5)	(0/2)	(0/3)	(0/6)	(0/6)	(0/6)	(0/7)	(0/11)	(0/18)	(0/17)	(0/9)			
			Month %		95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.00%	
E.B.12	Cancer within 62 days from Urgent GP Referral to First treatment		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(4.5/21)	(7/21.5)	(10/35.5)	(14.5/45)	(17.5/50.5)	(9.5/41.5)	(6/34)	(9.5/38.5)	(14.5/44)	(10.5/38)	(8.5/33)	(12/42.5)			
			Month %		78.57%	67.44%	71.83%	67.78%	65.35%	77.11%	82.35%	75.32%	67.05%	72.37%	74.24%	71.76%	72.85%	85.00%	
E.B.13	Cancer within 62 days from NHS Screening Service to First treatment		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users in the Quarter who have waited more than 62 days during the Quarter exceeds the tolerance permitted by the threshold, £1,000 in respect of each such Service User above that threshold	Quarterly
	Total		Breaches		(0/0)	(0/0)	(0/0)	(0/10)	(1/8)	(0.5/8.5)	(2/13)	(0/5)	(1/7)	(0.5/9.5)	(1/4)	(0/6)			
			Month %					100.00%	87.50%	94.12%	84.62%	100.00%	85.71%	94.74%	75.00%	100.00%	90.00%	90.00%	
	Cancer within 62 days for First treatment following Consultant Decision to Upgrade		Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	YTD	Annual Target	Monthly CQR Report	Where the number of Service Users who have waited more than two weeks during the Quarter exceeds the tolerance permitted by the threshold, £200 in respect of each such Service User above that threshold	Monthly
	Total		Breaches		(11/33)	(6/40.5)	(3.5/19.5)	(3.5/28.5)	(5/25)	(9/35.5)	(9.5/32)	(7.5/26.5)	(6.5/37)	(4/28.5)	(2/24)	(6.5/37)			
			Month %		66.67%	85.19%	82.05%	87.72%	80.00%	74.65%	70.31%	71.70%	82.43%	85.96%	91.67%	82.43%	86.07%	85.00%	

Clinical Quality and Key Performance Review - Monthly Report

National Key Performance Indicators 3																	Method of Measure	Consequence of Breach	Sanctioned Applied																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																		
E.B.S.1	Sleeping Accommodation Breaches																Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	E250 per day per Service User affected	Monthly																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																				
	Total																Month Num	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Clinical Quality and Key Performance Review - Monthly Report

National Quality Performance Indicators																		Method of Measure	Consequence of Breach	Sanctioned Applied
E.A.S.4	MRSA Zero Tolerance		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	£10,000 in respect of each incidence in the relevant month	Monthly	
	Total	Month Num	0	0	0	0	0	0	1	0	1	0	1	0	1	0				
		Cumulative	0	0	0	0	0	0	1	1	2	0	1	1						
E.A.S.5	Clostridium Difficile Minimisation of Rates		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	As set out in Schedule 4G, in accordance with applicable Guidance	Annual	
	Total	Trajectory Num	2	2	2	3	2	2	2	2	2	3	2	2						
		Month Num	3	3	2	5	2	0	2	2	3	1	3	5	9	26				
		Trajectory Cum	9	11	13	16	18	20	22	24	26	3	5	7						
		Cumulative	13	16	18	23	25	25	27	29	32	1	4	9						
E.B.S.4	RTT Waits over 52 Weeks for Incomplete Pathways Zero Tolerance		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	£5,000 per Service User with an incomplete RTT pathway waiting over 52 weeks at the end of the relevant month	Monthly	
	Total	Month Num	9	8	14	14	37	110	324	687	768	554	445	433		0				
	18 Weeks RTT - 52 Week Breaches Forecast			Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target				
	Total	Month Num		8	12	10	8	160	199	234	750	814	881	1001						
	Ambulance Handover 15 mins or less		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly	
	Total	Month %	80.29%	79.35%	58.23%	57.04%	61.85%	57.67%	49.06%	51.04%	59.86%	60.73%	67.02%	60.43%	62.75%	100.00%				
		Month Num	2094	2160	1581	1527	1647	1646	1481	1281	1727	1752	2010	1825	5587					
		Month Den	2608	2722	2715	2677	2663	2854	3019	2510	2885	2885	2999	3020	8904					
	E.B.S.7A	Ambulance Handover 30 to 60 mins		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report	£200 per Service User waiting over 30 minutes in the relevant month	Monthly
Total		Month Num	18	39	153	194	137	156	214	55	45	59	66	87	212	0				
E.B.S.7B	Ambulance Handover 60 mins plus		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report	£1,000 per Service User waiting over 60 minutes (in total, not aggregated with E.B.S.7a consequence) in the relevant month	Monthly	
	Total	Month Num	0	5	20	66	42	19	23	0	1	11	1	3	15	0				
E.B.S.5	A&E Trolley waits no longer than 12 hours		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report	£1,000 per incidence in the relevant month	Monthly	
	Total	Month Num	0	0	1	1	2	0	1	1	2	2	2	1	5	0				
E.B.S.6	Cancelled Operations of Urgent Operations for a Second Time		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report	£5,000 per incidence in the relevant month	Monthly	
	Total	Month Num	0	0	0	0	0	0	0	0	0					0				
	VTE Risk Assessment		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report/ Qtrly Submission	Issue of Contract Performance Notice and subsequent process in accordance with GC9	Monthly	
	Total	Month %	93.67%	94.15%	89.51%	91.24%	90.93%	91.08%	90.75%	92.06%	94.45%	94.34%	93.22%	93.50%	93.67%	95.00%				
		Sepsis - % of patients screened who recieved antibiotics within 1 hour - ED													21/22 - Quarter 1	YTD	Annual Target	Monthly CQR Reporting		Quarterly
	Total	Quarter %													63.70%					
		Sepsis - % of patients screened who received antibiotics within 1 hour - Inpatients														21/22 - Quarter 1	YTD	Annual Target	Monthly CQR Reporting	
	Total	Quarter %													36.57%					
		Sepsis - % of patients screened who recieved antibiotics within 1 hour - ED (Manual Audit)			Apr 2021		May 2021		Jun 2021		21/22 - Quarter 1		YTD	Annual Target	Monthly CQR Reporting			Quarterly		
	Total	Quarter %		119/123		76/87		63/66		(258/276) 93.48%										

Clinical Quality and Key Performance Review - Monthly Report

Quality Performance Indicators																		Method of Measure	Consequence of Breach	Sanctioned Applied
Falls	Total Reported	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	57	60	42	70	65	71	74	70	51	51	52	51	154					
	Rate per 1000 Beddays	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	4.66	5.21	3.26	4.67	4.57	5.02	4.70	5.11	3.39	3.66	3.57	3.52						
	Resulting in Severe Harm or Injury : Total	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
Total	Month Num	0	3	1	2	0	1	0	0	2	0	1	0	0	1	0				
Pressure Ulcers	Rate per 1000 Beddays (Cat 2, 3, 4 & Unstageables) - Hospital	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Reporting			Monthly	
	Total	Month Num	0.90	0.72	0.49	0.85	0.53	0.75	0.63	1.07	1.24	0.91	0.92	0.73						
	Rate per 10,000 CCQ Population (Cat 2, 3, 4 & Unstageables) - Community	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Reporting			Monthly	
	Total	Month Num	0.45	0.86	0.24	0.24	0.59	0.34	0.48	0.38	0.65	0.72	0.34	0.59						
	Hospital : Cat 2, 3, 4	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
Total	Month Num	9	9	7	13	8	11	10	14	17	12	14	11							
Community : Cat 2, 3, 4	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly		
Total	Month Num	13	25	7	7	17	10	14	11	19	21	10	17							
Serious Incidents	Hospital	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	7.00	10.00	11.00	10.00	12.00	9.00	12.00	14.00	7.00	7.00	3.00	7.00	17.00					
	Community	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report			Monthly	
Total	Month Num	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00						
Never Events	Never Events	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	0	0	0	0	0	0	0	0	0	1	0	0	1	0				
	E Coli	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	3	2	3	2	1	1	6	2	2	3	5	2						
	MSSA	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
Total	Month Num	1	1	2	1	0	2	0	3	2	1	0	1							
Mortality	HSMR (HED)	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	97.08	97.75	112.24	121.95	139.63	123.47	151.02	135.08	103.95				100.00					
	SHMI (HED)	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
	Total	Month Num	89.65	111.77	108.95	106.69	121.12	97.68	118.20	89.09					100.00					
	Deaths in Hospital	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report			Monthly	
Total	Month Num	71	74	80	107	168	153	227	169	105	69	91	91	251						

Clinical Quality and Key Performance Review - Monthly Report

Quality Performance Indicators																	Method of Measure	Consequence of Breach	Sanctioned Applied
Workforce	Staff Sickness Absence Rates		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	4.28%	4.22%	4.83%	5.73%	6.13%	5.73%	4.88%	4.63%	4.08%	4.17%	4.84%	5.32%		4.50%			
	Turnover (Normalised)		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	7.15%	7.90%	9.21%	8.25%	7.98%	8.14%	7.40%	7.15%	9.30%	8.54%	9.63%	10.44%		10.00%			
	Vacancy Rates		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	6.89%	5.15%	7.75%	9.23%	10.59%	10.90%	8.73%	8.17%	7.49%	7.45%	8.59%	8.92%					
	Agency Usage		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	4.35%	4.94%	5.49%	7.62%	8.72%	8.07%	11.09%	12.08%	12.33%	7.70%	7.53%	7.13%		2.75%			
	Bank Usage		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	10.85%	10.56%	10.80%	11.34%	14.99%	13.86%	13.62%	12.73%	9.04%	10.31%	12.12%	9.64%		6.30%			
	Mandatory Training		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	85.69%	86.48%	86.50%	86.12%	86.35%	86.84%	85.99%	87.11%	89.11%	91.13%	91.29%	91.32%		90.00%			
	PDRs		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	73.53%	76.72%	74.93%	73.16%	89.74%	88.73%	87.12%	86.32%	79.81%	76.41%	72.04%	75.52%		90.00%			
Friends and Family Recommended	Inpatient		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	87.00%	88.00%	88.00%	92.00%	87.00%	85.00%	87.00%	88.00%	88.00%	87.00%	87.00%	87.00%					
	Outpatient		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	88.00%	92.00%	92.00%	92.00%	91.00%	90.00%	91.00%	92.00%	91.00%	91.00%	91.00%	91.00%					
	ED		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %	81.00%	79.00%	73.00%	75.00%	79.00%	79.00%	82.00%	84.00%	83.00%	84.00%	78.00%	78.00%					
	Community		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %							100.00%	93.00%	91.00%	96.00%	92.00%	93.00%					
	Maternity Antenatal		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %		100.00%	89.00%	59.00%	73.00%	79.00%	73.00%	71.00%	78.00%	78.00%	65.00%	78.00%					
	Maternity Birth		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %		94.00%	79.00%	87.00%	79.00%	84.00%	76.00%	84.00%	83.00%	95.00%	86.00%	69.00%					
	Maternity Postnatal		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %		86.00%	70.00%	73.00%	77.00%	78.00%	80.00%	71.00%	59.00%	93.00%	82.00%	73.00%					
	Maternity Postnatal Community		Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	21/22 YTD	Annual Target	Monthly CQR Report		Monthly
	Total	Month %		63.00%	95.00%	70.00%	60.00%	83.00%	92.00%	100.00%	79.00%	78.00%	86.00%	44.00%					

MEETING OF THE PUBLIC TRUST BOARD Thursday 2nd September 2021			
Director of Midwifery Report			AGENDA ITEM: 11
Report Author and Job Title:	Carla Jones-Charles, Divisional Director of Midwifery, Gynaecology and Sexual Health	Responsible Director:	Ann Marie Cannaby
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	- The service has maintained one to one care in labour as a focus to provide optimum safe care to women in labour despite the staffing challenges. - Update on perinatal mortality - Health Service Investigation Branch Update - Continuity of Care update		
Recommendation	Members of the Board are asked to: Review and note the contents of this report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF 1: Safe, high quality care 2066 Lack of registered nurses and midwives		
Resource implications	There are funding resource implications associated with this report that requires quantification. Support for temporary increase in maternity bank rates to incentivise staff to take up unfilled shifts.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☒	
	Resources ☒		

Divisional Director of Midwifery Report

1.0 PURPOSE OF REPORT

The purpose of the report is to provide a monthly update to assure the board in relation to:

- Activity within the maternity unit
- Midwifery staffing and acuity
- Perinatal mortality review update
- Ockenden update
- Health Service Investigation Branch update
- Continuity of Care (CoC)

2.0 BACKGROUND

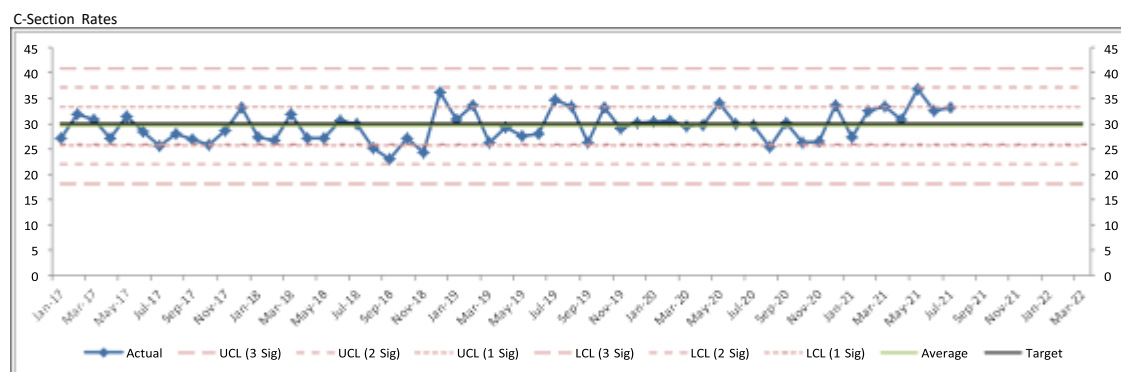
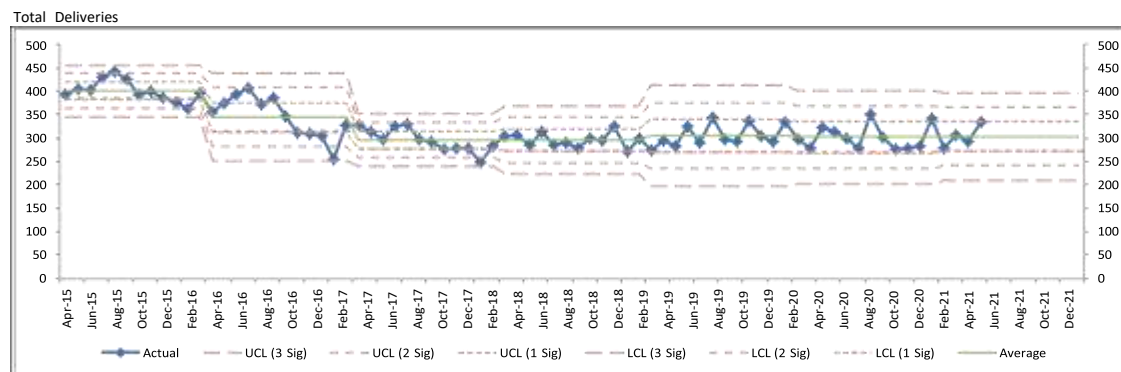
This report will update the on-going position on the key elements above by exception.

2.1 Activity within the Maternity Unit

Table one highlights the monthly activity within the Maternity Unit:

Table 1: Activity July 20 – July 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb 21	Mar 21	Apr 21	May 21	June 21	July 21
Births	314	299	279	351	301	276	279	285	342	279	307	293	334



3.0 MIDWIFERY STAFFING / ACUITY / 1:1 CARE IN LABOUR

Staffing is monitored daily and staffing deficits are managed using the maternity escalation policy. The current Trust uplift is 21%, this is to account for annual leave, sickness and training.

		Annual Leave	Other Leave	Parenting	Sickness	Study Leave	Working Day	Total
Women's Services	Delivery Suite - Nursing	11.7%	3.3%	9.4%	7.0%	1.3%	3.9%	36.6%

Acuity is monitored 6 times a day on the delivery suite and is used to assess staffing needs. The national recommendation is to strive to maintain an average acuity of 85%. The table below demonstrates average acuity over a period of a month. It illustrates that activity peaks against staffing. The service continues to use its escalation policy to mitigate staffing gaps in times of high acuity to maintain safety.

In anticipation of the 6 week school holiday and maximum levels of annual leave, the service suspended its homebirth service and brought the community midwifery team to provide 2 shifts per day to the in-patient service. The temporary suspension of home births affected 1 patient booked for a home birth in August. This lady was supported through alternative choices.

Table 2

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	June-21	Jul-21
Acuity	80%	87%	84%	83%	87%	85.2%	85%	74%	76%	87%	60%	72%	66%
1:1 Care in Labour	100%	100%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	99.3%	100%

The target is to maintain an average acuity of 85% or above.

3.1 Birth to Midwife Ratio

The unit continues to actively recruit to fill vacancies with 2 new starters commenced so far in August with another starting at the end of the month. We expect another 9 at the end of September. During August there was another 5 appointments who we anticipate will start around the beginning of November. There has been a rise in the birth to midwife ratio as the service has seen a rise in births in July and continues to support 9% parenting leave.

The national average birth to midwife ratio 1:28

Table 3: Birth to Midwife Ratio Jul 2020 – Jul 2021

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	June-21	Jul-21
Actual Ratio - Worked	32.7	30.8	28.3	37.0	31.4	28.9	27.2	29.1	34.4	29.3	30.4	32	36

4.0 Perinatal Mortality review

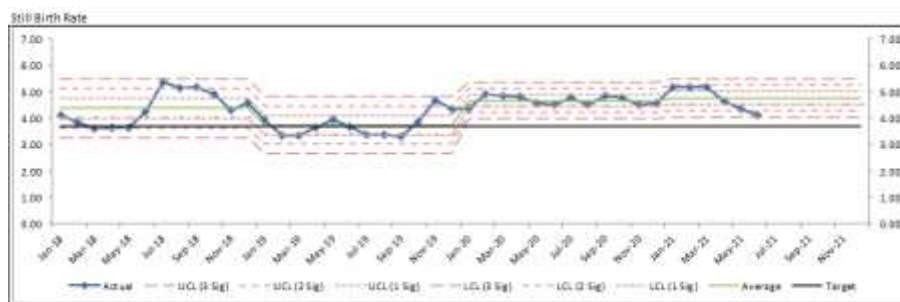
For information – Losses in Quarter 1 2021

Q2 2021	Late Fetal Loss <22/40	Late Fetal Loss 22-23+6/40	Stillbirth	Neonatal Death <22/40	Neonatal Death >22/40	Termination of Pregnancy	Total Monthly Losses	TOTAL ELIGIBLE FOR REVIEW
April	1	1	0	0	1	2	5	2
May	0	0	0	0	0	1	1	0
June	1	0	0	0	2	2	5	3
Total Loss by type	2	1	0	0	3	5	11	5

Looking at this year's data, Jan-Jun 2021: Walsall had 5 SB out of 1800 births (SB rate 2.7 per 1000). Walsall had 6 neonatal death. Therefore Extended mortality rate is 6 per 1000 (5 SB + 6 NND/1800). Please note the figures here is different to the dashboard as we include 12 months rolling data in our dashboard.

The breakdown of 6 neonatal death is as follow:

- 2 babies were < 22 weeks (pre-viability)
- 2 babies were deliver 23 and 22 weeks (extreme prematurity)
- 2 babies delivered at 34 and 36 weeks with congenital anomaly incompatible with life but declined termination of pregnancy



Key action points

	Issue	Aim	Method	Results	Evidence of improvement
1	Multi-disciplinary Team working in complex obstetric cases	To improve the MDT working in complex Bereavement cases	PMRT Lead consultants to take to Obs & Gynae Consultant meeting to discuss	- Update following meeting pending	
2	VTE & Risk Assessment at booking	Ensure VTE & Risk assessment is completed correctly at booking	Meeting with Out patient matron. Reminder to all staff and work collaboratively with other trusts in the LMNS	- Outpatient Matron has emailed all community midwives to remind them to complete assessments correctly. A failsafe has been implemented, to check VTE & Risk assessment again at 16 weeks. - Ongoing work with other trusts in the LMNS	Via Email.

5.0 OCKENDEN Update

The service has had confirmation of the Ockenden bid outcome and are working with finance to agree how the funds will be used.

The national evidence portal is now closed and the service has submitted the required information and is currently awaiting the outcome. The table below outlines the current position with regards actions from Ockenden.

Key:

	completed
	On target for completion but not complete
	Work not started.

Actions	updates			
Maternal medicine networks	Local maternity system coordination and is held at STP level	WHT working with Trusts across the Black country and the Midlands perinatal team		Sept 2021
perinatal surveillance network	Local maternity system coordination and is held at STP level	WHT working with Trusts across the Black country		Sept 2021
Formal risk assessment for women at every contact	Working with Maternity notes partners to provide the infrastructure	Engagement with current provider is on-going and is currently in test phase.		July 2021
Maternity staffing	Staffing review paper currently with Execs	Board support requested. The staffing pressures remain as the service works to recruit into the gap.		April 2021
Confirmation that monies allocated for maternity staff training is ring fenced for maternity including CNST refunds	All training funds have been allocated and last years CNST has been allocated.	CNST refunds going forward is not yet assured.		Sept 2021

All outstanding actions remain on trajectory and are monitored by the care group. The next actions are due in September and are currently on trajectory.

6.0 Health Service Investigation Branch Update

Please see table below for our Health Service Investigation Branch (HSIB) update for Walsall. The table outlines the total number of cases referred since the scheme commenced in April 2019 and the number of on-going cases for Walsall.

HSIB Cases to date	
Total referrals	22
Referrals / cases rejected	13 (2 lack of family consent, 3 did not meet HSIB criteria, 3 duplicate entries, 5 no harm on MRI scan and did not meet new HSIB COVID-19 criteria)
Total investigations to date	9
Total investigations completed	7
Current active cases	2
Exception reporting	0

7.0 Continuity of Care (CoC)

Continuity of care (CoC) trajectories timescales have been extended and revised during the ongoing COVID pandemic.

Percentage compliance has been removed and the focus is on providing CoC for vulnerable groups in the first instance.

Providing continuity of care has been a challenge during the ongoing pandemic due to COVID related staff absence and current vacancy position. The service is working on a revised action plan which will be shared with the board level safety champion, it will include plans to target vulnerable women and workforce changes to facilitate the provision of CoC.

8.0 RECOMMENDATIONS

Members of the Board are asked to review and note the contents of this report.

MEETING OF THE PUBLIC TRUST BOARD			
Thursday 2 nd September 2021			
Hospital Mortality Report (Quarter 1, 2021/22)			AGENDA ITEM: 12
Report Author and Job Title:	Dr Manjeet Shehmar Deputy Medical Director	Responsible Director:	Dr Matthew Lewis Medical Director
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	- In the last quarter, there have been 281 deaths at the Trust. A structured judgement (SJR) review has been raised for 62 deaths. In Q1, 5 SJRs have been completed. - Year to date; as assessed by SJR level 1 reviews, 40% of deaths were probably not avoidable (less than 50/50), 40% of deaths were probably not avoidable and 20% of deaths were not avoidable. - There is a backlog of notes delivered for SJRs due to a vacancy in the Learning from Deaths (LFD) coordinator post. This will be filled in September. The LFD process will be electronic from August 1st with the CORS system, which will send automated notifications for SJRs. - Learning from deaths is part of the SHQC Improvement Programme, with learning monitored via the Mortality Surveillance Group. - This paper summarises the learning and improvements as a result of the learning from deaths programme.		
	Members of the Trust Board are asked to note: - Performance data - Key areas for attention and learning		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	- BAF001 Failure to deliver consistent standards of care to patients across the Trust results in poor patient outcomes and incidents of avoidable harm - Performance against SHMI is recorded on the trust risk register - Systems and processes for the identification and learning from issues in care have been identified as ineffective by the CCG		
Resource implications	Continued employment of Medical Support Workers via the NHSI scheme to undertake SJRs until September.		
Legal and Equality and Diversity implications	- The equality and diversity implications to the trust for patients with learning disabilities are managed according to the trust policy and LeDeR recommendations. - National legislation relating to the review of child and perinatal deaths has been implemented.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Introduction

This report details:

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

1. PERFORMANCE

National Benchmarks

The Trust uses two national benchmarks as primary indicators for mortality, Hospital Standard Mortality rate (HSMR) and Standard Hospital Mortality Index (SHMI). Table 1 shows the Trust SHMI and HSMR. The appendices at the end of this report show SPC charts and benchmarks of mortality metrics.

Table 1: Trust mortality 2020-21

	HSMR	SHMI	Crude Mortality Rate
Apr-20	133.98	140.42	8.13
May-20	118.34	116.55	5.69
Jun-20	99.26	109.04	3.93
Jul-20	96.74	88.77	3.87
Aug-20	97.50	110.75	3.82
Sep-20	110.77	109.72	3.55
Oct-20	121.24	108.97	3.84
Nov-20	139.18	125.77	3.20
Dec-20	122.97	99.77	3.84
Jan-21	150.24	119.50	4.62
Feb-21	133.97	89.68	3.77
Mar-21	103.16		3.09

KEY AREAS FOR ATTENTION

Covid-19 Deaths Dashboard

There have been a total of 697 Covid positive deaths in the hospital (to 08/07/21). Covid deaths are scrutinised by the medical examiners and escalated at SJRs in line with the Learning from Deaths Policy. Any Covid deaths associated with a hospital acquired infection are reported with an incident via Safeguard.

Non Covid excess death rate

There have been 241 non Covid related deaths in Q1 2021 as compared to 197 in Q1 2020. This makes our non Covid death rate ratio 1.22. In Q1 2020, there were fewer inpatient admissions of non-Covid which is likely to explain the rates.

Table 2: Q4 Non Covid death rate 2020-2021

April 2020 - June 2020 (Non COVID deaths)	197	Death rate: 1.22
April 2021 - June 2021 (Non COVID deaths)	241	

Covid HCAI deaths

A Covid Healthcare Associated Infections (HCAI) deaths report was presented to QPES in February 2021 for deaths up to June 2020. The Trust is currently reviewing the Covid HCAI deaths from June 2020 onwards.

Mortality from Covid

The recent Intensive Care National Audit and Research Centre (ICNARC) report on mortality from Covid 19 in critical care units looked at predicted risk of dying versus observed to calculate a standardised mortality ratio (SMR). A ratio equal to 1 indicates that the 28 day in hospital mortality rate is the same as that of the predicted model based on demographics and co-morbidity predictors of dying. The figures below show funnel plots with 2 and 3 standard deviations of the comparator level of 1 for admissions before August 202 and then from September to December 2020. Walsall Healthcare's SMR is well within the control limits (so not an outlier) although slightly above 1.0.

Figure 1: Risk adjusted 28 day hospital mortality for patients critically ill with confirmed Covid 19 admitted up to 31st August [ICNARC report on Covid 19:risk adjusted outcomes by critical care unit March 2021].

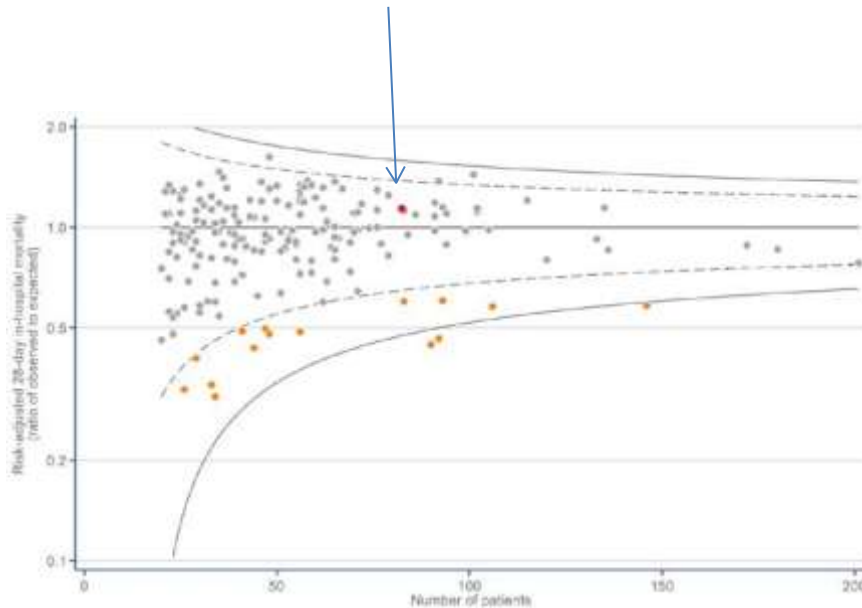
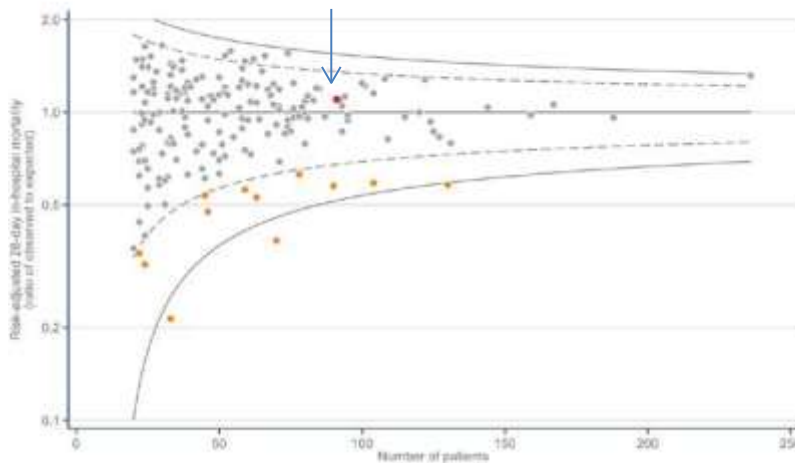


Figure 2: Risk adjusted 28 day hospital mortality for patients critically ill with confirmed Covid 19 admitted from 1st September 2020 to 31st December 2021 [ICNARC report on Covid 19:risk adjusted outcomes by critical care unit March 2021].



LEARNING FROM DEATHS

Process for reviewing deaths in hospital

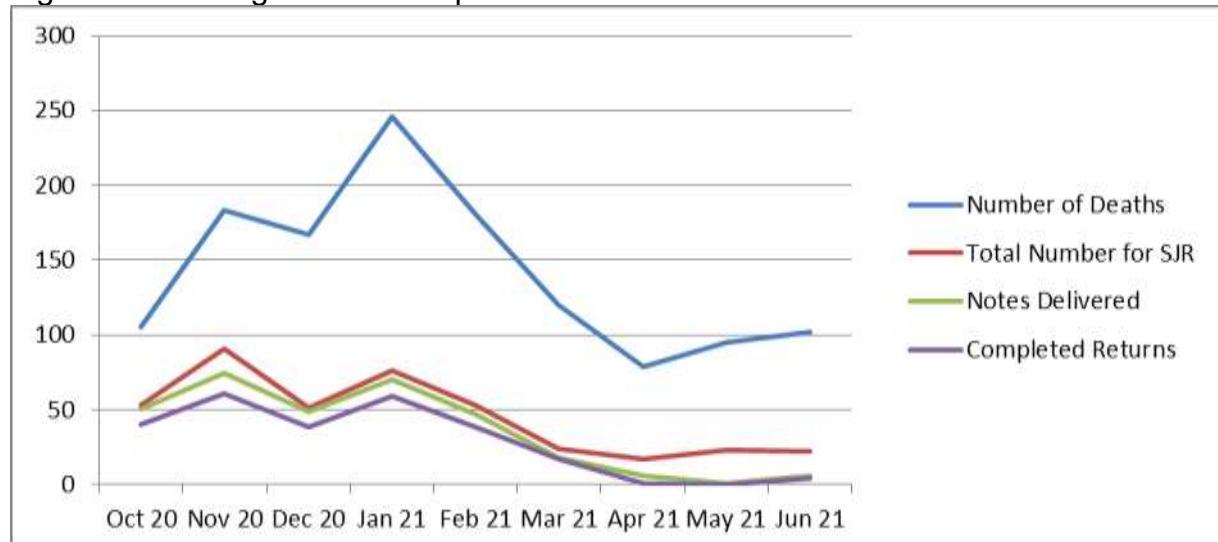
A number of reviews as referenced in the NQB guidelines as a minimal requirement undergo formal structured judgment review (SJR):

- All deaths where a bereaved family, carer or staff have raised a concern
- Patient deaths of those with a learning disability
- Patient deaths of those with a mental illness
- Unexpected deaths, such as following an elective procedure
- Particular groups where an alarm has been raised for example via HSMR, SHMI or CQC
- Deaths where learning will inform the providers quality improvement work
- All maternal deaths
- All child deaths, over 16 years of age
- All perinatal and still birth deaths.

Learning from deaths performance

The Trust has four medical examiners, two are anaesthetists and one is a microbiologist. Despite clinical pressures requiring these doctors to contribute to clinical care for Covid, the team have been able to maintain performance in scrutinising deaths shown in the figure 3:

Figure 3: Learning from deaths performance.



There has been a reduction in number of notes delivered and SJRs completed due to a vacancy in the learning from deaths co-ordinator post since May 2021. This post is now recruited to with a start date of September 2021. In the interim, specialities have been asked to access notes themselves with support from the business manager for the MD and the medical examiner officers. In the last quarter, there are 43 sets of notes for SJRs which have not yet been delivered. From August 2021, the

notification and process for learning from deaths will be electronic with the new CORS management system, which will allow transparency and visibility of the SJR process, automate notifications to complete SJRs and collect data for performance.

National Learning from Deaths Dashboard

- The Trust has adopted reporting via the National Learning from Deaths Dashboard (<https://view.officeapps.live.com/op/view.aspx?src=https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-learning-from-deathsdashboard.xlsm>). In the last quarter, there have been 281 deaths at the Trust. In Q1, 5 SJRs have been completed. Care has been assessed as level 3a or below in none of these cases (table 3).
- Year to date; as assessed by SJR level 1 reviews, 40% of deaths were probably not avoidable (less than 50/50), 40% of deaths were probably not avoidable and 20% of deaths were not avoidable (table 4)

Table 3: National Dashboard Learning from Deaths Performance

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)					
Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3a)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
107	95	3	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
281	547	5	112	0	11
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
281	1649	5	543	0	45

Figure 4: Trend of Learning from Deaths Performance 2019-2021

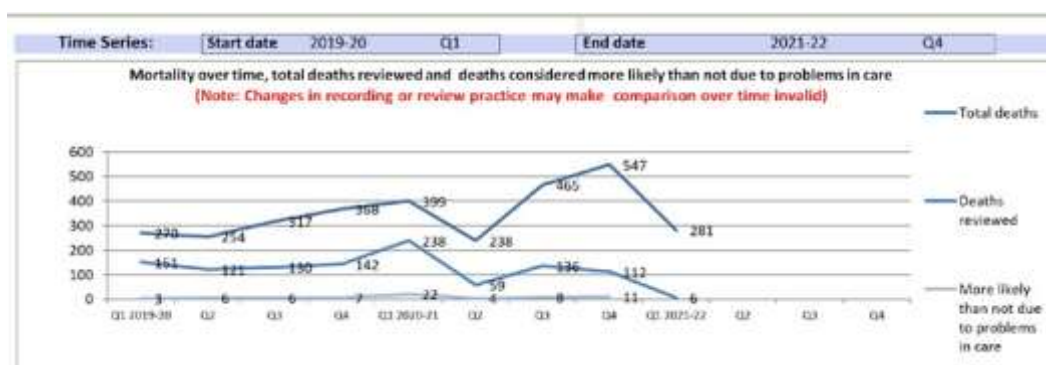


Table 4:

Score 3b Probably not avoidable (less than 50/50)			Score 4 Probably not avoidable			Score 5 Slight evidence or definitely not avoidable		
This Month	2	66.7%	This Month	1	33.3%	This Month	0	0.0%
This Quarter (QTD)	2	40.0%	This Quarter (QTD)	2	40.0%	This Quarter (QTD)	1	20.0%
This Year (YTD)	2	40.0%	This Year (YTD)	2	40.0%	This Year (YTD)	1	20.0%

Deaths of patients with a learning disability

There were 0 deaths of patients with learning disability in Q2 2021 (table 5)

Table 5: Deaths of patients with a learning disability

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities									
Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)				Total Number of deaths considered to have been potentially avoidable by RCP SJR score <=3a			
This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	4	0	4	0	4	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	14	0	14	0	14	0	0	0	0

Figure 5: Alerts and notifications

The following Trust alerts have been received from the National HED database.

Alert	Alert Period	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score	Alert Level
HSMR	Apr 2020 - Mar 2021	224 - Other perinatal conditions	7.13	23	471	322.71	Red
	Apr 2020 - Mar 2021	42 - Secondary malignancies	8.38	22	302	262.67	Red
	Apr 2020 - Mar 2021	199 - Chronic ulcer of skin	5.48	13	101	237.39	Red
	Apr 2020 - Mar 2021	14 - Cancer of colon	6.74	16	630	237.37	Red
	Apr 2020 - Mar 2021	131 - Respiratory failure; insufficiency; arrest (adult)	7.14	16	41	224.19	Red
	Apr 2020 - Mar 2021	19 - Cancer of bronchus; lung	14.91	31	324	207.97	Red
SHMI	Mar 2020 - Feb 2021	19 - Cancer of bronchus; lung	23.06	40	88	173.49	Red

A review of perinatal conditions was presented to QPES in April 2021 and a review of chronic skin ulcers has been undertaken with a quality improvement programme underway. A project has been commenced to improve documentation and subsequent coding to address capture of co-morbidities and end of life status in the Trust HSMR.

Colorectal cancer

The colorectal team have reviewed cases where death has occurred from cancer of the colon. There were 14 colon cancer deaths and 9 patients were palliative, of which 5 did not have surgery. If we consider the palliative patients separately, the observed deaths are in line with those expected. The learning for the team from this review was to ensure that palliative patients are referred to the palliative care team in order to ensure they receive the appropriate end of life care and so that we capture this on coding.

The respiratory team are working with the STP around deaths from respiratory conditions and have presented improvements to the service to MSG. Actions reported as a result of mortality and morbidity reviews include:

- Ambulatory pleural service
- Recruitment of band 6 pleural nurse
- Recruitment of Pleural coordinator (pending TMB discussion)
- Surge ventilation unit for COVID patients
- Post COVID follow ups in collaboration with community
- Advert out for 2 new consultant posts
- Shortlisted for 2 middle grades (interviews August 21)
- Lung cancer improvement project
- Lung cancer navigator post (pending TMB discussion)
- EBUS service expansion/training
- A lung nodule pathway which picks up cases which may be cancer much earlier. So far 8 such cases have been identified.

The respiratory service will present their mortality data back to MSG in 6 months and the Trust will monitor respiratory mortality via the National Database.

LEARNING FROM MORTALITY SURVEILLANCE GROUP

The Mortality Surveillance Group meets monthly to focus on the learning shared and implemented from the deaths within the speciality care groups. Each thematic focus group reports to the MSG quarterly.

Learning from Structured Judgments Reviews

Examples of learning from mortality reviews in the last quarter include:

- An agreed and implemented District General Hospital and Tertiary Trust Head Injury template for streamlined pathway to NORSE
- An obstructive uropathy pathway
- A new neutropenic sepsis pathway and guideline with a telephone triage service, training and a sepsis link nurse in ED. Expansion of service with a business case to 7 day 24 hour.
- Recruitment to the community palliative care team, advanced care planning clinics with return of face to face service.
- Intermittent pneumatic compression stockings to be made available at Holly Bank for Stroke patients.

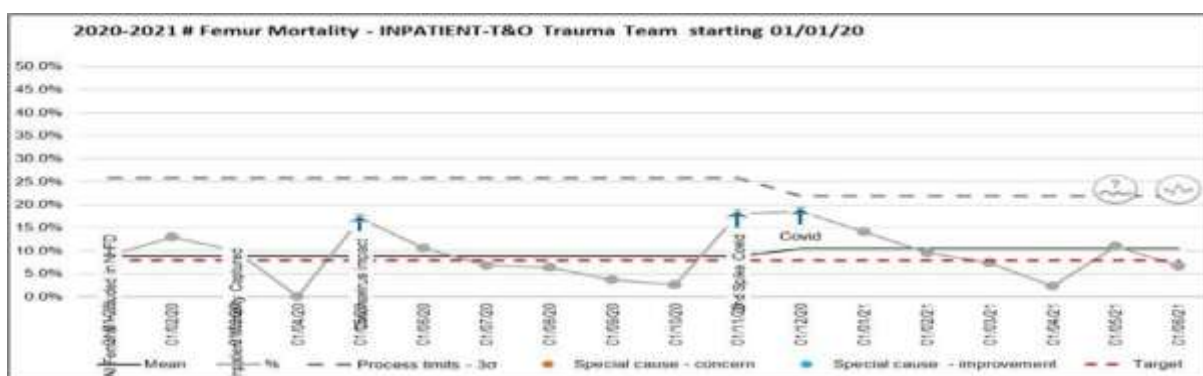
QUARTERLY UPDATES FROM SHQC LEARNING FROM DEATHS THEMES

A review of lessons from SJRs from March 2019 to March 2020 shows themes of responding to deterioration, end of life care and cancer delays. Along with the red SHMI alert for fractured neck of femur and Covid, these themes form our focus for learning this year. These themes are included in the SHQC improvement programme and monitored quarterly at MSG.

Fractured neck of femur

Monthly mortality from fractured neck of femur is tracked through MSG. For quarter 1, mortality rates are reducing and the group will continue to monitor until there is a sustained reduction.

Figure 4: Mortality from fractured neck of femur



Actions completed since last report:

- 2 trainee ACPs appointed to join the team
- Fractured femur pathway version 14 agreed and now professionally printed to include acute kidney injury risk assessment
- 8 Mortality reviews completed and learning shared at Care group meeting – preventing Constipation and obstruction.

- Excellence awards submitted for pre-operative MDT shared decision making
- Fascia iliac block administration reaches new high 100% in May

The team have submitted 5 posters to the Trust QI awards and have 3 oral presentations which has been a significant boost to morale.

Further steps include

- A policy for Enhanced recovery for fractured Neck of Femurs ongoing development
- Point of care haemoglobin haemacue assessment equipment in theatre recovery with associated training.
- Provision of a cell Saver – this is being scoped in collaboration with Royal Wolverhampton NHS Trust
- Increased physiotherapy support for 7 days a week service consistent orthogeriatrician cover

Reducing deaths from Cancer

Capacity and demand work has been completed for all tumour sites and with the exception of the breast service; all tumour sites are meeting the Two Week Wait Standard for an initial consultation. There has been recruitment to the breast cancer service and the less than 14 day wait is now being maintained.

The collaboration of urology at WHCT and RWT is due to be discussed at HOSC Board on 14/07/21.

End of life care

MSG heard from the Primary Care and Community Teams who reported a reduction in the number of deaths in hospital from 2009 at over 60% to 2019 to 48.6%.

Improvements in EoL care were due to:

- Additional investment in primary care and engagement with primary care
- Proactive identification of EOL patients by primary care leading to better care and support
- Proactive discussion on preferred place of care and death and support for patients to achieve their wishes
- Excellent support from Community teams: community palliative care nurses, ANPs, district nurses and Rapid Response
- Collaborative working with WHT and Palliative Care Team
- Annual update on EOL care for primary care clinicians with support from WHT
- Early identification in acute setting with rapid discharge from hospital for EOL pathway patients to home or D2A beds
- Goscote Hospice opened in 2011
- Increased public awareness about end of life care: e.g. Dying Matters week this week.

Deteriorating patient

A Trust Sepsis team is being formed and a business case for resilience in this team is in progress. A Trust Sepsis clinical lead appointment is underway with interviews this month.

The Trust has procured an online UK Sepsis Trust training package for adults; which will be mandated for all clinical staff who work at this Trust. A similar package for children is being evaluated.

A Deteriorating Patient Bundle tool has been agreed and piloted in AMU.

The e-sepsis dashboard is now available at ward level for local accountability.

QUARTERLY REPORTS

Child deaths report

The trust reviews child deaths through the Black Country Child Deaths programme (CDOP). In Q1, 5 deaths have been identified for review (2 neonatal and 3 older) and 2 have been completed. There are 11 outstanding deaths from 20/21 and current for the following reasons:

- 3 are awaiting police investigations
- 4 are awaiting coroners inquests
- 1 awaiting PMRT from elsewhere
- 2 awaiting PMRT from here
- 1 ongoing

As a result from the reviews:

- There is now embedded daily virtual MDTs for complex medical problems in children with Birmingham Children's Hospital

Perinatal mortality report

In Q1 2021, 8 cases were eligible for review by the National Perinatal Mortality Review Tool as shown in table 6 below

Table 6:

Walsall Healthcare  NHS Trust For Information – Ongoing Reviews (information as of 14.05.21)									
Reporting Period	Deaths eligible for review by PMRT	No Reported to Coroner	PMRT Reviews commenced within 4 months (standard = 95%)	No of deaths reviewed by MDT (at PNMM) within 4 months	No PNMM draft reports within 4 months (standard = 50%)	PMRT validated report within 4 months (standard = 50%)	No of parents involved in review (standard = 95%)	No of SI/RCA/ Concise/ HSiB	No of complaints
Q1 2021	8	0	8 (100%)	8 (100%)	8 (100%)	3* (on target)	8 (100%)	2	0

- Awaiting Final Post Mortem Reports / placental cytogenetic & histology reports
- 1 x Concise review
- 1 x SI Review

Lessons:

A Saving babies lives Midwife was appointed in April 2021 and a monthly audit is being undertaken to ensure that all pregnant women have a CO level taken at booking and then every antenatal appointment / contact. All women who smoke to be referred to smoking cessation services.

COVID 19 meant there were missed opportunities to provide the women with paper leaflets. In view of this the leaflet was uploaded to the maternity notes app that the women can access. At each antenatal appointment / contact the women were referred to the RFM leaflet within their app

Bereavement pathways have been created in BadgerNet for shared information with other relevant services.

Assurance

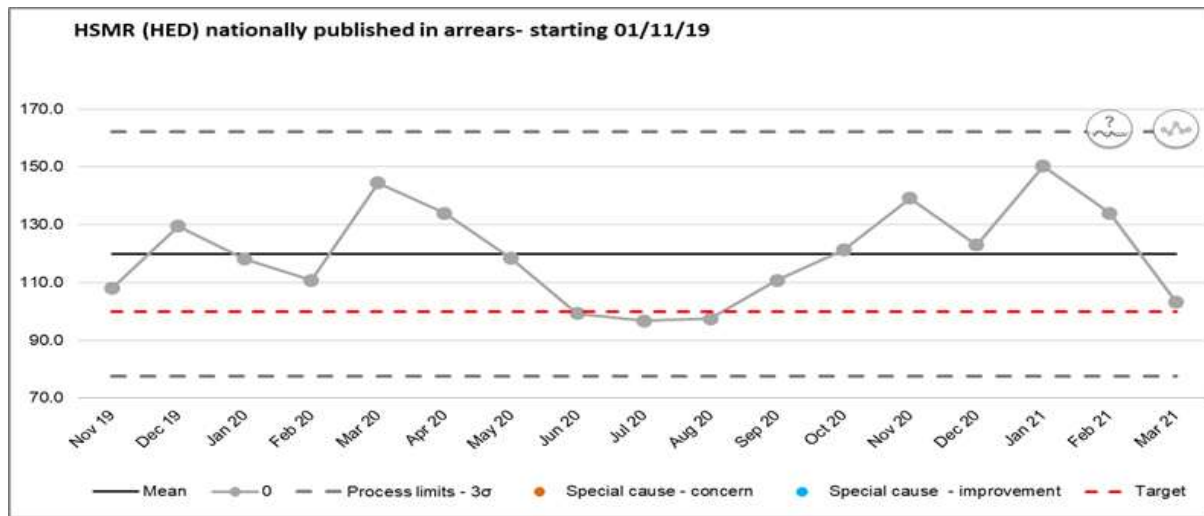
Bereavement cases reviewed in Quarter 1 via PMRT show 90% compliance when assessing for Aspirin.

In Quarter 1 we have seen a great approach to MDT working. Learning from excellence nominations have been received for some members of staff who have demonstrated the trusts values when delivering bereavement care.

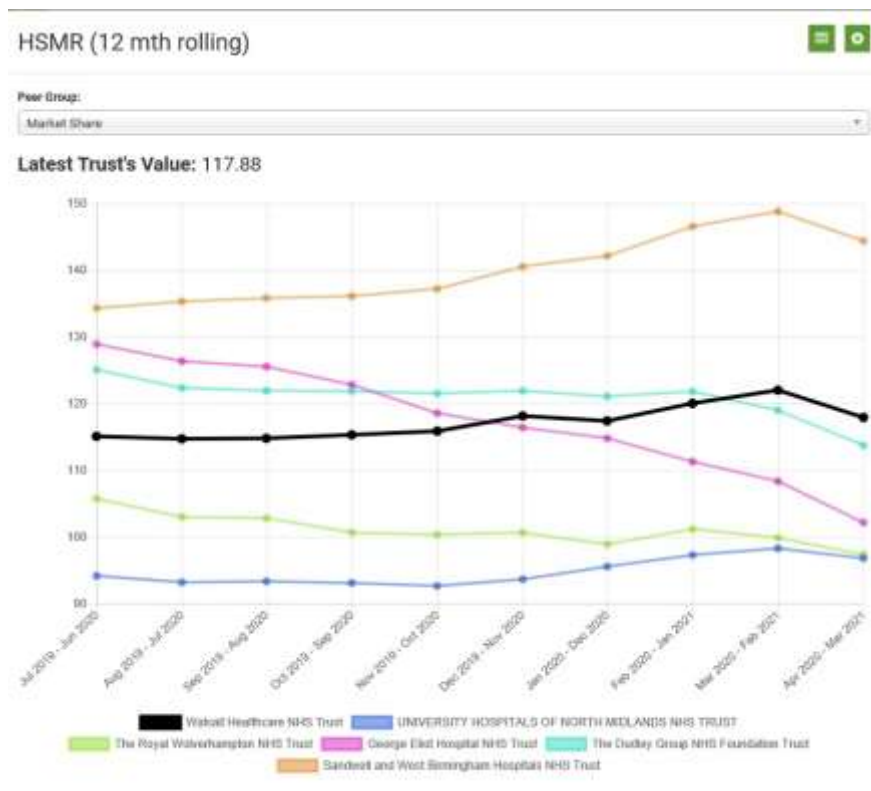
An improved bereavement follow up service where the named consultant meets the patient with the specialist midwife and neonatal consultant.

Appendices

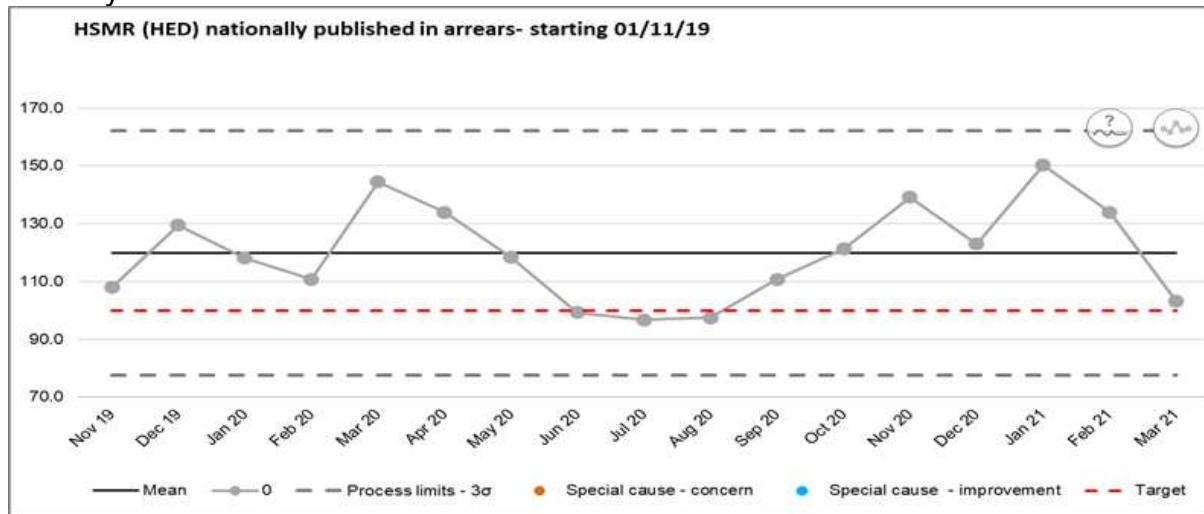
Monthly Rolling Hospital Standardised Mortality Rate (HSMR)



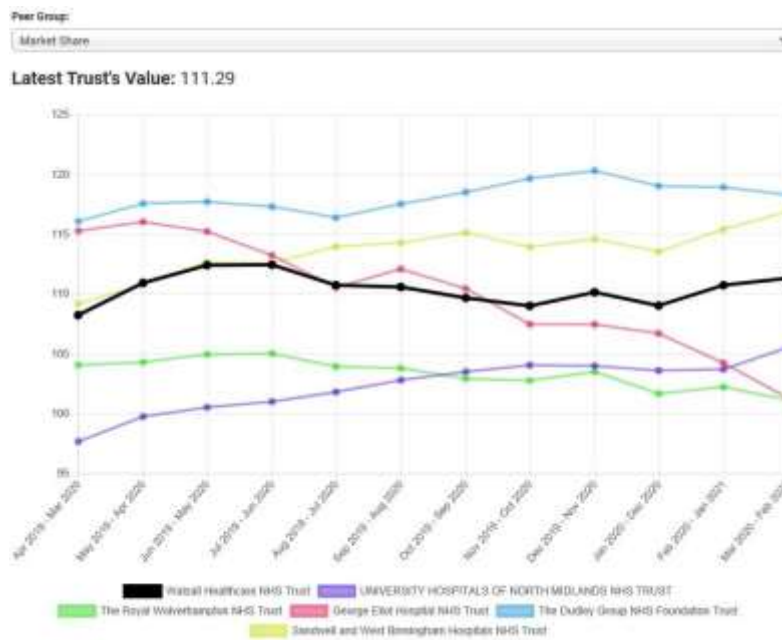
Market Benchmark HSMR



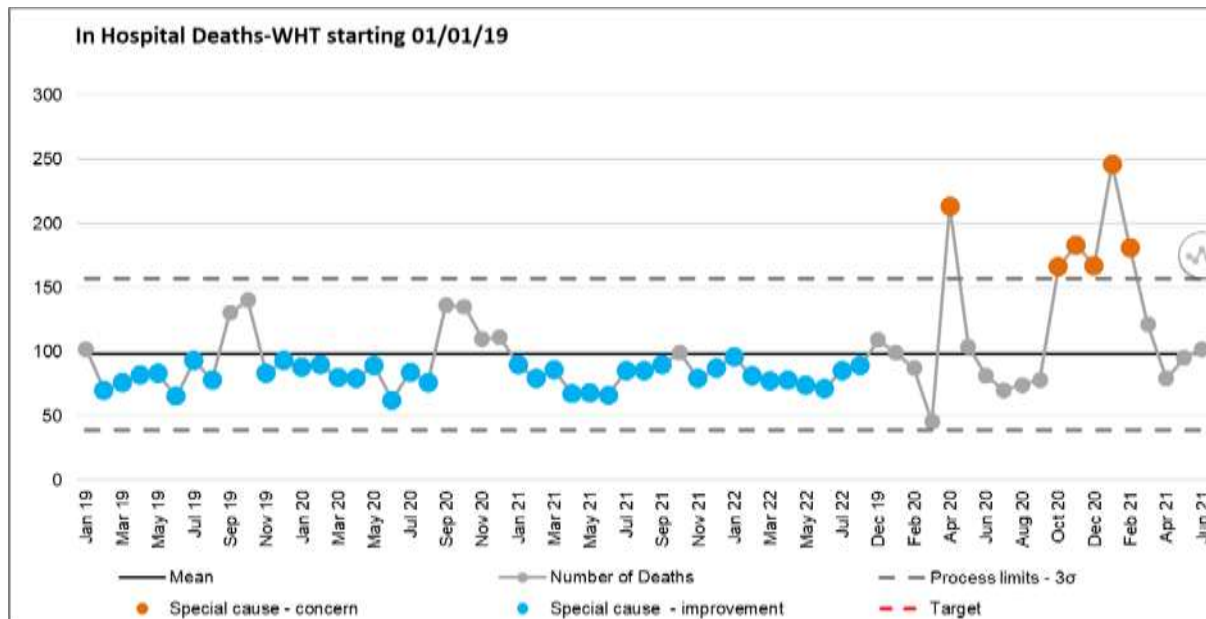
Standardised Hospital Mortality Index (SHMI) Monthly SHMI



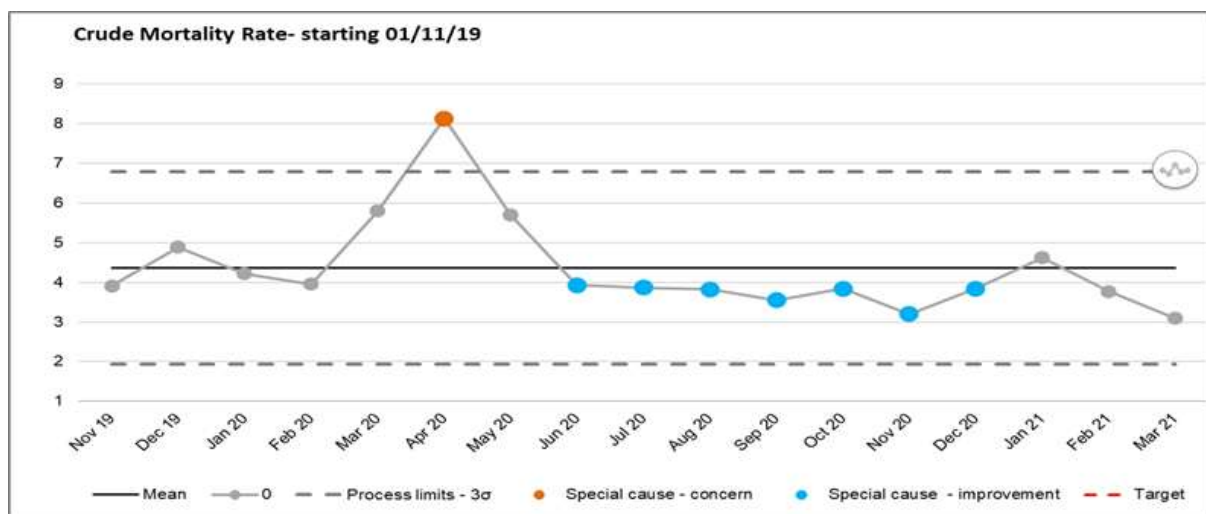
Market Benchmark SHMI



In Hospital Deaths



Crude Mortality 2015 – 2020 (deaths per 1000)



Glossary of Terms

HSMR Hospital Standard Mortality Rate
 SHMI Standard Hospital Mortality Index
 NQB National Quality Board
 CQC Care Quality Commission
 NHSI NHS Improvement
 SJR Structured Judgement Review
 ME Medical Examiner

MEO Medical Examiner Officer
LeDeR Learning Disability Mortality Review Programme
LD Learning Disability
DNAR Do not attempt resuscitation
MCA Mental Capacity Act
SI Serious Incident
RCA Root Cause Analysis
MTLC Medicine and Long Term Conditions division
LFD Learning from Death
CuSuM Cumulative Summary, a performance indicator demonstrating persistent deviation from the mean
PALS Patient Advisory and Liaison Services
CCG Clinical Commissioning Group
MSG Mortality Surveillance Group
MDT Multidisciplinary Team

MEETING OF THE PUBLIC TRUST BOARD			
Thursday 2 nd September 2021			
7 Day Service Standards			AGENDA ITEM: 13
Report Author and Job Title:	Lorraine Moseley Business Manager, Medical Directorate	Responsible Director:	Dr Manjeet Shehmar Acting Medical Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	Trust performance against 4 core standards: - Standard 2 – not met, compliance 43% against target of 90% - Standard 5 – met - Standard 6 – met - Standard 8 – not met, compliance 52%, against target of 90%		
Recommendation	The Board is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Risk No 633: Delivering a 7 day service as per the four critical standards in the NHSE guidance Risk No 1524: Failure to comply with professional standards of clinical record keeping which may impact on quality of care and patient safety. Risk No 2405: Incomplete patient health records documentation and lack of access to patient notes to review care due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes.		
Resource implications	Additional clinical staff required to provide a 7 day service		
Legal and Equality and Diversity implications	N/A		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

7 Day Service Spring/Summer 2021/2022

BACKGROUND

Reporting to NHSI has been paused during the current climate. The report completed in January 2020 indicated that an audit had not taken place and the results of the previous audit were relied upon. However, this may not be a true reflection of performance against standard 2 and 8 due to the insufficient sample size, 30%, audited for that return.

At the time of writing, NHSI have not indicated a date to recommence reporting.

The Board Assurance Framework (BAF) consists of a standard template that all trusts will complete with self-assessments of their performance against the 7DS clinical standards, supported by local evidence, this is collated centrally and an Evidence Grid (see Appendix 1) completed and available for review and form part of the BAF.

Priority Standards

4 priority standards are reported on and these form the basis of whether the Trust is meeting the 7 day service standard.

2. Time to first consultant review, within 14 hours in the acute admission setting
5. Availability of diagnostics
6. Consultant led interventions
8. On-going consultant review, all patients to be reviewed every 24 hours.

Additionally, Trusts were asked to provide assurance around the remaining standards for the last submission. This is an overview of provision of care and does not feed into the overall compliance.

METHODOLOGY

Each Standard has specific evidence sources and the Trust can decide which audits will best represent the 7DS standards. However, it should be noted that job plans are an expected source of evidence for all standards and should include services such as pharmacists (full details are set out in relevant Guidance). Evidence for this can be taken from Allocate system and confirmation from Clinical Directors.

The results for compliance for the four core standards are set out below.

Clinical Standard 2 – Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on three sources of evidence that in combination give a complete view of delivery of Clinical Standard 2.

Evidence source 1 relates to job plans (refer to Methodology above).

Evidence source 2 – local clinical audit. For the purpose of this report, an audit of emergency admissions was carried out for the period 7th – 13th April 2021 (sample size of 70 case notes was indicated for the total number of emergency admissions for this period - 477). At least 90% (63) of these case notes would need to confirm compliance with the clinical standard.

Three requests for notes were made over a period of 3 weeks. A total of 115 were requested but only 54 were available for audit, this equates to 78% of the required sample size. Compliance has

been measured against the sample size of 54 (to reach 90% compliance at least 49 of the notes would need to confirm compliance).

The Trust achieved an overall compliance of **43%** (against a standard of 90%) of patients reviewed by a consultant within 14 hours of admission. Compliance was as follows: weekday 44%/weekend 38%.

Evidence source 3 – wider performance and experience measures. Alongside the audit, evidence has been collated as illustrated in the attached Evidence Grid.

OUTCOME: CLINICAL STANDARD 2 – NOT MET

Clinical Standard 5 - The self-assessment template assesses the availability of each of the six diagnostic tests for weekdays and weekends. Overall compliance (i.e. achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments, with 50% weighting given to each

OUTCOME: CLINICAL STANDARD 5 - MET

Clinical Standard 6 - Timely 24-hour access seven days a week to nine consultant-directed interventions. The self-assessment template assesses the availability of each of the nine interventions for weekdays and weekends. Overall compliance (i.e. achievement of the 90% threshold) is based on a combination of these weekday and weekend assessments. This overall score is based on a 50% weighting for weekday and weekend availability.

OUTCOME: CLINICAL STANDARD 6 - MET

Clinical Standard 8 - Ongoing daily consultant-directed reviews received by patients admitted in an emergency, once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition. Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on four sources of evidence.

Evidence source 1 – consultant job plans - consultant job plans in all specialties that cover emergency admissions provide sufficient daily consultant presence to support the delivery of twice-daily ward rounds for high dependency patients (ITU) and once-daily ward rounds for all other ward patients.

Evidence source 2 – systems to support ongoing review - evidence of systems to support seamless and appropriate ongoing review. All of the above information is evidenced through current policies/protocols.

Evidence source 3 – local clinical audit - this is run in conjunction with the audit required for Clinical Standard 2. Daily review compliance is at **52%** (against the 90% compliance target). No ITU admissions were indicated within this audit period..

Evidence source 4 – wider performance and experience measures – this evidence base is the same as required for Clinical Standard 2 and therefore can be cross referenced.

OUTCOME: CLINICAL STANDARD 8 – NOT MET

7DS Standards for Continuous Improvement - the Board Assurance Framework introduces assessment of progress against all 7 Day Service Standards, this does not require an assessment of whether standards are being met, just evidence of overall improvement. The table below sets out evidence requirement:

The evidence for the above Standards has been collated centrally and is available from the Medical Director's office. The work around these Standards is ongoing and therefore the evidence base will change with each submission, progress will be highlighted in the completed 7DS Self-Assessment Template at Appendix 1.

OBSERVATIONS

The Audit for Standards 2 and 8 was difficult to complete. The original request for 75 records (for an audit of 70) only produced 42 records, the remaining records were either booked out or could not be located. 2 further requests were submitted resulting in a total of 54 records (total requested 115). There is an additional issue of loose records not being filed with the main record and therefore some admissions may not form part of the patient's health record.

There are a number of actions the Trust can take to improve compliance against the 7 day service Standards:

1. Improve the quality of record keeping.
 - a. Signatures were often illegible with no clinical designation and therefore impossible to confirm a senior review had been completed (11 records out of the sample 54)
 - b. Some entries were dated but did not have an associated time entry. Reviews that were dated within 14 hours of admission were included as meeting the Standard (for example if a patient was admitted to the ward at 10.00am and their review took place the same date, this was treated as compliant as it would have been within the prescribed 14 hours). – (8 records out of the sample 54)

If these issues were corrected and an assumption that those clinicians were consultants, the overall compliance could rise to 76%.

2. Weekend Consultant cover is not consistent throughout the Trust. Job plans indicate Consultant cover on weekends however this can be either resident or non-resident. The Standards are clear in that emergency admissions **must be seen** and have a thorough clinical assessment by a suitable consultant.
 - a. Paediatrics, cardiology provide onsite Consultant cover Saturday/Sunday with daily Consultant led ward rounds
 - b. Obstetrics and gynaecology, trauma and orthopaedics, urology, general surgery, weekend cover by Consultants is carried out from home, no Consultant led ward rounds
 - c. Respiratory are currently recruiting for an additional Consultant in order to provide a 7 day service
3. Protocols for designating treatment from senior clinicians should be introduced in each specialty. If there is an agreed, written protocol based on clinical needs, then reviews carried out by designated clinicians are deemed to be compliant. Requests to Divisions as part of this process indicated that such protocols are not in existence.

This assurance process will be repeated in Autumn/Winter 2021

July 2021



Walsall Healthcare Trust 7 Day Service Audit Spring/Summer 2021

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	TO BE COMPLETED For the purpose of this report, an audit of emergency admission patient profile with a sample size of 70 case notes (total number of emergency admissions for this period was 477) was carried out for the period 7th – 13th April 2021. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery. A total of 115 records were requested and a final sample of 54 records (78% of the required sample size) were reviewed. (The Trust achieved an overall compliance of 43% (against a standard of 90%) of patients reviewed by a consultant within 14 hours of admission. Compliance was as follows: weekday 44%/weekend 38%.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	
		Ultrasound	Yes available on site	
	MRI within the standards is not available for diagnostic or reporting. Patients requiring MRI within this time frame may be major trauma patients who would not be managed at the trust and would be redirected from source or from ED to a MTC as per network agreements. MRI for suspected spinal cord compression is available out of hours. Ultrasounds are available routinely between 8.00 to 20.00hrs. Use of an ultrasound for a critical patient would not be the diagnostic of choice, CT would be proposed	Echocardiography	Yes available on site	
		Magnetic Resonance Imaging (MRI)	No the test is not available	
		Upper GI endoscopy	Yes available on site	



Clinical standard	Self-Assessment of Performance		Weekday	Week end	Overall Score
(Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site, or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	the trust achieves this standard via a combination of inhouse and off site arrangements	Emergency Renal Replacement Therapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Urgent Radiotherapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Stroke thrombolysis	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
(Jlin ira ll Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (in cluding all acutely ill patients directly transferred and others who deteriorate). Once a d ear pathway of ,care has b een est ablished, pat ient s should be t e r i e w e d by a consultant at least ONCE EVERY 24 HOIJSRS, seven days a w eek, unlesi has been det ermined t hat t his would not aff ect the pa ient' s,care pa h w ay.	Dail y rev i ew compli ance i s at 52% (aga i nst th e 90% compli ance t arget). No ITU admi ssi ons we rei ndicate,d v ithin this audi t pe,ri od, hov ever W ice d ail y rev i ew s of pati ents ,di d tak e pl ace v here requ este,d (2cases)	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency.	Standard Not Met
		Twice dail y: Yes the standard is met for over 90% of patients admi tte d i n an emergency	Twice dail y: Yes th e standard is met f or over 90% of patients admi tte d i n an emergency	

7 DAY SERVICE EVIDENCE GRID (Spring/Summer 2021)

STANDARD	EVIDENCE	SOURCE
Standard 2: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital. Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on three sources of evidence that in combination give a complete view of delivery of Clinical Standard 2. A short commentary should be entered in the template to evidence their assessments, with areas for improvement noted in the cases where the standard is not met.	Evidence Source 1 - Consultant job plans Confirmation that consultant job plans in all specialties that receive emergency admissions provide sufficient daily consultant presence to support the delivery of 7DS Clinical Standard 2 within the organisation. Providers must also consider the availability of wider clinical services, such as pharmacy and therapy.	AVAILABLE • Allocate • Job Planning • Medical Staffing Rota Officers
		TO SOURCE • Pharmacy info
	Evidence source 2 – local clinical audit Conduct an audit representative of normal emergency admission patient profile. The minimum sample size would be 70 case notes out of 500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery. It may be necessary to provide further assurance that smaller specialties that may not be covered in this sample have arrangements to deliver the clinical standard.	• To be completed
	Evidence source 3 – wider performance and experience measures Wider sources of information with potential links to delivering this standard could indicate whether it is being achieved. These include: • weekday and weekend ratio data in mortality, length of stay, readmissions • patient experience data from weekdays versus weekends covering consultant presence/availability • General Medical Council (GMC) trainee doctor survey data on the support offered by consultants • wider, related patient flow and urgent and emergency care improvement programmes and metrics (for example, SAFER/number of red-green days and accident and emergency performance) • audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians'	AVAILABLE • Current Provision - Non Elective Services (Wards 9, 11, 12) • 1 ACP Trauma and Orthopaedics • Planned Provision (included in STP capacity spreadsheet) - Non Elective Services (Wards 9, 11, 12) • Addition of x3 ACP's to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon-Sun • Trainee doctor survey feedback

	Guidance on safe medical staffing • separate targeted ongoing audits of performance in specific specialties or locations as part of provider continuous improvement activity.	NHS Trust
		TO SOURCE • A&E Performance • Improvement Programmes (?SHQC)
Clinical Standard 5: the availability of six consultant-directed diagnostic tests for patients to clinically appropriate timescales: is within one hour for critical patients, 12 hours for urgent patients and 24 hours for non-urgent patients.	The self-assessment template requires each provider to assess the availability of each of the six diagnostic tests for weekdays and weekends. This is done by selecting one of the above answers from the drop-down menu in the yellow cells for each diagnostic test for weekdays and weekends. 9 The self-assessment template is designed to automatically calculate an overall compliance score for each provider based on the above weighting from the responses inputted for each diagnostic test.	• Evidence received from service setting out availability of services
Clinical Standard 6: timely 24-hour access 7 days a week to nine consultant-directed interventions. Self-assessment should be based on a response to the following question for each of the interventions: "Do inpatients have 24-hour access to the following consultant-directed interventions seven days a week, either on site or via formal network arrangements?"	The self-assessment template requires each provider to assess the availability of each of the nine interventions for weekdays and weekends. This is done by selecting one of the above answers from the drop-down menu in the yellow cells for each diagnostic test for weekdays and weekends. A provider can only comply with this standard if all these interventions are available both on weekdays and at weekends, with only one exception (ie there are nine interventions, so 18 potential responses (weekday and weekend scores), of which 17 must comply with the standard to achieve overall compliance).	• Evidence received from service setting out availability of services
	Evidence source 1 – consultant job plans Confirmation that consultant job plans in all specialties that cover emergency admissions provide sufficient daily consultant presence to support the delivery of twice-daily ward rounds for high dependency patients and once-daily ward rounds for all other patients.	AVAILABLE • Cross Reference to Standard 2 • Allocate • Job planning • Medical Staffing Rota Officers

Clinical Standard 8: ongoing consultant-directed reviews received by patients admitted in an emergency once they have had their initial consultant assessment. The standard aims to ensure that all patient cohorts receive an appropriate number and level of reviews from consultants depending on the severity of their condition. Patients with high dependency needs, usually but not always sited in AMU, SAU and ITU, should be reviewed by a consultant twice daily. All other patients admitted in an emergency should be reviewed by a consultant once daily unless the consultant has delegated this review to another competent member of the multidisciplinary team on the basis that this would not affect the patient's care pathway. Assurance of delivery of this standard for 90% of all patients admitted in an emergency should be based on four sources of evidence that in combination give a complete view of delivery of Clinical Standard 8. Providers should offer a short	Providers must also consider the availability of wider clinical services, such as pharmacy and therapy, over seven days in the delivery of this standard.	TO SOURCE • Policies • Physio/OT cover
	Evidence source 2: systems to support ongoing review The precise level of consultant presence required to deliver this standard is for the provider to assess locally rather than being specified centrally, as each organisation has its own requirements. Providers must also consider the availability of wider clinical services, such as pharmacy and therapy, over seven days in the delivery of this standard.	AVAILABLE • O&G pathways • Vitals
	In addition to the requisite level of consultant presence to deliver the standard, providers should have systems to support seamless and appropriate ongoing review, specifically: 1. a board round system that enables the responsible consultant to delegate reviews appropriately based on clinical need and the presence of agreed written protocols 2. a system of escalation for deteriorating patients based on agreed protocols, ideally built around monitoring each patient's National Early Warning Score (NEWS) 3. a clear process to decide which patients do not need a daily consultant review and the proportion of admitted patients in this category.	TO SOURCE • Written protocols from care groups for delegated care/ward rounds • Policies • Board/Ward round SOP/protocol
	Evidence source 3: local clinical audit As with Clinical Standard 2, if a provider believes it has sufficient consultant presence to deliver Clinical Standard 8 in theory, this should be evidenced by data from clinical audits of patient case notes or data taken from electronic patient records if these are able to provide this information. The minimum sample size would be 70 case notes out of 500 relevant admissions in a given period. At least 90% (63) of these case notes would need to confirm compliance with the clinical standard to support delivery. It may be necessary to provide further assurance that smaller specialties that may not be covered in this sample have arrangements to deliver the clinical standard.	• Audit to be completed (link with Standard 2)

commentary in the template as evidence of their assessments, with areas for improvement noted where the standard is not met.	Evidence source 4: wider performance and experience measures Alongside an assessment of job plans and supporting clinical audit evidence of delivery, wider sources of information with potential links to delivering this standard could indicate whether it is being achieved. These include: • weekday and weekend ratio data in mortality, length of stay, readmissions • patient experience data from weekdays versus weekends covering consultant presence/availability • GMC trainee doctor survey data on the support offered by consultants • wider, related patient flow and urgent and emergency care improvement programmes and metrics (for example SAFER/number of red-green days and A&E performance) • audits of staffing levels and activity related to 7DS as recommended by the Royal College of Physicians' Guidance on safe medical staffing • separate targeted ongoing audits of performance in specific specialties or locations as part of provider continuous improvement activity.	AVAILABLE • Current Provision - Non Elective Services (Wards 9, 11, 12) • 1 ACP Trauma and Orthopaedics • Planned Provision (included in STP capacity spreadsheet) - Non Elective Services (Wards 9, 11, 12) • Addition of x3 ACP's to support ACP led SACU to provide 7 day cover (10pm - 8am; 7 days per week) and ACP led Elective and Emergency wards. 24/7 Mon- Sun • Trainee doctor survey feedback (refer to Standard 4) TO SOURCE • A&E Performance (link with Standard 4) • Patient feedback • Healthwatch reports • Mortality data weekday/weekend
7DS Standards for Continuous Improvement All 10 7DS clinical standards are vital to consistently high quality care, and taken as a whole, impact positively on the quality of care and patient experience. As well as the four priority 7DS clinical standards, the 7DS programme supports providers to deliver the remaining six 7DS standards, referred to as the 7DS Standards for Continuous Improvement. To assess progress against these standards, providers must draft a commentary on work done relating to their delivery in the board assurance template. An assessment of whether a provider is meeting the standards is not required, just evidence of overall improvement.		
Clinical Standard 1: Patient experience	Information from local patient experience surveys on quality of care/consultant presence on weekdays versus weekends. Feedback from wider sources of patient experience, such as levels of complaints and local Healthwatch feedback directly related to quality of care on weekdays and at weekends.	AVAILABLE • TO SOURCE • Patient feedback (refer to Standard 8) • Healthwatch reports(refer to Standard 8)

Clinical Standard 3: Multidisciplinary team review	Assurance of written policies for MDT processes in all specialties with emergency admissions, with appropriate members (medical, nursing, physiotherapy, pharmacy and any others) to enable assessment for ongoing/complex needs and integrated management plan covering discharge planning and medicines reconciliation within 24 hours.	AVAILABLE • T&O business case to increase number of physios to accommodate 7 day service (March 2021) TO SOURCE • Discharge planning protocols • MDT Policy/Protocol • Transfer to Community protocols
Clinical Standard 4: Shift handovers	Assurance of handovers led by a competent senior decision-maker taking place at a designated time and place, with multiprofessional participation from the relevant incoming and outgoing shifts. Assurance that these handover processes, including communication and documentation, are reflected in hospital policy and standardised across seven days of the week.	AVAILABLE • Renal handover added to Fusion • SBAR tool in Badgernet • Introduction of CareFlow Connect TO SOURCE
Clinical Standard 9: Transfer to community, primary and social care	Assurance that the hospital services to enable the next steps in the patient's care pathway, as determined by the daily consultant-led review, are available every day of the week. These services should include: • discharge co-ordinators. • pharmacy services to facilitate discharge (eg provision of TTAs within same timescales on weekdays and at weekends) • physiotherapy and other therapies • access to social and community care providers to start packages of care • access to transport services.	AVAILABLE • T&O business case to increase number of physios to accommodate 7 day service (March 2021) (refer to Standard 3) • Community information pack to help with referrals and raise awareness of the support available for patients • Discharge lounge TO SOURCE • Discharge planning protocols • Pharmacy protocols for TTA • Transfer to community protocols
Clinical Standard 10: Quality improvement	Assurance that provider board-level reviews of patient outcomes cover elements of care and quality that relate to the delivery of high quality care seven days a week – such as weekday and weekend mortality, length of stay and readmission ratios – and that the duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high quality, safe patient care, seven days a week.	• Check reports on infohub

MEETING OF THE PUBLIC TRUST BOARD			
Thursday 2nd September 2021			
Infection Prevention and Control Board Assurance Framework Q2 Update			AGENDA ITEM: 14
Report Author and Job Title:	Amy Wallett Head of Infection Prevention and Control	Responsible Director:	Lisa Carroll, Director of Infection Prevention and Control and Director of Nursing.
Action Required	Approve ☐ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	- The IPC Board Assurance Framework has been updated to capture progress against the required actions - IPC audits are embedded in practice with a programme of work planned throughout the year - There have been no outbreaks during July and August 2021. - The old estate remains a significant challenge in maintaining environmental cleaning standards - NHSE/I inspection on the 22nd June was RAG rated as red.		
Recommendation	The report is for information and to promote the sustainability of improvements made across the organisation in infection prevention and control practices.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Findings and gaps in assurance are included on the IPC BAF assurance tool.		
Resource implications	None		
Legal and Equality and Diversity implications	None		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Summary of Infection Prevention and Control Board Assurance Framework

Compliance Criterion	Required action	Risk Score				
		Q4 2020 /21	Q1 2021 /22	Q2 2021 /22	Q 3	Change in level of risk
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other services users.	20	12	12		→
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections	15	20	20		→
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	16	6	6		→
4	Provide suitable accurate information on infections to services users, their visitors and any person concerned with providing further support or nursing/medical care, in a timely fashion	6	3	3		→
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	12	6	6		→
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	6	3	6		↑
7	Provide or secure adequate isolation facilities	20	20	20		→
8	Secure adequate access to laboratory support as appropriate	15	15	12		↓
9	Have and adhere to policies designed for the individuals and provide organisations that will help prevent and control infections	8	6	6		↓
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	8	6	6		↓

Details of gaps in control/assurance captured in BAE

COVID-19 routine screening compliance

Since February 2021 in line with national guidance the Trust implemented a policy of Covid-19 screening on the day of admission, day 3, day 5 and then every 7 days until discharge.

Improvements have been observed in COVID-19 screening compliance, particularly across the medicine division. Weekly screening compliance is significantly better than on days 3 and 5. Day 3 and 5 screens are essential to support prompt identification of asymptomatic patients coming in to hospital.

There have been two patients since April 2021 who have met case definition for HCAI COVID-19 due to a positive test after day 8 of admission. For both cases, they were asymptomatic, no links to transmission, correctly streamed but missed opportunities for screening within the first week of admission.

Staff members undertaking LAMP testing

To continue routine testing and identification of asymptomatic staff members with COVID-19, the Black Country Pathology Service facilitate LAMP testing, a simple and more accurate method of detecting COVID-19 in comparison to lateral flow testing. Uptake of LAMP testing across the Trust requires improvement to support controls in preventing transmission of COVID-19 within healthcare settings.

Actions being taken to improve testing compliance

- Systems are already in place to assist staff in identifying when screens are due; these include flashing tags on fusion, education, posters and screen savers
- The MLTC division quality matron has been focusing on inpatient screening with overall improved compliance. These standards will be shared through the infection prevention and control committee.
- Communications updates have been circulated during August 2021 through Daily Dose, via social media accounts and on the new Trust Reach App. Head of Infection Prevention and Control and Consultant Microbiologist have led on a LAMP testing video, promoting and guiding through the process.

Rapid testing for other infections

Molecular testing for rapid identification of Norovirus or Influenza is not currently available. Samples from suspected cases require processing via Black Country Pathology service leading to potential prolonged bay/ward closures pending results. Trust Consultant Microbiologist is liaising with Black Country Partners to increase in house rapid testing in preparedness for winter illness activity.

Infection Prevention in the healthcare environment

The old estate and current poor condition of many of the wards has resulted in a number of department environment audits not achieving >90% compliance score.

A recent NHS England and NHS Improvement infection prevention visit on 22nd June 2021 also identified the aspects of the estate that requires improvement. The report noted that refurbishments are currently being undertaken at the Manor Hospital site. The report, published in July 2021 provided an overall RED rating for the Trust. There was a lot of positive feedback shared with clinical areas regarding infection prevention practice. Key areas for improvement included:

- Therapies staff areas required improvement to support compliance with COVID-19 guidance.
- Decontamination of equipment, specifically underside of shower chairs and the internal aspects of IV infusion sets
- Estates issues including damaged environments, cracks to floors and worn surfaces.

The limited availability of side rooms in the Trust can lead to an inability to isolate all patients who require isolation in a timely manner.

Actions to improve compliance

- Estates issues highlighted on audit reports and shared with divisions and estates team. Divisions report back at Infection Prevention Committee on their actions and escalate.
- IPC supporting the ongoing refurbishment plans.
- Plans for Estates IPC group from August 2021 where minutes and actions shared at IPC Committee.
- Engagement sessions between IPC team and matrons/department leads on their responsibilities associated with infection prevention in the environment.
- Business case to be developed to increase isolation capacity via isolation pods.
- Action plan completed by Head of IPC in response to external review findings. This is shared monthly at infection prevention and control committee where feedback is shared by divisional leads on their ongoing actions.

Outbreaks during Quarter Two

Norovirus Full ward Closures - None

Bay Closures - Increased diarrhoea and vomiting - None

COVID-19 Full ward closures – None

Bay closures due to COVID-19:

July 2021- 8 bay closures due to unexpected COVID-19. Patients managed correctly at time of bay closure.

August 2021- 1 at time of report.

There have been no confirmed cases of transmission resulting from any of the bay closures during quarter two.

Performance: Infection Prevention and Control Targets

In August 2021, the Trust received a paper from NHS England and NHS Improvement, confirming target data for health care associated infections at Walsall Healthcare. In addition to *C.difficile*, gram-negative bacteraemias have been included for the first time.

Targets for 2021/22:

MRSA: Continues to be 0 cases as a National target

C.difficile: 33

E.coli: 64

Pseudomonas: 7

Klebsiella: 18

The new targets are now being captured in infection monthly reports for committee. The Trust is on target for all listed infections except for MRSA bacteraemias. Since April 2021, the Trust has reported 2 MRSA bacteraemias. These have been thoroughly investigated and the infection prevention programme of work captures MRSA prevention strategies as a high priority.

Infection Prevention and Control Audit Programme: Quarter Two Progress

The table below shows the audit plan for 2021/22. In addition to this, the Infection Prevention and Control Team will undertake audits based on incidents or obtaining assurances on updated infection prevention guidance/policy.

Audit	Location	Plan	Related Compliance Criterion	Related Strategic Theme	Q2 Progress
Full ward audit	All inpatient wards	To be completed by August 2021	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	100% completed
Community audits	Community clinics and units	To be completed by October 2021	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	60% completed 18.08.21.
Full departmental audits	Acute site departments	To be completed January 2022	1,2,6,9	Infection Prevention in the Environment, Hand Hygiene	To be completed during Q3
Ward kitchens	Inpatient wards	To be completed by March 2022	1,2,9	Infection Prevention in the Environment, Hand Hygiene	To be completed during Q4
Support services cupboards	Inpatient wards	To be completed by March 2022	1,2,9	Infection Prevention in the Environment,	To be completed during Q4

				Hand Hygiene	
Hand hygiene	Acute site	Quarterly: June 2021 September 2021 December 2021 March 2022	6,9	Hand Hygiene, Invasive Devices	Q1 completed. Q2 in progress.
Compliance to wearing personal protective equipment (PPE)	Acute site	Quarterly: June 2021 September 2021 December 2021 March 2022	6,9,10	Hand Hygiene, Invasive Devices	Q1 completed. Q2 in progress.

IPC Annual Report and Annual Programme of Work

Progress against the Annual Programme of Work will be overseen by the IPC Committee.

In addition to the set programme of work, the team deliver a “focus of the month” which includes distributing newsletters and providing specific education around the focus directly to colleagues within clinical areas.

Focus for July: MRSA screening and decolonisation.

Focus for August: Management of peripheral vascular devices

Focus for September: Aseptic non-touch technique

Infection prevention activity can be found via the Trust infection prevention Twitter page: @IPCWalsall.

End of Report

MEETING OF THE PUBLIC TRUST BOARD – 2nd September 2021

Performance, Finance & Investment Committee (PFIC) Highlight Report

AGENDA ITEM: 15
Report Author and Job Title:

 Russell Caldicott –
Director of Finance and
Performance

Responsible Director:

 Mr John Dunn – Chair
of PFIC (Non-
Executive)

Action Required

 Approve ☐ Discuss ☐ Inform ☒ Assure ☒
Executive Summary

This report provides the key messages from the Performance, Finance & Investment Committee meeting on 25th August 2021. Of note are:

- Post Implementation Reviews (PIRs) of business cases for Mammography Equipment and Theatre Monitors were presented. Lessons learnt from the process noted (enhancements to capital planning an example) going forward 2 PIRs to be presented each month.
- Committee reviewed Board Assurance Framework (BAF) and Corporate Risks for 'Use Resources Well' and 'Working Closely with Partners'.
Risk scores were debated, with uncertainty on income for the last 6 months of 2021/22 and delivery of efficiencies highlighted as key risks for horizon 2 (H2) financial delivery, and the future. National updates have indicated income for H2 will be set at that of Horizon 1 (April to September 2021) less a 3% efficiency. It was noted that investments agreed may further increase risk to delivery of financial plans.
The Chief Operating Officer and Director of Integration are to present (to PFIC in accordance with H2 planning) efficiencies identified for delivery throughout H2.
- Financial performance remains on plan at month 4 (a small surplus of £39K) forecasting to deliver plan for Horizon 1. However, the Division of Medicine and Long-Term Conditions (MLTC) are above plan by £999k. The cost overruns centre upon increased temporary staffing costs (offset by 'other' underspends) drivers increased Urgent and Emergency Care. The Trust has escalated the overspends through use of the Accountability Framework and Divisional Performance Review,

	with a view to mitigating these costs or realigning the financial plan if required (noting the underspends within the other areas offsetting this cost at present). • Restoration and recovery efforts in both the acute and community are on track. However, members received an update on Critical Care pressures, resulting in a review of surgical capacity allocated to recovery. • Operational performance is strong, despite increasing pressure in both Acute and Community particularly in Urgent and Emergency Care Pathway and with reduced capacity for packages of care in the community. • The Trust on occasions has also supported other Trusts with diverted ambulances, Dermatology and Breast Cancer procedures. • As performance was high, quality challenged by recent inspections and the Trust experiencing cost overruns in Urgent and Emergency Care, discussions centred upon how we manage the balance between quality of care, performance metrics and financial probity, Mr Hobbs agreed to facilitate a session for Non-Executive Directors on current practice. • Mr Caldicott presented the proposal to move to a full partner of the Integrated Supplies and Procurement Department, members recognised the significant benefits this will deliver and supported our moving forward. • The draft format of the Integrated Quality and Performance Report was presented, members noted the significant progression made in this area, the report format endorsed. As such, an action was agreed to populate the report with Trust performance data for the following meeting. • An options appraisal for the Safety and Quality Intelligence Management System was presented and agreed to be progressed to a business case. The next meeting of the Committee will take place on 29th September 2021.
Recommendation	Members of the Trust Board are asked to note the escalations and any support sought from the Trust Board.

Does this report mitigate risk included in the BAF or Trust Risk Registers?	This report aligns to the BAF risk for use of resources and working with partners, and associated corporate risks.	
Resource implications	The resource implications are set out in this highlight report.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☒	Value colleagues ☐
	Resources ☒	

MEETING OF THE PUBLIC TRUST BOARD – 2nd September 2021

Use Resources Well Executive Report

AGENDA ITEM: 16

Report Author and Job Title:	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance	Responsible Director:	Ned Hobbs, Chief Operating Officer Russell Caldicott, Director of Finance & Performance
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Use Resources Well strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Use Resources Well and NHS constitutional standards successes and areas for improvement. This report recognises the financial arrangements within which the Trust is operating during the 2021/22 financial year, as a result of the impact of the COVID-19 pandemic. It updates Board members on financial performance following formal adoption of the financial plan for April to September 2021 (Horizon 1). The Trust attaining plan of a £0.04m surplus in July 2021 (month 4 of 2021/22) and forecasting delivery of the H1 planned surplus. This further builds on the success in delivery of a surplus for the previous two financial years Whilst overall achieving run rate expenditure plans, the Medicine and Long-term Conditions Division has exceeded budgeted resources by £999k. Further work with the Divisional leadership is progressing, to mitigate or re-align plans for H1 accordingly. The report then focuses upon plans being developed for October to March 2022, Horizon 2 (H2). The Trust awaiting confirmation of income allocations, though national forums have confirmed an allocation of income comparable to H1, less a 3% efficiency ask. Expenditure plans (run rates) for H2 are being developed in draft based on receiving H1's allocation less a 3% efficiency ask. This		

will then be amended upon notification of actual resource allocations.

H2 is expected to present a more challenging financial climate than that of H1. Key being the need to commit additional resources for expected urgent and emergency care need over the winter, whilst a 3% efficiency requirement reduces available resources by c£4m. In addition, any investments would further place risk to achievement of expenditure within available resource allocations.

The report identifies the primary risks to delivery of 2021/22 financial plans as (a) additional costs to be incurred for winter (less those that will by default cease from elective care) (b) H2 actual income allocations yet to be confirmed (c) the need to deliver efficiencies to offset the efficiency ask of 3% and identification of further efficiencies to enable investment.

In addition, the income allocations for the 2022/23 financial year are expected to further reduce. The run rate in July 2021 c£3m more than historic periods (though costs are expected to reduce for Covid-19 and elective recovery non-recurrent measures).

If income allocations were to return to pre-Covid-19 levels the Trust would need to reduce costs significantly. However, the providerbase for the NHS would face a similar challenge. As such, whilst the Trust awaits guidance on income and financial planning for the 2022/23 financial, year, the focus remains on identifying baseline (normalised) expenditure exit run rate for March 2022, as we enter 2022/23.

The report identifies continued strong operational performance. It highlights exceptional constitutional standard performance in the DM01 6 week wait diagnostic standard with the sixth consecutive month of waiting times amongst the Top 10 general acute Trusts in the country, and the Trust now ranked 2nd (of 122 reporting general acute Trusts) in the country (June 2021) for diagnostic waiting times.

It highlights consistently strong relative performance in emergency care with the Trust's ambulance handover times (within 30mins) the best performing in the West Midlands for the sixth consecutive

	month, and 4-hour Emergency Access Standard performance in the Top 20 performing Trusts in the country for the fifth consecutive month. However, despite strong performance relative to other Trusts the report highlights deterioration in actual 4-hour Emergency Access Standard performance associated with record high levels of Type 1 Emergency Department attendances, and with higher hospital bed occupancy associated with increased numbers of Medically Stable For Discharge patients as a result of challenges in the domiciliary care market. The report highlights the stable Trust performance against the 18-week Referral To Treatment waiting time standard, which is mirrored by the Trust having the fourth lowest proportion of its elective waiting list over 52-weeks in the (combined West and East) Midlands. The Trust's GP referred 62-day Referral to Treatment Cancer waiting time performance has improved and is now significantly better than both the West Midlands average and national average (June 2021), and both suspected cancer and Breast Symptomatic 2week wait performance have also improved. The report notes that the Trust is providing mutual aid to Sandwell & West Birmingham Hospitals NHS Trust for the suspected Skin Cancer pathway, to The Royal Wolverhampton NHS Trust for the suspected Breast Cancer pathway and to a number of neighbouring Trusts for intelligently conveyed ambulances away from Emergency Departments with prolonged Ambulance Handover times.
Recommendation	Members of the Trust Board are asked to note the contents of this report, and the next steps: • H1 on plan for month 4 and forecast to deliver plan for H1 • Income for Horizon 2 is yet to be confirmed and the Trust is developing run rate models based on H1 less 3% for this period (to include winter costs). Efficiency attainment key. • The Trust is developing exit run rate models to understand expenditure baselines for 2022/23, when income allocations are known the Trust can then model outturn accordingly. • The Trust is seeking additional capital allocations to off-set the risk to the capital programme for much needed ward infrastructure works

Mitigate risk included in the BAF or Trust Risk Registers?	This report addresses BAF Risk S05 – Use Resources Well to provide positive assurance that there are mitigations in place to manage this risk and the related corporate risks.	
Resource implications	This strategic objective is: <i>We will deliver optimum value by using our resources efficiently and responsibly</i> - Financial impacts are as described within the recommendations section.	
Legal and Equality and Diversity implications	There is clear evidence that greater deprivation is associated with a higher likelihood of utilising Emergency Department services, meaning longer Emergency Access Standard waiting times will disproportionately affect the more deprived parts of the community we serve. Whilst not as strongly correlated as emergency care, there is also evidence that socioeconomic factors impact the likelihood of requiring secondary care elective services and the stage of disease presentation at the point of referral. Consequently, the Restoration and Recovery of elective services, and the reduction of waiting times for elective services must be seen through the lens of preventing further exacerbation of existing health inequalities too. The published literature evidence base for differential access to secondary care services by protected characteristic groups of the community is less well developed. However, there is clear evidence that young children and older adults are higher users of services, there is some evidence that patients who need interpreters (as a proxy for nationality and therefore a likely correlation with race) are higher users of healthcare services. And in defined patient cohorts there is evidence of inequality in use of healthcare services; for example end of life cancer patients were more likely to attend ED multiple times if they were men, younger, Asian or Black. In summary, further research is needed to make stronger statements, but there is published evidence of inequity in consumption of secondary care services against the protected characteristics of age, gender and race.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☐
	Resources ☒	

WALSALL HEALTHCARE NHS TRUST - TRUST BOARD

USE RESOURCES WELL

AUTHOR - CHIEF OPERATING OFFICER & DIRECTOR OF FINANCE

1. EXECUTIVE SUMMARY

This report provides an overview of the risks to delivery of the Use Resources Well strategic objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance on performance for Use Resources Well and NHS constitutional standards successes and areas for improvement.

This report recognises the financial circumstances that the Trust is now operating in during the new 2021/22 financial year, and the continued uncertainty surrounding financial allocations for Q3 and Q4.

It updates Board members on attainment of a surplus of £0.04m to July 2021 of the 2021/22 financial year (month 4 of 2021/22). The Trust forecasting of attainment of financial plans for H1 (Horizon 1 to September 2021) this representing the continued achievement of a surplus and financial plan (as has been the case for the previous two financial years).

The report also confirms key performance against financial plans for Horizon 1 (H1 - April to September 2021) of the 2021/22 financial year and reflects on the basis for development of expenditure plans for Horizon 2 (H2 – October 2021 to March 2022) income allocations post 30th September 2021 to be confirmed.

The report identifies continued strong operational performance following the extreme pressure experienced during the third wave of the Covid-19 pandemic in early 2021. It highlights exceptional constitutional standard performance in the DM01 6 week wait diagnostic standard with the 2nd best performance of 122 reporting general acute Trusts in the country. It highlights consistently strong performance in emergency care with the Trust's ambulance handover times (within 30mins) the best performing in the West Midlands for the sixth consecutive month, and 4-hour Emergency Access Standard performance in the Top 20 performing Trusts in the country for the fifth consecutive month. The report highlights the Trust's stable 18-week Referral To Treatment waiting

time standard performance, which is mirrored by the Trust having the fourth lowest proportion of its elective waiting list over 52-weeks in the (combined West and East) Midlands. The Trust's GP referred 62-day Referral to Treatment Cancer waiting time performance is now significantly better than the West Midlands and national average, and both suspected cancer and breast symptomatic 2-week waiting performance is improving.

2. BOARD ASSURANCE FRAMEWORK

The Use Resources Well Board Assurance Framework (BAF) risk has been further updated to include:

- Attainment of 2020/21 financial plan and delivery of a surplus.
- Updated NHS constitutional standard performance, showing sustained improvement in national rankings for access to care.
- Updated Model Hospital benchmarking showing operational productivity against key indicators including inpatient Length of Stay and cost per Weighted Activity Unit (WAU) improvements, detailed in the Improvement Programme section of this report.

Key financial risks centre upon the uncertainty over income levels for H2 (October 2021 to March 2022) further articulated within the corporate risk register, and inform the Use Resources Well section of the Board Assurance Framework, namely:

- Efficient running of the Trust, using every pound wisely in delivery of the financial plan and securing improved run rate performance to ensure financial sustainability in the longer-term
 - Modelling trajectories for temporary workforce
 - Identification of efficiencies to enable re-investment into services
 - Confirmation of income allocations for October 2021 and onwards
- Capital resource availability to service current Estate backlog works requirements and future major capital developments

The August 2021 meeting of the Performance, Finance and Investment Committee challenged if the BAF risk score of 15 was overstated given that the Trust is on track with its financial plan and is delivering strong constitutional standard performance. The Chief Operating Officer and Director of Finance agreed to review the risk score in light of the debate at the Committee in advance of the September Committee meeting.

3. PERFORMANCE REPORT

3.1.1 Financial Performance - background

The Trust entered the 2020/21 financial year having attained planned financial outturn for 2019/20. However, the onset of COVID-19 has resulted in emergency budgets being set by NHSEI and the normal planning process halted. However, the Trust attained a £0.14m surplus for the 2020/21 financial year.

The 2021/22 financial planning was also affected by the pandemic, and has been divided into two periods, Horizon 1 (H1) covering April to September 2021 and Horizon 2 (H2) covering October to March 2022. This section of the report will update members on H1, H2 and 2022/23 revenue and then capital & cash.

3.1.2 Revenue position – Horizon 1 (April 2021 to September 2021)

Income allocations have been confirmed for H1 (April to September 2021) and the Trust has endorsed a plan for income and expenditure for this period 2021/22. This H1 plan supported by Executive and Trust Management Board, and recommended for adoption by Performance, Finance, & Investment Committee, was endorsed at Private Board.

The Trust is reporting attainment of month 4 2021/22's financial plan, attaining a £0.04m surplus to July 2021. The Trust continues to forecast attainment of the H1 overall plan.

The Trust is attaining financial plan, the following key elements that are worthy of note:

- **Divisional performance against run rate**

The Medicine and Long-term Conditions Division has exceeded budgeted resources by £999k year to date. Further work with the Divisional leadership is progressing, to mitigate or re-align plans for H1 accordingly.

- **Elective Incentive Scheme**

The Trust can receive additional income should performance of the STP exceed historic elective activity, whilst in addition the STP will need to attain key gateways.

There is risk to receipt of this income, and whilst the Trust has modelled expected performance to month 4 to deliver a c£2m income gain, this income has been excluded through accruing out the benefit comparable to the income, owing to the risk to receipt of these funds.

It is of note the Trust is not expecting to receive significant further income from projected elective performance, largely owing to the historic activity thresholds increasing in future months. The STP members are accruing out the benefit from ERF potential income on a comparable basis, owing to the uncertainty regarding actual receipt.

- **Sustainability and Transformation Partnership (STP) Risk Share**

The Trust has entered a risk share with the STP, essentially indicating no member will be in surplus if one is in deficit. This presents an obvious risk should a member go into deficit to the Trust attaining break-even performance.

The STP has reported a surplus at month 4 of c£0.8m (year to date) though owing to timing of reports detailed performance by member is not available at this time. This surplus position for the STP including a reported year to date deficit of c£1.5m for West Midlands Ambulance Service (WMAS).

This WMAS reported position has been escalated to regulators for resolution as the STP is reporting the entire deficit, whilst the service covers activity from outside of the STP boundary (the full cost impact reported owing to the STP hosting the partner organisation).

In summary, the Trust is on plan to attain financial performance for H1, with ERF potentially offering a financial benefit if receivable for H2 for the Trust and wider STP (STP planned ERF c£17m of additional income). The STP potential adverse impacts from the risk share managed, as a surplus has been attained (WMAS deficit escalated with NHSEI and neighbouring STP's).

3.1.3 Revenue position Horizon 2 (H2 – October 2021 to March 2022)

Income allocations for H2 have not been released, this remains a key uncertainty in production of financial plans for the later half of the 2021/22 financial year.

The Executive, Trust Management Board and Performance, Finance and Investment Committee aligned to the recommendation of production of an expenditure plan for H2 in advance of confirmation of income. The key assumption in development of the plan being that the Trust will:

- (1) produce a balanced financial plan
- (2) base expenditure run rates on H1 allocations less a 3% reduction for efficiency

The development of run rate modelling to 'live within the expected income allocations' for H2 will result in a need to move expenditure between Divisional run rates, to off-set the increased ask of urgent and emergency care services during winter (expected to total c£3m) and in addition, reducing overall costs by c£4m to deliver the efficiency ask (with a further efficiency ask needed to support investment decisions).

It is clear, the second half of the financial year is set to be more challenging in delivery of break-even performance. However, it is of note that the Trust will be expecting additional income associated with hypothecated funds and approved developments (Emergency Department and Ockenden). The report identifies the primary risks to delivery of 2021/22 financial plans as

- a) Incorporation of expected additional costs to be incurred during winter
- b) H2 actual income allocations yet to be confirmed (and the efficiency ask of 3%)
- c) The need to deliver reductions in run rate to offset the efficiency ask of the 3% expected income reduction, and creation of further efficiencies to enable investment.

The results of the expenditure modelling and final allocations for H2 will then be used to refine the plans presented to members for endorsement in due course, to assure delivery of breakeven performance for the 2021/22 financial year.

3.1.4 Revenue financial modelling to 2022/23

Income allocations are expected to further reduce as the Government seeks to revise expenditure commitments post Covid-19. This is expected to place further pressure on expenditure budgets.

Expenditure totalled £3m more in July 2021 than historically, and whilst an element of this cost will be expected to reduce as Covid-19 subsidies and in part will be driven by separate funding for elective recovery, there will also be an expectation some costs will remain (Infection Prevention Control protocols for example). If income allocations for

2022/23 are in line with 2019/20 pre-Covid-19 allocations the Trust would need to reduce costs significantly to attain a balanced financial model.

This would not be an uncommon situation faced throughout the provider base for the NHS, and income allocations are expected to be revised to reflect an element of Covid-19 remaining. However, the expectation will be for reduced income to that currently received, and as such focus will be needed on controlling temporary workforce costs and delivery of efficiencies through the Improvement Programme as we move forwards.

In summary, H2 is expected to result in a reduced income allocation, with costs needing to reduce to deliver a balanced position. The expectation is that for 2022/23 income allocations are set to further reduce and hence the focus will need to be centred upon normal (recurrent) expenditure and exit run rates for March 2022 to assure delivery of future financial plans (when guidance and income allocation methodology and values are known).

3.1.5 Capital and cash

Capital expenditure in the 2021/22 financial year will place focus upon investment within critical infrastructure works, Digital and Medical Equipment, with the most significant scheme being the Emergency Department New build for which we are now seeing the steel works in progress and the development rise from the groundworks following their completion.

The capital programme remains over committed following placement of contracts for much needed capital infrastructure works within the ward environments. The Trust continues to seek additional allocations from the regulator to support these commitments and balance the programme accordingly.

The Trust has substantial cash holdings at the end of the financial year, and this has continued into the initial months of 2021 for the new financial year.

Operational

Emergency Care:

Despite May, June and July 2021 representing the 3 highest months of Type 1 Emergency Department attendances on record, the Trust maintained strong and statistically significantly improved performance for the percentage of patients triaged within 15 minutes of arrival to ED with nine consecutive months now above the mean average. In addition, the Trust delivered the best Ambulance Handover times (<30 minutes) in the West Midlands for the sixth consecutive month in July 2021, supporting

West Midlands Ambulance Service crews to get back on the road to attend to the next 999 call in a timely fashion. Of note, the Trust achieved this whilst continuing to assist neighbouring Trusts, having received 48 ambulances Intelligently Conveyed away from neighbouring EDs due to their prolonged ambulance handover times during July.

4-hour Emergency Access Standard performance has remained comparatively strong, with the Trust securing its fifth consecutive month in the Top 20 performing Trusts in the country. However, despite strong relative performance the report highlights deterioration in actual 4-hour Emergency Access Standard performance associated with record high levels of Type 1 Emergency Department attendances, and with higher hospital bed occupancy associated with increased numbers of Medically Stable For Discharge patients as a result of challenges in the domiciliary care market. The country has reported its worst ever 4-hour Emergency Access Standard performance on record in July 2021 and notwithstanding the Trust's strong relative performance there is significant risk in the Urgent & Emergency Care system with Autumn and Winter ahead. This risks directly impacting on the quality and safety of services, since we know that timely access to emergency care is directly associated with better patient experience and clinical outcomes, including mortality rates, and thus is a vital component of delivering safe, high quality care.

Elective Care:

The Trust's 6 Week Wait (DM01) Diagnostics performance remains in the Top 10 in the country for the sixth consecutive month (June 2021 reporting), out of 122 reporting Trusts, and has improved further in July 2021 with just 0.53% of patients now waiting over 6 weeks. The Trust has now met the constitutional standard of less than 1% of patients waiting over 6 weeks for two consecutive months. Maintaining timely access to Diagnostics is vital to detect serious conditions early, and thus to enable quicker treatment. In addition, the DM01 Diagnostic access standard includes GP requested Diagnostic tests, and thus timely access is also crucial to support primary care and community clinicians to manage patients safely without requiring hospital treatment. The previously most challenged diagnostic modality, Cystoscopy, has delivered a substantial improvement in waiting times over the Summer, contributing to the improved overall Trust performance.

Despite cessation of routine elective services during March and April 2020, and reduced elective operating capacity again from November 2020 to March 2021 over thesecond and third waves of the pandemic, the Trust's 18-week RTT performance is stable with 70.76% of patients now waiting under 18 weeks at the end of July 2021, and remains in the Top 50 (out of 122 reporting Trusts) nationally for June 2021

performance. In addition, the Trust's 52-week waiting time performance is 4th best in the Midlands (out of 20 Midlands Trusts). Although July 2021 had a slight increase with 473 patients waiting over 52-weeks, from 433 in June 2021, the numbers have reduced noticeably since March 2021. Providing timely routine elective care is important given many patients will be suffering pain, discomfort and loss of independence whilst awaiting treatment and the clear evidence that patient outcomes can be adversely affected by excessive waiting times for treatment. Furthermore, there is clear evidence of the association between increased access to elective treatments and reduced requirement for emergency care services, and so providing timely elective care can actually reduce demand for emergency care.

In June 2021, for 62-day Cancer performance the Trust was materially better than West Midlands average (63.9%) and national average (73.3%), with 81.68% of our patients treated within 62 days of GP referral. The Trust is ranked 34th out of 122 reporting general acute Trusts. The committee should be assured that patients referred with suspected Breast Cancer, or with other Breast symptoms are now being seen within 2 weeks of referral following implementation of an extensive recovery plan and that this is reflected in improved 2 week wait performance for suspected cancer (all tumour sites) and Breast Symptomatic referrals. A further round of mutual aid to the Royal Wolverhampton Trust has now also been offered for Breast services as a result of excessive waiting times for Breast patients in Wolverhampton. Timely care for patients with cancer is vital given the clear evidence that clinical outcomes (including survival rates) correlate with the stage of the cancer disease on diagnosis, and thus detecting and treating cancer early directly improves patient outcomes.

4. IMPROVEMENT PROGRAMME

The Operational Productivity improvements forming a key tenet of the Use Resources Well improvement programme are now being evidenced through the Trust's improved relative performance against key Model Hospital operational productivity metrics, including:

- Cost per Weighted Activity Unit (19/20) now below peer and national median (Model Hospital)
- Day case rates for British Association of Day Case Surgery better than peer and national medians (May 2021 – Model Hospital).
- Average Length of Stay for elective admissions rolling 6 months below peer and national median (May 2021 – Model Hospital)
- Average Length of Stay for emergency admissions rolling 6 months below peer and national median (May 2021 – Model Hospital)
- Average late starts and average early finishes in Operating Theatres better than national median (August 2021 – Model Hospital)

5. RECOMMENDATIONS

Members of the Trust Board are asked to:

- Note the contents of the report.
- Note the following actions;
 - H1 on plan for month 4 and forecasting to deliver plan for H1.
 - Income for Horizon 2 is yet to be confirmed and the Trust is developing run rate models based on H1 less 3% for this period (to include winter costs). Delivery of the efficiency ask will be key.
 - The Trust is developing exit run rate models to identify expenditure baselines for 2022/23, so when income allocations are known the Trust can model outturn accordingly.
 - Seeking additional capital allocations to off-set the risk to the capital programme for much needed ward infrastructure works

APPENDICES

1. Board Assurance Framework Risk S05
2. Performance Report (Finance and Constitutional Standards)

Risk Summary																											
BAF Strategic Objective Reference & Summary Tile:		BAF SO 05 - Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly.																									
Risk Description:		The Trust's financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.																									
Lead Director:		Chief Operating Officer.																									
Lead Committee:		Performance, Finance, & Investment Committee.																									
Links to Corporate Risk Register:	Title:																								Current Risk Score Movement:		
	208 - Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks. (Risk Score = 12). 2398 - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12). 665 - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation. (Risk Score = 15). 1005 - Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks. (Risk Score = 16). 1155 - Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation. (Risk Score = 16). 2081 - Delivery Operational Financial Plan. (Risk Score = 9). 2082 - Future Financial Sustainability. (Risk Score = 12).																								Likelihood = 3 Consequence = 5 = 15 High ↔		
																									Forecasted Risk Score Movement for Q2:		
																									Likelihood = TBC Consequence = TBC = TBC ↑↔↓		
Risk Appetite																											
Operational Status:		Balanced	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 14	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		< 16																									
Financial Status:		Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		<10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		<11																									
Compliance Status:		Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		<9	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		<11																									

Risk Scoring								
Quarter:	Q1 2021/22	Q2	Q3	Q4 2020/21	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3			3	<u>Evidence of risk control</u> - Achievement of 19/20 and 20/21 financial plans. - Adherence to revised financial arrangements during 20/21 as a result of the Covid-19 pandemic, despite significant planning uncertainty - Strong operational performance measured through constitutional standards, and associated operational performance metrics. - Development of draft 5-year capital programme - Majority of allied Corporate Risks associated with Use Resources Well mitigated to scores of 16 or less. <u>Evidence of risk gaps in control</u> - The Trust experienced run rate risk for the 19/20 financial year that led to needing to re-forecast outturn during the financial year. - High reliance on temporary workforce - Lack of credible capital plan to fully address backlog maintenance requirements, despite 5-year Capital Programme in place. <u>Evidence of planning uncertainty</u> - Normal national financial planning cycle for 21/22 financial year was postponed due to the Covid-19 pandemic - Financial improvement planning and delivery has been impacted by Covid-19. - Significant uncertainty still associated with H2 (Q3 and Q4) 2021/22 financial arrangements.	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	15 High			15 High		Risk Level:	10 Moderate	
Control & Assurance Framework - 3 Lines of Defence								
	1 st Line of Defence				2 nd Line of Defence		3 rd Line of Defence	
Controls:	- Financial position reported monthly via Care Groups, Divisions, Divisional Performance Reviews and Executive Governance Structures. - Revised financial governance in place for COVID-19 through the Trust's Governance Continuity Plan. - Board Development session for the Improvement Programme with				- Performance, Finance & Investment Committee in place to gain assurance. - Audit Committee in place to oversee and test the governance/financial controls. - Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation). - Use Resources Well work stream of the Improvement Programme has Governance		Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital.	

	identified 3-year targeted financial benefits.	infrastructure in place.	
Gaps in Controls:	• Business planning processes require strengthening. • Accountability Framework has been approved, however needs review further to the NHSI Governance Review report. • Leadership development needs at Care Group, Divisional and corporate support service levels, with commencement of Faculty of Medical Leadership and Management leadership development programme deferred to Spring 2021 due to Covid-19 second wave. • Covid-19 second and third waves significantly exceeded planning parameter assumptions.		
Assurance:	• Model Hospital Use of Resources assessments. • Proportion of acute surgical patients managed without overnight hospital stay has risen from less than 30% to over 50%. • Number of patients managed through the Integrated Assessment Unit's Frailty service without overnight hospital stay has increased by over 50%. • Inpatient Length of Stay in MLTC (excluding 0-day LoS) has reduced from over 9 days to less than 8 days on average. • Number of Medically Stable for Discharge inpatients sustained at lowest level on record through 20/21 (although rising since June 2021). • Delivery of 2020/21 Financial plan, representing the second consecutive year of meeting financial plan.	• Internal Audit reviews of a number of areas of financial and operational performance • Covid-19 'top-up' resource in line with peers as a percentage of turnover • Top 10 in the country out of 122 general acute reporting Trusts for the 6th consecutive month (June 2021) for 6 week wait Diagnostic (DM01) performance • Top 20 in the country (out of 113 reporting general acute Trusts) (July 2021) for the 5th consecutive month for 4-hour Emergency Access Standard, and best in the West Midlands out of 14 reporting Trusts for Ambulance handover <30 mins for the 6th consecutive month • 50th best in the country out of 122 reporting Trusts (June 2021) for 18-week RTT performance and 4th lowest proportion of elective waiting list waiting over 52 weeks in the Midlands (out of 20 reporting Midlands Trusts) • 34th (out of 122 reporting general acute Trusts) for Cancer 62-day from GP referral to treatment waiting time performance	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts • Cost per WAU (19/20) now below peer and national median (Model Hospital) • Day case rates for British Association of Day Case Surgery better than peer and national medians (May 2021 – Model Hospital). • Average LoS for elective admissions rolling 6 months below peer and national median (May 2021 – Model Hospital) • Average LoS for emergency admissions rolling 6 months below peer and national median (May 2021 – Model Hospital) • Average late starts and average early finishes in Operating Theatres better than national median (August 2021 – Model Hospital) • Medical specialties Same Day Emergency Care rates for ambulatory emergency care conditions rated second best in the country by the AEC Network.
Gaps in Assurance:	• NHSi Governance review highlighted areas of improvement for business process and accountability framework. • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident. Time lag on updating of some Model Hospital metrics means there is a delay in receiving some independent assurance of improved financial and operational productivity metrics. • External Audit limited due to Covid-19. • Late confirmation of 21/22 financial architecture for Q3 and Q4. • NHS Digital Templar Execs external review (Cyber Operational Readiness Support) has identified improvements required for the Trust's Cyber Security.		
Future Opportunities			
• Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area. • International Nurse Recruitment with RWT to significantly decrease reliance on temporary workforce.			

- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners).
- Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home).
- Improved Equality, Diversity and Inclusion in the Trust to harness the skills of the whole workforce and leadership development programme for Care Group and Divisional leaders to enhance capability (Valuing Colleagues).
- Utilisation of national productivity benchmark information (e.g. GIRFT and Model Hospital) to target work through the Use of Resources Improvement Programme.
- Development of major capital upgrades (e.g. new Emergency Department) to support improved recruitment of staff.
- Harnessing the teamwork and innovation so evident throughout the Covid-19 pandemic to develop service improvements that lead to improved use of resources.
- Capitalising on the digital advancement during Covid-19 to harness technology to improve effective use of resources.
- Rationalising Estate requirements through increased remote working.
- Enhanced leadership capability through Well-led Improvement Programme work stream.

Future Risks

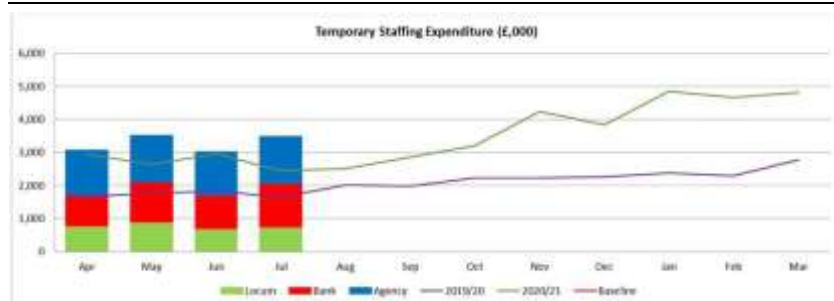
- Covid-19 second and third waves have significantly exceeded planning parameter assumptions, leading to increased costs delivering emergency and critical care, and reduced leadership time dedicated to long time resource planning during the height of the pandemic. Risk of a 4th wave in late Summer/early Autumn 2021.
- Likely move away from PbR towards block contracts and the associated paradigm shift for elective care in particular.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in 20/21, and early 21/22.
- Additional costs associated with safe non-elective and critical care during Covid-19.
- Significant changes to elective and non-elective demand during Covid-19 and in early 21/22 in emergency care in particular leading to difficulty planning for the future with confidence.
- Insufficient Capital to enable investments in the Estate, equipment and technology that would in turn support more effective use of resources, and significant lead time for deployment of capital.
- Impact of Covid-19 on the wider economy and supply chain markets may destabilise some costs of goods/services upon which the Trust relies.
- Workforce exhaustion and/or psychological impact from Covid-19 may result in higher sickness rates and/or colleagues deciding to leave the healthcare professions, and thus further reliance on temporary workforce.

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

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

Financial Performance to July 2021 (Month 4)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	105,401	109,534	4,133
Other Income (Education&Training)	2,808	2,580	(228)
Other Income (Other)	2,392	3,146	754
Subtotal Income	110,601	115,260	4,659
Pay Expenditure			
Substantive Salaries	(56,978)	(57,394)	(416)
Temporary Nursing	(5,367)	(5,888)	(521)
Temporary Medical	(4,780)	(4,634)	146
Temporary Other	(1,814)	(1,454)	360
Vaccination Programme	(2,429)	(1,372)	1,057
Subtotal Pay Expenditure	(71,368)	(70,742)	626
Non Pay Expenditure			
Drugs	(5,940)	(6,687)	(747)
Clinical Supplies and Services	(5,397)	(6,118)	(721)
Non-Clinical Supplies and Services	(4,840)	(5,684)	(844)
Other Non Pay	(17,056)	(19,171)	(2,115)
Vaccination Programme	0	(227)	(227)
Depreciation	(2,902)	(2,864)	38
Subtotal Non Pay Expenditure	(36,135)	(40,751)	(4,616)
Interest Payable	(3,116)	(3,272)	(155)
Subtotal Finance Costs	(3,116)	(3,272)	(155)
Total Surplus / (Deficit)	(18)	496	514
Donated Asset Adjustment	64	(457)	(521)
Adjusted Surplus / (Deficit)	46	39	(7)



Financial Performance

- The Trust has a small surplus at the end of July 2021 of £0.039m, a small deterioration from plan of £0.007m (planned surplus £0.046m)
- The deteriorating position has been driven by increasing temporary staffing spend particularly in areas of increased activity, the main driver being temporary nurse staffing as a result of increased activity in ED, ICU and Maternity.
- The Medicine and Long Term Conditions Division incurring expenditure above plans, offset by other underspends within the Trust. The Division are reviewing mitigations in accordance with The Accountability Framework in operation within the Trust.
- The Trust has included an assumed ERF receipt of £2.088m for May YTD. Inclusion of these funds has been requested by NHSEI in the July YTD position. However, working across the Sustainability and Transformation Partnership (STP) the Trust believes there remains significant risk to receipt of ERF monies.
- Risks to ERF receipt are underperformance against targets from other providers in the STP (this is an STP target) most notably use of independent sector, reducing the income Walsall can 'earn' and STP level failure to achieve 1 or more of the 5 Gateways
 - A need to re-direct income around the STP in line with the risk share agreement (something Walsall benefited from in 2020/21)
- The Trust has therefore included additional non pay costs to negate any benefit in the reported position from receipt of the ERF income. This complies with the NHSEI reporting requirement but negates risk to the Trust and is consistent with the approach taken by all STP Providers.
- Excluding ERF, Non Pay was above forecast due to High Cost Drugs and Devices usage and purchase of healthcare which has been offset by increased income.

Capital

- The approved programme for the year is made up of £17.4m for Emergency Department, £10.3m of other expenditure and £1.1m to support PFI Lifecycle (total of £28.8m). However, the Trust were informed in early May that some funding may not be released to the STP and the £10.3m would need to be reduced to £10m (total of £28.5m).
- Capital expenditure totals £3.761m for the financial year to date. The Trust seeking a further allocation from the STP of £1.6m and £1.8m from NHSEI to support the ward refurbishment programme.

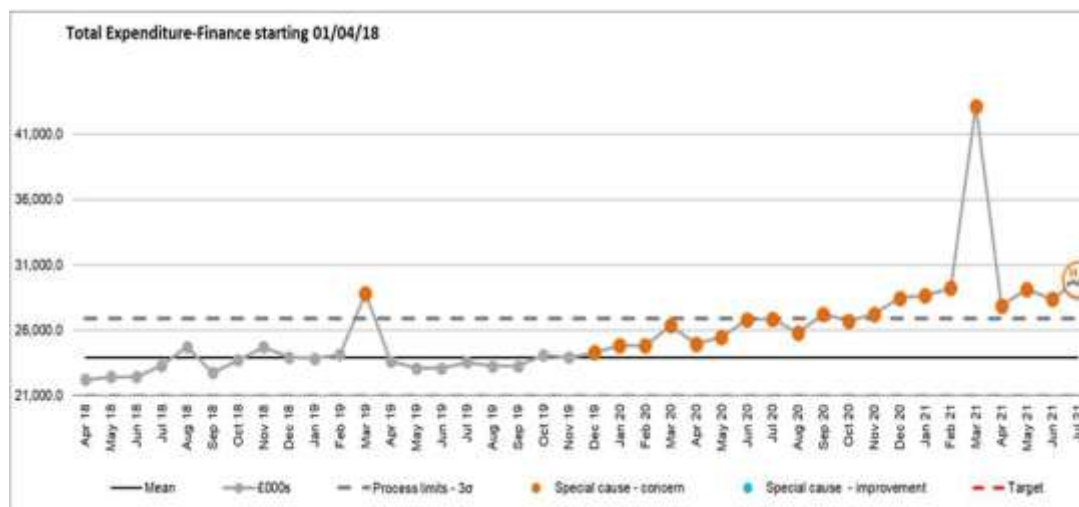
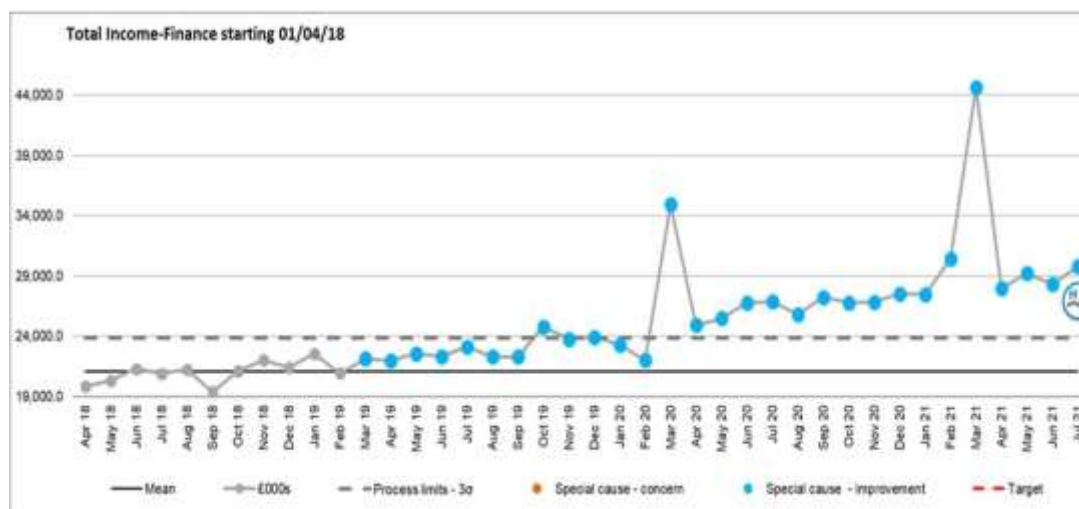
Cash

- The Trust has a positive cash holding of £43.4m as at 31st July 2021.

Efficiency attainment

- The emergency budget planning letter and guidance states there was no efficiency requirement for Months 1-6. However, development of Improvement Programme initiatives is key to ensuring financial sustainability moving forwards, with the outputs of this program to be reviewed by Performance, Finance and Investment Committee.

Income and expenditure run rate charts



Income additional information

- Income has continued to increase year on year, this reflects a level of tariff inflation and growth serviced through the Trust over this period.
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- From October there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.

Expenditure additional information

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

Cash Flow Statement & Statement of Financial Position (M4)

CASHFLOW STATEMENT		STATEMENT OF FINANCIAL POSITION			
Statement of Cash Flows for the month ending July 2021		Statement of Financial Position for the month ending July 2021		Balance as at 31/03/21	Balance as at 31/07/21
	Year to date Movement				Year to date Movement
	£'000		£000	£000	£000
Cash Flows from Operating Activities		Non-Current Assets			
Adjusted Operating Surplus/(Deficit)	3,768	Property, plant & Equipment	161,995	163,794	1,799
Depreciation and Amortisation	2,864	Intangible Fixed Assets	6,417	6,067	(350)
Donated Assets Received credited to revenue but non-cash	(608)	Receivables greater than one year	561	147	(414)
(Increase)/Decrease in Trade and Other Receivables	(4,652)	Total Non-Current Assets	168,973	170,008	1,035
Increase/(Decrease) in Trade and Other Payables	7,096	Current Assets			
Increase/(Decrease) in Stock	(156)	Receivables & pre-payments less than one Year	11,075	16,140	5,065
Increase/(Decrease) in Provisions	0	Cash (Citi and Other)	43,532	43,393	(139)
Interest Paid	(2,747)	Inventories	2,951	3,108	157
Dividend Paid	0	Total Current Assets	57,558	62,641	5,083
Net Cash Inflow/(Outflow) from Operating Activities	5,565	Current Liabilities			
Cash Flows from Investing Activities		NHS & Trade Payables less than one year	(35,179)	(40,503)	(5,324)
Interest received	0	Other Liabilities	(284)	(1,934)	(1,650)
(Payments) for Property, Plant and Equipment	(4,351)	Borrowings less than one year	(4,058)	(2,705)	1,353
Receipt from sale of Property	0	Provisions less than one year	(96)	(96)	-
Net Cash Inflow/(Outflow) from Investing Activities	(4,351)	Total Current Liabilities	(39,617)	(45,238)	(5,621)
Net Cash Inflow/(Outflow) before Financing	1,214	Net Current Assets less Liabilities	17,941	17,403	(538)
Cash Flows from Financing Activities	(1,353)	Non-current liabilities			
Net Increase/(Decrease) in Cash	(139)	Borrowings greater than one year	(111,956)	(111,956)	-
Cash at the Beginning of the Year 2021/22	43,532	Total Assets less Total Liabilities	74,958	75,455	497
Cash at the End of the July	43,393	FINANCED BY TAXPAYERS' EQUITY composition :			
		PDC	215,632	215,632	-
		Revaluation	24,307	24,307	-
		Income and Expenditure	(164,981)	(164,981)	-
		In Year Income & Expenditure	-	497	497
		Total TAXPAYER'S EQUITY	74,958	75,455	497

Use Resources well

Caring for Walsall together

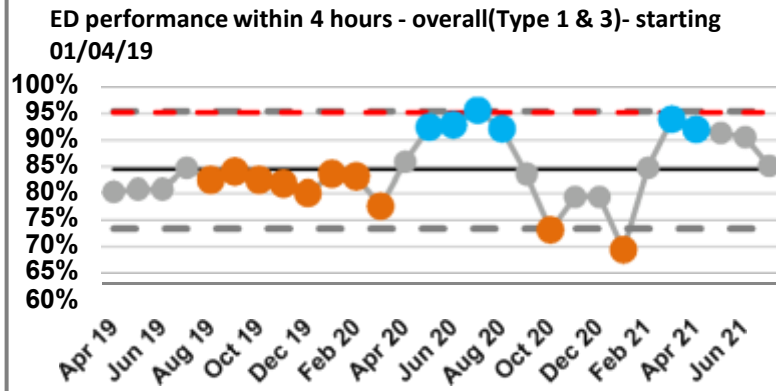


Use Resources Well - Performance

SPC Key

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

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

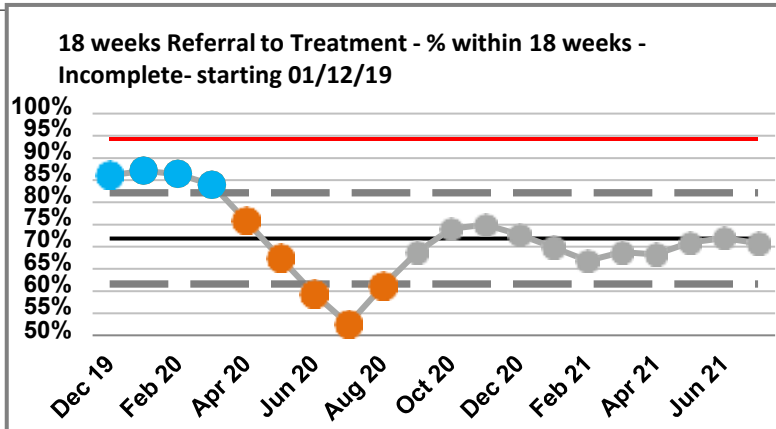


Narrative (supplied by Chief Operating Officer)

Emergency/Urgent Care

Despite the most challenged month of national performance on record, the Trust remains in the Top 20 best performing Trusts for the 4-hour Emergency Access Standard nationally for the 5th consecutive month and in the Top 5 best performing regionally for the month of July. 84.96% of patients were admitted or discharged within four hours of arrival. During July 2021 there was 7,925 Type 1 attendances. This is 9.9 % higher than July 2019 and 28.2% higher than June 2020. There is now a clear pattern of attendances being significantly higher than 2019. Analysis suggests this is being largely driven by lower acuity patients with many patients citing difficulty accessing Primary Care before presenting. However, given the number of attendances, the high acuity of patients and staff sickness /isolation, the Department has managed most patients' care in a timely manner.

18 weeks RTT – Incomplete
Pathways



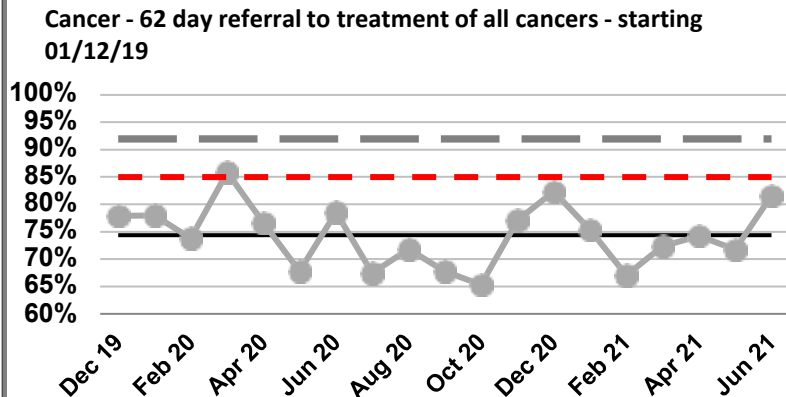
RTT (18 weeks Referral to Treatment)

In July 2021, 18 week RTT incomplete performance is in line with the forecast with 70.76% of patients waiting less than 18 weeks, relative to a trajectory of 70.20%. July 2021's performance sees the Trust placed 50th (out of 122 reporting general Acute Trusts) across the NHS and 6th in the Region. WHT continues to have the 4th lowest proportion of its elective waiting list over 52 weeks in the Midlands. Plans to address non-admitted pathway delays have been developed, including an expansion of patient initiated follow up appointments, advice & guidance and improved approaches to the validation of data quality issues on our pathways. There is a review of the Patient Access Policy underway to incorporate new guidance & refresh RTT training planned for the teams.

Use Resources Well - Performance

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

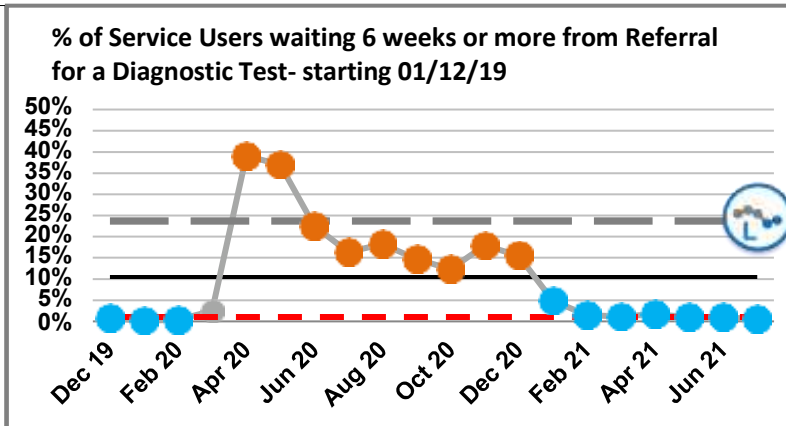
Cancer 62 Day RTT



Cancer

Excellent progress has been made against trajectory to delivery the 62 day from GP referral to treatment constitutional standard by August's reported position, with June's performance 81.6%, the highest since December 2020. This is reflected in the Trust's national position, which now places the Trust 34th of 122 general acute Trusts reported against the constitutional standard.

Diagnostic waiting times (DM01)

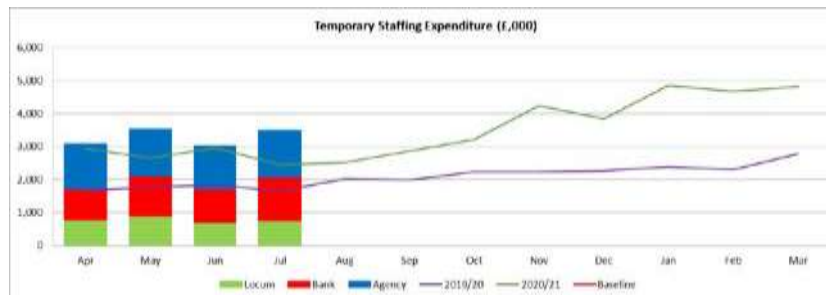


Diagnostic waiting times & activity (DM01)

Trust diagnostic performance improved from 0.96% of patients waiting over 6 weeks in June, to 0.53% of patients waiting over 6 weeks in July 2021. This represents sustained excellent performance in the context of both National and Regional restoration and recovery of diagnostic services. As an organisation, Walsall Healthcare NHS Trust is compliant with the National DM01 standard.

Financial Performance to July 2021 (Month 4)

	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Income			
Healthcare Income (Inc. Vaccs)	105,401	109,534	4,133
Other Income (Education&Training)	2,808	2,580	(228)
Other Income (Other)	2,392	3,146	754
Subtotal Income	110,601	115,260	4,659
Pay Expenditure			
Substantive Salaries	(56,978)	(57,394)	(416)
Temporary Nursing	(5,367)	(5,888)	(521)
Temporary Medical	(4,780)	(4,634)	146
Temporary Other	(1,814)	(1,454)	360
Vaccination Programme	(2,429)	(1,372)	1,057
Subtotal Pay Expenditure	(71,368)	(70,742)	626
Non Pay Expenditure			
Drugs	(5,940)	(6,687)	(747)
Clinical Supplies and Services	(5,397)	(6,118)	(721)
Non-Clinical Supplies and Services	(4,840)	(5,684)	(844)
Other Non Pay	(17,056)	(19,171)	(2,115)
Vaccination Programme	0	(227)	(227)
Depreciation	(2,902)	(2,864)	38
Subtotal Non Pay Expenditure	(36,135)	(40,751)	(4,616)
Interest Payable	(3,116)	(3,272)	(155)
Subtotal Finance Costs	(3,116)	(3,272)	(155)
Total Surplus / (Deficit)	(18)	496	514
Donated Asset Adjustment	64	(457)	(521)
Adjusted Surplus / (Deficit)	46	39	(7)



Financial Performance

- The Trust has a small surplus at the end of July 2021 of £0.039m, a small deterioration from plan of £0.007m (planned surplus £0.046m)
- The deteriorating position has been driven by increasing temporary staffing spend particularly in areas of increased activity, the main driver being temporary nurse staffing as a result of increased activity in ED, ICU and Maternity.
- The Medicine and Long Term Conditions Division incurring expenditure above plans, offset by other underspends within the Trust. The Division are reviewing mitigations in accordance with The Accountability Framework in operation within the Trust.
- The Trust has included an assumed ERF receipt of £2.088m for May YTD. Inclusion of these funds has been requested by NHSEI in the July YTD position. However, working across the Sustainability and Transformation Partnership (STP) the Trust believes there remains significant risk to receipt of ERF monies.
- Risks to ERF receipt are underperformance against targets from other providers in the STP (this is an STP target) most notably use of independent sector, reducing the income Walsall can 'earn' and STP level failure to achieve 1 or more of the 5 Gateways
 - A need to re-direct income around the STP in line with the risk share agreement (something Walsall benefited from in 2020/21)
- The Trust has therefore included additional non pay costs to negate any benefit in the reported position from receipt of the ERF income. This complies with the NHSEI reporting requirement but negates risk to the Trust and is consistent with the approach taken by all STP Providers.
- Excluding ERF, Non Pay was above forecast due to High Cost Drugs and Devices usage and purchase of healthcare which has been offset by increased income.

Capital

- The approved programme for the year is made up of £17.4m for Emergency Department, £10.3m of other expenditure and £1.1m to support PFI Lifecycle (total of £28.8m). However, the Trust were informed in early May that some funding may not be released to the STP and the £10.3m would need to be reduced to £10m (total of £28.5m).
- Capital expenditure totals £3.761m for the financial year to date. The Trust seeking a further allocation from the STP of £1.6m and £1.8m from NHSEI to support the ward refurbishment programme.

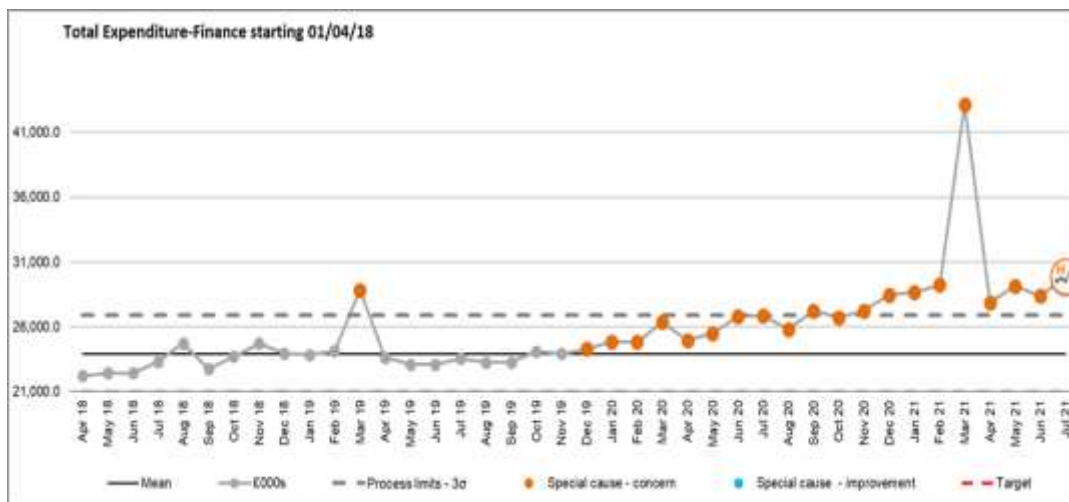
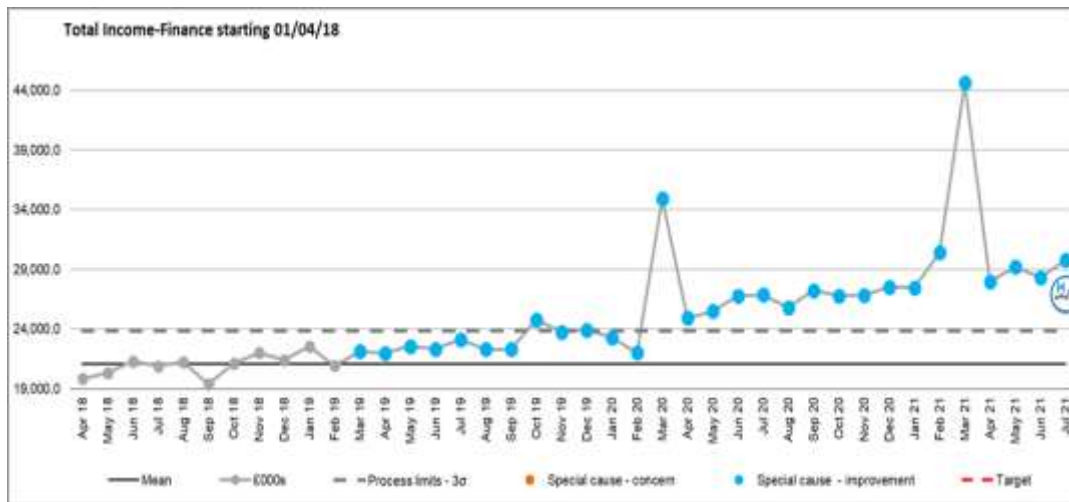
Cash

- The Trust has a positive cash holding of £43.4m as at 31st July 2021.

Efficiency attainment

- The emergency budget planning letter and guidance states there was no efficiency requirement for Months 1-6. However, development of Improvement Programme initiatives is key to ensuring financial sustainability moving forwards, with the outputs of this program to be reviewed by Performance, Finance and Investment Committee.

Income and expenditure run rate charts



Income additional information

- Income has continued to increase year on year, this reflects a level of tariff inflation and growth serviced through the Trust over this period.
- January and February 2020 income reduced as the Trust moved away from plan, losing central income from the Financial Recovery Fund (FRF) and Provider Sustainability Fund (PSF) during these months
- March 2020 saw the Trust move back on plan and receive the quarters FRF and PSF in month accordingly.
- April's income reflects the emergency budget income allocation (increasing monthly to reflect the increase in the top up of funding received).
- From October there will no longer be retrospective top up funding received, block income has been agreed based on operation run rates.
- February 2021 saw the receipt of additional NHSEI Income allocation to offset the 'Lost Income' assumed in the Deficit Plan.

Expenditure additional information

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

Cash Flow Statement & Statement of Financial Position (M4)

CASHFLOW STATEMENT

Statement of Cash Flows for the month ending July 2021

Year to date
Movement

	£'000
Cash Flows from Operating Activities	
Adjusted Operating Surplus/(Deficit)	3,768
Depreciation and Amortisation	2,864
Donated Assets Received credited to revenue but non-cash	(608)
(Increase)/Decrease in Trade and Other Receivables	(4,652)
Increase/(Decrease) in Trade and Other Payables	7,096
Increase/(Decrease) in Stock	(156)
Increase/(Decrease) in Provisions	0
Interest Paid	(2,747)
Dividend Paid	0
Net Cash Inflow/(Outflow) from Operating Activities	5,565
Cash Flows from Investing Activities	
Interest received	0
(Payments) for Property, Plant and Equipment	(4,351)
Receipt from sale of Property	0
Net Cash Inflow/(Outflow) from Investing Activities	(4,351)
Net Cash Inflow/(Outflow) before Financing	1,214
Cash Flows from Financing Activities	
Net Increase/(Decrease) in Cash	(139)
Cash at the Beginning of the Year 2021/22	43,532
Cash at the End of the July	43,393

STATEMENT OF FINANCIAL POSITION

Statement of Financial Position for the month ending July 2021

Balance
as at
31/03/21

Balance
as at
31/07/21

Year to
date
Movement

	£000	£000	£000
Non-Current Assets			
Property, plant & Equipment	161,995	163,794	1,799
Intangible Fixed Assets	6,417	6,067	(350)
Receivables greater than one year	561	147	(414)
Total Non-Current Assets	168,973	170,008	1,035
Current Assets			
Receivables & pre-payments less than one Year	11,075	16,140	5,065
Cash (Citi and Other)	43,532	43,393	(139)
Inventories	2,951	3,108	157
Total Current Assets	57,558	62,641	5,083
Current Liabilities			
NHS & Trade Payables less than one year	(35,179)	(40,503)	(5,324)
Other Liabilities	(284)	(1,934)	(1,650)
Borrowings less than one year	(4,058)	(2,705)	1,353
Provisions less than one year	(96)	(96)	-
Total Current Liabilities	(39,617)	(45,238)	(5,621)
Net Current Assets less Liabilities	17,941	17,403	(538)
Non-current liabilities			
Borrowings greater than one year	(111,956)	(111,956)	-
Total Assets less Total Liabilities	74,958	75,455	497
FINANCED BY TAXPAYERS' EQUITY composition :			
PDC	215,632	215,632	-
Revaluation	24,307	24,307	-
Income and Expenditure	(164,981)	(164,981)	-
In Year Income & Expenditure	-	497	497
Total TAXPAYER S' EQUITY	74,958	75,455	497

MEETING OF THE PUBLIC TRUST BOARD

Thursday 2nd September 2021

Value our Colleagues – Executive Update			AGENDA ITEM: 18
Report Author and Job Title:	Catherine Griffiths – Director of People and Culture	Responsible Director:	Catherine Griffiths – Director of People and Culture
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
	This report provides an update on actions relating to the Value Our Colleagues work-stream of the improvement programme. The following points seek to inform the Trust Board of progress, identify where assurance can be taken and where required to seek approval for actions proposed. 1. <u>Progress on Recruitment and Retention</u> The People and Organisation Development Committee noted and approved the safe staffing report, which shows a Registered Nurse vacancy rate below 7%. However the turnover rate for nursing and midwifery has increased from 8.65% in the year to March 2021 (target 10%) to 11.02% in June 2021 and 10.87% in July 2021. This and the reduction in bank fill rate 89.86% RN day and 84.7% CSW day (against target 95% fill), coupled with increased long term absence manifests in increased incidents relating to staffing levels. The establishment gap has increased from April 2021 (94 WTE) to June 2021 (121 WTE). The mitigating actions relate to the increased recruitment of overseas nurses: By the end of September 69 will have completed their OSCE, and by the end of the calendar year over 200 overseas nurses will have arrived and completed their OSCE within the Trust. A very successful and well attended welcome event was held during August. In addition, 8 of the current cohort of 38 nursing associates registered with the NMC during July. The trust has 83 individuals undertaking apprenticeships 38 nursing associates and 44 CSWs and 1 healthcare scientist. The People and Organisation Development Committee received a staff story which provided an update on the progress the trust is making with its anchor institute approach.		

	2. <u>Progress on Staff Experience and Engagement</u> The preparations for the National Staff Survey are well underway with a structured communication and engagement approach with the divisional oversight group leading the campaign. The survey will launch in September, date to be confirmed with a closing date of 6th December 2021. 3. <u>The Board Assurance Framework</u> The People and Organisational Development Committee noted the significant risk relating to staffing levels, which remains at level 20 and noted the approved the Board Assurance Framework (BAF) risk mitigations which have been divided into the three elements of assurance. • Leadership, Culture and Organisation Development • Organisation Effectiveness – recruitment, retention and career development • Making Walsall (and the Black Country STP) the best place to work 4. <u>Tackling Bullying, Harassment and Discrimination</u> The People and Organisation Development Committee noted the action plan in place to mitigate the risk created by bullying, harassment and discrimination. The committee received an update on the leadership development programme, manager competence framework to be launched later in September and the progress with EDI outcomes.
Executive Summary	This report provides an overview of the risks to delivery for the Value Our Colleagues' strategic objective and provides an update on the mitigations in place to manage the risks identified, as well as the actions identified to address gaps in controls and assurance. It provides the Trust Board with assurance relating to the improvement programme Value Our Colleagues work-stream and performance against the Value Our Colleagues strategic objective, this report highlights successes and identifies assurance gaps and areas for improvement.

Recommendation	1. Members of the Trust Board are asked to note the report and in particular note the activity and progress on overseas recruitment. 2. Members of the Trust Board are asked to note the staffing indicators for the nursing, midwifery and clinical support worker groups and note the risk relating to staffing. 3. Members of the Trust Board are asked to note the action plan to tackle bullying, harassment and bullying was received at the People and OD Committee along with an update on progress on EDI and leadership.
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk Value our Colleagues in order to provide positive assurance the mitigations in place to manage this risk and the related corporate risks.
Resource implications	There are resource implications that flow from recommendations in the report. In the short-term the resource requirements are being met from base budgets. The improvement programme priorities outlined in this report will require investment beyond the base budget in order to achieve the milestones and progress envisaged by 2022-2023. Specifically to retain the health and wellbeing support to the workforce as committed to by the Trust Board in April 2021 and to ensure adequate support for staff voice, freedom to speak up and other statutory and advisory work.
Legal and Equality and Diversity implications	There are significant issues relating to equality arising from matters addressed in the report. The Trust Board has been presented with the evidence base for differential staff experience based on ethnicity, disability, age, sexuality, gender, religion and other protected characteristics. This goes to the heart of both the Trust Board pledge and the Trust values and supporting behaviours. The improvement programme seeks to mitigate the risk on the BAF, noting the low baseline and the considerable challenge of achieving outstanding performance across the metrics by 2022-23. In addition the valuing our colleagues work-stream seeks to ensure the systems the Trust relies upon can delivery equality of outcome relating to career progression, development, promotion, talent

	management and recruitment such that the workforce is representative of the communities it serves and can be seen as an anchor institution within Walsall. The leadership and management development programmes both focus on equality outcomes and developing skills and understanding of an inclusive leadership approach, whilst leading for performance improvement in a compassionate framework that supports a just, restorative and learning culture.	
Strategic Objectives	Safe, high quality care ☐	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☐	

Value Our Colleagues – Improvement Programme

1. EXECUTIVE SUMMARY

The Trust Board made a pledge relating to Value Our Colleagues as follows:

“We the Trust Board, pledge to demonstrate through our actions that we listen and support people. We will ensure that the organisation treats people equally, fairly and inclusively with zero tolerance of bullying. We uphold and role-model the Trust values chosen by you”

The People and Organisation Development Committee received updates on the preparatory work prior to the National Staff Survey distribution in September 2021 and the progress on the actions designed to tackle bullying, harassment and discrimination evidenced by the national staff survey, the pulse survey and through network groups. The committee received progress updates on the Equality, Diversity and inclusion actions completed and the positive impact on a number of WRES and WDES indicators. The committee also received a progress update on the leadership development work, the Manager Competence Framework due to launch later this month and the divisional work on talent management and succession planning. The staff story related to the impact of the Trust’s approach on employment as an anchor institute. The purpose of the Value Our Colleagues enabling work-stream of the improvement programme is to deliver workforce improvement so colleagues recommend the Trust as a place to work and as a place to be treated. Colleague experience has a direct correlation with patient experience and outcomes. The focus on developing leaders and managers to role model the behaviours and values of the trust is a critical lever to change the direction of travel and to appreciate and build on good practice, learn from it and embed it elsewhere and to achieve the outcomes within the Trust Board pledge.

2. BOARD ASSURANCE FRAMEWORK

The People and Organisational Development Committee noted the significant risk relating to safe staffing levels and increased incidents over the past months. The Board Assurance Framework (BAF) risk mitigations are divided into the three elements of assurance as follows:

- Leadership, Culture and Organisation Development
- Organisation Effectiveness – recruitment, retention and career development
- Making Walsall (and the Black Country STP) the best place to work

3. IMPROVEMENT PROGRAMME

The People and Organisation Development Committee noted that the Value our Colleagues work-stream of the improvement programme has been profiled to focus on the priority area of tackling bullying, harassment and discrimination in a way capable of transforming the organisational culture. The restorative and learning approach is core to this along with the delivery of the EDI strategy and the leadership and management development programme, which will also require investment to accelerate the programme following delay through the pandemic.

The following are key updates in month:

Progress on Recruitment and Retention

The People and Organisation Development Committee noted and approved the safe staffing report, which shows a Registered Nurse vacancy rate below 7%. However the turnover rate for nursing and midwifery has increased from 8.65% in the year to March 2021 (target 10%) to 11.02% in June 2021 and 10.87% in July 2021. This and the reduction in bank fill rate 89.86% RN day and 84.7% CSW day (against target 95% fill), coupled with increased long term absence manifests in increased incidents relating to staffing levels. The establishment gap has increased from April 2021 (94 WTE) to June 2021 (121 WTE). The mitigating actions relate to the increased recruitment of overseas nurses: By the end of September 69 will have completed their OSCE, and by the end of the calendar year over 200 overseas nurses will have arrived and completed their OSCE within the Trust. A very successful and well attended welcome event was held during August. In addition, 8 of the current cohort of 38 nursing associates registered with the NMC during July. The trust has 83 individuals undertaking apprenticeships 38 nursing associates and 44 CSWs and 1 healthcare scientist.

The People and Organisation Development Committee received a staff story which provided an update on the progress the trust is making with its anchor institute approach.

Progress on Staff Experience and Engagement

The preparations for the National Staff Survey are well underway with a structured communication and engagement approach with the divisional oversight group leading the campaign. The survey will launch in September, date to be confirmed with a closing date of 6th December 2021.

4. PERFORMANCE REPORT

The workforce metrics performance report takes a standard set of quantitative metrics and tracks performance over time. The People and Organisation Development Committee will receive reports with a divisional focus from September onwards to enable a deep dive into the effectiveness of action taken to address bullying, harassment and discrimination, create a healthy culture and to address the safe staffing risk in line with the ambitions set out within the Equality, Diversity and Inclusion Strategy.

5. RECOMMENDATIONS

- Members of the Trust Board are asked to note the report and in particular note the activity and progress on overseas recruitment.
- Members of the Trust Board are asked to note the staffing indicators for the nursing, midwifery and clinical support worker groups and note the risk relating to staffing.
- Members of the Trust Board are asked to note the action plan to tackle bullying, harassment and bullying was received at the People and OD Committee along with an update on progress on EDI and leadership.

APPENDICES

None

MEETING OF THE PUBLIC TRUST BOARD - Thursday 2 nd September 2021			
Safe Staffing Report			AGENDA ITEM: 19
Report Author and Job Title:	Gaynor Farmer Corporate Senior Nurse for Workforce	Responsible Director:	Lisa Carroll Director of Nursing
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	- Registered Nurse (RN) /Midwife vacancy rate for July 2021 is just below 7%, this is a reduction since last month. 29 overseas nurses have OSCE's booked for the end of July 2021; a further 20 are booked for August and 19 for September 2021. - The Trust expects to recruit 200 overseas RN by the end of 2021. - There are 44 Clinical Support Workers undertaking apprenticeships and 38 Trainee Nursing Associates on apprenticeship programmes in the Trust. In addition, 1 Healthcare Sciences apprentice is in post within the Trust. - Off framework agency use has increased during July 2021 to 1046.25 hours. This is a significant increase from June 2021 when the Trust used 192.5 hours. - The lowest fill rate for July 2021 was for the CSW day shift at 84.70%. The overall fill rate (combined RN and CSW) was 91.66%, a decrease from the 92.07% reported for June 2021. - In July 2021, before consideration of escalation to Off Framework Agency, Matrons redeployed 1095 hours of substantive RN and 492 hours of CSW during the twice daily Staffing Hub meetings. - The staff experience audit score was 88.46% with 14 clinical areas completing this audit		
Recommendation	The Committee is requested to note the contents of the report		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF S01: We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022 Corporate Risk No 2066: Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15).		
Resource implications	Covid-19 impact - staff are working in different ways and locations; risk to staff health and well-being; impact on training and continual professional development		
Legal and Equality and Diversity implications	Covid-19 has impacted disproportionately on people who are men, from low socioeconomic backgrounds and from BAME backgrounds Our local population is subject to multiple inequalities which affect quality of life, health and mortality. Further work is required to consider how best we provide assurance on equality, diversity and inclusion and the resulting impact on outcomes.		
Strategic Objectives	Safe, high quality care ☒	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☒		

Introduction

Covid-19 impact has reduced across the Trust with many services now resuming ordinary business. There are still a small number of reconfigured areas within the acute departments which are working with Covid streaming, different patient groups and vacancies/absences that are impacting the ability to have complete fill of shift requirements. July 2021 has seen 50 shifts where the Ward Manager was used as an RN on duty to fill an RN gap and management time was impacted. This is an increase from 27 last month.

Nurse Staffing Update

1.1 Vacancy Position

The RN and Midwifery vacancy rate for July 2021 is lower than last month at just under 7%. The following SPC charts provide details on the number of vacancies against the current approved establishments at a Trust and divisional level.

Chart 1: Nursing and Midwifery vacancy % (excluding Nurse Associates)



Chart 2: MLTC Vacancy position (information via ESR)



Chart 3: Surgery Vacancy position (information via ESR)

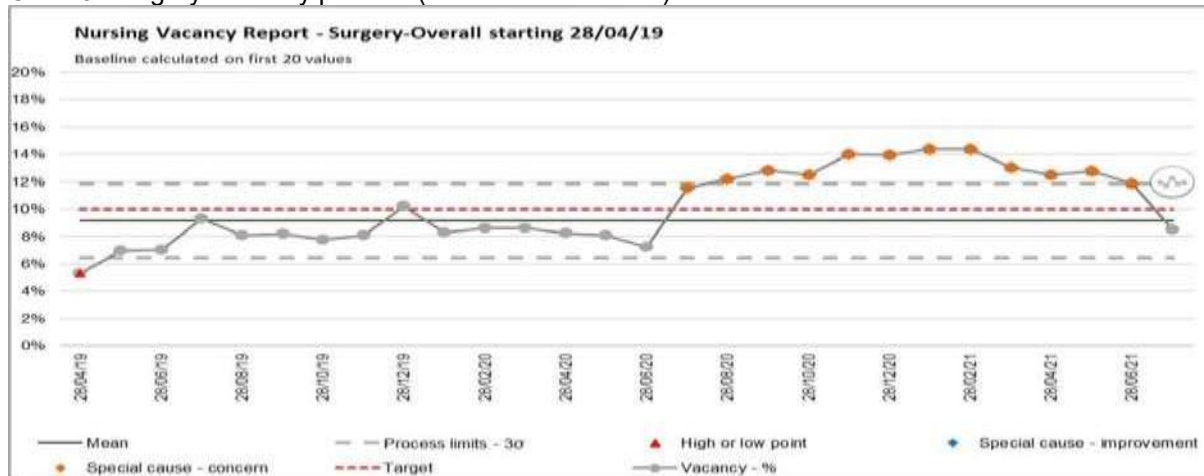
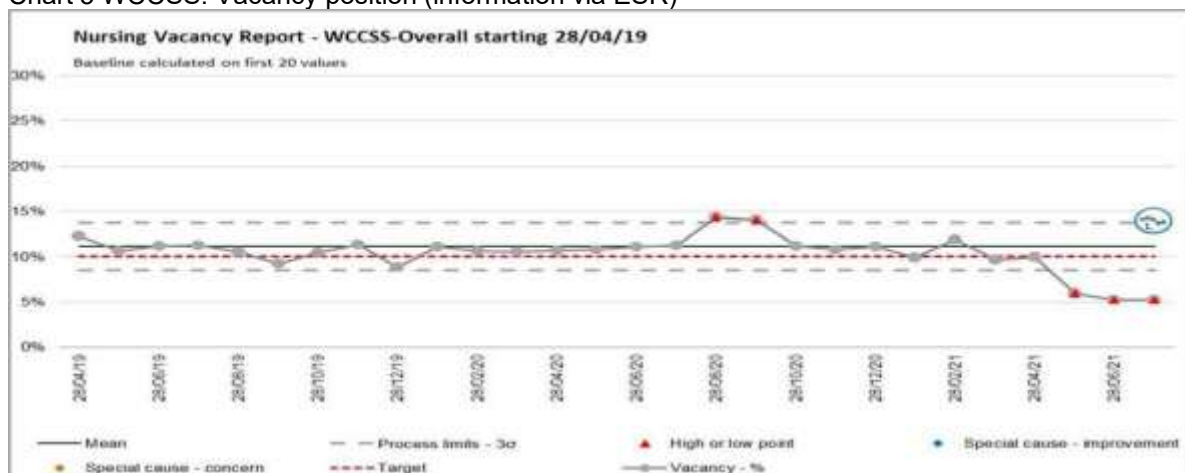


Chart 4: Community Vacancy position (information via ESR)



Chart 5: WCCSS: Vacancy position (information via ESR)



1.2 Overseas Recruitment

29 of the overseas nurses recruited and working within the Trust had OSCEs booked for July 2021. A further 20 have their OSCE's booked for August and 19 have their OSCE's booked for September 2021.

Pastoral care is being delivered by Team FORCE. There are a further 4 cohorts of overseas RNs due to commence in the Trust between July and October 2021. The current expectation is that approximately 200 overseas RNs will be recruited by the end of 2021.

1.3 CSW Recruitment

The Trust currently has 83 individuals undertaking apprenticeships. One individual has been employed as a healthcare science apprentice, 38 are Trainee Nursing Associates and 44 are CSWs undertaking either a level 2 or level 3 programme.

1.4 Nursing Associate Recruitment

Of the 38 Trainee Nursing Associates eight are expected to register with the NMC during July with a further 13 expected to register in January 2022. An additional eleven individuals will commence training in September 2021.

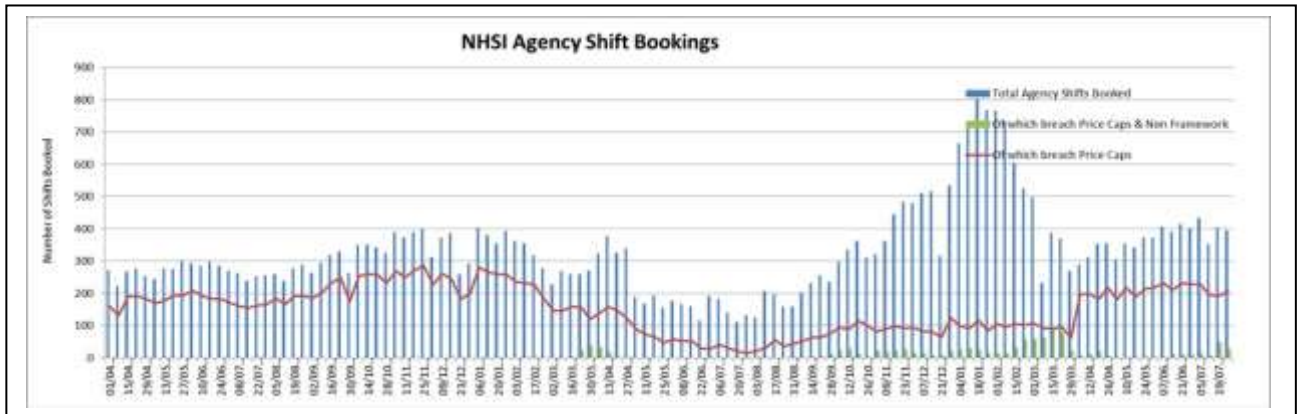
1.5 NHSI Agency Cap Breaches

NHSI Agency Cap Breaches (Chart 7) have continued to be reported weekly to NHSI and have reduced to the previous month (891 shifts in June and 822 shifts in July).

Off framework use has however increased during July and has been used to support ED (354 hours), ED Paeds (11.5 hours), ICU (582 hours), NNU (23 hours), SACU (10 hours), Ward 1 (19.25 hours), Ward 12 (11.5 hours), Ward 17 (6 hours), Ward 29 (17.5 hours), Ward 5/6 (11.5 hours). A total of 1046.25 hrs.

The Trust has experienced difficulty in filling a number of shifts which has required escalation to off framework agencies to maintain safety. The primary reason for the failure to fill with bank and agencies on framework is that other Trusts in the local area have increased their rates of pay, particularly in the specialist areas of maternity, ED and ICU.

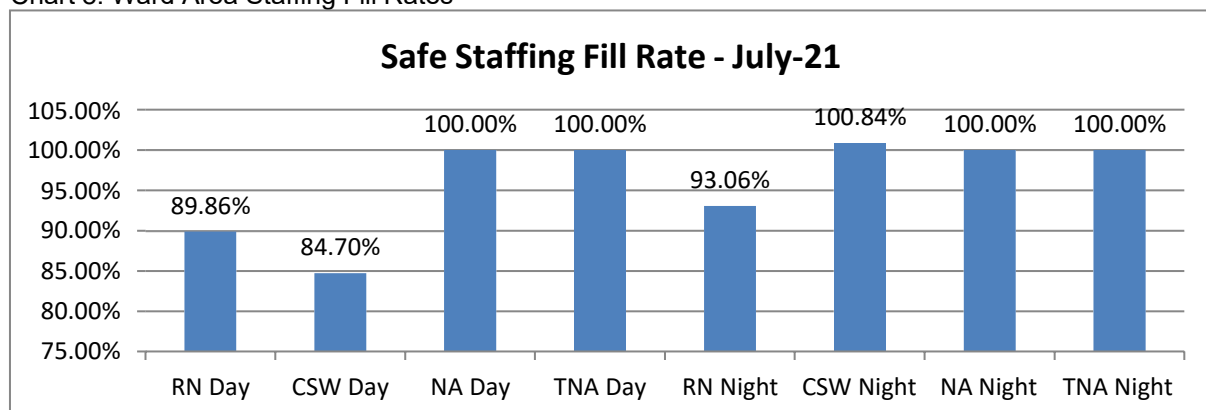
Chart 7: Agency Cap Performance



1.6 NHSI Model Hospital Staffing Fill Rates

The lowest fill rate for July 2021 was for CSWs on day shifts at 84.70%. This is a reduced fill compared to last month. The overall fill rate for July (combined RN and CSW) was 91.66%, the previous month was 92.07%.

Chart 8: Ward Area Staffing Fill Rates



1.7 Staffing Hub Activities

The Staffing Hub provides oversight of staffing levels across the Trust and supports and facilitates the speedy escalation of issues in relation to staffing, acuity and outstanding shift demand. The staffing hub maintains a 72 hour forward view of Trust wide staffing. The staffing hub supports twice daily matron led, safe staffing meetings. These meetings provide a forum for re-deploying staff across clinical units and divisions, management of red flags, assurance regarding safe staffing levels across the Trust and escalation if risks cannot be mitigated. Through the safe staffing meetings 1095 hours of RN and 492 hours of CSW were re-deployed across the trust in July 2021. This is an increase overall since June 2021 when 708.5 hours of RN and 427.5 hours of CSW time were re-deployed.

Red Flags are recorded, reviewed and where possible mitigated, within the safe staffing meeting. Matrons oversee the accuracy of the Red Flags recorded and their appropriateness. In July 2021 there were 333 Red Flags that were raised and 88

were resolved and mitigated during the safe staffing meeting. For the 245 Red Flags that could not be immediately mitigated this is escalated to the appropriate Divisional Director of Nursing for oversight, support and decisions regarding next steps via the Nursing and Midwifery Advisory Forum.

1.8 Electronic Rostering (E-roster) Levels of Covid-19 Related Absence

The Trust records all absence within the e-roster system. The system enables COVID-19 related absence to be recorded separately from other sickness absence (chart 9).

Chart 9: Covid-19 Related Absence in Erosters

Staff Type	Covid Related Absence Hours (Eroster)
RN	July= 561 hrs (decrease since previous month-June 21)
CSW	July= 471 hrs (decrease since previous month-June 21)

In July 2021 the temporary staffing bookings to cover for sickness and Covid-19 related absence for RN's was 3268 more than the actual hours of absence recorded. For CSWs there were 574 hours fewer hours booked than hours of absence recorded. There was an overall decrease in sickness/Covid-19 related absence in July 2021 compared to those recorded in June 2021 (Chart 10).

Ward 9 increased its bed base opening additional capacity during May 2021 and the establishment and safe staffing levels have remained increased to reflect this.

Chart 10: Comparison of Sickness/Covid-19 Absence against Temporary Staffing

Staff Type	Sum of Covid-19 Related Absence Hours + Sickness Absence	Temporary Staffing Hours Booked for Sickness and Covid-19 related absence
RN	3364 hours	6632 hours
CSW	4599 hours	4025 hours

In July 2021 there were 258 fewer RN hours of temporary staff booked compare to the actual hours of maternity related absence. For CSWs there were 403 more hours of temporary staff booked compared to the actual hours of absence (Chart 11).

Chart 11: Comparison of Maternity/Paternity absence against Temporary Staffing

Staff Type	Maternity/Paternity Absence hours	Temporary Staffing Hours Booked for maternity/paternity related absence
RN	2056 hours	1798 hours
CSW	1200 hours	1603 hours

1.9 Allocate System Roll Out

Forty Five departments have now attended Roster Manager training for Allocate and are now linked to the live payroll. There is one remaining department to transfer from RPC into Allocate that receive enhancements (Specialist Nurse Respiratory), they will be live from August 2021. There are six remaining departments in RPC that need to be transferred into Allocate that provide predominantly Monday-Friday services but do use bank staff. Endoscopy, Chemotherapy, Outpatients, Easibook, Medical

Day Case and Fracture Clinic have training planned during August and September but will be live in Allocate from 6th September onwards.

The RPC system licence has been extended until September 2021 to enable full roll out of the Allocate system. The Covid-19 pandemic has delayed the roll out plan for Allocate due to the inability to train clinical staff. Virtual methodologies have been tried without success. Face to face training in a COVID secure way has re-commenced.

In addition to the training delays Allocate have updated the user interface (version 11). The Trust must migrate from the current Version 10 to Version 11 by the end of September 2021. This migration will require all Allocate Managers, in forty departments to undertake a further 1-2 days of training. An initial trial of Version 11 training has highlighted some issues with the functionality which has been reported to Allocate who have now extended the migration date and noted the issues. Challenges with staff absence within the Eroster Team have added more complexity to this roll out and support has been requested from the Royal Wolverhampton NHS Trust and confirmation regarding available support is awaited.

1.10 : Staff experience audits – Perfect ward

The corporate nursing team has been working closely with the performance team to continue to develop the perfect ward audits. Within this suite of audits a monthly staff experience audit is undertaken. In July 2021 the staff experience audit score was 88.46% with 14 clinical areas completing this audit. The audit results, action plans, continued monitoring of progress and re-audit will be overseen and assurance on progress gained through the Trust wide Nursing, Midwifery and AHP Forum and Divisional Governance meetings.

END OF REPORT

MEETING OF THE PUBLIC TRUST BOARD			
Thursday 2 nd September 2021			
Revalidation Annual Report & Statement of Compliance 2020/21			AGENDA ITEM: 20
Report Author and Job Title:	Mark Read – Medical Revalidation & Job Planning Manager	Responsible Director:	Dr. Manjeet Shehmar Acting Medical Director
Action Required	Approve ☒ Discuss ☐ Inform ☐ Assure ☒		
Executive Summary	The Annual Report for Revalidation and Statement of Compliance are attached for review by the Committee and endorsement to the Trust Board for their approval. Of note is: Appraisal & Revalidation Performance 1 April 2020- 31 March 2021 - On 19th March 2020, NHS England's Responsible Officer (RO) formally requested the suspension of the Appraisal Programme due to the COVID19 Pandemic until further notice; - As a result, the NHS England Annual Organisational Audit was not conducted this year; - A limited, flexible Appraisal Programme was reinstated 1st October 2020 following recommendation on 3rd September from NHS England's Responsible Officer; 76% (209) of connected doctors completed an appraisal; 22% (62) of connected doctors had an RO approved missed appraisal owing to COVID-19, maternity leave, long term sickness etc. 2% (5) of connected doctors had an unapproved reason for their missed appraisal; - On 19th March 2020, the GMC also suspended all revalidation submissions until 31st March 2021; 2 doctors were due for revalidation prior to the GMC suspending revalidation and these doctors were recommended for revalidation. Key Actions undertaken 1 April 2020 – 31 March 2021 - Non-executive Director Mr Ben Diamond, attends the monthly Maintaining Professional Standards Group (MPSG); - Completed a programme of two refresher webinars for existing Medical Appraisers 18th and 23rd September 2020; - Completed a programme of one webinar for New Medical Appraisers training on 6th October 2020;		

	Key Actions Planned for 1 April 2021 - 31 March 2022 • Focus on a rebalanced approach to appraisal, that focuses on the doctor's professional development and wellbeing, and simplifies expectations around supporting information and pre-appraisal paperwork. • Medical Appraisal and Revalidation Policy (yet to be ratified by the Local Negotiating Committee). • Continuing bi-monthly drop in support sessions for Doctors via Microsoft Teams, to provide training, support and advice. • Continuing quarterly sessions for Appraisers to discuss support, training and the performance of the Appraisal Programme; • Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development. • Maintain performance - 0 late recommendations to the GMC. • Ensure positive recommendations are confirmed in writing to the doctor; Risks and Issues Identified risks include: • New Policy yet to be ratified; • Impact of COVID19 on Trust Appraisal Performance and Revalidation decision making processes;
Recommendation	Members of the Trust Board are requested to: • Approve the Annual Report for Revalidation and; • Approve the 'Statement of Compliance', confirming that the organisation, as a designated body, is compliant with the regulations (Section 7) <i>A Statement of Compliance with the regulations (Section 7) should be signed by the Chairman or Chief Executive Officer of the designated body's Board or management team and submitted to Dr David Levy, Regional Medical Director and Higher Level Responsible Officer, NHS England Midlands and East by <u>30 September 2021</u>.</i>
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report mitigates BAF Risk S01 - failure to deliver consistent standards of care to patients' across the Trust results in poor patient outcomes and incidents of avoidable harm by ensuring consistent processes for revalidation and compliance with the regulations.
Resource implications	There are no resource implications in this paper.

Legal and Equality and Diversity implications	There are no resource implications in this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☐
	Partners ☐	Value colleagues ☒
	Resources ☒	

A Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Contents

Introduction:	6
Designated Body Annual Board Report	7
Section 1 – General	7
Section 2 – Effective Appraisal	10
Section 3 – Recommendations to the GMC	12
Section 4 – Medical Governance	13
Section 5 – Employment Checks	15
Section 6 – Summary of comments, and overall conclusion	15
Section 7 – Statement of Compliance	17

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published by NHS England in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes was undertaken by NHS England, with the priority redesign of the three annexes below:

1. Annual Organisational Audit (AOA):

The AOA captures relevant numerical data necessary for regional and national assurance. The AOA has not been produced for 20/21 due to the formal suspension of the Appraisal Programme on 19th March 2020 by NHS England's Responsible Officer, due to COVID19 Pandemic.

See Appendix 1

2. Board Report:

The Board Report is presented to support Walsall Healthcare NHS Trust (hereafter referred to as the Trust) as a 'designated body' in reviewing progress over time. Whereas the previous version of the Board Report template addressed the Trust's compliance with the responsible officer regulations, the revised version now contains items to help the Trust assess its effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance¹. This handbook describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

The over-riding intention of this Board Report is to guide the Trust by setting out the key requirements for compliance with regulations and key national guidance. It provides a format to review these requirements, so that the Trust can demonstrate not only basic compliance but continued improvement over time. The Board Report will:

- a) help the Trust in its pursuit of quality improvement,
- b) provide the necessary assurance to the higher-level responsible officer, and
- c) act as evidence for CQC inspections.

¹ Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

3. Statement of Compliance:

The Statement Compliance (in Section 7) is now combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The Board of Walsall Healthcare NHS Trust can confirm that:

1. **The Annual Organisational Audit (AOA) for this year has been submitted.**

Date of AOA submission: No AOA was undertaken this year as NHS England's Responsible Officer formally suspended the Appraisal Programme.

Actions from last year: *None*.

Comments: ***Trust Appraisal Compliance***

Figure 1 demonstrates the Trust's overall Appraisal Completion rate decreased from 98% on 31 March 2020 to 76% on 31 March 2021, but this impact was due to the suspension of the Appraisal Programme between 19th March – 1st October 2020. The Trust currently has 276 doctors with a GMC prescribed connection.

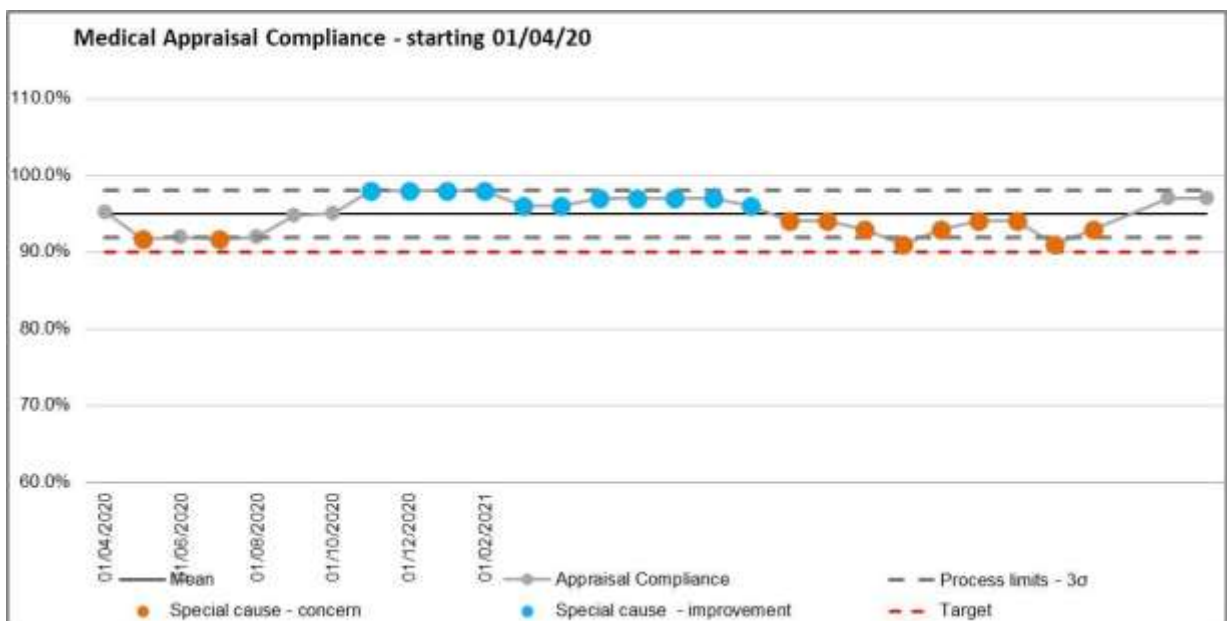


Figure 1- Appraisal Compliance Comparator

Trust Unapproved Missed Appraisals

Figure 2 the Trust had 5 doctors with unapproved, incomplete or missed appraisals, which are being managed and monitored through the monthly Maintaining Professional Standards Group (MPSG) chaired by the Medical Director/Responsible Officer. This group reviews the progress of the appraisal and revalidation programme, discusses concerns and identifies potential non-engagement.

Action for next year: *MPSG to continue to monitor appraisal compliance;*

2. **An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.**

Dr Matthew Lewis is Medical Director and Responsible Officer.

3. **The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.**

Action from last year: *Completed a programme of two refresher training sessions (webinars) for existing Medical Appraisers in September 2020 and one session for New Medical Appraisers in October 2020;*

Action for next year: *Complete a programme of refresher training for existing Medical Appraisers in 2021, for any doctor unable to attend in 2020.*

4. **An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.**

Action from last year: *No action.*

Comments: Doctors with a prescribed connection are managed and updated through GMC Connect online, by the Medical Revalidation and Job Planning Manager who has delegated access, on behalf of the Trust's Responsible Officer. The Manager is notified by the Workforce Information Team of new starters and leavers via a monthly report.

Action for next year: *No actions identified.*

5. **All policies in place to support medical revalidation are actively monitored and regularly reviewed.**

Action from last year: *Develop a New Medical Appraisal & Revalidation Policy.*

Comments: The 'Medical Appraisal & Revalidation Policy' is currently in the process of being ratified.

Action for next year: *Ratify the Medical Appraisal & Revalidation Policy*

6. **A peer review has been undertaken of this organisation's appraisal and revalidation processes.**

Action from last year: *No action.*

Comments: Last Independent Verification Visit was undertaken by NHS England in 24/11/ 2016; Points of learning and general feedback will be provided to appraisers through quarterly Appraiser Support Group Meetings (ASG), facilitated by the Appraisal Lead, to be conducted via Microsoft Teams. The MPSG also reviews training needs, performance and quality of appraisal and ensures consistency through the Medical Appraisal Lead's feedback data.

Action for next year: *No action.*

7. **A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.**

Action from last year: *None.*

Comments: The Medical Revalidation Team offers 1-2-1 training support for all new starters to the Trust, including Allocate e-Appraisal guidance.

Action for next year: *No action.*

Section 2 – Effective Appraisal

1. **All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.**

Action from last year: *No action.*

Comments: Confirmed, information regarding complaints and significant events are all documented within the Complaints and Significant Events Report which is a mandatory element of medical appraisal. This includes a report obtained from other healthcare organisations including private hospitals.

Action for next year: *No action.*

2. **Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.**

Action from last year: *Completion of Medical Appraisal Checklist for all connected Doctors.*

Comments: All 'missed appraisals' have a recorded reason on the Allocate "RO Dashboard", for tracking and monitoring. This includes, 'Approved Missed Appraisals' where the RO has agreed to a postponement (i.e. sickness absence, maternity leave, sabbatical). The RO dashboard is managed and maintained by the Medical Revalidation Manager.

Where risks or issues are identified or a lack of engagement in the appraisal process through MPSG, there is a procedure in place which includes a meeting with the doctor and Trust Lead Appraiser before the doctors appraisal due date and, if required, the development of an action plan to ensure appraisal completion on time. This has replaced the action from last year.

Action for next year: *None.*

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: *Develop New Medical Appraisal & Revalidation Policy.*

Comments: The 'Medical Appraisal & Revalidation Policy' is currently being ratified.

Action for next year: *Ratify Medical Appraisal & Revalidation Policy (Target Date August 2021).*

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: *Deliver New Medical Appraiser Training.*

Comments: 10 new Medical Appraisers trained in October 2020, increasing the Medical Appraiser cohort to 60. The ratio of appraisers to doctors is now less than 1: 5 based upon 276 connected doctors. Furthermore, 26 of the 50 existing appraisers attended refresher training in September 2020.

Action for next year: *Deliver Medical Appraisal Refresher Training for doctors unable to attend in September 2020.*

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers² or equivalent).

Action from last year: *Lead Appraiser to meet all Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development.*

Comments: Medical Appraisal Lead met all newly trained Medical Appraisers on 1-1 basis.

² <http://www.england.nhs.uk/revalidation/ro/app-syst/>

² Doctors with a prescribed connection to the designated body on the date of reporting.

All Medical Appraisers are members of the Appraiser Support Group (ASG) which will be chaired by one of the Trust's Lead Appraiser. These meetings will be held quarterly via Microsoft Teams. It is a requirement that all Medical Appraisers attend a minimum of 3 ASG meetings per appraisal year. The meetings will cover any issues and concerns to be addressed, the appraiser allocations for the forthcoming year, any training and development needs and Quality Assurance through reviews of anonymised appraisal outputs (to demonstrate good and poor practice) to ensure calibration of practice.

Action for next year: *Lead Appraiser to meet Medical Appraisers during Appraisal Year on 1-1 basis to discuss Appraisal Feedback, performance and development.*

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September 2020.*

Comments: The Annual Board Report is presented to the Board each year and provides a quality review framework.

Action for next year: *Present Annual Board Report and return the Statement of Compliance to NHS England by 30 September 2021.*

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: *A target of 0 late recommendations to the GMC*

Comments:

0 late GMC revalidation recommendations occurred in 2020/21.

Since April 2019, the Trust Lead Medical Appraiser supported by the Medical Revalidation Manager, has delegated responsibility for reviewing the Doctors Revalidation Portfolio (typically the last 5 years of Medical Appraisals).

The Medical Revalidation Manager records the decision on GMC Connect and Allocate. Where concerns arise i.e. insufficient supporting information, or where unresolved local/GMC concerns exist, these cases are escalated to the RO to discuss with their GMC Employee Liaison Officer (ELA)

Action for next year: *Target of 0 late recommendations to the GMC.*

- 2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.**

Action from last year: *Ensure positive recommendations are confirmed in writing.*

Comments: The GMC have suspended all revalidation submissions for this appraisal year. The Trust Medical Appraisal Lead reviews the doctor's appraisal portfolio once the doctor is 120 days away from their revalidation due date ('under notice'). If there are any likely causes for delay these are considered in advance by the Lead with an appropriate plan put in place with the Doctor, e.g. deferral if necessary.

Action for next year: *No action.*

Section 4 – Medical governance

- 1. This organisation creates an environment which delivers effective clinical governance for doctors.**

Action from last year: *No action.*

Comments: Confirmed.

Action for next year: *No action.*

- 2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.**

Action from last year: *No action.*

Comments: Confirmed. Trust Teams and systems provide information data as follows: Clinical Audit attendance (Departmental Clinical Audit Lead/Facilitator); Mandatory and in-house Training (ESR), complaints and significant events (Patient Safety/PALS - Safeguard) and e-360 feedback (Revalidation Team); Consultant Appraisal Summary Reports (Health Evaluation Data) to provide Consultants with an overview of their individual performance, Trust specialty performance and National specialty performance.

Current safeguards are in place as well as ongoing discussions between the Medical Director and GMC Employee Liaison Advisor (ELA). When there are concerns regarding conduct or capability, the Trust implements the framework set out in 'Maintaining High Professional Standards in the Modern NHS' (MHPS). This forms the basis of the medical disciplinary Policy.

Action for next year: *No action.*

- 3. There is a process established for responding to concerns about any licensed medical practitioner's¹ fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.**

Action from last year: *Arrange 1 further NHS Resolution Case Investigator Workshop(s);*

Comments: This did not occur, due to COVID19. Trust facilitated NHS Resolution delivered Case Investigator Training and Case Manager Training (May - July 2019). The Trust now has 20 trained Investigators, and 5 trained Case Managers. To ensure this was delivered in a cost effective manner, the Medical Revalidation manager arranged for a total of 24 external paying delegates to attend across the 3 sessions.in

Action for next year: *Arrange 1 further NHS Resolution Case Investigator Workshop.*

- 4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors³.**

Action from last year: *Involve a Non-executive Director or Lay Member in MPSG.*

Comments: A Non-executive Director, Mr Ben Diamond, has attended MPSG since May 2021.

Action for next year: *No planned action.*

- 5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation⁴.**

Action from last year: *No action.*

Comments: The Medical Practice Transfer of Information Form (MPIT) supports the appropriate transfer of information about a doctor's practice to and from the doctor's Responsible Officers (RO). When recruiting, handover information received is forwarded to the Trusts RO. Requests for information received are processed by the Medical Revalidation Manager.

¹ Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

³This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

⁴ The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: <http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents>

Action for next year: *No action.*

- 6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).**

Action from last year: *No Action.*

Comments: Confirmed. All Trust Policies are subject to Equality Impact Assessments.

Action for next year: *No Action.*

Section 5 – Employment Checks

- 1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.**

Action from last year: *No action.*

Comments: Standard Trust Recruitment Policy pre-employment checking process includes references, DBS checks, right to work checks and Occupational Health Assessment for new starters. Also, the Medical Practice Transfer of Information form (MPIT) is requested by the Trust's Recruitment Team once a final offer of employment is confirmed. This applied to all substantive, short-term contract holders. Doctors employed through an Agency are subject to checks by the Agency.

As part of the Recruitment process, candidates are expected to demonstrate that they are up-to-date with their practise and that they have an up-to-date Medical Appraisal. This requirement is incorporated into the local Medical Recruitment procedures.

Action for next year: *No action.*

Section 6 – Summary of comments, and overall conclusion

1. General review of 2020/21

- COVID19 related pressures and the temporary suspension of the appraisal programme impacted appraisal rates, which fell to 79% of all doctors eligible for appraisal completing the process. There were 11 doctors exempt from appraisal attributed to long term sickness, maternity leave and the suspension of the appraisal programme due to COVID19. These are all approved reasons for exemption. Reassuringly, there were no recommendations of non-engagement sent in 2020/21.

Appraisal Year	% of doctors with a prescribed connection who have had an appraisal
2016 - 2017	89.1%

2017 - 2018	97.1%
2018 - 2019	90.2%
2019 - 2020	98.5%
2020 - 2021	75.7%*

**Appraisal year suspended between 19/03/20-01/10/20 due to COVID-19 Pandemic.*

- A continued challenge in 2020/21 was meeting the target set by NHS England of returning completed appraisal documentation within 28 days of the appraisal meeting.

Appraisal Year	% of doctors submitting the completed documentation within 28 days
2018 – 2019	84%
2019 - 2020	87%
2020 - 2021	82%

- All reasons for delay in appraisal completion are clearly recorded on Allocate. The overwhelming reason cited for delays were workload pressures and appraiser unavailability due to COVID19.
- Following a change to reporting requirements in 2016/17, doctors are now required to have their appraisal by the same 'due date' each year, rather than within a designated quarter. Those that fall beyond 12 months are considered a missed appraisal. The relevant changes in reminders issued through Allocate at 12 weeks, 8 weeks and 4 weeks, and reporting has now been embedded and is working well. The priority for the appraisal team remains ensuring that all doctors have an annual appraisal.

2. Actions still outstanding

- Ratify the Medical Appraisal & Revalidation Policy by August 2021.

3. Current Issues

- The suspension of the appraisal programme 19th March 2020 was lifted locally by Dr Matthew Lewis on 2nd July 2020, having discussed this matter regionally and with the GMC. The GMC on 3rd September 2020 discussed the resumption of the programme on 1st October 2020 with a flexible approach.
- All doctors have been written to (via email) and encouraged to undertake an appraisal discussion focused upon reflection, learning and support given the recent unprecedented challenges faced during the COVID19 pandemic.

4. Completed Actions 2020/21

- 10 new Appraisers were trained and all have been met with by the Medical Appraisal Lead to discuss their performance and to offer support;

5. New Actions 2021/22

- Lead Appraiser to meet all remaining Medical Appraisers during Appraisal Year on 1-1 basis via Microsoft Teams to discuss Appraisal Feedback, performance and

- development;
- Target of 0 late recommendations to the GMC;
 - Ensure positive recommendations are confirmed in writing;
 - Arrange 1 further NHS Resolution Case Investigator Workshop;

Section 7 – Statement of Compliance:

The Board of Walsall Healthcare NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists))]

Official name of designated body: Walsall Healthcare NHS Trust

Name: _____

Signed: _____

Role: _____

Date: _____

MEETING OF THE PUBLIC TRUST BOARD Thursday 2 nd September 2021			
Walsall Together Partnership Highlight Report			AGENDA ITEM: 21
Report Author and Job Title:	Michelle McManus, Head of Transformation	Responsible Director:	Anne Baines, Non-Executive Director
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☐		
Executive Summary	This report provides an overview of the key items discussed at the Walsall Together Partnership Board at its meeting on Wednesday 18th August 2021. The key points for the attention of the Trust Board are: • The Partnership Board received a story from a gentleman with hearing impairment who described how inequalities in access to services have worsened through COVID-19. It demonstrated the need to consider the impact of decisions regarding access on all communities and reinforced the focus on ensuring COVID-19 recovery plans do not exacerbate health inequalities. The Board resolved to explore opportunities to work with the individual to better understand the current provision of interpretation services across the partnership. • The Partnership Board discussed the current system pressures around high demand for packages of care, noting that the issue is recognised nationally and not just in Walsall. There is an established cross-partnership daily tactical command structure, which is implementing a range of options to mitigate the risk to hospital discharges and flow. A System Pressures Plan is in development and will include input from the acute sector as well as all partners. • Project initiation documentation was approved for the NHS Charities bid that was awarded earlier this year, and also for a Resilient Communities project, Hope4U, which supports new and expectant mothers to improve the household's health and wellbeing through a potential uplift in income. • The Partnership Board raised concerns around the delayed implementation of the Integrated Shared Care Record and resolved to undertake a deep dive into the project at the September meeting. It is understood that delays are a result of needing to align with the wider Black Country system. The Partnership Board is seeking assurance that the proposed revisions to the project timeline will now be met without further delay. • A detailed overview of the evidence base for the Walsall Population Health and Inequalities Strategy was received and the Partnership Board approved an approach to finalising the		

	strategy. A pragmatic implementation plan is expected to be presented for approval in October. • All place-based partnerships have received an allocation of funding to support the transition towards achieving Integrated Care Provider status. The Committee approved the allocation of the Walsall funding at its June meeting, with the exception of the funding for an Associate Medical Director. The Committee approved the funding for the role at the August meeting on the basis that the role description and recruitment process would be developed in partnership with the Walsall Primary Care Networks. • There are 3 risks currently rated at 16 (major) and another 3 risks rated at 20 (major). These relate to the size and scale of population health challenges; funding for ICS beds; COVID vaccination uptake in BAME communities; recurrent investment in Walsall Together Services; Primary care demand and capacity; Delayed discharges due to low availability of packages of care (POC). • The Partnership Board requested that a review of the current workforce risk was undertaken to reflect the current system pressures and the number of new roles required across the partner organisations.	
Recommendation	Members of the Trust Board are asked to note the contents of this report.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk- S03 - Failure to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities.	
Resource implications	There are no new resources implications associated with this report.	
Legal and Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence in all forums across Walsall Together and there is now a dedicated Population Health & Inequalities workstream. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare.	
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☒
	Partners ☐	Value colleagues ☐
	Resources ☐	

MEETING OF THE PUBLIC TRUST BOARD Thursday 2 nd September 2021			
Care at Home Executive Report			AGENDA ITEM: 22
Report Author and Job Title:	Matthew Dodd Director of Transformation	Responsible Director:	Daren Fradgley Executive Director of Integration
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain. It covers: - Operational performance for community services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1); - Board Assurance Framework (BAF) for Care at Home; - An update on the transition to obtain Integrated Care Provider (ICP) status; - An update on the Care at Home Improvement Programme. Detailed discussions in these areas have been covered in the relevant Board Committees over the previous 2 months in addition to that noted in the Partnership Board highlight report.		
Recommendation	Members of the Trust Board are asked to note the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	BAF Risk- S03 - Failure to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation if not widening of health inequalities.		
Resource implications	There are no new resources implications associated with this report.		
Legal and Equality and Diversity implications	The issue of health inequalities continues to receive growing prominence in all forums across Walsall Together and there is now a dedicated Population Health & Inequalities workstream. It is reflected in the strategic objectives of the partnership and the associated BAF risk for Walsall Healthcare.		
Strategic Objectives (highlight which Trust Strategic objective this report aims to support)	Safe, high quality care ☐	Care at home ☒	
	Partners ☐	Value colleagues ☐	
	Resources ☐		

Care at Home Executive Summary

September 2021

1. PURPOSE OF THE REPORT

This report provides an overview performance, risk, assurance, and transformation in the Care at Home Strategic domain. The following attachments provide the evidence pertinent to the board requirements. Detailed discussions in these areas have been covered in the relevant Board Committees in the previous 2 months in addition to that noted in the Partnership Board highlight report.

- Operational performance for community services and Adult Social Care, situated within the context of the Walsall Together Partnership (Appendix 1);
- Board Assurance Framework (BAF) for Care at Home (Appendix 2);
- An update on the transition to obtain Integrated Care Provider (ICP) status;
- An update on the Care at Home Improvement Programme.

2. PERFORMANCE, ASSURANCE AND RISK – COMMUNITY SERVICES

The key risks to community services and assurances around the level of service provision are included in Appendix 1 and all relevant Board Committees have been briefed on these risks in July and August.

Appendix 1 incorporates the Community Services data in the context of Walsall Together services. The report continues its evolution towards greater focus on assurance around the Tiers of the Walsall Together clinical operating model.

2.1. Demand

The pressures outlined in previous reports regarding primary and secondary care are manifesting themselves within Community Services, where demand for Community Nursing is increasing, while the Care Navigation Centre had its highest number of calls in month.

2.2. Capacity

There are concerns about the capacity of providers to respond to demand. Community Nursing was unable to respond to 18% of its demand, while Care Agencies are reporting staff shortages which adversely impact on their ability to provide packages of care to people in their own homes. The latter has had the

consequence of leading to an increase in the number of people in the Manor Hospital and other Hospitals who are Medically Stable for Discharge and awaiting packages of care. It also has meant that the flow through community beds has slowed down as people requiring long term packages of care are unable to be discharged.

2.3. Mitigation

In August the partnership has focused on two key areas.

Response to diminishing availability of Packages of Care (POC): this has included use of community beds as an interim alternative, review of therapy resource & hospital discharge processes. Additional care agency capacity is being commissioned but there remains a need for interim measures to be implemented to maintain flow in both hospital and community pathways (and which don't destabilise the local health & social care economy as a whole).

Winter Planning: Plans to respond to the current surge in demand and the predicted increased levels of activity over the coming months are being developed. There is a focus on increasing the admission avoidance activity through the Integrated Assessment Hub and the Care Navigation Centre as well as expanding the capacity of community-based services to respond to this demand.

Initial bids have been submitted to the Integrated Care System for all these areas, with a view to recruiting staff at the earliest opportunity, whilst the final system-wide responses are being developed.

3. BOARD ASSURANCE FRAMEWORK

The BAF was reviewed following the Walsall Together Partnership Board and has been increased to an in-month risk score of 12 to reflect the following risk themes:

- Low resilience in terms of workforce capacity to deal with rising demand for routine services across all system partners, and the continued need to deliver a COVID-19 vaccination and booster programme.
- Increased population health challenges in the context of worsening of health outcomes, particularly around LTC management, and exacerbated health inequalities following COVID-19.

Associated controls, assurances and actions have been updated on the BAF, which reflect the level of resource being directed to mitigating these risks across the partnership.

4. ICP ROADMAP

The transition to delivery of an Integrated Care Provider (ICP) remains in progress. The focus is currently on the transition of services already provided by Walsall Healthcare community services.

As reported in June, the Walsall Together Partnership Board continues to explore options to strengthen the governance arrangements with the Health & Wellbeing Board for the delivery of improved health and wellbeing outcomes.

5. IMPROVEMENT PROGRAMME

As reported in June, discussions have continued to identify the principles upon which financial benefits are measured and transacted across the acute and community boundary. There is consensus across the MTLC and Community divisions that Community initiatives have impacted positively on the capacity and flow through the acute site. In advance of a Board development session in October, more detailed work is now in progress to identify the metrics that track shifts in activity for specific cohorts. This will also incorporate demand modelling on the assumption that an element of benefit delivered will be mitigation of growth.

The Board will need to consider a future investment strategy for how we can sustain these innovations against a background of continued growth in demand.

6. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.



Walsall Together Partnership Operational Update: August 2021

Matthew Dodd
Director of Transformation



Collaborating for happier communities

[Emergent] Score Card for WT Tiers – Tiers 0 & 1



Tier	Activity	Thresholds					2020-2021		
Tier 0: Resilient Communities									
Social Prescribing	whg - No. referrrals received								
	Primary Care - % referrrals received East 1	<0.4%		>= 0.4%			0.55%		
	Primary Care - % referrrals received East 2	<0.4%		>= 0.4%			0.50%		
	Primary Care - % referrrals received North	<0.4%		>= 0.4%			1.30%		
	Primary Care - % referrrals received South 1	<0.4%		>= 0.4%			0.71%		
	Primary Care - % referrrals received South 2	<0.4%		>= 0.4%			1.30%		
	Primary Care - % referrrals received West 1	<0.4%		>= 0.4%			0.80%		
	Primary Care - % referrrals received West 2	<0.4%		>= 0.4%			1.78%		
	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21
Workforce: Anchor institutions	No. staff employed by WHT via scheme								
	% staff still in post after 3 months								
Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21
Tier 1: Integrated Primary, Long Term Conditions Management, Social & Community Services									
Primary Care	Primary Care Appointment Access - Walsall	>2.0	1.5-2.0	<1.5		2.11	1.81		
	Primary Care Appointment Access - Sandwell & West Brom	>2.0	1.5-2.0	<1.5		2.77	2.32		
	Primary Care Appointment Access - Dudley	>2.0	1.5-2.0	<1.5		2.36	2.00		
	Primary Care Appointment Access - Wolverhampton	>2.0	1.5-2.0	<1.5		3.27	2.80		
	Amber sites (undertake all aspects of contractual work with +ve Covid patients seen in RED sites)					13	13		
	Green sites (undertake all aspects of contract - no face to face appointments)					37	37		
Community Services	Hours delivered by Locality teams	6,000<	6,000-9,500	>9,500	7317.25	6026.75	5578.25	5576	6574.25
	Hours cancelled by Locality teams	>600	400-600	400<	473	305	623	1020	1453
	% of hours demand unmet	>10%	5-10%	5%<	6.5%	5.1%	11.2%	18.3%	22.1%
MDTs	No. MDTs held	<20	20-24	>24	29	19	19	27	25
	No. referrrals received	<100	100-200	>200	29	27	35	37	26
	No. cases reviewed	<100	100-200	>200	29	27	32	40	90
Adult Social Care	Care & support assessments & 3 conversations incoming / in progress (snapshot in-month)				449	478	494	550	552
	Care and Support Assessments and 3 Conversations Completed - Total				267	242	234	195	186
	Monthly Adult contacts completed by Team				1,122	1,030	1,010	1,094	1,025
	Total Initial & Subsequent Reviews Completed				388	223	235	230	163

[Emergent] Score Card for WT Tiers – Tier 2



Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21
Tier 2: Specialist Community Services									
ASC Safeguarding Concerns	Concerns received				297	253	292	307	315
	Concerns progressing to s42 enquiry				72	79	84	83	88
	% of concerns progressing to s42 enquiry				24%	31%	29%	27%	28%
	Safeguarding cases in progress				39	25	48	15	36
Care Homes	Care Home residents	1,503<	1,503-1,650	>1,650	1,258	1,267	1,259	1,285	1,294
	Vacancies	>291	144-291	144<	436	430	441	416	408
	% vacant beds	>15%	8-15%	8%<	25.7%	25.3%	25.9%	24.5%	24.0%
	Total No of Care Homes	53<	53-56	>56	57	58	58	58	58
	Closed to admissions	>8	3-8	3<	14	7	8	8	2
	% of available homes closed to admissions	>10%	5-10%	5%<	24.6%	12.1%	13.8%	13.8%	3.4%

[Emergent] Score Card for WT Tiers – Tiers 3 (& 4)



Tier	Activity in-month	Thresholds			Mar-21	Apr-21	May-21	Jun-21	Jul-21
Tier 3: Intermediate Care, Unplanned Care & Crisis Services									
Care Navigation Centre	Calls received	316<	316-512	>512	550	580	691	747	821
Rapid Response Team	Referrals received	160<	160-247	>247	232	210	216	304	301
	% admission avoidance	73%<	73-86%	>86%	82.0%	88.0%	91.7%	89.5%	94.4%
Medically Stable For Discharge	Average number of MSFD in WMH	>51	41- 51	41<	29.33	31.13	31.86	31.89	48.56
	Average number of days MSFD	>7.8	4.8 - 7.8	4.8<	2.73	2.74	3.64	3.86	4.18
Domiciliary & Bed Based Pathways	Domiciliary Pathways - Discharged ALOS	>25	21 - 25	21<	30	27	29	N/A	N/A
	Domiciliary Pathways - Average service users				188	181	180	N/A	N/A
	Bed-based Pathways - Discharged ALOS	>36	24 - 36	24<	29	46	49	N/A	N/A
	Bed-based Pathways - Average beds in use				83	67	61	N/A	N/A
Integrated Assessment Hub	Hospital Avoidance	20<	20-28	>28	44	56	90	90	80
	Early Supported Discharge	40<	40-54	>54	52	51	106	43	48
	Assisted Discharge	35<	35-50	>50	75	62	71	63	103
	Prevent Readmission							63	60

Adult Social Care Outcomes Framework Measures - Monthly Data and Targets for 2020/21

Indicator	Data Source Data Provider Lead Officer	15/16 Result	16/17 Result	17/18 Result	18/19 Result	19/20 Result	20/21 Result	April 21/22 Data	May 21/22 Data	June Q1 Data	July 21/22 Data	Aug 21/22 Data	Sept Q2 Data	Oct 21/22 Data	Nov 21/22 Data	Dec Q3 Data	Jan 21/22 Data	Feb 21/22 Data	Mar 21/22 Data	21/22 Target
1C: Proportion of people using social care who receive self directed support, and direct payments (NI 130).	Mosaic, H21 & Provider spreadsheets	1731	1899	1985	2038	2100	2188	2211	2245	2203	2193									
	AACM	1895	1951	1954	2045	2100	2188	2211	2245	2203	2193									
	Ian Staples, Jennie Pugh & Jeanette Knapper	91.3%	97.3%	98.4%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%									100.0%
1E: Proportion of adults (aged 18-64) with learning disabilities in paid employment (NI 146).	Mosaic, H21 & Provider spreadsheets	6	10	1	7	14	19	15	15	16	16									12
	AACM	551	585	587	596	574	573	540	545	548	550									
	Jeanette Knapper	1.1%	1.7%	0.2%	1.2%	2.4%	3.3%	2.8%	2.8%	2.9%	2.9%									
1G: Proportion of adults (aged 18-64) with Learning Disabilities who live in their own home or with their family. (NI 145).	Mosaic, H21 & provider spreadsheets	473	497	505	502	494	489	458	466	463	467									
	AACM	551	585	587	596	574	573	540	545	548	550									
	Jeanette Knapper	85.8%	85.0%	86.0%	84.2%	86.1%	85.3%	84.8%	85.5%	84.5%	84.9%									
2A: Part 1 Permanent admissions of adults (aged 18-64) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts spreadsheet.	7	11	22	10	24	18	2	4	5	5									15
	AACM	160,336	161,838	164,309	165,555	165,355	167,500	167,500	167,500	167,500	167,500									
	Ian Staples, Jennie Pugh & Jeanette Knapper	4.4	6.8	13.4	6.0	14.5	10.8	1.2	2.4	3.0	3.0									9.1
2A: Part 2 Permanent admissions of older people (aged 65+) into residential/nursing care homes, per 100,000 population.	Mosaic, RAP approvals & WSS10 contracts spreadsheet.	271	309	311	329	301	311	35	72	94	116									335
	AACM	47,940	49,154	49,773	50,159	49,866	50,500	50,500	50,500	50,500	50,500									
	Ian Staples, Jennie Pugh & Jeanette Knapper	565.3	628.6	624.8	655.9	603.6	615.8	69.3	142.6	186.1	229.7									671.8
2B: Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement services. (NI 125)	Mosaic, Provider spreadsheets	254	113	220	55	76	94	113	95	111	101									
	Provider Services	317	130	266	73	91	125	143	113	141	122									
	Matthew Dodd & Jennie Pugh	80.1%	86.9%	82.7%	75.3%	83.5%	75.2%	79.0%	83.8%	77.6%	82.8%									85.0%



Tier 0: Walsall's Voluntary & Community Sector – One Walsall

- Engage Walsall Unit went live this month; It provides an easily accessible venue for organisations to use with good footfall through the Saddler's Centre including Citizens Advice and My Time Active, Zebra etc. The aim is to provide a location within which the VCSE can utilise the space for activities, service user support and meeting other like-minded organisations to share ideas etc.
- Volunteer support continues for vaccine sites and OW are now working with Walsall Council to source volunteer support for mobile vaccine units.
- A number of high profile businesses including DPD, RBS and Natwest have participated in CSR opportunities, enhancing community gardens and the canal pathways through a series of VCS-led initiatives with One Walsall.
- The development team are continuing to roll out a development tool which assesses VCS group sustainability, providing enhanced business planning designed to improve capacity and aiming to mitigate some of the impact the pandemic has had on the sector.

Tier 0: whg Resilient Communities

- whg continue to work with the NHS to secure local jobs for local people . This work directly contributes to the retention of the workforce and contributes to the workforce being more diverse and representative of the communities health services are delivered within . It also contributes to Resilient Communities reducing health inequalities by tackling the wider determinants of health . The first group are now well established in their roles and are being monitored and tracked to measure retention rates , progression and job satisfaction
- Building upon this success whg have been provided with the opportunity to recruit 50 Clinical Support Worker (Bank) opportunities to fill for September/October . This is part of the Return To Care initiative . Applicants will be enrolled on an 8 week Employment readiness programme to ensure they have the level 2 requirement requested by the hospital .
- The model is very scalable and colleagues from whg and the NHS are talking to people in Birmingham and Wolverhampton sharing the approach and enabling similar schemes to be set up . This is a great example of tweaking the system , thinking differently in order to achieve transformation of the health and social care sector .

Tier 0: whg

Social Prescribing

During June and July the team have recruited an additional **45** participants .

- ✓ Reasons for referrals during this period include Mental Health **40%** Social Exclusion including Debt and Poverty **42%** issues with housing **15%** Bereavement **2 %** Domestic Abuse **1 %**
- ✓ Key outcomes include Improved Health and Wellbeing **99% (WEMWBS)**
- ✓ All participants receive support for **a minimum of 6 weeks** with the majority remaining engaged for either **12 or 24 weeks** .
- ✓ During July **5** of the participants have secured work with **3** joining the whg Health and Wellbeing team as Kindness Champions . **4** have become volunteers . Volunteering is a key enabler of good HWB and reduces feelings of loneliness and isolation
- ✓ **12** participants have gained an accredited qualification which will equip them with key life skills , develop their capacity to manage their own health and help them into work or volunteering The interventions used within the SP Programme have therefore tackled health inequalities and reduced the impact of the wider determinants of health .

Tier 0: whg

Kindness Counts Resilient Communities

- ✓ whg's Kindness Counts programme which is part funded by NHS Charities is now live . We have successfully recruited **5** part time Kindness Champions who are representative of the communities we wish to work within .
- ✓ **3** of the **5** have community language skills . Language barriers are a key reason that people do not access services advice or guidance so this skill set is really important to have in house .
- ✓ All of the Kindness Champions are experts by lived experience having first hand experience of health inequalities and the wider determinants of health .
- ✓ They are currently undertaking an induction programme which will equip them with Coaching Conversation Skills and Motivational Interviewing Skills which will enable them to hold Clever Conversations with customers who are lonely or isolated .
- ✓ The Champions are taking part in a number of Life After Lockdown activities which provide residents with an opportunity to try something new . Included in this are visits to places outside of Walsall . Whilst travelling to the venue Champions will be seated strategically to ask people What Matters To Them in respect of their health and wellbeing .
- ✓ They are part of two whg community events where they will host a Kindness Counts Stall inviting people to record acts of kindness they have benefitted from along with signing a Kindness Counts promise where agree to carry out an act of kindness .

Tier 0: whg : Case Study whg Resilient Communities

Kindness Champion A :

This person was encouraged to take part in whg's confidence building programme by a local Community Champion . The Champion used the Stages of Change approach to encourage engagement and take up of the available services and support .

The CC recruited them onto the programme in the school playground as both of their children went to the same school . This was a trusted environment which the participant visited in their day to day life and was therefore a safe space .

Early relationships were developed as part of an organised family day out . The Champion used the activity as a platform to build trust and buy into the programme .

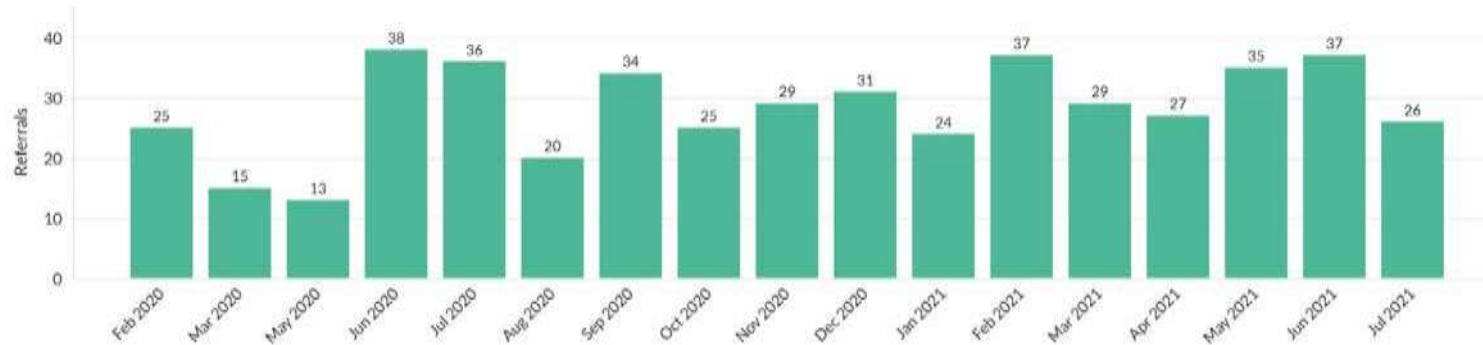
Their confidence increased and they progressed onto whg's Be The Best You Can Be programme . This is a positive psychology programme . This programme gave them a sense of their identity and untapped potential and was a catalyst to them taking up education completing ESOL Maths and English . Their increased confidence resulted in them learning to drive which is a key life and employment skill . Their spoken English improved and they began to use on line services and other digital activities .

The Champion provided ongoing support for around two years . The Kindness Champion positions became available and they were encouraged and supported to apply . They were successful and two years after stepping into a whg community room they stepped into whg as a paid colleague . This lived experience will taken into account as they undertake their role . The successful candidate has stated the importance of programmes working with people for the long term and having a reason to be in the community to offer support .

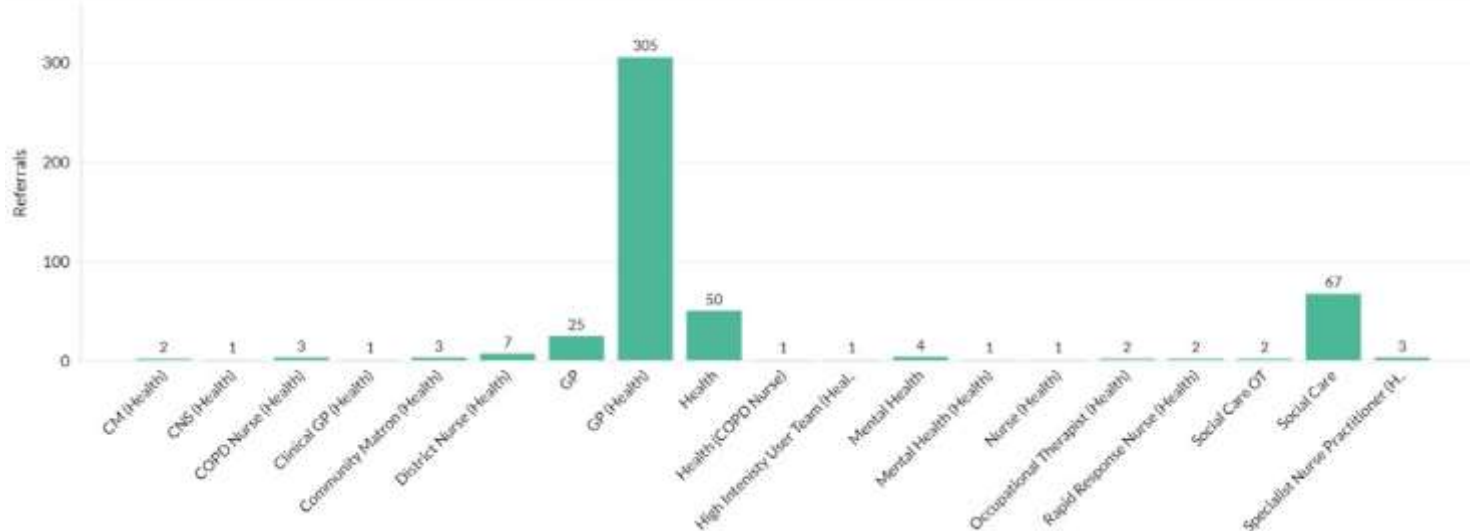
Tier 0: MDTs

Demand is significantly below capacity for GP-led MDTs

MDT Referrals Received



MDT Referral Source till date



The service is established for 7 x MDTs with up to 50 cases to be reviewed per week

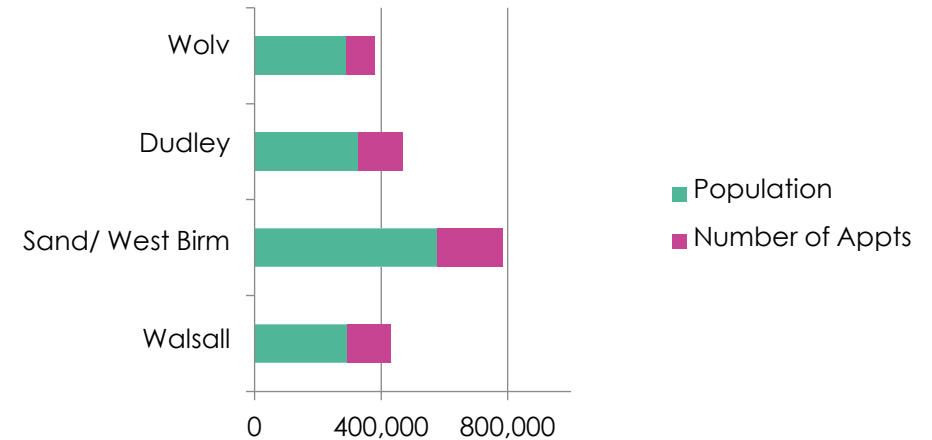
In July, 26 cases were considered

It has been agreed with PCNs that the risk stratification will change [eg case finding by the MDT Coordinators to focus on people who have had four admissions in the last year]

Further review meeting planned with PCN MDT lead to look at how to increase referrals from other teams

Tier 1: Primary Care Appointment Access (Mar 2021)

- Black Country STP
 - ✓ 676,437 appts
 - ✓ 569,202 attended (84.14%) up 3%
 - ✓ 55,863 – DNA (8.25%) down 1.75%
 - ✓ 51,372 – Not Booked(7.59%) down 1%
 - ✓ 2.19 (appt vs patient)
 - ✓ Compared to Feb 2021 2.59 (appt vs patient)
- 64 % F2F appts compared to 50% in August 2020
- 23,068 more appts in General Practice than in Feb 2021 -15% increase
- Birmingham & Solihull – 2.01 (appt vs patient)



CCG	Population	Number of Appts	Appt vs pt
Walsall	293,396	161,376	1.81
Sand/ West Birm	575,481	248,132	2.32
Dudley	328,093	163,405	2.00
Wolv	290,831	103,524	2.80
Total	1,487,801	676,437	2.19

Tier 1: Primary Care SOP

- Primary care operating telephone triage first – if patients require clinical face-to-face (F2F) examination they are invited in for an appointment
- Consultations are being completed via telephone, video consult, online and F2F
- Practices still following strict COVID-19 infection control guidance
- Quality and Outcomes Framework (QOF) returned for 2021-22 – Practices working through backlog of LTC management
- Locally commissioned services are being delivered based on clinical need of the patient.

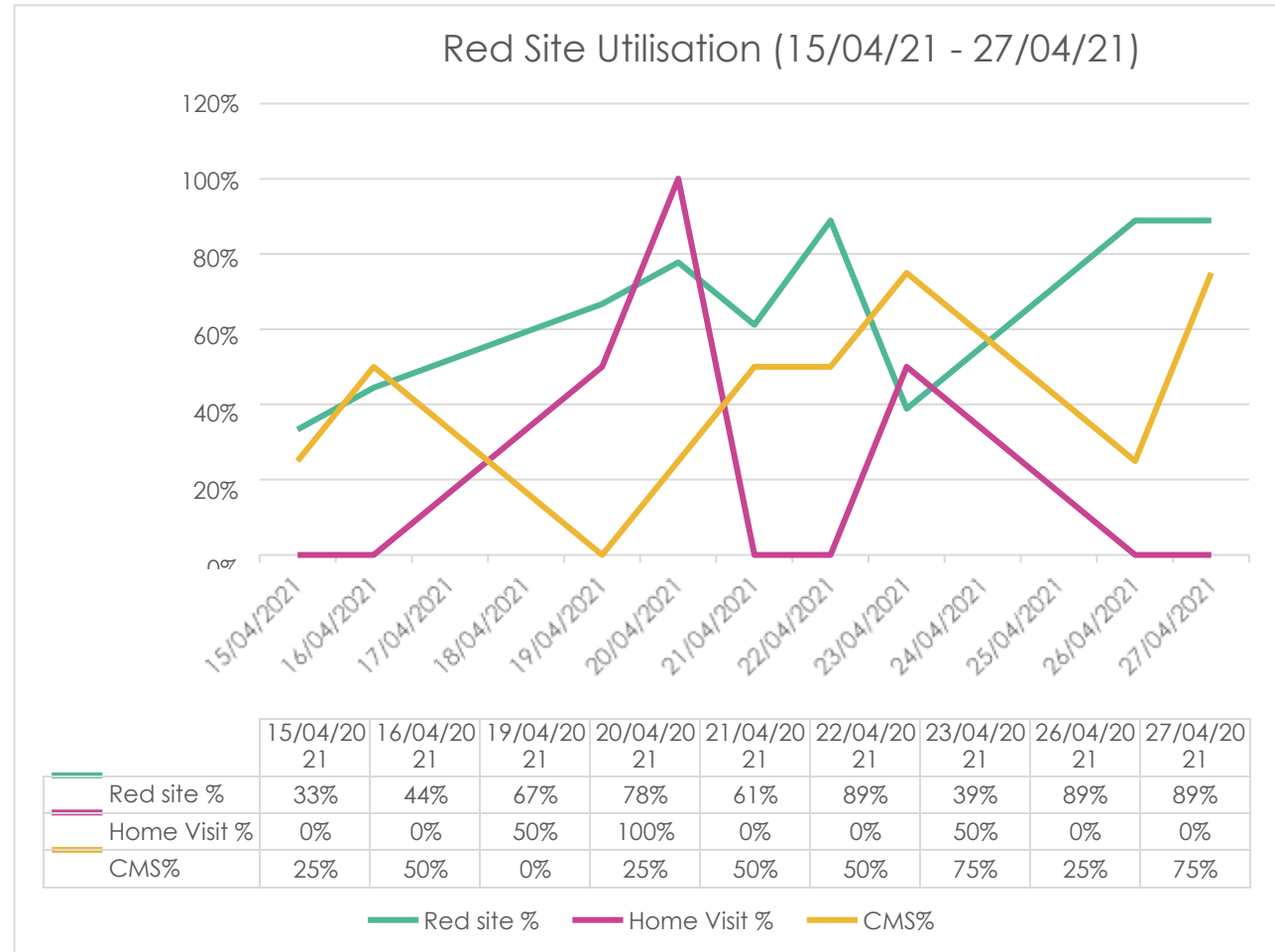
Tier 1: Primary Care Daily SitRep

- Amber & Green Practices in Walsall.
- Amber Sites – perform all aspects of contractual work - +ve COVID or COVID symptoms are seen in Red Sites
- Green Sites – perform all aspects of contract – no Face2Face appointments



Tier 1: Primary Care Red site demand capacity

- Home visits conducted by red sites have stopped from the 30th April and practices complete these for all HB patients.
- The CCG is asking red sites to taper down activity between April-June, commencing Monday 5th April, with a view that we will be able to bring the overall service across all red sites to a close on 30th June 2021.
- Primary care have requested a plan from CCG for management of red patients.



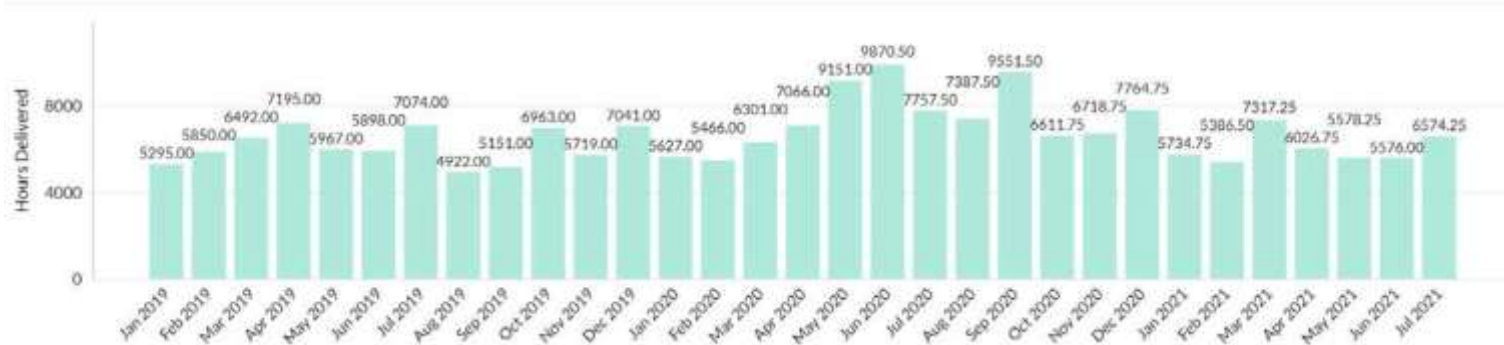
Tier 1: PCN – ARRS

- Currently 2 projects involving PCN ARRS and WT.
 - First Contact Practitioner (FCP)
 - Nursing Associates (NA)
- FCPs currently working in 4 PCNs – Data to follow in future meetings – initial feedback is very positive with reductions in MSK referrals and increase in access in primary care
- NAs awaiting start date – EOI from 4 PCNs with a commitment to employing via WT
- Risk – SLAs are currently the hold up which have taken a considerable amount of time to draft.

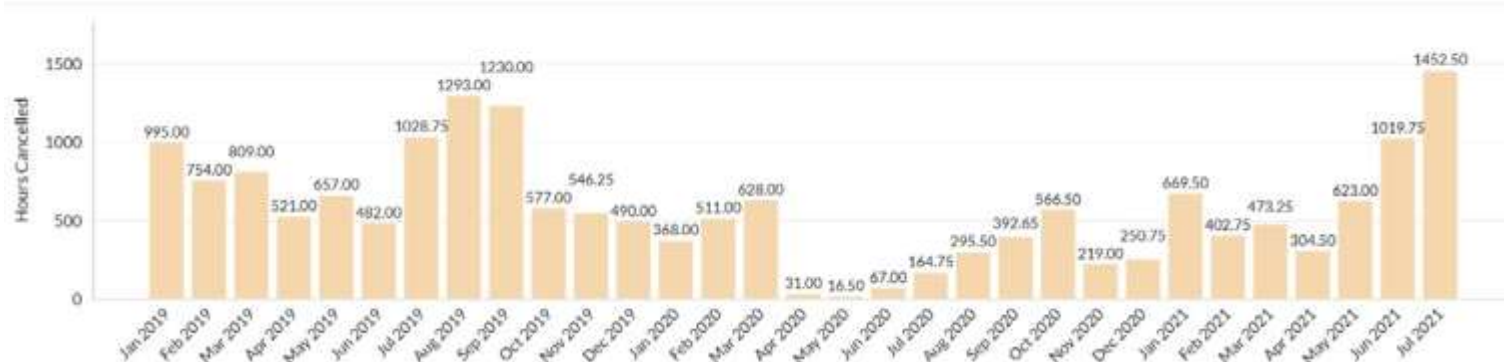
Tier 1:

Community Nursing Capacity and Demand: In July 2021, Community Services delivered more hours than the previous month and cancelled more hours of activity than in the past 2 years

Hours Delivered



Hours Cancelled



Absence levels within Community Services continue to be high throughout July. This combined with an increased number of staff on maternity leave and further staff leaving their posts within Locality Teams, this has impacted on the number of hours that have been cancelled. June has shown a significant increase on Mays figure.

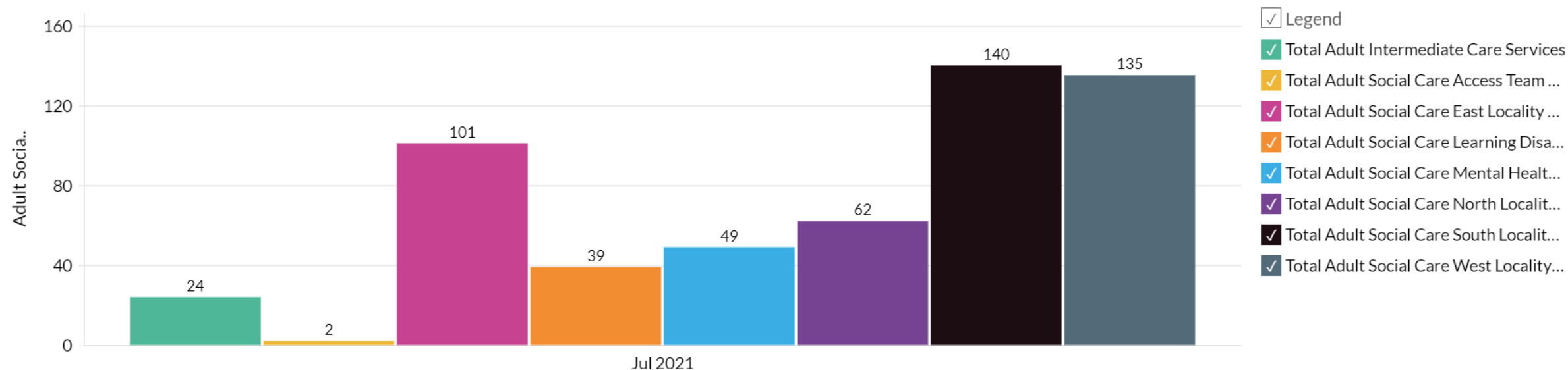
In order to address this a number of actions have been implemented to ensure the safe delivery of services:

- Review of capacity and demand modelling
- High risk (red) dependencies being seen by locality rapid response nurses
- Cross locality working to ensure priority patients are seen – Daily capacity calls in place with Locality leads
- Several vacancies in recruitment stages
- Recruitment day held on Saturday 24th July where 8 offers were made to B6 and B5 Nurses. New staff are expected to come into post in Autumn 2021.
- Resource has been redirected from other Teams (Locality Rapid Response, Diabetes and Podiatry) in order to minimise the number of patient hours being cancelled

Tier 1:

Adult Social Care

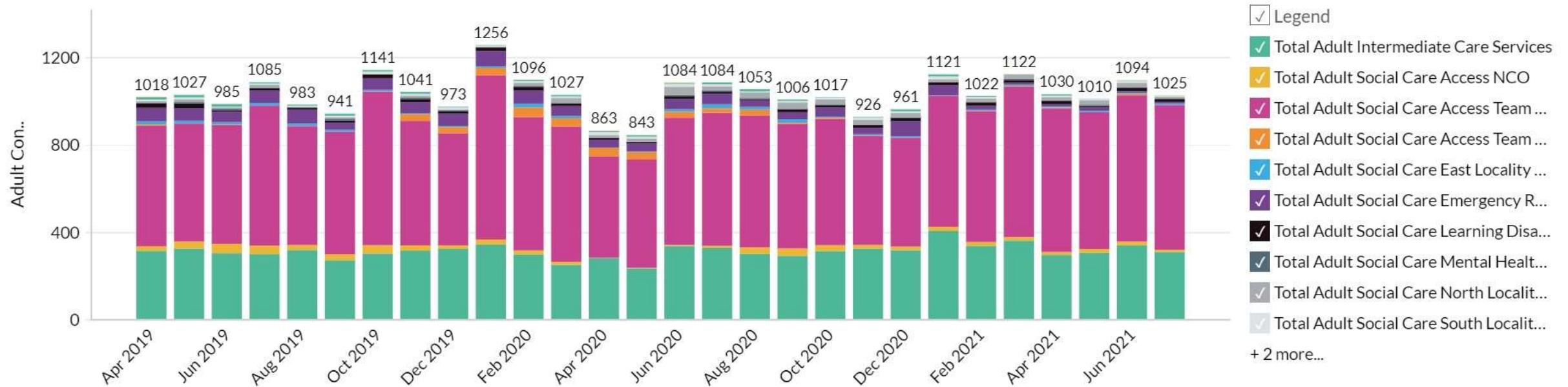
Care and support assessments and 3 conversations incoming/in progress as at snapshot date



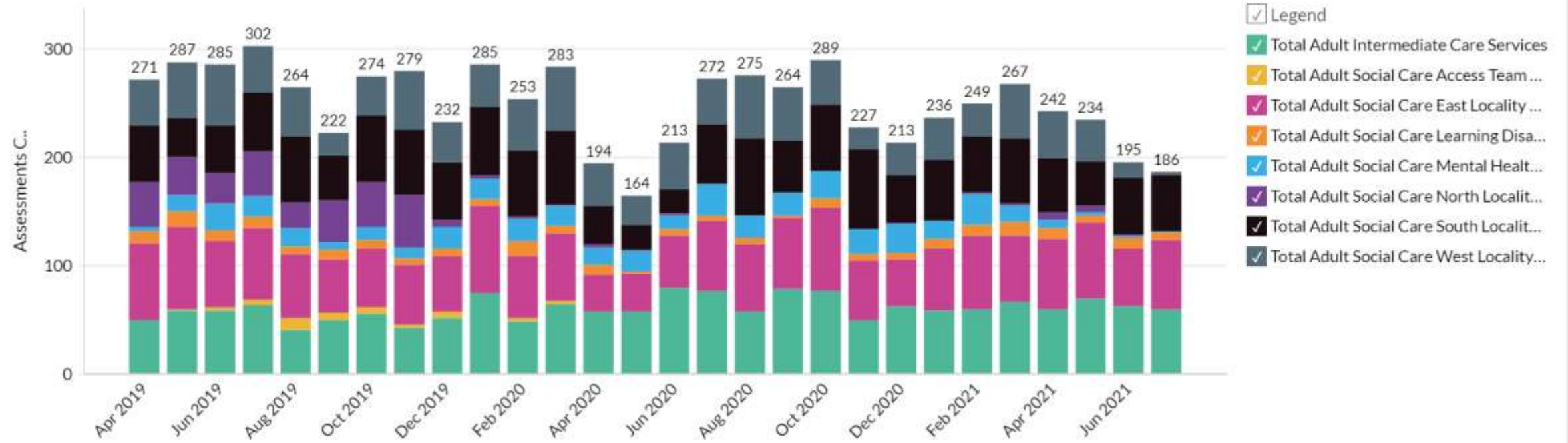
Tier 1:

Adult Social Care

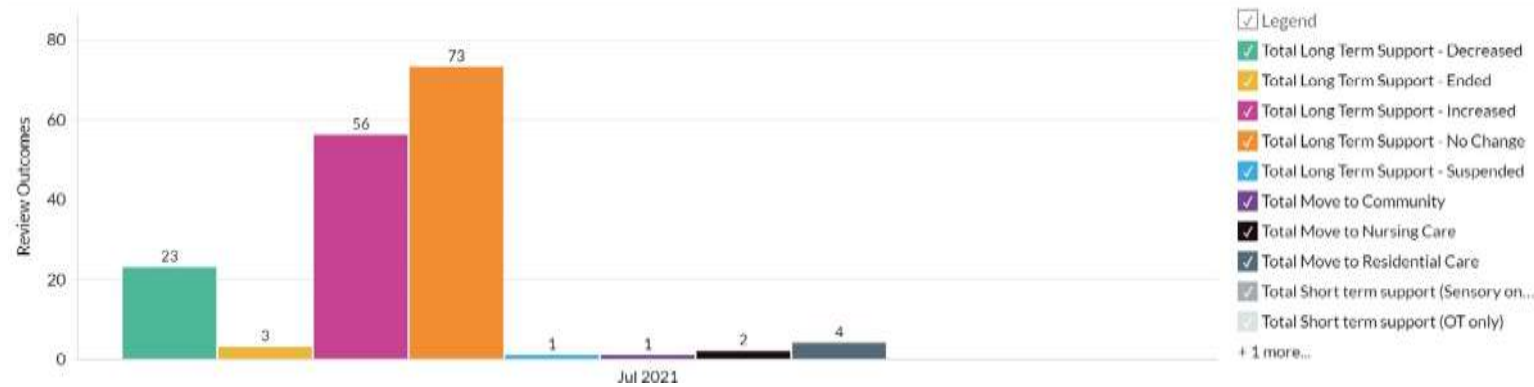
Adult Contacts Completed by Team



Care and Support Assessments and 3 conversations completed

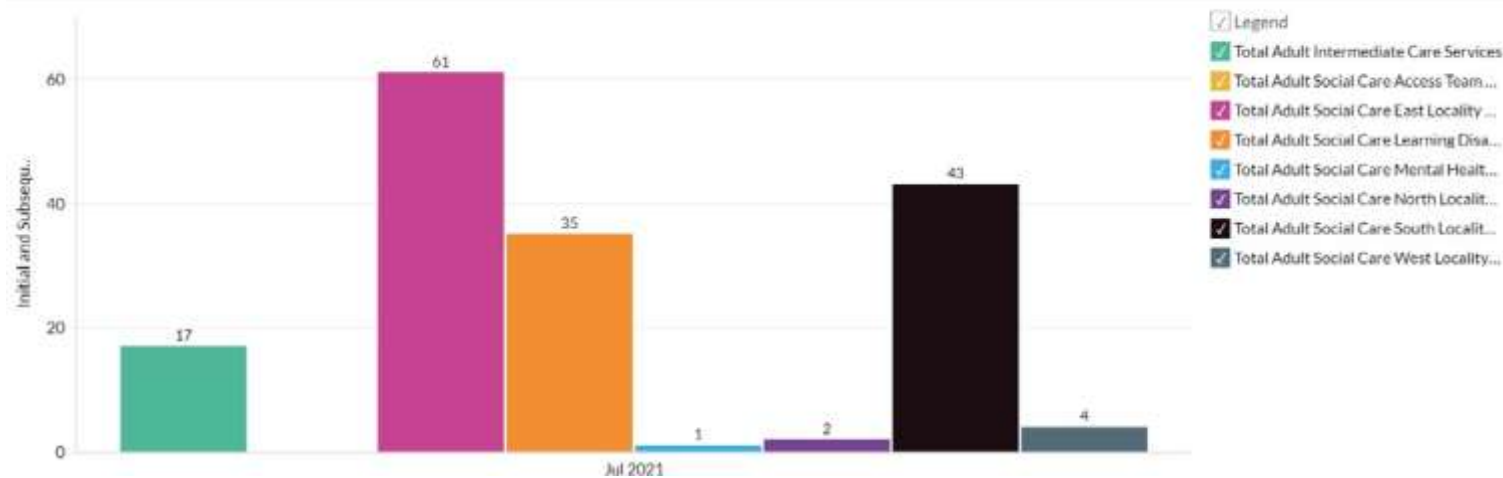


Initial and Subsequent Review Outcomes



Date	Sum of Total Initial and Subsequent Reviews Completed
Feb-21	334
Mar-21	388
Apr-21	223
May-21	235
Jun-21	230
Jul-21	163

Initial and Subsequent Reviews Completed by Teams



Tier 2: Adult Social Care

ASC have received 315 concerns in July which is an increase of 8 concerns on the June data.

The number of cases progressing to a s42 enquiry is slightly higher for July with 88 noting June was 83. The number of cases NFA in this period is quite high with only 27.94% of concerns proceeding to an enquiry. Further work will be undertaken through an audit to look at the themes of those cases where concerns resulted in NFA.

Safeguarding cases in progress have doubled in this period.

Neglect & Psychological abuse are the two highest categories of alleged abuse in this period.

Walsall Adult Social Care Safeguarding concerns

Reporting period: 01/07/2021 31/07/2021

315
Concerns received

27.94
% leading to S42 enquiry

88
S42 enquiries

0
Non-S42 enquiries

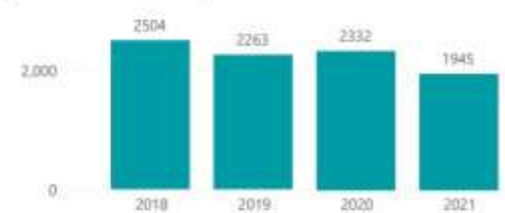
191
NFA

36
In progress

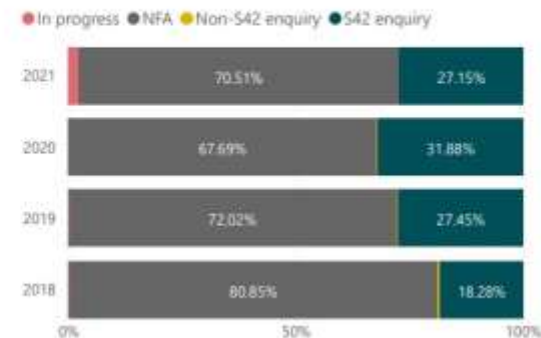
Concerns received by receipt date



Concerns concluded by conclusion date



Concerns received within parameter dates: outcomes



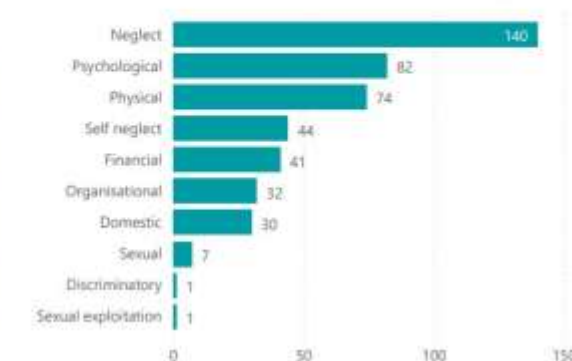
Concerns received: trends



Concerns concluded: trends



Concerns received within parameter dates: alleged abuse types

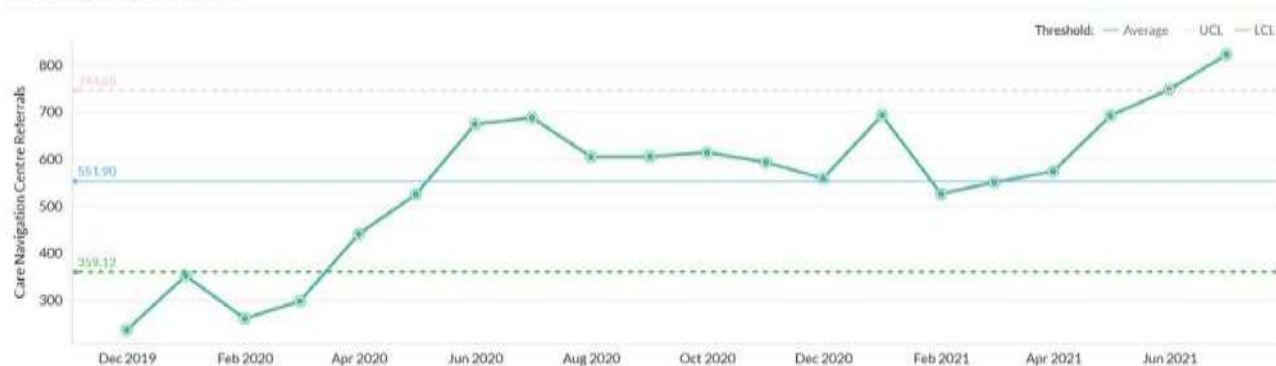


Tier 3:



Care Navigation Centre: Hours of availability have increased (November 2020) and calls continue to rise

Care Navigation Centre Referrals



Care Navigation Centre not Accepted due to Capacity



The Safe at Home pathway continues to operate with patients being referred from Acute Hospital services and GP practices. The current demand for this pathway has risen in July due to local picture of community cases.

The operational hours for the CNC as of 5th July increased to 08.00-22.00 to 08.00 - 00.00. This will provide operational resilience for the Hospital avoidance and Covid pathways through the Winter period.

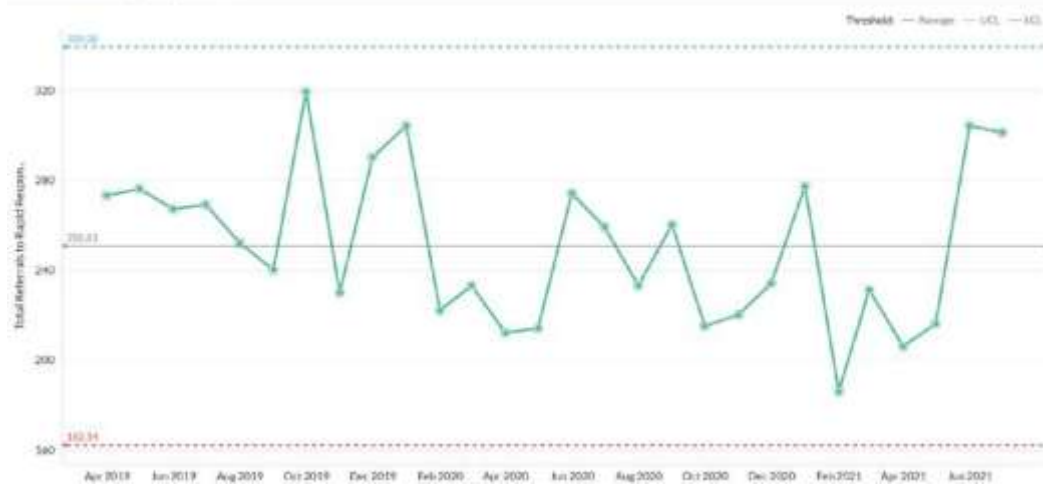
Work is in progress with WMAS and Acute to create a 999/111 SPA through CNC for hospital ED Divert including FES, AEC, SAKU and Gynae/ Early pregnancy services.

Tier 3: Rapid Response



The pattern of demand is changing [impact of CNC]

Patient Referrals - Rapid Response Team



Percentage Admission Avoidance-Rapid Response



Referrals into Rapid Response remain volatile due to the expansion of CNC and the enhanced case managers across care homes, the service has increased the operational hours until midnight from the 5th July to capture referrals later in the day. This will provide operational resilience for the Hospital avoidance through the Winter period.

Rapid Response is now visible to NHS111 and WMAS as a direct referral / call disposal route for clinical and non- clinical referrals(non – clinical calls as 3 month pilot with 6 identified conditions).

Tier 3: Medically Stable for Discharge (MSFD): numbers remain low

Medically Safe for Discharge - Average days per person



Medically Safe For Discharge - Total Patients



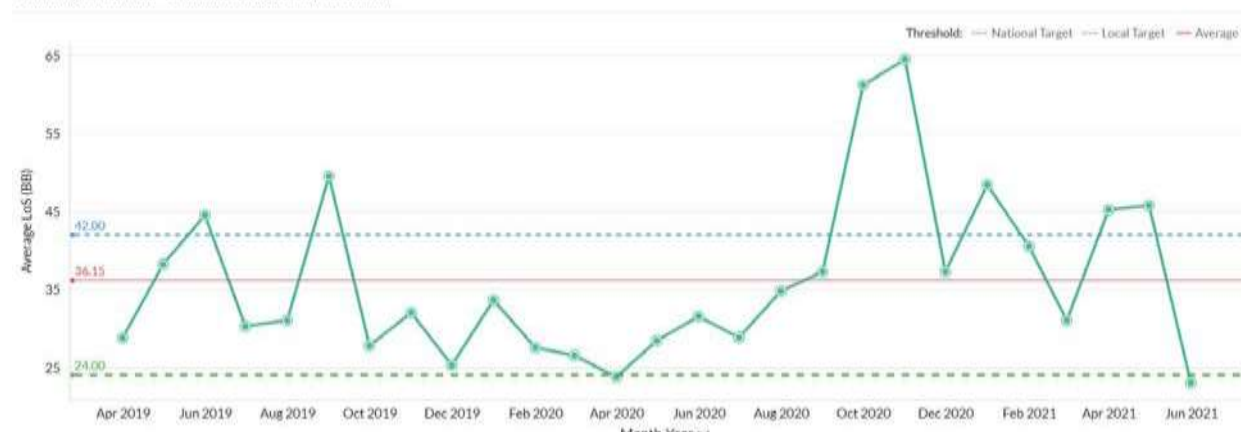
- The number of MSFD patients continues to be low throughout July, but has experienced increased demand, in particular from Surgery.
- The increase in demand and temporary delay in profiling of packages of care led to an increase in the list and LOS during July. A number of remedial actions have been put in place in order to manage the list below 50 patients. [This has worsened in August 2021]
- The ICS review has produced a mid-point paper with some key recommendations at this point. Final paper expected end of September.
- The team achieved a return to pre-covid bed based pathway levels of 51 as of 3rd June, this position remains, although some home closures are impacting on therapy led beds

Tier 3: Domiciliary and Bed-Based Pathways

Monthly Average - Discharged Patients LoS - Community Domiciliary Pathway



Discharged Patients - Monthly Average LoS (Bed-Based)



- Therapy demands and the change in national model is having a significant impact on community ICS therapists, unplanned crisis demands and hospital discharges remain key priorities in patient safety.
- Due to Covid, individuals have been more unwell and therefore have needed rehab/Reablement for a longer period of time- Long Covid MDT exceptional success.
- There is a recruitment plan underway for gaps in the social care workforce which is impacting on LOS

Tier 3/4: Integrated Assessment Hub:

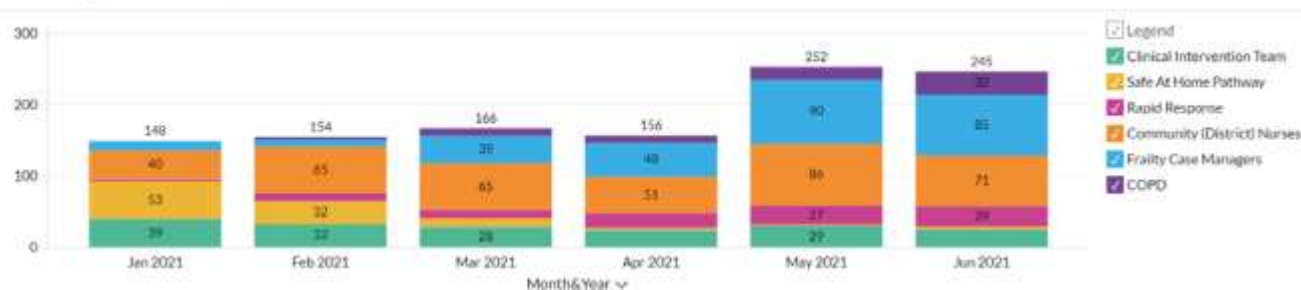


Recruitment is still in progress last B6 post

Total Monthly IAH Activity



IAH Discharge Referrals Activity



Integrated Assessment Hub

- Hospital Avoidance:** This IAH pathway enables people directly contacting the Frail Elderly Service or Ambulatory Care at the Manor with post-discharge complications to be seen by Rapid Response, Enhanced Care Home Support Team or CIT team instead and receive a community-based assessment & clinical review, thereby avoiding conveyance to hospital. The numbers of people accessing this pathway increased again for July
- In order to measure the success of the Hospital Avoidance, Early and Potential Discharge pathways the Team in addition to the Case Management undertaken in the Community the Team have started to report the numbers of patients that have been prevented from readmission within 30 days. This will enable the service to measure the impact of Quality driven case findings relating to stabilisation in community to avoid readmission.

Tier 4: Black Country Healthcare Mental Health & Learning Disability – Operational Issues

- Trust is continuing to implement a short to medium term plan – the ‘Black Country Route’ – which reflects the steps and priorities of the national ‘roadmap’. Focuses on an operating model for the next few months which maintains Covid-secure working practices whilst carefully re-introducing some ‘normal’ activities (e.g. visiting for inpatients)
- The Trust's inpatient resources are in the process of returning to pre-pandemic working arrangements. Specific admission wards (put in place to manage covid risks of newly admitted patients) have been stood down and 'red bed' capacity is now integrated into the normal ward configuration. There is still a high degree of demand for inpatient capacity, including significant pressures in accessing inpatient beds for under-18s.
- We continue to manage Covid outbreaks as and when they occur – currently no wards closed as a result of Covid.
- Continued efforts to encourage remaining staff to engage with the Covid-19 vaccination offer. Trust is working closely with locality partners to support the delivery of vaccines in the community to individuals with an LD or Severe MH problems (as part of JCVI cohort 6)
- Psychological wellbeing hub for staff in STP partners and third sector. More information about the Hub and a self-referral form can be accessed on the BCHFT website: www.blackcountryhealthcare.nhs.uk/our-services/hub.
- Planning for community mental health transformation programme is progressing well – this has already been discussed with Walsall partners via CPLG and there is ongoing dialogue via this forum with Laura Brookes, Clinical Lead for this programme.

Risk Summary																										
BAF Strategic Objective Reference & Summary Tile:		BAF SO 02 - Care at Home; We will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall together.																								
Risk Description:		Failure to work with partners and communities to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation of poor health and wellbeing and widening of health inequalities.																								
Lead Director:		Director of Integration.																								
Lead Committee:		Walsall Together Partnership Board.																								
Links to Corporate Risk Register:	Title:																				Current Risk Score Movement:					
	- Risks in this area relate to Walsall Together programme risks. The biggest ones are associated with the limited investment and the size and complexity of the population health challenges. - Non-programme risks relating to Community Services at the current time. These are updated through the divisional structure. - Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together. - Risks associated with creating an ICP contract will be considered through a formal due diligence process, supported by NHSI/E. - Operational capacity due to an increase in community prevalence of Covid since December 2020. - Winter preparedness due to change in patient flows during Covid 19 on the Trusts operating model - Programme risk register for the Walsall Together Partnership Board: ➤ R2370 - Population Health Management. (Risk Score = 16). ➤ R2628 - Funding for ICS beds. (Risk Score = 16). ➤ R2626 - COVID vaccinations. (Risk Score = 16). ➤ R2625 - WHT investment in Community/WT services in scope. (Risk Score = 20). ➤ R2624 - Primary Care demand and capacity. (Risk Score = 20). ➤ R 2641 – Delayed discharges for MSFD patients as a result of low availability of packages of care (Risk Score = 20)																				Likelihood = 4 Consequence = 3 = 12 Moderate ↔					
																					Forecasted Risk Score Movement for Q2:					
																					Likelihood = TBC Consequence = TBC = TBC ↑↔↓					
Risk Appetite																										
Status:	Hungry	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 21	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 25																									
Risk Scoring																										
Quarter:	Q1 2021/22	Q2	Q3	Q4 2020/21	Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:							
Likelihood:	3			3	Operational pressures are increasing across the system following the restart of routine activity post-COVID. Whilst staffing levels continue to be impacted by self-isolation and a loss of workforce to other sectors, demand is exceeding capacity in										Likelihood:		3	30 June 2021								
Consequence:	3			4											Consequence:		3									
Risk Level:	9 Moderate			12 Moderate											Risk Level:		9 Moderate									

				several areas. The care provider market has been impacted by COVID and Brexit and there is a shortage in packages of care (POC) for people MSFD within Walsall Manor and other healthcare settings. There is a further risk to capacity and flow during the winter pressures period. • The transformation pace has now been addressed as Covid pressures reduce through the relaunch of both the Walsall Together Senior Management Team and the Clinical Professional Leadership Group meetings. • Demand on partnership services continues to climb quickly as the Covid risks decreasing presenting additional pressure on urgent care. In addition to routine services, the system is preparing to administer booster vaccines. • Strongly established relationship with 50% of General Practice on robust vaccine delivery. Other practices chose not to connect with partnership and deploy alone. • Maturing place-based teams in all areas of Walsall on physical health and Social Care. Place-based mental health provision, including IAPT, Primary Mental Health, additional roles in general practice is not yet established and it is unclear how the contractual arrangements will be aligned to the place-based integration of services. • Significant maturity in communications and confidence in Walsall Together however public profile now needs to be established. • Funding has been secured and specification agreed for the development of a fully integrated performance, quality and risk scorecard. • Risk Stratification process for COVID developed with partners which demonstrates the evolving maturity of the partnership. • Substantial improvements in medically stable for discharge before and during Covid 19. However, challenges referenced above regarding stability of the care provider market, particularly during winter. • Virtual clinics & community outpatients maturing and triage & referral services now in place during Covid & being planned for the long term. • Partnership approach to managing care home		

				support and intervention being embedded into business as usual. The long-term financial model is not yet confirmed. • Strong evidence base being established for ICP due diligence and work now progressing at pace with the support of the ICS and NHSI/E. • The step up of the risk in Q3 2020/21 has now been de-escalated and predicted to fall through Q1 in 2021/22. • The number of safeguarding referrals has levelled off since June. Post-COVID increase in referrals is within tolerance levels and was predicted. • Capacity in the community teams as a result of the success of the WT has led to a new demand and capacity challenge which requires addressing with a demand and capacity review.		

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	• Executive Director appointed. • Non-Executive Director / Chair to be advertised • Partnership Board/Groups and meetings in place. • Business Case developed. • PMO/Project in place and reporting. • Daily operational coordination taking place. • Covid Vaccine delivery plan in place and operational. • WT acting as recruitment partner for PCN's on the new national roles	• Alliance agreement signed by Partners. • Governance structure in place and working. • S75 in place and operational practices now maturing. • Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee. • Business case approved by all partners. • Monthly report to Board and partner organisations.	• External assessment - CQC/Audit. • STP Scrutiny. • Health and Wellbeing Board Reporting. • Overview and Scrutiny Committee.
Gaps in Controls:	• No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust. This has been mitigated short term with Covid funding, but further work required to establish ongoing formal mechanisms through ICP contracts. • Commissioner contracts not yet aligned to Walsall Together although ICP planning will resolve this issue • Data needs further aligning to project a common information picture. • Effective engagement with community in development with local groups limited due to Covid social restrictions. • Organisational development for wider integrated working not yet outlined or agreed and delayed due to Covid. • Enactment of section 75 in terms of monitoring meetings. • Place based demand and capacity plan addressing the new flows apparent after covid • Variance in the understanding of other place based services in scope across the Black Country which is preventing the ICS due diligence commencing		
Assurance:	• Divisional quality board now starting to	• Walsall Together included on Internal Audit	• NHSE/I support of Walsall Together.

	look at the integrated team response. • Risk management established at a programme level and a service level integrating risks.	Programme. • Walsall Together Committee in place overseeing assurance of the partnership. • STP oversight of 'PLACE' based model. • Reporting to Board and Partners. • Oversight on service change from other committees. • ICP due diligence underway. • Safeguarding board to align reporting with WTPB	• STP support. • NHSE/I validation of ICP due diligence.
Gaps in Assurance:	• Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections although Walsall Together put forward as part of ICP development. • For Community services and ACS within the Section 75 there is direct accountability to WT / WHT; these formal arrangements do not cover other partners hence limited accountability for delivery of Walsall Together strategic aims.		

Future Opportunities

- Further development of the Governance around risk sharing.
- S75 Deployment based on other services relating to health prevention and public health commissions.
- PCN partnership alignment and risk share with building trust and confidence.
- Covid-19 offers an opportunity to increase the pace of delivery and more importantly stress test benefits before substantive deployment.
- Strategic partnership(s) with major primary care organisations to further accelerate vertical and horizontal integration of care in the borough.
- Formal contract through an ICP mechanism.
- Formal working with other partners to support their ability to achieve additional income and support via a partnership approach.
- CQC action oversight group.

Future Risks

- Insufficient promotion of success narrative.
- Inability to deliver enough investment up front to change demand flows in the system.
- Changes to commissioner & provider environment / landscape within the Black Country may change mechanisms for resourcing and resolution of service issues.
- A mechanism for gaining and sustaining resources to support strategic aims for 2021/22+ are unclear.
- National influences on constitutional targets moves focus from place to ICS.
- Retention of inspirational and committed leadership across partners.
- Estates - ability to fund the full business case offering (4 Health & Wellbeing Centres).
- Misalignment of provider strategies created by mergers or form changes or senior personnel turnover.
- Lack of uninterrupted community clinic space due to Covid Restrictions.
- Programme Resource - Capacity to deliver the WT programme will become more difficult as the same resource will be required to support the delivery of Covid-19 work streams, e.g. mass swabbing, flu vaccination programme, Covid-19 vaccination programme, outbreak management and the Covid-19 Management Service (CMS).
- Maintenance of the ICP agenda through the ICS Board by both the system partners and the Trust in relation to strategic objectives.
- Transition to a new chair and maintaining the current BAU

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Agree an investment plan initially with commissioners through 2021/22 funding round to address the current gaps in funding provision.	Director of Integration	July 21	Work is underway to confirm maintenance of transformation funding for the diabetes and care home services into established baselines. A longer-term conversation will then need to be coordinated with other ICP's through the ICS board for Health Commissioning.	
2.	Agree & implement joint service development opportunities between Walsall Together and PCNs that foster improved delivery of care through more integrated working.	Director of Integration	July 21	Work has started on revised recruitment and management arrangements for roles such as First Contact Practitioners and Pharmacists. Further opportunities are being identified.	
3.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations.	Director of Integration	July 21	The Resilient Communities work stream has held three sessions. The work stream has presented to WTPB (March 2021) the following next steps: • Discussion at the CPLG to confirm the local population challenges that we want to address, aligning to population health management and inequalities	

				priorities for the partnership. • Establishment of the Steering group including confirmation of membership and Terms of Reference. • Review of the multiple strands of work pertaining to citizen and communities engagement to create a single, defined approach. • Review of the full proposal to Changing Futures and proposal for how some or all of the elements can be taken forward without the external investment.	
4.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital work stream).	Director of Integration	July 21	This work is underway with the support of the STP Academy and Public health. The Population Health module as part of the Medway deployment is also in our test environment. The final strategy is interdependent with the production of the Health & Well Being strategy which is focused on the end of Q2.	
5.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure. This should include an outline governance structure that shows the links to other WHT committees and acknowledge the transition to holding a formal ICP contract.	Director of Governance	July 21	This work is on track as part of the ICP programme.	
6.	Prepare for implementation of a formal ICP contract under a Lead Provider model with WHT as Lead Provider. This will include confirmation of all services in scope and a clear rationale for the change in the context of improving outcomes for the population.	Director of Integration	July 21	On track and formally reported to WTPB monthly	

MEETING OF THE PUBLIC TRUST BOARD – 2 nd SEPTEMBER 2021			
Work Closely with Partners			AGENDA ITEM: 23
Report Author and Job Title:	Ned Hobbs, Chief Operating Officer	Responsible Director:	Ned Hobbs, Chief Operating Officer
Action Required	Approve ☐ Discuss ☐ Inform ☒ Assure ☒		
Executive Summary	This report provides an overview of the risks to delivery of the Work Closely with Partners Strategic Objective, mitigations in place to manage the risks identified, and actions identified to address gaps in controls and assurance. The Work Closely with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospitals. This report gives a brief update on Urology, Dermatology, Radiology, Orthopaedics, Haematology and Estates & Facilities functional integration, and appends a list of previously completed integration work.		
Recommendation	Members of the Trust Board are asked to note the contents of this report.		
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	This report addresses BAF Risk S04 Work Closely with Partners to provide positive assurance the mitigations in place to manage this risk and the related corporate risks There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066- Nursing and Midwifery Vacancies 2072- Temporary workforce		
Resource implications	There are no direct resource implications associated with this report.		
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.		
Strategic Objectives	Safe, high quality care ☐	Care at home ☐	
	Partners ☒	Value colleagues ☐	
	Resources ☐		

WORK CLOSELY WITH PARTNERS

1. EXECUTIVE SUMMARY

COVID-19 has accelerated significant collaboration between Trusts on many matters including mutual aid for Personal Protective Equipment, standardisation of policies in relation to the workforce, approaches to restoration and recovery planning, Critical Care mutual aid, mutual aid for the management of patients conveyed to Emergency Departments by ambulance, and shared learning to deal with a novel virus pandemic.

As a result, collaboration between Black Country & West Birmingham Trusts is stronger due to the experience of the last 18 months. There is a clear appetite to use this opportunity to build upon those foundations and progress functional service integration where there is an opportunity to improve care for the patients we serve and/or to improve the working lives of our staff. Recent developments including a single Chief Executive Officer and single Chair for both Walsall Healthcare NHS Trust and the Royal Wolverhampton NHS Trust have also facilitated strengthened bilateral service collaboration between the two Trusts.

2. BOARD ASSURANCE FRAMEWORK

The Working Closely With Partners BAF risk has been reviewed and updated. The risk has been brought up to date to reflect the evidence of successful partnership working, the demonstrable progress in functional service integration in further specialties now, and to recognise the approved Strategic Collaboration between The Royal Wolverhampton NHS Trust (RWT) and Walsall Healthcare NHS Trust (WHT), the new Integrated Supplies and Procurement Department (ISPD) alliance with RWT and University Hospitals North Midlands NHS Trust, and the introduction of a shared Chair and Chief Executive Officer between the Trust and RWT.

The risk score remains as a 6 (likelihood 2 x consequence 3) on the grounds that strong collaboration with partners is meaning that partnership working is not a barrier to providing high quality, sustainable care. The trajectory to reduce the overall risk score in Quarter 2 is subject to assurance on and approval of the Urology integration plan, which remains the top priority specialism within the Trust to strengthen and give greater resilience to be able to provide sustainable high quality care.

3. IMPROVEMENT PROGRAMME

The Work Closely with Partners Improvement Programme reflects the work of Divisional teams and the progression of functional integration between Acute Hospital specialties to support improved patient care, and improved working lives for our people.

Urology

The proposed model of care for an integrated Urology services across Walsall and Wolverhampton was presented to the Black Country & West Birmingham Urgent and Emergency Care Board on 2nd July 2021 and endorsed. It was presented to the Walsall Borough Council's Scrutiny Committee on 14th July 2021 and also endorsed. Finally it was presented and endorsed at the City of Wolverhampton Council Health Scrutiny Panel on 29th July 2021, where it was also endorsed with some conditions noted. As part of developing the proposal the Trusts undertook an active patient and user engagement exercise. Positive themes from the patient engagement included making the best use of NHS resources, and cutting waiting times; and concerns largely centred on travel and access issues, and quality of care.

Having secured support from both Councils for the proposed model of care, the detailed proposals will now work through both Trusts' internal Governance forums. The Trust and RWT are targeting implementation of phase 1 of the programme in Quarter 3 of 2021/22.

Dermatology

The joint Dermatology Steering Group continues to work through the structural integration of the departments in Walsall and Wolverhampton, to maximise the benefits of the collaborative service.

Radiology

The 3rd West Midlands Imaging Network Board meeting was held on 13th July 2021.

The Board received a presentation from Dr Jonathan Hopkins, Consultant Interventional Radiologist (University Hospitals Birmingham) and Head of School of Radiology, Health Education England West Midlands on Imaging (workforce) Academies. Phil Williams from the NHSEI Midlands Digital Transformation Team updated on Digital Transformation for Diagnostics, and members of the HEE Midlands (workforce) Observatory presented Imaging workforce supply and demand projections.

Orthopaedics

A WHT and RWT T&O Working Group was established in May 2021 to review opportunities for collaboration in the provision of elective Orthopaedic services. The first two pilot WHT operating lists at Cannock Hospital have been successfully undertaken in July, under Mr Goude, Consultant T&O Surgeon and Clinical Director, supported by WHT Consultant Anaesthetists and with Theatre staff and support staff from RWT. Initial feedback was very positive, and the two pilot operating lists will be evaluated to inform options for future service models, including the potential for regular WHT elective Orthopaedic operating lists at Cannock.

Haematology

Discussions have now commenced regarding the opportunities to further strengthen the collaboration between WHT and RWT Haematology services.

Estates & Facilities

WHT and RWT are working collaboratively to share expertise across a number of Estates and Facilities functions including Catering, Fire, Hard Facilities Management, Sustainability and PFI Contract management.

4. RECOMMENDATIONS

Members of the Trust Board are asked to note the contents of this report.

APPENDICES

1. List of secondary care partnership integration already delivered
2. BAF SO3

APPENDIX 1

List of secondary care partnership integration already delivered

Recently integrated/networked services

ENT Consultant on-call rota with RWT and DGFT

Sentinel Lymph Node Biopsy pathway with DGFT

Integrated Supplies and Procurement Department (ISPD) alliance with RWT and University Hospitals North Midlands NHS Trust

Offer of Colorectal Cancer Surgery capacity to other BCWB ICS partners

Black Country Pathology Service with RWT, DGFT and SWBH

Payroll with RWT

Clinical Fellowship programme with RWT

International Nurse recruitment programme with RWT

Historically integrated/networked services

Cardiology with RWT

Renal with RWT

Ophthalmology with RWT

Oral and Maxillofacial Surgery with RWT

Oncology with UHB

Neurology with UHB

Hyper Acute Stroke with RWT

Vascular Surgery with DGFT and RWT

Haematology with RWT

Rheumatology with SWBH

Risk Summary																										
BAF Strategic Objective Reference & Summary Title:		BAF SO 03 - Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.																								
Risk Description:		Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.																								
Lead Director:		Chief Operating Officer.																								
Lead Committee:		Performance, Finance, & Investment Committee.																								
Links to Corporate Risk Register:		Title:																				Current Risk Score Movement:				
		- There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066 - Nursing and Midwifery Vacancies (Risk Score = 15), 2072 - Temporary workforce (Risk Score = 16).																				Likelihood = 2 Consequence = 3 = 6 Low ↔				
																						Forecasted Risk Score Movement for Q2:				
																						Likelihood = TBC Consequence = TBC = TBC ↑↔↓				
Risk Appetite																										
Status:	Hungry	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:	< 22	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:	< 24																									
Risk Scoring																										
Quarter:	Q1 2021/22	Q2	Q3	Q4 2020/21	Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:							
Likelihood:	2			3	- This risk has been reduced to moderate due to the advancement of a number of key work streams. - Executive group established across provider organisations to review opportunities for collaboration. - Success of Black Country Pathology Service (BCPS). - Transfer of WHT payroll service to RWT. - Advanced collaboration in Dermatology including appointment of joint clinical director, and cross-site working of Consultant Dermatologists.										Likelihood:		2		Q2 2021/22 Subject to assurance on and approval of Urology integration plan.							
Consequence:	3			3											Consequence:		2									
Risk Level:	6 Low			9 Moderate											Risk Level:		4 Low									

				- Advanced discussions in Urology including cross site working. - Integrated ENT on-call rota in place. - Initial discussions re: bariatric services and radiology. - STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy. - Shared Clinical Fellowship Programme agreed with RWT, and first round of appointments made. - Shared international nurse recruitment programme agreed with RWT, and first round of appointments made. - New Integrated Supplies and Procurement Department (ISPD) alliance with Royal Wolverhampton NHS Trust and University Hospitals North Midlands NHS Trust commenced April 2021. - First WHT elective Orthopaedic operating list took place at Cannock Hospital in partnership with RWT in July 2021. - Health Overview & Scrutiny Committees for Walsall and Wolverhampton endorsed Urology integration proposal. However, despite progress, integration plans are not all yet fully implemented and the sustainability of the Urology service prevents the score being reduced further at this stage.			

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	- Sustainability review process completed. - Regular oversight through the Board and its sub committees. - Improvement Programme to progress clinical pathway redesign with partner organisations. - Executive to Executive Integration oversight meeting established between WHT and RWT (first meeting held 10/03/21) and agreed to be held every 4-6 weeks.	- Public Trust Board approved Strategic Collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust at February 2021 Board meetings, and approved a Memorandum of Understanding at March 2021 Board meetings. - West Midlands Imaging Network Board established with Trust Chief Operating Officer as voting member.	- Third line of control NHSE/I regulatory oversight. - Black Country and West Birmingham STP plan and governance processes in place.

	Black Country & West Birmingham Acute Care Collaboration Programme Board established March 2021.		
Gaps in Controls:	- Lack of co-alignment by our organisation and all neighbouring trusts. - Lack of formal integration at Trust level across all four BCWB Acute Trusts. - Mandated arrangements by regional networks.		
Assurance:	- Track record of functional integration of clinical services including hyper acute stroke, vascular surgery, cardiology, rheumatology, ophthalmology, neurology, oncology, Black Country Pathology Service and OMFS. - Non-clinical service integration such as Payroll and Procurement, and elements of Estates functions.	- Demonstrable evidence of recent functional integration in ENT, Urology and Dermatology and with the clinical fellowship programme. - Emerging commitment from BCWB Acute Collaboration partners to more formalised collaborative working. - Audit Committee has oversight of partnership working within its terms of reference. - System Review Meetings providing assurance to regulators on progress.	Progress overseen nationally and locally.
Gaps in Assurance:	- Clinical strategy is still emerging. - Additional pressures with Covid-19 have delayed acute collaboration, and organisational capacity is concentrated on managing the second and third waves of the pandemic. - Limited independent assessment of integrated services or collaborative working arrangements. - Embryonic independent evidence-base for successful collaborations to assess progress against.		

Future Opportunities

- Consolidate other services, including back office functions.
- Collaborate with partner organisations outside the Black Country Acute Trusts, including community and third sector organisations.
- Promote Walsall as an STP hub for selected, well-established services.
- Collaborative working during COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign.
- Shared Chair and CEO with RWT creates opportunities to accelerate bilateral collaboration with RWT where applicable.

Future Risks

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

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020	COMPLETE - Trust Board endorsed the benefits of BCWB Trust collaboration for the population of Walsall	
2.	Develop over-arching programme plan to support individual projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work).	Programme Manager	Dec 2020	COMPLETE - Delayed due to resurgence of Covid-19. To be incorporated into re-phased Improvement Programme Plan for June 2021.	

4.	Assess resource requirement to support Imaging Network programme	G Augustine & N Hobbs	Feb 2021	COMPLETE - Delayed due to resurgence of Covid-19. To be discussed at Black Country wide working group in April 2021.	
5.	Approve Urology integration plan through QPES, PFIC and Trust Board (if applicable)	N Hobbs	~~June 2021~~ October 2021	IN PROGRESS BCWB UEC Board endorsed proposal July 2021. Walsall and Wolverhampton Health Overview & Scrutiny Committees both endorsed proposals July 2021.	

MEETING OF THE PUBLIC TRUST BOARD

Thursday 2nd September 2021

Audit Committee Highlight Report

AGENDA ITEM: 24

Report Author and Job Title:

Trish Mills
Trust Secretary

Responsible Director:

Mrs Mary Martin, Chair of Audit Committee (Non-Executive Director)

Action Required

Approve ☒ Discuss ☒ Inform ☒ Assure ☒

Executive Summary

This report provides the key messages from the Audit Committee meeting on 26th July 2021. The report sets out escalations for the attention of the Trust Board, and key issues discussed and work underway.

- The Committee reviewed and endorsed the revisions to the standing orders, standing financial instructions, and reservation delegations. These were before the Board at their August meeting for approval.
- The Quarter 1 Board Assurance Framework and Corporate Risk Register was reviewed by the Committee, which is also before the Board for this meeting. The Committee requested a report at their next meeting from the Risk Management Executive on plans to improve education and training on risk.
- The Committee requested further information as to the reason why there had been an increase in the number of claims related to slips, trips and falls which will come to the next meeting.
- The Internal Audit recommendation tracker was reviewed, and the escalation process augmented with confirmation of any escalations to the Chair of the Audit Committee. Given the discussion and oversight at the Performance, Finance and Investment Committee and at the Quality, Patient Experience and Safety Committee on the issue of electronic discharge summaries, it was agreed to extend the deadline for recommendations on this review to the end of the calendar year.
- The Committee recommended that the anti-fraud survey report was re-run to ensure maximum coverage and update given a low response rate to the initial survey.
- The external auditors provided their progress report, noting that all matters were on track or complete, and a single item meeting will be held on 6th September to receive their final

	report prior to it being published. - The Committee was updated on the plans to address the two standards not met on Data Security and Protection and noted both were rectifiable with action plans in place. The next meeting of the Audit Committee will be held on 6th September 2021.	
Recommendation	Members of the Trust Board are asked to note the report and escalations.	
Does this report mitigate risk included in the BAF or Trust Risk Registers? please outline	Audit Committee is essential to Trust Board managing risk across the organisation.	
Resource implications	Poor internal control and/or management of risk would almost certainly result in financial loss.	
Legal and Equality and Diversity implications	There are no legal or equality & diversity implications associated with this paper.	
Strategic Objectives	Safe, high quality care ☒	Care at home ☒
	Partners ☒	Value colleagues ☒
	Resources ☒	

MEETING OF THE PUBLIC TRUST BOARD – 2 nd September 2021			
Board Assurance Framework and Corporate Risk Register Report			AGENDA ITEM: 25
Report Author and Job Title:	Vicky Haddock - Corporate Risk Manager	Responsible Director:	Jenna Davies - Director of Governance
Action Required	Approve ☒ Discuss ☒ Inform ☒ Assure ☒		
Executive Summary	This report provides the Trust Board with a status update in relation to the Board Assurance Framework ("BAF") and risks that sit on the Corporate Risk Register ("CRR"). Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable the Board to maintain effective oversight of Strategic Objective ("SO") risks through a regular process of formal review. Each Lead Director meets on a monthly basis with the Director of Governance to review their BAF and CRR risks. This report includes: • A summary of both the overall number and grade of risks contained in the BAF and CRR; • A description of the high risks included on the BAF and CRR; • A description of any changes made to the BAF and CRR; • A description of the BAF and CRR reviewed; and • A description of any BAF and/or CRR agreed risks to close. All BAF documents and CRR risks have been reviewed and update in month to reflect comments received last month. The Audit Committee reviewed this quarterly report at their meeting on 26th July 2021.		
Recommendation	The Trust Board are asked to note the updates to the BAF documents and progress against the CRR.		
Does this report mitigate risk included in the BAF or Trust Risk Registers?	Risk implications are outlined within the document.		
Resource implications	There is no resource implications associated with this report.		
Legal and Equality and Diversity implications	The BAF and indeed elements of the attached risks form part of our registration and licence requirements to both NHSi and CQC, which may result in regulatory or legal action under the Health and Social Care Act. There is clear evidence¹ of unequal and differential impact of COVID-19 on sections of our society including differential impact associated with levels of deprivation, occupations and ethnicity. ¹ https://www.health.org.uk/sites/default/files/upload/publications/2020/Build-back-fairer-the-COVID-19-Marmot-review.pdf#:~:text=Building%20back%20fairer%20will%20require%20fundamental%20thinking%20about,must%20be%20dealt%20with%20at%20the%20same%20time		
Strategic Objectives	Safe, high quality care ☒	Care at home ☒	
	Partners ☒	Value colleagues ☒	
	Resources ☒		

Board Assurance and Corporate Risk Register

1. PURPOSE OF REPORT

The purpose of the report is to present the current Board Assurance Framework (“BAF”) and the risks on the Corporate Risk Register (“CRR”) and to note the mitigating actions.

This report includes

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

2. BACKGROUND

These BAFs forms the strategic objective (“SO”) risk register of this organisation which have been raised and accepted by the Trust Board to determine adequacy of assurance and controls measured to effectively minimise these risks to acceptable levels.

3. DETAILS

3.1 Board Assurance Framework (BAF)

There are currently 6 identified SO risks included within the BAF risk register which have been approved by the Trust Board:

- 1) BAF SO 01 - Safe, High Quality Care,
- 2) BAF SO 02 - Care at Home,
- 3) BAF SO 03 - Working with Partners,
- 4) BAF SO 04 - Value our Colleagues,
- 5) BAF SO 05 - Use Resources Well, and
- 6) BAF SO 06 - COVID.

In May 2021, the People and Organisational Development Committee (“PODC”) agreed with the proposal to divide BAF SO 04 for Value our Colleagues into three separate BAF risk documents in order to focus on the milestones and outcomes for each sub-work stream within the Value our Colleagues element of the Improvement Programme for the 2021-2022 year. These are as follows:

- a) BAF SO 04a - Leadership Culture and Organisation Development,
- b) BAF SO 04b - Organisation Effectiveness, and
- c) BAF SO 04c - Making Walsall (and the Black Country) the best place to work.

The previous combined BAF SO 04 was brought to a close in March 2021.

All updated BAF risk documents are provided for the Committee in Appendix 2 - 9.

3.1.1 BAF Movement

Summary Risk Title	Strategic Objectives Under Threat	Change in Current Risk Score				
		Q1 2021/22	Q2	Q3	Q4 2020/21	Change
BAF SO 01 - Safe, High Quality Care		15 High			15 High	
BAF SO 02 - Care at Home		9 Moderate			12 Moderate	✓
BAF SO 03 - Working with Partners		6 Low			9 Moderate	✓
BAF SO 04 - Value our Colleagues 04a - Leadership Culture & OD 04b - Organisational Effectiveness 04c - Making Walsall & BC BPTW		20 High			20 High	
		20 High			20 High	
		20 High			20 High	
BAF SO 05 - Use Resources Well		15 High			15 High	
BAF SO - 06 COVID	    	6 Low			15 High	✓

3.2 Corporate Risk Register

There are currently 24 Corporate Risks. All risks have been reviewed; updated and revised within the specified review timescale; the process is led by the Lead Director for each risk and is detailed below.

3.2.1 Current Risks

A summary of the 24 Corporate Risks (in risk number order) are shown on the dashboard appended to this report (Appendix 1), with further detail and actions illustrated. All risks have been reviewed and updated within month.

3.2.2 Risk Movement

A summary of the; risk title, current risk score, & movement within Q1, are shown below (in risk number order):

- **Risk ID 208** - *Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks.*
 - Risk Score - **12 Moderate** (Severity 4 x Likelihood 3)
 - Risk Movement - The current risk score has remained the same this quarter in line with the Urgent and Emergency Care Board (UEC) STP- delivery Board overseeing system response 8th out of 113 reporting Trusts for 4 hour emergency access standards for June 2021.
- **Risk ID 665** - *Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc.) upon a NHS or partner organisation within the West Midlands Conurbation.*
 - Risk Score - **15 High** (Severity 5 x Likelihood 3)
 - Risk Movement - The current risk score has remained the same, there are now three new Divisional Risks that have been created to support the mitigation of this overarching Corporate Risk, by looking at; protection, internet facing security, and local area network security.
- **Risk ID 1005** - *Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - The current risk score has remained the same, with the ED works project on target to finish in the Summer of 2022. The capital allocation of circa £4 million will be used in part for the 2021/22 for works which includes the refurbishment of Theatres 5 & 6, which started on 12th July 2021 and the completion is set to be in November 2021.
- **Risk ID 1155** - *Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - The current risk score has remained the same. The review of tender process for fire engineer nearly concluded and a preferred company has been arrived at, however the criteria for the survey of the new build and retained estate needs to be agreed by PCo and WHT.
- **Risk ID 1658** - *Cessation of funding for NHS England Diabetes transformation scheme, will impact negatively on service provision resulting in deterioration of limb care within the diabetic community.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - Risk escalated to Walsall Together Board on 20/01/2021 with recommendations and agreement to escalate onto the Corporate Risk Register in February 2021. Risk score reduced from a 20 (High) as verbal confirmation received from CCG, however still waiting formal confirmation from the CCG that funding has been approved.

- **Risk ID 1664** - *The environment of Theatres 1-3 and 5 & 6 is poor and outdated which is having an impact on the ability to deliver optimal current infection control standards and theatre productivity.*
 - Risk Score - **9 Moderate** (Severity 3 x Likelihood 3)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in June 2021. Risk score reduced from a 20 (High) due to surgery taking place in a non-laminar airflow theatre only happening for low risk patients that are below the elbow or below the knee and wound care risk assessment will be undertaken for all procedures going through non-laminar airflow theatres.
- **Risk ID 1937** - *Not having the capacity to be able to fit test or sufficient resource/supply available for respiratory protective equipment (RPE; disposable FFP3 respirators, reusable FFP3's, PAPR devices), to protect staff from harmful substances (e.g. COVID-19).*
 - Risk Score - **9 Moderate** (Severity 3 x Likelihood 3)
 - Risk Movement - The current risk score has reduced this quarter from a 15 (High) in line with having interim control assurance in place for fit testing and sufficient resource/supply for respiratory protective equipment.
- **Risk ID 2066** - *Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels.*
 - Risk Score - **15 High** (Severity 3 x Likelihood 5)
 - Risk Movement - The current risk score has reduced this quarter from a 20 (High), the 2nd cohort of international recruits arrived in the Trust in June 2021, with recruitment expected to be completed by December 2021.
- **Risk ID 2072** - *Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - The current risk score remains due to still having high vacancy rates and agency usage. The position at end of May 2021 suggests an improved position and has focused attention on reducing the vacancy gap, with additional staff being recruited since.
- **Risk ID 2081** - *Delivery Operational Financial Plan.*
 - Risk Score - **9 Moderate** (Severity 3 x Likelihood 3)
 - Risk Movement - New version of risk created to represent current financial year review of risk. Risk scores to be increased to a 12 (Moderate).
- **Risk ID 2082** - *Future Financial Sustainability.*
 - Risk Score - **12 Moderate** (Severity 3 x Likelihood 4)
 - Risk Movement - The current risk score has reduced this quarter from a 16 (High), the June Improvement Programme approved the process for re-classifying Work Stream Project, which will be reviewed at the July Improvement Programme Board. The related PIDS will be forwarded for sign-off following the Board and the financial benefits have been aligned to all PIDS, which is tracked on a monthly basis.
- **Risk ID 2093** - *Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust.*
 - Risk Score - **6 Low** (Severity 3 x Likelihood 2)
 - Risk Movement - Is constantly under review and responsive to central command as well as control from the government. The current risk score has reduced over this quarter from a 20 (High) in line with BAF SO 06 - COVID. Vaccination progress as of 13th July, 86.42% of all staff having now received their first vaccination dose and 84.07% having received their second dose. That said, the forecasted risk movement for Q2 sees an increase to 15 (High).

- **Risk ID 2117** - *Risk to the delivery of the Emergency and acute capital build within timescale and affordability constraints.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - The current risk score remains due to programme ongoing at this stage.

- **Risk ID 2245** - *The maternity inpatient service has a significant shortfall in registered midwives to support the delivery of care.*
 - Risk Score - **20 High** (Severity 4 x Likelihood 5)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in May 2021. Ongoing recruitment in place with collaborative work with Royal Wolverhampton.

- **Risk ID 2325** - *Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in July 2021, as the risk spans all Divisions and the MLTC Divisional To3 is unable to influence any changes. Risk accepted on to CRR, where a review will be conducted to understand the scanning requirement for the current paper copies, as well as a process change implementation to bring a stop to paper copies being created.

- **Risk ID 2398** - *Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care.*
 - Risk Score - **12 Moderate** (Severity 4 x Likelihood 3)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in February 2021, risk to be reviewed as equipment has now been procured through the Covid provision and capital programme. Risk score reduced from 16 (High).

- **Risk ID 2430** - *Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record.*
 - Risk Score - **20 High** (Severity 4 x Likelihood 5)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in July 2021 and is currently going through a 12 week recovery plan.

- **Risk ID 2439** - *External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. There is a national GAP for Tier 4 beds - this is an external service provided by NHS England.*
 - Risk Score - **20 High** (Severity 4 x Likelihood 5)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in May 2021. Risk to be split out in to two risks, 1x for internal element and the 2nd for the external element. The Medical Director is to escalate the external element to NHSE and Head of CCG regarding the concerns surrounding a Tier 4 bed shortage and the impact and risk associated to WHT, as this is out of the Trusts control.

- **Risk ID 2475** - *The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.*
 - Risk Score - **25 High** (Severity 2 x Likelihood 5)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in April 2021, detailed action plan created and business case for additional staff being put together.

- **Risk ID 2489** - *Poor colleague experience in the workplace.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in May 2021 and agreed by the Risk Management Committee. The risk score remains the same based on the results of the National NHS Staff Survey 2020.
- **Risk ID 2512** - *Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes Best Practice Tariff Standards.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in May 2021, for recruitment and quality improvement to be progressed.
- **Risk ID 2540** - *Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems.*
 - Risk Score - **16 High** (Severity 4 x Likelihood 4)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in June 2021, as a plan to deliver Level 3 Safeguarding Adults Training needs to be confirmed due to the Trust currently being below the expected compliance performance level.
- **Risk ID 2581** - *Internal risk for patients awaiting Tier 4 hospital admission.*
 - Risk Score - **15 High** (Severity 3 x Likelihood 5)
 - Risk Movement - Risk escalated onto the Corporate Risk Register in July 2021, risk to be strengthened to be clear what the risk is (this is the split of Risk 2439 above).
- **Risk ID 2587** - *Not having sufficient staffing levels available to support the release for fit testing in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19).*
 - Risk Score = **20 High** (Severity 4 x Likelihood 5)
 - Risk Movement = New risk created 16/07/2021. Risk Owner agreed as Ann-Marie Cannaby to work with the Director of Nursing and the Medical Director to develop an implementation plan to support the release of staff for fit testing.

3.3 Reporting and Assurance

The CRR and BAF risk reports will be presented to the Trust Board and Audit Committee on a quarterly basis to provide assurance and mitigation where appropriate.

As part of the Well Led Work Stream of the Improvement Programme, we have a work stream which will be looking to strengthening the assurance processes associated with risk management.

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

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

To ensure the Corporate Risk Register is actively monitored and updated with progress to maintain its current position; the schedule for reviewing corporate risks has been revised. This is to allow sufficient time to facilitate confirm and challenge sessions with a view to strengthening the quality of risk evaluation, articulation, action planning and progress.

4. RECOMMENDATIONS

The Trust Board is asked to note the Corporate Risks and BAF Risk document and their respective progress.

5. APPENDICES

Appendix 1 - Corporate Risk Register Dashboard

Appendix 2 - BAF SO 01 - Safe, High Quality Care

Appendix 3 - BAF SO 02 - Care at Home

Appendix 4 - BAF SO 03 - Working with Partners

Appendix 5 - BAF SO 04a - Leadership Culture and Organisation Development

Appendix 6 - BAF SO 04b - Organisation Effectiveness

Appendix 7 - BAF SO 04c - Making Walsall (and the Black Country) the best place to work

Appendix 8 - BAF SO 05 - Use Resources Well

Appendix 9 - BAF SO 06 - COVID

Risk Summary																												
BAF Strategic Objective Reference & Summary Tile:		BAF SO 01 - Safe, High Quality Care; We will deliver excellent quality of care as measured by an outstanding CQC rating by 2022.																										
Risk Description:		The Trust fails to deliver excellence in care outcomes, and/or patient/public experience, which impacts on the Trust's ability to deliver services which are safe and meet the needs of our local population.																										
Lead Director:		Director of Nursing/Medical Director.																										
Lead Committee:		Quality, Patient Experience & Safety Committee.																										
Links to Corporate Risk Register:	Title:																									Current Risk Score Movement:		
	208 - Failure to achieve 4 hour waits as per National Performance Target of 95%, resulting in patient safety, experience and performance risks. (Risk Score = 12). 2066 – Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). 2398 - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12). 2437 - Service wide impact as a result of the risk of CYP are being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Internal factors). (Risk Score = 20). 2439 - External inadequate paediatric mental health and social care provision leading to an increase in CYP being admitted to our acute Paediatric ward whilst awaiting a Tier 4 bed or needing a 'place of safety'. (Risk Score = 20). 2475 - The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services. (Risk Score = 25). 2540 - Risk of avoidable harm going undetected to patient's, public and staff due to ineffective safeguarding systems. (Risk Score = 16).																									Likelihood = 5 Consequence = 5 = 25 High ↑		
																										Forecasted Risk Score Movement for Q2:		
																										Likelihood = 5 Consequence = 5 = 25 High ↔		
Risk Appetite																												
Status:		Averse		Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
Tolerate Score:		< 9																										
Risk Scoring																												
Quarter:		Q1 2021/22		Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:				
Likelihood:		3						3		- Risk score increased in line with worst case scenario SHQC risk, Mental Health Act (ID 2475) with a risk score of 25. - The Trust's Quality Strategy is evolving to address the emerging priorities from reviews of systems, process and services.										Likelihood:		2		31 December 2021				
Consequence:		5						5												Consequence:		5						
Risk Level:		15 High						15 High												Risk Level:		10 Moderate						

				• A review of the process for ensuring lessons learnt from incidents and patient feedback is embedded in practice is under way. • A CQC Assurance Oversight Group has been established to ensure compliance with all CQC must and should do actions. • The Trust is an early adopter site for the new patient complaint standards and will be rolling these out with additional support from the national team over the coming months. • A number of clinical guidelines policies and procedures are out of date. The Trust has a clear plan for reviewing and updating these. • Potential to breach statutory requirements under the Mental Health Act due to inconsistent knowledge and application of Trust Policy. • Evidence that safeguarding training is not embedded in practice with staff not recognising potential or actual abuse, reporting and escalating in a consistent manner. • Substantive staffing levels are below those agreed in establishment reviews to deliver safe, high quality care resulting in high usage of temporary staff.		

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	• Clinical audit programme & monitoring. Clinical divisional structures, accountability & quality governance arrangements at Trust, division, care group & service levels. • Central staffing hub co-ordinating nurse staffing numbers in line with acuity and activity arrangements with staff re-deployed across clinical units and divisions as required to maintain safe staffing levels • Safety Alert process in place and assured through QPES. • Perfect Ward app allows local oversight of key performance metrics. • Freedom to speak up process in place, reporting to the People and organisational development	• Patient Experience group in place. • Governance and quality standards managed and monitored through the governance structures of the organisation, performance reviews and the CCG/CQC. • Learning from death framework supporting local mortality review. • Faculty of Research and Clinical Education (FORCE) established to promote research and professional development in the trust.	• CQC Inspection Programme. • Process in place with Commissioners to undertake Clinical Quality Review Meetings (CQRM). • External Performance review meetings in place with NHSEI/CQC/CCG.

	- committee. - Covid-19 SJR undertaken for all deaths process of assurance for lessons learnt developed. - CQC registration for the regulated activity of assessment or medical treatment for persons detained under the Mental Health Act 1983 at Manor Hospital. - Weekly CQC Action Plan oversight meeting in place. - Improvement programme in place to oversee and monitor improvements associated with the Trust delivery of Safe, and High Quality Care. - Support to safeguarding team in place from RWT - Safeguarding Committee meetings increased to monthly - International Registered Nurse recruitment underway with 200 recruits expected by the end of 2021		
Gaps in Controls:	- Performance targets not being met for all activities, including complaints, Mental Capacity Act compliance and VTE assessments. - Out of date clinical policies, guidelines and procedures. - Training performance not meeting set targets. - Quality Impact Assessment process requires embedding within the trust. - Sepsis audit frequency and performance. - CQC rating of 'Requires Improvement' in 2019; Medicine rated as 'Inadequate' in May 2021 report. - NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required. - Dementia screening performance. - Failure to demonstrate compliance with terms of the Mental Health Act.		
Assurance:	Process in place through ward, business unit and divisional reviews and sub-committees of QPES to confirm and challenge and gain assurance with overarching report and assurance at QPES.	- Patient priorities for 2021 identified which aim to improve patient experience. Assurance of impact via patient feedback. - Learning Matters Newsletter published monthly - Fortnightly assurance meeting with CQC and CQRM meeting with CCG.	- NHSEI and CCG reviews of IPC practice in ED and Maternity have not highlighted any immediate concerns. - NHSEI scrutiny of Covid-19 cases/Nosocomial infections/Trust implementation of social distancing, Patient/Staff screening and PPE Guidance. - Quality Review 6 monthly reviews in place with NHSEI/CQC.
Gaps in Assurance:	- Some CQC 'MUST' and 'SHOULD' do actions remain outstanding. - Inconsistent evidence, both through quality governance structures and performance reviews, of practice having changed as a result of learning from adverse events. - Lack of assurance regarding equality, diversity and inclusion and actions to reduced inequalities.		

- Lack of evidence of risk assessments and quality impact assessments relating to staffing contingency planning and/or activity changes.
- Lack of robust strategic approach to ensuring effective patient/public engagement and involvement.
- Lack of clinical engagement and leadership oversight of the Quality Governance agenda.
- Lack of assurance regarding dementia screening data collection process.
- Lack of assurance internally and externally regarding staff ability to recognise, report and escalate safeguarding concerns

Future Opportunities

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

Future Risks

- Ongoing impact of Covid-19 plus additional significant time pressured programmes of work such as COVID vaccination, staff testing, etc. Communications across the organisation to share programme objectives.
- Performance targets not being met for all activities, including Mental Capacity Act and VTE.
- Sepsis audit frequency and performance.
- NHSEI review of Division of Surgery, focussing on meetings, leadership, and governance highlighted remedial actions required.

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Define action plan for addressing lack of assurance around provision of services in line with requirements of Mental Health Act	Medical Director	01/10/2021	Risk included on corporate risk register in May 2021. Action plan in place. 14/07/2021 - Business case in development to ensure adequate resource to Mental Health team. To be presented to PFIC July 2021. If approved recruitment will take approx. 3 months. Due date re-aligned to reflect this process	
2.	Develop a Clinical Audit Strategy and Policy	Director of Governance	01/08/2021		
3.	Oversight of progress to address out of date policies and procedures will be strengthened via the Clinical Effectiveness Group which be reflected in the revised terms of reference	Medical Director	01/04/2021	Complete - Terms of reference agreed through Clinical	
4.	NHSEI re-inspection of cleanliness and IPC practice in maternity services	Director of Nursing	31/06/2021	NHSEI IPC inspection is booked for 22.06.2021. Report expected end of w/c 12.7.2021. Feedback on the day very positive with no significant concerns. Review undertaken and report received	
5.	Further develop processes to provide assurance that lessons learnt from adverse events	Medical Director/ Director of Nursing	03/09/2021	Scoping of new ward performance boards continues.	

6.	Development of Patient Engagement and Involvement Strategy	Patient Experience Lead / Lead for Patient Involvement	30/09/2021	Work ongoing.	

7.	Review of dementia screening data collection process. Initial deep dive completed. Scoping of improvement options commence April 2021	Director of Nursing	30/09/2021	Scoping of improvement options complete; documentation options still under consideration. Collaboration with RWT to review resources, share best practice and where possible align documentation and process. 14.07.2021 - Monthly audit in place and demonstrates improved compliance with dementia screening. Work is underway to review documentation across WHT and RWT to align. Due date re-aligned to reflect this work	
8.	Develop Maternity Services BAF	Interim Director of Nursing	30/12/2021	Ongoing review.	

Risk Summary																												
BAF Strategic Objective Reference & Summary Tile:		BAF SO 02 - Care at Home; We will work with partners in addressing health inequalities and delivering care closer to home through integration as the host of Walsall together.																										
Risk Description:		Failure to work with partners and communities to understand population health and inequalities, integrate place-based services and deliver them through a whole population approach would result in a continuation of poor health and wellbeing and widening of health inequalities.																										
Lead Director:		Director of Integration.																										
Lead Committee:		Walsall Together Partnership Board.																										
Links to Corporate Risk Register:	Title:																								Current Risk Score Movement:			
	- Risks in this area relate to Walsall Together programme risks. The biggest ones are associated with the limited investment and the size and complexity of the population health challenges. - Non-programme risks relating to Community Services at the current time. These are updated through the divisional structure. - Each organisation retains its own risk log although the section 75 presents the opportunity to start to bring the logs together. - Risks associated with creating an ICP contract will be considered through a formal due diligence process, supported by NHSE/E. - Operational capacity due to an increase in community prevalence of Covid since December 2020. - Programme risk register for the Walsall Together Partnership Board: ➤ R002 - <i>Population Health Management</i>. (Risk Score = 16). ➤ R015 - <i>Funding for ICS beds</i>. (Risk Score = 16). ➤ R017 - <i>COVID vaccinations</i>. (Risk Score = 16). ➤ R018 - <i>WHT investment in Community/WT services in scope</i>. (Risk Score = 20). ➤ R019 - <i>Primary Care demand and capacity</i>. (Risk Score = 20).																								Likelihood = 3 Consequence = 3 = 9 Moderate ↔			
																									Forecasted Risk Score Movement for Q2:			
																									Likelihood = TBC Consequence = TBC = TBC ↑↔↓			
Risk Appetite																												
Status:		Hungry		Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 21		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		< 25																										
Risk Scoring																												
Quarter:		Q1 2021/22		Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:				
Likelihood:		3						3		The increased operational pressures due to Covid wave 2 have continued to abate and business continuity measures are being stood down in many areas of Community Services as capacity is better able to meet demand. However the locality teams as experiencing continued complexity in the community which is affecting productivity (as										Likelihood:		3		30 June 2021				
Consequence:		3				4		Consequence:												3								
Risk Level:		9 Moderate						12 Moderate												Risk Level:		9 Moderate						

				of 23/06/21). • The transformation pace has now been addressed as Covid pressures reduce through the relaunch of both the Walsall Together Senior Management Team and the Clinical Professional Leadership Group meetings. • Demand on partnership services continues to climb quickly as the Covid risks decreasing presenting additional pressure on urgent care (as of 23/06/21). • Strongly established relationship with 50% of General Practice on robust vaccine delivery. Other practices chose not to connect with partnership and deploy alone. • Vaccine delivery with operational teams mainly in primary care and latterly around the Saddlers Centre retains the potential to dilute focus on core delivery items and to increase system pressure. • Maturing place-based teams in all areas of Walsall on physical health and Social Care. Additional integration required for Mental Health with IAPT & primary care but not established yet. • Significant maturity in communications and confidence in Walsall Together however public profile now needs to be established. • Advancing maturity of integrated performance data - Work now commenced on aligned quality governance. • Risk Stratification process for COVID developed with partners which demonstrates the evolving maturity of the partnership. • Substantial improvements in medically stable for discharge before and during Covid 19. • Virtual clinics & community outpatients maturing and triage & referral services now in place during Covid & being planned for the long term. • Partnership approach to managing care home support and intervention being embedded into business as usual. • Strong evidence base being establish for ICP due diligence and work now progressing at pace with the support of the ICS and NHSI/E. • The step up of the risk in Q3 2020/21 has now been de-escalated and predicted to fall through Q1 in 2021/22.			

				Safeguarding board being aligned with WT as the number of referrals climbs post lock down (as of 23/06/21).			
Control & Assurance Framework - 3 Lines of Defence							
	1 st Line of Defence			2 nd Line of Defence		3 rd Line of Defence	
Controls:	- Executive Director appointed. - Non-Executive Director appointed. - Partnership Board/Groups and meetings in place. - Business Case developed. - PMO/Project in place and reporting. - Daily operational coordination taking place. - Covid Vaccine delivery plan in place and operational. - WT acting as recruitment partner for PCN's on the new national roles			- Alliance agreement signed by Partners. - Governance structure in place and working. - S75 in place and operational practices now maturing. - Integration of performance data across the partnership is being progressed and reported to the Walsall Together Committee. - Business case approved by all partners. - Monthly report to Board and partner organisations.		- External assessment - CQC/Audit. - STP Scrutiny. - Health and Wellbeing Board Reporting. - Overview and Scrutiny Committee.	
Gaps in Controls:	- No strategic finance plan for investment across the partnership which potentially impacts on the delivery notwithstanding the recent investment from the Trust. This has been mitigated short term with Covid funding, but further work required to establish ongoing formal mechanisms through ICP contracts. - Commissioner contracts not yet aligned to Walsall Together although ICP planning will resolve this issue. - Data needs further aligning to project a common information picture. - Effective engagement with community in development with local groups limited due to Covid social restrictions. - Organisational development for wider integrated working not yet outlined or agreed and delayed due to Covid. - Enactment of section 75 in terms of monitoring meetings. - Variance in the understanding of other place based services in scope across the Black Country which is preventing the ICS due diligence commencing						
Assurance:	- Divisional quality board now starting to look at the integrated team response. - Risk management established at a programme level and a service level integrating risks.			- Walsall Together included on Internal Audit Programme. - Walsall Together Committee in place overseeing assurance of the partnership. - STP oversight of 'PLACE' based model. - Reporting to Board and Partners. - Oversight on service change from other committees. - ICP due diligence underway. - Safeguarding board to align reporting with WTPB		- NHSE/I support of Walsall Together. - STP support. - NHSE/I validation of ICP due diligence.	
Gaps in Assurance:	- Limited in overall external assurance as regulators inspect individual organisations and as yet have not developed 'PLACE' based inspections although Walsall Together put forward as part of ICP development. - For Community services and ACS within the Section 75 there is direct accountability to WT / WHT; these formal arrangements do not cover other partners hence limited accountability for delivery of Walsall Together strategic aims.						

Future Opportunities

- Further development of the Governance around risk sharing.
- S75 Deployment based on other services relating to health prevention and public health commissions.
- PCN partnership alignment and risk share with building trust and confidence.
- Covid-19 offers an opportunity to increase the pace of delivery and more importantly stress test benefits before substantive deployment.
- Strategic partnership(s) with major primary care organisations to further accelerate vertical and horizontal integration of care in the borough.
- Formal contract through an ICP mechanism.
- Formal working with other partners to support their ability to achieve additional income and support via a partnership approach.
- CQC action oversight group.

Future Risks

- Insufficient promotion of success narrative.
- Inability to deliver enough investment up front to change demand flows in the system.
- Changes to commissioner & provider environment / landscape within the Black Country may change mechanisms for resourcing and resolution of service issues.
- A mechanism for gaining and sustaining resources to support strategic aims for 2021/22+ are unclear.
- National influences on constitutional targets moves focus from place to ICS.
- Retention of inspirational and committed leadership across partners.
- Estates - ability to fund the full business case offering (4 Health & Wellbeing Centres).
- Misalignment of provider strategies created by mergers or form changes or senior personnel turnover.
- Lack of uninterrupted community clinic space due to Covid Restrictions.
- Programme Resource - Capacity to deliver the WT programme will become more difficult as the same resource will be required to support the delivery of Covid-19 work streams, e.g. mass swabbing, flu vaccination programme, Covid-19 vaccination programme, outbreak management and the Covid-19 Management Service (CMS).
- Maintenance of the ICP agenda through the ICS Board by both the system partners and the Trust in relation to strategic objectives.

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Agree an investment plan initially with commissioners through 2021/22 funding round to address the current gaps in funding provision.	Director of Integration	July 21	Work is underway to confirm maintenance of transformation funding for the diabetes and care home services into established baselines. A longer-term conversation will then need to be coordinated with other ICP's through the ICS board for Health Commissioning.	
2.	Agree & implement joint service development opportunities between Walsall Together and PCNs that foster improved delivery of care through more integrated working.	Director of Integration	July 21	Work has started on revised recruitment and management arrangements for roles such as First Contact Practitioners and Pharmacists. Further opportunities are being identified.	
3.	Refresh strategic case for Resilient Communities, ensuring appropriate focus on reducing health inequalities and alignment of strategic objectives across partner organisations.	Director of Integration	July 21	The Resilient Communities work stream has held three sessions. The work stream has presented to WTPB (March 2021) the following next steps: • Discussion at the CPLG to confirm the local population challenges that we want to address, aligning to population health management and inequalities priorities for the partnership.	

				- Establishment of the Steering group including confirmation of membership and Terms of Reference. - Review of the multiple strands of work pertaining to citizen and communities engagement to create a single, defined approach. - Review of the full proposal to Changing Futures and proposal for how some or all of the elements can be taken forward without the external investment.	
4.	Develop population health management strategy across Walsall Together and PCNs including the deployment of the population health module (Digital work stream).	Director of Integration	July 21	This work is underway with the support of the STP Academy and Public health. The Population Health module as part of the Medway deployment is also in our test environment. The final strategy is interdependent with the production of the Health & Well Being strategy which is focused on the end of Q2.	
5.	Develop robust governance and legal frameworks for Walsall Together with devolved responsibility within the host (WHT) structure. This should include an outline governance structure that shows the links to other WHT committees and acknowledge the transition to holding a formal ICP contract.	Director of Governance	July 21	This work is on track as part of the ICP programme.	
6.	Prepare for implementation of a formal ICP contract under a Lead Provider model with WHT as Lead Provider. This will include confirmation of all services in scope and a clear rationale for the change in the context of improving outcomes for the population.	Director of Integration	July 21	On track and formally reported to WTPB monthly	

Risk Summary																												
BAF Strategic Objective Reference & Summary Tile:		BAF SO 03 - Working with partners; We will deliver sustainable best practice in secondary care, through working with partners across the Black Country and West Birmingham System.																										
Risk Description:		Failure to integrate functional and organisational form change within the Black Country will result in lack of resilience in workforce and clinical services, potentially damaging the trust's ability to deliver sustainable high quality care.																										
Lead Director:		Chief Operating Officer.																										
Lead Committee:		Performance, Finance, & Investment Committee.																										
Links to Corporate Risk Register:		Title:																				Current Risk Score Movement:						
		- There are no direct corporate risks associated with Partnership working. However increased partnership working provides a mitigation to the following Corporate risks; 2066 - Nursing and Midwifery Vacancies (Risk Score = 15), 2072 - Temporary workforce (Risk Score = 16).																				Likelihood = 2 Consequence = 3 = 6 Low ↔						
																						Forecasted Risk Score Movement for Q2:						
																						Likelihood = TBC Consequence = TBC = TBC ↑↔↓						
Risk Appetite																												
Status:		Hungry		Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 22		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		< 24																										
Risk Scoring																												
Quarter:		Q1 2021/22		Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:				
Likelihood:		2						3		- This risk has been reduced to moderate due to the advancement of a number of key work streams. - Executive group established across provider organisations to review opportunities for collaboration. - Success of Black Country Pathology Service (BCPS). - Transfer of WHT payroll service to RWT. - Advanced collaboration in Dermatology including appointment of joint clinical director, and cross-site working of Consultant Dermatologists.										Likelihood:		2		Q2 2021/22 Subject to assurance on and approval of Urology integration plan.				
Consequence:		3				3		Consequence:												2								
Risk Level:		6 Low						9 Moderate												Risk Level:		4 Low						

				- Advanced discussions in Urology including cross site working. - Integrated ENT on-call rota in place. - Initial discussions re: bariatric services and radiology. - STP Clinical Leadership Group, relevant restoration and recovery groups and relevant network collaboration continue to drive Clinical Strategy. - Shared Clinical Fellowship Programme agreed with RWT, and first round of appointments made. - Shared international nurse recruitment programme agreed with RWT, and first round of appointments made. - New Integrated Supplies and Procurement Department (ISPD) alliance with Royal Wolverhampton NHS Trust and University Hospitals North Midlands NHS Trust commenced April 2021. - First WHT elective Orthopaedic operating list took place at Cannock Hospital in partnership with RWT in July 2021. - Health Overview & Scrutiny Committees for Walsall and Wolverhampton endorsed Urology integration proposal. However, despite progress, integration plans are not all yet fully implemented and the sustainability of the Urology service prevents the score being reduced further at this stage.			

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	- Sustainability review process completed. - Regular oversight through the Board and its sub committees. - Improvement Programme to progress clinical pathway redesign with partner organisations. - Executive to Executive Integration oversight meeting established between WHT and RWT (first meeting held 10/03/21) and agreed to be held	- Public Trust Board approved Strategic Collaboration between The Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust at February 2021 Board meetings, and approved a Memorandum of Understanding at March 2021 Board meetings. - West Midlands Imaging Network Board established with Trust Chief Operating Officer as voting member.	- Third line of control NHSE/I regulatory oversight. - Black Country and West Birmingham STP plan and governance processes in place.

	- every 4-6 weeks. - Black Country & West Birmingham Acute Care Collaboration Programme Board established March 2021.		
Gaps in Controls:	- Lack of co-alignment by our organisation and all neighbouring trusts. - Lack of formal integration at Trust level across all four BCWB Acute Trusts. - Mandated arrangements by regional networks.		
Assurance:	- Track record of functional integration of clinical services including hyper acute stroke, vascular surgery, cardiology, rheumatology, ophthalmology, neurology, oncology, Black Country Pathology Service and OMFS. - Non-clinical service integration such as Payroll and Procurement, and elements of Estates functions.	- Demonstrable evidence of recent functional integration in ENT, Urology and Dermatology and with the clinical fellowship programme. - Emerging commitment from BCWB Acute Collaboration partners to more formalised collaborative working. - Audit Committee has oversight of partnership working within its terms of reference. - System Review Meetings providing assurance to regulators on progress.	Progress overseen nationally and locally.
Gaps in Assurance:	- Clinical strategy is still emerging. - Additional pressures with Covid-19 have delayed acute collaboration, and organisational capacity is concentrated on managing the second and third waves of the pandemic. - Limited independent assessment of integrated services or collaborative working arrangements. - Embryonic independent evidence-base for successful collaborations to assess progress against.		

Future Opportunities

- Consolidate other services, including back office functions.
- Collaborate with partner organisations outside the Black Country Acute Trusts, including community and third sector organisations.
- Promote Walsall as an STP hub for selected, well-established services.
- Collaborative working during COVID-19 presents an opportunity to accelerate some elements of clinical pathway redesign.
- Shared Chair and CEO with RWT creates opportunities to accelerate bilateral collaboration with RWT where applicable.

Future Risks

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

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Keep abreast of Trust Acute collaboration discussions and updates accordingly.	G. Augustine	Dec 2020	COMPLETE - Trust Board endorsed the benefits of BCWB Trust collaboration for the population of Walsall	
2.	Develop over-arching programme plan to support individual	Programme	Dec 2020	COMPLETE - Delayed due to resurgence of Covid-19.	

	projects for each phase (Phase 1, emergencies, Phase 2, Elective/Cancer work).	Manager		To be incorporated into re-phased Improvement Programme Plan for June 2021.	
4.	Assess resource requirement to support Imaging Network programme	G Augustine & N Hobbs	Feb 2021	COMPLETE - Delayed due to resurgence of Covid-19. To be discussed at Black Country wide working group in April 2021.	
5.	Approve Urology integration plan through QPES, PFIC and Trust Board (if applicable)	N Hobbs	~~June 2021~~ October 2021	IN PROGRESS BCWB UEC Board endorsed proposal July 2021. Walsall and Wolverhampton Health Overview & Scrutiny Committees both endorsed proposals July 2021.	

Risk Summary																												
BAF Strategic Objective Reference & Summary Tile:		BAF SO 04 - Value our Colleagues; We will be an inclusive organisation which lives our organisational values at all times. 04a - Leadership Culture & Organisational Development.																										
Risk Description:		Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.																										
Lead Director:		Director of People and Culture																										
Lead Committee:		People & Organisational Development Committee																										
Links to Corporate Risk Register:		Title:																				Current Risk Score Movement:						
		2489 - Poor colleague experience in the workplace. (Risk Score = 16, Consequence 4 x Likelihood 4).																				Likelihood = 4 Consequence = 5 = 20 High ↔						
																						Forecasted Risk Score Movement for Q2:						
																						Likelihood = 4 Consequence = 5 = 20 High ↔						
Risk Appetite																												
Status:		Averse		Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
Tolerate Score:		< 9																										
Risk Scoring																												
Quarter:		Q1 2021/22		Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):			Target Date:					
Likelihood:		4						4		<i>Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.</i>										Likelihood:		2		31 March 2022				
Consequence:		5						5												Consequence:		5						
Risk Level:		20 High						20 High		<u>Evidence of risk gaps in control.</u> - Staff recommending Walsall as a place to work is below all England average. - Staff recommending Walsall as a place to be treated is below all England average. - Employee Engagement Index of 6.7 below sector average of 7.0 - Bullying and Harassment Index of 7.6 below										Risk Level:		10						

				sector average of 8.1. • EDI Index of 8.7 below sector average of 9.1. • Safety culture index of 6.3 below sector average of 6.8 • WRES indicator 2; recruitment 1.52 [2020] – best performing organisations 1.0 or below. • WRES indicator 4: access to non-mandatory training and CPD 1.34 [2020]. • IPDR rates remain consistently below 90% Trust KPI. <u>Progress towards risk control - July 2021</u> • Review of leadership offer across WHCT and RWT for corporate and clinical agreed and underway (due to be completed end of September 2021) • WRES 2020/21 data submission shows improvements: - WRES indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts 1.40 [positive reduction from 1.52 in 2020] best performing organisations 1.00 or below. - WRES indicator 3: Relative likelihood of staff being involved in a formal disciplinary 0.12 [positive reduction from 0.65 in 2020] based on rolling 2 year average. - WRES indicator 4: relative likelihood of staff accessing non-mandatory training and CPD 0.91 [positive reduction from 1.34 in 2020] • PDR process has been updated to streamline requirements and incorporate talent management requirements – communicated across Trust via Divisional Leadership Teams.		

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	• Cycle of local Pulse Survey implemented • Participation in NHS National Staff Survey • Equality, Diversity and Inclusion Strategy co-designed through consultation agreed at Board May 2021. • Freedom to Speak-Up (F2SU) Strategy in	• People and Organisational Development Committee in place to gain assurance. • Implementation of delivery plan overseen by Equality, Diversity & Inclusion Group (reviewed monthly) and monitored by People and Organisational Committee (PODC) (reviewed quarterly).	• Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Improved outcomes from annual NHS Staff Survey which match sector average scores. • Improvement of Workforce Equality and Workforce Disability Standards

	place and service improvement programme embedded within Value Our Colleagues Improvement Programme. - Trust Board Pledge in place to eliminate workplace inequality, detriment, discrimination and bully & harassment. - Divisional cultural heat maps reflecting F2SU, Employee Relations activity (via dashboards) and local staff experience pulse survey produced for Divisional Boards to inform insight into local colleague experience. - Employee Engagement and Experience Oversight Group implemented to engage senior leaders across all divisions to address issues which have a detrimental impact on experience at work. - In depth Restorative Just and Learning Culture (RJLC) training secured for 30 leaders across Trust.	- Quarterly report to PODC and Trust Board. - Annual update against strategy received by PODC. - Progress against F2SU improvement programme monitored by PODC and Improvement Board. - PODC monitors progress against agreed metrics for Trust Board Pledge and provides assurance to the Board. - Monthly monitoring of Employee Engagement and Experience Oversight Group progress and actions via PODC. - Comparative performance against organisational workforce and culture indicators available via Model Hospital. - Joint Race Code action plan with RWT in place.	Performance (WRES / WDES). Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital.
Gaps in Controls:	- Limited capability and capacity to provide depth and breadth of leadership development for leaders / people managers across the Trust. - Workforce policies require review and update. - Management competency framework is not yet available, impact and evaluation not complete - RJLC and Civility and Respect leadership modules to be developed.		
Assurance:	- Divisional and organisational performance monitored by Accountability Framework. - Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. - Staff recommending Trust as a place to work has increased from 47.8% [2019] to 52.3% [2020 NSS]. - Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. - WRES indicator 2; recruitment improved from 2.73 to 1.52 [2020] - WRES indicator 3; disciplinary improved from 2.04 to 0.65 [2020] - Faculty of Leadership and Management Development programme has commenced Divisional Leadership and Care Group Management Teams. - Increased BAME representation in B7	- NHSIE support to develop F2SU service and achieve improvements identified within programme. - NHSIE culture programme	- NHSIE central and regional team oversight of progress against NHS People Plan. - Quarterly deep dive of key workforce metrics by CCG.

	and above roles from 18.81% to 19.17%				
Gaps in Assurance:	- Trust 2020 National Staff Survey results score below sector average for 9/10 indicators. - Independent review of all work streams identified in Value Our Colleagues Improvement Programme to be undertaken. - Less staff feel like the Trust acts fairly with regard to career progression or promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or ageLack of senior managers representing ethnic minority and disability. - Inability of colleagues with a disability or from an ethnic minority background to access training and promotion has increased from 0.94 [WRES 2019] to 1.34 [WRES 2020] – indicator 4. - Only 55.8% of BME colleagues believe that we provide equal opportunity for career progression and promotion compared to 81.8% of White colleagues. From a BME perspective the experience has worsened for the second consecutive year decreasing further from 63.2% in 2019. - The number of staff reporting that they have experienced discrimination at wok from their manager / team leader or other colleague has increased to 11.4% and is 4.2% higher than in 2018. - Insufficient representation of managers from an ethnic minority background across the Trust [19.17% against a target of 28%].				
Future Opportunities					
- Enhanced leadership capability through strategic alliance with RWT and collaborative working with BCWB STP. - Closer collaboration with RWT and across BCWB STP to increase capability and capacity to provide leadership and management development.					
Future Risks					
- Workforce exhaustion and/or psychological impact from Covid-19 may impact on the ability of managers to practice compassionate and inclusive leadership. - Uncertainty regarding senior leadership arrangements of the Trust may impact on extent to which colleagues feel psychologically safe in their role/work.					
Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)					
No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Internal Audit re Effectiveness of National Staff Survey preparation to be completed.	Catherine Griffiths	30/09/2021	Brief agreed and audit investigation underway.	
2.	Review of leadership offer / options / opportunities across Walsall Healthcare NHS Trust and RWT.	Catherine Griffiths	30/09/2021	Review process agreed between RWT and WHCT leads.	
3.	Restorative Just and Learning Cultural Programme to be implemented for operational managers.	Catherine Griffiths	31/10/2021	Supplier identified. Course content to be developed and agreed by 30 September 2021.	
4.	Senior Leadership Team to complete succession and talent mapping	Catherine Griffiths	31/10/2021	Templates and guidance circulated.	
5.	Divisional Leadership Teams to be supported to strengthen accountability towards improving the EDI agenda across their services.	Catherine Griffiths	30/09/2021		
6.	Staff Engagement and Experience Oversight Group to produce menu of best practice from Divisional feedback re response to NSS and Pulse Survey	Catherine Griffiths	31/08/2021	Delayed from intended July timescale	
7.	Review of self-assessment / progress against NHS People Plan to be received by PODC in August 2021	Catherine Griffiths	31/08/2021		
8.	WRES and WDES national data submission	Catherine Griffiths	31/07/2021	Completed.	

Risk Summary																												
BAF Strategic Objective Reference & Summary Title:		BAF SO 04 - Value our Colleagues; We will be an inclusive organisation which lives our organisational values at all times. SO 04b - Organisational Effectiveness.																										
Risk Description:		Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care.																										
Lead Director:		Director of People and Culture																										
Lead Committee:		People & Organisational Development Committee																										
Links to Corporate Risk Register:		Title:																				Current Risk Score Movement:						
		2072 - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency. (Risk Score = 16, Consequence 4 x Likelihood 4).																				Likelihood = 4 Consequence = 5 = 20 High ↔						
																						Forecasted Risk Score Movement for Q2:						
																						Likelihood = 4 Consequence = 5 = 20 High ↔						
Risk Appetite																												
Status:		Averse		Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
Tolerate Score:		< 9																										
Risk Scoring																												
Quarter:		Q1 2021/22	Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):				Target Date:					
Likelihood:		4					4		<i>Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.</i>										Likelihood:		2		31 March 2022					
Consequence:		5					5												Consequence:		5							
Risk Level:		20 High					20 High		<u>Evidence of risk gaps in control.</u> - Staff recommending Walsall as a place to work is below all England average. - Staff recommending Walsall as a place to be treated is below all England average. - Employee Engagement Index of 6.7 below sector average of 7.0. - High reliance on temporary workforce.										Risk Level:		10							

				• Apprenticeship levy underutilised. • High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%. • As of 31 March 2021 there were 98 FTE registered nurse vacancies. • 48 vacancies within band 2 positions in Estates & Facilities (E&F) to be filled during Q1 campaign planned for June. <u>Evidence of risk control - July 2021:</u> • Midwifery recruitment open day event held. • 235 international nurses projected arrivals by end of December 2021. Currently 86 in the UK. • ICS NHSIE funded 12 month retention across the Black Country Programme has commenced (Walsall host/led employer) with aim to develop innovative employment offer / model for nursing. • Re-enrolment in Midlands NHSEI HCSW recruitment programme - WHCT trajectory 15 a quarter. • Confirmation of ICS funding secured to develop Anchor Institute model in Walsall and support career attraction events for local people. • Collaborative bank financial assumptions under review by DoF across ICS. • Mandatory & Statutory compliance above 90% for three consecutive months. • ESR Programme to cleanse establishment data (staff details in each department) 60% complete and on track to complete by 30 September 2021. • Collaborative discussions to align Waiting List Initiative (WLI) rates between RWT and WHCT, to be concluded 31 August 2021.			

Control & Assurance Framework - 3 Lines of Defence

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

	reflect organisational hierarchies. • International nurse recruitment programme in place supported by Regional NHSIE and RWT Clinical Fellowship Scheme. • Partnership with Walsall Housing Group, Job Centre and local higher education providers to fill all clinical support worker, housekeeping and porter vacancies by end of October 2021. • Community division reviewing therapy services to understand demands and AHP capacity to deliver ensure effective use of resources and support recruitment to existing and new roles in accordance with service pathways. • Implemented Step Into Health programme which connects Trusts with the Armed Forces community, by offering an access route into employment and career development opportunities. • Anchor Employer model in place with WHG • Collaboration with Health Education England to pilot new role of Medical Support Worker.	eliminate agency staff by end of October monitored via PFIC and QPES for assurance.	• Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan. • Participant of STP collaborate bank proposal. • Leading STP BCWB Workforce Supply Group and member of STP Workforce Flexibility working groups. • Improved outcomes from annual NHS Staff Survey which match sector average scores • Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital. • STP Acute collaboration focus to enable movement of staff across the system and work in partnership to address recruitment hotspots.
Gaps in Controls:	• ESR data cleanse improvement project has slipped from 31 March 21 to 31 July 21. • Apprenticeship levy underutilised. • High levels of turnover for Allied Health Professional rolls which has increased consecutively for the last 3 months reaching 16.29%. • As of 31 March 2021 there were 98 FTE registered nurse vacancies. • 48 vacancies within band 2 positions in Estates & Facilities (E&F) to be filled during Q1 campaign planned for June.		
Assurance:	• Model Hospital Use of Resources assessments. • Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. • Staff recommending Trust as a place to work has increased from 47.8% [2019] to 52.3% [2020 NSS]. • Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. • Average 2-year retention rate across the Trust of 82.4%. • Time to hire 55 days - 2nd quartile of Model	• Implementation of Anchor Institute Recruitment Campaign • Associate Director of AHP appointed and commenced in role [May 2020].	• Work with education organisations and Health education England. • NHSIE central and regional team oversight of progress against NHS People Plan. • Quarterly deep dive of key workforce metrics by CCG.

	Hospital data - Clinical Support Worker (CSW) vacancies reduced to 0 as of 31 Mach 2021. 21/98 nurse vacancies filled by 10 May 2021.				
Gaps in Assurance:	- There is a lack of workforce planning capability across leaders within the Trust. - Lack of ability to meet local and national professional clinical staffing models / guidelines.				
Future Opportunities					
- Following growth in the number and variety of apprenticeships support colleagues to recognise and access apprenticeships as an opportunity to develop in current or alternative roles. - Collaborative recruitment campaigns with STP partners to attract candidates outside of the Black Country for hard to fill roles to reduce competition for same pool of staff within the system.					
Future Risks					
- Impact of Covid-19 restrictions on international travel which may delay the planned start date of newly recruited international nurses. - Workforce exhaustion and/or psychological impact from Covid-19 may impact on the ability of managers to practice compassionate and inclusive leadership. - Uncertainty regarding senior leadership arrangements of the Trust may impact on ability to; attract, recruit and retain required skills and talent to the organisation.					
Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)					
No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Official Launch of formal partnership with Walsall Housing Group to support local people into healthcare careers to be completed.	Catherine Griffiths	31/08/2021	On track for delivery	
2.	Update report to PODC re Anchor Institute and employment models to include overview of system work streams to be presented in August 2021.	Catherine Griffith	31/08/2021	On track for delivery - report to be complemented by staff story.	
3.	Ongoing recruitment and on boarding of international nurses via Clinical Fellowship Programme	Catherine Griffiths	31/12/2021	86 international nurses in the UK of 235 planned to be in place by end of December 2021.	
4.	NHSEI sponsored ICS work stream to develop Anchor Institute network across Walsall involving healthcare, local government and voluntary a partners.	Catherine Griffiths	31/03/2022.	Lead appointed – hosted by Walsall.	
5.	Formal TNA requirements informed by IPDR process to be collated to inform L&D funds and distribution.	Catherine Griffiths	31/01/2022	IPDR process updated to support data capture – July 2021.	
6.	Consideration of case to align WLI rates between Walsall and RWT	Catherine Griffiths	31/08/2021	Acute Collaborative paper outlining options to be considered by Executive Team.	
7.	Scoping of collaborative bank model between RWT and WHCT	Catherine Griffiths	31/08/2021	Outline paper to identify opportunity and what would be required to formalise collaborative approach due for joint HRD consideration. Progress towards Acute collaborative bank continues.	

Risk Summary																																	
BAF Strategic Objective Reference & Summary Tile:		BAF SO 04 - Value our Colleagues; We will be an inclusive organisation which lives our organisational values at all times. 04c - Making Walsall (and the Black Country) the Best Place to Work.																															
Risk Description:		Lack of an inclusive and open culture impacts on staff morale, staff engagement, staff recruitment, retention and patient care																															
Lead Director:		Director of People and Culture																															
Lead Committee:		People & Organisational Development Committee																															
Links to Corporate Risk Register:		Title:																				Current Risk Score Movement:											
		2072 - Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency. (Risk Score = 16, Consequence 4 x Likelihood 4). 2093 - Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust. (Risk Score = 6, Consequence 3 x Likelihood 2).																				Likelihood = 4 Consequence = 5 = 20 High ↔											
																						Forecasted Risk Score Movement for Q2:											
																						Likelihood = 4 Consequence = 5 = 20 High ↔											
Risk Appetite																																	
Status:		Averse		Averse					Cautious					Balanced					Open					Hungry									
Appetite Score:		< 4	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25						
Tolerate Score:		< 9																															
Risk Scoring																																	
Quarter:		Q1 2021/22	Q2		Q3		Q4 2020/21		Rational for Risk Level:										Target Risk Level (Risk Appetite):					Target Date:									
Likelihood:		4					4		<i>Level of BAF risk previously assessed on single BAF framework. From May 2021 the BAF has been divided into three distinct areas to assess, understand and monitor impact of mitigating actions in greater detail.</i>										Likelihood:					2					31 March 2022				
Consequence:		5					5												Consequence:					5									
Risk Level:		20 High					20 High												<u>Evidence of risk gaps in control.</u> - Staff recommending Walsall as a place to work is below all England average. - Staff recommending Walsall as a place to be treated is below all England average. - Employee Engagement Index of 6.7 below sector average of 7.0.														

				- Lack of SEQOHS accreditation. - Sickness absence levels were 5.3% excluding Covid-19 related absence against target of 4.5% [30 June 2021]. <u>Evidence of risk control - July 2021 (to be updated):</u> As of 3 August 2021 86.66% of all staff have received their 1st vaccine and 84.79% of all staff have received their second vaccine 80% BAME colleagues have received their 1st vaccine and 77% have received their 2nd vaccine. - To date, 9530 LAMP tests have been screened, with a 99% negative result rate. - Retirement Policy and Employment Break Policies reviewed at HR Policy Sub Group. - Health and Wellbeing and Occupational Health function joint working commenced - Gap analysis commenced on Health and Wellbeing offer – for completion by end August 2021- to shape HWB strategy - Rollout of MHFA trainer training has continued; issues being resolved with accrediting trainers so courses can be restarted - Extension of hours of MH offer to meet demand/ enhance staff recovery - OH KPIs and regular feedback mechanisms launched - Collaborative SOP developed with RWT and MDT to support healthcare staff notified to isolate to return to work in exceptional circumstances (agreed at Strategic Committee 23 July 2021).		

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	- Schwartz rounds have been implemented in accordance with Point of Care Foundation license. - Internal Mental First Aider network established, accredited training complete and network contact details and support	- People and Organisational Development Committee in place to gain assurance. - Monthly Schwartz Round Steering Group established to plan, prepare and debrief agreed rounds. - Colleague Health and Wellbeing group	- Achievement of SEQOHS accreditation and rolling improvement plan in Occupational Health - Assessment of activities in line with requirements of National NHS People Plan and BCWB STP People Plan.

	- available to staff promoted. - Detailed project improvement programme plans for; <i>Health & Wellbeing Strategy, Achieving SEQOSH accreditation</i> and <i>Enhancing Flexible Working</i>. - Calendar of Black Country career events in place to attract and recruit to health and social care employment opportunities(NHS, Social Care and Voluntary Sector) - Development of system workforce metric. - Digital passport (improving education and training and mobility of workforce) - Anchor employer - Implementation of BMA Facilities and Fatigue Charter.	- continues to meet and address feedback / act on ideas to enhance wellbeing in the workplace. - Trust Health and Wellbeing meets monthly to progress HWB activity and reports through to PODC. - Value Our Colleagues Improvement Programme has Governance infrastructure in place. 2021 Pulse Survey completed.	- Improved outcomes from annual NHS Staff Survey which match sector average scores. - Externally benchmarked people performance data, particularly (but not exclusively) through Model Hospital. - Leading STP (BCWB) Workforce Supply Programme Delivery Group. - Members of STP (BCWB) Work - Leadership & Culture - Workforce flexibility & consistency (improving workforce capacity) - Education & Training - Workforce Support (HWB) - Health Education England QA process re-experience of Doctors in Post Graduate Training.
Gaps in Controls:	- The Trust has not formally introduced the individual wellbeing plan which is a requirement on the NHS People Plan from March 2021. - Working towards gifting apprenticeship levy with social care partners / providers. - Development of Black Country Employer Brand. - Development of system health and social care roles to support system workforce gaps.		
Assurance:	- Increase in occupational health resources secured. - Divisional and organisational performance monitored by Accountability Framework. - Staff recommending Trust as a place to be treated has increased from 49% [2019] to 53.4% [2020 NSS]. - Staff recommending Trust as a place to work has increased from 47.8% [2019] to 52.3% [2020 NSS]. - Turnover has decreased from 11.64% in 2019 to 8.66% in 2020 against Trust target of 10%. % of colleagues confirming manager takes interest in wellbeing has increased from 65% to 69% in 2020 NSS. - Stage 3 hearings re ill health capability have reduced. - Opportunities for flexible working patterns increased from 50.9% to 54.6 % in 2020 NSS. - Funding for Covid / infection risk team agreed until March 2022.	Health and Wellbeing Guardian appointed at Trust Board	- Quarterly deep dive of key workforce metrics by CCG. - NHSIE central and regional team oversight of progress against NHS People Plan. - Development of ICS Workforce Metric - SEQOHS Accreditation.

Gaps in Assurance:	- Trust 2020 National Staff Survey results score below sector average for 9/10 indicators. - Independent review of all work streams identified in Value Our Colleagues Improvement Programme to be undertaken. - Approved Health and Wellbeing Strategy - Not all colleagues are recorded as having completed an individual Covid-19 Risk Assessment. - Not all colleagues have accessed two Covid-19 vaccines. - Currently lack ability to consistently achieve and sickness absence levels of 4.5% or below. - Junior Doctor national training programme feedback.

Future Opportunities

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

Future Risks

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

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

No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
1.	Substantively recruit to Occupational Health Consultant	Catherine Griffiths	31/10/2021	Recruitment paperwork in place.	
2.	Complete gap analysis on Health and Wellbeing offer – for completion by end August 2021- to shape HWB strategy	Catherine Griffiths	31/08/2021		
3.	Develop evidenced based Health and Wellbeing Strategy	Catherine Griffiths	31/12/2021	New project lead, milestones now on track	
4.	Achieve Occupational Health accreditation	Catherine Griffiths	31/03/2022	All milestones ahead or on track	
5.	Rapid roll out of Health and Wellbeing Conversation's via CHAT framework following successful pilot	Catherine Griffiths	30/09/2021	Pilot complete. HR Training to deliver sessions scheduled to take place.	
6.	Formally bring OH and HWB services together as one team.	Catherine Griffiths	30/09/2021	Conversations underway. No requirement for formal management of change.	

Risk Summary																											
BAF Strategic Objective Reference & Summary Tile:		BAF SO 05 - Use Resources Well; We will deliver optimum value by using our resources efficiently and responsibly.																									
Risk Description:		The Trust’s financial sustainability is jeopardised if it cannot deliver the services it provides to their best value. If resources (financial, human, physical assets & technology) are not utilised to their optimum, opportunities are lost to invest in improving quality of care. Failure to deliver agreed financial targets reduces the ability of the Trust to invest in improving quality of care, & constrains available capital to invest in Estate, Medical Equipment & Technological assets in turn leading to a less productive use of resources.																									
Lead Director:		Chief Operating Officer.																									
Lead Committee:		Performance, Finance, & Investment Committee.																									
Links to Corporate Risk Register:	Title:																								Current Risk Score Movement:		
	208 - Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks. (Risk Score = 12). 2398 - Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care. (Risk Score = 12). 665 - Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation. (Risk Score = 15). 1005 - Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks. (Risk Score = 16). 1155 - Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation. (Risk Score = 16). 2081 - Delivery Operational Financial Plan. (Risk Score = 9). 2082 - Future Financial Sustainability. (Risk Score = 12).																								Likelihood = 3 Consequence = 5 = 15 High ↔		
																									Forecasted Risk Score Movement for Q2:		
																									Likelihood = TBC Consequence = TBC = TBC ↑↔↓		
Risk Appetite																											
Operational Status:		Balanced	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		< 14	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		< 16																									
Financial Status:		Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		<10	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		<11																									
Compliance Status:		Cautious	Averse					Cautious					Balanced					Open					Hungry				
Appetite Score:		<9	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Tolerate Score:		<11																									

Risk Scoring								
Quarter:	Q1 2021/22	Q2	Q3	Q4 2020/21	Rational for Risk Level:	Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	3			3	<u>Evidence of risk control</u> - Achievement of 19/20 and 20/21 financial plans. - Adherence to revised financial arrangements during 20/21 as a result of the Covid-19 pandemic, despite significant planning uncertainty - Strong operational performance measured through constitutional standards, and associated operational performance metrics. - Development of draft 5-year capital programme - Majority of allied Corporate Risks associated with Use Resources Well mitigated to scores of 16 or less. <u>Evidence of risk gaps in control</u> - The Trust experienced run rate risk for the 19/20 financial year that led to needing to re-forecast outturn during the financial year. - High reliance on temporary workforce - Lack of credible capital plan to fully address backlog maintenance requirements, despite 5-year Capital Programme in place. <u>Evidence of planning uncertainty</u> - Normal national financial planning cycle for 21/22 financial year was postponed due to the Covid-19 pandemic - Financial improvement planning and delivery has been impacted by Covid-19. - Significant uncertainty still associated with H2 (Q3 and Q4) 2021/22 financial arrangements.	Likelihood:	2	31 March 2022
Consequence:	5			5		Consequence:	5	
Risk Level:	15 High			15 High		Risk Level:	10 Moderate	
Control & Assurance Framework - 3 Lines of Defence								
	1 st Line of Defence			2 nd Line of Defence		3 rd Line of Defence		
Controls:	- Financial position reported monthly via Care Groups, Divisions, Divisional Performance Reviews and Executive Governance Structures. - Revised financial governance in place for COVID-19 through the Trust's Governance Continuity Plan. - Board Development session for the Improvement Programme with			- Performance, Finance & Investment Committee in place to gain assurance. - Audit Committee in place to oversee and test the governance/financial controls. - Adoption of business rules (Standing Orders, Standing Financial Instructions and Scheme of Delegation). - Use Resources Well work stream of the Improvement Programme has Governance		Externally benchmarked Financial and operational productivity performance data, particularly (but not exclusively) through Model Hospital.		

	identified 3-year targeted financial benefits.	infrastructure in place.	
Gaps in Controls:	• Business planning processes require strengthening. • Accountability Framework has been approved, however needs review further to the NHSI Governance Review report. • Leadership development needs at Care Group, Divisional and corporate support service levels, with commencement of Faculty of Medical Leadership and Management leadership development programme deferred to Spring 2021 due to Covid-19 second wave. • Covid-19 second and third waves significantly exceeded planning parameter assumptions.		
Assurance:	• Model Hospital Use of Resources assessments. • Proportion of acute surgical patients managed without overnight hospital stay has risen from less than 30% to over 50%. • Number of patients managed through the Integrated Assessment Unit's Frailty service without overnight hospital stay has increased by over 50%. • Inpatient Length of Stay in MLTC (excluding 0-day LoS) has reduced from over 9 days to less than 8 days on average. • Number of Medically Stable for Discharge inpatients sustained at lowest level on record through 20/21 (although rising since June 2021). • Delivery of 2020/21 Financial plan, representing the second consecutive year of meeting financial plan.	• Internal Audit reviews of a number of areas of financial and operational performance • Covid-19 'top-up' resource in line with peers as a percentage of turnover • Top 10 in the country out of 122 general acute reporting Trusts for the 6th consecutive month (June 2021) for 6 week wait Diagnostic (DM01) performance • Top 20 in the country (out of 113 reporting general acute Trusts) (July 2021) for the 5th consecutive month for 4-hour Emergency Access Standard, and best in the West Midlands out of 14 reporting Trusts for Ambulance handover <30 mins for the 6th consecutive month • 50th best in the country out of 122 reporting Trusts (June 2021) for 18-week RTT performance and 4th lowest proportion of elective waiting list waiting over 52 weeks in the Midlands (out of 20 reporting Midlands Trusts) • 34th (out of 122 reporting general acute Trusts) for Cancer 62-day from GP referral to treatment waiting time performance	• Annual Report and Accounts presented to NHSE/I • NHSE/I oversight of performance both financial and operational • External Audit Assurance of the Annual Accounts • Cost per WAU (19/20) now below peer and national median (Model Hospital) • Day case rates for British Association of Day Case Surgery better than peer and national medians (May 2021 – Model Hospital). • Average LoS for elective admissions rolling 6 months below peer and national median (May 2021 – Model Hospital) • Average LoS for emergency admissions rolling 6 months below peer and national median (May 2021 – Model Hospital) • Average late starts and average early finishes in Operating Theatres better than national median (August 2021 – Model Hospital) • Medical specialties Same Day Emergency Care rates for ambulatory emergency care conditions rated second best in the country by the AEC Network.
Gaps in Assurance:	• NHSi Governance review highlighted areas of improvement for business process and accountability framework. • Trust scored requires improvement on its assessment of 'Use of Resources' owing to low productivity and high staff and support costs being evident. Time lag on updating of some Model Hospital metrics means there is a delay in receiving some independent assurance of improved financial and operational productivity metrics. • External Audit limited due to Covid-19. • Late confirmation of 21/22 financial architecture for Q3 and Q4. • NHS Digital Templar Execs external review (Cyber Operational Readiness Support) has identified improvements required for the Trust's Cyber Security.		
Future Opportunities			
• Further Development of LTFM to include potential additional income sources, such as non-clinical commercial opportunities and repatriation of patients resident to Walsall currently receiving care out of area. • International Nurse Recruitment with RWT to significantly decrease reliance on temporary workforce.			

- Enhanced clinical economies of scale through Acute Hospital Collaboration (Working with Partners).
- Reduced reliance on inpatient hospital care through Walsall Together Partnership (Care at Home).
- Improved Equality, Diversity and Inclusion in the Trust to harness the skills of the whole workforce and leadership development programme for Care Group and Divisional leaders to enhance capability (Valuing Colleagues).
- Utilisation of national productivity benchmark information (e.g. GIRFT and Model Hospital) to target work through the Use of Resources Improvement Programme.
- Development of major capital upgrades (e.g. new Emergency Department) to support improved recruitment of staff.
- Harnessing the teamwork and innovation so evident throughout the Covid-19 pandemic to develop service improvements that lead to improved use of resources.
- Capitalising on the digital advancement during Covid-19 to harness technology to improve effective use of resources.
- Rationalising Estate requirements through increased remote working.
- Enhanced leadership capability through Well-led Improvement Programme work stream.

Future Risks

- Covid-19 second and third waves have significantly exceeded planning parameter assumptions, leading to increased costs delivering emergency and critical care, and reduced leadership time dedicated to long time resource planning during the height of the pandemic. Risk of a 4th wave in late Summer/early Autumn 2021.
- Likely move away from PbR towards block contracts and the associated paradigm shift for elective care in particular.
- Adverse Covid-19 impact on ability to deliver improved productivity for elective care in 20/21, and early 21/22.
- Additional costs associated with safe non-elective and critical care during Covid-19.
- Significant changes to elective and non-elective demand during Covid-19 and in early 21/22 in emergency care in particular leading to difficulty planning for the future with confidence.
- Insufficient Capital to enable investments in the Estate, equipment and technology that would in turn support more effective use of resources, and significant lead time for deployment of capital.
- Impact of Covid-19 on the wider economy and supply chain markets may destabilise some costs of goods/services upon which the Trust relies.
- Workforce exhaustion and/or psychological impact from Covid-19 may result in higher sickness rates and/or colleagues deciding to leave the healthcare professions, and thus further reliance on temporary workforce.

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

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

Risk Summary									
BAF Strategic Objective Reference & Summary Tile:		BAF SO 06 - COVID; This risk has the potential to impact on all of the Trusts Strategic Objectives.							
Risk Description:		The impact of Covid-19 and recovering from the initial wave of the pandemic on our clinical and managerial operations is such that it prevents the organisation from delivering its strategic objectives and annual priorities.							
Lead Director:		Chief Operating Officer.							
Lead Committee:		Trust Board							
Links to Corporate Risk Register:	Title:							Current Risk Score Movement:	
	2066 - Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels. (Risk Score = 15). 2093 - Risk of staff contracting COVID-19 through the course of their duties in WHC NHS Trust. (Risk Score = 6). 2095 - Inability of the NHS supply chain to provide an adequate and on-going supply of PPE to meet the demand to ensure that Walsall Healthcare NHS staff are fully protected during the Covid-19 pandemic (Risk Score = 9). 208 - Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks (Risk score = 12). 2081 - Delivery Operational Financial Plan (Risk Score = 9). 2082 - Future Financial Sustainability. (Risk Score = 12).							Likelihood = 4 Consequence = 3 = 12 Moderate ↑	
								Forecasted Risk Score Movement for Q2:	
								Likelihood = 3 Consequence = 5 = 15 High ↑	
Risk Scoring									
Quarter:	Q1 2021/22	Q2	Q3	Q4 2020/21	Rational for Risk Level:		Target Risk Level (Risk Appetite):		Target Date:
Likelihood:	2			3	- Covid-19 is a novel virus and therefore there is only an emerging understanding of the disease, how it behaves and the likely trajectory of further resurgence in cases. - The initial wave of Covid-19 had a profound impact on the services that the Trust provides, both in terms of urgent, emergency and critical care services to manage Covid-19 positive patients (in the hospital and the community), and in terms of the reduction in capacity of elective care services. The initial wave had a particularly significant impact on care home residents within the Borough's population. - The initial wave of Covid-19 had a profound impact on the workforce of the Trust. By May 2020, almost 1 in 4 Trust staff that had undergone a Covid-19 Antibody test had been antibody		Likelihood:	2	30 June 2021 (at which point the Covid BAF risk would be recommended to be dissolved).
Consequence:	3			5			Consequence:	3	
Risk Level:	6 Low			15 High			Risk Level:	6 Low	

					positive that suggested a significant proportion of the workforce had experienced the disease themselves. Moreover, the challenges of managing the initial wave of the pandemic had a significant psychological impact on staff too. • The Trust is operating in an uncertain financial planning environment resulting in additional challenges to restoring and recovering services impacted by the initial wave of Covid-19, and planning for the second half (H2) of the 2021/22 financial year. • Covid-19 has exposed existing significant health inequalities in the population the Trust serves. Covid-19 has exacerbated some existing inequalities in colleague experience within the Trust. • Nosocomial deaths reported in Learning from Nosocomial Covid deaths report received at QPES 27/08/20, with further analysis presented to QPES 28/01/21 confirming 21 probable or definite nosocomial deaths from Covid in Wave 1. • Planning assumptions for a second wave of Covid-19 cases assumed a peak at half the level of the April 2020 peak. In November 2020 the Trust exceeded 80% of the April peak in terms of Covid-19 positive bed occupancy. In January 2021 the Trust had exceeded 140% of the April peak. As of 11th August 2021 the Trust's Covid-19 positive inpatients are at 15.4% of the April 2020 peak or 10.8% of the January 2021 peak. Walsall borough's rolling 7-day average Covid-19 prevalence per 100,000 population has been in excess of 250/100,000 for the majority of July 2021 and August 2021 to-date. • The Trust had the 7th highest proportion of its hospital beds occupied by Covid-19 positive patients in the country in early November 2020, and the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. • The Trust consistently had one of the highest Critical Care bed occupancy relative to baseline commissioned capacity across the Midlands region during the second wave. In January 2021 Critical Care bed occupancy has exceeded 250%			

				of baseline commissioned capacity, peaking at 306% of baseline commissioned capacity. In early August 2021 the Trust Critical Care bed occupancy has increased and exceeded 100% of baseline commissioned capacity. The Trust reduced from 7 to 6 elective operating theatres in July 2021 to release reservists to support Critical Care staffing. - The Trust has been successful in rolling out the Pfizer Vaccine to Patients, and staff across BCWB Health and Social Care organisations, with 90.3% of high-risk staff having received their first vaccination, and 89.09% of high risk staff having received their second vaccination. 86.66% of all staff have received their first vaccination dose and 84.79% have received their second dose (as of 11/08/21). - The Trust has 29 Covid positive in-patients within the hospital (as of 11/08/21).			

Control & Assurance Framework - 3 Lines of Defence

	1 st Line of Defence	2 nd Line of Defence	3 rd Line of Defence
Controls:	<u>Governance:</u> - Incident Command structure in place incorporating Strategic Command, Hospital Tactical Command, Walsall Together Community Tactical Command and Corporate Tactical Command. - Bespoke Incident Command structure in place for Covid-19 Vaccination programme. - Governance continuity plan in place to ensure Board and the Committees continue to receive assurance. - Specific Covid-19 related SOPs and guidelines. - ITU Surge Plan in place. - Covid Streaming processes in place. - Enhanced Health and Safety/IPC Process in place in relation to Covid-19, with particular focus on social distancing, patient/staff, screening, zoning of Ward/Department areas, visiting guidance and PPE Guidance.	- Individual committees consider specific impact relevant to their portfolio, i.e. Financial matters and Restoration and Recovery of elective services under PFIC; Quality, Safety and Patient experience matters under QPES and Workforce matters including staff wellbeing under P&ODC. - Board Development sessions (x2) on approach to Restoration and Recovery from Wave 1. Further Board Development session on Restoration and Recovery scheduled Summer 2021. - UEC and Covid resilience Winter Plan approved by Trust Board October 2020. - Covid-19 Deaths incorporated into SJR processes. - Nosocomial Covid-19 Infections are subjected to RCA and reported to the Infection Control Committee.	Regional and National Incident Control structure.

	- Daily risk assessment (RAG rating) of Community Locality teams to prioritise resource according to need. - Division of Surgery 8-week elective Surgery restoration plan commenced 08/03/21 and completed on 04/05/21.		
Gaps in Controls:	- Walsall borough disproportionately hard hit in second wave again. 7th highest proportion of beds occupied by Covid positive patients in the country, in early November 2020. One of the highest Critical Care bed occupancy levels relative to baseline funded Critical capacity in the Midlands Critical Care Network throughout waves 2 in the Autumn of 2020 and 3 over the Winter of 2020/21. The Trust has had the second highest proportion of its hospital beds occupied by Covid-19 positive patients in the Midlands during January 2021. - Resurgence of Covid-19 cases resulting in significant staff isolation required. - Significantly increased Critical Care demand resulting in a dilution of ratios of specialist Critical Care Nurses to patients, partially mitigated through use of Category B and Category C registrants. - Reduction in elective surgical operating theatre capacity due to requirement to support Critical Care staffing, resulting in prolonged waits for elective surgery. - High demand on key Covid-19 Community pathways including Community Pulse Oximetry monitoring (Safe at Home pathway) and Long Covid pathways. - Ability for neighbouring Trust's to manage demand from patients conveyed by ambulance resulting in additional ambulance patients being conveyed to Walsall Manor through WMAS Intelligent Conveyancing protocol. - National directives and mandates impact on the Trust's ability to make local decisions. - Ability of the Midlands Critical Care Network to successfully manage demand Critical Care demand across the region. - Unable to progress all elements of the improvement programme owing to capacity of senior leaders. - Comprehensive OD/Culture Improvement plan.		
Assurance:	IPC Board Assurance Framework.	- Nosocomial Covid-19 infection rate in line with peer-reviewed published evidence. - Antibody positive staff rate in line with BCWB peers. - Financial top up requests in line (or lower) as a proportion of turnover than BCWB peers. - Faculty of Research and Clinical Education evaluation of response to first wave. 60-day readmission rate for Covid-19 patients in line with peer-reviewed published evidence.	- Elective waiting times 2nd best in the country for Diagnostics (DM01) and Top 50 nationally for routine elective treatment (18-week Referral to Treatment) in June 2021 national reported performance, out of 122 general acute Trusts. - GP referred Cancer treatment commencing within 62-days 34th (June 2021) out of 122 general acute Trusts. - Elective 52-week wait performance 4th best in the Midlands (June 2021). 4hr EAS performance 16th best in the country (July 2021), and the 5th consecutive month in the Top 20. - Ambulance handover times (<30mins) best in the West Midlands for 6th consecutive month (July 2021). - CQC Assurance of the IPC Board Assurance Framework. - Productivity of Vaccination Programme compares favourably with other Acute Trusts.

Gaps in Assurance:	• Lack of assurance of communications within the organisation to ensure that staff feel well informed and engaged. • Evidence of higher staff absence rates than BCWB peers during initial wave of Covid-19, absence rates consistent with peers in second/third wave.				
Future Opportunities					
• With a more digital/virtual enabled organisation further opportunity to explore clinical application in improvement programme deliverables. • Increased focus on Walsall Together and partnership working to support reduced reliance on hospital care, and to support reduced health inequalities in the borough. • Covid-19 has necessitated closer collaboration with other Acute hospitals which can continue to be built upon. • Increased profile and appreciation of the NHS within the general public could be harnessed to attract and retain staff. • National planning guidance for Phase 3 (Recovery & Transformation) creates an expectation that services must not be reintroduced based on historical models. • Identifying and adapting the workforce and professions to create a modern and adaptable workforce group.					
Future Risks					
• Potential for further resurgence in Covid-19 cases over Summer/Autumn 2021. • Risk of further resurgence coinciding with RSV season. • Limited political appetite to re-introduce lockdown measures. • Uncertain vaccine efficacy against novel variants. • Ongoing pressure on community services associated with patients rehabilitating following Covid-19, including Long Covid patients. • Delayed and/or prolonged impact of managing the initial wave, second wave and third wave of the pandemic on staff wellbeing and mental health. • Potential workforce absence in the event of a further wave. • Limited management and leadership capacity to address core objectives due to the significant demands of managing covid-19 pandemic, and the restoration and recovery of services affected by covid-19. • More constrained financial operating environment. • Logistical challenges of delivering the Covid-19 Vaccination, including the requirement booster vaccination.					
Future Actions (to further reduce the Likelihood / Consequence of the risk in order to achieve the Target Risk Level in line with the Risk Appetite)					
No.	Action Required:	Executive Lead:	Due Date:	Progress Report:	BRAG:
6.	Confirmation of 2021/22 Financial arrangements.	DoF	Feb 2021	Delayed due to delayed national planning guidance. Q1 and Q2 Financial Plan agreed at Private Board 03/06/21, with Q3 and Q4 Financial Plan TBC.	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
208	Failure to achieve 4 hour wait as per National Performance Target of 95% resulting in patient safety, experience and performance risks. Linked to Divisional Risk - MLTC 157	Patients are not assessed in the ED department effectively or in a timely manner leading to an increase in patient wait times. Although much improved the risk still occurs when ED attendances are high or there is 'exit' block from the Department. This leads to a poor patient experience as well as adverse clinical outcomes including increased risk of mortality.	Kate Salmon	12	• Process • A governance process is in place to monitor performance throughout the organisation • Policy • Board approval of EAS improvement Trajectory to meet 95% agreed by Board • Process • Operational demand management policies & procedures in place. Escalation policy in place to manage overcrowding in ED. IP&C policy on Covid Streaming. Covid swab policy. • Physical Barrier • Insufficient ED cubicle capacity to enable effective and timely assessment of patients in ED, increasing WTBS.	• Monthly reports to Performance Finance & Investment Committee (and Quality & Safety for Patient Care Improvement plan progress) • Emergency & Urgent Care Task force in place, monitors actions • Daily escalation processes in place through Division to Executives where necessary • Urgent and Emergency Care Board (UEC) STP- delivery Board overseeing system response • 8th out of 113 reporting Trusts for 4 hour emergency access standards for June 2021. • Assured and overseen via divisional governance and performance reviews. • Monthly reporting to NHSi • System review meeting oversight via regulator and CCG • Newly introduced Flash report sub-60% performance. • We are part of the regional UEC ops forum chaired by NHSE where all EAS standards are scrutinised and learning shared across the patch. • Trust's performance is on a continuing improvement trajectory despite high attendances. • NHSE/I & ECIST 'Critical Friend' visit to be arranged for 16th June 2021. Missed opportunities audit undertaken in April and report presented to ED team and at MAC. Further presentations to be made and action plan developed to implement the recommendations. Following perfect week we are invigorating our escalation policy which has worked well. • Revised process are in place to deliver care • Increased staffing is required to ensure line of sight • Increased staffing is required owing to cohorting of Covid Patients • ED & Acute Medicine New build business case approved through	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						internal processes £4.1 million capital funding for additional UEC capacity. Additional 9 cubicles now open which has improved capacity. • ED & Acute Medicine New business case approved through internal processes - ED & Acute Medicine New OBC approval - ED & Acute Medicine New procurement through the national P22 framework £4.1m capital funding will provide additional portcabins to reduce over-crowding within the waiting room, and a further 9 cubicle spaces for ED. Work now complete as of 23/12/20. FBC has received DoH approval. Building has commenced. • Process • Substantive staff are in place to provide safe and high quality care and use our resources well • A rolling program of Nurse recruitment with interviews held on a monthly basis Staffing vacancies reviewed regularly via governance structure Nurse staffing reviewed daily Safe staffing report presented to People and OD Committee and Board Nursing and quality paper to QPES ED Medical workforce business case approved at Trust Board in June 2020 and will address the royal college guidance. New ED Matron appointed in October Interviewed for RGN Posts in November and offered: 4 x Band 6, 1 x Band 5 and 8 CSW's. Nurse recruitment continues to improve and recently permission given to over recruit due to number of appointable applicants. Medical recruitment is also progressing well. • Safe staffing report published monthly on website Staffing levels are overseen via system review meeting	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					• Process • Process agreed with WMAS to meet ambulance handover standards.	Agency meeting review with NHSi • Handover Policy with the Ambulance service in place Ambulance handover key metrics is monitored at care group, Divisional, performance reviews, PFIC and Board Additional 9-cubicles has mitigated the risk associated with capacity and social distancing to some extent. 4th consecutive month of being top in the West Midlands for ambulance handover within 30mins with 98% of our patients being transferred within this time. Direct referral and conveyancing from 999's to SACU, AEC and FES now in place, bypassing ED to help improve ambulance handover times and free up capacity in ED. • NHSE/I have introduced an escalation policy and COO must report any delays >60mins within 24 hours along with actions to address delays.	
					• • 12 hour breach policy in place	• •	
					• PFIC review of performance on a monthly basis •	• •	
					• •	• •	

Action Plan							
Start Date	Action Details / Description			Owner	Reminder Date	Target Date	
06/08/2021	Ms Joshi has discussed with all doctors concerned and a number are now pursuing their CESER applications so they are in a position to apply for substantive consultant posts.			Ruchi Joshi	14/11/2021	19/11/2021	
15/04/2021	Accident and Emergency referral policy reviewed and updated, signed off by MD to be redistributed and discussed with CD's across divisions. Presented at MAC. To be discussed further with Surgical Consultant and junior doctor team. Human Factors session also taking place with Surgery.			Kate Salmon	18/09/2021	23/09/2021	
08/06/2021	Matron to confirm if waiting area should be re-organised. It will require fixed chairs taking up, given current new build activity, uncertain if this can be progressed.			Elizabeth Slevin	18/09/2021	23/09/2021	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
13/07/2021		To run a Perfect Fortnight from 30th August with additional interventions from all of the Divisions, including Urgent Treatment Centre and GPs. NHSE/I have offered to support this.	Kate Salmon			19/09/2021	24/09/2021
22/06/2021		To become an early implementer of a new national tool looking at re-directing and streaming patients away from the hospital site. Project working group to be established.	Matthew Dodd			24/10/2021	29/10/2021
13/07/2021		Cross Divisional Implementation plan developed to address a number of areas. Cross Divisional Steering group to be established to implement the action plan.	Kate Salmon			Closed 25/07/2021	30/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
665	Risk of a cyberattack (ransomware, spearfishing, doxware, worm, Trojan, DDoS etc) upon a NHS or partner organisation within the West Midlands Conurbation	Risk of a deliberate/intentional attack/hack on any part of the IT services and systems within the NHS or partner organisations from an external or internal source which could include infecting computers/networks/systems with a lethal virus or malware resulting in disrupting to NHS services and NHS care provision.	Andrew Griggs	15	• Organisation IT related Disaster Recovery/BC plans. IG and Data protection compliance. • Process • Penetration testing undertaken annually through internal audit which identifies necessary digital safety actions required. • Physical Barrier • All vulnerable systems Sandboxed. • Physical Barrier • Windows OS upgrade programme • Physical Barrier • Cyber Next generation measures put in place • Process • NHS Cyber Alert. Membership of NHS Cyber Alert protocol.	• New EPRR Manager now in post • Data security Toolkit rating • Action plan developed following penetration testing and monitored via digital services governance meeting. • External partner Dionac has carried out an additional penetration test in July <u>2021. Report still waiting to be received</u> • Windows 7 term cut off from network to avoid prospect of viral attack. • Sandbox is a security mechanism for separating running programs, usually in an effort to mitigate system failures or software vulnerabilities from spreading. • All windows 7 devices will be upgraded to Windows 10 unless they host critical software that does not work on Windows 10. In these instances the devices will be sandboxed to provide protection • The number of Windows 7 devices is monitored nationally using Microsoft Advanced Threat protection software that is installed on all devices • Cyber next generation firewall was put in place early in 2020. • A next-generation firewall is a part of the third generation of firewall technology, combining a traditional firewall with other network device filtering functions, such as an application firewall using in-line deep packet inspection, an intrusion prevention system. • Notifications to key internal staff whenever a new cyber alert is published. This will include Day 0 and Day 0 + 1 threats. Guidance is provided on what action to take and updates on action are provided by the trust • Our responses to Cyber alerts are	

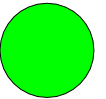
Walsall Healthcare Risk Register

reviewed and monitored by NHS Digital.

• Process • Greater visibility of Cyber agenda	• Inclusion of Cyber security summary in monthly PFIC report from Digital

and threats

Services. To include details of new



Walsall Healthcare Risk Register

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

cyber alerts and feedback from monthly STP Cyber security meeting
• None

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

01/01/2021	0Patch has been installed to mitigate risk until all devices are upgraded to Windows 10	Andrew Griggs	12/08/2021	17/08/2021

01/01/2021	The security perimeter is verified to be at low risk of any suggested external attack gaining entry. Ongoing exercises will verify this security level	Andrew Griggs	26/12/2021	31/12/2021

01/01/2021	The security perimeter is verified to be at low-medium risk of any suggested external attack gaining entry. Upgrade works are in progress to enhance this security. Ongoing exercises will verify that this security level is decreasing.	Andrew Griggs	26/12/2021	31/12/2021

01/01/2021	The Local Area Network is verified to be at medium risk of any suggested external attack gaining entry. Upgrade works are in progress to enhance this security. Ongoing exercises will verify that this security level is decreasing	Andrew Griggs	26/12/2021	31/12/2021

17/08/2021

15/07/2020	OS upgrade programme to Windows to be undertaken.	Daren Fradgley	12/08/2021	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1005	Insufficient capital funding for the estate relating to lifecycle, critical infrastructure and mechanical/engineering risks.	Insufficient capital invested annually to reduce the backlog maintenance, critical infrastructure and mechanical/engineering risks within the West Wing & Maternity elements of the estate in respect of theatre upgrades, ward refurbishments, upgrading current facilities and ED schemes. This has resulted in a poor environment in respect of lifts, lighting, flooring, nurse call and bathroom areas as well as theatres approaching end of life condition where the experience of the patient and staff working within these areas has been significantly reduced.	Jane Longden	16	• Process • Trust Capital Control Group - Finance lead group with clinical divisional and IT representation responsible for collating and monitoring spend requests and allocating capital monies for divisional developments, infrastructure backlog maintenance, capital projects and medical equipment. • Process • Black Country STP Streams - review the allocation of money according to the Trusts bids and associated risk assessments • Process • Lifecycle plan and prioritisation of high risk items 3.7 million infrastructure funding for the PFI fully funded through Project co. Skanska provide the plan on behalf of project co for Trust	• Emergency Department New build - £36 million agreed by Department of Health • NNU/ 1 d/s theatre successful expansion 1 d/s theatres some additional refurb is required • Critical Care Unit - New Build completed • Regular reporting to PFIC • Capital plan partly approved • Lifecycle programme • System capital envelopes for 21/22 (full year) will be allocated based on similar national quantum and distribution methodology to that used for 2020/21 capital planning. • STP leads are reviewing submissions and contacting individual Trusts for summary of individual items and rationale for inclusion within the programme. • Estates meetings facilitated monthly (informal), Hard FM monthly meetings to discuss all things relevant to the estate and captured via shared risk register. •	

Action Plan					
Start Date	Action Details / Description	Owner	Reminder Date	Target Date	
16/06/2021	The capital allocation of circa £4 million will be used in part for the 21/22 for works to include:-	Paul Richardson	26/03/2022	31/03/2022	
	o Refurbishment of Theatres 5 & 6 in West Wing theatres				
21/06/2021	A programme has been scoped and planned and the upgrade works to Wards 9; 10; 11 & 12 have commenced in June 2021 and should take 16 weeks from commencement - Oct 21.	Paul Richardson	16/10/2021	21/10/2021	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
16/06/2021		ED works were planned and then commenced in October 2020 with the ground works completed and services connected. The project is on target to finish in Summer 22 within commissioning of services included within this timeframe.			Paul Richardson	25/06/2022	30/06/2022
21/06/2021		Design, programme and start dates put in place for the end of June 21. Originally 21 June but annual statutory verifications had to be concluded before the works commenced.			Paul Richardson	11/08/2021	16/08/2021
11/08/2021		Capital Programme continues.			Ned Hobbs	26/08/2021	31/08/2021
10/08/2020		A review of the 20/21 lifecycle plan and risk assessed items is being undertaken by WHT and PCO/Skanska to produce a priority list of critical infrastructure that needs maintaining.			Colin Plant	Closed 26/03/2021	31/03/2021
01/04/2019		Located the summary of the latest update to PFIC.			Ned Hobbs	Closed 26/03/2021	31/03/2021
11/02/2021		Capital Control group to agree the 2021/22 5-year capital programme.			Jane Longden	Closed 25/04/2021	30/04/2021
05/11/2018		All areas to have business continuity plans			Mark Hart	Closed 25/04/2021	30/04/2021
16/06/2021		A capital allocation within a sum of circa £4 million has been allocated in 21/22 for works and is being reviewed to include:- o Lift upgrades for West Wing o Provision of a Changes Places Facility			Paul Richardson	Closed / /	16/06/2021
12/05/2021		Plan has been discussed and works to be costed as part of that plan and designs produce.			Jane Longden	Closed 26/06/2021	01/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1155	Fire Certification in the Retained Estate in order to demonstrate compliance with fire compartmentation.	There is a lack of assurance in the form of fire stopping certification to identify the integrity of the fire compartments in the Retained Estate and the remedial works undertaken. A failure to identify the key areas through surveys and complete the remedial works may result in a breach of fire safety regulations and risk to patients, staff and public safety	Colin Plant	16	• Process • Annual fire door PPM undertaken as part of schedule 14 works of contract • Process • Fire stopping meeting in place to develop risk assessment and requirements for survey works • Physical Barrier • Retained Estate Fire Compartmentation. Works stopped due to Covid have been recommenced. • Process • Fire stopping remedials and phase of work detailed and records held on Firetronic (Dtabase) accessible by WHT Fire Safety officer • Process • Joint appointment agreed between WHT, ProjectCo and Skanska to commission independent Fire Stopping advisor to assure suitability of works undertaken.	• 28A's produced for reactive maintenance. • Skanska undertake works and retain all documentation. • Fire Group mins attached • External company performing remedial works through Skanska and will give statutory accreditation after the works have been completed. • Trust has received confirmation of full programme of works and updated through monthly meetings. The works have now recommenced and will be reviewed on a monthly basis. • Trust Fire Risk Assessments all include caveat that unable to verify fire stopping • PFI partners updating trust through Hard FM meetings and ESG. • Phase 2, 3 and 4 - All data is on Fire Tronic and drawing with remedial specific reference numbers and photos are on the portal (the WHT Fire Officer (RD) has access to the data). Fire doors and dampers excluded • All partners updated through Trust Hard FM meetings and ESG.	

Action Plan				
Start Date	Action Details / Description	Owner	Reminder Date	Target Date
11/08/2021	Report remains outstanding.	Ned Hobbs	25/08/2021	30/08/2021
13/07/2021	Chasing external party of completed report.	Jane Longden	25/08/2021	30/08/2021
03/08/2021	Report remains outstanding - informed will be ready for submission early August.	Jane Longden	25/08/2021	30/08/2021
16/07/2020	Formulate an action plan with Skanska further to the fire survey of the Retained Estate areas, to review and address the issues with particular emphasis on key fire-resisting construction and escape routes	Paul Richardson	25/09/2021	30/09/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
15/07/2020		Review and update the existing Fire strategy and risk assessments taking account of the fire survey results.			Colin Plant	25/09/2021	30/09/2021
20/10/2020		To be completed in a 26-week period now all areas identified. Covid may cause some delays in respect of access.			Colin Plant	25/09/2021	30/09/2021
14/04/2020		Revised timetable needs to be agreed with Skanska and then the associated costs agreed. The current timetable for the works ceased on 14 April due to Covid 19.			Colin Plant	25/09/2021	30/09/2021
							30/09/2021
01/07/2020		A joint appointment is to be agreed with PCO to review both new build and the retained Russell Caldicott estate fire stopping compliance and current position.				25/09/2021	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1664	The environment of Theatres 1-3 and 5 & 6 is poor and outdated which is having an impact on the ability to deliver optimal current infection control standards and theatre productivity.	Patient Safety risk - Risk of increased SSIs due to poor airflow exchange. Risk peri-operatively due to failure of lighting / UPS provision. Poor compliance environmental Infection Control requirements, evidenced within infection control audits Estates issue / building, longevity and past life cycle replacement. Operational risk relating to delivery of surgical activity within failing estate, resulting in theatre closure and reduction in operating capacity. Failure of Theatres 5 & 6 would result in elective T&O work ceasing due to Trauma theatres having to be provided within the DTC	Louisa Adams	9	• • • • • Process • Monthly environmental audit by theatre Matron Regular works are carried out by the estates department Estates issues are reported on a regular basis • Process • Yearly validation of ventilation to give assurance of air exchanges per hour. Verification of 5 and 6 within the last week. Anaesthetic room not used in 2 and 3 to allow for diversion of air into operating theatres to assure adequate air exchanges per hour • Process • SOP currently in place to ensure that all clinical activity takes place within operating theatres within theatres 2 and 3 and not the anaesthetic rooms due to the diversion of ventilation to within the operating theatre environment to ensure adequate ventilation. • Process • Selective Trauma case mix within laminar airflow- Laminar airflow for all NOF/Intramedullary Nails and high risk patient groups such as diabetics/Vascular pathology	• • • • Monthly audit carried out • Cleanliness report is escalated via NMAF • • 3 monthly monitoring within theatres 2/3 • Ventilation airflow exchange report • Audit to be undertaken on a monthly basis to assess infection rate amongst non-laminar airflow cases and reported on monthly at Care Group Governance meeting. This to include continued monthly auditing for the next two years for all patients operated on through a non-laminar airflow theatre. Incident to be raised for all patients that develop an infection to ensure we capture all non-laminar airflow patients	

Walsall Healthcare Risk Register

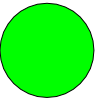
theatre estate (Th7)

as this is the only theatre with laminar airflow outside of West Wing theatres. This would further

impact on the backlog

- Process
- Non-laminar airflow this will be for surgery below the elbow and below the knee as well as washouts/MUAs and soft tissue cases. Fractures below elbow/Knee will be

- Audit to be undertaken on a monthly basis to assess infection rate amongst non-laminar airflow cases and reported on monthly at Care Group Governance meeting. This to include continued monthly auditing for the next two years



assessed on a case by case basis and for all patients operated on through a

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		position as a result of the COVID pandemic. Failure of West Wing theatre suite would result in the relocation			decision to be made based on individual patient co-morbidities. Wound care risk assessment to be undertaken for all procedures going through non-laminar airflow theatres. Only low risk patients can be	non-laminar airflow theatre. Incident to be raised for all patients that develop an infection to ensure we capture all non-laminar airflow patients	
		of emergency services to DTC theatres due to the current restrictions as a result of COVID, elective theatre capacity would reduce from 7 to 3 theatres per day. Non-achievement of			considered for non-laminar airflow.		
		block contracts resulting in loss of income to the organisation with the			- Process - Elective theatres can be utilised over a weekend through the implementation of elective pathway for patch and plan trauma patients to release theatre capacity.		
		reduction of elective theatre capacity Risk of patients deteriorating due to extending waiting times on the waiting list			Additional trauma sessions- extension of operating to 3rd session/extended weekend working within a laminar airflow theatre		
		Impact on emergency			- Process - Anaesthetic review of Golden Patient to ensure prompt start to trauma operating list	Trauma operating lists to have middle grade cover assigned for each list to ensure prompt start and robust and timely anaesthetic review	
		patients, risk of deterioration due to elongated waiting times for procedures. Delay in surgery can also impact length of stay.			- Process - Data reviewed weekly - Fractured NOF patients prioritised on operating lists - Optimisation of fractured NOF patients for theatre - Identified pathway from ED to theatres - Review by ortho-geriatrician to support	- Trauma operating lists to have middle grade cover assigned for each list to ensure prompt start and robust and timely anaesthetic review	
					optimisation of patient		
					- Process - West Wing Covid theatre SOP for use of non-laminar theatres and recovery in place to support recovery use where possible and identification of timings between intubation/extubation in theatre.	- Theatre PDN team to audit adherence to SOPs - Covid status of patient to be added to the Trauma handover each day	
					Access to rapid swabbing to identify Covid status of patients		
					Use of Holding Bay in recovery for Covid-negative patients to reduce		

Walsall Healthcare Risk Register

delays

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
Action Plan							
Start Date	Action Details / Description			Owner		Reminder Date	Target Date
12/07/2021	Refurbishment work to commence in theatre 6 on 12 July 2021. Theatre 5 programme of work to follow.			William Roberts		21/08/2022	26/08/2022
02/08/2021	Weekly list of T&O patients sent through Th 3 to be sent to IPC by Theatres			Louisa Adams		Closed 28/07/2021	02/08/2021
02/08/2021	All Th 3 T&O patients to be manually tagged on ICNet. List to be sent to IPC weekly by Amy Wallett theatres					Closed 28/07/2021	02/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
1937	Not having the capacity to be able to fit test or sufficient resource/supply	The Trust does not have the capacity to be able to fit test or sufficient	Simone Smith	9	• Policy • RPE Procedure developed providing guidance on the rationale for use of RPE and managers responsibilities under COSHH Regulations	• ESR Records of FIT testing - Locally developed COSHH Risk assessments. - Workforce Intelligence reports •	
	available for respiratory	resource/supply			Force 8 SOP in place		
	protective equipment (RPE; disposable FFP3 respirators, reusable FFP3's, PAPR devices),	available for respiratory protective equipment (RPE; disposable FFP3			• Training • FIT test Training delivered in Dec and Jan 2018, April 2020 and September 2020 to provide a resource of trained Fit Testers.	• ESR staff records of trained FIT testers and also those fit tested. - Workforce intelligence compliance • Low outbreak incidence.	
	to protect staff from	respirators, reusable			RPE Facilitator in post from Oct 2020.		
	harmful substances (e.g. COVID-19).	FFP3's, PAPR devices). This leads to an increase of staff not being protected against harmful substances (e.g.			• Physical Barrier • The Trust has 4 different types/ models of disposable FFP3 masks available with health supply. 1 x Reusable mask available - Force8 for high use areas - Hoods for staff who fail fit testing/	• Mask stock numbers maintained in distribution. - Procurement monitor and order stock based on usage. - Currently as of April we have 810 staff Fit tested on our current stocks. • Current stock levels uploaded daily	
		COVID-19), due to not conducting fit testing in a timely manner (30 minutes if passed first time, 60 minutes+ for retests) on at least two different masks (ideally three following updated resilience principles & performance measures from the Department of Health & Social Care).			bearded	365 days per year to Foundry system	
					• • Weekly Fit Test data is uploaded to ESR. •	• • •	
		> Patients & Staff Risk - Of developing disease as a result of			inhalation of harmful substances, diseases spread, associated illness, skin damage &/or other conditions,		

Walsall Healthcare Risk Register

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Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		mortality. > Trust Risk - Of depleted staffing numbers as a result of high sickness absence & associated reliance on bank/agency staff. Failure to meet COSHH requirements & DHSC performance measures resulting in Regulatory scrutiny & punitive action. Increased risk of liability claims & dissatisfaction as a result of failing to adequately protect staff/patient health.					

Action Plan						
Start Date	Action Details / Description	Owner	Reminder Date	Target Date		
30/07/2021	Understand the impact on the demand for PAPR + hood devices of not having a clear 'beard policy'	Simone Smith	26/08/2021	31/08/2021		
01/03/2021	Workforce intelligence report to provide accurate compliance figures in terms of fit testing; passes, fails, current mask usage, individuals names, monthly.	Simone Smith	26/03/2022	31/03/2022		
29/07/2021	To understand reporting improvements (ESR & Forms) to ensure all individuals being Fit Tested are then being reported on accurately & that the number match up.	Vicky Haddock	26/09/2021	01/10/2021		
04/01/2021	Provide increased capacity to increase Fit testing provision to 5 days per week and targeted sessions in areas currently under significant clinical pressure.	Simone Smith	29/08/2021	03/09/2021		
10/01/2020	Agree a Trust wide programme of FIT test Training & Cascade Fit Testing to be delivered annually.	Simone Smith	26/09/2021	01/10/2021		
06/07/2021	To liaise with Business Intelligence Reporting to understand the criteria & ensure/add; Agency Staff, Locum Staff, & Student (Nurses, Doctors, etc.), data is being utilised with the Trust data as an overall summary.	Simone Smith	29/08/2021	03/09/2021		
06/07/2021	To create a schedule of fit testing with the required leads (Divisional?), to ensure staff	Ann-Marie Cannaby	Closed	01/08/2021	06/08/2021	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		can attend fit testing drop ins as scheduled to meet the capacity required in place already within Governance Fit Test schedules.					
06/07/2021		To liaise with Business Intelligence Reporting to understand the caveats used for the Compliance reporting data.	Simone Smith			Closed	01/08/2021 06/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2066	Risk of avoidable harm to patients due to wards & departments being below the agreed substantive staffing levels	Substantive staffing levels are below the agree safe staffing levels for wards and departments leading to the potential for avoidable harm Lack of skilled registered nurses/midwives on a shift by shift basis leading to: _Poor patient experience leading to increase in complaints, increase in PALS referrals _Increase in episodes of harm, including falls, pressure ulcers, deconditioning, dehydration and malnourishment, loss of continent function; potential increase in incidents/SI's _Increased stress and poor staff morale caused by suboptimal staffing levels _Increased reliance on temporary staffing which has a potential negative impact both financially and to the ward/department skill mix	Caroline Whyte	15	- Development of two staffing hubs manned by the Nursing Team - one for general areas and one for Critical Care. These hubs will oversee the deployment of staff across all Professional Groups. 17/6/20 the staffing hub is no longer required as the staffing position is currently stable. If COVID demand increases then the hub will be reinstated 20/10/20 - staffing hub for nursing reinstated 13/07/2021 - staffing hub remains in place - Community Teams reviewing and adjusting caseloads as required. Roster sign off reduced to two weeks for the next three months. Use of bank/agency to cover short term gaps. Block booking in place for Critical Care. - Deployment of Corporate Nurses at times of high pressure. 17/6/20 - Roster sign off timelines returned to normal, critical care bookings no longer required to previous level as ITU capacity remains stable - Increased use of Volunteers and Administration roles to complete tasks to free up Registered Nurses to deliver direct patient care. 17/6/20 Volunteer support no longer required to initial levels **See Risk	- Daily reviews of staffing levels by Ward, - Monitoring of the number of patient harm incidents reported. - Monitoring of the number of complaints, whistle blowing and freedom to speak up concerns raised. 6 Monthly review and annual management board sign off of Nursing/Midwifery establishments to ensure appropriate planned staffing levels. - Daily review of staffing numbers by ward and moving staff to support areas of short staffing. - Identification of essential training required to maintain competence and	

Walsall Healthcare Risk Register

safety (COVID-19). Use of bank/agency staff to support essential training. 17/6/20 - training completed at height of COVID demand -not currently Assessment attached	• Overview of compliance levels at Performance Meetings. Rapid response to falls in levels of essential role based training.	required



Walsall Healthcare Risk Register

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

Action Plan				
Start Date	Action Details / Description	Owner	Reminder Date	Target Date
26/03/2020	Continued proactive recruitment strategy 16/3/21 international recruitment process in progress with first recruits expected April 2021; corporate nursing working collaboratively with HR to ensure we are continually reviewing our retention plans with the aim that we achieve as close to zero vacancies for RNs and CSWs by Q4 4/08/2021 86 international nurses currently in the UK and undergoing induction, training and OSCE completion to gain entry to the NMC register. Aiming for a total of 205 by December 2021	Lisa Carroll	26/12/2021	31/12/2021
27/09/2020	Establish central staffing hub to co-ordinate staffing across organisation and manage redeployment robustly. 16/3/21 -The hub is well established and the staffing meetings will continue post COVID. The risk regarding temporary staffing usage is predicted to reduce as the international nurses join establishments. Additional capacity areas have closed reducing the staffing demand - areas closed are Wards 10 and 14 and additional beds on Ward 4 have also closed	Caroline Whyte	26/12/2021	31/12/2021
04/08/2021	Business case currently under development to support recruitment to revised establishments following completion of establishment reviews	Lisa Carroll	26/08/2021	31/08/2021

Walsall Healthcare Risk Register

01/06/2021	Establishment review in conjunction with RWT commenced 1/6/21. Establishment	Lisa Carroll	Closed	26/07/2021	31/07/2021

Walsall Healthcare Risk Register

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

reviews completed and business case under development

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2072	Inability to recruit and retain the right staff with the right skills which impacts on fundamentals of care (both patients and staff), and undermines financial efficiency.	National planning decisions have impacted the supply of healthcare staff in particular doctors in training and theatre staff and therefore our ability to recruit is reduced .This can drive reliance on temporary staffing arrangements which may impact on quality and financial controls and the fundamentals of care	Clair Bond	16	• Process • A values based appraisal process which incorporates Talent Management and the ability to track access to Career progression should assist in retaining the staff already employed • BAF Control 05 • - Working across the system across the STP with HEE partners to define local, collaborative, system and <u>national workforce supply solutions.</u> • Process • Valuing Colleagues Improvement Programme involves a number of work packages which seek to improve staff experience, amplify Walsall as an anchor employer and enhance our ability to attract, recruit, retain and <u>develop the workforce.</u> • Training • Improvement in education and training offer intended to expand apprenticeship offer, identify and develop new roles on a local and system wider level, and improve the ability to transfer competencies and skills between NHS employers. • Policy • Improve workforce flexibility and availability by harnessing opportunity of agile working within the Trust, standardising job roles / descriptions and supporting the case to align bank processes internally and across the	• Valuing Colleagues Improvement Board and PODC. - Training and development sessions to support managers. - Coaching techniques to support conversations. - F2SU approach and feedback. • WRES and WDES performance. 2020 National Staff Survey • Workforce Plan is reviewed and agreed by TMB and PODC • Workforce STP agenda via STP people board - Collaboration with Walsall Together <u>Partnership Board.</u> • Improvement Programme Board People and Organisational Development Committee. • NHS People Plan - STP People Plan WRES/WDES data • Faculty of Medical Leadership Development training commenced in Feb 21 for Care Group leadership teams. - SLA with RWT re leadership development offer under development. - Interim Director of Education and Training in place re RWT • NSS results • Added as workstream in the Value our Colleagues Improvement Programme. PID completed and monitored via Core Team and exception basis to Improvement Board and PODC. • BCWB STP People Board	

Walsall Healthcare Risk Register

STP system.

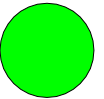
- Process
- Partnership with Walsall Housing

- Bulk recruitment model implemented.

Specific induction programmes

Group (WHG) to support residents to

developed for entry levels roles to



Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					access foundation roles as first step into NHS career with Walsall focusing on; Clinical Support Workers, House Keeping and Portering roles. • Process • Recruitment of international nurses via RWT Clinical Fellowship Scheme in line with NHSEI international recruitment drive. • Policy • Community Division undertaking review of Therapy services to understand the demands and AHP capacity to deliver, ensure effective use of their current resource, support the recruitment to vacancies and piloting different ways of working in order to address gaps in the service.	support entry into employment, NHS and role. Zero vacancies across HK, Portering and CSW's by end of September 2021 • • Zero nurse agency by 31 October 2021 Safer Staffing Report • • Associate Director of AHP's appointed and will commence in role May 2021. A robust action plan has been created around this piece of work, with defined actions, timelines and accountabilities. PODC and Quality Committee oversight in April 2021 •	
Action Plan							
Start Date	Action Details / Description				Owner	Reminder Date	Target Date
10/08/2020	Determine acknowledgement of the issue and seek resolution via the Improvement Programme.				Clair Bond	25/09/2021	30/09/2021
31/03/2021	Workforce Policy Framework to be aligned to the Valuing Colleagues Improvement Programme				Clair Bond	25/09/2021	30/09/2021
01/04/2020	Participation in STP task and finish group to scope business case and benefits for establishing collaborative nurse and midwifery bank.				Clair Bond	11/09/2021	16/09/2021
01/04/2020	The 'New Roles Group' is being reviewed to support the development of new roles, skills and career pathways.				Clair Bond	25/09/2021	30/09/2021
24/01/2021	NHSIE funds secured and commission with RWT Nurse Fellowship programme to secure 125 RGN nurses by the of 2021 has been agreed.				Clair Bond	26/10/2021	31/10/2021
04/01/2021	Collaboration with Walsall Housing Group to provide employment opportunities to residents in ancillary roles.				Marsha Belle	26/10/2021	31/10/2021
01/04/2021	Appointment of Associate Director of AHP's based within the Community Division - commencing May 2021				Matthew Dodd	Closed 26/05/2021	31/05/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2081	Delivery Operational Financial Plan	Operational expenditure incurred during the current financial year exceeds income allocations, which results in the Trust being unable to deliver the in-year financial plan. This results in us over spending & breaches our statutory break even duty.	Dan Mortiboys	12	• Process • Financial governance and reporting throughout the organisation • Through the Trusts Accountability Framework divisions and corporate Areas are held accountable for financial delivery. • Process • Covid Governance process approved by the Board Financial arrangements altered/set by NHSE/I • Standing Financial Instructions (SFI) are in place across the Trust • NHSI/E have been asked by Trust Board to do a review on Finance and	• PFIC review the financial performance with Executive on at least a monthly basis. • NHSI receive monthly reports from the Trust. NHSI raise key issues with the Trust. - STP Finance receive monthly updates from the Trust and comment as appropriate - NHSI governance and Accountability review noted the good level of challenge and oversight of the PFIC Committee • The Accountability Framework has been approved by the Trust Board and there is evidence it is in operation. Processes are all developed and continue to be developed • NHSI Governance and Accountability Framework • Strategic Command oversight of expenditure - Finance team oversee the adequacy of the controls, and ensuring the governance process has been followed • NHSI receive regular reports on expenditure and re-imburse as appropriate. Financial arrangements set by NHSE/I have been complied with in 2020/21 with no payments withheld and no issues • Breaches reported to Audit Committee - IT systems are set up to support the SFIs Internal Audit and External Audit will do specific pieces of assurance work in this area and more general pieces that reference SFI. Counter fraud in place	

Walsall Healthcare Risk Register

unctions. The draft outcomes

- Appropriately qualified staff
- Draft reporting from NHSE/I

of this report support the performance



Walsall Healthcare Risk Register

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

Action Plan

Start Date	Action Details / Description	Owner	Reminder Date	Target Date
15/05/2020	Finance will provide training to budget managers to improve financial literacy. In addition finance will undergo further training to continually professionally develop. This will be subject to Covid 19 pressures	Dan Mortiboys	25/09/2021	30/09/2021
	Finance will arrange training and development			
15/05/2020	SFI require improvement and will picked via Improvement Programme	Jenna Davies	07/08/2021	12/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2082	Benefits realisation from Improvement Programme outcomes	Failure to realise the benefits associated with the outcomes of the improvement programme workstreams results in the Trust not achieving the strategic priorities of the organisation which therefore impacts on the Trusts ability to provide safe, high quality care and consistently meet the needs of the population we serve and the people we employee.	Glenda Augustine	9	• Policy • PMO function in place to ensure standardisation of good project management process and reporting is in place. • Overall Programme and Workstreams PIDs in place • Process • Benefits realisation process in place	• Improvement programme governance in place for workstream oversight. SRO and Programme manager overseeing programme delivery • Internal Audit have given significant assurance on the current PMO function. (Audit report indicated good progress for the coming financial year 2021/2022) NHSI have reviewed the PMO function and the financial elements • Improvement programme in place to oversee the implementation of the Trust's Improvement Plan Programme plan approved by the Board Workstream PIDs approved by relevant Committees • NHSI/E are in attendance at the Improvement Board and can provide support and challenge as appropriate Internal Audit review of Improvement programme • PIDs including benefits realisation approved through Governance structure PFIC TOR include duties relating to benefits realisation Improvement programme Board in place which includes a duty	

Action Plan				
Start Date	Action Details / Description	Owner	Reminder Date	Target Date
17/05/2020	Establish a robust governance process in place to ensure financial improvement oversight via DoF, Performance Reviews, improvement board with Assurance gained at PFIC	Glenda Augustine	25/09/2021	30/09/2021
17/05/2020	PIDS to be developed and approved which outline Financial Benefit	Glenda Augustine	25/09/2021	30/09/2021
17/05/2020	Benefits realisation process to be developed including ongoing tracking and closure process	Glenda Augustine		30/09/2021

Walsall Healthcare Risk Register

25/09/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2093	Risk of staff contracting COVID-19 through the course of their duties in Walsall Healthcare NHS Trust	Staff are exposed to infection with COVID-19 through contact with infected patients, visitors and colleagues. There is a risk of significant physical and mental illness, including death. Mitigations include national measures to control the outbreak, training for staff in IPC/hand hygiene, provision of appropriate PPE in workplace settings.	Clair Bond	12	• Training • Systems and processes are in place to ensure designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas	• During the outbreak wards have gradually been converted to COVID-19 specialist areas, clinical staff have been supported by National Guidance, SOPs, Education by IPT, Matrons and Div DONs. Use of existing policies. PPE training and education has continued through the outbreak in line with the National guidelines including the don and doff of PPE with posters provided to all clinical areas along with links on the Intranet and Daily Dose communications. Staff letters have been sent reminding them of need to be re tested when different masks are received by the Trust. WHT has actively followed National Guidance throughout outbreak guidance from Royal Colleges reviewed and escalated to Strategic command where there is conflicting advice. PHE PPE guidance followed, posters are issued to each clinical area by IPN when a change is made and posted on Daily Dose daily communication. Trust Policies meet the National Cleaning Guidance requirements, with the addition of HPV decontamination where possible. • Internal and external command meetings • Where specific shortages are reported, a risk assessment is undertaken through Tactical Command Mitigations are put into place. Tactical command and strategic command in place Regular PPE Audit undertaken Regular Fit Mask training reports through to SLT. Additional resource recruited to sustain access to training.	

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
						February 2021 (12 week basis). • PHE and NHSE/I support in place to manage and monitor outbreak.	
					• Process • Since January 21, all colleagues have been offered access to the Covid-19 vaccine - those with at risk factors and working in areas at high risk / Covid-19 infection prevalence prioritised for access across December2020	• Daily reports of vaccination uptake of colleague with identified risk factors reported to Gold Command. Dashboard detailing access levels across all colleagues Line Managers briefing to encourage proactive conversations to ensure staff are aware of how to access the vaccine. • Local and system command structure.	
						regional and national reporting requirements.	
					• Process • Lateral Flow have been made available and distributed to frontline workers. LAMP testing replaced LTT kits.	• Internal command structure. LFT for staff have now been replaced by LAMP. Test results are monitored via dashboard. • System, regional and national reporting requirements.	
					• Process • Mental health and psychological wellbeing interventions and resources have been identified to support colleagues recover from the impact of Covid-19.	• Urgent interventional support via Black Country Mental Health Trust in place. Access to BC Hub and listening centre Poster raising awareness of access to psychological support in place. Colleague and corporate health and wellbeing steering groups identify and shape HWB responses. (including staff inclusion networks). Enhanced MHW offer at three levels (self, family and specialised). MH First Aider network established - supporting MH awareness raising sessions for managers. Monitored via PODC. Peer Listening circles implemented for ITU and Community. Team Time and Schwartz rounds implemented • HWB activity via strategic alliance, STP and region in place.	

Action Plan

Start Date	Action Details / Description	Owner	Reminder Date	Target Date

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
04/08/2021	Consider at future risk management executive (Aug or Sept) devolving risk to each division to monitor.				Catherine Griffiths	25/09/2021	30/09/2021
08/12/2020	To enable as many staff as possible to access the covid-19 vaccine.				Ann-Marie Riley	25/11/2021	30/11/2021
15/07/2020	Workforce to reflect assurance with regards to completion of risk assessments for 'at risk' staff internally and externally.				Catherine Griffiths	25/09/2021	30/09/2021
01/08/2021	Individual Covid-19 risk assessment process to be reviewed and updated.				Catherine Griffiths	25/09/2021	30/09/2021 04/08/2021
04/08/2021	Joint planning with the Vaccination Hub and OH Team re Flu vaccines underway - bi-weekly planning meeting in place.				Lisa Carroll	/ /	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2117	Risk to the delivery of the Emergency and acute capital build within timescale and affordability constraints	Risk to the delivery of the Emergency and acute capital build within affordability and timeframes due to - construction constraints - design constraints - affordability constraints - clinical model constraints	Debbie White	12	- Natural Barrier - Continual review of construction requirements against programme - Natural Barrier - Ability to provide full scope of work within affordability envelope - Process - Provide assurance of approval from both internal and external parties e.g. CCG and Walsall council	- Weekly review against construction plans in place jointly between Interserve and WHT - Weekly review against construction plans in place jointly between Interserve and WHT - Weekly reviews by programme board - Weekly reviews by programme board - Regular meetings and communication with all parties involved - Regular meetings and communication with all parties involved	

Action Plan				
Start Date	Action Details / Description	Owner	Reminder Date	Target Date
01/06/2020	To ensure the variation process does not cause delays to programme, regular reviews against programme of works are to be in place to ensure early initiation of variations	Colin Plant	25/06/2022	30/06/2022
15/06/2020	Continual review against design and clinical model to ensure adherence against programme is managed whilst Covid-19 guidelines are released accordingly	Debbie White	26/12/2021	31/12/2021
15/06/2020	Continual reviews as part of construction phases to ensure no additional work impacts on the overall programme such as mine shafts which commences Aug 20 and will be ongoing throughout the programme	Debbie White	27/05/2022	01/06/2022
01/06/2021	Complete latest indemnity letter for submission from the Trust to Walsall Hospitals Co (Project Co)	Russell Caldicott	26/08/2021	31/08/2021
10/05/2021	The Trust's Estate Strategy, Sustainable Development Management Plan and Premises Assurance Model are all to be updated and obtain Trust Board approval within 12 months	accommodation for services with the step change in demand expected in June 22 - obtain sign off of the Divisional Ward Reconfiguration in which will	provide the capacity across MLTC	
10/05/2021	Provide assurance that ED operation policy is in place and submit as part of the FBC approval conditions			
10/05/2021	review Generator and UPS requirements and provide assurance as part of FBC approval conditions that all can be supplied within the GMP			
10/05/2021	Provide assurance that the commercial elements of the project are incorporated into the GMP as part of FBC approval conditions			
13/10/2020	Review and redefine the commissioning programme to align the handover of			

Walsall Healthcare Risk Register

Russell Caldicott	05/05/2022	10/05/2022
Ned Hobbs	05/08/2021	10/08/2021
Russell	05/08/2021	10/08/2021
Caldicott	05/08/2021	10/08/2021
Russell	25/09/2021	30/09/2021
CaldicottKate		
Salmon		

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2245	The maternity inpatient service has a significant shortfall in registered midwives to support the delivery of care.	There is a high level of maternity leave within the maternity team, currently totalling 25.1% of registered midwives across all inpatient areas. When this is considered with the normal expected tolerance of 16% A/L which is essential for the health and wellbeing of staff a 3% tolerance for staff training. This is being further exacerbated by an increasing number of staff requiring to self-isolate or quarantine due to Covid-19 procedures. As a result of the above, there is growing concern about the ability to safely provide care across the inpatient team, including 1:1 care in labour, due to the lack of staff available to work.	Carla Jones-C harles	20	• Policy • Escalation policy • Process • Morning staffing review huddle where staff are reallocated to areas of need. • Process • Training requirements and delivery reviewed and streamlined where possible to reduce the amount of time required to complete mandatory training requirements. • Policy • Bank staffing service • Training • Secured agency midwives to support staffing at time of escalation or	• Daily Staffing huddles - Monitoring of acuity • Morning staffing huddles 3pm huddle • Matrons and Ward Manager update - Weekly performance meetings - Any changes to training is risk assessed based on training needs for individuals. • Morning staffing huddles 3pm huddles • Checked daily via acuity tool and monthly staffing reports • escalation papers to trust board	

Historically the service has been asked to maintain 10vacancies due to the planned closure of Foxglove ward and relating to a reduction

Walsall Healthcare Risk Register

planned limited staffing

Walsall Healthcare Risk Register

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

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

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

06/10/2020	Complete a review of none urgent activity and identify opportunities to undertake new ways of working to support care delivery.	Carla Jones-Charles	25/09/2021	30/09/2021
06/10/2020	Escalate to Executive via TMB and Monthly performance review to seek support to over recruit to manage staffing shortages in respoect of 5 yeartrajectory of significant numbers of maternity leave.	Carla Jones-Charles	26/08/2021	31/08/2021

23/03/2021	submitted paper to PFIC for approval	Carla Jones-Charles	Closed	25/04/2021	30/04/2021
06/10/2020	Request from Divisional Director of Midwifery to staff working part time to increase working hours to support the service during this period.	Carla Jones-Charles	Closed	24/03/2021	31/03/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2325	Incomplete patient health records documentation and lack of access to patient notes to review care. This is due to a known organisational backlog of loose filing and increased reported incidents of missing patient notes.	Potential for patient safety to be compromised as a result of delayed or inaccurate decision making from the inability to access all records. Potential risk to patient safety investigations i.e. Root Cause Analysis and delayed timeframes impacting the Division and organisation. Potential negative impact on patient/ service users in regards to the timely and effective investigation processes	Kate Salmon	16	• Process • Access Fusion for diagnostic/ clinical overview • Process • Incident reporting notes if unable to be located within a timely manner • Process • DoC Final Letters to be amended to acknowledge lack of access to patient notes or missing notes • Process • All investigations; TTR, Concise, RCA and complaints to be transparent in acknowledging missing notes or incomplete documentation with direct link with incident number	• • • • • •	
2398	Insufficient/ out-of-date equipment, utilised beyond its life cycle, has the potential to result in sub-optimal patient care.	Failure to identify, purchase and replace sufficient medical equipment has the potential to harm patients and impact staff negatively.	Jane Longden	12	• Process • Covid funding for medical equipment has secured equipment to date, including: Ventilators Patient monitors Critical care equipment • Process • Medical devices group established to	• The Estates Team along with Clinical Divisional Teams and Executive Sponsors have reviewed all medical equipment and risk rated them on the following basis; -Impact on service provision and the quality of care provided -Recommended year of replacement (expected lifecycle date) -Whether there is a maintenance contract in place -Equipment supported by manufacturer -Clinically fit for purpose -Replacement parts are available. The Trust has adopted a more commercial approach to leasing equipment to reduce capital outlay. Quarterly assurance reports to PFIC • • The Medical Director is taking up chairmanship of the medical devices	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					discuss upcoming purchases to determine funding, maintenance costs, consumable costs and options to procure via Purchase or leasing. • Process • Medical Equipment Lifecycle 5-year plan	group and reviewing terms of reference. • • Capital Controls Group PFIC QPES • CT scanner MRI - scanner - Inhealth Lease A significant proportion of imaging equipment is now leased reducing capital expenditure	
Action Plan							
Start Date	Action Details / Description				Owner	Reminder Date	Target Date
16/07/2021	Working with Michael Koushi to understand current view and creation of new risk in regard to capacity of workload as equipment has now been/is being procured through covid provision and capital programme.				Michael Koushi	29/07/2021	03/08/2021
03/08/2021	Critical Friend report has been received. Report will be reviewed and an action plan submitted for short/medium and long term objectives. Details in report to assist with the production for a business case.				Jane Longden	19/08/2021	24/08/2021
01/04/2021	Develop a business case to determine resource required to support the 5-year plan in terms of manpower required to maintain all assets.				Jane Longden	19/08/2021	24/08/2021
14/02/2021	Capital Control Group to approve 5-year Medical Equipment lifecycle plan				Jane Longden	Closed 26/03/2021	31/03/2021

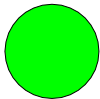
Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2430	Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record.	Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people. Over the last 2 years there have been a number of solutions proposed, however these have failed to gain momentum. This has left the service with a number risks which could result in a CQC inspection notice, as neither the current proposed solution for the legacy archive and the active Child Health Records (CHR) via the pre-existing CHR Project scope (2018	Mark Hulston	20	• Process • Digital Programme/EDMS plans articulated in Feb 21 by the Digital Programme team to introduce Mediview as a digitising of records solution instead of current plan under Folding Space were deemed as unviable by the Health Visiting and School Nursing services in a meeting on 18th Feb 2021. Mark Hulston has therefore submitted an escalation paper to Digital Programme board on 1st March 2021 regarding the future state and the Feb 2021 plan to drop Folding Space solution and transfer to FUSION via EPDR project. • BAF Control 01 • Child Health Records are currently held across various systems and in locations on service shared drives which prevent a clinician having access to the full child record. The way in which records are maintained falls short of the standard expected by the NMC, GMC. These multiple systems are taking time away from seeing and supporting children and young people. Over the last 2 years there have been a number of solutions proposed, however these have failed to gain momentum. This has left the service with a number risks which could result in a CQC inspection notice, as neither the current proposed solution for the legacy archive and the active Child Health Records (CHR) via the pre-existing CHR Project scope (2018 to date), nor the Feb 2021 proposed EDMS project additional scope will mitigate the CHR risk without a full consolidation of all records into a single solution. A May 2020 audit of additional child paper case note records, generated since the September 2019 when the	• The Digital Transformation Records Manager has escalated that the proposed solution under the EDMS Project will not mitigate the risks for the Trust and has asked for a meeting on Wednesday 24 March 2021 to discuss the outcome of the paper with the Head of Digital Transformation. • No agreed platform confirmed. • This work has been completed and while there's circa 40K outstanding files to be scanned these are not very large in size as identified by the low number of boxes storing these files. The original price fears have been alleviated with an estimated cost of around £25k -35k to scan the files. It's been identified that all the community projects require a joined up approach with a full deployment team as past projects have worked in isolation with limited resources resulting mixed results when looking at the Trust as a whole. The children's services area has a deadline of end of September to be completed • Its proposed a full project team is deployed to work with Children's Community and Community Paediatrics Services to maximise the potential for the use of the procured EDMS system as there is no longer a Child Health Informatics Service in the Trust (Staff were TUPED to NHS England in 2017). It was proposed at an executive level in QU 3 2020-2021 that the CHR be adopted and managed under the Health Records Library Service at the acute hospital. It needs to be stated this isn't	

Walsall Healthcare Risk Register

to date), nor the Feb

last digital upload completed, shows a fully defined solution within the EDMS



Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		2021 proposed EDMS project additional scope will mitigate the CHR risk without a full consolidation of all records into a single solution			that 40k of records are still left to be scanned and this project. This requires a detailed plan to map out a refreshed, best solution.	as it needs a Business Change analysis including the potential for procurement of new systems. The child health records are not yet in a state that can be passed over for management as proposed. The project management challenges facing this project are to implement the necessary technology within a timeline imposed so we are ready for future CQC inspections. Child Health Records have already been served with a recommendation in the 2018 Walsall Children's CQC inspection and report which needs auctioning prior to the next WHT CQC inspection. It cannot be emphasised enough how urgent the completion of these projects are to allow continued patient safety, data quality, clinical governance and staff retention.	

Action Plan						
Start Date	Action Details / Description	Owner		Reminder Date	Target Date	
02/08/2021	12 week action plan agreed - the ingestion of records in to folding space - which will mean all child health records will be visible on Fusion which will in turn reduce/mitigate the risk. All extraneous hard copy records within School Nursing and Health Visiting bases have been boxed and taken off site by supplier on 16th July 21.	Kelly Geffen		24/10/2021	29/10/2021	
02/08/2021	Ensure that while the 12 week plan is in progress, all current and new digital records are ingested directly on to Fusion. All extraneous hard copy records within School Nursing and Health Visiting bases have been boxed and taken off site by supplier on 16th July 21.	Kelly Geffen		24/10/2021	29/10/2021	
02/08/2021	To ensure Mediviewer is live for School Nursing to be able to undertake User Acceptance testing. Business change commenced Workshops with School Nursing and Health Visiting teams w/c 26th July 21 for potential migration to Total Mobile.	Kelly Geffen		11/08/2021	16/08/2021	
24/06/2021	£40K funding has been agreed by the Exec Team. Funding for historical - it was agreed at the Digital Transformation Meeting for Mark Hulston to complete a paper to detail the costing for the Child Health Records project. This will then be approved by the Exec Team.	Daren Fradgley	Closed	25/07/2021	30/07/2021	

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

		lth provider is often not appropriate to meet the complex needs of the CYP in crisis we see on the paediatric ward to assist us in maintaining patients safety. • Process • Not assured: Services are not	• Staff can challenge iCAMHS to provide further information in patient notes however, this will be dependent on their knowledge of gaps in care planning for mental health patients • • Senior nurses escalate throughout the organisation to highlight CYP	

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					commissioned to deliver therapy on the acute ward • Process • Escalation: The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads. • Process • Not assured: Access to places other than a hospital bed.	experiencing long stays. Weekly multi agency meetings have been set up to allow ward staff, senior nursing staff, CAMHS, Local Authority and the CCG to identify issues and obstacles. • The senior paediatric nursing team will liaise with the relevant team(s) on a daily basis to encourage and request a timely discharge from the acute paediatric unit. This will also include internal escalation to the Divisional team, the safe guarding team and our Paediatric Liaison Nurse/Paediatric Discharge Lead alongside external escalation to the necessary social care/CCG leads. • None • Meeting with the CCG Commissioner and key services on 16 March 2021 to start work on 'alternatives to hospital'.	

Action Plan					
Start Date	Action Details / Description	Owner		Reminder Date	Target Date
03/08/2021	Lead for Mental Health JK to devise an action plan and GAP analysis for the Executive lead for mental health to support an action plan for safe practice	Jodie Kirby		25/09/2021	30/09/2021
17/05/2021	Meeting held with NHSEI Quality Team on 17/5/21 to discuss (a) sharing best practice, (b) system escalation process. Further meetings to include lead CYP commissioner (Mags Courts) and BCH reps (e.g. Mark Weaver).	Matthew Lewis	Closed	12/05/2021	17/05/2021
28/04/2021	Divisional team to escalate to the corporate team as discussed in RME.	Louise Holland	Closed	23/05/2021	28/05/2021
12/07/2021	Clarification around expectations for transferring patients with previous clinical information from MH to ED.	Matthew Lewis	Closed	/ /	12/07/2021
16/07/2021	Medical Director - executive lead for mental health to escalate to NHSE and head of CCG regarding the impact and risk associated to WHT.	Matthew Lewis	Closed	/ /	16/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2475	The Mental Health Act (MHA) Code of Practice is not being applied in day-to-day practices for providing safeguards & protection for individuals who require mental health services.	The Trusts inability as a Mental Health (MH) provider to comply with its legal & moral responsibilities of the MH provider status, as well upholding the MHA Code of Practice, has the potential for: > Individuals who require mental health services to; - o Not be effectively or safely treated which could ultimately lead to a lack of appropriate admission for individuals in need of urgent care/an increase in avoidable harm, - o Not have their civil rights upheld as patients may be detained illegally (due to no section/appropriate beds), > Staff; - o To face verbal abusive, physical violence, & aggression, resulting in emotional distress &/or physical injuries, - o To treat individuals unlawfully without such	Jodie Kirby	25	• Staffing Resource - To ensure that MH services within the Trust meet our strategic objectives. • 3 year MH Strategy underdevelopment to include longer term strategic objectives. This includes the identification of additional MH trained resource required. knowledge, due to		

Walsall Healthcare Risk Register

Standard MH Training - To ensure that all policy & processes

changes have been captured, so that training material is up to date & reflects the current processes.

A review of the Standard MH Training is conducted by the MH Reporting Administrator/Manager [job title TBC] at least once annually (or less than when there have been amendments made to the MHA or CQC MH Legislations), to ensure it meets the requirements within the most up to date MHA Code of Practice & CQC legislations. Any amendments required as per the review process will go through the RACI Model (Responsible, Accountable, Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. This may require additionally Ad-hoc Training to cover changes made. Evidence of this is stored [location] of the actions taken.

Standard MH Training Reporting - To ensure all staff have accessed the Standard MH Training & that they go through refresher training schedules at least yearly.

On a monthly basis the MH Reporting Administrator/Manager [job title TBC] reconciles the list of all staff required to complete the Standard MH Training within each relevant ward, against the

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
					Consulted, Informed) to be updated, receive full sign off & be communicated out to all the relevant areas. Evidence of this is stored [location] of the actions taken. • Local Reporting - To ensure daily MH admissions are recorded & reported accurately. On a daily basis when the Matrons conduct their ward visits, they record if anybody have been detained or admitted under the MHA. Where records identify this finding, this data is passed to MH Reporting Administrator/Manager [job title TBC] [Further detail required - To understand where we have patients on a 5-2 or a 17 leave. Who, what, when, how, why, exceptions, evidence]. • External Reporting - To ensure quarterly MH admissions are recorded & reported accurately. On a quarterly basis the MH Reporting Administrator/Manager [job title TBC] will conduct validation checks to ensure that the MH admissions recorded across the Trust mirrors up with [further detail required - To manage & monitoring the MH data for audit purposes to be sent to CQC quarterly. Who, what, when, how, why, exceptions, evidence].		
Action Plan							
Start Date	Action Details / Description				Owner	Reminder Date	Target Date
08/06/2021	JK has escalated to Exec level and discussed options to collate the information.				Jodie Kirby	25/09/2021	30/09/2021
	To have an agreed and embedded process for reporting and auditing all the Mental Health Act detentions that happen within WHT.						
31/05/2021	Lead Nurse for Mental Health and the OPMHLT are developing mental health act awareness training and this will be rolled out over a period of several weeks.				Jodie Kirby	26/08/2021	31/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		This will be for staff at all levels across the trust . Training dates will commence from June 2021.					
12/05/2021		Lead Nurse for Mental Health will review the policy and escalate to exec level the difficulties in access to the MHA administrator - for joint update of the policy.	Jodie Kirby			26/08/2021	31/08/2021
		Plan to work with RWT to review MHA policy.					
08/06/2021		To complete a review of the MHA SLA and governance process that WHT are responsible for .	Jodie Kirby			25/09/2021	30/09/2021
		To feedback to the Executive lead for mental health the suggested staffing / resource required to ensure the MHA code of practice is adhered to and the MHA law is upheld. Escalated to Steering group to resolve and progress on 26/7/21					
08/06/2021		We have identified 11 policies out of date as follows:- -Mental Health Policy (inc px search) - in progress, draft due August -Transport Policy - in progress, draft due August -Violence and Aggression - Draft complete and going through approval process - should be finalised and published end of August -Rapid Tranquilisation - in progress, draft due August -Transgender - in progress, draft due August -136 MHA Policy (STP Wide) -Escalated to Steering group, in the interim T&F grp working on a SOP -draft due end of August -Psychiatric inpatients services- in progress, draft due August -Enhanced System Policy -- Draft complete and going through approval process - should be finalised and published end of August -Clinical Super vision - in progress, draft due August -MHA Administration Policy - in progress, draft due Sept/Oct following apt of MHA Administrators -Ligature - Draft complete and going through approval process - should be finalised and published end of August	Jodie Kirby			Closed 22/08/2021	27/08/2021
25/05/2021		To update the incident report system safeguard to enable Mental Health incidents to be coded correctly, this will allow WHT to generate reports and have a clear picture of MH incidents trust wide.	Jodie Kirby			Closed 22/08/2021	27/08/2021
08/02/2021		The SLA agreement needs to be within the 1 hour response time for MH patients, at present due to insufficient staffing levels within MHLS. 29/7 - escalated SLA issues to the Steering group to progress on 26/7. Also escalated to CQRM week before. MH team will be presenting the external blockers at this meeting in September	Matthew Lewis			Closed 12/09/2021	17/09/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
04/07/2021		WHT must have access to ligature cutters, training and process/ policy to support staff in the event that ligature cutters would be required. 29/7 - ligature cutters ordered and training video to be uploaded to e learning -			Jodie Kirby	Closed 08/08/2021	13/08/2021
08/06/2021		It was agreed through the patient safety group that funding would be provided for appropriate training for security and staff.			Jodie Kirby	Closed 25/08/2021	30/08/2021
22/06/2021		To Review the increase in CAMHS/LD admissions and identify the risks . Lead for Mental Health to devise and action plan and a GAP analysis to the Executive Lead for mental health to support an action plan for safe practice.			Jodie Kirby	Closed 26/08/2021	31/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2489	Poor colleague experience in the workplace	A significant loss of workforce diversity, talent, productivity and retention arising from poor colleague experience which prevents staff from reaching their potential and being their best selves at work (reduction in effort above and beyond contractual requirements), lack of opportunity to develop and progress, not feeling safe due to unacceptable behaviours such as racism, bullying and harassment, workforce fatigue and not valued for the incredible job that they do and therefore not recommending the trust as a place to work or a place to be treated.	Clair Bond	16	• BAF Control 04 • Value Our Colleagues Improvement Programme in place - workstreams based around three core domains; (i) leadership, culture and organisational development, (ii) organisational effectiveness and (iii) making Walsall and the Black Country the best place to work. • BAF Control 04 • A Staff Experience and Engagement Oversight Group has been established to provide assurance to PODC on behalf of the board re; staff engagement processes/systems, shared decision making councils, involvement of diversity in decision making, increasing staff survey participation levels. • Policy • Equality, Diversity and Inclusion Strategy in place supported by detailed 9 point delivery plan.	• monitored via PODC, Improvement Board and VOC Core Team. Core set of measures from base line year 2019, foundation year 2020 through to 2022/23. - Accountability Framework and Divisional Performance reviews • National Staff Survey WRES, WDES indicators CQC assessment / rating • Terms of Reference agreed. Outputs monitored via PODC on a monthly basis - divisional leaders present NSS action plans. Action Plan in place 2021 Pulse Survey completed. • National Staff Survey (2021) WRES, WDES, Gender Pay Gap report • Equality, Diversity and Inclusion Group to monitor progress against delivery plan on a monthly basis and report to PODC on a quarterly basis. • Legal duties in line with Public Sector Equality Duty 2011 and Equality Act 2010. - WRES, WDES and Gender Pay Gap reports • Lead Non-executive director. Regular access to Exec Team and Board 1/4ly reports to PODC and Board re F2SU activity - Operational support in place - Confidential Contact Link network established across the Trust - Speak Up training available for all staff to access. - Improvement plan monitored via PODC and Improvement Board. • Development of service supported by NHSIE and NGO - F2SU index available from NSS	

Action Plan

Start Date	Action Details / Description	Owner	Reminder Date	Target Date

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
11/05/2021		NHSIE funding secured in partnership with DHIC for 2 x cohorts of 15 colleagues (May and October 2021) for in depth training re RJLC. Once May cohort complete, leadership development module to be introduced for all leaders to attend.	Clair Bond			26/10/2021	31/10/2021
05/05/2021		Employment Relations and F2SU data will be triangulated with core People metrics.	Clair Bond			25/09/2021	30/09/2021
04/05/2021		Pulse survey to b distributed in May 2021 and results reported and reviewed in June 2021.	Marsha Belle			Closed 25/06/2021	30/06/2021
09/05/2021		RWT colleagues leading a series of conversations to engage staff to reflect on colleague experience (what works well and what could be better), career progression and HWB.	Catherine Griffiths			Closed 25/07/2021	30/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2512	Walsall Healthcare NHS Trust failure to meet Paediatric Diabetes	Paediatric Diabetes Best Practice Tariff is based on meeting 14	Stephen Jackson	16	• Process • Annual PIED assessment completed for each patient over 8 years of age.	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register.	
	Best Practice Tariff Standards	specific quality standards ensuring children and young adults with diabetes are receiving effective and responsive care. WHT have been receiving funding for best practice tariff which has been managed through Division of Women and children's. Diabetes services (which includes 2 paediatric diabetes nurses) were transferred to Community Division during 2019 therefore this risk is cross divisional. Funding is based on number of children under WHT care i.e. each patient receives a contribution of £3034 per year.Based on 2018/19 NPDA data 171 patients were			• Process • Monthly meetings with CAMHS psychiatrist consultant for supervision	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register.	• Not applicable
					• Process • CAMHS referral for patients is possible.	• To be discussed at Risk Management Executive with a view to escalating to the Corporate Risk Register.	• Not applicable.
					• Process • September 2020 Benchmarking exercise completed against the 14 Paediatric best practice standards	• Escalated to senior management teams and identified requirement to update current business case and resubmit to TMB • WHT has funded membership through Community Division to Regional Children's and Young Peoples network	to help support Trust to meet standards
					• Process • Discussed at Risk Management Executive for consideration of risk to be escalated to Corporate.	• Agreed at Risk Management Executive on 15 February 2021 for risk to be escalated to the Corporate Risk Register.	• Not applicable
					• Process • Paediatric National Peer Review completed in Walsall resulting in a serious concerns letter being presented to the Executive Team. This letter highlights gaps within the Trust which the business case aims to resolve.	• Action Plan has been completed, rag rating all gaps highlighted within the Peer Review and plans in place to improve with current resources available, however approval of the business case is required to meet all of the BPT Standards and Quality Peer Review Metrics.	• The Royal College of Paediatrics and Child Health issued their serious concerns communication on the 4 Jan 2021 and will be requesting an up date

Walsall Healthcare Risk Register

receiving care
therefore the funding

of progress imminently.

for BPT would be
£518,814 per annum.
Benchmarking against
the standards has
been completed and



Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		is attached to this risk. The 10 standards WHT are not meeting pose significant patient safety risks to this vulnerable population. Risks include lack of psychology for children who are struggling to come to terms with their LTC, lack of dietetic capacity, lack of consultant capacity to cover MDT and on call out of hours. A general gap in out of hours on call cover and very limited capacity in transitional management of patients from age of 16 - 19 years. This being a particularly vulnerable stage in their lives where young adults often do not cope with their diabetic control increasing their risk of serious short and long term complications which can have life limiting outcomes.					

05/07/2021 To recruit the following:

Daren Fradgley

25/09/2021

30/09/2021

Walsall Healthcare Risk Register



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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		- 0.6 WTE Band 8A Clinical Psychologist - 0.5 WTE Band 6 Dietician - 1 WTE Transition Nurse - Administration					
01/06/2021		To continue driving quality improvement in the areas the Trust is not fully compliant and through RCPCH quality review and also benchmarking best practice standards. See attached action plan and benchmarking document.			Daren Fradgley	24/07/2022	29/07/2022

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2540	Risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems	There is a risk of avoidable harm going undetected to patients, public and staff as a result of ineffective safeguarding systems. Ineffective safeguarding systems include: Safeguarding identified as a theme of concern in CQC reports with Section 29a notice and must do actions Staff ability to recognise, report and escalate actual or potential safeguarding concerns Low levels of Level 3 safeguarding training Low levels of adult safeguarding referrals from Trust in Local Authority CCG and CQC report no assurance of learning from safeguarding incidents due to repeated themes in incidents requiring independent investigation	Jennifer Robinson	16	• Process • The safeguarding adults policy supports staff in safeguarding practice by the recognition and referral of any safeguard concerns that staff encounter in the practice. • Training • Training compliance for level 3 safeguarding adults is below the expected performance compliance. Training is delivered monthly- (2or 3 sessions) delivered via teams. These are reviewed by the Divisions • Process • The external concerns received have identified some emerging themes which cannot provide assurance that ward / departments have implemented actions agreed as part of their feedback reports	• safeguard system used to record safeguarding related incidences monthly reporting commenced to the Divisions • Reporting through safeguarding committee • weekly training compliance reports received • escalation reports to safeguarding committee • safeguarding bespoke training as required • Monthly CQR provides an element of scrutiny • safeguarding performance framework development and reporting quarterly to the CCG • CCG assurance of quality of L3 training • weekly training compliance reports are received from workforce intelligence • The Divisional leads are required to report monthly through safeguarding committee regarding training compliance and actions taken to improve compliance • reporting through CQR • Safety briefings completed and disseminated across the teams to reinforce emerging themes and compliance with policy • LA monitoring number, appropriateness and quality of Safeguarding concerns received from WHT	

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

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
12/07/2021	schedule of be- spoke sessions to wards / department				Jennifer Robinson	26/08/2021	31/08/2021
12/07/2021	Delivery of Level 3 Safeguarding adults training				Jennifer Robinson	25/09/2021	30/09/2021
12/07/2021	revise training to reinforce emerging themes from concerns raised continue to develop safeguarding briefings as necessary				Jennifer Robinson	26/08/2021	31/08/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2581	Internal risk for patients awaiting Tier 4 hospital admission	WHT ability to support and manage any CYP awaiting a tier 4 admission. An increase in CYP in crisis within paediatrics which results in a failure to process and manage patient safety through the patient journey. 1) There is no provision of mental health training to ward staff but a misplaced conception that the staff at WHT are trained to meet the needs of CYP in crisis. 2) There is no access to mental health support or advice out of hours 3) There is no access to Paediatric psychiatry out of hours 4) There is restricted access to iCAMHS services with referrals being accepted 8am-4pm Mon-Fri and 8am-3pm weekends/bank holidays 5) The service received in WHT from our mental health	Jodie Kirby	15	• Training • Staff to have the required knowledge to manage mental health patients who are awaiting tier 4 admission. Staff to have the knowledge to understand and utilise the mental health act appropriately. • Process • To abide by the mental health act and uphold patient section 132 rights . To be able to utilise section 5(2) appropriately and lawfully. • Process • For patients to have a mental health assessment within ED or PAU to avoid admission to the paediatric ward. This will enable an appropriate assessment and diversion from the acute hospitals to link in with CAMHS community. • Process • For patients who are admitted to the ward to be supported by discharge planning at the point of admission. For patients to receive appropriate assessment, MDT working that is conducive for proactive discharge approaches.		

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		provider is not appropriate to meet the complex needs of the CYP in crisis we see on the paediatric ward. There is no detailed/shared risk assessments from iCAMHS and often no detailed plans of care to support non-mental health staff 6) There are often delays in discharge whilst discussions, assessments, reassessments and reviews (such as CTR's) are undertaken between social care and mental health. These delays often span into weeks and the CYP is kept on the ward with little engagement or therapeutic support from other agencies which contribute to deteriorations in behaviours. This is not in the CYP's best interest and is detrimental to their health and wellbeing. 7) There are often elongated periods of time between the decision to transfer the CYP into foster					

Walsall Healthcare Risk Register

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

Walsall Healthcare Risk Register

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

admission, or discharge to the community with appropriate sign posting and mental health service follow up in place.

Action Plan							
Start Date	Action Details / Description			Owner		Reminder Date	Target Date
12/07/2021	staff to have a training plan for mental health awareness			Jodie Kirby		26/08/2021	31/08/2021
12/07/2021	For staff to have mental health act training and de-escalation training (IKON)			Jodie Kirby		26/08/2021	31/08/2021
12/07/2021	Staff required to facilitate admission avoidance and to complete mental health assessments within ED and PAU, to support patient discharge.			Jodie Kirby		26/08/2021	31/08/2021
12/07/2021	Senior CAMHS staff member required to work with the paediatric department to focus on planning for discharge on arrival, care planning, risk management and wider patient discharge MDTs.			Jodie Kirby		26/08/2021	31/08/2021
29/07/2021	For lead nurse for mental health to agree a protocol and pathway for ED and nursing staff to understand section 136 for CYP.			Jodie Kirby		/ /	16/07/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2587	Not having sufficient staffing levels available to support the release for fit testing in line with Control of Substances Hazardous to Health Regulations 2002 (COSHH) requirements & Department of Health & Social Care (DHSC) resilience principles & performance measures, to protect staff from harmful substances (e.g. COVID-19).	The Trust does not have sufficient staffing levels available to fully support the necessary capacity of required staff that are undertaking aerosol-generating procedures (AGP) or present within the area where AGP's are taking place, for the release of fit testing in a timely manner (30 minutes if they pass first time, 60 minutes+ for retests). This leads to an increase of staff being at harm to substances (e.g. COVID-19), due to not having availability to be fit tested for sufficient respiratory protective equipment (RPE; disposable FFP3 respirators, reusable FFP3's, PAPR devices) on at least two different masks (ideally three following updated resilience principles & performance measures from the DHSC), that would reduce the dependency on one mask & reduce the	Lisa Carroll	20			

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
		risk of skin damage & other conditions linked to extended PPE use, whilst allowing users to build familiarities with several types of RPE. > Patients & Staff Risk - Of developing disease as a result of inhalation of harmful substances, disease spread, associated illness, skin damage &/or other conditions, mortality. > Trust Risk - Of depleted staffing numbers as a result of high sickness absence & associated reliance on bank/agency staff. Failure to meet COSHH requirements & DHSC performance measures resulting in Regulatory scrutiny & punitive action. Increased risk of liability claims & dissatisfaction as a result of failing to adequately protect staff/patient health.					
Action Plan							
	Start Date	Action Details / Description			Owner	Reminder Date	Target Date

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
16/07/2021		Develop an implementation plan to increase the number of masks an individual is fit tested too & ensure the different masks are available to the user to wear interchangeably.			Ann-Marie Cannaby	26/10/2021	31/10/2021
16/07/2021		Support a fit testing solution plan to enable all existing staff & new staff who will be users of FFP3s, to be released for fit testing.			Ann-Marie Cannaby	26/10/2021	31/10/2021

Walsall Healthcare Risk Register

Risk	Risk Title	Risk Description	Risk Assessor	Current Risk	Controls	Assurances	Review Status
2610	There are no ligature cutters in WHT or community sites, this is a national safety requirement for the NHS.	WHT must have access to ligature cutters, training and process/policy to support staff in the event that ligature cutters would be required.	Jodie Kirby	25	• Policy • Ligature cutter policy is currently out for comments • Physical Barrier • Ligature cutters have been ordered use until ligature cutters arrive andand delivery is awaited - Delivery expected by the end of this week (9.8.21)	• Policy has been written and is following correct trust process for sign off • • Tough cuts are available for staff to use until ligature cutters arrive andand correct training has been provided •	
Action Plan							
Start Date	Action Details / Description				Owner	Reminder Date	Target Date
02/08/2021	Ligature policy has been written and is currently in the ratification process - Once ratified, to roll out to all staff across WHT and Community				Jodie Kirby	25/09/2021	30/09/2021
02/08/2021	Training package to be agreed and added to ESR for staff - This will be a mandatory requirement for all staff				Jodie Kirby	25/09/2021	30/09/2021
02/08/2021	Once ligature cutters have been delivered - each clinical area is to be provided with a safe box (this includes a metal glove and x2 sets of ligature cutters) adhering to national standards				Jodie Kirby	25/09/2021	30/09/2021